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IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

THE STATE OF OHIO
Plaintiff

CHARLES MAXWELL
Defendant

Case No: CR-05-475400-A

Judge: DAVID T MATIA

INDICT: 2903.01 AGGRAVATED MURDER /RTS /MEAC /FRM3
2903.01 AGGRAVATED MURDER /MM /FMS /RTS /MEAC /FRM3
2905.01 KIDNAPPING /FRM3
ADDITIONAL COUNTS...

JOURNAL ENTRY

ORDER ON PETITION FOR POSTCONVICTION RELIEF. OSJ.

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IN THE COURT OF COMMON PLEAS
CRIMINAL DIVISION
CUYAHOGA COUNTY, OHIO

STATE OF OHIO,	)	Case No. CR-05-475400-A
Plaintiff-Respondent,	)	Judge David T. Matia
vs.	)	
CHARLES MAXWELL,	)	
Defendant-Petitioner.	)	**DEATH PENALTY CASE:** **No Current Execution Date**

FACTUAL AND PROCEDURAL HISTORY

The matter is before the Court on the petition of Defendant Charles Maxwell ("Maxwell") for postconviction relief under Ohio's serious mental illness statute, R.C. 2929.025 ("SMI Statute"). Effective April 14, 2021, the SMI Statute prohibits a death sentence and mandates a sentence of life without parole against a capitally sentenced offender who, at the time of the subject aggravated murder for which a death sentence had previously been imposed on that offender, was suffering with one of four enumerated serious mental illnesses and meets the other requirements of the SMI Statute by a preponderance of the evidence.

Defendant was charged and convicted for crimes he committed on November 27, 2005. In their opinion affirming Defendant's convictions and sentence, the Ohio Supreme Court set forth the relevant facts of this matter, which the Court adopts as follows:

> Evidence introduced at trial showed that McCorkle and Maxwell had a long-term relationship that began in 1999, living together on different occasions over the next few years. They had one child, C.M., nearly four years old. Nichole also had two other children, D.C. and D.K. In August 2005, she purchased a single-family home at 1046 East 146th Street in Cleveland and lived there with her father and two of the

children. Maxwell had a key to the side door of the house and kept some clothes there.

The prosecution introduced evidence showing that on October 6, 2005, Nichole went to the hospital and received stitches for head injuries after Maxwell struck her. Police came to the hospital and took Nichole's report about the incident. On the same date, Maxwell told John Gregg, a friend and coworker, that he had pistol-whipped Nichole. On October 13, 2005, she obtained a temporary protection order against Maxwell.

Afterward, prosecutors presented felonious-assault charges against Maxwell to the grand jury. Nichole was subpoenaed to testify before it on November 23, 2005.

Maxwell told Gregg that he was concerned about receiving prison time for felonious assault. Maxwell knew about the temporary protection order and that a warrant had been issued for his arrest. He had also learned that Nichole was going to testify against him at the grand jury.

At Maxwell's behest, Gregg contacted Nichole about her grand jury testimony in an effort to reduce the charges from felonious assault to a lesser offense. Gregg asked Nichole to "stick to the story that it was a simple domestic; she pushed him, he pushed her, she slipped and hit her head on the stove."

Following Nichole's testimony on November 23, 2005, the grand jury indicted Maxwell for felonious assault, abduction, and domestic violence. Brian Mooney, an assistant prosecutor for Cuyahoga County, informed Nichole that day that the grand jury had voted to indict and told her what the charges were. Because of the Thanksgiving holiday, the indictment was not signed by the grand jury foreman and filed with the clerk of court until November 28, 2005.

The evening of the grand jury's decision, Maxwell called Gregg and said that he had been trying to talk to Nichole about her grand jury testimony but had been unable to contact her. Maxwell then called Nichole while Gregg remained on the line and heard their conversation. Maxwell asked Nichole what happened in court that day. Nichole told him, "I told the truth. I had to tell the truth." According to Gregg, Maxwell was very upset after the phone call and said that "the bitch was going to make him kill her." Maxwell also asked Gregg where he could get a gun.

The prosecution presented evidence that on the evening of November 26, 2005, Nichole and Willie Hutchinson met at a bar. Lauretta Kenney, Nichole's sister, had introduced Hutchinson to Nichole after the October 6 incident. Nichole and Hutchinson arrived at the bar in separate cars and had a few drinks. When they departed, although Nichole had told Hutchinson that she would call him when she got home, she did not. But Hutchinson called Nichole, and a man answered the phone. Hutchinson then called Lauretta and told her to check on Nichole.

Near 2:30 a.m. on November 27, Lauretta called Nichole, and Maxwell answered the phone. Maxwell immediately gave the phone to Nichole. Lauretta asked Nichole why Maxwell was there and told her that he needed to leave. According to Lauretta, Nichole said that "she was confused and she didn't know what was going on."

Lauretta then drove to Nichole's home and arrived around 2:40 a.m. but did not see Maxwell's car on the street or in the driveway. Lauretta called Nichole, saying she was outside. Nichole "mumbled something" and then hung up. Lauretta went onto the porch, and Nichole and Maxwell were standing next to each other when Lauretta opened the screen door.

Lauretta told Maxwell that he was not supposed to be there and needed to leave. Maxwell said that he was just talking to Nichole. Lauretta testified, "I told him, there's no talking, that you needed to leave." He then called Lauretta "a bitch" and said, "[I]f anybody's leaving it's going to be you." Maxwell then stepped back and pulled a gun from his pants. Nichole screamed, "[O]h my God, Lauretta, he got a gun, run." Lauretta then jumped off the porch and started running. Lauretta heard two gunshots as she ran across the street and heard a third gunshot after she crossed the street. Lauretta then saw Maxwell kneeling down by Nichole.

C.M., a day short of four years old, was standing near Maxwell and Nichole when Lauretta came to the door. Later, when asked what she had seen, C.M. testified, "He shoot my mommy."

Maxwell ran from the house after shooting Nichole and fled down the street. Lauretta followed him for a short distance before he disappeared. Shortly afterwards, police officers and emergency medical personnel arrived on the scene. Nichole was taken to the hospital, where she died from her injuries.

On the morning of November 27, Michelle Kenney, Nichole's other sister, called Gregg and told him that Maxwell had killed Nichole. Gregg said that he then called Maxwell and asked him if he had killed Nichole. Maxwell admitted killing her and recounted what happened. He said he had followed Nichole from her home to the bar. She went into the bar, and Maxwell waited outside in his car. He then went inside and saw Nichole and another man sitting in the back of the bar "making out." Maxwell then returned to his car and waited. After they left the bar, he followed Nichole and the man as they drove in separate cars to Nichole's house. Nichole kissed the man and went into her house, and the man drove away.

Gregg also testified that Maxwell told him that he called Nichole after the other man drove away and asked if he could come over. Nichole said he could, and Maxwell went to her house. Maxwell answered the phone at Nichole's house, including repeated calls from a man who asked to speak to Nichole. He also answered a call from Lauretta. Maxwell told Gregg that "they started arguing and then he confronted her about that night." Lauretta then came to the front door, and

Maxwell "opened the door[,] pointed the gun and fired but she had ran." Then, Maxwell told Gregg, "he just turned around, shot Nichole and she fell down and * * * she moved and then he shot her again."

Police investigators found two .25 caliber shell casings inside the house. Investigators looked inside and outside the house for a third shell casing, which they never found. Investigators also did not find any bullet holes inside or outside the house.

Dr. David Dolinak, a medical examiner with the Cuyahoga County coroner's office, conducted Nichole's autopsy. Nichole suffered two gunshot wounds to the head. One gunshot in the middle of the right eyebrow broke the bones of the eye socket. The bullet did not enter the brain but lodged in the sinuses on the right side of the nose. The other gunshot went through the left side of the head into the right side of the brain. Dr. Dolinak concluded that Nichole died from gunshot wounds to the head and that the death was a homicide.

Detective James Ealey, a firearms examiner with the Cleveland Police Department, examined the two bullets recovered during the autopsy. Ealey testified that they had been fired from the same weapon. His written report stated that the bullets were "consistent with 25 auto type ammunition."

The police sought to locate and arrest Maxwell following Nichole's death. On December 16, 2005, FBI Special Agent Robert Riddlebarger and other members of the Cleveland/Cuyahoga County Fugitive/Gang Task Force went to a Cleveland home to arrest him. After entering the home, they found Maxwell hiding in a crawl space behind a bed in a second-floor bedroom. As he was being handcuffed, Maxwell was asked whether he was armed or whether there were any weapons nearby. He replied, "I do not have a gun anymore." A few seconds later, Maxwell blurted out that he had gotten rid of the gun that he had.

State v. Maxwell, 139 Ohio St.3d 12, 2014-Ohio-1019, ¶ 2-21.

Attorneys Thomas Rein and John Luskin were appointed to represent Maxwell at trial. Maxwell's attorneys hired expert Dr. Sandra McPherson to develop mitigation. Maxwell reported to Dr. McPherson that he had experienced auditory hallucinations or has been "hearing voices" for several years before the murder. (*See* Report of Dr. McPherson.) On September 1, 2006, the Court ordered the court psychiatric clinic to perform a competency evaluation. Dr. Michael Aronoff, a psychologist, first evaluated Maxwell and found him to suffer from paranoid personality disorder that was "possibly indicative of a psychotic disorder." (*See* Report of Dr. Aronoff.) Although he

noted that Maxwell's paranoia appeared genuine, Dr. Aronoff was ultimately unable to determine whether that paranoia reached "psychotic levels" because of a possibility of malingering. Nonetheless, Dr. Aronoff noted that Maxwell had experienced autoscopy (out of body experience), paranoia and delusions of people out to kill or persecute him, and auditory hallucinations of his deceased stepfather, deceased mother of his child, and God. (*Id.*) Maxwell also thought people in the jail were putting something into his beverages. (*Id.*) Dr. Aronoff spoke with Maxwell's mother, Ernestine Brewer, who told the doctor that her son "sometimes acts strange. Sometimes paranoid. He be quiet, just stare." (*Id.*) She also said that "[Maxwell] should have seen somebody," referring to a mental health professional, "I knew that something was going wrong." (*Id.*)

Per Dr. Aronoff's recommendation, this Court ordered Maxwell to participate in a 20-day competency evaluation at North Coast Behavioral Health. There, Dr. Alice Cook evaluated Maxwell and did not find "major mental illness or defect." (*See* Report of Dr. Cook.) However, her report was a competency evaluation and thus primarily focused on Maxwell's understanding of the legal system and the charges he was facing. (*See* Competency Hearing Transcripts at 76-77.) Upon review, the Court determined that Maxwell was competent to stand trial based on the evaluations by Drs. Aronoff and Cook.

The jury trial began on February 6, 2007. Defense counsel presented no witnesses during the guilt phase of trial. On February 23, 2007, the jury returned guilty verdicts against Maxwell for McCorkle's aggravated murder with retaliation, murder to escape accounting for another crime specification, and firearm specifications. The jury also found Maxwell guilty of having weapons while under disability, and of retaliation with a firearm specification. The jury returned not guilty verdicts for the course of conduct specification and attempted murder. All other counts were dismissed on Rule 29 motions.

At the sentencing and mitigation phase, defense counsel presented character witnesses and mitigation expert Dr. Sandra McPherson, Ph.D. Defense counsel also presented Maxwell's four siblings (William Steward, Teresa McNear, Andy Maxwell, and Sharon Graves), his mother Ernestine Brewer, his cousin Herbert Nelson and wife Veronica Nelson, a neighbor named Roscoe Horne, and Maxwell's brother-in-law Raynard McNear. Their testimony generally described Maxwell as a well-loved, but troubled family member. The jury recommended that Maxwell be sentenced to death.

Prior to imposing the sentence, the Court conducted its own independent analysis as to whether the aggravating circumstance of retaliation outweighed the mitigating factors presented by the defense. The Court reviewed the following factors:

1. Whether the victim induced the offence (R.C. 2929.04(B)(1);
2. That it was unlikely that the offence would have been committed but for the fact that the offender was under duress, coercion, or strong provocations;
3. Remorse;
4. Love and support of family;
5. Defendant's work ethic;
6. Defendant's lack of significant criminal history;
7. Defendant's conformance while incarcerated;
8. Residual doubt.

The Court also reviewed the psychological reports prepared by mitigation expert, Sandra McPherson, Ph.D., ABPP, the competency restoration report of Alice Cook, Ph.D. of Northcoast Behavioral Healthcare, and the court psychiatric clinic report of Michael Aronoff, Ph.D. However, the Court was never presented with evidence of a possible delusional disorder, nor any physical evaluations of Maxwell's brain trauma. On March 23, 2007, this Court issued its Findings of Fact and Conclusions of Law, accepting the jury's recommendation of the death penalty and sentenced Maxwell to death.

Maxwell timely appealed his conviction and sentence to the Supreme Court of Ohio. On March 20, 2014, the Supreme Court of Ohio affirmed Maxwell's conviction and sentence. *State v. Maxwell*, 139 Ohio St.3d 12 (2014). The U.S. Supreme Court denied certiorari. *Maxwell v. Ohio*, 574 U.S. 1160 (2015). Maxwell filed a petition to re-open his direct appeal in the Supreme Court of Ohio on September 9, 2014. It was denied on February 24, 2016. *State v. Maxwell*, 144 Ohio St. 3d 1502 (2016).

With his direct appeal pending, Maxwell filed a petition for postconviction relief in this Court. Among other exhibits, the petition included the report of neuropsychologist Dr. Barry Layton who had evaluated Maxwell for the postconviction proceedings. (*See* Affidavit of Dr. Barry Layton.) Dr. Layton's report averred, among other things, that Maxwell's impaired brain functioning could have stemmed from a traumatic brain injury he suffered in 1986 when he struck his head on a concrete parking divider. Dr. Layton noted that after the injury, Maxwell's behavior changed, and that he suffered impairment in his everyday functioning. Dr. Layton found that because Maxwell's frontal cerebrum was damaged, Maxwell's ability to "exercise judgment, plan and, effectively monitor his behavior" was impaired. (*Id.* at 3.)

This Court denied Maxwell's postconviction petition on September 2, 2016. On August 31, 2018, the Court issued its Findings of Fact and Conclusions of Law supporting its denial of Maxwell's petition. On October 4, 2018, Maxwell appealed to the Eighth District from this Court's denial of postconviction relief. The Court of Appeals affirmed this Court's ruling on May 21, 2020. *State v. Maxwell*, 2020-Ohio-3027 (8th Dist.). The Supreme Court of Ohio denied discretionary review on October 27, 2020. *State v. Maxwell*, 160 Ohio St. 3d 1438 (2020). The U.S. Supreme Court denied certiorari on April 5, 2021. *Maxwell v. Ohio*, 141 S. Ct. 2470 (2021).

As noted above, the SMI Statute was enacted effective April 12, 2021. On April 11, 2022, Maxwell filed a petition for postconviction relief from his death sentence pursuant to the provisions of the SMI Statute, as applicable to offenders such as Maxwell, who have already been sentenced to death prior to the effective date of the SMI Statute. See R.C. 2953.21(A)(1)(a)(iv). On April 21, 2022, the State requested additional time to file a response and a motion for a Court-ordered evaluation of Defendant. On October 25, 2022, Maxwell filed an Amended Petition for Postconviction Relief Due to Serious Mental Illness at Time of Offense (hereinafter "Amended SMI Petition").

On March 16, 2023 the Court ordered that unless the parties were able to reach an agreement on the scope of the examination of Defendant by the State-proposed expert, Defendant would have to file a brief in support of the parameters it sought to impose on the expert. No agreement was reached. On June 14, 2023, a hearing was held on the issue of a court-ordered examination of Defendant. The Court held that the State has an opportunity to present evidence to dispute a diagnosis of a serious mental illness, but the statute is silent on whether the State is permitted to an evaluation by its own chosen expert. Therefore, the Court denied the State's request but permitted the State to obtain its own expert to review any findings of the Defendant's expert.

By order of November 7, 2025, this Court granted Maxwell's unopposed motion for leave to supplement his Amended SMI Petition with the additional evidence and exhibits from the PET-MRI testing which, pursuant to this Court's order, was conducted on Maxwell on September 9, 2024, at the Ohio State University Medical Center. As so supplemented, the SMI petition pending before the Court is Maxwell's Amended SMI Petition. The Court finds, and the State does not dispute, that Maxwell's Amended SMI Petition was timely filed under the SMI Statute.

On December 4, 2025, this Court conducted an evidentiary hearing on Maxwell's Amended SMI Petition. Maxwell waived his presence at that hearing by filing, on December 2, 2025, a written and notarized waiver which he had signed on November 25, 2025. (*See* Notice of Waiver, filed on December 2, 2025.) At the evidentiary hearing, Maxwell presented the testimony of Dr. Siddhartha Nadkarni, M.D., and submitted twenty-three exhibits: Petitioner Exhibits ("PX") 1 through 23. In its case, the State presented the testimony of Stephen G. Noffsinger, M.D., and presented, and the Court admitted, three exhibits: State Exhibits ("SX") 1-3. (Tr. at 192.)

Having reviewed the transcript of the evidentiary hearing, the exhibits submitted by the parties, and their respective post-hearing submissions, and further being familiar with the February 2007 jury trial of this capital case at which this Court presided, the Court herein makes the following findings of fact and conclusions of law required by R.C. 2953.21(H).

FINDINGS OF FACT

1. On December 4, 2025, the Court held a hearing on the matter. Defense called one witness, Dr. Siddartha Nadkarni, and the State called one witness, Dr. Stephen Noffsinger.
2. Dr. Nadkarni has five Board certifications in neurology, psychiatry, epilepsy, and clinical neurophysiology, and behavioral neurology/neuropsychiatry from the American Board of Psychiatry and Neurology. (Hearing Transcript "Tr." 20.)
3. Dr. Nadkarni currently has a practice in New Jersey and works for the Northeast Regional Epilepsy Group. He teaches neuroscience at NYU School of Medicine for psychiatry. He worked at NYU for 25 years performing research in epilepsy and psychiatry. (Tr. at 21.)
4. The Court qualified Dr. Nadkarni as an expert in forensic neuropsychiatry, psychiatry, neurology, clinical neurophysiology, and epilepsy. (Tr. at 23.)
5. Dr. Noffsinger graduated from Northeast Ohio Medical University and completed a four-

year residency in psychiatry and did a fellowship in Forensic Psychiatry at Case Western Reserve University in 1996. He is currently employed at University Hospital as a professor of psychiatry and is the program director of the Forensic Psychiatric Fellowship.

6. This Court qualified Dr. Noffsinger as an expert in forensic psychiatry. (Tr. at 117-118)

Dr. Nadkarni's Findings

7. In 2021, Dr. Nadkarni diagnosed Maxwell with delusional disorder caused by traumatic brain injury. He reaffirmed this diagnosis in his later supplemental reports and in his testimony at the hearing (Tr. at 24-31.)

8. Dr. Noffsinger concluded that Maxwell did not have any of the four qualifying SMI diagnoses based on the previous doctors' examinations and reports. Dr. Noffsinger testified that the examinations conducted previously would have picked up delusional thinking and showed signs of delusional disorder. (Tr. at 124-127.)

9. Dr. Nadkarni described delusional disorder as: "an Axis 1 psychiatric disorder. In the DSM-V there are multiple axes. The first axis is for severe mental illnesses or major mental illnesses, and delusional disorder falls under the psychotic group of those illnesses in DSM-V." (Tr. at 32.)

10. Delusional disorder is a serious mental illness that affects the brain. Although the precise cause of delusional disorder is unclear to science ("idiopathic," as Dr. Nadkarni testified), Dr. Nadkarni explained that delusional disorder, albeit a relatively rare mental illness, is most commonly seen in cases of Alzheimer's disease and in patients who have suffered traumatic injury to the brain. (Tr. at 40-42, 84.) Maxwell sustained such brain injuries earlier in his life and long before this crime in November 2005. (Tr. at 31, 40-42, 67.)

11. Maxwell was involved in an altercation in Arkansas in 1986 when he was twenty-years-old where he hit his head on a rock and was kicked twice in the head. He was unconscious

for two days and stated that he has suffered from recurring headaches ever since. (Tr. at 42-44, 64.) Maxwell was also involved in a motorcycle accident in 2003 where he was thrown from his motorcycle when hit by a car. (PX at 1.) In the summer of 2005, months before the instant offense, Maxwell was assaulted by four men at a gas station who left him unconscious, resulting in worsening headaches, dizziness, trouble concentrating, and difficulty with processing speed. (*Id.*)

12. Both Maxwell and his family members noticed changes in his personality after these head injuries. (Tr. at 47, 60.) As Dr. Nadkarni testified: "The family notes examples of being beaten up and having head injuries and then sort of changing after those head injuries. This is a classical thing in neurology." (Tr. at 60.) For example, Maxwell's brother, Andy Maxwell, believed that Maxwell became less patient after his first concussion. (PX 6, at 2.) Maxwell himself said that he felt different after his 1986 concussion – he reported that he took more risks and chances, had less frustration tolerance, and was quicker to anger. (PX 5, at 3-4.) After his 2005 head injury, Maxwell reported that he had less patience, a shorter fuse, and elevated depression and suicidality. (PX 5, at 3.) Brother Andy Maxwell noticed that Maxwell became more of a "loner" after the assault; Maxwell was often lost in thought, more irritable, and appeared to be easily bothered and confused. (PX 6, at 3.)

13. This anecdotal evidence is supported by Maxwell's criminal record. Before the 1986 head injury, Maxwell had an absence of criminal activity. Afterwards, however, he received nine traffic citations in two years and went to prison twice before committing the underlying offense (Tr. at 47.)

14. With Maxwell's history of several head injuries as a potential source of a development of delusional disorder, Dr. Nadkarni found several categories of what he described as

"objective evidence" of brain dysfunction, all of which are consistent with delusional disorder. (Tr. at 42-62.) "[H]e has evidence of abnormal brain scans, evidence of abnormal neuropsychological testing, abnormalities on my examination of him and in embedded tests in the neuropsychological testing that specifically show frontal lobe dysfunction." (Tr. at 43.)

15. This objective evidence included:

A. Brain scans (PX 15, p. 6)
B. Neurological testing – Dr. Nadkarni (PX 5)
C. Neuropsychological testing – Dr. Layton (PX 4)
D. Not malingering per neuropsychological testing
E. Wisconsin Card Sorting test – 127/128, Dr. Layton (PX 4, p. 8)
F. MMPI score, elevated RC-6, Dr. McPherson (PX 1, p. 9)

16. While acknowledging that there is no "test" to detect delusional disorder, Dr. Nadkarni characterized this evidence as "objective" because they are all matters that are not capable of being faked or feigned and/or are not based upon the patient's own beliefs or self-reports. (Tr. at 56-59.)

17. Maxwell's CT scan, conducted at OSU on September 9, 2024, showed mild bilateral atrophy in his frontal lobe, or loss of brain cells. (Tr. at 45-47.) Dr. Nadkarni described this atrophy as the "death of nerve cells that will never come back." (Tr. at 45.) He testified that such a result is not unexpected with someone who has sustained organic brain damage. For a person Maxwell's age, with a healthy brain, "there should be zero atrophy, so it means that something pathologic is happening. It's not normal to have mild atrophy." (Tr. at 46.)

18. Based upon the findings of other neurological testing conducted on Maxwell over the years, and Maxwell's history of head injuries, Dr. Nadkarni explained that these 2024 findings of mild bilateral atrophy in Maxwell's frontal lobes are related to those head injuries and

corroborate the long-standing course of Maxwell's delusional disorder. (Tr. at 47.) "[A]trophy can be seen in delusional disorder with a higher rate in people who have had a prior brain injury before." (Tr. at 42.)

19. Dr. Nadkarni further noted that Maxwell consistently performed poorly on objective tests, both the neurological tests conducted by Dr. Nadkarni and the neuropsychological tests conducted by other mental health professionals. That poor performance likewise revealed problems with Maxwell's frontal and temporal lobes. (Tr. at 47-49.)

20. Dr. Nadkarni's testing of Maxwell showed exhibitions of impaired frontal and temporal lobes, an abnormally low score on a cognitive assessment, difficulty with language ("aphasia"), and impaired motor functioning. (Tr. at 48-49.) Maxwell also displayed a palmomental reflex and a Babinski reflex. These reflexes which are present in babies, and then go away after age 1.5, but will return later in life when there is brain degeneration or injury. (Tr. at 49-50.) As with his other examples of objective evidence, Dr. Nadkarni testified that these findings cannot be faked or malingered. (Tr. at 50.)

21. Dr. Barry Layton's 2008 neuropsychological testing findings likewise suggested brain damage. (Tr. at 51.) Dr. Layton reported then: "Charles Maxwell has significant brain impairment, and he suffered from this impairment during the time of the murder of Nichole McCorkle." (PX 4, at 2.) As with Dr. Nadkarni, Dr. Layton observed that Maxwell's brain injuries started in 1986 and have been present ever since then. (Tr. at 51.) Dr. Layton found that Maxwell has frontal lobe dysfunction at a level that is below 99 percent of the population in some measures. (Tr. at 51-52.) Dr. Layton also found that Maxwell had issues with perseveration. He stated that Maxwell was unable to change his strategy in the first 127 of 128 trials of the Wisconsin Card Sorting Test, indicating a rigidity borne of

frontal lobe dysfunction. (Tr. at 52-53; PX 4, p. 8.) Perseveration was described as "a very specific frontal lobe problem, the sticking to the same thing over and over and over." (Tr. at 54.)

> Q. So even when someone tells him to change his strategy, he's not capable of doing so?
> A. Even one on one in an intimate, like, testing setting where the person is, like, maybe you want to do this, you want to do this, 128 trials, I mean, that's striking. That's very striking to the point of how his brain functions. (Tr. at 54.)

22. Dr. Sandra McPherson's findings in 2006 psychological testing showed elevated paranoia and suspicion. (Tr. at 55, 60.) This was associated with Maxwell's elevated RC-6 scale on Dr. McPherson's testing: "[T]hat [elevated score] has to do with paranoia, suspicion, and people judging him. So that was very telling . . . as a corroborating bit of objective evidence for this diagnosis of delusional disorder." (Tr. at 55.)

23. Dr. McPherson's report also indicated that Maxwell saw himself or wants to be seen as having particular ability to think, organize, and reason at above average levels. However, her evaluation concluded that he is "overwhelmed, his resources are less than he has ever admitted to himself, and he is left to cope by some combination of denial of reality, withdrawal, and an anxiety driven perception of symptoms in the midst of internal turmoil." (See PX 1, at 8.)

24. Dr. McPherson suspected neurological dysfunction and recommended a neurological workup. (*Id.*)

25. Specifically, Dr. McPherson found that the "results from the Bender-Gestalt interestingly do show some distortions, which may reflect underlying central nervous system dysfunction of some kind. Since he has a history of relatively recent head injury, further evaluation of this aspect of his functioning needs to take place. (*Id.*)

26. While Dr. McPherson did not diagnose Maxwell with delusional disorder, her diagnosis included the need to rule out traumatic brain injury with residual symptoms.

27. A traumatic brain injury with residual symptoms was not ruled out prior to the mitigation phase of the trial.

28. Dr. Nadkarni identified other evidence which corroborated his diagnosis of delusional disorder as existing on and before the November 2005 aggravated murder; this evidence was summarized in the slide Dr. Nadkarni presented at the hearing which is captioned "Additional corroborating evidence." (PX 23.)

29. Dr. Michael Aronoff's evaluation in 2006 identified "Schneiderian symptoms," or symptoms of psychosis, along with paranoia, hallucinations, and referential thinking. (Tr at 58-59; PX 2, p. 3, 5-9; PX 19, p. 129.) Dr. Aronoff did not cite any evidence to suspect malingering, and none of the objective testing administered to Maxwell ever indicated exaggeration.

30. Dr. McPherson's interview revealed that, "after some prolonged questioning and careful inquires," Maxwell had had hallucinations since before the offense. (PX 1, p. 4.)

31. Dr. Nadkarni found that Maxwell was having hallucinations at the time of the offense and before. (PX 5, p. 4.) This included "episodes of watching himself from the outside -- out of body experience. That's called autoscopy. These are two of the five most common temporal lobe epilepsy seizure type or simple focal seizures, and he told me about that as well." (Tr. at 64.)

32. Maxwell reported to Dr. Nadkarni that, at the time of the crime and before, he was paranoid and had ideas that he was being followed or people were out to get him; he checked mirrors and was convinced that people were trying to kill him. (*Id.*; Tr. at 65-66.)

33. Dr. Nadkarni acknowledged that mental health professionals, before his involvement with Maxwell, had not diagnosed delusional disorder and that Maxwell's family and friends had not identified such behaviors. He argued that his expertise in both neurology and psychiatry makes him more suited, as compared to the previous professionals in Maxwell's case, to recognize and diagnose such an uncommon mental illness. (Tr. at 112-13.)

34. Dr. Nadkarni further explained that persons with delusional disorder often remain below the radar: "That's the whole thing about delusional disorders, they're under the radar. They're not odd, they're not bizarre. They keep to themselves. They do not want to talk about the paranoia." (Tr. at 90.)

35. Dr. Nadkarni opined that Maxwell's delusional disorder began after his head injury in 1986, and that Maxwell suffered from that delusional disorder on November 27, 2005. (Tr at 30-32, 67; PX 5, p. 7; PX 7, 12-15.)

36. The records show that Maxwell was not involved in criminal behavior and impulsivity until after his head injury in 1986. (Tr. at 47; PX 4, p. 5.)

37. Family accounts note that Maxwell had personality changes after his head injuries, all of which occurred before the offense. (Tr. at 47, 60; PX 5, p. 7; PX 6, p. 2-3.)

38. Maxwell told Dr. Nadkarni that "he has been depressed for much of his life following his head injury in the mid-1980's." (PX 5, p. 5.) Dr. Nadkarni opined that Maxwell's delusional system and hallucinations arose after that head injury. (*Id.*)

39. As noted above, Maxwell also reported depression, suicidality, and paranoia around the time of the offense. (Tr. at 64-65.) Leading up to the offense, he "had ideas he was being followed or people were out to get him," and was checking mirrors to see if someone was following him. (PX 5, p. 4; PX 7, p. 2; Tr. at 59.) "He was convinced people were trying

to kill him." (PX 5, p. 4.) This is consistent with Maxwell's reports to other doctors at the time of trial. (PX 1, p. 4; PX 2, p. 5.)

40. Maxwell also reported at that time to believing that "things from the TV were afraid of him, speaking to him." (Tr. at 69.) He likewise reported "that he was becoming increasingly depressed and suicidal and fearing for his life. Feeling like he was going to be attacked or killed at that time, around that time." (Tr. at 64-65.)

> [H]e's telling me people are killing him or going to kill him. Said that he's – he's had this thought many times in his life being executed by the police somehow or being killed by the police or death by police. That thought was happening to him more and more. In his depression, his delusional disorder was also becoming more prominent, and he felt like he was being followed. He felt like his partner was also going to kill him, he had that belief. So he was in sort of a paranoid state at the time, and his behaviors were as a result of that paranoia.
>
> Q. What was your assessment of his credibility?
>
> A. If [sic] I found him to be credible to the extent that I could know, meaning I did not find any evidence of him to be lying, or malingering, or telling a falsehood.

(Tr. at 65-66.)

41. Concerning the credibility of Maxwell's reporting about his mental health as he was experiencing it during the timeframe of the crime, Dr. Nadkarni further testified: "the neurological examination that I described before including the cognitive examination, the reflexes, the mental reflexes, those are sort of objective proofs of him not trying to fake his neurological examination. So that adds to his credibility, meaning if he was trying to fake his illness, I think that I would have found evidence of him trying to fake his findings on his exam also." (Tr. at 67.)

42. Dr. Nadkarni expressed his belief, to a reasonable degree of psychological and neuropsychiatric certainty as a forensic expert, that Maxwell's delusional disorder was "very active" on the day of the aggravated murder. (*Id.*)

Dr. Noffsinger's Findings

43. Dr. Noffsinger testified that psychiatry is a branch of medicine dealing with the evaluation and diagnosis of treatment of mental disorders. And forensic psychiatry is the subspecialty within psychiatry dealing with the assessment of matters that occur in a legal context either in a criminal or civil dispute. And training is required because it takes a specific methodology to assess forensic matters. (Tr. at 118)

44. Dr. Noffsinger argued that the SMI statute mirrors the Model Penal Code standard for not guilty by reason of insanity. Thus, the methodology used to conduct and SMI evaluation should mirror the methodology used to conduct a not guilty by reason of insanity evaluation. This methodology includes conducting a personal interview of the defendant for psychiatric history, conduct examinations, and get the defendant's account of the offense. As the SMI statute requires the mental disorder to have impacted the individual at the time of the offense, the methodology also requires a review of the contemporaneous data like police reports, witness statements, and medical records. (Tr. at 120)

45. Dr. Noffsinger concluded that Maxwell did not have any of the four qualifying SMI diagnoses based on the previous doctors' examinations and reports. Dr. Noffsinger testified that the examinations conducted previously would have picked up delusional thinking and showed signs of delusional disorder. (Tr. at 124-127)

46. Dr. Noffsinger testified that if someone had a persistent delusional disorder so severe as to qualify for the second prong of the SMI statute, it would have been noticeable. (Tr. at 129.)

47. Dr. Noffsinger testified that Dr. Nadkarni did not follow the forensic psychiatric evaluation

standards and therefore his conclusions are not credible. (Tr. at 131-132.)

LEGAL ANALYSIS

48. While there is minimal caselaw interpreting R.C. 2929.025, the Court is not without guidance. The Ohio General Assembly received letters, testimony, professional organization recommendations including: the American Bar Association's recommendations following the U.S. Supreme Court's decision in *Adkins v. Virginia*, 536 U.S. 304 (2002), the Ohio Supreme Court's Joint Task Force to Review the Administration of Ohio's Death Penalty's final report and recommendations, and testimony offered to Ohio's General Assembly during its hearings on the SMI statute[1]. This Court will now review each as follows.

R.C. 2929.025: The Serious Mental Illness Statute

49. Ohio law now prohibits the execution of persons with serious mental illnesses. The Governor signed House Bill 136 into law effective April 12, 2021. Under the new law, the State may not execute a person if (a) the person has been diagnosed with one of the four enumerated mental illnesses (the diagnosis prong), and (b) at the time of the offense, the mental illness "significantly impaired the person's capacity to exercise rational judgment in relation to the person's conduct" with respect to either conforming their conduct to the requirements of law or appreciating the nature, consequences, or wrongfulness of their conduct (the impairment prong). *See* R.C. 2929.025(A)(1).

50. A person meets the diagnosis prong of the serious mental illness exemption if they have been diagnosed with one of the following mental illnesses:

a. schizophrenia,
b. schizoaffective disorder,
c. bipolar disorder, or

1 Found at https://www.legislature.ohio.gov/legislation/133/hb136/committee, retrieved April 2, 2026.

d. delusional disorder.

51. The diagnosis does not need to predate the offense, but can be made "*at any time*," including "*after* . . . the day on which the person . . . raises the matter of the person's serious mental illness." R.C. 2929.025(B) (emphases added). A diagnosis after the offense "does not preclude the person from presenting evidence that the person had a serious mental illness at the time of the alleged commission of that offense." Id.

52. A person meets the impairment prong of the serious mental illness exemption if their mental illness significantly impaired their capacity to exercise rational judgment at the time of the alleged offense. R.C. 2929.025(A)(1)(b). Specifically, the person must show that the mental illness "significantly impaired the person's capacity to exercise rational judgment in relation to the person's conduct with respect to either of the following:

a. Conforming the person's conduct to the requirements of law; [or]
b. Appreciating the nature, consequences, or wrongfulness of the person's conduct." Id.

53. A person who has a serious mental illness under this standard and who has been sentenced to death is eligible for postconviction relief under R.C. 2953.21(A)(1)(a)(iv). The petitioner has the burden of proving the diagnosis and impairment prongs by a preponderance of the evidence. R.C. 2929.025(D). If the petitioner meets that burden, the court must void the sentence of death and resentence the petitioner to life imprisonment without the possibility of parole. R.C. 2929.06(A)(2), 2953.21(H). A disorder manifested primarily by repeated criminal conduct or attributable primarily to the acute effects of any use of alcohol or any other drug of abuse does not, standing alone, constitute a "serious mental illness" for purposes of division (A)(1) of this section.

American Bar Association Recommendation to the Ohio General Assembly

54. In 2006, the American Bar Association urged all jurisdictions to enact limitation on the death penalty for those with severe mental disorder or disability. The ABA recommended that all jurisdictions enact legislation limiting the death penalty when the offender had mental conditions that render them "less culpable and less deterrable than the 'average murderer.'"

55. The ABA's recommendations centered on "severe" disorders or disabilities. The ABA stated that those with "Axis I diagnoses" like schizophrenia, other psychotic disorders, mania, major depressive disorder would qualify at a severe mental disorder. In their acute state, all of these disorders are typically associated with delusions (fixed, clearly false beliefs), hallucinations (clearly erroneous perceptions of reality), extremely disorganized thinking, or very significant disruption of consciousness, memory and perception of the environment. The ABA further stated that while these disorders are severe in nature, this exemption must only apply to offenders that are less culpable and less deterrable due to significant impairment.

56. The ABA outlined three ways a defendant's severe mental disorder or disability could significantly impair their ability to, (a) to appreciate the nature, consequences or wrongfulness of their conduct, (b) to exercise rational judgment in relation to conduct, or (c) to conform their conduct to the requirements of the law.

57. The ABA clarified that significant impairment (a) is "meant to encompass those individuals with severe disorder who have serious difficulty appreciating the wrongfulness of their criminal conduct. For instance, people who, because of psychosis, erroneously perceived their victims to be threatening them with serious harm". It would also include delusional

offenders who "intended to commit the crime, and knew it was wrongful, but experienced confusion and self-referential thinking that prevented them from recognizing its full ramifications."

58. Significant impairment (b) is the inability to exercise rational judgment, however, "irrational conduct in this context does not mean 'inaccurate,' 'unusual,' or 'bad' judgment. Rather it refers to the type of disoriented, incoherent and delusional thinking that only people with serious mental disability experience."

59. Lastly, the third type of significant impairment is an inability to conform to the law. The ABA explained that this means that a defendant may experience significant cognitive impairment or feel impervious to punishment due to delusional thinking.

60. The ABA specifically stated that the language of their recommendation, "is similar to modern formulations of the insanity defense" particularly the language that the offender's significantly impaired capacity "to appreciate the nature, consequences or wrongfulness of their conduct" or "to conform their conduct to the requirements of the law," which are "almost identical to the language in the Model Penal Code's insanity formulation."

61. The ABA's language largely matches Ohio's SMI statute. R.C. 2929.025(A)(1)(b).

Ohio Supreme Court's Joint Task Force

62. In response, the Ohio Supreme Court appointed a Joint Task Force to review Ohio's death penalty. The Task Force made numerous recommendations to Ohio's legislature, including recommendations to exclude from eligibility for the death penalty defendants who suffer from serious mental illness.

63. Specifically, Recommendation 9 of the Joint Task Force stated that former Ohio Supreme Court Justice Evelyn Stratton expressed that if executing persons with

mental/developmental disability or juveniles is prohibited, she could not understand why this protection would not extend to those with "severe mental illness."

64. Recommendation 9 also references other states that adopted legislation stemming from the ABA's recommendations and five leading professional associations (ABA, American Psychiatric Assoc., American Psychological Assoc., National Alliance on Mental Illness, and Mental Health America) who have all adopted policy statements opposing the death penalty for those with severe mental illness.

Ohio General Assembly Testimony

65. The Ohio General Assembly responded by crafting and amending the proposed legislation, H.B. 136, what became R.C. 2929.025. Additional legislative materials include statements presented to the legislature by proponents and opponents of the bill, mostly legislators, professionals, and representative of Ohio legal organizations. In addition to the ABA and the Ohio Supreme Court Joint Task Force recommendations, the Ohio General Assembly considered testimony and open letters.

66. Ohio's SMI statute went through several variations before passage. Generally, each variation came after testimony from at least one witness, typically either a legislator, legal professional, legal expert, or medical expert.

67. University of Akron School of Law Professor Emeritus Marge Koosed submitted testimony on behalf of 52 law professors in support of H.B. 136. Professor Koosed testified that "those who commit violent crimes while in the grip of a psychotic delusion, hallucination, or other disabling psychological condition lack the judgment, understanding, or self-control" to be executed. She further argued:

> "The severely mentally ill often cannot meet Ohio's highly demanding M'Naghten-type standard for acquittal by reason of insanity, see O.R.C. 2901.01 (14) [requiring

that the defendant did not know (at all) the wrongfulness of his act]. Because a mentally ill defendant cannot often meet that standard, they are precluded from presenting expert testimony in the trial phase regarding their illness and impairment, and are convicted of capital murder. See *State v. Wilcox*, 70 Ohio St.2d 182 (1980). Thus, the trial jury generally will not learn of the defendant's mental illness during the trial phase. Once convicted, their mental illness is to be considered in mitigation at the penalty phase, see O.R.C. 2929.04(B)(3) and (7), but as often as not is treated as aggravating, a reason to impose death, instead of a grounds for mercy, as respect for human dignity, understanding of moral culpability, and judicial integrity requires. H.B. 136 devises fair procedures for reliably determining whether the severely mentally ill exemption applies in an individual case, procedures that are consistent with our existing ones for excluding those who are ineligible for capital punishment by reason of age and intellectual impairment."

68. Megan Testa, speaking on behalf of the Ohio Psychiatric Physicians Association, testified that

"delusional disorder is a brain disorder in which a false belief becomes fixed in a person's mind and takes over his/her entire life. Individuals with Delusional Disorder often develop persecutory delusions and fear their safety or lives as a result. Individuals with Delusional Disorder are unable to accept that their beliefs are not true and go to great lengths to convince others that their delusions are true. They behave in accordance with their delusion rather than in accordance with reality."

69. Dr. Testa testified that for the proposed SMI statute to apply, the trier of fact would have to find that the offender "had both serious mental illness and diminished capacity at the time of their crime." Id. at p. 3 And that a diagnosis is not enough to qualify under Ohio's SMI statute; that a "Forensic Mental Health Evaluator would also assess the individual's capacity at the time of the crime and determine if their capacity was diminished by their SMI or not." Dr. Testa's believed that the SMI statute as written would require a diagnosis by a "forensically-trained mental health professional."

70. Ohio's then State Public Defender Tim Young testified that "our justice system is equipped to filter out unfounded claims" by, among others allowing the State "ample opportunity to cross examine the defendant's expert in an effort to convince the court that the defendant's

expert did not follow the scientifically accepted standards and guidelines when making their diagnosis." Mr. Young testified that "symptoms of delusional disorder may include an unshakable belief in a delusion: something untrue, or something not based in reality."

71. Lastly, Former Ohio Supreme Court Justice Evelyn Stratton testified that "individuals under the definition in [Ohio's SMI statute] may know what they have done is wrong, but their delusional thinking may cause them to believe they are impervious to punishment or that some greater force compels them to act."

CONCLUSIONS OF LAW

72. This Court finds the legislative history of the SMI statute to be informative.

73. It is evident that the Ohio General Assembly intended that a mere diagnosis of one of the four listed serious mental illness is not in itself sufficient to meet the requirements of the second prong. Therefore, a defendant must also establish by a preponderance of the evidence that the serious mental illness significantly impaired his ability to conform his conduct to the law or to appreciate the nature, consequence or wrongfulness of his actions.

74. The Court begins by noting that the preponderance standard is the lowest burden of proof and is satisfied if a fact is more likely than not to exist:

> "A preponderance of the evidence is defined as that measure of proof that convinces the judge or jury that the existence of the fact sought to be proved is more likely than its nonexistence." *State ex rel. Doner v. Zody*, 130 Ohio St. 3d 446, 2011-Ohio-6117, 958 N.E.2d 1235, ¶ 54. This "more likely than not" standard does not require a firm conviction or belief (as where the standard is clear and convincing evidence). *Id.*

75. The preponderance of evidence standard is different from the clear and convincing standard in one critical component: the degree of certainty required to carry the burden. Under a preponderance of the evidence standard, the Court must simply be convinced that the fact at issue is more likely to exist than not. *Id.*

First Prong

76. The Court first evaluates whether Defendant has proved by a preponderance of the evidence that he has delusional disorder.

77. According to the DSM-5 by the American Psychiatric Association[2], delusional disorder is diagnosed by the following criteria:

a. The presence of one (or more) delusions with a duration of 1 month or longer.
b. Criterion A for schizophrenia has never been met.
    i. Hallucinations, if present, are not prominent and are related to the delusional theme (e.g., the sensation of being infested with insects associated with delusions of infestation).
c. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired, and behavior is not obviously bizarre or odd.
d. If manic or major depressive episodes have occurred, these have been brief relative to the duration of the delusional periods.
e. The disturbance is not attributable to the physiological effects of a substance or another medical condition and is not better explained by another mental disorder, such as body dysmorphic disorder or obsessive-compulsive disorder.

78. The General Assembly included explicit language in the SMI Statute that a defendant is not required to meet the standard to be found not guilty by reason of insanity in order to meet the SMI standard. See R.C. 2929.025(A)(1)(b). The legislative history of the SMI statute, as enumerated above, further supports the notion that the M'Naghten rule and the NGRI standard should not be applied in SMI cases. Dr. Noffsinger testified he could not render a finding of serious mental illness under Ohio's SMI Statute unless the petitioner also met the definition for legal insanity. (HT at 190; see also HT at 139.) The Court finds Dr. Noffsinger's analysis used an erroneous standard, one that is much more burdensome than the SMI Statute requires.

2 American Psychiatric Association. (2013). Anxiety disorders. In Diagnostic and statistical manual of mental disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

79. Dr. Noffsinger testified that Dr. Nadkarni did not follow the forensic psychiatric evaluation standards and therefore his conclusions are not credible. (Tr. 131-132). However, there is no requirement in H.B. 136 or under R.C. 2929.025 that a psychiatric evaluation must be given by a "forensically-trained" mental health professional.

80. Dr. Noffsinger testified that Dr. Nadkarni's methodology was unreliable, claiming that Dr. Nadkarni relied on the defendant's self-report of his symptoms given in 2021 without having any corroboration for that self-report, had "no objective data" and ignored previous psychiatric evaluations. Dr. Noffsinger also argued that a PET scan or CT scan are not used to diagnose delusional disorder. (Tr. 133-135).

81. The Court finds that the evidence does not support these claims by Dr. Noffsinger. Thus, this Court rejects Dr. Noffsinger's conclusions concerning Dr. Nadkarni's methodology.

82. As already detailed in part above and as testified about by Dr. Nadkarni at the hearing, there is significant evidence from before 2021 which corroborates Dr. Nadkarni's 2021 diagnosis of delusional disorder. A few such examples are:

a. Dr. Michael Aronoff found that Maxwell suffered from paranoid personality disorder that was "possibly indicative of a psychotic disorder." Dr. Aronoff noted that Maxwell had experienced autoscopy (out of body experience), paranoia and delusions of people out to kill him and persecute him, auditory hallucinations of his deceased stepfather, deceased mother of his child, and God. (PX 2 at page 5.) Maxwell also thought people in the jail were putting something into his beverages. (*Id.* at 5-6.)

b. On September 28, 2006, Maxwell's mother told Dr. Aronoff that her son "sometimes acts strange. Sometimes paranoid. He be quiet, just stare." (*Id.* at p. 4.) She also said

that "[Maxwell] should have seen somebody," referring to a mental health professional, "I knew that something was going wrong." (*Id.*)

c. Maxwell reported to Dr. McPherson that he had experienced auditory hallucinations or has been "hearing voices" since several years before the murder. (PX 1, p. 4).

d. The results of the MMPI given by Dr. McPherson in 2007 indicated he had a strong sense of being pursued by others who have negative intentions. (PX 1, p. 9).

e. Dr. McPherson found that the "[r]esults from the Bender-Gestalt interestingly do show some distortions, which may reflect underlying central nervous system dysfunction of some kind. Since he has a history of relatively recent head injury, further evaluation of this aspect of his functioning needs to take place." A delusional disorder due to previous head injuries was not ruled out prior to trial and sentencing.

83. When confronted with the evidence which pre-dated the 2021 diagnosis, Dr. Noffsinger refused to consider any of it to be valid. He testified that he would expect evidence of delusions to be "evident in their statements and behaviors," but when presented with such evidence, he rejected it as evidence of malingering.

84. The Court finds that the pretrial statements and evidence support Dr. Nadkarni's diagnosis of delusional disorder and do not support a finding of malingering.

85. This Court places little weight on the fact that prior experts did not diagnose Maxwell with delusional disorder, acknowledging that Dr. Noffsinger relied significantly on the lack of a prior diagnosis. The testimony of both experts supported the relative rarity of delusional disorder. This Court finds that a lack of a delusional disorder diagnosis is more likely due limited purpose evaluations and a failure to follow up on Maxwell's head trauma.

86. This Court finds Dr. Noffsinger's testimony and expert opinion to be unpersuasive.

87. In contrast, Dr. Nadkarni has specialized training and expertise in psychiatry, neurology, head injuries, and delusional disorder. Dr. Nadkarni explained in detail about the neurobiology of delusions and how they can be sourced to the brain.

88. Dr. Nadkarni found that Maxwell's history of several head injuries was a likely source of his development of delusional disorder. The CT scan he administered revealed a finding of mild bilateral atrophy in his frontal lobe. Dr. Nadkarni also relied on objective evidence to find Maxwell's frontal lobe dysfunction was consistent with delusional disorder

89. This Court finds that Dr. Nadkarni had a greater level of relevant subject-matter expertise and training than does Dr. Noffsinger about brain trauma and thus accepts Dr. Nadkarni's testimony as the more medically and psychiatrically sound opinion.

90. Based upon the reports and testimony of Dr. Nadkarni, and the exhibits presented by Maxwell at the evidentiary hearing, Maxwell has proven, by a preponderance of the evidence, that he has suffered with delusional disorder for many years, starting in or around 1986, and continuing to the present.

91. Based upon the reports and testimony of Dr. Nadkarni, and the exhibits presented by Maxwell at the evidentiary hearing, Maxwell has also proven by a preponderance of the evidence that he suffered with delusional disorder on November 27, 2005, at the time of the subject aggravated murder of Nichole McCorkle for which Maxwell has been sentenced to death.

92. Based upon the reports and testimony of Dr. Nadkarni, and the exhibits presented by Maxwell at the evidentiary hearing, the exclusionary provisions of the SMI Statute—for disorders which are manifested "primarily by repeated criminal conduct or attributable primarily to the acute effects of any use of alcohol or any other drug of abuse," R.C.

2929.025(A)(2) —are not implicated for the delusional disorder diagnosis in Maxwell's case. (*See* Tr. at 111.)

93. Therefore, Maxwell satisfies the diagnosis prong of the SMI Statute. R.C. 2929.025(A)(1)(a)(iv).

Second Prong

94. The Court next moves on to address the second prong of the SMI Statute.

95. Dr. Noffsinger testified that the SMI statute mirrors the Model Penal Code standard for not guilty by reason of insanity. He argued that because of this, the methodology used to conduct and SMI evaluation mirrors the methodology used to conduct a not guilty by reason of insanity evaluation. While similar, this analysis fails to address the language that largely differentiates the statutes.

96. The Model Penal Code states that a "person is *not responsible* for criminal conduct if at the time of such conduct as a result of mental disease or defect he *lacks* substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law."

97. Ohio's NGRI statute R.C. 2945.391 requires proof that a "that at the time of the commission of the offense, the person *did not know*, as a result of a severe mental disease or defect, the wrongfulness of the person's acts.."

98. Both the Model Penal Code and the Ohio NGRI statute require a finding that a person lacked the capacity to conform one's conduct to the law and therefore they cannot be held responsible for their crimes. However, the SMI statute requires a lower threshold finding that a severe mental illness *substantially impacts* one's ability to conform their conduct to the requirements of law or to appreciate the nature, consequences, or wrongfulness of their conduct. Substantially impacting capacity is not the equivalent of completely lacking

capacity. Further, the SMI statute does exculpate an offender due to their mental illness; it functionally serves as a mitigating factor to prevent capital punishment against those with severe mental illnesses.

99. In fact, had this statute been in existence at the time of trial, the jury and Court would have had the opportunity to consider how Maxwell's delusional disorder substantially impacted his ability to conform his conduct to the law or to appreciate the wrongfulness of his act.

100. A jury could still have found Maxwell to be guilty, but the jury and Court may have recommended or sentenced differently had the diagnosis and its effects been known during the mitigation phase.

101. Therefore, this Court finds that Dr. Noffsinger's reliance of an interpretation more aligned with the NGRI statutes is erroneous.

102. The Court finds that Dr. Nadkarni applied the correct threshold when evaluating Maxwell's ability to conform his conduct to the requirements of law or to appreciate the nature, consequences, or wrongfulness of his conduct.

103. Dr. Nadkarni explained that Maxwell is unable to read the world correctly due to his delusional disorder, making it very difficult for him to exercise rational judgment and it significantly impairs his capacity in that respect when he tries to do so. (HT at 68-69.)

104. Dr. Nadkarni testified these difficulties, which are inherent with delusional disorder, inevitably result in a person experiencing significant impairment in his/her capacity to exercise rational judgment in most aspects of their daily life. He explained that difficulties with rational judgment are brain-based: The brain's circuits are impaired with respect to salience (or reference), agency (gauging the intentions of others and how they might feel

about you), and fear/paranoia (such that neutral stimuli can create fear and paranoia and feelings of being persecuted). (HT at 37-39.) As Dr. Nadkarni explained:

> So all three of these are active in a delusional disorder. [T]his assessment of salience, the intentions of others, and general paranoia and threat, all sort of happen in that frontal lobe area, that final decisionmaker that leads just before the behavior, just before acting something out. And in delusional disorder this is nonfunctional or dysfunctional leading to misinterpretations and abhorrent behavior based on those misinterpretations.

(HT at 39.)

105. By virtue of his serious mental illness of delusional disorder, Maxwell was thus in a perpetual state of paranoia, including on November 27, 2005, where he would constantly feel that he was under threat. His delusional disorder would cause Maxwell, for example, to interpret neutral cues as having specific implications in reference to him, which are negative, persecutory, and dangerous. (Tr. at 38, 69; PX 7, p. 2.) Maxwell's was a "classic persecutory delusional disorder," such that he would experience the delusion of being under threat. (Tr. at 71, 89.) He would misperceive events which happened around him, he would "misread" them, to gravely negative results, such as on November 27, 2005. (Tr. at 38.)

106. As Dr. Nadkarni explained about Maxwell at the hearing:

> I believe he was moving in a state of perpetual threat and paranoia. He was having salience problems, he was having referential problems in terms of exercising judgment. Same thing is true with the paranoia and fear circuit. It's the same kind of cancer, misreading people's intentions, or how they might be behaving towards you would affect his rational judgment.
>
> . . . .
>
> His misreading of cues puts him in a state of feeling under threat, like, his life is in danger which would color all of his behaviors and stations and significantly impair appropriate judgments and decisions.
>
> Q. So is he -- is he looking at everything through a paranoid lens?

> A. Yes, that's my impression that he was looking at a lot of his life through this lens of paranoia, which both has -- makes it difficult for him to conform to conduct that's in line with the law. But also, in significantly -- capacity to understand the consequences and nature of his behavior because it's based on a wrong assumption to begin with so it's going to be a false understanding of the nature and consequences because he's acting from a position of being under threat constantly.

(Tr. at 69, 72-73.)

107. The evidence presented shows that Maxwell suffered from this "chronic" and "persistent" type of disorder resulting from compounding brain injuries.

108. This Court finds that Maxwell's delusional disorder was exacerbated by psychosocial stressors at the time of the offense, including increasing depression and suicidality.

109. In sum, Maxwell's behavior and decision making, at the relevant time, were based on a false understanding of the nature and consequences because of his delusions.

110. As demonstrated by his neuropsychological testing, Maxwell was rigid in sticking to his beliefs and delusions. Maxwell's belief that the police were "after" him, while substantiated on November 27, 2005, does not invalidate or diminish the persecutory delusions already present in his brain that rendered him unable to accurately weigh the different options in front of him.

111. The events leading up to and at the time of the murder further support the existence of delusional disorder: paranoia to an elevated degree when under stress, the misreading of cues and circumstances to his detriment, the exaggeration of perceived threats to himself from the victim and others, poor executive functioning, cognitive dysfunction, the perception of being "cornered" such that the paranoia/fear circuit overwhelms his judgment, among others.

112. The Court thus finds that based upon the reports and testimony of Dr. Nadkarni, and the exhibits presented by Maxwell at the evidentiary hearing, Maxwell has proven by a preponderance of the evidence that on November 27, 2005, at the time of the subject aggravated murder of Nichole McCorkle, Maxwell's delusional disorder significantly impaired his capacity to exercise rational judgment in relation to his conduct with respect to conforming his conduct to the requirements of the law and also to appreciating the nature, consequences, or wrongfulness of his conduct. R.C. 2929.025(A)(1)(b)(i)-(ii).

113. Accordingly, the Court hereby finds that Maxwell satisfies the requirements for a finding of serious mental illness under R.C. 2929.025(A)(1) which thereby renders his death sentence void and requires imposition of a sentence of life without parole. R.C. 2953.21(H).

114. This Court shall proceed to resentencing. Counsel must provide the Court with the availability of all parties.

IT IS SO ORDERED.

Judge David T. Matia