No. 07-1114

IN THE
Supreme Court of the United States

GARY BRADFORD CONE,
Petitioner,

v.

RICKY BELL, WARDEN,
Respondent.

**On Writ of Certiorari
to the United States Court of Appeals
for the Sixth Circuit**

BRIEF OF *AMICUS CURIAE* VETERANS FOR AMERICA IN SUPPORT OF PETITIONER

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INTEREST OF AMICUS CURIAE[1]

Veterans for America is a nonprofit advocacy and humanitarian organization that unites the newest generation of military veterans with those from past wars to advance policies favorable to veterans and to elevate public discourse regarding the causes, conduct and, particularly, the consequences of war. Veterans for America has a direct interest in the questions presented in this case. Although the specific issues presented in the petition deal with the proper scope of federal post-conviction review, the substantive question ultimately at issue in this case is a matter of surpassing importance to Veterans for America – the debilitating and often tragic effects of post-traumatic stress disorder that so many of our nation's combat veterans suffer, and the relevance of that disorder to a proper assessment of their culpability in criminal cases.

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[1] No counsel for a party authored this brief in whole or in part. No person or entity other than Veterans for America and their counsel made a monetary contribution to the preparation or submission of this brief, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of the brief. The parties have consented to the filing of this brief. Letters reflecting such consent have been filed with the Clerk.

INTRODUCTION AND SUMMARY OF ARGUMENT

This case involves a Vietnam veteran and recipient of the Bronze star, whose sole defense to murder and argument against the death penalty hinges on the debilitating effects of post-traumatic stress disorder (PTSD) brought on by his military service. Petitioner Cone argued at trial and at sentencing that he was mentally incapacitated by psychosis caused by drug addiction arising from combat-induced PTSD. A jury then convicted him of first-degree murder and sentenced him to death. Only later did it emerge that the prosecution had suppressed an array of exculpatory evidence that would have supported his defense and argument in mitigation. To date, no court has considered the substance of Petitioner's claim under *Brady v. Maryland*, 373 U.S. 83 (1963). Petitioner Cone thus stands to be executed without any court having weighed the mitigating impact of PTSD on his culpability, and ultimately, on whether he should be put to death.

Petitioner's brief explains with clarity the many ways in which the Sixth Circuit erred in holding that federal post-conviction review of Petitioner Cone's claim was procedurally barred. Veterans for America will not repeat or amplify the precedent supporting that argument. Instead, we respectfully submit this brief to ensure that the Court understands that Petitioner's *Brady* claim is a powerful one on the merits that deserves full and fair consideration.

As we will demonstrate below, the substance of the defense that Cone raised both to the charge of murder and to the State's request for death – that he should not be held fully culpable because he suffers from post-traumatic stress disorder brought on by his military service – is one that finds strong support in a well-developed body of empirical evidence, as well as decades of practical experience on the part of entities such as Veterans for America.

The sad but undeniable truth is that tens of thousands of this nation's veterans bear the emotional and psychological scars of their battlefield service to their country – with PTSD chief among their afflictions. Even worse, veterans suffering from PTSD often turn to substance abuse to deaden their symptoms, bringing on a vicious cycle of self-destructive behavior. Regrettably, violence is a frequent manifestation of PTSD in the veteran population, particularly among substance abusers. A just assessment of criminal culpability requires that the nature and effects of PTSD be taken into account.

That is particularly true in this case. In seeking to win a conviction and death sentence, the prosecution did not deny that PTSD, particularly as exacerbated by the type of serious substance abuse that it so often brings about, could theoretically preclude a finding of the necessary *mens rea* or justify a "reasoned moral response" that a death sentence would be disproportionately severe. *See generally Penry v. Lynaugh*, 492 U.S. 302, 319 (1989). Instead, the prosecution challenged Cone's assertion that he suffered from PTSD and, in

particular, that he was in a state of amphetamine psychosis at the time of the crime. *See* Pet'r's Br. at 40-48 (detailing trial evidence presented by Cone regarding his diagnosis of PTSD and substance dependence, along with the State's response). But the prosecution told the jury that Cone was not a drug user at all, much less a person suffering from a chronic addiction to powerful amphetamines that began during his service in Vietnam and deepened over time as a consequence of his PTSD.

Thus, it was particularly shocking when subsequent discovery revealed that prosecutors had suppressed exculpatory evidence that flatly contradicted the prosecution's trial strategy – evidence confirming that the authorities believed Cone to be not merely a "heavy drug user," but also a person who was generally dangerous and who appeared "frenzied" and "wild eyed." *See* Pet'r's Br. at 42. This body of concealed evidence is plainly material to the core issue of Cone's culpability. It is directly relevant to his principal defense to the charge of murder. It is equally relevant to the sentencers' assessment of whether Cone should have received the death penalty. The fact is that Cone's psychological make-up, his addiction to powerful amphetamines, and the criminal acts of which he was accused are all completely consistent with a diagnosis of PTSD, which is hardly surprising given Cone's traumatic combat experience in Vietnam.

As will be developed below, the PTSD-based defense that Cone sought to put forth at trial and at sentencing is well supported by a significant body of evidence. That defense should have received full and

fair consideration by the jury that convicted and sentenced him. The prosecution, however, deprived the jury of the opportunity to give appropriate consideration to Cone's defense by suppressing evidence that directly supported that defense and that squarely contradicted the prosecution's statements to the jury that Cone was not a drug user at all, much less one suffering from the debilitating effects of PTSD. Because this evidence is material under any reasonable reading of *Brady*, there is every reason to think that Cone would obtain relief were he given the opportunity to adjudicate his *Brady* claim. This Court should therefore reverse the decision below.

ARGUMENT

I. The Prevalence of Post-traumatic Stress Disorder, Often Combined With Substance Abuse, Is Strikingly High In Veterans.

As far back as the Trojan War, commentators have documented the depression, anger, and gloom that plague many soldiers long after they have returned from combat. *See* Jonathan Shay, *Learning About Combat Stress From Homer's Iliad*, 4 J. Traumatic Stress 561 (1991); *see also* Edgar Jones, *Historical Approaches to Post-Combat Disorders*, 361 Phil. Transactions of the Royal Soc'y of London Series B 533 (2006). Such combat trauma is not surprising when one considers that exposure to combat is one of the most intense stressors known to man. *See* Inst. of Med., *Gulf War and Health Vol. 6: Physiologic, Psychologic, and Psychosocial Effects of*

Deployment-Related Stress 31-35 (2008); *see also* Jones, *supra*, at 533.

Perceptions about the frequency and severity of symptoms prompted the United States to establish "the first military hospital for the insane in 1863." Major Timothy P. Hayes, Jr., *Post-Traumatic Stress Disorder on Trial*, 190/191 Mil. L. Rev. 67, 70 (Winter 2006/Spring 2007). Over 850,000 active-duty U.S. soldiers were admitted to military hospitals for neuropsychiatric care during World War II. Paul Starr, *Social Transformation of American Medicine* 344 (1982). By 1979, the government decided it was necessary to open ninety counseling centers across the nation to treat such symptoms among soldiers returning from Vietnam. Hayes, *supra*, at 71. And within the next two years, the number of treatment centers for Vietnam veterans more than doubled. Eric T. Dean, Jr., *Shook Over Hell: Post-Traumatic Stress, Vietnam, and the Civil War* 15 (1997).

The problem received sustained attention from the relevant professional communities in the 1980s, with the proliferation of studies on the psychological effects of combat on Veterans. *See generally* Inst. of Med., *Gulf War and Health*, *supra*. Such attention included the official diagnostic classification of the disorder in 1980, when the American Psychiatric Association listed PTSD in its *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-III).[2] Dean, *supra*, at 27, 42.

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[2] Thus, PTSD was a clinically recognized disorder at the time Cone was convicted in 1982. The disorder continues to be

Indeed, Congress was so concerned about the prevalence of PTSD after the Vietnam War that it commissioned the National Vietnam Veterans Readjustment Study for an investigation of "post-traumatic stress disorder and other psychological problems" among Vietnam veterans. *See* Veterans' Health Care Amendments of 1983, Pub. L. No. 98-160, 97 Stat. 993. Although many Vietnam veterans readjusted to civilian life without experiencing symptoms, the prevalence of PTSD among Vietnam veterans was, and still is, alarmingly high. The results of the study indicate that nearly a third of men and over a quarter of women who served in Vietnam experienced post-traumatic stress disorder upon returning home. Richard A. Kulka et al., *Trauma and the Vietnam War Generation: Report of Findings from the National Vietnam Veterans Readjustment Study* 52-53 (1990). Overall, 1.7 million Vietnam veterans experienced stress symptoms, often continuing for decades following their return from the battlefield. *Id.*

Post-traumatic stress disorder also is strikingly common among Veterans of more recent wars. At the request of Congress and the U.S. Department of Veteran Affairs, the National Institute of Medicine reviewed all published evidence on the impact of combat trauma on veterans of the 1991 Persian Gulf War and the current conflicts in Afghanistan and

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listed in the most recent version of the American Psychiatric Association's manual ("DSM-IV"), with the diagnostic criteria for assessing PTSD largely unchanged. *See* Inst. of Med., *Posttraumatic Stress Disorder: Diagnosis and Assessment* 14-16 (2006).

Iraq. *See* Inst. of Med., *Gulf War and Health, supra*, at xvii, 1-3. The study concluded that 16% of combat troops experience PTSD symptoms within a year after their return from the current war in Iraq. *Id.* at 79. Active duty soldiers returning from the current conflict in Afghanistan face similarly high rates of PTSD. *See, e.g.*, Karen H. Seal et al., *Brining the War Back Home*, 167 Archives of Internal Med. 476, 480 (2007). The prevalence of PTSD is even higher among reservists, with nearly a quarter experiencing PTSD after returning from Iraq. Charles S. Milliken et al., *Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning from the Iraq War*, 298 JAMA 2141, 2143 (2007). The current conflicts in Iraq and Afghanistan have swollen the ranks of veterans suffering from PTSD.

Although symptoms vary, PTSD clearly disrupts the lives of those afflicted with the condition. The disorder can "leave patients with an array of disabilities from mildly distressing to severely incapacitating." Inst. of Med., *Posttraumatic Stress Disorder: Diagnosis and Assessment* 13 (2006). Even years after they have returned from war zone, veterans can develop "an array of psychopathological symptoms – from intrusive recollections such as nightmares and flashbacks, to disoriented thinking, startle reactions, social numbing, depression, and anxiety." Dean, *supra*, at 91.

Petitioner Cone, like other veterans, has suffered a panoply of these symptoms. In particular, he has experienced nightmares and has "for some time . . . manifest[ed] flashbacks . . . perceiving himself to be

back in a combat situation." J.A. 86 (expert testimony of M. Jaremko). As a result of PTSD, Cone also has become emotionally and socially distanced from society, and consequently, from the values held in civil society. *See* J.A. 86 (expert testimony of M. Jaremko). Further, Cone has experienced a host of other stress-related symptoms, including "depression, nervousness, [and] sleep disorders." J.A. 86-87 (expert testimony of M. Jaremko). Accordingly, Cone was described at trial as "[r]estless and sometimes hollering . . . [a]bout flying bodies back and . . . having to help handle them and how terrible it was, and the condition the bodies were in at the time." Trial Tr. 1644 (testimony of V. Cone). In these respects, Petitioner Cone's experience reflects the impact PTSD can, and does, have on many of our nation's Veterans.

Veterans with PTSD commonly suffer from other disorders, including drinking or drug problems. *See* Paula P. Schnurr et al., *Research on Posttraumatic Stress Disorder: Epidemiology, Pathophysiology, and Assessment*, 58 JCLP/In Session: Psychology in Prac. 877, 880 (2002). The rate of substance abuse among persons with PTSD may be as high as 60-80%. Beverly Donovan & Edgardo Padin-Rivera, *Transcend: A Program for Treating PTSD and Substance Abuse in Vietnam Combat Veterans*, 8 Nat'l Ctr. for Post-Traumatic Stress Disorder Clinical Q. 51, 51 (Summer 1999). Based on a comprehensive review of such studies, the Institute of Medicine concluded that there is "suggestive evidence of an association between deployment to a

war zone and drug abuse." Inst. of Med., *Gulf War and Health*, *supra*, at 162-63.

The common explanation for this high occurrence of substance abuse is the drive to mask the symptoms and effects of PTSD. Many health care professionals believe that substance abuse among Veterans with PTSD is a "copying strategy" to "self-medicate or diminish the stress symptoms and feelings [of PTSD]." Kulka et al., *supra*, at 283 (reporting results of National Vietnam Veterans Readjustment Study). *See* Casey T. Taft, et al., *Post-traumatic Stress Disorder Symptoms, Physiological Reactivity, Alcohol Problems, and Aggression Among Military Veterans*, 116 J. Abnormal Psychol. 498, 499 (2007).

The impulse to self-medicate through substance abuse is especially high among those suffering from PTSD as a result of combat trauma. Describing a typical example of the phenomenon, professionals treating veteran-sufferers detailed, "[The patient] witnessed many atrocities during combat in Vietnam . . . . Upon returning home, [he] often felt depressed and fearful; he was continuously agitated and always searched for the slightest sign of harm. He turned to heroin to shut out the pain." Patrick M. Reilly et al., *Anger Management and PTSD: Engaging Substance Abuse Patients in Long-Term Treatment*, 6 Nat'l Ctr. for Post-Traumatic Stress Disorder Clinical Q. 68, 68 (Summer 1996). "As with many Vietnam-combat veterans, [the patient] avoided addressing traumatic incident by using drugs and alcohol." *Id.* This story reflects the experience of many: "According to the National Vietnam Veterans Readjustment Study,

Vietnam veterans with PTSD are six times more likely to abuse drugs compared to Vietnam veterans without PTSD." *Id.*

Cone's experience was typical. After he returned from Vietnam, "[Cone] continued to use drugs . . . as a self-way to self-medicate against the stress . . . from having been a victim of . . . combat trauma." J.A. 87 (testimony of M. Jaremko). This is hardly surprising, given his traumatic combat experience, which included handling and transporting corpses of fallen soldiers. *See* Trial Tr. 1644 (testimony of V. Cone). As a scholar of the Civil War observed, "perhaps the most horrific" feature of war occurs on the battlefield "after the firing has subsided," when soldiers face "[m]angled men, dead and dying." Dean, *supra*, at 66. Studies of recent wars have similarly concluded that "exposure to dead and wounded comrades" is one of the uniformly traumatic features of war. Inst. of Med., *Gulf War and Health*, *supra* at 32.

Often those suffering from PTSD enter a dangerously addictive cycle. They suffer the symptoms of their disease, and then treat those symptoms through substance abuse, which only exacerbates their distance from society and amplifies propensities towards depression, anger, and violence. The particular maladies at the heart of Mr. Cone's case, therefore, are far from "balon[e]y." Pet'r's Br. at 41-42 (citing J.A. 108). Rather, the compounded effects of PTSD and substance abuse, and their prevalence in war veterans, are well-documented and serious, and there is ample evidence that Petitioner Cone was afflicted with the disorder.

II. PTSD, Particularly When Compounded By Substance Abuse, Is Directly Linked To An Increased Risk of Violent Crime.

PTSD, particularly when combined with drug and alcohol abuse, is associated with an increased proclivity for anger and violence. Research has revealed that "PTSD and its symptoms appear to be related to serious expressive violence." James J. Collins & Susan L. Bailey, *Traumatic Stress Disorder and Violent Behavior*, 3 J. Traumatic Stress 203, 217 (1990). Studies consistently show that veterans with PTSD "evidence higher rates of violent outbursts and aggressive behavior than those without the disorder, and exhibit more hostility expression and poorer anger control." Casey T. Taft, *Aggression Among Combat Veterans: Relationships With Combat Exposure and Symptoms of Posttraumatic Stress Disorder, Dysphoria, and Anxiety*, 20 J. Traumatic Stress 135, 135 (2007).

As the National Center for PTSD has explained, "[t]rauma can be connected with anger in many ways. After a trauma people often feel that the situation was unfair or unjust. They can't comprehend why the event has happened and why it has happened to them. These thoughts can result in intense anger." Nat'l Ctr. for PTSD, *Fact Sheet: Common Reactions After Trauma*, *available at* http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_commonreactions.html (last visited Sept. 9, 2008). This anger can be linked to the PTSD symptom known as hyperarousal. *See* Kulka et al., *supra*, at 33, 45-48. Hyperarousal can cause irritability,

anger, and even rage. Nat'l Ctr. for PTSD, *Fact Sheet: War-Zone Related Stress Reactions: What Veterans Need to Know*, *available at* http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/war_veteran.html?opm=1&rr=rr126&srt=d&echorr=true (last visited Sept. 9, 2008).

Hyperarousal also can lead sufferers to feel "out of control." Raymond W. Novaco, *Anger Treatment and Its Special Challenges*, 6 Nat'l Ctr. for Post-Traumatic Stress Disorder Clinical Q. 56, 58 (Summer 1996). When it attains levels of intense arousal, it can be profoundly troubling to the person having the anger experience." *Id.* Not surprisingly, uncontrollable anger often causes snap reactions, leading to violence and criminal acts.

Substance abuse exacerbates these effects. *See* Taft, et al., *Posttraumatic Stress Disorder*, *supra*, at 504 ("[H]yperarousal symptoms were associated with a greater frequency of aggression through their relationship with alcohol problems"). PTSD limits an individual's ability to control their responses to anger stimuli, and drugs and alcohol further limit the individual's capacity to deal with feelings of anger. Thus, those suffering from a combination of PTSD and substance dependence are particularly prone to commit violent acts as a result of impulses that they cannot fully control.

This risk is also elevated when those suffering from PTSD exhibit psychotic symptoms. One study found that "as many as 35% of treatment seeking veterans with PTSD may also experience psychotic

symptoms that are distinct from PTSD-related perceptual disturbances (e.g., flashbacks, trauma-specific hallucinations, disassociation), and this population represents a group of trauma survivors with significant vulnerabilities." Madeline Uddo, Frederick Sautter, & Larry Pardue, *Treatment of PTSD with Psychotic Symptoms*, 8 Nat'l Ctr. for Post-Traumatic Stress Disorder Clinical Q. 14, 14 (Winter 1998). The ranks veterans suffering from psychotic symptoms may be even higher. A study of male veterans seeking inpatient treatment found that, "more than 75% of the participants [met] the criteria for at least one personality disorder." Andres R. Bollinger, et al., *Prevalence of Personality Disorders Among Combat Veterans with Posttraumatic Stress Disorder*, 13 J. Traumatic Stress 259, 263 (2000). "By comparison, personality disorders are estimated to occur in approximately 10-13% of the general population." *Id.* Certain personality disorders can cause a decreased ability to control anger and to conform one's behavior to societal demands for non-violent reactions to anger stimuli. Those suffering from these effects of PTSD – particularly when they are also inflicted with substance abuse disorders – are more likely than the general population to resort to violence as a coping mechanism.

The risk is particularly prevalent in those – like Cone – suffering from PTSD as a result of war. As one Army Captain explained about a fellow soldier who committed a murder after he returned home, in war, the soldier was taught to solve "very dangerous problems by using violence and the threat of violence

as his main tools. He was congratulated and given awards for these actions. This builds in a person the propensity to deal with life's problems through violence and the threat of violence." Deborah Sontag & Lizette Alvarez, *War Torn; Across America, Deadly Echoes of Foreign Battles,* N.Y. Times, Jan. 13, 2008 (quoting a letter from Capt. Benjamin D. Tiffner, a criminal defendant's former platoon leader, who was killed in Iraq in November 2007). An Army reservist and Iraq veteran who now works as a prosecutor in California similarly explained that in war "[y]ou are unleashing certain things in a human being we don't allow in civic society, and getting it all back in the box can be difficult for some people." *Id.* (quoting William C. Gentry).

This anecdotal evidence illustrates a problem of significant scope. "In the mid-1980s, [Vietnam] veterans made up a fifth of the nation's inmate population." Sontag & Alvarez, *War Torn*, *supra*. According to one study, fully a quarter of the male Vietnam Veterans with PTSD had engaged in 13 or more violent acts in the year directly preceding the study. *See* Hayes, 190/191 Mil. L. Rev. at 76-77. And "half had been arrested or incarcerated multiple times as an adult." *Id.* Exposure to combat and prevalence of PTSD is also associated with an increased risk of incarceration among Gulf War veterans. *See* Donald W. Black, *Incarceration and Veterans of the First Gulf War*, 170 Mil. Med. 612, 614 (2005). Recent analyses confirm that veterans continue to be more likely than other inmates to have committed violent offenses. *See* Christopher J. Mumola, Bureau of Justice Statistics Special Report,

Veterans in Prison or Jail 1, 5 (2000). The risk that military veterans suffering from PTSD will commit acts of violence is thus disturbingly high.

The risks of violence fall when afflicted individuals receive treatment. Unfortunately, many sufferers do not seek or receive proper care – particularly those whose PTSD is traceable to combat trauma. The National Vietnam Veterans Readjustment Study revealed that three quarters of male and nearly half of female Vietnam veterans suffering from PTSD do not receive any mental care. Kulka et al., *supra*, at 201.

Some have attributed the lack of proper care during the Vietnam era to a dearth of a general understanding about the issues faced by PTSD-suffering veterans. "[C]linical staff rarely, if ever, evaluate and/or document the presence of PTSD in substance use disordered patients . . . . It is likely that unchecked PTSD is associate with poorer treatment outcome . . . ." Bonnie S. Dansky et al., *Post-traumatic Stress Disorder and Substance Abuse: Use of Research in a Clinical Setting*, 10 J. Traumatic Stress 141, 145, 147 (1997). Others have linked the problems to the veterans themselves: "Many Vietnam combat veterans diagnosed with PTSD view[ed] the VA hospital as an extension of the military, an institution for which they hold contempt." Reilly et al., *supra*, at 68.

Although treatment and understanding have surely improved since the Vietnam era, the problem of improper care among veterans persists. A recent government report concluded that extant mental

health services are inadequate to meet the needs of veterans returning with post-traumatic stress syndrome from combat in Iraq and Afghanistan. Task Force on Mental Health, Dep't of Defense, *An Achievable Vision* (2007).

The lack of infrastructure is compounded by stigma associated with seeking treatment. In a recent three-part series detailing the prevalence of violent crimes among those returning from the Afghanistan and Iraq wars, the *New York Times* reported that many veterans suffering from PTSD worry that people, and particularly military colleagues, will view them as emotionally weak if they seek treatment for their disorder. Sontag & Alvarez, *War Torn*, *supra*. Few of these veterans receive the necessary care. Veterans forced to deal privately with the symptoms and devastating effects of PTSD are ill-equipped to overcome impulses of anger and violence. As noted, many turn to drugs and alcohol to self-medicate and to numb the feelings of anger and rage.

III. Evidence of PTSD and Related Substance Abuse Are Directly Relevant To Determining Whether a Defendant Formed the Requisite Intent to Commit a Crime and as Mitigating Evidence at Sentencing.

In cases where the defendant suffers from PTSD due to combat trauma, it is both reasonable and necessary for the trier of fact to consider whether the defendant's symptoms have affected his ability to manifest the specific intent required for conviction.

Thus, in a trial for first-degree murder, it is reasonable for the trier of fact to ask whether a defendant's PTSD-related symptoms of hyperarousal and/or psychosis, along with any evidence of substance abuse, render it unlikely that the defendant acted with the clear intent to kill the victim. Of course, the consideration of these factors does not require that a defendant escape culpability entirely. Rather, review of this evidence would merely go to whether the defendant formed a specific state of mind. If the court were convinced that his symptoms made it unlikely that the defendant formed the requisite *mens rea* for a specific intent crime, he might very well still be guilty of a lesser charge. *See* 2 Wharton's Criminal Law § 142 (Charles Torcia ed. 15th ed., updated Sept. 2007).

Further, evidence of PTSD and related substance abuse may also be useful and necessary in the sentencing phase of a trial. Indeed, California has passed a law mandating the consideration of such evidence, providing judges with statutory a basis to depart from presumptive prison sentences for criminal defendants who suffer from PTSD arising from their military service. *See* Cal. Penal Code § 1170.09 (providing that veterans be screened for PTSD and, if suitable, given treatment in lieu of jail or imprisonment). Courts have been compelled to consider such evidence even without a statutory mandate. For example, in *Masterson v. State*, 516 So. 2d 256, 258 (Fla. 1987), the Florida Supreme Court vacated a death sentence where a jury found a defendant Veteran's post-traumatic stress disorder and attendant drug abuse were mitigating factors.

See also Holsworth v. State, 522 So. 2d 348, 354 (Fla. 1988) (vacating a death sentence where evidence of defendant's drug and alcohol abuse supported theory that defendant's capacity to grasp the criminality of his conduct was diminished). These cases further illustrate that the trier of fact could reasonably determine that though the defendant is guilty of the crime, his disorders represent valid mitigating factors, leading to a downward departure in sentencing.

To ignore evidence of PTSD and related substance abuse in war veterans denies reality and betrays the safeguards in our criminal justice system. One military defense counsel has explained of PTSD-suffering veterans, "I think they should always receive some kind of consideration for the fact that their mind has been broken by war." Deborah Sontag & Lizette Alvarez, *In More Cases, Combat Trauma Is Taking The Stand*, N.Y. Times, Jan. 27, 2008. A prosecutor trying a war veteran accused of a violent crime at home remarked, "I can't justify criminal activity. . . . But it would have been unjust to [the veteran defendant] and to society to throw out the circumstances that we as a society put him in." Deborah Sontag, *An Iraq Veteran's Descent; a Prosecutor's Choice*, N.Y. Times, Jan. 20, 2008. Taking it upon himself to consider the direct link between the violent symptoms of PTSD and the crime at hand, this prosecutor accepted a plea from the defendant for manslaughter, rather than murder. As such, he demonstrated a reasonable response to

the complex relationship between PTSD in war veterans and violent crimes.

In vivid contrast, the prosecution in this case sought to deny Cone the opportunity to make his case that one legacy of his service in Vietnam was PTSD, that this affliction had brought about a serious drug addiction, and that he had committed the criminal acts in question in a state of psychosis that could be traced to his afflictions. It is bad enough that the prosecution refused to disclose evidence in which officers of the State repeatedly described Cone in terms that would have directly supported his defense. But it is particularly shocking that, having suppressed this evidence, the prosecution would then try to shut down Cone's defense (both at trial and at sentencing) by falsely telling the jury that there was no evidence that Cone was a drug user at all, much less that he suffered from PTSD and a long term addiction that could have left him in the psychotic state he claimed to be in when the acts of which he was accused occurred.

Cone's ultimate substantive claim for relief under *Brady* is a powerful one, which deserves full and fair consideration, and vindication, in federal court.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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