UNDER SEAL AND SUBJECT TO PUBLIC INSPECTION ONLY BY ORDER OF A COURT OF THE APPELLATE DIVISION

No. 23A21, 64A21, 442PA20 DISTRICTS 22B, 13A, 12

SUPREME COURT OF NORTH CAROLINA

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STATE OF NORTH CAROLINA	)	
	)	
v.	)	From Davidson County
	)	
DARRELL TRISTAN ANDERSON	)	
	)	
_____	)	
STATE OF NORTH CAROLINA	)	
	)	
v.	)	From Columbus County
	)	
RILEY DAWSON CONNER	)	
	)	
_____	)	
STATE OF NORTH CAROLINA	)	
	)	
v.	)	From Cumberland County
	)	
JAMES RYAN KELLIHER	)	
	)	

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BRIEF OF AMICI CURIAE

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STATE OF NORTH CAROLINA v. RILEY DAWSON CONNER	)	From Columbus County
STATE OF NORTH CAROLINA v. JAMES RYAN KELLIHER	)	From Cumberland County

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BRIEF OF AMICI CURIAE

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Pursuant to Rule 28(i) of the North Carolina Rules of Appellate Procedure, the Center for Child and Family Health, National Association of Social Workers,

including its North Carolina Chapter, and Disability Rights North Carolina submit this brief as amici curiae in support of Defendant.[1]

NATURE OF APPLICANTS' INTERESTS

The organizations below request to participate in this matter as amici curiae to address the imperative to consider childhood trauma in sentencing children.[2]

Established in 1996, **Center for Child and Family Health (CCFH)** is a community-based nonprofit located in Durham, North Carolina; the Center is also a Category III site within the National Child Traumatic Stress Network (Substance Abuse and Mental Health Services Administration, U.S. DHHS). CCFH's mission focuses on the prevention, assessment, and treatment of childhood trauma in Durham and surrounding counties, serving more than 2,000 children and families each year. The organization is also committed to developing and sustaining a child (trauma) mental health workforce across North Carolina by offering clinical training, consultation, and technical assistance. CCFH faculty hail from Duke University, the University of North Carolina at Chapel Hill, and North Carolina Central University. They include clinicians, researchers, nationally endorsed trainers in evidenced-based treatment models, and implementation experts, all focused on childhood trauma and mental health. CCFH requests to participate in this matter as amicus curiae to address the impact this Court's ruling may have on the many children and youth in

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[1] No other person or entity, other than Amici, their members, or their counsel, directly or indirectly, either wrote this brief or contributed money for its preparation.

[2] Amici seek to submit this brief it in support of the Defendants in the above captioned cases, and in support of other similarly situated juvenile offenders.

our State who experienced significant psychological trauma and adversity in childhood and have trauma- and adversity-related symptoms that have been inadequately treated by mental health professionals.

The National Association of Social Workers (NASW), including its North Carolina Chapter, is the largest association of professional social workers in the U.S. with 110,000 members and 55 chapters. The North Carolina Chapter has 5,215 members. NASW has worked to develop high standards of social work practice while unifying the social work profession. NASW promulgates professional policies, conducts research, publishes professional studies and books, provides continuing education, develops and enforces the *NASW Code of Ethics*, and develops policy statements on issues of importance to the social work profession. Consistent with those statements, NASW supports the elimination of the imposition of life sentences without the possibility of parole for juveniles convicted of a capital offense in an adult court.[3] NASW also supports legislative and judicial action applying the principles of *Miller v. Alabama,* 567 U.S. 460 (2012) to prohibit the imposition of a life sentence without parole on minors. NASW participated in an amicus brief to the U.S. Supreme Court in *Miller v. Alabama*, filed by the American Psychological Association and joined by several other professional mental health provider groups, which addresses the scientific research demonstrating the fundamental differences

[3] NASW Policy Statement: Juvenile Justice and Delinquency Prevention, Social Work Speaks 198, 202 (11th ed. 2018).

between juvenile and adult minds, as well as the fact that juveniles have greater immaturity, vulnerability, and changeability than adults.

Disability Rights North Carolina (DRNC) is North Carolina's designated Protection and Advocacy System ("P&A"). DRNC is authorized by federal law to protect and advocate for the rights of individuals with disabilities. *See* Protection and Advocacy for Individuals with Mental Illness ("PAIMI Act"), 42 U.S.C. § 10801 *et seq*. The federal regulations governing the PAIMI Act mandate that, as the P&A, DRNC is empowered to "pursue administrative, legal or other appropriate remedies to protect and advocate on behalf of individuals with mental illness to address abuse, neglect or other violations of rights." 42 C.F.R. § 51.31(a). DRNC's interest in the present case is to highlight the cruelty of imposing *de facto* life sentences on juveniles whose crimes are committed amidst significant childhood trauma and who, as a result, are less culpable for their crimes and face reduced life expectancy.

ARGUMENT

Summary of Argument

Evolving understanding of brain science and childhood development have guided courts, including the U.S. Supreme Court, in assessing the legal and societal implications of punishing juveniles. Crafting constitutional parameters for *de facto* life without parole for juveniles must incorporate the developed body of science on the impact of trauma among youth subject to sentencing.

Childhood trauma impairs the ability of youth to assess danger and understand consequences, reducing culpability. Pervasive trauma in childhood

shortens life span on a population level. These realities, in the context of sentencing for serious crimes committed by juveniles, mean that sentencing such children to more than 25 years in prison without the possibility of parole is cruel and unusual punishment. [4]

I. The Well-Established Imperative to Consider Current Brain Science in the Context of Sentencing Children Must Include Consideration of the Brain Science of Childhood Trauma

It is a well settled feature of sentencing in the juvenile context that children's brain development must be considered in assessing culpability and other factors. *See*, *e.g.*, *Miller v. Alabama*, 567 U.S. 460, 471 (2012) ("[scientific] findings—of transient rashness, proclivity for risk, and inability to assess consequences—both lessened a child's 'moral culpability' and enhanced the prospect that, as the years go by and neurological development occurs, his 'deficiencies will be reformed.'") (citing *Roper v. Simmons*, 543 U.S. 551, 569- 570 (2005) and *Graham v. Florida*, 560 U.S. 48, 68-69 (2010)); *see also*, *State v. Young*, 369 N.C. 118, 120, 794 S.E.2d 274, 276, (2016) (applying standards to juvenile sentencing premised on differences in cognition as adults and children).

A disproportionate number of children who become involved in the juvenile justice system have experienced childhood trauma, as defined below. In one

[4] A summary of the trauma experienced by Defendant Conner, based on the Record in his case, is attached as Appendix A. This summary is intended to be illustrative. The records in *Anderson* and *Kelliher*, although less detailed, reflect trauma histories as well. Given the pervasive presence of childhood trauma history among those in the juvenile justice system, *see*, *infra*, Section I, considerations of trauma will generally be applicable to juveniles who come before the Court.

longitudinal study of juvenile offenders, over 90% had experienced at least one trauma, and 84% had experienced two or more. Karen M. Abram, *et al*, *PTSD, Trauma, and Comorbid Psychiatric Disorders in Detained Youth,* June 2013 U.S. Dep't. of Justice, Office of Juvenile Justice and Delinquency Prevention, Juvenile Justice Bulletin (2013) (adapting Abram, K.M., *et al*., 2004. *Posttraumatic stress disorder and trauma in youth in juvenile detention*. Archives of General Psychiatry 61:403–410; and Abram, K.M., *et al*., 2007. *Posttraumatic stress disorder and psychiatric comorbidity among detained youth*. Psychiatric Services 58:1311–1316.)

Trauma plays an important population-level role in cognition and long-term health and morbidity. As the Court evaluates whether sentencing juveniles to lengthy prison sentences is cruel or unusual, the prevalence of trauma histories among justice system-involved juveniles must be considered in addition to developmental considerations applicable to all children. *Id*.

II. Childhood Trauma Impairs Cognitive Processing and Population Life Expectancy

The National Child Traumatic Stress Network defines childhood trauma as the product of "a frightening, dangerous, or violent event that poses a threat to a child's life or bodily integrity"; alternatively, the event may threaten the life or physical security of the child's loved one. About Child Trauma, National Child Traumatic Stress Network (2018), https://www.nctsn.org/what-is-child-trauma/about-child-trauma. Examples of childhood trauma include sexual, physical, and psychological abuse; exposure to interpersonal and community violence; a serious accident; the unexpected or violent death of a close family member; natural

and man-made disasters; and neglect. Understanding Child Trauma (SMA-15-4923), U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2015), https://www.samhsa.gov/sites/default/files/programs_campaigns/nctsi/nctsi-infographic-full.pdf.

A. How Trauma Impairs a Child's Functioning

Complex biopsychosocial factors determine how trauma impacts an individual child. These factors include but are not limited to: trauma type; frequency, duration, and intensity of the traumatic experience or exposure; developmental timing of the traumatic experience; prior trauma history; caregiver response to the traumatic experience; social supports; and other factors. Helping Children and Adolescents Cope with Disasters and Other Traumatic Events (NIH Publication No. 19-MH-8066), U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health (2020), https://www.nimh.nih.gov/health/ publications/helping-children-and-adolescents-cope-with-disasters-and-other-traumatic-events/19-mh-8066-helpingchildrenwithdisasters-508_158447.pdf

When trauma is prolonged, chronic, or complex, the impact on an individual child may be heightened. Adverse effects are expressed by the early onset of risk behaviors, dysregulation of biological stress systems, alterations in brain anatomy and function, suppression of the immune system, and potential alterations in the child's epigenome. Michael D. De Bellis, *et al*, *Brain Structures in Pediatric Maltreatment-Related Posttraumatic Stress Disorder: A Socio-demographically*

Matched Study, 52 Biological Psychiatry, 1066-1078 (2002) (hereinafter "De Bellis"); Frank W. Putnam, *The Impact of Trauma on Child Development*, 57 Juvenile and Family Court Journal, 1-11 (2006); Dana M. Hagele, *The Impact of Maltreatment on the Developing Child*, September/October Vol. 66 No. 5 NC Med J, 356-359 (2005).

Chronic traumatic stress may manifest as anxiety, depressive symptoms, behavioral dysfunction, attention and impulse control difficulty, learning and cognitive difficulty, sleep and eating disturbance, somatic complaints, and even the development of psychiatric disorders such as posttraumatic stress disorder (PTSD) and substance use disorder. What is Child Traumatic Stress, National Child Traumatic Stress Network (November 05, 2018), https://www.samhsa.gov/sites/ default/files/programs_campaigns/ childrens_mental_health/what-is-child-traumatic-stress.pdf.

Trauma's adverse effect on children's cognition and behavior has been well-documented and must be considered in addition to the typical differences between child and adult cognition in evaluating culpability. As detailed below, studies of adverse childhood experiences have, for the last 20 years, also revealed serious long-term health consequences related to multiple trauma experiences, including shortened life span.

B. Cumulative Adverse Childhood Experiences Impair Mental, Physical, and Behavioral Functioning

Adverse childhood experiences (ACEs) are negative, potentially traumatic experiences or exposures that occur between birth and seventeen years of age. The Centers for Disease Control and Health Prevention, in collaboration with

researchers at Kaiser Permanente, examined the impact of ACEs on long-term health and well-being. V.J. Felitti, *et al*, *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study*, 14(4) American Journal of Preventive Medicine, 245-258 (1998) (hereinafter "Felitti"). The ten ACEs categories are: emotional abuse, physical abuse, sexual abuse, mother treated violently, substance abuse in the household, mental illness in the household, parental separation or divorce, incarcerated household member, emotional neglect, and physical neglect. About the Kaiser ACE Study, Centers for Disease Control and Prevention (April 6, 2021) https://www.cdc.gov/violenceprevention/aces/about.html (hereinafter "ACEs Study").

The landmark 1998 ACEs Study, as well as the dozens of studies that followed, demonstrated a graded relationship between childhood adversity and poor adult health outcomes. *Id*. Specifically, higher ACE scores were linked to greater risk of injury, mental health and maternal health concerns, and chronic and infectious diseases, and poor, long-term psychosocial functioning.[5] The impact of

[5] ACE checklists and scores are useful for population-level research, although they are not used to diagnose an individual, guide treatment planning, or predict future health for that individual. ACE scores are calculated as a simple sum of self-reported adversity selected from a relatively limited list of options. They do not address developmental timing of the experience; frequency, duration, or intensity of the reported experiences; additional trauma or ACEs not captured by the checklist; caregiver response to the traumatic experience; or social supports. L. Amaya-Jackson, *et al,* Beyond the ACE Score: Perspectives from the NCTSN on Child Trauma and Adversity Screening and Impact. National Center for Child Traumatic Stress (2021) https://www.nctsn.org/sites/default/files/resources/special-resource/beyond-the-ace-score-perspectives-from-the-nctsn-on-child-tauma-and-

childhood adversity on adult well-being is thought to be expressed by risk behaviors, the direct effect of elevated stress hormones on neurons and somatic cells, epigenetics, and psychosocial factors. De Bellis, *supra*, 52:1066–1078; Shannon M. Monnat, *et al*, *Long Term Physical Health Consequences of Adverse Childhood Experiences*, Sep. 56(4) Sociol Q., 723-752 (2015).

C. Childhood Trauma and Adversity Significantly Decrease Life Expectancy

A growing body of research has demonstrated that childhood trauma and ACEs are associated with premature death.

Retrospective analysis of data captured during the original CDC/Kaiser Permanente ACEs study examined the relationship between self-reported childhood ACE scores and premature death in adulthood. David W. Brown, *et al*, *Adverse childhood experiences and the risk of premature mortality*, 37(5) Am J Prev Med., 389-396 (2009). Investigators found that adults with ≥ six ACEs ***died approximately 20 years earlier*** than individuals who did not report similar childhood adversity; the average years of life lost per death was approximately three times greater among adults with ≥ six ACEs, compared to those without self-reported ACEs. *Id*. The five leading causes of premature death included diseases of the circulatory system and cancers, followed by diseases of the nervous, respiratory, and gastrointestinal systems. *Id*.

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adversity-screening-and-impact.pdf. Importantly, ACEs scores do not reflect the synergistic effect of more than one traumatic or adversity experienced during childhood, which collectively can increase the extent and severity of mental and physical illness. Karen T. Putnam, *et al*, *Synergistic childhood adversities and complex adult psychopathology*. 26(4) Journal of Traumatic Stress, 435-442 (2013).

A retrospective, population-based study evaluated a large cohort of Danish children born between 1980 to 1988, following them until they reached 16 to 34 years of age. Naja H. Rod, *et al*, *Trajectories of childhood adversity and mortality in early adulthood: a population-based cohort study*. Aug. 396(10249) Lancet, 489-497 (2020). Subjects were categorized in terms of low, moderate, and high levels of childhood adversity. Young adults in the high adversity category had a 4.5 times higher risk of premature death as compared to the low adversity group; the most common causes of premature death among the high-risk group were accidents and suicides, followed by diseases of the circulatory and nervous systems. *Id*.

A prospective birth cohort study tracked children born in Great Britain in 1958, assessing for predetermined adversities at specific time intervals. Michelle Kelly-Irving, *et al*, *Adverse childhood experiences and premature all-cause mortality*. Sep. 28(9) Eur J Epidemiol., 721-734 (2013). Specifically, children were evaluated for: out-of-home placement, physical neglect, household member in prison or on probation, juvenile justice involvement, parental separation, household member with mental illness, and family member with a history of alcohol abuse. They were then assigned to one of three categories: no adversity, one adversity, or ≥ two adversities. At follow-up, adult men with ≥ two childhood adversities were found to have a 57% higher death rate compared to those with no adversity. Among women, a graded relationship was observed between childhood adversity and mortality; women with one ACE had a 66 % increased risk of death and women with ≥ two

ACEs had an 80 % increased risk of death, as compared to women with no reported adversity. *Id.*

In summary, significant exposure to trauma – as experienced disproportionately by those in the juvenile justice system – impairs cognition and reduces culpability, and can be expected, on a population level, to lead to shortened life span.

III. Sentencing a Traumatized Youth to More Than 25 Years Without the Possibility of Parole Is Inconsistent With Current Brain Science, Would Exacerbate Existing Racial and Socioeconomic Disparities, and Would Constitute Cruel or Unusual Punishment

A. *A Shorter Life Due to Childhood Trauma May Convert a Sentence to* De Facto *Life Without Parole*

Life expectancy of a specific individual is unknowable. The Court of Appeals has used mortality tables as an average expected lifespan in determining whether a sentence is a *de facto* sentence of life in prison. *State v. Conner,* 853 S.E.2d 824, 825 (N.C. App. 2020). To the extent that mortality tables or similar averages are used, the reduced life expectancy of those who experience childhood trauma should inform the likely range of life expectancy for juveniles facing lengthy sentences. *See*, *supra*, pp. 10-11 (summarizing literature finding decreased life expectancy of up to 20 years); *see also*, *Tisdale v. State*, 257 So. 3d 357, 363, (Fla. 2018) (Pariente, J., concurring) (noting research indicating a 20-year lower average life expectancy for those with five or more ACEs). Given the prevalence of trauma among juveniles involved in the justice system, and the data pointing to decreased life expectancy of

up to 20 years, a sentence of more than 25 years without parole would frequently result in *de facto* life without parole.

B. *Some Children Are More Exposed to Trauma and Are Less Able to Develop Resilience Based on Social and Environmental Factors Beyond Their Control, Exacerbating Existing Disparities*

Children who live otherwise stable lives with protective adults, adequate means, and safe environments, are generally able to weather a traumatic event more effectively than those without similar protective elements. Children who are living in poverty, without parental support, amid violence, and with other exposures generally have much lower reservoirs of resilience.

> Exposure to traumatic events is not random. . . . Findings from the trauma literature indicate that numerous factors - for example, race, environment, socioeconomic status, education, and gender - may influence risk for exposure to traumatic events. In general, men, and especially African Americans, particularly socio-economically disadvantaged African Americans living in urban areas, people with lower educational levels, and urban youth are at heightened risk for traumatic exposures.

Kathleen Wayland, *Imagining Mitigation: The Importance of Recognizing Trauma Throughout Capital Mitigation Investigations and Presentations*, 36 Hofstra L. Rev. 923, 932-933 (2008). A North Carolina-specific study echoes this conclusion:

> Certain factors can help a child to build resiliency and mitigate the negative effects ACEs and the toxic stress response pose to health and development. The most important of these protective factors is a safe, stable and supportive relationship with a caring adult.

Anna E. Austin, *et al*, *The Effect of Adverse Childhood Experiences on Adult Health: 2012 North Carolina Behavioral Risk Factor Surveillance System Survey,* 167 May State Center for Health Statistics Studies, 3 (2014).

Ignoring the role of childhood trauma would exacerbate existing disparities created by the social and environmental factors that subject many justice system involved juveniles to trauma in the first place.

CONCLUSION

Courts have long understood that children's brains are different from adults' and have incorporated that understanding when it comes to sentencing. The experience of childhood trauma must also be factored into sentencing because of the role of trauma in altering brain functioning and impairing long term health and mortality. Trauma falls most heavily on children who are already subject to the harsher conditions of life. Permitting children who have endured significant trauma to be sentenced to more than 25 years without parole is cruel and unusual as a functional life sentence for crimes committed when their brains were not only immature in development, but impaired by traumatic events beyond their control.

Amici ask that the Court hold that sentencing a juvenile with significant trauma history to more than 25 years without parole is tantamount to a life sentence without parole and is therefore cruel and unusual. Amici further suggest that, given the prevalence of significant trauma history among those in the juvenile justice system, the Court should define the limits of life without the possibility of parole for all juvenile offenders to no more than 25 years.

Respectfully submitted, this 7th day of May, 2021.

DISABILITY RIGHTS NORTH CAROLINA

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CERTIFICATE OF SERVICE

I hereby certify that I have filed the original Motion for Leave to File Amicus Curiae Brief together with the proposed Brief of Amici Curiae, pursuant to Rule 26 by electronic means with the North Carolina Court of Appeals, and that I have served a copy of the brief pursuant to Rule 26 by email upon the following attorneys:

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APPENDIX A

Riley Dawson Conner Psychological Trauma and Significant Adversity Throughout Childhood

1. Riley Conner experienced significant adversity and psychological trauma throughout his childhood, minimally including: life-long history of caregiver and placement instability; limited and often deleterious relationship with his biological parents; inadequate and often deleterious adult supervision; removal from his home by Child Protective Services; fragmented and limited educational engagement, ultimately dropping out of school prior to completing 6th grade; exposure to parental substance use and its adverse effects; exposure to endemic community substance use; exposure to parental incarceration and criminal justice system involvement; and direct exposure to prostitution.

    a. Caregiver and Placement Instability
        i. Riley was born on 23 August 2000 to his twenty- and eighteen- year old father and mother, respectively. Following his birth, Riley resided in the home of his maternal grandparents; his father did not live in the home and his mother would "[d]rop in and drop out" of the home. Riley's aunt testified that "His mother and father was constantly in and out of his life. They were not by no means anywhere close to being stable parents. They rejected [Riley] time and time again" (Tpp 36, 42; Rp 74; Defendant's Exh. 17, Section 9).
        ii. When Riley was approximately five years of age, Child Protective Services ("DSS") became involved; the children were removed from their parents' custody due to active substance use (Tpp 39, 48, 150; Defendant's Exh. 17, Sections 9 and 10).
        iii. When Riley was six years of age, his grandparents gained full custody of him and his sister (Tpp 39, 48, 150; Defendant's Exh. 17, Sections 9 and 10). However, Riley often stayed with his maternal aunt on weekends because his grandmother struggled to care for the children (Tpp 38-39, 43-45, 48, 150, 268; Defendant's Exh. 17, Section 10).
        iv. When Riley was eight years of age, his maternal grandmother had a stroke. Riley alternatively resided with his mother and his paternal grandmother until his maternal grandmother completed rehabilitation.
        v. When Riley was eleven years of age, his father was released from prison. Riley went to live with his father and stepmother on Savannah Extension Road. (Tp 79, 99-101, 152; Defendant's Exh. 17, Section 10).
        vi. When Riley was twelve years of age, his father was arrested for robbing a bank in South Carolina. Riley went to live with his mother and stepfather after his father was arrested for robbing a bank in South Carolina.
        vii. When Riley was fourteen years of age, he was noted to be "just drifting from one place to the other." He lived with his stepsister and her boyfriend, his

grandmother, and his great-grandmother, his aunt (Charlene), and his cousin (Brad Adams) on Savannah Extension Road (Tpp 155-56).

viii. Just before turning fifteen, Riley went to live with his mother and stepfather in South Carolina. He moved often, residing with his father, his father's ex-wife, and his stepsister and her boyfriend (Tp 156).

ix. At 15 years of age, Riley and his father moved to Florida; Riley remained there for a short period of time before returning to North Carolina (Tpp 86-87, 157, 163-64).

x. After returning from Florida, Riley stayed with his mother for a short period of time before relocating to Savannah Extension Road.

xi. At fifteen-and-a-half-year-old Riley was residing with his cousin (Brad) and "legal guardian" (Aunt Charlene) on Savannah Extension Road (Tpp 11-14; Defendant's Exh. 17, Section 9).

b. Limited and Deleterious Relationship with Biological Parents

i. Riley's aunt testified that "His mother and father was constantly in and out of his life. They were not by no means anywhere close to being stable parents. They rejected [Riley] time and time again" (Tpp 36, 42; Rp 74; Defendant's Exh. 17, Section 9).

ii. Riley's mother only attended one or two of his birthday celebrations by the time he turned six (Tpp 38-39, 43-45, 48, 150, 268; Defendant's Exh. 17, Section 10).

iii. Riley's mother often promised to visit, but then failed to appear. Riley became emotional when he did see his mother. When Riley was just seven years of age, he begged his mother to remain with him. However, she left; he responded by running down the highway after her screaming, "I hate you, I hate you" (Tpp 38-39, 43-45, 48, 150, 268; Defendant's Exh. 17, Section 10).

iv. When Riley was fifteen years of age, he relocated to Florida with his father. However, "that didn't last long because he walked in on his daddy with a lady and man in a compromising position smoking crack, so he wanted to come back up here immediately" (Tpp 86-87, 157, 163-64).

v. While Riley was at hospitalized at UNC for uncontrollable seizures in March 2016, his mother slapped his face, jumped on him, and got him in a choke hold because he wanted to leave the hospital. Riley held up his hands and said, "I ain't going to hit you, mom. I love you." (Tpp 116-17, 172, 273, 278; Defendant's Exh. 17, Section 9)

c. Inadequate and Deleterious Adult Supervision

i. When Riley's was eight years of age, his grandmother had a stroke and spent time in a rehabilitation facility. During that time period, Riley became "kind of this free agent" (Tpp 47, 49-50, 78, 151, 173-74).

ii. From the age of nine years, Riley was regularly engaged in the use of marijuana, alcohol, and other illicit substances, often to the point of intoxication and

incapacitation. Riley's caregivers failed to provide even the most basic supervision to address this concern.

iii. From third grade onward, Riley had a history of significant school absence and truancy. Riley's caregivers failed to provide even the most basic supervision to address this concern.

iv. At eleven years of age, Riley was involved in selling marijuana (Tpp 49, 118, 182, 299; Defendant's Exh. 17, Section 9).

v. When Riley was twelve years of age, he became sexually active and had four female partners (Tpp 152, 174; Defendant's Exh. 17, Section 9).

vi. When Riley was fourteen years of age and in the care of his grandmother:

1. Riley acted as a "free agent", spending time in an abandoned trailer and using illicit substances on Savannah Extension Road (Tpp 47, 50-51, 81).
2. Riley spent extensive time with his cousin, Brad Adams, whom he reportedly "worshipped" [Note: Brad is ten years older than Riley. Riley's mother testified that Brad Adams and his father discovered that Brad's grandmother had died; reportedly, they buried her in the back yard so that they could collect her Social Security checks] (Tpp 47, 50-51, 81).
3. Riley was "just drifting from one place to the other." He did not go to school. Rather, he "was just doing drugs and partying with Brad" and others (Tpp 155-56).
4. Riley was obtaining illegal drugs from Brad who sold heroin, methamphetamine, and pills. (Tpp 80-81, 119-22, 136; Defendant's Exh. 17, Section 9).

vii. When Riley was fifteen years of age, he relocated to Florida with his father. However, "that didn't last long because he walked in on his daddy with a lady and man in a compromising position smoking crack, so he wanted to come back up here immediately" (Tpp 86-87, 157, 163-64).

viii. At 15 years of age, Riley returned to North Carolina after briefly residing in Florida with his father; he stayed with his mother briefly and then relocated to Savannah Extension Road. Reportedly, Riley just wanted to be with Brad because there were no rules when he lived on Savannah Extension Road (Tpp 86-87, 157, 163-64).

d. Removal from the home by Child Protective Services ("DSS")

i. When Riley was approximately five years of age, Child Protective Services ("DSS") became involved with the family because Riley and his sister had spent time in a "crack house." DSS ultimately removed Riley and his sister from their parents' custody due to active substance use; they were placed with their grandparents (Tpp 39, 48, 150; Defendant's Exh. 17, Sections 9 and 10).

ii. In March 2016, Riley was admitted to UNC Hospitals due to numerous seizures per day. Riley's mother slapped his face, jumped on him, and got him in a choke hold because he wanted to leave the hospital. Riley held up his hands and said, "I ain't going to hit you, mom. I love you." Riley's mother was asked to leave the hospital. A social worker from UNC hospital filed a complaint with DSS. Riley was placed with his stepsister and her boyfriend (Tpp 116-17, 172, 273, 278; Defendant's Exh. 17, Section 9).

e. Fragmented and Limited Educational Engagement

i. Riley had seventeen absences and failed his End-of-Grade (EOG) testing in 3rd grade (Tpp 47, 49-50, 78, 151, 173-74).

ii. Riley repeated the 3rd grade and was absent twenty-five days (Tpp 47, 49-50, 78, 151, 173-74).

iii. Riley was absent eleven days in 4th grade (Tpp 62, 73, 152, 174).

iv. Riley was absent from 5th grade for sixteen days; he failed his End-of-Grade (EOG) testing and was scheduled to repeat 5th grade.

v. Riley transferred to Nakina Middle School; rather than repeating 5th grade, he was placed in 6th grade. Riley was then transferred to Waccamaw Elementary School in Ash.

vi. Riley transferred to Nakina Middle School in January 2013 after his father was arrested, and he was sent to live with his mother and stepfather. Reportedly, the school would not put Riley in a classroom; he was placed with school janitors (Tp 77). Ultimately, he was expelled for disruptive behavior and bullying (Tpp 77, 152, 175, 203-04; Defendant's Exh. 17, Sections 9 and 10.

vii. Riley attended an alternative school in Columbus County and then an alternative school in South Carolina. While in South Carolina, he was charged with assault and expelled after striking another student in the head with a textbook. The charge was later dismissed; Riley re-enrolled as a 6th grade student (Tpp 124, 152-53, 155-56, 176, 204-05; Defendant's Exh, 17, Section 9).

viii. While in 6th grade student in South Carolina, Riley was adjudicated delinquent and expelled for simple possession of marijuana (Tpp 124, 152-53, 155-56, 176, 204-05; Defendant's Exh, 17, Section 9).

ix. Following adjudication and expulsion, Riley was sent to Georgetown Marine Institute and then, ultimately, back to his grandmother's home (Tpp 124, 152-53, 155-56, 176, 204-05; Defendant's Exh, 17, Section 9).

x. Riley's last education records were from sixth grade (Tpp 124, 152-53, 155-56, 176, 204-05; Defendant's Exh, 17, Section 9).

xi. At fourteen years of age, following diagnosis of substance use disorder, Riley was "homeschooled" by his grandmother who lacked the ability to offer this support; with regard to homeschooling "most of the work was over grandma's head" and Riley was "just too out of hand" (Tpp 49, 77-78, 176, 261, 267).

f. Direct Exposure to Parental Substance Use

i. Riley's father has a history of substance use disorder (crack cocaine). (Tpp 171, 267; Defendant's Exh. 17, Section 9). On several different occasions, Riley's father stole all of the children's Christmas presents and sold them for drugs. (Tpp 41-43, 82-83)

ii. Riley's mother has a history of substance use disorder (crack cocaine). She testified that "crack takes over your whole life and that was all I was worried about was going to get the next hit." (Tpp 68-71, 172).

iii. When Riley was approximately five years of age, he and his sister were removed from their parents' custody due to active parental substance use (Tpp 39, 48, 150; Defendant's Exh. 17, Sections 9 and 10).

g. Exposure to a Community with Endemic Substance Use

From the time he was one year of age until he was arrested, Riley lived on-and-off on Savannah Extension Road. Riley's aunt testified that their neighborhood was a "dead end, dirt-gravel road, one way in, one way out. It's about a mile long. It's a rough area of the community. Everything that's transpired and come out of that area I call the pits of hell" (Tp 38). Riley's mother testified "there's nothing but drugs down there"; it was "nowhere for a child to be" (Tpp 38, 79, 150).

h. Direct Exposure to Prostitution

When Riley was eleven years of age, his paternal aunt, Charlene, took him to motels where men paid her for sex (Tp 79, 99-101, 152; Defendant's Exh. 17, Section 10).

i. Direct Exposure to Parental Criminal Behavior and Incarceration

i. During Riley's first year of life, his father was convicted of passing worthless checks, felony breaking and entering, larceny, and possession of stolen goods (Tpp 171, 267; Defendant's Exh. 17, Section 9).

ii. When Riley's younger sister was born in June 2004, his father borrowed his grandparents' car in order to bring her home from the hospital. Instead, Riley's father drove the car through the front window of a convenience store and robbed it (Tpp 41-43, 82-83).

iii. When Riley was just four years of age, he witnessed a police raid on Savannah Extension Road. His father and uncle were arrested by armed officers as they were in possession of a truck full of marijuana. Per the record, Riley was terrified. The incident was "one of the first really traumatic things that happened in Riley's life at least that we know about" (Tpp 38-39, 72, 160; Defendant's Exh. 17, Section 10).

iv. When Riley was approximately five years of age, his father went to prison for five years and five months for larceny from the person, common law robbery,

and attaining habitual felon status. Riley's mother received probation, but could not complete it because she was "strung out on crack." She went to prison for two months when Riley was seven. (Tpp 70, 73; Defendant's Exh. 17, Sections 9 and 10).

v. When Riley was twelve years of age, his father was arrested for robbing a bank in South Carolina.

vi. By the time Riley was fifteen years of age, his father had thirty-five charges and convictions and had been in and out of prison and jail throughout Riley's life (Tpp 171, 267; Defendant's Exh. 17, Section 9). Riley's mother had been convicted of aiding and abetting robbery, worthless check, and disorderly conduct by the time Riley was fifteen years old (Tpp 68-71, 172).

2. Riley Conner's symptoms of psychological trauma and adversity were not fully treated prior to committing the crimes for which he was convicted and sentenced. Per the findings of the court:

a. As a young boy, Riley became emotional and distraught every time he saw his mother (Tpp 38-39, 43-45, 48, 150, 268; Defendant's Exh. 17, Section 10); there is no evidence that he participated in mental health assessment and/or treatment.

b. A doctor who saw eight-year-old Riley was concerned about the possibility of posttraumatic stress disorder (PTSD). Riley never received mental health treatment for the "emotional roller coaster" he was on (Tpp 44, 73-75, 126, 161, 180; Defendant's Exh. 17, Section 9).

c. At nine years of age, Riley chipped his teeth and cut his lip with a machete while using illicit substances. Riley required stitches, but there is no indication that mental health assessment and/or treatment was sought (Tpp 57, 117, 152; Defendant's Exh. 17, Section 9).

d. At eleven years of age, Riley began drinking alcohol almost daily, experiencing intoxication, vomiting, headaches, black outs, hangovers, and behaviors he later regretted. Additionally, he started using Xanax. His aunt testified he sometimes seemed "very spaced out" (Tpp 49, 118, 182, 299; Defendant's Exh. 17, Section 9). However, there is no indication that Riley benefited from comprehensive evaluation and/or treatment.

e. Riley began using opiates and heroin at thirteen and fourteen years of age, respectively. At fourteen, Riley was diagnosed with conduct disorder, cannabis use disorder, alcohol use disorder, sedative /hypnotic use disorder, and disruption of family. He was sent to Waccamaw Mental Center where he was evaluated; however, he did not receive intensive substance abuse counseling (Tpp 118-19).

3. Riley Conner was diagnosed with a significant brain (seizure) disorder at thirteen years of age; there are significant concerns that the onset of his seizure disorder predated his diagnosis by several years.

   Despite medical intervention, Riley Conner continued to experience seizures following discharge from UNC Hospitals in March of 2016. Riley's seizures were poorly controlled and debilitating at the time he committed the two crimes for which he plead guilty and was sentenced.

   a. At thirteen years of age, Riley was diagnosed with frontal lobe epilepsy, with a secondary diagnosis of behavioral problems. He was discharged on two medications "as needed for seizure clusters" (Tpp 114-15).
   b. Following his initial seizure diagnosis, Riley's family became concerned that he had been experiencing undiagnosed and untreated seizures for most of his life. Specifically:
      i. Riley's aunt testified that Riley started having night terrors around eight or nine. He would "not wake up, but he would be – the outbursts, the flailing of his arms, the slinging, the beating, walking to one end of the house to the other, trying – you could not wake him up" (Tpp 44, 73-75, 126, 161, 180; Defendant's Exh. 17, Section 9).
      ii. Riley's mother testified that Riley experienced night terrors starting two years of age. Reportedly, he held his breath, thrashed, and turned purple (Tpp 44, 73-75, 126, 161, 180; Defendant's Exh. 17, Section 9).
      iii. Riley's mother testified, "So, now that we're looking back at it, you know, we're thinking maybe he was having seizures the whole time" (Tpp 44, 73-75, 126, 161, 180; Defendant's Exh. 17, Section 9).
      iv. Riley's grandmother testified that "he's always been like that. He wakes up three or four times a night crying, screaming, talking about his dreams" (Tpp 44, 73-75, 126, 161, 180; Defendant's Exh. 17, Section 9).
   c. At fifteen years of age, Riley's seizures had become more frequent. He was having six to ten seizures per night; the number of seizures increased when Riley he ran out of his prescription medications. Riley's father took him to Conway Medical Center in South Carolina; his medication regimen was changed at that time (Tpp 163-64, 186-87; Defendant's Exh. 17, Section 9).
   d. On 22 February 2016, Riley's mother and stepfather took him to a doctor because he continued to have six to twelve seizures per night. By 25 February 2016, his nocturnal epilepsy was progressively worsening. Riley saw another doctor, who thought the seizures might be due to PTSD. The doctor changed Riley's medication again (Tpp 164, 186; Defendant's Exh. 17, Section 9).
   e. On 27 February 2016, during this period of intense seizure activity, Riley was charged with breaking and entering, larceny after breaking and entering, and felony possession of stolen property after breaking into Fowler's Supermarket and stealing cigarettes. He was also charged with larceny of a motor vehicle and possession of a stolen vehicle belonging to his aunt Charlene (Tpp 11-14; Defendant's Exh. 17, Section 9).

f. On the morning of 11 March 2016, during this period of intense seizure activity, Riley smoked marijuana and snorted PCP. At 9:30 am - 10:00 am, he was observed approaching the home of his aunt, Felicia Porter. Riley later plead guilty to the sexual assault and murder of his aunt (Tpp 16-20, 110, 122, 230-31; Defendant's Exh. 17, Section 10).
g. On 16 March 2016, Riley was experiencing fifteen seizures per night. His seizures had become "so severe that he [was] developing bruises along his elbows and shins" where he kicked and threw his arms. He weighed only 178 pounds; his normal weight is approximately 200 pounds. Riley's mother took him to an emergency department (Tp 157, 187; Defendant's Exh. 17, Section 9).
h. On 21 March 2016, Riley experienced a seizure with loss of bowel and bladder control and foaming at the mouth. The seizure was so violent that he flipped over a couch. Riley was transported to UNC Hospitals (Tpp 157-58, 165-66, 264-65; Defendant's Exh. 17, Section 9).
i. During a five-day admission at UNC Hospitals in March 2016, Riley experienced up to thirty seizures per night. During one seizure, Riley broke a hospital bed (Tpp 115-17, 132-33, 142, 167; Defendant's Exh. 17, Sections 9 and 10). Per the medical evaluation at UNC Hospitals:
    i. An MRI of his brain was positive for "mesial temporal sclerosis, which is like damage to the frontal lobe" (Tpp 115-17, 132-33, 142, 167; Defendant's Exh. 17, Sections 9 and 10).
    ii. Riley was diagnosed with "intractable frontal lobe epilepsy that is poorly controlled" (Tpp 115-17, 132-33, 142, 167; Defendant's Exh. 17, Sections 9 and 10).
    iii. A physician found that "This case is complicated by non-compliance of medication, lack of insight of his condition and severe oppositional behavior problem and agitation that often is due to frequent partial epilepsy" (Tpp 115-17, 132-33, 142, 167; Defendant's Exh. 17, Sections 9 and 10).
    iv. A physician found that Riley's "partial seizures are associated with psychiatric agitation" and that significant behavioral changes "could well be due to uncontrolled frontal seizures" (Tpp 115-17, 132-33, 142, 167; Defendant's Exh. 17, Sections 9 and 10).
    v. A physician noted that "frontal lobe epilepsy may affect a patient's ability to regulate his emotions and prevents a patient from getting adequate sleep" (Tpp 115-17, 132-33, 142, 167; Defendant's Exh. 17, Sections 9 and 10).
j. At the time of Riley's discharge from UNC Hospitals, he was having up to seven seizures per night (Tpp 116-17, 172, 273, 278; Defendant's Exh. 17, Section 9).
k. On March 30, 2016, Riley was arrested after offering contradictory statements to investigators. While in the detention center the night of his arrest, Riley had a violent seizure and was taken to the hospital. He tested positive for marijuana and PCP and weighed 166 pounds (Tpp 21-23, 269; Defendant's Exh. 17, Section 9).

4. Riley Conner was diagnosed with behavioral problems and conduct disorder at thirteen and fourteen years of age, respectively; there was additional concern for posttraumatic stress disorder (PTSD) at eight and fifteen years of age.

   These mental health concerns were not fully treated prior to the time he committed the two crimes for which he plead guilty and was sentenced.

   a. When Riley was eight years of age, a physician expressed concern that Riley had posttraumatic stress disorder (PTSD). Per the court record, Riley was not provided counseling for the "emotional roller coaster" he was on. (Tpp 44, 73-75, 126, 161, 180; Defendant's Exh. 17, Section 9).
   b. When Riley was nine years of age, he began demonstrating significant anger and had confrontations at school when peers teased him because his parents were drug addicts (Tpp 62, 73, 152, 174).
   c. Riley was expelled from Nakina Middle School in 6th grade for disruptive behaviors and bullying [Note: The court found that prior to his expulsion, the school would not put Riley in a classroom. Rather, he was told to remain with the school janitors] (Tpp 77, 152, 175, 203-04; Defendant's Exh. 17, Sections 9 and 10).
   d. While attending an alternative school in South Carolina in 6th grade, Riley was charged with assault and expelled after hitting another student in the head with a textbook (Tpp 124, 152-53, 155-56, 176, 204-05; Defendant's Exh, 17, Section 9).
   e. Riley was diagnosed with frontal lobe epilepsy and a secondary diagnosis of behavior problems at age thirteen years of age (Tpp 114-15).
   f. Riley was diagnosed with substance use disorder at thirteen and fourteen years of age. He was diagnosed with conduct disorder at fourteen years of age (Tpp 118-19).
   g. At fifteen years of age, Riley's epilepsy was poorly controlled and progressing. Riley saw a physician who thought that his seizures might be triggered by posttraumatic stress disorder (PTSD) (Tpp 164, 186; Defendant's Exh. 17, Section 9).
   h. A forensic psychologist testified that Riley had a full-scale IQ of 79 (Tpp 305, 311, 314, 320, 335, 369).

5. Riley Conner regularly used alcohol and illicit substances from the age of nine; he was diagnosed with significant polysubstance use disorder (considered a mental health disorder) at thirteen years of age.

   Riley's substance use disorder was significant, untreated, and active at the time he committed the two crimes for which he plead guilty and was sentenced.

   a. Riley began using marijuana at nine years of age, reportedly smoking four times per day (Tpp 57, 117, 152; Defendant's Exh. 17, Section 9).
   b. Riley began drinking alcohol almost daily at eleven years of age He drank six beers in one sitting, but sometimes drank more until he was highly intoxicated, which resulted in

vomiting, headaches, blacking out, hangovers, and doing things he later regretted (Tpp 49, 118, 182, 299; Defendant's Exh. 17, Section 9).

c. Riley began ingesting Xanax at eleven years of age and took multiple pills at a time to get high on a monthly basis. Riley also sold marijuana off and on. His aunt testified he sometimes seemed "very spaced out" (Tpp 49, 118, 182, 299; Defendant's Exh. 17, Section 9).
d. Riley began using opiates at age thirteen years of age (Tpp 118-19).
e. Riley began using heroin at fourteen years of age (Tpp 118-19).
f. At fourteen years of age, Riley was diagnosed with conduct disorder, cannabis use disorder, alcohol use disorder, sedative/hypnotic use disorder, and disruption of family. (Tpp 118-19).
g. At fourteen years of age, Riley was largely obtaining drugs from his cousin, Brad. Riley was using marijuana, alcohol, opiates, and heroin, Riley used PCP, methadone, K2 spice, Percocet, Oxycodone, ETOH, mushrooms, crystal methamphetamine, hallucinogens, acid, Molly, and Dabs. He also crushed and snorted Klonopin that had been prescribed to him. Riley later said he was addicted to marijuana, heroin, opiates, and methadone and he took drugs "[t]o get away from all the bullshit that rained down every day" (Tpp 80-81, 119-22, 136; Defendant's Exh. 17, Section 9).
h. On 11 March 2016, fifteen-and-a-half-year-old Riley smoked marijuana and snorted PCP prior to approaching the home of his aunt, Felicia Porter (Tpp 16-20, 110, 122, 230-31; Defendant's Exh. 17, Section 10).
i. Riley was arrested on March 30, 2016 at 12:15 a.m. and was charged with murder. That night, Riley had another violent seizure in the detention center and was taken to the hospital. He tested positive for marijuana and PCP (Tpp 21-23, 269; Defendant's Exh. 17, Section 9).