IN THE CLAIMS COMMISSION OF THE STATE OF TENNESSEE
EASTERN GRAND DIVISION

FILED
JUN 02 2009
Tennessee Claims Commission
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SHERRY JOHNSON, as mother, survivor, and next of friend of DEDRICK JOHNSON, a minor, deceased,	
Claimant,	
v.	**Claims Commission No. 20050013**
STATE OF TENNESSEE,	**Regular Docket**
Defendant.	

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FINAL DECISION

THIS MATTER came on to be heard before the Commission on November 19 and 20, 2008, sitting in Chattanooga, Tennessee. [1]

Present and representing the Claimant at that time were attorneys, Jesse O. Farr, Esq. and Darren G. McBride, Esq., of the Hamilton County Bar. Present and representing the State of Tennessee were Mary M. Bers, Esq., Senior Counsel, and Stephanie Bergmeyer, Esq., of the Office of the Attorney General.

Based upon stipulations of the Parties, evidence presented at trial, testimony of the Parties, statements of Counsel, Exhibits introduced and admitted, and the record as a whole, the Commission **ORDERS** Judgment in favor of the Claimant be entered.

[1] References in this portion of the Decision are to the transcript of the trial testimony (TR ___, p ___), exhibits introduced at that time (EX ___), and to four volumes of medical records numbering two thousand two hundred and seventy-two (2,272) pages which both parties agreed the Commission could review in reaching its decision. References to those four volumes will be to the page number in those volumes since the documents contained in all four volumes are numbered sequentially, e.g. MR, p ___.

Procedural History:

This claim was filed with the Division of Claims Administration ("the Division") on September 27, 2004. Pursuant to Tennessee Code Annotated, Section 9-8-402(c), on December 28, 2004, the Division transferred the claim to the Tennessee Claims Commission.

Overview of Case:

The Claimant filed this claim against the State asserting jurisdiction under Tennessee Code Annotated, Section 9-8-307(a)(1)(E), dealing with the negligent care, custody, or control of persons. Specifically, Claimant maintains that this case involves the negligent release of a psychiatric patient with known violent propensities. Further, the Claimant alleges the negligent release of that patient, Dedric Atkins ("Mr. Atkins"), from Moccasin Bend Mental Health Institute ("MBMHI") caused the death of young Dedrick Johnson.

The facts of this claim are tragic and fairly straightforward. This matter involves the murder of Claimant Sherry Johnson's son, Dedrick Johnson, by his father Mr. Atkins. After having been admitted to MBMHI on September 10, 2003, Mr. Atkins was discharged on September 19, 2003. Mr. Atkins had a long history of mental illness, including but not limited to schizophrenia and antisocial personality disorder, and had been hospitalized on eleven (11) prior occasions at MBMHI, as well as on other occasions at various psychiatric institutions and providers in the North Georgia and North Alabama areas. Following his discharge from MBMHI on September 19, 2003, arrangements were made for Mr. Atkins to spend the weekend with his son beginning on Friday, September 26, 2003. On Saturday, September 27, 2003, he killed his five year, three month old son by choking him, then throwing him on the ground and stomping him, followed by drowning him in a bathtub full of water in a small apartment located in the Patton Towers public housing facility in Chattanooga, Tennessee. (MR 1876.) The

Certificate of Death lists the cause of death of young Dedrick as blunt trauma to the head and strangulation.

Stipulations:

The parties stipulated to the admission of Collective Exhibit 1, containing Dedrick Johnson's Birth Certificate, Social Security Card, and his Certificate of Death. Per those documents, the parties stipulated the following facts: (1) Dedrick Johnson, a minor child, was born on June 29, 1998, in Hamilton County, Tennessee, to Sherry Johnson; (2) the minor child, Dedrick Johnson, died on September 27, 2003; (3) the minor child died as a result of a homicide that took place at the residence of his father, Mr. Atkins, located at 1 East 11th Street, Apartment 303 (Patton Towers), Chattanooga, Tennessee; (4) Mr. Atkins beat and strangled his son and then placed him in a bath tub containing water; and (5) the immediate cause of death to Dedrick Johnson was blunt head trauma and ligature strangulation inflicted upon him by Mr. Atkins, his father. Additionally, the Parties stipulated to the admissibility of the certified medical records from MBMHI for Mr. Atkins, entered as Collective Exhibit 2, consisting of four (4) large volumes of records, containing two thousand two hundred seventy-two pages. These records have been "Bates" stamped in continuous sequential order.

Mr. Atkins was well-known to personnel at MBMHI since he had been hospitalized there on twelve occasions prior to the murder. The dates of those hospitalizations are attached hereto as Exhibit 1. After the murder, Mr. Atkins was also examined by forensic specialists at Middle Tennessee Mental Health Institute ("MTMHI") and also again at MBMHI for a thirteenth time. After Atkins killed his son, he went to the lobby of the Patton Towers building and told the security guard there what he had done. (MR 1950.) He described the same events to the responding officers and medical personnel. His account of the murder indicated that on that Saturday evening, he was watching television, started hearing voices, and snapped. (MR 1914-

1922.) When questioned further about the killing, Mr. Atkins told the responders that his son "needed to be dead". (MR 1950.)

Mr. Atkins had moved into the Patton Towers building on October 14, 2002. The manager of that facility told investigators that she could tell when Mr. Atkins was not taking his medicines. (EX 6.) According to Dr. Yap, who testified at the hearing and who had treated Mr. Atkins on several of his hospitalizations at MBMHI, including the one before the murder, having a place to live was a stabilizing influence for Mr. Atkins' condition.

Witness Testimony:

Sherry Johnson

The first witness to testify was Sherry Johnson. Her Deposition testimony given May 8, 2007, was also admitted into evidence as Exhibit 8.

Sherry Johnson stated she had been employed at Erlanger Hospital in the Dietary Department for seven (7) years. Prior to that employment, Ms. Johnson had worked as a packer at Chattern in Chattanooga. Ms. Johnson stated she graduated from Howard High in Chattanooga. In her Deposition, she agreed that she received a special education diploma in 1996.

Regarding her relationship with Mr. Atkins, Ms. Johnson stated she had attended middle school and high school with him and his twin brother, Darrien. She testified that after high school she lost track of them until she moved into the East Lake area with her mother. Shortly after becoming reacquainted, she and Dedric Atkins had a brief relationship, and she became pregnant. However, she testified that she did not directly tell Mr. Atkins she was pregnant because she could not locate him but did tell his brother Darrien, who visited her at the hospital when her son Dedrick was born.

At her Deposition, Mr. Johnson testified regarding an incident involving Mr. Atkins which occurred before their son's birth. She stated that while she was pregnant she was walking to a store one day and ran into him when he threatened to smack her. Both at deposition and at trial, she acknowledged that she preferred to stay away from Mr. Atkins because he had changed a lot since school. It was her opinion that he acted strange, would get into fights with people, and talked to himself a lot. Ms. Johnson did confirm that before she became pregnant by Mr. Atkins she was aware he had been in and out of psychiatric hospitals.

Regarding the relationship between Mr. Atkins and his son, Dedrick Johnson, Ms. Johnson testified that during the early years of his life, Mr. Atkins saw his son only once when he was approximately two years old and that was only from a distance. She stated that Mr. Atkins did not help support the child nor did he assist in paying for any expenses for the child.

In the summer of 2003, shortly after Mr. Atkins moved into Patton Towers, Ms. Johnson took Dedrick there to see his father. She testified that Mr. Atkins was not there but that his brother Darrien was. She learned that Mr. Atkins was in MBMHI. After his discharge, Ms. Johnson made arrangements for her son to spend the weekend with Mr. Atkins. At that time, Dedrick was five years old, and she stated the plan was for him to spend some time with his father. However, she stated that Mr. Atkins and Dedrick were not to be alone together, and that his brother Darrien was supposed to be in the apartment with them on the weekend of the child's death.

At her deposition, Ms. Johnson admitted she did not know how Mr. Atkins would react around kids but she knew Darrien had children of his own and liked kids. Further, it was her opinion that it was a good time for Mr. Atkins and Dedrick to start a father/son relationship. She also testified that she thought Mr. Atkins was going to do the right thing as a father and she was hopeful that things would be better between him and her son.

Ms. Johnson testified that on Friday night (September 26, 2003) she called Darrien's cell phone and asked to speak with Dedrick. She stated that she learned that Dedrick and Mr. Atkins were out walking. The following Saturday morning she stated she again called Darrien's cell phone to speak with her son Dedrick but discovered that Darrien was not at the apartment but had left to check on his children. At that time, Ms. Johnson stated she began to worry. Later Saturday she received a call from Darrien who told her that she would be getting a call from a lady. Shortly thereafter, a female police officer came to her home and took her to the police station. She was informed then that Mr. Atkins had killed her son.

William D. Kenner, M.D.

William D. Kenner, M.D., next testified on behalf of the Claimant. Dr. Kenner is a physician licensed to practice medicine in the State of Tennessee and Board Certified in psychiatry. He graduated from the University of Tennessee Medical School at Memphis in 1969 and was licensed to practice medicine in Tennessee in 1970. Dr. Kenner completed a clinical clerkship in psychiatry at the Mayo Clinic in Rochester, Minnesota, in 1969. He also completed a rotating medical internship in 1970 at Baptist Memorial Hospital in Memphis, Tennessee.

From 1973 to 1975, Dr. Kenner completed a residency in adult psychiatry and a fellowship in child psychiatry at the Institute of Psychiatry and Human Behavior at the University of Maryland Hospital in Baltimore, Maryland. In 1975, he also completed a fellowship in child psychiatry at Vanderbilt University Hospital in Nashville, Tennessee. Dr. Kenner also received training in psychoanalysis from 1978 to 1983 at the St. Louis Psychoanalytic Institute in St. Louis, Missouri.

Dr. Kenner's professional experiences include the position of Assistant Professor of Psychiatry at Vanderbilt University from July 1973 to June 1975. Also from July 1973 to June of 1975, Dr. Kenner was Director of Vanderbilt's Admission Unit at Central State Hospital (now

known as Middle Tennessee Mental Health Institute). From 1976 to 1977, Dr. Kenner was the attending inpatient psychiatrist at the Vanderbilt University Medical School, Department of Psychiatry. Since 1977, Dr. Kenner has been in the private practice of adult and child psychiatry and psychoanalysis, as well as holding the position of Associate Clinical Professor of Psychiatry at Vanderbilt Medical School. Since 1984, Dr. Kenner has also been an instructor with the St. Louis Psychoanalytic Institute. Presently, Dr. Kenner is on staff at Vanderbilt Medical Center and Centennial Medical Center.

Testifying regarding the standard of care at state psychiatric hospitals, Dr. Kenner testified that all state owned institutions in the State of Tennessee are operated under the Department of Mental Health and commit and release patients under the same statutes. Additionally, Dr. Kenner stated he was familiar with that standard of care in the psychiatric community as it relates to and deals with mentally ill, as well as potentially violent and dangerous individuals.

In his testimony, Dr. Kenner affirmed that clinical judgment plays a large role in the standard of care and that as such, within the standard of care different doctors could perhaps take various approaches to treating a patient. However, he stated that using clinical judgment is highly structured and "there are specific things that one should look at and those things are laid down in text". (TR 119.) Dr. Kenner also went on to testify that a "part of clinical judgment is to recognize that paranoid patients in particular are going to lie to you ... because they believe quite often ... that the medicines are poisoning" them. (TR 122-123.) Additionally, he stated that as a part of their disease process paranoid patients will lie and fake being better and will not tell the clinician about their psychotic symptoms. (TR 123.)

In formulating his opinions and testimony in this case, Dr. Kenner reviewed Mr. Atkins' records from MBMHI from March 18, 1997, to August 21, 2004, Dr. Keith Caruso's September

28, 2005, preliminary psychiatric evaluation of Mr. Atkins, and Middle Tennessee Mental Health Institute's forensic services records from May 13, 2004, to June 10, 2004.

In reviewing psychological testing performed on Mr. Atkins during his fourth admission to MBMHI, from May 27 to June 22, 1999, Dr. Kenner stated the test results indicated left hemisphere dysfunction and significant deterioration of Mr. Atkins' front lobe function. Dr. Kenner elaborated by stating that schizophrenia is typically seen as a mental illness but in reality there are specific parts of the brain that begin to deteriorate and that some patients are more severely affected than others. After looking at Mr. Atkins' results, it was his opinion that Mr. Atkins fell into the group where brain deterioration and the related dysfunction were "profoundly affected". (TR 68-69.) Further, Dr. Kenner explained "what this means is that ... his [Mr. Atkins'] ability to control his impulses, and essentially the ability to put the brakes on, is severely decreased" (TR p. 69). On his fourth admission, Dr. Kenner stated Mr. Atkins was diagnosed with chronic paranoid schizophrenia.

In describing paranoid schizophrenia, Dr. Kenner explained that there is a part of the brain that operates like a filter that distinguishes whether stimuli are coming from outside or inside an individual and then attaches emotional valences to them. When the filter goes out slowly, he stated that a person will try to make sense out of it and therefore, paranoid schizophrenics will begin to develop their own conspiracy theories for the strange perceptions they are having.

Dr. Kenner opined that because of Mr. Atkins' history, as found in the records from MBMHI he reviewed, Mr. Atkins "represents a special class of mentally ill individuals who are recidivistically violent and who have been carefully studied going back to 1977". (TR 90.) Further, he stated that results of the studies also indicated "that recidivistically violent schizophrenic patients suffer from a more severe form of the disease" (TR p. 101). He opined

that in looking at the results of Dr. Brown's testing [MBMHI records] that it certainly fit Mr. Atkins' case since there was significant evidence Mr. Atkins had frontal lobe deterioration.

In general, Dr. Kenner stated that the rate of violence by former mental patients as a group is no more than that seen in the general population. However, he explained there is a subset within the mentally ill patient population who are recidivistically violent and that one must watch out for as these are the ones who exhibit violence over and over again, like Mr. Atkins. Dr. Kenner also stated that if a patient in that subset was schizophrenic, they would have a process of true dementia because their brains are deteriorating. (TR p. 188.) Additionally, it was his opinion that it is important to identify the recidivistically violent mentally ill individuals and keep them in the mental health system much longer than other mentally ill patients because they are the patients at higher risk of hurting people. (TR pp. 220-221.)

Under the proper standard of care, Dr. Kenner testified a violence assessment should be done on admission, prior to discharge, and any time the clinical picture changes and a patient poses an increased risk for violence. (TR p. 97.) In his review of the records, Dr. Kenner testified that even though Mr. Atkins was repeatedly violent, he found only one reference to a violence risk assessment being performed on Mr. Atkins and that was in the 2004 hospitalization records. (TR p. 97.) When questioned regarding admissions to MBMHI during which Mr. Atkins did not show violent behavior, Dr. Kenner commented that "We don't know about that. There was none referenced in the chart, but there wasn't an assessment of dangerousness either. So there was no one who asked him the questions that needed to be asked" (TR p. 129). Additionally, Dr. Kenner was critical of the records because there was not "a clear picture of when he [Mr. Atkins] was violent, or how" (TR p. 138). He opined that "paranoids are notorious for feeling people are picking on them just by looking at them or walking by them or whatever" (TR p. 138). It was his opinion that a violence assessment should have been utilized in

evaluating Mr. Atkins both at the time he was admitted to MBMHI in September of 2003 and prior to his discharge. The failure to do so, in his opinion, was negligent.

Testifying regarding the predictability of violence in patients, Dr. Kenner referenced a text by Ken Tardiff entitled "Medical Management of Violent Patients: Clinical Assessment and Therapy". It was Dr. Kenner's opinion that the best predictor of violence is past behavior. He stated that Tardiff's text, as well as his own professional opinion, recommended that episodes of past violence be dissected in a detailed concrete manner by the clinician. In his review of the records on Mr. Atkins, he stated that did not occur. Additionally, referencing Tardiff's text, he opined a patient's past history of violence should be treated as any other medical symptom. In looking at the totality of MBMHI's records on Mr. Atkins, he stated that although proper testing and procedures were not carried out that MBMHI had to have been aware of how dangerous Mr. Atkins was. Further, he stated it was critical for MBMHI to have conveyed that to the family.

Dr. Kenner testified that in his opinion Mr. Atkins was "extremely violent, recidivistically violent". Citing studies, he stated that 70 percent of assaults occurring in institutionalized psychiatric patients were committed by a very small group of one to four percent (1 – 4%) of patients in institutions. Dr. Kenner opined that Mr. Atkins was in that very small group, extremely violent, recidivistically violent mentally ill category, for a number of years. (TR pp. 212-213.) He also explained that because Mr. Atkins' prefrontal cortex was not working properly he was going to be violent over and over again when he was off his medications. (TR p. 189.) Further, with respect to Mr. Atkins' violence, he stated "the major precipitant for this fellow is that he gets off his medications..." (TR p. 83.)

Regarding the development of an alliance between paranoid patients and psychiatric professionals concerning the patient's medications, Dr. Kenner opined there was a negative relationship when working with these patients. In particular he believed there was a negative

alliance in dealing with Mr. Atkins because "he believes you're conspiring against him". (TR pp. 194-195.) Further, Dr. Kenner stated this was "a tip-off that this guy is not going to work with you. He's not going to tell you the truth about his symptoms. He's going to hide the extent of his delusional thinking from you." (TR p. 195.)

In reviewing Mr. Atkins' records, Dr. Kenner highlighted events and notes he found which supported his opinion that MBMHI deviated from the standard of care in negligently releasing Mr. Atkins from its care.

Mr. Atkins' first admission to MBMHI was March 18th to April 4, 1997. Dr. Kenner pointed out that at that time Mr. Atkins had threatened to strangle or cut up his brother, fought verbally with his father, and threatened to kill a police officer. (TR pp. 65 and 160.) Mr. Atkins was described as being "potentially homicidal" and he punched a psychiatric tech in the face and broke her glasses. (TR p. 65.) Dr. Kenner confirmed that the prognosis given at that time was "guarded" and that Atkins was noncompliant with medications and had a history of drug use. (TR p. 159.)

Dr. Kenner testified there were also episodes of violence noted on his second admission to MBMHI, between August 15 and 29, 1997. On that occasion, Mr. Atkins had hallucinated seeing his brother in a police uniform and had thoughts of killing others. His behavior on that admission was so violent and disturbing that Mr. Atkins was placed in four-point restraints. (TR pp. 66 and 161.)

On the third admission, occurring from April 19 to May 18, 1999, Mr. Atkins was brought in from Silverdale, a Corrections Corporation of America's facility, "because he decompensated from medication noncompliance" (TR p. 66). While at Silverdale, Dr. Kenner stated the notes reflected that Mr. Atkins had bit a correctional officer and was spitting at people. Also, during his admission at MBMHI, the records reflected he had assaulted a staff psychiatrist

and "was noted to be disorganized, hallucinating, grossly psychotic, had delusions that the water was contaminated" (TR p. 67). Interestingly, Dr. Kenner pointed out that on the Discharge Summary for that admission, it was noted "He would tend to hide so that he wouldn't risk the exposure of the cover he is trying to maintain that he is over his psychosis" (Trial Exhibit 2, Bates p. 2264).

During Mr. Atkins' fifth admission to MBMHI, between August 18, 1999, and August 27, 1999, Dr. Kenner testified that Mr. Atkins was charted as being homicidal, and that he was "dangerous when not medicated" (TR p. 71). Dr. Kenner also stated the records from that admission documented that his grandmother had told staff that in the prior June he had tried to kill her. It was also noted in the chart at that time Mr. Atkins was in the McMinn County Jail for two charges of assault on a police officer, as well as an aggravated theft charge. In the Discharge Summary, Dr. Kenner found Mr. Atkins' prognosis was guarded because of his previous delusions and violent behavior when off his medications. (TR p. 169.)

From November 7, 2000 to January 9, 2001, Mr. Atkins again was admitted to MBMHI. At that time, he had been off his medications for approximately one year. Dr. Kenner stated the records revealed he was psychotic, paranoid, delusional, and hearing voices on admission. Initially, notes from that admission described Mr. Atkins as being "inaccessible to interview" (TR p. 72).

On admission number eight, Mr. Atkins came to MBMHI from Erlanger Hospital's Emergency Room. Dr. Kenner stated he was described as being "near catatonic with paranoid delusions" (TR p. 73).

Mr. Atkins returned to MBMHI for admission number nine from June 19 to 29, 2001, for a forensic evaluation. Dr. Kenner testified the records then showed Mr. Atkins to have been found by the Social Security Administration to be "a person with severe and persistent mental

illness with a GAF [global assessment of functioning] of ten" (TR p. 74). Dr. Kenner testified the discharge summary from that admission revealed that his brother and father had both refused to let Mr. Atkins live with them.

On May 7, 2003, Mr. Atkins was admitted for the eleventh time to MBMHI, and was discharged on June 2, 2003. Dr. Kenner stated that on that admission Mr. Atkins "was mumbling about guns, sex, making threats, complaining that people wanted to kill him" (TR p. 74). He was also noted in the records as being "floridly psychotic with paranoid delusions" and had not been taking his medication (TR p. 74). On May 28, 2003, Mr. Atkins threatened a staff member for giving him a shot, stating "I took those shots, but you give me any more and next time I'll hit someone in the face" (TR p. 75).

On Mr. Atkins' twelfth admission, between September 10 and 19, 2003, to MBMHI Dr. Kenner stated that he was described as being "tense, irritable, suspicious, secretive, fearful, talks minimally to others, says he doesn't need medication" (TR p. 75). The Certificate of Need stated that Mr. Atkins "blames family for admission, threatened father, blames hospital staff as conspiring with family ... threats continue ... threatened family before admission" (Trial Exhibit 2, MR 1743). Dr. Kenner stated that "threats from somebody who is violent and has a past history of what is described in the literature as seriously violent, you've got to take them at their word" (TR p. 132).

During that twelfth admission, it was also noted that Mr. Atkins had a delusion that he was telepathic and could communicate with others through a scar over one of his eyes. Dr. Kenner stated Mr. Atkins believed the staff was conspiring with others because of his telepathy and that he very suspicious of others. On September 16, 2003, Dr. Kenner stated Mr. Atkins "remained delusional and paranoid" and continued to report his telepathic ability (TR p. 76). Dr. Kenner pointed out that on September 17th Mr. Atkins was resistant to the idea that he had a

mental illness and left the room when a discussion began about his delusional beliefs and medication noncompliance. On September 19, Dr. Kenner pointed out a note in the chart which stated Mr. Atkins was "nonresponsive to teaching about medications and symptoms relapse" (TR p. 77).

At discharge on September 19, 2003, Mr. Atkins was prescribed oral medications. In Dr. Kenner's opinion, releasing Mr. Atkins on an oral medication given his past history of medication noncompliance was negligent. He stated that in reviewing the records Mr. Atkins had never been compliant in taking his medications and had specific delusional beliefs about what the medications were doing to him and that people were out to harm him. (TR p. 95).

Testifying regarding the crime Mr. Atkins committed against his son, Dr. Kenner stated the crime occurred roughly eight (8) days after Mr. Atkins was discharged from MBMHI, on September 27, 2003. He testified it was noted in the records that Mr. Atkins reported to officers upon arrival that he had just killed his son. When asked "how long the victim had been down" Mr. Atkins curtly told officers that "it didn't matter. He needed to be dead" (TR p. 79). Mr. Atkins also went on to tell the officer that he had been watching television and the characters in the program and the commercials began calling to him and he snapped, choking his son, throwing him on the floor, stomping him, and then throwing him into the bathtub. Dr. Kenner opined that what had happened was that Mr. Atkins' "delusional beliefs had somehow included his son", and that was how he had concluded his son needed to die.

When Dr. Kenner was questioned regarding his review of Mr. Atkins' records and any place noted therein where Mr. Atkins had threatened a child or, in particular, his child, Dr. Kenner stated, "Not specifically against a child, but what you have to be careful with is that this fellow is grossly psychotic. … there could be an accident out on the street and he could take that as a sign from God that he needs to kill somebody and you're the smallest person in this room

and you might well be at risk. He's going to pick on and try to hurt people and be most dangerous to those who aren't able to defend themselves" (TR p. 147).

Dr. Kenner also reviewed the records of Dr. Keith Caruso, a forensic psychiatrist in Nashville. In reviewing those records, Dr. Kenner testified that Mr. Atkins had told Dr. Caruso he believed his son had became possessed by the devil as a part of a conspiracy against him, and that he was so suspicious of his son that Mr. Atkins related he was not even sure he was his son. (TR p. 80.)

Additionally, Dr. Kenner pointed out actual quotes from Mr. Atkins to Dr. Caruso. "...it's like somebody taking needles and injecting ice cold water, almost froze sticking in my stomach area where the wound is. ... it's like cancer eating my stomach because I never got my stitches out. Like maggots or something in my stomach moving around making me feel ill" (TR p. 81). Dr. Kenner opined that these statements point to the fact Mr. Atkins was likely having some kind of tactile hallucinations which can be seen with schizophrenia.

Looking at records from May 13 to June 10, 2004, from Middle Tennessee Forensic Services at MTMHI, Dr. Kenner testified Mr. Atkins was diagnosed with schizophrenia, undifferentiated type, and was found to be incompetent to stand trial and insane at the time of the crime. Dr. Kenner pointed out that records from MBMHI from July 15 to August 24, 2004, [after the murder] discount any notion Mr. Atkins was schizophrenic and only refer to "a history of schizophrenia, undifferentiated type, but ... his primary diagnosis was malingering and cannabis abuse ... antisocial personality disorder, and narcissistic personality disorder" (TR p. 82) and the team at Moccasin Bend found him competent to stand trial and sane at the time of the crime. Kenner's examination of the records from that hospitalization noted that Mr. Atkins was exhibiting some of the same symptoms he had earlier exhibited in behaving bizarrely and at one point became assaultive to the extent he was given an antipsychotic medication.

Regarding Mr. Atkins' medication compliance, Dr. Kenner stated the record was replete with instances of Mr. Atkins either being noncompliant, thinking the medication prescribed was harming him, or believing he simply did not need the medication. Dr. Kenner testified a way around this problem was ordering that Mr. Atkins be treated with Prolixin Decanoate given intramuscularly every two weeks. Treating a chronically mentally ill patient who is repeatedly medication noncompliant in Tennessee, Dr. Kenner stated, can be accomplished through the option of a Mandatory Outpatient Treatment program. He stated that on discharge of the patient the facility coordinates with the local community mental health center, which the patient will be following up with every two weeks, to receive the Prolixin Decanoate. If the patient does not show for the injection, then the patient goes straight back to the hospital by virtue of the fact the medications have not been administered. (TR p. 78.)

In summary, Dr. Kenner opined that because MBMHI was aware of Mr. Atkins' history and the specifics concerning his mental illness, it was negligent in releasing Mr. Atkins. First, he stated that on admission and prior to discharge the staff should have evaluated Mr. Atkins for violence, specifically looking for impulse control, anger, delusions, and so forth. Secondly, Dr. Kenner opined MBMHI was negligent in their release of Mr. Atkins by prescribing oral medications rather than the longer lasting Prolixin Decanoate, especially given the fact that he was known to be a chronically medication non-compliant patient. Dr. Kenner also testified that MBMHI failed to warn and counsel the family that Mr. Atkins was a chronically ill individual and that those who were small and vulnerable needed to be protected. (TR p. 104.) Lastly, Dr. Kenner stated that Mr. Atkins should have "remained in the hospital longer under a commitment and then the staff could have sought [a] mandatory outpatient treatment commitment to ensure that he followed up with his depot antipsychotic medications" (TR p. 102).

Dr. Kenner testified it was his opinion that the manner in which Mr. Atkins was released represented a danger to the public at large, mainly due to the fact of his release on an oral medication when he was a known medication noncompliant patient and known to be dangerous when off those medications. Further, he felt the institution breached a standard of care in not putting Mr. Atkins in a mandatory outpatient treatment program. (TR p. 111.)

E. Bruce Hutchinson, Ph.D.

The Claimant next called Economic Consultant, E. Bruce Hutchinson, Ph.D., to testify regarding the pecuniary value of Dedrick Johnson's life. In estimating the monetary value of a five and one quarter year old child, Dr. Hutchinson made three assumptions. He testified that these three scenarios represented mean averages for a male in the United States, working in the Chattanooga, Tennessee, area.

The first assumption made in arriving at a pecuniary value would be that the child Dedrick Johnson would have graduated high school, entered the workforce, and continued with a work life expectancy of 38 years. Under that scenario, Dr. Hutchinson arrived at a figure of Five Hundred Nine Thousand Nine Hundred Seventy-Four Dollars ($509,974.00).

Alternatively, Dr. Hutchinson assumed Dedrick Johnson would graduate with an Associate's Degree and enter the workforce with a work life expectancy of 37.58 years. The pecuniary value arrived at for that scenario totaled Five Hundred Fifty-Four Thousand Six Hundred Eight Dollars ($554,608.00).

Lastly, Dr. Hutchinson computed a pecuniary value based upon the assumption that Dedrick Johnson would have graduated with a Bachelor's Degree, entered the workforce, and continued to work with a work life expectancy of 39.17 years. Projecting that forward, Dr. Hutchinson arrived at a pecuniary loss of Six Hundred Seventy-Four Thousand Five Hundred Sixty-Seven Dollars ($674,567.00).

In explaining his calculations, Dr. Hutchinson stated he projected the amounts forward from the three dates Dedrick Johnson would have entered the workforce, adjusted using a 20-year average in order to determine the average annual change in the employment cost index, then discounted the figures, and also deducting past and future personal consumption, and adding in fringe benefits and the value of household services. Dr. Hutchinson also noted that his calculations were adjusted from the national figures in order to reflect the Chattanooga, Tennessee, area.

Dr. Hutchinson confirmed that he would have had a better idea of what Dedrick Johnson's future would have been had he had an income history to analyze. Explaining further, he stated that it was unfortunate in this case that no one would ever know what "the true history of Dedrick Johnson would have been and how society would have benefited", but that based upon his expertise he used very reasonable scenarios utilized by economists involving a male growing up in the Chattanooga area, later entering the workforce, discounting present earnings, less expenses, and adding in fringe benefits and value of household services, and thus arriving at reasonable conclusions as to the pecuniary value of Dedrick Johnson's life. He also stated that in forecasting these values it was outside his expertise, or anyone's for that matter, to take into account health history, work history, parent's educational history, or intellectual functioning. Additionally, he stated there was not any accepted means or tables or formulas for an economist to take those factors into account and then make adjustments to the pecuniary value.

Dr. Hutchinson said he did not see any information in this case that the child would have fallen either below or above the typical mean average captured in the three scenarios he forecasted.

Dolorosa Yap, M.D.

The State called as its first witness, Dr. Dolorosa Yap, a physician employed by MBMHI. Dr. Yap is licensed to practice medicine in Kentucky, Georgia, North Carolina, and Tennessee. She is board eligible in psychiatry. She began working at MBMHI in 1985. In addition to working 37.5 hours a week at MBMHI, Dr. Yap testified in 1989 she also began doing contract psychiatric work one day a week in the community mental health centers in several facilities – Fortwood, Joe Johnson, Hiwassee, and Lookout Mountain Community Services.

Regarding policies for administering psychiatric treatment and for patient care at MBMHI, Dr. Yap acknowledged there are institutional policies and a standard manual. Additionally, she explained that patient care and treatment is a multi-disciplinary team approach, which includes doctors, nurse practitioners, nurses, social workers, and technicians. Additionally, as a part of patient care and treatment at MBMHI, patients are seen every day by the treatment team. Generally, Dr. Yap testified a psychiatric evaluation is done when a patient is admitted to MBMHI. She stated this evaluation always included the patient's past history and that the patient was assessed from the first incident of breakdown through all subsequent admissions. (TR pp. 319, 322-323.)

In the course of her practice at MBMHI, she stated that she had the opportunity to see and treat Mr. Atkins on his seventh, tenth, and twelfth admissions.

Testifying regarding Mr. Atkins' seventh admission, from November 7, 2000, to January 9, 2001, Dr. Yap stated he had been off his medication for more than a year, was homeless, and referred from Erlanger because he was psychotic, very disorganized, with delusional thinking. She testified he had lost a lot of weight and his hygiene was poor at the time. It was her opinion that he was really suffering from being homeless with no income, as well as being more withdrawn and very depressed. Additionally, she opined that Mr. Atkins' most significant

problem was that he did not feel comfortable around people and avoided group activities. (TR pp. 324-325.)

Once Mr. Atkins was started on medication, she stated there was improvement and progress. She also stated that Mr. Atkins usually responded to medication "when he will just take it" (TR p. 326). On that seventh admission, Dr. Yap testified Mr. Atkins remained at MBMHI for sixty-three (63) days, mainly due to the fact no relative could be located who was willing to take him. She also stated that she felt Mr. Atkins was doing well on discharge but apparently did not maintain that status long since he was readmitted to MBMHI approximately a month later on February 26, 2001, because of delusional thinking that somebody was cutting his back.

Although Dr. Yap was not Mr. Atkins' treating physician on admission number eight, between February 26, 2001 and March 15, 2001, she did see him on March 3rd. At that time, she noted, "This patient is known to me. He is ... very guarded, doesn't give much information about himself. He can get very paranoid, suspicious, and delusional, but has no insight. Doesn't engage in any of social interactions." (MR 1221-1222.) At that time, she assessed him as schizophrenic, paranoid type and still psychotic. Her recommendation for a treatment plan was to continue his medications as ordered.

The next time Dr. Yap was Mr. Atkins' treating physician was on his tenth admission to MBMHI, between August 14, 2002, and August 26, 2002. At that time, she stated Mr. Atkins had been in an altercation on the streets and he "felt like he wanted to hurt that person" (TR p. 329). After being restarted on his medications, Dr. Yap thought he once again made good improvement. However, he was again homeless and thus, was discharged and sent to the Union Gospel Mission, a shelter.

On Mr. Atkins' twelfth admission to MBMHI, from September 10, 2003, to September 19, 2003, Dr. Yap testified she was once again Mr. Atkins' attending physician. The presenting problems on that occasion were that he was depressed and having suicidal thoughts. It was reported that Mr. Atkins was not taking his medications. At that time, he was also having delusions about his telepathic power to send messages to rich people so they would give him money. It was her opinion this delusional thinking was soothing to him because of his financial problems. (TR pp. 331-332, 397-398.)

In comparison with previous admissions, she stated that on this hospitalization Mr. Atkins was much better than he had been. Dr. Yap stated he had just gotten an apartment, was well-groomed, his Social Security benefits and food stamps were in place, and he had a case manager and Alcoholic's Anonymous ("AA") sponsor. Although she personally was unaware of whether he ever saw the case manager or his AA sponsor, the record showed these services had been coordinated and planned for him as a part of the discharge planning process by MBMHI, as well as transportation plans. Additionally, Dr. Yap opined that she felt his situation on this admission was completely different than it had been previously because he was not in an environment of conflict, either at home with his family, incarcerated, or on the streets; that he had his own home. She stated she was very positive about his discharge plan on that admission. (TR pp. 331-332, 334-336, 350-352.)

Throughout Mr. Atkins' twelfth admission under her care, Dr. Yap felt his level of functioning was much higher than it had been in the past. It was her opinion that because he did not have as many stressors on him that he was functioning at a higher level. (TR p. 421.) Further, Dr. Yap stated his presenting problems on his twelfth admission were less severe than they had been on previous admissions. (TR p. 419.)

Testifying about Mr. Atkins' course of treatment in the twelfth admission, Dr. Yap stated, "It was very small because he was able to discuss with us about the medication that helps him." (TR p. 342) She also stated that he was working with staff and suggested to the treatment team he would like to be put back on Zyprexa and Zydis, to help him sleep. It was Dr. Yap's opinion that the probable reason for Mr. Atkins' failure with outpatient care in the past was because he was homeless.

Regarding medication noncompliance by Mr. Atkins, Dr. Yap affirmed that there was a history of noncompliance, but it was her opinion it was because Atkins did not have much support and no place to go, as well as being incarcerated and not being given the injections. (TR pp. 348-349.) She also stated that it was not easy to supervise a patient who does not have a permanent place to live and difficult for the patient to get to a location for medication. (TR p. 345.) Further, she did not agree Mr. Atkins did not want to take his medications and to her knowledge he never refused medication when he was at MBMHI.

Since Mr. Atkins was working with the team during his twelfth admission regarding his medications, Dr. Yap stated that she tried him on the oral medications rather than the intramuscular injection (Prolixin Decanoate) because he complained of less side effects and because she was "trying to develop some kind of alliance with the patient, hoping ... that compliance would improve if he participates in the decision-making of what kind of medication he would take" (TR pp. 361, 363). She also stated it was an effort to hopefully get Mr. Atkins more interested in things because the oral medication is targeted to help with negative symptoms such as a flat emotional affect and lack of interest. (TR pp. 343-344, 361-362.) Dr. Yap testified that the first time Mr. Atkins was seen in the treatment team meeting to "negotiate about medication, discuss about medication", she learned he was not taking his medicine because it caused side effects. (TR p. 368.) When questioned regarding why she would negotiate and trust

someone who in the past had not been compliant with medications, Dr. Yap stated that on each admission she must make an assessment of the patient based on the situation presenting at the time. On this admission, it was her opinion Mr. Atkins' situation was completely different than it had been previously, and she was hopeful of establishing an alliance with Mr. Atkins and was sure he liked the medication and would continue taking it because things were so different for him. (TR pp. 361, 371-372, 374, 395.) When questioned regarding whether or not Mr. Atkins was taking his medications on the date of the death of young Dedrick Johnson, Dr. Yap agreed that had she prescribed an intramuscular injection medication when he was discharged that she would have known he was on his medications at the time of his son's death. (TR p. 452.)

Testifying about the possibility that Mr. Atkins was concealing his psychosis when she discharged him, Dr. Yap disagreed with that proposition. Because she had treated him on two prior occasions, she testified that Mr. Atkins was known to her, and she had seen him every day during his twelfth admission. She also testified she was able to observe his behavior, ask him questions, and assess his thoughts. In doing so, she opined that she was "very comfortable" in discharging him. (TR p. 358.) Further, Dr. Yap testified that when a patient is psychotic it is "impossible for them to lie because you can see the psychosis, which is obvious" (TR p. 473). She also opined that Mr. Atkins did not lie when he was interviewed or was being seen by the treatment team. Knowing Mr. Atkins, she stated that when he is psychotic he is more guarded and suspicious, which probably prevented him from telling more but that when he was re-started on medications he improved. (TR p. 473.) In support of her contention that Mr. Atkins was not lying, Dr. Yap also pointed out that when a patient becomes psychotic they do not have judgment. (TR p. 418.)

Generally, prior to a patient's discharge from MBMHI, Dr. Yap stated there is a probable cause hearing and at the hearing if the patient is to be kept, there has to be a justifiable reason.

The reason a hearing is held is so that the patient's rights are not violated. (TR p. 441.) In making a determination of whether to discharge a patient, she testified that a patient's past behavior cannot be taken into account. (TR p. 408.) Dr. Yap stated that MBMHI on discharge, as a part of its plan, arranged for follow-up care and treatment of patients but did not follow-up on that plan after discharge. (TR p. 374.) She testified the mental health centers had coordinators who worked with MBMHI regarding the patient's follow-up care and treatment, and that the patients are transferred to the center's care. (TR p. 335.)

Regarding the decision to discharge Mr. Atkins, Dr. Yap believed she made a good decision to discharge him. Further, she was very comfortable in releasing him because compared to the two prior occasions she had seen him, he seemed more positive and his outlook appeared much better. (TR p. 358.) Elaborating, she stated she had "a good feeling of him taking his medication and the support we put in place" (TR p. 402). She also stated that his symptoms of mental illness were in remission, and there was no further reason to keep him and that he was not a danger when she discharged him. (TR pp. 405, 407, 418.) Additionally, she testified that in psychiatry, the history is always there but one must give more weight to the presentation at the time of treatment and discharge of the patient than past behavior. (TR pp. 407-408, 453.) At the time of Mr. Atkins' discharge from MBMHI from his twelfth admission, Dr. Yap opined he was at the best level of functioning she had observed and she did not predict any problems. (TR p. 443.) She also stated that at the time of his discharge, he was exhibiting no signs of aggressive or assaultive behavior. (TR p. 455.)

Although she believed Mr. Atkins' discharge was a good discharge, Dr. Yap admitted she was aware of the Certificate of Need signed by Dr. Lowe on September 15, 2003. At that time, Dr. Lowe noted that Mr. Atkins continued to show symptoms of schizophrenia, posed a "substantial likelihood of serious harm because of the mental illness or serious emotional

disturbance, as shown by the following facts and reasoning: Threats" (TR p. 461). Additionally, Dr. Yap was aware Dr. Lowe had noted that Mr. Atkins required the care of MBMHI staff and that he had threatened or attempted suicide and was likely to deteriorate and to respond to others. (TR p. 462.) A Certificate of Need on Mr. Atkins was also prepared by Dr. Sheldon Gelburd, which Dr. Yap testified she was also aware of. In that Certificate, Dr. Gelburd, a clinical psychologist, noted Mr. Atkins was suffering from suicidal and delusional thinking.

When Dr. Yap heard of the death of Dedrick Johnson, she stated she was shocked to learn there was a child with Mr. Atkins. In her treatment and discharge plan of Mr. Atkins from his September 2003 admission, Dr. Yap testified there had been nothing mentioned about a child, that the child had not been in the picture, and that it was not known that a young child would be coming to Mr. Atkins. (TR pp. 343, 425-426, 439.) Further, she stated she had been present in a treatment team meeting when a social worker questioned Mr. Atkins if he had any children; therefore, she was aware he had a child but was satisfied there was no contact with that child. (TR p. 438.) Following the child's death, she reviewed Mr. Atkins' records in an attempt to see if there was something further in previous admissions about a child but she found nothing. (TR pp. 436-437.) Further, she testified that had she been aware a child was going to be visiting with Mr. Atkins she would have probably modified his discharge plan. (TR p. 445.) Elaborating, she stated that if Mr. Atkins had never had any contact with the child, initiation of the visit with the child would need to be slow. Further, she opined that the situation they were placed in must have been very scary and stressful for both of them. (TR pp. 445-446.)

In reviewing Dr. Keith Caruso's report on Mr. Atkins, Dr. Yap disagreed with his opinion that Mr. Atkins was and remained floridly psychotic. Further, she stated "there was no way he [Dr. Caruso] could know that because I was the attending physician and was the one who treated him" (TR p. 444). She emphatically emphasized it was her opinion that Mr. Atkins was not

floridly psychotic and that she "was very comfortable when [she] decided to discharge him" (TR 454).

Dr. Yap testified she had reviewed and was familiar with Mr. Atkins' chart at MBMHI. She stated that she did not administer a violence assessment study to Mr. Atkins because it is not required and she did not feel it needed to be done. It was her opinion that violence risk assessments are "not fair for the patient because it is too insensitive to the patient's clinical changes that guides our treatment interventions" (TR p. 377; see also pp. 423-425). Also, she stated that violence risk assessments could not be used in making clinical treatment judgments and that it would be unethical to so. (TR pp. 423-425.) Further, Dr. Yap testified that on Mr. Atkins' twelfth admission for which she was the attending physician that he did not present with any signs of aggression nor did he show signs of agitation or any possible violence. (TR pp. 404-406.)

Based on her review of the records, it was Dr. Yap's opinion that Mr. Atkins' first, second, fourth, fifth, sixth, seventh, eighth, ninth, tenth, eleventh, and twelfth admissions showed "no aggressive behavior" (TR p. 339). Regarding the incident involving biting a guard while incarcerated at Silverdale, which occurred shortly prior to his fourth admission, Dr. Yap agreed this was violent behavior but in her opinion it "was probably provoked" because Mr. Atkins felt like he was being mistreated (TR pp. 388, 391). She was also aware of Mr. Atkins' assaultive and aggressive behavior on the occasion when he had punched a female officer in the head. However, again she stated the behavior occurred "when he was in jail" (TR p. 381). Dr. Yap also admitted that she was aware of incidents where he attempted to strangle his twin brother, threatened his father, and threatened his grandmother.

Although she was aware of some aggressive behavior demonstrated by Mr. Atkins in his past, it was her opinion most of his aggression or violent behavior had been precipitated by bad

psychological stressors such as family conflict, being homeless, and being incarcerated. (TR pp. 378, 391, 415-416.) Further, she stated that a part of treatment and discharge included an attempt to reduce the risk of violence in patients. With Mr. Atkins, specifically, they reduced his psychosocial stressors which, she opined, may have been the reasons for his problems in the past. (TR 408.) However, she admitted that on several occasions his actions were not brought on by his environmental stressors but were due to the fact that he had "decompensated because he refused the medication" (TR p. 394).

Terry F. Holmes, M.D.

Clinical Director at MBMHI, Terry F. Holmes, M.D., was called as a witness to testify on behalf of the State of Tennessee. Dr. Holmes obtained his undergraduate degree from the Air Force Academy, a medical degree from Baylor College of Medicine in 1975, and a Masters Degree in Public Health and Tropical Medicine from Tulane University. He retired from the United States Air Force after a twenty-year career, which included a two year tour as Chief of Occupational Medicine for the Royal Australian Air Force. He completed his residency in psychiatry in 1989 and is Board Certified in psychiatry and licensed to practice medicine in the State of Tennessee.

After retiring from the United States Air Force, in 1994, Dr. Holmes moved to McMinnville, Tennessee, where he went into private practice in psychiatry. Dr. Holmes moved to Chattanooga, Tennessee, in 1996 and began working with MBMHI as a staff psychiatrist. At the time of trial, Dr. Holmes had been the Clinical Director at MBMHI for six years. Additionally, Dr. Holmes stated he had been associated with the Erlanger Hospital North geriatric psychiatry program, and at one point, had been the sole clinician for that unit.

Dr. Holmes testified MBMHI is a 150-bed psychiatric hospital. The average length of stay for someone diagnosed with schizophrenia is typically between ten (10) to fourteen (14)

days. In the acute ward at MBMHI, Dr. Holmes estimated that approximately eighty percent (80%) of the patients he attends are schizophrenic or have schizo-affective disorders. As a part of his duties, he testified that he directly supervises five nurse practitioners and twelve (12) physicians, including psychiatrists and two internal medicine specialists. Additionally, Dr. Holmes testified that he is responsible for all the acute inpatient admissions per month. He stated that on average around two hundred fifty (250) persons present each month, and that approximately seventy percent (70%) are admitted. On the acute unit, he stated the average length of stay was about nine (9) days.

Regarding the criteria for admission, Mr. Holmes testified that the individual must meet requirements for admission. First, the individual must have evidence of a mental illness. Secondly, dangerous symptoms must be exhibited. Third, the individual must present a need for an inpatient environment or in certain cases where there is no less restrictive environment available which would meet the individual's needs. Overall, Dr. Holmes testified that he and the staff at MBMHI are fulfilling the intended mission of the care, diagnosis, and stabilization of the serious and persistently mentally ill individuals within a twenty-three (23) country area.

Dr. Holmes testified that in the acute ward on which he is the full-time attending, eighty percent (80%) of the patients admitted are diagnosed with schizophrenia. For the initial diagnosis of schizophrenia, he explained there must be more than one month of continuous symptoms with hallucinations, delusions, disorganized thought or speech, and/or negative symptoms. Dr. Holmes testified that schizophrenia is a mental disorder with positive symptoms of either hallucinations or delusions, and negative symptoms of disturbance in interpersonal relatedness. Additionally, he stated there is typically a disruption in the individual's cognitive ability in that they will "often have trouble with thinking in a goal-directed manner" (TR 494). He also stated there is typically a disruption in the mood of an individual with schizophrenia.

Lastly, Dr. Holmes added that there is a dimension of hostility in schizophrenic patients, and that in some forms of paranoid schizophrenia the patient would show symptoms of negativism, agitation, aggression, and hostility. Typically, Dr. Holmes opined that lying and untruthfulness were more "a function of characterology than of disease" (TR 495-496).

Typically, with the schizophrenic patient, Dr. Holmes testified that during the first year before the patient's first breakdown, the brain will lose about three percent (3%) of its mass, represented by connection deterioration and withering away, rather than actual cell death. As a result of this deterioration, Dr. Holmes testified that a schizophrenic patient's ability to maintain emotional stability, to think, remember, and concentrate are all disrupted. (TR 497.)

Specifically in looking at Mr. Atkins, Dr. Holmes referred to a neuropsychological report by Dr. Bob Brown from MBMHI which indicated that Mr. Atkins had "significant pathology with respect to personality functioning ... antisocial traits ... with a low intellectual functioning" (TR 515). According to Dr. Holmes, the report reflected that immaturity, underdeveloped personality structure, and cognitive deficits, which are at times exacerbated by his schizophrenia, created significant vulnerabilities for Mr. Akins, and he easily became overwhelmed by typical stressors and the requirements of every day life. Dr. Holmes stated that at such times, Mr. Atkins' behavior would be inconsistent, unpredictable, and socially inappropriate, which could result in reactive violent conduct. Additionally, he opined that it was likely that Mr. Atkins would become easily frustrated with his social ineptness. (TR 516-517, 534.)

Regarding treatment options for individuals with schizophrenia, Dr. Holmes stated the most prominent is the dopamine theory, which deals with the four dopamine tracts in the brain. Additionally, he testified that while too much dopamine results in hallucinations and delusions, too little dopamine usually results in loss of motivation and a flat affect in one's personality. He stated that patients typically do not like taking antipsychotic medications because of the side

effects which can be uncomfortable and cause tremors, lack of movement in the face, muscle cramps, restlessness, and drooling. In his experience, he testified the older, or first generation, drugs, such as Haldol, Prolixin, and Thorazine have these side-effects. (TR 498-499.) Specifically in Mr. Atkins' case, he testified there were times that Mr. Atkins complained about the drugs. In looking at the records Dr. Holmes stated, "There were times when he, indeed, appeared to have one of those very scary, very painful acute dystonic reactions. And, in fact, at one point he threatened to kill the doctor who [he perceived] had given him the movement disorder." (TR 506.)

Dr. Holmes testified that the newer, or second generation, antipsychotic drugs usually have advantages over the first generation antipsychotics in that they improve negative symptoms, such as interpersonal relatedness, motivation, and expression of emotion, whereas the first generation drugs tended to make these aspects of personality worse. Zyprexa, a medication prescribed to Mr. Atkins, is a second generation drug and only comes in the oral form.

Regarding the treatment of psychosis in schizophrenic patients, Dr. Holmes testified he had developed a treatment regimen at MBMHI starting with either Haldol or Prolixin at a certain dose, waiting a period of time to see if there is any response, and if a response is obtained, then converting to either Haldol Decanoate or Prolixin Decanoate, and discharge when the patient is no longer dangerous. He stated that the "long-acting [drugs] are, indeed, part of the standard of care at Moccasin Bend" (TR 507). Dr. Holmes testified the long-lasting preparation, or decanoate form of Prolixin, was "for the vast majority of folks with schizophrenia who are going to show you medication noncompliance". (TR 501.)

Because MBMHI is overseen by several internal and external governmental and regulatory bodies, as well as being informed by numerous guidelines, Dr. Holmes stated the staff had significant structure and guidance. He testified that one goal at MBMHI is to keep the 30-

day re-admission rate as low as possible. In order to achieve that objective, he testified a careful study was done to determine why people came back to the hospital within 30 days. Dr. Holmes stated that among schizophrenic or schizo-affective disorder patients, the overwhelming reason was because they did not take their medications. (TR 509.)

Addressing the difference between the oral versus the injectable form of the first generation drugs [such as Prolixin Decanoate] used to treat psychosis in schizophrenic patients, Dr. Holmes stated there actually was no difference between them. Elaborating, he stated that the decanoates, or longer acting preparations, were either a week's supply or month's supply of the drug dissolved in peanut oil and injected into the gluteus, or buttocks. (TR 500.)

Regarding the issue of Dr. Yap having prescribed Mr. Atkins Zyprexa by mouth upon his release from MBMHI rather than an injectable form of medication, such as Prolixin Decanoate, Dr. Holmes opined she was justified "in trying … one of the newer drugs which might light up his frontal lobes … and give him some motivation to develop a recovery" plan (TR 510). Supporting that position, Dr. Holmes also stated that on Mr. Atkins' first, second, third, fourth, five, sixth, seventh, and eleventh admissions, decanoate medications were tried, did not work very well with Mr. Atkins, and were not successful in keeping him out of the hospital. (TR 531, 568.) Therefore, he felt it was worthwhile to try the oral medication, and MBMHI was hopeful that the newer medication "might offer this individual who had a fairly compromised front lobe function … a better chance of developing a recovery plan that would feature more motivation" (TR 531). Given Mr. Atkins' history of being violent, a past drug user, and noncompliant on medications, Dr. Holmes opined that it was reasonable, totally appropriate, and within the standard of care upon his release from MBMHI to prescribe Mr. Atkins Zyprexa, the second generation oral medication. (TR 570-572.)

In Dr. Holmes' personal experience in treating Mr. Atkins, as well as his experience in dealing with thousands and thousands of schizophrenic patients, it was his opinion that Mr. Atkins was not the recidivistic and dangerous person the Claimant portrayed. (TR 530.) He confirmed there had been four or five episodes of violence in Mr. Atkins' past, but that usually when he acted aggressively, he would do so in reaction to environmental stressors. He further explained that Mr. Atkins' violent reactive behavior emanated "as a function of character structure and his defective cognitive state" (TR 519). However, Dr. Holmes disagreed with the idea that Mr. Atkins' actions were driven by his psychosis. In his view of Mr. Atkins, that conclusion was simply wrong. Dr. Holmes opined that Mr. Atkins "has hostility at times driven by his decompensated psychotic process from the standpoint that in this particular patient with this particular brand of schizophrenia, he does feature hostility as a target symptom" (TR 518).

As far as the level of violence Mr. Atkins exhibited, Dr. Holmes opined Mr. Atkins was in the minor leagues. (TR 513-514.) He stated the records showed that Mr. Atkins' assaultiveness had decreased over the years. (TR 522). He also stated that in his opinion history had shown Mr. Atkins was only episodically dangerous and had not been so recently prior to September 2003. (TR 523, 525.) However, he acknowledged, "it is true that he [Mr. Atkins] is potentially perhaps more dangerous off of his medications" (TR 529). Dr. Holmes opined that in his experience it would be remarkable for a person who had been taking the oral medications in the hospital to experience an acute decompensation nine days after release. He testified that, in his opinion, there would have been other reasons for the decompensation such as smoking marijuana, exposure to methamphetamines, or cocaine. (TR 570.)

In spite of Mr. Atkins' prior episodes of aggressive behavior, it was Dr. Holmes' conclusion that what happened to young Dedrick Johnson was something completely unforeseeable and that Mr. Atkins had not been "a huge risk for this kind of horrific violence"

(TR 545, 557, 573.) Explaining further, he stated that in retrospect and having the luxury of reviewing Mr. Atkins' lengthy medical records, no one could have imagined or predicted Mr. Atkins would have been capable of such an act involving a protracted period of assault in light of the fact that prior events had included threatening people and "usually a one time hit somebody once and that was it" type of episode. (TR 521.)

Regarding the need for a violence risk assessment for evaluating the dangerousness of Mr. Atkins, Dr. Holmes opined that the "use of a specific actuarial dangerousness or violence assessment tool [was] not the standard of care anywhere" (TR 528). Further, he opined that the issue of dangerousness of a patient is best left to the clinical judgment of the physician. (TR 528, 553.) Dr. Holmes also stated that considerations of dangerousness are a part of the treatment team's daily evaluation. Additionally, Dr. Holmes pointed out that the problem with using an instrument to measure violence or dangerousness, in his experience, had been that they are not very good predictors of future events.

Generally, regarding the decision to discharge a patient, Dr. Holmes testified there are two questions to ask when making that decision. First, he said it must be determined that the patient has reached the maximum benefit of hospitalization and that their target symptoms have responded and hopefully even remitted. Secondly, Dr. Holmes stated the patient's follow-up program is looked at to be sure that adequate psychosocial supports are in place to "reasonably ensure that the individual will ...be able to engage in the recovery plan and make it outside the hospital" (TR 537-538).

Dr. Holmes testified he agreed with Dr. Yap and the treatment team's decision to discharge Mr. Atkins on September 19, 2003, and stated "it was a righteous discharge" (TR 538). He also opined that Mr. Atkins "had reached the point of maximum hospital benefit" at the time of his release. (TR 533.) Dr. Holmes also added that Mr. Atkins' global assessment of

functioning (GAF) indicated he was in the best shape he had ever been at. He believed one possible reason for the higher level of functioning was because of the newer, second generation medication he had been given. (TR 532-533.)

Dedric Atkins' Medical Records

On Mr. Atkins' first admission to MBMHI in March of 1997, there were reports that he had threatened to cut or strangle his brother and that he had fought with and threatened to kill his father. While hospitalized, Mr. Atkins punched a psychiatric technician and broke his glasses. He was described as potentially homicidal and placed on Prolixin Decanoate to be administered intramuscularly every two weeks. Mr. Atkins had experienced trouble with law enforcement when he stole a policeman's bike in 1996 and received a five month sentence. Medication compliance was noted to be a problem.

Again, on August 15, 1997, one hundred thirty-three (133) days after he was released from his first admission, Mr. Atkins was brought back to MBMHI after having been taken to a community mental health center in Chattanooga. At that time, it was reported that he had been thinking of hurting other people and was experiencing a hallucination of his brother in a police uniform. (MR 208.) He also made threats against "all whites" (MR 247) and was restrained because of highly violent and disturbing behavior. During this hospitalization, Mr. Atkins agreed to Prolixin Decanoate injections every three weeks and was released. There is a significant amount of testimony in this record that Prolixin Decanoate, which can be taken orally or by injection, is effective for two to three weeks if the patient timely receives the medication intramuscularly.

He next returned to MBMHI some five hundred ninety-eight (598) days later. In April of 1999, Mr. Atkins was brought to MBMHI from a Correction Corporation of America facility in Hamilton County known as Silverdale. Mr. Atkins had been at Silverdale since June of 1998

charged with assault. He was seen on this hospitalization by both Dr. Yap and Dr. Holmes. At Silverdale, Mr. Atkins had bitten one guard and thrown shampoo on another one. He was noted to be non-compliant with his medications and while at MBMHI, he assaulted a psychiatrist, Dr. Lowe, and methodically beat the glass out of a "window" on May 17, 1999. Atkins was observed as not responding to Prolixin Decanoate and was started on an oral drug, Zyprexa. He agreed that he would take this medicine at Silverdale. He told MBMHI treatment personnel that the thought of shooting his little brother had crossed his mind. (MR 459.) The doctors believed that he was attempting to hide his psychosis from the staff (MR 469), and they decided to try him on Zyprexa because they were looking for a medication which would work in resistant cases. (MR 478.) He had not responded well to low doses of Prolixin Decanoate. (MR 473.) On May 18, 1999, Atkins was returned to Silverdale. (MR 499.) Dr. Sewell at the Joe Johnson Mental Health Center in Chattanooga believed that Atkins was not competent for trial and could not be restored to competency as an outpatient. (MR 545.)

Nine days later, on May 27, 1999, Mr. Atkins was returned to MBMHI per the order of Judge Derby of the Hamilton County General Sessions Court. The purpose of the hospitalization was to determine Mr. Atkins' competency to stand trial for charges of assault arising out of an incident in which he punched the manager of a Burger King restaurant in the face. (MR 592.) While incarcerated at Silverdale, Mr. Atkins had also gotten into a fight with another inmate. On June 18, 1999, Dr. Bob Brown, a clinical psychologist, wrote the Court that the assault charges could be defended on the basis of an insanity defense. (MR 553-554.) There is also evidence in the file that Dr. Sewell at Joe Johnson had noted that Mr. Atkins was consistently refusing to take his medication. (MR 545.) Dr. Holmes characterized Mr. Atkins as a chronic paranoid schizophrenic. He was released on Zyprexa and Prozac. Dr. Holmes believed that he was free of psychosis on release. The forensic exam, conducted by Dr. Brown and Mr. Hartman, revealed

that Mr. Atkins had left hemispheric dysfunction, significant deterioration of the frontal lobes, and significant cognitive impairment with pronounced paranoid thinking. (MR 591.) The forensic examination also notes that Atkins "...suffers from severe mental illness" and "...will probably need lifetime psychiatric services to minimize the impact of his chronic psychiatric condition". Although Atkins was capable of legally defending himself and did not meet the standards for a judicial commitment, the forensic evaluation also determined that a defense of insanity could be supported. Dr. Holmes participated in this forensic exam. The exam also noted that Mr. Atkins had been hospitalized at Valley Psychiatric Hospital in 1994, which would have been prior to his first hospitalization at MBMHI. (MR 591.)

Mr. Atkins was out of MBMHI for only fifty-seven (57) days when he returned on August 18, 1999, from the McMinn County Jail. Apparently, he had become non-compliant with taking his medications. He had assaulted an officer at the jail. The notes from this fifth admission indicate that Mr. Atkins was considered dangerous when not medicated and that he had a guarded prognosis due to delusions and "violent behavior when not medicated". (MR 713-714.) The records from this admission also recite that Mr. Atkins became suspicious and violent when he suffered a relapse. He was discharged back to the jail on Prolixin Decanoate both by mouth for seven days and then intramuscularly.

Twenty-six (26) days later, Mr. Atkins was once again admitted to MBMHI for a forensic examination pursuant to the orders of Judge Carroll Ross of the McMinn County Criminal Court. Mr. Atkins was incarcerated in McMinn County on a charge of theft over one thousand dollars ($1,000.00). Apparently, he had taken the automobile of a female friend from her apartment where he had been staying, then went to a Goody's Clothing store where he attempted to steal items of clothing. (The forensic examination from this hospitalization is found behind the tab in the records for the fifth hospitalization, rather than the sixth where it should be placed.) The

forensic examination is found in the medical records between pages 734 and 745. Again, Dr. Bob Brown and Mr. Hartman were involved in the examination. The records indicate that since he had been previously discharged to the jail he had received no Prolixin Decanoate. The test results from the examination by the forensic team, including Dr. Brown, Dr. Holmes, and Mr. Hartman, reveal that Mr. Atkins has a full scale IQ in the border line range of intellectual functioning. (MR 738.) Additionally, he was found to have "...significant pathology with respect to personality functioning" and was "...unfit to function as an adult in terms of successful independent living." (MR 739.) The team also determined that when Mr. Atkins was "....significantly stressed from demands of relatively complex situations or scenarios ... or significant interpersonal conflict ... or unusual levels of stress, ... there will be serious deficiencies in [his] ability to inhibit or manage behavior." (MR 739-740.) "At such times, [his] behavior will be inconsistent, unpredictable, and too often be socially inappropriate for the situation (i.e. reactive violent conduct)". "...His reactivity [to others] (including violent conduct) may occur without warning." "...[T]here may be a surprising lack of guilt or remorse for behavior that is otherwise a violation of basic social norms." "...[A]ffective discharge may occur without provocation or without indication from conversation or behavior. Intense negative feelings can be expressed behaviorally without warning to include violence that is with respect to social factors inappropriate or incongruent with others' conduct. Thus, he is at risk of becoming violent and committing assault without warning." This exam also noted that Mr. Atkins wanted to harm people [Mr. Hartman] responsible for having him medicated at the time of a prior hospitalization that same year. (MR 741.) The Committee's conclusion was that Atkins suffered from a severe mental illness characterized as Chronic Schizophrenia with Paranoid Features "...which was in remission at the time of the exam" but that an insanity defense was not supported. (MR 742.) The team concluded that he was to be considered dangerous "because he

has on numerous occasions, been physically assaultive for minor provocation or without adequate reason and without being threatened or attacked by others." (MR 743.)

However, the report went on to conclude that the current charges pending against Mr. Atkins were the result of "characterological factors" and did not involve a diagnosis of schizophrenia. In this connection, the team described Mr. Atkins as extremely narcissistic with a history of antisocial conduct and an antisocial personality. The team also observed that "at times [he] ... does become quite psychotic and ... can also commit crimes that would meet the criteria for the insanity defense". (MR 743.) The team opined that Mr. Atkins could not be placed under a Mandatory Outpatient Treatment program since it concluded that at the time of this admission, an insanity defense for Mr. Atkins was not supportable. (MR 743.) However, several members felt that Atkins was at risk of committing serious injury to others without adequate intervention either from one or both of the legal and mental health systems. (MR 743.) It is also worth noting that at the time Atkins was admitted to this sixth hospitalization, there was an outstanding warrant for him in Hamilton County for aggravated assault and also that while he was in the McMinn County Jail, he inflicted a gash to a female officer's head. Dr. Holmes felt that Mr. Atkins was in far better shape on this than previous admissions, and believed that his personality decompensation traits mentioned above, gave an impression of a greater psychotic disturbance than actually existed. (MR 739.) The team also noted that at times Mr. Atkins would become psychotic and capable of committing crime meeting the criteria for developing an insanity defense. His prognosis was poor since he did not comply with the prescribed outpatient treatment. However, the team believed that "...criminal activity will occur in [the] absence of active symptoms of mental illness". Dr. Brown wrote that he would convey this observation to defense counsel in the hope that the court would intervene to assure compliance with outpatient treatment services such as a civil Mandatory Outpatient Treatment program. (MR 743.) The

team commented pointedly on the failure of the courts in June of 1999, following an examination at MBMHI which supported an insanity defense, to find Mr. Atkins not guilty by reason of insanity which would have supported a mandatory sixty (60) day judicial commitment at MBMHI and placement in a Mandatory Outpatient Treatment program. Apparently, according to the report, even though an insanity defense was warranted at the time of the fourth admission, the court dismissed the charges rather than finding Mr. Atkins not guilty by reason of insanity. (MR 743.)

The team recommended that Atkins was in need of continuous psychiatric and mental health services on an outpatient basis although he did not meet the criteria for an insanity defense. The team also noted that his narcissistic and anti-social personality features would likely cause further legal problems similar to the charges pending in McMinn County at the time. The team's recommendations also concluded that MBMHI could support a court injunction ordering Mandatory Outpatient Treatment "...based on [his] ... history of criminal activity, assaultive behavior related to his mental illness [and because he] meets the criteria for severe mental illness and is in need of continual outpatient services. There was likelihood that he would need future psychiatric hospitalization. (MR 745.) Members of the forensic interview Team commented on the interplay between Mr. Atkins' anti-social, narcissistic personality and his mental illness. At Bates page 743 of the medical records, the following passage is found:

> Members of the Team were in agreement that Mr. Atkins was likely to be continually involved in antisocial conduct with petty crimes such as his current charges and that his case will likely vacillate between the legal and mental health systems. The prognosis also appears to be poor do (sic) to Mr. Atkins failure to comply with treatment on an outpatient basis. Also, the likelihood of criminal activity greatly increases due to his noncompliance of treatment of a severe mental illness. However it was emphasized that criminal activity will occur in the absence of any active symptoms of mental illness.

Mr. Atkins was discharged back to the McMinn County Jail with a prescription for Prolixin Decanoate and follow-up with a mental health center in McMinn County. The Team also noted that narcissistic behavior is usually seen in individuals with above-average intellectual capabilities as compared to a person like Mr. Atkins who was functioning at a relative low intellectual level. (MR 739.)

Some four hundred (400) days after the sixth hospitalization, Mr. Atkins was back at MBMHI. At the time he came in, Mr. Atkins was homeless and was hearing voices. He told Dr. Yap he had been off his medications for a year. He was referred to MBMHI from Erlanger Hospital in Chattanooga where he had gone himself. Following a forty-eight (48) day hospitalization, Mr. Atkins was discharged on Prolixin Decanoate and given a bus ticket to Decatur, Alabama where an aunt had agreed to let him live with her. In Alabama, he was to be seen at a mental health center. He told Dr. Yap during this hospitalization that he was not comfortable around people. His condition was characterized as severe due to his noncompliance with taking his medications.

He did not stay in Alabama long since he was sent back to MBMHI from Erlanger Hospital where he was diagnosed as being in a near catatonic state on February 26, 2001. (MR 1264.) An unidentified individual had dropped him off at the hospital. (MR 1159.) Urine tests revealed that he was positive for marijuana in his system, and he was to return to the McMinn County Jail since he had not been compliant with probation granted by the courts there. After a seventeen (17) day stay, Atkins was discharged to the jail with a prescription for Prolixin Decanoate intramuscularly every two weeks. He was not considered to be a danger to himself or others. (MR 1160.)

Five hundred forty-two (542) days later, on June 19, 2001, Atkins was back at MBMHI for yet another forensic examination. At the time, he did report that he had a son. (MR 1331.)

Dr. Holmes personally treated Mr. Atkins on this admission with different medications and noted that he had stayed out of MBMHI for some fourteen (14) months. He was treated with Zyprexa Zydis and Trileptal and discharged back to the McMinn County Jail. It was the opinion of MBMHI that an insanity defense was not available to him at the time, and that he did not meet the standards for a judicial commitment. Apparently, Mr. Atkins had been charged in McMinn County for theft. At the time of his discharge, he was not suicidal or homicidal and was prescribed Geodon and Trazodone and was again to follow-up with the community mental health center in McMinn County.

Two hundred fifty-four (254) days later, on August 24, 2002, Mr. Atkins was referred to Moccasin Bend by Erlanger Hospital and the Chattanooga Crisis Response Team. He had been involved in a street altercation, although he did not know the name of the person he had been involved with. (MR 1411.) The treatment team considered him to be homicidal and noted that he had not been able to get along with his relatives in Alabama when previously discharged to their care. Atkins told the staff that he was not into outpatient treatment. Since he was uncooperative with the discharge plan, he was released to the care of a mission in Chattanooga with a prescription for Zyprexa, Zydis, and Triliptol. His prognosis was poor. He was not displaying bizarre symptoms at that time. His GAF (global ability to function) was at a relatively high level of forty-five (45), and he appeared to be calm and free of psychosis.

Two hundred fifty-four (254) days after this hospitalization, Mr. Atkins was back to MBMHI again. At that time, he was hospitalized for twenty-six (26) days. He was described as being "floridly psychotic", homicidal, and talking to himself about "guns, sex, and making threats (sic)". (MR 1620.) On May 23, 2003, he was restricted to a unit for threatening MBMHI staff. On June 2nd, 2003, Mr. Atkins was prescribed Prolixin Decanoate and was not considered a threat to himself or others. (MR 1582.) He had a guarded prognosis, again contingent on his

compliance with the medication schedule. (MR 1583.) At the time, he was living in Patton Towers and told MBMHI staff if he was administered any more Prolixin Decanoate, he would hit someone in the face. He was discharged on Prolixin every three weeks, Zyprexa, Zydis, and Depakote.

On September 10, 2003, Atkins was admitted to MBMHI for the last time before he murdered his son on September 27th. He was admitted at 7:57 p.m. by Dr. Lowe who, it will be recalled, he had attacked by striking him on the head during an earlier admission.

At the time of this admission, Atkins was seen by both Dr. Lowe and Dr. Sheldon Gelburd, a clinical psychologist. Trial Exhibit 9 is the Certificate of Need signed by Dr. Lowe. (MR 1744.) Dr. Lowe, in that document, noted that Atkins blamed his family for his admission to the hospital, had threatened his father, and believed the hospital staff was in a conspiracy with his family. Dr. Lowe felt that Atkins posed a substantial risk of serious harm and was mentally ill or seriously emotionally disturbed because he had threatened his family before admission. Because Atkins needed continued treatment, Dr. Lowe signed the Certificate of Need on September 15, 2003, observing that the patient needed constant observation "to minimize risk of danger to self/others". (EX 9.) Dr. Gelburd, also on September 15, 2003, opined in a Certificate of Need that Atkins needed maximum structure and control by others and that he had threatened to inflict serious bodily injury. (EX 10; MR 1747.) Atkins was referred to MBMHI by the staff at Patton Towers. Atkins himself reported that he had not been taking his medications for a few weeks because of the side effects and his original admission was involuntarily continued after a court hearing at MBMHI. The extension hearing took place on September 16, 2003. (MR 1773.)

While at MBMHI, Atkins was treated again by Dr. Yap who documented a history of homicidal ideation and cutting himself. Atkins told her that he had stopped taking the medicine because it had side effects.

By September 18, 2003, Dr. Yap believed that Atkins had no psychotic symptoms and that his thinking was appropriate and logical and that he was being compliant with taking his medicines. She prescribed Zyprexa Zydis and felt that working with Mr. Atkins in determining a medicine which he liked was beneficial to their relationship and served to reinforce an alliance between the physician and the patient. She did not prescribe Prolixin Decanoate. Rather, she prescribed Zyprexa Zydis which was to be monitored after release by the Fort Wood Mental Health Center in Chattanooga, which is only a few blocks away from Patton Towers where Mr. Atkins was living at the time.

A case file had been opened at the Fort Wood facility for Mr. Atkins on June 23, 2003, and a case manager named Hines had been assigned to him at the time. The case manager was aware that Mr. Atkins was to be treated with Prolixin Decanoate and Zyprexa and was to receive the intramuscular injections every three weeks. Reports indicated she made sure he was getting his medicines. Ms. Hines was not sure that Mr. Atkins was compliant in taking his oral medications. The last shot of Prolixin Decanoate he had received at Fort Wood was administered on August 7, 2003. She assumed that the last injection of that medication before the murder was administered at MBMHI. (EX 6.) Ms. Hines met with Mr. Atkins on September 9, 2003, two days before his twelfth admission and reported that he was not suicidal and not hearing voices. She was concerned that he may have been smoking marijuana since she saw "roaches" in his apartment. (MR 1828.)

The medical records from his twelfth hospitalization indicate that on September 15, 2003, Mr. Atkins related to staff that he was "telepathic". (MR 1835.) A note from that day states

"... patient not ready to be discharged at this time." (MR 1838.) The next day, he was described as being delusional and paranoid and becoming paranoid "about [his] medications". (MR 1842.) While being interviewed that same day about medication, Atkins "...got up and left the room". (MR 1843.) However by September 18, 2003, Atkins was reporting no psychotic symptoms with appropriate and logical thinking, accompanied by compliance with medication. (MR 1847.) On September 19, 2003, he was "non-responsive to teaching" about medications and symptom relapse (MR 1848.) but was "being discharged" with an appointment with a nurse practitioner. (MR 1847.)

On this twelfth and final pre-homicide hospitalization, Dr. Yap testified that Atkins was talking about going back to work in the fast food industry, was calmer and more positive, not delusional, and picking the medicines he wanted. (TR 454.) She also said that a case manager had been put in place for him. Additionally, on September 12, 2003, Atkins reported to the staff that Zyprexa "makes him feel much better". (MR 1830.)

On September 27, 2003, eight days after discharge from the twelfth hospitalization, Atkins brutally murdered his young son. Following arrest for the murder of his son, Mr. Atkins was jailed in Hamilton County. Eventually, between May 13, 2004, and July 9, 2004, he underwent a forensic examination at MTMHI in Nashville, a state facility which regularly evaluates defendants in criminal proceedings. (See EX 6.) Dr. Farooque, a psychiatrist, opined that Atkins was psychotic during the assessment period and the nursing reports indicated that he said he wanted to kill other people. Dr. Craddock, a clinical psychologist there, also signed a Certificate of Need which stated that there was a likelihood of substantial harm in Atkins' case and that he had threatened homicide. (MR 1911.) Based upon their examinations, the providers at MTMHI opined that Atkins was not competent to stand trial; that an insanity defense would be available to him; and that he was committable pursuant to mental health laws in Tennessee. The

examiners at that facility also stated that any suspicions of malingering behavior on Atkins' part were unsupportable.

As a part of his defense, Atkins was also examined by Dr. Keith Caruso, a psychiatrist in Nashville. Dr. Caruso's reports are Trial Exhibit 5 to the record in this case. Dr. Caruso's reports state that Atkins told the police officers at the scene that he had not taken his medications in two weeks. In his May 28, 2004, report, Dr. Caruso also was able to report that Atkins told him that his son had asked him to shoot off some rockets and he interpreted that as an attempt by the child to psych him out.

Later, on December 8, 2005, on a subsequent interview, Dr. Caruso also opined that because of his psychosis Atkins could not cooperate with his defense team.

After the evaluation at MTMHI, Atkins was sent back to MBMHI in connection with an effort to restore his competency. At that time, his thirteenth admission to that facility, Atkins was diagnosed as malingering, and a cannabis abuser with a history of schizophrenia, undifferentiated type. He also was described as having an anti-social personality disorder and a narcissistic personality disorder. On August 23, 2004, because he had assaulted a patient at MBMHI, he was sent to jail in Chattanooga with medications. He apparently deteriorated there and told officials that he needed to go back to MBMHI. Drs. Brown and Holmes, who had previously conducted the forensic exams on Mr. Atkins discussed above, along with Mr. Hartman, were members of the forensic team for this thirteenth admission.

Applicable Law.

This case involves the issue of how the State must handle that "...very delicate balance between the safety of the public and [the] effective [treatment] and rehabilita[tion]..." of a mentally ill individual. (See *Hembree v. State*, 925 S.W.2d 513, 517 (Tenn.) [Hembree I].)

There is no doubt that Dedric Atkins killed his young son, Dedrick Johnson, and that Dedric Atkins had been hospitalized twelve (12) times prior to that event at MBMHI where he had been diagnosed as a paranoid schizophrenic with other personality disorders.

The determination of whether the State was negligent in releasing Mr. Atkins from MBMHI eight (8) days before he murdered his son must be made, under the Tennessee Claims Commission Act, based on "traditional tort concepts of duty and a reasonably prudent person's standard of care". See Tenn. Code Ann. § 9-8-307(c); see also *Hembree* I at 517.

Of course, in order to prevail on her claim, the Claimant here must establish a duty of care owed by the State to her son; conduct by the State falling below that standard of care, resulting in a breach of the owed duty; an injury or loss; causation in fact; and finally, legal cause. See *Naifeh v. Valley Forge Life Ins. Co.,* 204 S.W.3d 758, 771 (Tenn. 2008).

At the outset of the trial in this matter, the Commission discussed with the parties that very recently the Supreme Court has addressed at length the concept of "duty". See *Satterfield v. Breeding Insulation*, 266 S.W.3d 347 (Tenn. 2008) and *Downs v. Bush*, 263 S.W.3d 812 (Tenn. 2008). The Commission also noted that the Court had pending before it at the time a case styled *Giggers v. Memphis Housing Authority*. On February 3, 2009, in a decision authored by Justice Wade, the Court rendered its decision in *Giggers*, No. W2006-00304-SC-R11-CV, 2009 WL 249742, and once again addressed, at some length, the concept of duty.

Duty has been defined as the "...legal obligation to conform to a reasonable person standard of care in order to protect others against unreasonable risk of harm." *Satterfield* at 355, citing *Burroughs v. Magee*, 118 S.W.3d 323, 328-329 (Tenn. 2003). Currently in Tennessee, "...one owes a duty to refrain from engaging in conduct that creates an unreasonable and foreseeable risk of harm to others." *Satterfield, supra,* at 363, citing *Draper v.* Westerfield, 181 S.W.3d 291 (Tenn. 2005). The "foreseeability" requirement does not require that the tort-feasor

have seen the precise manner in which the damage would occur "...provided it is determined that the tort-feasor could have foresee[n] or through the exercise of reasonable diligence should have foreseen the general manner in which the injury or loss occurred". (*Hembree v. State*, No. 2000-00767-COA-R3-CV, 2001 WL 575561, at *11 (Tenn. Ct. App.) [Hembree II], citing *McClenahan v. Cooley*, 806 S.W.2d 767, 775 (Tenn. 1991).)

The foreseeability element of the formula set out above "...has proven to be a useful hub from which central organizing principles can be maintained, while at the same time allowing for prudent modification and refirmation of those principles". *Satterfield, supra*, at 366. "However, because almost any outcome is possible and can be foreseen, the mere fact that a particular outcome might be conceivable is not sufficient to give rise to a duty. For the purpose of determining whether a duty exists, the courts' consideration of foreseeability is limited to assessing whether there is some probability or likelihood of harm that is serious enough to induce a reasonable person to take precautions to avoid it. In this context, the courts are not concerned with the ultimate reasonableness, or lack of reasonableness, of the defendant's conduct. Rather, the courts are simply ascertaining 'whether [the] defendant was obligated to be vigilant of a certain sort of harm to the plaintiff'." *Satterfield, supra*, at 367 citing *Goldberg and Zipursky,* 54 Vand. L. Rev. at 728-729.

In the three recent Supreme Court decisions alluded to above, the Court endeavored to establish some guidance to assist the courts and this Commission in gauging the balance between the foreseeability of the risk and the gravity of the harm as balanced against the burden imposed on the State "...to engage in an alternative course of conduct that would have prevented the harm." *Satterfield, supra,* at 365. In this somewhat murky area of attempting to determine whether or not a duty exists, the Court has utilized at least seven (7) factors. Interestingly, these seven (7) guidelines were developed in two cases which dealt with duties allegedly owed by

physicians to third persons other than their immediate patient. In *Burroughs v. Magee*, 118 S.W.3d 323 (Tenn. 2001), the Court wrote as follows:

> A 'risk is unreasonable and gives rise to a duty to act with due care if the foreseeable probability and gravity of harm posed by defendant's conduct outweigh the burden upon defendant to engage in alternative conduct that would have prevented the harm.' ... A number of factors are considered in making this determination, including: the foreseeable probability of the harm or injury occurring; the possible magnitude of the potential harm or injury; the importance or social value of the activity engaged in by defendant; the usefulness of the conduct to defendant; the feasibility of alternative, safer conduct and the relative costs and burdens associated with that conduct; the relative usefulness of the safer conduct; and the relative safety of the alternative conduct. *Id.* at 329, citing *McCall v. Wilder*, 913 S.W.2d 150, 153 (Tenn. 1995); see also *Satterfield, supra,* at 364, and *Turner v. Jordan*, 957 S.W.2d 815, 818 (Tenn. 1997).

These "determinations regarding the existence and scope of a particular legal duty ... reflect 'society's contemporary policies and social requirements concerning the right of individuals and the general public to be protected from another's act or conduct'." *Satterfield, supra,* at 364, citing *Bradshaw v. Daniel*, 854 S.W.2d 865, 870 (Tenn. 1993); see also *Turner, supra,* at 818, citing W. Keeton, Prosser & Keeton on the Law of Torts, § 37 at 236 (Fifth ed. 1984).

Tennessee courts have wrestled with determining the extent of a duty owed by medical providers to third parties in the context of treating their own patients. For example, in *Burroughs, supra,* the Court declined to find a duty in a situation where a truck driver caused a collision which took the life of a husband and seriously injured his wife in an automobile accident. The allegation asserted against the physician was that he had negligently prescribed medications to the truck driver and that the side effects of those medications caused a physical reaction which impaired the driver's ability to operate his truck, thus causing the accident. In declining to extend a duty owed by the prescribing physician to the third party husband and wife,

the Court relied on decisions from Indiana (*Webb v. Jarvis*, 575 NE2d 992 (Ind. 1991) and Hawaii (*McKenzie v. Hawaii Permanente Med. Group, Inc.*, 47 P3d 1029 (2002).) and quoted *Webb* for the following proposition:

> A physician's first loyalty must be to his patient. Imposing a duty on a physician to predict a patient's behavioral reaction to medication and to identify possible plaintiffs would cause a divided loyalty. Were we to impose a duty on a physician to consider the risk of harm to third persons before prescribing medication to a patient, we would be forcing the physician to weigh the welfare of unknown persons against the welfare of his patient. Such an imposition is unacceptable. The physician has the duty to his patient to decide when and what medication to prescribe the patient, and to inform the patient regarding the risks and benefits of a particular drug therapy. He should fulfill that duty without fear of being exposed to liability to unknown, unidentified third persons. *Id.* at 997.

However, in *Turner, supra,* the Court did find a psychiatric physician potentially liable to psychiatric nurse Turner and wrote that:

> We stress that we are not requiring psychiatrists or physicians to possess perfect judgment or a degree of clairvoyance in determining whether a patient poses a risk of harm to a third person. Instead, we merely hold that a duty of care may exist where a psychiatrist, in accordance with professional standards, knows or reasonably should know that a patient poses an unreasonable risk of harm to a foreseeable, readily identifiable third person. *Id.* at 820.

Nevertheless, as the *Hembree* I Court observed, "Even though the State may be liable if the decision to release an involuntarily committed patient [is] negligently made, the State does not insure the public's safety from release." *Hembree* I at 517.

Hence, utilizing these parameters developed by Tennessee courts through an analysis of "traditional tort concepts", the Commission has some assistance in reaching a decision on the duty issue in the case now before it.

Additionally, important in the Commission's decision in this case are several sections from the Tennessee Code Annotated regarding persons with mental health and developmental disabilities. Tennessee Code Annotated, Sections 33-6-602, 609, and 623 provide as follows:

> **33-6-602. Release from hospitalization subject to outpatient treatment. –**
> IF
>
> (1) on the basis of a review of the person's history before and during hospitalization, the hospital staff concludes that:
>
> (A) the person has a mental illness or serious emotional disturbance or has a mental illness or serious emotional disturbance in remission,
>
> (B) the person's condition resulting from mental illness or serious emotional disturbance is likely to deteriorate rapidly to the point that the person will pose a likelihood of serious harm under 33-6-501 unless treatment is continued,
>
> (C) the person is likely to participate in outpatient treatment with a legal obligation to do so,
>
> (D) the person is not likely to participate in outpatient treatment unless legally obligated to do so, and
>
> (E) mandatory outpatient treatment is a suitable less drastic alternative to commitment,
> THEN
>
> (2) the person shall be eligible for discharge subject to the obligation to participate in any medically appropriate outpatient treatment, including, but not limited to, psychotherapy, medication, or day treatment, under a plan approved by the releasing facility and the outpatient qualified mental health professional.
>
> . . . .
>
> **33-6-609. Failure to comply with outpatient treatment plan – Action to enforce. –**
> IF
>
> (1) the parent, legal guardian, conservator, spouse, responsible relative, or qualified mental health professional of a service recipient who has been discharged subject to the obligation to participate in outpatient treatment, the person who initiated the commitment proceeding of the service recipient, or the chief officer of the discharging facility files an affidavit with the court that committed the service recipient or any court with jurisdiction under chapter 6, part 5, of this title in the county where the person is being treated or is staying showing that:
>
> (A) the person is required to be participating in outpatient treatment under 33-6-602,
>
> (B) the person is, without good cause, out of compliance with the treatment plan, and

(C) the qualified mental health professional believes the noncompliance is not likely to be corrected voluntarily,
THEN

(2) the court shall have jurisdiction to conduct original proceedings to enforce the outpatient treatment obligation, AND

(3) the court may order the person to appear before the court at a stated time not later than five (5) days after the order is issued to determine whether the person is required by this part to be participating in the outpatient treatment and has failed, without good cause, to participate in the treatment as required, AND

(4) the order and a copy of the affidavit shall be served immediately on the person, the qualified mental health professional, and, if the discharge was under 33-6-708, the district attorney general for the jurisdiction in which the committing court is located.

. . . .

33-6-623. Outpatient treatment obligation limited to six (6) months –
IF

(1) a person with mental illness or serious emotional disturbance is discharged subject to an outpatient treatment obligation under § 33-6-602, AND

(2) the qualified mental health professional has not terminated the outpatient treatment obligation under § 33-6-620,
THEN

(3) the person's obligation to participate in outpatient treatment terminates six (6) months after the discharge or last renewal of the obligation.

Finally, some explication of the nature of damages in a wrongful death case involving the death of a child is in order.

A wrongful death case in Tennessee has been described as follows:

> A wrongful death action in Tennessee is a hybrid survival/wrongful death action, which (a) preserves and continues the existence of the cause of action that was vested in the victim at the time of death, and (b) compensates the decedent's survivors for their losses consequent upon the injuries received by the decedent. See Pivnick, Vol. 1, Tennessee Circuit Court Practice, Section 1:19 at p. 144; citing *Jordan v. Baptist Three Rivers Hosp.*, 984 S.W.2d 593 (Tenn. 1999) and *Ki v. State*, 78 S.W.3d 876 (Tenn. 2002).

In this hybrid survival/wrongful death action provided for in Tennessee Code Annotated, Section 20-5-113, there is but one right of action and that action is the one possessed by the decedent had he survived, along with any recovery which might be forthcoming from that action. *Rogers v. Donelson-Hermitage Chamber of Commerce*, 807 S.W.2d 242, 246 (Tenn. Ct. App. 1990). The right to bring and prosecute the action passes, pursuant to Tennessee Code Annotated, Section 20-5-106(a), to the personal representative or next of kin and any recovery forthcoming from such an action "...passes to the beneficiaries named in the statute not in their own right 'but because it passes to them in the right of the deceased'." *Id.* at 246, citing *Herrell v. Haney*, 341 S.W.2d 574 (1960).

The kinds of damages recoverable in a wrongful death action include "...the mental health and physical suffering, loss of time, and necessary expenses resulting to the deceased" set out specifically in Tennessee Code Annotated, Section 20-5-113, as well as those "incidental damages" suffered by the decedent's next of kin and also referred to in Tennessee Code Annotated, Section 20-5-113 as "...the damages resulting to the parties for whose use and benefit the right of action survives from the death consequent upon the injuries received". In *Jordan v. Baptist Three Rivers Hospital*, the Court further defined incidental damages to include the "pecuniary value" of the decedent's life and, quoting language from *Spencer v. A-1 Crane Serv., Inc.*, 880 S.W.2d 939, at 943 (Tenn. 1994), defined pecuniary value as follows:

> Pecuniary value has been judicially defined to include the expectancy of life, the age, condition of health and strength, capacity for labor, and earning money through skill, any art, trade, profession, and occupation or business, and personal habits as to sobriety and industry. *Id.* at 943; *see also Hancock v. Chattanooga-Hamilton County Hosp. Authority*, 54 S.W.3d 234 (Tenn. 2001).

In *Thurmon v. Sellers*, 62 S.W.3d 145 (Tenn. Ct. App. 2001), the Court held that an element of damages for a parent in a case involving the death of a minor child, under Tennessee

Code Annotated, Section 20-5-113, includes loss of filial consortium-type damages which takes into account the decedent's life expectancy, age, condition of health and strength, capacity for labor, and for earning money through skill in any art, trade, profession, and occupation or business. Such an award also must be reduced in the case of a minor child by those living expenses associated with child-rearing. Expert testimony is deemed to be helpful concerning the evaluation of a pecuniary loss. Pecuniary value also was held in *Thurman* to encompass the value of human companionship. However, this element of damage does not include the grief, suffering and anguish endured by the parent since that loss is not monetary in nature. *Thurman v. Sellers* at 158-161; *see also* Pivnick, *supra*, section 1:19, pp. 148-149, fn. 26.

With these basic rules of law in mind, the Commission can then analyze whether a duty to young Dedrick Johnson was owed and breached by the State through any actions it took or failed to take which resulted in Dedric Atkins having access to his son in light of his psychiatric history and condition.

Decision

As suggested previously, this case presents the extremely difficult issue of whether or not the State was negligent in the release of a mental patient from a state hospital when that release was followed some eight (8) days later by the patient's unimaginably brutal murder of his five (5) year old son.

This issue by necessity involves an examination of the concepts of foreseeability and duty, areas of the law which have very recently received a great deal of attention from this state's highest court.

The case was tried ably by both parties over a two day period in Chattanooga, Tennessee. Much testimony was taken and several exhibits introduced.

Additionally, the parties both agreed that the Commission could, without objection, have available for review and utilization in reaching a decision in this case, some two thousand two hundred seventy-two (2,272) pages of medical records from MBMHI regarding Mr. Atkins. The Commission has availed itself of this opportunity, and reviewed those records, and, as will be noted, utilized some of the same in reaching a decision here.

In this state both individuals and entities owe a duty to refrain from conduct creating unreasonable and foreseeable risks of harm to others. *Satterfield, supra,* at 363. At the core of any negligence action in Tennessee is, of course, the concept of foreseeability. In *Tompkins v. Annie's Nannies, Inc.*, 59 S.W.3d 669 (Tenn. Ct. App. 2000), foreseeability is explained:

> Foreseeability is the test of negligence. Everyone has a duty to use reasonable care to refrain from conduct that will foreseeably cause injury to another. ... No person, however, is expected to protect against harm from events which one cannot reasonably anticipate or foresee or which are so unlikely to occur that the risk, although recognizable, would commonly be disregarded. ... Specifically, '[t]he defendant in order to be liable must have been able to anticipate or reasonably foresee what will happen.' ...
>
> 'The general rule in Tennessee is that negligence, to be actionable, must result in damage to the plaintiff which the defendant could reasonably have anticipated or foreseen.' ... Foreseeability requires an awareness of a general character of injury similar to those suffered by the plaintiff. ... If plaintiff's injuries are of a type that could not have been reasonably foreseen, a duty of care never arises.
>
> ...'[t]he actor's conduct must be judged in the light of the possibilities apparent to him at the time, and not by looking backward with the wisdom born of the event.' The standard is one of conduct, rather than consequences. It is not enough that everyone can see now that the risk was great, if it was not apparent when the conduct occurred. *Id.* at 673-674. (Citations omitted.)

Foreseeability does not require that the alleged tort-feasor have anticipated the precise manner in which the resulting damage would occur. What is required is that "...the tortfeasor could have foreseen or through the exercise of reasonable diligence should have foreseen the general manner in which the injury or loss occurred". *Hembree*, II, *supra*, at 11. The fact that

some result is conceivable does not establish duty. What the courts do seem to require is that "...a defendant be vigilant in a situation where there is some probability or likelihood of harm which would motivate a reasonable person to take precautions to avoid it". *Satterfield, supra*, at 367.

Once the foreseeability of possible harm is established, the fact finder must then balance the foreseeability of that result and its gravity against the burden imposed on a person or entity "...to engage in an alternative course of conduct that would have prevented harm". *Satterfield, supra*, at 365.

In going through that balancing process, the fact finder must evaluate "society's contemporary policies and social requirements concerning the right of individuals and the general public to be protected from another's act or conduct." *Satterfield, supra*, at 364.

In attempting to carry out that analysis, the Court most recently in *Giggers v. Memphis Housing Authority, supra*, set out seven (7) separate factors, apparently non-exclusive, which the fact finder may resort to in making a determination of which way the balance falls as between foreseeability of risk and gravity of harm versus burden imposed, thus determining whether a duty is owed by the State to a claimant.[2]

Of course, any negligence claimant must not only prove a duty and its breach but also damages, cause in fact, and legal (proximate cause).

Cause in fact requires a showing that "but for" the defendant's breach of a duty owed the claimant the damages would never have occurred. *Waste Management, Inc. of Tennessee v. South Central Bell Telephone Company*, 15 S.W.3d 425, 431 (Tenn. Ct. App. 1997); (citing W.

[2] These seven (7) factors, found at page 6 of the *Giggers* Opinion, appear to be the same factors discussed in *McCall v. Wilder, supra*, at 153; *Satterfield v. Breeding, supra*, at 365; and *Burroughs v. McGee*, 118 S.W.3d 323, 329 (Tenn. 2003). Those decisions actually list eight (8) factors. The *Giggers* Court appears to have merged factors five and six.

Prosser and Page Keeton, Prosser & Keeton on the Law of Torts, Section 41, at 266, "[t]he defendant's conduct is a cause in fact of the event if the event would not have occurred but for that conduct...". See also *Riddings v. Ralph M. Parsons Company*, 914 S.W.2d 79, 83 (Tenn. 1996); *Snyder v. LTG Lufttechnische GmbH.*, 955 S.W.2d 252, 256 at n. 6 (Tenn. 1997); *Kilpatrick v. Bryant*, 868 S.W.2d 594, 598 (Tenn. 1993).)

Additionally, after cause in fact has been established, the claimant must go on to prove legal or proximate cause. Legal cause has been described as containing (3) elements:

> the tort-feasor's conduct must have been a 'substantial factor' in bringing about the harm being complained of; and (2) there is no rule or policy that should relieve the wrongdoer from liability because of the manner in which the negligence has resulted in the harm; and (3) the harm giving rise to the action could have reasonably been foreseen or anticipated by a person of ordinary intelligence and prudence. *McClenahan v. Cooley*, 806 S.W.2d 767, 775 (Tenn. 1991).

In *Rains v. Bend of the River, et al*, 124 S.W.3d 580 (Tenn. Ct. App. 2003), then Judge now Justice, Koch expanded on just how legal cause was determined:

> The concept of 'legal cause' was formerly known as 'proximate cause'. It connotes a policy decision made by the judiciary to establish a boundary of legal liability, ... and to deny liability for conduct that would otherwise be actionable. ... These decisions are based on considerations of logic, common sense, policy, precedent, and other more or less inadequately expressed ideas of what justice demands or of what is administratively possible and convenient. ... An actor's negligent conduct is the legal cause of harm to another if the conduct is a substantial factor in bringing about the harm and there is no rule of law relieving the actor from liability because of the manner in which the actor's negligence resulted in the harm. *Id.* at 592. (Citations omitted.)

Therefore, determining legal cause once again invokes a consideration of foreseeability.

Utilizing the seven (7) factors recently emphasized by the Supreme Court in *Giggers v. Memphis Housing Authority, supra*, the Commission now has some guidance in balancing the

foreseeability of harm and its gravity against the burden on the state to take steps to avoid a bad result in the fact situation now before it.

The first factor isolated by the *Giggers* Court involves evaluating whether there is a foreseeable probability of harm or injury occurring.

The record is clear in this case that Dedric Atkins is a dangerous man whether that dangerousness results from a schizophrenic disorder or from a characterological failing. There is a substantial amount of proof in this record that Mr. Atkins is schizophrenic. Before the Commission are the records from twelve (12) separate pre-murder hospitalizations at MBMHI, along with evidence that Mr. Atkins had been hospitalized at other institutions in the Chattanooga geographical area on at least another occasion or two.

Dr. Kenner described schizophrenia as a deterioration of the brain which resulted in an inability to control one's impulses. Dr. Holmes discussed in detail the role of dopamine in the development of a schizophrenic condition. Testing done at MBMHI had indicated to Dr. Holmes that Mr. Atkins' brain was withering away, particularly in the frontal lobes, and that he also had left hemispheric brain dysfunction. Drs. Holmes and Yap testified that a small percentage of the institutionalized mentally ill, between one and four percent (1 – 4%), account for seventy percent (70%) of assaults.

Dr. Kenner described Mr. Atkins as being recidivistically violent. Dr. Holmes testified that patients re-admitted to a psychiatric hospital within thirty (30) days of a prior release usually had been non-compliant in taking their medications, a trait of Mr. Atkins well established in the medical records before the Commission.

Clinically, throughout his numerous hospitalizations at MBMHI prior to September 27, 2003, Mr. Atkins had been diagnosed as being schizophrenic but also as having an anti-social personality, with below average intelligence, and as being narcissistic. On other occasions, he

was described as either homicidal or suicidal and generally non-compliant with taking his medications, whether they were administered intra-muscularly (Prolixin Decanoate) or taken by mouth (Zyprexa and Prolixin). In fact, throughout the medical records, Mr. Atkins re-hospitalizations seem to occur more frequently following periods of time during which he had not been taking his prescribed medications.

What is striking throughout the two thousand two hundred seventy-two (2,272) pages of records received from MBMHI is the frequency and variety of threatening behaviors either carried out or contemplated by Mr. Atkins.

Early on, Mr. Atkins had made threats of either strangling or cutting one of his brothers. He also had fought with his father and eventually, both siblings and other family members refused to let Mr. Atkins live with them. Mr. Atkins cut a gash in the head of a female officer in the McMinn County Jail and punched a psychiatric technician at MBMHI, breaking his glasses. At another juncture, he had threatened to kill the doctor who had prescribed drugs for him which had caused dystonia, or muscle cramping – a side effect of Prolixin Decanoate. At another juncture, he had hallucinated that he saw his brother in a police uniform. He told personnel at MBMHI that he had thoughts of killing others. While incarcerated at a penal institution in Hamilton County, he bit one corrections officer and threw shampoo in the face of another. In 1999, he had struck Dr. Lowe, a psychiatrist at MBMHI, on the head. During that same 1999 hospitalization, Atkins had methodically beaten the glass out a door at MBMHI. This is the same Dr. Lowe who twelve (12) days before Atkins killed his son opined that his hospital stay at MBMHI should be extended because he posed a substantial risk of serious harm because of mental illness and serious emotional problems as evidenced by threats he had made. Dr. Lowe also observed at the time that Atkins was likely to respond to others.

In August of 1999, Atkins' grandmother told staff at MBMHI that he had tried to kill her. He also incurred two charges of assaulting a police officer in McMinn County and at times blamed his immediate family and staff at MBMHI for his admission there. At one point, he was brought to MBMHI from Erlanger Hospital in a near catatonic state. In August of 2002, Atkins had an altercation with a person on the street in the Chattanooga.

Mr. Atkins had undergone three (3) separate forensic examinations at MBMHI before the murder. The most extensive of those examinations occurred in 1999 on a referral from the McMinn County Criminal Court. The report of the forensic team, which included Dr. Holmes, a psychiatrist, and Dr. Brown, a forensic clinical psychologist, found at pages MR 734 – 745, is chilling. A full review of this is found in the factual portion of this decision. Briefly, the report recited that Akins, when stressed, would not have the ability to manage his behavior which too often could result in "reactive violent conduct". This conduct would occur without warning and without remorse which, according to the proof, was the attitude the police officers witnessed when they responded to the September 27, 2003, incident at Patton Towers. At that time, Atkins told them that his five (5) year old son needed to be dead. The 1999 forensic exam also noted that Atkins was "...at risk of becoming violent and committing assault without warning". He was to be considered dangerous, according to the team. The team also wrote that the charges then pending against him were characterological as a result of Atkins' anti-social and narcissistic personality. Some team members felt that these personality traits gave the impression of greater psychotic disturbance than actually was present. Some members of the team also felt that he would be involved in criminal activity even in the absence of any active mental illness.

However, the report notes that some team members felt that Mr. Atkins was at risk of committing serious injury to others without either or both mental health and legal intervention.

Reading this report, the Commission is impressed with how prescient it is with regard to the forecast of what could happen in Dedric Atkins' life.

At the time of the September 2003 hospitalization, the admission documents noted that Atkins posed a substantial risk of harm because he had threatened his family and that he needed constant observation to minimize the risk of danger both to himself and to his family.

During the police investigation of Dedrick Johnson's death and the forensic examinations in Nashville and Chattanooga, Atkins at one point stated that he felt his five (5) year old son had become possessed by the devil and was part of a conspiracy against him.

During a 1999 forensic examination, Dr. Brown, chief of forensic services at MBMHI, opined that an insanity defense was supportable in connection with criminal charges then pending against Atkins.

While it is not apparent from any of the medical records or proof introduced at the hearing that Atkins had any previous contact with his son which could have predicted the events of September 27, 2003, Dr. Holmes' testimony that the murder was "completely unforeseeable" is simply not sustainable in light of the vast array of both disturbing actions and thoughts described in Dedric Atkins' clinical records.

Therefore, the Commission has no difficulty in holding that factor one from the *Giggers* framework weighs strongly in favor of a duty owed to not only Dedrick Johnson but also to the community at large by MBMHI in connection with its treatment decisions regarding Mr. Atkins.

The second factor used in the balancing analysis set out in *Giggers* addresses the magnitude of the potential harm or injury possible. Actually, the analysis just recited with regard to factor one above is very applicable with regard to factor two. Atkins had exhibited behavior and ideation since at least 1997 which clearly made it foreseeable that homicide might be a part of his future. He had attacked not only members of the public, unknown to him, on the streets of

Chattanooga, but also the manager of a local restaurant, as well as penal authorities in both McMinn and Hamilton counties. Even at MBMHI, he attacked not only technicians but also, at one point, a treating psychiatrist. His behavior was so aberrant that even his family, both in Chattanooga and Alabama, did not want him in their homes. His behavior had no constraints. He had stolen a policeman's bicycle in downtown Chattanooga in the 1990's and later, in McMinn County, had stolen a girlfriend's car and gone into a local clothing store where he attempted to walk out with new clothes simply because he wanted them and was tired of his old clothes. There is even evidence in one of the discharge summaries from MBMHI that while incarcerated in McMinn County there were two aggravated assault charges pending against him in Chattanooga.

It is not surprising that his behavior escalated to murder and therefore, factor two from *Giggers* firmly supports the conclusion that a duty was owed by the state institution in connection with this patient.

Factors three (the importance or social value of the activity engaged in by the defendant) and four (the usefulness of the conduct to the defendant), as was the case with factors one and two above, invoke some of the same considerations. The work done by MBMHI is daunting. Its service or catchment area comprises twenty-three (23) separate counties and a screening of two hundred fifty (250) seriously mentally disturbed patients monthly, seventy percent (70%) of whom are admitted, with the most acutely ill of this population being hospitalized for at least nine (9) days. There can be no denial of the good intentions and professionalism that personnel at MBMHI exhibit in an effort to normalize the lives of their patient populations and avoid simply warehousing people who are mentally ill. For example, Dr. Yap testified that Mr. Atkins did not appear to be exhibiting signs of aggression or violence at the time of his twelfth admission. In fact, Dr. Yap felt that at the twelfth admission, Atkins was a completely different

person from the patient she had treated before. He appeared to be well-groomed, had a place to live, a Social Security disability check, a case manager, and transportation to and from his medical appointments at a local mental health center. Also, he had a sponsor for Alcoholics Anonymous meetings. Additionally, Dr. Yap testified that Atkins was able to discuss with her his preferences with regard to medications as a part of the treatment alliance she was attempting to build with him. In the past Atkins had experienced drug side-effects and the Commission believes Dr. Yap was trying to avoid a recurrence of those problems. Dr. Yap emphasized that in treating a mentally ill person, she ethically and professionally must look to the future and not to the past.

However, on August 24, 2002, Mr. Atkins told MBMHI personnel that he was not into outpatient treatment and, in fact, on one of his previous admissions had gone to Erlanger hospital and asked to be sent to MBMHI.

The efforts by MBMHI to appropriately treat and normalize Mr. Atkins' life were, as evidenced by the medical records, substantial, professional, and carried out in good faith. Therefore, these two factors from the *Giggers*' analysis weigh in favor of the finding of no breach of duty against the state because of actions taken at MBMHI.

Factor five from *Giggers* dealing with the feasibility of alternative, safer conduct and the relative costs and burdens associated with that conduct would appear also to work in tandem with factor six which addresses the relative usefulness of the safer conduct. Of course, at the time of Atkins' admission to the hospital on September 10, 2003, a full scale evaluation was done and according to Dr. Yap, a treatment team saw Atkins every day while he was hospitalized. Dr. Yap also testified that an initial evaluation on admission includes a study of the past history of the patient which here is set out quite succinctly in the twelve (12) previous discharge summaries found in Atkins' medical records. As discussed previously, Atkins' initial

admission on September 10, 2003, was re-evaluated and extended after a hearing on September 15. The Affidavits prepared by Drs. Lowe and Gelburd prior to that hearing describe a dangerously ill Dedric Atkins who nevertheless was released from MBMHI four (4) days later. Dr. Lowe had experienced firsthand what Atkins was capable of as the victim of a prior assault. Therefore, the Commission finds that keeping Mr. Atkins at MBMHI for longer than nine (9) days was not only feasible but in all probability warranted.

Another significant consideration in this connection is the question of why Atkins was not placed in a mandatory outpatient treatment program at that time. Mandatory outpatient treatment is provided for in Tennessee Code Annotated, Section 33-6-601, *et seq.* Previously, the Commission has set out three provisions from that portion of the Code which are particularly germane to these proceedings.

In fact, as early as 1999, the forensic team at MBMHI had concluded that the institution could support an application for a court injunction ordering mandatory outpatient treatment. (MR 745.)

It would appear that mandatory outpatient treatment was not only possible here but warranted in light of the provisions of Tennessee Code Annotated, Section 33-6-602(1)(A) since Atkins had been diagnosed as having a mental illness and/or serious emotional problems. Subsection (B) of that same Code section would also seem to apply to Mr. Atkins since because of his non-compliance with medications, Atkins was in all likelihood going to deteriorate to the point that he would "pose a likelihood of serious harm". Additionally, since Atkins had previously told personnel at MBMHI that he did not like outpatient treatment, his participation in the same probably would not occur unless he was "legally obligated" to do so. (See Tenn. Code Ann. § 33-6-602(1)(D).)

Had Atkins been placed in mandatory outpatient treatment and fallen out of compliance with his treatment plan, then he could have been ordered returned to MBMHI for further treatment. (See Tenn. Code Ann. § 33-6-610.) Atkins' obligation to participate in mandatory outpatient treatment, with the threat of return to the hospital if he did not do so, would continue until six (6) months after his discharge or the last renewal of his obligation to participate in such a plan. (See Tenn. Code Ann. § 33-6-623.)

Following the MBMHI forensic examination of Mr. Atkins, which found a defense of not guilty by reason of insanity to be viable, the discharge summary faults the court system for dismissing criminal charges against Atkins. According to that discharge summary, had the court found Atkins not guilty by reason of insanity and not merely dismissed the charges, then a mandatory outpatient treatment program could have been implemented. However, the Commission's review of Tennessee Code Annotated, Section 33-6-601, *et seq.* does not seem to require a verdict of not guilty by reason of insanity for placement into a mandatory outpatient treatment program. As far back as 1999, MBMHI personnel thought mandatory outpatient treatment for Mr. Atkins was warranted. It is clear, for example, throughout these records that Mr. Atkins refused to take his medicine on schedule regardless of whether it was Prolixin Decanoate intramuscularly or Zyprexa by mouth. Although Dr. Yap believed that Atkins had many more support systems in place at the time of his twelfth admission than in the past, the fact remains that without some psychiatric "sword of Damocles" hanging over his head, Mr. Atkins simply would not comply with state of the art medical treatment offered to him. Therefore, criteria five (5) and six (6) from *Giggers* support the position of the Claimant in this duty and breach of duty analysis.

Finally, the *Giggers* Court directs parties to a consideration of the relative safety of the possible alternative conduct. Here, that conduct would consist of either keeping Mr. Atkins at

MBMHI or forcing him to participate in a mandatory outpatient treatment program. Either alternative presented no threat to his safety and in all likelihood would have built another firewall between him and his son and society at large. This factor augers in favor of the Claimant's position on duty in this case.

Having reviewed each of the seven (7) guidelines developed by the *Satterfield*, *Downs*, and *Giggers* trilogy, the Commission FINDS that a duty was owed to young Dedrick Johnson by the State of Tennessee through MBMHI since the foreseeability and gravity of what happened to him at the hands of his father far outweighed any burden placed on MBMHI to take measures which could have avoided that result.

The same factors discussed above which established the duty owed also make it clear that that duty was breached by the State in this case. Mr. Atkins was a time bomb waiting to explode. Clearly, his own family was afraid of him and he attacked people at random including strangers he encountered on the street and the manager of a local business in Chattanooga. For that mater, Atkins was prone to attack virtually anyone he came into contact with, including Ms. Johnson when she was pregnant with their son, his family, corrections officers, psychiatric technicians, doctors, and ultimately a defenseless, blameless five (5) year old child. At the very least, Mr. Atkins should have been forced into mandatory outpatient treatment.

Alternatively, a persuasive case could be made that Mr. Atkins is an individual who simply cannot be trusted to function safely in society at large and therefore, must be hospitalized at a mental health facility until such time as more effective treatments are available for individuals with his illnesses.

The damages in this case are self evident. The pain, suffering, and outright terror no doubt experienced by this innocent five (5) year old child alone warrant payment of a Judgment of Three Hundred Thousand Dollars ($300,000.00). Of course, a professional economist

calculated the monetary value regarding the child's loss of future earnings. The State questioned the economist to some extent but his testimony and the proof in that regard remains un-refuted and un-rebutted. The damages, therefore, clearly reach the maximum set out in Tennessee Code Annotated, Section 9-8-307(e).

Next, cause in fact must be shown in any negligence case and the parties stipulated the cause of this child's death, in fact, was the actions of his father Dedric Atkins.

Finally, the Commission FINDS that legal cause has been established here since based on the extensive evidence in this case, and the discussion previously had, it has been clearly shown that the actions of the State, through MBMHI, were a substantial factor in the death of Dedrick Johnson. Here, using Justice Koch's language in *Rains v. Bend of the River, et al, supra*, the Commission FINDS that a finding of negligence and legal liability based on considerations "...of logic, common sense, policy, precedent, and other more or less inadequately expressed ideas of what justice demands..." cries out for a finding in favor of the Claimant here. *Id.* at 592. If, in fact, legal or proximate cause also includes an analysis of foreseeability, the foreseeability of this child's death has been established by overwhelming proof.

The Commission would further observe that the MBMHI forensic team's conclusions in August of 2004, after Atkins had been returned to MBMHI from MTMHI provide a clear inference that MBMHI knew it had made a mistake when it released Mr. Atkins in September of 2003. Suddenly, Mr. Atkins' diagnosis was that of a malingering, narcissistic, anti-social, cannabis-user, rather than the undifferentiated schizophrenic who was known to abuse alcohol and marijuana and to be non-compliant with his medications who had been treated on twelve (12) previous occasions. As far back as 1999, MBMHI through Drs. Holmes and Brown had characterized Atkins as a chronic paranoid schizophrenic "suffer[ing] from severe mental illness". It is true that in an extensive forensic examination of Mr. Atkins, conducted by Holmes,

Brown, and others, Atkins' characterological problems had been commented on. Nevertheless, these sorts of emotional disturbances also comprise a category of mental disease which up until the thirteenth hospitalization, post-murder, were believed by MBMHI to be working in tandem with Atkins' schizophrenia. In that thirteenth, post-homicide hospitalization, the forensic team wrote that "whether Mr. Atkins has ever had a Psychotic Spectrum Illness (schizophrenia, schizo-affective disorder) is highly conjectural". The Commission FINDS that that is a truly astounding statement in light of the contents of the two thousand two hundred seventy-two (2,272) pages of medical records which this Commission was invited to review - - - and did. The thirteenth admission/discharge summary is not credible.

The Commission does not discount the day-in, day-out good work being done at MBMHI. However, mistakes are made and a mistake was made in connection with the release of Mr. Atkins on September 19, 2003. That mistake resulted in the absolutely horrible death of a five (5) year old child.

Dedric Atkins appears to be at this point where he has needed to be for some time – in a hospital for the criminally insane. Hospitalizing dangerous and criminally insane individuals is sometimes clearly warranted.

The United States Supreme Court has addressed this troublesome problem. In *Kansas v. Hendrix*, 521 U.S. 346, 366 (1997), the Court said the following:

> While we have upheld state civil commitment statutes that aim both to incapacitate and to treat, ... we have never held that the Constitution prevents a State from civilly detaining those for whom no treatment is available but who nevertheless pose a danger to others. A State could hardly be seen as furthering a 'punitive' purpose by involuntarily confining persons afflicted with an untreatable, highly contagious disease. ... Similarly, it would be of little value to require treatment as a precondition for civil confinement of the dangerously insane when no acceptable treatment existed. To conclude otherwise would obligate a State to release certain confined individuals who are both mentally ill and

> dangerous simply because they could not be successfully treated for their afflictions. ... ('The fact that at present there may be little likelihood of recovery does not defeat federal power to make this initial commitment of the petitioner.') ... ('[I]t remains a stubborn fact that there are many forms of mental illness which are not understood, some which are untreatable in the sense that no effective therapy has yet been discovered for them, and that rates of 'cure' are generally low.') *Id.* at 366. (Citations omitted.)

Our own Supreme Court has recently paid a great deal of attention to the entire concept of duty. Teachings from those cases are extremely useful in addressing the always admittedly difficult issue of whether a duty was owed to a damaged individual or entity.

Each of this type of case when presented must be analyzed in depth based on its own set of facts.

Here, the Commission FINDS that a duty was breached which resulted in the death of an innocent young child and that the damages for his cause of action resulting from that death easily warrant a Judgment of Three Hundred Thousand Dollars ($300,000.00).

The issue of comparative fault of Sherry Johnson, if any

During the course of the hearing, and also in the post-trial proposed findings of fact and conclusions of law submitted by the parties, reference is made to possible comparative fault on the part of the Claimant mother here, Sherry Johnson. However, those references by the Commission and the parties are in all likelihood in error in light of the nature of Tennessee wrongful death actions brought pursuant to Tennessee Code Annotated, Sections 20-5-101, 106, and 113.

Earlier in this decision, a brief discussion of a wrongful death action in Tennessee was undertaken. That analysis was necessary in light of the State's contention that any recovery awarded to Sherry Johnson in this case should be reduced by her comparative fault, if any.

It is at least arguable that from a factual perspective, Sherry Johnson has some degree of fault with regard to her son's death.

She had known for some time that Dedric Atkins was unbalanced. In fact, while she was pregnant with their son, Atkins threatened to slap her. Additionally, the proof shows that she knew Mr. Atkins had been in and out of psychiatric hospitals, and that his behavior was at times extremely strange. Although she had limited contact with him since she had graduated from high school with Mr. Atkins and his twin brother, in the summer of 2003, a few months before her son's death, she made the decision to let her son get to know his father since her other son had a relationship with his natural father. At that time, she discovered that Mr. Atkins was hospitalized at MBMHI and therefore, the visit did not take place. However, on September 26, 2003, she did agree to permit her son to visit with his father with the understanding that Mr. Atkins twin brother, Darrien, would be present during visitation. On the Friday before the child's death, she called Darrien and learned that Mr. Atkins and her son were out walking. The testimony showed further that on the following Saturday morning, she became somewhat concerned when she called again and found that Darrien Atkins was not at the apartment since he had gone to visit with his own children. She was alarmed at that time but apparently did not go to Patton Towers. Of course, in the early evening of that same day, Dedric Atkins killed her son.

Therefore, the State seems to argue that Ms. Johnson was on notice by virtue of these facts that Mr. Atkins was a dangerous man and that harm could come to her son.

At most, the Commission finds that Ms. Johnson's comparative fault, if in fact fault can be attributed to her, would be in the range of fifteen to twenty percent (15 – 20%). However, given the fact that, as discussed earlier in this decision, the cause of action here is that of the minor child, Dedrick Johnson, and not the mother's, it is doubtful that legally fault could be attributed to his mother as next of kin.

Parenthetically, the Commission would note that this whole issue is unsettled in Tennessee law. A leading treatise on the law of comparative fault in Tennessee, Day, Capparella and Wood, Tennessee Law of Comparative Fault, 2008-2009 Edition, opined that a definitive resolution of this issue awaits action by Tennessee appellate courts. In their treatise, they describe the issue as follows:

> Can fault be assigned against a parent who is a beneficiary of a wrongful death claim on behalf of a deceased child for the negligent supervision by the parent of the child that contributed to cause the child's death? *Id.* at section 15:8, pp. 354-355.

Here, the damages so far exceed Three Hundred Thousand Dollars ($300,000.00) that the Commission believes a reduction of the same by fifteen to twenty percent (15 – 20%) would still leave intact a judgment for Three Hundred Thousand Dollars ($300,000.00).

The absolute terror that Dedrick Johnson endured as his father first strangled, then stomped, and finally drowned him is unimaginable and easily worth Three Hundred Thousand Dollars ($300,000.00) were no other sorts of damages assessed. Additionally, the economist's testimony in this matter established damages ranging from Five Hundred Nine Thousand Nine Hundred Seventy-Four Dollars ($509,974.00) to Six Hundred Seventy-Four Thousand Five Hundred Sixty-Nine Dollars ($674,569.00). Aggregating the pain and suffering damages of Dedrick Johnson with the economic loss and reducing the same by fifteen or twenty percent (15 or 20%) still leaves intact an award of Three Hundred Thousand Dollars ($300,000.00) in this case which could never compensate for what this child endured.

Therefore, as stated above, the Commission ORDERS judgment in favor of the Claimant in this matter of Three Hundred Thousand Dollars ($300,000.00).

ENTERED pursuant to **Tenn. R. Civ. P.** Rule 58, this the 29th day of May, 2009.

William O. Shults, Commissioner
P.O. Box 960
Newport, TN 37822-0960

CERTIFICATE

I certify that a true and exact copy of the foregoing Order has been forwarded to:

Jesse Farr, Esq.
Flatiron Building
707 Georgia Avenue, Suite 401
Chattanooga, TN 37402-2023

Darren G. McBride, Esq.
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Chattanooga, TN 37411-3532

Mary M. Bers, Esq.
Stephanie Bergmeyer, Esq.
Office of the Attorney General
P.O. Box 20207
Nashville, TN 37202

This the 2nd day of June, 2009.

Exhibit 1

Dedric Lamont Atkins Admissions to Moccasin Bend Mental Health Institute

Admission:	**Dates:**
#1	03/18/1997 – 04/04/1997
#2	08/15/1997 – 08/29/1997
#3	04/19/1999 – 05/18/1999
#4	05/27/1999 – 06/22/1999
#5	08/18/1999 – 08/27/1999
#6	09/22/1999 – 10/04/1999
#7	11/07/2000 – 01/09/2001
#8	02/26/2001 – 03/15/2001
#9	06/19/2001 – 06/29/2001
#10	08/14/2002 – 08/26/2002
#11	05/07/2003 – 06/02/2003
#12	09/10/2003 – 09/19/2003
#13	07/15/2004 – 08/24/2004