

No. _____

IN THE
SUPREME COURT OF THE UNITED STATES

JAMAAL HOWARD,
Petitioner,

v.

TEXAS,
Respondent.

On Petition for a Writ of Certiorari
to the Texas Court of Criminal Appeals

APPENDIX TO PETITION FOR A WRIT OF CERTIORARI

**THIS IS A CAPITAL CASE
EXECUTION SCHEDULED FOR OCTOBER 7, 2026**

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Appendix A



**IN THE COURT OF CRIMINAL APPEALS
OF TEXAS**

NO. WR-77,906-02

EX PARTE JAMAAL HOWARD, Applicant

**ON APPLICATION FOR POST-CONVICTION WRIT OF HABEAS
CORPUS AND MOTION TO STAY EXECUTION
FROM CAUSE NO. 15114-B IN THE 356TH DISTRICT COURT
HARDIN COUNTY**

Per curiam.

ORDER

We have before us a subsequent application for a writ of habeas corpus filed pursuant to the provisions of Texas Code of Criminal Procedure Article 11.071 § 5 and a motion to stay Applicant's execution.¹

In April 2001, a jury convicted Applicant of capital murder for the May 2000

¹ All references to "articles" in this order refer to the Texas Code of Criminal Procedure unless otherwise specified.

murder of a store clerk committed during the course of a robbery. *See* TEX. PENAL CODE § 19.03(a). Based on the jury’s answers to the special issues submitted under Article 37.071, the trial court sentenced Applicant to death. This Court affirmed Applicant’s conviction and sentence on direct appeal. *Howard v. State*, 153 S.W.3d 382 (Tex. Crim. App. 2004).

Howard filed his initial post-conviction application for writ of habeas corpus in the convicting court in April 2003, and this Court denied relief in 2012. *Ex parte Howard*, No. WR-77,906-01 (Tex. Crim. App. Dec. 12, 2012) (not designated for publication).

On September 28, 2026, Applicant filed in the trial court this, his first subsequent writ application. Therein, he raises a single claim that he is intellectually disabled and, therefore, constitutionally exempt from execution.

We have reviewed the application and find that Applicant has failed to show that his allegation satisfies the requirements of Article 11.071 § 5. Accordingly, we dismiss the application as an abuse of the writ without reviewing the merits of his claim. *See* Art. 11.071 § 5(c). We deny Applicant’s motion to stay his execution.

IT IS SO ORDERED THIS THE 5th DAY OF OCTOBER, 2026.

Do not publish

Appendix B

15114B

**IN THE 356th JUDICIAL DISTRICT
OF HARDIN COUNTY, TEXAS
and**

**IN THE COURT OF CRIMINAL APPEALS OF TEXAS,
IN AUSTIN, TEXAS**

**Ex parte
Jamaal Howard,**

Applicant

**Trial Court Cause
No. 15,114-B**

CCA Cause No. WR-77,906-02

**SUBSEQUENT APPLICATION FOR
POST-CONVICTION WRIT OF HABEAS CORPUS**

**This is a death penalty case. Mr. Howard is scheduled to be
executed on Wednesday, October 7, 2026, after 6:00 p.m.**

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**IN THE 356th JUDICIAL DISTRICT
OF HARDIN COUNTY, TEXAS
and**

**IN THE COURT OF CRIMINAL APPEALS OF TEXAS,
IN AUSTIN, TEXAS**

**Ex parte
Jamaal Howard,**

Applicant

**Trial Court Cause
No. 15,114-B**

CCA Cause No. WR-77,906-02

**SUBSEQUENT APPLICATION FOR
POST-CONVICTION WRIT OF HABEAS CORPUS**

I. Introduction

Applicant, Jamaal Howard, an inmate confined at the Allan B. Polunsky Unit of the Texas Department of Criminal Justice, Correctional Institutions Division, TDCJ #999383, under sentence of death, brings this Subsequent Application for Post-Conviction Writ of Habeas Corpus. Applicant alleges that he suffers from intellectual disability and his execution is thus prohibited by the Cruel and Unusual Punishment Clause of the Eighth Amendment and the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution.

Because this is the first time Howard has sought habeas relief from this Court since 2003 (fourteen years before the Supreme Court issued its opinion in *Moore v. Texas*, 581 U.S. 1 (2017)), Howard respectfully asks this Court to find his claim satisfies section 5(a)(1) of article 11.071 of the Texas Code of Criminal Procedure. Howard raised a claim pursuant to *Atkins* in his initial application (and also on direct appeal), and this Court relied on the factors announced in its opinion issued in *Ex parte Briseño*, 135 S.W.3d 1 (Tex. Crim. App. 2004), in denying Howard relief.

In addition to being intellectually disabled, Howard suffers from a schizoaffective disorder and attention deficit hyperactivity disorder. As is more thoroughly discussed below, the interplay between these mental illnesses and his intellectual disability made it difficult for Howard's previous attorney (who represented him during his federal habeas proceeding before the federal district court) to raise an *Atkins* claim on his behalf in either the federal district court or this Court. Specifically, the experts working for Howard's previous attorney believed it would be difficult to argue the deficits in Howard's adaptive behavior they observed from around the time Howard was sixteen were due to intellectual disability

and not the emergence of his mental illness (which occurred around that time). However, as this Court has recognized, the DSM-5-TR (published five years after Howard’s previous attorney decided an *Atkins* claim was not then-feasible) no longer requires a diagnostician find the deficits in a person’s adaptive behavior they observe to be directly related to intellectual disability and not a mental illness. *Ex parte Mays*, 686 S.W.3d 745, 748 n.5 (Tex. Crim. App. 2024).

As this Court is aware, the removal of the so-called “relatedness” requirement is not the only change recently made to the clinical definition of intellectual disability. This Court has recognized that the 12th edition of the American Association on Intellectual and Developmental Disabilities Manual (“AAIDD-12”) expanded the developmental period to include the time from a person’s birth until he reaches 22 years of age. *Ex parte Estrada*, No. WR-53,499-02, 2025 WL 1122323, at *1 n.2 (Tex. Crim. App. Apr. 16, 2025). While in *Estrada*, this Court left open the question of whether it would similarly expand the developmental period when considering *Atkins* claims, Counsel respectfully suggest this proceeding is the one in which this Court should adopt the AAIDD’s change, or, in the alternative, set the issue

for submission after staying Howard's execution.

As is more thoroughly discussed below, adopting the AAIDD's change will give this Court access to evidence of Howard's adaptive deficits which is of the sort Counsel believe this Court will find to be more reliable than the other evidence available. Specifically, the transcript of Howard's trial contains evidence of deficits in his adaptive behavior from the time that he was 20-21. This testimony was given by people who had sworn to tell the truth and who had no incentive for perjuring themselves by exaggerating his adaptive deficits because their testimony was given a year before the Supreme Court issued its opinion in *Atkins*. The trial testimony about Howard's behavior when he was 20-21 is consistent with that contained in the declarations attached to this application, gathered by previous counsel when she was contemplating raising an *Atkins* claim and dealing with Howard's behavior before he turned 18. In other words, the trial testimony about when Howard was 20-21 confirms the deficits in his adaptive behavior, which began by the time he was 16, continued. The AAIDD-12 explains the organization does not anticipate its change to the age of the developmental period will have any impact on prevalence rates because the overwhelming

number of people who are diagnosed as being intellectually disabled begin exhibiting adaptive deficits in early childhood. That will continue to be the case. This change enables a more accurate diagnosis of the small percentage of individuals who, like Howard, are identified nearer the end of the developmental period. While Howard's deficits emerged before he turned 18, neuropsychologists believe accurate diagnosis requires being able to observe adaptive deficits at multiple points in the developmental period.

Counsel suggest that even if this Court opts not to adopt the AAIDD's change to the developmental period, the evidence contained herein makes a prima facie case that Howard is intellectually disabled and believe it would be appropriate for this Court to stay Howard's execution and remand his *Atkins* claim to the trial court for further development. However, if this Court adopts the AAIDD's change and allows itself to consider testimony from Howard's 2001 trial that confirms the deficits in his adaptive behavior, which began when he was around fifteen years of age, continued, Counsel argue it is beyond question that Howard's claim, at a minimum, makes this threshold showing.

II. Relevant facts and procedural history

A. The homicide and subsequent arrest

On May 12, 2000, a co-worker discovered Vickie Swartout's body at the gas station where both worked in Silsbee, Texas. 20 R.R. 25.¹ The store's security camera recorded Ms. Swartout's being shot by a young Black man, who was quickly identified as Jamaal Howard. 20 R.R. 20, 25, 42-45.

Shortly after the murder, a local resident saw Howard coming out of a shed where the gun used to kill Ms. Swartout was later found. 20 R.R. 33, 53, 60. The man described Howard as looking nervous and visibly shaking, with eyes that looked wild, glazed over, and teary. 20 R.R. 37, 142. Law enforcement officers soon responded to the house where Howard lived with his grandfather and found Howard hiding in a vacant house next door to his house. 20 R.R. 119-20.

Howard was arrested and taken to the Silsbee Police Department where he was interrogated by a Texas Ranger and soon confessed. 20 R.R. 122-26.

¹ Citations to the Reporter's Record of Howard's 2001 capital murder trial appear herein as [volume number] R.R. [page number].

B. Trial

Because a question had been raised as to whether Howard was competent to stand trial, prior to the commencement of the trial, the court appointed psychologist James Duncan, Ph.D., to evaluate Howard's competency to stand trial. 1 C.R. 126-28.² As part of his work, Duncan administered the verbal portion of the WAIS-R to Howard in March 2001. Exhibit 1. Duncan believed Howard's IQ to be somewhere between 65 and 70. Exhibit 1.

At trial, Duncan testified as the first witness for the defense, and, consistent with his belief that Howard's IQ falls between 65 and 70, Duncan testified that Howard's intellectual functioning was at "a borderline to mildly impaired kind of level." 21 R.R. 26. Regarding his opinion about whether Howard was competent to stand trial, Duncan now testified he believed it was questionable. 21 R.R. 42.

Counsel for both sides agreed that because Duncan's testimony had raised a question regarding whether Howard was competent to stand trial,

² Citations to the Clerk's Record of Howard's 2001 trial appear herein as [volume number] C.R. [page number].

the court should recess the trial and convene a competency trial before a separate jury. 21 R.R. 45-51. That jury deadlocked, and the court declared a mistrial. 30 R.R. 36-37. A second competency trial resulted in a finding that Howard was competent, and the guilt phase resumed. 32 R.R. 134, 137. The jury rejected Howard's insanity defense and convicted him of capital murder. 24 R.R. 53-54.

Fred Fason, M.D., who was employed by Howard's trial attorney to evaluate Howard to assist in determining whether he was competent to stand trial, testified during the punishment phase of trial. Fason testified that he attempted to administer a psychological inventory known as the MMPI-2 to Howard but was forced to abandon the attempt because Howard could not read at the sixth-grade level the test requires; Howard did not know the words "mechanics" or "appetite" in the first two questions. 26 R.R. 22; *see also* S.H.C.R. 125.³ Fason testified that at that point the question of whether Howard is intellectually disabled "really entered my mind." 26 R.R. 22. The jury answered the special issues in favor of death, 27 R.R. 57, and the court

³ Cites to the main volume of the State Habeas Clerk's Record appear herein as S.H.C.R. [page number]. Cites to the supplemental volume appear as Suppl. S.H.C.R. [page number].

sentenced Howard to death.

C. Direct appeal and state habeas proceeding

Even though direct appeal counsel filed Howard's direct appeal brief eight days before the Supreme Court issued its opinion in *Atkins v. Virginia*, 536 U.S. 304 (2002), the second point of error raised in the brief was that it violated the Eighth Amendment's prohibition against cruel and unusual punishment to execute an intellectually disabled defendant.

On October 13, 2004, this Court issued its opinion affirming Howard's conviction and sentence. Applying the framework it had announced only months earlier in *Ex parte Briseño*, 135 S.W.3d 1 (Tex. Crim. App. 2004), the Court acknowledged that "experts for both the State and the defense testified that the appellant's intellectual functioning and adaptive behavior were impaired to some degree," but held that the testimony "was not sufficiently developed to establish that appellant was" intellectually disabled "under the guidelines we set in *Briseño*." *Howard v. State*, 153 S.W.3d 382, 386-87 (Tex. Crim. App. 2004). The Court noted that evidence of adaptive behavior was presented at trial, including Howard's lack of attention to personal hygiene, but also noted that it was presented by

defense counsel at trial as evidence that Howard suffers from a schizoaffective disorder. *Id.* at 387. *But see Ex parte Mays*, 686 S.W.3d 745, 748 n.5 (Tex. Crim. App. 2024) (acknowledging that the DSM-5-TR has removed the “relatedness” requirement from its criteria required for a diagnosis of intellectual disability). The Supreme Court subsequently denied Howard’s petition for a writ of certiorari. *Howard v. Texas*, 546 U.S. 1214 (2006).

Howard’s initial state habeas counsel filed his initial application for a writ of habeas corpus in the trial court on April 24, 2003. S.H.C.R. 21. Its first claim for relief alleged that Howard’s execution would run afoul of the Supreme Court’s decision in *Atkins*. S.H.C.R. 25-35. No evidentiary hearing was held, and the application contained no expert or lay declarations and no new testing. Counsel simply attached as an exhibit to the application Fason’s 2001 letter to trial counsel recommending someone administer a WAIS to Howard so his intellectual functioning could be assessed. S.H.C.R. 125.

More than nine years later, on June 15, 2012, the convicting court signed the State’s proposed findings, which found that Howard’s “intellectual functioning and behavior are impaired to a slight degree” but

“do not rise to the level of” intellectual disability. Suppl. S.H.C.R. 21-22, 38.

This Court adopted those findings and denied Howard relief on December 12, 2012. *Ex parte Howard*, No. WR-77,906-02, 2012 WL 6200688 (Tex. Crim. App. Dec. 12, 2012). In so doing, the Court adopted the trial court’s apparent belief that the deficits in Howard’s adaptive behavior stemmed from his ADHD and his inconsistent use of medication to treat the disorder, and not intellectual disability. Suppl. S.H.C.R. 3 (“Applicant began as a bright student in school, but suffered from attention-deficit disorder, which responded well to medication. . . . Applicant’s grades and behavior declined when he refused to take [his] medication for attention-deficit disorder.”).⁴

D. Federal habeas proceeding

Howard timely filed his federal petition for writ of habeas corpus on December 12, 2013. *Howard v. Stephens*, No. 1:13-cv-256 (E.D. Tex. Dec. 12, 2013), ECF No. 16. Ground seven in the initial petition alleged that Howard is ineligible for execution because of intellectual disability. The district court authorized funding for a mitigation specialist and for three experts, including

⁴ This was the view of Dr. Edward Gripon, who testified at trial for the State. 26 R.R. 101-02. Gripon believed Howard suffers from antisocial personality disorder. 26 R.R. 109.

Richard O. Temple, Ph.D., a neuropsychologist. ECF No. 97 at 3. On March 6, 2017, Dr. Temple administered a WAIS-IV to Howard and found his full-scale IQ to be 74, meaning he was 95% confident Howard's IQ is somewhere between 70 and 79. Exhibit 2. As Temple's report makes clear, he believed Howard satisfied both the first and third prongs of *Atkins*.

Dr. Temple's report also explains that a formal assessment of Howard's adaptive behavior was beyond the scope of his work, and that another expert was going to handle that portion of Howard's evaluation. The expert charged with assessing whether Howard satisfied the adaptive prong of *Atkins* was Dr. James Patton. During Howard's federal habeas proceeding, Dr. Patton was not able to find Howard satisfied *Atkins*'s adaptive deficit prong, and Howard's then-attorney⁵ abandoned the claim in the amended petition. The Fifth Circuit denied Howard a certificate of appealability.

Howard v. Davis, No. 19-70018 (5th Cir. May 11, 2020). The Supreme Court denied certiorari on January 11, 2021.

⁵ Neither Attorney Bailey nor Attorney Newberry represented Howard during his federal habeas proceeding in the district court. Mr. Bailey was appointed to represent Howard in the U.S. Court of Appeals for the Fifth Circuit after he had been denied relief in the district court, and Newberry was subsequently appointed as co-counsel after certiorari had been denied.

Counsel have attached as Exhibit 3 to this Application a document which undersigned counsel have confirmed Dr. Patton created for Howard's federal habeas attorney. The document makes clear Dr. Patton believes there were significant deficits in Howard's adaptive behavior by the time he was 16 but believed the deficits he observed were related to the emergence of Howard's severe mental illness and not intellectual disability. Counsel have spoken to Dr. Patton and acknowledge this is not the sole reason Dr. Patton was unable to find Howard satisfies *Atkins*'s second prong. Consistent with the APA's recently issued Guidelines on Diagnosis of Intellectual Disability in Forensic Settings, Dr. Patton believes finding someone satisfies *Atkins*'s second prong requires him to observe deficits in a person's adaptive behavior at multiple points in a person's developmental period and not a singular moment in time. APA, Guidelines on Diagnosis of Intellectual Disability in Forensic Settings, Guidelines 6.2, 6.6, <https://www.apa.org/about/policy/intellectual-disability-forensic-settings.pdf>.

As explained in greater detail below, because of two recent changes to the way in which adaptive behavior is to be considered, Counsel believe this

Court should find that Howard's present claim makes the threshold showing required by section 5(a)(1), notwithstanding the fact that reputable experts were previously unable to find he satisfied, at least in 2017, *Atkins*'s second prong. These two recent changes are: 1) the aforementioned acknowledgement by this Court in *Mays* that the relatedness requirement has been removed from the text revision of the DSM-5; and 2) the AAIDD's recent expansion of what is considered the developmental period, which this Court acknowledged in *Ex parte Estrada*, No. WR-53,499-02, 2025 WL 1122323, at *1 n.2 (Tex. Crim. App. Apr. 16, 2025).

III. Mr. Howard's death sentence violates the Eighth and Fourteenth Amendments because he is an intellectually disabled person.

A. The intellectual disability standard

The execution of an intellectually disabled person violates the Eighth Amendment's proscription against cruel and unusual punishment. *Atkins v. Virginia*, 536 U.S. 304, 321 (2002).

The Texas Legislature has not provided a statutory definition of intellectual disability. In the absence of such a statutory definition, it is appropriate for this Court to rely on the definitions set out by the American

Association on Intellectual and Developmental Disabilities (“AAIDD”)⁶ and the American Psychiatric Association (“APA”) when assessing an *Atkins* claim.⁷ See *Moore v. Texas*, 581 U.S. 1, 7 (2017). Intellectual disability is characterized by (1) “significantly subaverage” (APA) or “significant limitations” in (AAIDD) intellectual functioning, (2) accompanied by “significant limitations” in adaptive behavior, (3) the onset of which occurs during the developmental period. See AAIDD, *Intellectual Disability: Definition, Classification, and Systems of Supports* ch. 2 (12th ed. 2021) (“AAIDD-12”); APA, *Diagnostic and Statistical Manual of Mental Disorders* 38 (5th ed., text rev. 2022) (“DSM-5-TR”); see also *Moore*, 581 U.S. at 7.

⁶ At the time that *Atkins* was decided, the AAIDD was referred to as the American Association on Mental Retardation (“AAMR”).

⁷ When *Atkins* was decided, the definition of intellectual disability was based on definitions from the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (“DSM-IV”) and the AAMR’s definition in *Mental Retardation: Definition, Classification, and Systems of Supports*, 10th Edition (“2002 AAMR Manual”). *Atkins*, 536 U.S. at 309 n.3. Since *Atkins*, the medical community has updated these definitions, as reflected in the DSM-5 and 2010 AAIDD Manual. In 2020, this Court adopted the definitions from the DSM-5 and 2010 AAIDD Manual in assessing claims of intellectual disability within the capital-sentencing context. *Brownlow v. State*, No. AP-77,068, 2020 WL 718026 (Tex. Crim. App. Feb. 12, 2020). Counsel believe it is not incorrect to characterize this Court’s opinion in *Mays* as having adopted the DSM-5-TR’s abandonment of the “relatedness” requirement, but acknowledge, as this Court made clear in *Estrada*, it is an open question as to whether this Court will adopt the AAIDD’s expansion of the developmental period.

Significantly subaverage intellectual functioning is defined by an IQ score that is approximately two standard deviations below the mean, adjusted for the standard error of measurement. AAIDD-12 at ch. 3; DSM-5-TR at 42. For IQ tests that have a standard deviation of 15 points, such as the Wechsler Scales, an IQ score of 70 is two standard deviations below the mean and the standard error of measurement is approximately 5 points. Thus, an IQ score of up to 75 would be included within the range of significant limitations in intellectual functioning.

Courts are now required to account for an IQ test's standard error of measurement when assessing an *Atkins* claim, as is advanced by the APA and AAIDD. *Moore*, 581 U.S. at 15. For that reason, the Supreme Court has invalidated statutes that have a strict IQ test score cutoff. *Hall v. Florida*, 572 U.S. 701, 718 (2014).

The AAIDD Manual requires that there be “significant limitations . . . in adaptive behavior as expressed in conceptual, social, and practical skills.” AAIDD-12 at ch. 3. “Significance” can be established if an individual's adaptive skills fall two or more standard deviations below the mean in at least one of the three domains. *Id.*; DSM-5-TR at 43. The AAIDD Manual

provides examples of “representative skills” in each of the three domains.

Representative conceptual skills are language; reading and writing; and money, time, and number concepts. AAIDD-12 at Glossary. Representative social skills are “interpersonal skills, social responsibility, self-esteem, gullibility, naiveté (i.e., wariness), follows rules/obeys laws, avoids being victimized, and social problem solving.” *Id.* Representative practical skills are “activities of daily living (personal care), occupational skills, use of money, safety, health care, travel/transportation, schedules/routines, and use of telephone.” *Id.*

Prior to the Supreme Court’s decision in *Moore*, this Court also considered an applicant’s adaptive strengths when assessing *Atkins* claims. *Moore*, 581 U.S. at 15. However, *Moore* established that the Court’s focus should not be placed on adaptive strengths, but it should instead focus its inquiry on the individual’s adaptive deficits. *Id.* Further, it is now established an individual may possess adaptive strengths in one or more areas, but still sufficiently establish an overall limitation in adaptive functioning. *Id.*

As noted above, the initial edition of the DSM-5, published in 2013, required that, to meet the diagnostic criteria for intellectual disability, a

person's deficits in adaptive functioning must be found to be directly related to their intellectual impairments and not some other source. APA, *Diagnostic and Statistical Manual of Mental Disorders* 38 (5th ed. 2013) ("DSM-5").

This relatedness requirement is not contained in the text revision edition of the DSM-5, released in 2022. Relevant to Howard, this means that a person can now possibly satisfy the adaptive deficits criterion of *Atkins* even if the expert evaluating the person's deficits believed those deficits might be related to a severe mental illness, such as a schizoaffective disorder, and not intellectual impairment.

Finally, as noted above, the AAIDD now defines the developmental period as "before the individual attains age 22." AAIDD-12 at ch. 3. Relevant to Howard's claim, this means that both the murder of Vickie Swartout and the subsequent 2001 trial occurred during Jamaal Howard's developmental period. As recounted below, the trial record is chock full of testimony which demonstrates that there were significant deficits in his adaptive behavior at both the time of the murder (when he was 20) and trial (when he was 21). This testimony was made in open court, by witnesses who had sworn to tell the truth, over one year before the Supreme Court issued

its opinion in *Atkins*. The testimony confirms that the deficits in Howard's adaptive behavior, which began by the time he was 16, continued until he was 20-21. No expert has yet had the opportunity to opine on whether this portion of the trial record supports a finding that Howard satisfies *Atkins*'s second prong because the evidence which the undersigned have harvested from the trial record was considered outside of Howard's developmental period when the experts retained during Howard's federal habeas proceeding performed their work. Not until 2021 did the AAIDD change the definition of developmental period, making testimony about Howard's adaptive behavior around the time of the murder and around the time of trial relevant.

B. Mr. Howard is intellectually disabled.

Mr. Howard is intellectually disabled. The evidence shows that: (1) he possesses significantly subaverage intellectual functioning; (2) he has significant limitations in his adaptive functioning; and (3) he exhibited these diagnostic features during the developmental period (beginning when he was around 15 and then continuing through the remainder of Howard's developmental period).

1. Mr. Howard possesses significantly subaverage intellectual functioning.

On March 6, 2017, Dr. Temple administered the Wechsler Adult Intelligence Scale—Fourth Edition (“WAIS-IV”) to Howard. His draft report is attached to this Application as Exhibit 2. The report contains handwritten notes from Howard’s previous attorney indicating she discussed the report with Dr. Temple and two consulting attorneys on April 10, 2017. Exhibit 2. To the extent the attorney’s notes reflect changes she believed needed to be made to the document, there were few. Counsel believe the only reason previous counsel’s file (which she turned over to the undersigned) does not contain a signed copy of the report is that the attorney decided the claim was not then-feasible before asking Dr. Temple to sign the report.

As the report reveals, Dr. Temple found Howard to possess a full-scale IQ of 74. When taking into account the standard error, this means Dr. Temple believes, with 95% confidence, that Howard’s full-scale IQ falls between 70 and 79. Exhibit 2. Two formal effort measures, including the Test of Memory Malinger, showed good effort on Howard’s part. *Id.*

While this Court has explained its preferred practice is not to adjust IQ scores to account for what is referred to as the Flynn Effect when considering *Atkins* claims, this Court is, of course, aware that most practitioners working in clinical settings heed the advice of the APA and AAIDD and make this adjustment. Dr. Temple's report makes clear the proper Flynn adjustment for the WAIS-IV he administered to Howard in 2017 (nine years after the test was published) is three points. Exhibit 2. Making this adjustment to the 95% confidence interval contained in Temple's report appears to indicate Howard's true IQ could be as low as 67. Nevertheless, even without adjusting for the Flynn Effect, Howard's IQ might be 70, which would be indicative of significantly subaverage intellectual functioning.

This Court previously considered the results of the partial WAIS-R administered by Dr. James Duncan to Howard shortly before his trial, which is attached as Exhibit 1, and indicates Duncan believed Howard's IQ to be between 65 and 70. Exhibit 1; *see also* 29 R.R. 76 (testifying Howard's IQ is "around 70"). Specifically, a finding adopted by this Court appears to imply the Court believed the results of the administration of only a portion of an

intelligence test cannot, alone, satisfy *Atkins*'s first prong. Suppl. S.H.C.R. 3 ("Applicant was subjected to only a portion of an I.Q. examination, which resulted in only an estimate of [A]pplicant's I.Q."). Of course, in this proceeding, Howard has presented evidence that Dr. Temple conducted a full administration of the WAIS-IV (which this Court has recognized is considered the gold standard). Counsel believe the partial test is informative because of its consistency with Dr. Temple's results. While Dr. Duncan's estimate (based on only having administered the verbal portion of the test) that Howard's true IQ falls between 65 and 70 is somewhat lower than what Temple found, the verbal portion was the portion of Temple's test on which Howard performed most poorly. Exhibit 2 (indicating, with 95% confidence, that Howard's true score on the verbal portion of the WAIS-IV falls between 66 and 77).

Counsel are aware of two other instances in which experts have attempted to measure Howard's intelligence. Counsel's knowledge of these two instances comes from a letter written by Dr. George Woods, who was one of the experts employed by federal habeas counsel. Counsel have

attached the letter from Dr. Woods as Exhibit 4.⁸ According to Woods' letter, a psychiatrist named Dr. Lane (whom Howard saw around the time he was diagnosed with ADHD) estimated Howard's IQ to be around 60. Exhibit 4 at 19. It is unclear from the letter whether this estimate was based on tests Lane had administered to Howard or instead based on his review of tests Howard had taken at school. *See* Exhibit 4 at 13-14 (noting that subtests of the Cognistat and Montreal Cognitive Assessment were administered to Howard in the portion of the letter containing information he learned from Howard's school records).

While not a formal intelligence test, the Otis-Lennon Scholastic Aptitude Indices have been found to be at least informative. Dr. Woods' letter reports that Howard scored an 88 on the exam when he was in fourth grade and a 74 when in fifth grade. Exhibit 4 at 11. Witnesses at trial and this Court in habeas seemed to attribute Howard's dramatic deterioration from

⁸ Undersigned Counsel have not spoken to Dr. Woods, but Counsel believe he agreed with the 2017 decision (made two years after this letter was written) that an *Atkins* claim was not then-feasible. Woods' 2015 letter was written at a time before Dr. James Patton was employed by prior counsel to conduct a formal assessment of Howard's adaptive behavior. While Woods apparently was ultimately persuaded that the deficits in Howard's adaptive behavior did not become significant until he was around 15, the deficits Woods observed in records of Howard's life before he was 15 are nonetheless relevant to this claim.

fourth to fifth grade to his ADHD and failure to consistently take his medication.

- 2. Howard had significant deficits in adaptive functioning by the time he was eighteen, which continued at least until his 2001 trial, when he was twenty-one.**

Mr. Howard also meets the second prong of the definition of intellectual disability: he possesses significant limitations in adaptive behavior. Mr. Howard possesses significant limitations in his conceptual, social, and practical skills. This criterion is met when a person is sufficiently impaired in at least one of three domains of adaptive functioning (i.e., conceptual, social, or practical) that ongoing support is needed for the person to perform adequately in one or more life settings. DSM-5-TR at 43.

While the exhibits attached to this Application contain a great deal of information about deficits in Howard's adaptive behavior throughout his childhood, because the experts employed by federal habeas counsel appear to have decided the deficits did not become significant until Howard was around fifteen, Counsel focus herein on deficits in his adaptive behavior observed beginning around the time Howard was fifteen and not from observations about his behavior in elementary school. Because this Court has

not yet decided whether to adopt the AAIDD-12's change to the developmental period, Counsel have separated testimony about Howard's behavior after he turned 18 from that dealing with the time he was around 14-17. Throughout this section, Counsel cite to both materials developed by Howard's previous attorney when she was considering raising an *Atkins* claim on his behalf and also to testimony from his trial, which occurred one year before the Supreme Court issued its opinion in *Atkins*.

a. Conceptual skills

The conceptual domain involves competence in memory, language, reading, writing, math reasoning, acquisition of practical knowledge, problem solving, and judgment in novel situations. DSM-5-TR at 43. Mr. Howard's deficits in this domain were apparent in his high-school-aged years and at his trial.

At trial, school officials testified that in high school, Howard cycled from regular classes to in-school suspension, to the district's alternative campus, to homebound instruction, and to expulsion, and then back through the same cycle, until he quit school. 25 R.R. 20-26, 30. He was dropped from homebound instruction for noncompliance and nonattendance. 25 R.R. 26-

27. At the alternative campus, he “simply did not want to do the work.” 25

R.R. 48. This testimony was confirmed by Howard’s mother, who gave a declaration to federal habeas counsel, which is attached to this Application as Exhibit 5. Exhibit 5 at 7.

Trial testimony reveals these deficits in Howard’s conceptual skills continued after he turned 18. When Howard was twenty-one, the defense psychiatrist attempted to administer the MMPI-2 (a personality inventory) to Howard and had to abandon the attempt because Howard could not read at the sixth-grade level the test requires; he did not know the meaning of “mechanics” or “appetite,” words that appear in the test’s first two questions. 26 R.R. 22; *see also* 29 R.R. 89-90. The court-appointed psychologist, who evaluated Mr. Howard the same year, found his functioning at “a borderline to mildly impaired kind of level,” 21 R.R. 26, and reported that his “logic is unusual and at times unintelligible,” 1 C.R. 126.

b. Social skills

The social domain involves awareness of others’ thoughts and feelings, interpersonal communication skills, friendship abilities, and social

judgment. DSM-5-TR at 43. Gullibility and vulnerability to being manipulated or victimized are hallmarks of mild intellectual disability. *Id.* at 44; AAIDD-12 at ch. 3, tbls. 3.1, 3.3.

Howard's grandfather, with whom he lived, testified at trial that he felt closer to Howard than to his other grandchildren because Jamaal "never could explain hisself. What the other kids do always put things on him that he didn't do. . . . He couldn't defend hisself." 23 R.R. 83. His mother testified that the most she could get from him in conversation was "maybe a yes or no answer," and that "[w]e didn't pretty much communicate at all." 23 R.R. 56. His older brother testified that when he picked Jamaal up to ride around and talk, Jamaal would not respond when spoken to. 23 R.R. 28–29. A cousin described him sitting alone and talking and laughing to himself. 23 R.R. 3. Another cousin testified about how Howard would just stand in the middle of the street and stare at people. 23 R.R. 14. School officials described his failure to follow even the most basic rules of the alternative campus, such as the dress code and the requirement that students tuck in their shirts, even after the rules were read to him, explained to him, and copied out by him. 25 R.R. 47–49, 101–03.

Statements obtained by Howard's previous counsel confirm trial testimony regarding deficits in Howard's social skills. In her declaration, Howard's mother explained that at about sixteen, Jamaal stopped being around people; he would go to a neighbor's house or to the park, but he would sit without speaking to anyone and "stare into nothing." Exhibit 5 at 7-8. His younger sister, whose declaration is attached as Exhibit 6, described how, when she asked him questions, he did not answer, and she did not think he heard or understood her; when family members tried to talk to him, he laughed as though he did not understand what they were saying. Exhibit 6 at 1-2. A family friend who saw him nearly every day in 1998 and 1999 recalls that he gave one- or two-word answers, sometimes looked at her and walked away without a word, and stood apart from his peers at the park rather than joining them. Exhibit 7 at 1-2. In the year before the offense, people in the neighborhood laughed at him and called him crazy every time he was around, and on one occasion a group of men hosed him down while he stood with his pants around his ankles; he pulled up his pants "like nothing happened." *Id.* at 3.

Should this Court decide that information from when Howard was 20-

21 is relevant to its consideration of whether he suffered significant deficits in his social skills, the trial record contains many examples that the deficits which began before Howard was 18 continued until he was 20-21. For example, the officer who arrested Howard after he killed Ms. Swartout testified that when he found Howard, Howard was “smiling, grinning from ear to ear.” 20 R.R. 119-20. Dr. James Duncan, who evaluated Howard’s competency to stand trial in March 2001, testified that Howard sometimes did not respond at all to his questions or mumbled so unintelligibly that Duncan had to ask him repeatedly, and smiled or chuckled for no reason in the middle of serious conversation. 21 R.R. 23-25; 29 R.R. 65, 75-76; 31 R.R. 105-06. A Hardin County jailer testified that he observed Howard talking to himself. 25 R.R. 138. Regarding her son during this period of time, his mother testified at trial that she “could be speaking to him and he just don’t respond. He is looking past me.” 26 R.R. 95-96; *see also* 29 R.R. 53-54; 31 R.R. 140-41.

In addition to this 2001 trial testimony related to deficits in Howard’s social skills, the declarations obtained by prior counsel also demonstrate the deficits continued after Howard turned 18. His sister recalled that in the

weeks before the murder, Howard would not engage in conversation with anyone. Exhibit 6 at 2. His sister also recounted Howard's blank stare during trial. *Id.*

c. Practical skills

The practical domain involves learning and self-management across life settings, including personal care, job responsibilities, money management, recreation, self-management of behavior, and school and work task organization. DSM-5-TR at 43.

Howard's mother testified at trial that, as Howard grew into adolescence, the child who had once starched and ironed his clothes every day stopped bathing and stopped changing or washing his clothes for days at a time, wore a wool hat in the summer, and bathed only after being asked again and again. 23 R.R. 55. His sister testified that he went long periods without bathing unless he was told to. 23 R.R. 18. His brother testified that Howard wore the same clothes for two weeks and would not put on or wash the clothes his brother gave him, 23 R.R. 28, and that when his brother took him to a relative's house and told him to take a shower, Howard stood in the shower fully clothed until his brother told him to take his clothes off, 23 R.R.

35–38. Howard’s cousin Pam Fulton confirmed this account of Howard standing fully clothed in the shower one day before he shot Ms. Swartout. 23 R.R. 9. Fulton described Howard as looking “wild eyed” and filthy that evening. 23 R.R. 4-8.

The declarations obtained by federal habeas counsel confirm this trial testimony regarding deficits in Howard’s practical skills during his adolescence. His mother explained that Howard’s work history consisted of a job at a pallet factory that he held for only a few days and picking blueberries for cash. Exhibit 5 at 7. His sister described him wearing the same clothes all week, without a belt, holding his pants up with his hand, unshaven and unbathed. Exhibit 6 at 1. A family friend describes him arriving at her door in the heat of July wearing an undershirt, a long-sleeved shirt, and a flannel jacket, with gray, dingy clothes and pants “ten times too big,” holding the waistband balled up in his hand, and not washing “for days and days.” Exhibit 7 at 2-3.

As is also true of Howard’s deficits in the conceptual and social domains, his practical skills deficits also continued after Howard turned 18. At trial, a jailer who had gone to church with Howard when they were

younger testified, regarding Howard's then-current behavior at the jail: "His hygiene, he doesn't do it," by which he meant take a bath, "unless you tell him to." 25 R.R. 137-38; *see also* 29 R.R. 47-48. Howard lived with his grandfather when the murder occurred, because, with his mother leaving for work in Beaumont each morning, no one would be home to get him up, and he would not get up on his own. 23 R.R. 56. His grandfather described Howard's running an air conditioner, two fans, a large heater, and a record player all at the same time in his room. 23 R.R. 84-85.

IV. This claim satisfies section 5 of Article 11.071.

Mr. Howard filed his only previous application for a writ of habeas corpus on April 24, 2003, almost a year before this Court decided *Briseño* and nearly fourteen years before the Supreme Court decided *Moore I*. His *Atkins* claim was rejected on direct appeal under "the guidelines we set in *Briseño*," *Howard*, 153 S.W.3d at 387, and again in the habeas proceeding on findings that assessed whether his impairments were more than "slight," without the benefit of current clinical standards.

Under section 5(a)(1), this Court may consider a subsequent application if its claim rests on a legal basis that was unavailable when the

previous application was filed. Tex. Code Crim. Proc. art. 11.071, § 5(a)(1). A legal basis is unavailable if it was not recognized by, and could not reasonably have been formulated from, a final decision of the Supreme Court, a federal court of appeals, or a Texas appellate court on or before that date. *Id.* § 5(d). This Court has repeatedly held that *Moore I* is such a new legal basis. *See, e.g., Ex parte Butler*, No. WR-41,121-03, 2019 WL 4464270 (Tex. Crim. App. Sept. 18, 2019).

Butler is especially instructive. Like Mr. Howard, Butler had previously litigated an *Atkins* claim that this Court rejected under the *Briseño* framework. *Ex parte Butler*, 416 S.W.3d 863 (Tex. Crim. App. 2012). This Court nevertheless held that his post-*Moore* claim satisfied section 5(a)(1). *Ex parte Butler*, 2019 WL 4464270, at *2. The same result is warranted here.

This Court's recent decision in *Gonzales* does not suggest otherwise. There, the applicant had never raised an intellectual disability claim, even at a 2009 resentencing held seven years after *Atkins*, and he argued that his claim satisfied section 5(a)(1). *Ex parte Gonzales*, No. WR-40,541-07, slip op. at 3-4, 9-10 (Tex. Crim. App. Aug. 20, 2026). This Court held that the evidence had been available, and that *Atkins* had been available since 2002.

Id. It did not address whether *Moore* is a new legal basis, and nothing in its order questions *Butler* or the other decisions like *Butler* in which this Court found *Moore* to constitute new law. Mr. Howard's claim rests on *Moore*, and his posture is the reverse of Gonzales's: Mr. Howard was tried before *Atkins* was decided, raised intellectual disability on direct appeal within days of *Atkins*, and raised it again in his initial habeas application. Both times, this Court resolved the claim under the *Briseño* framework that *Moore* later rejected. He has not bypassed any opportunity to litigate the claim. *Cf. Gonzales*, slip op. at 5-6 (Yeary, J., concurring) (questioning whether applicants tried after *Atkins* who did not raise the claim at trial have defaulted it).

Howard also makes the required prima facie showing. He presents a WAIS-IV full-scale IQ of 74, corroborated by an estimate of 65 to 70 made when he was twenty-one and by lay and expert declarations and trial testimony documenting deficits in his conceptual, social, and practical skills by the time he was around fifteen years of age. Trial testimony from 2001 confirms these deficits continued to be present when Howard was 20-21. If this Court uses this proceeding to adopt the AAIDD's change to the

developmental period, then the Judges of this Court will be the first to consider this testimony and the degree to which it confirms that adaptive deficits the experts working with federal habeas counsel believed emerged around the time Howard was fifteen were not transient in nature and instead continued to affect him during the latter stages of what is now, in the clinical setting, considered part of the developmental period. However, as argued above, Counsel believe Howard's claim makes the prima facie case required by section 5(a)(1) even if this Court opts not to adopt the AAIDD's change.

Prayer for Relief

WHEREFORE, Mr. Howard prays that this Court:

1. Stay his execution, currently scheduled for October 7, 2026;
2. Find his claim satisfies section 5 of Article 11.071 of the Texas Code of Criminal Procedure;
3. Either adopt the change in the developmental period announced in the AAIDD-12 or set the issue for submission;
4. Remand his claim to the trial court with instructions that the court should convene an evidentiary hearing; and
5. Grant all other relief to which he may be entitled in equity or under law.

Respectfully submitted,

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/s/ Jeffrey R. Newberry

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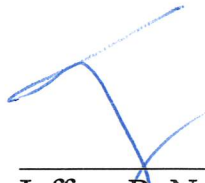
Counsel for Jamaal Howard

STATE OF TEXAS §
 §
COUNTY OF HARRIS §

Verification

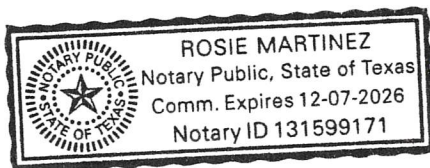
BEFORE ME, the undersigned authority, on this day personally appeared Jeffrey R. Newberry, who upon being duly sworn by me testified as follows:

1. I am a member of the State Bar of Texas.
2. I am counsel for Jamaal Howard, having the authority to prepare and verify Mr. Howard's 11.071 Application for Post-Conviction Writ of Habeas Corpus.
3. I have prepared and have read the foregoing Application, and I believe all the allegations therein to be true and correct.



Jeffrey R. Newberry

SUBSCRIBED AND SWORN TO BEFORE ME on September 25,
2026.





Notary Public, State of Texas

Certificate of Service

I hereby certify that on the 28th day of September 2026, I served a true and correct copy of this Application upon Counsel for the State:

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/s/ Jeffrey R. Newberry

Jeffrey R. Newberry

Exhibit 1

WAIS-R RECORD FORMWECHSLER ADULT
INTELLIGENCE SCALE—
REVISED

NAME

ADDRESS

SEX

AGE

RACE

MARITAL
STATUS

OCCUPATION

EDUCATION

PLACE OF TESTING

TESTED BY

TABLE OF SCALED SCORE EQUIVALENTS*

Scaled Score	RAW SCORE										Scaled Score	
	VERBAL TESTS					PERFORMANCE TESTS						
	Information	Digit Span	Vocabulary	Arithmetic	Comprehension	Similarities	Picture Completion	Picture Arrangement	Block Design	Object Assembly		Digit Symbol
19	—	28	70	—	32	—	—	—	51	—	93	19
18	29	27	69	—	31	28	—	—	—	41	91-92	18
17	—	26	68	19	—	—	20	20	50	—	89-90	17
16	28	25	66-67	—	30	27	—	—	49	40	84-88	16
15	27	24	65	18	29	26	—	19	47-48	39	79-83	15
14	26	22-23	63-64	17	27-28	25	19	—	44-46	38	75-78	14
13	25	20-21	60-62	16	26	24	—	18	42-43	37	70-74	13
12	23-24	18-19	55-59	15	25	23	18	17	38-41	35-36	66-69	12
11	22	17	52-54	13-14	23-24	22	17	15-16	35-37	34	62-65	11
10	19-21	15-16	47-51	12	21-22	20-21	16	14	31-34	32-33	57-61	10
9	17-18	14	43-46	11	19-20	18-19	15	13	27-30	30-31	53-56	9
8	15-16	12-13	37-42	10	17-18	16-17	14	11-12	23-26	28-29	48-52	8
7	13-14	11	29-36	8-9	14-16	14-15	13	8-10	20-22	24-27	44-47	7
6	9-12	9-10	20-28	6-7	11-13	11-13	11-12	5-7	14-19	21-23	37-43	6
5	6-8	8	14-19	5	8-10	7-10	8-10	3-4	8-13	16-20	30-36	5
4	5	7	11-13	4	6-7	5-6	5-7	2	3-7	13-15	23-29	4
3	4	6	9-10	3	4-5	2-4	3-4	—	2	9-12	16-22	3
2	3	3-5	6-8	1-2	2-3	1	2	1	1	6-8	8-15	2
1	0-2	0-2	0-5	0	0-1	0	0-1	0	0	0-5	0-7	1

Clinicians who wish to draw a profile may do so by locating the subject's raw scores on the table above and drawing a line to connect them. See Chapter 4 in the Manual for a discussion of the significance of differences between scores on the tests.

Year Month Day

Date Tested

Date of Birth

Age

SUMMARY

Raw Score Scaled Score

VERBAL TESTS

Information

Digit Span

Vocabulary

Arithmetic

Comprehension

Similarities

Verbal Score

PERFORMANCE TESTS

Picture Completion

Picture Arrangement

Block Design

Object Assembly

Digit Symbol

Performance Score

Sum of Scaled Scores IQ

VERBAL

PERFORMANCE

FULL SCALE

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9-991829

1. INFORMATION		Discontinue after 5 consecutive failures.	Score 1 or 0
1. Flag			1
2. Ball			1
3. Months	12		1
4. Thermometer			1
5. Sun	SUN W		1
6. Presidents	B, C, R		1
7. Weeks	(LONG WAIT) 36		1
8. Armstrong	INVENTOR		1
9. Panama	K		1
10. Labor Day	MAR		1
11. Brazil	EUROPE		1
12. Hamlet	JOSEPH PARKER		1
13. Civil War			1
14. Earhart			1
15. Clothes			1
16. Italy			1
17. King			1
18. Genesis			1
19. Sahara			1
20. Relativity			1
21. Yeast			1
22. Senators			1
23. Paris			1
24. Blood vessels			1
25. Temperature			1
26. Curie			1
27. Population			1
28. Koran			1
29. Faust			1
Note: Be sure to include scores for Items 1-4 in Total.			Max=29
Total			6

2. PICTURE COMPLETION		Discontinue after 5 consecutive failures.	Score 1 or 0
1. Door			
2. Tennis			
3. Frog			
4. Playing card			
5. Car			
6. Pitcher			
7. Glasses			
8. Pliers			
9. Boat			
10. Beach			
11. Mirror			
12. Crab			
13. Violin			
14. Sun			
15. Watch			
16. Leaf			
17. Man			
18. Horse			
19. Female profile			
20. Woodpile			
Total			Max=20

3. DIGIT SPAN					
Discontinue after failure on BOTH TRIALS of any item.					
Administer BOTH TRIALS of each item, even if subject passes first trial.					
DIGITS FORWARD		Pass-Fail	Score 2, 1, or 0	DIGITS BACKWARD *	
1.	5-8-2	P	2	1.	2-4
	6-9-4	P			5-8
2.	6-4-3-9	P	1	2.	8-2-9
	7-2-8-6	F			4-1-5
3.	4-2-7-3-1	F	1	3.	3-2-7-9
	7-5-8-3-6	F			4-9-6-8
4.	6-1-9-4-7-3			4.	1-5-2-8-6
	3-9-2-4-8-7				6-1-8-4-3
5.	5-9-1-7-4-2-8			5.	5-3-9-4-1-8
	4-1-7-9-3-8-6				7-2-4-8-5-6
6.	5-8-1-9-2-6-4-7			6.	8-1-2-9-3-6-5
	3-8-2-9-5-1-7-4				4-7-3-9-1-2-8
7.	2-7-5-8-6-2-5-8-4			7.	9-4-3-7-6-2-5-8
	7-1-3-9-4-2-5-6-8				7-2-8-1-9-6-5-3
Total Forward			Max=14	Total Backward	

*Administer DIGITS BACKWARD even if subject scores 0 on DIGITS FORWARD.

Forward	+	Backward	=	Max=28
				5
				Total

8. OBJECT ASSEMBLY		Give entire test to all subjects.															
Object	Time	Score (Circle appropriate score for each object.)															
1. Manikin 120"		0	1	2	3	4	21-120 5	18-20 6	11-15 7	1-10 8							
perfect assembly																	
2. Profile 120"		0	1	2	3	4	5	6	7	8	30-120 9	26-38 10	21-26 11	1-20 12			
perfect assembly																	
3. Hand 180"		0	1	2	3	4	5	6	51-180 7	36-50 8	26-35 9	1-25 10					
perfect assembly																	
4. Elephant 180"		0	1	2	3	4	5	6	7	51-180 8	31-60 9	21-30 10	1-20 11				
perfect assembly																	
																Max=41	
Total																	

LONG LATENCY

9. COMPREHENSION		Discontinue after 4 consecutive failures.		Score 2, 1, or 0
1. Clothes				2
2. Envelope	TAKEN IT IN TO SECURITY PLANS			1
*3. Foods	KEEP FROM SPOILING OUT HAS BE IN SKO AREA OR ST			1
*4. Child labor	GO AROUND WITH LAW OR ST NOT POTENTIALLY ALLOW			0
5. Deaf	PROBABLY A BAD INFLUENCE INVOLVED			0
6. Borrow	BEST OPPORTUNITY OR ST			0
7. Movies	NO ANSWER ON THAT			0
8. License	N.R.			
9. Taxes	N.R.			
10. Forest	BOTTLE IN DAYLIGHT AT ABOUT EARLY SOB (Q) IPK			
11. Prescription				
12. Iron				
13. Land				
14. Brooks				
15. Swallow				
16. Press				
*If the subject replies with only one idea, ask for a second response. Rephrase the test item appropriately, saying, "Tell me another reason why...."				Max=32
Total				4

SAMPLES
2
1
3
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2
1
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9
8
6

10. DIGIT SYMBOL

—	1
T	2
7	3
L	4
U	5
O	6
V	7
X	8
—	9

SCORE

--

11. SIMILARITIES		Discontinue after 4 consecutive failures.	Score 2, 1, or 0
1. Orange—banana	FRUIT		2
2. Dog—lion	ANIMALS		2
3. Coat—suit	CLOTHES		2
4. Boat—automobile	TRANSPORTATION		0
5. Eye—ear	BODY PARTS		1
6. Button—zipper	FIT ON CLOTHING		1
7. North—west	DIRECTIONS		2
8. Egg—seed	PLANTATION		0
9. Table—chair	IDK (FURNITURE?) NO RESP		0
10. Air—water	IDK		0
11. Poem—statue	IDK		0
12. Work—play	IDK		
13. Fly—tree	IDK		
14. Praise—punishment			
Total			Max=28 10

Rorschach

I BF
 Dragonfly

W A
 W A

II Different kind of BF
 different shape

vague reasoning

III I cant really think
 of BF
 WB like a spider
 or ST

long entry

IV (rej)

V Now that's a BF

VI (rej)

just stared at
 and no
 reaction

VII (rej)

VIII I saw it before but
 cant remember
 it appears on the
 side

IX it a put together painting
 X (rej)



Adult Response Sheet

Name _____ Sex _____ Age _____ Marital Status _____
 Place _____ Date _____

Complete these sentences to express your real feelings. Try to do every one.
 Be sure to make a complete sentence.

1. I like to be free at times
2. The happiest time is my life
3. I want to know how to work
4. Back home at some time
5. I regret my action
6. At bedtime I sleep
7. Men are sometimes surprising
8. The best place is home
9. What annoys me is my action of life Q NR
10. People are surprising
11. A mother is nice
12. I feel life passing free at my times Q NR
13. My greatest fear is death
14. In school we get mostly the same
15. I can't to much respect

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11 12 A B C D E 0154685844

16. Sports are nice to me
17. When I was a child I act to play out ^{out and} ~~out~~
18. My nerves are very bad I appendixed, n, r
19. Other people are around me
20. I suffer at my time
21. I failed the greatest test
22. Reading is fun and useful
23. My mind is mostly come
24. The future is the past
25. I need to be more needed
26. Marriage is not for me
27. I am best when I am alone
28. Sometimes I reach my goal
29. What pains me is the looks of reality
30. I hate the way I be
31. This place is crazy
32. I am very not popular
33. The only trouble is myself
34. I wish I go be better
35. My father is not to be
36. I secretly is the greatest
37. I not that be down
38. Dancing is like taking my spirit
39. My greatest worry is fast life
40. Most women are not to be

~~Raymond~~

~~Raymond~~

Dyrone Monkrippe

713 557 4887

- He talking to himself
- He cant make judgement calls - ;
- His history ADHD Ritalin
 later Prozac depression

Dyrone Monkrippe
 Re: Jamaal Howard
 11/1 Wed. - Will need you
 to testify
 (713) 557-4887 call
 Please call

Tomorrow am
 @ 9:00
 plunk

JAMES A. DUNCAN, PH.D.
3560 DELAWARE, STE .602
BEAUMONT, TX 77706
(409)892-1220 FAX (409)898-7545

.....
facsimile transmittal

To: Rita- Judge Plunk Fax: 246-4700
From: JAMES A. DUNCAN, PH.D. Date: 3-15-01
Re: Assess. on Howard Pages: 4
CC: amb

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Notes:
.....

Exhibit 2

4/10/17
Richard O. Temple, Ph.D.
Clinical Neuropsychology
706-B W. Ben White Blvd
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Austin, TX 78704
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Confidential
877-311-2008
PW 566504#

NEUROPSYCHOLOGICAL EVALUATION
CONFIDENTIAL

****PRIVILEGED DRAFT****

NAME: Jamaal Howard

CAUSE: #1:13-cv-00256; Jamaal Howard (Petitioner) v. William Stephens, Director of
Criminal Justice, Institutional Division (Respondent)

DATE OF BIRTH: 2/8/1980

DATE OF EVALUATION: 3/6/2017

REFERRAL QUESTIONS: Mr. Jamaal Howard was referred for a neuropsychological evaluation by Ms. Lydia Brandt, his attorney, to determine the presence or absence of an intellectual disability and other cognitive dysfunction. This evaluation was requested based on the conclusion of Dr. George Woods that Mr. Howard likely meets criteria for an intellectual disorder, and Dr. Woods' request for additional evaluation to objectively determine whether such a disability in fact exists.

CREDENTIALS:

I am a licensed Clinical Psychologist specializing in clinical neuropsychology. I am currently a member of the American Psychological Association and the National Academy of Neuropsychology. I am currently in private practice in Austin, Texas and conduct clinical and neuropsychological evaluations of criminal offenders, medical patients, psychiatric patients, and medical-legal patients, serving individuals with a wide variety of psychological needs. I earned a Bachelor of Science degree in Psychology and Master of Science degree in Clinical Psychology from Illinois State University in 1993 and 1995, respectively. Following my master's degree, I spent two years as a child and family outreach therapist with Center for Human Services in Bloomington, Illinois, where I provided psychotherapy services to children and families. I then earned a Ph.D. in Clinical Psychology with a Neuropsychology emphasis from the University of Alabama – Birmingham in 2002. As part of my Ph.D. training, I completed a one-year clinical internship at the Medical University of South Carolina. In addition to advanced training in clinical neuropsychology, I completed rotations in child and family therapy with disadvantaged families, as well as a rotation with the National Crime Victim Center, providing treatment for Posttraumatic Stress Disorder to victims of psychological trauma during my internship year. Following matriculation from my doctoral program, I completed a two-year postdoctoral fellowship in clinical neuropsychology at Brown Medical School in Providence, Rhode Island. From 2004-2008 I served as the Director of Neuropsychology at the Transitional Learning Center in Galveston, Texas, a post-acute rehabilitation facility serving individuals with acquired brain injury. From 2008-2012 I served as the Vice President of Clinical Operations at CORE Health Care in Dripping Springs, Texas, also a post-acute rehabilitation facility for individuals

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with brain injuries. A true and correct copy of my current Curriculum Vitae is attached as Exhibit A, to provide a complete listing of my education, training, and experience.

RECORD REVIEW: As part of my evaluation of Mr. Howard, the following documents were provided to me and reviewed:

1. Letter from James A. Duncan, Ph.D. to Honorable Britt Plunk, District Judge, providing results of an independent medical evaluation, dated 3/9/2001.
2. Email chain from Ms. Lydia Brandt, Attorney, requesting records on Mr. Howard, dated 9/23/13.
3. Two letters from Fred Fason, MD to Tyrone Moncriffe, Attorney, dated 3/5/01 and 4/11/01, addressing Mr. Howard's competency to stand trial.
4. Letter from Ms. Lydia Brandt, Attorney, to Ravikumar Kanneganti, MD requesting medical records dated 9/12/13, and handwritten medical notes from Dr. Kanneganti.
5. Letter from Edward B. Gripon, MD, PA to Honorable Britt Plunk, District Judge dated 4/13/01.
6. Declaration of Gaye Lokey, school administrator, dated 11/3/16.
7. Letter from George E. Groves, MD to Honorable Britt Plunk, District Judge providing results of psychiatric evaluation, dated 4/2/01.
8. School Records from Silsbee Public Schools.
9. Response to request for medical records by James A. Duncan, Ph.D., with attached records.
10. Results of neuropsychiatric evaluation by George W. Woods, MD, dated 9/16/15.
11. Public Verification / Physician Profile of Fred Lanier Fason, MD, dated 9/11/13.
12. Petition #1:13-cv-00256; Jamaal Howard (Petitioner) v. William Stephens, Director of Criminal Justice, Institutional Division (Respondent)

CLINICAL INTERVIEW: Mr. Howard was evaluated at the Polunsky Unit of the Texas Department of Criminal Justice (Death Row) in Livingston, Texas. He was evaluated via a contact visit in a small conference room, which began approximately at 8:15 AM. On interview,

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Mr. Howard expressed his understanding that he was incarcerated due to a "capital murder case" in which he "plead guilty to stealing a gun, robbing a lady, and shooting her." He reported the date the crime as May 12, 2000. When asked about current cognitive problems, Mr. Howard reported that he "really can't think back, remember stuff from the past, or currently." He reported that those problems have been present since childhood. Mr. Howard denied any current physical limitations. When asked about his current emotional functioning, he reported that he is typically "pretty calm," and indicated that his current medication regimen is effective in controlling his mood. However, he also stated "hypertension affects my mind...makes me feel calm, but I'm not." On further questioning, it became evident that he was not referring to hypertension in the accepted medical sense, but instead to a subjective feeling of hyperactivity. When asked about other psychiatric symptoms, Mr. Howard reported auditory hallucinations of voices talking to him, though he expressed confusion about whether those voices were merely his "way of thinking." He reported vivid dreams, but denied current delusions. Mr. Howard reported being prescribed Haldol and Benadryl at the time of this evaluation, though that information was not independently verified with medical records.

Currently, Mr. Howard denied any difficulty with ambulation. He reported decreased motivation to get up in the morning and shower, but he reported being physically capable of doing so. Mr. Howard reported that he typically stays up late at night listening to his radio. He reported sleeping from approximately 3:00 AM until 11 AM most days. He reported going to sleep sometime between 2:00 AM and 3:00 AM the night prior to this evaluation.

When asked about current medical history, Mr. Howard initially denied any history of significant injuries, illnesses, hospitalizations, or surgeries. However, he then gave a seemingly implausible account of being shot in the back of the head in 1999, presenting at the hospital, receiving treatment, and being released several hours later. In terms of psychological treatment, he reported meeting with a "therapist" weekly. When asked about past substance use, he reported past, occasional consumption of a 40-ounce beer, and occasional use of marijuana. In terms of family medical history, Mr. Howard indicated that both of his parents are still living, though he was not certain about their medical or psychiatric history.

Mr. Howard reported completing 10 years of formal education, and he denied earning a high school diploma or GED. He reported being placed in a "trouble school" due to his behavior, where he was isolated from other children. He denied any history of gainful employment. Mr. Howard reported being single (never married) and having no offspring. When asked about current leisure interest, he reported reading and listening to music.

BEHAVIORAL OBSERVATIONS AND MENTAL STATUS: Mr. Howard was evaluated at the Polunsky unit (Death Row) of the Texas Department of Criminal Justice on 3/6/17. He was evaluated during a contact visit that occurred in a small conference room. Mr. Howard was escorted to the conference room by prison guards, handcuffed and in leg irons. Upon entering the room, the handcuffs were removed, but the leg irons remained in place. Mr. Howard presented as a well-nourished African-American man who appeared his stated age. He ambulated independently and without apparent difficulty. He was dressed in prison attire.

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Grooming was marginal, as body odor was evident. At the start of the evaluation, Mr. Howard carefully read the informed consent document provided to him, and signed the document. Mr. Howard was alert and oriented to person, place, and most aspects of time, being unable to state only the date. He was able to name the current and most recent past U.S. Presidents.

Spontaneous speech was fluent, with normal pace and prosody, and free from paraphasic errors. Thought processes were logical and goal-directed, and there was no evidence of delusions, hallucinations, or other forms of thought disorder. Mr. Howard presented as polite and cooperative throughout testing. There was no overt evidence of somnolence or fatigue. There was also no overt evidence of psychosis, including delusions, hallucinations, or negative symptoms. Behavioral observations and two formal measures of effort were indicative of good effort on the tasks presented. Thus, the results of this evaluation likely represent an accurate estimate of his current level of intellectual, academic, and cognitive functioning.

TESTS ADMINISTERED: Wechsler Adult Intelligence Scale-IV; Orientation Questionnaire; TOMM; Trail Making Test (A and B); Wechsler Memory Scale-IV; Wide Range Achievement Test-Fourth Edition; Boston Naming Test; Verbal Fluency Test; Booklet Category Test; Advanced Clinical Solutions Effort Calculation.

TEST RESULTS:

Intellectual Abilities: Composite scores, percentile ranks, and related confidence intervals, as well as subtest scaled scores for Mr. Howard's WAIS-IV performance are presented in the tables below:

Scale	Sum of Scaled Scores	Composite Score	Percentile Rank	95% Confidence Interval
Verbal Comprehension	14	70	2	66-77
Perceptual Reasoning	18	77	6	72-84
Working Memory	12	77	6	72-85
Processing Speed	17	92	30	84-101
Full Scale	61	74	4	70-79

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<u>Subtest</u>	<u>Raw Score</u>	<u>Scale Score</u>	<u>Subtest</u>	<u>Raw Score</u>	<u>Scale Score</u>
<u>Verbal Comprehension</u>			<u>Perceptual Reasoning</u>		
Vocabulary	11	3	Visual Puzzles	7	5
Similarities	13	4	Matrix Reasoning	12	7
Information	8	7	Block Design	24	6
<u>Working Memory</u>			<u>Processing Speed</u>		
Digit Span	18	5	Coding	52	7
Arithmetic	11	7	Symbol Search	32	10

As can be seen from the data above, Mr. Howard's performance on intellectual testing placed him in the borderline deficient range of overall functioning (Full-Scale IQ at the 4th percentile). Processing Speed emerged as an area of relative intellectual strength (low end of the average range), whereas other domains were well below average (at or below the 6th percentile). Given the publication year of the WAIS-IV (2008), inflation of true IQ estimation due to the well-established Flynn Effect must be taken into consideration. Recent research in peer-reviewed scientific journals have estimated the Flynn Effect at 2.93 (Trahan, Stuebing, Fletcher, & Hiscock, 2014) to 3.0 (Beaujean & Sheng, 2014) points per decade. Incorporating this correction for artificial inflation of IQ estimation, Mr. Howard's true intellectual abilities are estimated to be at a standard score of 71.

Academic Abilities: Standard scores, percentile ranks, confidence intervals, and grade equivalents for academic domains are presented in the table below:

Subtest/ Composite	Raw Score	Age-Normed Standard Score	95% Confidence Interval	Percentile Rank	Grade Equivalent
Word Reading	40	74	67-83	4	4.7
Sentence Comprehension	31	72	65-81	3	6.0
Spelling	31	76	68-87	5	5.1
Math Computation	35	84	74-96	14	6.3
Reading Composite	146	71	66-77	3	N/A

As can be seen from the scores above, Mr. Howard's academic achievement appears to be well below that of age-matched peers, and also well below expectation for an individual who

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completed 10 years of formal education. However, his achievement levels are not surprising, given his report of difficulty in school, including placement in alternative schools for behavioral problems.

Attentional Functions: Attentional functions were mixed. Speeded visual scanning with a psychomotor component was average compared to sex-, age-, education-, and race-matched peers. Speed of information processing was low average to average. Mental arithmetic was low average. Auditory attentional capacity was mildly impaired.

Executive Functions: Executive functions were mixed. Ability to maintain a two-step response set in a speeded fashion was average compared to sex-, age-, education-, and race-matched peers. Performance on a problem-solving task requiring hypothesis testing and response to feedback was low average compared to sex-, age-, education-, and race-matched peers. Nonverbal matrix reasoning was low average. Abstract verbal reasoning was moderately impaired.

*How it affects
it in everyday
functioning*
Language Functions: Language functions were generally impaired. Verbal fund of knowledge was low average. Verbal fluency was mildly impaired under phonemic constraints, and low average under semantic constraints, compared to sex-, age-, education-, and race-matched peers. Confrontation naming was borderline impaired compared to sex-, age-, education-, and race-matched peers. Vocabulary skills were severely impaired.

Visuospatial Functions: Visuospatial skills were generally impaired. Block construction was at the low end of the low average range. Mental assembly of two-dimensional puzzles was mildly impaired.

Learning and Memory: Learning and memory was generally below expectation. Initial learning of contextual verbal information (i.e., brief stories) was severely impaired. Delayed recall of the information was mildly impaired. Immediate learning of verbal word pairs was low average, and delayed recall was at the low end of the low average range. Initial learning of sequentially-presented abstract designs was average. However, delayed recall of the information was at the low end of the low average range.

IMPRESSIONS: The results of this neuropsychological evaluation revealed global intellectual performance observed at the 4th percentile. Applying the correction based on available evidence regarding the Flynn Effect, Mr. Howard's true intellectual abilities are estimated to be at a standard score of 71, which places him at the 3rd percentile of ability compared to age-matched peers. This level of functioning falls in the deficient level of intellectual performance. The Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition (DSM-5; American Psychiatric Association, 2013) defines Intellectual Disability as "*a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains*" (Pg. 33). Three criteria must be met to satisfy a diagnosis of Intellectual Disability, including A) deficits in intellectual functioning, confirmed by both clinical assessment and individualized, standardized intelligence testing, B) deficits in

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adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility, and C) onset in the developmental period. Based on his performance on intellectual testing during this evaluation, Mr. Howard meets the Criteria A standard for Intellectual Disability. Assessment of Criteria B (deficits in adaptive functioning), was outside the scope of this evaluation. It is my understanding that assessment of adaptive functioning will be conducted by another professional. Regarding Criteria C, analysis of available school records indicates inconsistent, below-average performance in multiple domains, suggesting onset of intellectual difficulties in the developmental period. Further, there is no report or evidence of discrete injuries or illnesses in adulthood that could account for the observed weaknesses. Analysis of academic performance during this evaluation suggests that Mr. Howard's intellectual disability has adversely impacted academic development, and that impairment persists to the present day. Assessment of major neurocognitive domains revealed deficits across all domains, including language, visuospatial skills, and aspects of attention, executive functioning, and learning and memory for new information. There was no behavioral evidence that Mr. Howard's performance during this evaluation was adversely affected by somnolence, fatigue, or overt psychotic experiences.

Based on the results of this evaluation, it is my conclusion, within a reasonable degree of psychological certainty, that Mr. Howard suffers from an Intellectual Disability that has been present throughout his life, and continues to adversely affect him today. This disability has interfered with his ability to accumulate knowledge and skills through the educational system. His disability likely adversely affected his ability to attend carefully to relevant stimuli, reason, use good judgment, and develop normal moral and ethical principles. His intellectual limitations appear to be present in both verbal and nonverbal domains, resulting in very limited ability to accumulate knowledge over the course of his lifespan. Thus, it is likely that his disability has in the past, and continues to this day, to preclude him from functioning at his expected level of his age-matched peers.

Richard O. Temple, Ph.D.
Clinical Neuropsychology
Licensed Psychologist

on date of office

Exhibit 3

ABAS-3 Results – Shirley Howard

	<u>Age 14</u>	<u>Age 16</u>
GAC (General Adaptive Composite)	93	67
Conceptual	91	69
Social	90	62
Practical	99	74

Notes:

- Guessing limit was not exceeded in any of the adaptive skill domains on either administration.
- I have not performed a detailed comparison of responses between the age-14 and the age-16 administrations. I am not sure that such an analysis is needed; however, I will not be able to do so until I return.

Quick Interpretation:

- Jamaal does not demonstrate significant deficits in AB prior to age 15.
- Jamaal does demonstrate significant AB deficits after age 15.
- His school-related problems (e.g., being placed into the “transition” class and being eligible for special education under the “other health impaired” category) prior to age 15 are best explained by the ADHD Dx.
- The significant deficits after age 15 are strongly linked to the onset of his mental health issues. In other words, it would be very difficult to argue otherwise, in light of the information that exists in terms of statements, interviews, school records, and ABAS-3 results.
- The second ABAS-3 administration (from Shirley) does provide very powerful arguments about the impact of his mental health issues on functioning.

Exhibit 4



GEORGE W. WOODS, JR., M.D., F.A.P.A.

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415 503 3959
E-mail: gwoods@georgewoodsmd.com
Oakland Atlanta

September 16, 2015

Lydia M.V. Brandt, Esq.
The Brandt Law Firm, P.C.
P.O. Box 326
Farmersville, TX 75442-0326

Re: Jamaal Howard

Ms. Brandt,

Pursuant to your request, I have performed a neuropsychiatric examination of Jamaal Howard, a 35-year-old African American male, who is currently incarcerated on the Polunsky Unit in Huntsville, Texas.

In order to perform this examination, I interviewed Mr. Howard on September 3, 2015. I also interviewed Ms. Shirley Howard, his mother; Ms. Sheanna Howard, his sister; and Ms. Gaye Lokey, the assistant principal at Silsbee Middle School where Mr. Howard attended. In addition, I have reviewed the available records, including childhood and adult medical records as well as his school records. A complete list of the documents reviewed is attached as Appendix A.

QUALIFICATIONS, BACKGROUND, AND EXPERIENCE

I am a licensed physician specializing in neuropsychiatry. I am in private practice with a focus on neuropsychiatry, psychopharmacology, workplace safety, and forensic consultations. For the last twenty-nine years, I have treated clients with developmental disabilities, acquired brain injuries, and cognitive impairments secondary to neuropsychiatric disorders.

I am a Fellow of the American Psychiatric Association. I am a member of the Northern California Psychiatric Association, the California Psychiatric Association, the American Neuropsychiatric Association and the American Psychological Association. I am President of the International Academy of Law and Mental Health (IALMH), where I also serve on the Scientific and Executive Committees. I am a member of the American Association on Intellectual and Developmental Disabilities (AAIDD) and the AAIDD Task Force on the Determination of Intellectual Disability for the Courts. I co-wrote two chapters in the *AAIDD Manual*, "The Death Penalty" and "Intellectual Disability." I am also a member of the International Association for the Specialized Study of Intellectual and Developmental Disabilities (IASSIDD), in which I serve on the Executive Committee and am Editor for the Challenging Behavior and Mental Health Special Interest Research Group (SIRG) newsletter.

I am a lecturer at the University of California, Berkeley – Boalt Hall, School of Law. I teach a course on Law and Mental Health with Jennifer Johnson, Esq. We also teach a continuing education webinar, "Where Mental Health Meets the Law," a comprehensive curriculum that tackles the evolving field of forensic mental health through West Legal Education (Thomson Reuters). I am Adjunct Professor at Morehouse School of Medicine in Atlanta, Georgia. I currently teach "Clinical Aspects of Forensic Psychiatry" to third and fourth year residents. I also teach "Introduction to Geriatric Psychiatry."

My curriculum vitae is attached as Appendix B.

SUMMARY

It is my opinion which I hold to a reasonable degree of medical certainty that Jamaal Howard meets the criteria for intellectual disability (ID), or mild mental retardation, pursuant to the *DSM-5*, *DSM-IV-TR* and the *AAIDD 2010 Manual*. Mr. Howard displays significant limitations in intellectual and adaptive functioning. These problems arose during the developmental period of his life.

It is my medical opinion that Mr. Howard was mildly intellectually disabled at the time of the offense for which he is charged. It is also my opinion that Mr. Howard has other impairments, specifically Schizophrenia, that have impacted his mental state. This is relevant to understanding his conduct and behavior.

PRINCIPLES OF ASSESSMENT OF INTELLECTUAL DISABILITY

DSM-5

After a number of years in development, the American Psychiatric Association announced the publication of the newest *Diagnostic and Statistical Manual* in May of

2013. A condition that was referenced in *DSM-IV* as *mental retardation*, in the *DSM-5* is now called *intellectual disability*, parenthetically, *intellectual developmental disorder*. The disorder characteristics involve impairments of mental abilities that impact adaptive functioning in three domains or areas, e. g., conceptual domain, social domain, and practical domain.

The *DSM-5* defines intellectual disability as follows:

Intellectual disability (intellectual developmental disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. The following three criteria must be met:

- A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.
- B. Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.
- C. Onset of intellectual and adaptive deficits during the developmental period.

Under the *DSM-5*, the diagnostic criteria are also to be accompanied by a statement of current severity ranging from mild to profound.

Intellectual functions (Criterion A) include reasoning, problem solving, planning, abstract thinking, judgment, learning from instruction, learning from experience, and practical understanding (Evans, 2008; Gottfredson, 1997; Harris, 2006; King & Kitchner, 2002; Margolis, 1987; Schalock, 2011; World Health Organization, 2011). Critical components include verbal comprehension, working memory, perceptual reasoning, quantitative reasoning, abstract thought, and cognitive efficacy. Intellectual functioning is typically measured with individually administered and psychometrically valid, comprehensive, culturally appropriate tests of intelligence.

The *DSM-5* no longer includes intelligence quotient (IQ) scoring as part of the criteria for intellectual disability. It has demoted IQ test scores to associated features. It is accepted that individuals with intellectual disability have scores of approximately two

standard deviations or more below the population mean, including a margin for measurement error (generally ± 5 points). On tests with a standard deviation of 15 and a mean of 100, this involves a score of 65–75 (70 ± 5). The *DSM-5* also recognizes the necessity of applying the Flynn Effect (Flynn, 2010) to formulate accurate IQ scores. It also seeks to ensure possible artificial IQ and neuropsychological testing enhancements, such as practice effect and brief intelligence instruments, are taken into consideration by the examiner. The *DSM-5* also requires that clinical training and judgment be used to interpret test results and assess intellectual performance.

The *DSM-5* endorses neuropsychological testing as an important instrument in understanding cognitive dysfunction.

The *DSM-5* requires impairments in adaptive functioning and recognizes the importance of understanding the supports utilized by individuals with Intellectual Developmental Disorder in attempting to lead an independent life. Deficits in adaptive functioning (Criterion B) refer to how well a person meets the community standards of personal independence and social responsibility in comparison to others of similar age and sociocultural background. (Tassé et al., 2012)

Adaptive functioning involves adaptive reasoning in three domains: conceptual, social, and practical. The conceptual (academic) domain involves competence in memory, language, reading, writing, math reasoning, acquisition of practical knowledge, problem solving, and judgment in novel situations. The social domain involves awareness of others' thoughts, feelings, and experiences; empathy; interpersonal communication skills; friendship abilities; and social judgment. The practical domain involves learning and self-management across life settings, including personal care, job responsibilities, money management, recreation, self-management of behavior, and school/work task organization. Intellectual capacity, education, motivation, socialization, personality features, vocational opportunity, cultural experience, and coexisting general medical conditions or mental disorders all influence adaptive functioning.

Adaptive functioning is assessed using both clinical evaluation and individualized, culturally appropriate, psychometrically-sound measures. Standardized measures are used with knowledgeable informants (e.g., parent or other family member, teacher, counselor, care provider) and the individual to the extent that it is possible. Additional sources of information include educational, developmental, medical, and mental health evaluations. Scores from standardized measures and interview sources must be interpreted using clinical judgment. When standardized testing is difficult or impossible due to a variety of factors (e.g., sensory impairment, severe problem behavior), the individual may be diagnosed through clinical judgment.

Adaptive functioning may be difficult to assess in a controlled setting (e.g., prisons, detention centers). If possible, corroborative information reflecting functioning outside those settings should be obtained. Criterion B is met when at least one domain of

adaptive functioning – conceptual, social, or practical – is sufficiently impaired that ongoing support is needed in order for the person to perform adequately in one or more life settings, such as school, work, home, or in the community. To meet diagnostic criteria for intellectual disability, the deficits in adaptive functioning must be directly related to the intellectual impairments described in Criterion A.

AAIDD 2010 Manual

The AAIDD's definition of "intellectual disability"¹ is as follows:

Intellectual disability is characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before 18. The following five assumptions are essential to the application of this definition:

1. Limitations in present functioning must be considered within the context of community environments typical of the individual's age peers and culture.
2. Valid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor, and behavioral factors.
3. Within an individual, limitations often coexist with strengths.
4. An important purpose of describing limitations is to develop a profile of needed supports.
5. With appropriate personalized supports over a sustained period, the life functioning of the person with intellectual disability generally will improve. (*AAIDD 2010 Manual*, p 1)

The "significant limitations in intellectual functioning" criterion for a diagnosis of intellectual disability "is an IQ score that is *approximately* two standard deviations below the mean, considering the standard error measurement for the specific instruments used and the instruments' strengths and limitations." (*AAIDD 2010 Manual*)

¹ For a variety of reasons, including that the term "intellectual disability" (ID) is less offensive to persons with the disability than the term "mental retardation", the AAIDD 2010 Manual uses the former term exclusively. As stated in the 2010 Manual, "the term ID covers the same population of individuals who were diagnosed previously with mental retardation in number, kind, level, type, and duration of the disability and the need of people with this disability for individualized services and support; and every individual who is or was eligible for a diagnosis of mental retardation is eligible for a diagnosis of ID." (*AAIDD 2010 Manual*, p. xvi.)

(emphasis added) “It is clear from this significant limitations criterion used in this Manual that AAIDD (just as the American Psychiatric Association, 2000) does not intend for a fixed cutoff point to be established for making the diagnosis of ID. Both systems (AAIDD and APA) require clinical judgment regarding how to interpret possible measurement error... It must be stressed that the diagnosis of ID is intended to reflect a clinical judgment rather than an actuarial determination. A fixed point cutoff score for ID is not psychometrically justifiable.” (*AAIDD 2010 Manual*, p. 40)

The *AAIDD 2010 Manual* also discusses the “Flynn Effect” as it relates to calculating IQ scores,

The Flynn Effect raises potential challenges for the diagnosis of ID (Kanaya et al., 2003). Because Flynn (1984) reported that mean IQ increases about 0.33 points per year, some investigators (e.g., Flynn, 2006) have suggested that any obtained IQ score should be adjusted 0.33 points for each year the test was administered after the standardization was completed. For example, if the Wechsler Adult Intelligence Scale (WAIS-III; 1997) was used to assess an individual's IQ in July 2005, the population mean on the WAIS-III was set at 100 when it was originally normed in 1995 (published in 1997). However, based on Flynn's data, the population mean on the Full-Scale IQ raises roughly 0.33 points per year; thus the population mean on the WAIS- III Full-Scale IQ corrected for the Flynn Effect would be 103 in 2005 (9 years X 0.33 = 2.9). Hence, using the significant limitations of approximately two standard deviations below the mean, the Full-Scale IQ cutoff would be approximately 73 (plus or minus the standard error of measurement). (*AAIDD 2010 Manual*, p. 37)

The Manual specifically states that “best practices require recognition of a potential Flynn Effect when older editions of an intelligence test (with corresponding older norms) are used in the assessment or interpretation of an IQ score”, and that “ ‘[i]n cases where a test with aging norms is used, a correction for the age of the norms is warranted.’ ” (*AAIDD 2010 Manual*, p. 37)

The Manual also states that “significant limitations in adaptive behavior are operationally defined as performance that is approximately two standard deviations below the mean of either (a) one of the following three types of adaptive behavior: conceptual, social, and practical or (b) an overall score on a standardized measure of conceptual, social, and practical skills. The assessment instrument’s standard error of measurement must be considered when interpreting the individual’s obtained scores.” (*AAIDD 2010 Manual*, p. 43)

Adaptive behavior is defined in the 2002 and 2010 AAMR-AAIDD Classification Manuals by three domains of functioning: Practical, Social, and Conceptual. (Schalock et al., 2010, p. 44)

Conceptual skills include:

- Language
- Reading and writing
- Money, time, and number concepts

Social skills include:

- Interpersonal skills
- Social responsibility
- Self-esteem
- Gullibility
- Naïveté (i.e., wariness)
- Follows rules/obeys laws
- Avoids being victimized
- Social problem solving

Practical skills include:

- Activities of daily living (personal care)
- Occupational skills
- Use of money
- Safety (AAIDD 2010 Manual, p. 44)

These skills are critical in making an assessment “because subscale scores on adaptive behavior measures are moderately correlated, a generalized deficit is assumed even if the score on only one domain meets the operational criterion of being approximately two standard deviations below the mean. A total score of two standard deviations below the mean from an instrument that measures conceptual, social, and practical skills will also meet the operational definition of a significant limitation in adaptive behavior.” (AAIDD 2010 Manual, p. 46).

Use of standardized instruments to assess adaptive behavior is preferable, but the Manual recognizes that “[i]f a standardized assessment measure cannot be used (e.g., if the assessment cannot be reliably administered per the test’s recommended administrative procedures or if there are no reliable respondents to provide adaptive behavior information regarding the assessed person), other sources of adaptive behavior information can be used.” (AAIDD 2010 Manual, p. 48). It should not be expected that persons with mild intellectual disability will be deficient in *all* aspects of adaptive behavior. A significant limitation in *one* of the three domains of adaptive behavior is sufficient for the diagnosis of mental retardation, assuming significant limitations in general intellectual functioning. As Assumption C states, “Within an individual, limitations often coexist with strengths.” This means that people with ID are complex human beings who likely have certain gifts as well as limitations. Like all

people, they often are better at some things better than others. Individuals may have capabilities and strengths that are independent of their ID (e.g., strengths in social or physical capabilities, some adaptive skill areas, or one aspect of an adaptive skill in which they otherwise show an overall limitation. (AAIDD 2010 Manual, p. 7) The DSM-5 has adopted the same criterion, that is, deficits in one of three adaptive behavior domains.

The accurate application of these assumptions requires clinical judgment, which is defined by the AAIDD as:

[A] special type of judgment based on one's professional ethics or standards. Clinical judgment is a special type of judgment rooted in a high level of clinical expertise and experience. It emerges directly from extensive data and is based on training, experiences, and specific knowledge of the person and his or her environments. (AAIDD, page 85)

To utilize clinical judgment as the basis for making the determination of intellectual disability, the supporting documentation must be extensive with first-hand knowledge of the person and his environments.

In determining the developmental and etiological factors of intellectual disability in a client, the AAIDD suggests a multifactorial approach, which will be utilized in this report.

The multifactorial approach to etiology expands the list of causal factors in two directions: types of factors and timing of factors. The first direction expands the types or categories of factors into four groupings:

1. **Biomedical:** biologic processes, such as genetic disorders or nutrition
2. **Social:** social and family interaction, such as stimulation and adult responsiveness
3. **Behavioral:** potentially causal behaviors, such as dangerous (injurious) activities or maternal substance abuse
4. **Educational:** availability of educational supports that promote mental development and the development of adaptive skills.

The second direction concerns the timing of the occurrence of causal factors according to whether these factors affect the parents of the person with ID, the person with ID, or both. This aspect of causation is termed *intergenerational* to describe the influence of factors present during one generation on the outcome in the next generation.

The modern concept of intergenerational effects must be distinguished from the historical concept that ID was related to "weak genes" due to psychosocial, cultural, or familial factors. (Scheerenberger, 1983) This modern concept recognizes that reversible environmental factors in the lives of some families may be related to the etiology of ID and stresses that the understanding of these factors should lead to enhanced individual and family supports.

Any risk factor causes ID only when it results in impaired functioning sufficient to meet the criteria for a diagnosis of ID as described in the *Manual*. There is emphasis that the impairment of functioning that is present when an individual meets the three criteria for a diagnosis of ID usually reflects the presence of several risk factors that interact over time. Thus, the search for the etiology of ID in a particular individual must consist of all of the risk factors that might have resulted in impaired functioning for that person. It involves obtaining as much historical medical information as possible, performing psychological and physical examinations, and pursuing individuals who can provide insight into an individual's functioning

ASSESSMENT OF MR. HOWARD – INTELLECTUAL DISABILITY

The material assembled in this case reveals a man with neurological and environmental deficits that support the diagnosis of intellectual disability, or mild mental retardation. Mr. Howard meets the *DSM-5* and AAIDD criteria for mild Intellectual Disability.

School Records

A review of Mr. Howard's school records shows a classic deterioration in academic functioning. The intellectually disabled often are successful in their early elementary school career. By fourth or fifth grade, a degradation in academic functioning is often seen, with the intellectually disabled falling behind, often two to three grade equivalents.

Ms. Lokey was the Assistant Principal at Silsbee Middle School when Mr. Howard attended. She currently acts as an academic consultant. She recalled Mr. Howard and noted, "No matter how hard he tried, he just couldn't get it." Ms. Lokey reviewed Mr. Howard's standardized test scores. She commented that it was frustrating to see his academic performance deteriorating "on her watch." The school system was unable to support further academic progress for Mr. Howard.

In the Texas Assessment of Academic Skills: Confidential Student Report for the third, fifth, and seventh grades, Mr. Howard was never able to pass the proficiency exam in reading for any year. Being able to develop reading skills has been found to be particularly relevant to IQ development.

In previous research (Ferrer & McArdle, 2004), we found a strong association between the development of cognitive ability and changes in academic achievement (i.e., academic knowledge and quantitative abilities) during childhood and adolescence. We described these interconnections as coupled developmental sequences in which levels of one variable were positively related to changes in time in the other variable. Of particular relevance, we found evidence for a strong coupling over time between cognitive abilities (i.e., Full Scale, Nonverbal, and Verbal IQ on the Wechsler Intelligence Scale for Children–Revised, or WISC-R) and reading (i.e., Letter-Word Identification, Word Attack, and Passage Comprehension reading scales from the Woodcock-Johnson Psycho-Educational Battery, or WJ) for individuals in Grades 1 to 12 (Ferrer et al., 2007). Such couplings represented influences from, for example, cognition in a given year to positive changes in reading the following year. Results from those analyses indicated that (a) there was a positive dynamic relation between reading and cognitive ability from Grades 1 to 12; (b) this dynamic relation was symbiotic, with each process influencing the other over time; and (c) the mutual dynamics of reading and cognition appeared to be strongest during Grades 1 to 3, less strong during 4th to 8th grade, and weakest from 9th to 12th grade. (Ferrer, Shaywitz, Holahan, Marchione, & Shaywitz, 2010)

In third grade, Mr. Howard passed the minimum writing and math proficiency. In fifth grade, he did not meet any minimum proficiency for any subject. In seventh grade, he passed the mathematics computation section for the seventh grade. Math computation is his strength. However, his mathematical abilities were minimal, at best.

The Normed Reference Assessment of Texas was given to Mr. Howard in the 6th grade. It found, “The composite score for this student is in the low range for this grade, which means that the student’s performance in all subjects combined is well below average.”

His scores on the Higher Order Thinking Skills Component of the Normed Reference Assessment showed Mr. Howard performing between the 8.7 and 23.9 national mean for number of problems completely correctly.

HIGHER ORDER THINKING SKILLS

There is a separate higher order thinking skills score for each of the five subject areas in NAPT. Higher order thinking skills involve thought processes that are more complex than mere recall of information or simple comprehension. Items that measure higher order thinking skills usually involve the use of two or more pieces of information to interpret, infer, classify, analyze, or compare. The student's higher order thinking skills scores are shown below.

	Number of Items	Number Attempted	Number of Items Correct	Natl Mean No. Correct
Reading	29	21	12	18.5
Language	34	34	17	22.7
Mathematics	46	46	15	23.9
Social Studies	20	20	3	10.4
Science	21	21	3	8.7

His problem solving and data interpretation scores, at the 8th percentile, were his lowest performing skills.

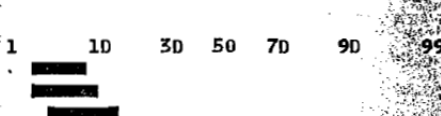
Mr. Howard's impaired academic functioning is reflected no better than in his Otis Lennon Scholastic Aptitude Indices (SAI). His SAI, recorded in 4th grade, show a total score of 88.

OTIS-LENNON SCHOOL ABILITY TEST	RAW SCORE	SAI	AGE PR-S	AGE NCE	SCALED SCORE	NATL GRADE PR-S	NATL GRADE NCE
Total	72	19	88	23-4	34.4	558	20-3 32.3
Verbal	36	6	80	11-3	24.2	535	6-2 17.3
Nonverbal	36	13	95	38-4	43.6	575	44-5 46.8



In the fifth grade, at 11 years, 7 months, Mr. Howard's SAI has fallen dramatically to 74.

OTIS-LENNON SCHOOL ABILITY TEST	RAW SCORE	SAI	AGE PR-S	AGE NCE	SCALED SCORE	NATL GRADE PR-S	NATL GRADE NCE
Total	72	16	74	5-2	15.4	559	4-2 13.1
Verbal	36	7	75	6-2	17.3	555	4-2 13.1
Nonverbal	36	9	79	10-2	23.0	562	6-2 17.3



Similar patterns of academic deterioration were seen on the Comprehensive Tests of Basic Skills (CTBS). Mr. Howard was administered the Comprehensive Test of Basic Skills during his elementary school years. Records documenting his scores during 6th grade already see him falling behind in all but two areas. Some areas, such as total reading and language expression, find him a year behind. He is consistently grade level in computational skills; however as Ms. Lokey pointed out, he is also eight months behind in math concepts. This means he can perform basic addition, subtraction, etc., yet he is unable to understand abstract mathematical questions.

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NAME		JAMAAL B		DISTRICT		SILSBEE		TX		FORM/LEVEL		U/C		00	
CLASS		WILSON P S		CITY/STATE		SILSBEE		TX		GRADE		02.6		00	
SCHOOL		KIRBY		RUN DATE		04/06/88				TEST DATE		03/88			
Comprehensive Tests of Basic Skills															
Individual Test Record															
NATIONAL PERCENTILE															
1 2 3 4 5 6 7 8 9															
10 20 30 40 50 60 70 80 90 95 98 99															
WORD ATTACK															
VOCABULARY															
COMPREHENSION															
TOTAL READING															
LANGUAGE EXPRESSION															
MATH COMPUTATION															
MATH CONCEPTS & APPL															
TOTAL MATH															
STANINE															
1 2 3 4 5 6 7 8 9															

GE = GRADE EQUIVALENT
NCE = NORMAL CURVE EQUIVALENT
OMS = OBJECTIVE MASTER SCORE
NS = NATIONAL STANINE
LP = LOCAL PERCENTILE
NP = NATIONAL PERCENTILE

NAME		JAMAAL B		DISTRICT		SILSBEE		TX		FORM/LEVEL		U/C		004502	
CLASS		HOBBES		CITY/STATE		SILSBEE		TX		GRADE		03.6		0041501	
SCHOOL		READ T		RUN DATE		04/23/89				TEST DATE		03/89			
Comprehensive Tests of Basic Skills															
Individual Test Record															
NATIONAL PERCENTILE															
1 2 3 4 5 6 7 8 9															
10 20 30 40 50 60 70 80 90 95 98 99															
WORD ATTACK															
VOCABULARY															
COMPREHENSION															
TOTAL READING															
LANGUAGE EXPRESSION															
MATH COMPUTATION															
MATH CONCEPTS & APPL															
TOTAL MATH															
STANINE															
1 2 3 4 5 6 7 8 9															

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The deterioration in cognitive skills, called the Matthew Effect, is rife in Mr. Howard's standardized testing. It is also consistent with the continued deterioration of academic skill deficits seen in individuals with Intellectual Disability.

Matthew effect originates from the Book of Matthew's Gospel, which states, "For unto every one that hath shall be given, and he shall have abundance: but from him that hath not shall be taken away even that which he hath" (Matthew 25:29). In simple terms the above phrase has often been summarized as, "The rich get richer, and the poor get poorer" (Stanovich, 1986; Walberg & Tsai, 1983). Researchers have noted repeatedly that some children come to school somewhat "wealthier" than their peers when it comes to early reading skills. As time goes by, those students who start out with some literacy advantages tend to thrive and grow academically, whereas their less fortunate peers tend to get left behind. Like the line in Matthew's Gospel, the rich students get richer and the poor students get poorer. Hence, in 1983, Walberg and Tsai first coined the term the "Matthew effect" to describe the fact that, without intervention, some students rapidly develop and build on strong literacy foundations, and other students languish behind their more fortunate peers." (Sideridis, 2011)

Although his grades were within the normal range, they are inconsistent with his past standardized testing showing poor functioning. It was at this time that the school decided to place him in the Other Handicapped Index (OHI) classes, which Ms. Lokey

likened to Special Education. This placement afforded him additional time to take tests and other such accommodations. During this first semester, he received the highest grades and was also a highly regarded athlete on the basketball team.

Mr. Howard had a dismal academic career. He has never been able to read effectively. His mathematic skills and his ability to abstract and comprehension are severely limited. This was corroborated on multiple neuropsychological screening instruments administered during my examination.

Neuropsychological Screening

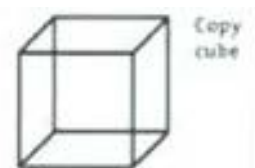
The *DSM-5* recommends neuropsychological testing as an important component of effective evaluation of intellectual disability, especially when IQ scores are missing or inconclusive. Neuropsychological testing provides the bridge between brain function, adaptive functioning, and behavior, what is called Ecological Validity. Mr. Howard appears not to have been given neuropsychological tests previously. However, we can surmise from his academic scores and behavior that he has a long history of cognitive deficits before the onset of his psychosis.

Many of his deficits, and his few strengths, were picked up in my neuropsychological screening examination. For example, Mr. Howard's computational skills were apparent. At the same time his impaired frontal lobe time sequencing ability was evident.

Mr. Howard performed serial 7s, in which he was required to start at 100 and subtract 7. If done correctly, the first answer is 93, and Mr. Howard answered correctly. The sequence continues by subtracting 7 from 93 and continues this serial subtraction. Mr. Howard gave the incorrect answer of 89. He did not self-correct. Thereafter, Mr. Howard's answers lost sequence and were also incorrect. His complete set of answers was 93, 89, 81, 84, and 96. Mr. Howard had "lost set." This means he had lost the purpose of the test and was no longer able to follow the directions.

Montreal Cognitive Assessment (MOCA)

Mr. Howard was administered subtests of the Montreal Cognitive Assessment. On the Trails Making Test, which looks at the gross ability to switch between one task or another, Mr. Howard was able to successfully complete the task. In order to accomplish this, he asked that the directions be repeated three times. He was also able to complete a clock drawing, a test of rudimentary visuospatial ability.



Mr. Howard was not able to copy a cube that was right in front of him. Drawing cubes test Constructional Apraxia, the ability to judge things like distances and perspectives in space. This is important for understanding distances, following directions successfully, and traveling.



Mr. Howard was given a Go/No Go test, which tested his ability to inhibit his behavior. He was given a string of letters with As scattered throughout. He was asked to tap every time he heard the letter "A", first with his right hand, then with his left hand. Mr. Howard performed poorly, making mistakes of omission (not tapping when he should tap), as well as mistakes of commission (tapping when he should not tap). Both of these cognitive errors indicate problems with being able to weigh and deliberate, as well as control thinking and behavior.

Mr. Howard performed poorly on the digit span test. Numbers were spoken to him that he then repeated. The digit span test is not a mathematics test. It is designed to test working memory, in the area of the brain that holds an event so that it can become part of the memory. Mr. Howard was not able to recall five digits in a row. More worrisome, he was not able to recall three digits read backward. Reverse digit span is a more refined test of working memory, since the element of repetition is removed. The individual must recall the numbers, rearrange them, and then state them. He was unable to work with three and four reverse digits, illustrating extremely poor working memory. His loss of set on screening tests like the Serial 7s is also illustrative of impaired working memory, even when he was able to complete the task.

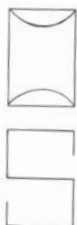
Mr. Howard demonstrated paraphasic speech issues on the MOCA. He was asked to repeat the sentence, "The cat always hid under the couch when dogs were in the room." He said, "The couch always hid up under the couch when dogs were in the room." His addition of words and misstatement reflects possible left temporal lobe dysfunction.

Mr. Howard is extremely concrete; he is unable to engage in abstract meaning. This is consistent with Ms. Lokey's observation that Mr. Howard was unable to solve word problems, yet he was capable of performing mathematical computation. It also illustrates how his brain had not continued to develop appropriately.

Cognistat

Mr. Howard was also administered subtests of the Cognistat, a neuropsychological screening instrument. He was administered the digit symbol test, a visual memory story task, and line drawings designed to test working memory, visual spatial skills, and construction apraxia.

He performed poorly on the digit symbol. He also was unable to accurately reproduce the line drawing. Rotation of drawn figures is indicative of cognitive dysfunction.



Mr. Howard was shown an image depicting a visual story for 30 seconds. The image was then taken away, and he was asked to tell the story shown in the picture.



Mr. Howard's rendition of the picture was extremely concrete. He said there was a "girl" fishing and a boy yelling on the bridge. He did not draw a relationship between the two people. He did also not notice the boy, not girl, was sleeping or the fish was jumping. This level of inaccurate reporting demonstrates impaired working memory, slow processing speed, difficulty recognizing the overall gestalt of a story and poor visual memory.

In sum, on screening tests for cognitive impairments, Mr. Howard exhibits significant working memory problems. He exhibits problems with processing speed, he has limited visual spatial abilities, and he is concrete. His school records indicate that he is academically impaired. Standardized testing reveals that he was more than 2-3 years behind his age group during his developmental years. These cognitive deficits are neurologically-derived impairments. They directly limit his adaptive functioning.

Adaptive Functioning

Ms. Lokey described Mr. Howard as easily taken advantage of by other students. She noted they could "Put him up to do things." He was described as gullible, which as noted in the AAIDD manual, is a cornerstone of Intellectual Disability:

By calling for diagnosticians to focus more on cognitively mediated adaptive deficits such as gullibility and risk-unawareness (p. 38), the intellectual disability/IDD section in DSM-5 has taken an important first step towards redefining intellectual disability/IDD as a biologically based disorder marked by limitations in everyday reasoning and judgement, rather than as a purely functional disability marked by seemingly arbitrary ceilings on psychometric measures that generally fail to capture the taxonomic essence of the category. (Greenspan & Woods, 2013)

Additional indications of impaired adaptive functioning were evident. Mr. Howard and

his mother, Shirley Howard, acknowledged that he only cooked scrambled eggs and, occasionally, hamburgers. When I asked Mr. Howard to tell me how he scrambled eggs, he said, "I crack the egg, put some salt and pepper on them, and put them in the pan." When asked how he cooked a hamburger, he said, "I pat on it and put it in the pan." Sheanna Howard, Mr. Howard's younger sister also reported Mr. Howard could prepare cereal, but not much else. Sheanna Howard stated that although she was four years younger than her brother, she often felt as though she were the older sibling as they grew up. He never lived independently.

Shirley Howard acknowledged that Mr. Howard rarely acted independently. He never received a driver's license, but would drive along with his grandfather. Mr. Howard did not know what direction Dallas was from his home. He admitted he would not know how to drive there. Similarly, when asked where we were, he correctly reported the name of the Polunsky Unit. However, he remarked that for years he did not know that Louisiana was East of Texas until someone in the prison corrected him. Although early in his life he was described as a neat person, this deteriorated, most probably due to his psychotic disorder.

His academic limitations reflect impaired adaptive functioning. His ability to utilize language, math skills, and reading skills all thwart him adapting successfully in the everyday world. Mr. Howard's academic impediments alone would meet the adaptive dysfunction criteria for the Conceptual Domain, placing Mr. Howard in the Intellectually Disabled status.

ASSESSMENT OF MR. HOWARD – SCHIZOPHRENIA

Mr. Howard has been diagnosed in prison with Schizophrenia. He is currently being treated with Haldol, a potent antipsychotic. He was diagnosed and treated shortly after his prison incarceration; however, clear signs of psychosis occurred prior to the offense and his arrest.

Multiple persons describe Mr. Howard's prodromal phase, that period of social deterioration that occurs early in the development of psychotic illnesses, especially schizophrenia (Knowles & Davidson, 2004; Addington & Addington). His prodromal phase seems to have begun in his mid-teens.

Family and friends describe him as someone who was extremely neat in his appearance. As he descended into his psychosis, his physical appearance changed. His sister, Sheanna, described how he would no longer would cut his hair neatly. He wore a cap over his hair and did not style it in any way. Mr. Howard refused to wash. He would go weeks without showering, refusing all entreaties by his family. Occasionally, his cousin would get him into a shower, but it was rare.

Mr. Howard was a relatively social person until his mid-teens. He acknowledges feeling “apart” from his family and friends, as the “sounds” continued to overtake his life. He became increasingly isolated from family and friends as his psychosis undermined and overtook his reality. Mr. Howard describes this as “My Isolation.”

Mr. Howard also described positive symptoms of schizophrenia, including the auditory hallucinations of sounds and voices he could not identify. As time went by without treatment, these positive symptoms occasionally became commanding in nature. Mr. Howard described the voices and sounds, “taking over my mind.”

Mr. Howard, his family, and others describe negative symptoms of schizophrenia as well. Shirley talked about Mr. Howard’s withdrawal. The family had a practice of watching movies together on Sunday. When he was younger, Mr. Howard had always participated in this. Nevertheless, as he became increasingly psychotic, he began to withdraw into his bedroom. He would sit alone and stare at the wall.

He would walk for hours at a time, ignoring long time friends and family. Often before the onset of his psychosis, he would go to the park where he played basketball for hours with friends. After the onset of psychotic symptoms, he no longer played, and would laugh to himself, ignoring the sport he loved and people he knew and to whom he was close.

It is my professional opinion, and clearly that of the Texas Department of Corrections, that Mr. Howard suffers from Schizophrenia. He has been hospitalized in acute psychiatric settings within the prison system. He has been treated with injectable antipsychotics whose sole indication is psychotic disorder when given intramuscularly. He continues on antipsychotic medication currently.

The prodromal syndrome of his schizophrenia started in his mid teens with classic symptoms of social withdrawal and deterioration, auditory hallucinations and isolation.

The Relationship between Intellectual Disability and Schizophrenia

In making the determination whether Mr. Howard meets the criteria for Intellectual Disability, his ongoing psychosis has to be taken into consideration. Freedman and Woods discusses the comorbidity of psychiatric disorders and Intellectual Disability.

Diagnostic accuracy is paramount in determining psychotic illnesses, particularly schizophrenia, among the persons with ID. In order to achieve diagnostic accuracy, several factors must be taken into consideration:

1. Diagnostic overshadowing is the assumption by clinicians that the presenting symptoms are secondary to organic, environmental, or

social causes, rather than a psychotic illness. The overlay of non-specific cognitive deficits may trump the clinician's determination of causation for psychosis. Care must be taken to differentiate symptoms which arise from psychotic processes from those which are better understood to be secondary to ID.

2. The delusions of persons with intellectual disability may not be as rich in detail and may be more culturally naïve than those suffering from delusions but who do not have ID. This lack of detail should not be mistaken for a lack of delusional strength or content. Clinicians should determine the pervasiveness and influence of the delusion, as well as the strength of the commitment to it, rather than merely judging the quality of its content.
3. Individuals with ID may be less likely to hide perceptual disorders, such as hallucinations, delusions, or paranoid ideation. However, differentiation must be made between auditory hallucinations and other language-based disorders that may present or be described as "voices." As with all assessments of hallucinations, careful exploration and differentiation from a common experience of hearing one's thoughts is necessary. For instance, "I hear my deceased mother's words," may be an auditory hallucination or a vivid recollection. It may be more difficult for a language-impaired person with ID to express the difference.
4. Medications may impact the organic dysfunction of persons with ID. They may present with mild delirium secondary to medication effects that may be incorrectly attributed to a psychotic illness (Fletcher, 2007). From a clinical standpoint, it appears that individuals with schizophrenia and borderline intellectual functioning obtain clear treatment benefit not only from antipsychotic medication, but also psycho-education groups geared to their level of vocabulary and processing (Pitschel-Walz, 2009).
5. Neuropsychological testing during more florid periods of a psychotic disorder may be informative regarding the question of how behavior is affected by the comorbid conditions, but may also be less stable and reliable compared to testing during remission or when the psychosis is better controlling. (Greenspan & Woods, 2013)

Mr. Howard had two specific periods of deterioration which help us differentiate between the two comorbid disorders. The first period of deterioration was in early childhood, which is consistent with Intellectual Disability. This period of deterioration reflects early academic functioning, poor understanding of social context, and

distractibility. The second period of deterioration was in his middle school and only year of high school. This is the classic prodromal period of psychotic disorders, often mistaken for teenage angst.

There is a clear distinction between his two disorders in spite of the severity of both his schizophrenia and his intellectual disability.

CLINICAL CONCLUSIONS

It is my professional opinion, which I hold to a reasonable degree of neuropsychiatric certainty, that Mr. Howard should be further evaluated to corroborate my diagnosis of mild intellectual Disability.

A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.

Mr. Howard's intellectual functioning should be measured with additional standardized intelligence testing. He was tested with subtests by Dr. Lane, and his IQ was estimated around 60. In connection with Mr. Howard's trial, Dr. Duncan testified that he also administered some subtests of the Wechsler Adult Intelligence Scale and estimated that his IQ was 65-70. A more comprehensive battery would determine the accuracy of this limited testing. A comprehensive neuropsychological battery -- which includes an IQ test -- would explain Mr. Howard's long standing cognitive deficits. Neuropsychological testing can differentiate between early onset cognitive impairments, such as academic problems, and those deficits that may have been acquired.

B. Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

It is my professional opinion that Mr. Howard's adaptive functioning is impaired in all three domains, especially the conceptual, which relies so heavily on reading, writing, and abstractions. He is also, in my opinion, impaired in the social domain, although his impairment in the social domain may be more difficult to separate from his behavior due to his schizophrenic illness. Mr. Howard also has significant limitations in the practical domain. He has never held a job or lived independently. His limitations in cooking, following directions, and taking advantage of community resources were

evident before the onset of his psychotic illness.

Mr. Howard also had significant support systems available to him in terms of a very active and supportive mother. Nevertheless, he was unable to take advantage of these support systems due to his significant cognitive deficits. A formal adaptive functioning evaluation is necessary to objectively determine Mr. Howard's adaptive functions.

C. Onset of intellectual and adaptive deficits during the developmental period.

Mr. Howard has had academic and social problems all his life, culminating in special education and accommodations in his final year of formal education. He has never tried to get a GED and recognizes that he is not intellectually capable of performing on the 10th grade level required to do so. His intellectual disability occurred in the developmental period.

FORENSIC RECOMMENDATION

It is my professional opinion, which I hold to a reasonable degree of neuropsychiatric certainty, that further evaluation of Mr. Howard's Intellectual Disability should be undertaken to corroborate my diagnosis of intellectual disability. Comprehensive intellectual and neuropsychological batteries should be undertaken to answer the question of his cognitive disorder and intellectual limitations. Further, a standardized measure of Mr. Howard's adaptive abilities should be administered by a qualified intellectual disability professional.

Thank you for allowing me these preliminary examinations of Mr. Howard.



George W. Woods, M.D.

REFERENCES

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Appendix A: Documents Reviewed

Signed witness declarations by Shirley Howard, Sheanna Howard, Kim Lewis, Gaye Lokey, Linda McCarter, Lisa Sanchez, and Thomas Tyler

Declaration of Mitigation Specialist Gina Vitale summarizing interviews with Karrion Cartwright, George Desha, Jinneh Dyson, Jasmonique Howard, Jerry Howard, Jr., Jerry Howard, Sr., Michael Lewis, Fred McGrew, Patricia Robertson, and Towona Washington

Medical records from Dr. Frank Lane and Dr. Ravikumar Kanneganti

School records of Mr. Howard from the Silsbee ISD

Pretrial and Trial Reports by Dr. James Duncan, Dr. Fred Fason, Dr. Edward Gripon, and Dr. George Groves

Competency hearing testimony of Dr. James Duncan, Dr. Fred Fason, Dr. George Groves, and Dr. Edward Gripon

Trial testimony of Dr. Edward Gripon (both phases of trial) and Dr. Fred Fason (penalty phase)

Social history compiled by Shirley Howard at the request of Dr. Fason

Voluntary Statement by Mr. Howard, 5/12/00, 5:15 pm

Surveillance video of the offense



GEORGE W. WOODS, JR., M.D., F.A.P.A.

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George W. Woods, Jr., M.D.

**401 Grand Avenue, #380
Oakland, California 94610**

**57 Executive Park South, #360
Atlanta, Georgia 30326**

EDUCATION

1981-1982: American Psychiatric Association/National Institute of Mental Health Fellowship
Pacific Medical Center, San Francisco, California

1981: Residency- Psychiatric - Pacific Medical Center, San Francisco, California

1977-1978: Internship—Medical/Surgical, Highland Hospital, Oakland, California

1977: MD, University of Utah, Salt Lake City, Utah

1969: BA, Westminster College, Salt Lake City, Utah

LICENSES & CERTIFICATIONS, OFFICES HELD

2015: President, International Academy of Law and Mental Health

2014: Certified International Association for the Specialized Study of Developmental Disorders
Academy (IASSDD) Academy Instructor.

2013: President Elect, International Academy of Law and Mental Health

2009-2013: Secretary General, International Academy of Law and Mental Health

2008: Certified Mediation Specialist, California State University, Sacramento, California

2004-2005: Interim License, Zanzibar Revolutionary Government

2004: Fellow: American Psychiatric Association

1992: Certified by the American Board of Psychiatry and Neurology

1979: Licensed Physician in California

CLINICAL EXPERIENCE & CONSULTATION

2015: San Francisco Police Department Crisis Intervention Training(CIT):
The Developing Brain

2015: Criminal Justice and Mental Health Reform.
San Francisco Collaborative Courts, Collaborative Courts Training Series

2015: Complex Trauma: Effects and Intervention.
San Francisco Collaborative Courts, Collaborative Courts Training Series

2014: Undoing the Damage: The Mental Health and Criminal Justice Tragedy.
San Francisco Collaborative Courts, Collaborative Courts Training Series

2014: The Constitutional Implications of Ebola: Civil Liberties & Civil Rights In Times of Health
Crises, University of California, Irvine Law School

2014: San Francisco Police Department Crisis Intervention Training(CIT): The adolescent and
geriatric brains, more alike than different?

2014: Moderator; The Easy Read Project: an investigation into the accessibility value of health-
based “easy read” literature; Television viewing habits and preferences of adults and your people
with intellectual disability: a survey using a Talking Mats Questionnaire; Effectiveness of
Computer-Based Simulations on Learning of Social and Communication Skills by Children with
IDD and ASD; Social media and intellectual disabilities: IASSID European Regional Congress,
Vienna.

2014 Risk Assessment in Neurodevelopmental Disorders, IASSID European Regional Congress,
Vienna

2013: Task Force on Determination of Intellectual Disability for the Courts, American
Association for Individuals with Intellectual Disabilities

2011: San Francisco Police Department Crisis Intervention Training (CIT): Suicide Assessment,
Mood disorders, thought disorders, and personality disorders

2010: Task Force on Mental Retardation and Forensic Practice, American Association for
Individuals with Intellectual Disabilities.

2006-2009: Projects Among African Americans To Explore Risks for Schizophrenia
(PAARTNERS), Consensus Diagnosis Group, Minority Mental Health Research Group,
Department of Psychiatry and Behavioral Sciences, Morehouse School of Medicine, Atlanta,
Georgia

1996-present: Individual Private Practice, California Bay Area

2006: National Consortium on Disaster Response for the Poor and Underserved, Developmental
Task Force for the Minority Mental Health Professions Foundation, Atlanta, Georgia

2006: Georgia Congressional Representative Cynthia McKinney’s Post-Katrina Working Task

Force

1998-2004: Consultant-the Board of Directors, Crestwood Behavioral Health Systems, Stockton, California

1994-1996: Senior Consulting Addictionologist, New Beginnings Programs, San Ramon and Pinole, California

1988-1996: Individual Private Practice, Pinole, California

1994-1995: Chemical Dependency Consultant, Physicians' Advisory Committee, Alameda Contra Costa Medical Association

1990-1995: Consultant, Insomnia Division of the Sleep Disorders Center, Doctors Hospital, Pinole, California

1992-1994: Qualified Medical Examiner, Industrial Medical Council, State of California

1990-1994: Medical Director, Pain Management Program, Doctors Hospital, Pinole, California

1991-1993: Psychiatric/Pharmacologic Consultant, Triumph Over Pain (TOP Program), Kentfield Rehabilitation Hospital, Kentfield, California

1991-1993: Psychiatric Consultation, NeuroCare Corporation, Concord, California

1989-1994: Clinical Director, New Beginnings Chemical Dependency Program, Doctors Hospital, Pinole, California

1988-1993: Private Practice, Comprehensive Psychiatric Services, Walnut Creek

1983-1990: Staff Psychiatrist, Crestwood Manor, Vallejo, California

1982-1983: Medical Director, Westside Geriatric Services of Family Service Agency of San Francisco

1982-1983: Staff Psychiatrist, Villa Fairmount Psychiatric Facility, San Leandro, California

1981-1982: Assistant Director of the Inpatient Center, Director of Geriatric Services, Pacific Medical Center, San Francisco, California

1980-1981: Medical Director, Clinica De La Raza, Blythe, California

1979-1981: Emergency Room Physician, Medical Emergency Services, Fairmount Hospital, San Leandro, California

INTERNATIONAL CLINICAL EXPERIENCE & CONSULTATIONS

2015: Neurodevelopmental Disorders: Training for Clinicians. Zomba Mental Hospital, Zomba, Malawi

2006-2008: Adjunct Professor, Makerere University, Department of Psychiatry, Kampala,

Uganda

2006-present: Human Rights Committee, International Academy of Law and Mental Health, Montreal, Quebec, Canada

2006: Visiting Staff Psychiatrist, Butabika National Hospital, Kampala, Uganda

2004: Clinical Consultant, Kidongo Chekundu Mental Hospital, Zanzibar, Tanzania

2004: Scientific Committee, International Academy of Law and Mental Health

1998-2004: Technical Advisor, Documentation Committee, Operation Recovery, Kenya Medical Association

1999-2003: Advisor - the Jomo Kenyatta National Hospital, PTSD Project, Nairobi, Kenya

1998-2003: Technical Advisor- Recovery Services, Ministry of Health, United Republic of Tanzania

ADVISORY BOARDS

2013: International Association of Trauma Professionals

2013: *Celebrating a Decade of Behavioral Health Court*, San Francisco, California, Honorary Committee

2012: Executive Committee, Challenging Behaviors Special Interest Research Group, International Association for the Scientific Study of Intellectual Disabilities

2006-present: Executive Committee, International Academy of Law and Mental Health

2004-2007: Advisory Board, Health Law Institute, DePaul University, College of Law

2004-present: Advisory Board, Human Dignity and Humiliation Studies, University of Trondheim, Norway

2004-2010: Board of Directors, The Center for African Peace and Conflict Resolution, College of Health and Human Services, California State University, Sacramento

2003-present: International Board of Directors, International Academy of Law and Mental Health

FACULTY AND PROFESSIONAL APPOINTMENTS

2012-present: Lecturer, University of California Berkeley School of Law

2012: Newsletter Editor, Challenging Behaviors Special Interest Research Group, International Association for the Scientific Study of Intellectual Disabilities

2008: Secretary, American Psychiatric Association's Africa Action Committee

2003: Adjunct Professor, California State University, Sacramento, Department of Educational

Leadership and Public Policy, Sacramento, California

2002-present: Adjunct Professor, Morehouse School of Medicine, Department of Psychiatry, Atlanta, Georgia

1999-2004: Affiliate Professor, University of Washington, Bothell Campus, Interdisciplinary Arts and Sciences

1996-2000: Adjunct Professor, University of California, Davis, Department of Psychiatry, Forensic Fellowship

1992: Summer Faculty, North Central Educational Research Laboratory, Northeastern University

1986-2002: Adjunct Professor, University of Nebraska, Omaha, College of Public Affairs

CLINICAL LECTURES

2015: Neurobehavioral Assessment: Malawi Human Rights Commission

2014: Adolescents and the Elderly; More alike than you would expect.” San Francisco Police Department Crisis Intervention Training.

2014: Bipolar Disorder in Pregnancy: Meena Kumari, MD: George Woods, MD, Faculty Discussant

2013: High Prevalence of Brain Pathology in Violent Prisoners: A Qualitative CT and MRI Scan Study: Journal Club, Racquel Reid, MD, George Woods, MD, Faculty Discussant

2013: Medical disorders that masquerade as psychiatric disorders. International Academy of Law and Mental Health, Amsterdam, Netherlands

2013: Does Policy Drive Science? University of California, Berkeley, Integrative Biology Course (MCB15).

2013: Understanding Combat-Related Post-Traumatic Stress Disorder: Andrea Brownridge, MD, JD; George Woods, MD, Faculty Discussant

2012: The Neurobiological Effects of Trauma: District of Columbia Criminal Court, Superior Division Third Annual Criminal Justice Conference, Mental Illness and Treatment: Past Present and Future

2012: Neurodevelopmental Disorders: International Association for the Scientific Study of Intellectual Disorders, Halifax, Nova Scotia

2012: Diabetes and Weight Control, Moderator: International Association for the Scientific Study of Intellectual Disorders, Halifax, Nova Scotia

2012: Health Inequalities in Developmental Disabilities, Moderator: International Association for the Scientific Study of Intellectual Disorders. Halifax, Nova Scotia

2012: The Neurobiology of Trauma: San Francisco YWCA Intern Training.

2011: Mood and Thought Disorders in Crisis Intervention: San Francisco County Sheriff's Office, Intervention Training, San Francisco, California.

2011: Fetal Alcohol Spectrum Disorders and the Criminal Justice System, National Press Club, Washington, DC.

2011: The Epidemiology of Medicalization of Prisoners in the United States, International Academy of Law and Mental Health, Berlin, Germany

2011: Intellectual Disability and Fetal Alcohol Spectrum Disorder: International Academy of Law and Mental Health, Berlin, Germany

2011: Neuronal Plasticity: Cognitive Skills Retraining for students with acquired brain injuries or learning disabilities. College of Alameda, Alameda, California

2011: "The Neurobiology of Trauma In Children: Lessons About Early Childhood; Families First, Atlanta, Georgia

2010: From the Plantations/Asylums to the Prisons: The Relationship between Humiliation, Stigma, Economics and Correctional Care for the Mentally Ill: 2010 Workshop on Transforming Humiliation and Violent Conflict representing the 16th Annual Human DHS Conference and the Seventh Workshop on Humiliation and Violent Conflict Columbia University, Teachers College, New York

2010: Applying the Institute of Medicine Quality Chasm Framework to Improving Health Care for Mental and Substance Use Conditions; Morehouse School of Medicine, Department of Psychiatry, Journal Club

2010: Psychiatric Manifestations of Physical Disease. Morehouse School of Medicine, Department of Family Practice, Atlanta, Georgia.

2009: Sleep Disorders in Psychiatric Practice: Morehouse School of Medicine, Department of Psychiatry, Atlanta, Georgia

2008: Moderator: The Impact of Mental Health Issues on Aging, Particularly as it Relates to Alzheimer's Dementia and Parkinson Disease, National Medical Association, Atlanta, Georgia

2008: Aging and Mental Health: What is Wellness and What is Pathology? National Medical Association, Atlanta, Georgia

2007: The Price of Leadership and the Cost of Success: Urban Leadership Program, Graduate School of Educational Leadership and Public Policy, California State University, Sacramento

2007: Cognitive Assessment and Curriculum, Department of Educational Policy, Urban Leadership Program, Graduate School of Educational Leadership and Public Policy, California State University, Sacramento

2007: Complex disorders of trauma and torture: The neurological bases examined through sleep disorders, Padua, Italy

2006: Clinical Aspects of Forensic Evaluation, Makerere University, Department of Psychiatry, Kampala, Uganda

2006: Memory, Medications, and Aging, Crockett, California Women's Club

2006: Cultural Differences: Ethics or Efficacy, Mental Health, Ethics and Social Policy, University of Montreal, Quebec, Canada

2006: An Update on Memory Function, Grand Rounds, Morehouse School of Medicine, Atlanta, Georgia

2006: Moderator & Respondent (Representing Morehouse School of Medicine) Consortium for the Poor and Underserved- Cultural Factors, DePaul University School of Law and Health, Health Law Institute

2005: Constitutional Theory and Medical Rights, Montreal, Quebec, Canada

2005: Medical Diseases with Psychiatric Manifestations: Morrison and Foerster, LLP

2004: Diagnosis and Treatment of Malaria-Induced Altered Mental States: Kidongo Chekundo Mental Hospital, Zanzibar, Tanzania

2003: Law, Mental Health, and Popular Culture: University of San Francisco College of Law

2003: Accommodating Mental Illness in the Workplace: The 28th International Conference, International Academy of Law and Mental Illness, Sydney, Australia

2002: Cultural and Psycho-biological Factors In the Assessment and Treatment of Trauma: Don't Believe Everything You Think: Traumatology 1003, The Trauma Recovery Institute, Morgantown, West Virginia

2002: Trauma, Recovery and Resiliency, University of Washington, Bothell, 2002

2001: Understanding the Relationship Between Neuroimaging, Neuropsychology, and Behavior: National Medical Association 2001 Annual Convention and Scientific Assembly, Nashville, Tennessee, 2001

2001: The Thrill is Gone: Keynote Address, African American History Month, Loras College, Dubuque, Iowa

2001: Disparate Access- Healthcare: University of Washington, Bothell Campus Nursing Program

2000: Anger Management: West Contra Costa Stroke and Aphasia Support Group, Doctors Hospital, San Pablo, California, 2000

2000: Race, Culture and Bioethics: American Society for Bioethics Annual Conference, Panel Discussion, Salt Lake City, Utah

2000: Globalization and Postmodernism: International Congress on Law and Mental Health, Siena, Italy

2000: Globalization and Neuropsychiatry: Answers that Transcend Culture? International Congress on Law and Mental Health, Sienna, Italy

1998: Managed Care in the Kenyan Medical Environment: Kenyan Medical Environment:

Kenyan Medical Association, Aga Khan Hospital, Nairobi, Kenya

1994: The Relationship Between Holidays and Mood Disorders: Doctors Hospital Pinole, California

1994: The Role of the Mental Health Expert as a Liaison Between Chemical Dependency and Pain Management Programs: American Academy of Pain Management, Vancouver, Canada

1994: Chemical Dependency: Selected Topics: Critical Care Conference, Doctors Hospital, Pinole California

1993: Detox: The First Step to Recovery: National Medical Enterprises Management Services Division Annual Conference, Colorado Springs, Colorado

1993: Substance Use and Substance Induced Organic Mental Disorders: National Medical Enterprises Management Services Division Annual Conference, Colorado Springs, Colorado

1993: Dual Diagnosis in the Inpatient Setting- Professional Seminar, Doctors Hospital, Pinole, California

1993: Depression and Strokes: Brookside Hospital, San Pablo, California

1992: Drug Interactions in the ICU: Clinical Care Rounds, Doctors Hospital, Pinole, California

1992: Overview of Sleep Disorders: Grand Rounds, Doctor Hospital, Pinole, California

1991: Benzodiazepines: Uses and Abuses: Grand Rounds, Brookside Hospital, San Pablo, California

1990: Sleep Disorders in Schizophrenia: Quarterly Medical Staff Meeting, East Bay Hospital

1987: Afro-Centricity in Psychology: Grand Rounds, San Francisco General Hospital, San Francisco, California

1982: Geriatric Psychiatry-University of Southern California

PROFESSIONAL AFFILIATIONS

American Academy of Psychiatry and the Law

International Association for the Scientific Study of Intellectual Disabilities

Northern California Psychiatric Society

American Society of Addiction Medicine

American Psychiatric Association

Black Psychiatrists of America

American Neuropsychiatric Association

American Psychological Association

American Association for Intellectual and Developmental Disabilities

CLINICAL PROFESSIONAL ACTIVITIES

2015: International Journal of Developmental Disabilities

2015: Journal of Policy and Practice in Intellectual Disability

2014: Cureus Journal Review

2014: Arts and Social Sciences Journal Review

2013: Journal of Politics and Law Journal Review

2012: Research in Developmental Disabilities Journal Review

2010: American Association for Intellectual and Developmental Disabilities, Task Force on Intellectual Disability and Forensic Practice

2007-2009: Neurocognitive Committee, PAARTNERS

2004-present: Scientific Committee, International Academy of Law and Mental Health

1993-1996: Medical Privileges Committee, Doctors Hospital, Pinole, California

1993-1995: Physicians' Advisory Committee, Alameda Contra Costa Medical Association, Oakland, California

1993-1994: Board of Directors, Solano Park Hospital, Fairfield, California

1992-1993: Board of Directors, East Bay Hospital, Richmond, California

1992: Chief of Staff, East Bay Hospital, Richmond, California

1992: Chairman, Medical Executive Committee, East Bay Hospital, Richmond, California

1992: Allied Health Committee, Doctors Hospital, Pinole, California

1992: Pharmacy & Therapeutics Committee, Doctors Hospital, Pinole, California

1991-1996: Physicians' Advisory Committee, Doctors Hospital, Pinole, California
(Chair, 1994- 1995)

1991: Professional Activities Committee, Easy Bay Hospital, Richmond, California

1990: Psychiatry Committee, Chairman, East Bay Hospital, Richmond, California

HONORS

- 2015: President, International Academy of Law and Mental Health
- 2013: Keynote Speaker, Tenth Anniversary of the San Francisco Behavioral Health Court
- 2013: Vice President/President Elect, International Academy of Law and Mental Health
- 2009-2012: Secretary General, International Academy of Law and Mental Health
- 2009: Co-Chair, International Academy of Law and Mental Health Congress, New York University Law School,
- 2007: Co-Chair, International Academy of Law and Mental Health Congress, University of Padua, Padua, Italy.
- 2007: Executive Committee, International Academy of Law and Mental Health
- 1993: Outstanding Professor Award, Goodrich Program, Department of Public Policy, University of Nebraska at Omaha
- 1992: National Medical Enterprises' Outstanding Medical Director of Psychiatric, Rehabilitation and Recovery Hospitals
- 1992: Chief of Staff Award for Outstanding Service, East Bay Hospital, Richmond, California

CLINICAL PUBLICATIONS

Greenspan, Harris, and Woods (2015) *Intellectual disability is "a condition, not a number": Ethics of IQ cut-offs in psychiatry, human services and law*. Ethics, Medicine, and Public Health

Woods, Freedman ((2015) *Symptom presentation and functioning in neurodevelopmental disorders: Intellectual disability and exposure to trauma*, Ethics, Medicine, and Public Health

Greenspan, Woods, and Switzky (2015) *Age of Onset and the Developmental Period Criteria*, Intellectual Disability and the Death Penalty

Greenspan, Woods, Wood (In Press) *Risk-Unawareness and Legal Jeopardy: Identifying Non-Obvious Brain-Based Impairment*, Springer's International Library of Ethics, Law, and the New Medicine

Woods, Freedman (2015) *Intellectual Disability, Comorbid Disorders and Differential Diagnosis*, Intellectual Disability and the Death Penalty

Greenspan, Woods (2014) *Intellectual Disability as a Judgment Disorder: The Gradual Move Away From IQ-Ceilings*, Current Opinion in Psychiatry

Freedman, Woods:(2013) *Neighborhood Effects, Mental Illness and Criminal Behavior: A Review*. Journal of Politics and Law; Vol. 6, No. 3;

Woods, Freedman, Greenspan: (2012). *Neurobehavioral Assessment in Forensic Practice*. International Journal of Law and Psychiatry.

Norton, Woods, (2012). *Secondary trauma among judges, jurors, attorneys, and court personnel*. Encyclopedia of trauma: an interdisciplinary guide. C. Figley, Sage Publications.

Greenspan, Switzky, Woods: (2012) *Intelligence Involves Risk-Awareness and Intellectual Disability Involves Risk-Unawareness: Implications of a Theory of Common Sense*, Journal on Intellectual & Developmental Disability. (Cited in Diagnostic and Statistical Manual, 5th Edition, online version)

Woods, Greenspan, Agharkar: (2012) *Ethnic and Cultural Factors in Identifying Fetal Alcohol Spectrum Disorders*: American Journal of Law and Psychiatry.

Bradford, Fresh, Woods: Not all patients are alike: (2007) *Ethnopsychopharmacology of Bipolar Disorder in African Americans*. Psychiatric Times, February.

Abueg, Woods, Watson: Disaster Trauma; (2000) *Cognitive-Behavioral Strategies in Crisis Intervention*: Second Edition, Guilford Press, New York and London; p. 73-290.

FORENSIC PRACTICE

1981-present: Psychiatric Consultant (Civil, Family Law, Criminal and Appellate Judicial Proceedings)

1993-2001: Consultant- the Victims' Assistance Program, State Board of Control, State of California, Sacramento, California

1983-2000: Medical Examiner Panel, San Francisco County, Marin County and Contra Costa County Superior Courts

FORENSIC PROFESSIONAL LECTURES

2015: Mass Murder: Patterns in Manifestoes: Discussant, Vienna, Austria

2014: ADA and Mental Disabilities: Inquiries, Exams and Accommodations, Practising Law Institute, New York, New York

2014: Psychological Issues in Employment Law 2014, Practising Law Institute, New York, New York

2012: An Evolution in Practice at the Intersection of Mental Health and the Law: Where Mental Health Meets the Law by Jennifer Johnson, J.D. and George Woods, M.D. of Johnson Woods Education: a comprehensive curriculum on the evolving field of forensic mental health. The authors present the series in one-hour live webinars designed to provide legal professionals with tools to inform advocacy when mental health is an issue in a case. The series features in-depth interviews with experts in the field who will bring practical and innovative perspectives to the discussion. Reuters Thomson Westlegal/EdCenter

2010: The Trial of Hamlet, Morrison and Foerster, LLP, Law College, San Diego, California

2009: Treatment of Mentally Ill Offenders in the United States, Canada, and Japan; Japanese Association of Forensic Psychiatry, Tokyo, Japan

1998-2007: In Association With The National Institute of Trial Advocacy Training, Dana Hogg University, South Bend, Indiana; Georgia State Law School, Atlanta, Georgia; New York University Law School, New York City, University of North Carolina Law School, Chapel Hill, North Carolina; University of Houston Law School, Houston, Texas; University of Tennessee Law School, Knoxville, Tennessee; Atlanta, Georgia; University of Texas Law School, Austin, Texas; Temple University School of Law, Philadelphia, Pennsylvania

2006: Aligning Clinical Services with Correctional Treatment, Luzira Prison, Kampala, Uganda

2006: Decision Tree for Forensic Evaluations, Butabika Hospital, Kampala, Uganda

2006: Neuropsychiatry and The Courts: The University of Texas Law School, Austin Texas

2002: Demystifying Emotional Damages Claims: Paul, Hastings, Janofsky & Walker, San Francisco, California

2000: An Introduction-Multi-Axial Assessment and DSM-IV: Second National Seminar on Mental Illness and the Criminal Law, Miyako Hotel, San Francisco, California

2000: Psychiatric Manifestations of Mental Disorders: Second National Seminar on Mental Illness and the Criminal Law, Miyako Hotel, San Francisco, California

1999: An Introduction-Multi-Axial Assessment and DSM-IV: First National Seminar on Mental Illness and the Criminal Law, Radisson Hotel, Washington, D.C.

1999: Psychiatric Manifestations of Medical Disorders: First National Seminar of Mental Illness and the Criminal Law, Radisson Hotel, Washington, D.C.

1999: The Kenya/Tanzania Embassy Bombings: When Forensic Science, Politics, and Cultures Collide: International Academy on Law and Mental Health, Toronto, Quebec, Canada

1999: Research Collaboration Between East Africa and the United States: World Psychiatric Association/Kenya Psychiatric Association, First Annual East African Conference, Nairobi, Kenya

1999: Trauma/Resiliency In East Africa Workshop: World Psychiatric Association/Kenya Psychiatric Association, First Annual East African Conference, Nairobi, Kenya

1998: Mental Health Litigation and the Workplace: Sponsored by the University of California Davis Health System, Division of Forensic Psychiatry, Department of Psychiatry, and Continuing Medical Education, Napa, California

1998: Psychological Disabilities: Charting A Course Under the ADA and Other Statutes: Yosemite Labor and Employment Conference, Yosemite, California

1998: Current Trends in Psychiatry and the Law: Developing a Forensic Neuro-Psychiatric Team: CLE, Federal Public Defenders for the District of Oregon, Portland, Oregon

1997: The Changing Picture of Habeas Litigation: The National Habeas Training Conference, New Orleans, Louisiana

1997: Accommodating Mental Illness in the Workplace: Employment Law Briefing, Orange County

1997: Accommodating Mental Illness in the Workplace: Employment Law Briefing, Palo Alto, California

1997: Accommodating Mental Illness in the Workplace: Employment Law Briefing, Morrison & Foerster, San Francisco

1997: Psychiatric Evaluations in the Appellate Process: Emory University, Department of Psychiatry, Forensic Fellowship, Atlanta, Georgia

1997: So You Wait Until Discovery Is Over to Consult with a Psychiatrist? Can You Tell Me More About That? Morrison and Foerster Labor Law College, Los Angeles, California

1997: The Changing Cultural Perspectives in Forensic Psychiatry, San Francisco General Hospital Grand Rounds, San Francisco, California

1996: Evaluations of an Elementary School Child: Criminal Competency and Criminal Responsibility, Stanford University School of Medicine, Department of Psychiatry and Behavioral Sciences, Division of Child, Psychiatry and Child Development, Grand Rounds, Palo Alto, California

1996: Forensic Psychiatry: Cultural Factors in Criminal Behavior, Malingering, and Expert Testimony: The Black Psychiatrists of America Transcultural Conference, Dakar, Senegal, West Africa

1996: Dangerousness; Evaluation of Risk Assessment: Grand Rounds, Department of Psychiatry, University of California, Davis

1995: Violence in the Workplace: A Psychiatric Perspective of Its Causes and Remedies: The Combined Claims Conference of Northern California, Sacramento, California

1995: Experts: New Ways To Assess Competency- Neurology and Psychopharmacology: Santa Clara University Death Penalty College, Santa Clara, California

1995: Multiple Diagnostic Categories in Children Who Kill: Psychological and Neurological Testing and Forensic Evaluation: The American College of Forensic Psychiatry 13th Annual Symposium, San Francisco, California

1995: Mock Trial: Client Competence in a Criminal Case: Testing the Limits of Expertise, The American College of Forensic Psychiatry 13th Annual Symposium, San Francisco, California

1995: The Use of Psychologists In Judicial Proceedings: The California Attorneys for Criminal Justice/California Public Defenders Association Capital Case Seminar, Monterey, California

1994: Commonly Seen Mental Disorders in Death Row Populations: The California Appellate Project, Training Session for Legal Fellows and Thurgood Marshall Investigative Interns, San Francisco, California

1994: Anatomy of a Trial: Mock Trial Participant, The California State Bar Annual Convention, Anaheim, California

1994: Developing a Forensic Neuropsychiatric Team: The American College of Forensic Psychiatry 12th Annual Symposium in Forensic Psychiatry, Montreal, Quebec, Canada

1994: Responsibility in Forensic Psychiatry: Department of Criminology Faculty Seminar, University of Nebraska, Omaha

1994: Attorney/Investigator Workshop: Brain Function: The 1994 California Attorneys for Criminal Justice/California Public Defenders Association Capital Case Seminar, Long Beach, California

1994: Appellate and Habeas Attorney/Investigator Workshop: Evaluating Mental Health Issues in Post-Conviction Litigation: The 1994 California Attorneys for Criminal Justice/California Public Defenders Association Capital Case Defense Seminar, Long Beach, California

1993: Psychological Issues in Police Misconduct: Police Misconduct Litigation, National Lawyers Guild, San Francisco

1993: Neuropsychiatry, Neuropsychology and Criminal Law: Maricopa County Office of the Public Defender, Seminar on Investigation for Mitigation and Capital Cases, Phoenix, Arizona

1993: Working With Experts: California Appellate Project, San Francisco, California

1991: Forensic Psychiatry and Ethnicity-Black District Attorneys Association, National Convention

PROFESSIONAL FORENSIC PUBLICATIONS

Psychiatry and Criminal Law, Contra Costa Lawyer, Volume II, No. 8, August 1998.

Mock Trial: Client Competence in a Criminal Case: Testing the Limits of Expertise, The Psychiatrist's Opinion as Scientific, The Expert's Foundation As Sufficient, 1995 (Available from The American College of Forensic Psychiatry and on Audiotape).

Multiple Diagnostic Categories in Children Who Kill: Psychological and Neurological Testing and Forensic Evaluation, 1995. (Available from the American College of Forensic Psychiatry and on Audiotape).

Developing a Forensic Neuropsychiatric Team, 1994. (Available from the American College of Forensic Psychiatry on Audiotape).

Anatomy of a Trial: 1994 (Available for the California State Bar).

FORENSIC PROFESSIONAL AFFILIATIONS

2013: American Academy of Psychiatry and the Law

1998: International Academy of Law and Mental Health

PROFESSIONAL DEVELOPMENT & CORPORATE SERVICES

2015: The Science Advisors, Partner

2015: Defend Your Head: Medical and Neuroscience Advisor

2014: Forefront Behavioral Telecare, LLC: Assistant Chief Medical Officer

2013: Generations in Transition: YearUp, Atlanta, Georgia

2011: Forefront Behavioral Telecare, LLC: Director of Clinical Research

2009-2010: Forefront Behavioral Telecare, LLC: Chief Medical Officer

2009: AgeServe Communications, LLC: Director of Research/Director of Government Programs

2004: Consultant, Corporate Structure, Tostan, Non Governmental Organization, Theis, Senegal

2004: Toward Effective Retention Efforts: The use of narratives in understanding the experiences of racially diverse college students., Narrative Matters, Fredericton, New Brunswick, Canada

2003: In Association with the Council on Education in Management, Charlotte, North Carolina, Accommodating Psychiatric Disabilities: Avoiding the Legal Pitfalls of the ADA, Human Resources Conference, Palm Springs, California

2001-2003: Consultant, Vulcan Inc., Seattle, Washington

1999: In Association with Matthew Bender Legal Publishing, New York: Psychiatric Disabilities and California Workplace Requirement, With the Bar Association of San Francisco, San Francisco

1998: Psychiatric Disabilities under the Americans With Disabilities Act: Without Pretrial Strategy, Atlanta, Georgia

1998: Psychiatric Disabilities under the Americans With Disabilities Act: Without Pretrial Strategy, Los Angeles, California

THE CRITICAL MOMENTS CONSULTING GROUP

2001: Part I- Responding Creatively to Cultural Diversity through Case Stories and Part II- Strategies and Challenges for Campus-wide Diversity Project: Models of Integrating Critical Moments, Fourteenth, Annual Conference on Race and Ethnicity in American Higher Education, Seattle Washington

2001: Teaching Complex Case Stories, Faculty Development, Loras College, Dubuque, Iowa

2000: Critical Moments: Creating a Diversity Leadership Learning Community, 13th Annual National Conference on Race and Ethnicity in American Higher Education (sponsored by the University of Oklahoma, Southwestern Center for Human Relations Studies), Santa Fe, New Mexico

2000: Critical Moments: Practicum on Teaching Diversity Through Case Stories, 13th Annual National Conference on Race and Ethnicity in American Higher Education (sponsored by the University of Oklahoma, Southwestern Center for Human Relations Studies), Santa Fe, New Mexico

2000: Improving Undergraduate Education: Teaching and Learning in the Context of Cultural Differences, The Washington Center for Improving the Quality of Undergraduate Education, Thirteenth Annual Conference, Seattle, Washington

1999: Critical Moments: Deepening Our Understanding of Cultural Diversity through Critical Analysis, Effective Interviewing, Case Writing, and Case Teaching, The Washington Center, Evergreen State College, Olympia, Washington

1999: Teaching Complex Issues with Case Studies: A Workshop for Faculty and Graduate Teaching Assistants, University of Nebraska at Lincoln, Teaching and Learning Center and Critical Moments Project

1999: Critical Moments: Writing the Stories of Diverse Students, Washington Center for Improving the Quality of Undergraduate Education Workshop for College and University Faculty, Administrators, Staff and Students, Evergreen State College, Bothell, Washington

1999: Critical Moments: A Case Study Approach for Easing the Cultural Isolation for Under-represented College Students, Presented at Transforming Campuses Through Learning Communities, National Learning Communities Conference, Seattle, Washington

1993: Contextualism and Multi-Cultural Psychology-Graduate Seminar, University of Nebraska, Omaha, Nebraska

1992: Curriculum and Developmental Stages-North Central Educational Research Lab, Northwestern University

CRITICAL MOMENTS PUBLICATIONS

Diane Gillespie, Ph.D., Gillies Malnarich, and George Woods, M.D. (2006). Critical Moments: Using College Students' Border Narratives as Sites for Cultural Dialogue, In M.B. Lee (Ed.), Ethnicity Matters: Rethinking How Black, Hispanic and Indian Students Prepare for and Succeed in College. (pp. 99-116). New York: Peter Land Publishing Group.

Diane Gillespie, Ph.D. and George Woods, Jr., M.D. (2000). Critical Moments: Responding Creatively Cultural Diversity Through Case Stories; Third Edition.

(Updated August 23, 2015)

Exhibit 5

State of Texas
County of Hardin

Declaration of HOWARD, SHIRLEY

My name is **HOWARD, SHIRLEY**. Except where stated that I have been told by someone else, I state that I have personal knowledge of the following facts, and that such facts are within my personal knowledge and are true and correct:

- I. My biological parents are R.C. Kyles, my father, and Gertie Goffney, my mother. I am the biological mother of Jerry Howard, Jr., Jamaal Howard, Jasmonique ("Treci") Howard, and Sheanna Howard by their biological father, Jerry Howard, Sr.
- II. **Jamaal's Lawyers:** I hired and paid Tyrone Moncriste \$35,000 to represent Jamaal Howard, my son, at the trial. I found Mr. Moncriste through a contact when I asked for *pro bono* help. I did not want Jamaal to have a lawyer from the local area here because I do not believe that African Americans can get a fair trial. Mr. Moncriste was from Houston, TX.
 - A. Mr. Moncriste had asked me about my immediate family. We talked about Jamaal's brothers and sisters and Mr. Moncriste and his investigator talked to them. Mr. Moncriste never really explained to me why he was asking those things so I didn't know what information to really give him.
 - B. I discussed Jamaal's medication with Mr. Moncriste. When Mr. Moncriste asked me to list the medications for Jamaal, I did one better. I gave Mr. Moncriste a whole bag with all of the medications right there in it. There were four or five bottles in the bag, but Jamaal hadn't been on them for over a year.
 - C. Mr. Moncriste depended on me for information. Mr. Moncriste told me what records he wanted me to get him. I met with Dr. Fason, the trial defense expert, once. The meeting was about 2-4 weeks before Jamaal's trial.
 - D. I also had one meeting with Russell Wright, the direct appeal lawyer for Jamaal, but that I never heard from Mr. Wright after that.
 - E. I was told by Jamaal that Mr. Hamm had been appointed to represent Jamaal. I had expected Mr. Hamm to contact me, but he never did.

III. The Jamaal Howard Immediate Family:

- A. I and Jerry Sr. grew up three houses away from each other. Jerry is four years older than me. We began dating when I was in the 11th grade. Jerry already had a son, Tirus Elam, by another woman. That woman was very young when she became pregnant with Tirus.
- B. I graduated from high school and in 1977-1998 I attended one fall and two summer semesters of college at Lamar University.
- C. Jerry Sr. and I had dated for two years before we married in June 1977, and we had Jerry Jr. who was born in March, 1978 in Galveston, TX because I did not have any insurance and that was the closest public hospital. When I was pregnant with Jerry Jr., Jerry, Sr. and I had a heated argument and Jerry Sr. tried to take Jerry Jr. from my arms and when I wouldn't let him, Jerry Sr. slapped me. I knew if I didn't do something then and there he'd think he could do that to me whenever he wanted, so I called the police. Jerry was counseled but not arrested. There wasn't any abuse before or after that incident.
- D. During the time Jerry Sr. and I were married, I realized that somebody had to go to work so I quit college at Lamar University in 1978 and moved to Houston to live with my aunt Frankie. My mother kept Jerry Jr. I worked as a secretary in Houston for United Gas Pipeline on Allen Parkway. Jerry Sr. remained in Silsbee.
- E. While in Houston, I discovered that I was pregnant with Jamaal, who was born in February 1980. Around that same time, Jerry Sr. found work with the railroad and so I moved back to Silsbee. Jerry, Sr. and I lived with my parents in Silsbee for 2 years beginning when Jamaal was about 3 yrs old until Jamaal was about 5 years old (1983-1985). When Jamaal was about 5 years old, I told Jerry Sr. that he had to move out although we continued to see each other periodically. At that time, we were still married.
- F. From the beginning of my marriage to Jerry Sr., I suspected that he was womanizing, but I did not have any actual proof. When Sheanna (born July 1984) was three (1987), Jerry Sr. and I broke up for good. I moved out of my parents home after Sheanna turned 4 years old, and I had nothing to do with Jerry Sr. again although he and I never divorced, and we are still legally married.
- G. Jerry Sr. and I argued over his womanizing, which he did the entire time of our marriage. What really broke up our relationship was that he was not financially supporting the family or being the husband or father that he should have been. Jerry Sr. was making money, but he was not using that money to put us in a house or provide for us the way a husband and father should. The straw that broke the camel's

back for me was when I found out Jerry Sr was using his money to buy drugs, specifically crack cocaine. I had suspected he was using drugs, but did not have any proof. Jerry Sr. would not tell me how he was spending his severance money from the railroad, so I was paying all the bills.

IV. **Jamaal Howard:**

A. **BIRTH:** Jamaal was born on February 8, 1980. Early in my pregnancy, I experienced some breakthrough bleeding and was placed on bedrest for one week. The remainder of the pregnancy was normal. I got prenatal care throughout the pregnancy. The birth was uncomplicated.

B. **CHILDHOOD:**

1. **0-2 yrs:** When Jamaal was very young, Jamaal never walked. He ran. Jamaal was curious, even as a baby. He was constantly into something. Jamaal met all developmental milestones early. Jamaal walked by age one. Jamaal was off the bottle by 8 months. Jamaal talked well before his 2nd birthday. Jamaal potty trained easily. I don't think he liked all that mess and his diaper slowed him down. As an infant/toddler, Jamaal would fall asleep at strange times. He'd be on the move trying to crawl and just fall asleep right in the middle. Sometimes he'd be in his high chair eating and he'd just fall out with his head on the tray – sound asleep.
2. **2-5 yrs:** I went back to work when Jamaal was 2 years old. When Jamaal was 3 years old, he started attending “school” at the home of a woman in the neighborhood. Jamaal liked to play basketball and as early as 3 years old he would stand outside by himself shooting baskets. Jamaal attended “school” in the home of a retired teacher, and by the time he was five he could write his name, do his abc's and his numbers
3. **K, 1, 2 grades:** When Jamaal was about 5 years old, he attended Robinson Kindergarten (where Billie Ruth Kyles, who is my sister, was a principal for the kindergarten school). Jamaal continued to do well getting all A's in 1st & 2nd grades at Kirby Elementary School (6 and 7 years of age).
 - a. As a child, Jamaal had lots of friends. Because Silsbee is a small community, Jamaal knew the same kids from school and athletics and they all lived nearby. The kids didn't really have sleepovers and stuff, they'd just go outside and play ball or hang with each other, but everybody liked him. Jamaal was affectionate as a child.

- b. I raised my children as a single mother with the support of my parents. I received very little child support from Jerry Sr. When Jamaal was young, he and his siblings would leave to get the school bus before I left for work about 7:25 am and 7:30 am. When the school bus dropped them off after school, my kids would go to R.C. Kyles home, where my mother, Gertie Lee Goffney Kyles, cared for them until I came home from work and picked them up about up about 5:45. Gertie Kyles, their maternal grandmother, was the "backbone" of the family.
- 4. **3rd grade:**
 - a. When Jamaal was about 8 years old (1988-1989), he was attending Reed Turrntine Elementary School, which had the 3rd and 4th grades. In the first six weeks of the first semester of third grade, Jamaal was doing fine academically and behaviorially. However, in the second six weeks of the first semester of third grade, Jamaal did a 180 degree turn. He had conduct problems and was failing his classes.
 - b. I made sure that Jamaal was involved with a lot of activities. Jamaal played every sport and excelled at them all. He was an All Star in every sport that he played. Basketball was his favorite and he played in the Little Dribblers from the 3rd grade through the 8th grade, which was as high as Little Dribblers went. After the 8th grade, Jamaal didn't have anything to focus him and to help burn off all that energy.
- 5. **4th grade:** In the 4th grade when Jamaal was 9 years old (1989-1990), Billie Ruth Kyles, who is my sister, was a principal for the kindergarten school. Ms. Sanchez told Ms. Kyles to tell me that Ms. Sanchez thought that Jamaal had attention deficit disorder (ADD) and needed to be tested. I took Jamaal to be tested at Beaumont Behavioral Center. The recommendation from that testing was that Jamaal be given medication either by a psychiatrist or a family physician. The family physician would not prescribe the medication, and I did not have good insurance then, so at that time, Jamaal's condition was left untreated. I told Mr. Moncriste, the trial lawyer, about this testing but he never told me to get the testing and test results.
- 6. **5th grade:** When Jamaal was 10 years old (1990-1991), he was in the fifth grade, and attended Laura Reeves Elementary School, a school for fifth and sixth graders only.
 - a. Teachers would send notes home to me that Jamaal was "uncontrollable." I remember receiving notes from teacher Karen

Newsom. The notes from Newsom said that Jamaal was constantly distracted and disrupted the other students. I don't remember the name of the teacher, but one of Jamaal's teachers told me that "if a pencil dropped on the floor, Jamaal would be distracted, but it would not bother the other kids."

- b. I did not know what to do and asked for guidance from Beth Withers. Ms. Withers had been my Physical Education teacher when I was in the 8th grade and her name at that time was Beth McGill. When Jamaal was in the 5th grade, Ms. Withers was then the elementary school counselor for Jamaal. Ms. Withers suggested that I take Jamaal to see Dr. Kanneganti, MD, a psychiatrist. I had insurance at that time, so I took Jamaal to see Dr. Kanneganti, who started Jamaal on ritalin. By the end of the first six weeks, there was an open house for the parents of the 5th graders. I attended that parent/teacher conference and all the teachers told me that there was a noticeable difference in Jamaal because he was on the medications. The school records also reflect this fact. See Exhibit A: Health School Record, attached. It reads: "91-92 diagnosis of ADD. Noon medication given. Great improvement /c medication."

- 7. **6th grade:** When Jamaal was in the 6th grade (11 years of age (1991-1992)) he continued to see Dr. Kanneganti.

- a. Dr. Kanneganti was from India and both Jamaal and I had a very difficult time understanding Dr. Kanneganti because he had such a heavy accent. I did not know what was normal behavior for a child with ADD. I did not know when I should discipline Jamaal because it was beyond Jamaal's control and what was a behavioral problem I needed to address with Jamaal. When Jamaal and I would see Dr. Kanneganti, Dr. Kanneganti would just ask: "So how is it going?" Dr. Kanneganti did not provide me with guidance on how to deal with Jamaal. Jamaal did not like the effects of the medication, so Dr. Kanneganti said it was ok to give Jamaal the medication only on week days and that Jamaal did not have to take it on the weekends or during the summer. During the summer, Jamaal would play softball and basketball as a way to burn off all that energy.
- b. My mother, Gertie Kyles, died in 1992 from breast cancer. This was a devastating loss to the family. Jerry Jr. became very angry and started acting out. Jerry Jr.'s behavior and the loss were so stressful that I began to lose weight and my hair fell out. I was not able to cope, so I contacted my Employee Assistance Program, so Jerry Jr.

and I went to therapy. I don't remember how Jamaal handled the loss. Maybe it effected him but Jamaal just kept it all inside

8. **7th and 8th grades:**

- a. When Jammal was in about the 7th or 8th grades, he was very concerned with his appearance. Jamaal starched and ironed his own clothes, kept his nails trimmed and neat and kept his hair combed. He took pride in his appearance and always liked to have the latest fashions – especially tennis shoes.
- b. I started looking for another psychiatrist for Jamaal when he was in the 7th grade because I didn't believe that Dr. Kanneganti provided any constructive feedback or guidance. In the 7th and 8th grades, I took Jamaal to Dr. Lane, a psychiatrist.
- c. I spent a great deal of time and effort tracking down Dr. Lane and obtaining Jamaal's records for the trial. I handed over my copy to Mr. Moncriste and put them in a brown envelope. Exhibit B: Brown Envelope and Contents attached.

9. **9th and 10th grades (1995-1996):** Jamaal really changed around 10th or 11th grade.

- a. Dr. Lane changed Jamaal's medications from Ritalin to Dexadrine and Imiprimine. Dr. Lane also gave me literature on the effects of these medications. I also did a lot of research on Imiprimine, and discovered that if you had certain ways of thinking or acting it would make them worse. When Jamaal started taking Imiprimie, he got in trouble for yelling and becoming verbally abusive at school. I believed it was the medication, and so I called Dr. Lane, who replaced Imiprimine with Prozac.
- b. Jamaal didn't like to take his medications because he said they made him "feel funny," so he would hide them under his tongue starting at least in middle school and then into high school. Jamaal's sisters told me what Jamaal was doing, so after that I had to check him real good to make sure he'd swallowed it when I gave him the meds before he left for school in the morning. However, Jamaal was also supposed to get the medication after lunch from the school nurse. However, because of the school nurse's schedule, he was getting them much earlier. Because the school nurse was giving Jamaal the medications early, he lost his appetite and did not eat. Also, the medications wore

off early and he began having problems in his afternoon classes. When Jamaal got older and with so many children, the nurse did not have the time to monitor Jamaal when he got older to make sure he was not hiding the pill under his tongue, like I did.

- c. Jamaal also began having problems with his school attendance when he was about 15 years old and in the 10th grade (1995-1996). Eventually, Jamaal stopped going to school altogether, and began working. I was working and didn't know this had happened. I thought Jamaal was still attending school. Instead he was working at the pallet factory where his uncle worked. Jamaal only held this job for a few days because he was arrested on drug charges. Jamaal's only other job was at the local blueberry patch. Like many of the young people in the area he worked there picking berries for cash.
- d. I sent Jamaal to live with RC Kyles, where Jerry Jr. was living. When Jerry Jr. was in the 9th grade, he had been skipping school and having parties while I was at work, so I had sent Jerry Jr. to live with his grandfather, RC Kyles. Jerry Jr. moved out shortly after Jamaal arrived.

10. **About 16 years of age:** Jamaal was about 16 years of age (1996-1997), and did not attend the 11th grade because he had quit school. Jamaal's appearance changed. He started wearing the same clothes everyday. His clothes were not clean and neat like his clothes used to be. Jamaal stopped bathing, and stopped combing his hair and having it cut. Jamaal also stopped being around people. He would go to the McGrue's house, or to the park, but he would just sit there. He didn't have conversations with anyone. He was withdrawn and would stare into nothing. Because of the changes in his behavior and appearance, I took Jamaal to Dr. Lane for help.

- a. Dr. Lane referred Jamaal to a mental hospital but because Jamaal was over 16 he had to sign in voluntarily. I believe that the name of the hospital was Beaumont Behavioral Hospital. This hospital was a private hospital, not a state run mental health hospital. The hospital was next to the Beaumont Behavioral Center, where Jamaal had been tested in 4th grade and also near Dr. Lane's office.
- b. I filled out an intake form, but the receptionist told me that because Jamaal was 16 years old, he would have to sign himself in, and that I could not do it for him. At first, I was able to convince Jamaal to agree to sign himself in, but Jamaal and I had to wait for more than

three (3+) hours for the hospital to admit Jamaal. During this wait, Jamaal changed his mind after seeing other, very severely mentally ill, patients being admitted. When Jamaal saw them, he got scared and we just left. Other than the intake form that I filled out, there were not any other records because Jamaal was never admitted.

- c. Dr. Lane moved to Florida and I did not want a repeat experience like I had with Dr. Kanneganti. I wanted a physician who spoke English well, and could tell me about Jamaal's condition. For this reason, I wanted Jamaal to see Dr. Groves. I knew Dr. Groves because when we tried to get disability benefits for Jamaal, the government had referred Jamaal to Dr. Groves for an evaluation. I liked Dr. Groves, who spoke English well, and would communicate with me. So I scheduled an appointment for Jamaal to see Dr. Groves. I drove home to pick Jamaal up for the appointment with Dr. Groves. However, Jamaal had left the house and I could not find him, so I went back to work. Later that evening when I got home from work, Jamaal said did not need the meds because he was fine and Jamaal refused to see Dr. Groves at all. Because Jamaal was over 16 years old, no one could make him see Dr. Groves.

- 11. **1999 Incarceration in County Jail:** Jamaal had been sentenced to six months in county jail for selling drugs, and was released in December 1999. During the first three months of Jamaal's incarceration, my father, RC Kyles, and I would visit Jamaal at the jail. We were allowed only 30-minute visits with Jamaal, so we really could not observe his behaviors very well. One behavior that was different was that starting about the fourth month of his incarceration, Jamaal would scream at me and his grandfather, RC Kyles, telling us not to come over there to see him at the jail anymore. This was unusual because he used to like to visit with us. Then when Jamaal got out of jail in December 1999, I didn't even know him. This is when I saw for the first time that Jamaal would sit and rock back and forth and burst out laughing for no reason, and would be talking to himself. I had not seen this happening before.
- 12. **January to May 2000:** After Jamaal was released from county jail in December 1999, he exhibited other unusual behaviors.

- a. I had been told by my son, Jerry, Jr. and a family friend, Evelyn Gilder, that Jamaal had become obsessed with my nephew's sister – Lamonda Johnson. Jerry, Jr. told me that Lamonda's boyfriend told him that Jamaal was peeping in her windows. Lamonda had reported it to the police. The police never followed up on this. Lamonda was

living with her boyfriend at the time, and she would stay with her mom when her boyfriend was not there with her at nights because she was afraid of Jamaal. Lamonda's boyfriend also told my oldest son, Jerry, Jr. that one time when Lamonda was not in her house that Jamaal had gotten into the house, made himself a sandwich and ate it there and then left.

- b. Evelyn Gilder, who is now deceased, told me that when Lamonda was home, she saw Jamaal hanging around outside Lamonda's home, and he would just rock back and forth. Ms. Gilder told me that because she knew Jamaal, she had tried to talk to Jamaal, but Jamaal would not answer her or respond in anyway.
- c. I had talked to a male and female officer about this situation with Lamonda, and explained to them that I understood they were looking for my son. The officer told me that if I could get Jamaal down to the station, they would talk to him and see what they could do. Jamaal agreed to get in the car with me, but then jumped from the car on the way to the police station when he found out where we were going.

13. **One Week Before the Offense:** Approximately one week before the murder that occurred on May 12, 2000, members of the family were at my home. It was me; Pamela Fulton who was Jerry Sr.'s cousin; Jamaal's two sisters, Treci and Sheanna; and Jerry, Jr. Jamaal was just sitting at table, and spontaneously said: "I wish I'd just die." He was talking to himself when he said this. He did not say it to us. But when we heard Jamaal say this, we asked him: "What do you mean, 'I wish I was dead?,'" but Jamaal did not respond at all. We didn't plan an intervention. It was just a spontaneous offer of help by Pamela who told Jamaal that she would take Jamaal to the doctor's if he did not want to go with me. But again, Jamaal did not respond at all. During this time, each of us tried to convince Jamaal to take his medications and go to the doctor, but he did not respond to us at all.

14. **JAMAAL'S MENTAL HEALTH FOLLOWING THE TRIAL:** Jamaal's mental health has continued to decline since the trial.

- a. Jamaal spent 4-5 years going back and forth between Livingston and Jester IV after the offense. A man named Aaron Land, from Silsbee, worked at Jester IV and was the only person that Jamaal would listen to. During that time, my daughters and I visited Jamaal often. Jamaal was confused and unable to hold a conversation when we visited him at the Jester Unit.
- b. After Jamaal had returned to Livingston, Jamaal asked me if the woman he killed was his friend Justin's mother. I cannot understand how he would get that confused since Justin was black and Jamaal had known Justin's mother all his life.
- c. I do not get to visit Jamaal as often now that he is back in Livingston. When I last visited Jamaal at Livingston, he was getting his medication by injection and was more like himself than he has been in years.

C. **Paternal (Howard) Family History:** Jerry Sr., Jamaal's biological father, is the third child of Herman Howard, Sr. and Christine Simpson. Herman Howard, Sr. died of prostate cancer several years ago.

1. Little is known about Christine's mother. The Simpson side of the family has many members that live in Katy, TX. I don't know anything about these individuals. Christine's older sister, Magdalene is deceased, but her daughter, Pam Fulton, is very close to them and was present at trial. Christine is an unpleasant woman who treated my children badly. My children lived only three doors away and wanted to be close to their father and his family, but they were always disappointed by the way Christine treated them.
2. Christine was a gossip, who talked bad about everyone behind their back. Christine also said nasty things to my kids. She would call them "dirty," she would yell at them, and my kids were not allowed to touch things in her refrigerator or her home because she thought they were going to steal from her. Christine treated her other grandchildren differently. On Christmas when all the grandkids were around, Christine would hand out presents, but Christine would not get anything for my kids. My father, RC Kyles, used to tell the kids, "don't go down there to that woman's house. You're only gonna come back upset." And sure enough, every time they'd come back crying

about something Christine did or said. I had nothing to do with the woman.

3. Herman Howard, Sr. and Christine Simpson Howard had several children: Herman, Jr.; Herbert "Sidney;" Jerry, Sr.; Linda (now Reddicks); Douglas Keith; and Patricia (now Robertson).
4. Herman Jr. was a fighter and a troublemaker who was kicked out of school for bad behavior. I think he went to the Texas Youth Commission (TYC) or the Boys Home and he may have finished school there. Herman was a severe alcoholic who had so many DWI's that he ended up doing time in the Texas Department of Criminal Justice (TDCJ).
5. Sidney was an alcoholic and crack addict. In earlier years when we would visit, we'd never see him without a drink. His wife used to talk to me about the drug stuff but I saw the alcohol with my own eyes. He was so bad that he'd get the shakes and sometimes he'd just drop his beer right on the ground. He may have gone to treatment for his substance abuse. As far as I know, he is not drinking now and is a truck driver.
6. Douglas Keith failed a grade and then was put in special education. Douglas was addicted to crack cocaine and alcohol. He got clean in SAFF, a drug and alcohol program run by the state for persons who were in the criminal justice system.
7. Jerry Sr. had a problem with alcohol and crack cocaine. Jerry Sr. is currently involved in AA meetings and I see a big difference in him. He's working, and not hanging around that crowd. He's in church. Jerry, Sr. has even become a deacon at his church. He's not in the streets all the time. He's cleaner, he's shaved and he put weight back on. I really do see a difference. Jerry Sr. failed 2 grades in school.
8. Like Jerry, Sr., Linda failed 2 grades in school. Linda never had a substance abuse problem.
9. Patricia failed one grade at school, which put her in my class. Patricia only graduated because I and my friends got her through school. Patricia had almost every class with me and my friend, so we gave Patricia all the test answers. Patricia has never had a substance abuse problem.

D. **Maternal (Kyles) Family History:** I am the only child of RC Kyles and Gertie Lee.

1. Gertie had another daughter, Carolyn, by Samuel Moffett. Carolyn is 13 years older than me, but the closest in age. Carolyn's daughter in law (Tonya Moffett) was at the trial.
2. RC Kyles had several children by other women. RC Kyles and a second woman, Alma Lee Cartwright, had Billie Kyles and Charles Kyles. Billie had no children, but was married and is divorced. Charles married and had a daughter (Denita Kyles) out of wedlock who was adopted by RC and Gertie. Alma is still living and is currently 96 years old. Charles worked as an engineer and Billie was an educator.
3. RC Kyles and a third woman, Beola (last name unknown), gave birth to Angel Kyles. Beola is now deceased. Beola was shot and killed at home by an unknown man when Angel was an infant. Angel is also deceased. Angel had worked at a local paper mill and had three children. The oldest of the children, Garciano, was killed in a motorcycle accident in 1990.
4. RC Kyles and a fourth woman (I don't know her name) gave birth to Jeanetta (now Gieger) who grew up in Center, TX. She lived in North Carolina at the time I had corresponded with her as a child. However, I did not meet her until we were grown women. Jeanetta worked as an accountant. Jeanetta has two children: Tony and Christopher. Tony is in the military and Christopher is a professor.
5. RC Kyles and a fifth woman (name unknown) gave birth to Darryl and Reginald Kyles. Darryl had mental challenges that I believe stemmed from birth. I think that some sort of medical issues caused by birth complications left him impaired. Darryl suffered from severe seizures and eventually died during an attack. I saw Darryl regularly and he would wave when he passed by but I didn't have a relationship with him and I am not sure what his diagnosis was. Reginald has anger issues. I know that he has gone to prison, but I am not sure if it was for family violence or assault.
6. RC Kyles had one older brother, LC Kyles. They did not have the same mother. LC died some years after Jamaal's trial. LC worked as a contractor for Dupont at the Sabine River plant and lived in Orange, TX. He did not know Jamaal well, but he and his wife came to Silsbee before the trial to support the family.
7. I never knew my paternal grandfather and paternal grandmother, who died when I was young. I remember my family saying it was a good thing because

she was spoiling me so much.

8. Gertie's family is from the town of Maynard, TX. She is the older of two daughters born to Morris Goffney. Gertie's mother died of breast cancer when Gertie was only 12 years old. I cannot recall her name. Gertie's sister is Frankie Watson. Frankie had one son, Weldon Watson, who was killed in a car wreck the day after he graduated from high school.

- E. Mr. Moncriste did not ask any questions about the maternal or paternal extended family and did not conduct any interviews of them.

I declare pursuant to 8 U.S.C. § 1746(1) under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Date: July 21, 2015

Shirley Howard
Signature
Shirley Howard
Silsbee, TX

Attached as exhibits:

- Exhibit A: Health School Record
Exhibit B: Brown Envelope and Contents

Exhibit 6

State of Texas
County of Hardin

Declaration of SHEANNA HOWARD

My name is **SHEANNA HOWARD**. Except where stated that I have been told by someone else, I state that I have personal knowledge of the following facts, and that such facts are within my personal knowledge and are true and correct:

1. I am the oldest of Jamaal's sisters by Shirley and Jerry Howard, Sr., but younger than Jamaal. Even though I was younger than Jamaal, he did not treat me like an annoying little sister. He was affectionate and would hug and tease me. Jamaal was the clown of the family and was always playing pranks. He use to sing funny songs and keep everyone laughing.
2. I can picture him in my mind when he was in the fourth (4th) grade and I was in the first (1st) grade. I remember Jamaal as "hyper." Jamaal would run back and forth and could never keep still. There was one incident when I was very young and sitting on the couch at my mother's house. Jamaal would come out of his room, tap me on the ear, go back to his room, come back out and tap me on the ear again, and do it over and over and over. Jamaal also would play basketball all day long.
3. My mom would give Jamaal his meds before he left for the bus stop to go to school. My mom had also given the meds to the school so they could give them to Jamaal. I remember Jamaal taking the meds when he was in the fourth and fifth (4th, 5th) grades. When Jamaal was on meds, he was quiet but we could still have a conversation. When Jamaal was not on meds, he was hyper, active, and he talked more.
4. When Jamaal was younger, he would wear a button down shirt. He did not like to get dirty. He would even clean his shoes with an old tooth brush. His facial hair was trimmed, and he would get his hair cut weekly. Jamaal would wash his own clothes. He made sure that his socks matched and he would put his clothes up. He ironed his clothes or he would take them to the cleaners.
5. As Jamaal got older, his behavior began to change for the worse. When Jamaal was about 17 or 18 years old, Jamaal acted really different. I remember this time frame because it happened after Jamaal had been released from jail. I can picture Jamaal. He was wearing a stripped, V-neck shirt. He was not wearing a belt on his pants and had to hold his pants up with his hand. He was wearing a dirty baseball cap. Jamaal would wear these same clothes all week. He had facial hair that was scruffy from not shaving. He would not bathe.
6. I remember a time when Jamaal and I were at the house of our grandfather, R.C. Kyles. I was on one couch and Jamaal was on another. R.C. Kyles was sitting in his recliner. We

were watching TV. Jamaal would just bust off laughing and bite his lip. This would happen about 4-5 times within an hour. I would ask Jamaal: "What are you laughing at?" but Jamaal would not answer. I don't think that Jamaal heard or understood my question to him. Jamaal would not talk like he used to. We used to have conversations. Jamaal might ask me for some candy or a cigarette, but during this time Jamaal just stopped talking. He tuned the outside world out and would not acknowledge my presence.

7. In the two to three (2, 3) weeks before the offense, Jamaal's behavior really went down hill. He was there, but not really there. Jamaal would walk up and down the street and to Waldo Park. When he got to the park, he'd sit there by himself. Sometimes Jamaal would go to Fred McGrue's momma's house. Jamaal would sit on the porch and ask for a beer but he would not engage in conversation at all with the people who were at that house. Other times, Jamaal would sit in his grandpa Kyles' back room by himself. I would hear Jamaal mumbling but I couldn't make out the words. He did not appear to be angry when he was mumbling. He would say something, then laugh, and he would rock and move his head like he was the only one hearing a tune. This happened frequently
8. We all tried to talk to him, to get him to clean himself up, and to take his meds, but Jamaal would just laugh. It was not like he was saying no. His laugh was weird, like he didn't understand what we were saying to him.
9. I was interviewed by Jamaal's trial attorney twice, both times at my mother's house. Both times were within a week before the trial started. When I was interviewed by Mr. Moncriffe, the trial attorney, there were three other persons who were present: my mom, my sister Treci, and my mom's friend. We were all sitting at the same table. I was 16 years old at that time.
10. Mr. Moncriffe would ask me questions, and then he would turn to Treci and ask her questions. Everyone was sitting there together. The total interview of everyone was about 2 hours. Mr. Moncriffe, talked to me for five minutes or less each time. Mr. Moncriffe asked me what had happened in the 24 hour period before the murder. We talked mostly about the day before the offense, the day that Jamaal took the gun. That was the focal point. Mr. Moncriffe also asked me about Jamaal's mental state and whether Jamaal had been hearing voices, but I don't remember my answer. Mr. Moncriffe did not ask me anything about Jamaal's childhood. It was like that part of Jamaal's life was not important. I would have liked to have offered more about my brother but I did not know how or what to do. I testified at the trial only, not the competency hearings.
11. I sat in the courtroom during the trial and saw my mother and grandfather and teachers testify. Even though I had been called as a witness, I did not have to sit out. The trial began at 9:00 am and ran to 12:00 pm. There was a lunch recess and it would resume from 1:00 pm to 4:00 pm. Jamaal was not paying attention even though he was on trial for his life. He would sit there with a blank stare. There was no emotion.

12. In the morning sessions of the trial, Jamaal would turn around and look back at the people in the courtroom and then look around the courtroom. This would happen about every 20 minutes. In the afternoon sessions, Jamaal would lean forward with his arms crossed on the table in front of him, and put his head down and fall asleep for about an hour and a half. This sleeping would start about 1:45 pm. When he woke up, Jamaal would be yawning, and leaning over like he was cold. He had on a long sleeve shirt. This behavior happened daily.
13. We had heard someone had been appointed to represent Jamaal after the trial, but no one called us. We did not talk to any attorney about the case until members of Jamaal's federal habeas defense team called us.

I declare pursuant to 8 U.S.C. § 1746(1) under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Date: 11-12-14

Sheanna Howard

Signature
Sheanna Howard
Silsbee, TX

Exhibit 7

State of Texas
County of Hardin

Declaration of KIM LEWIS

My name is **KIM LEWIS**. Except where stated that I have been told by someone else, I state that I have personal knowledge of the following facts, and that such facts are within my personal knowledge and are true and correct:

1. I was born and raised in Silsbee, TX. I am the same age as Jerry Howard, Jr., Jamaal's older brother. Because of the age difference, I did not attend the same schools at the same time as Jamaal. But Jamaal and I were so close, I think of him as my brother.
2. When I was five years old, my father murdered my mother, so Michael my brother and I were adopted by my grandparents. My grandparents raised us in the house across from Waldo Park, where Jamaal used to play basketball. Jamaal lived nearby. There were very few girls in the neighborhood, so I hung out with the boys. I played sports with them, and rode motorbikes with them.
3. I saw several odd habits that Jamaal had when he was a child. Jamaal would constantly be sniffing his hand. He would flex his wrist, holding the back of it and his hand under his nose. Jamaal did that often – as much as 10 times an hour. I used to ask Jamaal what he was smelling, but he never did answer me. I don't know when this behavior started. I don't remember a time that Jamaal did not do it.
4. Despite his unusual behaviors, Jamaal was very popular and people didn't tease him about these behaviors. When Jamaal was approx 14 he and his friends would go to Waldo Park and play basketball. Jamaal was so good that people would come from the neighborhood to watch him. They would cheer and he would smile and talk to the crowd.
5. Jamaal also couldn't sit still. He was always moving. I don't think he could sit still for five minutes, but we were outside so much that back then it didn't matter so much.
6. When Jamal was in school (Up until he was about 14/15 years old and while Jamaal was in school, I remember Jamaal as clean cut. He always smelled good. He wore cologne, and you could smell him coming he smelled so good. He always had his hair cut. You could tell just by looking that he kept his hair cut. And his clothes would be crisp. He and my brother would iron everything. Jamaal would stand up there and iron for an hour.
7. Then there was a gap of about a year when I didn't see Jamaal. I had graduated from high school and I was back and forth going to school in Beaumont, TX to get certificates as a medical assistant and nurse's aide. When I got back it was like Jamaal wasn't my brother anymore. I never understood what happened. It was about late 1998 or early 1999, when I

saw Jamaal for the first time like he is now. I freaked out.

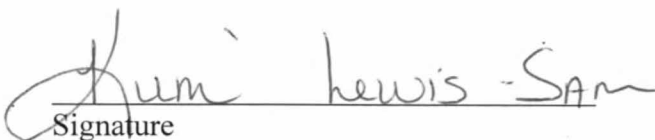
8. In 1998/1999, I was living at 770 Ave H – down the street from my current home. I saw Jamaal, in some capacity, every day during that time because Jamaal came to my house looking for Michael. At least once a week, Jamaal ended up sleeping on my couch. This typically happened when Michael wasn't there.
9. When I answered the door, I saw Jamaal wearing several layers of clothing in the middle of summer. Jamaal had on an undershirt, a long sleeved shirt on top of that, and a flannel jacket over it all, and pants ten times too big. This was in the heat of July. It was obvious to me, that Jamaal hadn't showered. His clothes were gray and dingy like they needed to be washed. His white t-shirts were a grayish-yellowish color. And Jamaal smelled like a herd of goats.
10. No matter how big Jamaal's pants were, this other Jamaal that I saw when I returned from Beaumont never wore a belt. He walked around with the waistband balled up in his hand. Jamaal's hair was in a big afro that must have been growing for months. The hair on his face was patchy and nappy. He wouldn't wash for days and days.
11. When I tried to talk to Jamaal, he seemed spaced out. Sometimes it seemed like he was listening and would give a short one or two (1-2) word answer but then he'd laugh and nothing would have been funny and it was like his mind took off again.
12. I would see Jamaal talking to himself on a daily basis. Typically, Jamaal would lower his head and mumble into his shoulder, but on one occasion, at the McGrue's house, Jamaal suddenly looked to his left – like someone was there all of a sudden – and then Jamaal just took off running. It was like someone came up on him all of a sudden and started chasing him only there wasn't anyone there.
13. Most of the time when I saw Jamaal talking to himself, it was like he was talking to someone sitting on his shoulder. Jamaal would look down and speak under his breath. When Jamaal was exhibiting this strange behavior, he might do it ten times an hour. When I first saw this behavior, I would ask Jamaal: "You ok Jamal? Who you talkin' to?" But Jamaal never answered me. Either he would say nothing or he would smell his hand and giggle.
14. There were other times when Jamaal was just quiet instead. He would sit without saying anything to himself or anyone else. It could be hours that Jamaal would just sit there without saying anything. It was like he was there, but not really there. If Jamaal was looking in the direction of the TV, he was staring through it, not watching what was on it. Jamaal would stare into space, but not focus on anything.
15. Sometimes Jamaal would bring hot fries for the kids and it was like I could see the old Jamaal again. But day to day, I never knew what Jamaal I was going to see. My children

were very young (infant and toddlers) at the time, but I never worried about Jamaal being in the house with them.

16. Some days Jamaal would knock softly on the door when he arrived. Other days he wouldn't come to the door at all, but would just sit outside on the porch waiting for someone to come out. When I answered the door, Jamaal usually just looked at me and rarely said anything. Because I knew Jamaal was there for Michael, I would usually talk to Jamaal and tell him where Michael was and what Michael was doing. Jamaal rarely said anything. There were some days when Jamaal would just look at me, turn around and walk off.
17. Unlike his behavior when he was young, and in the years just before the offense, Jamaal would go to Waldo Park, but instead of getting on the basketball court with his peers, Jamaal would stay off to himself (10-20 feet away) and not interact with anyone.
18. In the year before the offense, Jamaal's behavior had gotten so bizarre that people didn't want him around. They would laugh and tease him, and his sisters. They would tell Jamaal that he stunk and say that he was crazy. This happened every time that Jamaal was around. At least one person would say something about him "not bein' right."
19. I remember one time, when all of a sudden Jamaal was just standing there with his pants down around his ankles. He's just standing there giggling like always, everything hanging out, but acting like nothing is wrong. All the guys on the porch at the McGrue's house got the hose and started hosing him down. Jamaal didn't do anything except he bent down and pulled his pants up like nothing happened.
20. I did not attend the trial and did not speak to any attorneys about the case, other than talking to current members of Jamaal's federal habeas defense team.

I declare pursuant to 8 U.S.C. § 1746(1) under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Date: 11/2/14



Signature
Kim Lewis
Silsbee, TX

(409) 554-7043

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Filing Code Description: Application

Filing Description: Subsequent Application for Post-Conviction Writ of Habeas Corpus

Status as of 9/28/2026 1:17 PM CST

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