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IN THE SUPREME COURT OF FLORIDA

CASE NO. SC 13-717

TODD ZOMMER

Appellant,

v.

STATE OF FLORIDA

Appellee,

ON APPEAL FROM THE CIRCUIT COURT OF THE NINTH JUDICIAL CIRCUIT, IN AND FOR OSCEOLA COUNTY, FLORIDA

INITIAL BRIEF OF APPELLANT

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REQUEST FOR ORAL ARGUMENT

The resolution of the issues in this action will determine whether Mr.Zommer lives or dies. This Court has allowed oral argument in other capital cases in a similar procedural posture. A full opportunity to air the issues through oral argument would be appropriate in this case, given the seriousness of the claims involved and the fact that a life is at stake. Mr. Zommer accordingly requests that this Court permit oral argument.

CITATION KEY

The record on direct appeal of Mr. Zommer's trial shall be cited (FSC ROA Vol. # p.#). The record of Mr. Zommer's evidentiary hearing shall be cited as (PCR Vol. # p. #).

STATEMENT OF THE CASE AND FACTS

Procedural history

On May 17, 2005, a grand jury in and for Osceola County, Florida returned an indictment charging defendant, Todd Zommer, with the first degree murder of Lois Corrine Robinson. (FSC ROA Vol. I p. 19-20).

Defendant's case proceeded to a jury trial before the Honorable John M. Morgan on December 3-10, 2007. (FSC ROA Vol. XIX-XXXI). After the jury was selected, Mr. Zommer entered a plea of guilty to charges pending in other cases

consolidated for trial: Case Number 05CR-1078: grand theft of a motor vehicle, fleeing and attempting to elude a law enforcement officer, resisting an officer without violence, possession of drug paraphenalia; Case Number 05CR-1094: attempted felony murder, robbery, and aggravated battery with a deadly weapon; Case Number 05CR-2184; two counts of grand theft of a motor vehicle; Case Number 04CR-2982: uttering a forgery and grand theft; Case Number 05CR-2121: grand theft of a boat; and Case Number 05TC-1855: leaving the scene of an accident involving property damage. (FSC ROA Vol. XXVI p. 875-906).

Mr. Zommer maintained his not guilty plea on the first degree murder charge and proceeded to jury trial. After deliberating for thirty minutes, the jury returned a verdict of guilty on the charge of first degree murder. (FSC ROA Vol. XXXI p. 1439-45). The jury returned its advisory sentence by a vote of 10 to 2 recommending that the trial court impose the death penalty upon Mr. Zommer. (FSC ROA Vol. XII p. 1795, Vol. XXXVI p. 1943-44).

A Spencer hearing took place on January 4, 2008. The trial court sentenced Mr. Zommer to death. (FSC ROA Vol. XIII p. 1876). On direct appeal, Mr. Zommer was denied relief. See Zommer v. State 31 So.2d 733 (Fla. 2010). Mr. Zommer's petition for writ of certiorari was denied on October 8, 2010.

CCRC-Middle was appointed to represent Mr. Zommer by the Florida

Supreme Court on April 8, 2010. Mr. Zommer's 3.851 MOTION FOR POSTCONVICTION RELIEF was filed on September 19th, 2011. (PCR Vol. II p. 168-211). The postconviction court's ORDER GRANTING DEFENDANT'S MOTION FOR ACCEPTANCE OF DEFENDANT'S 3.851 MOTION FOR POST CONVICTION RELIEF AS TIMELY FILED NUNC PRO TUNC TO SEPTEMBER 20, 2011, was filed on 11/04/2011. (PCR Vol. II p. 232-233).

A competency hearing was held on June 15, 2012. (PCR Vol. III p. 408). The postconviction court found Mr. Zommer competent on 7/30/2012 (PCR Vol. III p. 423-427). An evidentiary hearing was held on January 30, 2013. The ORDER DENYING MOTION FOR 3.851 POST CONVICTION RELIEF was filed on April 1, 2013. (PCR Vol. IV p. 642-667). A timely notice of appeal was filed and this appeal follows.

Evidentiary Hearing Facts

Testimony of Michael Scott Maher M.D.

Michael Scott Maher is a physician and psychiatrist licensed to practice medicine in the state of Florida. (PCR Vol. XVIII p. 1562). Dr. Maher was qualified as an expert in forensic psychiatry by the postconviction court. (PCR Vol. XVIII p. 1566). Regarding the difference between psychologists and psychiatrists; Dr. Maher testified that a psychologist is more focused on the observation of

behavior and the cognitive and behavioral factors that may change that behavior. And a medical doctor is generally more focused on the etiology, the basic underlying physiological cause of behavior. (PCR vol. XVIII p. 1568).

Dr. Maher was retained to evaluate Mr. Zommer and was given a large amount of materials. He was provided with medical records, legal records associated with charges against him and his prosecution; corrections records, which include medical and legal records: records of where he was institutionalized, his behavior there; as well as his records of medical treatment in various facilities. Dr. Maher was also provided with various legal, proceedings which included testimony of other experts who had seen him in a variety of places and contexts; for example Dr. Danziger, who was the first professional who saw Mr. Zommer after his arrest on these murder charges.

He was also provided with medication records related to his treatment at the Florida State Prison, and medical records of his early childhood, where Mr. Zommer was diagnosed and treated at approximately age 12. Dr. Maher also interviewed Mr. Zommer's ex-wife. (PCR Vol. XVIII p. 1570-71). Dr. Maher was also provided with a taped interview given to the local media and a police interview. (PCR Vol. XVIII p. 1572).

Regarding the taped interviews, Dr. Maher testified as follows:

> Q. Just by looking at Mr. Zommer in these various tapes, which were introduced as evidence in court, uh, did Mr. Zommer appear to be under the influence of any kind of substance or any kind of drug shortly after his arrest?
> A. I - I couldn't conclude that without further explanation, based on simple observation of those.
> Q. Did you see his eyes, Doctor?
> A. What I mean by that is, he had an abnormal appearance, an appearance which was consistent with a psychotic manic condition and/or an agitated condition associated with stimulant drug use or withdrawal of stimulant drugs. So I wouldn't necessarily say that in my observation of those tapes I could narrow it down to one or the other, or both, but I did observe that and made the observation that it fit both characteristics. (PCR Vol XVIII p. 1572-73).

Dr. Maher testified that Dr. Danziger, 18 days after Zommer's arrest, noted that Mr. Zommer was having spells of both manic elation and depression. Furthermore, 10 days before Danziger saw Zommer, the jail psychiatrist had placed him on Depakine and Thorazine. (PCR Vol. XVIII p. 1573). Dr. Maher testified that Depakene is a drug that was originally used for the treatment of seizure disorders which could provide mood stabilization in individuals who had bipolar disorder. Thorazine is identified as a major antipsychotic or a major tranquilizer. It is a very heavy, strong side-effect-laden old drug that, is used essentially for chemical behavioral control in an individual who is in an agitated state.

Dr. Maher defined psychosis as a condition of abnormal brain functioning in which a person becomes disconnected with reality. It may manifest as having

hallucinations, having delusions; delusions being bizarre thoughts that are categorically false. It may also manifest in having what is described as a thought disorder; a thought disorder being a abnormal pattern of thinking which is contrary to logical common sense. Maher found that Mr. Zommer had psychotic tendencies. (PCR Vol. XVIII p. 1573-75). Dr. Maher also testified that Mr. Zommer was taking Sinequan and Atarax during his original trial. Sinequan is a major sedating antipsychotic drug, similar to Thorazine. (PCR Vol. XVIII p. 1576). Regarding Mr. Zommer's behavior during Maher's interview with Mr. Zommer, Dr. Maher testified in this manner:

> Q. Now, I know, sir, in the competency hearing, you testified that Mr. Zommer was contradictory, in that he told you he did not want to talk to you and then proceeded to talk for two and a half hours. Do you remember testifying to that at the competency hearing?
> A. I remember quite well testifying to that and I remember his – his behavior demonstrating that.
> Q. At the competency hearing?
> A. At – when I interviewed him.
> Q. Well, how about – how about the initial interview?
> A. That's what I'm talking about. So when I – I remember testifying to that and I remember it occurring.
> Q. Okay. Well, why would anybody be taking these antipsychotic drugs during the trial?
> A. Individuals with difficult to control bipolar disorder have periods of what are – is generally described as mania. Those periods of mania can, at times, be associated with positive feelings, reasonably quick-witted thinking and a significant degree of logical capacity.
>
> Unfortunately, individuals with bipolar disorder

who are not adequately treated, or who have more severe disorders, have manic episodes which are associated with, essentially, bad symptoms: Irritability, inability to think clearly, inability to follow through with their own thoughts, inability to control their impulses, inability to make decisions in a logical manner and follow through with them, even in the most basic common sense respect. For example, saying to a doctor who comes to visit you, I don't want to talk to you, I'm not gonna want to talk, I'm not gonna talk to you, and then talking a mile a minute for two and a half hours.

So the Sinequan, I suspect – I don't know the doctor who prescribed it, but it would be clinically understandable that a doctor would prescribe that so that he could essentially sit still and not disrupt the proceedings in court.

Q. When you interviewed Mr. Zommer at Union Correctional, did you note if he was or was not taking any medication?

A. When I interviewed him, he had been refusing medication. And he had been taking it very intermittently. It was my judgment that the medication was still having some effect on him but he was essentially, at that point, not taking regular medication.

Q. So this Sinequan and Atarax – you never did explain what Atarax was.

A. Atarax in – is sometimes described as a minor tranquilizer. Atarax is a medication which is more commonly used for people who have, uh, anxiety disorders – generalized anxiety disorders which may cause impairment, but may also be more mild and cause simple discomfort.

So he was taking that drug, as well as a much more substantial drug.

Q. Well, Doctor, are you – well, would this make him calmer. Would it control his bipolar behavior?

A. Yes. (PCR Vol. XVIII p. 1576-78)

Regarding Mr. Zommer's thought disorder and how that disorder affected the trial, Dr. Maher testified in this manner:

> Q. Doctor, are you aware that Mr. Zommer, during the trial, conversed with the courtroom bailiff and made admissions to the bailiff?
> A. Yes.
> MR. KILEY: And , Counsel, that's on FSC ROA, Volume XIX, page 65.
> BY MR. KILEY:
> Q. Were you aware, sir,that the bailiff became a witness against Mr. Zommer?
> A. Yes.
> Q. Would you say that would be a severe – severe – lapse in judgment on Mr. Zommer's part?
> A. Yes.
> Q. And –
> A. If I may? I think, to characterize my answer fully, I need to add that it is a severe lack of judgment in the context of a normal individual. It is, however, very typical of an individual who is in a manic condition; a manic condition which may be somewhat suppressed in its behavior by the medication he's on, but it's not fully suppressed. So those individuals act and behave in an impulsive, thoughtless manner, which does not consider the future consequences of their behavior.
>
> So, for example, a thought disorder would be the belief that I can just talk to whoever I want and it won't make any difference. And if a person is suffering from that kind of thought disorder, then it's the thought disorder, not so much the bad judgment, that leads them to blabber, if you will, or in colloquial terms, to a bailiff about things that could be contrary to his best interests. So it's not just a poor judgement, it's also the disorder of thinking that's occurring underneath that that's relevant.
> Q. Did you find that Mr. Zommer was somewhat defensive about his bipolar condition?

A. He was very – he was, and is, very defensive about it. (PCR Vol. XVIII p. 1579-80).

Regarding Mr. Zommer's attempts to deal with his mental illness, Dr. Maher testified in this manner:

Q. In other words, say, sir, he would deny he has a bipolar disorder?
A. Sometimes he has, yes. Sometimes he has acknowledged it.
Q. And would he, therefore, then, instead of explaining this murder as a result of a manic episode, would go out of his way to minimize his psychological or psychiatric impairment?
A. Yes.
Q. In other words, for Mr. Zommer to say, "I knew what I was doing and I loved every minute of it, " would that be consistent with Mr. Zommer's bipolar personality, if you will, sir?
A. Unfortunately, it is.
And, if I may, put that in context. Many, many individuals would rather be seen as foolish, stupid or bad, rather than mentally ill or crazy or mentally defective.
Q. That would be like the opposite if malingering, right? Someone who's not trying to fake mental illness but someone who's trying to hide mental illness?
A. Yes.
Q. And would you say Mr. Zommer falls into the latter category rather than the former?
A. He falls into the latter category, generally speaking, and he has since he was a teenager –
Q. And, sir –
A. – and continues to, long since this offense.
Q. How so, sir?
A. He – he continues to reject the notion that he is suffering from a serious mental illness that affects his thoughts, his behavior, his intelligence, his ability to make

decisions.

Q. How about exercise? Did you find that Mr. Zommer, after he refused medication, would exercise to the point of exhaustion?

A. Mr. Zommer does have some - presently, as of the time that I saw him in 2012, he had some ability to accept that he has a mental illness. He rejects the notion that treatment of that mental illness is necessary or desirable. He has, however, identified that he feels better and he thinks more clearly if he gets, uh, vigorous exercise on a regular basis and can exercise to the point of exhaustion.

And this is, indeed, a reasonable treatment intervention for an individual with bipolar disorder. It's not the only one that's necessary or desirable, but it is beneficial.

Q. And that's Mr. Zommer's treatment plan, not the prison psychiatrist's?

A. That is, indeed, Mr. Zommer's treatment plan, not the prison psychiatrist.

Q. And did you not just testify, sir, that Mr. Zommer was not taking or adhering to the plan prescribed to him by the prison psychiatrist?

A. I did, and that's correct. (PCR Vol. XVIII p. 1579-1582).

Dr. Maher then testified regarding Mr. Zommer's medical history in this manner:

Q. Doctor, can you tell the Court approximately when Mr.Zommer was first medicated for his disorder?

A. Twelve years old he was given an antipsychotic, Haldol, which is used to treat psychosis and agitated behavior.

Q. And - well, where was that done, in a medical institution, in an outpatient facility, or what?

A. It was done at a crisis stabilization facility - and I don't remember the name right offhand - after an incident of

agitated behavior. Uh, I think he also ran away at that time.
Q. Well, why would you give psychotropic medication – would you say – I'm sorry. You'd say Haldol is a pretty severe drug? It's a –
A. We don't have any more powerful drugs that we can use for that purpose. That's the most powerful drug – it's in the category of the most powerful drugs that we can use for that purpose
Q. Would you just give that to someone who is, to say, a truant or had a conduct disorder?
A. Absolutely not.

Dr. Maher also reviewed the records of the various placements of Mr.Zommer when he was a juvenile and testified that Mr. Zommer was prescribed psychotropic drugs in nearly all of his placements. (PCR Vol. XVIII p. 1584).

Dr. Maher testified that Zommer had symptoms of mania that were uncontrollable. It was an early presentation of bipolar disorder which usually does not present until late adolescence or early adulthood. (PCR Vol. XVIII p. 1584).

Dr. Maher opined that it is not unusual for someone who is diagnosed with bipolar disorder, and then taken off psychotropic medication, to medicate himself with alcohol and illegal drugs. He said it was very common. Maher opined that people get worse when they do this and they can develop a substance abuse problem. (PCR Vol. XVIII p. 1585-1587). It usually makes his bipolar condition worse. (PCR Vol. XVIII p. 1588).

Regarding the DSM IV and how it was used in Mr. Zommer's case the

following testimony was elicited at the evidentiary hearing:

> Q. Would you say that the DSM-IV is - that's a primary authority?
> A. I would.
> Q. And would you say that every - most mental health professionals rely on it?
> A. Yes.
> Q. Do you rely on it?
> A. I do.
> Q. Okay. In the DSM-IV, will you find diagnoses categorized into three axises, Axis I, Axis II and Axis III?
> A. Yes. There are also two other axises that are not diagnoses, per se.
> Q. What are they called, Axis IV and Axis V?
> A. Axis IV and Axis V. Axis IV is related to description of stressors in a person's life and Axis V is related to — or is described as a global assessment of function. So it is an attempt to describe, in a single number, the person's general ability to function in their life.
> Q. And when you say stressors, would it be - like, an Axis IV diagnosis for me would be that I'm standing here in open court, trying to make my case, and I may be under some considerable stress doing that?
> A. That might be a minor stress for you. It would be more things that are unusual for a person's life than a routine part of their life. So a divorce, car accident, an illness, loss of a job, those are things that would more typically be included on the Axis IV.
> Q. Okay. What is an Axis I?
> A. Axis I is the primary psychiatric diagnosis.
> Q. Is bipolar disorder an Axis I?
> A. It is.
> Q. Can you give me some other examples of Axis I diagnoses?
> A. Scizophrenia, primary depression, anxiety disorders, generalized anxiety disorders, phobias, other forms of

depression, dysthymic depression, adjustment disorder and depression. Um –
Q. PTSD?
A. Post-traumatic stress disorder, substance abuse disorders are also coded on Axis I.
Q. Okay. How about Axis II, what's that?
A. Axis II is reserved for what we call personality disorders; disorders of personality, development and identity.
Q. Can you give me some examples of that, sir?
A. Personality disorders would include dependent personality, narcissistic personality, antisocial personality and some others.
Q. You said conduct disorder?
A. Conduct disorder is a Axis I disorder appropriate to children.
Q. Okay. But – an Axis II diagnosis – narcissistic personality disorder, antisocial personality disorder – would you or would you not prescribe Haldol for the treatment of that?
A. No.
Q. Why not?
A. Because they're disorders of personality development. They're thought of and understood as disorders of personality development, not disorders of fundamental brain functioning or physiological medical functioning. So given that those disorders are not biological disorders, we would not focus on biological treatment to treat those disorders.
Q. I think I see what you mean. And I'm gonna try to paraphrase it and you correct me if I'm wrong. An Axis II diagnosis is "may, right? I mean, someone becomes a narcissist through his behavior over the years. An Axis I diagnosis is there's a chemical imbalance or some other physiological cause of the man's disorder.
A. That's very roughly correct. So an Axis II disorder, a personality disorder, is never made before 18 years of age, because – and often not until well after 18 years of age –

because the personality, in personality disorder, is the stable adult personality. And that's language directly from the diagnostic manual. So in order to be diagnosed with a personality disorder, it has to be a stable, adult personality characteristic. And that means it's something that a person grows into, develops into, um, manifests as a stable adult pattern of feeling, thought and behavior.

Q. So if you were to say that a child runs away from home and smokes marijuana and, uh - uh, is truant from school, therefore he is antisocial personality disorder, would that be a correct assessment of this man?

A. No. It's categorically a misuse of the Diagnostic and Statistical Manual. And the reason for that is, if we're talking about a child or adolescent, it absolutely is improper to characterize that as a stable collection of adult characteristics.

Q. Okay.

A. Now, it is true that children with that pattern of behavior are at higher risk for developing a personality disorder. But they're also at higher risk of developing a lot of other things and they may not develop a personality disorder. So it would be an improper, premature diagnosis to diagnose a person, who hasn't reached the stage of a stable adult personality, with a personality disorder.

Q. You testified before, though, that when Mr. Zommer was 12, he was being treated for bipolar disorder, an Axis I disorder; is that or is that not correct, sir?

A. In - he was, indeed, being treated for an Axis I disorder, and that's different than a personality disorder.

Q. Okay, sir. When a client - trained clinician, such as yourself, is confronted with a Axis I diagnosis, what do you do?

A. We attempt to understand why they're suffering from that. We attempt to understand any particular details, going beyond the basic diagnosis, the subtype or characteristics, which might trigger illness episodes in that disorder, and we develop a treatment plan. That

treatment plan generally includes consideration of biological treatment, usually medications, as well as social behavior and educational treatments.
Q. I'm a little confused, sir.
A. To make that simpler -
Q. Please?
A. - we prescribe a treatment plan which includes medication and talk therapy.
Q. Okay. So you - you'd say this man's bipolar?
A. Yes.
Q. And has been presenting bipolar symptoms since age 12?
A. Mr. Zommer, indeed, has bipolar disorder and preliminary presentation of that goes back to age 12.
Q. And that's why, at the children's home, they prescribed psychotropic medication to combat bipolar disorder, correct, sir?
A. That's correct, yes.
Q. Ultimately, what is your diagnosis of Mr. Zommer?
A. Bipolar disorder and substance abuse disorder.
Q. Okay. Bipolar disorder you said is Axis I, what is Axis II?
A. There is no Axis II diagnosis.
Q. For Mr. Zommer?
A. That's correct.
Q. What is substance abuse disorder?
A. It's an Axis I disorder. And the substance abuse is poly-substance abuse, focusing particularly on stimulants.
Q. And there's no doubt that Mr. Zommer abused stimulants, correct, sir?
A. I don't think there's any doubt in the record. And based on my interview with his wife - ex-wife and him, no, I don't think there's any doubts about that.
Q. He freely admits to using drugs?
A. He does.
Q. But denies medicating himself for his bipolar disorder?
A. He admits to using drugs. I don't think he freely

admits to the – to everything he knows about his drug use.
Q. Sir, in reviewing the records completely and listening to the witnesses, and having your evaluations, did you reach an opinion as to whether or not – I'm sorry. Do you recall –
MR. KILEY: Vol. XXXIV pages 1752, 1753.
BY MR. KILEY
Q. – trial counsel asked the following questions and the following answers were given by Dr. Jeffrey Danziger.
Question: In reviewing the records completely and listening to the witnesses, and having your evaluations, did you reach an opinion as to whether or not, on the day of the murder, April 9th, 2005, Todd Zommer was suffering from a mental illness?
Answer: In my opinion, he was suffering from a mental illness in April of 2005 at the time of this offense.
Question: And that mental illness was?
Answer: That mental illness, in my opinion, was bipolar disorder.
Question: Did you investigate the possibility of substance abuse as a secondary diagnosis of Mr. Zommer?
Answer: I did. Mr. –
Question: And – go ahead. I'm sorry.
Answer: yes, I did.
Question: And what did you base that diagnosis on?
Answer: That diagnosis was based on Mr. Zommer's self-report. But given what he admitted to me about his use, he was rather candid and did not appear to hold anything back about the substances he was using.
Question: The reports that you have read over the years, including reports of individuals that reportedly did drugs with him at or about the time of the – both before and after the time of the murder, did that help verify your diagnosis?
Answer: It did. And that diagnosis was that at or around April 2005, the major and most problematic drugs were two stimulants: Cocaine and crystal methamphetemine.

Q. Doctor, would that – do you, first of all, disagree with Dr. Danziger's opinion that on April 5th – or in April of 2005, Mr. Zommer was suffering from a mental illness of bipolar disorder?
A. First, let me say I'm very familiar with that testimony, and I've reviewed it in the context on many occasions, and I certainly do not disagree with his diagnosis of bipolar disorder.
Q. Well, can you tell me what a secondary diagnosis of substance abuse is? What would secondary be? Is that – you just said it wasn't an Axis II. What is a secondary diagnosis?
A. Generally, secondary means that – it doesn't mean simply a second diagnosis, it means a diagnosis which is in some way related to or caused by the primary diagnosis.

So what that diagnostic characterization would identify is that the diagnostician, the doctor, believes that the diagnosis is, or in part, caused by or related to the primary diagnosis.
Q. All right, sir. So because Mr. Zommer is bipolar, that led to his other diagnosis, his other Axis I diagnosis of poly-substance abuse; is that safe to say, sir?
A. That's the way I would use the terminology. I would defer to Dr. Danziger to understand his use of that terminology.
Q. Doctor, do you remember the following questions being asked and answered on Dr. Danziger's cross-examination –
MR. KILEY: In Volume XXXIV, page 1758 –
MR. LERNER: I'm gonna pose another objection. The claim is that they didn't – that the defense attorneys didn't present this evidence, yet he's reading extensively from the record that shows that they did present evidence of – of cocaine and drug use. So –
THE COURT: I think he's offering it –
MR. LERNER: – I'm not sure how this is relevant to prove this claim.
THE COURT: I think he's offering it for another purpose,

and I'll allow it. You may proceed.
MR.KILEY: Thank you, Your Honor.
BY MR. KILEY:
Q. Question: You did have an Axis II diagnosis. You did find he has an antisocial personality, correct?
Answer: Yes, I do.
Doctor, is that a valid diagnosis?
A. It's my strong opinion that that is not a correct diagnosis, no.
Q. Why is this diagnosis of antisocial personality not valid?
MR. LERNER: Your honor, again, I'm gonna object to the relevance of this. It has nothing to do with the claim, unless they're gone on to another claim. And they have made no claim on ineffective assistance of the psychological experts, it's ineffective assistance of the attorneys, who are entitled to rely on the opinion of the experts that they hire, by law.
THE COURT: Okay. Well, I understand your argument, but I'm –
MR. LERNER: how is this relevant?
THE COURT: – gonna allow the question. You may proceed.
MR. KILEY: Thank you.
MR. LERNER: Thank you, Your Honor.
BY MR. KILEY
Q. Why isn't it valid?
A. The diagnostic formulation that I believe is most strongly supported by the information and evidence available is bipolar disorder and substance abuse disorder. In order to make a valid personality disorder diagnosis, based on the criteria that are generally accepted in the field and the criteria explicitly enumerated in the DMS series, and DSM-IV in particular, one has to identify enduring personality qualities and characteristics during adulthood which are not caused by or directly related to an Axis I diagnosis.
Q. So, sir – let me just interrupt you, because I – quite

frankly, you're confusing me.
If you can attribute someone's behavior to an Axis I diagnosis, like bipolar disorder and substance abuse, is there any reason to go on to an Axis II disorder?
A. There's no proper diagnostic justification to add an Axis II disorder to further describe symptoms which are better or fully described in an Axis I diagnosis.
There are some other reasons here. I – I don't want to –
Q. Oh, please give 'em.
A. There are a number – the two primary criteria for antisocial personality disorder are behavioral criteria and relationship criteria.
Q. Well, let me get – I'll get to the two behavioral and...
A. Relationship.
Q. Relationship criteria, but does the – did you read the DSM-IV regarding antisocial personality disorder?
A. Many times.
Q. Does it say in the DSM-IV that he can't be antisocial personality if these incidents occur during a manic episode?
A. It doesn't have those exact words, but that is essentially the meaning of what I'm describing; that if symptoms are better or fully described by an Axis I diagnosis then they are not available to support an Axis II diagnosis then they are not available to support an Axis II diagnosis.
MR. KILEY: A moment please, Your Honor?
(Mr. Kiley conferring privately with co-counsel.)
BY MR. KILEY
Q. Doctor, regarding the antisocial personality disorder, the Diagnostic and Statistical Manual. Fourth Edition, defines antisocial personality, in Axis II, Cluster B, as : A, there is a pervasive pattern of disregard and for violation of the rights of others occurring since age 15, as indicated by three or more of the following.

So any diagnosis, sir, of Mr. Zommer's conduct at age 12, 13 or 14 – for example, fire-setting in the home, fights in the children's home – without – standing by

themselves, is not a proper diagnosis for – or not a proper criteria for Axis II antisocial personality disorder, right off the bat, right?

A. That is correct.

Q. Okay. Now,, three or more of the following: One, failure to conform to social norms with respect to lawful behavior, as indicated by repeatedly performing acts that are grounds for arrest.

Two, deception, indicated by repeatedly lying, uses of aliases or conning others for personal profit or pleasure.

Three, impulsiveness or failure to plan ahead.

Four, irritability and aggressiveness as indicated by repeated physical fights or assaults.

Reckless disregard for the safety of self or others.

Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.

Lack of remorse, as indicated by being indifferent or – rationalize having hurt, mistreated or stolen from another.

The individual is at least 18 years of age or other – or older.

There is evidence of conduct disorder with onset before age – 15 years old.

And, D, the occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode. Is that what it says?

A. Yes.

Q. Now, how does this apply to Mr. Zommer?

A. The criteria that you've read are accurate and, um, reasonably complete. There are additional criteria. And the – essentially, all of those criteria, up to D, he would meet the criteria for diagnosis of antisocial personality disorder.

But antisocial personality disorder also requires that those patterns of behavior, symptoms, manifestation of his life and behavior, are not being caused exclusively, as it states in criteria D, by manic episodes. It also requires

that they not be better explained by a variety of other conditions.

For example, if that pattern of behavior only occurs during the time the person is using, seeking or withdrawing from cocaine, and there's a significant period of their life that could be identified where they're not involved in cocaine use and those behaviors are not present, then that is very strong evidence contrary to the antisocial personality disorder diagnosis.

Q. For example, when you testified that Mr. Zommer was a very loving father and a loving, caring husband, he wasn't using drugs, so, therefore, he was a responsible adult, he was not irresponsible.

A. Indeed. There is an episode of his life, extending for a significant period of time, where he was married, engaged in a responsible family, married to a woman who was not, by any means, a pushover - wasn't easily exploited, wasn't easily tricked, wasn't abused by him, a person who wouldn't tolerate that kind of behavior and, in my judgment, would certainly have reported it to me when I interviewed her about it - where he did not demonstrate any of those antisocial personality characteristics.

What that says is those characteristics and those behaviors are related to his Axis I diagnosis. And they are not enduring, independent characteristics of his personality as an adult; rather, they are symptoms of illness identified in the Axis I disorder.

Q. Would you expect a psychiatrist to give a dual diagnosis such as that? (PCR Vol. XVIII p. 1590-1605).

An objection was lodged by the State and answered in this manner:

MR. LERNER: Your Honor, again, I'm gonna object. The -

MR. KILEY: Judge

MR. LERNER: - question-

THE COURT: Let him finish his objection, Mr. Kiley.

MR. LERNER: The question is about the psychiatrist. That's not the claim. We don't have a claim of ineffective assistance of psychiatric experts, we have a claim of ineffective assistance of counsel.
THE COURT: All right. Mr. Kiley.
MR. KILEY: Judge, that issue will be explored when they call counsel. But I think I'm allowed - or this man's allowed to make an opinion as to whether or not that was a valid psychiatric diagnosis.
THE COURT: And how does that relate to any of your three claims that we're here on?
MR. KILEY: Well, it relates to Claim III because it was an improper diagnosis. Mr. Sims -
THE COURT: Your Claim III is that the -
MR. KILEY: He failed to rehabilitate his own expert.
THE COURT: So how can he rehabilitate his expert by establishing his expert was wrong?
MR. KILEY: Well, by pointing out as -
THE COURT: That's not rehabilitation.
MR. KILEY: Well, sir, if I may, with all the other experts, Dr. Toomer, Dr. Tressler, the defense team - Miss Cashman did Dr. Tressler and Mr. Sims did Dr. Toomer - did answer or question these people the exact same way I'm questioning Dr. Maher. The only person he didn't do it to - and there lies the IAC - is Dr. Danziger. So, you know, I think I should be allowed to elicit an opinion that would - as Dr. Danziger testified, that this man's bipolar, this man was abusing drugs and he also has an antisocial personality disorder - I think I have the right to ask would an antisocial personality disorder be exhibiting some of the traits that Mr. Zommer was exhibiting.
THE COURT: Well, that doesn't go to your claim. What we're having here is simply testimony that is in - at this point, disagreeing with the testimony of the defense expert at trial. And it may relate to the claim that the defense didn't call the expert they should have, or something to that effect, but that's not the claim that's

made. The claim is that the - counsel failed to adequately rehabilitate his witness, referring to Dr. Danziger on redirection examination.

And it seems really strained to suggest that the - Dr. Danziger could have been rehabilitated by questioning showing that - or tending to show that his diagnosis was in error.

I'll allow some latitude. I don't want to cut you off from your theory here, but I - I really don't see where we're going at this point.

MR. KILEY: Very well, sir. I'll tie it up.

THE COURT: Very well.

BY MR. KILEY:

Q. Doctor, you were talking about Zommer not being antisocial personality if it occurred within a manic episode. Can you briefly tell the Court what other factors would lead you to believe that Mr. Zommer is not antisocial personality? Are [sic] there a two-prong test?

A. Yes, there is a two-prong test. And the two-prong test is related to, one, behavior. And essentially, antisocial personality disorder, under the proper circumstances, is made by the diagnosis of a pattern of rule-breaking behavior, usually criminal behavior, and a pattern of, um, exploitive, abusive - not necessarily physically, but exploitive, abusive, non-empathetic, non-caring relationships with others throughout the person's entire life, regardless of other circumstances. So there's a relationship criteria, where a person is nasty, selfish, exploitive, out for themself, doesn't care about anybody else and they break rules to get it. So those are the two criteria.

Q. Did you find Mr. Zommer had that?

A. No. He certainly had a pattern of breaking rules in a variety of different ways in his life, but related to the Axis I diagnoses. And there were times, during his drug use in particular, where he was certainly exploitive and selfish and - and disregarding of other people's feelings. But when he was not using drugs or under the

influence of a manic or other psychotic episode, particularly during this two and a half year period that can be identified when he was with - when he was married, he did not demonstrate those characteristics.
Q. How about when he was using drugs? Did he also exhibit some other behavior that would lead you to believe - for example, sharing his drugs?
A. Yes, he did, in fact. Even when he was using drugs he wasn't all bad, so to speak.
Q. How about providing other drug addicts with a place to live?
A. Yes, he had history of that. And that's typical of an individual who is hitting bottom because of drug use, but has better qualities. Which we can see in those bits and pieces of his drug use history and in the larger picture of his marriage. And all professionals, uh, addressing the big picture of diagnosis, um, are aware of that reality.
Q. And you read the testimony of - of Dr. Toomer, did you not, sir?
A. Yes.
Q. And - and did you not read the cross-examination of Dr. Toomer by the prosecution?
A. Yes, I did.
Q. And they pointed out that Mr. Zommer was exhibiting antisocial personality traits?
A. Yes.
Q. And then did you read the redirect of Dr. Toomer by Mr. Kelly Sims?
A. I did.
Q. And did Mr. Sims, or did not Mr. Sims, also elaborate what you just elaborated: Drug - antisocial personality drug addicts don't share their drugs?
A. Yes.
Q. Antisocial personality disorder drug addicts don't find other drug addicts a place to stay.
A. Yes.
Q. Antisocial personality disorder people do not stick up for weaker children.

A. Yes.
Q. All right.
A. It would be my opinion that the questioning of that witness brought out all of those issues in an effective manner.
Q. All right. Now, how about - do you recall Dr. Tressler, the second doctor?
A. I have to be careful about the names. I know the testimony but it's sometimes difficult to connect it with the names. Can yo tell me his credentials - remind me of his credentials?
Q. Dr. Tressler is a psychologist hired by the State.
A. All right. I think I do have the right information connected with Dr. Tressler.
Q. And he also diagnosed, right out [sic] of the bat, uh, antisocial personality disorder?
A. I recall that.
Q. And do you recall Miss Patricia Cashman impeaching Dr. Tressler with the criteria that Mr. Sims rehabilitated Mr. Toomer with?
A. Yes.
Q. And there was no attempt - you did read Dr. Danziger's testimony, right?
A. I did.
Q. Direct and cross, right?
A. Many times.
Q. Redirect, sir, right?
A. Yes.
Q. There was no attempt to rehabilitate this untrue statement - obviously untrue, as you testified - that Mr. Zommer does not have an antisocial personality disorder.
A. I did not see, in the line of questioning in that - on that expert, the questions that would have brought out these issues that I have testified about here today, no.
Q. In fact, there was no distinction made between antisocial personality disorder being an Axis II and Dr. Danziger finding an Axis I and, as you testified, if the

behavior can be adequately explained by an Axis I, a physiological disorder, like bipolar disorder, there's no reason to go on to Axis II.
A. No, I did not see that those questions were asked of Dr. Danziger.
Q. In fact, if the episode occurred in an episode of schizophrenia or mania, it is improper to attribute antisocial personality to the patient, or in this case, the defendant?
A. I agree.
MR. LERNER: Your honor, I'm gonna object. I think that's a restatement - a misstatement of what he has previously read in the record of the DSM-IV, which I think says that you can't diagnose that if it's exclusively during a manic period. So I - I think he's misstating facts he's already put in evidence in that -
THE COURT: Sustained.
MR. LERNER: - question and I'd object.
MR. KILEY: Sustained?
THE COURT: Sustained.
MR. KILEY: I have nothing further - well, one moment, Your Honor. May I consult with my colleagues? (PCR Vol. XVIII p. 1605-1612).

Testimony of Patricia Cashman

Patricia Cashman was appointed to represent Mr. Zommer at trial. (PCR Vol. XIX p. 1663). Regarding Mr. Zommer's pre-trial statements, Ms. Cashman gave the following testimony at the evidentiary hearing:

Q. And would you tell the Court the substance of your communication with Mr. Zommer.
Let me rephrase that. What did Mr. Zommer share with you concerning what he did in this homicide? How did he represent it to you?
A. Mr. Zommer never denied being involved in the

homicide. He – as he testified to in his trial, he did not believe it to be premeditated. He accepted responsibility for the victim's death.
Q. Let me – let me follow up about that. Mr. Zommer accepting responsibility – you were involved in his representation continuously from your appointment all the way through trial.
A. Yes.
Q. And in that, did you either personally become aware of or through discovery learn that Mr. Zommer confessed to law enforcement of his involvement?
A. Yes.
Q. That Mr. Zommer gave multiple news interviews in which he confessed to his involvement?
A. Yes.
Q. Were you aware that Mr. Zommer wrote letters to other persons that he knew –
A. Yes.
Q. – admitting his involvement? (PCR Vo. XIX p. 1664-65).

Further in her testimony, Ms. Cashman gave the following testimony at the evidentiary hearing:

Q. And would you tell us about the substance of those conversations concerning whether or not Mr. Zommer would testify at trial.
A. It was my recommendation to Mr. Zommer that it was not in his best interest to testify and to take the stand and that I didn't think he would make a very good witness. And Mr. Zommer was adamant that he wanted to testify. He wanted to take the stand and he wanted to explain to the jury what he'd done.
Q. Pretrial in this case you filed a motion to suppress his statements made to law enforcement.
A. Yes, sir.
Q. And did you discuss with Mr. Zommer that if he were

> to take the stand, that those - that evidence may be admissible?
> A. Yes. It would open the door and could be used to impeach him. (PCR Vol. XIX p. 1685).

Ms. Cashman was adamant in her assertion that Mr. Zommer never tried to say he didn't do it and always admitted to the homicide. (PCR Vol. XIX p. 1686).

Regarding the fact that Mr. Zommer was under the influence of psychotopic drugs at trial Ms. Cashman testified as follows:

> A. We were concerned how the jury would take that and that they would hold it against him, be scared of him, think he was crazy. I mean, Todd's behavior was, um... sort of (indicating) - he was a little bit on edge, as it was, while medicated. And if the jury saw that, they could be fearful that, if he's that way on meds, what if he gets off 'em? You know, what if this happens again? And you know, as a defense attorney you worry about jurors who are scared of the mentally ill, because there's no cure for it, all you can do is control it and ... (PCR Vol. XIX p.1687).

Ms. Cashman's fear of Zommer ever being released as perceived by the jury is reflected in her testimony:

> Q. And juror's attitudes or opinions concerning fear of somebody who has a mental health disorder if they're off their medications, as you said before, why - why was that so important in your thought process in deciding on how to strategically proceed with Mr. Zommer's trial?
> A. Because it is my opinion that a juror is likely to vote to kill a client that they're afraid someday might be released, someday might do it again, might be crazy ... (PCR Vol. XIX p. 1688).

On cross-examination, Miss Cashman answered the following question in this manner:

> BY MR. KILEY
> Q. Miss Cashman – okay. In light of Mr. Zommer's confession, which got suppressed, and Mr. Zommer's shout-out to the media, which you could not get suppressed, it was a – it was pretty certain that he would be convicted of this; do you not agree, madam?
> A. Yes. (PCR Vol. XIX p. 19950).

Ms. Cashman further clarified the point in this manner:

> Q. No, no. It's the former.
> And what I'm asking you, didn't you – didn't the defense team try to get as much evidence of drug use and mental instability in the guilt phase, knowing that this case was going to penalty phase?
> A. We never know anything for certain until the jury comes back, sir.
> Q. But, I mean –
> A. Certainly, you would be naive, as a defense attorney in a death penalty case, thinking that a jury's gonna find your client not guilty in a case with facts such as this. I think that that would have been probably poor foresight on my part to think a jury was gonna find him not guilty and so I didn't need to worry about a penalty phase happening. (PCR Vol. XIX p.1695-96).

Testimony of Toni Maloney

Toni Maloney was hired as an investigator to work as an investigator with Patricia Cashman and Kelly Sims concerning their representation of Mr. Zommer. (PCR Vol. XIX 1705). The relevant testimony regarding the claims raised in the

3.851 motion is as follows:

> Q. Were you aware of the fact that during jury selection – and this is in State's Exhibit 3 – were you aware that during jury selection Mr. Zommer made a statement to one of the court deputies concerning, why are we going through all this, everybody knows I'm guilty, or something to that effect?
> A. Yes.
> Q. The fact that Mr. Zommer made that statement, um, to a court deputy during his trial, did that stand out – based upon your interactions with Mr. Zommer and all your experience that you testified about, did that – does that strike you as being unusual for Todd, out of the ordinary for Todd, making those sorts of statements?
> A. No.
> Q. And why not?
> A. In my meetings with him, uh, he never denied his involvement in the case and he made statements like that fairly regularly to me.
> Q. And through your investigation, Mr .Zommer made these same types of statements to people, to all kinds of people?
> A. He did. He knew I was planning to travel to Connecticut to interview his family, and other people, um, and he was concerned about why are we going through all this. So that was kind of his theme.
> Q. And why would he share that as a concern? Did he explain that any further, his rationale behind that, why are we going through this?
> A. He never denied his involvement.(PCR Vol. XIX p. 1709-10).

Testimony of Kelly Sims

Kelly Sims represented Mr. Zommer at trial along with Patricia Cashman. (PCR Vol. XIX p. 1715). Mr. Sims testified that Mr. Zommer never denied

responsibility for the crime. (PCR Vol. XIX p. 1716).

Regarding the comments made by Zommer to the court deputy; Mr. Sims testified in this manner:

> Q. And did Mr. Zommer's comment to the court deputy, and the context and when it was given, did that - why did you not move for competency determination based upon his statement that he made to the court deputy during the trial?
> A. Two reasons. One is, that was classic Todd.
> Q. What do you mean by that?
> A. He would - he loved to shock. He wasn't shy about telling you the truth. Um, and he'd all along had that attitude. It was not a secret to him what he had or hadn't done and he fully expected the result that - that was achieved. So it wasn't surprising that he would say that. It was consistent with his behavior as I had noted it throughout my representation, and that which had been, un, adjudged to be competent via our experts.
>
> And the second part is, that's really a comment that many of our clients have made. What was surprising by that was that a court deputy would report it and then become a witness. 'Cause I know court deputies her those kinds of things, and that was not - that was the most surprising part about it, because many clients tend to say things they shouldn't say to people they shouldn't say it to. (PCR Vol. XIX p. 1725-26).

Regarding the decision not to request a special jury instruction that Mr. Zommer was under the influence of psychotropic drugs, Mr. Sims testified in this manner:

> Q. Okay. Now, during the trial itself, you and Miss Cashman made a decision to not seek a specific jury

instruction that the defendant was under the influence of psychotropic drugs.
A. Yes.
Q. Why did you – was that a strategic decision that you and Miss Cashman made?
A. It was.
Q. And what was the basis of that – what was your strategy in not seeking that?
A. Mine was simple, in that – and I told Trish, and I believed it – that Todd barely looked under control, and if we were to tell somebody that he's under control based on psychotropic medications, there might be great worry in the jury if Todd would ever get out or Todd would ever get into – um, get into a more free setting within the jails, you know, that would come with a life sentence as opposed to death. (PCR Vol. XIX p.1733-34).

Regarding the testimony of Dr. Danziger, Mr. Sims testified in the following manner:

Q. Well, let me just ask you, when you called Dr. Danziger to testify, why did you not elicit on direct examination the fact he diagnosed Mr. Zommer with antisocial personality disorder?
A. It didn't help us. It was in conflict with what our other expert testified to. And it was towards the end of the trial and – not that she would ever miss it, but – I was hoping there was a chance that Robin was tired, and this was a slam dunk, and Miss Wilkinson might miss that part, wasn't gonna bring it up, address it. Often I do a weak point and address it, but I didn't see a need to do that. I was kind of sliding and shucking and jiving at that point.
Q. Well, let me ask you, when you have a fact that is unfavorable to your theory of defense, your presentation of the case, is it sometimes a strategic decision to try to slide by or try to gloss over so that it doesn't become the focus?

MR. SHAKOOR: Objection, leading the witness.
THE COURT: Sustained.
BY MR. VESCIO:
Q. Well, let me ask you, when you have an unfavorable fact, is that something that you want pointed out?
A. Generally, no. The decision to be made is, is there anything - is the good that we can get out of the witness going to override the bad that's gonna come from the witness. And that was a strategic decision that we made. Dr. Danziger presents well; he's well-credentialed, he's known to both sides, he's worked for both sides, State and defense. He can explain himself magnificently. And the good we could get from him was worth the risk of the bad, especially when you had another doctor that said he wasn't diagnosed with that disorder - or did not diagnose with that disorder.
Q. And you're referring to Dr. Toomer?
A. Yes. (PCR Vol. XIX p. 1792-93).

Regarding the Rosales claim, the following testimony was elicited at the evidentiary hearing:

Q. You testified that you were afraid the jury might have concern that he would possibly, in the future, not be under the guidance of these medications and hurt someone else in the future.
A. Yes.
Q. But you would concede this case had pretty bad facts, right, with the confession and the nature of the crime?
A. Pretty - pretty bad is a fair assessment.
Q. So it was highly likely this case was gonna go to penalty phase, correct?
A. Right. (PCR Vol. XIX p. 1797).

Regarding Dr. Danziger's prior experience in trial, the following testimony was elicited at the evidentiary hearing:

Q. So it was definitely the defense side's idea to call Dr. Danziger?
A. Right. We called him. Or us. One of us or both of us.
Q. And you testified about Dr. Danziger's reputation of working both sides of the fence; is that a way to put it?
A. Yes.
Q. Were you aware that Dr. Danziger received a great deal of work from the State Attorney's Office in other cases?
A. Yes. He's been against me many times.
Q. More so than with you?
A. In death cases ... probably. And - and other felony cases, he's probably with me more than with them.
Q. Okay.
A. That's one of the reasons that I use him is because the State believes in him. And so if you get him early on, you might be able to work a - a resolution with the help of Dr. Danziger's insight.
Q. Okay. So you just testified in - more so in death cases, he's usually with the State?
A. Than with me, yes.
Q. Than with you. Okay. (PCR Vol. XIX p. 1800).

Regarding the rehabilitation of Dr. Danziger the following exchange took place:

Q. No. To clarify my question, you did not ask him anything that would -
A. Okay.
Q. - have elicited that; it came out in cross.
A. I didn't.
Q. Right.
A. I thought you said - you were asking me if I did, and I - I don't think I did, but I don't remember completely. It came out on cross, I believe.
Q. Yes.

And on redirect, you could have - could you not have questioned Dr. Danziger about some of those factors that you questioned Dr. Toomer about -i.e., helping out friends with living conditions, um, being a good father and a good husband - without directly challenging him on the word antisocial personality disorder? Could you have questioned him about Todd Zommer's behavior, without challenging his diagnosis in front of the jury in an explicit kind of way?
A. I - yeah, I could have. I could have just said, now, Doctor, let's talk about this and talk about that. You know, asked those same kind of questions - Which were pretty good, weren't they?
A. Yes, they were. (PCR Vol. XIX p. 1810).

Testimony of Dr. Jeffery Danziger

Dr. Jeffery Danziger testified at trial and in the evidentiary hearing. He was qualified as an expert in the area of forensic psychiatry. (PCR Vol. XIX p. 1743).

Regarding his diagnoses of Mr. Zommer; Danziger testified as follows:

Q. What were all the diagnoses that you had rendered concerning Mr. Zommer?
A. That he suffered from Bipolar Disorder Type I. And that when I had seen him most recently, actually during the quilt phase of the trial in December 2007, that he was at that point in a mixed phase, so the diagnosis would have been Bipolar Disorder Type I, most recent episode mixed. Also in Axis I was poly-substance dependence in remission in the controlled environment of the jail. And in Axis II, I diagnosed a personality disorder, or specifically, antisocial personality disorder.
Q. And is it appropriate for an individual to be diagnosed with an Axis I bipolar disorder and Axis II antisocial personality disorder?
A. They are not mutually exclusive. You can have both,

as no doubt would be brought out. If the antisocial behavior occurs only during manic or psychotic periods, you should not diagnose antisocial personality disorder. However, there is no reason you cannot be diagnosed, with both bipolar disorder, or any other Axis I diagnosis, and a personality disorder. They are not mutually exclusive.

Q. And is that based on your review of the diagnostic criteria as contained in the DSM-IV-Tr dealing with the antisocial personality disorder?

A. Yes. And, simply, I've been doing this for 30 years now. And, yes, all of my training and everything I've done since 1982, when I started as an intern in psychiatry, is that you can have simultaneous Axis I and Axis II diagnoses.

Q. I want to talk to you specifically about the foundation um, that you reviewed through the records, that you've previously testified in other hearings about, and your interactions with Mr. Zommer that led you to that diagnosis in Axis I and Axis II.

Concerning your diagnosis of the antisocial personality disorder, did you find specific instances of antisocial behavior that was not exclusively during the course of schizophrenia or manic episodes?

A. It's difficult, because you have to go back to episodes that may have happened in childhood or in the distant past, when nobody was around there to assess his mental state. (PCR Vol. XIX p. 1744-46).

Danziger's diagnosis of antisocial personality disorder was based on supposition and speculation as evidenced by the following testimony:

Q. And was there anything, based upon those records that you shared, that exhibited that all of those incidents were as the result of a – of a acute manic condition?

A. It's rare to see acute mania when somebody is 11 years old or younger. Nobody was doing a mental status

examination at the time, but it is rare to see overt mania with that sort of behavior. Particularly, A, at such a young age; B, such a repetitive pattern. Especially, it's highly unusual for somebody that age to have a legal problem with an ax or to repeatedly run away or to threaten family or engage in acts of vandalism. So those – those documented behaviors suggest a conduct disorder before the age of 15, meeting the criteria.

Then, looking into adulthood, we run into a similar issue where he has been to prison twice prior to this. I don't have his exact rap sheet or criminal record, but I think you related to me there were a number of arrests over the years. And, also there were likely other instances where he may have committed some act and was not caught. In his writings, Mr. Zommer talked about things like stealing a boat, breaking into a church, um, "so many burglaries;" so there were many offenses over the years. I think he said he was arrested eight, 10 times; there were likely others. There's no way to go back and say, well, at the time he did this burglary – 'cause I think he wrote there were so many of them – was he manic every time. Very difficult to say.

Q. And why is that difficult to say?

A. Because nobody was around to do a mental status examination at the time of a criminal offense that he may never have been caught or apprehended for. (PCR Vol. XIX p. 1747-48).

Danziger's concrete, observable evidence is detailed in this manner:

A. Again, I only saw him on the two occasions. Um, but I did obtain a history of multiple offenses, *long-standing problems*, (emphasis added) dating back to childhood, hitting all the major criteria for antisocial personality disorder.

Now, looking at some of the other behavior – if you look at people with bipolar disorder, their offenses tend to be affectively driven; they're angry and irritable, so they

> strike out and attack somebody. It's usually not well-planned, thought-out, purposeful aggression. Similarly, they may steal or embezzle because they feel entitled to the money; grandiose, it's mine, I'm gonna triple the money at the race track and pay it back. These are the sorts of problems my manic patients get into. (PCR Vol. XIX p.1750).

Given the fact that Todd Zommer was prescribed Haldol, a powerful anti-psychotic drug not used for "conduct disorders" at age 12, clearly the evidence suggests that Zommer's "long standing problems" were the result of bipolar disorder. The diagnosis of antisocial personality disorder was contrary to the DSM IV. Danziger gave the following testimony regarding Zommer's condition:

> Q. And you also indicated that he was fidgety?
> A. He was.
> Q. And he was restless?
> A. Yes.
> Q. And he talked about how his mood was high and he felt wonderful?
> A. Yes. Which I thought was not consistent with his current predicament.
> Q. That he 'd been arrested for murder.
> A. Yes. Normally people arrested for murder, 12 days later, do not report they're feeling great.
> Q. And at that time you felt, based upon your observations, that it was consistent with someone who's mentally ill?
> A. Yes.
> Q. And at that time you believed that the symptoms he presented looked very much like someone suffering from bipolar disorder?
> A. Yes.
> Q. And didn't Mr. Zommer tell you that throughout his

life he had spells of depression?
A. He did.
Q. And depression wouldn't support antisocial personality disorder, would it?
A. Well, certainly, many people I've seen over the years with antisocial personality disorder have also suffered from depression, so -
Q. But if a person were depressed, you wouldn't say, well, that person - that behavior - them being depressed, laying in bed, not getting out of bed, working, going to school, what have you - that's behavior of someone who is antisocialpersonality disorder?
A. No, that is different. But once again, they're not mutually exclusive. People that are antisocial personality disorder get depressed more often than the general population. But, no, what you are describing is core depressive symptoms, those are not the symptoms of antisocial personality disorder. (PCR Vol. XIX p. 1754-55).

The above testimony clearly details the flaw in Danziger's diagnosis. The DSM-IV-TR clearly states: D)" The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode." Zommer was on trial for the murder of Corrine Robinson; the condition of Zommer as stated by Danziger was that he was bipolar at the time of the offense.

Regarding the medications that Mr. Zommer was placed on and what said medications do was elicited in the following testimony:

Q. And did he tell you he was on medication when he was in the jail?
A. He was. Not only did he tell me, but before seeing him I had the opportunity to look at the MAR, which is the

medication sheet, and he had been placed on medications by the jail psychiatrist.
Q. What was he placed on?
A. He was placed on Depakene, 500 milligrams, twice daily; Thorazine, 25 in the morning and 50 at bedtime. It was a PRN, or as-needed, for Haldol. And then Naprosyn, 500 milligrams, twice daily.
Q. And what were each of those medications for?
A. Depakene is an antiseizure agent that also has mood stabilizing properties.

Thorazine, in higher doses - above 300 milligrams a day - is an antipsychotic, but at lower doses it's generally used more for behavioral control and sedation.

Haldol is an antipsychotic; given here PRN, the idea was, I presume, for any acute agitation or outbursts.

And Naprosyn is a non-steroidal anti-inflammatory. I believe he - during a period of apprehension he may have injured or hurt his shoulder, so he was taking it for shoulder pain.
Q. Now, you're a medical doctor, correct -
A. Yes.
Q. - as you testified?

Would you, um - would a medical doctor prescribe those drugs that you just mentioned to someone who - whom they're treating for antisocial personality disorder?
A. Those are not drugs used in antisocial personality disorder. There are no specific medications, FDA-approved, in antisocial personality disorder, nor are there any medications used as part of treatment. (PCR Vol. XIX p.1760-61).

Danziger ultimately detailed the reasons he diagnosed Zommer with bipolar disorder in this manner:

Q. And there's no doubt in your mind, definitively, that he suffered from bipolar disorder.
A. All of that is true. I looked at the jury, sitting in their

– I guess there were 14 or 15 of them, and I told them that.

And the reason I diagnosed bipolar was not just by his history, but the fact that as I saw him, on both occasions, he demonstrated symptoms suggestive of mania. On the second occasion I even did something called the Young Mania Rating Scale, which we use in psychiatric research to assess the level of mania. On both occasions I saw him – and it may have been just luck of the draw, I caught him on – during manic periods – he presented as a manic individual. Actually, the second time he was more of a mixed state, simultaneous depressive and manic symptoms.

But as confident as I can be in making a diagnosis – was I quite confident? Yes. I was very confident then, and remain now, that this is someone with a bipolar disorder diagnosis. (PCR Vol, XIX p. 1768-69)

SUMMARY OF THE ARGUMENTS

Issue I. Trial counsel was ineffective for failing to request a special jury instruction, informing them that Mr. Zommer was under the influence of psychotropic drugs during the trial. The appellant has a history of mental illness, including bipolar disorder. During the trial the appellant was ingesting the drugs Sinequan and Atarax. Established caselaw provides that the jury should have been informed that Mr. Zommer's attendance at trial was aided by medication for his mental condition. The lower court erred in denying this claim.

Issue II. During the penalty phase, trial counsel was ineffective for failing to properly rehabilitate his expert, Dr. J. Danziger, during redirect examination. Dr. Danziger diagnosed the appellant with bipolar disorder and explained such during

direct and cross examination. However, Dr. Danziger also diagnosed the appellant with antisocial personality disorder while the state was examining him during cross. The Diagnostic and Statistical Manual, fourth edition (DSM-IV-TR) defines antisocial personality disorder in a manner that does not fit Mr. Zommer's personality traits and history. Effective counsel would have properly rehabilitated Dr. Danziger's testimony with such information, as counsel effectively did with Dr. Toomer, under a similar trial posture. The lower court erred in denying this claim.

THE STANDARD OF REVIEW

All of the issues discussed in the brief, should be reviewed under the principles set forth by this Court in Stephens v. State, 748 So.2d 1028 (Fla. 1999), the claims are a mixed question of law and fact requiring de-novo review with deference only to the factual findings by the lower court.

ISSUE I

MR. ZOMMER WAS DENIED THE EFFECTIVE ASSISTANCE OF COUNSEL IN THE GUILT AND PENALTY PHASES OF HIS TRIAL IN VIOLATION OF THE SIXTH, EIGHTH, AND FOURTEENTH AMENDMENTS OF THE U.S. CONSTITUTION AND THE CORRESPONDING PROVISIONS OF THE FLORIDA CONSTITUTION, DUE TO COUNSEL'S FAILURE TO MAKE A MOTION TO INSTRUCT THE JURY THAT MR. ZOMMER WAS UNDER THE INFLUENCE OF PSYCHOTROPIC DRUGS DURING THE TRIAL.

The lower court denied this claim on March 28, 2013, filed it on April 1, 2013, and found that trial counsel exhibited "reasonable" trial strategy. (PCR Vol. IV p. 653-655). This was error.

The appellant has a substantial history of mental illness. He exhibited mental illness during the time of the offense, and particularly during the time of the trial. During the trial, Mr. Zommer was ingesting the medications Sinequan and Atarax. (FSC ROA Vol. XIX p. 50). During the course of the proceedings, Mr. Zommer was unable to control himself to the extent that he conversed with the courtroom bailiff and made extremely damaging admissions to him. (FSC ROA Vol. XIX p. 65). The bailiff became a witness against Mr. Zommer. Trial counsel was aware that Mr. Zommer was overly talkative and having difficulty controlling himself in the courtroom. (FSC ROA Vol. XIX p. 72).

Trial counsel was ineffective for not requesting that the jury be given an explanatory instruction that Mr. Zommer's attendance at trial was aided by medication for a mental condition. Regarding a proposed jury instruction that Mr. Zommer was under the influence of psychotopic drugs at trial, Attorney Patricia A. Cashman testified during the evidentiary hearing as follows:

> A. We were concerned how the jury would take that and that they would hold it against him, be scared of him, think

> he was crazy. I mean, Todd's behavior was, um... sort of (indicating) - he was a little bit on edge, as it was, while medicated. And if the jury saw that, they could be fearful that, if he's that way on meds, what if he gets off 'em? You know, what if this happens again? And you know, as a defense attorney you worry about jurors who are scared of the mentally ill, because there's no cure for it, all you can do is control it and ... (PCR Vol. XIX p.1687).

Ms. Cashman's irrational fear of Zommer ever being released as perceived by the jury, is reflected in her testimony here:

> BY THE STATE
> Q. And juror's attitudes or opinions concerning fear of somebody who has a mental health disorder if they're off their medications, as you said before, why - why was that so important in your thought process in deciding on how to strategically proceed with Mr. Zommer's trial?
> A. Because it is my opinion that a juror is likely to vote to kill a client that they're afraid someday might be released, someday might do it again, might be crazy ... (PCR Vol. XIX p. 1688).

On cross-examination, Miss Cashman answered the following question in this manner:

> BY MR. KILEY
> Q. Miss Cashman - okay. In light of Mr. Zommer's confession, which got suppressed, and Mr. Zommer's shout-out to the media, which you could not get suppressed, it was a - it was pretty certain that he would be convicted of this; do you not agree, madam?
> A. Yes. (PCR Vol. XIX p. 19950

Ms. Cashman further clarified the point in this manner:

> Q. No, no. It's the former.
>
> And what I'm asking you, didn't you – didn't the defense team try to get as much evidence of drug use and mental instability in the guilt phase, knowing that this case was going to penalty phase?
>
> A. We never know anything for certain until the jury comes back, sir.
>
> Q. But, I mean –
>
> A. Certainly, you would be naive, as a defense attorney in a death penalty case, thinking that a jury's gonna find your client not guilty in a case with facts such as this. I think that that would have been probably poor foresight on my part to think a jury was gonna find him not guilty and so I didn't need to worry about a penalty phase happening. (PCR Vol. XIX p.1695-96).

The testimony cited above shows the contradictory nature of how trial counsel was fully aware that the facts in this case provided the inevitability of a penalty phase proceedings. Yet, trial counsel puts forth the unreasonable and irrational concept that a juror would fear that Mr. Zommer may some day be released from prison. Why would a juror be more likely to "kill" a "crazy" convicted First Degree murderer out of fear that he may be released from prison, when established law and the jury instructions otherwise mandate a term of life in prison with no possibility of parole? Trial counsel was ineffective.

Kelly Sims also represented Mr. Zommer at trial along with Patricia Cashman. (PCR Vol. XIX p. 1715). Mr. Sims admitted that Mr. Zommer never denied responsibility for the crime. (PCR Vol. XIX p. 1716). Regarding the

decision not to request a special jury instruction that Mr. Zommer was under the influence of psychotropic drugs, Mr. Sims testified in this manner:

> BY MR. SHAKOOR
> Q.You testified that you were afraid the jury might have concern that he would possibly, in the future, not be under the guidance of these medications and hurt someone else in the future.
> A. Yes.
> Q. But you would concede this case had pretty bad facts, right, with the confession and the nature of the crime?
> A. Pretty - pretty bad is a fair assessment.
> Q. So it was highly likely this case was gonna go to penalty phase, correct?
> A. Right. (PCR Vol. XIX p. 1797).

Like Attorney Cashman, Mr. Sims was aware that it was inevitable at best, or "highly likely" at worst, that this case was going to penalty phase. There is nothing "reasonable" about trial counsel's strategy in failing to inform the jury that Mr. Zommer's presence at trial was aided with the use of psychotropic medication. Mr. Zommer was a very ill man who was prone to fits of rage with an agitated and rambling disposition. This was caused in part by Mr. Zommer's bipolar disorder, which would have been fully explained to the jury during penalty phase. In failing to request the jury instruction that Mr. Zommer was taking psychotropic medication during trial, counsel provided ineffective assistance.

Legal Argument

The Court in Rosales v. State, 547 So.2d 221 (1989) on page 222 held:

> With respect to appellant's first point, we find that the trial court erred in denying appellant's motion to instruct the jury that the appellant was on psychotropic medication at the time of trial. The defense argued that rule 3.215 (c)(2), Florida Rules of Criminal Procedure, requires the giving of an explanatory instruction when a defendant's attendance at trial is aided by medication for a mental condition. The trial court denied the motion. The rule however is quite specific:
>
> If the defendant proceeds to trial with the aid of medication for a mental or emotional condition, upon motion of defense counsel, the jury shall, at the beginning of the trial and in charge to the jury, be given explanatory instructions regarding such medication. (Emphasis added). Fla. R.Crim.P. 3.215 (c)(2)). (formerly Fla. R.Crim.P. 3.214 (c)(2)). The trial court's failure to instruct the jury requires reversal.

In the case at bar, Mr. Zommer was prejudiced by the fact that two mental health experts testified that Mr. Zommer suffered from mental problems, episodes of mania, depression, and drug usage, the effects of which Mr. Zommer was suffering during his trial. The mental illness actually affected his trial when Mr. Zommer made spontaneous statements to the bailiff who later testified against Mr. Zommer.

The jury did not observe Mr. Zommer's true demeanor due to the fact that Mr. Zommer was taking psychotropic drugs. To the jury, the testimony of the experts was in direct contrast to what they were observing with their own eyes. Without an explanation as to why Mr. Zommer was not as disturbed as the expert had so

testified, the jury could have discounted the expert testimony. Effective counsel would have requested the explanatory instruction. Then, the jury would have understood the extent of Mr. Zommer's mental disability. In light of the holding in Rosales, Mr. Zommer contends that if a denial of Mr. Zommer's motion for an explanatory instruction at time of trial requires reversal, then failure of trial counsel to make such a motion can rightfully be construed as ineffective assistance of counsel.

ISSUE II

MR. ZOMMER WAS DENIED THE EFFECTIVE ASSISTANCE OF COUNSEL AT THE SENTENCING PHASE OF HIS CAPITAL TRIAL, IN VIOLATION OF THE SIXTH, EIGHTH, AND FOURTEENTH AMENDMENTS TO THE CONSTITUTION OF THE UNITED STATES AND THE CORRESPONDING PROVISIONS OF THE FLORIDA CONSTITUTION. TRIAL COUNSEL FAILED TO ADEQUATELY REHABILITATE HIS WITNESS ON RE-DIRECT EXAMINATION. TRIAL COUNSEL'S PERFORMANCE WAS DEFICIENT, AND AS A RESULT THE DEATH SENTENCE IS UNRELIABLE.

The lower court denied this claim on March 28, 2013, filed it on April 1, 2013, found that trial counsel was not "deficient", and that Mr. Zommer failed to demonstrate prejudice. (PCR Vol. IV p. 659-662). This was error. During the penalty phase of the trial, defense expert Dr. Jethro Toomer was rehabilitated during

redirect examination, after the state insinuated through him during cross that Mr. Zommer had antisocial personality disorder. (FSC ROA Vol. XXXIII p. 1599-1607).

Trial counsel effectively elicited from Dr. Toomer that Zommer spent over two years happily married, drug free, with no criminal activity and was concerned about the welfare of others. (FSC ROA Vol. XXXIII p. 1600-1601). Also on redirect, Dr. Toomer opined that an antisocial personality would not, as Zommer did, give others the "shirt off his back" and reach out protect children in trouble. (FSC ROA Vol. XXXIII p. 1602). Overall, trial counsel did an outstanding job of getting Dr. Toomer to opine that it is completely inappropriate to diagnose the appellant with antisocial personality disorder. (FSC ROA Vol. XXXIII p. 1599-1607). At trial, Dr. J. Danziger had examined Mr. Zommer and gave the following testimony:

> And yet when I saw him and asked how he was feeling, his response was I feel great, which was very unusual. His speech was very, very rapid, pressured, difficult to interrupt. He was fidgety and restless. He talked about how his mood was just high and he felt wonderful. He was extremely irritable, referenced that he was getting by without much sleep, that his thoughts were racing. And to me as a psychiatrist, I said this doesn't fit someone in this situation facing death penalty level murder charges. I wouldn't expect him to feel great, be talking fast and have racing thoughts. And in my opinion at that time was this is consistent with someone who is mentally ill.

Q. Did you have an idea of what that mental illness might be at that point?
A. I did. And the symptoms he presented with looked very much like someone suffering from Bipolar Disorder. And indeed the next thing I did was inquire as to any past history consistent with Bipolar Disorder. (FSC ROA Vol. XXXIV p. 1741)

Further on in Dr. Danziger's testimony, the following testimony occurred:

A. Well, the first thing that I did even before looking at documents was ask Mr. Zommer about a history of episodes of both mania and depression. First thing you do is get the history from the person themselves.

And what he told me was that throughout his life he had had spells of depression. During those times, *he would not talk to anyone, he would isolate himself,* (emphasis added) he would leave jobs. Those were times where he would increase his use of drugs. He would think of dying. He reported that there was no joy or pleasure in things, feelings of worthlessness and erratic sleep and appetite.

He also referenced two episodes in his life where he attempted suicide, once at the age of 14 by cutting his wrist and once at the age of 22 where he tried to drive his car into a tree but missed and then decided not to. So he related to me episodes of depression in his past.

And then he also related to me previous episodes of mania. And during the manic episodes, he said his thoughts race as if they're going 100 miles an hour. He says he can't function well, he talks fast, people tell him to slow down, he's talking too fast, and his energy is markedly increased, so much to the point where he can't sit still.

During those times his mood may be euphoric, elated and extremely high to the point where he's displaying silliness, yet at other times he may be extremely irritable and aggressive and violent during these

episodes.

He also reported sometimes thinking he even had special powers, sonic boom powers, I-beam powers.

Basically what he described to me was consistent with what I was seeing with my own eyes; that he was having spells of both manic elation and depression.

Now, it's important to note that when I saw him it was 18 days after his arrest. One of the things had I seen him, say, one day after his arrest, I might have wondered am I seeing the effect of some drugs he was taking, because people who take drugs, it can mimic mental illness. But he was 18 days in the jail by the time I saw him. So any effects of drugs he was taking would have worn off by the nearly three weeks he was in there.

And what I saw was someone who had a mood that was completely incongruent and it make no sense with the predicament that he was in describing a history of both mania and depression. (FSC ROA Vol. XXXIV p.1742-1743).

Dr. Danziger further documented Mr. Zommer's history of mental illness in this manner:

> And what I saw was someone who had a mood that was completely incongruent and it made no sense with the predicament that he was in describing a history of both mania and depression. Now, at that point after I left the jail, I asked his attorneys to try to get me some records to see if there were other signs or symptoms of prior mental illness.
>
> What was of note, however, is that while I was at the jail on April 30th, 2005, I had the opportunity to look at the jail medical record file, He had been in jail back in April of 2004, a year before this charge, on an unrelated incident. And at that time he was placed on a medication called Desipramine, which is an antidepressant. The Desipramine was stopped because it made him agitated

and hyper. So apparently he was depressed. They put him on an antidepressant, ad it revved him up. This is what happens to people with Bipolar disorder.

If you have a depression and Bipolar disorder with the highs and low, it looks just like someone who only has depressive episodes. If you treat someone who has recurring depression with an antidepressant, you generally get them better. Someone who has bipolar disorder with the highs and lows, you give them an antidepressant, that can make things worse. It can blow them up into a manic episode.

And what's fascinating to me was that a year before they put him on an antidepressant and he couldn't stay on it because it make him too hyper and speeded up. Fascinating to me.

The other thing was just ten days before I saw him the jail psychiatrist placed him on Depakine, a mood-stabilizing agent, and Thorazine, which is an antipsychotic.

Now, the jail psychiatrist did not diagnose Bipolar disorder, but placed him on medications designed to control someone who is agitated, hyper, and restless.

So these were the things I learned at the jail; that you have someone with - showing symptoms of a full-blown manic episode in the jail, completely out of character with his situation, who gives me a good past history for episodes of mania, episodes of severe depression, the jail medical record file fits. And then I call the attorney and said, please get me some records, let's see if there's things we can find that may fit with this.

Q. So although you had this preliminary confirmation, you were not going to rely on the self-report of Mr. Todd Zommer in this, correct?

A. That's correct. It's important as a psychiatrist, particularly in a forensic case, you have to talk to the person. But you can't only rely on them. It's important to try to get other sources of information.

Q. So did you get some other sources of information?

A. I did.
Q. And what were they?
A. The first source of information I got was from back in 1982. And these were records from the Riverview Hospital, which came through the State of Connecticut's Department of Children and Family Services.

And what they showed was that there were serious problems with his behavior, that he had been getting into all sorts of trouble; as stated before, fire-setting, some aggressive and violent behavior, running away.

But in addition he had quite a bit of insomnia and trouble sleeping. It's important to me. People who purely have behavioral problems don't necessarily have trouble sleeping. The severe insomnia is more suggestive of someone with early stirrings of a mood disorder.

They thought he had attention deficit disorder, so they placed him on Ritalin. But Ritalin didn't work, which suggests it wasn't attention deficit disorder. There was something else going on.

Essentially, problems with depression were noted as well as impulsivity and increased motor behavior.

Now, in looking at those records from '82, how do I look back on that now? They're noting problems with his mood, problems with controlling his behavior, problems with sleep, problems with all sorts of impulsivity and getting himself into terrible trouble.

They didn't think it was hyperactivity, and a medicine for hyperactivity didn't work. So even though he had conduct problems and signs of a conduct disorder, they noted problems with emotion.

Looking at what I see of Todd Zommer now at his current age, those in my opinion represented early stirrings of a mood disorder.

I then looked at records from the Children's Center and essentially he was there off and on from 1983 to 1987, over a four-year period. And what they described is again problems with sleep, sometimes staying up three, four hours before he could fall asleep; impulsivity; acting silly;

unable to stay in his seat. They even said in May of 1987 it was tough to find enough activities to burn off his energy

Now, this is someone they did not think had attention deficit disorder, because he was fairly bright, he could sit and concentrate and focus on his school work. They didn't think he had A. D. H. D.

They even treated him there with Haldol. Haldol is actually an antipsychotic medication that also has some mood stabilizing properties. *And what's interesting to note is that we don't give Haldol to people for conduct problems; it doesn't work.* (Emphasis added).

It's interesting that the Haldol seemed to calm him down and he functioned better. The problem was he gained so much weight on it that they took him off it. And they also thought it make him lethargic. It's unfortunate they didn't try something else.

What's fascinating to me, looking back 20 years, is that they put him on a medicine that had mood-stabilizing properties and he seemed to do better, which makes me think as a psychiatrist this isn't just someone who's a bad egg or a conduct problem. These are clues showing early stirrings of a primary mental illness, which then expressed themselves later in his life.

Q. Did you access any other information to help you reach an opinion in this matter?

A. Other information was helpful. I learned from the records from the Riverview Hospital that he may have suffered a period of anoxia at birth. Anoxia means deprivation of oxygen. This is a very bad thing for babies at birth. So there was the possibility of some sort of damage or insult to his brain at birth. (FSC ROA Vol. XXXIV p. 1743-1748).

Dr. Danziger also examined Mr. Zommer in the middle of the guilt phase of the trial and based upon Mr. Zommer's unusual behavior, gave him additional tests.

Dr. Danziger was able to ultimately diagnose Mr. Zommer's primary mental illness as evidenced by the following testimony:

> When I met with Mr. Zommer on December 9th, obviously the situation is one that would be a distressing one for anyone. He was about to stand trial for first degree murder.
> Q. And I'm sorry to interrupt you, but he was actually in the middle of his trial.
> A. Oh, he was in the middle of his trial.
> Q. He had already been through a week of it.
> A. I didn't realize that. So actually he was in the middle of what for any person would obviously be a tremendously stressful, frightening, disturbing event.
>
> When I met with him, he again showed signs and symptoms of mania. And I'm looking at my notes here, his speech was fast and had what we call a push. His speech seemed to be pushed out of his mouth and was difficult to interrupt. He tended to talk somewhat excessively, overly detailed. His thoughts were racing. He was getting by on about five hours of sleep per night. It was hard for him to restrain being irritable. He described his energy as always up.
>
> However, he also simultaneously had some depressive symptoms. He said that even though he was so revved up and accelerated, he still felt sad and guilty and felt low at times. This is what we call a mixed state, where a individual has simultaneous features of both depression and mania.
>
> So in Mr. Zommer's case, he was bouncing around in his seat, he was irritable, symptoms of mania, but he also felt sad and guilty and blue. I call that a mixed Bipolar state.
>
> I also conducted a rating scale for mania, one of the things I do up in Maitland is we do research on mania. We're looking for new and better drugs to treat Bipolar disorder. And we have a rating scale for mania that we

use in our research, called the Young Mania Rating Scale.

Well, I brought a copy with me and I basically did one there at the jail. And what it showed was someone with a score of 24. And what that means is they're showing rather obvious signs and symptoms of mania.

So what I saw in December 2007 was consistent with what I saw on April of 2005, consistent with what the records revealed to me that I reviewed, and consistent with someone who suffers from, in my opinion as a psychiatrist, Bipolar Disorder.

Q. In reviewing the records completely and listening to the witnesses and having your evaluations, did you reach an opinion as to whether or not on the day of the murder, April 9, 2005, Todd Zommer was suffering from a mental illness?

A. In my opinion he was suffering from a mental illness in April of 2005 at the time of this offense.

Q. And that mental illness was?

A. That mental illness, in my opinion, was bipolar disorder. (FSC ROA Vol. XXXIV p. 1751- 1753).

It is clear from the above cited testimony that Todd Zommer, as a child, at the time of the offense, and during trial was clearly suffering from bipolar disorder. Dr. Danziger summed up his diagnosis as follows:

Q. Dr. Danziger, final question for me. Not an excuse but an explanation if you can, how does Todd Zommer end up in that orange jumpsuit today where he is?

A. As a forensic psychiatrist, I view this as a perfect storm. Everything bad that could have happened did. You have someone who has a loaded family history for substance abuse. You have someone who may have suffered some oxygen deprivation at birth. He grew up in a family where he witnessed domestic violence. He was physically abused, according to the records. There's reports that he may have been sexually abused by older

youths at one of the facilities that he was at. And he grew up in a home, according to the testimony today, with no love, emotional warmth, someone who was emotionally neglected.

All of this was very fertile ground for the development of mental illness and substance abuse.

We saw early in his life, looking at the records I did, early stirrings of a mental disorder. It was not attention deficit disorder. It was treated with Haldol, an antipsychotic. He had features of hyperactivity, impulsivity, aggression, uncontrolled conduct problems, all of these things together as he grew up and grew older.

As he got into his adulthood, the mental illness showed itself in its full form. Unfortunately, like many individuals with Bipolar disorder, he resorted to drugs; not surprising, given, A, Bipolar disorder and, B, his loaded family history.

The combination of crystal meth, cocaine, Bipolar disorder, all of these things together, combined with everything in his early life: a perfect, terrible storm.

The crystal meth and cocaine, acting in concert with the Bipolar disorder, put him in a state where he was, in my opinion, actively mentally ill, yet acting in a cruel, heartless fashion and committing this terrible crime. Not an excuse, but in my opinion it explains how Todd Zommer got to this point.

And again I base that on what I saw 18 days after his arrest, two and a half years after his arrest. This is someone with a primary mental illness, worsened by the substances, with a terrible, sad history, who did a terrible, terrible thing.

But in my opinion, the history of mental illness – and his active mental illness does play a role – it was there, in my opinion, at the time of the offense and something for consideration.

MR.SIMS: Thank you, Doctor. (FSC ROA Vol. XXXIV p. 1756-1758).

Yet, on cross-examination, the following questions were asked and answered:

> Q. However, you did have an Axis II diagnosis. You did find that he has an antisocial personality, correct?
> A. Yes, I do. (FSC ROA Vol. XXXIV p. 1758-1759)

Regarding antisocial personality disorder; the Diagnostic ans Statistical Manual, fourth edition (DSM-IV-TR) defines antisocial personality disorder (in Axis II Cluster B) as:

A) There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three or more of the following:

1. failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest.
2. deception, as indicated by repeatedly lying, use of aliases, or conning others for personal profit or pleasure;
3. Impulsiveness or failure to plan ahead;
4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults;
5. Reckless disregard for safety of self or others
6 consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations;
7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another;

B) The individual is at least age 18 years.
C) There is evidence of conduct disorder with onset before age 15 years.
D) *The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode.* (Emphasis added.)

Trial counsel was ineffective by failing to impeach/rehabilitate his expert with this information cited above. Mr. Zommer had been diagnosed bipolar by Dr. Danziger; the onset being from childhood and continued having episodes during the trial. Effective counsel would have at least opened the DSM-IV and discovered that Zommer did not fit the criteria for anti-social personality disorder. Effective counsel could have and should have rehabilitated Danziger in the same manner in which he rehabilitated Dr. Toomer regarding the contention that Zommer had anti-social personality disorder. (FSC ROA Vol. XXXIII p. 1599-1607).

The prejudice is clear, in that the State made a point in their penalty phase closing arguments, to highlight the testimony pertaining to Zommer having antisocial personality disorder:

> Mr. Zommer had years of acting out, throwing forks at his mother, threatening his mother, setting fires, getting in fights. And for a woman, an alcoholic mother, even a normal mother, at some point, could not control his behavior. Mr. Zommer has conduct disorders as a child, antisocial personality, which is your basic sociopath. And what Dr. Danzinger did tell you is that's not considered a major mental illness, along with Dr. Tressler.(FSC ROA Vol. XXXVI p. 1879).

Due to trial counsel's failure to rehabilitate Dr. Danzinger, you see that the State used the defense team's own expert against Mr. Zommer in closing argument. That is simply ineffective assistance of counsel. Later, in the trial court's

sentencing Order, the damaging mis-diagnosis of antisocial personality disorder was again addressed in a manner that demonstrates the prejudicial effect of trial counsel's ineffectiveness:

> Dr. Tressler and Dr. Danzinger both testified that the defendant has an antisocial personality disorder. As noted, the jail psychiatrists, whose records the experts relied upon, in part, also had diagnosed the defendant with antisocial personality disorder. (FSC ROA Vol. XIII p. 1869).

Had trial counsel rehabilitated Dr. Danzinger in the same manner as he did Dr. Toomer, there wouldn't have been such a devastating prejudicial impact, as both the State and the sentencing Judge, used the defendant's own expert against him, in support of a damaging diagnosis of antisocial personality disorder.

Michael Scott Maher is a physician and psychiatrist licensed to practice medicine in the state of Florida. (PCR Vol. XVIII p. 1562). Dr. Maher was qualified as an expert in forensic psychiatry by the postconviction court. (PCR Vol. XVIII p. 1566). Regarding the difference between psychologists and psychiatrists; Dr. Maher testified that a psychologist is more focused on the observation of behavior and the cognitive and behavioral factors that may change that behavior. And a medical doctor is generally more focused on the etiology, the basic underlying physiological cause of behavior. (PCR vol. XVIII p. 1568).

Dr. Maher was retained to evaluate Mr. Zommer and was given a large

amount of materials. He was provided with medical records, legal records associated with charges against him and his prosecution; corrections records, which include medical and legal records: records of where he was institutionalized, his behavior there; as well as his records of medical treatment in various facilities. Dr. Maher was also provided with various legal documents, transcripts, which included testimony of other experts who had seen him in a variety of places and contexts; for example Dr. Danziger, who was the first professional who saw Mr. Zommer after his arrest on these murder charges. He was also provided with medication records related to his treatment at the Florida State Prison, and medical records of his early childhood, where Mr. Zommer was diagnosed and treated at approximately age 12. Dr. Maher also interviewed Mr. Zommer's ex-wife. (PCR Vol. XVIII p. 1570-71). Dr. Maher was also provided with a taped interview given to the local media and a police interview. (PCR Vol. XVIII p. 1572).

Regarding the DSM IV and how it was used in Mr. Zommer's case the following testimony was elicited at the evidentiary hearing:

> Q. Would you say that the DSM-IV is - that's a primary authority?
> A. I would.
> Q. And would you say that every - most mental health professionals rely on it?
> A. Yes.
> Q. Do you rely on it?
> A. I do.

Q. Okay. In the DSM-IV, will you find diagnoses categorized into three axises, Axis I, Axis II and Axis III?
A. Yes. There are also two other axises that are not diagnoses, per se.
Q. What are they called, Axis IV and Axis V?
A. Axis IV and Axis V. Axis IV is related to description of stressors in a person's life and Axis V is related to — or is described as a global assessment of function. So it is an attempt to describe, in a single number, the person 's general ability to function in their life.
Q. And when you say stressors, would it be - like, an Axis IV diagnosis for me would be that I'm standing here in open court, trying to make my case, and I may be under some considerable stress doing that?
A. That might be a minor stress for you. It would be more things that are unusual for a person's life than a routine part of their life. So a divorce, car accident, an illness, loss of a job, those are things that would more typically be included on the Axis IV.
Q. Okay. What is an Axis I?
A. Axis I is the primary psychiatric diagnosis.
Q. Is bipolar disorder an Axis I?
A. It is.
Q. Can you give me some other examples of Axis I diagnoses?
A. Scizophrenia, primary depression, anxiety disorders, generalized anxiety disorders, phobias, othe forms of depression, dysthymic depression, adjustment disorder and depression. Um -
Q. PTSD?
A. Post-traumatic stress disorder, substance abuse disorders are also coded on Axis I.
Q. Okay. How about Axis II, what's that?
A. Axis II is reserved for what we call personality disorders; disorders of personality, development and identity.
Q. Can you give me some examples of that, sir?

A. Personality disorders would include dependent personality, narcissistic personality, antisocial personality and some others.
Q. You said conduct disorder?
A. Conduct disorder is an Axis I disorder appropriate to children.
Q. Okay. But - an Axis II diagnosis - narcissistic personality disorder, antisocial personality disorder - would you or would you not prescribe Haldol for the treatment of that?
A. No.
Q. Why not?
A. Because they're disorders of personality development. They're thought of and understood as disorders of personality development, not disorders of fundamental brain functioning or physiological medical functioning. So given that those disorders are not biological disorders, we would not focus on biological treatment to treat those disorders.

Q. I think I see what you mean. And I'm gonna try to paraphrase it and you correct me if I'm wrong. An Axis II diagnosis is "may, right? I mean, someone becomes a narcissist through his behavior over the years. An Axis I diagnosis is there's a chemical imbalance or some other physiological cause of the man's disorder.
A. That's very roughly correct. So an Axis II disorder, a personality disorder, is never made before 18 years of age, because - and often not until well after 18 years of age - because the personality, in personality disorder, is the stable adult personality. And that's language directly from the diagnostic manual. So in order to be diagnosed with a personality disorder, it has to be a stable, adult personality characteristic. And that means it's something that a person grows into, develops into, um, manifests as a stable adult pattern of feeling, thought and behavior.
Q. So if you were to say that a child runs away from home and smokes marijuana and, uh - uh, is truant from

school, therefore he is antisocial personality disorder, would that be a correct assessment of this man?
A. No. It's categorically a misuse of the Diagnostic and Statistical Manual. And the reason for that is, if we're talking about a child or adolescent, it absolutely is improper to characterize that as a stable collection of adult characteristics.
Q. Okay.
A. Now, it is true that children with that pattern of behavior are at higher risk for developing a personality disorder. But they're also at higher risk of developing a lot of other things and they may not develop a personality disorder. So it would be an improper, premature diagnosis to diagnose a person, who hasn't reached the stage of a stable adult personality, with a personality disorder.
Q. You testified before, though, that when Mr. Zommer was 12, he was being treated for bipolar disorder, an Axis I disorder; is that or is that not correct, sir?
A. In - he was, indeed, being treated for an Axis I disorder, and that's different than a personality disorder.
Q. Okay, sir. When a client - trained clinician, such as yourself, is confronted with a Axis I diagnosis, what do you do?
A. We attempt to understand why they're suffering from that. We attempt to understand any particular details, going beyond the basic diagnosis, the subtype or characteristics, which might trigger illness episodes in that disorder, and we develop a treatment plan. That treatment plan generally includes consideration of biological treatment, usually medications, as well as social behavior and educational treatments.
Q. I'm a little confused, sir.
A. To make that simpler -
Q. Please?
A. - we prescribe a treatment plan which includes medication and talk therapy.
Q. Okay. So you - you'd say this man's bipolar?

A. Yes.
Q. And has been presenting bipolar symptoms since age 12?
A. Mr. Zommer, indeed, has bipolar disorder and preliminary presentation of that goes back to age 12.
Q. And that's why, at the children's home, they prescribed psychotropic medication to combat bipolar disorder, correct, sir?
A. That's correct, yes.
Q. Ultimately, what is your diagnosis of Mr. Zommer?
A. Bipolar disorder and substance abuse disorder.
Q. Okay. Bipolar disorder you said is Axis I, what is Axis II?
A. There is no Axis II diagnosis.
Q. For Mr. Zommer?
A. That's correct.
Q. What is substance abuse disorder?
A. It's an axis I disorder. And the substance abuse is poly-substance abuse, focusing particularly on stimulants.
Q. And there's no doubt that Mr. Zommer abused stimulants, correct, sir?
A. I don't think there's any doubt in the record. And based on my interview with his wife – ex-wife and him, no, I don't think there's any doubts about that.
Q. He freely admits to using drugs?
A. He does.
Q. But denies medicating himself for his bipolar disorder?
A. He admits to using drugs. I don't think he freely admits to the – to everything he knows about his drug use.
Q. Sir, in reviewing the records completely and listening to the witnesses, and having your evaluations, did you reach an opinion as to whether or not – I'm sorry. Do you recall –
MR. KILEY: Vol. XXXIV pages 1752, 1753.
BY MR. KILEY
Q. – trial counsel asked the following questions and the following answers were given by Dr. Jeffrey Danziger.

Question: In reviewing the records completely and listening to the witnesses, and having your evaluations, did you reach an opinion as to whether or not, on the day of the murder, April 9th, 2005, Todd Zommer was suffering from a mental illness?
Answer: In my opinion, he was suffering from a mental illness in April of 2005 at the time of this offense.
Question: And that mental illness was?
Answer: That mental illness, in my opinion, was bipolar disorder.
Question: Did you investigate the possibility of substance abuse as a secondary diagnosis of Mr. Zommer?
Answer: I did. Mr. -
Question: And - go ahead. I'm sorry.
Answer: yes, I did.
Question: And what did you base that diagnosis on?
Answer: That diagnosis was based on Mr. Zommer's self-report. But given what he admitted to me about his use, he was rather candid and did not appear to hold anything back about the substances he was using.
Question: The reports that you have read over the years, including reports of individuals that reportedly did drugs with him at or about the time of the - both before and after the time of the murder, did that help verify your diagnosis?
Answer: It did. And that diagnosis was that at or around April 2005, the major and most problematic drugs were two stimulants: Cocaine and crystal methamphetemine.
Q. Doctor, would that - do you, first of all, disagree with Dr. Danziger's opinion that on April 5th - or in April of 2005, Mr. Zommer was suffering from a mental illness of bipolar disorder?
A. First, let me say I'm very familiar with that testimony, and I've reviewed it in the context on many occasions, and I certainly do not disagree with his diagnosis of bipolar disorder.
Q. Well, can you tell me what a secondary diagnosis of substance abuse is? What would secondary be? Is that

– you just said it wasn't an Axis II. What is a secondary diagnosis?
A. Generally, secondary means that – it doesn't mean simply a second diagnosis, it means a diagnosis which is in some way related to or caused by the primary diagnosis.

So what that diagnostic characterization would identify is that the diagnostician, the doctor, believes that the diagnosis is, or in part, caused by or related to the primary diagnosis.
Q. All right, sir. So because Mr. Zommer is bipolar, that led to his other diagnosis, his other Axis I diagnosis of poly-substance abuse; is that safe to say, sir?
A. That's the way I would use the terminology. I would defer to Dr. Danziger to understand his use of that terminology.
Q. Doctor, do you remember the following questions being asked and answered on Dr. Danziger's cross-examination –

MR. KILEY: In Volume XXXIV, page 1758 –

MR. LERNER: I'm gonna pose another objection. The claim is that they didn't – that the defense attorneys didn't present this evidence, yet he's reading extensively from the record that shows that they did present evidence of – of cocaine and drug use. So –

THE COURT: I think he's offering it –

MR. LERNER: – I'm not sure how this is relevant to prove this claim.

THE COURT: I think he's offering it for another purpose, and I'll allow it. You may proceed.

MR.KILEY: Thank you, Your Honor.
BY MR. KILEY:
Q. Question: You did have an Axis II diagnosis. You did find he has an antisocial personality, correct?

Answer: Yes, I do.

Doctor, is that a valid diagnosis?
A. It's my strong opinion that that is not a correct diagnosis, no.

Q. Why is this diagnosis of antisocial personality not valid?
MR. LERNER: Your honor, again, I'm gonna object to the relevance of this. It has nothing to do with the claim, unless they're gone on to another claim. And they have made no claim on ineffective assistance of the psychological experts, it's ineffective assistance of the attorneys, who are entitled to rely on the opinion of the experts that they hire, by law.
THE COURT: Okay. Well, I understand your argument, but I'm -
MR. LERNER: how is this relevant?
THE COURT: - gonna allow the question. You may proceed.
MR. KILEY: Thank you.
MR. LERNER: Thank you, Your Honor.
BY MR. KILEY
Q. Why isn't it valid?
A. The diagnostic formulation that I believe is most strongly supported by the information and evidence available is bipolar disorder and substance abuse disorder.

In order to make a valid personality disorder diagnosis, based on the criteria that are generally accepted in the field and the criteria explicitly enumerated in the DMS series, and DSM-IV in particular, one has to identify enduring personality qualities and characteristics during adulthood which are not caused by or directly related to an Axis I diagnosis.
Q. So, sir - let me just interrupt you, because I - quite frankly, you're confusing me.

If you can attribute someone's behavior to an Axis I diagnosis, like bipolar disorder and substance abuse, is there any reason to go on to an Axis II disorder?
A. There's no proper diagnostic justification to add an Axis II disorder to further describe symptoms which are better or fully described in an Axis I diagnosis.

There are some other reasons here. I - I don't

want to –
Q. Oh, please give 'em.
A. There are a number – the two primary criteria for antisocial personality disorder are behavioral criteria and relationship criteria.
Q. Well, let me get – I'll get to the two behavioral and...
A. Relationship.
Q. Relationship criteria, but does the – did you read the DSM-IV regarding antisocial personality disorder?
A. Many times.
Q. Does it say in the DSM-IV that he can't be antisocial personality if these incidents occur during a manic episode?
A. It doesn't have those exact words, but that is essentially the meaning of what I'm describing; that if symptoms are better or fully described by an Axis I diagnosis then they are not available to support an Axis II diagnosis then they are not available to support an Axis II diagnosis.
MR. KILEY: A moment please, Your Honor?
(Mr. Kiley conferring privately with co-counsel.)
BY MR. KILEY
Q. Doctor, regarding the antisocial personality disorder, the Diagnostic and Statistical Manual. Fourth Edition, defines antisocial personality, in Axis II, Cluster B, as : A, there is a pervasive pattern of disregard and for violation of the rights of others occurring since age 15, as indicated by three or more of the following.

So any diagnosis, sir, of Mr. Zommer's conduct at age 12, 13 or 14 – for example, fire-setting in the home, fights in the children's home – without – standing by themselves, is not a proper diagnosis for – or not a proper criteria for Axis II antisocial personality disorder, right off the bat, right?
A. That is correct.
Q. Okay. Now,, three or more of the following: One, failure to conform to social norms with respect to lawful behavior, as indicated by repeatedly performing acts that

showing that - or tending to show that his diagnosis was in error.
I'll allow some latitude. I don't want to cut you off from your theory here, but I - I really don't see where we're going at this point.
MR. KILEY: Very well, sir. I'll tie it up.
THE COURT: Very well.
BY MR. KILEY:
Q. Doctor, you were talking about Zommer not being antisocial personality if it occurred within a manic episode. Can you briefly tell the Court what other factors would lead you to believe that Mr. Zommer is not antisocial personality? Are [sic] there a two-prong test?
A. Yes, there is a two-prong test. And the two-prong test is related to, one, behavior. And essentially, antisocial personality disorder, under the proper circumstances, is made by the diagnosis of a pattern of rule-breaking behavior, usually criminal behavior, and a pattern of, um, exploitive, abusive - not necessarily physically, but exploitive, abusive, non-empathetic, non-caring relationships with others throughout the person's entire life, regardless of other circumstances. So there's a relationship criteria, where a person is nasty, selfish, exploitive, out for themself, doesn't care about anybody else and they break rules to get it. So those are the two criteria.
Q. Did you find Mr. Zommer had that?
A. No. He certainly had a pattern of breaking rules in a variety of different ways in his life, but related to the Axis I diagnoses. And there were times, during his drug use in particular, where he was certainly exploitive and selfish and - and disregarding of other people's feelings. But when he was not using drugs or under the influence of a manic or other psychotic episode, particularly during this two and a half year period that can be identified when he was with - when he was married, he did not demonstrate those characteristics.
Q. How about when he was using drugs? Did he also

exhibit some other behavior that would lead you to believe – for example, sharing his drugs?
A. Yes, he did, in fact. Even when he was using drugs he wasn't all bad, so to speak.
Q. How about providing other drug addicts with a place to live?
A. Yes, he had history of that. And that's typical of an individual who is hitting bottom because of drug use, but has better qualities. Which we can see in those bits and pieces of his drug use history and in the larger picture of his marriage. And all professionals, uh, addressing the big picture of diagnosis, um, are aware of that reality.
Q. And you read the testimony of – of Dr. Toomer, did you not, sir?
A. Yes.
Q. And – and did you not read the cross-examination of Dr. Toomer by the prosecution?
A. Yes, I did.
Q. And they pointed out that Mr. Zommer was exhibiting antisocial personality traits?
A. Yes.
Q. And then did you read the redirect of Dr. Toomer by Mr. Kelly Sims?
A. I did.
Q. And did Mr. Sims, or did not Mr. Sims, also elaborate what you just elaborated: Drug – antisocial personality drug addicts don't share their drugs?
A. Yes.
Q. Antisocial personality disorder drug addicts don't find other drug addicts a place to stay.
A. Yes.
Q. Antisocial personality disorder people do not stick up for weaker children.
A. Yes.
Q. All right.
A. It would be my opinion that the questioning of that witness brought out all of those issues in an effective manner.

Q. All right. Now, how about - do you recall Dr. Tressler, the second doctor?
A. I have to be careful about the names. I know the testimony but it's sometimes difficult to connect it with the names. Can yo tell me his credentials - remind me of his credentials?
Q. Dr. Tressler is a psychologist hired by the State.
A. All right. I think I do have the right information connected with Dr. Tressler.
Q. And he also diagnosed, right out [sic] of the bat, uh, antisocial personality disorder?
A. I recall that.
Q. And do you recall Miss Patricia Cashman impeaching Dr. Tressler with the criteria that Mr. Sims rehabilitated Mr. Toomer with?
A. Yes.
Q. And there was no attempt - you did read Dr. Danziger's testimony, right?
A. I did.
Q. Direct and cross, right?
A. Many times.
Q. Redirect, sir, right?
A. Yes.
Q. There was no attempt to rehabilitate this untrue statement - obviously untrue, as you testified - that Mr. Zommer does not have an antisocial personality disorder.
A. I did not see, in the line of questioning in that - on that expert, the questions that would have brought out these issues that I have testified about here today, no.
Q. In fact, there was no distinction made between antisocial personality disorder being an Axis II and Dr. Danziger finding an Axis I and, as you testified, if the behavior can be adequately explained by an Axis I, a physiological disorder, like bipolar disorder, there's no reason to go on to Axis II.
A. No, I did not see that those questions were asked of Dr. Danziger. (PCR Vol. XVIII p. 1605-1612).

The above cited testimony clearly explains how Mr. Zommer is a sufferer of bipolar disorder, and that antisocial personality disorder is an improper diagnosis. Dr. Jeffrey Danziger, M.D. also testified at the evidentiary hearing concerning bipolar disorder as follows:

> Q. What were all the diagnoses that you had rendered concerning Mr. Zommer?
> A. That he suffered from Bipolar Disorder Type I. And that when I had seen him most recently, actually during the quilt phase of the trial in December 2007, that he was at that point in a mixed phase, so the diagnosis would have been Bipolar Disorder Type I, most recent episode mixed. Also in Axis I was poly-substance dependence in remission in the controlled environment of the jail. And in Axis II, I diagnosed a personality disorder, or specifically, antisocial personality disorder.
> Q. And is it appropriate for an individual to be diagnosed with an Axis I bipolar disorder and Axis II antisocial personality disorder?
> A. They are not mutually exclusive. You can have both, as no doubt would be brought out. If the antisocial behavior occurs only during manic or psychotic periods, you should not diagnose antisocial personality disorder. However, there is no reason you cannot be diagnosed, with both bipolar disorder, or any other Axis I diagnosis, and a personality disorder. They are not mutually exclusive.
> Q. And is that based on your review of the diagnostic criteria as contained in the DSM-IV-Tr dealing with the antisocial personality disorder?
> A. Yes. And, simply, I've been doing this for 30 years now. And, yes, all of my training and everything I've done since 1982, when I started as an intern in psychiatry, is that you can have simultaneous Axis I and Axis II diagnoses.

> Q. I want to talk to you specifically about the foundation um, that you reviewed through the records, that you've previously testified in other hearings about, and your interactions with Mr. Zommer that led you to that diagnosis in Axis I and Axis II.
>
> Concerning your diagnosis of the antisocial personality disorder, did you find specific instances of antisocial behavior that was not exclusively during the course of schizophrenia or manic episodes?
>
> A. It's difficult, because you have to go back to episodes that may have happened in childhood or in the distant past, when nobody was around there to assess his mental state. (PCR Vol. XIX p. 1744-46).

Despite Dr. Danziger's assertion that Mr. Zommer has bipolar disorder, an Axis I diagnosis, he makes the error of coming up with a diagnosis of antisocial personality disorder. Again, Dr. Maher noticed that this improper assertion was never address by trial counsel during the proceedings:

> By Mr. KILEY
>
> Q. There was no attempt to rehabilitate this untrue statement - obviously untrue, as you testified - that Mr. Zommer does not have an antisocial personality disorder.
>
> A. I did not see, in the line of questioning in that - on that expert, the questions that would have brought out these issues that I have testified about here today, no.
>
> Q. In fact, there was no distinction made between antisocial personality disorder being an Axis II and Dr. Danziger finding an Axis I and, as you testified, if the behavior can be adequately explained by an Axis I, a physiological disorder, like bipolar disorder, there's no reason to go on to Axis II.
>
> A. No, I did not see that those questions were asked of Dr. Danziger. (PCR Vol. XVIII p. 1611-1612).

Trial counsel does not a reasonable excuse for his inconsistencies and omission. He testified at the evidentiary hearing in the following manner:

> By Mr. SHAKOOR
> Q. No. To clarify my question, you did not ask him anything that would -
> A. Okay.
> Q. - have elicited that; it came out in cross.
> A. I didn't.
> Q. Right.
> A. I thought you said - you were asking me if I did, and I - I don't think I did, but I don't remember completely. It came out on cross, I believe.
> Q. Yes.
> And on redirect, you could have - could you not have questioned Dr. Danziger about some of those factors that you questioned Dr. Toomer about -i.e., helping out friends with living conditions, um, being a good father and a good husband - without directly challenging him on the word antisocial personality disorder? Could you have questioned him about Todd Zommer's behavior, without challenging his diagnosis in front of the jury in an explicit kind of way?
> A. I - yeah, I could have. I could have just said, now, Doctor, let's talk about this and talk about that. You know, asked those same kind of questions - Which were pretty good, weren't they?
> A. Yes, they were. (PCR Vol. XIX p. 1810).

Dr. Danziger's overall testimony may be explained by the fact that he receives a great deal business from various State's Attorney offices in Florida; particularly when it comes to capital litigation. Mr. Sims further testified as follows:

> Q. So it was definitely the defense side's idea to call Dr. Danziger?

A. Right. We called him. Or us. One of us or both of us.
Q. And you testified about Dr. Danziger's reputation of working both sides of the fence; is that a way to put it?
A. Yes.
Q. Were you aware that Dr. Danziger received a great deal of work from the State Attorney's Office in other cases?
A. Yes. He's been against me many times.
Q. More so than with you?
A. In death cases ... probably. And - and other felony cases, he's probably with me more than with them.
Q. Okay.
A. That's one of the reasons that I use him is because the State believes in him. And so if you get him early on, you might be able to work a - a resolution with the help of Dr. Danziger's insight.
Q. Okay. So you just testified in - more so in death cases, he's usually with the State?
A. Than with me, yes.
Q. Than with you. Okay. (PCR Vol. XIX p. 1800).

Trial counsel was ineffective during penalty phase for not recognizing Dr. Danziger "working both sides of the fence" during his testimony. Counsel is ineffective for failing to rehabilitate Dr. Danziger's incorrect diagnosis. Relief is proper.

Legal Argument

In Wiggins v. Smith, 123 S.Ct. 2527 (2003) the Supreme Court of the United States ultimately held that "The performance of Wiggins' attorneys at sentencing violated his Sixth Amendment right to effective assistance of counsel." Id. At

2529. Justice O'Connor, in delivering the opinion of the Court, stated:

> We established the legal principles that govern claims of ineffective assistance of counsel in *Strickland v. Washington,* 466 U.S. 668, 104 S.Ct. 2052, 80 L.Ed.2d 674 (1984). An ineffective assistance claim has two components: A petitioner must show that counsel's performance was deficient, and that the deficiency prejudiced. *Id.*, at 687, 104 S.Ct. 2052. To establish deficient performance, a petitioner must demonstrate that counsel's representation "fell below an objective standard of reasonableness." *Id.,* at 688, 104 S. Ct. 2052. We have declined to articulate specific guidelines for appropriate attorney conduct and instead have emphasized that "[t]he proper measure of attorney performance remains simply reasonableness under prevailing professional norms." *Ibid.*

In this case, trial counsel's performance was ineffective in many areas under prevailing professional norms. However, even if trial counsel provided effective assistance at trial in some areas, the defendant is entitled to relief if counsel renders ineffective assistance in his or her performance in other portions of the trial. Kimmelman v. Morrison, 106 S.Ct. 2574, 2587-89 (1986). Even a single error can rise to the level of Sixth Amendment ineffectiveness. Chatom v. White, 858 F.2d 1479, 1485 11th Cir. (Ala.1988). The seriousness of the charges against the defendant, must also be taken into account, when assessing trial counsel's performance. Magill v. Dugger, 824 F.2d 879, 886 11th Cir. (Ala.1989). The Court in Magill also stated:

> Counsel's duty to be prepared is, of course, not lessened by the fact that his client admits to committing the acts alleged in the indictment. As the commentary following ABA Standards for Criminal Justice 4-4.1 states:
> 1. The lawyer's duty to investigate is not discharged by the accused's admission of guilt to the lawyer or by the accused's stated desire to enter a guilty plea. The accused's belief that he or she is guilty may not coincide with the elements that must be proved in order to establish guilt in law. In many criminal cases the real issue is not whether the defendant performed the act in question but whether the defendant had the requisite intent and capacity. Id. at footnote 11.

There were facts in this case that indicate that Mr. Zommer admitted his guilt prior to trial, on more than one occasion. However, similar to Magill, regardless of whether or not Mr. Zommer admitted any type of participation in the crime charged, trial counsel was still bound by the requirements of Strickland. Both Dr. Danziger and Dr. Maher testified during the evidentiary hearing that the appellant suffers from bipolar disorder, an Axis I diagnosis. Dr. Maher articulated in great detail about why it is improper for Mr. Zommer–a bipolar individual who has exhibited long episodes of kind, giving, and compassionate behavior-- to be diagnosed with antisocial personality disorder. (PCR Vol. XVIII p. 1590-1612). Trial counsel was ineffective for failing to rehabilitate the testimony of Dr. Danziger during the penalty phase. The prejudice is clear in that Dr. Danzinger's testimony was used against the defendant in the State's closing argument, and the trial court

made a point of addressing it, in the sentencing Order. Trial counsel should have rehabilitated Dr. Danzinger in the same manner in which he rehabilitated Dr. Toomer. He failed to do it. Had he done so, Mr. Zommer would have been sentenced to life in prison. Mr. Zommer was tried and convicted for First Degree Murder, in a case where he made multiple confessions. Penalty phase should have been the main preparation focus of the appellant's case at the trial level. Yet, he received ineffective assistance of counsel. Mr. Zommer is entitled to a new penalty phase as a remedy.

CONCLUSION AND RELIEF SOUGHT

In light of the facts and arguments presented above, Mr. Zommer never received a fair adversarial testing of the evidence. Confidence in the outcome is undermined and the judgement of guilt and subsequent sentence of death is unreliable. Mr. Zommer requests this Honorable Court to vacate the convictions, judgments and sentences including the sentence of death, and order a new trial.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true copy of the foregoing Initial Brief has been furnished by E-MAIL **Assistant** Attorney General Katherine Diamandis, Katherine.Diamandis@myfloridalegal.com, and U.S. Mail to Todd Zommer, Union Correctional Institution 7819 NW 228th Street Raiford, FL 32026-1000, on this 10th day of September, 2013.

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CERTIFICATE OF COMPLIANCE

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