RECEIVED
Jun 26 2026
S.C. SUPREME COURT

THE STATE OF SOUTH CAROLINA
In The Supreme Court

APPEAL FROM GREENVILLE COUNTY
Court of General Sessions

Alex Kinlaw, Jr., Circuit Court Judge

Unpublished Opinion No. 2026-UP-022
(S.C. Ct. App. filed January 28, 2026)

Ex Parte: South Carolina Department of Mental Health ..... Petitioner

In re:

The State, ... Respondents,

v.

Jevon Kenneth Carter ..... Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE COURT OF APPEALS

Desa Ballard (S.C. Bar No. 498)
BALLARD & WATSON
226 State Street
West Columbia, South Carolina 29169
Telephone 803.796.9299
Facsimile 803.796.1066
desab@desaballard.com

ATTORNEY FOR PETITIONER

OTHER COUNSEL OF RECORD:

D. Josev Brewer (S.C. Bar No. 69680)
The Law Office of D. Josev Brewer
650 E. Washington Street
Greenville, South Carolina 29601
Telephone 864.383.5250
joe@joebrewerlaw.com

ATTORNEY FOR RESPONDENT JEVON CARTER

Alan Wilson (S.C. Bar No. 71754)
J. Benjamin Aplin (S.C. Bar No. 8729)
Office of the Attorney General
Post Office Box 11549
Columbia, South Carolina 29211
Telephone 803.734.3727
agwilson@scag.gov
baplin@scag.gov

W. Walter Wilkins III (S.C. Bar No. 16740)
305 E. North Street
Greenville, South Carolina 29601
Telephone: 864.467.8647
walt@wilkinsdavis.com

ATTORNEYS FOR RESPONDENT
THE STATE OF SOUTH CAROLINA

INDEX

CERTIFICATE OF COUNSEL

Counsel for Petitioner certifies that two Petitions for Rehearing *En Banc* were filed by DMH and Mr. Carter on February 12, 2026. The petitions were finally ruled on by the Court of Appeals on May 29, 2026.

QUESTIONS PRESENTED

1. Has Mr. Carter's constitutional right to liberty been violated?
2. Did the Court of Appeals err in denying DMH's notification for Mr. Carter's transfer to outpatient status since the evidence was undisputed?
3. Did the Court of Appeals err in failing to address the issues raised on appeal?
4. Did the Court of Appeals err in failing to reverse the trial court when the evidence presented was undisputed?

STATEMENT OF THE CASE

This is an appeal from an order of the circuit court that overruled DMH's notification to the circuit court that Jevon Carter ("Mr. Carter") was no longer in need of inpatient hospitalization and should be transferred to outpatient treatment. Instead, the circuit court ruled that Mr. Carter remains in need of mandatory [inpatient] hospitalization. Petitioner, South Carolina Department of Mental Health, has custody of Mr. Carter by virtue of a 2022 order of commitment.

Mr. Carter was adjudicated[1] not guilty of criminal charges by reason of insanity on June 14, 2022.[2] Pursuant to S.C. Code § 17-24-40, Mr. Carter was committed to "the South Carolina State Hospital" for a period not to exceed one hundred twenty days." Section 17-24-40(A)[3] After

---

[1] The adjudication was made following a factual stipulation from Mr. Carter's counsel and the State. The original circuit court judge ruled that "the facts could have supported a jury finding of the lesser included charge of Voluntary Manslaughter and Possession of a Weapon During a Violent Crime. . . and Burglary 1st degree. (ROA p. 3). No facts of the underlying circumstances were recited in the order of commitment. (ROA pp. 3).

[2] Evidence of these facts was not before the trial court, nor was evidence of these facts included in the Record on Appeal, other than in unauthenticated medical records (*see* Issue Three). The facts recited by the Court of Appeals appear to come from unauthenticated medical records rather than competent evidence.

[3] The Code Commissioner's note following Section 17-24-40 references 2025 Act No. 3, § 18, explaining that "certain references" in the statute have been changed by the Code Commissioner "to reflect the restricting of these agencies

that period, the matter transforms into a civil commitment proceeding pursuant to S.C. Code § 44-17-580 for the subsequent steps. Thus, both chapters, with this Court's 2014 Administrative Order[4] ("the 2014 Administrative Order") provide the procedural steps to be followed by agencies involved as well as the legal standard for adjudicating the issues presented after the initial commitment following the not-guilty-by-reason-of-insanity adjudication and the passage of the 120 days. Since Mr. Carter has been found not guilty of criminal charges, this Petition refers to him correctly as "Mr. Carter." [5]

The Record on Appeal reflects two (2) occasions on which DMH notified the circuit court that Mr. Carter was no longer in need of inpatient hospitalization.[6] On both occasions, DMH

---

into component offices under the Department of Behavioral Health and Developmental Disabilities." This Petition continues the use of Department of Mental Health and "DMH" since the most recent orders from the Court of Appeals use that term.

[4] This Court issued an Administrative Order in 2014 entitled "Interagency Protocol for Defendants Found Not Guilty by Reason of Insanity" which details the "cooperation" of "multiple agencies across the sixteen judicial circuits" of persons who are adjudicated not guilty by reason of insanity. Order 2014-04-24-01. This Court's order recited there were then 135 individuals currently under supervision of the Department under S.C. Code 17-24-40. As directed by this Court, the only issue to be determined by the circuit court after the initial hospitalization following adjudication is whether "the Defendant IS NOT in need of continued hospitalization." *Id.* page 7, Section B. This is consistent with the statute. S.C. Code 17-24-40(C)(2)(a). Proceedings from that point forward are supposed to be governed by S.C. Code § 44-17-580.

[5] Most jurisdictions refer to the individuals who exist in this purgatory as "acquittees." *Moon v. Commissioner of Correction*, 354 Conn. 181, 350 A.3d 496 (2026); *People v. L.W.*, 245 N.Y.S.3d 68 (N.Y. 2025); *State v. Schaefer,* 419 Wis.2d 151, 30 N.W.3d 500 (2025); *State v. Wilhite*, 418 Wis.2d 471, 27 N.W.3d 239 (2025); *State v. Kim,* 716 S.W.3d 78 (Tenn. 2025); Schmuhl *v. Clarke*, 894 S.E.2d 854 (Va. 2023). South Carolina's statutes, on the other hand, interchangeably refer to these individuals as "person" and "defendant" with no consistency. *See* S.C. Code 17-24-10 through 80 (use of "defendant" 34 times and use of "person" 26 times in the same statutes). Conversely, this Court's 2014 administrative order uses the term "defendant" 72 times and the term "person" not at all. Neither did this Court use the term "acquittee" in the 2014 Administrative Order.

[6] Mr. Carter remains "committed" to DMH even when transferred to outpatient treatment. S.C. Code § 44-17-580 (B) (during outpatient treatment, an adjudicated person can be transferred back to inpatient treatment without court order should he "fail to adhere to the prescribed outpatient treatment order or program.") Mr. Carter's treating psychiatrist discussed this process in detail, identifying multiple tools in the outpatient arsenal for monitoring outpatient treatment and law enforcement's continuing role should circumstances present risk or noncompliance with the mandatory outpatient protocol. (ROA p. 25, line 19 – 26, line 5; p. 30, line 24 – p. 32, line 17). Cross examination detailed this further. (Tr. P. 38, line 11 – p,. 39, line 25; p. 40, line 23 – p. 41, line 6). Neither the circuit court nor the Court of Appeals made reference to the transfer to outpatient treatment being a continuation of the commitment. In fact, the Court of Appeals seemed to be unaware that Mr. Carter's commitment would continue. ". . . [W]e find no error in the circuit court's decision to require Carter to have a longer period of psychiatric stabilization before he is released." *Id.* p. 8. No release was being contemplated. This was a transfer from inpatient to outpatient commitment.

complied with its statutory obligation and determined that Mr. Carter was no longer in need of inpatient hospitalization, and should instead be transferred to outpatient care and monitoring. On November 10, 2022, DMH recommended that Mr. Carter be transferred to outpatient treatment with mandatory "terms and conditions for continued monitoring." (ROA pp. 357-363). On that occasion (as well as the instant proceeding), Mr. Carter's inpatient hospitalization was ordered to continue despite undisputed evidence no further inpatient hospitalization was required. (ROA pp. 7-11).

On July 7, 2023, DMH again notified the circuit court that Mr. Carter was no longer in need of inpatient hospitalization. (ROA pp. 364 – 371). The circuit court again denied[7] DMH's determination that Mr. Carter was no longer in need of inpatient hospitalization. (ROA p. 1-2). That order was the subject of the appeal from which this Petition arises.[8]

DMH also notified the circuit court a third time that Mr. Carter no longer required in-patient hospitalization, but a circuit court judge ruled that the matter could not be addressed because of the then-pending appeal. (ROA pp. 12-13). That order was not appealed.

The appeal was heard by the Court of Appeals on November 12, 2025, and the circuit court was affirmed. Unpublished Opinion No. 2023-UP-022(January 28, 2026).[9] Petitions for

---

Mr. Carter's "psychiatric stabilization" was intended to continue under DMH's decision to transfer him to outpatient treatment. This critical fact seemed lost on the circuit court and the Court of Appeals.

[7] DMH struggles with properly characterizing what the circuit court did on either occasion. The relevant statutes do not give the circuit court judge authority to "approve", "deny", "overrule" or disagree with DMH. On both occasions, the circuit court ordered "commitment", which already existed.

[8] While the pendency of the appeal necessarily renders the order on appeal stale with respect to Mr. Carter's status, the issues raised here are not moot. The wrongful application of the legal standard by the deciding court is "capable of repetition but evading review." *Curtis v. State*, 345 S.C. 557, 568, 549 S.E.2d 591, 596 (2001). DMH also notes that Mr. Carter's inpatient hospitalization continues despite DMH finding inpatient hospitalization not being required on three (3) prior occasions. The issue of the proper standard to be applied upon notification to the circuit court is still very much alive, unresolved and valid (as to Mr. Carter and likely many other individuals).

[9] Pursuant to Administrative Order 2024-04-30-02 and Footnote 2 of Rule 242, SCACR, no appendix is supplied. On information and belief, the documents will be obtained electronically by this Court.

Rehearing *En Banc* were filed by DMH and Mr. Carter on February 12, 2026. The petitions were denied by order of the Court of Appeals issued May 29, 2026. This Petition follows.[10]

ARGUMENT

1. **Has Mr. Carter's constitutional right to liberty been violated**?

DMH is Mr. Carter's custodian by virtue of several prior court orders, most recently, the order of Judge Kinlaw dated October 31, 2023. (ROA pp. 1-2) (". . . Defendant continue with inpatient treatment and be committed to the appropriate facility of SCDMH for further treatment.").[11] S.C. Code § 17-24-40(A) (". . . the trial judge must order the person who was the defendant committed. . .").

DMH is statutorily obligated to seek Mr. Carter's discharge from inpatient treatment when Mr. Carter is determined to no longer need inpatient hospitalization. S.C. Code §17-24-40(C)(2)(c)("If at a later date it is determined by officials . . . that the person is no longer in need of hospitalization, the officials must notify the chief administrative judge, the solicitor, the person and the person's attorney.").

The State has consistently resisted DMH's notifications, and has appeared and argued against the outpatient transfer proposed by DMH for Mr. Carter.[12]

---

[10] Mr. Carter and his counsel separately seek a Writ of Certiorari from the decision of the Court of Appeals as well. DMH incorporates by reference their separate Petition, which provides an illuminating view of the proceedings below.

[11] DMH had already determined that there was no "appropriate facility of SCDMH for further treatment" because outpatient treatment and monitoring was the appropriate venue. The October 1, 2023 was not a new "commitment" despite the language in the order on appeal.

[12] The State has never filed an objection to DMH's notifications that Mr. Carter no longer required inpatient treatment. However, in the case on appeal, the State did file a memorandum "in opposition" after the mandatory hearing was held before the circuit court. (ROA p. 404-420).

South Carolina has no case law construing the circumstances presented here.[13] However, this Court has recognized that "civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection." *Matter of Chapman*, 419 S.C. 172, 796 S.E.2d 843 (2017), citing *Addington v. Texas* 441 U.S. 418, 425, 99 S.Ct. 1804, 60 L.Ed.2d 323 (1979). This Court expressly stated that the right to counsel in such proceedings was "not merely a statutory right, but also a constitutional one arising under the Fourteenth Amendment and the South Carolina Constitution." *Id.* 419 S.C. at 180.[14]

During the hearing before the circuit court, Mr. Carter's counsel expressly argued that Mr. Carter's constitutional rights were being violated by continued inpatient commitment. (ROA p. 117). The circuit court did not address Mr. Carter's constitutional rights in its order. The Court of Appeals also did not address Mr. Carter's constitutional rights, even though the issue was briefed. (Appellant's final brief, Issue C, pp. 15-17). DMH's Petition for Rehearing *En Banc* also addressed this argument.[15] Mr. Carter's constitutional rights have not been addressed in these proceedings at all, despite being raised at every stage.[16]

Not only has this Court clearly addressed the issue of an individual's liberty interest in connection with civil commitment, there is no dispute as to Mr. Carter's legal status or the absence of any need for continued inpatient hospitalization. As discussed in more detail *infra*., the evidence

---

[13] The few published decisions in South Carolina involving a person that has been found not guilty by reason of insanity address distinct issues, and predate the current legislation. *See State v.* Huiett, 302 S.C. 169, 394 S.E.2d 486 (1990); State *v. Hudson*, 336 S.C. 237, 519 S.E.2d 577 (Ct.App. 1999).

[14] This Court's decision in Chapman analyzed the issue in the context of a sexually-violent predator's commitment pursuant to statute and cited U.S. Const. amend. XIV,§ 1 and S.C. Const. art I, §3, both of which guarantee liberty protections. The legal issue of civil commitment of Mr. Carter pursuant to S.C. Code §44-17-580 is identical.

[15] The pages of DMH's Petition for Rehearing *En Banc* are not numbered. The argument regarding the constitutional mandates appears on PDF pages 7-8 of the Petition.

[16] Post-hearing briefs at the circuit court by DMH and Mr. Carter argued these constitutional issues as well. (ROA p. 382; p. 395; p. 402). The solicitor filed a brief opposing the constitutional issues. (ROA p. 405-406).

is undisputed that Mr. Carter needs no further inpatient hospitalization and that further inpatient hospitalization provides Mr. Carter with "no benefit." (ROA p. 32, line 18 – p. 33, line 1). All of that has been ignored by the courts.

Continued inpatient hospitalization of an individual beyond the point that the inpatient hospitalization benefits that individual is unlawful. In *Foucha v. Louisiana*, 504 U.S. 71 (1992), the United States Supreme Court conducted a survey of many of its own cases involving persons subject to civil commitment, some involving criminal offenses and others purely civil in nature, and held "Due Process requires that the nature of commitment bear some reasonable relation to the purpose for which the individual is committed. 504 U.S. at 79. "There is no conceivable basis for distinguishing the commitment of a person who is nearing the end of a penal term from all other civil commitments." *Id.,* citing *Jackson v. Indiana,* 406 U.S. 715, 724 (1972).

"Freedom from bodily restraint has always been at the core of the liberty protected by the Due Process Clause from arbitrary government action." *Id. citing Youngblood v. Romeo*, 457 U.S. 307, 316 (1982). "We have always been careful not to 'minimize the importance and fundamental nature' of the individual's right to liberty." *Id.* 406 U.S. at 80,[17] *(citation omitted).*

There is generous body of case law from the United States Supreme Court that address the issues presented here, and if there is an exception to the holdings cited above, DMH has not found it. *See, e.g., O'Connor v. Donaldson*, 422 U.S. 563 (1975) (unconstitutional for a State to continue to confine a harmless, mentally ill person); *United States v. Salerno*, 481 U.S. 739, 746 (1987) (Due process contains a substantive component that bars certain arbitrary, wrongful government actions "regardless of the fairness of the procedures used to implement them."); *Schall v. Martin,*

[17] "No doctor or any other person testified positively that in his opinion Foucha would be a danger to the community, let alone gave the basis for such an opinion." *Foucha*, *supra.*, 504 U.S. at 82. The same is true of Mr. Carter.

467 U.S. 253 (1984). *See also Jones v. United States*, 463 U.S. 354, 368-370 (1983)("the acquitted is entitled to release when he has recovered his sanity or is no longer dangerous."); *Addington v. Texas*, *supra*. (to commit an individual to a mental institution in a civil proceeding, the State is required by the Due Process Clause to prove. . . that the person sought to be committed is mentally ill and that he requires hospitalization for his own welfare and the protection of others).

DMH respectfully seeks a writ of certiorari to address this issue in more detail.[18] Alternatively, as more fully discussed in Issue Three and Issue Four, DMH urges this Court to address the issues on appeal and reverse the circuit court summarily without additional briefing.

2. **The Court of Appeals erred in denying DMH's notification for transfer to outpatient treatment, when the evidence was undisputed that Mr. Carter is no longer in need of inpatient hospitalization.**

Per S.C. Code § 17-24-40(C)(2)(c), the only issue to be addressed when DMH notifies the circuit court that person committed has reached the stage for outpatient treatment is whether "the person [is] no longer in need of hospitalization."[19] No other considerations are permitted by statute, this Court's 2014 Administrative Order, or case law.

---

[18] Rule 242(d)(3) requires "a direct and concise argument in support of the petition." A thorough analysis of the relevant multiple United States Supreme Court opinions would be quite lengthy. There are also cases from other jurisdictions that have addressed the issues presented here. *See State v. DeAngelo*, 233 Conn.App. 764, 341 A.3d 960 (2025). DMH wishes to explore these cases with this Court in more detail, and seeks this Court's writ to do so.

[19] It appears that the failure of the applicable statutes to differentiate inpatient hospitalization from outpatient treatment (both of which are part of the civil commitment) have caused confusion by the courts throughout these proceedings. This Court's 2014 Administrative Order more clearly defines the different aspects of the commitment, but continues to use the term "release" without specifying whether it is a "release" of the commitment or a transfer to outpatient care. By way of example, Section B of the Administrative Order says a circuit court judge's order "may contain" a provision for immediate detention "until such time as a bed is available for *recommitment*. . ." (emphasis added). This again confuses the effect of the transfer from inpatient to outpatient hospitalization. The commitment continues at both stages. Clearly the 2014 Administrative Order was required to facilitate the cooperation of the various agencies, since the statutes are silent on that issue. However, it is respectfully asserted that this Court's reference to "recommitment" is an error and may compound the circuit court's understanding of this process.

"If the court's finding is that the person is not in need of continued hospitalization, it may order the person released upon such terms and conditions, if any. . . appropriate for the safety of the community and the well-being of the person." *Id.*

The undisputed evidence in the record was that Mr. Carter was no longer in need of [inpatient] hospitalization. The solicitor called no witnesses to dispute these facts, although he questioned DMH's witnesses whether they could "guarantee" Mr. Carter's future conduct. (ROA p. 41, lines 17-24; p. 102, line 23 – p. 103, line 18). This is discussed more in Issue Three.

Mr. Carter's treating psychiatrist testified:

> A. He's been psychiatrically stable since his admission. . .
> A. Mr. Carter is . . . on . . . self-administration of medication. . . since January of this year. . . he has not [refused medication]. . .
> A. Mr. Carter has good insight. . .
> Q. Do you believe Mr. Carter has sufficient insight with which to treat himself on an outpatient basis?
> A. I do. . .
> Q. Has [Mr. Carter] exhibited any of these signs you would be concerned about regarding harm to self or others?
> A. He has not.
> Q. Do you believe that he is likely to be a danger to himself or others if he's discharged under the terms of the current order?
> A. I think that he would be safe to be discharged under the current order under his current treatment regimen.

(ROA pp. 22, line 23 – p. 28, line 24).

A forensic expert was brought in to provide a "violence risk assessment" of Mr. Carter, which was not necessary or relevant to the outpatient plan. However, the assessment provided the circuit court with a standard by which to determine the appropriate conditions for the transfer to

outpatient treatment. (ROA p. 81, lines 12-21). After performing the evaluation, the forensic psychiatrist testified:

> A. It's 98 percent better. . . he has really good insight. . . and demonstrates a thorough knowledge of his illness, the reasons for the medications, the warning signs that he could be decompensating, the need for lifelong treatment, the need to avoid any drug use because it's likely to worsen his symptoms. He demonstrates very good insight. . . he's very remorseful. He can't believe what happened. . . and he certainly doesn't want anything like that to happen again. . . He's a very high functioning patient. And he doesn't display the sort of negative symptoms that a lot of patients with major mental illness have. . .

(ROA pp. – 88, line 11 - p, 97, line 18).

The treating psychiatrist testified that Mr. Carter's formal diagnosis is "schizoaffective disorder bipolar type" that is in "remission" which is "the same thing" as being "stable." (ROA p. 37, 8-14p. 41, line 15).

Despite the undisputed evidence, the circuit court erroneously ruled "the Defendant *(sic)*[20] is still in need of inpatient treatment. . . is mentally ill, needs involuntary treatment; and because of his condition lacks insight or capacity to make responsible decisions regarding treatment; and there is a likelihood of serious harm to himself or others." (ROA pp. 1-2). There is no evidence to support any of those findings.

The circuit court judge's determination was legal error. "If the court's finding is that the person is not in need of continued hospitalization, it may order the person released upon such terms

[20] It is respectfully asserted that Mr. Carter is not a "defendant" nor has he been for many years since his adjudication. Nonetheless, this error is compounded by the captioning of these proceedings as occurring in general sessions court, since these are civil proceedings.

and conditions, if any, as . . . the . . . judge considers appropriate for the safety of the community and the well-being of the person." S.C. Code §17-24-40(C)(2)(c). Moreover, "[a]ny terms and conditions . . . must be therapeutic in nature, not punitive." *Id*. §(C)(2)(d).

The statute does not give the circuit court judge the authority to ignore the undisputed testimony of experts, nor does it authorize the circuit court judge to err on the side of continuing inpatient hospitalization when it is not needed. *Id.* It seems the circuit court judge wanted "guarantees" about which the solicitor questioned the experts, but that is not the applicable standard. The Court of Appeals affirmed the circuit court's judge's "caution" which was based solely on facts that occurred while Mr. Carter was deeply psychotic, with both courts ignoring his current status. (COA op. p 7). The Court of Appeals gratuitously referenced the period of Mr. Carter's inpatient hospitalization as "short" which is completely irrelevant.

3. **The Court of Appeals erred in failing to address the issues raised on appeal**.

The Court of Appeals' opinion recited facts regarding the underlying offenses of which Mr. Carter was found not guilty by reason of insanity and events from his initial hospitalization in 2020. "Carter was nineteen years old . . . stabbed her in the neck. . . forcing open a glass door. . . regurgitating his prescribed psychiatric mediations" and "fifty separate occasions."[21] COA op. pp. 3-4.[22] However, The Court of Appeals failed to address any of the Issues on Appeal.

Instead, the Court of Appeals cited information pulled from medical records, none of which was proven by testimony, to recite events that occurred during the underlying events and when Mr.

[21] The record contains no evidence of this. This is a direct reference to the solicitor's argument, for which no competent evidence was introduced.

[22] "If the facts are against you, argue the law. If the law is against you, pound the table." Carl Sandburg https://www.goodreads.com/quotes/918291. *See also https://fordhaminstitute.org/national/commentary*.

Carter was first hospitalized, well before he had become psychiatrically stable and to rely on those facts to affirm the circuit court. (ROA pp. 408-409). These facts were irrelevant to the circuit court's consideration or to the issues raised on appeal. As discussed in Issue Two, the facts regarding Mr. Carter's readiness for transfer to outpatient treatment were undisputed.

By focusing its opinion on the facts of the irrelevant underlying events, the Court of Appeals ignored the facts proven at the circuit court hearing or the issues which were raised on appeal, concluding instead that the entire appeal could be disposed of on a "sufficiency of the evidence" or "abuse of discretion" standard.

An appellate court can affirm on any ground appearing in the record. Rule 220(c), SCACR. *See also Westbury v. Bauer*, 284 S.C. 385, 326 S.E.2d 151 (1985). DMH can find no law that allows an appellate court to base its opinion upon facts which are not proven in the in the proceeding below, nor can it locate any law addressing the error of an appellate court relying on unproven facts from noncompetent evidence in deciding an appeal.

It would serve no useful purpose and would unnecessarily delay this matter if this Court remanded the matter to the Court of Appeals to address the issues on appeal. Instead, it is respectfully suggested that this Court address the issues presented and rule that the proceedings require reversal on any of the grounds raised on appeal.

ISSUES ON APPEAL[23]

Per S.C. Code § 17-24-40(C)(2)(c), the only issue to be addressed then DMH notifies the circuit court that person committed has reached the state for a change in his status is whether

[23] These issues were fully briefed before the Court of Appeals. They are summarized here solely for the purpose of this Court expediting this proceeding with a grant of certiorari, dispending of briefing, and issuance of a decision that addresses the issues the Court of Appeals did not.

"the person [is] no longer in need of hospitalization." No other considerations are permitted by statute, this Court's 2014 Administrative Order, or case law.

"If the court's finding is that the person is not in need of continued hospitalization, it may order the person released upon such terms and conditions, if any. . . appropriate for the safety of the community and the well-being of the person." *Id.*

The undisputed evidence in the record was that Mr. Carter was no longer in need of [inpatient] hospitalization. *See* Issue Two.

The solicitor called no witnesses to dispute these facts, although he questioned DMH's witnesses whether they could "guarantee" Mr. Carter's future conduct. (ROA p. 41, lines 17-24; p. 102, line 23 – p. 103, line 18). The medical professionals were tolerant of the ridiculous questions.

> Q. "And were he to stop taking any of [medications], could you guarantee his current stability. . ."
> A. "Well, I can't guarantee anything."
> (ROA p. 41, lines 17-24).
> Q. ". . . can you guarantee with any medical certainty whether or not he will act out violently in the future?"
> A. "I can't guarantee whether <u>you</u> won't act out violently in the future. There's just no guarantee." . . .
> Q. ". . . you included in your report. . . you cannot predict or guarantee any –"
> A. "No doctor can do that. If you find one that says they can, I would want to challenge that."
> (ROA p. 102, line 24 – p. 103, line 18)(emphasis added).

The solicitor employed the same nonsensical questioning the first time Mr. Carter was the subject of an attempt to transfer his commitment to outpatient treatment. (ROA p. 148, lines 10-16; p. 203, lines 3-6).

The statute does not require any analysis which includes a prediction, and certainly not a guarantee, of whether a committed individual will engage in violence in the future. The statute is clear: the question is whether Mr. Carter needs continued [inpatient] hospitalization. S.C. Code §17-24-40.

The record was undisputed. *No one* testified Mr. Carter would benefit from further inpatient hospitalization.

Despite undisputed and uncontradicted evidence that transfer to outpatient treatment was the best move for Mr. Carter, the circuit court erroneously ruled "the Defendant *(sic)* is still in need of inpatient treatment. . . is mentally ill, needs involuntary treatment; and because of his condition lacks insight or capacity to make responsible decisions regarding treatment; and there is a likelihood of serious harm to himself or others." (ROA pp. ----). There is no evidence to support any of those facts. The facts affirmatively *dispute* these findings.

The State focused here and on appeal by criticizing the terms under which Mr. Carter would be transferred to outpatient treatment and repeatedly pointing to acts by Mr. Carter that occurred immediately upon hospitalization, while Mr. Carter was still mentally ill. (Final Brief of Respondent). There was, as noted, the ridiculous questions regarding a "guarantee" by professionals who testified.

The Code of Judicial Conduct requires that a "judge shall hear and decide matters assigned to the judge except those matters in which disqualification is required." Canon 3, (B)(1), Rule 501, SCACR.[24]

This Court reinforced that undisputed principle by administrative order issued June 4, 2026.

> [disqualification] . . . is a difficult, cumbersome procedure that should not be routinely invoked by a judge. . . . judges have a duty to "hear and decide matters assigned to the judge except in those matters in which disqualification is required. . .

Unnumbered Order amending Rule (*sic)* 3, Code of Judicial Conduct, Rule 501, South Carolina Appellate Court Rules, Appellate Case No. 2026-001047 (June 4, 2026).

There is no apparent reason why the judges of the Court of Appeals did address or decide the issues raised.[25] There is no explanation for why they did <u>not</u> address the issues on appeal. The unpublished opinion seems carefully crafted to dispose of the matter without addressing the specific issues presented on appeal, instead referencing irrelevant and unproven facts.

DMH recognizes that appeals are a "matter of grace." *Toomer v. Toomer*, 244 S.C. 399, 137 S.E.2d 406 (1964); *Horn v. Blackwell*, 212 S.C. 480 (1948). *See also Ralph v. McLaughin*, 432 S.C. 640, 856 S.E.2d 154 (2021) (the right of appeal arises from and is controlled by statute).

"A State may decide whether to have direct appeals. . . and if so under what circumstances. . ." *Carter v. Illinois*, 329 U.S. 173, 175-76 (1946). "It is wholly within the discretion of the State

---

[24] DMH certainly recognizes that issue preservation and other procedural mechanics applicable to appeal can result in the appellate court not addressing the issues argued. However, where no procedural defaults prevent the appellate court from addressing the issues presented, it is respectfully submitted that the issues should be addressed.

[25] Indeed, the Court of Appeals ostensibly addressed the merits of the appeal (even though the court did not state what those issues were), despite noting that "neither Carter nor DMH filed a motion to alter or amend the judgement." (COA op. p. 7). DMH again notes the inexplicable treatment of this case as a general sessions matter, even though the applicable statute, S.C. Code §17-24-40, incorporates Section 44-17-570, which is clearly a civil matter.

to allow or not to allow such a review." *McKane v. Durston*, 153 U.S. 684, 687 (1894). When a state does allow appellate review, it may not condition the privilege as to deny it irrationally to some persons. *Griffin v. Illinois*, 351 U.S. 12 (1956) (discussing Due Process and Equal Protection implication of denying appellate review to indigents).

The original order of commitment of Mr. Carter to DMH did not recite any facts other than the "not guilty by reason of insanity" verdict and the nature of the original criminal charges. (ROA pp. 3-6).

Two indictments of which Mr. Carter was found not guilty by reason of insanity do appear in the record, but the recitation of facts in each is minimal. One of the indictments alleges that an identified person was killed ". . .by means of stab wounds to the neck" and states the defendant charged did "possess or visibly display a sharp ended weapon during the commission or attempted commission of a violent crime. . ." (ROA p. 264). A second indictment alleges ". . . unlawful enter the dwelling . . . located at . . . with the intent to commit a crime. . . accompanied by circumstances of aggravation. . . physical injury to a person inside and/or the entry occurred during the night time hours." (ROA p. 266). None of these allegations were proved in this or any prior proceeding. Instead, as the solicitor did, the Court of Appeals recycled old facts that were not proven.

During the circuit court hearing on DMH's notification that Mr. Carter was now ready for outpatient treatment, there was colloquy when the circuit court judge inquired "a little bit about the family relationship." (ROA p. 118, lines 18-20). The victim was described as Mr. Carter's "great aunt on his paternal side" but there was no testimony on that point. (ROA p. 118, lines 23-25). Counsel introduced several members of Mr. Carter's family to the circuit court judge. (ROA p. 119, line 22 – p. 124 line 15). Several of the decedent's "representatives of the victim's family"

were present and made brief statements, but relatively few facts were provided. (ROA p. 107, lines 15-16). One witness was sworn and testified the decedent was "the matriarch of our family." (ROA p. 108, lines 9-22).

Following the hearing before the circuit court, the solicitor submitted a memorandum which includes references to documents that were not introduced into the record nor were they attributed to any filed document. (ROA pp. 404-420)

The Record on Appeal contains a "Designated Examiner's Report of Findings" in its current request to transfer Mr. Carter to outpatient care. (ROA pp. 366-371). The report contains a two-page "psychiatric history" with an undocumented recitation of Mr. Carter's initial hospitalization, which contains quotation marks but provides no attribution. Some of the facts in the Court of Appeals' opinion appear to come from this "psychiatric history" but certainly not all.

The "psychiatric history" is not sworn testimony nor is it supported by any competent factual information in the record. "A doctor's testimony as to history. . .should never be used as a tool to prove facts properly provided by other witnesses." *State* v. *Simmons,* 423 S.C. 552,564, 816 S.E.2d 566, 572 (2018). This point was previously discussed by this Court in *State v. Brown*, 286 S.C. 445, 447, 334 S.E.2d 816, 817 (1985). "The doctor's testimony should never be used as a tool to prove facts properly provided by other witnesses." *Id-*.

If the history in the doctor's "psychiatric history" is the source used by the Court of Appeals to recite "facts," it is clearly not competent or admissible evidence. However, it must be since there are relatively few facts in the actual record of the case, and virtually none in the existing court orders.[26]

[26] The Record on Appeals also includes what appear to be jail records documenting dates on which Mr. Carter did or did not take medication. (ROA pp. 307-335). These records were <u>not</u> introduced at the trial below. (Exhibit list ROA p. 16). These records were designated by the Attorney General for inclusion in the Record on Appeal improperly,

State's Exhibit No. 1 (ROA pp. 271-274)[27] in in the Record on Appeal. These are records from a psychiatric hospital when Mr. Carter was initially arrested for criminal charges and document events during the first weeks of his jail detention and initial inpatient hospitalization. While Mr. Carter's treating psychiatrist was asked if she was familiar with records stating that Mr. Carter had refused medication early in his hospitalization, she recalled the solicitor had "made that point" in a prior hearing, but she did not authenticate the records. (ROA p. 40, lines 3-7).

This Court has stated that "it is error for the Court of Appeals to rely on [a] recitation of facts contained in an appellate order, instead of restricting itself to the facts contained in the magistrate's return." *State v.* Osborne, 335 S.C. 172, 516 S.E.2d 201 (1999).[28] While not directly on point, it is apparent that the Court of Appeals has to rely on evidentiary materials to recite the facts in its decision, and it did not do so.

---

since they were not introduced at the trial level. (Designations by State filed August 28, 2024). Rule 209(b), SCACR (". . . the Designation may only propose to include . . . exhibits. . . which may properly be included in the Record on Appeal"); Rule 210(c), SCACR ("The Record shall not. . . include matter which was not presented to the lower court."). Neither DMH nor Mr. Carter objected to the inclusion of these records, but it is inescapable the Court of Appeals accepted these records as evidence upon which is relied. "Given his history of . . . medication noncompliance, we find no error. . ." (Op. p. 8). Since no one testified about these records or authenticated them, the Court of Appeals reference to this fact is not supported by the record.

[27] Page 1 of State's Exhibit No. 1 starts in the middle of a sentence, so it is obviously not complete. (ROA p. 271). The bulk of it is a medical report from a psychiatric hospital for July 21, 2020 which contains a history of events during hospitalization before concluding that Mr. Carter "may be safely managed on an outpatient basis." (ROA p. 272). The recitation references "several elopement attempts and two successful elopements" following Mr. Carter's initial admission in July 2020. (ROA p. 273). This exhibit was introduced by the solicitor but was not authenticated by anyone. The Record on Appeal reflects the exhibit was introduced between witnesses. (ROA p. 78, lines 21-22). To the extent the Court of Appeals pulled facts from this unauthenticated medical record, it also has no evidentiary value.

[28] In *Osborne*, the circuit court was sitting as an appellate court on appeal from a decision from magistrate's court. This court cited *State v. Barbare*, 280 S.C. 328, 313 S.E.2d 297 (1984) for the proposition that the magistrate's return is the official record of trial proceedings. Similarly, in the instant case, nothing in the unauthenticated medical history or the solicitor's references to documents outside the trial court record were properly used by the Court of Appeals to recite the facts of this case. Counsel has not attempted to locate possible sources for each factual statement set forth in the Court of Appeals' opinion, should the writ be granted, a line-by-line analysis can be provided to show the absence of factual support in the trial court record for the facts set forth in the opinion. *See* Footnote 14. Counsel has attempted here to point out possible sources where *some* of the facts may have been found, and none of them are evidentiary facts.

While the Court of Appeals' opinion is unpublished, DMH asserts that the consideration (and recitation) of facts from outside the record in an appellate opinion is a substantive and substantial defect that must be addressed for future application by the appellate courts.

DMH respectfully asserts that, when an appellant has properly complied with the statutes and rules governing appellate practice, an appellate court cannot arbitrarily look away and affirm by ignoring the issues properly presented on appeal. It is respectfully requested that this Court grant the petition, dispense with briefing, and reverse the circuit court. *Allen v. South Carolina Department of Corrections*, 439 S.C. 164, 886 S.E.2d 671 (2023); *Halsey v. Simmons*, 432 S.C. 54, 849 S.E.2d 578 (2020).

4. **The Court of Appeals erred in failing to reverse the trial court when the evidence was undisputed that Mr. Carter is no longer in need of inpatient hospitalization**.[29]

Pursuant to statute, as well as the guidelines in this Court's 2014 Administrative Order, the only issue to be determined after DMH determines that an adjudicated individual should be transitioned into outpatient treatment is whether the adjudicated individual is "in need of continued hospitalization." S.C. Code § 17-24-40(C)(2)(c). "The Chief Administrative Judge . . . must hold a hearing to determine if the person is in need of continued hospitalization." That is the only determination to be made. This Court's 2014 Administrative Order echoes this standard.[30]

As repeatedly argued, the only evidence in the record is that Mr. Carter was not in need of continued inpatient hospitalization. The solicitor spent considerable time arguing that the out-

[29] Issue Four is inextricably a part of Issue Three as well, since this issue was not addressed by the Court of Appeals, and Issue Three asks this Court to decide the issues on appeal.

[30] This Court's 2014 Administrative Order cites the standard as "if hospital officials . . . believe that he is no longer in need of hospitalization *and is capable of being released to a less restrictive treatment environment. . .".* The statutes do not include the italicized language from the 2014 Administrative Order, but perhaps it follows that the second standard is a natural corollary of the first. It appears this Court understands that transfer to outpatient care continues "treatment" unlike the circuit court in the instant matter, which seemed to believe (as did the Court of Appeals) that the transfer to outpatient treatment somehow terminated the "commitment."

patient plan for Mr. Carter was somehow deficient, that DMH had not made sufficient arrangements for continued treatment during the out-patient phase of the commitment, and that there was no "guarantee" that Mr. Carter would not suffer another mental health emergency. *See* Issues Two and Three. Those issues are not what the circuit court judge is supposed to determine.

Unfortunately, despite uncontradicted evidence in the record that Mr. Carter's transition to outpatient treatment was medically appropriate to continue the therapeutic commitment, the circuit court judge made the determination that Mr. Carter "is still in need of inpatient treatment." (ROA p. 1). No evidence in the record supports that determination and it is contrary to the entirety of this record.

The circuit court judge further ruled, despite uncontradicted evidence to the contrary, that Mr. Carter "is mentally ill; needs involuntary treatment; and because of his condition lacks insight or capacity to make responsible decisions regarding treatment; and there is a likelihood of serious harm to himself of others." (ROA pp. 1-2). No evidence in the record supports any of those findings. The evidence establishes exactly the opposite.

CONCLUSION

It is respectfully submitted that the Court of Appeals erred in multiple respects, and this Court is urged to grant the petition, dispense with further briefing, and reverse the circuit court.

It does appear that the sloppiness of the statutes, and the failure of existing guidance to differentiate between inpatient hospitalization and outpatient commitment/treatment, it would be incredibly helpful to update the 2014 Administrative Order to address the omissions of the statutes. The Courts appear confused, and persons like Mr. Carter suffer as a result.

Having fully set forth DMH's ultimate wish list, DMH respectfully urges this Court, at a minimum, to remedy the wrongs to which Mr. Carter has been subjected. Clarification of the law is encouraged, but it is respectfully understood that this matter landed on this Court's doorstep in a request for discretionary review only. DMH recognizes the limits imposed upon appellate courts as "well-behaved children. . ." (in the unforgettable words of the mythical retired Chief Judge Alex Sanders). DMH can't help but urge that this Court is the only forum in which guidance on these vitally important issues can be provided. *Thompson v. Killian*, 447 S.C. 177, 924 S.E.2d 606 (2026), citing *Langley v. Boyer*, 284 S.C. 162, 325 S.E.2d 550, 561 (Ct.App. 1984). Administrative Orders are the Holy Grail for which no appellate prompt is required.

Wherefore, DMH respectfully requests that the petition be granted and requests that the Court dispense with further briefing reverse the Court of Appeals and remand the matter to the circuit court to properly apply the mandatory standard to these proceedings.

Respectfully submitted,

s/ Desa Ballard

Desa Ballard (S.C. Bar No. 498)
BALLARD & WATSON
226 State Street
West Columbia, South Carolina 29169
Telephone 803.796.9299
desab@desaballard.com
ATTORNEY FOR PETITIONER

June 26, 2026