No. 10-35798

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

CAL COBURN BROWN,

Petitioner,

v.

STEVEN SINCLAIR,

Respondent.

ON APPEAL FROM THE U.S. DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
The Honorable John C. Coughenour

SUPPLEMENTAL APPENDIX

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DECLARATION OF GEORGE W. WOODS, JR., M.D.

I, George W. Woods, M.D., declare as follows:

1. I was asked to review records and conduct an evaluation at the request of counsel representing Cal Coburn Brown to determine:

a. Whether Mr. Brown currently suffers from a mental disease or defect; and, if he does,

b. Is that mental disease being treated and/or managed with the use of medication;

c. Whether Mr. Brown suffered from that same mental disease at the time of his crime and trial; and, if so,

d. Whether, at the time of Mr. Brown's crime, the use of appropriate medications would have helped treat his mental illness.

2. In response, I offer the following opinions, which I hold to a reasonable degree of medical certainty:

a. Mr. Brown suffers from a serious mood disorder, namely bi-polar disorder;

b. Mr. Brown suffered from this mental disorder at the time of his crime;

c. In fact, Mr. Brown suffered from this mental disorder long before his crime;

d. Mr. Brown's clinical history reflects that he has responded well to medication, including lithium and depakote (valproic acid);

e. Significantly, for over 15 years the Washington Department of Corrections has been treating Mr. Brown with medication in order to control his mood disorder. The medical personnel at the Department of Corrections would not have instituted and continued this course of treatment for so many years if it was not medically appropriate and effective. As recently as July 16, 2010, Mr. Brown was diagnosed by a DOC physician, Dr. Grubb, as suffering from "bipolar disorder, more or less stable" and requiring medication.

f. Any claim that mood stabilizing drugs like lithium or depakote do not have or would not have a positive and stabilizing effect on Mr. Brown is unfounded and contrary to a voluminous amount of evidence;

g. To the contrary, from the time that Mr. Brown was first started on lithium (while in the Oregon prison system) until the present he has responded well to medications.

3. In sum, it is reasonably medically certain—indeed, from the available evidence it is certain—that Mr. Brown suffers now and suffered at the time of his crime from a serious mood disorder—one that has been successfully managed through the use of psychotropic medication.

QUALIFICATIONS

4. I am a licensed physician specializing in psychiatry and neuropsychiatry. I currently maintain a private practice focusing on neuropsychiatry, psychopharmacology, workplace safety, and forensic consultations.

5. I am a Fellow of the American Psychiatric Association, and a member of the California Psychiatric Association and the Northern California Psychiatric Association. I am also a member of the American Neuropsychiatric Association, the American Psychological Association, the American Society of Addiction Medicine and the Black Psychiatrists of America.

6. I am Secretary General of the International Academy of Law and Mental Health, where I am a member of the Scientific and Executive Committees. I also serve on the Advisory Board of the Center for African Peace and Conflict Resolution, California State University, Sacramento, California; and the Global Advisory Board for Humiliation and Dignity Studies, Trondheim University, Norway, and Columbia University, New York, New York.

7. I received my bachelor's degree from Westminster College in Salt Lake City, Utah, in 1969; and was awarded my medical degree from the University of Utah in 1977. I then completed a rotating medical internship at Alameda County Medical Center (Highland Hospital), in Oakland, California, which included internal medicine, surgery, orthopedic surgery, Emergency Medicine, and Obstetrics/Gynecology. In 1981, I completed my psychiatric residency at the Pacific Medical Center in San Francisco, California, where I served as Chief Resident my senior year. During my psychiatric residency, I pursued specialized neurological electives at Kaiser Permanente Hospital, Oakland, California. These electives consisted of extended, three month clerkships, in which I was assigned to the Neurology department, conducting neurological examinations and diagnosing neurological disorders, including movement disorders, headache disorders and central nervous dysfunctions, among others.

8. In 1982, I then participated in a National Institute of Mental Health/American Psychiatric Association Fellowship, during which I developed the first medical/psychiatric unit at Pacific Presbyterian Hospital. This unit administered to patients with either medical illnesses that had psychiatric manifestations or psychiatric patients with severe medical illness that could not be treated effectively on regular medical units. The focus of my Fellowship was Geriatric Psychopharmacology, the study of medication use with elderly populations. Geriatric Psychopharmacology, however, is an extremely valuable approach to the study of psychopharmacology in general. The medical/psychiatric/neurological/pharmacological training and experience I gained during this period proved relevant to other patient populations, particularly forensic populations, who experience a higher incidence and greater interaction of

drug, mental and neurocognitive problems than the general population. Following the completion of my Fellowship, I become the Director of Outpatient Geriatric Services for the San Francisco Family Services Agency. In that capacity, I conducted home visits with elderly patients who manifested psychiatric symptoms. Medical examinations and neurological intervention were frequently required.

9. From 1983 through 1990, I provided neuropsychiatric care at Crestwood Manor, Vallejo, California, a long-term psychiatric facility, dedicated to treating severely ill patients. Many of these patients came from state hospitals with atypical presentations and the diagnosis of mental retardation. Atypical presentation of psychiatric symptoms is common among forensic populations as well, particularly in areas that may lack community mental health services and or widespread availability of intensive treatment. Many of these patients Many of Crestwood's clients also had multiple, co-occurring disorders that required an understanding of pharmacology, neurology, and psychiatry, as noted by the American Neuropsychiatric Association.

10. From 1989 to 1994, I served as Clinical Director of the New Beginnings Chemical Dependency Program, an inpatient substance abuse detoxification and rehabilitation center housed at Doctors Hospital in Pinole, California. In 1994, I was appointed as Senior Consulting Addictionologist by Doctors Hospital, and oversaw complex withdrawals and detoxifications, and developed research protocols for the use of new medications for opiate withdrawals and sedation in the intensive care units. During my tenure, New Beginnings evolved into program that treated patients with what are called co-occurring disorders, meaning persons who have multiple psychiatric disorders – which is the norm, rather than unusual. Many persons with neuropsychiatric disorders attempt to self-medicate their symptoms.

11. The clinical facilities at Doctors Hospital afforded access to a Single Photon Emission Computerized Tomography (SPECT), which was utilized to determine brain function. My neuroimaging experience also includes the study of Magnetic Resonance Imagining (MRI) and Cathode Scans (CT), focusing on the different uses of structural imaging and functional imaging, like the SPECT and the Positive Emission Tomography (PET). From 1990 through 1995, I also served as the Coordinator and Psychiatric Consultant to the Insomnia Division of the Doctors Hospital Sleep Disorders Center. The assessment of sleep disorders, the evaluation of disorders in the architecture of sleep, is a seminal component of diagnosing medical illness and psychiatric disorders, and formulating appropriate pharmacological interventions. Sleep disruption is frequently the first overt symptom of an underlying medical, neurological, or psychiatric disorder. Disruption of sleep can be found in almost all psychiatric disorders. Impairment of normal sleep patterns is also often a contributing cause of and exacerbated by substance abuse.

12. In 1991, I was retained by Neurocare Corporation, a treatment facility in Concord, California, specializing in head-injury and neurological disorders, to work with neurologically impaired individuals who had psychiatric manifestations of their cognitive impairments. The

facility was a multidisciplinary environment in which the treatment team consisted of neurologists, neuropsychiatrists, neuropsychologists, and social workers. Treating physicians required an intimate knowledge of brain/behavior relationships in order to avoid misdiagnosis of atypical symptom presentations.

13. In 1992, I received my board certification in psychiatry by the American Board of Psychiatry and Neurology. I joined the faculty of the University of California, Davis, Medical School, Department of Psychiatry, in 1996. For the next four years, I taught Forensic Psychiatry and Criminal Responsibility to psychiatrists in the Postgraduate Forensic Fellowship.

14. In 1998, at the request of Kenyan and Tanzanian Medical Societies, I assisted their nations in developing mental health delivery services after the Kenyan/Tanzanian Embassy bombings. The initial focus of the project centered on the acute trauma suffered by survivors and families of those killed and injured in the bombing. Appropriate diagnosis and treatment for trauma survivors required assessment of and treatment for pre-existing psychiatric and neurologic disorders and an appreciation of the consequences of chronic exposure to trauma that predated the bombings.

15. I am currently an Adjunct Professor on the faculty of Morehouse School of Medicine, Department of Psychiatry, in Atlanta, Georgia, where I teach courses in Clinical Aspects of Forensic Psychiatry to third and fourth year residents. I am also on the Faculty of the Department of Educational Leadership and Public Policy, California State University, Sacramento, California.

16. My clinical private practice is based in Oakland, California. I have been qualified and testified as an expert in numerous civil and criminal cases in state and federal courts.

CLINICAL IMPRESSIONS AND SUPPORTING INFORMATION

17. Mr. Brown suffers from an Axis I mood disorder. He presents with a lengthy history that is completely consistent with bi-polar disorder.

18. The fact that Mr. Brown suffers from a serious mood disorder is, in my opinion, a fact that I would not expect a psychiatrist who reviewed Mr. Brown's history to dispute.

19. Ample anecdotal and congruent documentary evidence confirm that Mr. Brown's mental disorders and defects pre-existed the date of his offense and his trial. Because time is short, this declaration sets forth only some of the salient facts. I can, of course, expand this declaration if given more time or testify in support, if permitted by the Court.

20. Cal Brown was born April 16, 1958 near San Jose, California. The delivery was complicated. Reports of his infancy and early childhood describe Mr. Brown as a "very agitated baby" and as "out of bounds." Brown was seeing mental health counselors by the first or second

grade. Evidence suggests family members rejected him and that teachers observed aggression by the age of eight.

21. While in prison in 1985, mental health professionals diagnosed Brown as suffering from a "mood disorder" and prescribed lithium. As I understand it, Mr. Brown filed a lawsuit in order to compel treatment by state officials. In any event, Mr. Brown took lithium for about 5 or 6 months before his release from the Oregon State Prison. After his release, Mr. Brown left Oregon, failed to take his medication, and went to California, where he visited his sister (Heidi Tetz). Ms. Tetz's description of Mr. Brown is entirely consistent with mania ("wild," pressured speech, and "way out.")

22. After Mr. Brown was sentenced to death, a psychiatric evaluation was performed by Dr. Tim McBath at the Washington State Penitentiary (WSP). Dr. McBath's evaluation drew from several sources. Dr. McBath concluded: "Probable Bipolar Disorder with history of at least hypomanic and possibly manic episodes. Currently exhibiting hypomanic symptoms...Antisocial Personality Disorder." Dr. McBath's treatment plan included: (1) Lithium 300 mg (2) CBC Chem Profile (3) Doxepin 50 mg.

23. A second psychiatric evaluation of Mr. Brown was performed in 1994 at WSP by Dr. Carl Baum. The evaluation noted that Brown had been taking lithium, but further noted that he nevertheless "appears hypomanic." Dr. Baum's diagnosis included the notation: "Rule out Atypical Bipolar Affective Disorder" Dr. Baum's treatment plan appropriately suggested increased doses of lithium and the monitoring of his blood levels.

24. A third evaluation was conducted in 1995, by Dr. Ronald Page, a clinical psychologist employed by the State of Washington Department of Corrections. Dr. Page's evaluation confirms Brown's continued use of lithium and sinequan and acknowledges that under the current regiment Brown maintains fair emotional stability and sleeps satisfactorily. Further, Page's evaluation acknowledges that Brown's adaption to prison has been satisfactory, committing one infraction of stockpiling sinequan. Dr. Page concluded that the continued use of psychotropic drugs was warranted.

25. Dr. Page conducted a follow up evaluation on September 11, 1996. That evaluation confirms Brown's continued use of doxepin, depakote, and lithium, "which further mitigates his tendency to hypomania and short-fused reactivity to provocation. The Doxepin assists him with sleep as well." Additionally, the evaluation concludes that Brown continues to exhibit bipolar features and continued hypomania even on the current dosage of medication. This is significant because Mr. Brown continues to exhibit symptoms of hypomania today, including sleep disruption, irritability, pressured speech and flight of ideas.

26. Department of Corrections records further reveal that Mr. Brown has continued on mood stabilizing, psychotropic medications.

MEDICOLEGAL FINDINGS

27. I hold the foregoing opinions to a reasonable degree of medical certainty, and if called as a witness, I would and could testify truthfully to the opinions set forth above.

28. The evidence is overwhelming that Mr. Brown suffers from a serious mood disorder.

29. In addition to the numerous times that Mr. Brown has exhibited the signs and symptoms of mania (which are amply described in Mr. Brown's history), the simple fact that he has been treated with mood stabilizing, psychotropic medications for nearly two decades can only lead to the conclusion expressed above.

30. Asserting that Mr. Brown does not now or did not at the time of his crime and trial suffer from a serious mood disorder which can be effectively controlled through the proper use of medication is contrary to the overwhelming weight of the evidence.

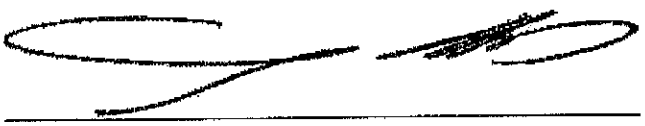
31. This is not only my opinion; it is the opinion of the psychologists and psychiatrists employed by the State of Washington who were charged with treating Mr. Brown while imprisoned since the early 1990's. It was also the opinion of the individual who treated Mr. Brown during his imprisonment in Oregon.

32. If anyone suggested at Mr. Brown's trial that he did not suffer from a serious mental disorder—one that could be effectively treated with psychotropic medications—history has clearly proven that suggestion to be completely incorrect, to a reasonable medical certainty.

33. Mr. Brown's medical disorder is such that, without medication during his entire period of imprisonment, there is a reasonable likelihood that, if not medicated by state actors, Mr. Brown would, again, suffer from symptoms of mood disruption of psychotic proportions which may impair his capacity to rationally understand the reason for his execution. I believe that a qualified physician familiar with Mr. Brown's diagnosis and history and involved in his treatment would confirm that likelihood. Indeed, I believe that the sole reason Mr. Brown is medicated is to control his mental disorder and prevent such decompensation. I have separately rendered opinions on that issue in another declaration signed this date.

I declare under the penalty of perjury under the laws of the State of California and the United States of America that the foregoing is true and correct and was executed on

September 3rd, 2010.



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

DECLARATION OF GEORGE W. WOODS, JR., M.D.

I, George W. Woods, M.D., declare as follows:

1. I am a licensed physician specializing in psychiatry and neuropsychiatry. I currently maintain a private practice focusing on neuropsychiatry, psychopharmacology, workplace safety, and forensic consultations. My *vitae* is attached.

2. As a forensic neurpsychiatrist, I am familiar with the legal standards relating to "incompetency" or "insanity" at the time of execution, as discussed in the leading federal and state cases.

3. I was asked to conduct an evaluation at the request of counsel representing Cal Coburn Brown to determine Mr. Brown's current mental state as it relates to his "competence" in light of his imminent execution date. Because time is short, I have set forth the essence of my opinion. If given more time, I could expand on this opinion orally or in writing.

4. I offer the following opinions, which I hold to a reasonable degree of medical certainty:

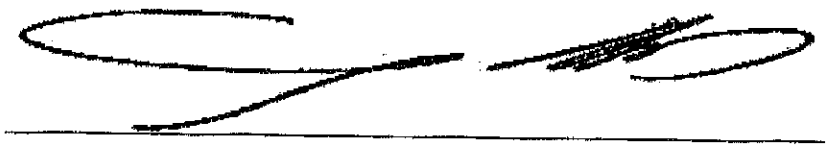
a. Mr. Brown suffers from a serious and severe mental disease or disorder. He has a lengthy history of bi-polar disorder. There are many instances in his life where he experienced mania. On several occasions, he has experienced psychosis.

b. But for the psychotropic medications that have been administered to Mr. Brown by the State of Washington Department of Corrections during his entire period of imprisonment, there is a reasonable likelihood that, if not medicated by state actors, Mr. Brown would, again, suffer from symptoms of mood disruption, including both mania and/or depression. Mr. Scott has experienced both depression and mania of psychotic proportions. These disruption of Mr. Brown's mood may impair his capacity to rationally understand the reason for his execution due to his severe mental illness.

c. Mr. Brown continues to have symptoms of hypomania. In my telephone interview, Mr. Brown described difficulty sleeping that keeps him awake several times per week. His speech continues to be pressured, and he was grandiose. These symptoms exist even when he has been medicated for decades.

I declare under the penalty of perjury under the laws of the State of California and the United States of America that the foregoing is true and correct and was executed on

__September 3rd, 2010.



_George W. Woods, Jr., M.D.