S105908

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

PEOPLE OF THE STATE OF CALIFORNIA,

Plaintiff and Respondent,

v.

JOHN SAMUEL GHOBRIAL,

Defendant and Appellant.

Orange County
Sup. Ct. No. 98NF0906

APPELLANT'S REPLY BRIEF

Appeal from the Judgment of the Superior Court
of the State of California for the County of Orange

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INTRODUCTION

The Attorney General has struggled to preserve this conviction by ignoring pertinent facts, and dismissing all error as harmless. Respondent's efforts, however, cannot alter the fact that grievous error occurred, and the convictions and death judgment must be reversed.[1]

[1]Appellant has found it unnecessary to reply to all the arguments in the response since respondent raises very little that is not fully addressed in the opening brief, and appellant has only addressed respondent's contentions that require further discussion for the proper determination of the issues raised on appeal. Appellant specifically adopts the arguments presented in her opening brief on each and every issue, whether or not discussed individually below. Appellant intends no waiver of any issue by not expressly reiterating it herein.

I.

THE DEATH JUDGMENT MUST BE REVERSED BECAUSE THE TRIAL COURT VIOLATED GHOBRIAL'S STATE AND FEDERAL CONSTITUTIONAL RIGHTS TO DUE PROCESS AND A RELIABLE DEATH VERDICT BY FAILING TO INITIATE COMPETENCY PROCEEDINGS SUA SPONTE

Psychotic disorders, which include schizophrenia and schizoaffective disorder,[2] "are significantly correlated with incompetence." (Jacobs, et al., *Competence-Related Abilities and Psychiatric Symptoms: An Analysis of the Underlying Structure and Correlates of the MACCAT-CA and the BPRS* (2008) 32 Law & Hum. Behav. 64, 65 (hereinafter *Competence-Related Abilities*).) As outlined in detail in the opening brief, the trial court had before it abundant evidence, which, when considered in the aggregate, was more than sufficient to raise a reasonable doubt that Ghobrial suffered from the symptoms of an intractable psychotic disorder that impaired his ability to rationally understand the proceedings, consult with counsel, and assist in the preparation of his defense against capital charges. (AOB 5-7, 30-45, 56-71.)

Respondent does not dispute the facts set forth in the opening brief. Indeed, respondent attempts to refute Ghobrial's claim by citing virtually the same evidence as that cited by Ghobrial in support of his claim (RB 23-48), thereby conceding its accuracy. Respondent nevertheless asserts that Ghobrial's claim fails for four reasons: (1) the evidence of Ghobrial's mental illness presented during trial did not amount to substantial evidence

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[2]The Diagnostic and Statistical Manual of Mental Disorders (DSM) applicable at the time of Ghobrial's trial, the DSM-IV-TR, includes schizoaffective disorder in the chapter entitled "Schizophrenia and Other Psychotic Disorders." (DSM-IV-TR (4th ed. text revision 2000), p. 297.)

of mental incompetency to stand trial; (2) no mental health expert gave an opinion that Ghobrial was incompetent; (3) Ghobrial's trial counsel never declared a doubt about his mental competency; and (4) the trial court's observations of Ghobrial did not provide any indication of mental incompetency. (RB 49, 57.) These arguments do not withstand scrutiny.

A. The Evidence Before the Trial Court Raised a Bona Fide Doubt as to Ghobrial's Competence to Stand Trial

The trial court heard evidence that two days after Ghobrial's arrest and admission to the Orange County Jail, jail psychiatrist Dr. Jasminka Depovic diagnosed him as suffering from a psychotic disorder not otherwise specified (NOS). (10 RT 2428-2430.) Thereafter, Ghobrial was examined at least once a month, and frequently much more often, by multiple members of the jail mental health staff. Over the course of the next three and a half years, while his diagnosis was changed from psychotic disorder NOS to the more specific schizoaffective disorder, Ghobrial never went a month without being plagued by at least one, and often more, of the following symptoms: auditory, visual, and olfactory hallucinations; delusional thought processes; labile affect; grossly disorganized behavior, including decompensation in grooming and self-care; suicidal ideation and delusional suicide attempts, including tying a string and sheet around his penis in the belief that he would stop breathing; other acts of self-mutilation; depression; blunted affect; and internal preoccupation. (See Attachment A.)

Ghobrial also was prescribed anti-psychotic medication shortly after his arrival at the jail and continued on multiple anti-psychotics and anti-depressants of varying doses throughout his incarceration, including Haldol, Mellaril, Zyprexa, Seroquel, Depakote, Risperdal, Ativan, Prozac, and

Paxil. (See Attachment A.) Dr. Jose Flores-Lopez, a forensic psychiatrist (10 RT 2502) who, at the time of his testimony, was the chief psychiatrist at the Norco Prison (10 RT 2475), initially questioned whether Ghobrial might be malingering; in April 1999, however, he raised a doubt as to Ghobrial competence, noted that he "needed a competency assessment," and recommended that he be sent to a state mental hospital for evaluation. (10 RT 2492.) On December 17, 2001, Flores-Lopez testified before the jury that Ghobrial suffered from chronic schizoaffective disorder, "meaning that he was going to have it for the rest of his life." (10 RT 2498.)

Neuropsychological testing administered to Ghobrial by forensic neuropsychologist Dr. Ali Kalechstein in early 2001, showed both that Ghobrial put forth his best efforts and was not malingering, and, inter alia, that Ghobrial's executive functioning tested in the impaired range in three out of the four executive functioning tests, placing him in the 1st percentile, and borderline impaired in the fourth, which placed him in the 6th percentile. (10 RT 2525-2548.) Kalechstein testified that Ghobrial's test results were consistent with a psychotic illness, such as schizophrenia or schizoaffective disorder. (10 RT 2546.)

Respondent's general argument that "the evidence of Ghobrial's mental illness [and the administration of anti-psychotics and anti-depressants] presented during his trial did not include any substantial evidence of mental incompetency to stand trial" (RB 49) implies that *before a hearing is even warranted*, a defendant must present evidence that discloses a present inability because of mental illness to participate rationally in the proceedings. In fact, the only showing necessary to trigger a hearing is evidence raising a *reasonable doubt* as to the defendant's

competence.[3] At a competency hearing, a defendant must establish incompetence by a "preponderance of the evidence." (§ 1369, subd. (f).) Evidence that is substantial enough to raise a reasonable doubt as to a defendant's competence may not be sufficient to sustain a finding of incompetence by a preponderance of the evidence. To the extent that respondent, and this Court's opinions cited by respondent, equates the quantum of evidence necessary to trigger a competency hearing with the quantum of evidence necessary to prevail at such a hearing, respondent's argument violates the principles established in *Pate v. Robinson* (1966) 383 U.S. 375, and *Drope v. Missouri* (1975) 420 U.S. 162.

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[3]As discussed in the opening brief (AOB 52-54), it bears reemphasizing that when the trial court is deciding whether competency proceedings are warranted, the court is not deciding the ultimate issue, *i.e.* whether the defendant actually possesses the necessary cognitive, emotional, and communicative capabilities. Rather, the court simply is answering the threshold question of whether there is any evidence which, assuming its truth, raises a reasonable doubt about the defendant's competency. (*People v. Ary* (2004) 118 Cal.App.4th 1016, 1021 ["Importantly, we are not deciding here whether defendant is, in fact, competent to stand trial, but whether there was evidence sufficient to raise a reasonable doubt as to defendant's competence to stand trial. We conclude there was"]; *Moore v. United States* (9th Cir. 1972) 464 F.2d 663, 666) [sole function of trial court in applying *Pate*'s substantial evidence test is to decide whether there is any evidence raising a reasonable doubt as to defendant's competence]; *Chavez v. United States* (9th Cir. 1981) 656 F.2d 512, 516 ["We review the record to see if the evidence of incompetence was such that a reasonable judge would be expected to experience a genuine doubt respecting the defendant's competence"].)

1. The United States and California Supreme Courts Have Held That Evidence of Mental Illness Characterized by a History of "Pronounced Irrational Behavior" and Psychotic Symptoms is Sufficient to Warrant a Competency Hearing

The United States Supreme Court in *Pate v. Robinson*, *supra*, 383 U.S. 375, addressed a claim that the trial court's failure to hold a hearing pursuant to the Illinois statute requiring the judge to conduct a hearing when presented with evidence raising a bona fide doubt as to the defendant's competence to stand trial deprived the defendant of due process. The Supreme Court had no quarrel with the statutory procedures enacted by Illinois to ensure that prior to being put to trial a defendant meets the standards for competency articulated in *Dusky v. United States* (1960) 362 U.S. 402, that is, whether the defendant has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and whether he has a rational as well as factual understanding of the proceedings against him. (*Pate v. Robinson*, *supra*, 383 U.S. at p. 385.) The Supreme Court instead focused on the evidence before the trial court and concluded that the error lay in the trial and reviewing courts' failure to find the "uncontradicted testimony of [the petitioner's] history of pronounced irrational behavior" sufficient to warrant resort to the hearing into his competency. (*Id.* at pp. 385-386.) Although the Supreme Court's decision turned on the facts, the High Court did not identify with any specificity, other than reference to the petitioner's "history of pronounced irrational behavior," the nature and quantum of evidence mandating a hearing.

In *Drope v. Missouri*, *supra*, 420 U.S. 162, the Supreme Court's next opinion addressing whether the trial court heard evidence sufficient to

conclude that the defendant was entitled to a competency hearing, the Court acknowledged the *Pate* Court's disinclination to "prescribe a general standard with respect to the nature or quantum of evidence necessary to require resort to an adequate procedure." (*Id.* at p. 172.) In *Drope*, as in *Pate*, the Court recognized the constitutional adequacy of the state's statutory procedures to determine competence, but focused on the lower courts' determination that the evidence presented failed to establish "reasonable cause to believe that the accused ha[d] a mental disease or defect excluding fitness to proceed." (*Drope v. Missouri*, *supra*, 420 U.S. at p. 173.) The Court again concluded that the lower courts erred in finding the facts relevant to the petitioner's competency inadequate to warrant a hearing, but once more declined to set strict standards for the quantum or type of evidence a defendant must present before being entitled to a competency hearing. Stated the Court: "There are, of course, no fixed or immutable signs which invariably indicate the need for further inquiry to determine fitness to proceed; the question is often a difficult one in which a wide range of manifestations and subtle nuances are implicated." (*Id.* at p. 180.)

In *People v. Aparicio* (1952) 38 Cal.2d 565 – an opinion presaging *Dusky v. United States* by eight years and anticipating the decisions in *Pate v. Robinson* and *Drope v. Missouri* – this Court found that the trial court erred in failing to inquire into the defendant's sanity pursuant to Penal Code section 1368[4] where one psychiatrist who had examined the defendant testified that "the defendant was suffering from delusions of persecution

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[4]The *Aparicio* Court refers to "sanity" to stand trial rather than competency in keeping with language of section 1368 applicable in 1952. (*People v. Aparicio*, *supra*, 38 Cal.2d at p. 567, quoting section 1368.)

and hallucinations; another stated that he was 'paranoid and delusional'; while a third described him as possibly psychotic from a psychiatric point of view even though he was not legally insane."[5] (*People v. Aparicio*, *supra*, 38 Cal.2d at p. 569.) As with *Pate v. Robinson* and *Drope v. Missouri*, notably absent from the evidence before the trial court was any evidence specifically stating that the defendant could not understand the nature and purpose of the proceedings or assist in his own defense in a rational manner. Nevertheless, this Court concluded that the evidence presented, which the Court characterized as "a continuous course of irrational conduct" – necessitated a hearing. (*People v. Aparicio*, *supra*, 38 Cal.2d at p. 570.)

The holdings of *People v. Aparicio*, *Pate v. Robinson*, and *Drope v. Missouri* establish that when a defendant presents evidence raising a reasonable doubt as to his ability to rationally understand the proceedings, communicate with counsel, and assist in his own defense, he is entitled to a hearing, but that the evidence itself need not include documentary or testimonial commenting specifically on the defendant's competence. The evidence sufficient to raise a reasonable doubt as to a defendant's incompetence need not be couched in the terms of incompetence.

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[5]*People v. Aparicio* is cited as authority in *People v. Koontz* for the proposition that "[w]hen there exists substantial evidence of the accused's incompetency, a trial court must declare a doubt and hold a hearing pursuant to section 1368 even absent a request by either party." (*People v. Koontz* (2002) 27 Cal.4th 1041, 1064, citing *Aparicio*, *supra*, 38 Cal.2d at p. 568.)

2. Respondent Erroneously Conflates the Evidentiary Showing Warranting a Hearing With the Evidentiary Showing Required at the Hearing to Establish a Defendant's Incompetence

Respondent's claim that Ghobrial must present evidence to the trial court specifically stating that he currently is incapable of rationally understanding the proceedings, communicate with counsel, and assist in his own defense prior to being afforded a hearing to determine exactly whether he possess those very capabilities is an unconstitutional reading of *Pate v. Robinson*, *supra*, 383 U.S. 375, and *Drope v. Missouri*, *supra*, 420 U.S. 162. (See also *People v. Aparicio*, *supra*, 38 Cal.2d at p. 570 [evidence presenting continuous course of irrational conduct requires competency hearing].) As noted above, respondent contests neither the credibility of the evidence presented to the trial court nor the severity of Ghobrial's symptoms; respondent's disagreement is with the inferences to be drawn therefrom. (See *Drope v. Missouri*, *supra*, 420 U.S. at pp. 174-175 [no dispute as to the evidence possibly relevant to petitioner's mental condition; rather, dispute concerns inferences to be drawn and whether the failure to make further inquiry into petitioner's competence denied petitioner a fair trial].) In fact, respondent fails to make *any* inferences from the evidence before the trial court, and simply asserts repeatedly that Ghobrial has failed to present "substantial evidence of incompetence" because the court heard no testimony specifically finding that Ghobrial was incompetent. (RB 51, 53-55.)

Respondent states that "evidence of mental illness alone is insufficient to raise a doubt as to Ghobrial's competency" (RB 51) – an uncontroversial proposition (see AOB 57). Respondent relies on *People v.*

Young, where the court found that a psychologist's testimony about defendant's mental condition is insufficient "*when he did not relate his finding in terms of defendant's competency to stand trial.*" (RB 51, citing *People v. Young* (2005) 34 Cal.4th 1149, 1218, italics added.) Respondent also relies on *People v. Welch*, where the Court explained that more is necessary than that defendant is psychopathic "*with little reference to defendant's ability to assist in his own defense.*" (RB 51, citing *People v. Welch* (1999) 20 Cal.4th 701, 742, italics added.) Similarly, respondent asserts that "there was no testimony that any of the prescribed medications *interfered with his ability to understand the proceedings or to assist with his defense.*" (RB 52, citing *People v. Danielson* (1992) 3 Cal.4th 691, 726-728, italics added.) Respondent also asserts that "[e]vidence that merely raises a suspicion[6] that the defendant lacks present sanity or competence *but does not disclose a present inability because of mental illness to participate rationally in the trial* is not deemed 'substantial' evidence requiring a competence hearing." (RB 51, citing *People v. Deere* (1985) 41 Cal.3d 353, 358, italics added.)

Respondent's reasoning erroneously conflates the evidentiary showing necessitating a hearing to determine a defendant's competence to stand trial with the evidentiary showing required at the hearing to establish the defendant's incompetence. As demonstrated above, respondent's

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[6]Roget's International Thesaurus identifies "doubt" as a synonym of "suspicion." (Roget's International Thesaurus, (6th ed. 2001) p. 680.) Thus, this Court's assertion can be read as: "Evidence that merely raises a [doubt] that the defendant lacks present . . . competence . . . is not deemed 'substantial' evidence requiring a competence hearing." Such a reading violates the the holdings of *Dusky, supra,* 362 U.S. at p. 402, and its progeny.

position eviscerates the protections guaranteed to potentially incompetent defendants established in *Pate v. Robinson*, *supra*, 383 U.S. 375, *Drope v. Missouri*, *supra*, 420 U.S. 162, and *People v. Aparicio*, *supra*, 38 Cal.2d at p. 570.

3. A Court Must Hold a Competency Hearing When a Defendant Presents Evidence That His Mental Illness Precludes Him From Accurately Perceiving, Interpreting, and/or Responding to the World Around Him

The evidence sufficient to raise a reasonable doubt as to a defendant's competence to stand trial makes clear that "competence" is not a diagnostic category with a checklist of symptoms or behaviors that, when present, manifest incompetence and when absent, demonstrate competence. Each case is unique (*United States v. Jones* (3rd Cir. 2003) 336 F.3d 245, 256-57, citations omitted [court must examine the unique circumstances of the case]), and the defendant's functional abilities must be considered in the context of the particular case or proceedings. (See Sadock & Sadock, eds., Kaplan & Sadock's Comprehensive Textbook of Psychiatry (8th ed. 2005) Vol. II, p. 3983 [an individual who is incompetent to stand trial in a complicated tax fraud case may not be incompetent to stand trial on a simple misdemeanor charge].) A trial court must consider all relevant evidence in the aggregate, but also recognize "that even one of the [relevant] factors standing alone may, in some circumstances, be sufficient." (*Ibid.*)

"[T]he crucial component of the inquiry [into a defendant's competence to stand trial] is the defendant's possession of a 'reasonable degree of rational understanding.' In other words, the focus of the *Dusky* formulation is on a particular level of mental functioning." (*Godinez v.*

Moran (1993) 509 U.S. 389, 404 (conc. opn. of Kennedy, J.), citing *Dusky*, *supra*, 362 U.S. 402.) At whatever stage competence is examined, "the proper inquiry is whether [the defendant] is capable of making rational decisions in service of [his or her] defense."[7] (Maroney, *Emotional Competence, "Rational Understanding," and the Criminal Defendant* (2006) 43 Am. Crim. L. Rev. 1375, 1382.)[8] At the most basic level, a defendant must have sufficient contact with reality to be deemed competent to stand trial. "It is beyond dispute that the Supreme Court's legal definition of competency . . . mandates the conclusion that a defendant lacks the requisite rational understanding if his mental condition precludes him from perceiving accurately, interpreting, and/or responding

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[7]This author and others have attempted to formulate a more concrete definition of the ability to communicate with the defendant's lawyer with a "reasonable degree of rational understanding" and "a rational as well as factual understanding of the proceedings" by referring to competence as "decisional competence." (See also Bonnie, *The Competence of Criminal Defendants: Beyond Dusky and Drope* (1993) 47 U. Miami L. Rev. 539, 567.)

[8]A defendant competent enough to stand trial must possess sufficient "mental functioning" to make rational decisions about, inter alia, whether to waive the privilege against compulsory self-incrimination by taking the witness stand; if the option is available, whether to waive the right to trial by jury; in consultation with counsel, whether to waive the right to confront his accusers by declining to cross-examine witnesses for the prosecution; whether and how to put on a defense and whether to raise one or more affirmative defenses. (*Godinez v. Moran*, *supra*, 509 U.S. at pp. 398-399; see also *Riggins v. Nevada* (1992) 504 U.S. 127, 139-140 (conc. opn. of Kennedy, J.) [the requirement of competence at trial is the foundation upon which the other constitutional rights afforded the accused at trial gain meaning]; *Cooper v. Oklahoma* (1996) 517 U.S. 348, 364 ["[A]n erroneous determination of competence threatens a 'fundamental component of our criminal justice system' – the basic fairness of the trial itself."].)

appropriately to the world around him." (*Lafferty v. Cook* (10th Cir. 1991) 949 F.2d 1546, 1551 [sufficient contact with reality is the "touchstone for ascertaining the existence of a rational understanding"], citing *Coleman v. Saffle* (10th Cir. 1990) 912 F.2d 1217, 1227.)[9]

When evaluated in light of the specific facts available to the trial court, respondent's assertion that Ghobrial failed to present evidence sufficient to raise a reasonable doubt as to his competence to stand trial against capital charges – that is, his ability to think and respond rationally to the world around him – simply cannot be credited. As discussed above and in detail in the opening brief (AOB 30-45, 54-67), Ghobrial suffered from the time of his arrest and throughout pretrial proceedings and trial – and continues to suffer from – either schizoaffective disorder (AOB 57), which is characterized by symptoms of both schizophrenia and a major mood disorder (DSM-IV-TR, Diagnostic criteria for 295.70 Schizoaffective Disorder, p.323), or schizophrenia, paranoid or disorganized type (AOB 57-58). The characteristic symptoms of both schizoaffective disorder and schizophrenia are delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms such as

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[9]Other courts finding that "sufficient contact with reality" is the touchstone of competency include *United States v. Hemsi* (2nd Cir. 1990) 901 F.2d 293, 296; *Balfour v. Haws* (7th Cir. 1989) 892 F.2d 556, 561; *Strickland v. Francis* (11th Cir. 1984) 738 F.2d 1542, 1551-1552; see also *Loko v. Capps* (5th Cir. 1980) 625 F.2d 1258, 1267; *State v. Hawkins* (Idaho Ct.App. 2009) 229 P.3d 379, 383; *People v. Mondragon* (Colo. Ct.App. 2009) 217 P.3d 936, 940; *State v. Haycock* (N.H. 2001) 766 A.2d 720, 722; *Edwards v. State* (Fla. Ct.App. 2012) 88 So.3d 368, 371; see also *People v. Pennington* (1967) 66 Cal.2d 508, 514 [psychologist's testimony that defendant suffering from an acute mental sickness in which he was delusional and out of contact with reality sufficient evidence to warrant a hearing].)

affective flattening (restrictions in expression), alogia (restrictions in fluency of thought and speech), and avolition (restrictions in goal-oriented behavior). (DSM-IV-TR, Diagnostic criteria for Schizophrenia, p. 312.) Every one of these symptoms significantly interfered with Ghobrial's grasp of reality. "Actively psychotic individuals are typically far more impaired than individuals with mild mental retardation in the areas of understanding and processing information, logical and rational communication, abstraction, logical reasoning, and impulse control. Delusions and hallucinations typically severely compromise the psychotic individual's ability to appreciate the meaning of one's environment, including the motives and meanings of others' behavior . . . . Severe perceptual distortion is not uncommon in schizophrenia." (Ryan & Berson, *Mental Illness and the Death Penalty* (2006) 25 St. Louis U. Pub. L. Rev. 351, 366.) As noted above, symptoms of psychosis are "significantly negatively correlated with . . . competence-related abilities." *(Competence-Related Abilities, supra,* at p. 75.) Although Ghobrial's florid psychotic symptoms at times abated, he never went symptom free. (Attachment A; see also AOB 57, citing 10 RT 2305 [normal for disease to fluctuate over time]; and *Indiana v. Edwards* (2008) 554 U.S. 164, 175 ["Mental illness itself is not a unitary concept. It varies in degree. It can vary over time. It interferes with an individual's functioning at different times in different ways"].)

Respondent's own nearly twenty-six page statement of facts was devoted to the testimony of Ghobrial's father and the twenty mental health professionals who observed or assessed Ghobrial in the Orange County Jail. It is also a reasonably accurate chronicle of Ghobrial's long history of erratic behavior; his poor social, educational, and occupational functioning; and his psychiatric treatment in Egypt, including electro-convulsive therapy

and unsuccessful treatment with psychiatric medications. Respondent also describes from the point of Ghobrial's arrest and onward, his auditory and visual hallucinations, delusions, delusional suicide attempts, other self-harming behavior, profound neglect of hygiene, and other psychotic symptoms and disordered thoughts that substantially impaired his contact with reality. (RB 18-20; 23-48.) On respondent's facts alone, a reasonable doubt existed as to whether Ghobrial could rationally understand the proceedings, communicate with counsel, and assist in his own defense.

4. Evidence Raising a Doubt About a Defendant's Competence to Stand Trial Must be Considered in the Aggregate

Respondent also parses the evidence presented at trial into discreet symptoms or behaviors and then argues how each individual symptom is insufficient to raise a doubt. (See e.g. RB 51 ["Evidence of mental illness alone is insufficient to raise a doubt as to Ghobrial's competency"], citing *People v. Rogers* (2006) 39 Cal.4th 826, 849); and RB 54 ["A person with significant brain damage may be nonetheless be competent to stand trial"], citing *People v. Leonard* (2007) 40 Cal.4th 1370, 1415-1416.) Respondent's failure to consider the indicia of Ghobrial's incompetence in the *aggregate* violates the mandate articulated in *Drope v. Missouri.* (*Drope v. Missouri*, *supra*, 420 U.S. at pp. 179–180 [state courts failed to give insufficient attention to the *aggregate* of indicia of petitioner's incompetence]; see also *Moore*, *supra*, 464 F.2d at p. 666; *Chavez*, *supra*, 656 F.2d at p. 518 [In determining whether or not there is a substantial doubt, the trial judge must evaluate all the evidence and evaluate the probative value of each piece of evidence in light of the others"].)

Respondent asserts that "[n]one of the mental health experts testified that they had examined Ghobrial and found him to be incompetent to stand

trial." (RB 53.) In the next sentence respondent acknowledges "Dr. Girgis testified that Ghobrial's hallucinations interfered with his ability to communicate" (RB 53, citing 11 RT 2599, 2601), but goes on to make the contradictory claim that "Dr. Girgis's testimony said nothing about Ghobrial's competence to stand trial" (RB 53). "Hallucinations" are defined as the "[p]erception of visual, auditory, tactile, olfactory, or gustatory experiences without an external stimulus and with a compelling sense of their reality, usually resulting from a mental disorder." (The American Heritage Dictionary of the English Language (5th ed. 2011) at p. 793.) When an individual suffers from false and unreal perceptions that the individual believes to be real and which interfere with the individual's ability to communicate, a reasonable doubt exists that the individual will be able to able to communicate with counsel and assist in his defense in a reasonably rational way. Dr. Girgis described symptoms raising a doubt as to Ghobrial's competence; that he never was asked by trial counsel to opine specifically on Ghobrial's competence does nothing to diminish the weight of his testimony.

Respondent's dispute with the inferences to be drawn from Dr. Flores-Lopez's testimony are equally weightless and demonstrably false. Dr. Flores-Lopez was the only forensic mental health expert to examine Ghobrial and therefore was the one expert well versed in competency requirements. Respondent concedes that Flores-Lopez testified that Ghobrial's psychotic illness led him to doubt Ghobrial's competence and recommend a full assessment as to Ghobrial's competence. While acknowledging that Flores-Lopez specifically testified that Ghobrial "needed a competency hearing" (RB 54, citing 10 RT 2492-2493), respondent goes on to claim that "Dr. Flores-Lopez's testimony was based

on his examination of Ghobrial in 1999. Nothing in his testimony suggests that Ghobrial was incompetent at the time of trial in November - December 2001." (RB 54.) In fact, Flores-Lopez first described the symptoms of Ghobrial's psychosis, including his responding to auditory hallucinations and an inability to focus on their conversation, in early April 1998 (10 RT 2477), diagnosed Ghobrial as suffering from psychosis NOS in December 1998 (10 RT 2484-2486), and updated Ghobrial's diagnosis to chronic schizoaffective disorder in September 1999 (10 RT 2497-2498). In September 2000, Flores-Lopez characterized Ghobrial as "chronic and responding to stressors and having bizarre affect." (*Ibid.*) Flores-Lopez left the employ of the Orange County Jail around this same time, but affirmed his conclusion at trial that Ghobrial suffered from schizoaffective disorder. Dr. Flores-Lopez *testified on December 17, 2001*, that Ghobrial suffered from chronic schizoaffective disorder, "meaning that he was going to have it for the rest of his life." (10 RT 2498.) At the close of his testimony, Dr. Flores-Lopez was asked:

Q: Did you end up agreeing with the diagnosis of schizoaffective disorder?
A: Yes, I did.
Q: Do you continue to agree with that diagnosis?
A: Yes, I do.

(10 RT 2501.) Respondent's assertion that "[n]othing in his testimony suggests that Ghobrial was incompetent at the time of trial in November - December 2001" (RB 54) is controverted by the record.

Respondent states that "Ghobrial's claim of error is belied by the fact that . . . no mental health expert ever gave an opinion that he was incompetent." (RB 57.) To the extent that respondent is arguing that a mental health expert must testify that a defendant is incompetent before a

hearing to determine competency is warranted, respondent's efforts to impose a standard higher than that outlined both in *Pate v. Robinson* and *Drope v. Missouri* and must be rejected. Although expert testimony that a defendant is incompetent can certainly constitute substantial evidence triggering the requirement of a hearing into the defendant's competence to stand trial (see *People v. Pennington, supra*, 66 Cal.2d at p. 519), the absence of a mental health expert's opinion does not obviate the need for a hearing if other evidence – documentary or testimonial – raises a reasonable, genuine, or good faith doubt as to the defendant's competence. (See *People v. Ary, supra*, 118 Cal.App.4th at p. 1024 [expert testimony that a defendant is incompetent may constitute substantial evidence, but it is not required].) "[T]he question as to what constitutes such substantial evidence in a proceeding under section 1368 'cannot be answered by a simple formula applicable to all situations.'" (*People v. Laudermilk* (1967) 67 Cal.2d 272, 283, quoting *People v. Wolff* (1964) 61 Cal.2d 795, 805.)

Requiring the opinion of a mental health professional that a defendant is incompetent prior to ordering a hearing intolerably risks that an incompetent defendant will be put to trial simply because neither the trial court nor counsel, or both – as in Ghobrial's case – ever posed the relevant question to a competent mental health professional. (See *Cooper v. Oklahoma* (1996) 517 U.S. 348, 364 ["For the defendant, the consequences of an erroneous determination of competence are dire"].) The testimony of a mental health expert is not the sine qua non of a reasonable doubt regarding a defendant's competency to stand trial. In neither *Pate v. Robinson* nor *Drope v. Missouri* did a mental health professional testify regarding the defendants' current competency to stand trial, and nothing in either opinion remotely suggests that the United States Supreme Court

meant to impose such a requirement before a competency hearing was warranted.

In *Pate v. Robinson*, the Supreme Court held that the testimony of four lay witnesses that petitioner was insane and his history of pronounced irrational behavior was sufficient to require the trial court to hold a hearing. (*Pate v. Robinson*, *supra*, 383 U.S. at p. 385.) In *Drope v. Missouri*, the Court noted that *Pate* did not "prescribe a general standard with respect to the nature or quantum of evidence necessary to require resort to an adequate procedure." (*Drope v. Missouri*, *supra*, 420 U.S. at pp. 172-173.) The petitioner in *Drope* had been examined pretrial by a psychiatrist who prepared a report containing descriptions of symptoms that the Court characterized as "suggesting competence, such as the impressions that petitioner did not have 'any delusion, illusions, hallucinations . . .' was 'well oriented in all spheres,' and was able to answer questions testing judgment." (*Id.* at p. 175.) The Court went on to note, however, that the report also contained contrary data showing that the petitioner, although cooperative in the examination, had a difficult time participating and relating, and was markedly circumstantial and irrelevant in his speech. The report also described "episodic irrational acts" and contained diagnoses of "[b]orderline mental deficiency" and "[c]hronic anxiety reaction with depression." (*Ibid.*) The Court specifically noted that it did "not appear that the examining psychiatrist was asked to address himself to medical facts bearing specifically on the issue of petitioner's competence to stand trial, as distinguished from his mental and emotional condition generally." (*Id.* at p. 176.) Rather than finding this omission fatal to the petitioner's claim, the Court evaluated the *nature of the symptoms* described in the report, which – combined with the testimony of petitioner's wife regarding his erratic and

violent behavior and his suicide attempt – "created a sufficient doubt of his competence to stand trial to require further inquiry on the question." (*Id.* at p. 180.) The Court went on:

> The import of our decision in *Pate* is that evidence of a defendant's irrational behavior, his demeanor at trial, and any prior medical opinion as to competence are all relevant in determining whether further inquiry is required, but even one factor standing alone, may, in some circumstances, be sufficient.

(*Drope v. Missouri*, *supra*, 420 U.S. at p. 180.)

Respondent's discussion of the inferences to be drawn from Ghobrial's suicidal ideation, multiple suicide attempts, and frequent self-mutilation are as oblique as her other arguments. Respondent recognizes that "actual suicide attempts or ideation may, *in combination with other factors*, constitute substantial evidence raising a doubt as to mental competence to stand trial" (RB 55, italics added), but continues with an argument wholly untethered to the record by claiming Ghobrial's suicidal and self-harming thoughts and behavior were unaccompanied by "bizarre behavior, testimony of a mental health professional as to competence, or any indication of an inability to understand the proceedings or to assist counsel." (RB 55.) Respondent's own recitation of examples of Ghobrial self-harming behavior include numerous examples of what would qualify as "bizarre behavior" under any definition. Respondent recounts Ghobrial's multiple efforts throughout the three years and a half years of pre-trial incarceration to commit suicide by tying a string or sheet around his penis (RB 56, citing 9 RT 2149, 2170, 2122, 2215; 10 RT 2286-2287, 2410-2412, 2467, 2485); his hearing of voices telling him to shave his eyebrows, pick at his face, and then rub his face with butter and coffee grounds (RB 56, citing

9 RT 2149, 2212; 10 RT 2410-2412); and his hearing voices telling him to scratch himself and pull his hair (RB 56-57, citing 10 RT 2236-2238, 2419-2420, 2356). Respondent states that "[a]part from these [thirteen] instances of suicidal or self-harming behavior, he denied any suicidal ideation." (RB 57.) If thirteen different instances of, or attempts at, bizarre and deluded self-harming behavior do not seem sufficient to respondent to raise a doubt about Ghobrial's competence, it is hard to imagine the quantum necessary for her to concede that a hearing would be warranted. Respondent also acknowledges that Ghobrial was under a Welfare and Institutions Code section 5150 "flag" to prevent his release before assessment of his danger to himself or others, but unpersuasively argues that because he was not involuntarily committed, the evidence should be dismissed rather than considered with the other relevant evidence that raised a reasonable doubt as to Ghobrial's competence. (RB 56.)

As to trial counsel's failure to declare a doubt as to Ghobrial's competence, respondent herself concedes that trial counsel's failure to declare a doubt is not dispositive. (RB 57.) Section 1368, subsection (b) specifically authorizes a court to order a competency hearing despite trial counsel's stated belief that the defendant is mentally competent. (§ 1368, subd. (b).) Trial counsel are not "'trained mental health professional[s] and failure to raise petitioner's competence does not establish that petitioner was competent.'" (*Maxwell v. Roe* (9th Cir. 2010) 606 F.3d 561, 574, quoting *Odle v. Woodford* (9th Cir. 2001) 238 F.3d 1084, 1089.) Much like defense counsel in *Maxwell*, who failed to request formally a competency hearing but "clearly expressed concern about Maxwell's competence" (*Maxwell v. Roe*, *supra*, 606 F.3d at p. 574), Ghobrial's trial counsel never raised a doubt about his competence on the record, but the penalty phase

evidence she presented consisted almost entirely of testimony from mental health professionals regarding Ghobrial's psychotic symptoms and testimony from Dr. Flores-Lopez that he believed Ghobrial needed to be evaluated for competency to stand trial. (AOB at pp. 67-68.)

As with trial counsel's failure to declare a doubt, respondent's argument that the trial court's observations of Ghobrial did not provide any indication of mental incompetency also carries little weight on this record. As noted in the opening brief, the trial court had little direct interaction with Ghobrial; Ghobrial neither testified nor engaged in any colloquy with the court beyond agreeing to waive time or his presence. (AOB 69, fn. 29; *compare People v. Jones* (1991) 53 Cal.3d 1115, 1153 [trial court may appropriately take its personal observations into account when deciding whether competency hearing is required when defendant actively participated in trial, and trial court had opportunity to observe and converse with defendant throughout trial and posttrial proceedings].) Again, many of Ghobrial's symptoms were negative symptoms of schizophrenia and schizoaffective disorder. The mental health professionals at the Orange County Jail frequently noted that Ghobrial exhibited throughout the entirety of his pretrial incarceration a blunted affect, which would cause Ghobrial to appear calm and expressionless. (See, e.g., 10 RT 2429 [inappropriate affect, which could be negative symptom of schizophrenic or psychotic illness]; 10 RT 2296-2299, 2386-2387, 2434, 2435, 2437-2441, [flat or blunted affect]; 10 RT 2489-2490 [inappropriate affects, which are negative symptom associated with psychotic illness]; 10 RT 2438 [affect blunted, which is negative symptom of schizophrenia or schizophrenic illness]; 10 RT 2496, 10 RT 2500-2501 [remained bizarre and blunted; blunted affect is negative symptom of schizophrenic illness].)

Just as a defendant's "bizarre behavior" and "strange words" do not themselves mandate a competency hearing (*People v. Lewis* (2008) 43 Cal.4th 415, 524, citations omitted; RB 51), "calm behavior does not necessarily mean a defendant is competent" (*Dickey-O'Brien v. Yates* (E.D. Cal. June 12, 2013) 2:07-CV-1241 WBS CKD, 2013 WL 2664418, citing *Odle v. Woodford, supra*, 238 F.3d at p. 1089). "The reasonable inferences available from a defendant's calm behavior are necessarily dependent" on the other evidence available. *(Dickey-O'Brien v. Yates, supra*, 2013 WL 2664418, *22; see also *People v. Samuel* (1981) 29 Cal.3d 489, 503 ["Evidence that a defendant can obediently walk into the courtroom and sit quietly during the trial does not constitute substantial proof of competence; indeed, it could describe one in a catatonic state"].) Moreover, respondent's assertion misses the gravamen of Ghobrial's claim: Ghobrial's argument is not that the court should have declared a doubt based on any behavior evident during trial, but on the voluminous testimony presented during the penalty phase that Ghobrial suffered from, beginning at a young age, at the time of his arrest, through all pretrial proceedings, and likely throughout trial, a major mental illness whose symptoms raised a reasonable doubt that he could rationally understand the proceedings, communicate with his lawyer, and participate in his own defense

B. The Trial Court's Failure to Suspend Proceedings to Determine Ghobrial's Competence Requires Reversal of his Conviction

"We begin with first principles. The Constitution provides criminal defendants with the right to be competent during trial."[10] (*United States v.*

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[10]The right to competence "does not derive exclusively from a desire to protect the defendant's right to a fair adjudication. The doctrine also

Duncan (9th Cir. 2011) 643 F.3d 1242, 1248, citations omitted.) The right to be competent begins at arraignment (*Godinez v. Moran*, *supra*, 509 U.S. at p. 403 (conc. opn. of Kennedy, J.)), and continues to judgment (§ 1368, subd. (a)). The evidence presented during Ghobrial's penalty phase raised more than a reasonable doubt that his intractable psychotic illness made it impossible, from the time of his arrest on, for him to rationally understand the proceedings, communicate with counsel, and assist in his own defense. Because the trial court failed to suspend criminal proceedings to evaluate Ghobrial's competence to stand trial on capital charges, his conviction must be reversed.

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affects societal interests in moral dignity and reliability of the criminal process." (Bonnie, *Beyond Dusky and Drope*, *supra*, 47 U. Miami L. Rev. at p. 544.)

II.

SUBJECTING A DEFENDANT SUFFERING FROM A SEVERE PSYCHOTIC ILLNESS TO A SENTENCE OF DEATH VIOLATES THE FIFTH, SIXTH, EIGHTH, AND FOURTEENTH AMENDMENTS AND INTERNATIONAL LAW

In *Atkins v. Virginia* (2002) 536 U.S. 304, and *Roper v. Simmons* (2005) 543 U.S. 551, the United States Supreme Court concluded that characteristics inherent in individuals with mental retardation, such as their diminished cognitive and psychological capabilities, and juveniles under 18, who are characterized by undeveloped psychological and emotional maturity, rendered both groups categorically exempt from the most extreme sanction for criminal conduct: the death penalty. As demonstrated in the opening brief, no legal or rational reason exists for not also exempting from the death penalty the severely mentally ill, whose symptoms of delusions, hallucinations, disordered thought processes, and disorganized behavior significantly impair their ability to interpret reality, accurately perceive the world, control their impulses, and function in society. (AOB 75-93.)

Respondent's three-page answer is so cursory and unresponsive that this Court should disregarded it in its entirety. Respondent focuses primarily on a point conceded in the opening brief, that currently no legislative consensus exists that the severely mentally ill should be excluded from the death penalty. (RB 58-60; AOB 81.) Respondent says nothing, however, about the remaining objective evidence presented in the opening brief outlining the "substantial agreement amongst professional, religious and world communities that defendants with severe mental disorders should be excluded from capital punishment," along with the doubt expressed by various justices and judges presiding over capital cases about the propriety

of subjecting those suffering from severe mental illness to the death penalty. (AOB 82-86.)

Moreover, additional objective evidence exists of the evolving standards of decency against subjecting the mentally ill to the death penalty beyond that outlined in the opening brief. (AOB 81-86.) Connecticut has enacted legislation prohibiting the applicability of the death penalty if the defendant's mental capacity was significantly impaired or ability to conform his or her conduct to the law was significantly impaired, but not so impaired as to provide a complete defense. (Conn. Penal Code, ch. 952, § 53-a-46a (h).) Amnesty International USA has issued a report based on an in-depth study calling for state legislatures to enact legislation which prohibits the execution of the severely mentally ill.[11]

In a concurring opinion in *Commonwealth v. Baumhammers* (Penn. 2008) 960 A.2d 59, 72-80, Justice Todd of the Supreme Court of Pennsylvania stated that "[a]n individual with a serious mental illness may be just as seriously impaired in his ability to 'understand and process information' as an individual with a diminished IQ or an individual who has not yet reached the age of legal majority." (*Commonwealth v. Baumhammers, supra*, 960 A.2d at p. 79.) Justice Todd recognized that the manifestations of mental illness, "such as the delusions that accompany paranoid schizophrenia," impair the sufferer's ability to engage in logical reasoning, and noted that the "disconnect" between a paranoid

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[11]"State legislature should in consultation with experts in the field of criminal law and mental health, adopt legislation prohibiting the execution of people with serious mental illness or other impairments other than mental retardation at the time of the crime of the time of execution." *USA: The Execution of Mentally Ill Offenders* (2006). Available at <http://www.amnesty.org/en/library/info/AMR51/003/2006/en> (as of February 11, 2014).

schizophrenic's basic understanding of the world and those "not similarly afflicted will make it difficult for the schizophrenic to understand others' reactions." (*Ibid.*) Justice Todd concluded by urging the Pennsylvania legislature to consider whether the state's law was "in line with the demands of the Eighth Amendment and of fundamental fairness, considering the best scientific evidence of the impact of severe mental illnesses on individual culpability."[12] (*Id.* at p. 80.)

Similarly, the international community condemns the execution of the severely mentally ill. In finding juveniles under 18 ineligible for the death penalty, the *Roper v. Simmons* Court found it significant that the United States was the only country in the world to continue "to give official sanction to the juvenile death penalty." (*Roper v. Simmons*, *supra*, 543 U.S. at p. 575.) In addition to the European Union's opposition to inflicting the death penalty on any person with a serious mental illness cited in the opening brief (AOB 85-86), the United Nations Human Rights Committee has held that the execution of a mentally disturbed but not "insane" individual amounts to cruel, inhuman or degrading treatment in violation of Article 7 of the International Covenant on Civil and Political Rights, a treaty ratified by 149 countries, including the United States. (See *Francis v. Jamaica*, Communication No. 606/1994 U.N.H.C.R. (12 August 1994) available at <http://www1.umn.edu/humanrts/undocs/html/vws606.htm> (as

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[12]Justice Todd also expressed support for the opinions against executing the severely mentally ill of Justice Evelyn Lundberg-Stratton of the Ohio Supreme Court in *State v. Ketterer* (Ohio 2006) 855 N.E.2d 48, cited in the opening brief (AOB 83-84, 86), along with the concurring opinion of Justice Zazzali in *State v. Nelson* (N.J. 2002) 803 A.2d 1, and the dissenting opinion of Justice Rucker in *Corcoran v. State* (Ind. 2002) 774 N.E.2d 495, both also cited in the opening brief (AOB 82-83).

of February 11, 2014).) The United Nations Commission on Human Rights (replaced by the Human Rights Council) has persistently urged countries who continue to impose the death penalty "[n]ot to impose the death penalty on a person suffering from any form of mental disorder or to execute any such person."[13]

Although respondent appears to acknowledge that the Supreme Court considers not only objective evidence when reviewing a death sentence under the Eighth Amendment, but also will apply its own judgment to the issue (RB 59), respondent says nothing to rebut the applicability of the Supreme Court's analyses in *Atkins v. Virginia* and *Roper v. Simmons* to those suffering from severe mental illness, analyses which rested in large part upon the Supreme Court's own assessment of the limitations of the mentally retarded and juveniles under 18. Respondent cites to this Court's conclusion in *People v. Castaneda* (2011) 51 Cal.4th 1292, 1345, that the defendant there failed to establish his antisocial personality disorder was "analogous to mental retardation or juvenile status for purposes of imposition of the death penalty." (RB 58.)

Ghobrial has no dispute with this proposition, but the point is irrelevant. The defendant in *Castaneda* suffered from anti-social personality disorder, not a severe psychotic disorder, and none of the diagnostic criteria for anti-social personality disorder includes symptoms of disorganized thinking, hallucinations, psychotic thought processes, and disconnection from reality; that is, the inherent impairments of the severely

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[13]U.N. Commission on Human Rights, Question of the Death Penalty, U.N. Doc. E/CN.4/1999/61 (1999); *id.* at E/CN.4/ 2000/65 (2000); *id.* at E/CN.4/ 2001/68 (2001); *id.* at E/CN.4/2002/77 (2002); *id.* at E/CN.4/2003/67 (2003); and *id.* at E/CN.4/2004/67 (2004).

mentally ill that render them less culpable than those without such impairments in their functioning. (See DSM-IV-TR, Diagnostic criteria for 301.7 Antisocial Personality Disorder, p. 706.)

Respondent goes on to state simply that "[n]ot every mental illness is comparable to mentally retarded and/or juvenile offenders with respect to reasoning, judgment, and impulse control." (RB 60.) Ghobrial also has no quarrel with this position, but respondent fails completely to address Ghobrial's claim that the severe mental illness from which *he* suffers, whose symptoms by definition substantially impair his reasoning, judgment, and impulse control, lessens his culpability and, as a consequence, imposition of the death penalty would violate the protections of the Eighth and Fourteenth Amendments.

Respondent's citation to ten cases for the proposition that "[o]ther federal and state courts have consistently declined to extend *Atkins* to the mentally ill" (RB 59) fails to acknowledge that the concurring and dissenting opinions issued in four out of the ten cases all express a belief that the severely mentally ill should be excluded from death penalty eligibility. (See *Joshua v. Adams* (2007) 231 Fed. Appx. 592, 594 (dis. opn. of Ferguson, J.); *Commonwealth v. Baumhammers*, *supra*, 960 A.2d at p. 72 (conc. opn. of Todd, J.); *State v. Ketterer*, *supra*, 111 Ohio St.3d at p. 82 (conc. opn. of Stratton, J.); *Matheny v. State* (Ind. 2005) 833 N.E.2d 454, 458 (conc. opn of Rucker, J.).) In a fifth opinion, *State v. Hancock* (Ohio 2006) 840 N.E.2d 1032, 1059, the court denied the claim primarily because the claim "appear[ed] to rest on nothing but [the defendant's] assertion that it is so." The court chastised the defendant for failing to offer any basis for concluding that defendants with severe mental illnesses are comparable to those suffering from mental retardation "with respect to reasoning,

judgment, and impulse control," and for failing to offer any definition of "severe mental illness." (*Ibid.*) The court went on, however, to recognize that "[m]ental illnesses come in many forms; different illnesses may affect a defendant's moral responsibility or deterrability in different ways and to different degrees." (*Ibid.*) Three of the remaining cases arise from a single state: Texas. Respondent's cases, rather than bolstering her argument that no national consensus exists for banning the execution of the severely mentally ill, demonstrate the growing recognition that evolving standards of decency demand that such defendants be exempt from the death penalty.

Respondent dismisses the necessity for a categorical ban on death penalty eligibility for the severely mentally ill by noting that "[c]apital defendants are permitted to present evidence of mental illness or impairment in mitigation." (RB 60, citing § 190.3, subd. (h).) This option is insufficient to protect the severely mentally ill from being sentenced to death. As the Supreme Court recognized both in *Atkins v. Virginia* and *Roper v. Simmons*, there exists a strong likelihood that jurors will treat the characteristic that should be mitigating as a factor in aggravation. In *Atkins v. Virginia*, the Supreme Court stated that "reliance on mental retardation as a mitigating factor can be a two-edged sword that may enhance the likelihood that the aggravating factor of future dangerousness will be found by the jury." (*Atkins v. Virginia*, *supra*, 536 U.S. at p. 321, citing *Penry v. Lynaugh*, 492 U.S. 302, 323-325.) Similarly, in *Roper v. Simmons*, the Court held that "[a]n unacceptable likelihood exists that the brutality or cold-blooded nature of any particular crime would overpower mitigating arguments based on youth." (*Roper v. Simmons*, *supra*, 543 U.S. at p. 573.)

The concerns articulated in *Atkins v. Virginia* and *Roper v. Simmons* apply equally to those suffering from severe mental illness; jurors likely

will conclude that the intractable nature of a severe mental illness should be treated as the aggravating factor of future dangerousness, and the brutality or gruesomeness of the murder – as in Ghobrial's case – should not be considered as evidence of the defendant's mental illness, but as circumstances of the crime for which nothing less than the death penalty is the appropriate sanction. (See Fleischaker, *Dead Man Pausing: The Continuing Need for a Nationwide Moratorium on Executions* (2004) 31 Human Rights 14, 18 [indicating that juries often consider mental illness as an aggravating factor and "states often fail to monitor or correct the unintended and unfair results of the error"]; see also Izutsu, *Applying Atkins v. Virginia to Capital Defendants With Severe Mental Illness* (2005) 70 Brook. L. Rev. 995, 1023-1024, fn.13 [opining that "it is the jurors' perception of the defendant's future dangerousness at sentencing that appears to be the decisive factor in the decision to impose the death penalty, regardless of the level of the defendant's culpability]; Slobogin, *Mental Illness and the Death Penalty* (2000) 1 Cal. Crim. L. Rev. 3, pars. 19-23 [research shows that one of the best predictors of a death sentence is assertion of an insanity defense at trial, and that presentation of evidence supporting a claim of extreme mental or emotional stress is much more likely to correlate with a death sentence than a life sentence].) As with mentally retarded and juvenile defendants, the severely mentally ill "in the aggregate face a special risk of wrongful execution." (*Atkins v. Virginia, supra*, 536 U.S. at p. 321.)

"A central feature of death penalty sentencing is a particular assessment of the circumstances of the crime and the *characteristics of the offender.*" (*Roper v. Simmons, supra*, 543 U.S. at p. 572, italics added; see also *Graham v. Florida* (2010) 560 U.S. 48, 67 ["The judicial exercise of

independent judgment requires consideration of the culpability of the offenders at issue in light of their crimes and *characteristics*, along with the severity of the punishment in question"], italics added, citing *Roper v. Simmons*, *supra*, 543 U.S. at p. 568, and *Kennedy v. Louisiana* (2008) 554 U.S. 407, 434-436.) The characteristics of those suffering from a severe mental illness, such as schizoaffective disorder, include by definition symptoms of a "range of cognitive and emotional dysfunctions that include perception, inferential thinking, language and communication, behavioral monitoring, affect fluency and productivity of thought and speech, hedonic capacity, volition and drive, and attention." (*Joshua v. Adams, supra,* 231 Fed. Appx. at p. 594 (dis. opn. of Ferguson, J.), quoting Slobogin, *What Atkins Could Mean for People with Mental Illness* (2003) 33 N.M.L. Rev. 293, 303-304.) This Court has the authority to and must recognize that these inherent characteristics render the severely mentally ill less culpable for their crimes and therefore ineligible for the death penalty.

"The penological justifications for the sentencing practice are also relevant to the analysis." (*Graham v. Florida*, *supra*, 560 U.S. at p. 71, citing *Kennedy v. Louisiana*, *supra*, 554 U.S. at pp. 434-436, *Roper v. Simmons*, *supra*, 543 U.S. at pp. 571-572, and *Atkins v. Virginia*, *supra*, 536 U.S. at pp. 318-320.) As noted in the opening brief, the *Atkins* Court recognized that "[i]f the culpability of the average murderer is insufficient to justify the most extreme sanction available to the State, the lesser culpability of the mentally retarded surely does not merit that form of retribution . . . ." (*Atkins v. Virginia*, *supra*, 536 U.S. at p. 319; accord *Roper v. Simmons*, *supra*, 543 U.S. at p. 571 ["Retribution is not proportional if the law's most severely penalty is imposed on one whose culpability or blameworthiness is diminished"].) Just as those with mental

retardation and juveniles under 18 are considered less culpable as a consequence of their inherent limitations and therefore undeserving of the ultimate sanction, the functional impairments caused by severe mental illness diminish the culpability of defendants suffering from such illnesses, making the "most extreme sanction available to the State" unwarranted. (AOB 93.) The goal of deterrence also is not promoted by executing the severely mentally ill. "Capital punishment can serve as a deterrent only when murder is the result of premeditation and deliberation." (*Atkins v. Virginia*, *supra*, 536 U.S. at p. 319, quoting *Enmund v. Florida* (1982) 458 U.S. 782, 799.) A severely mentally ill defendant who suffers from symptoms impairing his or her perception of reality, thought processes, and volitional control is incapable of engaging in the "kind of cost-benefit analysis that attaches any weight to the possibility of execution." (*Roper v. Simmons*, *supra*, 543 U.S. at pp. 561-562, quoting *Thompson v. Oklahoma* (1988) 487 U.S. 815, 836-838.)

There also exists with the severely mentally ill the same "unacceptable risk of wrongful executions" as exists with the mentally retarded. (See *Atkins v. Virginia*, *supra*, 536 U.S. at p. 320.) The severely mentally ill may be as likely as the mentally retarded to falsely confess to a crime, and the disordered thinking, impaired communication skills, delusions, hallucinations, and distractions of internal stimuli attending a severe mental illness impede the defendant's ability to communicate effectively with counsel and assist in the defense, including developing mitigating evidence.

Finally, criteria may be developed to meaningfully distinguish those who should be exempt from a punishment of death from those who should not. Respondent's assertion that Ghobrial is asking this Court to "establish

a new, ill-defined category of capital murderers who would be exempt from the death penalty" is unsupported. (RB 60.) As discussed in the opening brief, the Supreme Court's opinions in *Panetti v. Quartermen* (2007) 551 U.S. 930, and *Ford v. Wainwright* (1986) 477 U.S. 399[14], suggest that "when severe mental illness produces gross delusions or other cognitive effects, significantly distorting the offender's understanding and appreciation of his conduct and of its wrongfulness, capital punishment will serve no retributivist purpose, and therefore would be cruel and unusual." (AOB 91.) "By stressing gross delusions that significantly impair comprehension," the *Panetti* Court suggests that only those suffering from major mental illnesses with psychotic features should be considered ineligible for the death penalty. (*Ibid.*) The opening brief also cites resolutions by the American Bar Association, American Psychiatric Association, American Psychological Association, and the National Alliance for the Mentally Ill exempting those with severe mental illness from the death penalty, and the nearly identical resolutions all identify criteria by which to identify defendants qualifying for the exemption. (AOB 85.) Lastly, as noted above, the Connecticut legislature enacted legislation exempting defendants whose "mental capacity was significantly impaired or ability to conform his or her conduct to the law was significantly impaired, but not so impaired as to provide a complete

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[14]Respondent apparently misunderstands the purpose for which these cases were cited in the opening brief. (See RB 60.) As discussed above, Ghobrial cites these cases to demonstrate that the Supreme Court has offered guidance and criteria by which courts can identify those whose mental illness is so severe that it renders them less culpable and therefore ineligible for the death penalty. Ghobrial says nothing in the opening brief about incompetence to be executed.

defense." (Conn. Penal Code, *supra.*) Establishing criteria is a familiar role for the Court, not an insurmountable task that would leave those suffering from severe mental illness unprotected from cruel and unusual punishment.

"It is an axiom of criminal law that mental illness bears heavily on an individual's culpability. We have recognized 'the belief, long held by this society, that defendants who commit criminal acts that are attributable . . . to emotional and mental problems[ ] may be less culpable than defendants who have no such excuse.'" (*Joshua v. Adams*, *supra*, 231 Fed. Appx. at p. 598, quoting *California v. Brown* (1987) 479 U.S. 538, 545 (conc. opn. of O'Connor, J.).) As outlined in Argument I, above, evidence establishes that, from a young age, Ghobrial has suffered from a severe mental illness that significantly impairs his ability to function socially, educationally, and occupationally. He has been plagued by delusions and hallucinations that substantially impair his cognitive and psychological abilities and ability to comprehend reasonably rationally his world. To execute a defendant disabled by a severe mental illness through no fault or choice of his own is a disproportionate punishment. Ghobrial's death judgment must be reversed.

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III.

NO REASONABLE AND CREDIBLE EVIDENCE OF SOLID VALUE SUPPORTED THE FIRST DEGREE MURDER CONVICTION AND THE SPECIAL CIRCUMSTANCE FINDING

A. Introduction

The federal and California constitutions provide a criminal defendant with the guarantee that any conviction obtained will be based on substantial evidence. (AOB 94-95; *People v. Holt* (1997) 15 Cal.4th 618, 667.) The federal Constitution further guarantees that, to meet the heightened reliability requirements of the Eighth Amendment, a death sentence cannot be imposed based on speculative evidence. (AOB 94; *Edelbacher v. Calderon* (9th Cir. 1998) 160 F.3d 582, 585; *Flowers v. State* (Miss. 2000) 773 So.2d 309, 317.) To ensure that these constitutional guarantees have been fulfilled, when evaluating whether the evidence was sufficient to support a conviction and death sentence, this Court must "review the whole record in the light most favorable to the judgment to determine whether it discloses substantial evidence – that is, evidence that is reasonable, credible, and of solid value – from which a reasonable trier of fact could find the defendant guilty beyond a reasonable doubt." (AOB 95, quoting *People v. Stanley* (1995) 10 Cal.4th 764, 792; see also *People v. Whalen* (2013) 56 Cal.4th 1, 55.) Regardless of whether the evidence is direct or, as in this case, primarily circumstantial, to support a conviction, special circumstance, and sentence of death, the evidence must be substantial and the inferences drawn therefrom reasonable. (See *People v. Stanley, supra*, 10 Cal.4th at pp. 793-794 [standard of review is same regardless of whether evidence is direct or circumstantial, but circumstances must reasonably justify trier of fact's findings].) As demonstrated in the opening brief, a

thorough review of the complete record fails to disclose sufficient evidence that was reasonable, credible, or of solid value on which the jury could find Ghobrial guilty of first degree murder under either a theory of premeditation and deliberation or a felony murder occurring during the attempted commission of a lewd act in violation of Penal Code section 288 (AOB 97-118); the charged crimes and resulting verdict, special circumstance finding, and death sentence were based solely on speculation, suspicion, and conjecture.

Respondent's primary response is repeated reiteration of the undisputed standard of review applicable to sufficiency of the evidence claims: this Court must presume in support of the judgment the existence of every fact the jury could reasonably infer from the evidence. (See RB 61, 62, 66, 69, 72.) Respondent's repeated citation to the standard of review cannot, however, substitute for the evidence missing from the prosecution's case. The lion's share of the prosecution's case against Ghobrial was circumstantial, as defense counsel recognized explicitly (see 9 RT 1941 ["This is an inference driven case"]) and the prosecution recognized implicitly by focusing primarily during closing argument on the inferences he believed were supported by the evidence (see e.g., 8 RT 1912 ["This is circumstantial evidence. . . . And so you're drawing inferences from the evidence"]). Respondent's focus on the presumption in favor of the judgment cannot obscure the fact that no substantial evidence supported the inferences necessarily made by the jurors in order to convict Ghobrial.

"Circumstantial evidence is like a chain which link by link binds the defendant to a tenable finding of guilt." (*People v. Redrick* (1961) 55 Cal.2d 282, 290.) Circumstantial evidence requires the trier of fact to draw reasonable inferences from facts proven beyond a reasonable doubt; a

"'reasonable inference may not be based on suspicion alone.'" (*People v. Tripp* (2007) 151 Cal.App.4th 951, 959, quoting *People v. Raley* (1992) 2 Cal.4th 870, 891 [citations omitted].) Although the trier of fact is tasked with determining the existence and strength of the facts that form the evidentiary links, "'if there has been a conviction notwithstanding a missing link it is the duty of the reviewing court to reverse the conviction.'" (*Id.* at p. 956, quoting *People v. Redrick, supra,* 55 Cal.2d at p. 290.) If the inferences drawn are based on a suspicion that merely raises the possibility of the inferred fact's existence, there is insufficient evidence to support a conviction. "'A finding of fact must be an inference drawn from evidence rather than . . . a mere speculation as to probabilities without evidence.'" (*Id.* at p. 959, quoting *People v. Raley, supra,* at p. 891.) "'Evidence which merely raises a strong suspicion of the defendant's guilt is not sufficient to support a conviction.'" (*Id.* at p. 958, quoting *People v. Redmond* (1969) 71 Cal.2d 745, 755.) Respondent unsuccessfully attempts to fill the gaps in the prosecution's evidence by "mere speculation as to probabilities."

B. No Substantial Evidence Supported a Finding That Ghobrial Premeditated and Deliberated

The California Legislature has expressed a clear intention that the "unlawful killing of a human being . . . with malice aforethought" (§ 187) be divided into two degrees (§ 189), and that the unjustified killing of a human being is presumed to be second degree murder unless the prosecution proves beyond a reasonable doubt that the defendant premeditated and deliberated (*ibid.*; AOB 97-98; *People v. Anderson* (1968) 70 Cal.2d 15, 25). Nevertheless, this Court has acknowledged the historical "lack of conceptual consistency" (*People v. Holt* (1944) 25 Cal.2d 59, 88) in differentiating between murder of the first degree and murder of the

second. (*People v. Anderson, supra,* 70 Cal.2d at p. 25; see also Mounts, *Premeditation and Deliberation in California: Returning to a Distinction Without a Difference* (2002) 36 U.S.F. L. Rev. 261.) "Recognizing the need to clarify the difference between the two degrees of murder and the bases upon which a reviewing court may find that the evidence is sufficient to support a verdict of first degree," the *Anderson* Court "set forth standards, derived from the nature of premeditation and deliberation as employed by the Legislature and interpreted by [the Court], for the kind of evidence which is sufficient to sustain a finding of premeditation and deliberation."[15] (*People v. Anderson, supra,* 70 Cal.2d at pp. 25-26.) The *Anderson* analysis established a "framework to assist reviewing courts in assessing whether the evidence supports an inference that the killing resulted from preexisting reflection and weighing of considerations" (*People v. Thomas* (1992) 2 Cal.4th 489, 517), or instead was the result of an unconsidered or rash

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[15]As noted in the opening brief (AOB 98, fn. 42), nowhere does the *Anderson* Court suggest that its articulation of standards be used to define premeditation. Rather, the Court recognized the potential and actual challenges in distinguishing between the two degree of murder and the inconsistencies apparent in reviewing courts' findings that the evidence was or was not sufficient to sustain a conviction for first degree murder. (See *People v. Anderson, supra,* 70 Cal.2d at pp. 25-26.) Although this Court cautioned against "[u]nreflective reliance on *Anderson*" in *People v. Thomas*, in assessing the sufficiency of the evidence of premeditation, the Court there and in other cases has consistently used the "*Anderson* analysis as a guide." (See, e.g., *People v. Thomas, supra,* 2 Cal.4th at p. 517; *People v. Stitely* (2005) 35 Cal.4th 514, 543 [when record discloses evidence in all three categories, verdict generally will be sustained]; *People v. Silva* (2001) 25 Cal.4th 345, 369 [addressing insufficiency claim by reference to the three factors identified in *Anderson*]; *People v. Combs* (2004) 34 Cal.4th 821, 850-851 [same]; *People v. Bolin* (1998) 18 Cal.4th 298, 331-333 [same].)

impulse. As discussed in the opening brief, this Court has identified three types of evidence usually found sufficient to sustain a finding of premeditation and deliberation: (1) planning activity prior to the killing; (2) facts about the defendant's prior relationship and/or conduct with the victim from which the jury reasonably could infer a motive; and (3) facts about the nature of the killing from which the jury could infer that the manner of the killing was "so particular and exacting that the defendant must have intentionally killed according to a 'preconceived design' to take [the] victim's life." (*People v. Anderson*, *supra*, 70 Cal.2d at pp. 26-27, quoted in *People v. Thomas*, *supra*, 2 Cal.4th at pp. 517; see AOB 97-98.) Appellant's opening brief analyzed the prosecution's evidence of premeditation and deliberation admitted against Ghobrial utilizing the *Anderson* guidelines and established that the jury had before it no substantial evidence on which to find that Ghobrial premeditated and deliberated before the killing. (AOB 99-103.)

Respondent also utilizes the *Anderson* guidelines to analyze the sufficiency of the evidence of premeditation and deliberation (RB 63), and in so doing, affirms the opening brief's position that no substantial evidence supports a finding of premeditation and deliberation. First, respondent concedes, as she must, that the prosecution presented no substantial evidence from which the jury reasonably could infer the manner of killing. (RB 64.) The official cause of death was listed as "by unspecified means" (AOB 103, citing 7 RT 1460, 8 RT 1926]), and the forensic pathologist who performed the autopsy, Dr. Aruna Singhania, would not definitively identify the cause of death, observing only that asphyxia seemed the most likely cause (AOB 103, 7 RT 1460, 1479-1483]). The prosecutor himself suggested that the killing could have been accidental. (AOB 103-104, 8

RT 1927].)

Respondent unsuccessfully strains to discover evidence in the two remaining categories: planning activity and preexisting motive. Respondent's discussion of alleged planning activity is pure speculation. Respondent cites Ghobrial's statements to Juan of "I am going to kill you. I will kill you and eat your pee-pee," but does nothing to explain how these statements are evidence of planning. (RB 64.) As discussed in the opening brief, Ghobrial's mental status, Juan's teasing of Ghobrial at the time, Juan's dismissal of any danger, and a witness's failure to take any action, suggest that these statements more likely were a "disturbed man's rash and heated response to Juan's taunts at sometimes, and a bizarre, deranged jest at others." (AOB 101.) Even if the statements were meant literally, as the prosecutor himself noted, Ghobrial's words suggest an intent only, not a plan. (AOB 101, fn. 47, 8 RT 1909].) Missing from respondent's proposal is any evidence, substantial or otherwise, from which a reasonable fact-finder could infer Ghobrial was in the process of developing or did develop "a deliberate judgment or plan." Respondent also describes Juan's conduct on the Wednesday prior to his disappearance, including seeking a place other than his own home to spend the night. Respondent does not, however, link Juan's behavior to evidence of Ghobrial's planning. (RB 64.) The *only* reasonable inference from this evidence is that Juan sought out Ghobrial, not that Ghobrial sought out Juan.

When respondent finally does turn to evaluating Ghobrial's behavior, she points to the evidence of his actions following, rather than preceding, the killing. Respondent's inference that Ghobrial "considered the possibility of homicide from the outset" is dependant on the evidence of two alleged facts being substantial: the threats *and* Ghobrial's purchases

before Juan's death. (RB 65.) Although the prosecutor specifically rejected the theory that Ghobrial purchased the equipment used to dispose of the body prior to the killing (AOB 99, 8 RT 1910, 1913]), respondent speculates that the jury could have inferred these purchases took place prior to the killing. (RB 65.) For such an inference to be at all reasonable, there must be some evidence in the record to explain how Ghobrial immobilized Juan while he went shopping alone, and none of the witnesses saw Ghobrial at either Kmart or Home Depot on March 19, reported that he was accompanied by anyone. The forensic pathologist found no evidence of a struggle or defensive wounds on Juan (AOB 18, 7 RT 1492, 1499]), and the record is completely devoid of any other evidence suggesting that Juan was alive when Ghobrial made his purchases. As noted above, an inference is only as valid as the evidence upon which it depends. Although Ghobrial did make statements the jury could construe as threats, there is absolutely no evidence supporting an inference that the purchases were made prior to the killing.

Respondent further claims that Ghobrial's dismemberment of the body after the killing "would appear to be inconsistent with a state of mind that would have produced a rash, impulsive killing." (RB 65.) This equivocal and ambivalent conclusion underscores the speculative nature of using post-crime actions to infer a pre-crime state of mind as evidence of premeditation and deliberation. Although post-crime "cover-up" evidence "may possibly bear on defendant's state of mind after the killing, it is irrelevant to ascertaining defendant's state of mind immediately prior to, or during, the killing." (*People v. Anderson*, *supra*, 70 Cal.2d at p. 31; see AOB 102, fn. 48.) Respondent's inability to identify substantial evidence sufficient to support an inference of "preexisting reflection" demonstrates

the lack of substantial evidence of premeditation and deliberation available to the jurors.

Finally, respondent engages in the same circular reasoning as the prosecutor to ascribe a motive to Ghobrial: that is, that Ghobrial molested Juan and therefore must have killed him to hide the molestation; and because Ghobrial murdered Juan, he must have molested him. (RB 66.) As demonstrated in the opening brief, the prosecution had no credible evidence sufficient to prove beyond a reasonable doubt that Ghobrial attempted to molest Juan. (AOB 106-118.) Furthermore, even if the jury reasonably could infer that Ghobrial had a motive to kill Juan, absent evidence of planning activity or the nature of the killing, a defendant's possible motive is an insufficient basis on which to find premeditation and deliberation beyond a reasonable doubt. (*People v. Anderson*, *supra*, 70 Cal.2d at pp. 26-27; AOB 102-103.)

Respondent concludes by asserting that Ghobrial argues in the opening brief for "his version of the events rather than facts and inferences to be drawn in favor of the verdict." (RB 66.) Once again, respondent misses the gravamen of the claim. Ghobrial does not simply argue that the jury reasonably could have believed a scenario other than the one posited by the prosecution. The opening brief demonstrates that no evidence of any kind existed from which the jurors reasonably could find that Ghobrial planned the killing. The assertions that Ghobrial "had no weapon or bindings or anything to suggest he was prepared to harm anyone" (AOB 100), and that he "made no preparations for disposing of the body" (AOB 100) do not describe an alternative scenario; they reveal an absence of evidence of planning. Once more, respondent's mere parroting of the standard of review does not create substantial evidence on which the jury

reasonably could have based a finding of premeditation and deliberation. There simply was none.

Respondent utterly fails to respond to appellant's argument that Ghobrial's sentence is unreliable and in violation of the Eighth Amendment because the jurors were not instructed that they could not use deliberate premeditated murder for the purposes of factor (a) when considering the appropriate sentence for Ghobrial. (AOB 106.) This Court should construe respondent's failure as a concession that, if this Court finds the evidence insufficient to support a finding of premeditation and deliberation but legally sufficient to support the felony murder and the jury relied on a felony murder theory, the failure by the trial court to instruct the jury that they could not consider Ghobrial as culpable as one who committed deliberate and premeditated murder warrants reversal of his death sentence.

C. No Substantial Evidence of Felony Murder Was Presented

In response to appellant's argument that the felony murder conviction is not supported by substantial evidence, respondent once again resorts to repeated recital of the standard of review on appeal, rather than addressing the substance of the claim. (See RB 67, 69.) The prosecution did not charge Ghobrial with a violation of section 288, but argued to the jurors that the killing occurred during the attempted commission of a lewd act on a child in violation of section 288, within the meaning of section 190.2, subdivision (a) (17) (5). (AOB 107, 1 CT 87].) As explained in the opening brief, the prosecution presented no substantial evidence that Ghobrial touched Juan, did so with the specific intent "to arouse, appeal to, or gratify the lust, passions, or sexual desires of that person or child, or did so to a child under 14 years of age." (AOB 107, § 288, subd. (a); CALJIC

No. 10.41; 2 CT 420; 9 RT 2018-2019].)

Unlike the prosecutor, who clearly harbored reasonable doubt about the evidentiary value of the potential discovery of three to five sperm cells in anal swabs taken from the pelvic section, respondent inaccurately states that "[s]perm cells were found inside Juan's rectum," and that their presence was sufficient for the jury to find beyond a reasonable doubt that Ghobrial committed a lewd act, citing *People v. Thompson* (1990) 50 Cal.3d 134, 170. (RB 69; AOB 116, 7 RT 1611, 1626, 1628, 1630; 8 RT 1870].) Although the fact of the body's dismemberment is gruesome and difficult, this fact cannot be used to excuse the requirement that reasonable inferences be based on substantial evidence. If the material identified by Aimee Yap were, in fact, sperm cells, they were not found inside Juan's rectum. Laurie Crutchfield, the Orange County criminalist who obtained the anal swabs from Juan's body, testified that the practice of the Orange County criminalists is to obtain samples both from the perianal region and the anus. (7 RT 1622-1624.) When taking swabs from the pelvic remains, she was able to swab the perianal area only because only the anus and the sphincter were recovered. (7 RT 1621-1624.) This is not a mere technicality. Not only was the sperm not found inside the anus, but also no forensic testing included Ghobrial as a possible source. (*Compare People v. Thompson*, *supra*, 50 Cal.3d at 171, fn. 3.) As discussed in the opening brief, although the jurors had the right to accept the prosecution's assertion that the items identified by Yap were, in fact, sperm – a conclusion strongly contested by the defense – no further evidence existed supporting an inference that the sperm had been deposited by Ghobrial; the sperm could have originated from Juan's testicles or vas deferens when they were severed, or it could have been deposited by someone other than Ghobrial. (AOB 118.) The simple fact is that the evidence is, at best, inconclusive.

Respondent also cites the fact that the body was found nude, although she concedes a victim's lack of clothing "is insufficient to establish specific sexual intent." (*People v. Johnson* (1993) 6 Cal.4th 1, 41.) Both cases cited by respondent in support of her position are factually distinguishable in significant ways. In *People v. Rundle* (2008) 43 Cal.4th 76, 139, this Court reiterated that "the circumstance of the victim's being found partially or wholly unclothed is not by itself sufficient to prove a rape or attempted rape has occurred," and pointed to other indicia of rape present in that case. There, the victim was found in a secluded area with her arms bound tightly behind her back, and, "most importantly, defendant's own admission support the conclusion there was sufficient evidence for a rational trier of fact to find he attempted to rape [the victim]." (*Ibid.*) No similar evidence exists in the prosecution's evidence against Ghobrial.

People v. Holloway (2004) 33 Cal.4th 96, 139, is also inapposite as this Court found "substantially more [evidence] than the victim[']s[] nudity" to prove sexual intent. In *Holloway*, the defendant challenged the sufficiency of the evidence to establish he had attempted to rape the second of his two victims. This Court noted that the defendant had only shortly before sexually assaulted and killed one victim in her car. In addition, pubic hair consistent with defendant's and inconsistent with the victim's was found in the car, and the second victim was found lying nude on her back on her bed, with ligature marks on her neck, wrists, and ankles. (*Id.*, at pp. 105-106.) No similar evidence beyond the victim's nudity was presented against Ghobrial.

Respondent also posits that the fact that Juan's penis was severed from his body and never recovered "strongly suggested that the crime was sexually motivated." (RB 69, *People v. Guerra* (2006) 37 Cal.4th 1067, 1131-1132].) Respondent accurately characterizes the strength of the

evidence by *suggesting* that the crime was sexual motivated, but the fact that Juan's penis was severed fails utterly to establish the elements of a violation of section 288. Recognizing that this Court must view the evidence in the light most favorable to the prosecution, no evidence provides a substantial inferential link from the postmortem removal of the penis to a conclusion that Ghobrial attempted to touch Juan in a lewd manner with the requisite intent while he was alive. The *only* evidence suggesting Ghobrial's mental state at the time of the crime are his earlier statements that he wanted to kill Juan and "eat his pee-pee." As made clear in the opening brief, the *only* reasonable inference from Ghobrial's statement is that Ghobrial "did exactly what he asserted he would do, eat Juan's penis. While such a violation of the ultimate human taboo suggests compelling evidence of Ghobrial's mental illness, it does not represent evidence of premortem sexual molestation." (AOB 116.) A suspicion that the crime was sexually motived does not provide the substantial evidence of the elements of the crime necessary to sustain a conviction.

Furthermore, Juan's clothes showed no signs of having been forcibly removed, and, as addressed below, Juan's body showed no signs of forcible sexual assault. To the extent that some evidence exists supporting an inference that some type of sexual activity occurred, such evidence – when considered along with Ghobrial's statements – only supports the inference that Ghobrial intended to engage in the activity postmortem. A violation of section 288 requires a live victim. (See *People v. Kelly* (1992) 1 Cal.4th 495, 524, citing *People v. Sellers* (1988) 203 Cal.App.3d 1042, 1050, *People v. Stanworth* (1974) 11 Cal.3d 588, 604-605, *People v. Morales* (1989) 48 Cal.3d 527, 552, *People v. Ramirez* (1990) 50 Cal.3d 1158, 1176 [applying similar rule to crime of sodomy].) Respondent's citation to cases holding that the victim need not be alive to support an attempted lewd act if

the defendant intended to commit the lewd act with a live body are inapposite because respondent has failed to point to any substantial evidence establishing that Ghobrial harbored an intent to sexually assault Juan while Juan was alive. (RB 71 [citations omitted].)

The forensic pathologist who performed the autopsy on Juan found no evidence of trauma, other than the dismemberment, to any of the body parts recovered days after the killing, no anal tears on the pelvic region discovered approximately one year later, and, upon microscopic examination, no evidence of bruising to the anal region. (7 RT 1461, 1479-1481; 1459; 1478). Respondent has no response to these facts, and instead focuses on Dr. Singhiana's testimony that she could not say conclusively there were no anal tears based on the condition of the body. Respondent posits that "the absence of such evidence is inconclusive and does not tend to eliminate a sexual assault, depending on the nature of the crime scene or when the body is found in an advanced state of decomposition," again citing *People v. Rundle*, *supra*, 43 Cal.4th at p. 139. (RB 70.) As noted above in *People v. Rundle*, this Court found that the fact that the crime occurred near "a secluded highway exit in a rural area," the victim was found nude and with her hands "bound very tightly behind her back," and the defendant *admitted* having sex with the victim provided strong evidence of a forcible or attempted rape occurred. (*Id.* at pp. 138-140.) Considering this other strong evidence that a rape or attempted rape had occurred, this Court found that the absence of evidence of "trauma to the body or sexual organs, or the presence of the perpetrator's bodily fluids . . . did not tend to eliminate a sexual assault; it simply was inconclusive due to the nature of the crime scene and the advanced state of decomposition of [the victim's] body." (*Id.* at p. 139.) Here, in the face of no additional evidence of a sexual assault, respondent is attempting to use the absence of evidence of

sexual assault to prove that a sexual assault must have occurred. The requirement that a reasonable inference be based upon facts proven beyond a reasonable doubt cannot be turned on its head to allow an inference based upon the absence of facts.

Finally, as established in the opening brief, the prosecution failed to present substantial evidence from which the jury reasonably could infer that Juan was under 14 at the time of the offense. (AOB 118-119.) Respondent asserts that the testimony of Armando Luna, a classmate of Juan's, that both he and Juan were 12 years old was sufficient to establish that Juan was younger than 14, an essential element of a violation of section 288. (RB 71-72.) Respondent must recognize that Armando simply was assuming that he and Juan were the same age because they were in the same grade together; Armando had no evidence other than their shared grade upon which to base his assumption. Respondent cites *People v. Young* (2005) 34 Cal.4th 1149, 1181, and *People v. Allen* (1985) 165 Cal.App.3d 616, 623, for the proposition that the "testimony of a single witness is sufficient of support a conviction" "unless the testimony is physically impossible or inherently improbable." (RB 72.) Both those cases, however, address eyewitness testimony and the sole responsibility of the trier of facts to determine the credibility of a witness. Here, Armando was not testifying to any fact that called for a credibility determination; he simply was speculating about Juan's age based on the fact that he and Juan were in the same grade. Speculation is not substantial evidence sufficient to support a finding of fact that is an element of a crime.

D. Conclusion

The United States Supreme Court recognized thirty-five years ago that "a properly instructed jury may occasionally convict even when it can be said that no rational trier of fact could find guilt beyond a reasonable

doubt." (*Jackson v. Virginia* (1979) 443 U.S. 307, 317.) The facts of this case must have presented extraordinary challenges for the jurors. A young boy had been killed, dismembered, and the body parts encased in concrete; the defendant was an Egyptian national suffering from a severe mental illness who spoke no English and was missing part of his arm. Jury selection began six weeks after the attack on the Twin Towers World Trade Center and the Pentagon; by then, the Arab nationality of the terrorists, including one Egyptian, was common knowledge. Despite being properly instructed, it may not have been humanly possible for the jurors to put aside their horror at the crime and their fear of the defendant to approach the case with dispassionate reason. Although the evidence either was inconclusive or missing entirely, when faced with the gruesome facts of the crime and in the context of 9/11, perhaps no jury could have found Ghobrial guilty of anything less than first degree murder or sentenced him to anything less than death. This Court must provide the logical reasoning that may have been elusive for the jurors despite their best intentions, and recognize that no substantial evidence exists supporting the guilty verdict, special circumstance finding, and sentence of death.

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IV.

THE TRIAL COURT VIOLATED GHOBRIAL'S RIGHT TO PRESENT A DEFENSE WHEN IT REFUSED TO ALLOW DEFENSE WITNESSES TO TESTIFY THAT THE VICTIM SOUGHT OUT THE COMPANIONSHIP OF ADULT MEN

The right to offer the testimony of witnesses "is in plain terms the right to present a defense, the right to present the defendant's version of the facts as well as the prosecution's to the jury so it may decide where the truth lies. Just as an accused has the right to confront the prosecution's witnesses for the purpose of challenging their testimony, he has the right to present his own witnesses to establish a defense. This right is a fundamental element of due process of law." (*Washington v. Texas* (1967) 388 U.S. 14, 19.) A defendant's right to present relevant evidence "stands on no lesser footing than the other Sixth Amendment rights." (*Taylor v. Illinois* (1988) 484 U.S. 400, 409, citing *Washington v. Texas, supra*, 388 U.S. at p. 18.) As a result, a trial court's authority to exclude a witness must yield to a defendant's right to a fair trial if that witness is capable of providing relevant testimony, including evidence of facts from which ultimate facts may be presumed or inferred, and the testimony is not barred by statute. (AOB 132, citing Evid. Code § 351; *People v. Williams* (1996) 46 Cal.App.4th 1767, 1777, citing *Chambers v. Mississippi* (1973) 410 U.S. 284, 302.)

The trial court violated Ghobrial's constitutional right to present relevant evidence in his defense. Appellant's opening brief makes clear that the excluded testimony of eleven different witnesses, who could have described Juan's escalating efforts in the weeks prior to the homicide to seek out unfamiliar adults to provide him with food and companionship, his endeavors to avoid going home, and his spending a night in a car with an unknown man, all was relevant to dispute the prosecutor's arguments that the jurors should construe Ghobrial's relationship with Juan as "unnatural"

(8 RT 1921); view the pornography found in Ghobrial's shed as a "magnet" used to "entice and to excite" Juan (8 RT 1924); and conclude that the material identified by the prosecution's experts as sperm necessarily came from Ghobrial (8 RT 1928). (AOB 136-139.) This testimony also further undermines respondent's claim that Ghobrial engaged in any "planning activity" prior to the homicide. (RB 65.)

Respondent fails to understand the relevance of this proposed testimony. Respondent asserts, without citation, that defense counsel argued "the evidence was relevant to explain Juan's motivation for seeking out Ghobrial or accompanying him to the shed." (RB 77.) In both defense counsel's offer of proof (2 CT 381-386) and at argument on the motion (5 RT 1237), defense counsel made clear that evidence was relevant not to any *motivation* of Juan's. Instead, it was offered to show that Juan actively "approached and attempted to latch onto strange adults, particularly males, and who, particularly in the weeks leading up to the homicide, did not want to spend the night at home," from which the jurors could infer that Juan formed his relationship with Ghobrial in the same fashion. (2 CT 385.) The evidence negated an inference that Ghobrial's relationship with Juan "was a desire for sex." (5 RT 1237.) In other words, the excluded evidence would have established that Juan had any number of relationships with adult men similar to the one he had with Ghobrial.

Respondent continues in the same vein by arguing that "Juan's motivation or intent in spending time with Ghobrial was not at issue, and does nothing to prove or disprove whether Ghobrial himself sought out Juan for sexual purposes." (RB 77-78.) Again, defense counsel never argued that the evidence was related to Juan's "motivation or intent"; rather, the evidence was relevant to Juan's behavior. If Juan sought out Ghobrial more actively than Ghobrial sought out Juan, the jurors certainly could disbelieve

the prosecution's argument that Ghobrial sought out Juan for an "unnatural" purposes. Furthermore, the ultimate issue for the jurors was not whether Ghobrial did or did not seek out Juan, but rather whether Ghobrial premeditated or deliberated prior to the homicide or whether a molestation occurred. If the prosecution wanted the jurors to infer an "unnatural relationship" from the age difference between Juan and Ghobrial, the jurors were entitled to know that Juan had a number of relationships with older men, not just Ghobrial. Furthermore, if Juan went to Ghobrial's shed of his own accord, looking for a place to spend the night, then the pornography found in the shed could not have been the "magnet" the prosecution claimed, used to "entice and excite this little boy." (RT 1924.) And if Juan went on his own accord, Ghobrial could not be found to have planned the encounter.

As noted in the opening brief, the defense also sought to introduce testimony that Juan sought out and had contact with multiple adult men, which suggested that Ghobrial was not the only possible source of the alleged sperm found in Juan's anus. "'Given the degraded nature of the alleged sperm, there is no way to know when it was deposited' in relation to the time of death" or by whom. (AOB 131, citing 2 CT 385.) Respondent asserts that the "proffered evidence was too tenuous and speculative to be admitted as third party culpability evidence." (RB 78.) Once again, respondent has missed, or avoided, the point.[16] The defense did not seek to

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[16]Ghobrial was not charged with a violation of section 288; the information alleged only as a special circumstance that the murder was committed while appellant was engaged in the commission or attempted commission of the performance of a lewd and lascivious act upon a child under 14, in violation of section 288, within the meaning of section 190.2 subdivision (a) (17) (E). (1 CT 87.) Appellant has been unable to discover any authority suggesting that a defendant can introduce third party culpability evidence to defend against a special circumstance allegation

introduce this evidence to identify a third party as the source of the alleged sperm, but to undermine the prosecution's argument that only Ghobrial could be the source. The trial court recognized the relevance of the testimony. The court held a side-bar during the defense opening statement after the prosecution objected to the "defense giving a background and history of the victim." (5 RT 1235.) Defense counsel explained that the information was relevant to "negate a presumption that the nature of Mr. Ghobrial's relationship with Juan was a desire for sex and, therefore, is circumstantial evidence on the issue of whether or not the killing occurred in the commission of a sexual act." (5 RT 1237.) After the prosecutor asked, "How can it possibly be relevant?", the court responded, "What is possibly relevant is that somebody else might have had a consensual sexual act with him, I suppose." (5 RT 1237.) The court overruled the prosecutor's objection, but when the issued was revisited during the defense case, although still recognizing the relevance of the evidence, the court – perhaps realizing that the evidence was damaging to the prosecution's case – sustained the prosecution's objection to the testimony of Oscar Leon. (58 RT 1685.) Leon would have testified that, less than a month before the crime, Juan approached him at a donut shop somewhere between 11 p.m. and 12 a.m. and asked Leon to take him to look for his mother. Juan directed him to two different grocery stores, and after he still could not find his mother and Leon offered to take him home, Juan claimed he could not identify his own house. Juan then cried when Leon suggested taking him to the police station. They returned to the donut shop between 3:30 a.m. and 4:30 a.m. where they spent the remainder of the night in Leon's car, and Leon drove Juan to the police station at 6:00 a.m. (2 CT 384.) In

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when the underlying felony has not been charged as a separate crime.

sustaining the objection to this testimony, the court stated:

> Mr. Cook, you are barking up the wrong tree. He spends the night or part of a night in a car with Mr. Leon. Well, you know what jurors could infer? That maybe something went on in that car. And maybe the boy [m]ight have been promiscuous. . . . I don't think that is a fair inference, but it is certainly an inference that some people might draw. . . . It has nothing to do with what might have gone on in that shed on the night in question.

(8 RT 1685.) Of course, the evidence had everything to do with "what might have gone on in the shed on the night in question." Without accusing Leon of depositing the alleged sperm in Juan's anus, the jurors reasonably could believe that spending the night with strange adult men was not outside of Juan's experience and completely separate from his relationship with Ghobrial.

As appellant's opening brief makes clear, the exclusion of this evidence resulted in prejudice to Ghobrial: had the jurors heard the excluded testimony, it is reasonably probable that at least one juror would have had a reasonable doubt about whether Ghobrial molested or attempted to molest Juan. (AOB 138.) Respondent cites only to an irrelevant issue – the absence of evidence of third party culpability – and an uncontested issue – that "witnesses observed him planning and carrying out the disposal of Juan's body"– in response. (RB 79.) Respondent's inability to cite substantial and relevant evidence in rebuttal should be construed as an implicit recognition of the prejudice suffered by Ghobrial from the exclusion of this testimony.

The prosecution's case against Ghobrial was entirely circumstantial and dependant upon inferences. The prosecutor was able to argue to the jurors inferences from the evidence that he believed pointed to Ghobrial's guilt; Ghobrial had a constitutional right to present evidence that undermined the prosecution's inferences and raised a reasonable doubt.

The court's ruling on Ghobrial's Penal Code section 190.4, subdivision (e) motion confirms the prejudice Ghobrial suffered; by excluding the evidence, the court was able to accept only the prosecution's inferences. At the hearing on Ghobrial's application for modification of the verdict, the court stated that the evidence showed "there was some kind of attachment between Mr. Ghobrial and Juan" (11 RT 2829), and asserted that Ghobrial "lured the child for a particular purpose into the room consistent with his pre-offense statement"[17] (11 RT 2839). The excluded evidence established that Juan sought out attachments with any number of older men and that Ghobrial did nothing to "lure" Juan to the shed. More likely, Juan went to Ghobrial's shed on his own accord, looking for someplace other than home to spend the night. The trial court's refusal to allow the defense to present the excluded testimony violated Ghobrial's constitutional right to present a defense. His conviction and sentence of death must be vacated.

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[17]Presumably the court is referring to Ghobrial's taunts that he would kill Juan and eat his "pee-pee."

VIII.

THE PROSECUTOR COMMITTED PREJUDICIAL MISCONDUCT REQUIRING THE REVERSAL OF THE DEATH JUDGMENT

Ghobrial's trial took place under extraordinary circumstances. One day after jury selection began, terrorists attacked the Twin Towers World Trade Center and the Pentagon. When voir dire resumed on September 17, 2001, a substantial number of jurors disclosed that they could be neither unbiased nor fair toward Ghobrial. The court granted the prosecutor and defense counsel's joint motion to postpone the trial. (AOB 175, 2 RT 539].) Voir dire resumed on October 29, 2001, only 48 days later. (AOB 175, 2 CT 341; 3 RT 557] Defense counsel, the trial court, and the prosecutor were well aware of the challenge they faced finding unbiased jurors in the period immediately following the bombings. (AOB 174-175, 2 RT 537, 539].) As demonstrated in the opening brief, despite the extraordinary risk that the prejudice engendered against Ghobrial could be revived by jurors inaccurately and unfairly connecting him, as a consequence of his Egyptian nationality and Arab ethnicity, to the terrorists responsible for the September 11 bombings, the prosecutor improperly and prejudicially compared Ghobrial to the terrorists and repeatedly referred to September 11 and Osama bin Laden. (AOB 174-183.) In so doing, the prosecutor deprived Ghobrial of the guarantee of fundamental fairness provided by the Due Process Clause of the Fifth and Fourteenth Amendments. (AOB 176.)

Respondent relegates to a footnote the extraordinary context in which Ghobrial was tried and jurors were selected. (RB 84, fn. 4.) Respondent further attempts to dismiss Ghobrial's claim by repeated references to defense counsel's failure to object to certain instances of misconduct, a point conceded in the opening brief. (AOB 181.) This

Court, however, will excuse the failure to object to prosecutorial misconduct and request a curative instruction when the misconduct is of such a character that no instruction to the jurors could obviate its prejudicial effect. (See *People v. Green* (1980) 27 Cal.3d 1, 28, overruled on other grounds in *People v. Martinez* (1999) 20 Cal.4th 225; see also *People v. Benson* (1990) 52 Cal.3d 754, 793.) This exception flows "logically from the purpose of the objection rule: if . . . the requirement of an objection is intended to give the trial court the opportunity to cure the harm by an appropriate instruction, objection is an idle act when it is reasonably probable that no such cure will follow." (*People v. Green*, *supra*, 27 Cal.3d at p. 28.) In Ghobrial's case, which was "tried less than two months after the terrorist attacks, the prosecutor's repeated references to September 11, his comments regarding terrorists, his comparison of Ghobrial to suicide bombers, his unsupported assertion that the bombers were all schizophrenic, and his description of Ghobrial as an immigrant who came to this county to beg for money," all fueled "an already incendiary situation" that no instruction from the court could cure. (AOB 180.)

Unlike respondent, the prosecutor and the trial court recognized that the effects of the bombings on jurors' psyches would linger not only beyond the thirty day continuance requested by defense counsel, but likely would intensify. Initially denying the defense request for a continuance on September 13, the court questioned its value, asking, "[b]ut how is [a continuance] really going to help? More and more investigation is going to take place, more and more is going to be discovered and known, more and more press is going to be solidified." (2 RT 406.) The court went on to remark that Pearl Harbor continued to have a significant impact fifty years later, stating "I mean that event is still vivid in the minds of people, and it has been passed down to new generations." (2 RT 407.) The prosecutor

agreed: "I know the impact of the actual horror of what happened has started, but it is going to keep going for a while. We are going to retaliate, we are just going to be at war perhaps, we don't know what's going to happen. I just don't see how continuing it for two weeks or four weeks or eight weeks makes any difference." (2 RT 411.) Predictably, when the court asked of the prospective jurors whether, as a consequence of the 9/11 bombings, any harbored bias against Ghobrial or believed the events would "impact or affect your decisions in this case," 17 jurors revealed they could not be fair.[18] (AOB 174, 2 RT 523, 527].) At that point the prosecutor stipulated to a continuance, which the court granted. (2 RT 539.)

When Ghobrial's trial resumed, the prosecutor appeared attentive to the continued danger of bias against Ghobrial based on the events of 9/11. The prosecutor asked the court to "make a short little patriotic speech" informing the prospective jurors that Ghobrial was an Egyptian of the Coptic Christian faith and not Islamic. (3 RT 552.) The prosecutor also suggested that the court tell the jurors that Ghobrial had nothing to do with and had no sympathy towards the terrorist bombing, "[a]nd that if they would search their hearts and would be willing to serve. Something short, something patriotic, along the line, let them know we are not here trying a terrorist. This case is its own case. It happened years before. It has nothing to do with those events." (3 RT 552.) The court granted the prosecutor's request and stated to each panel of prospective jurors, "Mr.

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[18]After receiving the questionnaires but prior to questioning jurors about their potential biases against Ghobrial arising from the events of 9/11, the prosecutor identified 29 jurors he believed should be dismissed for cause, the defense identified 60 jurors, and the trial court identified 87. (2 RT 416.) When jury selection resumed on October 29, defense counsel noted that "we lost a relatively high percentage the last time with the combination of death and a child victim, and that was without factoring in the September 11th event." (3 RT 610.)

Ghobrial was born in Egypt, is a Coptic Christian, and has no sympathy for terrorist philosophy or their actions." (3 RT 560, 570, 577, 586, 596, 603, 615, 622.) The prosecutor's caution was well founded: "Determining whether a juror is biased or has prejudged a case is difficult, partly because the juror may have an interest in concealing his own bias and partly because the juror may be unaware of it." (*Smith v. Phillips* (1982) 455 U.S. 209, 221-22.) Nevertheless, despite the prosecutor's professed concern that the jurors not identify Ghobrial with the terrorist attacks, when the trial began the prosecutor, rather than scrupulously avoiding any suggestion that the two were related, improperly and prejudicially invited the comparison. (AOB 178-181.)

Ghobrial does not dispute respondent's argument that, when discussing the disputed testimony between the prosecution's expert and the F.B.I.'s protocol for identifying sperm during guilt phase closing argument, the prosecutor's statement that he would not take a "shot at" the F.B.I. because "right now . . . [it is] out there trying to hunt down terrorists," while unnecessarily invoking 9/11, did not itself amount to misconduct. (AOB 178, 8 RT 1929].) The prosecutor did not, however, limit his reference to 9/11 to this one instance, but rather, during the penalty phase, escalated his rhetoric and made explicit his belief that Ghobrial and the terrorists should be linked. In cross-examining Dr. Jose Flores-Lopez, a psychiatrist who treated Ghobrial at the Orange County Jail and diagnosed him as suffering from schizoaffective disorder, the prosecutor sought to elicit from the doctor a concession that Ghobrial's symptoms of schizophrenia did not "stop him from being an evil person if he wants to be an evil person." (10 RT 2509-2510.) When Flores-Lopez declined to validate the prosecutor's notion of evil, the prosecutor asked whether the doctor considered Osama bin Laden "an evil man." (10 RT 2509-2510.) Although the trial court

sustained defense counsel's objections, the prosecutor's line of questioning invited the jury to equate Ghobrial's moral culpability with that of Osama bin Laden's.

Respondent has no substantive response to this instance of the prosecutor's misconduct, but simply notes that trial counsel failed to request an admonition and the jurors were instructed they were to neither consider attorney's statements as evidence nor assume to be true any insinuation suggested by a question asked of a witness. (RB 89.) As noted in the opening brief and above, however, no instruction by the trial court could have ameliorated the prejudicial impact once the prosecutor introduced references to September 11 and Osama bin Laden. "As this Court has recognized, 'You can't unring a bell.'" (AOB 181, citing *People v. Hill* (1997) 17 Cal.4th 800, 845-846.)

The opening brief demonstrates how the prosecutor's continued references to Ghobrial's foreignness and the Al Qaeda suicide bombers during the penalty phase closing argument reinforced his prior efforts to associate Ghobrial with the tragedy of September 11. (AOB 179-180.) Respondent asserts that the prosecutor only invoked Ghobrial's status as an immigrant from Egypt for proper purposes: one, to argue that, because Ghobrial had been in the country only a short period of time, the jurors could view the absence of a prior felony conviction under factor (c) as having minimal mitigating effect, and two, to dismiss the disabling impact of his schizoaffective disorder because he "managed to get out of Egypt and to work his way here . . . to beg for money . . . [and pay] $100 a month for a shed." (RB 92-93.) If these were the prosecutor's only remarks reminding the jury of Ghobrial's status as a foreigner and an Egyptian, respondent's argument might have some validity. These references, however, must be evaluated in the context of the entire record. (*People v. Green*, *supra*, 27

Cal.3d at p. 28.) When combined with the prosecutor's other comments invoking the suicide bombers – who the jurors knew to be of Arabian ethnicity and that at least one was Egyptian – and Al Qaeda, the jurors likely viewed these remarks as an additional invitation to act on bias and prejudice when deciding whether Ghobrial should be sentenced to life or death.

The prosecutor also improperly and prejudicially equated Ghobrial's psychotic delusions with what he characterized as the religious delusions of the suicide bombers. (AOB 179-180.) Respondent defends the prosecutor's likening of Ghobrial's mental illness to that of the suicide bombers, claiming that "the prosecutor did not compare Ghobrial or his crimes to those infamous figures. He simply used those figures to illustrate that a person suffering from delusions could still choose to commit criminal acts." (RB 95.) The figures the prosecutor chose to illustrate his point, however, had, just a little over three months earlier, attacked the United States and caused the death of almost 3000 people. As the court noted in *People v. Zurinaga* (2007) 148 Cal.App.4th 1248, six years after the 9/11 bombings, We . . . consider it naïve at best — and disingenuous at worst — to suggest . . . that the mere mention of 9/11 does not continue to invoke fear, dread and anger in the listener." (*Id.* at pp. 1259-1260.) If six years later the "mere mention" of 9/11 continued to "invoke fear, dread and anger in the listener," the extremely prejudicial impact of such references only a little over three months later cannot be doubted.[19]

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[19]In a 2012 case, defendants charged with conspiracy to levy war or to oppose by force the authority of the United States government filed a motion in limine to exclude, *inter alia*, a bumper sticker stating: "Remember 9-11 was an inside job." The district court granted the motion as to the bumper sticker stating, in part, that "bringing 9/11 into this case risks distracting the jury from the real issues." (*United States v. Stone* (E.D.

Respondent's broad defense of the prosecutor's actions is by citation to cases holding that prosecutors are generally afforded "wide latitude during closing argument." (RB 97.) Respondent's effort to minimize the uniqueness of Ghobrial's situation and normalize the prosecutor's misconduct by citing to cases addressing garden-variety prosecutorial hyperbole that this Court has found acceptable must be rejected.[20] The prosecutor began jury selection for Ghobrial's trial recognizing the enormous potential for jurors to harbor prejudice and bias against Ghobrial as a consequence of the September 11 bombings; once the trial commenced, however, rather than meticulously and conscientiously avoiding any comment or remark that might connect Ghobrial in the minds of the jurors with the events of 9/11, the prosecutor exploited that potential for prejudice and bias in his zeal to obtain a death verdict. Whether he acted in good faith or bad is of no matter; prosecutorial misconduct is measured by the injury inflicted on the defendant as a consequence. (See *People v. Bolton* (1979) 23 Cal.3d 208, 213-214.) By repeatedly reminding the jurors of the horrifying events of 9/11, the prosecutor encouraged the susceptible jurors to view Ghobrial with the same sense of horror when deciding whether he

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Mich. 2012) 852 F.Supp.2d 820, 838.)

[20]See e.g., RB 90, citing *People v. Schmeck* (2005) 37 Cal.4th 240, 298-299 [prosecutor described defendant as a "dope dealing lying rat"]; *People v. Sassounian* (1986) 182 Cal.App.3d 361, 396 [in a case being tried 23 years later, prosecutor referenced the assassination of President Kennedy]; RB 95, citing *People v. San Nicolas* (2004) 34 Cal.4th 614, 665-666 [prosecutor described defendant as "that animal," "vicious," and as a "base individual"]; RB 95-96, citing *People v. Jones* (1997) 15 Cal.4th 119, 180, *People v. Millwee* (1998) 18 Cal.4th 96, 153, *People v. Pinholster* (1992) 1 Cal.4th 865, and *People v. Maury* (2003) 30 Cal.4th 342, 420, all cases in which the prosecutor made references either to Nazis, Charles Manson, or both; and RB 99, citing *People v. Edelbacher* (1989) 47 Cal.3d 983, 1030 [prosecutor called defendant a "snake in the jungle"].

should live the rest of his life in prison or be executed. In the absence of the prosecutor's misconduct, it is likely the jurors would have concluded that a punishment of life without the possibility of parole was sufficient. As a consequence, Ghobrial's sentence of death must be reversed.

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X.

THE CUMULATIVE EFFECTS OF THE ERRORS REQUIRES REVERSAL OF GHOBRIAL'S CONVICTION AND SENTENCE

As stated in the opening brief, Ghobrial's case should never have been sent to the jury. (AOB 3.) Ghobrial suffers from a severe mental illness – schizoaffective disorder – the symptoms of which include auditory and visual hallucinations, paranoia, bizarre delusions, disorganized speech and thought process, profoundly impaired social and occupational functioning, and suicidal ideation. The trial court's failure to suspend proceedings and conduct a competency hearing was the first of multiple errors occurring during Ghobrial's trial whose cumulative effects require that his conviction and sentence of death be reversed. (AOB 201-203.) Respondent's meager four paragraph answer must be dismissed. (RB 108-109.)

The likelihood that the cumulative errors so infected "the trial with unfairness" (*Donnelly v. DeChristoforo* (1974) 416 U.S. 637, 642-643), cannot be underestimated. Once Ghobrial stood before the jury, symptoms of his illness, including his flat affect and focus on internal stimuli, would have left the jury with the view that he was indifferent to the tragic facts of the crime and lacked remorse. He also stood before the jury as an Egyptian national a little over two months after the terrorist attacks on the Twin Towers and the Pentagon, accused of murdering a child – a crime for which potential jurors frequently admit they cannot be fair and unbiased. The prosecutor presented no substantial evidence on the contested issue of whether Ghobrial attempted to molest Juan, and the trial court excluded relevant evidence that would have further refuted the unreasonable inferences the prosecutor asked of the jurors. The court also failed to properly instruct the jurors, but even if they had been properly instructed,

the symptoms of Ghobrial's illness, the fact of his Egyptian nationality, and the nature of the crime likely led the jurors to overlook the insufficiency of the evidence and the court to improperly exclude evidence helpful to Ghobrial.

Ghobrial's sentence of death also was infected by the cumulative impact of multiple errors. The prosecutor exploited the factor most likely to inflame the jurors' prejudice against Ghobrial despite their best intentions by referring frequently during closing arguments to Osama bin Laden and the terrorists responsible for the bombings. The jurors not only were swayed by the prosecutor's misconduct, they also likely treated Ghobrial's severe mental illness as a factor in aggravation rather than as mitigation. The victim was a child and the crime especially gruesome. Ghobrial should never have been sent to trial and his life put in the hands of the jury. The substantial impairments Ghobrial suffered as a result of his severe mental illness left him less culpable than those without such impairments, but more vulnerable to prosecutorial misconduct and juror biases. His conviction and sentence of death must be reversed.

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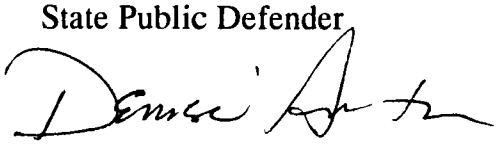
CONCLUSION

For all of the reasons stated above, both the judgment of conviction and sentence of death in this case must be reversed.

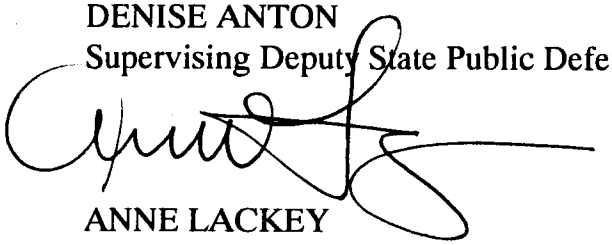
DATED: February 13, 2014

Respectfully submitted,

MICHAEL J. HERSEK
State Public Defender



DENISE ANTON
Supervising Deputy State Public Defender



ANNE LACKEY
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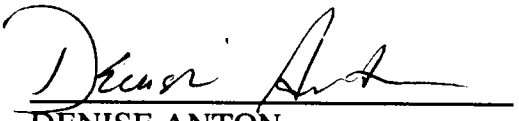
Attorneys for Appellant

CERTIFICATE OF COUNSEL
(CAL. RULES OF COURT, RULE 8.630(b)(2))

I, Denise Anton, am the Supervising Deputy State Public Defender assigned to represent appellant, John Ghobrial, in this automatic appeal. I directed a member of our staff to conduct a word count of this brief using our office's computer software. On the basis of that computer-generated word count, I certify that this brief is 18,800 words in length excluding tables, certificates and attachments.

Dated: February 13, 2014



DENISE ANTON
Supervising Deputy State Public Defender

Attorney for Appellant

ATTACHMENT A

DATE	OBSERVATION	OBSERVED BY	RT
3-24-1998	• D[1]'s mood and affect were inappropriate to the situation, that is, his arrest. • He was mumbling to himself and had rapid eye blinking. • He was looking to the floor most of the time. • Needed an interpreter before making any decision about his orientation, memory or intellectual functioning. Saw D later with an interpreter. • Upon questioning, D admitted he had seen someone in Egypt for his mental problems. • She asked about auditory hallucinations and D said he had had command hallucinations telling him to hurt others and himself. • D also said he had had suicidal thoughts and told her he wanted to be through with courts in his life. • During the interview, D was laughing, which was absolutely inappropriate affect. • He used to take medication, but didn't know the name and was no longer taking it. • Believes D told her that his father brought him to the doctor earlier.	Virginia Sollars, RN	10 RT 2404-06

[1] "D" refers to Mr. Ghobrial.

DATE	OBSERVATION	OBSERVED BY	RT
3-25-1998	Diagnosed D as a psychotic disorder NOS (not otherwise specified). Symptomatology that caused her to reach this diagnosis: • D was disheveled, alert, and not speaking much English. Not aware whether suicidal or homicidal because he could not answer. • D told nurses he was hearing voices because he was seeing a translator. • Appeared to have "very bright affect." • Affect was inappropriate, which could be a negative symptom of a schizophrenic or psychotic illness.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2429-30
3-26-1998	D is on safety status and can't be pulled for interviews. Also will need interpreter. No treatment history with OC mental health, but past psychiatric treatment in Egypt. • Positive history of auditory hallucination of command nature telling him to harm others and self. *That is not what D said but info she received.* • Appeared with express suicidal ideation, "wanting to get through with courts, end with life." *She was told he said that; he didn't tell her that.* • History of suicide attempts but no specifics known.	Kay Cantrell, Nurse	10 RT 2260-61
3-28-1998	• D talking to himself.	Dr. Teresa Farjalla, Psychiatrist	10 RT 2464
3-29-1998	• D drew a devil with soap for her. She asked him to do that. Can't recall how it came about.	Dr. Teresa Farjalla, Psychiatrist	10 RT 2464
3-31-1998	• D uncooperative and refusing to speak. • D was making a mess of his cell and not fully dressed.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2477

DATE	OBSERVATION	OBSERVED BY	RT
4-1-1998	• D uncooperative and refusing to speak. • D was making a mess of his cell and not fully dressed.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2477
04-7-1998	• D told her, "I am not crazy." • Refusing meds and wanted regular housing.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2433-34
4-2-1998	Saw D with translator. D seen by team due to increased willingness to talk. Diagnosis unclear. • Denying suicide ideation, plan or intent. • History of intermittent feeling like the devil is in him. • Also intermittent auditory hallucinations and claims of long periods of having no recall of his activities. • Treatment in Egypt and 7 years treatment with Dr. Brahim. • D was spontaneous in interview and briefly tearful couple of times. • Refusing at first but then willing to take meds. • Noted he had refused or refrained from speaking English with her, but learned he was able to speak some English. He would use signing and expressions.	Kay Cantrell, Nurse	10 RT 2263-65

DATE	OBSERVATION	OBSERVED BY	RT
4-2-1998	D informed her "I speak only little English." Said he had had mental health treatment. "I am crazy in Egypt. "Was in hospital." • D wanted medication for voices or problems in his head. • D said sometimes he loses his English. • Affect was labile. D goes from being very, very flat to very, very happy or very, very angry. • D was crying.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2431-32
4-3-1998	Not done well communicating with D. D tried to communicate with his hands. • D was dirty and disheveled. • Appeared N.A.D. – not in apparent distress. • D was on and Johnson continued him on Haldol, an antipsychotic, and cogentin, to counteract Haldol side effects.	Dr. Steven Johnson, Psychiatrist	10 RT 2273
4-4-1998	• D had silly grin that seemed inappropriate or unusual. • Interpreted that D was responding to auditory hallucinations and not focusing on conversation.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2477
4-6-1998	• D claimed he was not seeing or hearing anything and he refused meds for 2 days. • "I was scared."	Dr. Jasminka Depovic, Psychiatrist	10 RT 2432
4-7-1998	• D told her, "I am not crazy." • Refusing meds and wanted regular housing.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2433

DATE	OBSERVATION	OBSERVED BY	RT
4-9-1998	D was on no restrictions.	Dr. Steven Johnson, Psychiatrist	10 RT 2273-74
4-9-1998	Case management follow-up. • Alert, smiling and spontaneous but keeps indicating limited English. • Not willing to sign release of info for talks with atty. Attempting this conversation in English. Asked why they needed to talk to his attorney and indicated that attorney spoke very little English.	Kay Cantrell, Nurse	10 RT 2265-67
4-10-1998	• Subjective: D wants to shave. • Objective: Disheveled, dirty; • Calm, broad affect. Assessment: hard to assess w/o interpreter. Clear for L 16, which means move to less acute ward. Already off observation	Dr. Steven Johnson, Psychiatrist	10 RT 2275
4-11-1998	D is on no restriction.	Dr. Steven Johnson, Psychiatrist	10 RT 2275
4-13-1998	Difficult to communicate. • Disheveled. • Denies ideations or hallucinations, but seems unreliable. Assessment: probably psychotic, despite denials. Refuses meds. Continue observation.	Dr. Steven Johnson, Psychiatrist	10 RT 2275-76
4-13-1998	D had refused medication and medication stopped on 4-7-98. Saw no evidence of acute mental illness to warrant acute intervention. Does not mean D was not mentally ill.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2477-78

DATE	OBSERVATION	OBSERVED BY	RT
4-23-1998	He was in Mod L, which is psychiatric portion of jail. • Alert, awake and normal. • Aware of surroundings. • Oriented times 3 • Appears clean and well-groomed. • Smiling. Mood appears euthymic and affect is congruent. Doesn't seem depressed or angry. "I'm happy because I give myself for God." • Reports he eats and sleeps well. Denies thoughts of harming self or others. Discussed case with team earlier; end of observations at that time.	Jill Savage, Case Manager	9 RT 2160-63
05-1998	• D was referred by deputy on Mod J due to "bizarre behavior." Deputy said D would not respond to verbal commands. Food was all over the cell and floor and D was "talking to himself." • When she arrived, D was in the rec area, walking up and down the side wall, eyes down, talking to himself. Did not look or respond to her verbal prompts. • He sat down and began crying and talking to himself. Appears to be R.T.I.S. – responding to internal stimuli. • Mood is labile, but he is hard to assess, due to uncommunicative behavior and possible language barrier. • Too unpredictable and potential danger to himself and others. Doesn't answer question of being suicidal or intent to harm others. Treatment Plan 1. Safety gown; observation; 2. Psychiatrist evaluation; 3. Case manager DC planning [discharge plan]; 4. 5150.	Linda Kay Price, Nurse	10 RT 2256-2258

DATE	OBSERVATION	OBSERVED BY	RT
5-13-1998	• D said, "I am not crazy." • Denied suicidal ideation and hallucinations. • Alert, coherent and oriented. • Thoughts were organized; sleeping fine; cooperative. • Affect was appropriate and he was friendly.	Margaret Wiggenhorn, Mental Health Specialist	10 RT 2372-73
5-18-1998	• Friendly and said "there are no voices in my head." • Denied ideations or intent to hurt anyone. • Alert, coherent, oriented with organized thoughts. • Attitude was cooperative.	Margaret Wiggenhorn, Mental Health Specialist	10 RT 2373-74
5-20-1998	• Cell was dirty with papers scattered. • Slow in his response and grinning and smiling inappropriately. Thought D was responding to internal stimuli. • Alert and coherent, but thoughts seemed confused. • Denied hallucinations or desire to kill himself. • Said sleeping and eating ok. • Cooperative.	Margaret Wiggenhorn, Mental Health Specialist	10 RT 2374-75
5-20-1998	• Subjective: D says "I no sick." Refuses meds. • Objective: Denies ideations or hallucinations; • Speech normal; speaks little English. Assessment: seems stable. Already cleared for L 16. Rate, rhythm and volume of speech normal. Not screaming, whispering, etc.	Dr. Steven Johnson, Psychiatrist	10 RT 2276-77
5-23-1998	No complaints; not in distress; no restrictions.	Dr. Steven Johnson, Psychiatrist	10 RT 2277

DATE	OBSERVATION	OBSERVED BY	RT
5-25-1998	• Mood and affect were anxious. Said he felt scared of everything. • Admitted to auditory hallucinations "calling my name." • Eating only 1 meal a day. • Alert and coherent. • Thought confused. • Speech clear. • Denied any thought of doing harm to himself or others. • Cooperative.	Margaret Wiggenhorn, Mental Health Specialist	10 RT 2375-76
5-25-1998	• Subjective: Complaining of anxiety. • Objective: Anxious affect; • Disheveled; • Normal speech. Assessment: anxiety, psychotic ? Plan: start Mellaril, 10 mg 4x/day. Usually, anxious just means anxious. But a psychotic may say that when doesn't want to admit he is hearing voices or seeing things. ? after psychotic because D denied psychotic symptoms, but Dr. suspected he was not telling whole story. Mellaril is an antipsychotic to eliminate voices, hallucinations, paranoid ideations, etc.	Dr. Steven Johnson, Psychiatrist	10 RT 2277-78
5-27-1998	• Subjective: D likes that meds have no side effects. • Objective: Disheveled; • Soft-spoken; • Denied ideations, hallucinations. Assessment: seems stable. Plan: continue Mellaril, 10 mg/day.	Dr. Steven Johnson, Psychiatrist	10 RT 2278-79

DATE	OBSERVATION	OBSERVED BY	RT
6-1-1998	• Appropriate mood and affect. • Not scared or sick anymore and didn't need meds. Asked to be transferred. • Alert and coherent. Oriented. Denied hallucinations or desire to hurt himself. • Appetite and sleep were "okay."	Margaret Wiggenhorn, Mental Health Specialist	10 RT 2376-77
6-1-1998	"I don't needs medication." Notes say: "DC Haldol. Patient refusing." On 6-1-98 changed Mellaril to 25 at bedtime. Mellaril is for psychotic thinking. Between April and June he got back on meds.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2433
6-2-1998	• Mood and affect seem appropriate. "I no sick anymore. I go home." • Denied hallucinations or suicidal ideation. • Coherent; speech was clear with no pressure. • Appetite good. • Cooperative.	Margaret Wiggenhorn, Mental Health Specialist	10 RT 2377-78
6-4-1998	• D asking why he had to take meds, but he was taking them. • Cooperative. Always smiling during this visit.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2434
6-4-1998	• D asked to go back to regular housing. \ • Alert; coherent; clearly expressed himself. • Denied hallucinations. • Cooperative.	Margaret Wiggenhorn, Mental Health Specialist	10 RT 2378

DATE	OBSERVATION	OBSERVED BY	RT
6-12-1998	• He was refusing psychiatric medications, saying "I'm all better. No more voices." • D saw no reason for meds but D will most likely begin to hear voices again without them. Meds would have been antipsychotic meds.	Jill Savage, Case Manager	9 RT 2164
6-22-1998	• D denies problems. No medication side effect. D agrees to continue meds. • Alert, oriented X3, speaks little English. • Broad affect; cheerful mood; no fearfulness; no signs of depression; no overt psychosis; no suicidal ideation, no homicidal ideation. • No verbalization – minimal speech. Ability or desire to speak English fluctuated. • No EPS, having to do with med side effect. • Psychomotor normal. • Good hygiene. Assessment: stable on his meds; continue on Mellaril. Ability or desire to speak English fluctuated. Aware that nurses and deputies observed D communicating with other.	Kristen Whitmore, Nurse Practitioner	9 RT 2188-89
7-10-1998	• D appeared even more disheveled. • Grinning inappropriately. • Reported decreased appetite and difficulty sleeping. • Insists there are four black men in his cell. Returned to cell and pointed to empty cell, insisting they're in there. Referred him to nurse practitioner to evaluate his medication.	Jill Savage, Case Manager	9 RT 2165

DATE	OBSERVATION	OBSERVED BY	RT
7-13-1998	D was not actually seen. Deputies told her that they couldn't allow patient to come out to see her at the time. She normally saw him in the dayroom area and deputies were concerned about his safety. Other inmates wanted to kill him. • She read a note from the case manager saying that D had a delusion about 4 black men in his cell and stating case manager's observations that D was psychotic. • Got information from psychiatrist Dr. Lopez that D was sexually preoccupied. He was insisting that nurses put antifungal cream in his groin for him, because he only had one arm. D was on mellaril and she increased the dose. It is an antipsychotic to control psychotic symptoms.	Kristen Whitmore, Nurse Practitioner	9 RT 2175
7-24-1998	• Becoming increasingly bizarre. • At present time mute. Wouldn't respond to questions. • Smiling inappropriately, unkempt, doesn't follow simple commands. • Took psych meds in front of her.	Jill Savage, Case Manager	9 RT 2167-68
7-27-1998	Patient was not seen again. She had a conversation with Dr. Lopez and noted there was some different assessments by different members of the team as to whether D was malingering. That is, presenting himself to appear mentally ill for benefits he might gain from that. It is always a possibility in a jail setting. Also possible to malinger wellness. Mentally ill trying to deny symptoms. Team was debating whether D was malingering or truly mentally ill. Diagnosis wasn't clear at that point.	Kristen Whitmore, Nurse Practitioner	9 RT 2177-78, 2190

DATE	OBSERVATION	OBSERVED BY	RT
7-30-1998	D's case discussed amongst Whitmore, case manager and Dr. Lopez. They decided to increase his dosage of mellaril. Discussed that he was under stress going to court. Not unusual for psychotic symptoms to worsen under stress. That is what she thought might be happening. Also noted that patient states he cannot understand English. Wrote that she would attempt to see him next day with an interpreter.	Kristen Whitmore, Nurse Practitioner	9 RT 2179-80, 2191
8-3-1998	Tried to interview D to assess his mental status in Arabic. • D was uncooperative and kept responding "I don't know" and "I don't remember." • She was asking to see if D was aware of the time and asking if he was hearing voices or seeing visions to assess the mental status. D answered he didn't remember or know. • D had been taking medications that interfere with memory. Possible that that is reason for saying he didn't know or remember.	Nabeel Bechara, RN	10 RT 2254-55
8-15-1998	D moved to Mod J, which is non-psychiatric unit, on 8-12. • D was smearing food in cell and shaking. D seen outside cell with deputy. D is mute. Eyes making slightly jerking movements, then moving lips w/o speaking. • Decompensating. Appears responding to internal stimuli. • Will return him to Mod L, psych. unit, and observation. Inmates being treated for mental illness don't always stay on the psych unit. It is for most acute patients. Chronic mental illness controlled with meds will be moved into non-psych ward. • D was not saying anything in any language. Not responding at all.	Kay Cantrell, Nurse	10 RT 2267-68

DATE	OBSERVATION	OBSERVED BY	RT
8-16-1998	• D was likely responding to internal stimuli, not talking to Dr. Flores-Lopez. • Paranoid and delusional.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2478
8-17-1998	• D remained the same. • Trashing his cell and messing it up.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2478
8-18-1998	• D dislikes concentrate and requests tablets. • Disheveled, unkempt, anxious affect. Assessment: dislikes concentrate. Plan: discontinue concentrate. Mellaril, 100 mg. tabs 2/day.	Dr. Steven Johnson, Psychiatrist	10 RT 2280
8-19-1998	• D had silly grin and was acting bizarrely. • Looked unkempt. • Sticking his fingers in his ears and is to drown out the noise. Common in somebody experiencing auditory hallucinations. • Appears anxious. Pacing in his cell. • D likely suffering from schizophrenia, but could be delusional disorder. Exploring possibility of psychosis, whether schizophrenia or delusional disorder.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2479
8-20-1998	D sent back to L-18, which is the acute unit. • D was apparently smearing food on cell wall while on regular housing Mod J. • D did not show signs of being overly psychotic. She felt he was in control.	Dr. Teresa Farjalla, Psychiatrist	10 RT 2464-65

DATE	OBSERVATION	OBSERVED BY	RT
9-3-1998	• Reported auditory hallucinations. Heard family talking to him. Hears unseen people talking inside his cell. • Affect was inappropriate. Constantly smiling, regardless of topic.	Jill Savage, Case Manager	9 RT 2166, 2168
9-16-1998	• Deputy said D understands English perfectly when spoken to by deputies. Patient insists, "No English" when Whitmore asked questions. • D trying to tell her he heard voices. Mod L nurses told her that D converses clearly with another inmate. • D was alert and oriented to person. Unable to fully assess orientation or do complete mental status exam. Knew who he was. But wasn't conversing in English so mental status exam not complete. • D had a silly grin. Mood was euthymic, basically, normal. Not depressed, tearful. No overt signs of depression. • Behavior was calm. • No overt signs of psychosis or depression. Synopsizes info from deputies and nurses about possible malingering. "Per information from deputies and nurses the patient is manipulating and likely wants a label as mentally ill." Did nothing to determine whether opinions were correct or how they formulated them. It is not her personal assessment. • Continued on meds. No dosage change.	Kristen Whitmore, Nurse Practitioner	9 RT 2181-85
9-19-1998	• D tied string tightly around his penis. Doesn't remember doing so. States he just woke up and it was there. This has happened many times and usually he can get the string off himself. • She then housed him in a more acute housing in a safety gown to prevent him from harming himself.	Jill Savage, Case Manager	9 RT 2168-69

DATE	OBSERVATION	OBSERVED BY	RT
9-20-1998	Saw D after he was returned to L-19, transferred from L-16 secondary to dangerous to self. • D went from less acute to acute housing because he was dangerous to himself. • He had tied a string around his penis. D denied he had done so. • D admitted suicide ideations and he had increased talking to himself. • Affect was flat.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2434-35
9-21-1998	• D remained bizarre, associated with schizophrenia or schizo-affective disorder. Behavior doesn't lead to anything. • D was manipulating his clothes. Not really significant to diagnosis because it happens in jail setting where limited clothing and temperature. • D might be self-mutilating.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2480-81

DATE	OBSERVATION	OBSERVED BY	RT
9-22-1998	• Subjective: D complaining of auditory hallucinations; • Requests translator; and • Denies side effects of medications. • Objective: D disheveled; poor hygiene; • Auditory hallucinations; suicidal ideations; • Poor communication due to language. Assessment: psychotic. Plan: find translator. Increase mellaril to 100 mg, 3/day to decrease hallucinations. psychotic means person is out of touch with reality. Either hallucinating or having delusions, like paranoid ideation. Holding beliefs not consistent with reality or seeing or hearing things not consistent with reality. Disheveled and hygiene have significance in that depressed people often don't have energy to attend to own hygiene. Psychotic people often aren't even aware of their own hygiene. More complicated because D missing an arm.	Dr. Steven Johnson, Psychiatrist	10 RT 2280-81
9-23-1998	• Difficult to talk because of language; • Disheveled and dirty; • Talks to self; • Smiling affect; • Auditory hallucinations. Assessment: still psychotic. Plan: interpreter; continue Mellaril, 100mg, 3x/day.	Dr. Steven Johnson, Psychiatrist	10 RT 2282

DATE	OBSERVATION	OBSERVED BY	RT
9-24-1998	Trying to get translator. • No obvious signs of distress. Later that day he and entire treatment team assessed D with interpreter: • D admits auditory hallucinations, suicidal ideation and depression. • Agrees to try anti-depressant. Denies side effects. • Wants more medications. Start Prozac, 20 mg in AM. Increase Mellaril to 100 mg 4x/day.	Dr. Steven Johnson, Psychiatrist	10 RT 2282-83
9-25-1998	Can't communicate because of language. • D and cell are "extremely" filthy. Cell "must have been really awful for Dr. to underline "extremely," because he was used to seeing very dirty cells." • No apparent distress. Assessment: difficult to assess. Plan: request translator; continue meds.	Dr. Steven Johnson, Psychiatrist	10 RT 2285
9-26-1998	• D thought medicine was helping. • D had been engaging in self destructive behavior and mutilating his own genitals. Talked to D about not hurting himself or tying anything around his penis. Assumes he promised not to otherwise she would have intervened.	Dr. Teresa Farjalla, Psychiatrist	10 RT 2465-66
10-2-1998	• Asked D whether he intended to tie anything around his penis and he said he wasn't.	Dr. Teresa Farjalla, Psychiatrist	10 RT 2466

DATE	OBSERVATION	OBSERVED BY	RT
10-7-1998	• Subjective: language problem; • D says too sleepy on Mellaril 4 x/day. • Objective: Somnolent; • Disheveled; • Calm and cheerful. Assessment: oversedated by Mellaril. Plan: decrease Mellaril to 200 mg in p.m. Continue Prozac, 20 mg in am.	Dr. Steven Johnson, Psychiatrist	10 RT 2285
10-8-1998	• D appeared disheveled.	Dr. Teresa Farjalla, Psychiatrist	10 RT 2466
10-9-1998	• D had not engaged in any more self-destructive behavior since being brought back to L-18.	Dr. Teresa Farjalla, Psychiatrist	10 RT 2466
10-13-1998	• D talking to the mirror. D stopped when he saw her and came over and tried to talk to her.	Dr. Teresa Farjalla, Psychiatrist	10 RT 2466-67
10-31-1998	• Disheveled, smiles and nods. • Semi-cooperative. Probably due to language barrier. • Denied suicidal, homicidal, hearing voices or feeling paranoid.	Jill Savage, Case Manager	9 RT 2169

DATE	OBSERVATION	OBSERVED BY	RT
11-2-1998	• D says Prozac is good. Likes the Mellaril at nighttime. • Seems to be making increased effort to interact, though still insisting he doesn't understand English. D is more interactive, talking more. • Affect increased, more appropriate. • Mood euthymic. Didn't look depressed. Not suicidal. Behavior calm. • Claimed to still hear voices. Points to his ears and makes statements re: voices Oriented. Not uncommon for mental state of one with psychotic illness to fluctuate.	Kristen Whitmore, Nurse Practitioner	9 RT 2186-87
11-3-1998	no observable evidence that D responding to internal stimuli. Saw nothing bizarre.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2481
12-8-1998	• D refused to give eye contact. • Not responding to questions. • Continuously talking to self and staring at floor. Next court date 1-27. Continue with Ward D. Will discuss with psychiatric MD per regular nurse. When receives meds, D is compliant, cooperative and doesn't seem inappropriate. When in dayroom, socializes with certain inmates in his dorm thru their cell door.	Jill Savage, Case Manager	9 RT 2169-70

DATE	OBSERVATION	OBSERVED BY	RT
12-14-1998	• D looking into mirror and talking to himself whenever Dr. was in the area. • Sometimes staff told him that D talked to himself only when he was there. Received other info, including from other inmates, that D talked to himself when no one was around. Had info that D talked to himself even when no psychiatric staff observed him. • Possibility that D might be malingering. Indicated that in his assessment, he would give D the benefit of the doubt. As jail psych, must assess possibility of malingering. Everyone in prison trying to get something from them that they can't get otherwise. Must always be on the lookout – everyone does it. Not specific to a diagnosis.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2482-84
12-19-1998	D seen at request of CMS after he approached nurse and said "I'm hurt." • Abrasion on left scrotum. History of self-mutilative behavior to penis. • Refused to respond to questions. Housed in L-14. Safety gown only.	Jill Savage, Case Manager	9 RT 2170
12-20-1998	• Flat affect	Dr. Jasminka Depovic, Psychiatrist	10 RT 2435
12-21-1998	• Staff found abrasions once again to D's genitals. D admitted causing the abrasion.	Dr. Teresa Farjalla, Psychiatrist	10 RT 2467

DATE	OBSERVATION	OBSERVED BY	RT
12-22-1998	Language difficulties. • Move to L18 due to self-mutilation of genitalia again. Assessment: danger to self. Plan: no translator available. Informed service chief of need for one. Continue suicide precautions and continue meds. D had history in jail of self-mutilation of genitals. He would tie strings around his penis. Knew D had been treated for tying a string around his penis.	Dr. Steven Johnson, Psychiatrist	10 RT 2286-87
12-24-1998	• D had been self-mutilating his genitals. • D also talking and laughing to himself. • Assessed D as having psychosis NOS [not otherwise specified.] • Also noted, "rule out exaggerated malingering." W/o proper testing or examination, he couldn't rule it out. D did not exhibit any behavior that caused him to think he was malingering.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2484-86
12-29-1998	Participated in a team staffing on D's case. An interpreter was also present. • D was not showering or changing his clothes. • Assessment was that D was suffering from psychosis and depression.	Dr. Teresa Farjalla, Psychiatrist	10 RT 2467-68
12-30-1998	11th day of observation, which means cell confinement as a suicide precaution. (First and most severe level in cell confinement is a safety gown, which they can't rip into shreds to hang themselves. Little less acute, regular jail-issue clothes, but still in cell confinement so can't jump off upper tier.) • D is hiding under a blanket and is unresponsive.	Dr. Steven Johnson, Psychiatrist	10 RT 2288

DATE	OBSERVATION	OBSERVED BY	RT
12-31-1998	Day 12 of observation. • D says he is "okay," but no meaningful conversation because of language barrier. • No apparent distress.	Dr. Steven Johnson, Psychiatrist	10 RT 2289
1-1-1999	D remained manipulative re: housing. He needed to stay in mental health housing, but because of beds, they have to send people to regular housing. Often a person may be truly mentally ill, but knows he may be attacked or ridiculed in general housing. They fear going to general population and will try to remain mentally ill so they stay in mental health housing. Some prefer to stay in mental health housing; some prefer regular housing; some who are mentally ill change their minds. Their pattern is to ask for what they don't have. Psychotic illnesses like schizophrenia and schizo-affective disorder are very stress-related illnesses. Being under stress can increase the discomforts caused by the illness. General premise is that mentally ill inmate is under more stress in regular housing. "Absolutely" not unusual for mentally ill inmate to go into regular housing and decompensate, even if they remain on meds.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2486-88

DATE	OBSERVATION	OBSERVED BY	RT
1-3-1999	• D remained unchanged. No change in meds. D had several changes of medication thruout his treatment at the jail, which is not uncommon. Often meds have breakthroughs. After a certain length of time on an effect med, patient will decompensate anyway and have to change to other meds. Changing meds is not unusual in a truly psychotic patient. Also not unusual for psychotic patient to respond to one med and not another. • On 1-1-99 and 1-3-99, D was on Zyprexa and Mellaril and Prozac. Zyprexa and Mellaril are antipsychotic meds. Later switched to Seroquel.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2488-89
1-5-1999	D says he is okay but difficulties assessing because of language barrier. • Objective: Disheveled; • Calm; • Unable to communicate. Assessment: difficult to assess. Plan to "team" patient with translator. 1-5-99 was day 17 of observation. When have difficult or challenging cases, try to get entire team together to decide what to do. That has happened several times in D's case.	Dr. Steven Johnson, Psychiatrist	10 RT 2289-90
1-6-1999	Day 18 of observation. • Objective: Poor hygiene; • Smiles but seems forced. Assessment: difficult to assess. Plan: team with translator asap. Seemed that D was not really happy but wanted to look like he was. probably because on day 18 of confinement – that is long time for cell confinement. Made same observations as on 1-5-99.	Dr. Steven Johnson, Psychiatrist	10 RT 2290-91

DATE	OBSERVATION	OBSERVED BY	RT
1-7-1999	D seen by team with translator. Will discontinue observation and increase zyprexa to 20 mg at bedtime. Zyprexa is an antipsychotic.	Dr. Steven Johnson, Psychiatrist	10 RT 2291-92
1-8-1999	• Subjective: D says he is ok; language problems. • Objective: No apparent distress; • Disheveled. Assessment: seems improved on meds. Plan: find translator. Continue Zyprexa, 20 mg at bed; Prozac, 40 mg in am.	Dr. Steven Johnson, Psychiatrist	10 RT 2292
1-15-1999	• Subjective: D denies any itching today; • Complains of increase in auditory hallucinations; wants to resume meds to decrease them. • Objective: Disheveled; • No rash; • Auditory hallucinations, no ideations or other hallucinations; • Has anxious affect; • Increase in psychosis. Assessment: post drug allergy to either prozac, zyprexa or colace. Restarted zyprexa "with caution," because of drug allergy. Looks like they took away all the meds to try to alleviate the rash, but because of increase in hallucinations, restarting meds at lower dose.	Dr. Steven Johnson, Psychiatrist	10 RT 2292-94
1-17-1999	Not sure whether D understood his English. D periodically smiled at him. Attempting to understand English, but always unsure whether D did. • Thought maybe D was saying he had auditory hallucinations, but not sure.	Leonard Luna, LCSW	10 RT 2381

DATE	OBSERVATION	OBSERVED BY	RT
1-19-1999	Saw D with interpreter. • Subjective: Complaining of rash in groin several months; itches; • Increase in auditory hallucinations. • Objective: Alert; oriented x3; • Auditory hallucinations, no ideations or other hallucinations; • Anxious affect; • Poor hygiene; • Normal speech; Assessment: rule out rash in groin. Psychotic. Plan: increase zyprexa to 20 mg at bed to decrease hallucinations. Clear for L19 or L16.	Dr. Steven Johnson, Psychiatrist	10 RT 2295-96
1-20-1999	• Subjective: D reports no side effects; • Slept well; • Voices less. • Objective: Disheveled, alert, oriented x3; • No ideations; • Auditory hallucinations but less than before; • Anxious affect; • Coherent. Assessment: less psychotic. Rule out jock rash. Continue zyprexa at same level.	Dr. Steven Johnson, Psychiatrist	10 RT 2296
2-10-1999	Met with D w/o interpreter. • Seemed to be reporting he did not have problems with his housing. Just her interpretation as to whether D understood her or not. • Behavior appropriate.	Leonard Luna, LCSW	10 RT 2382

DATE	OBSERVATION	OBSERVED BY	RT
2-11-1999	• D admitted to hearing voices, but "just a little."	Dr. Teresa Farjalla, Psychiatrist	10 RT 2468
2-25-1999	• D was responding to internal stimuli. Talking to himself in the cell. Facing the mirror and engaging in conversations with it. He said nothing about internal stimuli. Her observations. • Pleasant to her. • D didn't report any problems.	Leonard Luna, LCSW	10 RT 2382-83
3-3-1999	• Observed D talking to himself in front of the mirror. Smiled and acknowledged her. • Told him he had a 3-12-99 court date. D nodded and exhibited no distress. • Still talking to himself. Not causing any problems. • Next court date was 9-10-99. There had been articles about D's case in the paper that week and D had cut them out. Showed them to her.	Leonard Luna, LCSW	10 RT 2383
3-8-1999	• D had silly affect and silly grin. They are inappropriate affects, which is a negative symptom that can be associated with psychotic illness.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2489-90
3-25-1999	• D remained manipulative. • D said he had diarrhea. Didn't know whether he really did, or wanted to change meds. That is what he described as manipulative. • D denied auditory hallucinations and denied all positive psychiatric symptoms he asked D about.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2490-91

DATE	OBSERVATION	OBSERVED BY	RT
4-1-1999	• D reported he was hearing more voices and wanted to see the doctor. • D speaking in limited English. • Still talking to himself. • Not causing any problems. • Next court date was 9-10-99. There had been articles about D's case in the paper that week and D had cut them out. Showed them to her.	Leonard Luna, LCSW	10 RT 2383-84, 2396-97
4-7-1999	• D reported increased auditory hallucinations and appeared to be responding to internal stimulus, only when being witnessed. • Deputies reported that D's behavior was within normal limits and that D had an increased ability to speak English at other times. • At other times, he got info that D was responding to internal stimuli even when he didn't know he was being observed. • He recommended that D go to someplace like Patton State Hospital so he could be fully assessed by the appropriate specialist in the appropriate setting. Wanted to rule out malingering for meds. • **In his notations for 4-7-99, he made recommendation that he wasn't sure whether D was competent. Needed a competency assessment.** • Not competent to stand trial. Not competent to understand the nature of the proceedings against him because of a psychotic illness.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2491-93
4-8-1999	• D still reporting auditory hallucinations. • Still talking to self while looking in the mirror. • No other distress.	Leonard Luna, LCSW	10 RT 2385

DATE	OBSERVATION	OBSERVED BY	RT
4-29-1999	• D again reported he was hearing voices. • Other than talking to self, behavior was appropriate. • Noted that lack of English limited ability to get all symptoms.	Leonard Luna, LCSW	10 RT 2385
5-6-1999	• Saw D talking to self. • Smiled politely to her, then returned to his bunk. Usually he would wait to hear what she had to say. • Admitted to auditory hallucination and exhibited them.	Leonard Luna, LCSW	10 RT 2385-86
5-17-1999	• Noted that D remained unchanged on or off meds. At that time, D was on Zyprexa and Depakote.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2493

DATE	OBSERVATION	OBSERVED BY	RT
5-19-1999	Day 1 of observation. D was moved back from Mod L to Mod J due to odd behavior. Mod J is protective custody housing. Moved from there to Mod L, which is psychiatric acute housing area, because of odd behavior. • Subjective: "Don't speak English." • Objective: D was disheveled; • blunted affect; and • Language problem. • Behavior above sounds psychotic but others notes suggest D might be a malingerer. • Behavior that sounded psychotic was from case manager who saw D immediately before him: "Client seen on Mod J. Apparently he has been urinating in his cell. Does not respond to directions at this time. Inappropriate for Mod J." Number of different doctors work in jail's mental health team. Generally take turns seeing clients in 2-month rotations. Exacerbated when inmates move around to different housing. D moved from L18, L19, L16, Mod J. Each time he moves, different psych or nurse seeing him.	Dr. Steven Johnson, Psychiatrist	10 RT 2296-99
5-20-1999	• Report that D had been urinating in his cell. • D was returned to acute mental health housing. • Noted that D had not engaged in self destructive activity for over 4 months.	Dr. Teresa Farjalla, Psychiatrist	10 RT 2469

DATE	OBSERVATION	OBSERVED BY	RT
5-25-1999	• D admitted auditory hallucinations. • Either responded to her questions re: that or she would see him engaged in activities demonstrating that he was responding to internal stimuli. Like talking into the mirror or to himself. • Noted on 5-25-99 that D's hallucinations were not causing any behavior problems.	Dr. Teresa Farjalla, Psychiatrist	10 RT 2469-70
6-3-1999	• D reported that he was feeling very bad. • Voices were increasing. • He seemed more upset and more depressed than in prior sessions. More depressed that she had ever seen him. That conclusion based on what she saw – his affect, emotion, face. • Denied any intent to hurt self or others. • Still talking to himself. D had court date of 9-10-99.	Leonard Luna, LCSW	10 RT 2386-87
6-7-1999	• Noted that D remained psychotic, even though he did not at that time report auditory hallucinations. Opinion based on his observations of D.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2493
6-8-1999	• Saw D sitting on his bed talking to himself. • He had been urinating on the floor of his cell. • Cell was a mess. • D did not respond to her prompting. She diagnoses mental states in her capacity as a social worker in the jail.	Leonard Luna, LCSW	10 RT 2387-89

DATE	OBSERVATION	OBSERVED BY	RT
6-14-1999	• Told that D had been defecating and urinating in his cell and constantly talking to himself. • Indicated in notation that there was a strong element of malingering. But he would give D the benefit of the doubt. In a psychiatric format, 3 elements used to diagnosis or define a treatment: mental status exam and observation of inmate; self-reporting and past history and medical records; and actual lab and psych testing, including neuropsych testing. Without testing, he could not make a "definitive rule-out" of malingering.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2494-95
6-16-1999	• D back in L-19. Claimed to have no idea why he was back there. • D was transferred for observation and titration of medication. Per Dr. Lopez's note, D transferred secondary to not eating, defecating and urinating on himself.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2435-36
6-17-1999	Saw D after he was transferred to L18. Day 2 of observation. • Subjective: Moved to L19 for possible suicidal ideation. • Reportedly not eating on L16. Per RN report, D has eaten 100% of his meals in 24 hours. • Alert, trembling, quiet speech. • Appears anxious. Decided to have team meeting on him that day. Kept on suicide watch.	Dr. Steven Johnson, Psychiatrist	10 RT 2299-2300

DATE	OBSERVATION	OBSERVED BY	RT
6-18-1999	Day 3 of observation. • Language barrier. • Poor hygiene. • Trembling. • Eaten all meals since transfer to L18. Assessment: thought suicidal based on refusal to eat. Since now eating, ok to take him off safety gown. Plan: discontinue gown and food monitoring. Observe off gown. Weigh weekly for 4 weeks. Get translator. Team D next week.	Dr. Steven Johnson, Psychiatrist	10 RT 2300
6-19-1999	• D said he was not having any hallucinations at the time of the interview.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2436
6-22-1999	Couldn't communicate. • D has been calm and quiet during time on L18. • No signs of psychosis or depression. • Eating.	Dr. Steven Johnson, Psychiatrist	10 RT 2301
6-23-1999	No interpreter. • Subjective & objectuve: can't talk because of language barrier. • Poor hygiene. • Calm; smiles. Assessment: difficult to do. No behavior problem on Mod L18. Per nurse, eating. Plan: clear for L19. Continue zyprexa, 30 mg at bed; depakote, 500 mg 3x/day. Team tomorrow. Check valproic acid level.	Dr. Steven Johnson, Psychiatrist	10 RT 2301-02

DATE	OBSERVATION	OBSERVED BY	RT
6-24-1999	Difficult to assess because of language barrier; try to get translator. • Poor hygiene and anxious.	Dr. Steven Johnson, Psychiatrist	10 RT 2302

DATE	OBSERVATION	OBSERVED BY	RT
6-25-1999	No translator. • Anxious affect. • Poor hygiene. Assessment: difficult to do. Seems stable. Therapeutic depakote level. Plan: clear for L19 or L16 per team's decision. Continue depakote, 500 mg, 3x/day. Zyprexa, 300 mg at bed. SMA – serum metabolic assessment – is 20. Ask Mr. Georgy at Theo Lacy to translate. valproic acid is generic for depakote, which is a mood stabilizer usually used to treat bipolar illness. Also used for schizo-affective disorder. Bipolar is inherited chemical imbalance causing mood swings unrelated to what is going on in their life. Euphoric or crash into extreme depression. Highs: excessive energy; sleep 2 or 3 hours a nite; involved in multiple projects that they tend not to finish; poor concentration; poor judgment; irritable and obnoxious; alienate friends and family tend to get into fights, lots of trouble. During depression, can become suicidal. 10-20% of bipolars kill themselves. Schizophrenia is also inherited. ~1% of population. Chemical imbalance that renders them unable to distinguish reality from fantasy. Often have hallucinations and delusions, which are fixed false beliefs that are unswayable be evidence of reality. An hallucination is seeing something that isn't there or hearing something that isn't there. Affects all 5 senses. Sensing something not there in reality. Schizo-affective applies to people who have symptoms of both. Ranges from mild to severe. Normal for symptoms to fluctuate in individuals. Meds do not work for all who suffer from schizo-affective disorder. Some do not respond at all.	Dr. Steven Johnson, Psychiatrist	10 RT 2302-05

DATE	OBSERVATION	OBSERVED BY	RT
6-26-1999	• Flat affect	Dr. Jasminka Depovic, Psychiatrist	10 RT 2437
6-28-1999	• D had urinated on the floor. • Affect blunted. Recommended D be placed on observation because of behavior she had seen.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2437
6-29-1999	• D denied ever not eating. • D was disheveled and affect was blunted. • Denied hallucinations.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2437
6-30-1999	• Affect blunted.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2438
7-1-1999	• Affect blunted. Blunted or flat affect is a negative symptom of schizophrenia or schizophrenic illness. • Could also be depression.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2438
7-2-1999	• D was chronic and stable. D was on Zyprexa and Depakote, which he felt was appropriate treatment for schizo-affective disorder. Had taken Zyprexa to maximum dose indicated. Whatever benefits D would get from his meds were probably at a plateau, since D remained symptomatic.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2495-96

DATE	OBSERVATION	OBSERVED BY	RT
7-6-1999	• Affect flat.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2438
7-7-1999	• Affect flat. • D reported reduced auditory hallucinations.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2438
7-8-1999	• Affect blunted. • Said was not having hallucinations that day.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2438
7-12-1999	• Affect blunted.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2438
7-13-1999	• Affect flat.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2439
7-14-1999	• Affect flat.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2439
7-15-1999	• Affect blunted.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2439

DATE	OBSERVATION	OBSERVED BY	RT
7-20-1999	• Affect blunted.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2439
7-21-1999	D seen in cell. • Alert, smiling. Nods he is ok. • Denies hallucinations. • Cleared for mod L 16 – psych unit but sub-acute. She had communication with him. Next court date 9-10.	Kay Cantrell, Nurse	10 RT 2269
No date just before 7-26-99	• D remained bizarre and blunted. Blunted affect, which is negative symptom of schizophrenic illness. • D talked about the devil speaking to him. Did not say what devil said.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2496
7-27-1999	• Affect blunted.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2439
7-29-1999	• Affect blunted.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2439

DATE	OBSERVATION	OBSERVED BY	RT
7-30-1999	• D had been moving his lips as though talking to self when alone.	Dr. Teresa Farjalla, Psychiatrist	10 RT 2471
8-4-1999	Saw D with translator on L19. • Subjective: Complains of tremor; dry mouth, auditory hallucinations and excessive sleep. Wants haircut. • Objective: Positive coarse tremor; • Long, disheveled hair; • Auditory hallucinations; • Smiles; quiet and soft-spoken; polite. Assessment: still psychotic [underlined] after months on zyprexa. Tremor despite cogentin. Dry mouth 2ndary to cogentin. Hypersomnolent 2ndary to zyprexa. Plan: discuss with Dr. Depovic. Discontinue zyprexa because failed to rid D of hallucinations after many months. Discontinue cogentin. Discuss case at treatment team meeting to discuss trying seroquel to decrease hallucinations. Continue depakote and paxil. Seroquel is another antipsychotic. Not unusual to try different ones to see what is effective. Also not unusual for patient to have different levels of symptoms, altho less so when already on meds. Should be less variation if the meds are working. If not working, may be fluctuation between psychotic non-psychotic states.	Dr. Steven Johnson, Psychiatrist	10 RT 2306-08
8-5-1999	**Updated diagnosis.** • In March 1998 diagnosed as psychotic disorder, not otherwise specified. • On 8-5-99, after team meeting, given diagnosis of **schizo-affective disorder**.	Dr. Steven Johnson, Psychiatrist	10 RT 2308-09

DATE	OBSERVATION	OBSERVED BY	RT
8-13-1999	Assessment that D was suffering from psychosis. NOS, likely schizo-affective disorder. D had been transferred back to L-19, acute ward. When asked, D could not tell him why he had been transferred. His assessment was that D was suffering from that illness.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2496-97
8-20-1999	Seen with Dr. Girgis, Egyptian speaking psych, yesterday. • Likes new meds better. Doesn't make him shake. • Still hears auditory hallucinations. Discussed case with Girgis. Suggested increase in seroquel dose. If that fails, clozaril, another antipsychotic. Probably best, but last resort because 1% of those taking it develop agranulocytosis – bone marrow stops producing blood cells. Assessment: still psychotic. Plan: increase seroquel to 200 mg, 2x/day; depakote, 500 mg, 3x/day; paxil, 2, h.s. "I might add that the fact that we were even considering clozaril really is an indication of our desperation as a treatment team to help him." **Objection; editorializing; non responsive. Sustain. Stricken.** Team considered D seriously ill at this point.	Dr. Steven Johnson, Psychiatrist	10 RT 2310-11
8-27-1999	• Saw no moving disorder or tremor, which are side effects of antipsychotic meds and depakote.	Dr. Steven Johnson, Psychiatrist	10 RT 2312
8-30-1999	• Affect blunted.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2439

DATE	OBSERVATION	OBSERVED BY	RT
8-31-1999	• Affect blunted. • D reported no hallucinations. Meaning, she asked him and D said no. She always asked him. [i.e., D never volunteered info.]	Dr. Jasminka Depovic, Psychiatrist	10 RT 2439
9-1-1999	• Affect blunted.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2440
9-3-1999	• D was chronic, meaning he remained ill with chronic schizo-affective disorder. Chronic meaning that D most likely would going to have it for the rest of his life. • Also noted poor personal hygiene. Poor hygiene is another negative symptom of a schizophrenic illness.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2497-98
9-7-1999	• Affect blunted. • D reported reduced auditory hallucinations.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2440
9-9-1999	Saw D w/o interpreter. • Appeared in good spirits. • Good hygiene; no distress. The team who considered D seriously ill consisted of all the psychiatrists working on his case, nurse practitioners, psychologists, case managers and service chief.	Dr. Steven Johnson, Psychiatrist	10 RT 2312

DATE	OBSERVATION	OBSERVED BY	RT
9-15-1999	• Affect blunted. • D disheveled.	Dr. Jasminka Depovic, Psychiatrist	2440
9-17-1999	• D was still having auditory hallucinations. She observed him in his cell talking to self. • D appeared unkempt and disheveled; referring to personal hygiene. • D was talking to himself in the cell. D came to the door but it appeared he understood very little of what she said. He answered yes to almost all of her questions, so she wasn't sure he understood the questions.	Leonard Luna, LCSW	10 RT 2389-91

DATE	OBSERVATION	OBSERVED BY	RT
10-27-1999	D just transferred for L-16. Unable to obtain subjective statement as patient repeatedly states no speak English. [Ask him about side effects to meds?] He said no. [To what? Side effects or questioning?] Would normally be asking D if he was having hallucinations or symptoms. Note indicates D was not telling her whether having hallucinations or delusions. Said couldn't speak English. • Alert and oriented and responded to commands from deputies to close doors. • Presents inappropriate with bizarre bright grin. He looked bizarre. Not normal. Affect isn't matching perceived mood. • Mood euthymic. Euthymic means normal or no mood. The kind you can't pick up. • Cooperative. • Clothes unbuttoned; hair closely cropped; grooming fair; walks with slight limp. • Doesn't appear to comprehend much English. Thoughts questionable. Seemingly attentive. Doesn't appear to be responding to internal stimuli as before. • Determined he didn't have auditory or visual hallucinations. Saw no symptoms of paranoid or suicidal thoughts. Assessment: appeared stable on psych meds yet does appear mentally ill via affect. Antipsychotic meds treat positive symptoms of psychotic illness. Meant to diminish or eliminate things like hallucinations, delusions, etc. Can present other symptoms of illness even though meds are working. One such symptom might be inappropriate affect. Such as she observed here.	April Barrio, Nurse Practitioner	9 RT 2198-2203

DATE	OBSERVATION	OBSERVED BY	RT
11-23-1999	Doing a medication renewal. He was in Mod J housing.	April Barrio, Nurse Practitioner	9 RT 2194
11-29-1999	Again assessed that D was suffering from chronic mental illness. D had been decompensating in regular housing. As noted before, someone stabilized in mental health setting can react to stressors of regular housing and become more symptomatic. That's common.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2498-99
12-7-1999	• D had been observed talking to himself more often. That was mostly her own personal observations. While talking, D wasn't acknowledging what she asked him and was "pretty much preoccupied in his own psychosis." • D seemed preoccupied, as if his thoughts were turned elsewhere. • He indicated physical pain on his left side.	Leonard Luna, LCSW	10 RT 2391-92
12-17-1999	• D was agin preoccupied. • D was receptive to her despite his limited English.	Leonard Luna, LCSW	10 RT 2392-93

DATE	OBSERVATION	OBSERVED BY	RT
12-25-1999	• D was complaining of pain, pointing to side of abdomen. • Cell was trashy; toilet area was a mess; came out with clothes unkempt; shoes w/o laces. Jumpsuit unclean. Unkempt. • Appeared to be responding to internal stimuli. Voices or hallucinations of some kind. A psychotic symptom. He was moving his lips as if carrying on a conversation w/o anyone around. • He was alert. • Questioned whether he was oriented. • Mood euthymic with blank stare. • Speech nonspontaneous. Wasn't really listening or speaking to her. • Wrote positive hallucination. Auditory hallucinations, zero paranoid ideation. Zero behaviors indicative of suicidal or homicidal ideations. • Deputies report patient compliant – not giving problems. Her conclusion re hallucinations was based on her observations of him. D did not tell her about any hallucinations. Blank stare but mood seemed normal. Assessment: slightly increased in his psychosis, with decompensation of grooming and self-care. Non-acute, meaning he didn't seem to be in danger at that moment. Look at decompensation of grooming and self-care to determine if getting worse psychiatrically. Sign symptoms are getting worse. Renewed his seroquel, depakote and paxil. Seroquel is a neuroleptic antipsychotic. Dose of 300 mg twice a day. Depakote is mood stabilizer and anti-seizure med. Dose of 500 mg twice a day. Paxil is antidepressant. 20 mg at nite. Recommended a transfer. He transferred to L-16 w/o restrictions for closer psychiatric monitoring.	April Barrio, Nurse Practitioner	9 RT 2194-98

DATE	OBSERVATION	OBSERVED BY	RT
12-29-1999	• D again talking to self in front of the mirror in his cell. No signs of self-destructive behavior. When she asked about his meds, D responded, yes. D reported no problems	Leonard Luna, LCSW	10 RT 2393
1-13-2000	• D appeared to be in a good mood. He was smiling and answering questions politely. • He said his meds were all right. • No complaints of physical pain. • D was talking to himself "constant."	Leonard Luna, LCSW	10 RT 2393-94
1-27-2000	• D appeared to have no distress. Said he had no problems. • He was still seen talking to himself. Next court date was 7-28-00.	Leonard Luna, LCSW	10 RT 2394
1-29-2000	• Improved with addition of risperdal. Less auditory hallucinations and increased sleep. Axis I, schizo-affective disorder. • Complaining of depression. • Weight gain requires monitoring. Correctional medical services does not think D is diabetic. Goal to increase risperdal to target auditory hallucinations. Kept regular meds; increased colace and increased risperdal to 2 mg at night. "Keep his 5150 flag, patient danger to others and gravely disabled. Return with psychiatrists in two weeks."	April Barrio, Nurse Practitioner	9 RT 2192-2248

DATE	OBSERVATION	OBSERVED BY	RT
1-31-2000	• D might respond to the increased stress of trial, meaning court dates. Court dates can be a stressor that can cause deterioration. "Absolutely, absolutely." • Saw symptoms of psychosis that day. "Psychosis" was in " " because they had not completely ruled out other things. Which would never be ruled out until they had a history and neuropsychological testing.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2499
2-18-2000	• Characterized D as chronic and responding to stressors and having bizarre affect. • He became aware that D was diagnosed as suffering from schizo-affective disorder after team meetings of all the mental health professionals that saw him. He agreed with schizo-affective disorder diagnosis and continues to agree with it.	Dr. Jose Flores-Lopez, Psychiatrist	10 RT 2500-01

DATE	OBSERVATION	OBSERVED BY	RT
3-9-2000	Observations: saw him on Mod J, transferred from L-16 2 weeks ago. Continues to have poor communicative capacity in English but elaborated more. Shaking head affirmatively re preference for Mod J. • Admitted hearing voices. "Calls my name. Tells me to kill myself." Heard such a voice 1 week ago. • Denies side effects to meds. But noted weight gain. An occasional side effect of seroquel and depakote. 900 mg of seroquel a day. • Alert and oriented. • Grooming better. • Less disheveled. Cell still trashy, according to deputies. • Speech monosyllables. Normal rate. • Mood euthymic; affect broad – appropriate. • Doesn't seem to be responding to internal stimuli. Not talking to self. • Open good eye contact. • Thoughts hard to assess. Seems coherent. No hallucinations; no paranoia; denies suicidal or homicidal ideation. Assessment: stable chronic on meds. Much improved since 11-99. Means he's stable but still manifests mental illness. Chronic, not acute. Renewed meds.	April Barrio, Nurse Practitioner	9 RT 2203-05

DATE	OBSERVATION	OBSERVED BY	RT
4-7-2000	• Grooming improved. • Eye contact good. • Attempting to interact. • No auditory hallucinations; no paranoid ideation; denies suicidal ideations. • Appears stable chronic. Responding to meds. Renewed seroquel, depakote and paxil.	April Barrio, Nurse Practitioner	9 RT 2205-2206
4-25-2000	Saw D with an interpreter. • She had received report that D had defecated in the shower. • D claimed that 1 week ago he was hurting himself by tying the knot on his penis. He did so to stop breathing. Did not make sense so she put a question mark by that.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2440-41
4-25-2000	• Affect appropriate.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2441
4-26-2000	• Affect blunted.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2441
4-27-2000	• D reported reduced hallucinations, even though his medication had been reduced.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2441
5-4-2000	• D denied hallucinations or suicidal or homicidal ideations. • But he was still talking to himself and appeared disheveled.	Leonard Luna, LCSW	10 RT 2394-95

DATE	OBSERVATION	OBSERVED BY	RT
5-5-2000	D seen with help of Egyptian speaking inmate, Mr. Hannah. • Denies problems. • D instructed to clean up his room and take a shower because his cell was in "very" messy condition, as was he.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2442
5-10-2000	• D said he had no problems. Denied hallucinations or desire to hurt himself. • Observed him talking to himself in the cell most of the time. • Appeared unkempt and disheveled. • Pretty much said he was having no problems with his meds. Next court date 7-25-00.	Leonard Luna, LCSW	10 RT 2395
5-16-2000	Saw D w/o translator. • Subjective: Auditory hallucinations; wants more meds. • Objective: Talks to himself constantly; auditory hallucinations; no ideations; • Poor hygiene; • Calm. Assessment: still psychotic. Plan: increase seroquel to 200 mg 3x/day. Check valproic acid level. Continue depakote and paxil.	Dr. Steven Johnson, Psychiatrist	10 RT 2313
5-17-2000	• D was depressed. • His affect was flat.	Saundra King, Case Manager	10 RT 2409
5-31-2000	• D was withdrawn. • His affect was flat.	Saundra King, Case Manager	10 RT 2410

DATE	OBSERVATION	OBSERVED BY	RT
6-17-2000	Saw him on Mod L-16 while making rounds. Presents as always. Unable to speak English. • Cell fairly clean compared to when he was in regular housing. • Diagnosis: psychosis NOS, provisional schizo-affective. Schizo-affective indicates symtoms of schizophrenia and major mood disorder. Subjectively: he says no problems. Meds ok. • Observed him talking to himself in dayroom. Positive auditory hallucinations. • Grooming better but inappropriate affect. • Responding to internal stimuli. He did not report hallucinations. She observed them. Assessment: partially stable. Remains bizarre and inappropriate but improved self-care and cell care due to increase of mood stabilizer – or closer monitoring by deputies. Not sure. He's in different housing. Repeats provisional diagnosis of schizo-affective disorder.	April Barrio, Nurse Practitioner	9 RT 2206-2208
6-20-2000	• D had poor hygiene.	Saundra King, Case Manager	10 RT 2410
6-27-2000	• D's hygiene had improved.	Saundra King, Case Manager	10 RT 2410

DATE	OBSERVATION	OBSERVED BY	RT
7-1-2000	D on L-16 and speaking English today. • Reports he read his bible. Words from god every day. Reports he is hearing voices. • Denies self-destructive behavior. • Doesn't want meds increased. • Sleeping day and night, but less at night. • Cell is cleaner. • He is more appropriate and seems more responsive. Alert. Oriented. • Mood is labile – variable, fluctuating. • Preoccupied, cheerful with inappropriate affect. • Increased communication in English. • Thoughts coherent. • Positive religiosity. • Positive auditory hallucinations. No visual. No paranoid ideations. No suicidal or homicidal ideations. Assessment: chronic, slightly improved from last visit. Seroquel needed. Continued Paxil, depakote and seroquel. Paxil now at 40 mg at night. Depakote 1000 mg twice a day. Seroquel is 200 mg, 3 times a day.	April Barrio, Nurse Practitioner	9 RT 2208-2210
7-5-2000	• D's mood was pleasant and his affect was appropriate.	Saundra King, Case Manager	10 RT 2410
7-11-2000	• D reported that a couple of days earlier, he'd had a hallucination commanding him to wrap a sheet around his penis. • D said he heard voices telling him to do it. He reported happy voices at present.	Saundra King, Case Manager	10 RT 2410-11

DATE	OBSERVATION	OBSERVED BY	RT
7-12-2000	D on L-16. • D complained of increased auditory hallucinations resulting in sexual preoccupation and impulses to indulge in self-destructive behavior. • Symptoms: positive auditory hallucination, reduced sleep, positive sexual preoccupation. • Observed he was actively responding to stimuli. • Subtherapeutic neuroleptic. Subtherapeutic neuroleptic means she suspects D is not on enough antipsychotic. She increased his seroquel to 200 mg morning and noon and 300 mg at night.	April Barrio, Nurse Practitioner	9 RT 2210-2212

DATE	OBSERVATION	OBSERVED BY	RT
7-15-2000	D on L-16. • Admits shaved eyebrows because auditory hallucinations told him to. • Complaining of not sleeping and increased hallucinations. • Observed med side-effects: sleeplessness; poor response to meds; good compliance to meds. • Appeared disheveled, unkempt, responding to internal stimuli. • No redness on penis. • Broad inappropriate grin. • No suicidal, homicidal or paranoid ideations. Assessment: psychotic. Not sleeping. Last increase of seroquel ineffective. Meds: increased paxil to 40 mg in a.m. to increase nighttime sleep. Held night dose. Renewed depakote, 1000 mg twice a day. Increased seroquel to 200 mg in morning; 200 mg at noon and 400 mg at nite to target sleep and auditory hallucinations. Also going to consult with psychiatrist re behavior and lack of response to neuroleptic. Consider added second atypical antipsychotic.	April Barrio, Nurse Practitioner	9 RT 2212-2214
7-20-2000	Consulted with Dr. Johnson. As a result, added ativan for sleep. Consideration of 2nd atypical neuroleptic. 7-15-00 observations: Telephone call paged to on-call psychiatrist to request stat ativan for sleep to reduce auditory hallucination activity. Ok per consultation with Dr. Farjalla. Stat order ativan tonite and 2 nites only for sleep. Will discuss case in meeting and recheck.	April Barrio, Nurse Practitioner	9 RT 2214-15

DATE	OBSERVATION	OBSERVED BY	RT
7-20-2000	• "Patient mostly rocking in his bed. Refusing to tell me if he's suicidal." • D was very disheveled. "Positive for body odor. Room messy. Food all over. • Responding to internal stimuli. Questionable if dangerous to self or questionable if dangerous to others. • Insight and judgment poor."	Dr. Jasminka Depovic, Psychiatrist	10 RT 2442-43
7-21-2000	• D starting to feel better. Eating. Smiling. • Denied ideations, but hearing voices.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2443
7-22-2000	• D starting to feel better. Eating. Smiling. • Denied ideations, but hearing voices.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2443
7-22-2000	• Anxious affect. At some point, D's diagnosis was changed to schizo-affective disorder. She was in agreement with that diagnosis. Remains in agreement that D suffers from psychotic illness.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2443
7-23-2000	• D starting to feel better. Eating. Smiling. • Denied ideations, but hearing voices.	Dr. Jasminka Depovic, Psychiatrist	10 RT 2442

DATE	OBSERVATION	OBSERVED BY	RT
7-25-2000	• D had been picking his face. She saw abrasions on D's face in the middle of his forehead, between his eyebrows. • He reported that voices were telling him to pick at his face, then to rub butter and coffee grounds on the abrasions.	Saundra King, Case Manager	10 RT 2411-12
7-26-2000	• D again transferred back to acute mental health housing, because he was smearing butter and coffee on abrasions he caused to his forehead by picking his skin. • Stress probably had something to do with D's behavior. Tries to correlate transfer to acute unit with being more stressed. Stress can affect a psychotic illness and can make the symptoms worse. Schizophrenia or schizophrenic illness is a stress-related illness and can fluctuate.	Dr. Teresa Farjalla, Psychiatrist	10 RT 2470-71
7-30-2000	• D reported thru same interpreter that he had a poor sleep pattern the night before and regretted that he'd asked him to reduce the evening dosage of one of the meds. So he increased D's dosage.	Dr. Juventino Lopez, Psychiatrist	10 RT 2517

DATE	OBSERVATION	OBSERVED BY	RT
7-31-2000	D was housed in Mod L. • He was alert and oriented; spoke broken English; soft-spoken but goal directed. • Denied suicidal or intent to harm self. • Admitted auditory hallucinations of hearing his name being called. He had been hearing command hallucinations to tie things on his penis and rub his forehead, but denied them at that moment. Said he'd had them in the past. Denied having anything tied to his penis. • D had vaseline on his lips and forehead. • Said he had not been sleeping at night. She noted that a flag is to remain in place. A flag is a communication between mental health and sheriff's dept and medical staff that D's to be evaluated for a 72-hour hold upon release from the facility. 72-hour is an involuntary psychiatric hold due to danger to self or others or grave disability. He would be evaluated at the time of release.	Rachelle Gardea, RN	9 RT 2148-50
8-3-2000	• D reported depressions and anxiety. • Concerned about legal issues. Asked when his court date was and it was 8-11. Her note that D was concerned about legal issues could have been based on such questions.	Saundra King, Case Manager	10 RT 2412, 2422-23, 2425-26

DATE	OBSERVATION	OBSERVED BY	RT
8-12-2000	Observations on Mod L-16 rounds. • D admits auditory hallucinations telling him to put butter on his mouth and coffee between his eyebrows. She saw positive auditory hallucinations. • Sleeping better. • Depression is up and down. • Denies suicidal ideation. • Admits was tying his penis. Zero desire to tie penis off now. Note indicates there was a cloth on the floor he was tying to his penis. She remembers a little cloth and knew he had been tying his penis. • Clothes on the floor. Disheveled; cell is trashed. Response to meds: partially stable. Poor responder to meds, not sure why. Axis II, on diabetic diet only. Zero meds. Increased weight.	April Barrio, Nurse Practitioner	9 RT 2215-18
8-24-2000	• D had gained a lot of weight. • He was unkempt. Trashy cell. Broad affect. • Able to communicate with translator. • Thoughts coherent but illogical. • Positive auditory hallucinations. Assessment: partially stable only. Psychotic still. Poor responder to meds. Put a lot of questions because wondering if he had diabetes, and whether that was affecting his mental status. **"He's still so psychotic."** Renewed paxil, depakote, ativan and seroquel. Asked case manager to increase contact with D.	April Barrio, Nurse Practitioner	9 RT 2218-19

DATE	OBSERVATION	OBSERVED BY	RT
8-26-2000	Mod L rounds. • Hears voices, mother calling his name, telling him not to kill himself. • Denies tying his penis. • Zero further fixation with coffee grounds or cutting eyebrows. • No side effects to meds. Fair response to and compliance with meds. • Cell cleaner; calmer; better groomed. • Speaking more English. • Less preoccupied with internal stimuli. • Seems more appropriate. • Positive auditory hallucinations. No ideations. Assessment: chronic, mostly stable on meds but still psychotic. Renewed paxil, depakote, ativan and seroquel. Paxil, 40 mg. Depakote, 1000 mg twice a day. Seroquel, 200 mg in morning; 200 mg at noon and 400 mg at nite. That is max dose. Noted 5150 definitely. Fits the 5150 criteria, which is danger to self or others or gravely disabled. It would be not able to care for self due to mental illness.	April Barrio, Nurse Practitioner	9 RT 2219-20
9-6-2000	• D reported auditory and visual hallucinations. D reports auditory hallucinations "all the time." One of hallucinations he reported on 9-6-00 was the sound of footsteps. A • D reported he felt a woman touching him while he slept. • He had numerous somatic complaints. She wrote down headaches.	Saundra King, Case Manager	10 RT 2413-14

DATE	OBSERVATION	OBSERVED BY	RT
9-10-2000	Observations during mod L-16 rounds. • Cell strewn with candy wrappers, unkempt. • Describes sounds and noises from windows. • Someone is touching him. • Denies self-destructive voices or impulses. • Denies side effects. • No dyskinesia, but obesity side effect. Good compliance with meds. Stomach, increased fat. Eating candy bars. • Mood is up. Smiling cheerful. Broad, inappropriate affect. • Poor English. Not sure if thoughts coherent. • Positive auditory hallucinations. No ideations. Assessment: chronic, partially stable. Schizo-affective. Still psychotic despite meds. Renewed depakote, ativan, paxil and seroquel.	April Barrio, Nurse Practitioner	9 RT 2221
9-13-2000	• D's hygiene was poor and his cell was very dirty. • His mood was anxious and his affect was appropriate to his mood.	Saundra King, Case Manager	10 RT 2414
9-19-2000	• D's mood was euthymic, that is, blunted, and his affect was flat. • Cell still messy; hygiene was better.	Saundra King, Case Manager	10 RT 2414-15

DATE	OBSERVATION	OBSERVED BY	RT
9-25-2000	Observations during Mod L rounds. • Lying supine on back with head hanging off end of bed. Lips moving as if chanting or talking with someone. Not responding when door opened. Jumped up after name called. • Seemed disoriented with decreased comprehension of English or ability to communicate. Using hands to motion. Appeared startled by sound of his name. • Asked if he was hearing voices: "Voices, food, John, eat." • Observed positive auditory hallucinations and positive confusion. Assessment: only partially stable. Rule out subtherapeutic meds. Renewed depakote, ativan, paxil and seroquel. Same dosages. Ativan at 1 mg at night. Order lab work to check liver function, glucose and folic acid level. Indicated 5150 flag should stay in place. That's a warning sign to alert others he should not be released w/o assessment for mental health.	April Barrio, Nurse Practitioner	9 RT 2222-24
9-26-2000	• D reported olfactory hallucinations; reported smelling something she did not think was there. • D also complained of problems sleeping. • Hygiene was poor. • Mood was pleasant and affect was appropriate. • **10-3-00**: hygiene was okay; cell was messy.	Saundra King, Case Manager	10 RT 2415-16

DATE	OBSERVATION	OBSERVED BY	RT
10-8-2000	• Subjective: Relates positive continued same auditory hallucinations: woman's voice telling him when to eat; constant commenting on his behaviors; • Reports positive visual hallucination of a woman running by; • Feels someone is touching his shoulder; • Sleep is now ok; • Denies self-destructive behavior or commentaries to do so. • Objective: D lying on back with head hanging off bunk; • Increased English today; spontaneous; speech normal. Increased English spontaneous means offering or attempting to related info w/o prodding. Reduced spontaneity affect means he's not as relaxed or expressive as usual. Flat or nonmoving. • Thoughts coherent and organized; • Increased grooming; • Euthymic; • No ideations. Had had hallucinations but not then. Assessment: chronic with psychotic symptoms. Responds to and compliance with meds; no side effects. Renewed same meds at same levels. Court date 1-19.	April Barrio, Nurse Practitioner	9 RT 2225-27
10-11-2000	• D was "hyper talkative." He was rambling. Mumbling a lot, on and on. What he said didn't make a lot of sense. Sometimes talked in broken English, sometimes it was clear. • He said his mother and sister came to see him and that they came often.	Saundra King, Case Manager	10 RT 2416-17

DATE	OBSERVATION	OBSERVED BY	RT
10-21-2000	Observations while on Mod L rounds. • D says he's ok. • Hears voices; lady touching him. Auditory hallucinations continue. • Broad inappropriate affect. • Sleep ok. • Observations: lying flat on back. More appropriate. • Cheerful. Broad inappropriate affect. • No tying off of penis. E • English still poor. • Thoughts coherent and organized. No hallucinations. No ideations. Not as bizarre as previously noted. Assessment: chronic. Still psychotic, but maintaining in L-16. Stabilized somewhat.	April Barrio, Nurse Practitioner	9 RT 2227-29

DATE	OBSERVATION	OBSERVED BY	RT
11-4-2000	From Mod L-16 rounds. • D denies problems. • Auditory hallucinations. Lady calling his name, "John, John." • Occasional tactile hallucinations. • Sleep ok. • No T.D. – tardive dyskinesia. Involuntary movements that are side effect of antipsychotics. • Unkempt, but not as bad as before. • Broad, inappropriate, cheerful mood. • Thoughts coherent, questionable. Organization, questionable. Limited English. • No hallucinations. No ideations. Didn't observe anything to suggest he was having hallucinations or delusions while talking to him. Assessment: partially stable; schizo-affective disorder with psychoses. Axis III, increased glucose. Noted lab results on 10-31. Increase in glucose and total protein. Renewed meds at same dosages.	April Barrio, Nurse Practitioner	10 RT 2231-32
11-7-2000	• Mood was euthymic and affect was flat. • D was actively hallucinating. During the interview, D was mumbling and talking to himself.	Saundra King, Case Manager	10 RT 2417, 2423
11-12-2000	• Mood was pleasant and affect appropriate.	Saundra King, Case Manager	10 RT 2417

DATE	OBSERVATION	OBSERVED BY	RT
11-14-2000	• Continued complaint of auditory hallucinations. "Go, John; eat, John; John bad." • Complaining he wants to shower. No time out. • Deputies report D refuses to go to dayroom when given the time. • Target symptoms: Reported auditory hallucinations. Slightly increased tactile hallucinations. Female touches him; increased poor grooming; unkempt clothing; cell unclean. • She observed: unkept; diminished grooming; dysthymic; diminished spontaneity of affect. Even. Speech is soft and whispering. Poor English. Thoughts coherent but sparse due to lack of language capabilities. Seems organized, but auditory hallucinations. No ideations. Assessment: status quo. Chronic schizo-affective; poor responder to psych meds. Renewed same meds.	April Barrio, Nurse Practitioner	10 RT 2234-36
11-16-2000	• D had a number of somatic complaints.	Saundra King, Case Manager	10 RT 2417
11-22-2000	• Mood was pleasant and affect appropriate. • D was actively hallucinating. During the interview, D was mumbling and talking to himself.	Saundra King, Case Manager	10 RT 2417, 2423

DATE	OBSERVATION	OBSERVED BY	RT
12-2-2000	• Complaining of auditory hallucinations telling him to scratch himself and pull his hair. • Symptoms: auditory hallucinations; ok sleep. No depression. Inappropriate affect. • Observations: sleeping; unkept; cell not too messy. Alert, oriented, euthymic. Broad, inappropriate smiling affect. Poor English; low tone. Thoughts coherent and organized. Auditory hallucinations. No ideations. 12-2-00 assessment: subtherapeutic med levels. Poor responder. Despite max levels on meds, still psychotic. Axis I, schizo-affective disorder. Renewed meds at same doses. Considered adding risperdal.	April Barrio, Nurse Practitioner	10 RT 2236-37

DATE	OBSERVATION	OBSERVED BY	RT
12-15-2000	• Continues to complain of auditory hallucinations telling him to pull hair on top of head. Noted thinning of hair. Also tells him to pull off his toenails. Saw thinning on front of his head. • Also tactile hallucinations of someone touching him. • Not sleeping. • Constipated for 4 days. • Response to meds is fair to poor. • Observations: alert, oriented, cheerful, broad, inappropriate affect. Thoughts coherent and organized; "I am not sure about that." She has a ? on her notation. Auditory hallucinations. No ideations. Assessment: only partially stable. Poor responder to treatments. Schizo-affective with positive psychotic symptoms. Consulted with psychiatrist Dr. Depovic. re target symptoms and possible use of risperdal. Decision to add risperdal. One mg at night to target hallucinations. Renewed rest of meds at same doses. Started colace, 250 mg, twice a day, and 30 cc's of milk of magnesia, both for constipation.	April Barrio, Nurse Practitioner	10 RT 2238-40

DATE	OBSERVATION	OBSERVED BY	RT
12-29-2000	• "Voices are better, not so much. "Sometimes I feel sad." • Status of target symptoms: reduced auditory hallucinations telling him to pull his hair. Diminished visual hallucinations. Diminished tactile hallucinations. • Increased sleep. "Better now." • Up and down mood swings – sad, happy. Mood up; still incongruent with content. • Diminished compulsive hair pulling behavior. • Reduced constipation. • "Better subtherapeutic neuroleptic of risperdal." I.e., suspects not an adequate level. • Smiling inappropriately. Feeling sad but smiling. Content is said with diminished auditory hallucinations. No auditory when she saw him. No ideations.	April Barrio, Nurse Practitioner	10 RT 2240-43
1-3-2001	• Mood was euthymic and affect flat.	Saundra King, Case Manager	10 RT 2417
1-9-2001	• Somatic complaints. Headaches and jock itch. • Hygiene poor. D had tons of hair in his cell and bald spots on his head, so she asked him if he'd been pulling it out. D said no.	Saundra King, Case Manager	10 RT 2417-18

DATE	OBSERVATION	OBSERVED BY	RT
1-9-2001	• Subjective: D has cold. Headache gone. • Obj: alert and oriented x3. Language barrier. Disheveled. Auditory hallucinations per case manager. Assessment: upper respiratory infection. Still psychotic. Headache related to paxil. Plan: discontinue paxil. Decrease colace to 250 mg 2x/day	Dr. Steven Johnson, Psychiatrist	10 RT 2314-15
1-23-2001	• D was anxious and restless. • Hygiene poor.	Saundra King, Case Manager	10 RT 2418, 2423-24
1-26-2001	Administered neuropscyh tests to D.	Dr. Ari Kalechstein, Neuropscyhologist	2530
2-1-2001	• D having headaches. • Objective: alert and oriented x3; poor English; • Disheveled; • Denies ideations or hallucinations. Assessment: headache. Depakote? Plan: discontinue depakote. start depakote extended release., 1000 mg at bedtime. Continue Colace and metamucil. Risperdal, 2 mg at bed. Ativan 1 mg at bed.	Dr. Steven Johnson, Psychiatrist	10 RT 2315-17
2-5-2001	Administered neuropscyh tests to D.	Dr. Ari Kalechstein, Neuropsychologist	2530

DATE	OBSERVATION	OBSERVED BY	RT
2-13-2001	• Mood pleasant and affect appropriate.	Saundra King, Case Manager	10 RT 2419
2-16-2001	• D no longer having side effects. • Sleeping ok. • Alert and oriented. • Good hygiene and cheerful mood. • Limited English. Denied ideations and hallucinations. • D seemed to be improving. Continued meds.	Dr. Steven Johnson, Psychiatrist	10 RT 2318-19
2-27-2001	• Still no side effects. • Alert and oriented. • Calm and coherent. • Poor hygiene. • Denied ideations and hallucinations, but case manager's notes said D had expressed auditory hallucinations. Assessment: still psychotic. Increased risperdal to 3 mg at bed. Rest of meds the same.	Dr. Steven Johnson, Psychiatrist	10 RT 2139-2320
2-27-2001	• D was actively hallucinating. During the interview, D was mumbling and talking to himself.	Saundra King, Case Manager	10 RT 2423

DATE	OBSERVATION	OBSERVED BY	RT
3-7-2001	• D told her he had been pulling out his hair. • Said he wanted medication to make him feel happier. • Said he was getting more sleep than he had been. Also reported that hallucinations occurred mostly at night. • Hygiene was poor.	Saundra King, Case Manager	10 RT 2419
3-16-2001	• D complained of depression and requested the happy pill. Could not express it any more articulately. Assumed he meant paxil. • Reported no side effects but frequent headaches. • Alert and oriented. • Denied ideations or hallucinations. • Good hygiene. • Quiet and soft spoken. Concluded headaches not due to paxil. Restarted paxil and increased seroquel to 600 mg at bed. Increased risperdal to 4 mg at bed and changed depakote to 500 mg 4x/day to minimize side effects.	Dr. Steven Johnson, Psychiatrist	10 RT 2320-22
3-16-2001	• D continued to pull out chunks of hair. Saw bald spots on him and hair on the floor. • Mood was euthymic and affect flat. • Hygiene poor.	Saundra King, Case Manager	10 RT 2419-20
3-20-2001	• D was still pulling out chunks of his hair. • Depressed with sad affect.	Saundra King, Case Manager	10 RT 2420
3-29-2001	• D reported he felt much better. • No longer pulling out hair and she did not observe indication that he was.	Saundra King, Case Manager	10 RT 2420

DATE	OBSERVATION	OBSERVED BY	RT
4-3-2001	Nursing staff reported there had been decreased observations of D pulling his hair.	Dr. Juventino Lopez, Psychiatrist	10 RT 2517
4-10-2001	• D was stable with moderate residual depressive symptoms. First time he'd interviewed D with a colleague who spoke to D in his native tongue. • After that, assessment that D had schizo-affective disorder with improved stability and moderate residual depressive symptoms. • D's affect was bland. Affect was bland when trying to describe his emotional tone. • Depression, on scale of 1 - 10, was in the middle.	Dr. Juventino Lopez, Psychiatrist	10 RT 2518-19
4-17-2001	• D's cell was "moderately malodorous."	Dr. Juventino Lopez, Psychiatrist	10 RT 2519
4-20-2001	• Mood pleasant and affect appropriate.	Saundra King, Case Manager	10 RT 2420
4-27-2001	• Mood depressed and affect sad. • Hygiene poor	Saundra King, Case Manager	10 RT 2420

DATE	OBSERVATION	OBSERVED BY	RT
5-8-2001	Saw D with interpreter. • Complained of headaches and auditory hallucinations at ~noon everyday. • Also tremor and insomnia. Mild tremor. • No ideations or other hallucinations. • Coherent. Normal speech. • Disheveled. Increased seroquel to 200 mg at noon and 600 mg at bedtime. Increased risperdal to 4 mg at noon and bedtime. Switched paxil from morning to bedtime. Renewed depakote.	Dr. Steven Johnson, Psychiatrist	10 RT 2322-23
5-16-2001	Observed D on Mod L-16. Interviewed him as a psychiatrist and talked to him in Arabic. • Subjective: D said he was feeling better and hearing less voices. Sleeping better. Not shaking because Dr. Lopez changed some of his meds. • Objective: Alert; oriented x3; had fair eye contact. • When first saw D, he was not bright; he was shaking; having some problem. Doing much better on today than he was a month earlier. Fewer hallucinations and less depressed mood. • He had poor insight and poor judgment. Didn't have insight about what was going on with him. Look at insight to determine whether person has recognition of how ill he is. Assess D as suffering from schizo-affective disorder and continued meds.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2347-49
5-16-2001	• Mood euthymic and affect flat. • Poor hygiene.	Saundra King, Case Manager	10 RT 2421

DATE	OBSERVATION	OBSERVED BY	RT
5-21-2001	• D said still shaking. Shaking so badly Khaled reviewed lab work. It was ok. • D was otherwise alert and oriented; fair eye contact; fairly groomed; claimed voices not bothering him as much. • Less depressed mood and brighter affect. • No ideations. • Judgment and insight remained poor. Continued meds but added cogentin because of the shaking.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2349-50
5-31-2001	• D said voices were the same. • Less shaking. • Alert, oriented, fair eye contact. • Mood and affect were blunt. • Because he is only one who can speak Arabic with D, D is usually a little brighter when he visits, but not that day. • Complaining of voices. • Denied ideations. • Remained poor insight and judgment. Continued meds.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2351

DATE	OBSERVATION	OBSERVED BY	RT
6-4-2001	• D reported that his auditory hallucinations were getting better. A reflection of the fact that they had increased D's medication – one of the major tranquilizers. D had been taking 4 mg. of Risperdal 2x/day. Even though it decreased D's reported hallucinations, it caused adverse muscle stiffness and incoordination, so had to reduce dosage. That is an antipsychotic medication. • Also taking Seroquel, another antipsychotic medication. And Depakote, which is mood stabilizer. • And Paxil, an antidepressant, that he'd increased form 20 to 30 mg a month earlier.	Dr. Juventino Lopez, Psychiatrist	10 RT 2519-20
6-13-2001	• Interviewed D with Dr. Khaled. Noted that D's mood was anxious and affect was flat.	Dr. Juventino Lopez, Psychiatrist	10 RT 2520
6-15-2001	• Mood euthymic and affect appropriate to his mood. • He talked about tremors in his hands and an unsteady gait.	Saundra King, Case Manager	10 RT 2421
6-21-2001	• D said: "the voices are on and off, half and half." • D was only oriented x2. • D was falling off a lot and complained of being dizzy. Concerned he was falling down. • No ideations; poor judgment; poor insight. Reviewed lab work and noticed blood sugar low. May be why he was dizzy and falling down.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2352-53
6-22-2001	• D's judgment and insight were poor. Insight into his illness. **Didn't have good recognition that he was sick.**	Dr. Teresa Farjalla, Psychiatrist	10 RT 2472

DATE	OBSERVATION	OBSERVED BY	RT
6-25-2001	• D said "I can't sit up. If feel dizzy." "I fell three times." • Alert, but not able to talk a lot. Laying down. Said he could not sit up and talk. • Still hearing voices. Denied ideations. • Poor insight and judgment. Consulted with M.D. to see if physical reason D was falling. She said blood sugar stable. She visited D with doctor and found no reason for D's falls and dizziness. Continued meds. D had court date of 6-29.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2353-54
6-25-2001	• D was escorted from his sector by deputy and staggered and started to fall to the floor, using hand to brace himself. • D was alert and oriented. Attempted to talk to him about why he fell, but he was unable to explain how he had been feeling. • Denied suicidal thoughts. • He admitted to continued auditory hallucinations. Heard a voice that said his name and sometimes his mother's voice talking to him. • He had been taking medication as prescribed. He felt medication diminished the voice but they never stopped all together. He admitted that he had been pulling his hair out a little bit, but could not give a reason why. He denied any anxiety about upcoming trial.	Rachelle Gardea, RN	9 RT 2150-53

DATE	OBSERVATION	OBSERVED BY	RT
6-26-2001	• D couldn't remember how many times he had fallen the day before. Said he could not stand straight even to go to the bathroom. • Alert with fair eye contact. Sitting down. Claimed he couldn't stand w/o feeling dizzy. • Admitted, when asked, that hearing voices, but less. • Shaking arm is also less. • Still paranoid. Guarded. • Denied ideations. • Still poor insight and judgment.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2354-55
6-27-2001	• D still complaining of dizziness and inability to sit up in bed. Decided to present case to treatment team to see if they could help him more.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2355-56
6-28-2001	• D reported he had been pulling his hair more. Doesn't know why. • Feeling better on 6-28, but day before wasn't well. • Alert; fair eye contact; claimed auditory hallucinations, but less. • Guarded, preoccupied. Everyone noticed it. Thinks because of court the next day. • Denied ideations. • Poor insight and judgment. Also poor memory. After discussed D's case with treatment plan, they recommended closer observation of vital signs, blood pressure, blood sugar. Continued meds.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2356-57

DATE	OBSERVATION	OBSERVED BY	RT
7-2-2001	• D said he couldn't remember if he'd fallen day before. • Alert; fair eye contact; fairly groomed. • Denied ideations; said voices were less, but couldn't remember a lot of the questions, so noted poor memory. • Still guarded and suspicious and poor insight and judgment. Meds the same.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2357-58
7-3-2001	• "I wanted to kill myself. And I looked around, and I can't find anything to kill myself with." • In response to question: "Yes, I hear voices." • Alert and oriented x2. Preoccupied with his depression and wanted to hurt himself. • Auditory hallucinations and suicidal ideation. • Poor memory, insight and judgment. Assessment: still suicidal and psychotic; fell down 4x in the morning per deputy – D couldn't remember. Continued on suicidal precaution.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2358-59
7-4-2001	• D appeared anxious. • Language problem. • Denied falling down, but notes suggest he had been falling down prior to this. • Denied suicide ideations. • Disheveled. Difficult to assess. Continued on meds.	Dr. Steven Johnson, Psychiatrist	10 RT 2323-24

DATE	OBSERVATION	OBSERVED BY	RT
7-5-2001	• "I am not going to hurt myself. Voices still coming from the window and the doors. I look and nobody is there." • Alert and oriented x2. • Complained of auditory hallucinations. • Very paranoid. Looking around cell. • Very poor insight and judgment. Assessment: still psychotic but not suicidal. Continued on suicidal precaution observation.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2359-60, 70
7-6-2001	• D had milk and cereal spilled over his table.	Dr. Teresa Farjalla, Psychiatrist	10 RT 2472
7-9-2001	• D said he keeps falling. Feels knees are giving up on him. Doesn't feel dizzy anymore. • Oriented; had full eye contact; fairly groomed. • Auditory hallucinations but denied ideations. • Preoccupied with physical illness. And falling down. • Poor insight and judgment. Reduced paxil and depakote.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2360-61
7-10-2001	• D said he felt tired. A • lert; fair eye contact; fairly groomed. • Reported auditory hallucinations. • Unable to sit up. Very sleepy. Snoring.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2361

DATE	OBSERVATION	OBSERVED BY	RT
7-11-2001	• D said he kept hearing 2 people talking to each other, but not to him. • Alert and oriented x2. Only partially oriented. • Claimed he couldn't remember a lot of things. Answered many questions with "I can't remember." • No ideations. • Said he felt depressed. • Poor insight and judgment.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2361-62
7-12-2001	• D said the voices were still there. • Alert; oriented x2; fair eye contact; fair grooming. • Said he felt depressed and sad – in response to questions. • Poor insight and judgment. No ideations. • Discontinued suicidal observation, because 4 days in a row claimed not suicidal. But continued no sharp objects in cell.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2362-63
7-16-2001	• D reported improvement. Not falling as much; not pulling hair as much; voices not as much. • Denied ideations, but admitted hearing voices.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2363-64
7-17-2001	He'd changed blood sugar medication and already feeling better. • Alert; fair eye contact; more awake. • Still had auditory hallucinations but less depressed mood. • Affect blunted, but said not depressed. • Poor insight and judgment.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2364

DATE	OBSERVATION	OBSERVED BY	RT
7-17-2001	• D was slightly disheveled, but had been requesting a shave. • Speech was sparse. Not talking much to her. • Denied feeling suicidal. • D admitted to hearing voices – his mother and his sister. Denied any type of command hallucinations. Compliant with meds. • Denied anxiety about upcoming court date. • Said he'd had occasional falling, but it had decreased since last time. • His behavior on the unit had been appropriate. Recommended that flag remain in place. She suggested that the psychiatris and she, as case manager, follow up.	Rachelle Gardea, RN	9 RT 2153-54
7-18-2001	• Fairly groomed. • Auditory hallucinations; still paranoid; guarded and suspicious; denied ideations. Felt D was paranoid because some days D communicated freely and on other days he was blocking and guarded.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2364-65
7-19-2001	• D hadn't fallen at all. Complained his ankle was swollen. • Same observations as those on 7-18-01. Continued on same meds.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2365
7-23-2001	• D said not suicidal, but still hearing voices. • Same observations as those on 7-19-01.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2365-66
7-24-2001	• D said felt ok; not suicidal and voices still there. • Said he had been feeling anxious. • Other than that same observations as before.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2366

DATE	OBSERVATION	OBSERVED BY	RT
7-25-2001	• D said felt good and needed a shower. • Seemed more awake. • Noted D had been more anxious. Still guarded but no indication of paranoia. D was talking more that day. • Other than that, same observations as before.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2366-67
7-26-2001	• D said voices weren't that bad; felt better; wanted a shave. Voices were less. • Fewer falling spells. • Otherwise same observations.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2367
7-31-2001	• D said voices less but felt little anxious. • Noted fewer paranoid symptoms. • Otherwise, same observations.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2367
8-13-2001	• D had no comments to share re 8-10 court appearance. Not anxious; neutral mood. Affect bland.	Dr. Juventino Lopez, Psychiatrist	10 RT 2521
8-14-2001	• Affect bland. Primarily monitoring D's meds. D had been there 1 year before he started seeing D. Objective was to address D's meds.	Dr. Juventino Lopez, Psychiatrist	10 RT 2521

DATE	OBSERVATION	OBSERVED BY	RT
8-20-2001	• Staff reported D was more quiet and withdrawn. • Cell was markedly malodorous with food spilled on floor. • D not registering any complaints. • Increased depressive symptoms. • Assessed that D by history had schizo-affective disorder and appeared to be regressed with more repressive symptoms.	Dr. Juventino Lopez, Psychiatrist	10 RT 2522
8-22-2001	Saw D with Dr. Khaled. • Cell still malodorous. • D's head was covered under his blanket. • D was easily aroused and made full eye contact.	Dr. Juventino Lopez, Psychiatrist	10 RT 2523-24
8-24-2001	No side effects. Sleeping well. • D has not been put on clozaril. Rarely used in the jail. Have never started anyone on clozaril. In rare case where someone comes to jail already taking it, they will continue it. Would never consider prescribing it to someone who he did not consider to be seriously mentally ill.	Dr. Steven Johnson, Psychiatrist	10 RT 2324-26
8-27-2001	• D said he hears his father's voice cursing at him thru the TV. Still hearing voices but denied suicidal. • Guarded, but no notation about paranoia. • Otherwise, similar observations.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2368
8-28-2001	• D said he felt fine. • Voices better. • Depression better. • Otherwise, similar observations.	Dr. Ebtesam Khaled, Psychiatrist	10 RT 2368

DATE	OBSERVATION	OBSERVED BY	RT
8-30-2001	• Mood euthymic and affect flat. • Hygiene unkempt. • Speech was slow but clear. D had gone to court the day before.	Saundra King, Case Manager	10 RT 2421
9-4-2001	Saw D after he returned from court. • D was alert and coherent. • Mood was pleasant and affect appropriate	Saundra King, Case Manager	10 RT 2421-22
9-5-2001	• D's insight and judgment were poor. She has been involved in staffing or teaming of D in which diagnoses have been discussed. Aware that D has been diagnosed with schizo-affective disorder for some time. She participated in the team meetings that resulted in that conclusion. Agrees with it.	Dr. Teresa Farjalla, Psychiatrist	10 RT 2472

DECLARATION OF SERVICE

Re: *People v. John Samuel Ghobrial*

CA Supreme Ct. No.S105908
Orange County Superior Ct
No. 98NF0906

I, Tamara Reus, declare that I am over 18 years of age, and not a party to the within cause; my business address is 1111 Broadway, 10th Floor, Oakland, California 94607. I served a true copy of the attached:

APPELLANT'S REPLY BRIEF

on the following, by placing same in an envelope addressed as follows:

Collette C. Cavalier, Deputy Attorney General
Office of the Attorney General
110 W. "A' Street, Suite 11000
San Diego, CA 92101

Habeas Corpus Resource Center
303 2nd Street, Suite 400 South
San Francisco, CA 94107

John Samuel Ghobrial, # T-50232
(Appellant)
CSP-SQ
2-EB-66
San Quentin, CA 94974

Capital Case Clerk
Orange County Superior Court
Room L-100
700 Civic Center Drive West
Santa Ana, CA 9270

Each said envelope was then, on February 14, 2014, sealed and deposited in the United States Mail at Oakland, Alameda County, California, the county in which I am employed, with postage thereon fully prepaid.

I declare under penalty of perjury that the foregoing is true and correct.

Signed on February 14, 2014, at Oakland, California.

Tamara Reus
DECLARANT