

problems and had been treated in the past for paranoid schizophrenia.¹ Consequently, on December 21, 2007, we entered an Order granting the Government's request to have Pogos Voskanian, M.D., examine Defendant for the purpose of evaluating his competency to stand trial. (ECF No. 597.)

Dr. Voskanian, a clinical and forensic psychiatrist, examined Defendant on December 27, 2007, and submitted a report dated December 31, 2007 ("Voskanian Report"). Dr. Voskanian was unable to definitively diagnose Defendant, concluding that he possibly suffered from a thought disorder but that malingering² could not be ruled out. Dr. Voskanian recommended close monitoring and follow-up in a psychiatric facility to develop a better understanding of Defendant's mental state. On January 18, 2008, based on Dr. Voskanian's report, we issued an Order directing Defendant's transfer to a psychiatric facility for 30 days, for a psychiatric or psychological examination to be conducted and a report filed with the Court, in accordance with 18 U.S.C. §§ 4241(b) and 4247(b)-(c). (ECF No. 643.)

Defendant was admitted to the Metropolitan Correctional Center in New York City ("MCC-NY") on February 20, 2008. In a report dated March 27, 2008 ("Ryan Report"), after evaluating Defendant, forensic psychologist William J. Ryan, Ph.D., provided a diagnosis of Psychotic Disorder Not Otherwise Specified and Polysubstance Dependence, In Partial

¹ On December 17, 2007, we granted Ms. Laguzzi's motion to withdraw and appointed Paul M. George, Esq., to represent Defendant.

² The Voskanian Report does not define "malingering." A more recent psychiatric report on Defendant defines "malingering" as "the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as . . . evading criminal prosecution." (Report of July 28, 2009, by Drs. Pyant & Williamson (quoting American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision ("DSM-IV-TR")).)

Remission in a Controlled Environment. Dr. Ryan concluded that Defendant was not competent to stand trial and recommended that he be committed for the purpose of restoring his competency. Based upon Dr. Ryan's recommendation, the Government filed a motion requesting that Defendant be committed for a period of treatment in order to restore his competency to stand trial. (ECF No. 829.) On May 5, 2008, based upon the medical reports and other information before us, we found that Defendant was not competent to stand trial and ordered that he be hospitalized for treatment pursuant to § 4241(d). (ECF No. 830.)

On June 2, 2008, pursuant to our Order, Defendant was admitted to the Mental Health Unit of the Federal Medical Center in Butner, North Carolina ("FMC Butner"). At FMC Butner Defendant was evaluated by staff psychologist Carlton Pyant, Ph.D. In a report dated October 15, 2008 ("FMC Butner Report I"), Dr. Pyant stated that he was unable to offer a definitive opinion regarding Defendant's competency to stand trial. Dr. Pyant recommended that Defendant undergo an additional period of hospitalization and treatment while he attempted to obtain additional medical records and other information concerning Defendant's mental health. The Government then filed a motion requesting that Defendant be committed to the custody of the Attorney General for an additional 120 days for the purpose of further evaluating his competency. (ECF No. 1040.) We granted the Government's motion on February 4, 2009, finding that a period of close monitoring and follow-up in a psychiatric facility would assist us in adequately assessing Defendant's competency. (ECF No. 1041.)

On March 13, 2009, Defendant was readmitted to FMC Butner. Defendant was again evaluated by Dr. Pyant, with input from a different staff psychiatrist. In a report dated July 28, 2009 ("FMC Butner Report II"), Dr. Pyant diagnosed Defendant with Malingering and concluded

that he was competent to stand trial. The Report noted that “[w]ith the passage of time, evidence of malingering became apparent” and concluded that Defendant was competent to stand trial.

(*Id.* at 6, 9.)

On August 17, 2009, Defendant’s counsel moved to retain forensic psychologist Kirk Heilbrun, Ph.D., to conduct a competency evaluation of Defendant. (ECF No. 1193.) We granted Defendant’s motion on August 19, 2009. (ECF No. 1204.) Dr. Heilbrun evaluated Defendant and rendered a report dated October 12, 2009 (“Heilbrun Report”).³ Dr. Heilbrun offered the opinion that Defendant was not competent to stand trial, but that treatment with medication may remedy his condition and restore his competency.

On November 17, 2009, we held a competency hearing in accordance with §§ 4241(c) and 4247(d). Dr. Pyant, Dr. Heilbrun, and Defendant’s mother, Shelly Tucker, testified at the hearing. At the conclusion of the hearing, we granted defense counsel’s request for additional time to obtain Defendant’s juvenile mental health records to supplement the record and to provide a more complete picture of Defendant’s mental health. By letter dated June 2, 2010, defense counsel informed us that he was unable to locate any such records. Counsel advised that

³ On August 31, 2009, after we granted Defendant’s motion but before Dr. Heilbrun evaluated him, Defendant filed a pro se motion entitled Motion to Receive Death Sentence if Convicted. (ECF No. 1210.) In this two-page handwritten motion, Defendant claims that the “government has in the past experimented with [his] body and plans to continue with these [sic] illegal testing once gaining custody and control of [his] body through fictitious, deliberately deceptive and false charges.” (*Id.* at 1.) Defendant states that he is seeking a death penalty to “prevent government from moving forward with planned mental and physical torture of [him.]” (*Id.*) Defendant also states that he is a “devout muslim . . . being targeted for his religious belief,” and his execution “will allow him to die as a martyr defending his faith.” (*Id.*) Defendant notes that “the courts and tax payers will also benefit from [his] immediate execution by not having to financially pay for his warehousing.” (*Id.*) This pro se motion was dismissed on September 1, 2009.

a firm retained to conduct an investigation did not discover anything, and “it appears that if these records existed, they are no longer available.”

II. LEGAL STANDARD

The criminal trial of a defendant who lacks mental competency violates the defendant’s due process right to a fair trial. *See Cooper v. Oklahoma*, 517 U.S. 348, 354 (1996); *United States v. Renfro*, 825 F.2d 763, 765-66 (3d Cir.1987) (citing *Drope v. Missouri*, 420 U.S. 162, 172 (1975)). The basic standard for competency, set forth by the Supreme Court in *Dusky v. United States*, requires that, in order to plead guilty or to stand trial, a defendant must have a rational and factual understanding of the proceedings and a “sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding.” 362 U.S. 402, 402 (1960) (per curiam); *see also Taylor v. Horn*, 504 F.3d 416, 430 (3d Cir. 2007) (citing *Dusky*, 362 U.S. at 402). Requiring a criminal defendant to “be competent has a modest aim: It seeks to ensure that he has the capacity to understand the proceedings and to assist counsel.” *Godinez v. Moran*, 509 U.S. 389, 402 (1993); *see also Riggins v. Nevada*, 504 U.S. 127, 139-40 (1992) (Kennedy, J., concurring) (“Competence to stand trial is rudimentary, for upon it depends the main part of those rights deemed essential to a fair trial, including the right to effective assistance of counsel, the rights to summon, to confront, and to cross-examine witnesses, and the right to testify on one’s own behalf or to remain silent without penalty for doing so.” (citing *Drope*, 420 U.S. at 171-72 (1975))).

Congress codified the competency standard in 18 U.S.C. § 4241, which provides that:

If, after the [competency] hearing, the court finds by a preponderance of the evidence that the defendant is presently suffering from a mental disease or defect rendering him mentally incompetent to the extent

that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense, the court shall commit the defendant to the custody of the Attorney General.

18 U.S.C. § 4241(d). “At the competency hearing, the Government has the burden to prove the defendant’s competency.” *United States v. Velasquez*, 885 F.2d 1076, 1089 (3d Cir. 1989) (citing *United States v. DiGilio*, 538 F.2d 972, 988 (3d Cir.1976)). Pursuant to § 4241, psychiatric or psychological examinations of the defendant may be conducted, psychiatric or psychological reports prepared, and a hearing held, in accordance with 18 U.S.C. § 4247(b), (c), and (d), respectively. 18 U.S.C. § 4241(b)-(c). Accordingly, “court[s] must examine the unique circumstances of the case and decide whether the defendant ‘(1) has the capacity to assist in her or his own defense and (2) comprehends the nature and possible consequences of a trial.’” *United States v. Jones*, 336 F.3d 245, 256 (3d Cir. 2003) (citations omitted). When evaluating a defendant’s competency, we “must consider a number of factors, including ‘evidence of a defendant’s irrational behavior, his demeanor at trial, [and] any prior medical opinion on competence to stand trial.’” *Id.* (quoting *United States v. Leggett*, 162 F.3d 237, 242 (3d Cir. 1998)).

III. DISCUSSION

A. Conclusions of Mental Health Professionals

1. Dr. Voskanian

Dr. Voskanian examined Defendant at the Federal Detention Center in Philadelphia (“FDC”) on December 27, 2007, for approximately two hours. (Voskanian Report at 1.) He also reviewed several documents, including our Order for Competency Examination and Hearing Under 18 U.S.C. § 4241 (ECF No. 597), the Indictment, and the Government’s Motion for

Pretrial Detention. (*Id.*)

Dr. Voskanian's report indicated that his examination of Defendant was essentially an interview. (*Id.* at 2.) Dr. Voskanian reported that for over thirty minutes at the start of the interview, Defendant "expressed his opinions regarding systemic issues." (*Id.* at 2.) For example, Defendant was adamant that a criminal defense attorney who had previously worked as a prosecutor, as had his previous counsel, Ms. Laguzzi, could never be loyal to a client. (*Id.*) He was also convinced that a defense attorney who is a government employee works together with prosecutors to prosecute defendants. (*Id.*) Defendant "would not accept alternative explanations." (*Id.*)

During the interview, Defendant recounted hearing voices when he was a child, which had led his grandmother to send him to a psychiatric hospital. (*Id.* at 3-4.) With regard to the voices, Defendant stated: "It's like they inform you . . . it's like telling you what's going on" (*Id.* at 6.) He explained that he was not sure if the voices were "coming from [his] ears" and that the voices he heard were male "but it's not the same person." (*Id.*) Defendant also mentioned having had implants, such as a tracking device, installed in, and then removed from, his body. (*Id.* at 4.) Defendant admitted to using drugs, but only for the purpose of "mak[ing] voices and headaches go away . . . if apple juice did it I would use apple juice." (*Id.* at 6-7.) In response to further questions about his drug use, Defendant became very suspicious and guarded and refused to answer the questions in detail, leaving the interview room after stating that Dr. Voskanian was "trying to incriminate him and [was] setting him up." (*Id.* at 7.)

In summarizing his opinion, Dr. Voskanian stated that Defendant "had expressed a considerable amount of paranoid ideation [and] believed that he is being unjustly persecuted."

(*Id.* at 7.) He noted that Defendant had stated that he experienced auditory hallucinations. However, Defendant “made statements that indicated he had understanding of his legal charges [and] knew the reason his common-law wife had received a sentence.” (*Id.* at 7-8.) In addition, Defendant “clearly understood who [Dr. Voskanian] was and the purpose of the current evaluation.” (*Id.* at 7.) Dr. Voskanian concluded that “it would be difficult to definitively diagnose the defendant”: while “his presentation was suggestive of a serious thought disorder . . . , malingering cannot be ruled out.” (*Id.* at 8.) Dr. Voskanian ultimately did not offer an opinion regarding Defendant’s competency, instead recommending close monitoring and follow-up in a psychiatric facility to acquire a better understanding of Defendant’s mental state. (*Id.*)

2. *Dr. Ryan, MCC-NY*

On February 20, 2008, Defendant was admitted to MCC-NY, where Dr. Ryan evaluated him over a period of a little more than a month, until March 27, 2008. Dr. Ryan was assisted by two psychology externs. (Ryan Report at 1.) Dr. Ryan’s evaluation included four clinical interviews, conducted on February 28, 2008, and March 11, 19, and 25, 2008. (*Id.* at 2.) In addition, Dr. Ryan and his team reviewed several documents from this proceeding, including the Voskanian Report, and conducted telephone interviews with Ms. Laguzzi, Mr. George, and one of the attorneys for the Government. (*Id.*) Dr. Ryan noted that because of Defendant’s lack of cooperation, the opinions expressed in the Ryan Report “are offered with less than the usual degree of psychological certainty.” (*Id.* at 8.)

Dr. Ryan noted that Defendant “appeared very paranoid and guarded throughout the current evaluation,” as he had with Dr. Voskanian, and that he “also reported many of the same delusional beliefs . . . as he did to Dr. Voskanian.” (*Id.* at 4.) He “refused to speak at length with

evaluators” (*id.* at 1) and “was only marginally cooperative during interviews” (*id.* at 2). For example, he refused to answer questions about his childhood, “display[ing] the capacity to withhold almost all meaningful information” during several interviews. (*Id.* at 2.) As a result, Dr. Ryan collected most background information about Defendant from discussions with attorneys and the Voskanian Report. (*Id.* at 8.)

According to Dr. Ryan, Defendant “voiced vague paranoid ideation about why the evaluation was being conducted.” (*Id.* at 1.) This was after Defendant was told who would perform the evaluation, that its purpose was to assist the Court in evaluating his competency, that neither the interviews nor the results of the testing would be confidential, and that he could consult his attorney at any time. (*Id.*) Defendant refused to participate in any psychological testing even after the nature and purpose of all attempted tests were explained to him. (*Id.* at 4.)

The MCC-NY psychiatrist met with Defendant on February 22, 2008. (*Id.*) She noted that Defendant “was extremely paranoid, refused to answer many questions, and whispered, ‘they are always watching me.’” (*Id.*) Her diagnosis was Psychosis Not Otherwise Specified (NOS), history of Polysubstance Abuse, and a possible history of Schizophrenia. (*Id.*)

The Ryan Report briefly summarizes the first two interviews of Defendant. During the first interview, Defendant expressed his discomfort because a particular extern was in the room. (*Id.* at 5.) “After answering a few questions for several minutes [Defendant] refused to answer anymore [sic] questions or make eye contact with the evaluators.” (*Id.*) The second interview with Defendant “was similar to the first.” (*Id.*) Defendant was “paranoid, suspicious, angry, and anxious.” (*Id.*) He accused the evaluator of “playing mind games” with him and appeared to suggest that the evaluator and some other people were conspiring against him “to assist in [his]

demise.” (*Id.*) When offered the opportunity to speak with another forensic psychologist, Defendant refused, claiming he did not want to speak with anyone. (*Id.*) Dr. Ryan related that “[w]hen [Defendant] looked depressed and was asked whether he might be interested in antidepressants, he got very upset and stated, ‘that’s your whole angle from the beginning. Everybody’s trying to put stuff in me.’” (*Id.*) After that, Defendant refused to talk anymore.

Defendant also appeared “extremely wary of the externs, convinced they were working for the ‘people that sent [him] here.’” (*Id.* at 4.) Defendant stated that one of the externs gave off a particular odor and he refused to answer any questions in front of that extern. (*Id.* at 5.) His explanation for the smell was that he had learned that “certain people, when you do certain things, it darkens your heart and you give off a specific odor.” (*Id.* at 4-5.) According to Dr. Ryan, “[t]his was likely an olfactory hallucination signaling to [Defendant] the extern had motives other than the evaluation.” (*Id.* at 6.) Dr. Ryan evidently had some question concerning Defendant’s complaints regarding the odors emitted by certain individuals. His reports noted that “if [Defendant] is experiencing olfactory hallucinations, or smells which are not real, then he is likely suffering from a severe psychotic illness.” (*Id.* at 5.)

During his stay at MCC-NY, Defendant was cooperative with staff, did not receive any disciplinary actions, and was not cited in any incident reports. (*Id.* at 4.) Staff members indicated that Defendant was capable of managing his personal needs, kept to himself, and slept all day. (*Id.*) According to the Ryan Report, Defendant “was observed in the Law Library with a pad and pen in front of him, listening attentively to the wire tapped phone calls from his discovery. When the evaluators approached him, [Defendant] became very paranoid and belligerent, stating, ‘what I’m working on is none of your business.’” (*Id.*)

Dr. Ryan noted that “[i]t was difficult to assess Mr. Tucker’s current mental status because of his refusal to speak with evaluators.” (*Id.* at 5.) Based on the evaluation and Defendant’s history, he was diagnosed with Psychotic Disorder Not Otherwise Specified (NOS), as well as Polysubstance Dependence, In Partial Remission in a Controlled Environment. (*Id.* at 6.) The Ryan Report refers to the DSM-IV-TR in describing Psychotic Disorder NOS as including “either psychotic symptomatology (including delusions, hallucinations, disorganized speech, and grossly disorganized behavior) about which there is inadequate or contradictory information, or disorders with psychotic symptoms that do not meet the criteria for any specific Psychotic Disorder, like persistent auditory hallucinations in the absence of other features.” (*Id.*) The DSM-IV-TR describes Polysubstance Dependence, Defendant’s only other diagnosis, as being “characterized by repeated use of at least three groups of substances during a 12-month period in which no single substance predominated.” (*Id.*) The latter diagnosis was based on Defendant’s statements about his drug use during the two years prior to his arrest. (*Id.*) Consequently, Dr. Ryan classified Defendant as a “Mentally Ill Chemical Abuser (MICA),” a category of patients who “typically self-medicate their painful mental illness by illicit substance abuse” and “are particularly problematic for treatment personnel.” (*Id.* at 6-7.) With regard to treatment recommendations, Dr. Ryan concluded that Defendant “requires psychiatric treatment and an 18-month Residential Drug Treatment Program, preferably a program with a strong MICA component.” (*Id.* at 7.)

Based upon these diagnoses, Dr. Ryan opined that Defendant was not competent to stand trial. Dr. Ryan noted that Defendant’s “lack of cooperation is an impediment to determining his competency with the usual degree of psychological certainty.” (*Id.*) Nevertheless, he concluded

that Defendant “lacks a rational and factual understanding of the proceedings against him and he is not capable of assisting counsel with his defense.” (*Id.* at 9.) Dr. Ryan’s reasoning was that

[Defendant] is not currently capable of maintaining proper courtroom behavior, nor appropriately attending to and participating in courtroom proceedings. [Defendant] is not fully oriented or in good contact with reality. He is incapable of comprehending the seriousness of his case and the recommendations of defense counsel. He is incapable of communicating with or trusting his counsel, weighing the merits of various defenses, or making decisions regarding numerous constitutional protections such as his right to trial, his right to an attorney, his right to enter into a plea, and his right to call witnesses, etc. [Defendant] is currently not capable of testifying in his own defense and speaking during sentencing proceedings should it be necessary.

(*Id.* at 7.) Dr. Ryan recommended that Defendant “be sent away for restoration of his competency” pursuant to § 4241(d). (*Id.* at 8.)

3. *Dr. Pyant, FMC Butner, 2008*

In the course of Defendant’s first stay at FMC Butner, between June 2, 2008, and September 26, 2008, Defendant was primarily evaluated by Dr. Pyant, with a psychiatric consultation provided by staff psychiatrist Bruce Berger, M.D., and input from other staff. (FMC Butner Report I at 1-2.) The medical team also reviewed our Orders of May 5, 2008, and June 24, 2008; the Voskanian Report; the Ryan Report; and the Indictment; and held telephone conferences with one of the attorneys for the Government and with defense counsel, Mr. George. (*Id.* at 1-2.)

According to the Report, Defendant arrived at FMC Butner surprised and disappointed “about having to participate in another mental competency evaluation.” (*Id.* at 4.) “[H]is thought processes were organized” and “[h]e did not endorse auditory or visual hallucinations.”

(*Id.*) The Report notes that Defendant “appeared guarded in self-disclosures” and, therefore, his reliability with regard to historical information that he provided to the medical team “was questionable.” (*Id.* at 2.) In addition, Defendant “refused to participate in any psychological testing” (*id.* at 6), just as he had previously at MCC-NY.

The medical team noted that “[d]uring interviews, persecutory themes emerged early on and were persistent and prominent within his communication.” (*Id.* at 4.) Defendant accused the doctors and the government of placing him at FMC Butner “to make [him] look like something is wrong with [him].” (*Id.*) Defendant related that he had last taken psychotropic medication in 1994 at a facility called “Vision Quest,” where, in Defendant’s own words, “[t]hey said it would help me with the stuff I was hearing.” (*Id.* at 5.) Similar to his previous statement about having objects implanted in his body, Defendant claimed that he had been “cut open before” and that his internal organs had possibly been removed. (*Id.*) He expressed his belief that he had been involved in a some type of a study as a child, which resulted in scars on his body, and that the government wanted to keep his body under control. (*Id.*) According to the Report, Defendant indicated that the government was accusing him of selling drugs merely as a diversion. (*Id.*) During further interviews, Defendant continued the paranoid theme in accusing staff of placing a spy in his room and accusing the “staff, law enforcement and court officials” of sharing a goal of causing him harm. (*Id.*)

On several occasions, Defendant was moved from an open mental health unit to a restricted movement housing unit in response to his concerns about “people ‘watching’ him,” his “peers . . . ‘spying’ on him,” and “snitches.” (*Id.* at 5-6.) At one point he accused Dr. Pyant of “contacting his family and telling his 8-year-old, ‘bad’ things about his father. He warned the

psychologist to stay away from his family.” (*Id.* at 6.) Defendant refused to address his concerns with members of his treatment team and instead submitted a “written request to speak with the Chief Psychiatrist regarding complaints about his primary clinician and the evaluation process.” (*Id.*) During the subsequent discussion with the Chief Psychiatrist, Defendant “accused his primary clinician of working with the government against him and thereby ‘contaminating the fairness of the evaluation.’ He espoused the position that the entire governmental system was ‘biased’ against him.” (*Id.*) In the weeks following that, Defendant filed a “formal written complaint alleging [that] his primary clinician [was] attempting to ‘sabotage’ his ‘credibility’ and bring about his ‘demise.’” (*Id.*)

Dr. Pyant diagnosed Defendant as Psychotic Disorder NOS, based on “the clinical data reported in this report,” but stated that “there is also contradictory information suggesting [Defendant] is not mentally ill and may be malingering.” (*Id.* at 7.) The Report notes that according to DSM-IV-TR,

Malingering should be suspected when:

- (1) it occurs in a medico-legal context, such as forensic examination;
- (2) there is a marked discrepancy between the person’s claimed stress or disability and the objective findings;
- (3) there is a lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regiment; and
- (4) there is the presence of Antisocial Personality Disorder.

(*Id.*)

Dr. Pyant provided five reasons that supported the possibility that Defendant was malingering. First, “several randomly monitored telephone calls placed by [Defendant] to his family revealed no evidence of anxiety or distress.” (*Id.*) In these conversations, Defendant

made no references to being harmed, being spied on, or any “conspiratorial plots against him by the government.” (*Id.*) Second, Defendant’s lengthy criminal history and his having previously spent a total of 13 years in prison “indicate he has a history of being found competent to proceed to trial and addressing charges against him.” (*Id.* at 8.) Third, Defendant’s “lack of cooperation with the evaluation process, i.e., refusing to participate in clinical interviews and psychological testing, is possibly indicative of malingering.” (*Id.*) Fourth, Dr. Pyant noted that Dr. Voskanian also noted that Defendant might have a psychotic illness but could not rule out malingering. (*Id.*) Dr. Pyant pointed out that while Defendant reported auditory hallucinations to Dr. Voskanian, he did not report any auditory hallucinations during his almost four months at FMC Butner. (*Id.*) And finally, Dr. Pyant observed that both during Defendant’s interview with Dr. Voskanian and during his stay at FMC Butner, Defendant frequently alluded to the “unfairness of the system” and “staff ‘contaminating the evaluation process,’” which are “fairly common statements made by individuals who have a history of repeated violations of the law” and are thus “not necessarily indicative of a psychotic process.” (*Id.*)

Dr. Pyant and Dr. Berger concluded that they could not “offer a definitive opinion regarding whether [Defendant] suffers from a mental disease or defect” that would render him incompetent to stand trial. (*Id.*) They therefore requested that the Court order an additional period of hospitalization and treatment for Defendant, pursuant to § 4241(d), during which time they would attempt to obtain additional mental health records about Defendant and to speak with Defendant’s prior counsel. (*Id.*)

4. *Dr. Pyant, FMC Butner, 2009*

During Defendant’s second evaluation at FMC Butner, between March 13, 2009, and July

14, 2009, Defendant was again primarily evaluated by Dr. Pyant, this time with a psychiatric consultation provided by staff psychiatrist Kwanna Williamson, M.D., and input from other staff. (FMC Butner Report II at 1-2.) The medical team also held telephone conferences with one of the attorneys for the Government and with Mr. George. (*Id.* at 2.)

During this evaluation period at FMC Butner, Defendant “interacted with treatment team members in a guarded fashion. He also appeared angry, annoyed and communicated information in a sarcastic tone.” (*Id.* at 4.) The FMC Butner Report II relates that “[u]pon arrival to his assigned unit,” Defendant “verbalized not wanting to come back to this institution.” (*Id.* at 3.) “He denied current auditory hallucinations, but indicated ‘hearing voices’ in February.” (*Id.*)

On March 20, 2009, Defendant refused to participate in psychological testing, as he had during his previous evaluation. (*Id.*) He also “acknowledged being angry about being back at FMC Butner and requested return to Philadelphia.” (*Id.*) In a team meeting on March 30, 2009, “[t]he unit nurse described [Defendant] as displaying no evidence of severe mental illness” and “characterized him as ‘egocentric, belligerent, entitled, persistent and manipulative.’” (*Id.*) She also noted that “he was skilled at getting his personal needs met.” (*Id.*) Further, a “correctional officer indicated [that Defendant] displayed hostility and arrogance towards staff and peers.” (*Id.*)

In an interview that took place on March 17, 2009, Defendant claimed that Dr. Pyant and “Brian McKnight (a famous singer/song writer) were conspiring against him.” (*Id.* at 4.) Defendant suggested that Dr. Pyant was abusing his position for someone else’s, supposedly Brian McKnight’s, benefit. (*Id.*) The medical team’s diagnostic impressions after that interview were “Psychotic Disorder versus Malingering.” (*Id.*)

Defendant's attitude toward Dr. Pyant persisted: he "directed anger at [Dr. Pyant,] whom he solely blamed for his return to [FMC Butner]." (*Id.* at 4.) For example, during a team meeting on April 2, 2009, "the social worker inquired about the reason for [Defendant's] recent hospital admission." (*Id.* at 4-5.) In response, Defendant "angrily stared at [Dr. Pyant], rolled his eyes, pointed and replied, 'because of him.'" (*Id.* at 5.) On April 22, 2009, a correctional officer reported some comments that Defendant had made that elaborated on why Dr. Pyant was to blame for Defendant's return to FMC Butner:

[Defendant] told the officer [that] Brian McKnight and [Dr. Pyant] were acquaintances. [Defendant, Dr. Pyant], and Brian McKnight were at a picnic. During that social event, [Defendant] wrote a poem for his girlfriend. Sometime thereafter, the lyrics ended up in a song written by Brian McKnight. [Defendant] filed a lawsuit against him for plagiarism. As a result of the pending legal action, Brian McKnight and [Dr. Pyant] conspired against him and are keeping him imprisoned to obtain a conviction.

(*Id.*)

Dr. Pyant noted that in previous evaluations, Defendant also "accused all of the mental health professionals of either conspiring against him or trying to harm him." (*Id.*) Even though "[o]n the surface, [Defendant's] verbalizations suggested the possibility of paranoid delusions," Dr. Pyant opined that Defendant's "presentation suggested he was engaging in goal-directed behavior of posing as a victim." (*Id.*) "Team members also suspected [that Defendant] was engaging in strategic actions designed to create the appearance of a paranoid, suspicious, and fearful individual." (*Id.*) According to Dr. Pyant, "the presentation of a mentally impaired person provided a convenient excuse for [Defendant] to oppose an evaluation conducted by a clinician he claimed was intent on causing him harm." (*Id.*) Dr. Pyant found it notable that

Defendant “made no such accusations of other BPO staff.” (*Id.*) Throughout the evaluation period, Defendant “continued to foster the perception that [Dr. Pyant] had personal issues with him.” (*Id.*)

However, “[t]here were constant inconsistencies within [Defendant’s] presentation.” (*Id.* at 6.) He frequently placed chairs against his cell door to alert him to anyone entering his cell while he slept. (*Id.*) He appeared to have “excellent personal hygiene, organized thought processes and the absence of reported auditory hallucinations.” (*Id.*) He was guarded when questioned about his alleged criminal offenses. (*Id.*) In addition, Defendant was “described as a person who intimidated peers to get his way” and “displayed a hostile and demanding attitude with nurses.” (*Id.*)

According to Dr. Pyant, “[w]ith the passage of time, evidence of malingering became apparent.” (*Id.*) For example, on May 17, 2009, Defendant reported feeling unsafe, due to “auditory hallucinations informing him [that Dr. Pyant] wanted to hurt him.” (*Id.*) After being moved to a restricted movement housing unit, observations of him during daily rounds “were not indicative of him responding to internal stimuli.” (*Id.*) The staff reported that he often read a book, was calm, and did not engage in any behavioral misconduct. (*Id.*) He “was not demonstrating evidence of psychosis” and “displayed no fear or anxiety while conversing with” Dr. Pyant. After a nine-day period during which Defendant was extensively observed and evaluated, he returned to a open population mental health unit, at which time “he denied auditory hallucinations.” (*Id.*)

According to a nursing note from June 3, 2009, Defendant “informed a correctional officer the previous night he was hearing voices and had heard them since he was a child.” (*Id.*)

However, “he had made no such report to medical staff ‘at any times.’” (*Id.*) The nursing note further indicated that

Inmate has shown no signs of Schizophrenia, such as responding to internal stimuli, talking to unseen others or appearing to be listening to voices . . . His behavior on the unit has been hostile and threatening to other inmates, particularly in the unit TV room when other inmates want to watch a particular program . . . Inmate is frequently observed lying quietly in bed reading a book.

(*Id.*)

Dr. Pyant’s report summarizes several interactions between FMC Butner staff and Defendant over the ensuing weeks that deal with Defendant’s attitude toward medication and psychological testing. On one occasion, Defendant requested “to speak with the team psychiatrist about medication,” but when Dr. Pyant and a social worker met with him because the psychiatrist, Dr. Williamson, was unavailable, Defendant “angrily informed [Dr. Pyant that] he did not want to discuss the matter. (*Id.* at 7.)

During a meeting with Defendant on June 16, 2009, Dr. Williamson “expressed a desire to . . . obtain information about his specific symptoms to determine the most appropriate course of action.” (*Id.*) Defendant reported that “he was hearing voices and could not sleep.” (*Id.*) “He stated the voices told him this place (FMC Butner) was ‘evil’” and “told him to ‘put blood on the yard (recreation yard) to purify it.’” (*Id.*) Defendant “provided a history of mental health treatment as a child, but reported no psychiatric treatment or medications since the age of 16.” (*Id.*) He “also reported using ‘marijuana and PCP’ as a youth to ‘make the voices better.’” (*Id.*) Defendant then “informed [Dr. Williamson] he had wanted to know about medication since 1993,” specifically “if there were improvements or changes in medications over the years that

would prevent side effects.” (*Id.*) According to the Report, Defendant did not, however, “actually request[] to be medicated, nor sought assistance to eliminate voices.” (*Id.*) Even though Dr. Williamson encouraged Defendant “to participate in psychological testing for diagnostic and treatment purposes,” he again declined. (*Id.*)

On June 21, 2009, Defendant again sought to be moved to the restricted movement housing unit, reporting that he was “hearing voices and no one believed him.” (*Id.*) “Prior to making those verbalizations, however, he was described as socializing appropriately with peers.” (*Id.*) When Dr. Williamson came to interview him, Defendant was ““angry and hostile when asked to provide descriptions of his symptoms.”” (*Id.*) Dr. Williamson further noted that Defendant ““tended to complain about historical and current providers and attorneys.”” (*Id.*) Defendant “was also described as ‘perseverating about wanting treatment for hearing voices, however ambivalent about participating in diagnostic testing for better clarification of his diagnosis and utility of information.’” (*Id.* at 7-8.)

Defendant did “eventually agree[] to participate in psychological testing.” (*Id.* at 8.) However, he failed to show up for his appointment and then “refused to complete any testing and stated, ‘They’re just trying to get evidence to prove I’m guilty.’” (*Id.*)

After describing Defendant’s behavior and conduct during this evaluation period at FMC Butner, the Report provides a diagnosis of Malingering, giving nine reasons for the diagnosis.⁴ The first reason stated by Dr. Pyant is that Defendant “was evaluated in a medico-legal context.” (*Id.*) The second is that “he is facing a possible prison term in the range of 25 years to life,”

⁴ Section III.A.3, *supra*, lists factors identified in the DSM-IV-TR that generally support a Malingering diagnosis.

which “provides sufficient motivation to evade criminal prosecution.” (*Id.*) Third, Defendant “was uncooperative with the evaluation process,” which is consistent with malingering. (*Id.*) The fourth reason is “a discrepancy between [Defendant’s] subjective reports of ‘hearing voices’ and the objective findings.” (*Id.*) Specifically, “there was no overt behavioral evidence indicating that he was responding to internal stimuli” and Defendant further “lacked the ability to describe those ‘voices.’” (*Id.*) In addition, Dr. Pyant noted that Defendant’s “reports of auditory hallucinations were not consistent with those with genuine psychosis.” (*Id.* at 9.) Fifth, Defendant “has no documented adult history of mental health inpatient or outpatient treatment.” Dr. Pyant also expressed scepticism about Defendant’s self-reporting in this area. Defendant had stated that he had used marijuana and PCP when he was younger to provide relief from the “voices” he was hearing. However, those drugs “would likely exacerbate auditory hallucinations.” (*Id.*) The sixth reason stated by Dr. Pyant is that Defendant “tended to report claims of distress during periods when staff most familiar with him were not working, i.e., nights and weekends.” (*Id.*) Seventh, Dr. Pyant could discern no consistent pattern in the delusional material discussed by Defendant. (*Id.*) For example, while Defendant repeatedly claimed being harmed by the government during his first stay at FMC Butner, during his second stay there, the “theme” of his communication involved the conspiracy between Dr. Pyant and Brian McKnight. (*Id.*) Eighth, while Defendant claimed to “have no knowledge of his current charges . . . , an individual displaying the level of adaptive functioning displayed by [Defendant] would be expected to have knowledge of pending criminal charges.” (*Id.*) And the ninth reason for Dr. Pyant’s diagnosis was that “monitored phone calls were not significant for paranoid delusions or auditory hallucinations.” (*Id.*)

Dr. Pyant and the clinical team at Butner concluded that Defendant “currently does not suffer from a mental disease or defect which prevents him from having a factual and rational understanding of the proceedings against him and assisting an attorney in defending him.” (*Id.*) Moreover, Dr. Pyant noted that “there is no evidence that [Defendant] suffers from severe mental health illness.” Observation of Defendant during evaluation “suggests [that Defendant] is able to read, comprehend information, and learn concepts essential in understanding case events.” He also “does not suffer from delusions or hallucinations that would affect his ability to engage in rational decision-making.” (*Id.*) With regard to Defendant’s ability to assist his counsel, Dr. Pyant noted that he “displays the ability to: (1) relate meaningful information to his lawyer in an organized manner; (2) testify on his own behalf; and (3) assist in challenging witnesses against him.” (*Id.*) However, as long as Defendant “is invested in presenting himself as mentally ill . . . , it is likely he will be unreceptive to feedback or advice from an attorney.” Nevertheless, “any lack of cooperation with an attorney should be viewed as volitional, rather than a symptom of mental illness,” according to Dr. Pyant. (*Id.*)

5. *Dr. Heilbrun*

Dr. Heilbrun evaluated Defendant on September 28, 2009, at the FDC for approximately two and a half hours, with the assistance of a graduate student from his clinic at Drexel University. (Heilbrun Report at 1; Hr’g Tr. 49-50.) Of these two and a half hours, he spent 45 minutes discussing the purpose of the evaluation with Defendant, an hour and 25 minutes interviewing him, and 20 minutes attempting to administer tests. (*Id.*) He also conducted an interview with Defendant’s mother, which lasted approximately an hour, and another with Shana Bradley, the mother of three of Defendant’s four children, which lasted approximately 30

minutes. (Heilbrun Report at 1.) Dr. Heilbrun reviewed the Voskanian Report, the Ryan Report, both reports from FMC Butner, and Defendant's Pro Se Motion to Receive Death Sentence if Convicted. (*Id.* at 1-2.)

Dr. Heilbrun reviewed Defendant's background, including his family history, medical and psychiatric history, and history of substance abuse, obtaining relevant information primarily from Ms. Tucker, but also from Defendant himself, Ms. Bradley, and the earlier evaluations of Defendant. Ms. Bradley stated to Dr. Heilbrun that Defendant and his mother "have a good relationship," but Ms. Tucker stated that Defendant "thinks even when I come to visit him that I am there to spy on him" and "[h]e really believes in his heart that I did something to put him in this situation." (*Id.* at 3, 4.)

In describing Defendant's clinical condition, Dr. Heilbrun noted that Defendant "presented as very suspicious" during the evaluation. (*Id.* at 8.) He "was reluctant to participate in any testing, but agreed after looking over a structured inventory of symptoms of mental and emotional disorders, the Brief Symptom Inventory (BSI)." (*Id.* at 9.) However, "[a]fter answering the first 15 items of the BSI, [Defendant] became visibly upset and testing was discontinued." (*Id.*) At one point, Defendant indicated that scars on various parts of his body were due to the "experiments which he said were conducted on him when he was young." (*Id.*) He stated that "the government did an 'experiment' on his body" when he was a child, where "devices that could release chemicals' were placed in his body to see how he 'would react,'" and the scars resulted from the removal of those devices. (*Id.* at 4.) Based on Defendant's "responses throughout the evaluation, combined with collateral information provided by his mother and partner," Dr. Heilbrun concluded that Defendant "has a chronic and entrenched belief

system” due to a “mental illness.” (*Id.* at 9.)

With regard to Defendant’s understanding and appreciation of the charges and penalties, Dr. Heilbrun opined that Defendant “appears to have an elaborate, delusional belief system that interferes with his ability to” understand the charges against him and their possible consequences. (*Id.* at 10.) Dr. Heilbrun supported that opinion by quoting Defendant’s musings that ““there are no drugs, they are ghost drugs,”” that charging Defendant with drug offenses was an excuse for the government to ““hold[] him hostage,”” that nothing was going to happen to him as a result of the charges because ““all this is a play,”” and that he was in the federal rather than state justice system because he had “told people what he knows happened to him” and the government had greater power to ““control”” him within the federal system. (*Id.* at 9.)

As for Defendant’s understanding of the roles of the judge, prosecutor, and defense attorney, Dr. Heilbrun concluded that Defendant appears to have “significant deficits in his factual and rational understanding of” those roles. (*Id.* at 10.) He quoted Defendant as stating that the prosecutor “tell[s] the judge what to say,” that the prosecutor’s role is “[t]o put people in custody and lie about what he is doing,” and that his attorney is an ““officer of the court, not of the client.”” (*Id.*) Dr. Heilbrun noted that Defendant’s “rational understanding of these roles is the more impaired; he does not believe (even in theory) that the judge is a neutral decision-maker who will consider the evidence presented by each side in rendering a verdict,” and that Defendant does not believe that his attorney is working in his best interest. (*Id.*)

Specifically with regard to Defendant’s attorney, Dr. Heilbrun noted that Defendant was “suspicious of his lawyer who is paid by the government” and cited a few examples of Defendant’s dissatisfaction with his lawyer not acting on Defendant’s requests to obtain

information from the government about the “experiment that was done to him.” (*Id.* at 11.) Dr. Heilbrun opined that, consequently, Defendant “has limited potential to assist counsel and provide testimony so long as his delusions remain as active and influential symptoms of his mental illness.” (*Id.*) Dr. Heilbrun also noted that Defendant may have a problem “making a rational decision regarding [a] plea or testifying in court.” (*Id.*)

Dr. Heilbrun concluded that Defendant lacks the competency to stand trial but that “[i]t is possible that the deficits associated with [Defendant’s] factual understanding and rational understanding and ability to assist in his own defense would be remediable within a reasonable period of time” by “treatment with psychotropic medication.” (*Id.* at 12.) Notably, Dr. Heilbrun stated that “[t]he genuineness of [Defendant’s] symptoms could not be tested . . . given his extreme suspiciousness,” but it “seems reasonable to conclude that [Defendant’s] apparent delusions are genuine” given Ms. Tucker’s and Ms. Bradley’s observations of “similar suspicious and apparently delusional behavior.” (*Id.* at 12.)

B. Hearing

On November 17, 2009, we held a competency hearing in accordance with §§ 4241(c) and 4247(d). We heard testimony from Dr. Pyant, Dr. Heilbrun, and Ms. Tucker. Dr. Pyant testified by means of a video conference from FMC Butner.

At the beginning of the hearing, during Dr. Pyant’s swearing in and the beginning of his testimony, Defendant repeatedly interrupted the proceedings by attempting to address Dr. Pyant and by referring to him in derogatory terms. (Hr’g Tr. 6-7.) After being warned that such conduct would result in his expulsion from the hearing and that his counsel would have an opportunity to cross-examine Dr. Pyant, Defendant calmed down. (*Id.* at 7.) As the attorney for

the Government attempted to qualify Dr. Pyant as an expert, Defendant again interrupted and continued speaking over the attorney for the Government and the Court. (*Id.* at 9.) In response to another warning that he would be removed from the courtroom, Defendant stated: “I already don’t mind. This stuff is a circus anyway. If you want to remove me, remove me. But, don’t sit here and tell me that this joker that’s sitting[,] you giving him qualifications he don’t have.” (*Id.*) However, Defendant stopped interrupting after the Court directed defense counsel to speak to him. Defense counsel then proceeded to agree that Dr. Pyant’s qualifications established him as an expert, though “[n]ot an expert that’s necessarily correct in this case.” (*Id.*)

Dr. Pyant stated that during his tenure at FMC Butner he had completed between 450 and 500 competency evaluations. (*Id.* at 8.) When questioned about his initial evaluation of Defendant, Dr. Pyant stated that Defendant’s behavior had been similar to that reported by Dr. Ryan. (*Id.* at 12) And given Defendant’s statements about the device that had been implanted in his body and the guarded and suspicious nature of his behavior, “there was certainly some concern that he might be mentally ill.” (*Id.*) However, the clinical team was puzzled by the absence of any adult mental health treatment and the fact that when Dr. Pyant monitored some of Defendant’s phone calls, “there was not a presentation of mental illness as he had talked with either his mother or his girlfriend. Or, the mother of his children.” (*Id.* at 13.) Dr. Pyant explained that toward the end of the first evaluation, he thought that Defendant “had some type of mental illness,” but because he took a “conservative approach to asking the courts to medicate people” and “given the inconsistencies based on the phone calls,” the clinical team decided to ask the Court for additional time to continue evaluating Defendant. (*Id.* at 13-14.)

Dr. Pyant then explained why the clinical team arrived at the conclusion that Defendant

was malingering, elaborating on some of the reasons stated in his report (*see* FMC Butner Report II at 8-9). (Hr’g Tr. 15-20.) For example, the significance of Defendant being routinely observed reading a book in the restricted movement housing unit where he was placed after he had reported hearing voices was that “if he were truly experiencing auditory hallucinations, . . . it would be disruptive for him, and [in essence] it’d be fairly difficult for him to be calmly in our restricted housing unit reading a book.” (*Id.* at 18.) Dr. Pyant also noted that the use of PCP, which Defendant claimed to have used to medicate the “voices” he was hearing, would probably exacerbate any psychiatric symptoms and “it’s really unlikely that those drugs would have a calming effect on him.” (*Id.* at 19.) With regard to Defendant’s stated fear of Dr. Pyant, Dr. Pyant noted that he weighs 90 pounds less than Defendant and, typically, people with persecutory delusions suffer internal distress, with which they want to deal very aggressively. (*Id.*) And given Defendant’s history of aggressive behavior, “it would be somewhat unlikely for him to just say, ‘Oh, gee, I’m afraid of a guy,’ who’s 90 lbs. lighter than him, and, again, just kind of go down to our restricted housing unit calmly.” (*Id.* at 18-19.) Dr. Pyant also alluded to the lack of any mental health treatment when Defendant was an adult. An absence of any mental health records from a 15-year period preceding the evaluation appeared suspect to Dr. Pyant, because “many times” patients with mental illness have a history of treatment, and in Defendant’s case that history would at least “legitimize or give some credibility to reports of—of him having a mental illness.” (*Id.* at 20.)

In response to defense counsel’s questioning, Dr. Pyant acknowledged that when considered separately, the reasons provided for the malingering diagnosis may be consistent with the behavior of a person with a genuine mental illness. (*Id.* at 24-30, 38-39, 43-45.) For

example, Dr. Pyant agreed that the fact that someone is being evaluated in a medico-legal context does not, standing alone, indicate whether someone has a medical illness or is malingering. (*Id.* at 24-25.) In his position at FMC Butner, where all evaluations take place in the medico-legal context, he had indeed found some patients to be incompetent. (*Id.* at 25.) Dr. Pyant also acknowledged that Defendant's attitude and behavior in not cooperating with evaluations and expressing suspicion toward medication was consistent throughout his evaluations by Dr. Voskanian, Dr. Ryan, and at FMC Butner. (*Id.* at 28-29.) Notably, Dr. Pyant's testimony that he would not have been able to "render[] a proper and complete evaluation of Mr. Tucker after having spoken to him for simply an hour and a half" went unchallenged. (*Id.* at 22.)

Dr. Heilbrun's testimony followed. After explaining his methodology, Dr. Heilbrun stated that he would "have liked to have administered several additional tests and a—a specialized measure, the MacArthur Competence Assessment Tool Criminal Adjudication, but . . . Mr. Tucker did not want to take that." (*Id.* at 50-51.) He explained that he wrote his report based on the information gathered from talking to Defendant, but "had to rely more on third party information—both the previous records and the interviews—than [he] usually would have" because of Defendant's demeanor during the evaluation. (*Id.* at 51-52.) Dr. Heilbrun testified that the reasons he came to the conclusion that Defendant was not competent to stand trial were: (1) Defendant's "extended family history of severe mental illness," on both sides of his family; (2) "a long personal history of being diagnosed with symptoms of severe mental illness"; (3) descriptions of Defendant by his mother and Ms. Bradley "as very suspicious and what his mother called 'schitzzy'"; (4) Defendant being suspicious of Dr. Heilbrun and his assistant "when [they] were sitting down with him and conducting the evaluation"; and (5) the apparent absence

of treatment “with psychotropic medication as an adult, which is something that would be routinely tried for symptoms that are potentially—as he had—potentially symptoms of a severe mental illness.” (*Id.* at 52-53.) Dr. Heilbrun opined that if Defendant “were treated with [psychotropic] medications, he would be quite likely to improve in a number of these areas, and . . . the deficits and the lack of capacities that kind of interfere with his ability to rationally proceed and understand things and so on would get a lot better.” (*Id.* at 53.)

In response to a series of questions about Dr. Pyant’s testimony, Dr. Heilbrun admitted that he did not have the “luxury” of observing Defendant over a period of time; while, on the other hand, “Dr. Pyant had the . . . capacity to . . . have [Defendant] observed at great length while he was at Butner, and that’s a . . . good luxury to have, and it’s important information.” (*Id.* at 54.) Instead, Dr. Heilbrun attempted to ascertain whether Defendant’s symptoms appeared to be part of a genuine mental illness based on collateral information, and “was able to gather that there’s a lot of evidence that they are,” such as Defendant’s family mental health history. (*Id.* at 54-55.) This information led Dr. Heilbrun to conclude that Defendant “has a severe mental illness that is probably in the schizophrenic spectrum, and that what he’s experiencing are delusions that leave his thinking in conversation fairly intact.” (*Id.* at 55-56.)

On cross-examination, counsel for the Government noted that Dr. Heilbrun stated on several occasions during his testimony, as well as in his report, that Defendant suffers from a mental illness, but “it wasn’t until the very end of [his] direct examination” that Dr. Heilbrun stated, for the first time, what that mental illness may be—a mental illness in the schizophrenic spectrum. (*Id.* at 57.) Dr. Heilbrun acknowledged that he did not provide any schizophrenic diagnosis in his report. (*Id.*) He explained that the report only focused on Defendant’s

competency, but he was now testifying that Defendant has paranoid schizophrenia. (*Id.* at 58.)

Dr. Heilbrun also acknowledged that when evaluating somebody who is not reliable and honest, it is a good idea to get information from third party sources, and Defendant's responses during his evaluation had not been "entirely reliable or honest." (*Id.* at 63-65.) Dr. Heilbrun noted that because third parties may be biased or may have an interest in the outcome of the assessment, the evaluator should consider other sources of information as well, such as mental health records, which are very important in this context. (*Id.* at 66-68.) For his evaluation, Dr. Heilbrun did not have any mental health records for Defendant that predated his indictment in this case. (*Id.* at 69.) For information about Defendant's prior mental condition, Dr. Heilbrun relied on Defendant's own words, as well as information provided by Ms. Tucker and Ms. Bradley, acknowledging "that it's possible that [Ms. Tucker and Ms. Bradley] were distorting information somewhat." (*Id.* at 69-70.) To reduce the chance of being given incorrect information, Dr. Heilbrun "tried very hard not to—to depend on any one source of information, but looked for something that was consistent across sources." (*Id.* at 70.) Dr. Heilbrun admitted, however, that he was unaware that Ms. Bradley had been convicted of perjury for lying before a federal grand jury in an attempt to protect Defendant. (*Id.* at 70-71, 97.) He also admitted that Ms. Tucker had "a good deal of guilt for the way that she had brought up the defendant" and probably "doesn't want to see her son go to jail for the rest of his life." (*Id.* at 73.)

With respect to Defendant's possible malingering, Dr. Heilbrun acknowledged that he did not discuss the possibility of malingering in his report, even though, in his own words, "any time someone is being evaluated in the context of a criminal case at the request of an attorney or on order of the Court, according to [the DSM-IV-TR], malingering should be very strongly

suspected.” (*Id.* at 73-75.) He also admitted that he “certainly cannot rule out malingering,” and “there’s a lot more information that [he] would like to get.” (*Id.* at 77.) For example, he would have liked to see how Defendant “would respond to appropriately prescribed psychotropic medication” and he would have liked to have had more time to examine Defendant, an evaluation on an in-patient basis, like the one conducted by Dr. Pyant, being a “very nice” opportunity and “quite a luxury.” (*Id.* at 77-78.) Dr. Heilbrun indeed noted that “if [he] had the opportunity to—to see [Defendant] kind of periodically and over a long period of time, then [he] would get some very valuable information about the patterns of [Defendant’s] behavior.” (*Id.* at 78-79.)

The next witness at the hearing was Ms. Tucker. However, before she took the stand, Defendant requested to be excused from the courtroom, as he did not want to be present for his mother’s testimony. (*Id.* at 87-89.) Ms. Tucker stated that she had been in telephone contact with Defendant during his incarceration and had also visited him. (*Id.* at 90.) She testified that she often has normal conversations with Defendant, but sometimes, during a conversation, “he’ll go into another world.” (*Id.* at 91.) Some examples she mentioned were Defendant’s statements to her that she “sold him to the government” and that some device was implanted in him at FMC Butner. (*Id.* at 92.) She testified that Defendant had told her that “he d[id]n’t have a lot of trust in” defense counsel, believing that his counsel is “working with the government against him.” (*Id.* at 92-93.)

C. Analysis and Findings of Fact

Based upon the record before us, we are compelled to conclude that the Government has proven, by a preponderance of the evidence, that Defendant does not suffer from a mental disease or defect that renders him incompetent to stand trial. *See Velasquez*, 885 F.2d at 1089 (noting

that the Government has the burden of proof at the competency hearing). The record demonstrates that Defendant is able to understand the nature and consequences of the instant proceedings and can assist properly in his defense. We agree with Dr. Pyant's findings that Defendant is competent to stand trial and that Defendant's conduct and the other evaluators' findings that he suffers from a mental illness should be attributed to malingering. Dr. Pyant's testimony and Dr. Heilbrun's testimony at the competency hearing provide further support for our conclusion.

Defendant has been in federal custody on these charges since April 26, 2007. He was arrested in the Northern District of Georgia after being a fugitive for over a year. In moving for pretrial detention of Defendant, the Government stated that Defendant was facing a statutory mandatory minimum penalty "of life imprisonment, plus 30 years, a fine of \$14,000,000, from 10 years to a lifetime of supervised release, a special assessment of \$1,000, and forfeitures." (ECF No. 368 at 4.) During the time that Defendant has been in federal custody, he has spent approximately nine months undergoing competency evaluations at MCC-NY and FMC Butner. He has consistently refused to undergo psychological testing and has refused psychotropic medications. During court proceedings, Defendant has exhibited a range of behavior, from calm to belligerent. He has been evaluated five times, by several psychologists and psychiatrists, with mixed results. Of all the evaluations, Dr. Pyant's was the longest and most comprehensive and involved more medical professionals than the other evaluations. Dr. Pyant's diagnosis of Malingering provides the most credible explanation for Defendant's conduct during the pendency of this case. We agree with Dr. Pyant's findings and his diagnosis that Defendant is malingering. (See FMC Butner Report II at 8-10.) Defendant may have some mental health issues, but he is

not mentally incompetent. We find that Defendant is malingering and that he is able “to understand the nature and consequences of the proceedings against him” and “to assist properly in his defense.” *See* 18 U.S.C. § 4241; *cf. United States v. Moruzin*, No. 05-306 , 2010 WL 2817191 (D.N.J. July 15 2010) (“[A] Court need only assess the defendant’s ability to understand and assist with the proceedings, and need not determine whether the defendant will act in conformity with such understanding and ability.”). Our finding is certainly consistent with Dr. Voskanian’s concern and with Dr. Pyant’s opinions after months of evaluating Defendant at FMC Butner. Dr. Voskanian noted that Defendant’s “presentation was suggestive of a serious thought disorder; however, on the other hand, malingering cannot be ruled out.” (Voskanian Report at 8.) He recommended close monitoring and follow-up in a psychiatric facility setting. (*Id.*) Dr. Pyant did exactly that, and his findings obviously support and verify Dr. Voskanian’s assessment.

With respect to the opinion of Dr. Ryan, who evaluated Defendant over approximately a one month period, certain aspects of his evaluation appear inconsistent with those of the other evaluators, but consistent with malingering. For example, the olfactory hallucinations that Defendant frequently reported while at MCC-NY and which Dr. Ryan referred to as a basis for diagnosing Defendant with “a severe psychotic illness” (Ryan Report at 5) do not appear in the reports of any of the other evaluators. There are no mentions of Defendant suffering from or reporting any olfactory hallucinations during two separate four-month periods at FMC Butner. And while Defendant reported auditory hallucinations both during Dr. Voskanian’s evaluation and while at FMC Butner, he “denied any during [Dr. Ryan’s] evaluation.” (*Id.* at 6.) Notably, as he had in all other evaluations, Defendant “was uncooperative [with Dr. Ryan], offering

inadequate information to refine the diagnosis [of Psychotic Disorder NOS].” (*Id.*) Dr. Ryan noted that “[i]t was difficult to assess Mr. Tucker’s current mental status because of his refusal to speak with evaluators.” (*Id.* at 5.) Yet even in view of Defendant’s lack of cooperation with the evaluation process, which certainly complicated Dr. Ryan’s evaluation, and the medico-legal context of Defendant’s evaluation—two of several factors indicative of malingering (*see* FMC Butner II Report at 8)—Dr. Ryan does not appear to have considered the possibility that Defendant was malingering (*see* Ryan Report). This is difficult to comprehend, especially since “any time someone is being evaluated in the context of a criminal case at the request of an attorney or on order of the Court, according to [the DSM-IV-TR], malingering should be very strongly suspected.” (Hr’g Tr. 75.) Defendant’s evaluation at FMC Butner lasted several months longer than his evaluation at MCC-NY, a greater range of Defendant’s behavior was monitored at FMC Butner, and Dr. Pyant considered the possibility of malingering in arriving at his opinion. On the basis of the record before us, we conclude that Dr. Pyant’s findings more accurately reflect Defendant’s condition than those of Dr. Ryan.

As for Dr. Heilbrun’s evaluation, he spent approximately two and a half hours with Defendant, of which less than an hour and a half were spent interviewing him. (Heilbrun Report at 1.) While the length of time they spent together is not dispositive, we do note that Dr. Pyant testimony that he “could [not] have rendered a proper and complete evaluation of [Defendant] after having spoken to him for simply an hour and a half” (Hr’g Tr. 22) is perfectly reasonable. Indeed, Dr. Heilbrun himself referred to an in-patient evaluation, such as the one Dr. Pyant had the opportunity to perform, as a “luxury,” further testifying that it would have allowed him to “get some very valuable information about the patterns of [Defendant’s] behavior.” (*Id.* at 78-

79.) In the absence of any past mental health records, Dr. Heilbrun relied, to a significant extent, on information gathered from Defendant, Ms. Tucker, and Ms. Bradley to make up for the short amount of time he spent with Defendant. (Id. at 66-70.) We find that this information, gathered from questionable sources, does not compensate for Dr. Heilbrun's inability to evaluate Defendant over a longer period of time. We also note that Dr. Heilbrun's failure to consider malingering is problematic. (*id.* at 73) We find that Defendant's malingering and Dr. Heilbrun's inability to evaluate Defendant over a longer period of time resulted in his less than compelling opinion about Defendant's lack of competency.

IV. CONCLUSION

For all of the reasons set forth above, we conclude that Defendant is competent to stand trial.

An appropriate Order follows.

BY THE COURT:



R. BARCLAY SURRICK, J.

