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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM GREENVILLE COUNTY
General Sessions

Alex Kinlaw, Jr., Presiding Judge, 13th Circ.

Appellate Case No. 2023-001766

Ex Parte: South Carolina Department of Mental Health....Appellant-Respondent,

In re:

The State.....Respondent,

v.

Jevon Kenneth Carter.....Respondent-Appellant.

RECORD ON APPEAL

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF GENERAL SESSIONS
	)	THIRTEENTH JUDICIAL CIRCUIT
COUNTY OF GREENVILLE	)	
	)	
The State of South Carolina,	)	INDICTMENT # 2021GS2305230, -5231
	)	
vs.	)	**ORDER FOR CONTINUED INPATIENT TREATMENT**
	)	
JEVON KENNETH CARTER, Defendant.	)	
	)	

FILED
23 OCT 31 PM 4:15
GREENVILLE COUNTY, SC

This matter was before the court on August 30, 2023, to determine the manner of treatment pursuant to SC Code §17-24-40(c)(1) after the Defendant was found Not Guilty by Reason of Insanity of Voluntary Manslaughter, Burglary in the 1st Degree and Possession of a Weapon During a Violent Crime. The South Carolina Department of Mental Health (SCDMH) submitted a Request for Discharge pursuant to §17-24-40(B) and proposed outpatient plan for Defendant's discharge on July 7, 2023. At the hearing SCDMH was represented by Logan Royals. The Defendant was present with his attorney, D. Josev Brewer, and the State was represented by Assistant Solicitor Andrew Miller.

In making its determination, the Court has reviewed and considered the Briefs and Memoranda submitted by the parties, arguments made at the hearing, the Violence Risk Assessment and other supporting documentation submitted at both the August 30 2023 and the December 8, 2022 hearing, the Courts previous orders in this case, and the testimonies of Dr. Jennifer Alleyne and Dr. Richard Frierson.

Based on this review, the Court finds by clear and convincing evidence that the Defendant is still in need of inpatient treatment pursuant to the standard of §44-17-580(A). The Court finds that the Defendant 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. Therefore, the Court orders that Defendant continue with inpatient treatment and be committed to the appropriate facility of SCDMH for further treatment.

IT IS SO ORDERED.

Alex Kinlaw Jr.
Presiding Judge, 13th Circuit

Date: 10/3/23
Greenville, South Carolina

Initial General Sessions Order following bench trial
Finding Defendant Not Guilty by Reason of Insanity
§17-24-40(A)

22 JUN 13 AM 9:28
GREENVILLE COUNTY SC

STATE OF SOUTH CAROLINA **COUNTY OF GREENVILLE**	**IN THE COURT OF GENERAL SESSIONS** Indictment No(s): **2021GS2305230, -5231** Warrant No(s): **2020A2320602678, -2679, -2680**
The State of South Carolina, vs.	**FINDING OF NOT GUILTY BY REASON OF INSANITY** **INITIAL ORDER OF COMMITMENT FOR PERIOD NOT TO EXCEED 120 DAYS**
Jevon Kenneth Carter Defendant.	

This matter comes before me for trial on June 8, 2022. The Defendant is charged with Murder, Possession of a Weapon during a Violent Crime, and Burglary, First Degree. The State is represented by Assistant Solicitor Andrew Miller, and Defendant is represented by D. Josev Brewer. Both prosecution and defense waived a jury trial pursuant to Rule 14 of the South Carolina Rules of Criminal Procedure, and proceeded with a bench trial.

Pursuant to a previous Order from this Court, the South Carolina Department of Mental Health (hereafter, SCDMH) evaluated Defendant's criminal responsibility and capacity to conform conduct to the requirements of the law on or about July 5, 2020 pursuant to S.C. Code Ann. § 17-24-10 (1976) and M'Naughten. In the evaluation report, the SCDMH examiners found that Defendant, at the time of the commission of the acts charged, as a result of mental disease or defect, lacked the capacity to distinguish moral or legal right from moral or legal wrong, or to recognize the particular acts charged as morally or legally wrong. Without objection, this report was entered into evidence, and a copy of the report is attached hereto.

PHC

The State and Defense put forth a stipulation of facts along with exhibits and an affidavit from witnesses. This Court finds 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 as to indictment 2021-GS-23-5230, and Burglary, 1st Degree as to indictment 2021-GS-23-5231.

In addition to her report, as described above, the Court heard the uncontested testimony of Dr. Stephanie Le, a supervising physician for the SCDMH, who further explained the reasons for the report's conclusion that Defendant lacked criminal responsibility for the offenses charged. The Court also reviewed medical records of the Defendant from Marshall Pickens Hospital dating from the relevant time period. The State and the Defendant both consent to a finding of Not Guilty By Reason of Insanity for the offenses charged and any lesser included charges.

After reviewing all the evidence, including numerous exhibits and testimony of Dr. Le, I find that at the time of the commission of the alleged offense, the Defendant, as a result of mental disease or defect, did not have the capacity to distinguish moral or legal right from moral or legal wrong.

THEREFORE IT IS ORDERED that the Defendant is found Not Guilty by reason of insanity of Voluntary Manslaughter and Possession of a Weapon During a Violent Crime as to indictment 2021-G-S23-5230 and Burglary, 1st Degree as to indictment 2021-GS-23-5231.

IT IS FURTHER ORDERED, pursuant to S.C. Code Ann. §17-24-40, Defendant is hereby committed to a facility designated by SCDMH for a period of hospitalization not to exceed 120 days. During that time, SCDMH shall examine Defendant to determine Defendant's need for continued hospitalization, and provide such treatment as is beneficial

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and necessary, pursuant to the standards set forth in S.C. Code Ann. §44-17-580. SCDMH shall make a report of its findings to the Chief Administrative Judge of this judicial circuit, the Clerk of Court (for filing), the Defendant's attorney, and the Solicitor. Thereafter, the Chief Administrative Judge shall conduct a hearing to determine Defendant's ongoing custody status.

IT IS FURTHER ORDERED that the Defendant shall be immediately taken into custody by the Sheriff, and the Sheriff's office is hereby authorized and required to transport defendant to the facility designated by SCDMH following confirmation that a bed is available.

FILING, SERVICE, AND TRANSMITTAL OF THIS ORDER. It is the responsibility of the Solicitor to file and serve this order as outlined herein. After being signed by the Court, the original order must be immediately filed with the Clerk of Court and a certified copy served upon the opposing party. Further, **within five (5) business days**, a certified copy of this order must be served upon the examining agency at the address listed below. To expedite the agency's ability to implement this order and prepare for legal proceedings, the Solicitor is instructed to immediately contact the examining agency to advise of the issuance of this order and forthcoming service upon the agency:

Information for Service of Order on Agency

Department of Mental Health

Forensic Evaluation Service Paralegal
S.C. Department of Mental Health
CBHS Forensic Center
7901 Farrow Road
Columbia, SC 29203-3220
(803)935-5540 (Phone)
(803)935-5544 (Fax)
Email: *FES-PARALEGAL@SCDMH.ORG*

3

IT IS SO ORDERED.

Date: June 13, 2022

Perry H. Gravely,
Presiding Judge, 13th Judicial Circuit

Assistant Solicitor:
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STATE OF SOUTH CAROLINA	)	IN THE COURT OF GENERAL SESSIONS
	)	THIRTEENTH JUDICIAL CIRCUIT
COUNTY OF GREENVILLE	)	
	)	
The State of South Carolina,	)	**ORDER FOR INPATIENT TREATMENT**
	)	
vs.	)	Indictment No. 2021GS2305230-31
	)	
Jevon Kenneth Carter	)	Case No. 2020A2320602678-2680
	)	
Defendant.	)	

This matter was before the Court on December 8, 2022 to determine whether Defendant Jevon Kenneth Carter should be released pursuant to S.C. Code §17-24-40(c)(1) after being found Not Guilty by Reason of Insanity for Voluntary Manslaughter, Burglary in 1st Degree and Possession of a Weapon During a Violent Crime. The South Carolina Department of Mental Health (SCDMH) submitted a proposed treatment plan which recommended that Defendant be released from SCDMH and pursue outpatient treatment under certain conditions.

Defendant was found not guilty of the referenced charges by Order of this Court on June 13, 2022 and pursuant to the Order and S.C. Code §17-24-40, was admitted to SCDMH for inpatient care "for a period not to exceed one hundred twenty days" on August 16, 2022 and has been in the custody and care of SCDMH since his admission. On November 10, 2022, SCDMH submitted a Request for Discharge pursuant to §17-24-40(B) indicating that Defendant is no longer in need of inpatient treatment under the standards of S.C. Code §44-17-580 and submitted an outpatient plan for Defendant's release. The hearing held on December 8, 2022 addressed these issues.

At the hearing, Logan Royals represented SCDMH, Josev Brewer represented Defendant and Assistant Solicitor Andrew Miller represented the State.

In making its determination, the Court has reviewed and considered Briefs/Memoranda submitted by all 3 parties, Designated Examiner's Report (11/4/22), Criminal Responsibility and Conform report (10/4/21), arguments at the hearing and the testimony of Dr. Jennifer Alleyne as treating psychiatrist.

Based on this review and the findings set forth below, the Court finds by clear and convincing evidence that the Defendant is still in need of inpatient treatment and a more adequate transitional plan for release into society and outpatient treatment.

The relevant statutes for the Court to consider in rendering its decision are as follows:

1) §17-24-40 (C)(1) provides that after SCDMH submits a report that no further hospitalization is needed, the Court must hold a hearing "to decide whether the person should be hospitalized pursuant to the standard of Section 44-17-580." Further, this section states:

> "(a) if the Chief Administrative Judge finds the person not to be in need of hospitalization, the judge may order the person released upon such terms or conditions, if any, as the judge considers appropriate for the safety of the community and the well-being of the person.
> (b) In the event the chief administrative judge finds the person to be in need of hospitalization, the judge must order the person committed to the South Carolina State Hospital." §17-24-40 (C).

2) §44-17-580(A) provides as follows:

> "If, upon completion of the hearing and consideration of the record, the court finds upon clear and convincing evidence that the person is mentally ill, needs involuntary treatment and because of his condition:
> (1) lacks sufficient insight or capacity to make responsible decision with respect to his treatment; or
> (2) there is a likelihood of serious harm to himself or others, the court shall order in-patient treatment at a mental health facility, public or private, designated by the Department of Mental Health and may order out-patient treatment following in-patient treatment. If the court finds that the person is not mentally ill and not in need of involuntary treatment the court shall dismiss the proceedings."

Even though SCDMH has asserted that Defendant is no longer in need of inpatient treatment, the Court finds that SCDMH has not provided sufficient evidence for Defendant to be released and transferred to outpatient treatment. SCDMH has not proposed an appropriate care plan based on the Defendant lacking sufficient insight or capacity to make responsible decisions with respect to his treatment and the likelihood of serious harm to himself or others.

The Court's decision is based on the following factors:

1) SCDMH's recommendation for Defendant's release was rendered after the Defendant had been housed at SCDMH for only 80 days and received limited counseling and evaluation from the treating psychiatrist. (Defendant entered custody of SCDMH on August 16, 2022 and the report was issued on November 4, 2022.).

2) The medical history of this Defendant shows numerous occasions when Defendant failed to take his medication during his commitment and resulted in 2 separate incidents of escape from a mental institution and the commission of a violent crime during one of his "elopements".

3) The Defendant's statements just prior to being transferred to SCDMH custody causes concern when he stated that "I'm going to Columbia for four to six months and then I will get out… I will [comply]. I want to get out." This could be interpreted as the Defendant's awareness of how to "play the system".

4) As Dr. Alleyne testified, the compliance with directives for medication was a crucial part of the Defendant's success in his outpatient treatment. As stated in SCDMH's report, taking prescribed medication "is necessary to maintain stability". The Defendant's recent history does not support Defendant's ability or desire to comply with taking his medication as prescribed. In the six months immediately prior to his commitment to SCDMH, February 2022 to July 2022,

Defendant refused or failed to take medication on 50 separate occasions. These refusals were during a period where he was being monitored by jail personnel. And four months later, SCDMH asserts that he is responsible enough to take his medication as prescribed to "maintain stability".

5) The environment where the Defendant will be placed does not appear to be a stable environment with the structure needed for his compliance with the treatment program and continued progress. Defendant's mother, with whom Defendant will reside, has failed in the past to properly supervise Defendant and his medication compliance and, as noted in the report and testimony of Dr. Alleyne, she suffers from significant mental health issues herself along with recent problems with illegal substances. The recommendation from SCDMH requires that Defendant not associate with felons, although residing with his mother will violate this directive of the treatment plan and proposed Order.

If the Defendant should fail to take his medication, based on his history and the evidence presented, the consequences could be severe and could result in violence as shown by his prior killing of his great aunt without any apparent motive.

The Court finds, upon clear and convincing evidence, that Defendant lacks sufficient insight or capacity to make reasonable decisions with respect to his treatment and that there is a likelihood of harm to himself or others. Therefore, the Court orders that Defendant continue with inpatient treatment and be committed to the appropriate facility of SCDMH for further treatment. If SCDMH determines that Defendant should be released at some point in the future, then a more appropriate treatment plan regarding supervision of Defendant will need to be provided, including the consideration of transitional housing and a more stable environment with appropriate monitoring and supervision.

It is Ordered.

January 9, 2023

Perry H. Gravely
Presiding Judge, 13th Circuit

Greenville, S.C.

STATE OF SOUTH CAROLINA COUNTY OF GREENVILLE The State of South Carolina, vs. Jevon Kenneth Carter, Defendant.	IN THE COURT OF GENERAL SESSIONS THIRTEENTH JUDICIAL CIRCUIT Indictment No(s).: 2021-GS-23-05230, -5231 Case No.: 2020A2320602678-80 **ORDER**

'24 MAY 8 AM 9:14
Brice Garrett COC GVL SC

This matter comes before the Court upon the State's Motion to Stay the requested discharge hearing scheduled for May 8, 2024 based on the appeal of the previous Order for Continued Inpatient Treatment. This issue was briefed by both parties and counsel were consulted in a phone conference on May 7, 2024.

On October 31, 2023, Judge Alex Kinlaw, Jr. issued an Order for Continued Treatment of Defendant based on the hearing held on August 30, 2023. In the Order, Judge Kinlaw found "by clear and convincing evidence that the Defendant is still in need of inpatient treatment pursuant to the standard of S.C. Code Ann. §44-17-580(A) [and] is mentally ill; need 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 other." On November 13, 2023, Judge Kinlaw's Order was appealed by the Defendant and the South Carolina Department of Mental Health (SCDMH).

On April 5, 2024, SCDMH submitted a request for a hearing on the same matter to determine if Defendant should be discharged. The State now raises the issue that this Court does not have jurisdiction to hear this new request because of the pending Appeal of the previous Order. Rule 205, SCACR, states that "upon the service of the notice of appeal, the appellate

court shall have exclusive jurisdiction over the appeal [but] nothing in these Rules shall prohibit the lower court. . . from proceeding with matters not affected by the appeal."

In support of its request, SCDMH attached a "Designated Examiner's Report of Findings- Request for Discharge" issued March 15, 2024. Even though this report has been updated from previous reports submitted to the Court and contains a new recommended treatment plan, there is no new information or findings as it relates to the specific findings in Judge Kinlaw's Order of October 31, 2023. The matter before this Court could be affected by the ruling of the Appellate Court. If the Court of Appeals affirms the findings of Judge Kinlaw, then it could support a similar finding by this Court, if the evidence supported such a ruling. Also, if the Court of Appeals reverses Judge Kinlaw's Order based on the required standard then it would seemingly dictate the ruling of this Court or render the issue moot.

This Court finds that the Appeal of the previous Order stays any further proceedings in this matter. The Court is aware of the requirements of S.C. Code Ann. §17-24-40(C) and the rights afforded to the Defendant in this matter, but the Court finds that it does not have appropriate jurisdiction to address those issues at this time.

Therefore, the State's Motion to Stay is granted until further direction is provided by the Court of Appeals.

IT IS SO ORDERED.

Perry H. Gravely
Chief Administrative Judge-General Sessions
Thirteenth Judicial Circuit

May 7, 2024

Pickens, South Carolina

STATE OF SOUTH CAROLINA	)	
	)	COURT OF GENERAL SESSIONS
COUNTY OF GREENVILLE	)	2021-GS-23-05230
	)	
	)	
	)	
	)	
	)	
STATE OF SOUTH CAROLINA,	)	
	)	
	)	
vs.	)	TRANSCRIPT OF RECORD
	)	
JEVON KENNETH CARTER,	)	
DEFENDANT1.	)	
_____	)	

August 30, 2023
Greenville, South Carolina

B E F O R E:

THE HONORABLE ALEX KINLAW, JR., JUDGE.

A P P E A R A N C E S:

ANDREW P. MILLER, ESQ.
Assistant Solicitor

D. JOSEV BREWER, ESQ.
Attorney for the Defendant

LOGAN Y. ROYALS, ESQ.
Attorney for the Department of Mental Health

HOLLIE M. JENKINS
Circuit Court Reporter

I N D E X

(DMH) - Denotes Department of Mental Health Witness

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All Exhibits were retained by the Clerk of Court for Greenville County.

P R O C E E D I N G S

THE COURT: This is in the interest of the State of South Carolina vs. Jevon Kenneth Carter.

Is that you, Mr. Carter?

DEFENDANT CARTER: Yes, sir.

THE COURT: How are you doing today?

DEFENDANT CARTER: I'm great.

How about you?

THE COURT: Good, good. I'm doing well, doing well.

This -- this is indictment number 2021-GS-23-05230.

And the case number, which I'll put on the record as well is 202823060267880.

I'm going to let counsel introduce themselves.

Representing the State is who?

MR. MILLER: Andrew Miller, Your Honor.

THE COURT: Andrew Miller and his -- Ms. Harrison.

MS. HARRISON: Yes, sir.

THE COURT: Sylvia Harrison.

Also, on the -- and Mr. Carter.

MR. BREWER: May it please the Court, Your Honor.

Joe Brewer. I'm Mr. Carter's defense counsel.

THE COURT: All right. And go ahead.

MR. ROYALS: And, Your Honor, I'm Logan Royals for the Department of Mental Health.

THE COURT: Okay. Is it Broils?

MR. ROYALS: Royals like the baseball team, Your Honor.

THE COURT: Royals. Logan is your first name?

MR. ROYALS: Yes, sir. Sorry. North Carolina drawl gets in the way sometimes.

THE COURT: That's all right.

And, Mr. Brewer, what's your first name?

MR. BREWER: Joe.

THE COURT: Joe Brewer.

All right. Any preliminary matters, counsel, before we get started? Anything?

MR. BREWER: Your Honor, one housekeeping matter. I had filed on Friday a motion to exclude that I had sent to Your Honor and to the solicitor's office. And just -- just so that that part is cleared up, I'm withdrawing that motion to exclude and clear anybody from the courtroom at this time.

THE COURT: All right. And I think you guys received that.

So that motion is withdrawn; is that right, Mr. Brewer?

MR. BREWER: Yes, Your Honor.

THE COURT: All right. Anything other than that before we get started?

MR. ROYALS: I don't believe so, Your Honor.

MR. MILLER: Nothing from the State, Your Honor.

THE COURT: All right. You can call your first witness.

MR. ROYALS: Thank you, Your Honor.

The Department of Mental Health calls Dr. Jennifer Alleyne.

THE COURT: And I did not get into about how we got here. I think it's pretty evident by the pleadings how we got here, so.

MR. ROYALS: Yes, Your Honor.

THE COURT: Raise your right hand.

WHEREUPON,

JENNIFER ALLEYNE, M.D.,

after first having been duly sworn, testified as follows:

THE COURT: All right. Have a seat there.

And the bailiff will put that microphone in close proximity to you.

And keep your voice up so everybody can hear you.

All right. Mr. Royals.

MR. ROYALS: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. ROYALS:

Q Dr. Alleyne, for the benefit of the court reporter, will you, please, spell your name?

A Yes. Jennifer Alleyne, J-E-N-N-I-F-E-R,

A-L-L-E-Y-N-E.

Q Thank you, Doctor.

Would you mind telling us a little bit about your education as it pertains to psychiatry?

A Yes. I obtained a Bachelor of Science in Psychology from the University of Connecticut in 2006. I obtained a medical doctorate from Ross University School of Medicine in 2010. I attended the University of Louisville in Kentucky for my general psychiatry residency program graduating in 2015. And I attended the University of South Carolina in Columbia, South Carolina, for my forensic fellowship graduating in 2016.

Q Thank you, Doctor.

And where have you worked as a psychiatrist?

A I have been employed by the Department of Mental Health for the State of South Carolina since graduating in 2016.

Q And are you a member of any professional organizations?

A I belong to the South Carolina Psychiatric Association, the American Psychiatric Association, and the American Academy of Psychiatry and the Law, also, known as APPLE.

MR. ROYALS: Thank you.

Your Honor, I would move to have Dr. Alleyne

qualified as an expert in the field of forensic psychiatry.

THE COURT: Any objection from the State?

MR. MILLER: No, Your Honor.

THE COURT: All right. She's so qualified in that designated field.

MR. ROYALS: Thank you, Your Honor.

BY MR. ROYALS:

Q Dr. Alleyne, how do you know Mr. Carter?

A I am his treating psychiatrist.

Q And when you're a treating psychiatrist, how often do you, typically, see a patient like Mr. Carter?

A We see them once a week for their first eight weeks in the hospital. We see them once a month thereafter for what we call a treatment team meeting.

And then we see them in passing in the hallways. We see them for interim meetings if they have concerns, questions, if there was some kind of behavioral issue, if we needed to make medication adjustments.

Q And for approximately how long have you been Mr. Carter's treating psychiatrist?

A For just over a year.

Q Okay. What is your role at the forensic hospital?

A I am the chief psychiatrist for the forensic hospital.

Q Based on your treating Mr. Carter, are you familiar with his treatment and diagnosis?
A Yes.
Q To your knowledge, what is Mr. Carter's diagnosis?
A He's diagnosed with schizoaffective disorder, bipolar type.
Q You're speaking to someone who's never been to med school. And what does that entail?
A So schizoaffective disorder is a mental illness which entails what we consider psychotic symptoms in addition to mood symptoms.

So in Mr. Carter's case, he's experienced things like decreased need for sleep. He has experienced increased energy, disorganized thoughts, grandiose beliefs that are not in touch with reality. We would call those delusions. He's, also, experienced auditory hallucinations and what we would consider ideas of reference, such as giving special meaning to something that other people wouldn't. In his case, it was numbers.

Q And when you are -- when you are understanding schizoaffective disorder and you talk about ideas of reference, hallucinations, has he endorsed any of those since he's been under your treatment?
A He's been psychiatrically stable since his admission.
Q Understood. As far as schizoaffective disorder,

bipolar type, how is that, typically, treated?

A We treat it with antipsychotic medications and mood stabilizing medications.

Q For Mr. Carter, in particular, would you mind telling us what medication you prescribe to him, what he's currently taking?

A Yes. He is taking a medication called Abilify Aristada. It's a long-acting injectable version of an antipsychotic called Aripiprazole or Abilify. He is, also, taking a medication called Trileptal. This is an antiseizure medicine by its creation. It's used off label for mood stabilization.

And then he, also, takes a medication called Trazodone. It's an antidepressant by design, but has sedation as a side effect. So we use it frequently for insomnia to assist with sleep.

Q For those three medications, could you tell us approximately how often he takes each of them?

A He takes the Trileptal and the Trazodone every day. The Trileptal is, actually, twice a day and the Trazodone is at bedtime. And then he takes the Abilify injection once per month.

Q And in terms of which symptoms, would you mind telling us which medication effects which symptom?

A Sure. So the Abilify is meant to treat the psychotic

symptoms, so the disorganized thoughts, disorganized behaviors, auditory hallucinations, ideas of reference, these symptoms. The Trileptal is meant to treat his mood symptoms. So he has mood elevations, decreased need for sleep. Those symptoms would be controlled by the Trileptal. And the Trazodone is meant to treat insomnia.

Q Thank you, Doctor.

In terms of the method by which those are taken, how do each of those -- how does Mr. Carter take each of those?

A So Mr. Carter takes the Trileptal and the Trazodone orally. And the Abilify is an injection.

Q And who administers the injection to Mr. Carter?

A The injection is administered by a nurse, registered nurse or LPN.

Q And who administers the oral medication to Mr. Carter?

A Mr. Carter is, actually, on what we call self-administration of medication. So he is responsible for administrating his medicine to himself.

Q Approximately how long has he been administrating his medication to himself?

A He's been doing that since about January of this year.

Q To your knowledge, since he has been

self-administering, has he had any refusals of administration?

A He has not.

Q To your knowledge, has he had any missed medications?

A He has not.

Q Thank you, Doctor.

In terms of our request today for Mr. Carter to be discharged, would recommend that he stay on this medical regimen when discharged?

A Yes, I would.

Q In term of the injectable medication we discussed, how could DMH or any other concerned entity find out whether or not Mr. Carter had taken that medication?

A You can order drug levels of the medications. So the Trileptal and Abilify could both be what we call leveled. So you could draw his blood and run a test to see how much of it is in his system, which would tell you whether or not he's compliant with the medication.

Q And for the injectable, would there likely be a medical record of a nurse administering that to him on the outpatient side of things?

A Yes. It would have to be administered at the mental health center.

Q Understood. Is it your understanding that failure to take his medication, show up at the mental health center

as scheduled, things like that, would missed adherence to his medication be grounds for him to be readmitted into the hospital?

A Yes, under the NGRI release order that we put in place on our patients.

Q Thank you, Doctor.

Regarding Mr. Carter, you know, the -- the hospitalization statute asks about insight. Would you mind telling us, again, for a lay person like me, what does insight mean?

A Insight is a patient's understanding of their mental health symptoms and their need for treatment.

Q How does a patient demonstrate insight?

A They are able to identify what symptoms they experienced when they were ill. They're able to identify warning signs that they may be starting to exhibit symptoms again. They are able to communicate their needs, including things like side effects to their medications, in addition to symptoms that they may be experiencing.

Q How would you characterize Mr. Carter's insight?

A I think Mr. Carter has good insight.

Q What makes you say that?

A He communicates clearly and effectively with the treatment team. He makes his needs known at all times. He is able to describe in detail the symptoms he

experienced, as well as warning signs and triggers that might indicate that he is decompensating should he become ill in the future, as well as identify his support system and how to utilize the support system effectively.

Q Understood. Do you believe Mr. Carter has sufficient insight with which to treat himself on an outpatient basis?

A I do.

Q Thank you, Doctor.

The flip side of that same statute is regarding a person's propensity for harming themselves or others by virtue of a mental illness. When you are analyzing that for a patient of yours, what kind of things are you looking for?

A We look at self-report. We look at mood. We look at their behavior on the unit and interactions with other people.

Q And in Mr. Carter's case, has he 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.
Q Understood. Are you familiar with the proposed discharge plan?
A Yes.
Q To your knowledge, where would Mr. Carter discharge to?
A He would discharge to his grandmother's home here in Greenville, South Carolina.
Q Understood. Have you visited this residence?
A I did a virtual tour of this residence a couple of months ago. I don't recall the date exactly.
Q Understood. You've physically been to this area before previously; correct?
A I have visited his mother's house, which is next door, in person. So I have observed this residence from the outside as well.
Q Understood. And you've spoken with some of Mr. Carter's support system for his discharge; correct?
A Yes.
Q To your knowledge, who have you spoken with?
A His grandmother, his mother, his attorney, some family friends, and the head of a program that we're referring him to that helps with reintegration into community.
Q Do you believe that a residence in this home is

likely to be therapeutic for Mr. Carter?
A I think it would be.
Q What's the basis for that belief?
A I think that having social support and family support is very important in mental health recovery. And I think that he has one of the most supportive families I have seen. They engage properly with him. They are sweet. They are loving. They are kind. And I think that they have a vested interest in his future success.
Q Understood. Dr. Alleyne, by virtue of your position at forensics, do you occasionally discharge patients to community residential care facilities?
A Very frequently.
Q What is your understanding of what CRCF is?
A A community residential care facility is a facility that is monitored 24 hours a day by mental health staff. It is filled with mental health patients who require assistance in obtaining and taking their medications, in getting to appointments, in managing their mental health, needing a little bit more support or assistance with ADL's, which are activities of daily living, and just need kind of extra structure around them.
Q In this case, why did the treatment team not recommend a CRCF for Mr. Carter?
A I think that Mr. Carter has a significant social

support system to bolster his success in the community. We, also, think as a team that Mr. Carter's goals of going back to school and working are things that are achievable for him given how well he has done in school previously, as well as how well he's done in the hospital with us, and his current symptom stability.

Q Understood. We spoke briefly a moment ago, but I want come back to the idea of Mr. Carter administering his oral medications to himself. Is that a typical procedure at Bryan Forensics?

A No.

Q Why not?

A I don't know that I have a good answer for that, other than trust of the patients. With this case, because it is so rare that we recommend patients to go home, we wanted to be able to show the Court and the patient that he was capable of doing this himself, of taking care of himself in such a way.

Q Sure. Has Mr. Carter exhibited any behavior, any -- verbalized any reason for you to believe that he would not take his medication when he gets on the outside?

A No. He firmly believes his medication is helping him and that it's necessary for his recovery.

Q Understood. Dr. Alleyne, to your knowledge, who would be either treating or monitoring Mr. Carter if he is

allowed discharge under the terms of the proposed order?
A So under the terms of the proposed order, Mr. Carter would be monitored by the Greenville -- Greater Greenville Mental Health Center. He will be monitored by the forensic outreach clinic, which is our clinic located in Columbia that monitors NGRI patients throughout the state, as well as the Department of Probation, Pardon, and Parole. And then he has the family support system around as well.
Q And have you ever interacted with a patient at forensics that was returned to the forensic unit by virtue of a violation of their underlying order?
A More often than I would like.
Q Understood. In terms of reasons why you've seen people come back to the hospital for a violation, what were those, typically, initiated by?
A The number one reason patients get returned would be medication noncompliance, or not showing up for their mental health appointments. We have, also, returned people for using drugs or alcohol and not living in an approved placement.
Q Dr. Alleyne, in terms of physically getting it to -- or getting a patient like this back to the hospital, who would initiate that transportation?
A The sheriff's office is responsible for transport.

Our forensic outreach clinic sends them a pickup letter. And they immediately go and obtain the patient and bring them to our doorstep.

Q Understood. As far as probation, parole, and pardon services role, what role do they have?

A There's is a little more supervisory. They do quarterly check-ins with the Mental Health Center where they receive a report from them. However, if they are notified that someone is out of compliance with treatment, they, also, immediately step up and assist in the process of getting the patient back to hospital.

Q And, to your knowledge, do those entities speak with one another about a patient's --

A Regularly.

Q Understood. Are any of these entities required to provide regular notices to the Court?

A Yes.

Q Understood. Dr. Alleyne, do you believe Mr. Carter could derive any additional benefit from hospitalization?

A Not at this time.

Q Why not?

A He has attended all of the groups that we have to offer. He's psychiatrically stable. At this point in time, there's no benefit to him staying in the hospital. He's not going to learn any additional skills or obtain

any additional psychiatric stability.

Q Do you believe that Mr. Carter has sufficient insight with which to properly treat himself on an outpatient basis?

A I do.

Q Do you believe that there's a likelihood of serious harm to himself or others by virtue of his illness if Mr. Carter were to be discharged under the terms of this order?

A No, I do not.

Q Have you had a chance to review this order?

A I have.

Q Are you in agreement with the terms of it?

A I am.

MR. ROYALS: Your Honor, that's all I have.

THE COURT: Cross-examination.

MR. BREWER: Just a few direct, Your Honor.

DIRECT EXAMINATION

BY MR. BREWER:

Q Dr. Alleyne, very briefly, with respect to the residential living facility, what is the high degree of functioning that Mr. Carter has exhibited at the hospital? How does that inform your decision about recommending his transfer to the residential facility, as opposed to his grandmother's home?

A It's the opinion of most of the treatment teams within the facility and me, in particular, that patients who require that level of care need more assistance. Mr. Carter has been able to demonstrate that he can manage his own medications. He participates in all of the groups. He helps out on the unit. So he helps when there are new patients that maybe don't know what's going on. He'll help them settle in. He helps the staff.

He's not allowed to have a job because we don't have a work program. But he does as much to help around the unit and be kind of a unit champion. He, also, serves on our patient rights committee. So he attends a patient rights meeting as the representative for his unit once a month. And I just think that putting him in a residential care facility with lower functioning patients would be a disservice to his future success.

Q In your six years, how does Mr. Carter's responsibleness compare to other patients that have been there at the hospital?

A He is one of the more responsible patients I've taken care of.

Q And in his compliance, how does he compare to other patients you supervise?

A He is one of the most compliant patients. He is on top of his medications every day.

Q And in his behavior, how does he compare?
A He has had no behavioral incidents, no band demotions. I would say that he is one of the most well behaved. The staff always describe him as polite and respectful.
Q Has he had any physical or violent altercations with any other patient or staff member during his time at the hospital?
A Not in his hospitalization.
Q Do you have any reason to believe that he is faking any of those behavioral characteristics?
A No.
Q Do you believe that a patient could fake those behavioral characteristics and fool the Department of Mental Health?
A I think a patient could fake those behavioral characteristics for a short period of time. I don't think that they could be as consistently well behaved, respectful, and polite as Mr. Carter is.
Q And then just one last question. Do you know how many individuals have been discharged and are currently on active monitoring in the community whose underlying offense was either murder or attempted murder?
A 47 of our NGRI patients who are on active monitoring out in the community that have had those offenses.

MR. BREWER: Thank you, Doctor.

I have no further questions.

THE COURT: All right. Mr. Miller.

CROSS-EXAMINATION

BY MR. MILLER:

Q Doctor, so when was Mr. Carter first admitted to the hospital?

A In August of 2022. I believe it was the 16th.

Q Okay. So this report was generated on June 23rd of this year?

A Which report?

Q This -- your report. This one dated July 7th. I believe it's dated at the top July 7th. But at the bottom, it says the review board meeting was June 23rd.

A Oh, the updated forensic review board, yes.

Q So this was after a little under 10 months total at the hospital; right? At 10 months?

A Yes.

Q Okay. So between the last hearing and now, how often did you meet with Mr. Carter?

A I meet with him in a scheduled meeting once per month. I see him on the unit much more frequently than that. I honestly couldn't tell you how many times I've talked to him between then and now.

Q So the scheduled meetings, how long do those last?

A They're about 10 to 15 minutes long.
Q Okay. So about 15 minutes long. And it's been about six months since the last hearing?
A Okay.
Q So in scheduled formal meetings, about an hour and a half total?
A That sounds about right.
Q Okay. What did you say was Mr. Carter's formal diagnosis?
A Schizoaffective disorder bipolar type.
Q And does that still exist today?
A Yes.
Q Okay. Will it always exist?
A Yes.
Q Moving on to the medications. You kept referring to Trileptal, is that what is Oxcarbazepine?
A Yes. Oxcarbazepine is the generic name. Trileptal is the trade name it was marketed under.
Q And that is a mood stabilizer?
A It's designed as an antiseizure medication. We've found that it works well for mood stabilization in addition to treating seizures. So we use it off label to treat mood symptoms related to bipolar or schizoaffective disorders.
Q And is that why it's administered to Mr. Carter?

A Yes.
Q And how often is he supposed to take that?
A He takes that twice a day.
Q And that is an oral medication?
A Yes.
Q And the Aripiprazole, you said that was administered by a nurse?
A Yes.
Q So he does not administer that one himself?
A No.
Q If you were out in the community, where would that be administered?
A At the Greater Greenville Mental Health Center.
Q Okay. What could happen if he missed a dose of that?
A Of --
Q Of the Aripiprazole.
A If he missed a dose of the Aripiprazole, it would take a few weeks, but he would, eventually, start to have symptoms return.
Q Okay. What about the Trileptal, how long after someone stopped taking that would it stop working?
A It would take a few days for symptoms to start to come back. However, the Aripiprazole, also, has mood stabilizing properties, so it would help keep his mood symptoms under control as well.

Q And then the Trazodone, that is taken once a day?
A Yes.
Q And what is that for?
A That is for sleep.
Q Okay. Could he have an issue with sleeping if he did not take it?
A He could.
Q So he was moved to self-administered medications, you said -- you testified in January. Your report says February 9th; is that correct?
A That sounds accurate.
Q Okay. What does that mean?
A What that means is that he is responsible for knowing what times he is to take his medications and what medications he is to take. He has to present himself to the nurse's station and request the medications by name. They then hand him the unopened medication and observe him opening it and taking it himself.
Q Okay. But someone observes him taking it?
A Yes.
Q Do they make a log of that?
A Yes.
Q Okay. Are those records -- have they been kept up-to-date?
A Yes.

Q Okay. Has he ever missed a dose?
A No.
Q Would you agree that at the last hearing, we established that just prior to going to the Department of Mental Health, he refused or failed to take his medication in, at least, 50 separate occasions?
A You did make that point, yes.
Q And those records were admitted at the last hearing?
A I don't recall.
Q Okay. But was it part of Judge Gravely's order from the last hearing?
A I believe it was, yes.
Q We, also, established at the last hearing that he has knowledge that he has to comply in order to go home, in his own words?
A Yes.
Q Do you recall that from the clinical note, as well as being included in Judge Gravely's previous order?
A Yes.
Q Okay. Are these medications ever likely to be changed, those three medications?
A I can't answer that.
Q Okay. What would happen if they needed to be changed?
A His psychiatrist treating him in the community, if

they thought the medications needed to be changed, they would make changes to them appropriately.

Q Okay. Would he be monitored if those medications were changed?

A Every patient is monitored when their medications are changed.

Q Okay. How closely would he be monitored?

A I can't answer that. I don't know how the outpatient mental health center does their business.

Q All right. I'll move on. What is the current state of his mental illness?

A He is in what we would call remission.

Q Is that different from being stable?

A No. It's the same thing.

Q Okay. Just different terminology?

A Yeah.

Q Can you guarantee his stability if he continues to take those medications?

A If he continues to take his medications, he would remain psychiatrically stable, but I can't guarantee anything.

Q If he failed to take any of those medications, could you guarantee his stability?

A I cannot.

Q Okay. The psychiatric history portion of your report

found that he was also -- or mentioned that he was noted to be psychiatrically stable on July 22nd as well; is that correct?

A I don't recall.

Q Do you have a copy of your report?

A I do not.

MR. MILLER: Okay. One moment.

(Pause.)

MR. MILLER: May I approach, Your Honor?

THE COURT: Yes, sir.

BY MR. MILLER:

Q Towards the bottom of the second paragraph there.

A Okay. What's the question?

Q Just would you agree he was found to be stable at that point as well?

A Marshall Pickens opined that he was stable enough for discharge.

Q Have you reviewed those discharge records from Marshall Pickens?

A I have, but not in some time.

Q Okay. Do you recall if the family was part of that discharge plan or present for it that he was discharged to?

A I do not recall.

MR. MILLER: May I approach again?

THE COURT: Yes.

MR. MILLER: And these were part of the original discovery.

THE COURT: All right.

THE WITNESS: Yes. Family was involved in the discharge plan and process from Marshall Pickens Hospital.

BY MR. MILLER:

Q Okay. Who was involved in that process?

A It says that the patient and his grandmother were involved.

Q Okay. Is that the same grandmother referenced today?

A Yes.

Q There was, also, it appears a risk assessment conducted?

A Yes.

Q And from that --

MR. MILLER: Your Honor, the State would ask that that portion of the medical record be made a part of the Court's record for this hearing. It was, I believe, admitted at the bench trial.

MR. ROYALS: No objection.

THE COURT: Without objection.

BY MR. MILLER:

Q Going back to your report, that is, essentially, where the psychiatric history portion ends; is that

correct?
A Yes.
Q Okay. From his Marshall Pickens records, it looks like he had -- if you'll agree with me, a follow-up appointment for the Abilify injection on August 15th, 2020. Do you know if he went to that appointment?
A I do not.
Q Okay. Do you know what happened when he was discharged from Marshall Pickens?
A I do not.
Q Do you remember us discussing at the last hearing an incident involving the Greenville Police Department on July 27, 2020?
A I honestly do not.
MR. MILLER: Okay. If I may approach. I think this was discussed at the previous hearing.
BY MR. MILLER:
Q If you recall discussing that incident. I'll give you a minute to look at it.
A Okay.
Q Okay. So according to that report, about five days after he was discharged from the hospital, was he found by the Greenville Police Department driving under suspension?
A That's what this says.
Q Was he, apparently, also, acting erratically and not

making sense?
A It says that he was shaking and not making sense.
Q Okay. Was he, also, in possession of and using, apparently, marijuana at the time?
A It does not say he was using. It does say they observed a green leafy substance known to be marijuana.
Q Do you agree with me that that was five days after the discharge notice that we just went over?
A Yes.
Q Your report, also, says now, at this moment, he is denying all symptoms of psychosis. Is there an objective standard to determine whether or not he is experiencing any symptoms?
A Yeah. We observe him on the unit and in group therapy sessions where we see how he interacts, whether or not he's responding to internal stimuli while he's walking up and down the hallways, things like that.
Q Is he observed when he doesn't know he's being observed?
A All day long.
Q And who is observing him during that time?
A Nursing staff, mental health techs, security officers, cameras.
Q Did you ever discuss the underlying incident we're here for today with Mr. Carter?

A Not in great detail, but, yes, we have.
Q Okay. How did he express to you what happened?
A Matter of factually.
Q Okay. Has he expressed an understanding of the gravity of what occurred underlying this case?
A Yes.
Q Has he ever expressed any remorse?
A Yes.
Q Did he ever deny breaking into Ms. Mattison's home?
A No.
Q Did he ever deny taking her life?
A No.
Q Is there a plan to, essentially, help him grasp with what has happened here, any sort of therapy or anything, followup?
A He is interested in engaging in psychotherapy when he discharges from the hospital.
Q And you said you've been with the Department of Mental Health since 2016; is that correct?
A Uh-huh.
Q And how many of these evaluations have you done?
A I honestly don't know the number off the top of my head, and I should.
Q Do you have a rough idea how many you recommended discharged for? I believe you said it was greater, but I

don't remember exactly --
A Recommend discharge for -- I guess can you clarify your question?
Q On these reviews, recommended somebody be discharged from the hospital?
A Our goal is always to discharge patients from the hospital. Discharge starts on the day of admission for any hospital.
Q Okay. But after you discharge them, how many are returned to the hospital?
A I don't know that number.
Q You testified it was more than you would like.
A It is more than I would like. I would like for everyone to stay out of the hospital and be successful.
Q I'll move on to the discharge plan here. Who came up with this discharge plan, the seven points here?
A The plan is fairly standard for forensic patients. But the terms of the plan and where they go, what county they reside in is decided by the treatment team.
Q Okay. Was the previous plan referenced when you kind of came up with this, the last one and this one?
A The -- as I said, the plan is fairly standard for our patients. We have, basically, the same goals for everybody at discharge, that they will attend and participate in treatment, that they will follow the rules,

that they will live in an approved placement.
Q Okay. So out of this -- let's see here -- seven page document, there are, I believe, two additional paragraphs showing what he's done since the last hearing?
A That sounds correct.
Q And as far as the discharge plan, the 3 Harrison Avenue was changed to 5 Harrison Avenue?
A Yes.
Q And mother -- his mother's name was changed to his grandmother and her name?
A Yes.
Q Other than that, there have been no changes?
A Well, we added the self-administration of medication while he was in the hospital, but no changes to the discharge plan.
Q Okay. Did you consult Judge Gravely's order when coming up with this discharge plan?
A I'm not sure I understand what you mean by that.
Q The order issued after the last hearing, was that consulted as part of coming up with the new plan?
A Yes.
Q It was?
I have a copy for you.
MR. MILLER: Your Honor, if I may approach.
THE COURT: Yes, sir.

BY MR. MILLER:

Q The second half of the last paragraph, what does that say?

A If SCDMH determines Defendant should be released at some point in the future, then the more appropriate treatment plan regarding supervision of the Defendant will need to be provided, including the consideration of transitional housing or a more stable environment with appropriate monitoring and supervision.

Q Okay. What is the additional supervision in the new request to discharge?

A The Court had an issue with our recommendation that he live with his mother, given his mother's symptoms and difficulties with maintaining her own health. His grandmother has agreed to assist in monitoring him and his medication, ensure that he gets to his appointments, and be a supervisory figure in the home.

Q So will she be responsible for him?

A Mr. Carter is responsible for himself.

Q Okay. I believe last time you testified that he would be supervising himself day-to-day. Is that still the case?

A Absolutely. Everybody is responsible for supervising themselves day-to-day.

Q Okay. Would you consider that a more appropriate

treatment plan regarding supervision of the Defendant?
A I think that that is appropriate for his level of functioning, yes.
Q Okay. Would you agree with me that that does not comply with Judge Gravely's prior order?
A I'm not going to agree with that, no.
Q Okay. Is the address listed on here, in fact, next door to the address on the previous discharge order?
A Yes.
Q How close would you say those two residences are?
A Maybe 50 feet apart.
Q Okay. So it's, essentially, discharging him into the exact same location?
MR. ROYALS: Objection, Your Honor. Is there a question there?
THE COURT: Rephrase and ask a question, Counsel.
BY MR. MILLER:
Q Would this be discharging him to the same geographic location?
A I guess.
Q Within 15 to 20 feet --
THE COURT: Is that your answer?
THE WITNESS: Yes.
BY MR. MILLER:
Q Does this plan include any curfews or sort of ways to

account for the Defendant's day-to-day whereabouts?
A Not specifically.
Q Okay. Well, essentially, would he be free to come and go from the house as he pleases 24 hours a day?
A Yes.
Q Okay. Who would be monitoring him when he leaves the house?
A Again, Mr. Carter is responsible for himself.
Q Okay. Once again, like the last plan, the recommendations say he will need a structured and supervised living environment. What does that mean?
A That he has people around him to support him, that he has a safe place to live. And we think that the family support that he has, as well as the support from the Mental Health Center, and the other entities that we have discussed already would be providing the appropriate structure for him.
Q Okay. And they would be supervising him?
A They supervise him, yes.
Q Okay. Would they be responsive or required to be responsive to the Department of Mental Health or the outreach clinic?
A They would -- yes. They would let the Mental Health Center know or the outreach clinic know if there were some kind of issue.

Q And what obligation are they under to do that?
A I don't necessarily have an answer for that.
Q Okay. So they are under no obligation to do that. It's, essentially, on good faith?
A Yes.
Q Was Ms. Chapman interviewed as part of this process?
A Yes.
Q Okay. Is she fully aware of the Defendant's condition?
A Yes.
Q Would she be under any obligation to report a decline in his condition?
A There's nothing that is going to require her from the Court. However, the safety of her grandson as well as the safety of herself and her home would necessitate that she would let somebody know.
Q But in practice, the Defendant could be gone from that home 23 hours a day if he wanted to?
A I suppose that's true.
Q And he would be, essentially, unmonitored at that point?
A I'm not sure what you're looking for there.
Q The second point said he would keep all scheduled appointments with the Greater Greenville Mental Health, the clinic, and random drug screens. I believe you

testified that those appointments are monthly to begin with; is that correct?

A The appointments with the forensic outreach clinic are monthly to begin with. I can't say how frequently the Mental Health Center will see him when he is released from the hospital.

Q Okay. Are they -- is the frequency decreased over time?

A Yes.

Q How quickly is that decreased?

A I don't know the answer to that. It depends on the patient's stability.

Q Okay. How often -- you testified that they could measure the drug levels in his system to make sure he's taking medication. How often would that be done?

A At the psychiatrist's discretion.

Q Okay. So there is no set time on that?

A No.

Q If an incident of any type -- number three says that he will sign all releases to allow communication between professionals. What does that mean?

A To allow the Mental Health Center to release his records to the forensic outreach clinic, for Probation, Pardon, and Parole -- if he were to seek treatment for general medical problems at a physician's office that he

would sign releases so that we would have access to those records as well.

Q Okay. Number four states that he should not obtain any weapons, guns, or knives. Would that include knives in the home?

A I believe we had this conversation last time. No. We are not expecting people not to own butter knives or steak knives. But within reason, they can have knives in the home to cook with. But he would not go out and buy hunting knifes, or a Samurai sword, or something of that nature.

Q Okay. Are you aware of how the underlying incident occurred in this case?

A Yes.

Q Are you aware that he "stabbed her with a knife he found in the kitchen while she was sleeping"?

A Yes.

Q Knowing that, would it not be important to remove knives from the home?

A I'm not going to ever tell anyone that they can't cook food again because they're not allowed to have a knife.

Q I'll move on to number five. He will not associate with any known felons outside of the treatment program. I believe we addressed this at the last hearing when he was

proposed to be discharged to 5 Harrison Avenue. Is that, in fact, his mother's address?

A Yes.

Q And is his mother, in fact, a convicted felon?

A From what you've told me, yes.

Q Okay. Did we not admit a certified conviction at the last hearing for unlawful neglect, which is a felony in South Carolina, in which the Defendant was the victim?

A Yes.

Q That was admitted at the last hearing?

A Yes.

Q So he is now to be placed next door to his mother?

A Yes.

Q Yet, he's still not to associate with any known felons?

A May I provide maybe some clarification?

Q Sure.

A So the spirit of that terminology is so that our patients when they are released from the facility will not go out and join a gang, or start dealing drugs, or somehow become entangled in behaviors that would not be appropriate or safe. It's not meant to isolate them from people that they are in treatment with or from their social support system.

Q Okay. We, also, did establish at that home there's

been some issues with drug use recently?
A Yes.
Q Okay. And this whole issue came up at the last hearing; correct?
A Yes. You brought this up last time.
Q And Judge Gravely, actually, brought it up in his order as well?
A Yes.
Q And then it was not changed for this proposal?
A We changed the placement.
Q But you did not change this term in here or address it in any way?
A We cannot change that term. It's part of our standard discharge orders in order to protect our patients from engaging in behaviors that would not be appropriate. As we established last time, though, we are discharging patients who are felons from our program to houses that are housing multiple other mental health patients from our program with consent of the judge.

Therefore, it's allowing for them to reside around felons for the purpose of them being safely released to the community.
Q Okay. That's what it says, not to associate with any known felons outside of the treatment programs?
A Correct.

Q Is his home a treatment program?
A His home is part of his treatment program, yes.
Q In what way?
A It's where he lives. It's where he receives support. It's where he takes his medication.
Q Okay. So if he -- what you're saying is anywhere can be part of a treatment program?
A Down on Main Street hanging out with a drug dealer on a street corner is not a treatment program.
Q But what if he took his medications there?
A It's not a treatment program.
Q It would be.
It says he will refrain from the use of drugs or alcohol. We agreed at the last hearing, it was established a history of drug use at the neighbor's residence. The last hearing, we established that?
A Yes, you did.
Q And by that neighbor, we mean the same prior address of 5 Harrison Avenue?
A Yes.
Q Okay. Would you, also, agree that we established today and at the last hearing that the last time he was discharged, within five days, he was found in possession and possibly using marijuana?
A Yes.

Q Okay. Has he ever been in any sort of transitionary program?
A Not to my knowledge.
Q Okay. So he's been either fully inpatient or discharged to his family?
A Yes.
Q And the last time he was discharged to his family, he was returned to the hospital within five days?
A Yes.
Q Okay. So is there any track record in between inpatient and him being fully out on the street that we can rely on today?
A Not based on the evidence you're presenting.
Q With the evidence that you've presented, is there anything there?
A I have three years of psychiatric stability under his belt at this point.
Q So you've been seeing him for three years?
A No. I've been seeing him for a year. He was stable on arrival a year ago and had been stable in the detention center for, at least, a year before that.
Q Okay. But, to your knowledge, you have seen him in the last year; is that correct?
A Yes.
Q And 15-minute scheduled visits?

A Yes.
Q And I believe between the last hearing and this hearing, you have spent about an hour and a half with the Defendant in scheduled visits?
A Yes.
Q Okay. If he were to violate any of the terms in this, how quickly could anyone be notified? Could the proper authorities be notified?
A They're notified immediately.
Q By who?
A By whoever notices that he -- so if he misses an appointment, the Mental Health Center notifies the forensics outreach clinic immediately. If the family notices that he's not taking his medicine or something, they would notify the Mental Health Center, who would notify the forensic outreach clinic and PPP.
Q But the family is under no obligation to notify anyone. And these meetings would be probably monthly?
A Again, I can't say.
Q I believe when I spoke with them on the phone, it says they start out monthly. And then there's bimonthly within about --
MR. BREWER: Objection, Your Honor. He's testifying --
THE COURT: Hold on.

MR. BREWER: I said the Solicitor is testifying about a conversation he had out of court with somebody through his questions.

THE COURT: I'm going to sustain the objection.

Rephrase your question if you have a question.

BY MR. MILLER:

Q Do -- those appointments start monthly; is that correct?

A I don't know the answer to that.

Q So we don't know how often they occur?

A They could happen more frequently than monthly.

Q Or they could happen less frequently. There's no obligation under any of this to be more or less frequent than that?

A The obligation is just that they provide treatment.

Q Okay. This, also, says they would not be notified upon a violation, but upon a rehospitalization. What is the difference between those two?

A So there are times where there may be a violation of the order that we will address without rehospitalizing that will have them engaged. Let's say they use a drug and have a dirty drug screen. We would engage them in outpatient substance treatment. That wouldn't require a rehospitalization and, thus, you would not be notified.

Q So we would not be notified if he violates this

order?
A You will be notified if he is readmitted to the hospital.
Q Would the Court be notified if he violates this order?
A They will be notified if he is readmitted to the hospital.
Q Okay. Who notifies the victim's family if he violates this order?
A I don't know the answer to that. I assume that falls to the solicitor's office.
Q But we aren't notified if he violates this order; is that correct?
A So do you mean who notifies them when he is readmitted?
Q No. If he violates a term of this order.
A Then nobody would notify the victim's family.
Q And no one would notify the solicitor's office?
A Not to my knowledge.
Q And no one would notify law enforcement?
A Not to my knowledge.
Q Okay. So if he theoretically were to leave the house the day after one of these scheduled meetings, it could be 30, 60, 90 days before anyone noticed?
A I would hope somebody would notice he wasn't at home.

Q Well, anyone with an obligation to report anything?
A Potentially. Although he has to report monthly to receive his injections. So it can't be more than 28 days.
Q Okay. But would those injections be administered by the NGRI outreach clinic or a different entity?
A They are given by the outpatient Mental Health Center. So Greater Greenville Mental Health is responsible for administering the injection.
Q And are they under an obligation to report if he fails to appear for that?
A Yes.
Q And would that result in rehospitalization immediately?
A That is determined between the forensic outreach clinic and the Mental Health Center. Frequently, if they miss their appointment, they will call the patient and have them come in the following day or later that day to try and reschedule. If that's not done then, yes, it would result in immediate rehospitalization.
Q Okay. So at that point, it would be about a -- he could theoretically be unaccounted for for about a month before anyone is notified?
A In theory.
Q Or anyone with an obligation to report it was notified?

A In theory.

MR. MILLER: Okay. I have no further questions at this moment.

THE COURT: Redirect examination.

MR. ROYALS: Thank you, Your Honor.

REDIRECT EXAMINATION

BY MR. ROYALS:

Q Dr. Alleyne, I believe the State referred to your -- you and I would call it an FRB, but the document dated July 7th on the front of the letter --

A Yep.

Q -- with relation to Mr. Carter's hospitalization in Marshall Pickens. Is that your understanding as well?

A Yes.

Q Based on the timeline that you have in this report and your own recollection, for approximately how long was Mr. Carter hospitalized at Marshall Pickens?

A Mr. Carter was hospitalized at Marshall Pickens for a couple of days early in July. He left from the facility. He was rehospitalized for four days. He left again from the facility and was hospitalized for approximately two weeks.

Q So front to back of that is less than a month; is that fair to say?

A Yes.

Q Understood. How long have you treated Mr. Carter?
A For over a year.
Q During that entire period during that one year, how often was Mr. Carter monitored by staff at the forensic hospital?
A 24 hours a day, seven days a week.
Q How often would a nurse interact with Mr. Carter?
A I can't quantify that over the course of a day even. It's all day long.
Q If Mr. Carter was experiencing any kind of distress, that be on his own volition or to him, would there be people nearby that could interact on that front?
A Yes.
Q Is there a document made regarding Mr. Carter daily while he's at the forensic unit one way or the other?
A There's nursing notes on him every day twice a day, as well as social work notes, activity therapy notes, forensic clinical treatment services, which is our group therapy notes, in addition to a medical practitioner aside from myself providing medical care for physical ailments, and my notes on him.
Q Do you think it's fair to say that you've spent more -- Mr. Carter has been subject to the forensic unit at Bryan Hospital longer than he was at Marshall Pickens?
A Yes.

Q Do you believe that you have a -- you have more information in which to make a discharge recommendation than Marshall Pickens back in 2020?
A Yes.
Q Do you believe that Mr. Carter remains appropriate for discharge as the statute allows?
A Yes.
Q Dr. Alleyne, regarding the risk assessment at Marshall Pickens as to Mr. Carter, do you have any understanding or basis for knowing what that risk assessment was?
A I don't know what was entailed in the risk assessment. But reading what's documented, it's a standard. We asked him if he had thoughts of hurting himself or others, if he was hearing things or seeing things before he walked out the door.
Q Understood. Regarding Mr. Carter's geographic location for where he'll be living, Dr. Alleyne, are you familiar with apartments?
A Yes.
Q When people live in apartments, are they occasionally within five feet of another person in another residence?
A Yes.
Q Can those people maintain completely different households given that geographic location?

A Yes.
Q Do you believe that what happens in one household is likely to have any bearing on what happens in another household based entirely on geographic location?
A No.
Q Understood. For individuals that you've discharged that have resided at CRCFs, are they permitted to leave those CRCFs?
A Yes.
Q Why?
A They're allowed to go out on passes to see family. They're allowed to go to the store. They're allowed to go out to eat. They're allowed to go to the movies.
Q Is the goal for treating somebody -- whether they be NGRI or a civilly committed patient, is the goal for that patient, ultimately, to go back to a normal productive life?
A Yes.
Q Do you believe that leaving a household unmonitored is important for living a typical life for somebody?
A Absolutely.
Q Do you believe that Mr. Carter has exhibited any signs or symptoms since he's been in your care that would indicate that he would need absolute -- he would need somebody with him at all times in order to stay compliant

with his medical regimen or treatment?
A Not at all.
Q Dr. Alleyne, to your knowledge, are -- any of the patients that you have discharged to a CRCF, have any of those CRCFs ever been court ordered to report when somebody is out of compliance with the order?
A No.
Q Do you frequently still have CRCFs report when someone is out of compliance with an order?
A All the time.
Q Why is that?
A Because they are concerned for the patient in their care.
Q Would it be fair to say they're incentivized to make sure that that person is keeping up with their care?
A Yes.
Q And to make sure they are behaving in a manner that's been prescribed both by the treatment provider and the courts?
A Yes.
Q Understood. Do you believe that Mr. Carter's family is similarly incentivized to ensure that he remains in compliance with his medication?
A I do.
Q Why is that?

A Because they want to keep their house safe. They want to keep Mr. Carter safe.
Q Do you believe that his family is similarly incentivized to let any of the monitors and this Court know if Mr. Carter were associating with gangs, for example?
A Absolutely.
Q Do you think they would be similarly incentivized to let this Court or the forensic outreach clinic know if Mr. Carter came in possession of a firearm?
A Yes.
Q Why?
A For their safety, for his safety, for the safety of the community.
Q Based on your interaction with the family, do you believe that they would make those calls if the time came?
A Absolutely.
Q Why?
A They are very invested in his success in the future. And they are firm believers that he needs to stay in treatment.
Q Dr. Alleyne, the State referenced on Page 4 of your report the need for a structured supervised living environment that was, once again, presented at the previous hearing as well. Is it your understanding that

Mr. Carter would be supervised by probation, parole, and Pardon Services?
A Yes.
Q Is it your understanding he'd be supervised by the forensic outreach clinic and Department of Mental Health?
A Yes.
Q Is it your understanding that the Greater Greenville Mental Health Clinic would provide structure for Mr. Carter under the terms of his discharge plan?
A Yes.
Q Is it your understanding that his family, friends, and other associates would provide structure for him under the terms of this plan?
A Yes.
Q Do you believe that a discharge plan like this is appropriate supervision and structure for someone like Mr. Carter?
A I do.
Q Why is that?
A Because he is a high -- what would we consider a high functioning patient. He has good insight into his illness. He understands the importance of treatment. He is engaged. And he has big goals for his future.
Q Understood. Dr. Alleyne, you testified a moment ago that the provision related to interaction with known

felons outside a treatment program is a standard -- is standard for an outpatient order; is that fair to say?
A For the forensic patients that are discharged to the community, yes.
Q What's your understanding of the need for that?
A To protect them from engaging with people who would get them into more trouble than they already have been in in the past.
Q To your knowledge, has that provision since you have been chief of medicine at Bryan Hospital ever been utilized to keep somebody from interacting with their own mother?
A No.
Q Their own father?
A No.
Q Any member of their family?
A No.
Q Dr. Alleyne, the statute requires any of the terms of this discharge plan remain therapeutic. In your opinion, would it be therapeutic to force Mr. Carter to reside in a community residential care facility?
A I do not think it would be therapeutic for him.
Q What's the basis for that?
A The community residential care facility is designed to provide more assistance to patients who are not quite

ready to take care of themselves in the community. So it has somebody there 24 hours a day to assist people. It is for what we would consider transitions to the community for people who aren't able to have that social support around them like Mr. Carter has.

Many of our patients have nobody. And this helps them kind of get their feet back under them, whereas Mr. Carter has a very strong support system around him ready to help him take the next steps to become a productive member of society.

Q Do you believe that Mr. Carter would likely glean a single iota of therapeutic benefit living in a CRCF?

A No.

Q Do you believe that it might be contradicting for Mr. Carter to live in a CRCF?

A I do think it would cause more harm than good.

Q Why is that?

A The risk of having somebody attack him unprovoked, the risk of not being able to engage in things to give his life purpose to build him up to allow him to reach his potential.

Q Understood. Dr. Alleyne, do you believe there would be any therapeutic benefit from disallowing him to reside with his family?

A No.

Q Why not?
A I think that family is the most important thing that we have.
Q Do you believe that family is important for patients like Mr. Carter?
A Absolutely. It's one of the most integral parts of recovery.
Q Why is that, to your knowledge?
A It's support when you need it. It's somebody you can rely on. It's somebody to help keep you on track.
Q Understood. Do you believe there would be any benefit to banning Mr. Carter from interacting with his own mother?
A No.
Q Why is that?
A It's his mother.
Q Do you believe that his mother would be a benefit to his treatment regime?
A I think so. I think as -- many mental health centers use a peer support specialist. They can support each other in their mental health recovery. But I, also, think that having that additional support and love is very important to his ability to thrive.
MR. ROYALS: Understood.
That's all I have, Your Honor.

THE COURT: Mr. Brewer.

MR. BREWER: Nothing further, Your Honor.

THE COURT: Mr. Miller.

MR. MILLER: Very briefly.

RECROSS-EXAMINATION

BY MR. MILLER:

Q You mentioned a few seconds ago a number of programs that he participates in within the hospital.

A Yes.

Q Are those available at his home?

A They would be available through the Mental Health Center.

Q Okay. All of them?

A I don't know what groups the Mental Health Center offers, but they will offer him groups to participate in when he is, initially, taken in. They do an intake assessment to see what the needs are and then recommend group activities for them to participate in.

Q So they make recommendations and he would have to go to them to participate in them?

A Yes.

Q Okay. You testified about CRCFs and that people are permitted to leave those?

A Yes, they are.

Q Are they allowed to go to school?

A They are offered assistance through the mental health centers, if necessary, yes, sir.
Q Are they allowed to work part-time, or anything?
A It's a little more challenging to hold a job while living in a CRCF. I'm not going to say it's not done, but it's less frequent.
Q You, also, testified that they are monitored, at least, daily, if not 24 hours a day?
A There's staff in the home 24 hours a day.
Q And these are professional staff?
A They're -- I don't want to testify to what their level of training is.
Q Are they employed in a mental health facility?
A They are employed in a residential care facility.
Q Okay. But they are under, at least, some legal or professional obligation to keep an eye on people?
A They are supposed to be watching the patients that they are overseeing while living in that home, yes.
Q A family and friends system you described, are they under any professional or any legal obligation to supervise the Defendant?
A No.
Q No obligation whatsoever?
A Not a professional or legal obligation.
Q Okay. What -- a good faith obligation, essentially,

on their own?
A If you want to call it that.
Q Okay. This issue with the associating with felons outside the treatment programs was an issue at the last hearing; correct?
A You had an issue with it, yes.
Q Okay. And Judge Gravely had an issue with it as well in his order?
A Yes.
Q Why did you not include an exception for family if that's what you intended?
A I don't -- I don't know how to answer that question. It's standard language that we utilize. We've never needed to include an exception for family. It's just understood that family is supportive. And it's understood that, for instance, when we discharge to a CRCF that they are going to be residing with other felonious offenders.
Q Okay. But the Court took an issue with that at the last hearing?
A I've never seen a Court take issue with it before. So I don't really know how to address that for you.
Q Okay. But you will agree -- and I believe you have a copy of Judge Gravely's order up there -- that he did take an issue with it.
A Yes.

Q Okay. So even though the Court took an issue with it, you chose not to fix it for this one?
A Again, I don't know how to "fix it." The spirit of the language is that they would not be seeking out felonious offenders and spending time with them, engaging in behaviors or activities that would be illegal or counterproductive to their treatment.
Q Okay. But you'll agree that's not what the order says?
A The order says that the recommendation from SCDMH requires that the Defendant not associate with felons, although residing with his mother will violate this directive of the treatment plan and proposed order. And we are not proposing that he reside with his mother at this point in time.
Q Okay. Just 15 feet away in the house next door; correct?
A Yes. He will reside in the house next door.
Q Okay. And then on the final paragraph of the Court's order from the previous hearing, we already addressed that a more appropriate treatment plan regarding supervision of the Defendant will need to be provided. What additional supervision or monitoring that is under any kind of professional or legal obligation to report is included in this?

A I would argue that this doesn't, actually, say that they have to have a responsibility to the Court or a professional responsibility. It just says that they wanted a more appropriate treatment plan.

Q With appropriate monitoring and supervision is the last line of that; correct?

A It says a more stable environment with appropriate monitoring and supervision.

Q Okay. So supervision does not need to be accountable supervision in the legal sense?

A Well, the staff of a CRCF are not accountable in a legal sense either.

Q Well, are they not there in a professional setting? That is their job?

A That is their job. They are not required to report to you.

Q No. But they are required to report to someone?

A To the supervisor of the house.

MR. MILLER: Okay. No further questions.

MR. ROYALS: I have one question, Your Honor.

THE COURT: Go ahead.

FURTHER EXAMINATION

BY MR. ROYALS:

Q Dr. Alleyne, counsel asked about group therapies occurring in different residences. And I believe you

testified that Mr. Carter would not be participating in groups in his home. To your knowledge, whenever people are discharged to CRCFs, do they participate in group therapy within the CRCF?

A No.

MR. ROYALS: That's all I have.

THE COURT: Anything else?

MR. BREWER: No, Your Honor.

THE COURT: All right. Thank you, ma'am.

You can step down.

THE WITNESS: Thank you.

THE COURT: All right. Do you want this witness to remain?

MR. ROYALS: She's riding with me, Your Honor. She'll be sticking around until I leave.

THE COURT: She's riding with you. Okay.

MR. ROYALS: Yes.

THE COURT: Okay. We'll take a 15-minute break. We'll be down about 15 minutes.

(WHEREUPON, a break was taken.)

(WHEREUPON, State's Exhibit No. 1 was marked for identification and admitted into evidence.)

THE COURT: Are y'all ready to proceed?

MR. ROYALS: Yes, Your Honor.

MR. MILLER: Yes.

THE COURT: You may call your next witness.

MR. ROYALS: We call Dr. Richard Frierson.

THE COURT: Doctor, place your left hand on the Bible and raise your right hand.

WHEREUPON,

RICHARD LESESNE FRIERSON, M.D.,

after first having been duly sworn, testified as follows:

THE COURT: All right. Mr. Royals.

MR. ROYALS: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. ROYALS:

Q Dr. Frierson, thank you for your presence today.

Would you mind spelling your name for the court reporter?

A My name is Richard Lesesne Frierson, R-I-C-H-A-R-D, L-E-S-E-S-N-E, F-R-I-E-R-S-O-N.

Q Thank you, Doctor.

Would you mind telling us about your education as it pertains to psychiatry?

A In order to get into medical school, I completed four years of college and received a Bachelor of Music Degree at the University of South Carolina. I then entered medical school, completed four years of medical school at the University of South Carolina School of Medicine in Columbia. I completed a four-year residency in general

psychiatry at William S. Hall Psychiatric Institute, and a one-year fellowship in forensic psychiatry at William S. Hall Psychiatric Institute.

Q Thank you, Doctor.

Where have you worked as a psychiatrist?

A I started, initially, with forensic evaluation services for the Department of Mental Health many years ago. And then I transitioned in 1999, I believe, to the University of South Carolina School of Medicine where I was named the training director for the forensic psychiatry fellowship program. And I've been there ever since.

I'm currently a professor of psychiatry in the Department of Neuropsychiatry and Behavioral Science at USC School of Medicine in Columbia.

Q Thank you, Dr. Frierson.

And are you a member of any professional organizations?

A I am a member of the American Psychiatric Association, the American Medical Association, the South Carolina Psychiatric Association organization called the Group for Advancement of Psychiatry, and the American Academy of Psychiatry in the law, which is the largest organization of forensic psychiatrists in the country.

MR. ROYALS: Thank you, Dr. Frierson.

Your Honor, I would move to have Dr. Frierson qualified as an expert in the field of forensic psychiatry.

MR. MILLER: No objection.

THE COURT: All right. He's so qualified in that designated field.

MR. ROYALS: Thank you, Your Honor.

BY MR. ROYALS:

Q Dr. Frierson, are you familiar with Mr. Carter?

A Yes.

Q How so?

A I was contacted, I believe, by your office sometime in March or April of this year and requested to do a formal violence risk assessment on him. So I met him in April of this year.

Q And what is a violence risk assessment?

A Well, it depends on who you ask.

Q In your opinion --

A Well, in a forensic -- a violence risk assessment is much different than what you might do in a clinical -- a nonforensic setting. But for me, a forensic violence risk assessment involves looking at old medical records and prior treatment, reviewing the inpatient record of the notes of various providers that have seen him over time, reviewing information related to the index offense for

which he is -- was adjudicated not guilty by reason of insanity, conducting an interview with the patient, and, finally, utilizing an instrument, if you will, that -- that represents structured professional judgment to identify risk factors for violence, both static and dynamic, and to look at potential recommendations to minimize the dynamic risk factors.

Q You say "static" and "dynamic." Would you mind telling us what that means?

A Right. Static risk factors are things you can't change, being young, being male gender. Those are -- you know, associated with violence more than old women or old men. So being young, being male, maybe growing up in a -- in an environment where violence was normalized, I can't change a person's experience as a child. Those are more static risk factors.

Dynamic factors would include the presence of mental illness that can be treated, the presence of substance use that can be treated, lack of insight into one's mental illness, which can be treated with therapy, looking at the environment someone is going to be placed in, access to weapons, looking at what services are available for the person in the community. All of those are dynamic factors that either increase or decrease risks.

Q Understood. Thank you, Doctor.

Did you render a report that went into your violence risk assessment?

A Yes, I did.

MR. ROYALS: Your Honor, may I approach?

THE COURT: Yes, sir.

BY MR. ROYALS:

Q Dr. Frierson, to your understanding, is that the report that you entered into?

A Yes.

MR. ROYALS: Thank you.

Your Honor, I would move to have this entered as DMH Exhibit, I suppose, No. 1 at this point.

THE COURT: Any objection?

MR. MILLER: No objection, Your Honor.

THE COURT: So entered.

(WHEREUPON, Department of Mental Health Exhibit No. 1 was marked for identification and admitted into evidence.)

BY MR. ROYALS:

Q Dr. Frierson, do you have a copy of that with you?

A I have a copy.

Q Dr. Frierson, on the first and second page under Sources of Information, there are numbered sections indicating documents and, looks like, interviews that you did to put together this violence risk assessment.

Looking at those two, is that your understanding that those are the sources that you utilized in making your assessment via the violence risk assessment?

A Yes. Those are the documents that I reviewed, the interviews that I conducted on Mr. Carter.

Q Were there documents that you reviewed from prior to Mr. Carter's admission to the forensic unit at Bryan Hospital?

A Yes.

Q Were there documents contemporaneous to Mr. Carter's treatment at the forensic hospital?

A Yes.

Q Did you interview Mr. Carter?

A Yes.

Q How many times?

A Twice.

Q Approximately how long combined did you speak with Mr. Carter?

A Combined, two hours and 30 minutes.

Q And where were those interviews conducted?

A Those were conducted in the forensic hospital in Columbia in an interview room.

Q And given how important electronic media is these days, were those electronic or in person?

A In person.

Q Thank you, sir.

When you are doing a violence risk assessment, what kind of documentation are you utilizing? And what things are you looking for in that documentation?

A I'm, first of all, wanting to understand how the person ended up where they are. So I want to know their mental health history. And I want to know what was the index offense for which they were charged and adjudicated in this case not guilty by reason of insanity.

Then I want to look at their treatment in the hospital, how they responded to treatment, are they currently experiencing symptoms of mental illness, do they have insight into their mental illness and need for treatment. And, you know, can they likely be responsible to make decisions concerning their person.

Q Thank you, Doctor.

In meeting with Mr. Carter and, obviously, reviewing his documentation, what diagnosis did you find for Mr. Carter?

A The diagnosis is schizoaffective disorder bipolar type.

Q Understood. And I believe you were present earlier when Dr. Alleyne spoke about that. In your mind, what is schizoaffective disorder bipolar type?

A I think that his illness began primarily with mood

symptoms and symptoms of bipolar disorder. But once the symptoms of bipolar disorder were treated -- he, also, had hallucinations. He was hearing voices telling him he had a football scholarship to Clemson, that people were hiding from him. So he had mood symptoms along with psychotic symptoms, which can happen in bipolar disorder.

But then once the mood symptoms were treated and resolved, he continued at times to hear voices and have ideas of reference. So he had a period of time where he had psychiatric symptoms without mood symptoms.

So that is what gives you the diagnosis of -- that's what makes it schizoaffective disorder rather than just bipolar disorder. He continued to have some hallucinations and ideas of reference after the mood symptoms had been successfully treated.

Q And can schizoaffective disorder bipolar type be properly treated with medication?

A Yes.

Q To your knowledge, what kind of medication is Mr. Carter taking?

A He's on a long-acting injectable and a psychotic medication called Abilify. And then he is on a mood stabilizing drug. It's, actually, an anticonvulsant or seizure drug used often for mood stabilization called Lamictal. And he takes a dose of Trazodone just to make

sure he continues to sleep well.
Q Now, in your estimation, is Mr. Carter properly medicated for his illness?
A Yes.
Q Understood. When you were reviewing Mr. Carter's history, both prior and current, did you review his medical compliance?
A His?
Q Medical compliance.
A Yes.
Q How would you characterize his medical compliance prior to his admission to Bryan Hospital?
A Well, at the very onset of his mental illness when he was hospitalized at Marshall Pickens, he, obviously, didn't know anything was wrong. He never realized he was psychotic. I know that he was -- eventually, after his arrest, he was in the Greenville County Detention Center. I think there were some times there where he did not take medications.

But towards the end of that, the last part of his incarceration, he was compliant with his medications. And he has been taking all of his prescribed medications appropriately for the past over one year in the hospital.
Q When you say prior to admission, when he was at Marshall Pickens, he didn't know anything was wrong, would

that indicate a lack of insight?
A Absolutely. He had no idea he was mentally ill. And when you're ill, you don't realize it. It's when you get better and you look back and you say, I can't believe I did that. I can't believe I was thinking those things.
Q And when you contrast Mr. Carter's -- or compare or contrast Mr. Carter's insight from the records you have available to you at Marshall Pickens and even at the Greenville Detention Center versus now, how would you characterize his insight shift?
A It's 98 percent better. I mean, he has really good insight with my interviews with him 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.
Q Understood. And regarding your, let's say, psychoanalysis of Mr. Carter's insight -- so you heard earlier from Dr. Alleyne. She's his treating psychiatrist. She has, obviously, a different relationship with Mr. Carter. And she opined about her understanding of his insight.
From you having interviewed Mr. Carter and looking through the documentation, what kind of things are you

looking for when putting together this assessment to analyze his insight?

A Yeah. To see if he can explain to me his understanding of his mental illness, what he realizes from the past that were symptoms of mental illness that he didn't realize at the time, his understanding of the medicines and what they are used for, his ability to understand his need for ongoing monitoring and treatment, his understanding that he likely will need lifelong treatment for this illness, that -- and the risk that could happen if he were to fail in that or to become, let's say, noncompliant.

Q Understood.

A I mean, he's very remorseful. He can't believe what happened.

Q Understood.

A And he, certainly, doesn't want anything like that to happen again.

Q Based on your evaluation of Mr. Carter, do you think he has enough insight to properly treat himself on an outpatient basis?

A Yes.

Q So, obviously, the whole point of your evaluation is to analyze any potential violence risk that Mr. Carter may exhibit. When you are looking at his possible propensity

of being a danger to himself or others, what kind of things, specifically, are you looking for in these records and during your interview?

A Well, we can divide them into several categories. The first would be historical risk factors, things like does he have a history of violent behavior? He does. And that's the index offense. That's his one offense for which he was adjudicated not guilty by reason of insanity.

Other historical factors, does he have a history of antisocial behaviors? Was this a bad kid growing up or was he, you know, a good student not in trouble with suspensions, or expulsions, or conduct problems? And he does not have a history of antisocial behavior.

Does he have a history of relationship problems or employment problems? He does not. He's held several jobs prior to his incarceration and did not experience being fired, or what have you.

Other historical risk factors include substance abuse and major mental illness. He did smoke marijuana some in high school. So he does have a history of substance abuse issues. And he does have a major mental illness, obviously, or we wouldn't be here. So those are positive.

Does he have evidence of a personality disorder? No. Does he have traumatic experiences? Partially. And what I mean by that is he himself hasn't been the victim,

necessarily, of trauma. But he's witnessed trauma in his childhood home from his father against his mother. Does he hold violent attitudes? No. And does he have a history of failed treatment? The answer would be no, not when he's been engaged and compliant with the [inaudible]. So those are all historical factors.

Then I look at clinical factors. Does he have insight? He does have insight. Does he have violent ideations? No. Does he have current symptoms of his mental illness? No. Does he have affective or mood instability? No. And is he treatment compliant? Yes. So those are clinical factors I look at.

And then for the risk management factors, are there professional services and plans available? Yes. In this case, he will be followed by a local mental health center. He will be followed by the forensic outreach program in Columbia. And he will be followed by the Department of Probation, Pardon, and Parole. So he has three separate agencies that are involved with following him as an outpatient.

Does he have a living situation? When I saw him, that was up in the air. There was not a final decision about where he would be placed. Does he have personal support? Yes. He has a very involved family. I met them for the first time this morning, some of them out in the

lobby. And it was obvious just observing their interactions that they care a lot about him and are very supportive.

Does he have a history of compliance? Yes. For the past year and a half, two years, he has been very compliant with his treatment. And does he have stress and coping skills? Yes, he does. In the hospital and, of course, when he leaves the hospital, you know, someone has got -- you've got to do your own laundry. It's not like the cafeteria is going to bring you everything. So it's going to be an adjustment. But compared to the patients that I've seen and done this type of violence risk assessment on in the past for the Department of Mental Health, he is probably one of the ones, at least, overall risk given his factors.

Q Thanks, Dr. Frierson.

And I do want to call attention to -- you mentioned a couple factors for violent ideation or intent. Would you mind telling us a little bit more about what that entails? There's a lot of words there closely related to --

A Someone that harbors a history of engaging in fights, or wanting to get back at somebody, or having thoughts about wanting to harm anybody. He doesn't have that. He has not been in altercations at all with -- and that, actually, says something in the forensic hospital.

Because you can encounter some persons or other patients that are very difficult to deal with and that are rude or themselves engage in violent behaviors. And he's been able to demonstrate the skills to stay clear of that or getting involved in that.

Q Certainly. And by virtue of being present today and reviewing the facts and talking with Mr. Carter, you're familiar with the index offense that led to all these proceedings?

A Yes.

Q Would that -- him engaging in behavior that lead to that offense, was that not violent ideation or intent?

A No. Because he was acutely psychotic. So when we say violent ideations or intent, we're talking about ideations or intent when someone is not experiencing symptoms of mental illness.

Q Would it be fair to say that that would be ideations or intent as part of a personality versus a mental illness?

A Correct. Correct.

Q Understood. Dr. Frierson, as part of this report, did you make any recommendations to the department regarding Mr. Carter's discharge?

A Yes.

Q Looking at Page 10, is it your understanding these

are your recommendations you made to the department?
A Yes.
Q Okay. Going to number one related to Mr. Carter remaining on a long-acting injectable antipsychotic medication, is it your understanding that Mr. Carter is currently on a long-acting injectable antipsychotic medication?
A Yes.
Q Can you tell me, and for the Court's benefit, why being on a long-acting injectable would be beneficial and necessary for Mr. Carter?
A It would be beneficial because there's no way to hide not taking it. You either show up for your shot or you don't. And the nurse sees the injection and the medicine go into the body, so we know he's getting the medicine. You don't cheat an injection. I mean, he's never done that anyway. But it's just another level of insurance.

And for me, I would not necessarily say he needs that if it wasn't for the index offense. And it's just an added layer of protection.

When I look at patients, I look at their history. And if someone has engaged in an act that lead to the death of another person, then I want to make sure we're taking every precaution possible to prevent them from -- or every reasonable, let me say, because there's always --

we could never let them out of the hospital and they're never going to injure anyone. But reasonable precautions given the clinical situation to prevent decompensation or relapse.

Q Understood. Looking at number two that's related to Mr. Carter's Cannibis use, you indicated that you would recommend periodic and unannounced drug screens for, at least, one year following discharge. Why would that be?

A Just to make sure that when he goes back to the community that he doesn't engage in using any further marijuana. Doing it -- you know, spot checks rather than scheduled. If he were to test positive, then I think that should lead to possible return to the hospital.

Q And aside from being illegal in the State of South Carolina, why would marijuana use be problematic for Mr. Carter?

A Because Cannabinoids can worsen symptoms of psychosis.

Q Understood.

A They can make voices worse.

Q And is it your understanding that the clinics that will be following Mr. Carter have the ability to test him for drugs?

A Yes.

Q Moving down to number three. You recommended that

the department ensure that he is on the NICS list. What is the NICS as far as you know?

A That's the National Instant Criminal Background Check System. Like, if you walk into a store to buy a firearm or ammunition, they're supposed to run a screen through that system to make sure you are not identified as a person who is prohibited from purchasing or possessing a firearm or a concealed weapons permit.

Q Understood. And why would that be important for someone like Mr. Carter?

A Well, there have been reports in other states that people who are found not guilty by reason of insanity were not reported to that system. And they're supposed to be by law. But, you know, given that fact, I think it behooves the Department of Mental Health to make sure that that's been reported.

Q And to your understanding, would -- an order that would render from today's hearing, would submitting that to the NICS qualify Mr. Carter to be on the NICS list?

A Yes. The order that found him not guilty by reason of insanity, that formal adjudication order would suffice.

Q Understood. For number four, you indicated at the time of the assessment that Mr. Carter's final discharge plan had not been, let's say, finalized. Is that the case?

A That was in April when I first saw him.
Q What is your understanding of Mr. Carter's ultimate discharge destination at this point?
A I've been told since then that they want to discharge him to his grandmother's custody in her home here in Greenville, that there has been a tour of the home virtually by Dr. Alleyne. There have been interviews with his grandmother to make sure she understands what his treatment plan, if he were to come live with her, would be, the warning signs of decompensation and what she should do if she has any concerns.
Q And do you believe the discharge to his grandmother's home would be proper for Mr. Carter?
A Yes.
Q Why?
A He is 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. What I mean by that, he has social skills. He can engage in joking conversations, enjoying life. He maintains his hygiene without any problem. He's able to physically take care of his grooming, that kind of thing.

And persons that are that high functioning will do better when they're placed in a place where they have opportunities to socialize with other people that have

social skills and to interact with the community, pursue things to maximize their potential, like education, which is not always possible in a CRCF.

Q And with you learning that Mr. Carter is going to be discharging to a home as opposed to a CRCF, does that change your opinion as it relates to his violence risk assessment?

A No.

Q And on number five, Mr. Carter reports a desire to resume his education. This is highly recommended as is known that a risk for violence and educational level are adversely proportional. What do you mean by adversely proportional?

A The more education a person has, the less likely they are to engage in violent behaviors. So education is protective. Mr. Carter was expected in the fall of the year where this index offense happened to enter the bridge program, which is a technical college, I believe, here in the upstate with a plan to, eventually, transfer to Clemson. He would like to -- not necessarily that program, but to -- he's still motivated to get on with his life and further his education.

Q Understood. Do you believe that if Mr. Carter were to remain at Bryan Psychiatric Forensic Hospital he would be able to obtain the kind of education he is looking to

receive at this time?
A No.
Q If he were to be discharged to a CRCF, do you believe that he would be able to get that kind of education?
A I don't know of any CRCF where that would be available. I have not visited every single CRCF in South Carolina, so I don't know. I would be surprised, but I don't know.
Q Do you believe that discharge to his grandmother's residence would provide Mr. Carter the kind of latitude to allow him to further his education?
A Yes.
Q Understood. Dr. Frierson, in reviewing all of this, do you believe that Mr. Carter is getting any additional therapeutic benefit by remaining inpatient at Bryan Hospital?
A No.
Q Do you believe that the discharge plan as it's been related today and the reports, as well as the proposed order in this matter is clinically appropriate for Mr. Carter?
A I do.
Q Do you believe that such a discharge would be therapeutic for Mr. Carter?
A It would be the most therapeutic option.

MR. ROYALS: Your Honor, that's all I have.

THE COURT: All right.

MR. BREWER: Just briefly, Your Honor.

DIRECT EXAMINATION

BY MR. BREWER:

Q Dr. Frierson, you said you had worked at the Department of Mental Health Services previously?

A Yeah. The distant past, yes.

Q And you were present here today when Dr. Alleyne was testifying about her obligations and relationship to Mr. Carter?

A Yes.

Q And you heard her detail the volume of interaction, the records under review, the supervision and observation that he was under during his time -- his time at the mental health hospital?

A Yes.

Q And in your expert opinion, is -- the supervision, monitoring records, volume of time, therapy group and individual sessions that Mr. Carter has been subjected to over this year's time, is that a sufficient amount of observation to make a decision about his need for hospitalization going forward beyond a reasonable degree of medical certainty?

A I think it's much more than an adequate amount, but,

yes.

MR. BREWER: Thank you.

No further questions.

THE COURT: Mr. Miller.

CROSS-EXAMINATION

BY MR. MILLER:

Q Dr. Frierson, was Mr. Carter notified of the reason for the interview?

A Yes.

Q He was told this was part of a violence risk assessment?

A Yes.

Q And there were a total of just under four hours of interviews; is that correct?

A Four hours and 30 minutes, plus reviewing of records from the inpatient, the progress note, the treatment team notes, and other people's observations of him.

Q Okay. What did y'all discuss during your interviews, just generally?

A Well, first of all, just getting to know who he is, then getting to know his mental health history, what led to his coming to the hospital. So we went through the index offense, what happened, what he was thinking about. I wanted to see his affect or expression when he reports about what happened.

Q Did he discuss the details of the index offense?
A Some of them, yes.
Q Okay. So he discussed how he did, in fact, break into Ms. Mattison's home at night?
A Yes.
Q And he did, in fact, take her life?
A I'm sorry?
Q He did, in fact, take her life?
A Yes.
Q Did he show any sort of remorse or understanding of the gravity of that situation?
A Yes.
Q How did he do that?
A Through his facial expressions. He, also, talked about how that action has impacted other people in the family.
Q Okay.
A And how it has changed his life. This is something he will always have to live with, the knowledge that this happened. And all he can do is try to move forward the best way he can and see how successful he can try to be with the life that he has remaining.
Q If Mr. Carter were to remain on the three medications we discussed earlier with Dr. Alleyne, can you guarantee with any medical certainty whether or not he will act out

violently in the future?
A I can't guarantee whether you won't act out violently in the future. There's just no guarantee. We are not mind readers. Predicting violent behavior is difficult. It's like predicting when there's going to be an earthquake or predicting when there's going to be a volcano, because they are rare events. So we don't get into the business of saying we can predict or guarantee.
Q Okay. So along --
A But this gives him the best chance of not behaving or having any further problems. And the fact that he has been stable for an entire year, I would imagine if he continues with this regimen that he would remain stable.
Q And I believe you included that in your report, that there is no -- to a medical degree, 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.
Q Okay. Would the likelihood of violence increase if he stopped taking the oral medication?
A I'm not as worried about the oral -- I mean, maybe very slightly. I'm more worried about the antipsychotic medication because it's delusions that led to the violent behavior before.
Q So if he were to miss a dose of that injection, can

you with any -- can you make any prediction as to the risk of violence in that situation?

A I think the -- the more time that elapses after the scheduled dose was due, the more likely he is to experience a recurrence of the symptoms. If he had a return of the symptoms, it is possible that he could develop a delusion about another person and engage in violent behavior towards that other person.

Q Okay. So we talked a little bit about violent ideations and intent. So those are not part of his personality, but are those present in his illness, would you say?

A Yeah. They were present, obviously, when this index offense occurred. But they were motivated by delusions that the victim was harming people and that's what motivated them.

Q Okay. And your main recommendation here says that failure to take a scheduled dose of his medication -- this medication should be grounds for rehospitalization. Would you advocate for immediate hospitalization?

A It depends on why he missed it.

Q What do you mean by that?

A Let's say he gets in a car wreck on the way to the mental health center and gets diverted to a hospital and he misses his appointment because he was unable to attend.

Do I think that requires immediate rehospitalization? No. If he purposely chose not to go and there wasn't, you know, some miscommunication about the appointment date, then that's a different story. I think you have to base your decision on what the clinical factors are at the time and depending on the reason and what happened.

Q Okay. And you discussed on direct a little bit about Mr. Carter's family and the situation. Have you met them before today?

A No.

Q Okay. So you did not interview any of them?

A I didn't know that that was the discharge plan when I first -- when I saw him in April.

Q Okay. So your recommendations really don't have any insight on that situation?

A Other than what I have been told.

Q Okay.

A I mean, I know the mother has bipolar disorder. I know the mother has a history of neglect charge when he was about 17 because he was left at home with a much younger child and there was evidence of marijuana in the home. I'm aware of that.

I'm aware that his grandmother is a nurse and is a -- from what I've been told been interviewed, appears to be reliable and stable on interview, like you would interview

somebody you were going to get a job. So that's what I know about his family now.

I wasn't looking necessarily at his family back then in April. There was thinking about a CRCF. And I thought then, well, he's not going to do well at Turning Point. Well, he will do well, but it's not therapeutic for him because the people at that particular CRCF are relatively much lower functioning than Mr. Carter. I doubt that he would have much in common to talk to them about, actually. But they were going to see if there were any other CRCFs with really high functioning patients that he might be appropriate for.

The problem is CRCFs, by definition, are -- sort of exist to help people who cannot do certain tasks that Mr. Carter can do. So it's -- you know, it's hard to find the perfect solution.

Q Okay. But at the end of the day, this is their opinion developed based on materials in front of you and there are no guarantees?

A Yes. That's -- yeah. That's, I think, the best that anybody in my situation can do.

MR. MILLER: No further questions, Your Honor.

THE COURT: All right.

MR. ROYALS: No redirect. Your Honor.

MR. BREWER: None, Your Honor.

THE COURT: All right. You can step down.

All right. Do we need to keep him or can he be excused?

MR. ROYALS: He's driving himself, Your Honor. I don't believe I'll need him.

THE COURT: Any objection?

MR. MILLER: No, Your Honor.

THE COURT: Okay. Let's see, you've got how many more?

MR. ROYALS: That's all of the witnesses, Your Honor.

THE COURT: That's it?

MR. ROYALS: Yes, sir.

THE COURT: All right. And anything?

MR. MILLER: Your Honor, there are some representatives of the victim's family here. I don't know if they want to address the Court in any way.

THE COURT: I'll be glad to hear from them if they want to.

What I'm going to do is, y'all stand right there. I'll go in the order. The only thing I want you to do -- I'm going to put you under oath because that's procedure, what we do. And after that, I need you to speak loud enough so that the young lady that's right in front of me can take down what you say.

So I'm going to ask your name, young man, since

you're on the front row.

What's your name?

MR. NICK WHITNER: My name is Nick Whitner.

THE COURT: Nick Whitner?

MR. NICK WHITNER: Yes, sir.

THE COURT: Raise your right hand for me, Mr. Whitner.

WHEREUPON,

NICK WHITNER,

after first having been duly sworn, testified as follows:

THE COURT: All right. What do you want to tell me?

MR. NICK WHITNER: Well, Your Honor, first of all, thank you for giving me the opportunity to be able to speak on behalf of my aunt, Frances Mattison. I'm her great nephew.

I'm, also, the person that made the 911 call that morning. So this is a very near and dear situation to my heart. I want to point out that she was the matriarch of our family, the last of 10 siblings. I know you weren't the Judge that was here for the last hearing, but I just wanted to let that be known.

I, also, wanted to point out the fact that Mr. Royal, Ms. Alleyne, and the Department of Mental Health hasn't spent as much time as we spent in this courtroom for the hearings evaluating the Defendant. I mean, a couple of

hours, that's not enough time to determine if he's a danger to this community.

I want to point out, again, he's -- he killed a family member. And they want to release him to family. It just doesn't make sense, sir, you know. He's a danger to others.

And they've been talking about him wanting to continue his life. What about her life? What about her life? Do we want to allow him into society, into a school so he can continue his education around other students? Do we want him around -- his mom and grandmom aren't even safe if we want to be matter of fact. And I ask that you really sit down and think about this situation. We're here because he killed somebody.

I appreciate the time you've given me to speak on behalf of my family. We ask that you stop wasting the county and the State's time and money by even having these hearings and keep him where he needs to be.

He's stable right now because he's on medications. He's being monitored and he's in a facility. That's where he belongs. They should feel blessed enough that Mr. Carter isn't in a jail cell. The fact that he's in these mental facilities is a blessing alone, Your Honor.

So, again, I ask that you take some careful consideration and just do the right thing on behalf of my

aunt and my family.

Thank you.

THE COURT: Thank you, sir.

MR. MILLER: The other family members do not wish to speak. The victim's granddaughter that lives out of state submitted a written statement.

THE COURT: You've seen it?

MR. ROYALS: Yes, Your Honor. No objection.

THE COURT: Okay.

MR. MILLER: And, Your Honor, there are some investigators from the case here just on the State's behalf.

THE COURT: All right. Do they want to share anything?

MR. MILLER: I don't believe they want to address the Court. But they are -- they are -- I believe they would just like to say they're opposed to the proposal, not out of a sense of vindictiveness, but a danger to the community standpoint, Your Honor.

THE COURT: Counsel, since you provided this to me, I'm just going to make sure the record is pristine. I'm going to go ahead and read this into the record. This is a letter dated August 29th, 2023.

It says, Good morning, Your Honor. My name is Stephonee Smith. Georgia was my grandmother. It's with a

heavy heart we end up here again in less than six months.

I was astonished when I received the call from the solicitor's office stating that Mr. Carter would be coming to court in such a short period. My heart is broken because it feels as if Georgia is being forgotten and Mr. Carter is not being held accountable.

I am, also, fearful that releasing Mr. Carter in such a short timeframe will result in the death of someone else's loved one. Another family will have to deal with a traumatic event such as this and be left to deal with the aftermath of grief and loss, just like my mother, Linda Smith, has to. My mother has experienced immense loss throughout her life. Along with her mother, she has, also, lost her husband and two oldest sons. I wonder every day how she has managed losing her mother in such a brutal manner and how much more grief can she carry.

I think about my grandmother every day. Prior to her murder, I would pick up the phone to call her or I would send her flowers to let her know I was thinking of her. Due to Mr. Carter's actions, I can no longer do those things. I can only hold in my heart this feeling and hope she can feel it, too. My grandmother was everything to us and her life was stolen.

Your Honor, I sincerely urge you to consider whether or not Mr. Carter is safe to be back in the community or

if he is still a danger. Please don't let another family experience trauma at the hands of Mr. Carter.

This was signed by Stephonee, S-T-E-P-H-O-N-E-E, Smith, Georgia's granddaughter. And that was dated today's date, August 29th -- or yesterday's date, August 29th, 2023.

And I'm going to let the court reporter just mark this, if that's okay.

MR. MILLER: Yes, Your Honor. That's fine.

THE COURT: Any objection to that?

MR. ROYALS: No.

THE COURT: I'm going to give these back to Madam Court Reporter.

And I think based on -- counsel indicated no one else wants to say anything; is that right? Am I correct in that?

MR. MILLER: That's correct, Your Honor.

THE COURT: All right. Gentlemen, what I am going to do is a number of things have been submitted to the Court, either by way of e-mail or personally hand delivered documents. And I've also -- in that is, also, the order of Judge Gravely back in January, I think, of this year when you had the prior hearing. This was about six or seven months ago.

So what I'm going to do is I'm going to ask both

sides to do, essentially, the same thing that Judge Gravely asked you to do last time, submit me a brief/memorandum outlining your respective positions and the -- any support you might want to render for that position.

And, certainly, my role -- and I want to -- the family to know that my role as the judge of the law is to look at the law and make decisions based purely on that basis. And that's what I'm mandated to do. So it's tragic that you have to be here. I understand that. But I will look at the information submitted to me by both sides. And I will quickly render a decision once I have the opportunity to review what I have.

I'm going to give you about 30 days.

Is that enough time for you to submit me a brief/memorandum, Mr. Royals, Mr. Miller, and Mr. Brewer?

MR. BREWER: We'll do it much sooner, Your Honor.

MR. MILLER: Yes, Your Honor.

THE COURT: So the sooner you get it to me, the sooner I can take a look at it.

MR. ROYALS: Your Honor, if I may, I know we're sitting at the same table, I do represent the department and not Mr. Carter himself. I was hoping if Mr. Brewer has anything to say from his side -- I got the whole day. I just wanted to make sure he had a chance.

THE COURT: Yes. And I'll be glad, Mr. Brewer, for you to say anything. And, certainly, I've got your memorandum you gave me. But I'll be happy to open the floor up to you for you to say anything.

MR. BREWER: Your Honor --

THE COURT: And, also, I don't know if -- what protocol dictates, but Mr. Carter is sitting here. And, I mean, if he wants to say anything, you know, he can, also, have an opportunity to do that as well if he chooses to do that.

MR. BREWER: Thank you, Your Honor.

Your Honor, there's a lot to say. You've given us this opportunity to file a memorandum in support. I don't want to abuse Your Honor's time. If I could just's -- as briefly as I can, I'd like to start -- and I say this every time and you've heard it independently from two doctors, but Mr. Carter, Jevon, is desperately sorry to the Mattison family. And everybody that stands by Jevon as to this process is deeply sorry to the Mattison family. And it is, literally, his great, great aunt, Your Honor. He's devastated by it. We're devastated with him.

And precisely because the mental health issue has been remedied, both with treatment and medicine. You heard some testimony about this today. He sits very sober with a deep reality of what he was associated with. And

he wishes it would have never happened for her and for them.

I think what I'd like them -- say to the Court is what is unequivocally true, that both parties agreed to is he was adjudicated not guilty by reason of insanity. He was out of his mind sick on the incident date.

And both parties, also, agreed at that same time that he should not be held accountable for those actions because he is not accountable medically or legally. And by virtue of those decisions, Judge -- and this is -- Mr. Whitner is not a lawyer. They're not lawyers. I don't expect them to know.

But, Your Honor, we have the South Carolina Supreme Court -- the solicitor's offices knows it, we've talked about it ad nauseam. We talked about it with Judge Gravely. We have an entire administrative order dictating these procedures, everything from the 120 days when the Department of Mental Health has to come back to the supervision of probation. And we knew these days were coming. None of this is a surprise. This is the procedure that everybody submitted to, Your Honor.

And, importantly -- and these are not my words. It's been used a lot in here. These are the words of our South Carolina Supreme Court in the administrative order and in the statute, Your Honor, in Section 17-24-40, which

governs this. This is a therapeutic moment, not a punitive one. It's not my words. This is our General Assembly's words. It's our Supreme Court's words. And it's the words of the United States Supreme Court.

And so even though this process feels very alien and strange to a bunch of us in this room who haven't touched this a bunch, it happens all the time because this is the way it happens. We heard testimony today that 47 people that are, actually -- not to disparage, but are much more significant risk than Mr. Carter based on his high functioning are, actually, out and under monitoring and have been discharged who are charged with serious crimes, murder and attempted murder.

Judge, I think there -- and this is the most important part, there are two questions before Your Honor, and the first is a Constitutional one. Does he need -- it's Constitutional and medical. Does he need further hospitalization? That's the threshold question. And the only evidence we have ever had and we have here today beyond clear and convincing and all the other is the medical testimony of two experts unrebutted that he no longer needs hospitalization.

And once that threshold is met -- and they have an obligation. I mean, I understand their concerns. But once that obligation is met, they have to come forward

with clear and convincing evidence that that's not -- that he needs hospitalization. And they never have. The part -- and this is very respectfully, the part that they conflate with that is the conditions of release.

That's the second question, what are the conditions of release? And, Your Honor, that's your -- again, respectfully, and you know this, that's your role. The experts in this case have made recommendations. But Your Honor can make some different decisions about how that looks. I've asked the Government for their recommendations. They haven't offered any.

But what can't be done -- and I would offer -- it's in our memorandum to some extent, but I would offer additionally Foucha vs. Louisiana, 112 SC Supreme Court 1780. Once that threshold is met, that he no longer needs hospitalization, he has to be discharged. It's Unconstitutional to hold him. The question there is just what are the conditions? And Your Honor is well positioned -- if there's any concerns about what's been recommended, Your Honor is well positioned to modify those in various degrees.

Your Honor, nobody knew that Jevon was sick. This was a genetic hidden disease in July when this happened. Nobody knew. And it was triggered by the tragic death of his girlfriend that happened. You've heard today he had

no previous history of violence, or acting out, or antisocial. And he's had none since he's been properly medicated.

And so DMH, they're not -- Judge, this is the other part. This is the State of South Carolina. I didn't hire them. Jevon didn't hire them. The State of South Carolina has entered your courtroom and rendered their expert opinion twice over. They have no incentive to be wrong. It's quite the opposite.

And, Your Honor, we would just respectfully request that you accept those recommendations. And along those lines, I've sort of beat this horse. They've submitted a proposed order, Your Honor. It's in Microsoft Word. It can be modified. That is not a fixed recommendation. And, Your Honor, we'd ask you to accept the recommendation of discharge and modify that order in whatever way you feel is appropriate.

THE COURT: How are these parties -- give me a little bit -- tell me a little bit about the family relationship, the family unit relationship. He was related?

MR. BREWER: On his paternal side. So she is a great aunt on his paternal side.

THE COURT: The victim was a great aunt on his paternal side?

MR. BREWER: That's correct.

THE COURT: What's the relationship between the -- the suggested grandparent or parent? How is that -- how are these parties connected?

Because I think Mr. Whitner made a point about this involved family. And now, you're -- the placement is being suggested to family. What's the -- keep in mind, now, I don't know anything about this case, other than what you guys are telling me. I don't know the facts. I know what occurred.

But what's the relationship between all of these [sic] family?

What's concerning is I did not hear anything about the family. All I heard was that the -- Mr. Carter by being placed with the family will have normal social skills -- or exhibit normal skills. And I think the first witness talked about that. But I know nothing about the family, nothing except a witness that says this family is going to be -- is going to be therapeutic in nature. But I don't know anything about that.

MR. BREWER: And I appreciate that. I meant to start there, Your Honor. I'd like to start.

So Ms. Cynthia Chapman, if you'd stand, please, for a second.

This is Ms. Cynthia Chapman. This is, actually, Jevon's grandmother. This is the individual that lives at

the residence that's been identified.

Ms. Young, Keshawna Young, this is Jevon's mother, who lives in the --

THE COURT: How are these parties interacted with the deceased?

MR. BREWER: They are his -- so this is his mother. This is his maternal grandmother. They don't live near each other. And this is Ms. Tamara Carter. And she actually -- and I --

Maybe I should let you explain.

But she is associated with the paternal side of the family and is in support of this outcome.

THE COURT: How are the three of you -- and in no specific order. How -- how are the three of you connected to Ms. Mattison, the deceased?

MS. KESHAWNA YOUNG: I'm not.

THE COURT: Hold on. Let me start right here.

What's your name, ma'am?

MS. CYNTHIA CHAPMAN: Cynthia Chapman.

THE COURT: Cynthia Chapman?

MS. CYNTHIA CHAPMAN: Yes.

THE COURT: And what's your name, ma'am, right next to her?

MS. KESHAWNA YOUNG: Keshawna Young.

THE COURT: Keshawna Young. Spell your first name.

MS. KESHAWNA YOUNG: K-E-S-H-A-W-N-A.
THE COURT: Ma'am, what's your name?
MS. TAMARA CARTER: My name is Tamara Carter.
THE COURT: Tamara Carter?
MS. TAMARA CARTER: Yes.
THE COURT: In what way, if at all, do you know the deceased, Ms. Mattison?
MS. CYNTHIA CHAPMAN: Oh, I just know that she's Jevon Carter's great aunt.
THE COURT: You never met her?
MS. CYNTHIA CHAPMAN: No. I never met her.
THE COURT: You never had any contact with her?
MS. CYNTHIA CHAPMAN: No.
THE COURT: All right. What's your name?
MS. KESHAWNA YOUNG: Keshawna. No. I don't know her.
THE COURT: You don't know who she is at all?
MS. KESHAWNA YOUNG: No.
THE COURT: And, ma'am, what's your name?
MS. TAMARA CARTER: My name is Tamara Carter. I'm Jevon's aunt.
THE COURT: You haven't met the deceased?
MS. TAMARA CARTER: Yes. That's my family over there. So you can imagine how hard this is for me.
THE COURT: So what relationship are you to the

deceased?

MS. TAMARA CARTER: To the deceased, she was my great aunt.

THE COURT: She was your great aunt?

MS. TAMARA CARTER: Yes, sir.

THE COURT: These families, y'all have lived in close proximity to one another?

MS. TAMARA CARTER: The same neighborhood, yes, sir. We grew up in the same neighborhood.

THE COURT: What neighborhood would that be?

MS. TAMARA CARTER: That would be the Nicholtown community.

MR. BREWER: Just to clarify, Ms. Cynthia and Ms. Young do not live in that same community. They do not live -- and that's not where Mr. Carter is being recommended to live.

THE COURT: What -- he's being recommended to Nicholtown --

MR. BREWER: No, he is not.

THE COURT: Where?

MR. BREWER: It's near Cherrydale, Your Honor.

THE COURT: With who?

MR. BREWER: Ms. Cynthia Chapman, in the pink right there.

THE COURT: Who lives with you, ma'am?

MS. CYNTHIA CHAPMAN: My -- it's a brother. I'm taking care of his brother.

THE COURT: His brother lives with you?

MS. CYNTHIA CHAPMAN: Yes.

THE COURT: Other than that, who lives with you?

MS. CYNTHIA CHAPMAN: My fiance.

THE COURT: Your boyfriend?

MS. CYNTHIA CHAPMAN: Yeah, from time to time.

THE COURT: He's there from time to time?

MS. CYNTHIA CHAPMAN: He is.

THE COURT: Okay. Other than that, who?

MS. CYNTHIA CHAPMAN: Excuse me?

THE COURT: Other than that, who else lives there?

MS. CYNTHIA CHAPMAN: Oh, nobody.

THE COURT: Do you work during the day?

MS. CYNTHIA CHAPMAN: Yes.

THE COURT: Where do you work?

MS. CYNTHIA CHAPMAN: At CVS Academy. I take care of handicapped kids and people that come in there that need to be treated that's got disabilities.

THE COURT: What are your work hours?

MS. CYNTHIA CHAPMAN: 11:00 to 6:00. I just work part-time.

THE COURT: And your fiance that lives there, does he work?

MS. CYNTHIA CHAPMAN: Oh, yes, sir.

THE COURT: Where does he work?

MS. CYNTHIA CHAPMAN: He works for Ike's Cleaning Company.

THE COURT: Anybody in the house have any prior involvement with the law, if you're privileged to tell me that? You don't have to tell me what. Say either "yes" or "no."

MS. CYNTHIA CHAPMAN: No.

THE COURT: Here's my question, I was sitting here listening to all of this. I'm just trying to fathom in my mind -- because it was talked about this environment being a therapeutic environment.

MR. BREWER: In the sense that it's family.

THE COURT: It's family.

MR. BREWER: Judge, I think the hard thing to process is -- and, again, that's why I think this administrative order is so important and the statute. The NGRI process doesn't -- it's not a pre-trial detention bond situation. It anticipates, based on the recommendation of experts, that someone would be released unsupervised. It is not a pre-trial detention.

So it's a little confusing. That's why I think you heard the expert say over and over again, Mr. Carter is responsible for Mr. Carter from their recommended

perspective, but, also, legally. And you'll see a little bit in the case law. I mean, if he commits a crime, he will be arrested. If he violates your order, he will be picked up and brought back to the Department of Mental Health services.

But we can't -- and this is the other part and this will show up in our memorandum to Your Honor. But the generalized concerns about the underlying conduct can't be the basis just for endless extrapolated risks going forward. It's a determination right now. It's a medical determination right now as to whether he needs hospitalization. It's not a question of whether he has to be incarcerated indefinitely because he committed a crime under the influence of a horrible psychotic disease. That's not what the law asks.

THE COURT: All right. Just submit me what I requested. And then I will make a decision.

(WHEREUPON, State's Exhibit No. 2 was marked for identification and admitted into evidence.)

**********END OF TRANSCRIPT OF RECORD**********

STATE OF SOUTH CAROLINA	)	
	)	COURT OF GENERAL SESSIONS
COUNTY OF GREENVILLE	)	2021-GS-23-05230; 05231
	)	
	)	
	)	
THE STATE	)	
PLAINTIFF	)	
vs.	)	TRANSCRIPT OF RECORD
	)	
JEVON KENNETH CARTER	)	
DEFENDANT	)	

December 8, 2022
Greenville, South Carolina

B E F O R E:

THE HONROABLE PERRY H. GRAVELY, Judge.

A P P E A R A N C E S:

ANDREW MILLER, ESQ.
Attorney for the State

JOE BREWER, ESQ.
Attorney for the Defendant

LOGAN ROYALS, ESQ.
Attorney for the South Carolina Department of Mental Health

APRIL HERRON
Official Court Reporter

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December 8, 2022

THE COURT: All right, be glad to hear from you.

MR. ROYALS: Thank you, Your Honor, may I approach?

THE COURT: Yes.

MR. ROYALS: Thank you, Your Honor, may it please The Court. I'm Logan Royals for The Department of Mental Health. Your Honor, we're here today on The Department's motion for outpatient treatment for Mr. Kenneth Jevon Carter. This is Indictment No. 2021-GS-23-05230 through 31. Your Honor, Mr. Carter was found not guilty by reason of insanity on June 13th of this year on the charges of voluntary manslaughter, burglary first, as well as possession of a weapon during the commission of a violent crime. Shortly after that, Your Honor, Mr. Carter was admitted to the Department of Mental Health inpatient treatment by virtue of the statutes governing NGRI treatment. He was admitted on August 16th of this year and has been in treatment at the department since that time.

Your Honor, under the statute Mr. Carter is entitled to a hearing at the 120 day mark at inpatient care. Whereupon The Department will make a recommendation for his treatment to continue with

inpatient to outpatient. Your Honor, The Department is recommending outpatient treatment for Mr. Carter, at this time, based on his current treatment and how well he is doing with his mental health treatment. Your Honor, the current plan is for him to be discharged to his mother's home at 5 Harrison Avenue in Greenville. He would, also, be followed by the department's Forensic Outreach Clinic. He would receive mental health treatment through the Greenville Greater Health Clinic here in the Upstate area. And he would, also, be monitored the by Department of Probation Pardon and Parole.

Your Honor, just as aside, we do have probation, pardon and parole in the courtroom today, Kayla Gibbs, representing PPP. I do not anticipate any questions for them. I just wanted to let you know they are here if Your Honor does have any questions for them. Your Honor, in anticipation of questions from The State, as well as Your Honor, I have brought Jevon's current treating psychiatrist, Dr. Jennfier Alleyne. And with your lead, Your Honor, I call her for direct testimony.

THE COURT: Yes, you may proceed.

MR. ROYALS: The Department calls Jennifer Alleyne.

THE CLERK: Ma'am, if you'd please come forward. Please pause at the end of the bench. And place your left hand on the Bible and raise your right hand.

JENNIFER ALLEYNE, after being duly sworn{,}testified as follows:{F}

THE CLERK: Thank you, please be seated. And would you, please, state your name for the record?

THE WITNESS: Jennifer Alleyne.

THE CLERK: Thank you.

THE WITNESS: A-L-L-E-Y-N-E.

THE CLERK: Thank you, ma'am.

MR. ROYALS: May I proceed, Your Honor?

THE COURT: Yes, sir.

MR. ROYALS: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. ROYALS:

Q Dr. Alleyne, thank you for being here today, we certainly appreciate it. Would you mind just, briefly, giving us a brief background of the recitation of your educational background?

A Absolutely. I received a Bachelor's of Science in Psychology from the University of Connecticut in 2006. I then went to medical school at Ross University and graduated in 2010. I attended a general psychiatry residency at the University of Louisville in Kentucky and

graduate in 2015. At which time, I started a forensic psychiatry fellowship at the University of South Carolina for one year, graduating in 2016. And then I started working for The Department of Mental Health.

Q When you say you work for The Department of Mental Health, what is your current role?

A I am the chief psychiatrist for the forensic hospital for The State of South Carolina.

Q And what license do you currently hold?

A I carry a South Carolina License in Medicine for Psychiatry.

Q And are you a member of any professional organizations related to psychiatry?

A Yes, I belong to the American Psychiatric Association, The South Carolina Psychiatric Association and The American Academy of Psychiatry and the Law.

Q Thank you, doctor.

MR. ROYALS: Your Honor, I would move to qualify Dr. Alleyne in the field of forensic psychiatry.

THE COURT: Any objections or voir dire from The State?

MR. MILLER: No objection, Your Honor.

THE COURT: On behalf of Mr. Carter?

MR. BREWER: No, Your Honor.

THE COURT: Okay.

All right, then so qualified.

MR. ROYALS: Thank you, Your Honor.

THE COURT: In the field of psychiatry, is that what you said?

MR. ROYALS: Forensic psychiatry.

THE COURT: Forensic, okay.

MR. ROYALS: Thank you.

BY MR. ROYALS:

Q Dr. Alleyne, how do you know Mr. Carter?

A I have been his treating psychiatrist since his admission in August of this year.

Q And when you say treating psychiatrist, where is he currently treated at?

A He is being treated at Brian Psychiatric Hospital Forensics Division in Columbia, South Carolina.

Q Okay. And what ailments is Mr. Carter being treated for at Brian Forensics?

A He's being treated for schizoaffective disorder bipolar type.

Q Okay. And for somebody like for me that's not a doctor, could you, please, explain what that means systematically and what that looks like for a person?

A So Schizoaffective disorder is a psychiatric illness in which people have symptoms of psychosis. Which could be things like auditory and visual hallucinations.

Could be disorganized thoughts or behaviors. Could be delusional beliefs, grandiose beliefs, paranoid beliefs. Can also be what we consider negative symptoms. So lack of affect or kind of loss of interest in doing things and inability to care for themselves. And then it, also, has a mood component, which would be like mood elevations, irritability, sometimes depressive symptoms. It just depends on which part of the bipolar spectrum they are.

Q Okay. And how would you, typically, treat somebody with schizoaffective disorder?

A You treat them with a combination of mood stabilizers and antipsychotic medications.

Q Is Mr. Carter currently on any antipsychotic or mood stabilizers?

A Yes. He takes an antipsychotic called, Aristada, which is a long-acting injectable version of Abilify. He also takes a mood stabilizer called, Trileptal. And then he takes a sleeping medicine.

Q And how are those administered?

A The antipsychotic is a once monthly injection. And the other two medications he takes orally.

Q And who administers the injection?

A This is administered by nurse and staff.

Q Okay. Dr. Alleyne, just to clarify, you've been treating Mr. Carter since he's been at Brian forensics; is

that true?

A Yes, sir.

Q So you were there when he was admitted?

A Yes.

Q How would you characterize his temperament, for lack of a better word, whenever he was admitted?

A He was calm, cool, collected, polite, cooperative, appropriately interacted, answered all of our questions. He was very nice.

Q Did he display any psychotic symptoms at admission?

A He did not.

Q It is typical for people to be admitted without any psychotic symptoms to Brian Forensics.

A It's pretty rare that we get patients that are as stable as Mr. Carter was on admission.

Q And how do you account for his condition at admission?

A He was adherent with his medications throughout the entire time with the detention center.

Q And were those medications at the detention center, relatively similar to the ones you have him on currently?

A It's the same medications with the exception of we transitioned his antipsychotic from oral to injectable.

Q Okay. Thank you. Doctor, since his admission -- or would you mind telling me, to a doctor, what insight means, when you're talking about somebody's insight to their mental illness?

A So insight is a patient's understanding of what their symptoms are. What their diagnosis is and what their medications do for them and the need to take those medications, as well as engage in the treatment process.

Q Okay. And as of today, how would you characterize Mr. Carter's insight into his mental illness?

A I, actually, think that Mr. Carter has very good insight into his mental illness.

Q How so?

A He has demonstrated on numerous occasions an understanding of his symptoms. He has engaged in intelligent discussions with us about his medications, about potential side effects. He has shown us that he is invested in this treatment at the hospital. I have an example, that he had a scheduled phone call, actually, with his attorney, that he asked us to reschedule so he could attend his treatment groups. Which is pretty insightful for a patient in our facility.

Q Okay. Is it your opinion that Mr. Carter has the requisite insight into his mental illness, as of today, such that he would be able to treat himself

properly on a outpatient basis?

A Yes, it is.

Q Okay. And, doctor, I know you're familiar with the underlining crime that kinds of bring us all in today, and, obviously, that's on all of our minds as we're going through this process. The statute, also, calls for a understanding of whether or not somebody, by virtue of the mental illness, is likely to be a danger to themselves or to others. When you are making that analysis for one of your patients, what kind of things are you looking at to determine whether they are likely to be a danger to themselves or others, by virtue of mental illness?

A So we look at the stability of their illness. So the symptom cluster that they have, Mr. Carter, in particular, since his time in the detention center and his time with us, has not had any incidents of aggression or behavioral disturbances. He's been adherent with his medications throughout his hospitalization. He has avoided, you know, adverse incident with peers. So, you know, if people are disagreeing on the unit, he stays out of those kinds of arguments and disagreements. And we look at, obviously, past violent acts. And, I mean, aside from the index offense, Mr. Carter has a pretty clean history.

Q Okay. Using that as your guideline, do you

think that Mr. Carter is, to a reasonable degree of medical certainty, likely to be a danger to himself or others if he were allowed to be discharged under this outpatient order?

A To a reasonable degree of medical certainty, at this time, I do not think that Mr. Carter is a danger to himself or to others.

Q Okay, doctor. And I referenced the proposed discharge plan, have you had a chance to review my proposed order in this matter?

A Yes, I have.

Q Are you in agreement with its terms?

A Yes, I am.

Q Under the terms of this discharge plan, where would Mr. Carter be residing day-to-day?

A He would reside in a house with his mother, here in Greenville.

Q Okay. Have you had a chance to visit that home?

A I did.

Q And did you feel it would be appropriate for somebody like Mr. Carter?

A I did.

Q Whenever you are evaluating a home for somebody that's being discharged from forensics, what kind of things are you looking for to determine if it's

appropriate for them?

A Looking for the safety of the home. So the physical state of the home. Is it clean, it is -- is there electricity, is there running water, is there food? In this home, in particular, Mr. Carter would have his own bedroom, his own space. His family has kind of set it up with all of his belongings so it's something that is familiar to him. And then we, also, look at the interactions of the patient and the people that they're going to be living with. So we got to observe Mr. Carter with his family and some close family friends during our time at the home. And I thought that it was an appropriate place for him to go.

Q Okay. And did those interactions with both family and friends seem appropriate for somebody like Mr. Carter?

A Yes.

Q Okay. How so?

A They were very loving, caring. There were -- everyone was very excited to see each other. They greeted each other warmly. They caught up on what's been going on with everybody since the last time they had seen him. And they were just -- it was a loving, kind home.

Q Okay. Does Mr. Carter, to your knowledge, understand the terms of the order?

A Yes.

Q To your knowledge, does his mother seem to understand the terms of the order?

A I believe so.

Q Okay. Did he, at least, understand that readmission would be a possibility if he were not to comply with the order?

A Yes.

Q Okay. In terms of the actual order itself, I think we're all in agreement that Mr. Carter, for him, treatment is paramount for the importance for everybody involved. Who would Mr. Carter be treated by under the terms of this proposed order?

A The court order requires that the Greater Greenville Mental Health Center provide his outpatient psychiatric treatment. So he will see a psychiatrist. They will determine whether or not he needs, you know, case management, therapy, groups, et cetera and assign those accordingly. And then he will receive oversight from our Forensic Outreach Clinic. Which is a group of people located in Columbia who do drug testing and we have a psychiatrist on staff there who, also, assess him and make sure that he is doing well. And then a group of social workers that work there that review his mental health center records and communicate with the mental

health center about the treatment that he's receiving.

Q Okay. And, Dr. Alleyne, I alluded to this earlier, but understand the terms of this order, if Mr. Carter were to violate any of the terms, what would likely happen to him in that scenario?

A If Mr. Carter violates the terms of the proposed order, then he would immediately return to the hospital and we would notify The Court and request a hearing to let them know.

Q Okay. And by virtue of your position, have you seen other patients that have had outpatient orders be readmitted under those orders?

A Many times.

Q Okay. And, doctor, we keep talking about the potential terms, I know we talked about the treatment regimen, what are some of the other terms of this order that you think are appropriate for Mr. Carter?

A So the Outpatient Court Order requires that he attend and participate in treatment. Which is, obviously, the most important part. And requires that he adhere to his medications. It, also, requires that he attend groups as requested by the treatment staff. It requires that he sign releases of information so that treating staff can discuss him with each other to make sure that everybody knows what's going on. It requires that he not own

weapons. He's not allowed to use drugs or alcohol. He's not allowed to associate with felons outside of treatment programming. And I think that's all of it.

Q Well, would the prohibition on drugs and alcohol, would any of the entities you mentioned a moment ago, have the ability to drug test him to make sure that he's abstaining from drugs and alcohol?

A He will receive drug tests from both the mental health center and The Forensic Outreach Clinic. And if I'm not mistaken, probation, pardon and parole can also mandate that he get a drug test, if they have concerns.

Q Would any of those entities, also, be able to ensure that any medicine that Mr. Carter is taking, remains at a therapeutic level by virtue of a blood test?

A Yes. The Forensic Outreach Clinic and the mental health center both have the ability to check his drug levels in his blood.

Q Okay. Dr. Alleyne, with you having treating Mr. Carter, do you believe that he is appropriate for outpatient care, at this time?

A At this time, I do think that outpatient care would be most appropriate for Mr. Carter.

Q Do you believe that Mr. Carter could glean any additional benefit from remaining inpatient treatment, at this time?

A I do not think that continued inpatient would be of any further benefit.

Q Okay. Do you believe that outpatient treatment would likely be the most -- excuse me. Outpatient treatment would be the least restrictive means for Mr. Carter to get that treatment?

A I do.

MR. ROYALS: Thank you.

Your Honor, that's all I have for Dr. Alleyne, at this time.

THE COURT: All right, how do we want to do this? Cross-examination from The State then anything you want?

All right, cross-examination.

CROSS-EXAMINATION

BY MR. MILLER:

Q All right, Dr. Alleyne; is that right?

A Alleyne.

Q Alleyne, okay. Andrew Miller for The State.

A Nice to meet you.

Q Okay. So Mr. Carter was admitted to the hospital on August 16th of this year; is that correct?

A Yes.

Q Is that the first time you met him?

A Yes.

Q Okay. Starting with that day, how often would you meet with him?

A I meet with Mr. Carter once every week for the first two months that he's in the hospital. We see him once a month for treatment team. And then I see him in the hallways and anytime that he has questions or concerns I meet with him.

Q Okay. Just round about, how many hours total do you think you spent with Mr. Carter during that 120 days?

A I'm not sure I can come with a number. I honestly don't know. I do not.

Q Okay. Those weekly meetings, how long would they be?

A They're typically 10 to 15 minutes, where we discuss his treatment regimen, how he's doing, what he's learning in group. We review his treatment plan and make updates to the treatment plan.

Q Okay. What is his current formal diagnosis?

A Schizoaffective disorder bipolar type.

Q Okay. And I believe it was different, initially, when he was discharged from Marshall Pickens Hospital to here. I think they describe it as -- I can't remember, you probably know. What changed with that?

A So Marshall Pickens diagnosed him with bipolar disorder. Bipolar disorder is strictly a mood disorder

and they said that he had psychotic features within bipolar disorder. The diagnosis was changed given that he had continued psychotic symptoms past the mood episode. So -- but he was no longer manic, his mood had come back down to normal but he was still having some psychotic symptoms and delusional beliefs.

Q Okay. So, essentially, the psychotic symptoms are not tide to the mood swings?

A Correct. So that makes the schizoaffective more appropriate diagnosis.

Q Okay. So you said what medications you say he's currently on for that?

A He takes Aristada, which is a long-acting injectable version of Abilify. Then he takes Trileptal or Oxcarbazepine. And he takes a medication called Trazadone for sleep.

Q Okay. In the report we received, it says he takes Abilify 10 milligram by mouth twice a day?

A Yes.

Q When did that change occur?

A That change occurred shortly after that report was written. We had been discussing with him the transition from oral to injectable. But we had to put in the report what he was on at the time that we took him at the NGRI meeting.

Q So how many months has he been on the injectable?

A I think one.

Q Okay. So you said this report was written one month ago?

A This report was written -- I honestly don't remember the exact date of this report.

Q Okay. Would you agree that if he's been on the injectable monthly for, at least, a month and that's not reflected in this report, that this report was written over a month ago?

A Yes.

Q Okay. So after less than 90 days this report was written? Roughly, 90 days? If you substract a month from 120 days?

A Yes.

Q Okay. Going back to these medications, what does the Trileptal; is that correct?

A Yes.

Q What does that do?

A That is a mood stabilizer. So it's meant to help people who have bipolar disorder, keep their meds leveled.

Q Okay. And he takes that by mouth twice a day?

A Yes.

Q Okay. What would happen if say he missed a day of that?

A If he misses a day of it, probably nothing.

Q Okay. What if he missed like a couple days, when would we start to see signs or would he start to experience an issue if he missed that medication?

A So, typically, medication such as this are -- I would have to look up [indiscernible] I don't know it off the top of my head. But based on, kind of the fact that it has, what I assume is a average half life, not knowing the exact number off the top of my head, stays in the system for, at least, a day in and of itself. But to clear out of the system, you would have to be off of it for about a week before you start to see that it's not providing any benefit anymore.

Q Okay. Now, often, people in these outpatient programs, how often are the medications checked to see if they're cooperative and the blood tests are done to see if their therapeutic levels, how often is that done?

A So that's up to the mental health center. I can't tell you how often they will choose to do that.

Q Okay. So the Aripiprazole, that's Abilify?

A Yes.

Q Okay. And that is now a monthly injectable?

A Yes.

Q Okay. And he's been on that for about a month?
A Yes.
Q For the injection, is the dosage similar to what was in the report when he's taking it orally?
A Yes. That is the dose conversion. So the dose he's receiving of the injectable is equivalent to the oral dose he had been receiving.
Q Okay. And chemically is pretty much the same thing?
A It is.
Q Okay. Then Trazodone at night, you said?
A Yes.
Q What is that for?
A Trazodone is a antidepressant medication by design. However, at lower doses it provides sedating qualities to help people sleep.
Q Okay. So what would happen if he missed a few days of those?
A Realistically, probably nothing.
Q Okay. Would he experience some insomnia effects, possibly?
A He could.
Q Okay. If he's experiencing inosemia effects, are people there to help him 24/7 in a hospital setting?
A I mean, yes. And there's, I guess, I don't know

what help you would give to someone who is having trouble sleeping other than to give them the medicine.

Q If he's awake in the middle of the night, is someone else present and awake?

A Yes. There are staff that are present and awake.

Q Okay. Are these three medications, are they there to maintain his current status?

A Yes.

Q Okay. And if he were to stop taking any of them, could you guarantee his current stability, I think is the word you used?

A Well, I can't guarantee anything.

Q Okay. If he were to maintain taking them, can you guarantee his stability longterm?

A Again, I can't guarantee anything.

Q Okay. If he were to start to lose that stability, would it be readily apparent to a layperson. Say a family member?

A His family members are familiar with his symptoms. So they should be able to recognize, as he, also, should be able to recognize that something is different.

Q Okay. At the hospital, in his current setting, how are -- I know one's an injectable now, as of a month

ago. The other two, how are they administered?

A The nurse gives him his medication twice a day.

Q Okay. So they count it out for him?

A Yes.

Q Does someone watch him take them?

A Yes.

Q Okay. Now, on any of these three medications listed, could they have negative interactions with alcohol?

A I wouldn't recommend alcohol with any of our antipsychotic or mood stabilizing medications because it could effect the way that the medicines work in the body, yes.

Q Okay. What about recreational drug use, what about marijuana?

A I would not recommend using drugs with any of our psychiatric medications either.

Q Cocaine or any stimulants?

A Correct.

Q Okay. Have you had a chance to review the monthly medication logs from before he arrived?

A Yes.

Q That were shared with you yesterday?

A Uh-huh.

Q Okay. If I can refer to those. I don't know if

you have a copy, so I have a extra, if you need it. I'm, also, going to ask to make these Court's Exhibits at the end, put them all together. Starting six months ago?

A Uh-huh.

Q We have February of this year, 2022?

A Okay.

Q Have you noted or can you look through there and say if his medication was successfully administered every time?

A He had -- I have to count.

Q I believe I. . .

A In February of this year he had -- it looks like he had about 15 medication refusals.

Q Okay. Fifteen incidents of the different medications, I guess, that gets counted. So it was 39 total, is what I have?

A Right. But some of those medicines are given all at the same time and he just refused the entire med pass.

Q So 39 dosages of medication were refused in February of this year?

A Yes.

Q Okay. Then in March. If I counted correctly, there were 22 medications refused. Some of those were multiple medications in the same instance but 22 refusals?

A Yep.

Q Okay. Then in April we have an additional three refusals?

A Uh-huh.

Q Okay. In May of this year, we, actually, do not have any. That's a good month. Then in June we have an additional six refusals; is that correct?

A Yes.

Q Then in July, the month before he came to the hospital, if my count was correct, it's an additional 17 medications refused?

A Yes.

Q Okay. Then in August he was transferred to the hospital?

A Yes.

Q Okay. Did he ever refuse medication while at the hospital?

A No.

Q Did he ever --

THE COURT: You want to go ahead and make that an exhibit? State's exhibit? Just so we can keep the record clear.

MR. MILLER: There's, actually, two copies of each month here, Your Honor. And The State would ask to make these a Court's Exhibit for purposes of this

hearing.

THE COURT: Okay.

(WHEREUPON, Court's Exhibit No. 1 was marked for identification only.)

BY MR. MILLER:

Q Did he ever refuse medication while in the hospital, to your knowledge?

A No to my knowledge.

Q Okay. Would you have knowledge of that?

A Yes.

Q Okay. Did he ever express an understanding of why he was at the hospital?

A Yes.

Q Did he express an understanding what the purpose of this evaluation process is?

A Yes.

Q Okay. Did you have a chance to look at a note from the detention center that was provided along side those? I have an extra copy here.

A This one?

Q Yes, ma'am.

A Yes.

Q Would you agree with he -- that it says that the -- he reports his medications are working says and I'm going to Columbia for four to six months, then I will get

out. The counselor encourages him to be compliant with the facility where he was going.

He says, I will, I want to get out.

Would you agree that's what that says?

A Yes.

Q Would you agree that he is aware -- he was aware that when he went there, if he complied with those rules he would get out?

A Yes.

Q Okay. So he was compliant with his medications with the end goal of getting out?

A Yes. As are all patients in our facility.

Q But prior to arriving to the hospital, he refused, I believe, I counted a total of -- he refused a total of 87 medications within six months prior to transferring him?

A Yes.

Q Okay.

MR. MILLER: Your Honor, The State would, also, ask that this note be made a Court's Exhibit, it's been shared.

THE COURT: Let's go ahead mark them now so we know what -- so we can refer to them as the proper number of something.

MR. MILLER: Okay.

THE COURT: You want those as separate months or how do you want to do that?

MR. MILLER: I'm with whatever is easiest for The Court.

THE COURT: Is that exhibit one, Court's Exhibit 1?

MR. MILLER: I don't have a sticky note.

THE COURT REPORTER: I have labels, if you'll give me a chance to mark them, I can do that.

(WHEREUPON, Court's Exhibit No. 2 was marked for identification only.)

THE COURT: So we have Court's Exhibits 1 and 2, any objection from The Defendant or The Department?

MR. BREWER: No, Your Honor.

MR. ROYALS: No, Your Honor.

MR. MILLER: Your Honor, we do have a couple more exhibits. I don't know if you want to --

THE COURT: Go ahead --

MR. MILLER: -- mark those.

(WHEREUPON, State's Exhibits Nos. 1-4 were marked for identification only.)

THE COURT: What do we have, again, to identify them as you go?

MR. MILLER: Yes, Your Honor, as we go.

THE COURT: Okay, sorry for the interruption

there.

BY MR. MILLER:

Q The report in here, also, says he denied symptoms of psychosis?

A On admission?

Q I believe, yes.

A Okay.

Q Okay. When you say that, does that mean he verbally denied them to you?

A Yes.

Q Okay. Is there an objective kind of standard people use to see if someone is having symptoms, even though they deny them?

A Yes.

Q Okay. And how is that done?

A We observe him on our inpatient unit. We -- the physicians, the social workers, the group therapists, nursing staff, activity therapists, all provide input on how he's functioning. We look for things like responding to internal stimuli. Which would be like him talking to himself or talking to unseen others. We look at his mood, his social interactions, things like to assess whether or not he's having psychiatric symptoms.

Q Okay. I want to refer back -- do you have a copy of the initial -- when I say initial evaluation,

evaluation regarding criminal responsibility dated October 15th.

A I have seen it, I don't have it with me.

Q Okay. Let me give you a copy of this, if you'd like.

A Sure.

Q And I'll refer you to an issue on Page 9. I believe it is the paragraph towards the bottom is what I'm referring to.

A Okay.

Q Okay. I pointed you to the right paragraph but the section I'm referring to describes his interactions during the police interview?

A Uh-huh.

Q Okay. It says, The video recorded him laughing and smiling inappropriately and looking around the room. He attempted to mask this when officers were present but the symptoms presented when he was left alone. Which is consistent with psychosis and likely not fainting as he tried to conceal his symptoms.

He's in the hospital, is anyone watching him when he doesn't know he's been watched?

A Yes.

Q Okay. And how is that done?

A He is constantly monitored. Like I said, by all

of the treatment staff. So he's observed even when he doesn't realize that he's being observed.

Q Is that 24 hours a day?

A Yes.

Q Okay. Did you ever discuss the underlining incidents from these charges with Mr. Carter?

A Not in detail, no.

Q Okay. What do you mean, not in detail?

A We discussed his understanding of why he's in the hospital, what it means to be in NGRI, what he's in NGRI for. I did not go through the details of the index offense with him.

Q Okay. Did he express and understand of the gravity of what, actually, happened?

A Yes.

Q Okay. Is there any kind of concern of confronting what, actually, happened could trigger some sort of mental?

A I am not concerned about that, no.

Q Okay. How many of these evaluations would you estimate you have done in your career with DMH?

A A NGRI 120 day evaluation?

Q Yes, ma'am.

A Probably 15 or 20 of them. NGRI's are rare in The State of South Carolina.

Q How many have you recommended go discharge to a home after the 120 day period?

A This is, I believe, the first I've ever recommended to go home, personally.

Q Okay. So this is a pretty rare thing?

A Yes.

Q Okay. Now, on the proposal to go home, switch gears, start working on that.

A Okay.

Q Per the plan, it says, He is in need of continued mental health treatment, followed-up care, plus treatment for substance abuse. Mr. Carter will need a structured and supervised living environment. What do you, usually, entail by a structured and supervised living environment?

A I mean, he will be living with family. And so that would provide him with some supervision. And honestly, I'm not really sure why we use the word structure in this report. This is co-authored with one of the social workers on the team.

Q So you're saying he does not need structured and supervised living environment?

A I mean, I'm not going to say that he doesn't need a structured and supervised living environment, I'm just not entirely sure how to describe what a structured

environment would be, other than to have a stable home to live in. And having people around him to support him and assist him in getting to his appointments and making sure that he's participating in treatment appropriately.

Q Okay. So as part of that structured living environment, he was approved to live at 5 Harrison Avenue; is that correct?

A Yes.

Q Point one says that he will reside with his mother, Ms. Young?

A Yes.

Q And what was the process by which that was approved?

A My social worker that I work with, who's assigned to Jevon's case, and I went out and made a home visit. We met with the family. We spoke with them. We talked to them about the care and treatment that is required, if and when Jevon discharges to a community. And had that discussion with Jevon and his family together. And then we observe the home. Like I said earlier, we had interactions between him and his family and family friends.

Q Okay. Would the home be monitored in any outside way, aside from the family there?

A Not to my knowledge.

Q Okay. Would he be free to come and go kind of as he please?

A Yes.

Q Okay. Would there be hours he would be required to be at the house?

A Not to my knowledge.

Q Okay. Who would account for his whereabouts if he simply walked off?

A Mr. Carter is responsible for his own actions.

Q Okay. Do you know if the house has a security system?

A I believe that they have cameras, I'm not sure if there's a monitored security system or if it's, you know, homeowner security and they set it up themselves. But I do know they have cameras in the home.

Q Okay. And you mentioned Ms. Young will be living there with him so she would be the supervision of the structure and supervision?

A Well, she will be residing there with him. His grandmother lives, literally, a stone's through away nextdoor and, also, provides, I think, some of that supervision structure for him.

Q Okay. Was that house visited as well?

A I did not go into that home, no.

Q Okay. What was the process by which living with

Ms. Young was approved?

A Like I said, we went to the home, did a home visit. The home appeared appropriate for him to live in. Like I said, they have a bedroom for him, they have electricity, they have running water, they have food. It seems like a safe environment for him to live in. We then brought that information back to the hospital and shared that with our discharge review board.

Q Okay. Were the family members you mentioned, the mother and grandmother, were they interviewed as part of the process?

A Yes.

Q Okay. Was a background check conducted on any of them?

A No.

Q Okay. Are you aware of any convictions that exists?

A You have shared information with us, yes.

Q Okay. Were you aware that Ms. Young was convicted of unlawful neglect in February of 2020?

A I believe so, yes.

Q Okay. Have you seen the certified conviction of that?

A If that was in the documentation that you sent me, then yes.

Q I have copies I can show you. Did you have the chance to see the indictment that was included in that, who the victim in that case was?

A Yes.

Q Who was that?

A Jevon.

Q That was Mr. Carter?

A Yes.

Q Okay. Are you aware that Ms. Young was convicted of possession of cocaine in April of 2019?

A Yes.

Q Okay. Are you aware that on that sentencing sheet, she was ordered herself to mental health counseling as part of the sentence?

A Yes.

Q Okay. Did anyone check into Ms. Young's mental health status as part of this?

A I did not because Ms. Young is not my patient.

Q Okay. Were you aware that Ms. Young was, also, convicted of driving under the influence second offense in October of 2022?

A If that was included, then yes.

MR. MILLER: Your Honor, we have certified prior convictions of those that we would like to make an exhibit.

THE COURT: All right, any objection from?

MR. BREWER: Your Honor, I would. Your Honor, we are going to object. The -- both the report of The Department of Mental Health Services and the proposed order orders and recommends to The Court, the compliance is the obligation of Jevon Carter. And the three state agencies that have been identified. Cashauna Young, his mother, not biologically disassociated with, is not responsible legally for the supervision of Jevon Carter or his compliance. So any prior criminal convictions in her past have no relevance to whether, really, the single issue that's here today, and that's whether he requires additional hospitalization. Or whether he is functional, at this point, to supervise himself. That's the only testimony we've heard today. Is that it's his responsibility.

And as Your Honor already knows, today's question is not a punitive one, it's a therapeutic one. And his obligations as an adult, he's not a juvenile, this is not a custody determination. Cashauna Young's background -- and Judge, I didn't -- Cashauna Young is a victim of domestic violence, she was hit by a previous spouse, paralyzed on the left side, she's lived a hard life. I hate she's being

put on trial today. But the bottom line is she's not responsible legally or on the recommendation of the testimony of this witness here today for Jevon Carter. And on those grounds, I just don't think it's relevant.

THE COURT: All right. I think--

MR. ROYALS: Your Honor, I support Mr. Brewer's objection. The purpose of today's hearing is whether or not Mr. Carter is appropriate for inpatient or outpatient care. I understand The State's interest and understanding where Mr. Carter is going to be discharge to. And, Your Honor, I think that both in my direct and Mr. Brewer's cross so far, you got a pretty good idea where he's going to be discharged to. I don't know that another individual's criminal record has a lot to do with whether or not somebody is medically appropriate for discharge or not.

THE COURT: I just think that for the decision that I'm going to be having to make, I want to have everything. I want to be able to consider everything.

MR. ROYALS: Yes, Your Honor.

THE COURT: So I'm going to allow it in.

(WHEREUPON, State's Exhibit No. 3 was admitted into evidence.)

BY MR. MILLER:

Q Would any of these factors that we just brought up, change an evaluation of whether the home will qualify as a structured and supervised living environment?

A I don't think that her criminal record effects his ability to live safely in that environment. So in my opinion, no.

Q Would drug or alcohol use within the home contribute to whether it was structured and supervised living?

A Drug use in the home would be concerning to me but does not change the level of structure or supervision that Mr. Carter is expected to adhere to.

Q Okay. As part of preparation for this, we provided you with a recorded call made from the detention center on June 5th of this year. Have you had a chance to review that?

A I did.

Q Okay. And does that -- on that call, does Ms. Young, in fact, state that she was under the influence of drugs, at that time?

A Yes, she did.

Q And she was freely talking about that with Mr. Carter?

A Yes, she is.

Q Okay. Can you clearly hear that she is under the influence, at that time?

A Yes.

Q Can you, also, hear her make references to the drugs being left on the table and that someone took them, on that call?

A Yes.

Q Okay. Are you aware that she, also, states that she did not take her prescribed medicine that day, on the call?

A Yes.

Q Okay. And that she, also, acknowledges that she is, also, under the care of Greenville Mental Health?

A Yes.

MR. MILLER: Your Honor, at this point, we would make that call Court's Exhibit 4, if there's no objections.

THE COURT: All right.

MR. BREWER: Just same objection, Your Honor.

MR. ROYALS: Likewise, Your Honor.

THE COURT: All right, I think, again, I'm going to let it in.

(WHEREUPON, State's Exhibit No. 4 was admitted into evidence.)

BY MR. MILLER:

Q Okay. It's not my intention to stigmatize her mental health treatment either, but I have to ask, did anyone from The Department of Mental Health--

MR. BREWER: Your Honor, may it please The Court, I'd like to add to my objection, if I may. I would just, also, object to hearsay grounds. Dr. Alleyne cannot testify to the substance of that recorded call. It's a out-of-court statement by somebody who is not here to testify.

THE COURT: Your position on that?

MR. MILLER: Your Honor, this is not a trial, it's a hearing, sort of like a sentencing phase or a restitution hearing, so the rules of evidence do not, actually, apply in this situation, Your Honor.

THE COURT: All right. I'll review it and give it the value I think it deserves.

MR. BREWER: Yes, Your Honor.

BY MR. MILLER:

Q Okay. Did anyone from The Department of Mental Health look into the last time she was hospitalized?

A No. She, again, is not my patient. It's not my job to look into her mental health treatment.

Q Okay. Did anyone look into the last time she was incarcerated?

A Not relevant to the case that we are discussing here.

Q Okay. If she were hospitalized or incarcerated who would Mr. Carter live with?

A He would still reside in that home. Which is owned by his family.

Q Okay. So, at that point, who would be supervising him at home?

A His grandmother would still be supervising, as well, from next door.

Q Okay. Was she interviewed as part of this process?

A Yes, she was.

Q Did anyone look into her past?

A No.

Q Okay. Next, I will refer you to the original Prisma Health records. And there's a portion I'd like to highlight, Page 37, the bottom paragraph.

A Okay.

Q Okay. In that note from Prisma Health says, The care provider make a note that when he initially eloped from Marshall Pickens Hospital, they attempted to contact the patient's father, mother and grandmother were called. Contact was made with the grandmother after failed attempts to get the mother and the father on the phone.

The mother happened to be at the grandmother's home. The mother was irate and told this writer, you're responsible for finding him, y'all should have chained him down and given him shots.

Does that reaction give you any hesitation to housing Mr. Carter with Ms. Young?

A Her opinion of how the psychiatric treatment should have been provided when he was psychotic, I'm not really sure how that effects his ability to live in that home. He is, again, responsible for his own care, at this point in time, as he is an adult.

Q Okay. But if there were an emergency situation in the home, who would be there?

A Mr. Carter is there. I mean, I can't speak to that. It would depend on the time of day and who's working, who's at home. I can't answer that question.

Q Okay. So discharging him to a home but wouldn't know who was there?

A I mean, the people residing in the home would be Mr. Carter and his mother. I can't speak to who's going to be in the house all day.

MR. MILLER: Your Honor, we'd make that note from Prisma Health. It has been, previously, admitted in another hearing, but we'd just ask to make those Court's [verbatim] exhibits.

THE COURT: All right.

Mr. Brewer, he wants to put this in.

MR. BREWER: No objection.

THE COURT: Okay, in without objection. What number is that?

MR. MILLER: That would be Exhibit 2.

THE COURT: Exhibit 2.

(WHEREUPON, State's Exhibit No. 2 was admitted into evidence.)

MR. BREWER: Your Honor, if I may, could I see Court's Exhibit 1.

THE COURT: All right. We have -- I got 1 and 2. And then you got State's Exhibit 2; is that right?

MR. MILLER: Well, yes, Your Honor, they are marked States 1, 2, 3 here.

MR. BREWER: I'm sorry, I think I mean Court's Exhibit 1 and 2.

THE COURT: All right.

BY MR. MILLER:

Q So Mr. Carter was originally discharged from inpatient care from Marshall Pickens hospital on July 22nd; is that correct?

A Yes.

Q Okay. And those same records, it does state,

and would you agree with me that it states, Patient has been informed how the effects of alcohol, recreational drugs, misused prescription medications, can significantly elevate the risk of such dangerous behaviors.

Would you agree that's a common thing when he's discharged from Marshall Pickens, to say?

A Yes, we would warn patients on discharge of the dangers of using drugs and alcohol.

Q Okay. Were you aware that he was then returned to the hospital on July 27th of 2022 or 2020?

A Yes.

Q Okay. Are you aware how that occurred?

A Not off the top of my head, I would have to look at the records again.

Q Okay. Are you aware that he was stopped by an officer driving with a suspended tag?

A Yes, I have those police reports that you shared with us.

Q Okay. Are you aware that he was using marijuana and it was present in the vehicle?

A Yes.

Q Were you aware that law enforcement reported that he was not making sense?

A Yes.

Q Are you aware that they thought he was

experiencing a seizure and returned him to the emergency room?

A Yes.

Q Okay. And would you agree with me that that was within five days of him being discharged to his family?

A Yes.

Q Okay. Are you still of the opinion that it's a good idea to discharge him to that same family now?

A Yes.

Q Okay. Mr. Carter was, again, discharged from Marshall Pickens at the end of July 2020; is that right?

A Yes.

Q Okay. He was then arrested on these charges on August 29th; is that correct?

A That sounds correct, yes.

Q Okay. He was, once again, when he was discharged from Marshall Pickens, would you agree that he was probably in -- he was in stable condition, at that point?

A I can't answer that question.

Q Okay. What condition would he have to have been in for them to discharge him from inpatient hospital?

A I would like to think that he would be psychiatrically stable, but I can't answer that. I was not part of that treatment.

Q Okay. I'll refer back to the criminally responsibility evaluation. I think we've handed up, look through it a couple of times.

A Uh-huh.

Q Would you agree that it's noted that on September 4th, after his arrest in August, he reported his mood was depressed, he admitted paranoid, racing thoughts. Mid October 2020, he continued to report auditory hallucinations from God telling him scripture and that he was going to be famous.

Would you agree that that is in there once he's back in the detention center?

A What page are you referring to?

Q I believe it's on Page 6.

A Yes.

Q Okay. So, once again, would you agree that once he was discharged to his family, we have a return of symptoms?

A Yes, they were returning symptoms after he was discharged.

Q Okay. Were you aware of any of these incidents, the police reports and such that we have on you today, prior to us sharing them with you in preparation for this hearing?

A I had not seen these police reports before. I

was familiar with the forensic report, though.

Q Okay. Move on to the second point of the plan that was brought forth to be considered today. So keep all scheduled appointments with Greater Greenville Mental Health, the NGRI Outreach Clinic and random drug screens?

A Yes.

Q Okay. Do we know how often these appoints would occur?

A That is at the discretion of the mental health center. Though, typically, the mental health center meets with patients monthly when they are first seeing them. In addition -- that's the physician in addition to them seeing a clinical care counselor. And they may be assigned to groups. And then the Forensic Outreach Clinic will meet with him monthly.

Q Okay. And so these would occur monthly, most likely?

A Yes.

Q Even though the last time he was discharged, would you agree there was another incident within five days?

A Per the information and reports and hospital records, yes.

Q Okay. Where would these meetings and appointments occur?

A At the mental health center, at the Forensic Outreach Clinic, sometimes by telephone, sometimes by video conference, it just depends on what the needs of the patient and the availability of the clinics are.

Q Okay. Is there any monitoring in between appointments?

A They -- that I don't know.

Q So, potentially, every time he has an appointment, there could be a one month gap in monitoring?

A There could be.

Q Okay. And we would have no way in that month to know if had refused to -- stopped taking his medications?

A He would still have the injection in his system.

Q Okay. If he were to walk away from the residence, on sometime say day two of that month, if his family doesn't report it, how we would we ever know?

A We wouldn't.

Q Okay. It would take about a full month for that to come to fruition?

A (The witness nods.)

Q Okay. Okay. If he were to relapse and have some sort of episode at home, who would be responsible for notifying either medical resources or law enforcement, whatever was needed?

A I can't assign responsibility to anybody.

Mr. Carter, obviously, is responsible for his own care. However, I would like to think that if his family noticed that he was having symptoms that they would notify somebody.

Q Okay. But he's not required to account for his whereabouts?

A He is not on probation, no.

Q Okay. So if that happened away from the home, if he had some sort of relapse, psychotic episode, he would be on his own?

A Yes.

Q And it would be likely that probation would not know for up to a month?

A Yes.

Q Okay. Moving on to point three. It says, He will sign releases for professional services to cooperate with each other.

That includes all, I believe, three entities that were mentioned here?

A Yep.

Q Okay. Number four, he would not obtain any weapons, guns or knives.

So does that mean that no weapons of any kind would be in the home?

A Yes.

Q Okay. Who will ensure that there are no weapons in the home?

A Mr. Carter, again, is responsible for his surroundings.

Q Okay. Would anyone make periodic home visits to make sure that that's still the case?

A That would fall to the mental health center or the Forensic Outreach Clinic or probation pardon and parole for monitoring.

Q The crime in this case involves an edged weapon. When you say no weapons, does that include no knives in the home?

A I'm not going to say he's not allowed to have a butter knife or a steak knife to eat with, but, technically, the order says no knives.

Q Okay. Has anyone checked to see if there's still a knife block in the kitchen?

A I did not, specifically, look for a knife block while I was there, no.

Q Okay. The home you're referencing, 5 Harrison Avenue, are you aware of its location, in general?

A I am not familiar with Greenville's topography but I have been to the home, so I have sort of a idea where it is, yes.

Q Okay. So on your -- so these two houses, are

they like close together, I guess you're saying?

A You can almost lay down and touch them between the two homes because they are so close.

THE COURT: Are you at a good stopping point? We have a question, evidently, from this verdict -- I mean, a question from this jury. So let's take a short break from this.

And you can step down.

THE WITNESS: Thank you, Your Honor.

THE COURT: All right, we'll take a short break.

(WHEREUPON, a short break was taken.)

THE COURT: All right, back on the case of State vs. Jevon Carter.

Mr. Miller, you can proceed.

MR. MILLER: Thank you, Your Honor.

BY MR. MILLER:

Q Before we get back into the plan, during the break, did you have a chance to discuss your testimony with any of the parties in this case?

A I have not discussed any testimony, no.

Q Okay. All right. Once again, the plan at the top says, He will need a supervised and structured living environment.

Is that correct, that's written on the plan?

A Yes.

Q Okay. Now, I believe, we left off on point five on that. What does point five say?

A Jevon Carter will not associate with any known felons outside the treatment programs.

Q Okay. Are you aware if unlawful neglect is a felony in South Carolina?

A I believe that it is but I'm not 100 percent positive.

Q Okay. It is. Would it be difficult from associating with any known felons if he were placed to live with a known felon?

A I suppose that would be true, yes.

Q Okay. So on its face from day one, would he be violating the proposed order and this plan?

A You can say that. However, we discharge patients to structured residential care facilities that are filled with known felons everyday, as part of their discharge plan. So, I guess, in a sense we just violate this order every time we discharge a patient.

Q Okay. So patients are frequently, just off the bat, in violation of their orders?

A We wouldn't call it that because it's a place that is approved by The court. So they are residing with other felons by the nature of their discharged plan.

Q Okay. So in this process, did DMH run background checks on anyone who would be around Mr. Carter?

A No.

Q Are they sure of all the people that reside in the house? Do we know all their identities?

A I believe so, yes.

Q Okay. Move on to point six. Says, He will refrain from the use of drugs or alcohol.

Is that correct?

A Yes.

Q Okay. Ideally, when someone in this situation -- would that be easier on the situation where drugs or alcohol are not present?

A Can you rephrase that question?

Q Would you agree that it would be easier to refrain from the use of drugs or alcohol if they were not present in the home?

A Yes.

Q Okay. As we established earlier, would anyone be checking to see if there was any drugs or alcohol in the home?

A Not necessarily.

Q Okay. And you would agree that someone who you're cohabiting with who has pled guilty to drug charges

within the past recent history, two years?

A Yes.

Q And pled guilty to alcohol related offense no more than two months ago?

A Yes.

Q Okay. Next, point seven. He will cooperate with services provided by the offices of PPP, drug screens conducted, Forensic Outreach Clinic, and, I believe, there's one other there. That if he has recurrence of symptoms or violates the court order, he will be referred to reassessment treatment, hospitalization is deemed clinically necessary. The Chief Judge, solicitor and defense attorney will be notified if rehospitalization -- it says, Notify of rehospitalization.

Is that the only time we would be notified?

A In effect of this, yes. So you're notified if he violates his court order and is rehospitalized.

Q Okay. So we would not be notified if he had, essentially, a small violation of this?

A I don't understand what you mean by that.

Q Say he missed an appointment, would we be notified?

A I don't know the answer to that.

Q Okay. What if he tests positive on a drug screen, would we will be notified?

A I don't know the answer to that.

Q Okay. It says, On a recurrence of symptoms, as well.

Who determines if he has a recurrence of symptoms?

A His treatment providers.

Q Okay. And he would meet with those, you said, about monthly?

A It may be more frequently than that but that's at the discretion of the mental health center.

Q I believe your early testimony was first released they meet monthly?

A Typically.

Q Okay. Who would be responsible for notifying the solicitor's office, The Court and the victim's if there is a violation?

A I don't know who gives that notification.

Q Okay. If he associates with a known felon, what would be the recourse in that situation?

A The recourse for violation of any of the points that are listed here is rehospitalization.

Q Okay. So he would be instantly rehospitalized if he violated any of these orders?

A That is how we handle these patients, yes.

Q Okay. But you just testified that he would,

basically, be in violation of the order from day one?

A Again, approved by The Court to live where he lives.

Q Is there anything in this to prevent contact with, say, the victim's families?

A Not to my knowledge, no.

Q Okay. Would that be a good idea in a situation like this, a traumatic situation, where he had, obviously, mental illness issues, to keep them separated?

A I'm not sure I understand what you're. . .

Q Essentially, would it be a good idea if Mr. Carter ran into the victim's family of an offense in this?

A I don't think it would be a good idea for Mr. Carter to actively seek out the family members of the victim. However, I don't know how to prevent him from, perhaps, accidently running into somebody.

Q But as for these three agencies listed, would any of them be responsible for his whereabouts on a day-to-day basis?

A No, Mr. Carter is responsible for his whereabouts

Q Okay. And none of them would be responsible for him not coming into contact with the victim's family members?

A No, Mr. Carter is responsible for his actions.

Q Okay. Outside of this plan, have you vetted any other resources for Mr. Carter as part of this? Preparing for this hearing?

A I'm not sure I understand what you mean by vetted other resources.

Q Is the entirety of your plan included in this proposed order and the plan for The Department of Mental Health?

A As far as I'm aware, yes.

Q Okay. So all of the treatment plan is included in this and this court order? Proposed order that was submitted?

A Yes, the court order is in place to order the required parties to be involved in his care.

Q Okay. So you haven't met with or vetted or consulted anyone outside of these?

A I'm not--

Q Outside of these resources.

A So, we have talked about other resources for him, as mentioned in this report that you received from the department. And we've talked to a DMH, like, substance counselor person, to determine whether or not he needed substance treatment, as a potential additional resource.

Q Okay. And that was included in here, I believe, that he did need substance abuse treatment?

A The recommendation is that he be assessed for outpatient substance abuse treatment, yes.

Q Okay. But aside from that, DMH's consideration are, basically, within the four walls of this order and the plan?

A Yes.

Q Okay.

I don't believe I have any further questions, Dr. Alleyne, thank you.

We would you have a representative of the victim's family that would like to address The Court at the appropriate time.

THE COURT: Mr. Brewer.

MR. BREWER: Beg The Court's indulgence for one second, Judge.

MR. MILLER: Your Honor, I believe, we would ask this in reference and, I believe, we passed it up before but I'm not sure it was, actually, made a Court's Exhibit. It's the prior evaluation that's been referenced by both parties numerous times.

THE COURT: All right, any objection to that from--

MR. BREWER: None, Your Honor.

THE COURT: -- Mr. Carter.

Any objection From the department?

MR. ROYALS: No, Your Honor.

THE COURT: Okay.

(WHEREUPON, State's Exhibit No. 1 was admitted into evidence.)

MR. BREWER: Your Honor, may I see the Court's Exhibits 1 and 2, again? I think I handed those back up. Thank you, Judge.

CROSS-EXAMINATION

BY MR. BREWER:

Q Ms. Alleyne, good to see you today.

A It's good to see you, too.

Q Thank you for being here. You testified that you went out to 5 Harrison Avenue; is that correct?

A Yes.

Q I'm going to hand you a set of pictures. Will you just review them real quickly?

A Absolutely. Okay.

Q Okay. Are you familiar with the images or the locations and houses that are depicted in those pictures?

A Yes. These are -- the house that Mr. Carter will be residing in as well his grandmother's house nextdoor.

Q Okay. And are those consistent with the

condition of the homes and the surrounding area at the time you did your home visit?

A Yes.

Q Okay. And is there a map in there?

A Yes.

Q Okay. And would you just look at that, briefly?

A Absolutely.

Q And is that map somewhat consistent with the orientation of those houses relative to the surrounding area?

A Yes.

MR. BREWER: Your Honor, at this time, I would move to enter into Defense -- as Defendant's Exhibit 1, these pictures of the map.

THE COURT: All right, any objection from The State?

MR. MILLER: No, objection, Your Honor.

THE COURT: Or The Department?

MR. ROYALS: No, Your Honor.

THE COURT: Okay. All right, Defense 1 admitted.

(WHEREUPON, Defendant's Exhibit No. 1 was marked for identification and received into evidence.)

BY MR. BREWER:

Q And if you'd keep those for a second longer.

Will you look at the two homes there together? And you've given some testimony about it, would you just describe a little bit which house is the house that's been recommended for Mr. Carter to live in?

A Mr. Carter will be residing in the home on the right-hand side of this picture.

Q What color is that house?

A Green in color.

Q Okay. And --

THE COURT: You said the one on the right?

THE WITNESS: Yes, this one here.

THE COURT: Okay.

BY MR. BREWER:

Q And which one does Ms. Cynthia Chapman live in?

A She lives in this gray house nextdoor on the left.

Q And you testified that there's security cameras on those houses?

A Yes, there are.

Q And you've been inside the 5 Harrison Avenue home; correct?

A Yes.

Q Will you find the picture of the interior of that home?

A Yes.

Q And what do you see there?
A These are pictures of the bedroom in which Mr. Carter will reside.
Q Okay. And could you just describe those a little bit?
A Sure. They have a made-up bed with photos of Mr. Carter from his childhood, a dresser, television, some memorabilia from his, I believe, time playing high school football. As well as a lamp and what looks like, maybe, a storage box or like a low kind of dresser type thing.
Q And are you comfortable with the quality and the condition of that room?
A Yes.
Q I'm going to hand you back what's been marked as Court's Exhibit 1 and 2.
A Okay.
Q And those are the detention center records regarding his compliance with medications?
A Yes.
Q And in the assistant solicitor's examination regarding those records, he asked you about how many times or how many medications that Mr. Carter had declined. In your understanding in reviewing those records, is there a difference between the number of medications declined and the number of incidents declined?

A Yes because he's prescribed multiple medications each med pass, he would have declined to take more medications than the number of times he, actually, refused.

Q Okay. And we don't know, there's no recordation there with respect to the reasons for the noncompliance; correct?

A Correct.

Q Okay. And in your experience with other NGRI patients or other patients that are committed to The Department of Mental Health, are there -- what sort of reasons are there that people sometimes don't comply with the medication?

A Sometimes they -- sometimes they just don't want to take it. Sometimes they are asleep. Sometimes they -- nurses don't -- or the jails don't have the staff to, actually, do the med pass. And so they just skip it. Sometimes the medications aren't available for whatever reasons.

Q So they're circumstances unrelated to Mr. Carter's willingness to take the medications, why he might have been marked as noncompliant on that day; correct?

A Yes, they are.

Q And we don't have any indication as to why he

was?

A Correct.

Q Okay. In your experience, how does the record before you of compliance compare to the record of compliance of other individuals who have been committed to The Department of Mental Health?

A Mr. Carter has shown, based on these medication administration records, better compliance than many patients that we receive from the detention centers. In that he has taken his medication more often than not and showed improving compliance as he progressed through his time at the detention center.

Q All right. And as you testified earlier, confirmed earlier, he was taken into custody around August 28th of 2020, correct?

A Yes.

Q And he was not moved to The Department of Mental Health until sometime late in the summer of 2022; correct?

A August of 2022.

Q Okay. So he was there for almost two years; correct?

A Yes.

Q And in all of that time, we have this particular record of noncompliance; correct?

A Yes.

Q So we have many, literally, hundreds, hundreds and hundreds and hundreds of days of perfect compliance in that record; correct?

A Yes.

Q We talked about there was some conversation about the methodology of the medications administered. And you've already testified that the dosage and the type of medication did not change; correct?

A Correct.

Q And does the methodology of delivery effect the effectiveness of the medications?

A No, the long-acting injectable antipsychotic is equal dose of that to the oral dose.

Q And, in fact, y'all prefer it?

A We do.

Q I'd like to go back to the effect and the diagnosis of the disease of his mental health issues in the summer of 2020. Does it take some time for these medications to stabilize a patient?

A Yes.

Q Okay. Can you explain that a little bit more?

A Sure. We, typically, see some response to treatment within the first few days. Particularly, within antipsychotic medications, they work faster than antidepressants and mood stabilizers do. However, for the

brain to fully recover back to a baseline level of functioning, it can take weeks, even months for a patient to fully stabilize.

Q Okay. And I think the assistant solicitor asked this but I'm not sure you, actually, answered a time. Were there other -- what are the living environments do you all recommend to a court in NGRI?

A The most common discharge that the department recommends is to what we call a CRCF, which is a Community Residential Care Facility. Which is a housing environment filled with other mental health patients. That is staffed 24 hours a day.

Q Okay. Did you -- did The Department of Mental Health evaluate that option for Mr. Carter?

A Yes. We, as a treatment team, gave consideration to that option for Mr. Carter.

Q And what did y'all conclude about the suitability of that arrangement for Mr. Carter?

A It was the opinion of the treatment team that Mr. Carter is higher functioning than most of the patients that would be housed in such a setting. And that his ability to provide for himself would be hindered. We would like to see him be able to, you know, get a job or go to school. And we felt that he would be able to take responsibility for his actions in a less restrictive

setting than a CRCF would provide.

Q How would you describe Mr. Carter, relative to most of your population at The Department of Mental Health?

A Mr. Carter is, I would say, is a more responsible and receptive, insightful patient than a lot of patients that come through our facility.

Q Okay. How would you describe the way he treats people?

A He is kind, he is caring, he is polite. He's helpful to other patients on the unit. He interacts appropriately with staff and patients. He's just -- he's genuinely a nice man.

Q Has there been a single incident of his aggression toward any other person at The Department of Mental Health?

A In his time with us he has not been aggressive towards anybody.

Q Did he have any disciplinary record out of the detention center based on violence or aggression toward anybody else?

A In the records that I received from the detention center, there were no episodes of aggression.

Q In addition to you, who else is, actually, observing Mr. Carter at The Department of Mental Health?

A He is observed by myself, by his assigned social worker, by the other assigned social workers on the unit, 24 hours nursing care, activity therapist. We call our group therapist Forensic Clinical Treatment Staff. So we have two of them that are assigned to the unit that he resides on. And then he attends groups off unit in another building. And there's another 10 or 15 therapeutic staff there that, also, observe and interact with him.

Q Okay. Based on your recommendation, your experience and what has been recommended to The Court, who is responsible for supervising Jevon Carter?

A Jevon Carter.

Q And who else?

A The Department of Mental Health, Greater Greenville Mental Health Center and the Forensic Outreach Clinic and then Probation Pardon and Parole.

Q Oaky. And is that the same group of people that are responsible for the supervision of all the NGRI individuals who are released?

A Yes, those three entities oversee all NGRI -- well, not necessarily Greater Greenville Mental Health, in particular. But a mental health center, whatever NGRI patient resides in.

Q And the patient themselves?

A And the patient themselves.

Q You said you listened, you reviewed the jail call between Mr. Carter and his mother. And The Court is going to be available to listen to it itself. And I won't hold you to the exact timestamp. But after Ms. Carter -- or excuse me, Ms. Cashauna Young kind of explains what's going on with her, does about a minute and a half in, doesn't Mr. Carter say to her, Mom you're wrong for that?

A I believe that is true.

Q Did The Government reach out and request the ability to hire their own separate expert to evaluate his fitness or any sort of supervisory plan?

A They have not made that request to my knowledge.

Q Okay. Did they offer to The Department of Mental Health Services, any suggestions about the supervision that they wanted for Mr. Carter?

A No, they have not.

Q On Page 4 of the report of The Department of Mental Health Services, in the last sentence of the -- do you have it there in front you?

A The discharge report?

Q Yes.

A Yes.

Q Okay. The last sentence of the -- really, the first full paragraph on there that starts with, Due to

Mr. Carter's continue -- at the bottom, that last sentence what is -- it says -- it starts with, In addition.

What does that say?

A It says, In additon, Mr. Carter will be given the opportunity to work with Caroline Caldwell of New Mind Health and Care in Greenville, who specializes in community reentry programming for formally incarcerated individuals.

Q Okay. So in addition to the three entities we've talked about, Jevon Carter's separate responsibility, the family that lives there that y'all have identified. He, also, has a reentry program that The Department of Mental Health Services have been informed about and will be participating in his life; is that right?

A Yes.

Q And as you've already testified, The Court, obviously, can order that Mr. Carter live at this residence and create some exception with respect to the felony association; correct?

A Yes.

MR. BREWER: No further questions, Your Honor.

THE COURT: All right, anything else from The Department?

MR. ROYALS: Your Honor, I know we've gone long

but just some brief redirect, if that will be all right?

THE COURT: Yes.

REDIRECT EXAMINATION

BY MR. ROYALS:

Q Dr. Alleyne, thank you, again, for your time, I'll do my best to be brief here. When a individual in the greater Greenville or the Forensic Outreach Clinic is speaking with Mr. Carter and they are trying to get an idea of whether he might be out of compliance with taking his medications, specifically, his mood stabilizers, since that's the medication here, what kind of thing would they be looking at in that kind of scenario to figure out if they need to explore the possibility that he's not taking his medication?

A They would be looking at his clinical presentation. So, his mood affect, which is the outward expression of mood, so how he appears emotionally. They would look at his behavior. Whether he appears more impulsive or erratic. Whether he appears like he's responding to internal stimuli, as we heard earlier about his presentation during a police interview. They would be looking at those types of things. At his physical presentation.

Q Doctor, since you've been working at forensics,

have you had people readmitted due to the fact that they were not taking their medication in violation of the outpatient order?

A Yes.

Q Okay. Mr. Miller earlier referenced, I believe it was in State's Exhibit 2, but it was something from the Greenville jail, indicating that it was the goal of Mr. Carter's to get out. That's to get out of prison or get out of inpatient hospital. Is that unusual for patients?

A No. That's the first question they ask when they arrive.

Q Is it, also, the goal of The Department of Mental Health to discharge somebody once they are admitted?

A Yes.

Q Why is that?

A Every hospitalization, whether Department of Mental Health or acute care hospital, discharge planning begins on the day of admission. The goal is always to treat someone in the least restrictive environment possible.

Q Is that a ethical mandate for you as a doctor?

A Yes.

Q Is that a legal mandated for you as a doctor?

A Yes.

Q Is this discharge plan in conjunction with your ethical and medical requirements to discharge somebody that is no longer needed inpatient care?

A Yes.

Q Thank you, doctor. In terms -- Mr. Miller, also, referenced on the discharge plan, the idea of needing structured supervision support, a couple of different words are going on there. Would you consider having a roof over somebody's head structured?

A Yes.

Q Would you consider having a stable source of nutrition structured?

A Yes.

Q Would you consider having the support of friends, family, other peers, structured?

A Yes.

Q And would you consider access to adequate health care structured for somebody?

A Yes.

Q Do you believe under the current plan, Mr. Carter would be able to get those things either through the different entities that have been named here or a resident of this home?

A Yes.

Q Thank you. Dr. Alleyne, how long have you been a doctor at the forensics unit?

A I've worked at The Department of Mental Health's Forensic Hospital for six years.

Q Okay. In your estimation, is there any way to prevent somebody that wants to get illegal elicit drugs from getting those drugs?

A No.

Q Have you discharged individuals to community residential care facilities who later on had access to drugs?

A Yes.

Q Have you discharged individuals to sober living environments who later on had access to drugs?

A Yes.

Q Have you discharged individuals to boarding homes that later on had access to drugs?

A Yes.

Q Do you believe that an individual -- do you believe that anybody, other than the individual, is responsible for abstaining from drugs?

A No.

MR. ROYALS: Your Honor, that's all I have.

THE COURT: Do you have anything additional?

MR. MILLER: Very brief.

RECROSS-EXAMINATION

BY MR. MILLER:

Q Doctor, just to clarify, those records from the detention center, they are only for the last six months?

A Yes.

Q That's what's before you here today?

A Yes.

Q Would you agree that's probably what's best to look at to get to his current state, the most recent records?

A Sure, yeah.

Q Okay. And then you commented during redirect there, that he -- it looked good because he's taking his meds more often than he's not; is that correct?

A Yes.

Q Is that the standard you look for?

A In these records from the detention center, yes. Receiving someone from the detention center that took their medication more often than they did not, is a huge thing for us. Many of our patients come in completely noncompliant.

Q Okay. Is it usual for them to come in and then suddenly be 100 percent compliant?

A Yes. There's some structure that the hospital provides and some [indiscernible] that the hospital

provides that is different than what the detention center provides that encourages compliance.

Q So when we remove that structure that you just mentioned, is there any guarantee that he will be in compliant?

A I cannot guarantee anything, no.

Q Okay. And how long would you say you spent with Mr. Carter yourself?

A I don't know.

Q If I remember correctly, you said it was weekly meetings?

A For 15 minutes a week.

Q For 15 minutes a week?

A Yeah. Plus, I see him, individually, periodically, on the unit.

Q And per your original testimony, this report was made before the medicine was changed. So it was made, at least, a month ago?

A Uh-huh.

Q And so in total, my math is not very good on that, but in total you probably spent a couple of hours with Mr. Carter?

A Okay.

Q Is that correct?

A Again, I have not calculated how much time I

have spent with him.

Q Okay. And the plan says he would be given the opportunity to work with New Mind Health Care?

A Yes.

Q What is that?

A It is a transitional community reentry program.

Q Okay. What would they do for him?

A I do not know the details of what they would do, that is up to them to create a treatment plan for him and their level of engagement with him.

Q Okay. Are you aware if it's included in the proposed order?

A It's not ordered by The Court. It is an additional wraparound resource that we have prepared for him.

Q So if he did not comply with any of their conditions, would any of us ever find out about it?

A No.

Q Okay. You mentioned for failure to take medications, you used the term, I think, Clinical presentations that appear?

A Uh-huh.

Q Okay. So that sounds like a medical term, basically?

A Yes.

Q Okay. Would your everyday layperson on the street know how to look for that?

A He's not being treated by a layperson, he's being treated by medical professionals.

Q Okay. Are they supervising him day-to-day?

A No.

Q Okay. So who's going to notice those clinical presentations?

A The treatment staff, as Mr. Royals indicated, would be looking at him in the clinics.

Q Okay. The ones he, basically, says that -- or that you have testified that he will see, at most, probably once a month?

A I did not say at most but --

Q Well, most likely once a month?

A -- typical see him once a month.

Q Okay.

No further questions.

THE COURT: Mr. Brewer, anything else from you?

MR. BREWER: No, Your Honor.

THE COURT: All right, thank you, may step down.

THE WITNESS: Thank, you Your Honor.

THE COURT: All right, anything else from The Department?

MR. ROYALS: No, Your Honor, other than to

emphasize the statue in this case, Your Honor, indicates when a person has sufficient insight and is no longer a harm to himself or others by virtue of mental illness, discharge is made, at that point, Your Honor. Otherwise, nothing from The Department.

MR. BREWER: Your Honor, I'm not sure how you want to proceed. I do have some remarks --

THE COURT: Do you have anything you're going to be presented?

MR. BREWER: No, Your Honor.

THE COURT: The State have anything they want to present?

MR. MILLER: Your Honor, I think a representative of the victim's family would like to address The Court, at the appropriate time. Mr. Whitner, when you would like.

THE COURT: I mean, is there anything else that y'all need to -- are y'all planning on--

MR. MILLER: No more testimony, Your Honor.

THE COURT: All right, I'm going to hear from the -- I think it's appropriate to hear from the victim's family. I don't know. . .

MR. MILLER: Like him to come up to the podium, Your Honor?

THE COURT: Just going to -- he can be right

there. As long as. . .

MR WHITNER: My name is Steven Whitner.

THE COURT: Okay.

MR WHITNER: I go by Nick, as well. I'm the victim's great nephew. Your Honor, I just want to say that I'm the great nephew of Georgia Francis Mattison. I was the individual who made the 911 call the morning of July 5th, 2020, to report the heinous and violent act that had been committed against my aunt. I would like to let you know that she was the matriarch of the family on my dad's side. She was the last of ten siblings. And at age of 93 she was taken from us.

It's awful that her life had to end in such a violent way and by a family member, at that. Our lives have been deeply affected by the loss of our aunt. Several of us now have PTSD. And each day that I walk out of my house, which is right across the street from my aunt, at 7 Merlocke Drive, the crime happened at 6, I'm reminded of the day when I see what use to be a family meeting hub, is boarded up and abandoned now. So we're reminded daily of the heinous crime that Mr. Carter committed against her.

I would, also, like to add that our cousin, Joe Cory Brown, was falsely accused of this crime because

he was living with the victim, at the time, and circumstances pointed towards him. Now, that individual has been entirely tarnished his relationship with the entire family, it's tarnished for life. It will never be the same, okay. I'm coming to you humbly and I'm asking you to do the right thing to ensure that our family sees justice, Your Honor.

I understand that Jevon is a young man and some may argue he has his whole life ahead of him. I've heard his attorney brag about how much of a bright and smart young man he was and was headed to Clemson, things like that on several occasions. But I want you to take a moment and ask yourself, Your Honor, how could someone who's such a upstanding citizen and so intelligent, to commit such a crime against such a helpless and loving person. I would ask that you make Greenville County and our surrounding counties, a little bit more safer for all the citizens of this area, as well as me and my family. It's bad enough that he's not going to spend any time behind bars.

But, you know, I ask that you find it in your heart and in your mind to do what's just and right. I know that The Department of Mental Health was ones that, ultimately, made the determination that he was

mentally incompetent to stand trial. But if he's mentally incompetent to stand trial, then he's mentally incompetent to come to the house. I'm going to take a little bit from Johnnie Cochran on that one, okay. He doesn't need to be on the streets, Judge. That's just my personal opinion. And again, I ask that you make sure that my aunt sees justice. And that you can find it in your heart to give me, my family and Greenville County some justice, as well, to ensure that this young man is in some type of facility for the rest of his life. Thank you.

THE COURT: All right, thank you for being here. Sorry for what you've been through.

MR. MILLER: Your Honor, the victim's granddaughter, she lives pretty far out of state and could not be here today on short notice, but did want to submit a written statement.

THE COURT: All right, if you'd show that to them.

MR. MILLER: Your Honor, if I may approach with that?

THE COURT: All right. So that's all the information or evidence? My thought was that, in light of the nature of this, is to give everybody like 10 days to submit written memorandums, is what I

would like for all sides to do. As to proposed orders, suggestions or what, you know, what they think the ruling should be. All right. Does that -- is that good with everybody?

MR. BREWER: It is okay with Mr. Carter.

THE COURT: Anything else from The Department?

MR. ROYALS: No, Your Honor. We're happy to brief the case.

THE COURT: All right, anything else from Mr. Carter?

MR. BREWER: No, Your Honor.

THE COURT: Anything else from The State?

MR. MILLER: Nothing further, Your Honor.

THE COURT: All right, 10 days, y'all could send that to us, we'll take a look at it and let y'all know what we come up with. Thank you.

MR. ROYALS: Thank you, Your Honor.

MR. BREWER: Thank you, Judge.

MR. MILLER: Thank you, Your Honor.

(WHEREUPON, the proceedings were concluded.)

STATE OF SOUTH CAROLINA	)	
	)	COURT OF GENERAL SESSIONS
COUNTY OF GREENVILLE	)	2021-GS-23-05230; 05231
	)	
	)	
	)	
THE STATE	)	
PLAINTIFF)		
vs.	)	TRANSCRIPT OF RECORD
	)	
JEVON KENNETH CARTER	)	
DEFENDANT)		

June 8, 2022
Greenville, South Carolina

B E F O R E:

THE HONORABLE PERRY H. GRAVELY, Judge.

A P P E A R A N C E S:

ANDREW MILLER, ESQ.
Attorney for the State

JOE BREWER, ESQ.
ANASTASIA WALKER, ESQ.
Attorneys for the Defendant

APRIL HERRON
Official Court Reporter

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2	Autopsy Report	5	13
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4	Affidavit	5	13
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NO	DESCRIPTION	ID	EV
1	DMH Report	16	16
2	Marshall Pickens Records	16	16
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All exhibits were retained by the Greenville County Clerk of Court.

June 8, 2022

(WHEREUPON, State's Exhibits Nos. 1-13 were marked for identification.)

THE COURT: All right, this is the case of The State vs. Jevon Kenneth Carter, Indictments 2021-GS-23-5230 and 5231. This is a hearing to determine culpability and mental capacity of The Defendant, at the time.

Mr. Miller, be glad to hear from you.

MR. MILLER: Thank you, Your Honor. The State and The Defense has submitted a stipulation of facts agreed upon, as well as exhibits. Your Honor, The State would rely on those for this case. As The State--

THE COURT: Has that been marked as an exhibit?

MR. MILLER: Yes, Your Honor, the stipulation itself is marked as State's Exhibit 13.

THE COURT: Okay.

MR. MILLER: Yes, Your Honor. And as that stipulation states, this incident took place on the night of July 4th of 2020 at Ms. Francis Maddison's home at 6 Merlocke Drive in Greenville County, South Carolina. Ms. Maddison was discovered on the morning of July 5th by her great nephew, Mr. Joe Cory Brown. She was found deceased in the home and a kitchen

window had been broken. Mr. Brown, actually, shared that residence with the victim, Ms. Maddison.

Exhibit 1 for The State and Defense have agreed upon, is a series of five photographs which show that window that had been broken both from the inside and the outside and a screen had been removed. Mr. Brown then alerted relatives across the street before leaving the scene. An autopsy of Ms. Maddison was conducted later. The manner of death was found to be homicide and the cause of death was stab wounds to the neck area. Agreed upon Exhibit 2 is a copy of the autopsy record. I would also note that the autopsy pointed out, at the time of death she was 93 years old and weighed 93 pounds.

THE COURT: Let me stop you there, Mr. Miller, just to make sure. It's my understanding that all exhibits marked by both The State and The Defendant have been agreed to and no objections; correct?

MR. BREWER: That's correct, no objection, Your Honor.

THE COURT: Okay.

Correct?

MR. MILLER: Yes, Your Honor.

Mr. Brown made some comments, at the time, at the scene that was incriminating and was, actually,

initially charged in this incident. At the time of this incident, Mr. Jevon Carter, The Defendant, was a patient at Marshall Pickens Hospital. Law enforcement didn't have a reason to suspect him. During the investigation, a palm print was recovered from two pieces of broken glass on the counter, under the broken window.

THE COURT: Hold on, I hate to stop you again. Can I get a copy of your exhibits?

MR. MILLER: Yes.

THE COURT: That you've marked.

Do you have an extra set? That's fine, if you don't have an extra set, I've got the ones you provided in the notebook, that will be sufficient.

MR. MILLER: Okay.

A palm print was found on a broken glass under the window. And that print was found to belong to The Defendant. Exhibit 3, which has been agreed upon by The State and The Defense, is a copy of the forensic report from that location identifying that fingerprint. Exhibit 4, which has also been agreed upon, is a affidavit of the latent print examiner in this case. In that affidavit he explains what we find to be the importance of that print. Notably, it was two prints across two pieces of broken glass.

One from the top pane and one from the bottom pane. Showing that it really could have only been left after the window was broken. He also noticed that directionally, it points to the interior of the kitchen from the outside, as if someone came through that window.

Also of note, a left index fingerprint found to belong to The Defendant was found on the exterior of the window screen. Investigators further learned, after that print was found, that The Defendant had, actually, fled from Marshall Pickens Hospital by jumping a fence at approximately 5:30 p.m. on the evening of the July 4th, the same day as this incident.

Exhibit 5, should have been previously agreed upon, submitted to you, Your Honor, in advance, is the CCTV footage, showing this Defendant jump the fence and leave. Notably in that footage he is still wearing a Marshall Pickens issued attire. Later that night on the 4th of July, at around 11:30, Greenville police were called to a residence on Stone Lake Drive in Greenville County. The Defendant was present, he had shown up there acting erratically and he was, actually, returned to Marshall Pickens hospital that night.

Exhibit 6 is body-worn camera footage from an officer that responded to that scene and interacted with The Defendant that night. That has also been agreed opinion by The State and Defense. And Exhibit 7 is Ring Doorbell footage from The Defendant arriving at that residence. Of note he is wearing a orange Carthart shirt, black sweatpants, green socks and no shoes. Is no longer wearing his Marshall Pickens issued attire.

As you can see in the video, a small spot of blood is noted on the right side of the chest of his T-shirt and is, I believe, it's in the body cam footage, The Defendant had a small cut on the left side of his chest. The clothes he arrived in were later recovered by investigators but they had been washed by that point and this was later on down the road and the investigation continued.

On August 28th of 2020, investigators conducted a recorded interview with The Defendant. That is contained in what's agreed upon in Exhibit 8. In that interview, he acknowledged that he did jump the fence and flee from Marshall Pickens. He state's that he walks to his father, Kenneth Carter's house. But states that an altercation took place and he was picked back up by law enforcement. Investigator

showed him photos of the victim's residence at 6 Merlocke Drive. He initially stated he had only been there five to six years prior. And then stated once more, when further asked about it that, that he had, actually, gone to the victim's house to do yardwork for the victim once he was released from Marshall Pickens. But as far as the timeline goes, that wouldn't have been accurate, the victim had already been deceased.

Your Honor, further on September 2, 2020, The Defendant's father gave an audio recording statement, that is contained in Exhibit 9, which has been agreed upon by The State and Defense and provided to Your Honor in advance. He states that he was at home when he was awaken by his son in his house between 6:30 and 8:00 p.m. on the night of July 4th. The Defendant had taken a shower and changed into different clothes. But he made The Defendant change back into his Marshall Pickens attire and made him leave his house. He denied that any physical altercation took place. And as I note, The Defendant's father's residence is approximately .2 miles from the victim's home.

Sadly, Mr. Kenneth Carter passed away in October of 2020, his death was later ruled a suicide, that's

contained in our stipulation. Later, forensics were able to recover a DNA mixture from fingernail clippings from the hands of the victim. The mixture contained a female, the victim's DNA, as well a male contributor. They were able to exclude Mr. Joe Cory Brown as the male contributor. That's contained in Exhibit 10, which has been agreed upon by The State and The Defense and, submitted to Your Honor in advance.

A Schmerber hearing was held and a DNA sample was obtained from The Defendant in January of 2021. Then at scene, a second DNA analysis report, that's Exhibit 11, agreed upon by The State and Defense and submitted to Your Honor in advance, no conclusive match could be made using the traditional methodology. But when YSTR testing was conducted, the white chromosome DNA in the mixture was found to be a match to The Defendant's white chromosome DNA. As noted, that would include The Defendant, as well as any paternal male relatives which share that portion of DNA.

THE COURT: All right, let me stop you. That was the DNA found underneath the victim's fingernails?

MR. MILLER: Yes, Your Honor.

THE COURT: Okay.

MR. MILLER: According to the DNA report that's been submitted to Your Honor, it did not match any of the 29,182 individuals in the YSTR data base and would not be expected more frequently than one in every 9,742 individuals. That portion of DNA.

On September 30th of 2020, investigator were able to speak with Mr. Joe Cory Brown. That interview was audio recorded, has been included as Exhibit 12 and it's been agreed upon by The State and The Defense and has been submitted in advance. That interview.

He was shown pictures of clothing The Defendant was wearing when he arrived there at that residence at Stone Lake Drive around 11:30 on the night of the incident. He was able to identify the shirt he was wearing in that video -- or the photos from that, as shirt that belonged to him that would have come from the residence that he shared with the victim in this case. He was not able to affirmatively identify the pants he was wearing. But said maybe if he got a closer look, in the future, he might be able to identify the pants, as well.

As acknowledged in the stipulation of facts, at the end, signed by both The State and The Defense,

both sides agree that notwithstanding any affirmative defenses may be raised, if these following facts and exhibits were presented to a jury, the substantial likelihood that a verdict would be returned as to guilty as to the lesser included involuntary manslaughter, possession of a weapon during the commission of a violent crime and burglary first degree.

Your Honor, at this point, The State would move admit Exhibits 1 through 12, as well as the signed stipulation as Exhibit 13 into evidence.

THE COURT: All right, I think that's without objection.

MR. BREWER: No, Your Honor.

THE COURT: All right, so admitted.

(WHEREUPON, State's Exhibits Nos. 1-13 were admitted into evidence.)

MR. MILLER: Your Honor, before The State rests on this, the Investigator, Mr. Andrew Smith, with the Greenville Police Department, as well as Tim Conroy with the Greenville Police Department, are present if The Court has any further questions or needs any clarification on any of these issues.

Your Honor, the victim's next of kin could not be here today, Ms. Smith. She does live in

Connecticut and planned to attend by WebEx, have done the hearing that way. But she is aware of this hearing, we spoke this morning and I'm speaking with her immediately afterwards to let her know what happens.

THE COURT: All right. Is there anything that you want to present from officers or?

MR. MILLER: Not at this point, Your Honor. The investigator has also signed the stipulation as well as myself, The Defense counsel and The Defendant.

THE COURT: All right. Does The Defense have -- before you present your case, anything in reference to The State's case?

MR. BREWER: No, Your Honor.

THE COURT: All right. Okay.

All right, so The State rests with that?

MR. MILLER: Yes, sir, Your Honor.

THE COURT: All right, Mr. Brewer.

MR. BREWER: May it please the Court, Joe Brewer on behalf of Jevon Carter, Your Honor. I have Ms. Anatasia Walker here with me, she's a former public defender and works for a non-profit here in town, she also represents Mr. Jevon Carter. I also have with me today Mr. Jevon Carter's mother, Ms. Cashauna [ph] Young. His grandmother,

Ms. Cynthia Chapman, his paternal grandmother, Ms. Agnus Carter and aunts, Tamara and Kendra Carter, the Hayes family and a number of other family, friends are all here in support of Mr. Carter.

Your Honor, as Your Honor mentioned, we've already admitted without objection certain exhibits, if I may approach Your Honor?

THE COURT: Yeah.

MR. BREWER: These are The Defendant's exhibits. Your Honor, number one is the report of the Department of Mental Health Services from Dr. Stephanie Le, who is here on the front row, Your Honor, that I'll be calling here in just a second. Number two, is some excerpts from from Marshall Pickens records. Number three, is just some photographs of Mr. Jevon Carter prior to the time of the alleged incident and arrest. Four is his high school transcript. Five, Your Honor, is the complete version of Marshall Pickens records. Then six, Your Honor, are letters of support. Your Honor, Exhibit 6 is offered today not in mitigation, Your Honor, but for some context for Mr. Carter's affect and character prior to the onset of The Defense we will put up today.

(WHEREUPON, Defendant's Exhibits Nos. 1-6 were marked for identification and received into evidence.)

MR. BREWER: Your Honor, if I might, I'd like to now call Mr. Stephanie Le to the stand.

THE COURT: All right, Dr. Le, if you'd come forward and be sworn.

MR. BREWER: Your Honor, may I approach as well?

THE COURT: Yes.

THE CLERK: Please place your left hand on the Bible and raise your right hand.

STEPHANIE LE, after being duly sworn{,}testified as follows:{F}

THE CLERK: Thank you, please be seated. Please state your name.

THE WITNESS: Stephanie Le. Last name is spelled L-E.

MR. BREWER: Your Honor, as one matter of housekeeping, I've got Ms. -- Dr. Le's curriculum vitae here, it's been provided to The Government, there's no objection. Can I also admit this as Defense Exhibit 7, Your Honor?

THE COURT: That will be fine.

MR. BREWER: Thank you, Your Honor.

(WHEREUPON, Defendant's Exhibit No. 7 was marked for identification and received into evidence.)

BY MR. BREWER:

Q Good morning, Dr. Le, appreciate you driving up from Columbia.

A Good morning.

Q Would you just, state for the record, your full name again and your title.

A Stephanie Le. I'm a forensic psychiatrist for the South Carolina Department of Mental Health.

Q And can you give The Court a little bit of description of your professional background and expertise?

A Yes. I graduated from the University of South Carolina School of Medicine in 2013. Following my doctor in medicine, I went on to complete a general psychiatry residence for four years. After that was completed, I did a fellowship in forensic psychiatry.

Q Okay. What is your current title?

A I'm a chief psychiatrist.

Q Okay. And can you describe a little bit of your present responsibilities?

A Yes. I'm currently employed in the forensic evaluation service with the South Carolina Department of Mental Health. And part of my role there is to perform evaluations of criminal defendants that can be competent

to stand trial evaluations and criminal responsibility and conformity evaluations. I'm also over the NGRI Outreach Clinic.

Q Okay. So you're the supervising physician for the NGRI program; is that correct?

A Yes.

Q Okay. Can you describe for The Court, generally, how criminal responsibility evaluations are conducted?

A Yes. We have defendants, we interview them. Initially, when they come in we just try to get how they're doing presently, their mental state. We have to assure that they're competent. Because if they're not, we ask for another order for competency. We access which medications they're on, their mental state. We have a lot of background information such as their social history, their educational background, mental history. We do mental state examinations and are fairly detailed review of all of their past and present mental health symptoms.

Q I'm going to show you a copy of what's been marked as Defendant's Exhibit 1 and admitted. If you could just state to The Court what that is.

A This is my forensic report for Mr. Carter.

Q And can you tell The Judge what -- what documentation and information that you reviewed and

evaluated in preparing that report?

A In preparation for the evaluation, we receive all the discovery material provided from the case. That's videos, audio, incident reports, police reports. And we are also provided with information on Jevon's background such as educational records and his mental health records, things of that nature.

Q What specific medical records did you have access to in this case?

A We had access to his Marshall Pickens hospitalization. We also had Greenville Mental Health Center.

Q And you don't have to tell me the exact number of pages but was it a pretty large amount of documents?

A Yes, it was pretty exhaustive.

Q And you were able to review all of those?

A Yes.

Q Okay. And did you also meet in person with Mr. Carter?

A I did. I met with Mr. Carter and spoke for about an hour and a half.

Q And you've done a little bit but can you describe a little bit of your procedures or the process in your in-person evaluations?

A So, in particular, for criminal responsibility,

we go over all the details that he can recall around the time of the alleged offense, how he's doing before, after and anything that he can recall, remember or give details of that incident. So that I might be able to form an opinion based off of his state, if he had responsibility or he had the capacity to conform.

Q And before we get into some of the details of that, how did Mr. Carter present to you and affect and other qualities that day?

A During that evaluation I didn't have any concerns for competency. He appeared stable. He was taking his medications. I called the detention center and they confirmed that he was complying with medications and that he had been really a model inmate in the center, causing no problems with staff or other inmates. So when he presented to me it was exactly as it was when I called the detention center, quite stable.

Q And how did you view the credibility of information that he was sharing with you that day?

A He was very forthcoming. He did not attempt to exaggerate symptoms but he also didn't try to hide the things that he had been through. He certainly was -- he admitted that he didn't want to have mental illness, due to his stigma and a lot of negative associations with it, but he was open and forthcoming about the symptoms that he

experienced.

Q And we're going to talk about that a little bit more in detail but what conclusion, what ultimate conclusion, did you come to about his criminal responsibility on or around July 4, 2020?

A That he would not be criminally responsible.

Q Okay. And did you conclude that he would not have been able to distinguish legal or moral right from wrong on that day?

A That was my opinion that he would not have been able to distinguish legal or moral right from legal or moral wrong.

Q Okay. And what was the basis for that conclusion?

A It's always quite complex, particularly, in cases like Mr. Carter when he has some lapses in memory. So what I had to do is go fairly in-depth into all of the records. He is able to give me some details of how he had been doing around that time and some of the symptoms he'd experienced. But on the particular day of the alleged incident, he did have some lapses in memory. This is not uncommon for someone who has schizophrenia or schzioaffective disorder. The reason for that is likely a multitude of things. It's just that it's ego-protected to not remember those things. But it's also likely due to

his ability to concentrate. Because when you're experiencing an episode of psychosis, you have disorganized thoughts, behaviors. And as you, you know, might understand, it's difficult for the brain to retain memories when you can't think clearly.

So I did my best to attempt to line up what he told me with the records. And everything that he explained to me followed closely to the records. Like I said, there was no exaggeration of symptoms but it didn't appear that he was trying to hide anything from me either. In some cases, we don't have these extensive records like we do have from the hospital. And I might not be able to come to an opinion. And in that case, I might submit a no opinion report. Or say that someone is responsible because we don't have any evidence to support what the person is able to tell me. Or not tell me.

In Mr. Carter's case, we did have evidence. I have reviewed everything from the hospital records and it showed that he was in a pretty severe state of psychosis and mania. He had disorganized thoughts, disorganized behaviors. He had rapidly shifting paranoid ideation that would cause him to be cooperative with staff, then fairly shortly thereafter, uncooperative with staff. It showed that he was not able to have his normal thought process. So I look at some of his educational

records, his background, some of the information that was provided from family and friends and saw that his behaviors during that time period were consistent with his episode of psychosis. And so putting all of that together, I was able to form my opinion.

Q I want to go into a little bit more specifics and I know it's all a little delicate but in terms of his behavior there in the hospital that day, can you describe some of the things he was saying, some of the delusional delusions he was having to The Court?

A Yes. He explained to me, and again, I verified through the records, that he had a delusional belief that he had been accepted to Clemson University on a full scholarship. He heard voices that he said were from God and from football players telling him that he was going to be rich and famous. And, essentially, that's why he needed to go to Clemson. When he started to have these erratic behaviors, that's when he was brought to the detention and he was admitted to the hospital.

In the hospital, he became fearful that staff were trying to abuse him. And in certain ways that he mentioned to me, and in the record, is that he thought they were trying to give him HIV by giving him food that had been tampered with. He thought that they were trying to steal his blood and he had this delusion that his blood

was some type of magical religious -- had magical religious healing properties. And he thought that when they drew labs from him that they were, actually, trying to steal his blood so that they could administer it to other people for its healing properties.

He, initially, was cooperative and this was consistent with the records. He was, initially, cooperative with the admitting psychiatrist. And when I reviewed what Mr. Carter told me, he said, at that point, he thought, in his delusion, he incorporated the thought that every football player for Clemson had to go through this process. It was for like some kind of initiation and they had to go to the hospital. And so in his mind, he thought that Dabo Sweeny and Clemson football players were going to show up and take him out of the hospital. So that's why he was, initially, cooperative with the general psychiatrist, the admitting psychiatrist.

Immediately after that, when he realized that wasn't happening, he became paranoid again. And he stated having this delusional belief that the psychiatrist, who he had been cooperative with, had also taken his acceptance letter and had hidden it from him. So with the beliefs that they were trying to harm him and with the beliefs that they were hiding these important documents from him, he thought that he needed to escape

the hospital.

Q Were there some other behaviors around his blood at all that you recall? I think you reference it in your report.

A Some of his thoughts about the staff there?

Q Yeah.

A Yeah, he thought that they were vampires. That they were trying to steal his blood. And he thought that each time they were taken labs from him, that they were going to be draining his blood and taking it to steal some type of property that he had in his blood.

Q Okay. What is your understanding of Mr. Carter's family history of mental health issues? Be sort of discrete about that or generic about that.

A That's part of our review, also, when we see some of the genetic loading that someone might have for mental illness. And what we were informed of is that Mr. Carter was a first degree relative, his mother, who is currently disabled and has a diagnosis of bipolar disorder. And as we know, his father committed suicide not too along ago.

Q How dose genetic predisposition play into your evaluation and diagnoses of an individual?

A It's something that we keep in mind. Particularly, with someone who, like Mr. Carter, is fairly

young and having what appears to be his first psychotic break. Because someone who has first degree relatives with serious mental illnesses, they are at a higher risk to develop those mental illnesses as well.

Q And can you talk a little bit about what causes the onset or the manifestation of schzioaffective or schizophrenic disorders?

A It's typically a multitude of factors. It can be environment, the genetic loading. And, also, someone who has experienced trauma or traumatic situations. And it appears that Mr. Carter, likely, had all of those factors.

Q What would be the -- what would have been some of the traumatic triggers for Mr. Carter, approximately, at this time?

A Well, he graduated high school, he was about to go into college, which is quite stressful. He had experienced the loss, traumatic loss, of his girlfriend just a month prior to the point where he said he started to hear voices. His age, as it goes to genetic loading, he was at the age where we, typically, psychotic illnesses start. So this is -- this is normal for someone who would be schizophrenic or schzioaffective disorder.

Q Okay. What is your diagnosis of Mr. Carter based on your evaluation of the records?

A Based on my evaluation, I evaluated Mr. Carter with schzioaffective disorder bipolar type.

Q All right. So -- and you've already testified that this would have been present and was actively present on July 4th, the day in question. Is there -- did you evaluate or make a decision about kind of when the general onset timeframe would have started for Mr. Carter?

A From his report and what I reviewed, it does appear that it started around June of, I believe, it was 2020. And Mr. Carter, at that time, would have been 18 years old, I believe. And he mentioned to me that he started hearing voices, at that time. That's initially what he heard. He had more of a challenge to describe some of the mood symptoms that he was experiencing. And that's why I went into the records. Again, that's not uncommon for someone to have lapses of memory when there's been those type of episodes.

So went through the records from the hospital and also reviewed records from friends and family. Particularly, for bipolar disorder and manic episodes, people will discuss that terminology colloquially. Like, say someone is bipolar but that just means someone who has episodes of outbursts. Saying maybe they're happy one minute and then they're excited or frustrated the next. And bipolar disorder, which is,

actually, a illness, that is part of what Mr. Carter experiences, those symptoms are much more severe and they're not just behavioral or emotional outbursts.

So when I reviewed the records of some of the friends who have no experience in the medical system or with mental health treatment, the things that they describe are consistent with a manic episode. He wasn't sleeping for days at a time, he was hyper religious, he was delusional. He was -- he had this overly excited elevated mood. He was behaving erratic and irrationally, related to those beliefs. And then he was--

Q I don't mean to interrupt you but just to clarify, these were observations by friends and family, potentially, in the relevant timeframe?

A Yes.

Q In the spring or so of 2020?

A Yes. Giving description of certain things that Mr. Carter did in that timeframe.

Q And you've said it all along, sort of been your testimony, but can you just line up kind of in summary fashion, what you observed in Mr. Carter with the basic characteristics of the diagnoses you have made again for The Court?

A For that diagnosis, one has to have symptoms of psychosis. He experienced auditory and visual

hallucinations. He had delusional beliefs, he had disorganized behaviors and disorganized speech. That's the psychosis portion. The reason I say it's schizoaffective disorder bipolar type because he also had an episode of mania and then he had a reduce in sleep. Random delusions, [indiscernible] idea, rapid speech, fluctuating irritability to elation. He was acting out in manners that could have gotten -- well did get him into trouble and they were out of character for him.

For it to be schizoaffective disorder bipolar type, that means that psychotic symptoms have to persist pass by the mood episode. His mood period cleared but he remained psychotic for many months afterward. Because he explained to me that he was still hearing voices, even after his mood had been stabilized with mood stabilizing medications.

Q We started hearing, just sort of in here, what is your view with respect to Mr. Carter's criminal responsibility on July 4th, 2020?

A So, again, Mr. Carter had difficulty explaining exactly what he did. He got some of the hospital visits mixed up because of the events. But what he was able to share with me it that he was extremely paranoid. He said that he was paranoid about family. He thought family members were trying to harm him. And that's why he had

sort of pulled back from them a bit. He couldn't explain exactly what it was but he just feared that they were going to harm him. As I spoke, he was fearful of medical staff. And he had this strong belief that if he did not leave the hospital that he was not going to be safe. Due to his disorganized behaviors, disorganized thoughts, his severe paranoia and his hallucinations, all related and tied into his family, his behaviors, shows that he would not have been able to distinguish legal or moral right from legal moral wrong.

Q And has your opinion changed at all since the time of your evaluation of Mr. Carter?

A No.

MR. BREWER: I have no further questions, Your Honor.

Dr. Le, if you'd answer any questions that The Court may have for your or The Government may have for you.

THE COURT: Any questions?

MR. MILLER: None from The State, Your Honor.

THE COURT: All right, I got a couple of questions, Dr. Le.

EXAMINATION BY THE COURT

BY THE COURT:

Q First of all, why was he originally admitted

into Marshall Pickens at the time that he was there?

A He was, initially, admitted into the hospital -- he was brought in by police officers on July 2nd, he was agitated, paranoid and delusional. And that's when he began to tell them that he had the acceptance letter from Clemson and his high school football coaches were hiding it from him. People were scared for him and his behaviors because he was so agitated and appeared to be responding to internal distractions.

Q All right. And when he came in on July 2nd and prior to July 4th, was there any diagnosis made by anyone at Marshall Pickens, based on your review of the records?

A I believe I probably looked at it, usually I don't use it to confirm initial diagnoses because they haven't seen everything. But they did mention that he was psychotic. That he was not admitting to those symptoms but he was witnessed by the nursing staff and the physicians to be laughing and talking to himself.

Q Okay. And what is the treatment for such a diagnosis?

A The treatment that we commonly use are anti-psychotic medications. And for the mood disorder would have been mood stabilizers and that's exactly what they started for him. They started Risperdal, which is a anti-psychotic medication. And he was so agitated, at the

time, they had to give him a sedative, as well.

Q How long does it take before those start having a positive effect?

A It varies for some people. With very severe illnesses, sometimes people are slow to respond and it can take months. For others, I've had people who rapidly respond and can see a turn around within a matter of five to seven days.

Q All right. And I believe that based on your general evaluations, you're not able to have this kind of before and after medical record of the time. I mean, is that why you're able to pinpoint it so precisely, that as of July 4th, that he was in this mental state?

A Yes. And that's part of what made this -- made me able to form that opinion. Because we have such detailed records. Again, if he had no memory and we didn't have the records, it's very likely it would have been a no opinion report or even possibly a responsible report.

Q Okay. How can you determine whether someone is actually having the symptoms or the issues complained of and they're not faking it?

A Oh, yeah. I mean, obviously, we see that pretty often. People come in and they attempt to faint because it's self-protected and they don't want to get into

trouble. Some of the things I look at for every defendant, but in particular about Mr. Carter's case, is in the interview, I tried to -- they're techniques that I use to push people. So I tried to get everything from them as we build a rapport. But there's also instances where I short of push them, emotionally, maybe agitate them a little bit. When you push people to certain levels with their emotions, they will sometimes share things that they didn't intend to share or they will shut down.

In Mr. Carter's case, he was open with me the entire time. He didn't seem to attempt to hide symptoms. And another thing that is really important is that he never tried to overreport symptoms. And that's not just with me but even in the hospital. So after the alleged offense, he was back in the hospital, he was still telling staff that, I'm not sick, I don't hear voices, there's nothing wrong with me. But yet, they documented that he was responding to hallucinations. That he was laughing to himself, that he was making gestures as if were hearing things. And then he continued to behave in a paranoid manner. Although, he was continuing to try to convince them to let him out of the hospital.

When we see people who are fainting illnesses, they usually do the opposite. They try to put on a show to make it look like they're psychotic and they

try to stay in the hospital. And Mr. Carter wasn't doing any of those things.

Q All right. And I think you also said you reviewed all the records from Marshall Pickens?

A Yes.

Q All right. The records after this event, is there any reference or any discussions in those about anything dealing with this victim or anything about this incident whatsoever?

A There were not. He continued to make comments that he was paranoid about family. But that was just in general. And he didn't make remarks about wanting to harm anyone, including his family. So there was really no mention. And even when I spoke to him, he didn't have a recollection of having a specific thought about the victim in this case or the even any of his particular family members. He said he was just avoiding all of the family members.

Q Based on your review of the records and your evaluation, was there any evidence or any indication of violence involving Mr. Carter?

A No. There were no episodes where he was violent with any of the staff at the hospital. Now, you can look at his records and see that they were -- I mean, he used force to leave the hospital but he never attempted to harm

a staff member or another patient in the hospital.

Q And, I guess, if this is something you can comment, that's within your expertise, you go from somebody that is having these delusional issues, don't appear to be any significant issues with violence to something that is as violent as he's been charged with?

A You can. In fact, since I'm over the NGRI Outreach Clinic, I see every person that has been adjudicated NGRI in the State of South Carolina, I monitor their cases for the state. So I see people who are -- if you met them on the street, they're just -- they would appear as normal as -- I mean, using the word as, you know, not that people with mental illness are abnormal but you know what I mean. You wouldn't think anything. They own their own businesses, they're married and have children. And some of them have committed what we would think are pretty heinous offenses.

Q Have all of your opinions that you have made here today, are they to a reasonable degree of psychiatric certainty?

A Yes.

THE COURT: All right. I think that's all the questions.

In light of my questions, any follow-up questions from?

MR. BREWER: Your Honor, just for your -- just to help answer Your Honor's question. May I show her -- this is part of the record that's already been admitted.

THE COURT: Okay.

MR. BREWER: You'd asked her about the diagnosis and whether it had been made. Just see if it reflects her recollection whether a diagnosis had been made there at Marshall Pickens.

THE COURT: This was exhibit what?

MR. BREWER: This is actually -- this is Page 106, Your Honor, of the entire Marshall Pickens file. So it's exhibit -- I'm sorry, Judge. Five, Your Honor.

THE COURT: Okay.

MR. BREWER: But it's Page 106 of nearly a 600 page document.

THE COURT: All right, okay.

MR. BREWER: You have it as a hard drive, Your Honor. It's a electronic copy. Yes, sir, that's it, right there.

THE COURT: All right, I'm sorry, go ahead.

THE WITNESS: And out of context, I don't think, because the way the records are written, has -- I'm not sure if this is part of the discharge summary or,

actually, as you mentioned, what they thought when he, initially, came into the hospital. They had him diagnosed as schizophrenia. If that was their initial diagnosis, I'd have to look because they might have changed it by the time he was discharged from the hospital, again.

MR. BREWER: Sure.

Nothing further, Your Honor.

THE COURT: All right. I have one other question.

BY THE COURT:

Q So again, based on your opinion to a reasonable degree of psychiatric certainty, do you believe at the time of the event, that he had the capacity to distinguish between moral or legal right or moral or legal wrong?

A At that time, I do not believe he had the ability to distinguish legal or moral right from legal or moral wrong.

Q All right. And that's your opinion to a reasonable degree of psychiatry certainty?

A That is my opinion, yes.

THE COURT: All right, thank you.

Anything else, again, from The Defense?

MR. BREWER: Not with respect to Dr. Le.

THE COURT: Anything from The State?

MR. MILLER: Nothing from The State.

THE COURT: All right, thank you. I'm sorry you had to come up here. I know we have WebEx but I just felt like the nature of this case that--

THE WITNESS: I understand. We have to do it often, so.

THE COURT: Okay, thank you.

MR. BREWER: Your Honor, I have a brief sort of closing statement that I'd like to make.

THE COURT: All right.

MR. BREWER: But I don't have any other additional witnesses to present for The Court.

THE COURT: Counsel, can y'all approach for a second?

(WHEREUPON, an off-the-record bench conference was held.)

MR. BREWER: We're ready to proceed, Your Honor.

THE COURT: All right, Mr. Carter, if you could stand, at this time, raise your right hand.

JEVON CARTER, after being duly sworn{,}testified as follows:{F}

EXAMINATION BY THE COURT

BY THE COURT:

Q And I can hear you. I know that's kind of awkward sometimes. You can put your hand down. We're at

the stage and I know this is a little unusual proceedings, but as a defendant, I want to make sure you understand that you have a right to testify. And have you discussed this with your attorney whether you want to testify or not?

A Yes, Your Honor.

Q All right. And do you wish to waive that right?

A Yes, sir.

Q Okay. Do you understand that is your right and after consultation with your attorney, do you believe -- is that your decision?

A Yes, Your Honor.

Q Okay. Thank you.

All right. Anything else The Defense wants to present, at this time?

MR. BREWER: Nothing but a brief statement, Your Honor.

THE COURT: All right.

Anything in reply from The State?

MR. MILLER: Nothing from The State, Your Honor.

THE COURT: All right. I'll be glad to hear concluding remarks from both sides.

CLOSING STATEMENT

MR. MILLER: Your Honor, The State would simply rest on the stipulation that we have submitted.

Essentially, stating all the elements of the offenses have been met, notwithstanding the defense's affirmative defenses they have been presented today. Your Honor, we simply don't have anything to ask. We just ask that you review the attached exhibits and stipulations as presented.

THE COURT: All right.

Mr. Brewer.

CLOSING STATEMENT

MR. BREWER: May it please the Court, I'd like to start by thanking The Court and The Government for coordinating today under less than typical circumstances over many months. Judge, you and Mrs. Pratt have been very generous in working through everything with us. I'd also like to thank The Government and Assistant Solicitor Miller and law enforcement for their reasonableness throughout this entire process in working towards what I think is a proportionment comprise of a very difficult case.

And to that end, Your Honor, I'd like to, specifically, acknowledge our sympathies for Ms. Maddison's family. This has been a very difficult process for them and we've grieved along with them the entire time. Not any small part because Jevon is related family with Ms. Maddison.

Which is among many, many other very variables to this case that's made it all very difficult and confusing and hard for everyone.

Your Honor, as you know, The Government and The Defendant had consent, essentially, to two things. The first is the stipulation of evidence and facts, that if submitted to the jury, would have been sufficient, potentially, for them to conclude that he committed the crimes alleged, including lesser-included offenses of voluntary manslaughter, first degree burglary and possession of a weapon during a violent crime.

Your Honor, the second thing we have consented to, Your Honor, is that we have a report from The Department of Mental Health Services, that unqualifiably indicates that he could not have distinguished legal moral right from wrong at the time of this incident. And therefore, could not have been criminally responsible. Therefore, Your Honor, by Section 17-24-30, the administrative order from 2014, Your Honor, the Supreme Court has said that where the parties or where legal insanity is not in dispute and is clear, the parties may consent to NGRI findings to submit to The Court and that's what we've done here today.

If Your Honor is inclined to accept that joint consent recommendation, Your Honor, I don't have a lot to say but I think for the record I'd like to say some of the following, briefly. Judge, you know, in light of some of what Dr. Le said to some of your questions and even the stipulations that we have made, nobody knows exactly what happened on July 4th of 2020. Mr. Carter has no memory of it and consistently so. His father, who's the only person that saw him in Nicholtown that day, subsequently, and very tragically passed away after Mr. Carter was arrested.

So while The Defendant certainly agrees there's evidence sufficient to convict -- would have been sufficient to convict him, potentially, at trial, we have less than a plain and complete picture. And the truth is we may never know. But what is unequivocally true, what we know without any shadow of a doubt and that we have direct insight into, was Mr. Carter's mental condition on that same day. And for better for worst we have a fully comprehensive medical record of what was going on with Mr. Carter psychologically because he was at Marshall Pickens, Your Honor.

And so now we know from the report and Dr. Le's testimony here today, that she does not have to guess or speculate or extrapolate like they're asked to do

in a lot of these cases. She has a very contemporaneous objective third-party window into what was going on with Mr. Carter, in addition to his very consistent and non-hyperbolic recollection and representations to Dr. Le.

Your Honor, he's been diagnosed with schizophrenia or schizoaffective disorder bipolar type. And if it ever was, it was full blown in the relevant period of time period, Your Honor. And continuing to -- it's in her report, Your Honor, and you can look at it with a little bit more detail and, certainly, the Marshall Pickens records. But for discreetness and delicateness today, I would just say that he was having very serious and grandiose delusions, Your Honor. Very intense behavior and language with respect to his own body and blood that date. The disorganization of thought, the voices from God and other folks.

Your Honor, this is all consistent with the typical onset age, as Dr. Le has testified, when these things typically manifest in the late teen years. He has a family history and predisposition to these sort of conditions. And then we have a very difficult and proximate trigger of the death of his girlfriend just months before. All of this is consistent with the diagnosis you've heard. Both historically and from Dr. Le.

So, Judge, kind of what we're left with is whatsoever his involvement that day, Your Honor, Jevon Carter apologized many times to Andrew Miller, I'll do it again, he's heard me say it too many times, but Jevon Carter is [indiscernible] of a criminal. And to a person, and the letters support this, that you are literally the tip of the iceberg. This room is full of people, family and friends that would spend the rest of your week telling you what kind of man a individual Jevon Carter is. And, Judge, they say these things not in the way that you say them about a young man who has a bright future. They say superlatively so. He's the sweetest and most thoughtful person that they have ever known. And I wish The Court could have known him a little bit more personally.

I say all this, Your Honor, again, not in mitigation but additional context for the person that Jevon Carter was before he was in the grips of this mental illness for which he knew nothing about. And the horrible effect it has had on him. There was zero context in his life for any of the kind of allegations that were, ultimately, made against him prior to the onset. He has been received by this illness, he's a victim of it, he had no control over it, it was literally laden in his genes.

And when he graduated from Wade Hampton, as a honor roll student, Your Honor has his transcript. A

multi-sport athlete. You'll see some of the photographs that we have submitted with his friends. And, Your Honor, just for just -- for sake I've blown up a couple. Your Honor, this -- and I've shared this before but this is what Jevon Carter looked like right before this happened. This is the person that mental illness brought to this situation. Not the man that two years in the detention center and the mental illness has brought.

And when he graduated that day, not Jevon and nobody in his life could have ever imagined that he would be here or in that detention center. It was absolutely inconceivable, Your Honor. Judge, he had a friend who sort put it this way. If you made a list of everybody that you knew in order of most likely to be accused of a murder at some point, Jevon Carter wouldn't appear in the middled of that list or the bottom corner tile of that list, he would be at the bottom of that list.

Your Honor, you know, by some misfortune of his illness and some miracle for purposes of today in the defense of his case, we have a very strong and clear opinion that he was not able to distinguish moral right from moral wrong at the time of this incident and could not have been criminally responsible. Judge, we would just respectfully ask that you accept the opinion of Dr. Le and the consent of the parties. I would just

express, again, my thankfulness to The Court and to Assistant Solicitor Miller. And our sympathies to the victim's family, in this case, Your Honor. Thank you.

THE COURT: All right, couple of housekeeping matters, just to make sure we're protected on the record. And since Dr. Le was not, specifically, moved to be qualified as a expert, do the parties stipulate that she was qualified as a expert in the field of psychiatry, specifically, as to the mental evaluation competency and criminal responsibility defense?

MR. BREWER: No objection, I apologize, Your Honor.

THE COURT: You consent to that as well?

MR. MILLER: Yes, Your Honor.

THE COURT: All right. And also, just for the record, I believe you mentioned this at first, but both The State and The Defendant consent to this matter being heard by a bench trial and not waiving the right to a jury trial. And that was a stipulation from The State?

MR. MILLER: Yes, Your Honor.

THE COURT: And The Defense?

MR. BREWER: That's correct, Your Honor.

THE COURT: All right.

All right, anything else from The State?

MR. MILLER: No, Your Honor.

THE COURT: Anything else from The Defense?

MR. BREWER: No, thank you, Judge.

THE COURT: All right. And let me, since we've got quite a bit of evidence that I need to review, I thought I'd kind of get y'all something today. But I really want to carefully look through all of the evidence that has been presented. And if there's any issues or questions, I will let either one of you know. But based on that -- I know that we've looked at a proposed order but I'll let y'all know if there are any issues.

MR. BREWER: Judge, we have a updated version of that.

THE COURT: Okay, I'll look at that. Like I said, I want to review all the of exhibits that were presented before I make a final decision.

MR. BREWER: Thank you, Judge.

THE COURT: All right, thank you.

MR. BREWER: Thank you, Judge.

MR. MILLER: Thank you, Your Honor.

THE COURT: Good luck, Mr. Carter.

(WHEREUPON, the proceedings were concluded.)

WITNESSES

Jacob U Kalu JKB

Greenville County Sheriffs Office

10/15/2018

ARREST WARRANT NUMBER
2018A2310100453

ACTION OF GRAND JURY

TRUE BILL

FOREMAN GRAND JURY
Foreperson of Grand Jury

VERDICT

Foreperson of Petit Jury
Date:

DOCKET NO. 2018-GS-23- BSS 09991

The State of South Carolina

County of Greenville

COURT OF GENERAL SESSIONS

TERM 2018 2019

~~October~~

THE STATE

vs.

KESHAWNA TANIKA YOUNG

Indictment for

2481

UNLAWFUL CONDUCT TOWARDS A CHILD

VIOLATION § 63-05-0070

FILED

DEC 26 2018

Clerk of Court
Greenville County

A Certified Copy
Clerk of Court C.P & G.S.
Greenville County, SC
Date 12-2-22

STATE OF SOUTH CAROLINA)
)
COUNTY OF GREENVILLE)

INDICTMENT FOR
UNLAWFUL CONDUCT TOWARDS A CHILD

At a Court of General Sessions, convened on OCT 29 2019 the Grand Jurors of Greenville County present upon their oath:

That KESHAWNA TANIKA YOUNG did in Greenville County, between April 27, 2018 and July 27, 2018, being the legal custodian, parent, or guardian, place her children, J. C. and G. K., (1) at unreasonable risk of harm affecting the child's life, physical or mental health, or safety; or (2) unlawfully or maliciously do or cause to be done any bodily harm to the child so that the life or health of the child is endangered or likely to be endangered; or (3) willfully abandon the child. This is in violation of § 63-05-0070 of South Carolina Code of Laws (1976) as amended.

Against the peace and dignity of the State, and contrary to the statute in such case made and provided.

SOLICITOR BAR # 65398

STATE OF SOUTH CAROLINA)
COUNTY OF Greenville)
STATE VS.)
Keshawna Tanika Young)
AKA:)
[redacted])

IN THE COURT OF GENERAL SESSIONS 0-104

INDICTMENT/CASE#: 2018GS2 3 0999
A/W#: 2018A2310100453
Date of Offense: 7/26/2018
S.C. Code § : 63-05-0070
CDR Code #: 2481

SENTENCE SHEET

*CDL Yes☐ No☐ CMV Yes☐ No☐ Hazmat Yes☐ No☐
In disposition of the said indictment comes now the Defendant who was ☐ CONVICTED OF or ☒ PLEADS
TO: CHILDREN/LEGAL CUSTODIAN, UNLAWFUL NEGLECT OF CHILD OR HELPL
in violation of § 63-05-0070 of the S.C. Code of Laws, bearing CDR Code # 2481
☒ NON-VIOLENT ☐ VIOLENT ☐ SERIOUS ☐ MOST SERIOUS ☐ Mandatory GPS(CSC w/minor 1st or Lewd Act) ☐ §17-25-45
The charge is: ☒ As Indicted, ☐ Lesser Included Offense, ☐ Defendant Waives Presentment to Grand Jury. _____ (defendant's initials)
The plea is: ☐ Without Negotiations or Recommendation, ☐ Negotiated Sentence, ☒ Recommendation by the State.
ATTEST:

Polsinello, Derek	101058	[signature]	Pro Se	
	SC Bar#	Defendant	Attorney for Defendant	SC Bar#

WHEREFORE, the Defendant is commited to the ☐ State Department of Corrections, ☐ County Detention Center, for a determinate term of 3 days/months/years or ☐ under the Youthful Offender Act not to exceed _____ years and/or to pay a fine of $_____; provided that upon the service of 5 CP days/months/years and/or payment of $_____; plus costs and assessments as applicable*; the balance is suspended with probation for _____ months/years and subject to South Carolina Department of Probation, Parole and Pardon Services standard conditions of probation, which are incorporated by reference.
☒ CONCURRENT or ☐ CONSECUTIVE to sentence on: 2/3/2020
☒ The Defendant is to be given credit for time served pursuant to S.C. Code §24-13-40 to be calculated and applied by SCDOC. 3d
☐ The Defendant is to be placed on the Central Registry of Child Abuse and Neglect pursuant to S.C. Code §17-25-135.
Pursuant to 18 U.S.C Section 922,it is unlawful for a person convicted of a violation of Section 16-25-20 or 16-25-65 (Domestic Violence) to ship, transport, possess, or receive a firearm or ammunition.

SPECIAL CONDITIONS:

☐ **RESTITUTION:** ☐ **Deferred** ☐ **Def. Waives Hearing** ☐ **Ordered** **PTUP** _____

Total: $ _____ plus 20% fee: _____ $ _____
Payment Terms: _____
☐ Set by SCDPPPS _____
Recipient: _____ MB

*Fine:		$
§14-1-206 (Assessments 107.5 %)		$
§14-1-211(A)(1) (Conv. Surcharge)	$100	$ 100.00
§14-1-211(A)(2) (DUI Surcharge)	$100	$
§56-5-2995 (DUI Assessment)	$12	$
§56-1-286 (DUI Breath Test)	$25	$
Proviso (Public Def/Probation)	$500	$
§14-1-212 (Law Enforce. Funding)	$25	$ 25.00
§14-1-213 (Drug Court Surcharge)	$150	$
§50-21-114(DUI Breath Test Fee)	$50	$
§56-5-2942(J) (Vehicle Assessment)	$40/ea	$
3% to County (if paid in installments)		$ 3.75
TOTAL		$ 128.75

_____ days/hours Public Service Employment
Obtain GED ☐
Attend Voc. Rehab. or Job Corp. _____
May serve W/E begining _____
Substance Abuse Counseling ☐
Random Drug/Alcohol testing ☐
Fine may be pd. in equal, consecutive weekly/monthly pmts. of $ _____ beginning _____
$ _____ paid to Public Defender Fund
Other: _____

☐ Appointed PD or appointed other counsel, Proviso requires $500 be paid to Clerk during probation and shall be collected before any other fees.

Clerk of Court/ Deputy Clerk: Paul B. Wilkerson
Court Reporter: Hudgins
Presiding Judge: [signature]
Judge Code: 2755
Sentence Date: FEB 03 2020

SCCA/217 (04/2018)

BLT

WITNESSES

Ryan A Gibson

Greenville County Sheriffs Office

4/30/2019

ARREST WARRANT NUMBER
2019A2330203893

ACTION OF GRAND JURY

TRUE BILL

FOREMAN GRAND JURY

Foreperson of Grand Jury

VERDICT

Foreperson of Petit Jury
Date:

DOCKET NO. 2019-GS-23- KBS 008020

The State of South Carolina

County of Greenville

COURT OF GENERAL SESSIONS

October **TERM 2019**

THE STATE

vs.

KESHAWNA TANIKA YOUNG

Indictment for

3011

POSSESSION OF COCAINE

VIOLATION § 44-53-0370

A Certified Copy
Paul B. Wilson
Clerk of Court C.P & G.S.
Greenville County, SC
Dated 12-2-22

STATE OF SOUTH CAROLINA)
)
COUNTY OF GREENVILLE)

INDICTMENT FOR
POSSESSION OF COCAINE

At a Court of General Sessions, convened on OCT 29 2019 the Grand Jurors of Greenville County present upon their oath:

That KESHAWNA TANIKA YOUNG did in Greenville County, on or about the 30th day of April, 2019, willfully and unlawfully have in her possession and under her control a quantity of Cocaine. This is in violation of §44-53-370 of the South Carolina Code of Laws (1976) as amended.

Against the peace and dignity of the State, and contrary to the statute in such case made and provided.

SOLICITOR BAR # 73989

STATE OF SOUTH CAROLINA)
COUNTY OF Greenville)
STATE VS.)
Keshawna Tanika Young)
AKA:)
Race: [redacted])
DOB:)
Addres)
City,S)
DL#:)
*CDL Yes☐ No☐ CMV Yes☐ No☐ Hazmat Yes☐ No☐

IN THE COURT OF GENERAL SESSIONS

INDICTMENT/CASE#: 2019GS2308020
A/W#: 2019A2330203893
Date of Offense: 4/30/2019
S.C. Code § : 44-53-0370 (d)(3)
CDR Code #: 3011

SENTENCE SHEET

In disposition of the said indictment comes now the Defendant who was ☐ CONVICTED OF or ☒ PLEADS
TO: Drugs/ Possession Of Cocaine, 1st Offense

in violation of § 44-53-0370 (d)(3) of the S.C. Code of Laws, bearing CDR Code # 3011
☒ NON-VIOLENT ☐ VIOLENT ☐ SERIOUS ☐ MOST SERIOUS ☐ Mandatory GPS(CSC w/minor 1st or Lewd Act) ☐ §17-25-45

The charge is: ☒ As Indicted, ☐ Lesser Included Offense, ☐ Defendant Waives Presentment to Grand Jury. _____ (defendant's initials)
The plea is: ☐ Without Negotiations or Recommendation ☐ Negotiated Sentence, ☒ Recommendation by the State.

ATTEST: _____ 101058 _____ Pro Se
Polimelio, Derek Defendant Attorney for Defendant SC Bar#

WHEREFORE, the Defendant is commited to the ☐ State Department of Corrections, ☐ County Detention Center, for a determinate term of 3 days/months/years or ☐ under the Youthful Offender Act not to exceed _____ years and/or to pay a fine of $ _____; provided that upon the service of 15 days/months/years and/or payment of $ _____; plus costs and assessments as applicable*; the balance is suspended with probation for 2 months/years and subject to South Carolina Department of Probation, Parole and Pardon Services standard conditions of probation, which are incorporated by reference.

☒ CONCURRENT or ☐ CONSECUTIVE to sentence on: 2/3/2020.

☒ The Defendant is to be given credit for time served pursuant to S.C. Code §24-13-40 to be calculated and applied by SCDOC. 30

☐ The Defendant is to be placed on the Central Registry of Child Abuse and Neglect pursuant to S.C. Code §17-25-135.

Pursuant to 18 U.S.C Section 922,it is unlawful for a person convicted of a violation of Section 16-25-20 or 16-25-65 (Domestic Violence) to ship, transport, possess, or receive a firearm or ammunition.

SPECIAL CONDITIONS:

☐ **RESTITUTION:** ☐ **Deferred** ☐ **Def. Waives Hearing** ☐ **Ordered** **PTUP** _____

Total: $ _____ plus 20% fee: _____ $ _____

Payment Terms: _____

☐ Set by SCDPPPS _____

Recipient: _____ MB

*Fine:		$
§14-1-206 (Assessments 107.5 %)		$
§14-1-211(A)(1) (Conv. Surcharge)	$100	$ 100.00
§14-1-211(A)(2) (DUI Surcharge)	$100	$
§56-5-2995 (DUI Assessment)	$12	$
§56-1-286 (DUI Breath Test)	$25	$
Proviso (Public Def/Probation)	$500	$
§14-1-212 (Law Enforce. Funding)	$25	$ 25.00
§14-1-213 (Drug Court Surcharge)	$150	$ 150.00
§50-21-114(BUI Breath Test Fee)	$50	$
§56-5-2942(J) (Vehicle Assessment)	$40/ea	$
3% to County (if paid in installments)		$ 8.25
TOTAL		$ 283.25

_____ days/hours Public Service Employment

Obtain GED ☐
Attend Voc. Rehab. or Job Corp. _____
May serve W/E begining _____
Substance Abuse Counseling ☒
Random Drug/Alcohol testing ☒
Fine may be pd. in equal, consecutive weekly/monthly pmts. of $ _____ beginning _____
$ _____ paid to Public Defender Fund
Other: Mental Health Assessment + follow counseling

☐ Appointed PD or appointed other counsel, Proviso requires $500 be paid to Clerk during probation and shall be collected before any other fees.

Clerk of Court/ Deputy Clerk: Paul B. Wilkerson
Court Reporter: [illegible]
Presiding Judge: [illegible]
Judge Code: 3755
Sentence Date: FEB 03 2020

SCCA/217 (04/2018)

Prob begins today

WITNESSES

Andrew S Smith

Greenville Police Department

8/28/2020

ARREST WARRANT NUMBER

2020A2320602678 and 2020A2320602680

ACTION OF GRAND JURY

TRUE BILL

FOREMAN GRAND JURY

Foreperson of Grand Jury

VERDICT

Foreperson of Petit Jury

Date:

DOCKET NO. 2021-GS-23-APM 005230

The State of South Carolina

County of Greenville

COURT OF GENERAL SESSIONS

August **TERM 2021**

THE STATE

vs.

JEVON KENNETH CARTER

Indictment for

0116/0549

Murder and Possession of a Weapon during the Commission of a Violent Crime

VIOLATION § 16-03-0010, §16-23-490

STATE OF SOUTH CAROLINA)
)
COUNTY OF GREENVILLE)

INDICTMENT FOR
Murder and Possession of a Weapon during the Commission of a Violent Crime

At a Court of General Sessions, convened on AUG 0 3 2021 the Grand Jurors of Greenville County present upon their oath:

COUNT I - MURDER

That JEVON KENNETH CARTER did in Greenville County, on or about the 4th day of July, 2020, unlawfully and with malice aforethought kill FRANCES MATTISON by means of stab wounds to the neck, and that FRANCES MATTISON died as a proximate result thereof. This is in violation of §16-3-10 of the South Carolina Code of Laws (1976) as amended.

COUNT II – POSSESSION OF A WEAPON DURING THE COMMISSION OF A VIOLENT CRIME

That JEVON KENNETH CARTER did in Greenville County, on or about the 4th day of July, 2020, possess or visibly display a sharp edged weapon during the commission or attempted commission of a violent crime, to wit: Murder. This is in violation of §16-23-490 of the South Carolina Code of Laws (1976) as amended.

Against the peace and dignity of the State, and contrary to the statute in such case made and provided.

SOLICITOR BAR # 102782

WITNESSES

Andrew S Smith

Greenville Police Department

8/28/2020

ARREST WARRANT NUMBER

2020A2320602679

ACTION OF GRAND JURY

TRUE BILL

FOREMAN GRAND JURY

Foreperson of Grand Jury

VERDICT

Foreperson of Petit Jury
Date:

DOCKET NO. 2021-GS-23- APM 005231

The State of South Carolina

County of Greenville

COURT OF GENERAL SESSIONS

August **TERM 2021**

THE STATE

vs.

JEVON KENNETH CARTER

Indictment for

0079

Burglary, First Degree

VIOLATION § 16-11-0311

STATE OF SOUTH CAROLINA)
)
COUNTY OF GREENVILLE)

INDICTMENT FOR
Burglary, First Degree

AUG 0 3 2021

At a Court of General Sessions, convened on the Grand Jurors of Greenville County present upon their oath:

That JEVON KENNETH CARTER did in Greenville County, on or about the 4th day of July, 2020, willfully and unlawfully enter the dwelling of FRANCES MATTISON located at 6 Merlocke Drive, Greenville, SC, without consent and with the intent to commit a crime therein, and the burglary was accompanied by circumstances of aggravation, to wit: did cause physical injury to a person inside and/or the entry occurred during the night time hours. This is in violation of §16-11-0311 of the South Carolina Code of Laws (1976) as amended.

Against the peace and dignity of the State, and contrary to the statute in such case made and provided.

SOLICITOR BAR # 102782

WITNESSES

Christopher R Colberg

SC Highway Patrol Troop 3

6/6/2021

ARREST WARRANT NUMBER
20212350544192

ACTION OF GRAND JURY

Foreperson of Grand Jury

VERDICT

Foreperson of Petit Jury
Date:

DOCKET NO. 2022-GS-23- 6308
AOF

The State of South Carolina

County of Greenville

COURT OF GENERAL SESSIONS

TERM 2022

THE STATE

vs.

KESHAWNA TANIKA YOUNG

Indictment for

A357

DRIVING UNDER THE INFLUENCE

VIOLATION § 56-05-2930

ENTERED ACCT
GW

A Certified Copy
Paul B. Wilbanks
Clerk of Court C.P & G.S.
Greenville County, SC
Dated 12-2-22

STATE OF SOUTH CAROLINA)
)
COUNTY OF GREENVILLE)

INDICTMENT FOR
DRIVING UNDER THE INFLUENCE

At a Court of General Sessions, convened on the Grand Jurors of Greenville County present upon their oath:

That KESHAWNA TANIKA YOUNG did in Greenville County, on or about the 6th day of June, 2021, drive a motor vehicle while under the influence of alcohol, or other drug or substance, or combination of alcohol, other drug and/or substance which caused impairment to the extent that the defendant's faculties to drive were materially and appreciably impaired; such not being the first offense within a period of ten (10) years including and immediately preceding the foregoing date. This is in violation of §56-05-2930 of the South Carolina Code of Laws (1976) as amended.

Against the peace and dignity of the State, and contrary to the statute in such case made and provided.

SOLICITOR BAR # 17016

30 D - 24 R

STATE OF SOUTH CAROLINA)
COUNTY OF Greenville)

IN THE COURT OF GENERAL SESSIONS

$2,100 - 95, 15

STATE)
VS.)
Keshawna Tanika Young)
AKA: [redacted])

INDICTMENT/CASE#: 2022 GS-23- 6308

A/W#: 202123505441 92
Date of Offense: 6/6/2021
S.C. Code §: 56-05-2930
CDR Code #: 3357

SENTENCE SHEET

*CDL Yes ☐ No ☐ CMV Yes ☐ No ☐ Hazmat Yes ☐ No ☐

In disposition of the above indictment comes now the Defendant who was ☐ CONVICTED OF or ☑ PLEADS

TO: Driving Under the Influence (>=.10% BAC), Second Offense

in violation of § 56-05-2930 of the S.C. Code of Laws, bearing CDR Code # 3357

☒ NON-VIOLENT ☐ VIOLENT ☐ SERIOUS ☐ MOST SERIOUS ☐ Mandatory GPS ☐ §17-25-45
(CSC w/minor 1st d; CSC w/minor 3rd)

The charge is: ☐ As Indicted, ☐ Lesser Included Offense, ☑ Defendant Waives Presentment to Grand Jury. KK (def.'s initials)

The plea is: ☐ ~~Without Negotiations~~ or Recommendation, ☐ Negotiated Sentence, ☑ Recommendation by the State.

ATTEST:

Fretwell, Allen — 17016 (SC Bar#) — Defendant — SC Bar#

WHEREFORE, the Defendant is committed to the ☒ State Department of Corrections / ☐ County Detention Center, for a determinate term of 2 ~~days/months/years~~ Time Served ☐ Youthful Offender Act not to exceed ~~5~~ H-I years and/or to pay a fine of $2,500 provided that upon the service of 30 ~~days/months/years~~ Time Served and ~~or~~ payment of $ ~~1,100.65~~ plus costs and assessments ~~as applicable~~, the balance is suspended with probation for ~~months/years~~ and subject to South Carolina Department of Probation, Parole and Pardon Services standard conditions of probation, which are incorporated by reference.

payment Schedule

The sentence shall run
☐ CONCURRENT or ☐ CONSECUTIVE to sentence on: Next Page

☐ The Defendant is to be given credit for time served pursuant to S.C. Code §24-13-40 to be calculated and applied by SCDOC. _____ days/months
☐ To include time spent on monitored house arrest prior to trial and sentencing.

☐ The Defendant Shall be Released from County Detention Center.

Pursuant to 18 U.S.C. § 922 and § 16-25-30 it is unlawful for a person convicted of a violation of § 16-25-20 or § 16-25-65 (Domestic Violence) to ship, transport, possess, or receive a firearm or ammunition.

STATE VS Keshawna Tanika Young INDICTMENT/CASE#: 2022 GS-23- 6309

SPECIAL CONDITIONS: A/W#: 20212350544192

☐ PTUP after _____ months/years

And Other Terms Listed Below:

☐ Substance Abuse Counseling ☐ Completion of GED ☐ Random Drug/Alcohol testing

☐ Attend Voc. Rehab. or Job Corp ☐ No Contact with ☐ Domestic Violence Intervention Program

☐ Mental Health Counseling ☐ May serve W/E beginning : _____

☐ Sex Offender Registry pursuant to S.C. Code § 23-3-430 ☐ Public Service Employment _____ days/hours

☐ Central Registry of Child Abuse and Neglect pursuant to S.C. Code §17-25-135.

☐ Other: fine and costs to be paid in $200 monthly increments beginning 12/1/22 and on the 1st of each month thereafter.

☐ RESTITUTION: ☐ Deferred ☐ Def. Waives Hearing ☐ Ordered

Total: $ _____ plus 20% fee: _____ $ _____

Payment Term _____ ☐ Set by SCDPPPS

Recipient: _____

*Fine:		$ 1100.00
Fine may be pd. in equal, consecutive weekly/monthly pmts. of $ _____ Beginning _____		
§14-1-206 (Assessments 107.5 %)		$ 1182.50
§14-1-211(A)(1) (Conv. Surcharge)	$100	$ 100.00
§14-1-211(A)(2) (DUI Surcharge)	$100	$ 100.00
§56-5-2995 (DUI Assessment)	$12	$ 12.00
§56-1-286 (DUI Breath Test)	$25	$ 25.00
§14-1-212 (Law Enforce. Funding)	$25	$ 25.00
§14-1-213 (Drug Court Surcharge)	$150	$
§34-11-70(b)and(c), and 34-11-90(c)and(d) (Admin Fraud Check Court Costs)	$41	$
§50-21-114(BUI Breath Test Fee)	$50	$
§56-5-2942(J) (Vehicle Assessment)	$40/ea	$
3% to County (if paid in installments)	TBD	$ 76.34
☐ Appointed PD or appointed other counsel. Proviso requires $500 be paid to Clerk during probation and shall be collected before any other fees.	$500	$
☐ § 17-3-30(B) Unpaid Application Fee to be paid to the Public Defender Fund	TBD	$
	TOTAL	$ 2620.84

GW

Clerk of Court/ Deputy Clerk: Paul B. Wilkerson

Court Reporter: Moffitt

Presiding Judge: _____

Judge Code: 2117

Sentence Date: 10/24/22

SCCA/217 (07/2021)

Page 2 of 2

Discharge Summary Note (continued)

not adherent with treatment recommendations and declined all treatment modalities while hospitalized[GW.1M].

Allergies: Patient has no known allergies.

Review of Systems:
I have performed a complete review of systems. All systems are negative and without any complaints except as noted above in the history of present illness.

Vital Signs:
Vitals:

	07/21/20 1930
BP:	130/64
Pulse:	75
Resp:	17
Temp:	98.6 °F (37 °C)
SpO2:	

Body mass index is 26.91 kg/m².

Summary of Examination and Laboratory Data:
The patient had a complete physical examination performed by[GW.1T] 7/8/2020[GW.2M] on[GW.1T] Amelia Crowley, PA[GW.2M].

Laboratory data:
Recent Labs
** No results found for the last 48 hours. **

Imaging:[GW.1T] None[GW.2M]

Consultations:[GW.1T] None[GW.2M]

Condition at Discharge: Prior to discharge, the patient was evaluated by a physician, case manager and nursing staff. On the day of discharge, the patient was denying suicidal or homicidal ideations, intent or plan. Insight and judgment were at baseline. Patient denied access to firearms. Patient stated they planned to continue taking their medications and follow up with their outpatient providers. Patient expressed safety plan if[GW.1T] psychotic symptoms[GW.2M] were to be experienced again. While hospitalized, several modifiable risk factors for[GW.1T] psychosis[GW.2M] were addressed and improved. Diagnosis, prognosis, medications, outpatient service options, and discharge planning were discussed with the

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STATE'S EXHIBIT 1 8/30/23

PENGAD 800-631-6989

MIP INTENSIVE MGMT
701 GROVE RD
GREENVILLE SC 29605-4210

patient[GW.1T] and Grandmother, Cynthia Chapman[GW.2M] and questions were answered to their satisfaction. The treatment team agreed that major treatment goals had been attained, that the patient has reached maximum therapeutic benefit from this hospitalization, and that a safe and appropriate discharge plan is in place. Patient stated he felt safe outside the hospital and was asking to leave. No withdrawal symptoms or medication side effects were observed, and there were no physical or medical concerns at time of discharge. The patient endorses a mild continuation of[GW.1T] delusional[GW.2M] symptoms; however the patient and treatment team agree that these residual symptoms may be safely managed on an outpatient basis.

Risk Assessment: A comprehensive risk assessment was performed prior to discharge. In my clinical opinion, based on the patient's current mental status examination, past and current psychiatric history; the patient represents a[GW.1T] low[GW.2M] risk of suicide, homicide, or self-damaging behavior. Further inpatient treatment will not significantly mitigate this risk, however the team has discussed issues around self-harm with the patient and techniques to lower this risk. Patient has been informed of how the effects of alcohol, recreational drugs, and misused prescription medications can significantly elevate the risk of such dangerous behaviors. The patient has been advised to seek immediate medical attention if experiencing further or new suicidal or homicidal ideations, signs mania, or psychosis.

Mental status examination upon discharge:[GW.1T]
Appearance: age appropriate and dressed in plum scrubs, laying on bed[GW.2C] upon entering[GW.2M]
Sensorium: AOx4
Behavior: normal and appropriate
Speech: normal pitch, normal volume and normal rate
Mood: "[GW.2C]great[GW.2M]"
Affect: mood-congruent[GW.2C], appropriate[GW.2M]
Thought Process: Linear, Goal directed and focused on his discharge
Thought Content: Patient denies[GW.2C] AVH[GW.2M] Patient does not appear to be responding to internal stimuli.
Suicidality: Patient Denies suicidal ideation, intent or plan.
Homicidality: Pt denies homicidal ideation, intent or plan
Impulsivity: fair
Memory: recent and remote memory intact
Fund of knowledge: average and appropriate for level of education
Insight: fair, reports feeling better on medication and endorses taking it once he leaves.
Judgement:[GW.2C] fair[GW.2M]

Assessment:[GW.1T] This is an 18 year old male without a past psychiatric history, who is currently admitted to MIPH for his first hospitalization his first episode of mania and psychotic

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Discharge Summary Note (continued)

symptoms. Patient was admitted to the hospital from 7/4/2020-7/22/2020; his admission was complicated by several elopement attempts and two successful elopements. The patient is at an increased predisposing risk for his first psychotic break due to the recent traumatic and untimely death of his long-term girlfriend who fell to her death at the Pickens waterfall, age of first psychotic break, drug use and depressive episode. The patient is at an increased predisposing genetic risk to mental health diagnosis given the family history of schizophrenia in his mother. Working diagnosis at this time of discharge includes Bipolar I Disorder, with mood congruent psychotic features, with schizophreniform features, meeting several clinical symptoms required including persistently elevated mood, expansiveness and irritability, grandiosity, decreased need for sleep and increased goal directed activity, with auditory hallucinations. Given success of Abilify and Lithium, patient will benefit from continuation of these medications. Patient will also benefit from ongoing outpatient treatment which was mandated by probate court for 6 months.[GW.2M]

Discharge Diagnoses:[GW.1T]
Bipolar I Disorder, with mood congruent psychotic features
Schizophreniform features[GW.2M]

Plan:
1. Discharge Medications:

Home Medication Instructions

Carter, Jevon Kenneth
HAR:107000020714
Printed on:07/22/20 1551

Medication Information
ARIPiprazole (Abilify Maintena) 400 mg IM injection Inject 1 Syringe (400 mg) into the muscle every 30 (thirty) days Do not start before August 19, 2020. 1st dose administered 07/20/20. PO overlap through 08/02/20.
ARIPiprazole (ABILIFY) 15 mg tablet Take 1 tablet (15 mg) by mouth daily before evening meal for 12 doses LAST DOSE on given 08/02/20.

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Discharge Summary Note (continued)

diphenhydrAMINE (BENADRYL) 25 mg tablet Take 2 tablets (50 mg) by mouth nightly								
lithium 300 mg capsule Take 4 capsules (1,200 mg) daily before evening meal								
melatonin 5 mg tablet Take 1 tablet (5 mg) by mouth nightly								

2. Follow Up: Patient has a follow up appointment with[GW.1T] Greenville Mental Health Center[GW.2M]. A long-acting injectable[GW.1T] was administered on 7/20/2020, and[GW.2M] has been scheduled for[GW.1T] after 8/15/2020[GW.2M]. Patient has been instructed to obtain labs on[GW.1T] Friday, 7/242020 for Lithium Levels[GW.2M].
3. Further Recommendations:
   a. Patient will benefit from[GW.1T] Breavement[GW.2M] therapy moving forward. Please consider a referral to[GW.1T] Greenville Mental Health[GW.2M].
   b. Future plans for goal of treatment was discussed with the patient prior to discharge. Recommend[GW.1T] continuing Lithium 1200 mg QHS at current dose, and continue Abilify 15 mg for 12 doses for last dose to be on 8/2/2020.[GW.2M]

The above assessment and plan was discussed with the attending physician, Dr.[GW.1T] Edmund Parsons[GW.2M] who agrees with this treatment plan.[GW.1T]

Gena Williams[GW.1M]*, MD*
PGY-1 Psychiatry[GW.1T]

Electronically signed by Williams, Gena Nicole, MD at 7/22/2020 4:54 PM
Electronically signed by Parsons, Edmund Cole, MD at 7/24/2020 9:56 PM

Attribution Key
GW.1 - Williams, Gena Nicole, MD on 7/22/2020 3:51 PM
GW.2 - Williams, Gena Nicole, MD on 7/22/2020 4:26 PM
C - Copied, M - Manual, T - Template

Consult Notes

Consults

Crawford, Patricia Ann, MD at 7/5/2020 12:00 AM

Author: Crawford, Patricia Ann, MD | Service: — | Author Type: Physician
Filed: 7/7/2020 5:08 PM | Date of Service: 7/5/2020 12:00 AM | Status: Signed
Editor: Crawford, Patricia Ann, MD (Physician)

PH HIM
701 GROVE RD
GREENVILLE SC 29605-4210

Carter, Jevon Kenneth
MRN: 970195696, DOB: 9/14/2001, Sex: M

Patient

Demographics

Name: Jevon Kenneth Carter
Address: 3 Harrison Avenue Greenville SC 29617-7712
Date of birth: 9/14/2001 | Sex: Male | Gender identity: Male
Ethnicity: Non-Hispanic or Non-Latino | Race: Black or African American | Home phone: 864-800-2382
Mobile: 864-800-2382

Relationships

Name	Relation to Patient	Phone Number
Chapman, Cynthia	Grandparent	Mobile: 864-423-9425 (primary)
Young,Keshawna	Mother	Mobile: 864-772-7457 (primary)
Carter, Kenneth	Father	Mobile: 864-243-9425 (primary)

Patient Contacts

Patient Contacts

Name	Relationship	Phone	Roles
Carter, Jevon Kenneth	Patient Physical Address		
Young, Keshawna	Mother	864-772-7457	Assists with Medications
Chapman, Cynthia	Grandparent	864-423-9425	
Carter, Kenneth	Father	864-243-9425	

Active Coverages

BCBS OF SOUTH CAROLINA

Plan: BCBS PPC/PPO PREFERRED BLUE | Group: 270094M4R4 | Member: EZVAN8258422
Effective from: 1/1/2020 | Subscriber: KELLY,BYRON D | Subscriber ID: EZVAN8258422

MEDICAID ABSOLUTE TOTAL CARE

Plan: MEDICAID ABSOLUTE TOTAL CARE | Member: 8782039766 | Effective from: 2/1/2020
Subscriber: CARTER,JEVON KENNETH | Subscriber ID: 8782039766

Visit List

Date	Type
07/03/2020 07/22/2020	Admission (Discharged)

Care Team

Active

Name	Relationship	Specialty	Phone	Duration
Pcp No, MD	PCP - General	—	—	02/09/2020 - Present

Problem List

Problems last reviewed by Goss, Bailey, CMA(AAMA) on 8/25/2020 1443

Bipolar affective disorder, manic, severe, with psychotic behavior (HCC) *[last edited by Williams, Gena Nicole, MD on 7/14/2020 1610]*

Diagnosis: Bipolar affective disorder, manic, severe, with psychotic behavior (HCC)
ICD-9-CM: 296.44
Noted on: 07/02/2020 | Chronic: No

Bipolar I disorder, current or most recent episode manic, with psychotic features (HCC) *[last edited by Williams, Gena Nicole, MD on 7/14/2020 1613]*

Diagnosis: Bipolar I disorder, current or most recent episode manic, with psychotic features (HCC)
Noted on: 07/14/2020 | Chronic: No

Cannabis use disorder, moderate, dependence (HCC) *[last edited by Ross, Maggie Pierson, MD on 7/2/2020 2236]*

Diagnosis: Cannabis use disorder,
Noted on: 07/02/2020 | Chronic: No

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Carter, Jevon Kenneth
MRN: 970195696, DOB: 9/14/2001, Sex: M

Patient (continued)

Problem List (continued)

moderate, dependence (HCC)

Narcissistic personality disorder (HCC) *[last edited by Williams, Gena Nicole, MD on 7/17/2020 1453]*

Diagnosis: Narcissistic personality disorder (HCC)
ICD-9-CM: 301.81
Noted on: 07/14/2020
Chronic: No

Psilocybin use disorder, moderate (HCC) *[last edited by Ross, Maggie Pierson, MD on 7/2/2020 2236]*

Diagnosis: Psilocybin use disorder, moderate (HCC)
Noted on: 07/02/2020
Chronic: No

Schizophreniform disorder (HCC) *[last edited by Williams, Gena Nicole, MD on 7/14/2020 1610]*

Diagnosis: Schizophreniform disorder (HCC)
ICD-9-CM: 295.40
Noted on: 07/03/2020
Chronic: No

Seizure (HCC) *[last edited by Madubuike, Iheoma C, NP on 8/25/2020 1509]*

Diagnosis: Seizure (HCC)
ICD-9-CM: 780.39
Noted on: 07/27/2020
Chronic: No

Allergies

Allergies last reviewed by Goss, Bailey, CMA(AAMA) on 8/25/2020 1443
No Known Allergies

Immunizations

No documentation.

Current Medications

Medications

This report is for documentation purposes only. The patient should not follow medication instructions within.
For accurate instructions regarding medications, the patient should instead consult their physician or after visit summary.

Current Medications

Medications last reviewed by Goss, Bailey, CMA(AAMA) on 8/25/2020 1443

ARIPiprazole (Abilify Maintena) 400 mg IM injection

Instructions: Inject 1 Syringe (400 mg) into the muscle every 30 (thirty) days Do not start before August 19, 2020. 1st dose administered 07/20/20. PO overlap through 08/02/20.
Authorized by: Williams, Gena Nicole, MD
Start date: 8/19/2020
Refill: No refills remaining
Ordered on: 7/21/2020
Quantity: 1 Syringe

ARIPiprazole (ABILIFY) 15 mg tablet

Instructions: Take 1 tablet (15 mg) by mouth daily before evening meal for 12 doses LAST DOSE on given 08/02/20
Authorized by: Williams, Gena Nicole, MD
Start date: 7/21/2020
Refill: No refills remaining
Ordered on: 7/21/2020
Quantity: 12 tablet

lithium carbonate 300 mg capsule

Instructions: Take 4 capsules (1,200 mg) daily before evening meal
Authorized by: Madubuike, Iheoma C, NP
Start date: 8/25/2020
Refill: 2 refills by 8/25/2021
Ordered on: 8/25/2020
Quantity: 120 capsule

melatonin 5 mg tablet

Instructions: Take 1 tablet (5 mg) by mouth nightly

NOV 4 2020

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701 GROVE RD
GREENVILLE SC 29605-4210

Carter, Jevon Kenneth
MRN: 970195696, DOB: 9/14/2001, Sex: M

Patient (continued)

Current Medications (continued)

Authorized by: Williams, Gena Nicole, MD
Start date: 7/21/2020
Refill: No refills remaining

Ordered on: 7/21/2020
Quantity: 30 tablet

Vitals

Vital Signs - Last Recorded — Most recent update: 8/25/2020 2:48 PM

BP	Pulse	Temp	Resp	Ht
153/82 (BP Location: Right arm, Patient Position: Sitting)	81	98.2 °F (36.8 °C) (Oral)	18	1.727 m (5' 8") (29 %, Z = -0.54)*

Wt	SpO2	BMI
91.2 kg (201 lb) (93 %, Z= 1.51)*	100%	30.56 kg/m² (96 %, Z = 1.78)*

*Growth percentiles are based on CDC (Boys, 2-20 Years) data

History

Medical History

Medical last reviewed by Goss, Bailey, CMA(AAMA) on 8/25/2020

Past Medical History

Diagnosis	Date	Comments	Source
Seizures (HCC) [R56.9]	—	—	Provider

Surgical History

Surgical last reviewed by Goss, Bailey, CMA(AAMA) on 8/25/2020
None

Family History

Family History as of 9/4/2020
None

Substance & Sexuality History

Tobacco Use

Tobacco Use last reviewed by Goss, Bailey, CMA(AAMA) on 8/25/2020

Smoking Status	Smoking Start Date	Smoking Quit Date	Packs/Day	Years Used
Unknown If Ever Smoked	—	—	—	—

Types	Comments	Smokeless Tobacco Status	Smokeless Tobacco Quit Date	Source
—	—	Never Used	—	Provider

Alcohol Use

11/05/2020 MLP

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701 GROVE RD
GREENVILLE SC 29605-4210

Carter, Jevon Kenneth
MRN: 970195696, DOB: 9/14/2001, Sex: M

Patient (continued)

History (continued)

Alcohol Use last reviewed by Goss, Bailey, CMA(AAMA) on 8/25/2020

Alcohol Use	Drinks/Week	Alcohol/Week	Comments	Source
Not Currently	—	—	—	Provider

Frequency	Typical Drinks	Binge Drinking
—	—	—

Drug Use

Drug Use last reviewed by Goss, Bailey, CMA(AAMA) on 8/25/2020

Drug Use	Types	Frequency	Comments	Source
Not Currently	—	—	—	Provider

Sexual Activity

Sexually Active	Birth Control	Partners	Comments	Source
Yes	—	Female	—	Provider

Socioeconomic History

Socioeconomic

Marital Status	Spouse Name	Number of Children	Years Education	Education Level	Preferred Language	Ethnicity	Race	Source
Single	—	—	—	—	English	Non-Hispanic or Non-Latino	Black or African American	—

Financial Resource Strain	Food Insecurity: Worry	Food Insecurity: Inability	Transportation Needs: Medical	Transportation Needs: Non-medical
—	—	—	—	—

Advance Care Planning

Plan

Patient Capacity

The patient has full capacity. There is no history of patient status change.

Current Code Status

Date Active	Code Status	Order ID	Comments	User	Context
7/28/2020 0339	Full Code	236770829		Hajmurad, Mohamed Faris, MD	ED

Health Care Agents

There are no Health Care Agents on file.

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PH HIM
701 GROVE RD
GREENVILLE SC 29605-4210

Carter, Jevon Kenneth
MRN: 970195696, DOB: 9/14/2001, Sex: M

Patient (continued)

Documents

Patient ID

Scan on 7/27/2020 6:06 PM by Strollo, Dolores

Scan (below)

[redacted]

CARTER, JEVON KENNETH
DOB: 9/14/2001
MRN: 970195696
HAR: 800007300498
Adm Date: 7/27/2020

10001506
08640

11/05/2020MLP

MIP INTENSIVE MGMT
701 GROVE RD
GREENVILLE SC 29605-4210

Carter, Jevon Kenneth
MRN: 970195696, DOB: 9/14/2001, Sex: M
Adm: 7/3/2020, D/C: 7/22/2020

07/03/2020 - Admission (Discharged) in Marshall I. Pickens Intensive Management

Reason for Visit

Hospital Problems

Name	Code	Date Noted	Date Resolved	Present on Admission?	Last Updated By	Last Updated On
Bipolar affective disorder, manic, severe, with psychotic behavior (HCC)	F31.2	07/02/2020	—	Yes	Williams, Gena Nicole, MD	07/14/2020 1610
Bipolar I disorder, current or most recent episode manic, with psychotic features (HCC)	F31.2	07/14/2020		Unknown	Williams, Gena Nicole, MD	07/14/2020 1613
Narcissistic personality disorder (HCC)	F60.81	07/14/2020	—	Unknown	Williams, Gena Nicole, MD	07/17/2020 1453
Schizophreniform disorder (HCC)	F20.81	07/03/2020	—	Yes	Williams, Gena Nicole, MD	07/14/2020 1610

Visit Information

Admission Information

Arrival Date/Time		Admit Date/Time	07/03/2020 1259	IP Adm. Date/Time:	07/03/2020 1259
Admission Type:	Urgent	Point of Origin:	Hospital (Acute Care Facility)	Admit Category:	
Means of Arrival:		Primary Service:	Psychiatry	Secondary Service:	N/A
Transfer Source:		Service Area:	PRISMA HEALTH	Unit:	Marshall I. Pickens Intensive Management
Admit Provider:	Parsons, Edmund Cole, MD	Attending Provider:	Parsons, Edmund Cole, MD	Referring Provider:	

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
07/22/2020 1315	Home Or Self Care	Home	None	Marshall I. Pickens Intensive Management

Follow-up Information

Follow-up With	Details	Why	Contact Info
PHOENIX CENTER	Call	To schedule an assessment for Adult Outpatient Services, please call (864) 467-3737	1400 Cleveland St Greenville South Carolina 29607 864-467-3790
GREENVILLE MENTAL HEALTH CENTER	Go on 7/24/2020	An aftercare appointment for Friday, 7/24/20 at 1 30 pm. Please bring ID, Social Security Card, and proof of insurance.	124 Mallard Street Greenville South Carolina 29601 864-241-1040

Visit Account Information

Hospital Account

Name	Acct ID	Class	Status	Primary Coverage
Carter, Jevon Kenneth	107000020714	Inpatient	Billed	BCBS OF SOUTH CAROLINA - BCBS PPO/PPO PREFERRED BLUE

Guarantor Account (for Hospital Account #107000020714)

Name	Relation to Pt	Service Area	Active?	Acct Type
Carter, Jevon Kenneth	Self	GHS	Yes	Personal/Family
Address	**Phone**			
3 Harrison Avenue	864-800-2382(H)			

11/05/2020MLP

07/03/2020 - Admission (Discharged) in Marshall I. Pickens Intensive Management (continued)

Visit Account Information (continued)

Greenville, SC 29617-7712

Coverage Information (for Hospital Account #107000020714)

1. BCBS OF SOUTH CAROLINA/BCBS PPC/PPO PREFERRED BLUE

F/O Payor/Plan	Precert #
BCBS OF SOUTH CAROLINA/BCBS PPC/PPO PREFERRED BLUE	
Subscriber	**Subscriber #**
Kelly, Byron D	EZVAN8258422
Address	**Phone**
PO BOX 100300 COLUMBIA, SC 29202-0300	800-868-2510

2. MEDICAID ABSOLUTE TOTAL CARE/MEDICAID ABSOLUTE TOTAL CARE

F/O Payor/Plan	Precert #
MEDICAID ABSOLUTE TOTAL CARE/MEDICAID ABSOLUTE TOTAL CARE	
Subscriber	**Subscriber #**
Carter, Jevon Kenneth	8782039766
Address	**Phone**
PO BOX 3050 FARMINGTON, MO 63640-3821	866-433-6041

Treatment Team

Provider	Service	Role	Specialty	From	To
Parsons, Edmund Cole, MD	—	Admitting Provider	Psychiatry	—	—
Parsons, Edmund Cole, MD	—	Attending Provider	Psychiatry	07/03/20 1259	07/22/20 1315
Wade, Jenna, RN	—	Registered Nurse	—	07/22/20 0741	—
Porterfield, Angela D, RN	—	Registered Nurse	—	07/21/20 1900	07/22/20 0900
Shehan, Paula Annette, RN	—	Registered Nurse	—	07/21/20 1852	—
Porterfield, Angela D, RN	—	Registered Nurse	—	07/20/20 1951	07/21/20 0951
Shehan, Paula Annette, RN	—	Registered Nurse	—	07/20/20 1908	07/20/20 2248
Wade, Jenna, RN	—	Registered Nurse	—	07/20/20 1502	07/20/20 1903
Sowell, Clara Eloisa, RN	—	Registered Nurse	—	07/20/20 0000	—
Pullan, Gemma, RN	—	Registered Nurse	—	07/19/20 1933	—
Blevins, Renee, RN	—	Registered Nurse	—	07/19/20 0837	07/19/20 2237
Porterfield, Angela D, RN	—	Registered Nurse	—	07/18/20 1900	07/19/20 0900
Blevins, Renee, RN	—	Registered Nurse	—	07/18/20 0901	07/18/20 2301
Porterfield, Angela D, RN	—	Registered Nurse	—	07/17/20 2314	07/18/20 0900
Gilles, Kelly, RN	—	Registered Nurse	—	07/17/20 0728	07/17/20 1802
Porterfield, Angela D, RN	—	Registered Nurse	—	07/16/20 1900	07/17/20 0900
White, Rosemerry R, RN	—	Registered Nurse	—	07/16/20 1109	07/17/20 0109
Golden, Yolanda Nichele, RN	—	Charge Nurse	—	07/16/20 0950	07/16/20 2350
Golden, Yolanda Nichele, RN	—	Charge Nurse	—	07/15/20 1916	07/16/20 0916
Porterfield, Angela D, RN	—	Registered Nurse	—	07/15/20 1900	07/16/20 0900
Golden, Yolanda Nichele, RN	—	Charge Nurse	—	07/15/20 0754	07/15/20 1914

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07/03/2020 - Admission (Discharged) in Marshall I. Pickens Intensive Management (continued)

Treatment Team (continued)

Provider	Service	Role	Specialty	From	To
Roberts, Brian, LPN	—	Licensed Practical Nurse	—	07/15/20 0730	07/15/20 1513
Reilly, Jennifer, RN	—	Registered Nurse	—	07/15/20 0726	07/19/20 0735
Porterfield, Angela D, RN	—	Registered Nurse	—	07/15/20 0416	07/15/20 0900
Blevins, Renee, RN	—	Registered Nurse	—	07/14/20 0944	07/14/20 1052
Porterfield, Angela D, RN	—	Registered Nurse	—	07/14/20 0037	07/14/20 0900
Shehan, Paula Annette, RN	—	Registered Nurse	—	07/13/20 1856	07/15/20 1505
Golden, Yolanda Nichele, RN	—	Charge Nurse	—	07/13/20 0751	07/13/20 2151
Porterfield, Angela D, RN	—	Registered Nurse	—	07/12/20 1937	07/13/20 0537
Sowell, Clara Eloisa, RN	—	Registered Nurse	—	07/12/20 1931	07/12/20 2301
Wade, Jenna, RN	—	Registered Nurse	—	07/12/20 1622	07/12/20 2222
Porterfield, Angela D, RN	—	Registered Nurse	—	07/11/20 2300	07/12/20 0900
Johnson, Sally, RN	—	Registered Nurse	—	07/10/20 2020	07/11/20 1020
Porterfield, Angela D, RN	—	Registered Nurse	—	07/10/20 1954	07/11/20 0954
Pullan, Gemma, RN	—	Registered Nurse	—	07/10/20 1530	07/14/20 1514
Porterfield, Angela D, RN	—	Registered Nurse	—	07/09/20 1900	07/10/20 0900
Wade, Jenna, RN	—	Registered Nurse	—	07/09/20 1852	07/09/20 1937
Horton, Michelle R, RN	—	Charge Nurse	—	07/09/20 1650	07/10/20 2250
Tipton, Darla, RN	—	Registered Nurse	—	07/09/20 1500	07/10/20 0100
Bolta, Omayra G, RN	—	Registered Nurse	—	07/09/20 0811	—
Porterfield, Angela D, RN	—	Registered Nurse	—	07/09/20 0435	07/09/20 0940
Golden, Yolanda Nichele, RN	—	Charge Nurse	—	07/08/20 0720	07/08/20 1828
Porterfield, Angela D, RN	—	Registered Nurse	—	07/07/20 1900	07/08/20 0900
Shehan, Paula Annette, RN	—	Registered Nurse	—	07/07/20 1851	07/13/20 1855
Gilliam, Heather, RN	—	Registered Nurse	—	07/07/20 0840	07/13/20 0755
Golden, Yolanda Nichele, RN	—	Charge Nurse	—	07/07/20 0746	07/07/20 2146
Porterfield, Angela D, RN	—	Registered Nurse	—	07/06/20 1942	07/07/20 0900
Blevins, Renee, RN	—	Registered Nurse	—	07/06/20 1848	07/06/20 2225
Tucker, Holly, LMSW	—	Case Manager/Social Worker	—	07/06/20 1027	—
Johnson, Sally, RN	—	Registered Nurse	—	07/06/20 1002	07/07/20 0002
Chapman, Julie Elizabeth	—	Recreational Therapist	—	07/06/20 0914	—
Hendricks, Tabatha	—	Case Manager/Social Worker	—	07/06/20 0822	—
Wilkerson, Lacretia, LPN	—	Licensed Practical Nurse	—	07/05/20 1934	07/06/20 0534
Allison, Wayne, RN	—	Registered Nurse	—	07/05/20 1928	07/06/20 0528
Golden, Yolanda Nichele, RN	—	Charge Nurse	—	07/05/20 0827	07/05/20 1911
Porterfield, Angela D, RN	—	Registered Nurse	—	07/05/20 0700	07/05/20 2100
Wilkerson, Lacretia, LPN	—	Licensed Practical Nurse	—	07/04/20 1922	07/05/20 0522
Porterfield, Angela D, RN	—	Registered Nurse	—	07/04/20 1900	07/05/20 0624
Jackson, Alison, RN	—	Registered Nurse	—	07/04/20 1824	07/07/20 0744

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07/03/2020 - Admission (Discharged) in Marshall I. Pickens Intensive Management (continued)

Treatment Team (continued)

Provider	Service	Role	Specialty	From	To
Golden, Yolanda Nichele, RN	—	Charge Nurse	—	07/04/20 0735	07/04/20 1901
Porterfield, Angela D, RN	—	Registered Nurse	—	07/03/20 1900	07/04/20 0631
Reilly, Jennifer, RN	—	Registered Nurse	—	07/03/20 1321	07/04/20 0726

Events

Admission at 7/3/2020 1259

Unit: Marshall I Pickens Intensive Management — Room: 0117 — Bed: 0117AP
User: Clark, Patricia — Patient class: Inpatient

Patient Update at 7/3/2020 1328

Unit: Marshall I. Pickens Intensive Management — Room: 0117 — Bed: 0117AP
User: Sakla, Rachel, DO — Patient class: Inpatient

Transfer Out at 7/3/2020 2053

Unit: Marshall I. Pickens Intensive Management — Room: 0117 — Bed: 0117AP
User: Gilles, Kelly, RN — Patient class: Inpatient

Transfer In at 7/3/2020 2053

Unit: Marshall I Pickens Intensive Management — Room: 0114 — Bed: 0114AP
User: Gilles, Kelly, RN — Patient class: Inpatient

Leave of Absence Out (Send to ED or Procedural Area) at 7/5/2020 0047

Unit: Marshall I. Pickens Intensive Management — Room: 0114 — Bed: 0114AP
User: Drummond, Thempsheia L, RN — Patient class: Inpatient

Leave of Absence Return at 7/5/2020 0256

Unit: Marshall I. Pickens Intensive Management — Room: 0114 — Bed: 0114AP
User: Crowther, Charlotte L, RN — Patient class: Inpatient

Leave of Absence Out (Send to ED or Procedural Area) at 7/8/2020 1750

Unit: Marshall I. Pickens Intensive Management — Room: 0114 — Bed: 0114AP
User: Kashi, Jadan, RN — Patient class: Inpatient

Leave of Absence Return at 7/8/2020 2343

Unit: Marshall I Pickens Intensive Management — Room: 0114 — Bed: 0114AP
User: Porterfield, Angela D, RN — Patient class: Inpatient

Discharge at 7/22/2020 1315

Unit: Marshall I. Pickens Intensive Management — Room: 0114 — Bed: 0114AP
User: Turner, Kimberly D. RN — Patient class: Inpatient

Medication List

Medication List

This report is for documentation purposes only. The patient should not follow medication instructions within.
For accurate instructions regarding medications, the patient should instead consult their physician or after visit summary.

MIP INTENSIVE MGMT
701 GROVE RD
GREENVILLE SC 29605-4210

Carter, Jevon Kenneth
MRN: 970195696, DOB: 9/14/2001, Sex: M
Adm: 7/3/2020, D/C: 7/22/2020

Medication List (continued)

Prior To Admission

None

Discharge Medication List

Medications last reviewed by Williams, Gena Nicole, MD on 7/17/2020 1700

melatonin 5 mg tablet

Instructions: Take 1 tablet (5 mg) by mouth nightly
Authorized by: Williams, Gena Nicole, MD
Start date: 7/21/2020
Refill: No refills remaining
Ordered on: 7/21/2020
Quantity: 30 tablet

ARIPiprazole (Abilify Maintena) 400 mg IM injection

Instructions: Inject 1 Syringe (400 mg) into the muscle every 30 (thirty) days Do not start before August 19, 2020. 1st dose ~~adminstered~~ 07/20/20. PO overlap through 08/02/20.
Authorized by: Williams, Gena Nicole, MD
Start date: 8/19/2020
Refill: No refills remaining
Ordered on: 7/21/2020
Quantity: 1 Syringe

diphenhydrAMINE (BENADRYL) 25 mg tablet

Instructions: Take 2 tablets (50 mg) by mouth nightly
Authorized by: Williams, Gena Nicole, MD
Start date: 7/21/2020
Quantity: 60 tablet
Ordered on: 7/21/2020
End date: 7/29/2020
Refill: No refills remaining

ARIPiprazole (ABILIFY) 15 mg tablet

Instructions: Take 1 tablet (15 mg) by mouth daily before evening meal for 12 doses LAST DOSE on given 08/02/20.
Authorized by: Williams, Gena Nicole, MD
Start date: 7/21/2020
Refill: No refills remaining
Ordered on: 7/21/2020
Quantity: 12 tablet

lithium 300 mg capsule

Instructions: Take 4 capsules (1,200 mg) daily before evening meal
Authorized by: Williams, Gena Nicole, MD
Start date: 7/22/2020
Quantity: 120 capsule
Ordered on: 7/22/2020
Action: Patient taking differently
Refill: No refills remaining

Stopped in Visit

None

H&P Notes

H&P by Lobwede, Consola E, MD at 7/4/2020 7:15 PM

Author: Lobwede, Consola E, MD
Filed: 7/4/2020 8:49 PM
Editor: Lobwede, Consola E, MD (Resident Physician)
Service: Psychiatry
Date of Service: 7/4/2020 7:15 PM
Author Type: Resident Physician
Status: Attested
Cosigner: Frost, Rebecca Anne, MD at 7/4/2020 9:22 PM

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Attestation signed by Frost, Rebecca Anne, MD at 7/4/2020 9:22 PM

Attending Note: I and the resident performed key portions of the history and examination. I participated actively in treatment team planning and supervised all aspects of the management of the patient. I discussed the case with the resident and agree with the findings and management plan as documented in the note.
Rebecca Anne Frost, MD

Marshall I. Pickens Hospital
Psychiatric Admission History and Physical Exam

PATIENT NAME:[CL.1T] Jevon Kenneth Carter[CL.2T]
ADMISSION DATE:[CL.1T] 7/3/2020[CL.2T]
MEDICAL RECORD NUMBER:[CL.1T] 970195696[CL.2T]
SERVICE: Psychiatry
ATTENDING PSYCHIATRIST:[CL.1T] Parsons, Edmund Cole, MD[CL.2T]
RESIDENT PHYSICIAN:[CL.1T] Consola Esambe Lobwede[CL.1M]
PRIMARY CARE PHYSICIAN:[CL.1T] Pcp, No, MD[CL.2T]
OUTPATIENT PSYCHIATRIST:[CL.1T] none[CL.1M]

PATIENT IDENTIFYING DATA:[CL.1T]
Jevon Kenneth Carter[CL.2T] is a[CL.1T] 18 yrs[CL.2T] old,[CL.1T] single (never married)[CL.1M],[CL.1T] African American[CL.1M],[CL.1T] unemployed[CL.1M],[CL.1T] gentleman[CL.1M] who is[CL.1T] involuntarily[CL.1M] admitted to the[CL.1T] intensive management[CL.1M] of Marshall I. Pickens Hospital for treatment of[CL.1T] acute psychosis.[CL.1M]

CC:[CL.1T] "Why am I here."[CL.1M]

HPI:
This is the[CL.1T] first[CL.1M] admission to Marshall Pickens Hospital and the[CL.1T] first[CL.1M] inpatient psychiatric hospitalization for this individual. The patient was seen and examined today on morning in-take rounds by[CL.1T] resident physician and attending physician[CL.1M] and is judged to be[CL.1T] unreliable[CL.1M] historian. Collateral information was also gathered from review of the available medical record, as well as contact with[CL.1T] mother Keyshauna Young.

Per patient, he played football in with Hampton High School and got an offer to play in Clemson University, but the people around him were hiding it from him. He also got 1300 on the ACT and they were also hiding it from him, "because of the call of my skin." Patient stated that a lot of people were jealous of him because he recently got a job as a patient transporter Bon Secors, which is an amazing feat for an 18-year-old. Patient stated that he went to Clemson University to speak to Coach Sweeney, the recruiter about his offer later. He states that he did not have an appointment and was sitting at the coach's doorstep when the police arrested him for trespassing. He was taken to jail, the other jailers told him that there was flesh eating bacteria on the jail floor. He stated that he licked the floor because "my true name is Ezekiel because I am a disciple, the right hand all Jesus Christ." Patient stated, I am here because "they want my blood, I an angelic demon." Patient stated that he was released from jail the next day and he went to his girlfriend's house. He did not have the keys to get inside. As he was waiting the police arrested him again, because "I am a black guy dating a white girl." Per chart review, patient's girlfriend died

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recently. When asked about this patient agreed that his girlfriend Natalie Ospino died on 5/3/2020, but he was talking about his other girlfriend, Madison. Patient then proceeded to ask why he is in the hospital, because he wants to go home. Patient was told that he is in the hospital because he endorsed auditory hallucinations. Patient became tearful stating that that was the first time anybody told him that. Patient denied SI/HI/AVH patient denied symptoms of depression, mania, psychosis or anxiety. He insisted that he was fine and wanted to go home.

During the interview, patient was calm and cooperative, with appropriate eye contact. However, patient's speech was pressured, he exhibited talkativeness, grandiosity, religiosity and flight of ideas. Per ED notes, patient endorsed auditory hallucinations and was laughing inappropriately and responding to internal stimuli. Today, patient denied auditory hallucinations, did not seem to be internally preoccupied or responding to internal stimuli. Patient did state that he felt like people were out to get him. Patient also continued to make bizarre statements as noted above. Patient exhibits impaired reality testing and delusion of grandeur and paranoia.

Per patient's mom, Keyshauna Young man patient started exhibiting strange behaviors about a month ago, after the sudden and untimely death of his girlfriend. She slipped off a cliff. This strange behaviors include hearing voices, being antisocial, insomnia and isolation. Mother stated that he became depressed. He also was trespassing in multiple apartment complexes in Clemson and that is where the police arrested him and brought him to the hospital. Per mom, patient just graduated from Wade Hampton High School, where he played football with honors and is supposed to start Tri-County community college in the fall, before going to Clemson University the following year.[CL.1M]

ROS:
General: no fatigue, no difficulty sleeping, no appetite changes
HEENT: no rhinorrhea, no mouth lesions, no visual changes, no sore throat
Chest: no chest pain or palpitations, no galactorrhea
Lungs: no shortness of breath, no wheezing
Abdo: no abdominal pain, no N/V/D/C
Extrem: no edema
MSK: no muscle stiffness or rigidity, no tremors
Skin: no rash, no lesions
Neuro: no seizures or involuntary movements, no akathisia
Psych: please see HPI

HOME MEDICATIONS:
Home Medications 7/3/20 1407
Not on File

ALLERGIES:[CL.1T]
No Known Allergies[CL.2T]

PAST HISTORY:

Past Psychiatric History[CL.1T]
No previous psychiatric illnesses or hospitalizations, no history of cutting or self-injurious behavior.[CL.1M]

Substance Use[CL.1T]
Smokes marijuana occasionally[CL.1M]

Social History

-**Family/Marital Status:**[CL.1T] Unmarried[CL.1M]

-**Current Living Situation**: Patient currently lives with[CL.1T] mom[CL.1M]. Social supports include[CL.1T] mom, dad, grandmother and siblings[CL.1M]

-**Childhood**: Lived wit[CL.1T]h mom[CL.1M]

-**Education:**[CL.1T] graduated high school[CL.1M]

-**Employment:**[CL.1T] unemployed[CL.1M]

-**Military History:**[CL.1T] none[CL.1M]

-**Spirituality:** Patient identifies as a[CL.1T] Christian[CL.1M].

-**Legal Problems**: Patient[CL.1T] denies any current legal troubles[CL.1M].

-**Trauma History:**[CL.1T] Denies[CL.1M]

-**Head Trauma/Seizures:**[CL.1T] Denies[CL.1M]

Past Medical History:[CL.1T]
History reviewed. No pertinent past medical history.[CL.2T]

Past Surgical History:[CL.1T]
No past surgical history on file.[CL.2T]

Family Medical History:[CL.1T]
History reviewed. No pertinent family history.[CL.2T]

VITAL SIGNS:

	Current	Range (last 24 hours)
Temperature:[CL.1T]	97.9 °F (36.6 °C)	[97.9 °F (36.6 °C)][CL.2T]
Heart Rate:[CL.1T]	(I) 96	[96][CL.2T]
Resp Rate:[CL.1T]	18	[18][CL.2T]
Blood Pressure:[CL.1T]	122/80	(122)/(80)[CL.2T]
Oxygen Sats:		

PHYSICAL EXAM:

Constitutional: Well developed, well nourished and in NAD.

Musculoskeletal: Normal muscular tone and no significant atrophy noted. Gait and station observed and no significant abnormalities. No noted contractures, tics, signs of extrapyramidal symptoms, tardive dyskinesia, or other abnormal movements.

Neurological: Cranial nerves II-XII are grossly intact. EOMI. PERRLA. No facial asymmetry. Tongue protrudes midline and palate elevates symmetrically. Strength 5/5 throughout. Sensation intact to soft touch throughout. No dysdiadochokinesia with finger to nose task bilaterally. Reflexes 2+ throughout. Normal walking gait.

Mental Status Exam:

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MIP INTENSIVE MGMT
701 GROVE RD
GREENVILLE SC 29605-4210

Carter, Jevon Kenneth
MRN: 970195696, DOB: 9/14/2001, Sex: M
Adm: 7/3/2020, D/C: 7/22/2020

H&P Notes (continued)

General Appearance: Awake and alert, No apparent distress. Appears well developed, appears stated age, good hygiene, dressed in purple paper hospital scrubs.
Orientation: Oriented to person, place, time, and situation
Attitude/Behavior: Cooperative and engaged. Appropriate eye contact. Appropriate mannerisms and posturing
Mood: Dysphoric
Affect: flat/blunted
Speech: Spontaneous, fluent and coherent with normal volume, tone
Cognition: Memory grossly intact however not formally tested at this time. Concentration intact to conversation. Language and use of vocabulary appropriate for level of education.
Thought Content: Reality[CL.1T] testing is impaired with paranoid and grandiose delusions.[CL.1M] No evidence of suicidal ideations/vague threats to self/overt threats to self. No evidence of homicidal ideations. Does not appear to be responding to internal stimuli
Thought Process: tangential/flight of ideas
Insight: poor
Judgement: poor

LABS:

CBC:[CL.1T]

Lab Results

Component	Value	Date
WBC	5.6	07/02/2020
HGB	14.9	07/02/2020
HCT	46.7	07/02/2020
MCV	81.8	07/02/2020
PLT	279	07/02/2020[CL.2T]

Chem 7:[CL.1T]

Lab Results

Component	Value	Date
NA	140	07/02/2020
K	3.2 (L)	07/02/2020
CL	106	07/02/2020
CO2	28	07/02/2020
CREATININE	1.18	07/02/2020
BUN	10	07/02/2020[CL.2T]

LFTs:[CL.1T] No results found for: BILITOT, BILIDIR, ALBUMIN, AST, ALT, PROT, AMMONIA[CL.2T]

Hepatitis[CL.1T] No results found for: HAV, HEPAIGM, HEPBIGM, HEPBCAB, HBEAG, HEPCAB[CL.2T]

HIV[CL.1T] No results found for: HIV1X2[CL.2T]

HA1C[CL.1T] No results found for: HGBA1C[CL.2T]

Lipids[CL.1T] No results found for: CHOL, HDL, LDLCALC, TRIG[CL.2T]

Vitamin B12:[CL.1T] No results found for: VITAMINB12[CL.2T]

Folate[CL.1T] No results found for: FOLATE[CL.2T]

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H&P Notes (continued)

Thyroid function studies:[CL.1T]	No results found for: TSH, T3TOTAL, T4TOTAL, THYROIDAB, FREET4[CL.2T]
RPR:[CL.1T]	No results found for: RPR[CL.2T]
UA[CL.1T]	No results for input(s): COLORU, CLARITYU, BILIRUBINUR, KETONESU, LABSPEC, BLOODU, PHUR, PROTEINUR, UROBILINOGEN, NITRITE, LEUKOCYTESUR, RBCU, WBCU, BACTERIA, SQUAMEPIU, MUCUS, AMORPHOUS, CRYSTALSU, SPERM, YEAST, TRICHOMONAS, MISCU in the last 72 hours. Invalid input(s): GLUCOSEUPOC, CASTSU[CL.2T]
EtOH:[CL.1T]	Lab Results

Component	Value	Date
ALCOHOL	<10	07/02/2020[CL.2T]

Urine Tox:[CL.1T]	No results found for: BARBITURATES, BENZOURQL, CANNABUR, COCAINE, METHSCRNUR, PHENOBARB, UCREAT, PHUR, OPIATES[CL.2T]

IMAGING:
Ct Head Wo Contrast

Result Date: 7/3/2020
EXAM: CT HEAD WO CONTRAST, 7/3/2020 8:21 AM ACCESSION: GMH204271462 INDICATION: Encephalopathy; COMPARISON: None. FINDINGS: No focal brain lesion is identified. No mass or mass effect is seen. No evidence of intracranial hemorrhage or subdural fluid collection is identified. The ventricles are normal in size.

1. No acute intracranial process is identified. Signed by: 7/3/2020 8:34 AM: Udall, John

DIAGNOSES:[CL.1T]
1. Schizophreniform disorder
2. Rule out schizophrenia
3. Rule out schizoaffective disorder
4. Rule out bipolar disorder with psychotic features
5. Rule out MDD with psychotic features
6. Rule out adjustment disorder
7. Rule out substance induced psychosis
8. Brief psychotic disorder[CL.1M]

FORMULATION:[CL.1T]
Patient is an 18-year-old African-American male with no past psych history who presents to the ED with acute psychosis. He is a previously healthy athletic 18-year-old male, who recently graduated from high school and is about to start college in the fall. Mother has a history of schizophrenia, so there is a genetic predisposition to developing schizophrenia. Patient is at at the age when schizophrenia would develop. Patient does have many of the symptoms of schizophrenia including auditory hallucinations, paranoia and delusions. Per mother symptoms started about a month ago, when patient's girlfriend died unexpectedly. Therefore this could have started as brief psychotic disorder that has gone undiagnosed and untreated. However mom indicated the patient appeared depressed, which could be the negative symptoms of depression or a presentation of MDD with psychotic features. Patient also appears to have

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MIP INTENSIVE MGMT
701 GROVE RD
GREENVILLE SC 29605-4210

Carter, Jevon Kenneth
MRN: 970195696, DOB: 9/14/2001 Sex: M
Adm: 7/3/2020, D/C: 7/22/2020

H&P Notes (continued)

pressured speech, grandiose and hyperreligious needing to the thought that he could have bipolar disorder with psychotic features. Because of the presence of both bipolar and psychotic features, patient may have schizoaffective disorder. Patient also smokes marijuana, so this could be a substance induced psychosis. Patient was in the emergency room for 1 day and was started on Risperdal 1 mg at bedtime and Zyprexa as needed. On 7/3/2020, patient was placed in seclusion due to paranoia and had to be given 5 mg of Zyprexa IM. After reading the ED note, it does appear that patient seems to have been improving. He was still paranoid, grandiose, hyperreligious and delusional. But he was calm, cooperative, maintained adequate eye contact did not seem to be responding to internal stimuli or internally preoccupied and denied SI/HI/AVH.[CL.1M]

Suicide Risk Assessment[CL.1T] high[CL.1M]

Provoking factors[CL.1T]
male gender, family history of suicide, history of alcohol or substance abuse, impulsive or aggressive tendencies, isolation, feeling of being cut off from other people, Barriers to accessing mental health treatment, loss (financial, relational, work, or social), unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts[CL.1M].

Protective factors[CL.1T]
effective clinical care for mental, physical, and substance abuse disorders, Easy access to a variety of clinical interventions and support for help seeking, family and community support (connectedness), support from ongoing medical and mental healthcare relationships, skills in problem solving, conflict resolution, and non-violent ways to handling disputes, cultural and religious beliefs that discourage suicide and support instincts for self-preservation, engagement in treatment[CL.1M]

RISK ASSESSMENT : A thorough risk assessment was performed and in my clinical opinion, based on current mental status examination and past history, the patient represents a[CL.1T] moderate[CL.1M] of dangerousness while hospitalized. Outside the hospital, based on the patient's current state, dangerousness to self or others would be significant due to[CL.1T] inability to avoid dangers in the environment[CL.1M]. Therefore, inpatient psychiatric hospitalization is the least restrictive environment at this time.

PLAN:
1. Safety:
- Patient will[CL.1T] be admitted to Intensive Management Unit[CL.1M] at Marshall I Pickens Hospital.
- Standard precautions will be taken.
- Continue q15m suicide checks.

2. Legal:
- Patient is admitted[CL.1T] involuntarily[CL.1M].
- Patient is found to have capacity to make medical treatment decisions at this time.

3. Mood/psychosis/anxiety:[CL.1T]
- Continue Risperdal 1 mg at bedtime for acute psychosis.
- Continue Zyprexa 5 mg every 8 as needed for agitation[CL.1M]
- Encourage active participation in individual therapy, groups, and milieu.
- Consider outpatient needs and ensure continuity of care upon discharge with outpatient providers.

4. Substance Abuse issues:
- Admission UDS: Positive for[CL.1T] cannabinoid[CL.1M]
- No acute indications for initiation of withdrawal protocol.

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H&P Notes (continued)

5. Medical Issues:
[CL.1T] no medical issue.[CL.1M] Labs reviewed.
- Consult Dr. Crawford[CL.1T] if needed[CL.1M]

6. Social/Disposition
- Obstacles to Discharge:[CL.1T] Improved judgement and insight[CL.1M]
- Expected discharge plan:[CL.1T] Home[CL.1M]
- Estimated additional LOS:[CL.1T] 7 to 10 days[CL.1M]

The risks, benefits, side effects, and alternative[CL.1T] medications/treatments[CL.1M] were discussed with the patient and/or available caregivers. Medication chosen to treat anxiety. In the future, we may alter the dose/frequency of this based on treatment response.

Time spent: Approximately 70 minutes. More than 50% of time was spent in counseling/coordination of care.

Consola Esambe Lobwede, MD
Psychiatry Resident, PGY-[CL.1T]2[CL.1M]

Electronically signed by Lobwede, Consola E, MD at 7/4/2020 8:49 PM
Electronically signed by Frost, Rebecca Anne, MD at 7/4/2020 9:22 PM

Attribution Key
CL.1 - Lobwede, Consola E, MD on 7/4/2020 7:15 PM
CL.2 - Lobwede, Consola E, MD on 7/4/2020 7:16 PM
M - Manual, T - Template

Discharge Summary Note

Discharge Summary by Williams, Gena Nicole, MD at 7/22/2020 1:15 PM

Author: Williams, Gena Nicole, MD	Service: Psychiatry	Author Type: Resident Physician
Filed: 7/22/2020 4:54 PM	Date of Service 7/22/2020 1:15 PM	Status: Attested
Editor: Williams, Gena Nicole, MD (Resident Physician)		Cosigner: Parsons, Edmund Cole, MD at 7/24/2020 9:56 PM

Attestation signed by Parsons, Edmund Cole, MD at 7/24/2020 9:56 PM

Attending Note: I and the resident performed key portions of the history and examination on 7/22/2020. I participated actively in treatment team planning and supervised all aspects of the management of the patient. I discussed the case with the resident and agree with the findings and management plan as documented in the note. Time spent 35 minutes >50% in counseling and coordination of care including obtaining the interval history, assessing the mental status, and reviewing the safety plan and aftercare plan.
Ed Parsons MD

Marshall I. Pickens Hospital
Discharge Summary

Patient Name: Jevon Kenneth Carter
MRN: 970195696
Date of Birth: 9/14/2001
Admission Date: 7/3/2020[GW.1T]
Discharge Date: 7/22/2020[GW.1M]
Psychiatry Resident: Gena Nicole Williams, MD
Psychiatry Attending: Dr.[GW.1T] Parsons[GW.1M]
Referring Physician: Pcp, No, MD

Time Spent: Patient care lasted for[GW.1T] >30 minutes[GW.1M].

Reason for Hospitalization: The patient is a 18 yrs old,[GW.1T] single (never married)[GW.1M],[GW.1T] African American[GW.1M],[GW.1T] employed male[GW.1M] who was admitted for treatment of[GW.1T] Bipolar I Disorder, first Manic Episode[GW.1M].

Hospital Course: The patient was admitted to Marshall I Pickens hospital on the[GW.1T] intensive management unit[GW.1M] for[GW.1T] psychosis[GW.1M]. Please refer to the dictated psychiatric history and physical examination note written on[GW.1T] 7/4/2020[GW.1M] for full details of patient's pre-hospital course.

Patient was given the opportunity to participate in a multifaceted approach, which includes individual, group, and milieu therapy. Individual sessions were also held with the resident and attending psychiatrist daily. The patient was provided daily individual psychiatric services, medication management, and supportive psychotherapy from the resident physician and attending psychiatrist. Case management services were also made available to the patient throughout the hospital stay.

Patient's clinical symptomatology was consistent with[GW.1T] Bipolar I Disorder, manic episode with psychotic features[GW.1M]. Patient meets criteria for[GW.1T] persistently elevated, expansive mood, with irritability for 1 week prior to presentation[GW.1M] based on report of[GW.1T] family and friends[GW.1M].[GW.1T] During hospitalization, demonstrated decreased need for sleep, grandiosity, and increased goal directed activity[GW.1M]. Medication management consisted of[GW.1T] Lithium and Abilify[GW.1M].

The treatment team met on a regular basis throughout the hospital course to assess progress, and amended the treatment plan as necessary. Patient ate and slept well during this admission. The patient's family[GW.1T] participated in this patient's care and included Grandmother Cynthia Chapman[GW.1M]. Patient[GW.1T] required restraints and seclusion during their hospitalization due to repeated elopement attempts, and 2 successful elopements[GW.1M]. Patient[GW.1T] was not adherent with treatment recommendations, yet made progress in treatment once ITC with Grandmother as surrogate was placed.,"was

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not adherent with treatment recommendations and declined all treatment modalities while hospitalized[GW.1M].

Allergies: Patient has no known allergies.

Review of Systems:
I have performed a complete review of systems. All systems are negative and without any complaints except as noted above in the history of present illness.

Vital Signs:
Vitals:

	07/21/20 1930
BP:	130/64
Pulse:	75
Resp:	17
Temp:	98.6 °F (37 °C)
SpO2:	

Body mass index is 26.91 kg/m².

Summary of Examination and Laboratory Data:
The patient had a complete physical examination performed by[GW.1T] 7/8/2020[GW.2M] on[GW.1T] Amelia Crowley, PA[GW.2M].

Laboratory data:
Recent Labs
**** No results found for the last 48 hours. ****

Imaging:[GW.1T] None[GW.2M]

Consultations:[GW.1T] None[GW.2M]

Condition at Discharge: Prior to discharge, the patient was evaluated by a physician, case manager and nursing staff. On the day of discharge, the patient was denying suicidal or homicidal ideations, intent or plan. Insight and judgment were at baseline. Patient denied access to firearms. Patient stated they planned to continue taking their medications and follow up with their outpatient providers. Patient expressed safety plan if[GW.1T] psychotic symptoms[GW.2M] were to be experienced again. While hospitalized, several modifiable risk factors for[GW.1T] psychosis[GW.2M] were addressed and improved. Diagnosis, prognosis, medications, outpatient service options, and discharge planning were discussed with the

patient[GW.1T] and Grandmother, Cynthia Chapman[GW.2M] and questions were answered to their satisfaction. The treatment team agreed that major treatment goals had been attained, that the patient has reached maximum therapeutic benefit from this hospitalization, and that a safe and appropriate discharge plan is in place. Patient stated he felt safe outside the hospital and was asking to leave. No withdrawal symptoms or medication side effects were observed, and there were no physical or medical concerns at time of discharge. The patient endorses a mild continuation of[GW.1T] delusional[GW.2M] symptoms; however the patient and treatment team agree that these residual symptoms may be safely managed on an outpatient basis.

Risk Assessment: A comprehensive risk assessment was performed prior to discharge. In my clinical opinion, based on the patient's current mental status examination, past and current psychiatric history; the patient represents a[GW.1T] low[GW.2M] risk of suicide, homicide, or self-damaging behavior. Further inpatient treatment will not significantly mitigate this risk, however the team has discussed issues around self-harm with the patient and techniques to lower this risk. Patient has been informed of how the effects of alcohol, recreational drugs, and misused prescription medications can significantly elevate the risk of such dangerous behaviors. The patient has been advised to seek immediate medical attention if experiencing further or new suicidal or homicidal ideations, signs mania, or psychosis.

Mental status examination upon discharge:[GW.1T]
Appearance: age appropriate and dressed in plum scrubs, laying on bed[GW.2C] upon entering[GW.2M]
Sensorium: AOx4
Behavior: normal and appropriate
Speech: normal pitch, normal volume and normal rate
Mood: "[GW.2C]great[GW.2M]"
Affect: mood-congruent[GW.2C], appropriate[GW.2M]
Thought Process: Linear, Goal directed and focused on his discharge
Thought Content: Patient denies[GW.2C] AVH[GW.2M] Patient does not appear to be responding to internal stimuli.
Suicidality: Patient Denies suicidal ideation, intent or plan.
Homicidality: Pt denies homicidal ideation, intent or plan
Impulsivity: fair
Memory: recent and remote memory intact
Fund of knowledge: average and appropriate for level of education
Insight: fair, reports feeling better on medication and endorses taking it once he leaves.
Judgement:[GW.2C] fair[GW.2M]

Assessment:[GW.1T] This is an 18 year old male without a past psychiatric history, who is currently admitted to MIPH for his first hospitalization his first episode of mania and psychotic

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symptoms. Patient was admitted to the hospital from 7/4/2020-7/22/2020; his admission was complicated by several elopement attempts and two successful elopements. The patient is at an increased predisposing risk for his first psychotic break due to the recent traumatic and untimely death of his long-term girlfriend who fell to her death at the Pickens waterfall, age of first psychotic break, drug use and depressive episode. The patient is at an increased predisposing genetic risk to mental health diagnosis given the family history of schizophrenia in his mother. Working diagnosis at this time of discharge includes Bipolar I Disorder, with mood congruent psychotic features, with schizophreniform features, meeting several clinical symptoms required including persistently elevated mood, expansiveness and irritability, grandiosity, decreased need for sleep and increased goal directed activity, with auditory hallucinations. Given success of Abilify and Lithium, patient will benefit from continuation of these medications. Patient will also benefit from ongoing outpatient treatment which was mandated by probate court for 6 months.[GW.2M]

Discharge Diagnoses:[GW.1T]
Bipolar I Disorder, with mood congruent psychotic features
Schizophreniform features[GW.2M]

Plan:
1. Discharge Medications:

Home Medication Instructions

Carter, Jevon Kenneth
HAR:107000020714
Printed on:07/22/20 1551

Medication Information
ARIPiprazole (Abilify Maintena) 400 mg IM injection **Inject 1 Syringe (400 mg) into the muscle every 30 (thirty) days Do not start before August 19, 2020. 1st dose administered 07/20/20. PO overlap through 08/02/20.**
ARIPiprazole (ABILIFY) 15 mg tablet **Take 1 tablet (15 mg) by mouth daily before evening meal for 12 doses LAST DOSE on given 08/02/20.**

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Discharge Summary Note (continued)

diphenhydrAMINE (BENADRYL) 25 mg tablet **Take 2 tablets (50 mg) by mouth nightly**								
lithium 300 mg capsule **Take 4 capsules (1,200 mg) daily before evening meal**								
melatonin 5 mg tablet **Take 1 tablet (5 mg) by mouth nightly**								

2. **Follow Up:** Patient has a follow up appointment with[GW.1T] Greenville Mental Health Center[GW.2M]. A long-acting injectable[GW.1T] was administered on 7/20/2020, and[GW.2M] has been scheduled for[GW.1T] after 8/15/2020[GW.2M]. Patient has been instructed to obtain labs on[GW.1T] Friday, 7/242020 for Lithium Levels[GW.2M].
3. **Further Recommendations:**
   a. Patient will benefit from[GW.1T] Breavement[GW.2M] therapy moving forward. Please consider a referral to[GW.1T] Greenville Mental Health[GW.2M].
   b. Future plans for goal of treatment was discussed with the patient prior to discharge. Recommend[GW.1T] continuing Lithium 1200 mg QHS at current dose, and continue Abilify 15 mg for 12 doses for last dose to be on 8/2/2020.[GW.2M]

The above assessment and plan was discussed with the attending physician, Dr.[GW.1T] Edmund Parsons[GW.2M] who agrees with this treatment plan.[GW.1T]

Gena Williams[GW.1M], MD
PGY-1 Psychiatry[GW.1T]

Electronically signed by Williams, Gena Nicole, MD at 7/22/2020 4:54 PM
Electronically signed by Parsons, Edmund Cole, MD at 7/24/2020 9:56 PM

Attribution Key
GW.1 - Williams, Gena Nicole, MD on 7/22/2020 3:51 PM
GW.2 - Williams, Gena Nicole, MD on 7/22/2020 4:26 PM
C - Copied, M - Manual, T - Template

Consult Notes

Consults

Crawford, Patricia Ann, MD at 7/5/2020 12:00 AM

Author: Crawford, Patricia Ann, MD | Service: — | Author Type: Physician
Filed: 7/7/2020 5:08 PM | Date of Service: 7/5/2020 12:00 AM | Status: Signed
Editor: Crawford, Patricia Ann, MD (Physician)

11/05/2020MLP

MIP INTENSIVE MGMT
701 GROVE RD
GREENVILLE SC 29605-4210

Carter, Jevon Kenneth
MRN: 970195696, DOB: 9/14/2001, Sex: M
Adm: 7/3/2020, D/C: 7/22/2020

Consult Notes (continued)

This is an 18-year-old African American male who relates he does not have any medical problems. He does not smoke or drink. He occasionally smokes marijuana but only occasionally.

PAST MEDICAL HISTORY:
He has never been hospitalized.

SOCIAL HISTORY:
Single and lives with his mother. He does not have any children. He does not work.

FAMILY HISTORY:
Is not obtained.

MEDICATIONS:
Prior to admission: None.

ALLERGIES:
None known.

REVIEW OF SYSTEMS:
Negative.

PHYSICAL EXAMINATION:
Completely negative physical exam reveals a well-developed, well-nourished male in no distress. Temperature 97.8, respirations 18 and unlabored, blood pressure 148/92 with a pulse of 63.
HEENT: Head is atraumatic. Motor, cranial nerves are intact. Pupils equal, round, reactive to light and accommodation bilaterally, extraocular muscles are intact. Sclerae and conjunctivae are normal. Nose is normal, sinuses nontender. Oropharynx with no redness or pus.
NECK: Neck supple, no adenopathy or bruits.
BACK: Back is nontender to palpation and percussion.
CHEST: 1-cm gouge type laceration of the left upper chest which is not bleeding and does not appear to be infected at any way.
LUNGS: Lungs are clear bilaterally.
HEART: Cardiac exam regular rate, no murmurs, gallops, or rubs.
ABDOMEN: Abdomen is soft, nontender, normoactive bowel sounds, no masses or megaly appreciated.
EXTREMITIES: Extremities with no edema.
NEUROLOGIC: Nonfocal.

IMPRESSION:
1. Wound left upper chest. Advise daily Bactroban and dressing placement.
2. Elevated blood pressure without the diagnosis of hypertension. Advise monitoring vital signs and instituting therapy for blood pressure remaining

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greater than or equal to 140/90 over a 3-day period of time.
3. Further workup and evaluation will be pursued as requested.

Patricia A. Crawford, MD

cc:
D: 07/06/2020 08:40 PM T: 07/07/2020 07:35 AM pdm/
Job #: 61604/ / Doc #: 4059247
[242][243]

[PC.1M]

Electronically signed by Crawford, Patricia Ann, MD at 7/7/2020 5:08 PM

Attribution Key
PC.1 - Crawford, Patricia Ann, MD on 7/7/2020 7:36 AM
M - Manual

Diehl, Luther A, PhD at 7/14/2020 11:26 AM

Author: Diehl, Luther A, PhD | Service: Psychology | Author Type: Psychologist
Filed: 7/14/2020 1:20 PM | Date of Service: 7/14/2020 11:26 AM | Status: Signed
Editor: Diehl, Luther A, PhD (Psychologist)

Consult Note

MARSHALL I. PICKENS HOSPITAL
PSYCHOLOGICAL REPORT

NAME:[LD.1T] Jevon Kenneth Carter[LD.2T]
SEX:[LD.1T] male[LD.2T]
ETHNIC GROUP:[LD.1T] African-American[LD.1M]
AGE:[LD.1T] 18 y.o.[LD.2T]
DOB:[LD.1T] 9/14/2001[LD.2T]
MRN:[LD.1T] 970195696[LD.2T]
EDUCATION:[LD.1T] 12[LD.1M] years
MARITAL STATUS:[LD.1T] Single[LD.1M]
REFERRED BY:[LD.1T] Edmund C. Parsons, MD, attending psychiatrist and Gena N Williams, MD, psychiatric resident[LD.1M]
REASON FOR REFERRAL:[LD.1T] Assessment of current psychological status to evaluate for clarification of clinical syndrome diagnosis, rule out mood disorder with underlying psychosis versus schizophrenia and personality traits.[LD.1M]
DATE OF REPORT:[LD.1T] 7/11 through 7/14/2020[LD.1M]
PSYCHOLOGIST: Luther A. Diehl, Ph.D.

TECHNIQUES EMPLOYED:
Clinical interview

Mood Disorder Questionairre[LD.1T]s

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Incomplete Sentences Blank[LD.1M]

Millon Clinical Multiaxial Inventory - Fouth Edition (MCMI-IV)
Highest three personality scales 65 or above:[LD.1T]
Compulsive: BR = 100
Turbulent: BR = 93
Narcissistic: BR = 79[LD.1M]

Highest clinical syndrome scales:[LD.1T]
Bipolar spectrum: BR = 82
Generalized anxiety: BR = 77
Posttraumatic stress: BR = 71

Rorschach Inkblot Technique[LD.1M]

Minnesota Multiphasic Personality Inventory - Second Edition (MMPI-2RF)
Higher Order Scales:[LD.1T]
Emotional/internalizing dysfunction: 41
Thought dysfunction: 48
Behavioral/externalizing dysfunction: 46[LD.1M]

PRESENTING PROBLEMS:[LD 1T] During the initial portion of the interview, the patient was provided with a statement of informed consent regarding the purposes and process of the evaluation. When asked about his admission he said that he had paid his $150 and was excepted at Clemson University. He was feeling that he needed to clarify the plan for school and was over at the University to see Coach Sweeney. The patient indicated that he was sitting outside of the coaches office building and did not see anything unusual and felt that this was a reasonable thing to do since he was expecting to play football at Clemson and had played for weight Hampton high school.

The patient did acknowledge that his previous girlfriend, Natalie, did die within the last several months subsequent to a fall from a waterfall. When asked about whether this was still a problem for him the patient maintained that he had cried a lot and had been through feelings of grief and that he was not any longer particularly bothered by this situation. He does reportedly have a girl he is now seeing named Madison whom he seems to refer to has his current girlfriend. Javon characterizes as an individual who worked hard and did not feel that he had any need for past treatment and denies any psychiatric history. It was noted in the record that a friend of his had been interviewed by staff members and reported that the patient started experiencing a change in mood about a week after the death of his girlfriend which occurred on 4 May, 2020. The patient went from being depressed to hyper religious and having unusual thoughts about everything in life having a meeting or taking place for some reason. He was also reporting diminished sleep, feelings of invincibility, and was described as having pressured speech and was calling the friend that 3:30 AM to go to Clemson and speak with the coach.[LD 1M]

HISTORY OF PRESENT ILLNESS:[LD.1T] Admitted involuntarily to MIPH Prisma/Greenville the patient had been initially taken to jail after security found him in front of Coach Sweeney's office on the Clemson campus. He made strange statements about licking the floor when he was in jail as he was told there were flesh eating bacteria on the floor and he was "Ezekiel, the right hand of Jesus Christ." When interviewed at the time of his admission he displayed a lack of insight into reasons for his involuntary admission to the hospital. He was observed to continue to make bizarre statements and was presenting with pressured speech, grandiosity and religiosity with flight of ideas.[LD.1M]

MEDICAL HISTORY.[LD 1T] Inspection of the medical record indicated no specific medical problems. He did undergo CT of the head and results indicated no acute intracranial process.[LD.1M]

PRIOR PSYCHIATRIC HISTORY.[LD 1T] Patient denies any previous psychiatric treatment. The statements by his friend also did not reveal any indication of psychiatric involvement in the past.

Consult Notes (continued)

Current psychotropic medications include the following: Abilify 15 mg every morning; clonazepam 0.5 mg 3 times daily and clonazepam 1.0 mg at bedtime; lorazepam 2 mg every 6 hours as needed for agitation. It was reported that the patient eloped from the hospital on 2 occasions since his admission, once scaling offense and the other breaking down a metal and glass door.[LD.1M]

SUBSTANCE ABUSE HISTORY:[LD.1T] Data from the record indicated patient smokes marijuana occasionally.[LD 1M]

FAMILY PSYCHIATRIC AND SUBSTANCE ABUSE HISTORY:[LD.1T] When questioned about family history the patient indicated that both his mother and father had psychological problems. He characterized father as being antisocial. He was not specific about emotional problems on the part of his mother but did indicate that there was a good bit of tension between them and he did move about. He also discussed a particularly close relationship with his paternal uncle, Devon Carter. He characterizes this individual as a father figure for him and noted unfortunately his uncle was now incarcerated.[LD.1M]

PSYCHOSOCIAL HISTORY:[LD.1T] Background by the patient indicated that he was born and raised in Greenville County and did indicate that he lived primarily with his mother,Keyshauna Young. His mother also reported that about of month ago he began displaying some unusual behavior after the girlfriend had slipped off of a cliff. She noted he was trespassing in multiple apartment complexes and Clemson and this probably contributed to his arrest by the police in that city. Javon stated that he has a brother who is 9 years of age and a sister who is 7 years of age and it appears that they are half siblings. He also reportedly has an adopted brother and sister and stated that during his childhood he lived mostly with his mom until he was 18 years of age. He said he was never close with his father and this is where the relationship with his uncle seem to be helpful to him.

In terms of school history, Javon reportedly was a good student from his perception. He said he was ranked 102 In his class but said that he thinks he should have been 12th and commented that a guidance counselor had some signs and that because of his race he thinks that there was some tampering with his grades. He said he obtained a score of 1300 on the SAT, though he had previously cited this score from information in the record to be on the ACT.

History indicated that he was to be in school at Tri-County Tech as part of the Clemson Bridge program. In the interview he maintained that he was not in the bridge and that his peers had made some things up about his GPA and he was actually going to be attending school in Clemson. He related that he planned to major in criminal justice and said he had thoughts about eventually working for the FBI. He was at St. Francis on Secours but said he was doing patient transport and it seemed the "colored" staff were the ones who were assigned to move COVID patient's and he thus quit this job. He said more recently he has been selling up someone cut co-knives. When asked about his plans after discharge he stated that he wants to go stay with his adoptive sister, Karen Weaver, who has her own home and is 49 years of age. He stated that she had been to the hospital to see him and they have discussed this plan for him to reside there when discharged.[LD.1M]

MENTAL STATUS EXAM:[LD.1T] Jevon Carter is an 18-year-old African-American male of athletic physical development with shortly trimmed hair attired in a purple scrub suit when seen in his room on Intensive management unit. He presented generally adequate grooming and attention to personal hygiene and during the clinical interview related in a cooperative manner. He seemed to at times be somewhat superficial in his interpersonal style and on occasion smiled, almost to the point of slight laughter, for no particular reason. He was asked about this on 1 occasion and dismissed any unusual response saying he was just laughing about something the examiner had ask, and there was no real content in the interview suggesting humor in the immediately preceding questions.

Patient was cooperative in completing his paper and pencil testing rather quickly and did seem to be somewhat annoyed with the inquiry portion of the Rorschach. He did remain generally polite but overall his response style suggested a guarded and rather defensive pattern with a tendency to be evasive in giving detail about his background. He was asked about racial matters as there have been reports of concerns in this area that he had previously reported. He was again somewhat inclined to generalize about mistreatment that had occurred in school but did allow that sometimes it seemed people were fake in the way that they treated him and he thought that they were his friends when that was really not the case. During the testing portion of the evaluation Javon was quite focused upon going

home and at the conclusion of the interview question whether the completion of testing would lead to his discharge. Immediately following the psychological assessment interview, psychiatric staff came to see the patient for the regular therapy and assessment process.

When asked about specific symptoms Jevon maintained that he was feeling very good and was not depressed. When questioned about feelings or his personality he tended to smile even though he was appearing somewhat serious and even a bit sullen at times. He denied any suicidal ideation and indicated he has not harmed anyone during his hospital stay. He denies that he has been an individual who has been inclined to get into fights with people and record did not specifically indicate physical altercations or legal problems other than the recent incarceration before this hospital stay. He denied that he is experiencing either auditory or visual hallucinations. He was asked about any specific significance in terms of his role as a person of faith and whether he had special connections as a part of his religious belief system. He denied that this was the case and that he was just a young guy who was going to high school and followed "Yahweh and Yashua."

In response to a question about his personality, the patient indicated it was his view that he was a caring person who was hard-working and persistent. He said generally he got along well with other people and was fairly calm and was open to doing new things such as traveling or getting a new job. When asked if he was a risk taker he said that he was and gave the example of quitting his job but said he did not particularly engage in dangerous activities. In further questioning him about the job situation he said that he does think this was a good decision and he is able to go on an sell cutlery at this point.[LD.1M]

TEST FINDINGS:

Mood Rating Scales[LD.1T] In responding to the depression checklist, the patient obtained a score which was within the upper end of the borderline range of depressive symptomatology. He did acknowledge some elements of sadness and irritability along with some frustration. He also noted moderate concerns with agitation and significant difficulties with sleep deficit. On the generalized anxiety scale this type of response pattern indicates relatively low symptom endorsement with primary concern indicating poor sleep and tendency to be more worried than usual. Mild elements of panic symptoms were noted, he endorsed mild concerns with sweating, tingling sensations and feeling a sense of fear of loss of control.

The mood disorder questionnaire is a technique utilized to help delineate risk for development of cyclical mood disorders. The patient endorsed a number of symptoms below the critical value. He did indicate some propensity to sleep blasts and not feel that he was missing sleep, have racing thoughts, and have episodes of elevated energy. He characterized the problems as minor and indicated he has never been told he has a manic depressive illness but does report a history of bipolar disorder and his family.[LD.1M]

Emotional/Personality Factors [LD.1T] As a means of attempting to better understand thought content and associated affect, the patient was administered the Incomplete Sentences Blank. Themes which emerged included a sense of disappointment and some negativism regarding his perception of his parents. There was a mixture of fairly strong feelings of positive esteem but then also a comment of perceiving himself as a follower. He does have a self perception that he is a hard-working individual and views himself as inclined to persevere in difficult situations.

Completing the MCMI-IV and MMPI-2-RF, Mr. Carter seemed to have no difficulties in understanding items on the questionnaires. Individuals with this type of protocol typically are giving adequate attention to completion of the items. Further inspection of validity scales did reflect a fairly strong need for social approval and a tendency to underreport symptoms with a very high level of virtuous self presentation, even for an individual with a traditional background. Results of the Rorschach indicated a protocol which was sufficient to allow utilization of the Exner scoring system. There are elements in this protocol that suggest the patient may be an individual undergoing psychosocial stressors and may be exhibiting symptoms that are possibly transient in nature. However, inspection of results in both the objective and projective findings reveal an individual who is likely to be experiencing substantial amount of intrusive ideation and worrisome thoughts about being unable to prevent other people or events from determining his destiny. The protocol is reflective of an individual who was experiencing difficulties in thinking logically and coherently and

07/03/2020 - Admission (Discharged) in Marshall I. Pickens Intensive Management (continued)

Clinical Notes (group 2 of 6)

Nursing Note

Reilly, Jennifer, RN at 7/3/2020 1:27 PM

Author: Reilly, Jennifer, RN | Service: Psychiatry | Author Type: Registered Nurse
Filed: 7/3/2020 1:27 PM | Date of Service: 7/3/2020 1:27 PM | Status: Signed
Editor: Reilly, Jennifer, RN (Registered Nurse)

Pt refused assessment. Will try again later[JR 1M]

Electronically signed by Reilly, Jennifer, RN at 7/3/2020 1:27 PM

Attribution Key
JR 1 - Reilly, Jennifer, RN on 7/3/2020 1:27 PM
M - Manual

Reilly, Jennifer, RN at 7/3/2020 1:30 PM

Author: Reilly, Jennifer, RN | Service: Psychiatry | Author Type: Registered Nurse
Filed: 7/3/2020 1:35 PM | Date of Service: 7/3/2020 1:30 PM | Status: Signed
Editor: Reilly, Jennifer, RN (Registered Nurse)

Patient brought to unit via wheelchair by GHS staff.[JR 1T] Pt irritable and agitated with staff. Pt states "I am being held against my will, can I be released?" Pt educated on involuntary status. Pt went to door trying to leave. Therapeutic 1:1 provided to pt. Pt was introduced to his room and laid down. Pt states "I need to leave, I have things to do, can someone tel me why I am here being held against my will? The people in the ER took my blood and drank my blood to cure the addiction. I am only here because you want to drink my blood and shoot my body with HIV." Pt reassured we do not do that here. Pt continues to be paranoid and disorganized, thought process is tangential. Delusions of drinking blood and being shot with HIV. Pt denies any SI or HI. Pt belongings included OTC supplements.[JR.1M] Pt is ambulatory and involuntary. Pt oriented to unit. Rules reviewed by RN. MD notified for admission orders.[JR.1T]

Electronically signed by Reilly, Jennifer, RN at 7/3/2020 1:35 PM

Attribution Key
JR 1 - Reilly, Jennifer, RN on 7/3/2020 1:30 PM
M - Manual, T - Template

Porterfield, Angela D, RN at 7/3/2020 7:36 PM

Author: Porterfield, Angela D, RN | Service: Psychiatry | Author Type: Registered Nurse
Filed: 7/3/2020 11:02 PM | Date of Service: 7/3/2020 7:36 PM | Status: Addendum
Editor: Porterfield, Angela D, RN (Registered Nurse)

Locked seclusion at[AP.1C] 1925[AP.1M] (new adm[AP.1C]it this afternoon[AP.1M])[AP.1C]

Patient experiencing extreme paranoia and delusional thought process. Patient voicing a fixed delusion that staff at MIP and GHS are injecting HIV into patients blood stream and inside patients eyeballs. Patient noted to increase with paranoia and started demanding to leave. While hand-off nursing report was in process, patient jumped over split door leading into nursing station and grabbed patients cell phone. Security on unit escorted patient out of nursing station at 1911.[AP.1M] Patient was noted to be dangerously unpredictable, hyper verbal, rapidly breathing with darting eyes.[AP.2M] Patient ran to room, barricaded door with bedroom chair[AP.1M][AP.2M] At 1917, security entered room[AP.1M] after loud banging sounds were heard from room. P[AP.2M]atient[AP.1M] was[AP.2M] in[AP.1M] full motion[AP.2M] of busting out[AP.1M] bedroom[AP.2M] window[AP.1M] with pieces of broken wood patient removed from under bedroom chair[AP.2M]. Security intervened and walked patient out of bedroom for window was observed shattered with a complete[AP.1M] (small)[AP.2M] hole in the center of shattered glass.[AP.1M] Patient not receptive to

Clinical Notes (group 2 of 6) (continued)

verbal de-escalation; redirection, diversion, distraction, problem solving, time-out, 1:1 supervision, or distraction; all of which[AP.1C] were[AP.1M] unfruitful. MD, additional security, additional staff, supervisor on unit. Verbal order given for locked seclusion at[AP.1C] 1920[AP.1M] related to patients safety and the safety of others[AP.1C] ..[AP.2M] as a last resort. Patients response to verbal order given for locked seclusion: presented with[AP.1C] active[AP.1M] resistance and[AP.1C] was physically carried in[AP.1M] to locked seclusion[AP.1C] by[AP.1M] 5 security guards.[AP.1C] Cell phone that patient grabbed earl[AP.1M]ier[AP.2M] from nursing station was confiscated from patient[AP.1M] at this time[AP.2M]. At 1923, IM Zyprexa 5 mg administered to right ventrogluteal area with a physical hold.[AP.1M] Patient immediately released after injection. No physical harm to patient.[AP.2M] Door locked at 1925. MD on unit, face to face completed.[AP.1M]

Electronically signed by Porterfield, Angela D, RN at 7/3/2020 11:02 PM

Attribution Key

AP.1 - Porterfield, Angela D, RN on 7/3/2020 7:36 PM
AP.2 - Porterfield, Angela D, RN on 7/3/2020 10:42 PM
C - Copied, M - Manual

Porterfield, Angela D, RN at 7/3/2020 10:00 PM

Author: Porterfield, Angela D, RN	Service: Psychiatry	Author Type: Registered Nurse
Filed: 7/3/2020 10:06 PM	Date of Service: 7/3/2020 10:00 PM	Status: Signed
Editor: Porterfield, Angela D, RN (Registered Nurse)		

Unlocked seclusion at 2145

Patient fell asleep on mat in seclusion room. Door unlocked per policy. Will continue to monitor for further agitation. Safety measures in place.[AP.1M]

Electronically signed by Porterfield, Angela D, RN at 7/3/2020 10:06 PM

Attribution Key

AP.1 - Porterfield, Angela D, RN on 7/3/2020 10:00 PM
M - Manual

Porterfield, Angela D, RN at 7/4/2020 6:27 AM

Author: Porterfield, Angela D, RN	Service: Psychiatry	Author Type: Registered Nurse
Filed: 7/4/2020 6:27 AM	Date of Service: 7/4/2020 6:27 AM	Status: Signed
Editor: Porterfield, Angela D, RN (Registered Nurse)		

Patient slept all night without incident. No sign of distress. All safety measures in place.[AP.1C]

Electronically signed by Porterfield, Angela D, RN at 7/4/2020 6:27 AM

Clinical Notes (group 2 of 6) (continued)

Attribution Key
AP 1 - Porterfield, Angela D, RN on 7/4/2020 6:27 AM
C - Copied

Golden, Yolanda Nichele, RN at 7/4/2020 4:44 PM

Author: Golden, Yolanda Nichele, RN | Service: Psychiatry | Author Type: Registered Nurse
Filed: 7/4/2020 4:44 PM | Date of Service: 7/4/2020 4:44 PM | Status: Signed
Editor: Golden, Yolanda Nichele, RN (Registered Nurse)

D. Alert and moving about unit. Flat affect.[YG.1T] M[YG.2M]ood[YG.1T] is irritable[YG.2M]. Patient denies suicidal/homicidal ideations. Denies auditory/visual hallucinations. Adequate sleep[YG.1T], poor[YG.2M] appetite.[YG.1T] Patient only ate a few snacks this morning. Patient declined meals that were brought back to the unit.[YG.2M] Adequate hygiene and ADL's. Patient[YG.1T] dressed in hospital scrubs. Denies pain. Patient has asked for his phone 4-5 times today. Patient was informed that he could only be able to use his phone to retrieve numbers. The patient stated several times, "I'm a grown 18 year old man that pays bills. I don't even know why I'm here. Do you know when I'll be able to go home?"[YG.2M] Compliant with medications. No falls. Patient interacting[YG.1T] minimally[YG.2M] with peers and staff.

A. Staff will provide support, structure, medications, and safety checks. Allow patient to vent feelings. Encourage and redirect as needed.

R. Patient agrees to come to staff with any questions, concerns, or thoughts of self harm, or harm to others. Continue q 15 minute rounds for safety and changes in mood or behavior.[YG.1T]

Electronically signed by Golden, Yolanda Nichele, RN at 7/4/2020 4:44 PM

Attribution Key
YG.1 - Golden, Yolanda Nichele, RN on 7/4/2020 10:44 AM
YG.2 - Golden, Yolanda Nichele, RN on 7/4/2020 4:12 PM
M - Manual, T - Template

Golden, Yolanda Nichele, RN at 7/4/2020 6:32 PM

Author: Golden, Yolanda Nichele, RN | Service: Psychiatry | Author Type: Registered Nurse
Filed: 7/4/2020 6:52 PM | Date of Service: 7/4/2020 6:32 PM | Status: Signed
Editor: Golden, Yolanda Nichele, RN (Registered Nurse)

Patient was in the day area when patients were about to go outside. and walked past this writer and scaled the fence to elope when the door was opened to the outside patio The patient was dressed in hospital scrubs and was last seen headed to the Employee garage 9C. Security and Greenville Hospital Police were notified. Greenville police and Greenville county Police were notified by GHS police department. COB and Physician notified. Patient's father, mother, and grandmother were called. Contact was made with grandmother after failed attempts to get mother and father on the phone. The mother happened to be at grandmother's home. The mother was irate and told this writer, "you are responsible for finding him. Y'all should've chained him down and given him shots." The mother was informed that we could not tie him down or give him shots unless he was agitated and/or posed a threat to himself or others. The mother was asked if she would call the hospital or the police if she heard from him.[YG.1M]

Electronically signed by Golden, Yolanda Nichele, RN at 7/4/2020 6:52 PM

Attribution Key
YG.1 - Golden, Yolanda Nichele, RN on 7/4/2020 6:32 PM
M - Manual

Porterfield, Angela D, RN at 7/5/2020 5:43 AM

Author: Porterfield, Angela D, RN | Service: Psychiatry | Author Type: Registered Nurse
Filed: 7/5/2020 5:43 AM | Date of Service: 7/5/2020 5:43 AM | Status: Signed
Editor: Porterfield, Angela D, RN (Registered Nurse)

Patient[AP.1C] asleep by 0245[AP.1M]. No sign of distress. Safety maintained.[AP.1C]

Electronically signed by Porterfield, Angela D, RN at 7/5/2020 5:43 AM

Attribution Key

AP 1 - Porterfield, Angela D, RN on 7/5/2020 5:43 AM
C - Copied, M - Manual

Golden, Yolanda Nichele, RN at 7/5/2020 10:30 AM

Author: Golden, Yolanda Nichele, RN | Service: Psychiatry | Author Type: Registered Nurse
Filed: 7/5/2020 10:32 AM | Date of Service: 7/5/2020 10:30 AM | Status: Addendum
Editor: Golden, Yolanda Nichele, RN (Registered Nurse)

D. Alert and moving about unit. Flat affect.[YG.1T] Labile[YG.1M] mood.[YG.1T] Patient irritable at times and pleasant at others. Patient has no insight. Patient came to the window and stated. "my adoptive mother Karent Weaver called up here to get me released. When are yall going to get my paperwork so I can go?"[YG.1M] Patient just asked, "can I go outside and isn't it illegal to hold me here? This is bullshit."[YG.2M] Patient was informed that he is here by court order and only a judge or his doctor can release him. Patient[YG.1M] Patient denies suicidal/homicidal ideations. Denies auditory/visual hallucinations[YG.1T] although it is apparent that the patient is responding to internal stimuli. Patient is smiling and giggling inappropriately.[YG.2M] Adequate sleep and appetite. Adequate hygiene and ADL's. Denies pain. Patient is[YG.1T] clean and dressed in hospital scrubs.[YG.2M] disheveled in appearance. Compliant with medications.[YG.1T] Watch patient for cheeking.[YG.2M] No falls. Patient interacting[YG.1T] minimally[YG.1M] with peers and staff.[YG.1T] Patient has been in his room most of the morning.[YG.1M]

A. Staff will provide support, structure, medications, and safety checks. Allow patient to vent feelings. Encourage and redirect as needed.[YG.1T] Patient's mother Keyshawna Young and grandmother Cynthia Chapman were spoken to this morning on the same call. His mother was at his grandmother's home. Mother was asked for her number so she can be contacted directly. 864-772-7457.[YG.1M]

R. Patient agrees to come to staff with any questions, concerns, or thoughts of self harm, or harm to others. Continue q 15 minute rounds for safety and changes in mood or behavior.[YG.1T]

Electronically signed by Golden, Yolanda Nichele, RN at 7/5/2020 10:32 AM

Attribution Key

YG.1 - Golden, Yolanda Nichele, RN on 7/5/2020 9:32 AM
YG.2 - Golden, Yolanda Nichele, RN on 7/5/2020 10:25 AM
M - Manual, T - Template

Golden, Yolanda Nichele, RN at 7/5/2020 5:07 PM

Author: Golden, Yolanda Nichele, RN | Service: Psychiatry | Author Type: Registered Nurse
Filed: 7/5/2020 7:11 PM | Date of Service: 7/5/2020 5:07 PM | Status: Signed
Editor: Golden, Yolanda Nichele, RN (Registered Nurse)

07/03/2020 - Admission (Discharged) in Marshall I. Pickens Intensive Management (continued)

Clinical Notes (group 3 of 6)

Nursing Note

Golden, Yolanda Nichele, RN at 7/8/2020 2:45 PM

Author: Golden, Yolanda Nichele, RN | Service: Psychiatry | Author Type: Registered Nurse
Filed: 7/8/2020 4:13 PM | Date of Service: 7/8/2020 2:45 PM | Status: Signed
Editor: Golden, Yolanda Nichele, RN (Registered Nurse)

At approximately 1303 t[YG.1M]he patient tried to go out the side door when an employee was coming through the door.[YG.2C] The employee shut the door to prevent the patient from exiting.[YG.1M] Security came in the nurse's station to let the charge nurse know. The patient went to his room and the charge nurse went to talk to the patient accompanied by security to talk about him trying to leave. The patient asked firmly if both of the staff could leave from his doorway. Staff left his room because the patient was irritable. The nurse got on the phone for orders for the patient[YG.2C] to be placed on a 1:1 with security[YG.1M]. The patient came out of his room and[YG.2C] walked[YG.1M] around the nurse's station and into the day area when he took off running and busted through the glass door[YG.2C] with his body and kept running. Staff alerted of the elopement. Security and police were alerted[YG.1M],[YG.2C]

Electronically signed by Golden, Yolanda Nichele, RN at 7/8/2020 4:13 PM

Attribution Key
YG.1 - Golden, Yolanda Nichele, RN on 7/8/2020 2:51 PM
YG.2 - Golden, Yolanda Nichele, RN on 7/8/2020 2:45 PM
C - Copied, M - Manual

Porterfield, Angela D, RN at 7/8/2020 10:30 PM

Author: Porterfield, Angela D, RN | Service: Psychiatry | Author Type: Registered Nurse
Filed: 7/8/2020 10:30 PM | Date of Service: 7/8/2020 10:30 PM | Status: Signed
Editor: Porterfield, Angela D, RN (Registered Nurse)

Received handoff report from ED that patient is returning back to unit after eloping earlier today. Security notified at 5-7931 of 1:1 order placed by MD to be covered by security. Security states "We are very aware of this situation. I will let my supervisor no of patients return to unit."[AP.1M]

Electronically signed by Porterfield, Angela D, RN at 7/8/2020 10:30 PM

Attribution Key
AP.1 - Porterfield, Angela D, RN on 7/8/2020 10:26 PM
M - Manual

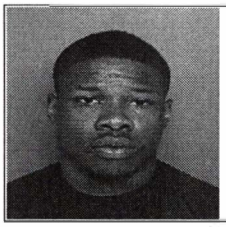
Porterfield, Angela D, RN at 7/9/2020 12:00 AM

Author: Porterfield, Angela D, RN | Service: Psychiatry | Author Type: Registered Nurse
Filed: 7/9/2020 4:57 AM | Date of Service: 7/9/2020 12:00 AM | Status: Signed
Editor: Porterfield, Angela D, RN (Registered Nurse)

Patient given some food and soda, took QHS meds, and went to sleep after returning from ED. Patient did not speak to staff; however, patient was observed smiling inappropriately and whispering as if talking to someone. 1:1 with security continues. All safety measures in place.[AP.1M]

Electronically signed by Porterfield, Angela D, RN at 7/9/2020 4:57 AM

11/05/2020MLP



CARTER, JEVON KENNETH, #318696 @ SOL
Male, 21 years old. DOB 9/14/2001
Allergies: NKDA
Current Problems:

2022-04	01 Fri	02 Sat	03 Sun	04 Mon	05 Tue	06 Wed	07 Thu	08 Fri	09 Sat	10 Sun	11 Mon	12 Tue	13 Wed	14 Thu	15 Fri	16 Sat	17 Sun	18 Mon	19 Tue	20 Wed	21 Thu	22 Fri	23 Sat	24 Sun	25 Mon	26 Tue	27 Wed	28 Thu	29 Fri	30 Sat
3 - MORNING ARIPIPRAZOLE (ABILIFY) 10MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Req Start: 6/20/2021 Req End: 6/19/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3 - MORNING NP/PA level Urgent Exam Discontinued: 4/21/2022																														
3 - MORNING OXCARBAZEPINE (TRILEPTAL) 300MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Yearly script expiration, reordering Req Start: 10/20/2021 Req End: 10/19/2022 Discontinued: 4/5/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	No	MP																									
3 - MORNING OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Req Start: 4/5/2022 Req End: 4/5/2023 Quantity per Dose:1.00 Prescriber:Martin, Ernest						Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3 - MORNING Staff level (MT, CCT, Nurse) Exam														Yes																
8 - BEDTIME ARIPIPRAZOLE (ABILIFY) 10MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Req Start: 6/20/2021 Req End: 6/19/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8 - BEDTIME OXCARBAZEPINE (TRILEPTAL) 300MG, #730 TAKE																														

2022-04	01 Fri	02 Sat	03 Sun	04 Mon	05 Tue	06 Wed	07 Thu	08 Fri	09 Sat	10 Sun	11 Mon	12 Tue	13 Wed	14 Thu	15 Fri	16 Sat	17 Sun	18 Mon	19 Tue	20 Wed	21 Thu	22 Fri	23 Sat	24 Sun	25 Mon	26 Tue	27 Wed	28 Thu	29 Fri	30 Sat
ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Yearly script expiration, reordering Req Start: 10/20/2021 Req End: 10/19/2022 Discontinued: 4/5/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	No	No	Yes																										
8 - BEDTIME OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Req Start: 4/5/2022 Req End: 4/5/2023 Quantity per Dose:1.00 Prescriber:Martin, Ernest					Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8 - BEDTIME TRAZODONE HCL 150MG, #365 TAKE 1 TABLET(S) BY MOUTH EVERY NIGHT AT BEDTIME QHS- RUR Req Start: 2/19/2022 Req End: 2/18/2023 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
9 - STAT IBUPROFEN 600 MG TABLET (MOTRIN) 600 MG TAB, #1 Take 1 TABLET by mouth 1 time per day for 1 day STAT Req Start: 4/14/2022 Req End: 4/14/2022 Fully Administered: 4/14/2022 Quantity per Dose:1.00 Prescriber:Marty Lutz, MD														Yes																

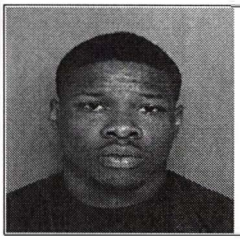
Details						
Date	**Shift**	**Med Administered**	**Medication/Order**	**Reason**	**Comments**	**User**
04-01-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
04-01-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SREYNOLDS
04-01-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
04-01-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
04-01-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	EJAMES
04-02-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
04-02-2022	8 - BEDTIME	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	IBLACKWELL
04-02-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
04-02-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
04-02-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	EJAMES
04-03-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
04-03-2022	8 - BEDTIME	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	SBYRD
04-03-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD
04-03-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	CBENNETT
04-03-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	CBENNETT
04-04-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL

Details						
Date	Shift	Med Administered	Medication/Order	Reason	Comments	User
04-04-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300 MG, #730	NA	NA	IBLACKWELL
04-04-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
04-04-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MELHALL
04-04-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	MELHALL
04-05-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
04-05-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
04-05-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	IBLACKWELL
04-05-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
04-05-2022	3 - MORNING	MEDPASS	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBURRIS
04-06-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
04-06-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
04-06-2022	8 - BEDTIME	NO	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	Patient refused	NA	SREYNOLDS
04-06-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Not in Stock	NA	BKELLETT
04-06-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	BKELLETT
04-07-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
04-07-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD
04-07-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBYRD
04-07-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
04-07-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EJAMES
04-08-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
04-08-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
04-08-2022	8 - BEDTIME	NO	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	Patient refused	NA	SREYNOLDS
04-08-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
04-08-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	TATHOMPSON
04-09-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
04-09-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
04-09-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
04-09-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MELHALL
04-09-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	MELHALL
04-10-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
04-10-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
04-10-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
04-10-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
04-10-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBURRIS
04-11-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
04-11-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
04-11-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	IBLACKWELL
04-11-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	CBENNETT
04-11-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	CBENNETT
04-12-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
04-12-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD
04-12-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBYRD
04-12-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	BKELLETT
04-12-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	BKELLETT
04-13-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
04-13-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
04-13-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
04-13-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
04-13-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	TATHOMPSON
04-14-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
04-14-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD
04-14-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBYRD
04-14-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MELHALL
04-14-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	MELHALL
04-14-2022	3 - MORNING	YES	Staff level (MT, CCT, Nurse) Exam	NA	NA	RALVAREZ
04-14-2022	9 - STAT	YES	IBUPROFEN 600 MG TABLET (MOTRIN) 600 MG TAB, #1	NA	NA	RALVAREZ
04-15-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
04-15-2022	8 - BEDTIME	YES	TRAZODONE HCL 150 MG, #365	NA	NA	SREYNOLDS
04-15-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
04-15-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	FHALL
04-15-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	FHALL
04-16-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
04-16-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
04-16-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
04-16-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	CBENNETT
04-16-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	CBENNETT
04-17-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
04-17-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	EJAMES
04-17-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EJAMES
04-17-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	BKELLETT

Details						
Date	Shift	Med Administered	Medication/Order	Reason	Comments	User
	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	BKELLETT
04-18-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
04-18-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
04-18-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
04-18-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
04-18-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBURRIS
04-19-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
04-19-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
04-19-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	IBLACKWELL
04-19-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
04-19-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	TATHOMPSON
04-20-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
04-20-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
04-20-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
04-20-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	FHALL
04-20-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	FHALL
04-21-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
04-21-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD
04-21-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBYRD
04-21-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
04-21-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EJAMES
04-22-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
04-22-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	EJAMES
04-22-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EJAMES
04-22-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MELHALL
04-22-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	MELHALL
04-23-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
04-23-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
04-23-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
04-23-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
04-23-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBURRIS
04-24-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
04-24-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
04-24-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
04-24-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LATPITTS
04-24-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LATPITTS
04-25-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
04-25-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
04-25-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	IBLACKWELL
04-25-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	JHYATT
04-25-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	JHYATT
04-26-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
04-26-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD
04-26-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBYRD
04-26-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	JHYATT
04-26-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	JHYATT
04-27-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
04-27-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
04-27-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
04-27-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MELHALL
04-27-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	MELHALL
04-28-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
04-28-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD
04-28-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBYRD
04-28-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
04-28-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBURRIS
04-29-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
04-29-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
04-29-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
04-29-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	JHYATT
04-29-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	JHYATT
04-30-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
04-30-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
04-30-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
04-30-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LATPITTS
04-30-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LATPITTS

Legend									
White	Outside Prescription/Order's start and end date	Green	Dose/Treatment was administered	Red	Dose/Treatment was NOT administered	Blue	Future Dose/Treatment to be administered	Yellow	Missed Dose/Treatment
			Dose/Treatment is NOT to		PRN - Dispense/Treat as		Dose previously dispensed		

Purple	Treat ONCE during this time	Silver	be administered	Orange	needed	Pink	(KOP)		
Yes	YES	No	NO	Kop	KOP	M	MISSED	R	REVOKED
IC	IN CELL	MP	MED PASS	T	TARGET				



CARTER, JEVON KENNETH, #318696 @ SOL
Male, 21 years old, DOB 9/14/2001
Allergies: NKDA
Current Problems:

2022-02	01 Tue	02 Wed	03 Thu	04 Fri	05 Sat	06 Sun	07 Mon	08 Tue	09 Wed	10 Thu	11 Fri	12 Sat	13 Sun	14 Mon	15 Tue	16 Wed	17 Thu	18 Fri	19 Sat	20 Sun	21 Mon	22 Tue	23 Wed	24 Thu	25 Fri	26 Sat	27 Sun	28 Mon
3 - MORNING ARIPIPRAZOLE (ABILIFY) 10MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Req Start: 6/20/2021 Req End: 6/19/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3 - MORNING OLANZAPINE (ZYPREXA) 2.5MG, #365 TAKE ONE TABLET(S) BY MOUTH IN THE MORNING QAM - RUR Yearly script expiration, reordering Req Start: 10/20/2021 Req End: 10/19/2022 Discontinued: 2/18/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	—	—	—	—	—	—	—	—	—	—
3 - MORNING OXCARBAZEPINE (TRILEPTAL) 300MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Yearly script expiration, reordering Req Start: 10/20/2021 Req End: 10/19/2022 Discontinued: 4/5/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3 - MORNING Psychiatrist level Urgent Exam	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Yes	—	—	—	—	—	—	—	—	—	—
8 - BEDTIME ARIPIPRAZOLE (ABILIFY) 10MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Req Start: 6/20/2021 Req End: 6/19/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

2022-02	01 Tue	02 Wed	03 Thu	04 Fri	05 Sat	06 Sun	07 Mon	08 Tue	09 Wed	10 Thu	11 Fri	12 Sat	13 Sun	14 Mon	15 Tue	16 Wed	17 Thu	18 Fri	19 Sat	20 Sun	21 Mon	22 Tue	23 Wed	24 Thu	25 Fri	26 Sat	27 Sun	28 Mon
8 - BEDTIME OLANZAPINE (ZYPREXA) 5MG, #365 TAKE 1 TABLET(S) BY MOUTH AT BEDTIME QHS- RUR Yearly script expiration, reordering Req Start: 10/17/2021 Req End: 10/16/2022 Discontinued: 2/18/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes										
8 - BEDTIME OXCARBAZEPINE (TRILEPTAL) 300MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Yearly script expiration, reordering Req Start: 10/20/2021 Req End: 10/19/2022 Discontinued: 4/5/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8 - BEDTIME TRAZODONE HCL 100MG, #365 TAKE 1 TABLET(S) BY MOUTH AT BEDTIME QHS- RUR Yearly script expiration, reordering Req Start: 10/20/2021 Req End: 10/19/2022 Discontinued: 2/18/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes										
8 - BEDTIME TRAZODONE HCL 150MG, #365 TAKE 1 TABLET(S) BY MOUTH EVERY NIGHT AT BEDTIME QHS- RUR Req Start: 2/19/2022 Req End: 2/18/2023 Quantity per Dose:1.00 Prescriber:Martin, Ernest																			No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

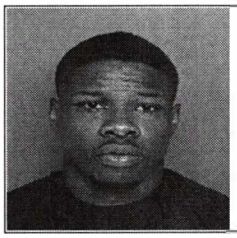
Details						
Date	**Shift**	**Med Administered**	**Medication/Order**	**Reason**	**Comments**	**User**
02-01-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
02-01-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	IBLACKWELL
02-01-2022	8 - BEDTIME	YES	TRAZODONE HCL 100MG, #365	NA	NA	IBLACKWELL

Details						
Date	Shift	Med Administered	Medication/Order	Reason	Comments	User
02-01-2022	8 - BEDTIME	YES	OLANZAPINE (ZYPREXA) 5MG, #365	NA	NA	IBLACKWELL
02-01-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MIMCGOWAN
02-01-2022	3 - MORNING	YES	OLANZAPINE (ZYPREXA) 2.5MG, #365	NA	NA	MIMCGOWAN
02-01-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	MIMCGOWAN
02-02-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
02-02-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	EJAMES
02-02-2022	8 - BEDTIME	YES	TRAZODONE HCL 100MG, #365	NA	NA	EJAMES
02-02-2022	8 - BEDTIME	YES	OLANZAPINE (ZYPREXA) 5MG, #365	NA	NA	EJAMES
02-02-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	JREEVES
02-02-2022	3 - MORNING	YES	OLANZAPINE (ZYPREXA) 2.5MG, #365	NA	NA	JREEVES
02-02-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	JREEVES
02-03-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
02-03-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBYRD
02-03-2022	8 - BEDTIME	YES	TRAZODONE HCL 100MG, #365	NA	NA	SBYRD
02-03-2022	8 - BEDTIME	YES	OLANZAPINE (ZYPREXA) 5MG, #365	NA	NA	SBYRD
02-03-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
02-03-2022	3 - MORNING	YES	OLANZAPINE (ZYPREXA) 2.5MG, #365	NA	NA	EJAMES
02-03-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	EJAMES
02-04-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
02-04-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	EJAMES
02-04-2022	8 - BEDTIME	YES	TRAZODONE HCL 100MG, #365	NA	NA	EJAMES
02-04-2022	8 - BEDTIME	YES	OLANZAPINE (ZYPREXA) 5MG, #365	NA	NA	EJAMES
02-04-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	CBENNETT
02-04-2022	3 - MORNING	YES	OLANZAPINE (ZYPREXA) 2.5MG, #365	NA	NA	CBENNETT
02-04-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	CBENNETT
02-05-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	CBENNETT
02-05-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	CBENNETT
02-05-2022	8 - BEDTIME	YES	TRAZODONE HCL 100MG, #365	NA	NA	CBENNETT
02-05-2022	8 - BEDTIME	YES	OLANZAPINE (ZYPREXA) 5MG, #365	NA	NA	CBENNETT
02-05-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	ASTERLING
02-05-2022	3 - MORNING	YES	OLANZAPINE (ZYPREXA) 2.5MG, #365	NA	NA	ASTERLING
02-05-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	ASTERLING
02-06-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
02-06-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBYRD
02-06-2022	8 - BEDTIME	YES	TRAZODONE HCL 100MG, #365	NA	NA	SBYRD
02-06-2022	8 - BEDTIME	YES	OLANZAPINE (ZYPREXA) 5MG, #365	NA	NA	SBYRD
02-06-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MIMCGOWAN
02-06-2022	3 - MORNING	YES	OLANZAPINE (ZYPREXA) 2.5MG, #365	NA	NA	MIMCGOWAN
02-06-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	MIMCGOWAN
02-07-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
02-07-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	IBLACKWELL
02-07-2022	8 - BEDTIME	YES	TRAZODONE HCL 100MG, #365	NA	NA	IBLACKWELL
02-07-2022	8 - BEDTIME	YES	OLANZAPINE (ZYPREXA) 5MG, #365	NA	NA	IBLACKWELL
02-07-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
02-07-2022	3 - MORNING	YES	OLANZAPINE (ZYPREXA) 2.5MG, #365	NA	NA	SBURRIS
02-07-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBURRIS
02-08-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
02-08-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBURRIS
02-08-2022	8 - BEDTIME	YES	TRAZODONE HCL 100MG, #365	NA	NA	SBURRIS
02-08-2022	8 - BEDTIME	YES	OLANZAPINE (ZYPREXA) 5MG, #365	NA	NA	SBURRIS
02-08-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
02-08-2022	3 - MORNING	YES	OLANZAPINE (ZYPREXA) 2.5MG, #365	NA	NA	TATHOMPSON
02-08-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	TATHOMPSON
02-09-2022	8 - BEDTIME	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	EJAMES
02-09-2022	8 - BEDTIME	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	EJAMES
02-09-2022	8 - BEDTIME	YES	TRAZODONE HCL 100MG, #365	NA	NA	EJAMES
02-09-2022	8 - BEDTIME	NO	OLANZAPINE (ZYPREXA) 5MG, #365	Patient refused	NA	EJAMES
02-09-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	CBENNETT
02-09-2022	3 - MORNING	YES	OLANZAPINE (ZYPREXA) 2.5MG, #365	NA	NA	CBENNETT
02-09-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	CBENNETT
02-10-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
02-10-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBYRD
02-10-2022	8 - BEDTIME	YES	TRAZODONE HCL 100MG, #365	NA	NA	SBYRD
02-10-2022	8 - BEDTIME	YES	OLANZAPINE (ZYPREXA) 5MG, #365	NA	NA	SBYRD
02-10-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	ASTERLING

Details						
Date	Shift	Med Administered	Medication/Order	Reason	Comments	User
	3 - MORNING	NO	OLANZAPINE (ZYPREXA) 2.5MG, #365	Patient refused	NA	ASTERLING
02-10-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	ASTERLING
02-11-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
02-11-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	EJAMES
02-11-2022	8 - BEDTIME	YES	TRAZODONE HCL 100MG, #365	NA	NA	EJAMES
02-11-2022	8 - BEDTIME	YES	OLANZAPINE (ZYPREXA) 5MG, #365	NA	NA	EJAMES
02-11-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	SBURRIS
02-11-2022	3 - MORNING	NO	OLANZAPINE (ZYPREXA) 2.5MG, #365	Patient refused	NA	SBURRIS
02-11-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	SBURRIS
02-12-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
02-12-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBURRIS
02-12-2022	8 - BEDTIME	YES	TRAZODONE HCL 100MG, #365	NA	NA	SBURRIS
02-12-2022	8 - BEDTIME	YES	OLANZAPINE (ZYPREXA) 5MG, #365	NA	NA	SBURRIS
02-12-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	TATHOMPSON
02-12-2022	3 - MORNING	NO	OLANZAPINE (ZYPREXA) 2.5MG, #365	Patient refused	NA	TATHOMPSON
02-12-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	TATHOMPSON
02-13-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
02-13-2022	8 - BEDTIME	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	TATHOMPSON
02-13-2022	8 - BEDTIME	YES	TRAZODONE HCL 100MG, #365	NA	NA	TATHOMPSON
02-13-2022	8 - BEDTIME	NO	OLANZAPINE (ZYPREXA) 5MG, #365	Patient refused	NA	TATHOMPSON
02-13-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	LATPITTS
02-13-2022	3 - MORNING	NO	OLANZAPINE (ZYPREXA) 2.5MG, #365	Patient refused	NA	LATPITTS
02-13-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	LATPITTS
02-14-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
02-14-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	IBLACKWELL
02-14-2022	8 - BEDTIME	YES	TRAZODONE HCL 100MG, #365	NA	NA	IBLACKWELL
02-14-2022	8 - BEDTIME	YES	OLANZAPINE (ZYPREXA) 5MG, #365	NA	NA	IBLACKWELL
02-14-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	EJAMES
02-14-2022	3 - MORNING	NO	OLANZAPINE (ZYPREXA) 2.5MG, #365	Patient refused	NA	EJAMES
02-14-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	EJAMES
02-15-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
02-15-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	IBLACKWELL
02-15-2022	8 - BEDTIME	YES	TRAZODONE HCL 100MG, #365	NA	NA	IBLACKWELL
02-15-2022	8 - BEDTIME	NO	OLANZAPINE (ZYPREXA) 5MG, #365	Patient refused	NA	IBLACKWELL
02-15-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	CBENNETT
02-15-2022	3 - MORNING	NO	OLANZAPINE (ZYPREXA) 2.5MG, #365	Patient refused	NA	CBENNETT
02-15-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	CBENNETT
02-16-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
02-16-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SREYNOLDS
02-16-2022	8 - BEDTIME	YES	TRAZODONE HCL 100MG, #365	NA	NA	SREYNOLDS
02-16-2022	8 - BEDTIME	YES	OLANZAPINE (ZYPREXA) 5MG, #365	NA	NA	SREYNOLDS
02-16-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	JHYATT
02-16-2022	3 - MORNING	NO	OLANZAPINE (ZYPREXA) 2.5MG, #365	Patient refused	NA	JHYATT
02-16-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	JHYATT
02-17-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	FHALL
02-17-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	FHALL
02-17-2022	8 - BEDTIME	YES	TRAZODONE HCL 100MG, #365	NA	NA	FHALL
02-17-2022	8 - BEDTIME	YES	OLANZAPINE (ZYPREXA) 5MG, #365	NA	NA	FHALL
02-17-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	JHYATT
02-17-2022	3 - MORNING	NO	OLANZAPINE (ZYPREXA) 2.5MG, #365	Patient refused	NA	JHYATT
02-17-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	JHYATT
02-18-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
02-18-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	IBLACKWELL
02-18-2022	8 - BEDTIME	YES	TRAZODONE HCL 100MG, #365	NA	NA	IBLACKWELL
02-18-2022	8 - BEDTIME	YES	OLANZAPINE (ZYPREXA) 5MG, #365	NA	NA	IBLACKWELL
02-18-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	ASTERLING
02-18-2022	3 - MORNING	NO	OLANZAPINE (ZYPREXA) 2.5MG, #365	Patient refused	NA	ASTERLING
02-18-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	ASTERLING
02-18-2022	3 - MORNING	YES	Psychiatrist level Urgent Exam	NA	NA	LMCCOMBS
02-19-2022	8 - BEDTIME	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	SREYNOLDS
02-19-2022	8 - BEDTIME	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	SREYNOLDS
02-19-2022	8 - BEDTIME	NO	TRAZODONE HCL 150MG, #365	Patient refused	NA	SREYNOLDS
02-19-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	MIMCGOWAN
02-19-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	MIMCGOWAN
02-20-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES

Details						
Date	Shift	Med Administered	Medication/Order	Reason	Comments	User
	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	EJAMES
02-20-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	EJAMES
02-20-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	CBENNETT
02-20-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	CBENNETT
02-21-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SNAGLE
02-21-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SNAGLE
02-21-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SNAGLE
02-21-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
02-21-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	EJAMES
02-22-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
02-22-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SREYNOLDS
02-22-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
02-22-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
02-22-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBURRIS
02-23-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
02-23-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SREYNOLDS
02-23-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
02-23-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	ASTERLING
02-23-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	ASTERLING
02-24-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
02-24-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	IBLACKWELL
02-24-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
02-24-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MIMCGOWAN
02-24-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	MIMCGOWAN
02-25-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
02-25-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	EJAMES
02-25-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	EJAMES
02-25-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	JHYATT
02-25-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	JHYATT
02-26-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
02-26-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	EJAMES
02-26-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	EJAMES
02-26-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	JHYATT
02-26-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	JHYATT
02-27-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
02-27-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	EJAMES
02-27-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	EJAMES
02-27-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	JHYATT
02-27-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	JHYATT
02-28-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
02-28-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	IBLACKWELL
02-28-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
02-28-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	CBENNETT
02-28-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	CBENNETT

Legend									
White	Outside Prescription/Order's start and end date	Green	Dose/Treatment was administered	Red	Dose/Treatment was NOT administered	Blue	Future Dose/Treatment to be administered	Yellow	Missed Dose/Treatment
Purple	Treat ONCE during this time	Silver	Dose/Treatment is NOT to be administered	Orange	PRN - Dispense/Treat as needed	Pink	Dose previously dispensed (KOP)		
Yes	YES	No	NO	Kop	KOP	M	MISSED	R	REVOKED
IC	IN CELL	MP	MED PASS	T	TARGET				



CARTER, JEVON KENNETH, #318696 @ SOL
Male, 21 years old, DOB 9/14/2001
Allergies: NKDA
Current Problems:

2022-07	01 Fri	02 Sat	03 Sun	04 Mon	05 Tue	06 Wed	07 Thu	08 Fri	09 Sat	10 Sun	11 Mon	12 Tue	13 Wed	14 Thu	15 Fri	16 Sat	17 Sun	18 Mon	19 Tue	20 Wed	21 Thu	22 Fri	23 Sat	24 Sun	25 Mon	26 Tue	27 Wed	28 Thu	29 Fri	30 Sat	31 Sun
3 - MORNING ARIPIPRAZOLE (ABILIFY) 10MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR yearly prescription refill Req Start: 6/20/2022 Req End: 6/19/2023 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	Yes
3 - MORNING OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Req Start: 4/5/2022 Req End: 4/5/2023 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	Yes
8 - BEDTIME ARIPIPRAZOLE (ABILIFY) 10MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR yearly prescription refill Req Start: 6/20/2022 Req End: 6/19/2023 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MP	No	Yes	Yes	MP	MP	MP
8 - BEDTIME OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Req Start: 4/5/2022 Req End: 4/5/2023 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MP	No	Yes	Yes	MP	MP	MP
8 - BEDTIME TRAZODONE HCL 150MG, #365 TAKE 1 TABLET(S) BY																															

2022-07	01 Fri	02 Sat	03 Sun	04 Mon	05 Tue	06 Wed	07 Thu	08 Fri	09 Sat	10 Sun	11 Mon	12 Tue	13 Wed	14 Thu	15 Fri	16 Sat	17 Sun	18 Mon	19 Tue	20 Wed	21 Thu	22 Fri	23 Sat	24 Sun	25 Mon	26 Tue	27 Wed	28 Thu	29 Fri	30 Sat	31 Sun
MOUTH EVERY NIGHT AT BEDTIME QHS-RUR Req Start: 2/19/2022 Req End: 2/18/2023 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MP	No	Yes	Yes	MP	MP	MP

Details						
Date	**Shift**	**Med Administered**	**Medication/Order**	**Reason**	**Comments**	**User**
07-01-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
07-01-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
07-01-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
07-01-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	ADMINKIM
07-01-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	ADMINKIM
07-02-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
07-02-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
07-02-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
07-02-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	TDONOFRIOI
07-02-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TDONOFRIOI
07-03-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	TIWATSON
07-03-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	TIWATSON
07-03-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TIWATSON
07-03-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	TDONOFRIOI
07-03-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TDONOFRIOI
07-04-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
07-04-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
07-04-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
07-04-2022	3 - MORNING	NO	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	Patient refused	NA	LISTRICKLA
07-04-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	LISTRICKLA
07-05-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
07-05-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
07-05-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
07-05-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	ADMINHALL
07-05-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	ADMINHALL
07-06-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
07-06-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
07-06-	8 -	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS

Details						
Date	Shift	Med Administered	Medication/Order	Reason	Comments	User
2022	BEDTIME					
07-06-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	ADMINKIM
07-06-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	ADMINKIM
07-07-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
07-07-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
07-07-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
07-07-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	ADMINKIM
07-07-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	ADMINKIM
07-08-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
07-08-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
07-08-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
07-08-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EGARBACKA
07-08-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EGARBACKA
07-09-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
07-09-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
07-09-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
07-09-2022	3 - MORNING	NO	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	Patient refused	NA	EGARBACKA
07-09-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	EGARBACKA
07-10-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	TATHOMPSON
07-10-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	TATHOMPSON
07-10-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
07-10-2022	3 - MORNING	NO	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	Patient refused	NA	TDONOFRIOI
07-10-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	TDONOFRIOI
07-11-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
07-11-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	IBLACKWELL
07-11-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
07-11-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	TIWATSON
07-11-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TIWATSON
07-12-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
07-12-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	IBLACKWELL
07-12-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
07-12-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LISTRICKLA
07-12-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LISTRICKLA
07-13-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	RALVAREZ
07-13-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	RALVAREZ
07-13-	8 -	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	RALVAREZ

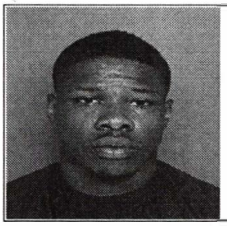
Details						
Date	Shift	Med Administered	Medication/Order	Reason	Comments	User
2022	BEDTIME					
07-13-2022	3 - MORNING	NO	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	Patient refused	NA	TATHOMPSON
07-13-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	TATHOMPSON
07-14-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	NMAYFIELD
07-14-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	NMAYFIELD
07-14-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	NMAYFIELD
07-14-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	TATHOMPSON
07-14-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
07-15-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	MCULBERSON
07-15-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	MCULBERSON
07-15-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MCULBERSON
07-15-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	MCULBERSON
07-15-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MCULBERSON
07-16-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	MCULBERSON
07-16-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	MCULBERSON
07-16-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MCULBERSON
07-16-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	MCULBERSON
07-16-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MCULBERSON
07-17-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	LNODURFT
07-17-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LNODURFT
07-17-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LNODURFT
07-17-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	PCHRISTIAN
07-17-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	PCHRISTIAN
07-18-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
07-18-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	IBLACKWELL
07-18-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
07-18-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	ADMINKIM
07-18-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	ADMINKIM
07-19-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
07-19-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
07-19-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
07-19-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	ADMINKIM
07-19-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	ADMINKIM
07-20-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
07-20-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
07-20-	8 -	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS

Details						
Date	Shift	Med Administered	Medication/Order	Reason	Comments	User
2022	BEDTIME					
07-20-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	BKELLETT
07-20-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	BKELLETT
07-21-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	LISTRICKLA
07-21-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LISTRICKLA
07-21-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LISTRICKLA
07-21-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LISTRICKLA
07-21-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LISTRICKLA
07-22-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	LNODURFT
07-22-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LNODURFT
07-22-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LNODURFT
07-22-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LNODURFT
07-22-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LNODURFT
07-23-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	LNODURFT
07-23-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LNODURFT
07-23-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LNODURFT
07-23-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	IBLACKWELL
07-23-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
07-24-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	TATHOMPSON
07-24-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	TATHOMPSON
07-24-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
07-24-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LNODURFT
07-24-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LNODURFT
07-25-2022	8 - BEDTIME	MEDPASS	TRAZODONE HCL 150MG, #365	NA	NA	ROBTUCKER
07-25-2022	8 - BEDTIME	MEDPASS	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	ROBTUCKER
07-25-2022	8 - BEDTIME	MEDPASS	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	ROBTUCKER
07-25-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LISTRICKLA
07-25-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LISTRICKLA
07-26-2022	8 - BEDTIME	NO	TRAZODONE HCL 150MG, #365	Patient refused	NA	ROBTUCKER
07-26-2022	8 - BEDTIME	NO	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	Patient refused	NA	ROBTUCKER
07-26-2022	8 - BEDTIME	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	ROBTUCKER
07-26-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	BKELLETT
07-26-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	BKELLETT
07-27-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	LNODURFT
07-27-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LNODURFT
07-27-	8 -	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LNODURFT

Details						
Date	**Shift**	**Med Administered**	**Medication/Order**	**Reason**	**Comments**	**User**
2022	BEDTIME					
07-27-2022	3 - MORNING	NO	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	Refused to Officer,Officer to Enter Daily Activity	NA	TIWATSON
07-27-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Refused to Officer,Officer to Enter Daily Activity	NA	TIWATSON
07-28-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	LNODURFT
07-28-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LNODURFT
07-28-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LNODURFT
07-28-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	TATHOMPSON
07-28-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
07-29-2022	8 - BEDTIME	MEDPASS	TRAZODONE HCL 150MG, #365	NA	NA	BKELLETT
07-29-2022	8 - BEDTIME	MEDPASS	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	BKELLETT
07-29-2022	8 - BEDTIME	MEDPASS	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	BKELLETT
07-29-2022	3 - MORNING	NO	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	Patient refused	NA	ROBTUCKER
07-29-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	ROBTUCKER
07-30-2022	8 - BEDTIME	MEDPASS	TRAZODONE HCL 150MG, #365	NA	NA	BKELLETT
07-30-2022	8 - BEDTIME	MEDPASS	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	BKELLETT
07-30-2022	8 - BEDTIME	MEDPASS	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	BKELLETT
07-30-2022	3 - MORNING	NO	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	Patient refused	NA	ROBTUCKER
07-30-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	ROBTUCKER
07-31-2022	8 - BEDTIME	MEDPASS	TRAZODONE HCL 150MG, #365	NA	NA	KMILES
07-31-2022	8 - BEDTIME	MEDPASS	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	KMILES
07-31-2022	8 - BEDTIME	MEDPASS	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	KMILES
07-31-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LISTRICKLA
07-31-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LISTRICKLA

Legend

White	Outside Prescription/Order's start and end date	Green	Dose/Treatment was administered	Red	Dose/Treatment was NOT administered	Blue	Future Dose/Treatment to be administered	Yellow	Missed Dose/Treatment
Purple	Treat ONCE during this time	Silver	Dose/Treatment is NOT to be administered	Orange	PRN - Dispense/Treat as needed	Pink	Dose previously dispensed (KOP)		
Yes	YES	No	NO	Kop	KOP	M	MISSED	R	REVOKED
IC	IN CELL	MP	MED PASS	T	TARGET				



CARTER, JEVON KENNETH, #318696 @ SOL
Male, 21 years old. DOB 9/14/2001
Allergies: NKDA
Current Problems:

2022-06	01 Wed	02 Thu	03 Fri	04 Sat	05 Sun	06 Mon	07 Tue	08 Wed	09 Thu	10 Fri	11 Sat	12 Sun	13 Mon	14 Tue	15 Wed	16 Thu	17 Fri	18 Sat	19 Sun	20 Mon	21 Tue	22 Wed	23 Thu	24 Fri	25 Sat	26 Sun	27 Mon	28 Tue	29 Wed	30 Thu
3 - MORNING ARIPIPRAZOLE (ABILIFY) 10MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Req Start: 6/20/2021 Req End: 6/19/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	MP	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes										
3 - MORNING ARIPIPRAZOLE (ABILIFY) 10MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR yearly prescription refill Req Start: 6/20/2022 Req End: 6/19/2023 Quantity per Dose:1.00 Prescriber:Martin, Ernest																				Yes	Yes	No	Yes	Yes	MP	Yes	Yes	Yes	Yes	Yes
3 - MORNING OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Req Start: 4/5/2022 Req End: 4/5/2023 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	MP	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	MP	Yes	Yes	Yes	Yes	Yes
8 - BEDTIME ARIPIPRAZOLE (ABILIFY) 10MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Req Start: 6/20/2021 Req End: 6/19/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MP											
8 - BEDTIME ARIPIPRAZOLE (ABILIFY) 10MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR yearly prescription refill Req Start: 6/20/2022 Req End: 6/19/2023 Quantity per Dose:1.00 Prescriber:Martin,																				Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	MP

2022-06	01 Wed	02 Thu	03 Fri	04 Sat	05 Sun	06 Mon	07 Tue	08 Wed	09 Thu	10 Fri	11 Sat	12 Sun	13 Mon	14 Tue	15 Wed	16 Thu	17 Fri	18 Sat	19 Sun	20 Mon	21 Tue	22 Wed	23 Thu	24 Fri	25 Sat	26 Sun	27 Mon	28 Tue	29 Wed	30 Thu
Ernest																														
8 - BEDTIME OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Req Start: 4/5/2022 Req End: 4/5/2023 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MP	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	MP
8 - BEDTIME TRAZODONE HCL 150MG, #365 TAKE 1 TABLET(S) BY MOUTH EVERY NIGHT AT BEDTIME QHS- RUR Req Start: 2/19/2022 Req End: 2/18/2023 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MP	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MP

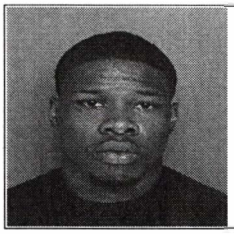
Details

Date	Shift	Med Administered	Medication/Order	Reason	Comments	User
06-01-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
06-01-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
06-01-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
06-01-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	JHYATT
06-01-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	JHYATT
06-02-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
06-02-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
06-02-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
06-02-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	JHYATT
06-02-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	JHYATT
06-03-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
06-03-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	EJAMES
06-03-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EJAMES
06-03-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MELHALL
06-03-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	MELHALL
06-04-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
06-04-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
06-04-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
06-04-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
06-04-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBURRIS
06-05-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
06-05-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
06-05-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
06-05-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LISTRICKLA
06-05-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LISTRICKLA
06-06-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
06-06-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	EJAMES
06-06-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EJAMES
06-06-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	JHYATT
06-06-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	JHYATT
06-07-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
06-07-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD
06-07-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBYRD
06-07-2022	3 - MORNING	MEDPASS	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
06-07-2022	3 - MORNING	MEDPASS	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	TATHOMPSON
06-08-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
06-08-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
06-08-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
06-08-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	BKELLETT

Details						
Date	Shift	Med Administered	Medication/Order	Reason	Comments	User
06-08-2022	3 - MORNING	NO	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	Patient refused	NA	BKELLETT
06-09-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
06-09-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD
06-09-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBYRD
06-09-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MELHALL
06-09-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	MELHALL
06-10-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
06-10-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
06-10-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
06-10-2022	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	CHRPHIPPS
06-10-2022	3 - MORNING	NO	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	Patient refused	NA	CHRPHIPPS
06-11-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
06-11-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
06-11-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
06-11-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	CHRPHIPPS
06-11-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	CHRPHIPPS
06-12-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
06-12-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
06-12-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
06-12-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	CHRPHIPPS
06-12-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	CHRPHIPPS
06-13-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
06-13-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
06-13-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	IBLACKWELL
06-13-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MELHALL
06-13-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	MELHALL
06-14-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
06-14-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
06-14-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	IBLACKWELL
06-14-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	FHALL
06-14-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	FHALL
06-15-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
06-15-2022	8 - BEDTIME	YES	TRAZODONE HCL 150 MG, #365	NA	NA	SREYNOLDS
06-15-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
06-15-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	FHALL
06-15-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	FHALL
06-16-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
06-16-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
06-16-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
06-16-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
06-16-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EJAMES
06-17-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
06-17-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
06-17-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
06-17-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
06-17-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EJAMES
06-18-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
06-18-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
06-18-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
06-18-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
06-18-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EJAMES
06-19-2022	8 - BEDTIME	MEDPASS	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	BKELLETT
06-19-2022	8 - BEDTIME	MEDPASS	TRAZODONE HCL 150MG, #365	NA	NA	BKELLETT
06-19-2022	8 - BEDTIME	MEDPASS	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	BKELLETT
06-19-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	FHALL
06-19-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	FHALL
06-20-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
06-20-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
06-20-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
06-20-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	FHALL
06-20-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	FHALL
06-21-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SNAGLE
06-21-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SNAGLE
06-21-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SNAGLE
06-21-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	HAMORGAN
06-21-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	HAMORGAN
06-22-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	EJAMES
06-22-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EJAMES
06-22-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
06-22-2022	3 - MORNING	NO	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	Patient refused	NA	JHYATT

Details						
Date	**Shift**	**Med Administered**	**Medication/Order**	**Reason**	**Comments**	**User**
	3 - MORNING	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Patient refused	NA	JHYATT
06-23-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD
06-23-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBYRD
06-23-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
06-23-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	JHYATT
06-23-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	JHYATT
06-24-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	EJAMES
06-24-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EJAMES
06-24-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
06-24-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	TATHOMPSON
06-24-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
06-25-2022	8 - BEDTIME	YES	TRAZODONE HCL 150 MG, #365	NA	NA	SREYNOLDS
06-25-2022	8 - BEDTIME	NO	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	Not in Stock	NA	SREYNOLDS
06-25-2022	8 - BEDTIME	NO	ARIPIPRAZOLE (ABILIFY) 10MG, #730	Not in Stock	NA	SREYNOLDS
06-25-2022	3 - MORNING	MEDPASS	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EJAMES
06-25-2022	3 - MORNING	MEDPASS	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
06-26-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
06-26-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
06-26-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
06-26-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	TATHOMPSON
06-26-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
06-27-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
06-27-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	IBLACKWELL
06-27-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
06-27-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	FHALL
06-27-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	FHALL
06-28-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
06-28-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
06-28-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
06-28-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	FHALL
06-28-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	FHALL
06-29-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
06-29-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
06-29-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
06-29-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	ADMINKIM
06-29-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	ADMINKIM
06-30-2022	8 - BEDTIME	MEDPASS	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD
06-30-2022	8 - BEDTIME	MEDPASS	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBYRD
06-30-2022	8 - BEDTIME	MEDPASS	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
06-30-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	ADMINKIM
06-30-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	ADMINKIM

Legend									
White	Outside Prescription/Order's start and end date	Green	Dose/Treatment was administered	Red	Dose/Treatment was NOT administered	Blue	Future Dose/Treatment to be administered	Yellow	Missed Dose/Treatment
Purple	Treat ONCE during this time	Silver	Dose/Treatment is NOT to be administered	Orange	PRN - Dispense/Treat as needed	Pink	Dose previously dispensed (KOP)		
Yes	YES	No	NO	Kop	KOP	M	MISSED	R	REVOKED
IC	IN CELL	MP	MED PASS	T	TARGET				



CARTER, JEVON KENNETH, #318696 @ SOL
Male, 21 years old, DOB 9/14/2001
Allergies: NKDA
Current Problems:

2022-03	01 Tue	02 Wed	03 Thu	04 Fri	05 Sat	06 Sun	07 Mon	08 Tue	09 Wed	10 Thu	11 Fri	12 Sat	13 Sun	14 Mon	15 Tue	16 Wed	17 Thu	18 Fri	19 Sat	20 Sun	21 Mon	22 Tue	23 Wed	24 Thu	25 Fri	26 Sat	27 Sun	28 Mon	29 Tue	30 Wed	31 Thu
3 - MORNING ARIPIPRAZOLE (ABILIFY) 10MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Req Start: 6/20/2021 Req End: 6/19/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3 - MORNING One Time Weight Check																														Yes	
3 - MORNING OXCARBAZEPINE (TRILEPTAL) 300MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Yearly script expiration, reordering Req Start: 10/20/2021 Req End: 10/19/2022 Discontinued: 4/5/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	No	No	Yes	No	No	No	Yes	No	No	No	No	Yes	Yes
8 - BEDTIME ARIPIPRAZOLE (ABILIFY) 10MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Req Start: 6/20/2021 Req End: 6/19/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8 - BEDTIME OXCARBAZEPINE (TRILEPTAL) 300MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Yearly script expiration, reordering Req Start: 10/20/2021 Req End: 10/19/2022 Discontinued: 4/5/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	No	No	No	No	Yes	Yes	No	Yes	No	No
8 - BEDTIME TRAZODONE HCL 150MG, #365 TAKE																															

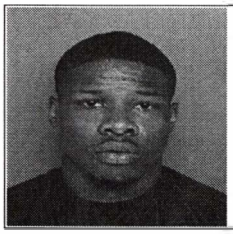
2022-03	01 Tue	02 Wed	03 Thu	04 Fri	05 Sat	06 Sun	07 Mon	08 Tue	09 Wed	10 Thu	11 Fri	12 Sat	13 Sun	14 Mon	15 Tue	16 Wed	17 Thu	18 Fri	19 Sat	20 Sun	21 Mon	22 Tue	23 Wed	24 Thu	25 Fri	26 Sat	27 Sun	28 Mon	29 Tue	30 Wed	31 Thu
1 TABLET(S) BY MOUTH EVERY NIGHT AT BEDTIME QHS-RUR Req Start: 2/19/2022 Req End: 2/18/2023 Quantity per Dose: 1.00 Prescriber: Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Details						
Date	**Shift**	**Med Administered**	**Medication/Order**	**Reason**	**Comments**	**User**
03-01-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
03-01-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	IBLACKWELL
03-01-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
03-01-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	ASTERLING
03-01-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	ASTERLING
03-02-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
03-02-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SREYNOLDS
03-02-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
03-02-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
03-02-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	TATHOMPSON
03-03-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
03-03-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBYRD
03-03-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD
03-03-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
03-03-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	EJAMES
03-04-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
03-04-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SREYNOLDS
03-04-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
03-04-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MIMCGOWAN
03-04-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	MIMCGOWAN
03-05-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
03-05-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	IBLACKWELL
03-05-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
03-05-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	CBENNETT
03-05-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	CBENNETT
03-06-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
03-06-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBYRD
03-06-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD
03-06-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	ASTERLING
03-06-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	ASTERLING
03-07-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
03-07-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	IBLACKWELL
03-07-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
03-07-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
03-07-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBURRIS
03-08-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
03-08-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SREYNOLDS
03-08-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
03-08-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
03-08-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	TATHOMPSON
03-09-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
03-09-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SREYNOLDS
03-09-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
03-09-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MIMCGOWAN
03-09-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	MIMCGOWAN
03-10-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
03-10-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBYRD
03-10-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD
03-10-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	CBENNETT
03-10-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	CBENNETT
03-11-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
03-11-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBYRD
03-11-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD

Details						
Date	Shift	Med Administered	Medication/Order	Reason	Comments	User
03-11-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
03-11-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	EJAMES
03-12-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
03-12-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBURRIS
03-12-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBURRIS
03-12-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
03-12-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBURRIS
03-13-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
03-13-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SREYNOLDS
03-13-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
03-13-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
03-13-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	TATHOMPSON
03-14-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
03-14-2022	8 - BEDTIME	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	IBLACKWELL
03-14-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
03-14-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	ASTERLING
03-14-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	ASTERLING
03-15-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
03-15-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	IBLACKWELL
03-15-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
03-15-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MIMCGOWAN
03-15-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	MIMCGOWAN
03-16-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
03-16-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SREYNOLDS
03-16-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
03-16-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
03-16-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	EJAMES
03-17-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
03-17-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBYRD
03-17-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD
03-17-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
03-17-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBURRIS
03-18-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
03-18-2022	8 - BEDTIME	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	EJAMES
03-18-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	EJAMES
03-18-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	CBENNETT
03-18-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	CBENNETT
03-19-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
03-19-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SREYNOLDS
03-19-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
03-19-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	ASTERLING
03-19-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	ASTERLING
03-20-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	CBENNETT
03-20-2022	8 - BEDTIME	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	CBENNETT
03-20-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	CBENNETT
03-20-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MIMCGOWAN
03-20-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	MIMCGOWAN
03-21-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
03-21-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBURRIS
03-21-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBURRIS
03-21-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
03-21-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	TATHOMPSON
03-22-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
03-22-2022	8 - BEDTIME	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	SREYNOLDS
03-22-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
03-22-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	FHALL
03-22-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	FHALL
03-23-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
03-23-2022	8 - BEDTIME	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	SREYNOLDS
03-23-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
03-23-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	CBENNETT
03-23-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	CBENNETT
03-24-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
03-24-2022	8 - BEDTIME	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	SBYRD
03-24-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD
03-24-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	ASTERLING
03-24-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	ASTERLING
03-25-2022						

Details						
Date	**Shift**	**Med Administered**	**Medication/Order**	**Reason**	**Comments**	**User**
	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
03-25-2022	8 - BEDTIME	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	SREYNOLDS
03-25-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
03-25-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
03-25-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBURRIS
03-26-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
03-26-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	SBURRIS
03-26-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBURRIS
03-26-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
03-26-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	TATHOMPSON
03-27-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
03-27-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	EJAMES
03-27-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	EJAMES
03-27-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MELHALL
03-27-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	MELHALL
03-28-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
03-28-2022	8 - BEDTIME	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	IBLACKWELL
03-28-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
03-28-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MIMCGOWAN
03-28-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	MIMCGOWAN
03-29-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
03-29-2022	8 - BEDTIME	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	IBLACKWELL
03-29-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
03-29-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	CBENNETT
03-29-2022	3 - MORNING	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	CBENNETT
03-30-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
03-30-2022	8 - BEDTIME	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	SREYNOLDS
03-30-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
03-30-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
03-30-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	EJAMES
03-30-2022	3 - MORNING	YES	One Time Weight Check	NA	NA	KWARD
03-31-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
03-31-2022	8 - BEDTIME	NO	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	Patient refused	NA	IBLACKWELL
03-31-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
03-31-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
03-31-2022	3 - MORNING	YES	OXCARBAZEPINE (TRILEPTAL) 300MG, #730	NA	NA	TATHOMPSON

Legend									
White	Outside Prescription/Order's start and end date	Green	Dose/Treatment was administered	Red	Dose/Treatment was NOT administered	Blue	Future Dose/Treatment to be administered	Yellow	Missed Dose/Treatment
Purple	Treat ONCE during this time	Silver	Dose/Treatment is NOT to be administered	Orange	PRN - Dispense/Treat as needed	Pink	Dose previously dispensed (KOP)		
Yes	YES	No	NO	Kop	KOP	M	MISSED	R	REVOKED
IC	IN CELL	MP	MED PASS	T	TARGET				



CARTER, JEVON KENNETH, #318696 @ SOL
Male, 21 years old, DOB 9/14/2001
Allergies: NKDA
Current Problems:

2022-05	01 Sun	02 Mon	03 Tue	04 Wed	05 Thu	06 Fri	07 Sat	08 Sun	09 Mon	10 Tue	11 Wed	12 Thu	13 Fri	14 Sat	15 Sun	16 Mon	17 Tue	18 Wed	19 Thu	20 Fri	21 Sat	22 Sun	23 Mon	24 Tue	25 Wed	26 Thu	27 Fri	28 Sat	29 Sun	30 Mon	31 Tue
3 - MORNING ARIPIPRAZOLE (ABILIFY) 10MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Req Start: 6/20/2021 Req End: 6/19/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3 - MORNING OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Req Start: 4/5/2022 Req End: 4/5/2023 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8 - BEDTIME ARIPIPRAZOLE (ABILIFY) 10MG, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Req Start: 6/20/2021 Req End: 6/19/2022 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8 - BEDTIME OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730 TAKE ONE TABLET(S) BY MOUTH TWICE DAILY BID- RUR Req Start: 4/5/2022 Req End: 4/5/2023 Quantity per Dose:1.00 Prescriber:Martin, Ernest	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8 - BEDTIME TRAZODONE HCL 150MG, #365 TAKE 1 TABLET(S) BY MOUTH EVERY NIGHT AT BEDTIME QHS- RUR Req Start: 2/19/2022 Req End: 2/18/2023 Quantity per	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

2022-05	01 Sun	02 Mon	03 Tue	04 Wed	05 Thu	06 Fri	07 Sat	08 Sun	09 Mon	10 Tue	11 Wed	12 Thu	13 Fri	14 Sat	15 Sun	16 Mon	17 Tue	18 Wed	19 Thu	20 Fri	21 Sat	22 Sun	23 Mon	24 Tue	25 Wed	26 Thu	27 Fri	28 Sat	29 Sun	30 Mon	31 Tue
Dose:1.00 Prescriber:Martin, Ernest																															

Details						
Date	**Shift**	**Med Administered**	**Medication/Order**	**Reason**	**Comments**	**User**
05-01-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
05-01-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
05-01-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
05-01-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LATPITTS
05-01-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LATPITTS
05-02-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
05-02-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
05-02-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	IBLACKWELL
05-02-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	KDERBY
05-02-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	KDERBY
05-03-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
05-03-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
05-03-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	IBLACKWELL
05-03-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MELHALL
05-03-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	MELHALL
05-04-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
05-04-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
05-04-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
05-04-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	JHYATT
05-04-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	JHYATT
05-05-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
05-05-2022	8 - BEDTIME	YES	TRAZODONE HCL 150 MG, #365	NA	NA	SBYRD
05-05-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBYRD
05-05-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	JHYATT
05-05-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	JHYATT
05-06-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
05-06-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
05-06-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET(TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
05-06-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
05-06-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBURRIS
05-07-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
05-07-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	EJAMES
05-07-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EJAMES
05-07-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	BKELLETT
05-07-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	BKELLETT
05-08-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
05-08-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	EJAMES
05-08-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EJAMES
05-08-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MELHALL
05-08-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	MELHALL
05-09-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
05-09-2022	8 - BEDTIME	YES	TRAZODONE HCL 150 MG, #365	NA	NA	SREYNOLDS
05-09-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
05-09-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
05-09-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	TATHOMPSON
05-10-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
05-10-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
05-10-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
05-10-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	DEVGRIFFIN
05-10-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	DEVGRIFFIN
05-11-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LISTRICKLA
05-11-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	LISTRICKLA
05-11-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LISTRICKLA
05-11-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LISTRICKLA
05-11-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LISTRICKLA
05-12-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
05-12-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD
05-12-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBYRD
05-12-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	BKELLETT
05-12-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	BKELLETT

Details						
Date	Shift	Med Administered	Medication/Order	Reason	Comments	User
05-13-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
05-13-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	EJAMES
05-13-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EJAMES
05-13-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
05-13-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EJAMES
05-14-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
05-14-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
05-14-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
05-14-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	KDERBY
05-14-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	KDERBY
05-15-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
05-15-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
05-15-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
05-15-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	KDERBY
05-15-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	KDERBY
05-16-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
05-16-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
05-16-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	IBLACKWELL
05-16-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MELHALL
05-16-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	MELHALL
05-17-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
05-17-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
05-17-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	IBLACKWELL
05-17-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
05-17-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBURRIS
05-18-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
05-18-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
05-18-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
05-18-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	CHRPHIPPS
05-18-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	CHRPHIPPS
05-19-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
05-19-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	EJAMES
05-19-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EJAMES
05-19-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	EJAMES
05-19-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	EJAMES
05-20-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
05-20-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
05-20-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
05-20-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
05-20-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBURRIS
05-21-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
05-21-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
05-21-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
05-21-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LISTRICKLA
05-21-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LISTRICKLA
05-22-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
05-22-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
05-22-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
05-22-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	BKELLETT
05-22-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	BKELLETT
05-23-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
05-23-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
05-23-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	IBLACKWELL
05-23-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
05-23-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	TATHOMPSON
05-24-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
05-24-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
05-24-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
05-24-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	DEVGRIFFIN
05-24-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	DEVGRIFFIN
05-25-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
05-25-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
05-25-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
05-25-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	MELHALL
05-25-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	MELHALL
05-26-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
05-26-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
05-26-2022						

Details						
Date	**Shift**	**Med Administered**	**Medication/Order**	**Reason**	**Comments**	**User**
	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	IBLACKWELL
05-26-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBURRIS
05-26-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBURRIS
05-27-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
05-27-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
05-27-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
05-27-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	ROWHITMIRE
05-27-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	ROWHITMIRE
05-28-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
05-28-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
05-28-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
05-28-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	CBRIGGS
05-28-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	CBRIGGS
05-29-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SREYNOLDS
05-29-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SREYNOLDS
05-29-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SREYNOLDS
05-29-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	TATHOMPSON
05-29-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	TATHOMPSON
05-30-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	IBLACKWELL
05-30-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	IBLACKWELL
05-30-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	IBLACKWELL
05-30-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	LISTRICKLA
05-30-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	LISTRICKLA
05-31-2022	8 - BEDTIME	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	SBYRD
05-31-2022	8 - BEDTIME	YES	TRAZODONE HCL 150MG, #365	NA	NA	SBYRD
05-31-2022	8 - BEDTIME	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	SBYRD
05-31-2022	3 - MORNING	YES	ARIPIPRAZOLE (ABILIFY) 10MG, #730	NA	NA	BKELLETT
05-31-2022	3 - MORNING	YES	OXCARBAZEPINE 150 MG TABLET (TRILEPTAL) 150 MG TAB, #730	NA	NA	BKELLETT

Legend									
White	Outside Prescription/Order's start and end date	Green	Dose/Treatment was administered	Red	Dose/Treatment was NOT administered	Blue	Future Dose/Treatment to be administered	Yellow	Missed Dose/Treatment
Purple	Treat ONCE during this time	Silver	Dose/Treatment is NOT to be administered	Orange	PRN - Dispense/Treat as needed	Pink	Dose previously dispensed (KOP)		
Yes	YES	No	NO	Kop	KOP	M	MISSED	R	REVOKED
IC	IN CELL	MP	MED PASS	T	TARGET				

Encounter				06-06-2022 03:45 PM
CARTER, JEVON KENNETH	**Pack# 318696**	**Gender: Male**		**DOB 09-14-2001**
Dictation:	MENTAL HEALTH PROGRESS NOTE: Date/Time: 06-06-2022 Mon / 1400 Name: JEVON KENNETH CARTER Pack: 318696 DOB: 09-14-2001 Gender: Male Race: B Method of Contact: follow-up Location Seen: 4A S: Counselor meets with Mr. Carter for the first time in 4A. Mr. Carter reports his medications are working and says, "I'm going to Columbia for four to six months and then I will get out." Counselor encourages him to be compliant with the facility where he is going. He says, "I will. I want to get out." Counselor asks if there is anything he would like to discuss and he says, "No, I'm good." O: Oriented X4 and reports no AVH. He denies SI/HI/SIB thoughts, plans, or intent. Presents being alert, responsive, and cooperative. A: Stable P: Will see inmate per GCDC policy. Electronically Approved by Thomas Martin on 06-06-2022 03:50:07 PM.			
Vitals:				
Condition Related To:	Other Accident			
Dates:	Current Illness Date: 1st Date Of Illness: Unable To Work Dates: Hospitalization Dates:			
Diagnosis:				
Procedures:				
Providers:	Attending Provider: Lutz, Marty, MD, Greenville County Detention Center ID:			
Facility:	Greenville County Detention Center			
Encounter Type:	Mental Heath Progress Note			
Sign Off:	Signed Off By: THOMARTIN on: 2022-06-06 Mon 03:50 PM			

State of South Carolina
Department of Mental Health

MENTAL HEALTH COMMISSION:
L. Gregory Pearce, Jr., Chair
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Bob Hiott

STATE DIRECTOR
Kenneth N. Rogers, MD

Division of Inpatient Services
Forensic Evaluation and Outpatient Services
7901 Farrow Road, Building #6
Columbia, SC 29203
Information: (803) 935-5600

October 15, 2021

Joe Brewer
Attorney at Law
650 E. Washington Street
Greenville, SC 29601

Re: The State of South Carolina vs. Carter, Jevon
DMH Case #: 1052-3276
Greenville County, Court of General Sessions

Dear Attorney Brewer:

In accordance with the court order issued by the Honorable Edward W. Miller, evaluations of criminal responsibility and capacity to conform were conducted by the South Carolina Department of Mental Health (SCDMH) pursuant to S.C. Code Ann. § 17-24-10 (1976) and § 17-24-20 (1976).

Please see the attached report for the results of this evaluation.

This **11**-page document is certified to be the original court-ordered evaluation report issued pursuant to S.C. Code Ann. § 17-24-10 (1976) and § 17-24-20 (1976).

10-15-2021
Date

Donna Jones for
Kelly Gothard, Ph.D.
Director
Forensic Outpatient Services
Department of Mental Health

KG/dj

CRIMINAL RESPONSIBILITY AND CAPACITY TO CONFORM EVALUATION
FORENSIC EVALUATION SERVICE
SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH (SCDMH)

DATE OF EVALUATION:	October 4, 2021
NAME:	Jevon Carter
SCDMH #:	1052-3276
PRESIDING EXAMINER:	Stephanie M. Le, MD Forensic Psychiatrist
SECOND EXAMINER:	Elizabeth Dawn Whetstone, LISW-CP SCDMH Social Worker
PSYCHIATRIC DIAGNOSIS:	Schizoaffective Disorder, Bipolar Type

OPINION REGARDING CRIMINAL RESPONSIBILITY

Mr. Jevon Carter would not have been criminally responsible on or about July 4, 2020.

DISPOSITION

Mr. Carter returned to the Greenville County Detention Center upon conclusion of the evaluation.

IDENTIFYING INFORMATION

Mr. Jevon Carter is a 20-year-old African American male who was seen at the Forensic Evaluation Service pursuant to a court order from the Greenville County Court of General Sessions. This court order requested an evaluation of the defendant's criminal responsibility for his actions on or about July 4, 2020, and if responsible, a determination of his capacity to conform his conduct to the requirements of the law pursuant to S.C. Code Ann. §17-24-10 (1976). The defendant is currently charged with Murder, Burglary, and Possession of a weapon during the commission of a violent crime. According to the court order, this request was issued for the following reason: "At the time of the incident at issue in this case, July 4, 2020, the defendant had been admitted to Marshall Pickens Hospital. There is reason to believe that he was suffering severe mental health issues when he escaped from that facility on that same date. The basis for that view includes, but is not limited to, (1) a family history of mental health issues; (2) the Defendant's inpatient admission to Marshall Pickens Hospital during the relevant timeframe; (3) the evaluations, records, and diagnoses from Marshall Pickens; (4) the Defendant's mental health and behavior on the date of the murder at issue in this case; (5) the Defendant's two escapes from Marshall Pickens during the relevant timeframe; (6) the tragic death of

the Defendant's girlfriend prior to his admittance to Marshall Pickens; and (7) the subsequent evaluations of other physicians."

STATEMENT OF NONCONFIDENTIALITY

Prior to participating in the examination, Mr. Carter was warned regarding the limitation of confidentiality. He was informed that this evaluation was court ordered. He was informed that the evaluators were employed by the South Carolina Department of Mental Health and were not being paid by his attorney or the solicitor in his case. He was informed that after the evaluation was completed a report would be submitted to his attorney. He was also informed that a report might be submitted to the solicitor and the judge in his case. Finally, he was informed that the evaluators could be called to court to testify at a hearing related to his criminal responsibility and his capacity to conform his behavior. He was able to answer questions regarding this information correctly, and he voluntarily agreed to participate in the evaluation.

SOURCES OF INFORMATION

1. An order from the Greenville County Court of General Sessions requesting this evaluation dated July 20, 2021.
2. Arrest warrant 2020A2320602678 for Murder/Murder, offense dated July 5, 2020.
3. Arrest warrant 2020A2320602680 for Weapons/Poss. weapon during violent crime, if not also sentenced to life without parole or death, offense dated July 5, 2020.
4. Arrest warrant 2020A2320602679 for Burglary/Burglary (After June 20, 1985) – 1st degree, offense dated July 5, 2020.
5. Greenville City Police Department Incident Report dated July 5, 2020
    a. Supplemental Report dated July 5, 2020 and July 6, 2020
    b. Greenville Police Department Crime Scene Entry Log
    c. Statement by Ms. Tiffany (last name was illegible)
    d. Greenville City Forensic Division Crime Scene Investigation Report, Case #2-20-041211
        i. Supplemental Report dated September 8, 2020
        ii. Search warrants, affidavits, and returns
        iii. County of Greenville DNA Lab Report
        iv. Recorded police interview with the defendant dated August 28, 2020
        v. Three-year driver's record for the defendant
        vi. Pictures of the defendant and his friends
        vii. Letters of support
6. Greenville Health Authority Police Incident Report dated July 3, 2020; July 4, 2020; and July 8, 2020.
    a. Incident Reports Supplemental
7. Greenville County Coroner's Office report dated July 5, 2020.
8. National Crime Information Center (NCIC) report for the defendant dated September 17, 2020.

9. Psychiatric evaluation for bond release by Dr. Donna Maddox, MD dated June 2, 2021.
10. Medical records from Prisma Health Greenville dated February 9, 2020 to July 29, 2020.
11. Medical records from the Greenville County Detention Center dated September 4, 2020 to September 2, 2021.
12. Medical records from the Greenville Mental Health Center (MHC) dated July 1, 2020 to August 14, 2020.
13. Medical records from Marshal I. Pickens Psychiatric Hospital dated July 3, 2020 to July 22, 2020.
14. Wade Hampton High School transcript for the defendant
15. SCDMH Episodes of Care form
16. Telephone interview with Mr. Joe Brewer, Esq. on October 1, 2021
17. Telephone interview with Ms. Marie Livingston, Greenville County Detention Center Mental Health Liaison on October 4, 2021
18. SCDMH Forensic Evaluation Service social work assessment conducted by Ms. Elizabeth Dawn Whetstone, LISW-CP on September 8, 2021 with information gathered from the defendant's grandmother, Ms. Cynthia Chapman.
19. An approximately one-and-a-half-hour clinical forensic interview conducted on October 4, 2021.

We reserve the right to alter our opinion should further information become available.

CLINICAL AND PSYCHIATRIC HISTORY

Mr. Carter was transported to the evaluation center by detention center officers. He reported he is housed in "four A," the unit for inmates with mental illness. He stated, "I'm doing great, just bored...I stick to myself." He described a typical day of watching television, reading the Bible, talking to family on the phone, and working out during recreation time. He described his mood as "stable." The defendant reported he is prescribed aripiprazole (Abilify®, an antipsychotic) and trazodone (Desyrel®, for sleep).

He expressed grief over the deaths of his father and girlfriend and stated he would like to be with his family. He denied he experienced depressed mood, suicidal or homicidal ideations. Additionally, he denied a history of suicide attempts. He reported he sleeps about eight hours each night. He described an adequate appetite and energy level.

He reported he experienced episodes in the past where he "wasn't sleeping very well" and had "headaches and stuff." He felt his mood was "fine" but he recalls that he did not want to be around his family. He stated he heard the "voice of God" in the summer of 2020. While he did not remember all of the statements, he reported most of the voices were talking about him being "special" and "going to Heaven." Mr. Carter reported he also believed he had a football scholarship to Clemson around that time. He stated the voices told him to go to Clemson to find out about his offer, because he believed his high school football coaches were hiding it from him. He recalls being arrested outside of the house of the president of Clemson. He also held the belief that he could read other

people's thoughts. When he saw numbers on license plates, he thought they were messages from his dead girlfriend. While he was in the hospital in July 2020, he thought that the staff were vampires trying to take his blood for its' "healing powers." He accused his inpatient psychiatrist of trying to keep him from going to Clemson by hiding his offer letter. The voices also told him that he did not need help and to escape the hospital.

The defendant reported his admission to Marshal I. Pickens Psychiatric Hospital (MIP) was his first episode of psychiatric treatment. After he was discharged from the hospital, he followed up with the Greenville MHC where he received aripiprazole decanoate (Abilify Maintena®, a long-acting injectable antipsychotic).

His grandmother reported he had a "nervous breakdown" after his girlfriend died. She stated he was admitted to MIP for treatment. She described him as "acting strange" around that time.

REVIEW OF AVAILABLE RECORDS

According to records from Prisma Greenville, including MIP, Mr. Carter presented to the emergency department (ED) on February 9, 2020 with altered mental status after he took "shrooms." He started preaching to a friend about God, had trouble sleeping, and then got into an altercation with police officers. He was discharged from the ED after his "anxiety" resolved.

He was brought into the ED on July 2, 2020 by police officers. He presented as agitated, paranoid, and delusional. He told staff that his "high school" hid his acceptance letter from Clemson to play football. He was administered risperidone (Risperdal®, an antipsychotic) and lorazepam (Ativan®, a sedative-hypnotic) due to his agitation. Staff observed him "actively responding to internal distractions." He was seen looking at his hands and laughing. He repeatedly stated he had an offer for a scholarship to play football at Clemson, and it was being hidden from him. He reported he had not slept in a week, because he was "up talking with God." He described increased energy and an "excited" mood. He stated, "Numbers have a special meaning for me…that's how Christ and I communicate…everything happens for a reason…everything is programmed in this life." He made paranoid statements about heroin being in cigarettes and "HIV in orange juice." While he was cooperative with the consult psychiatrist, he had a tangential thought process and "flight of ideas." His concentration was impaired and he had poor impulse control. It was recommended that he be admitted for inpatient psychiatric treatment.

Mr. Carter was admitted to MIP on July 3, 2020. He divulged he went to Clemson to talk to Coach Sweeney because he thought people were hiding his offer letter and ACT scores. He stated he was "Ezekiel because I am a disciple, the right hand of Jesus Christ." He reported he proved this by licking the floor of the detention center. This was proof because the floor had "flesh-eating bacteria" on it. He expressed fear that the staff at MIP were trying to harm him. The defendant stated, "I am here because they want my blood…I am an angelic demon." He was calm and cooperative during the initial evaluation but became tearful when told he was being admitted for psychosis. He displayed

pressured speech, talkativeness, grandiosity, flight of ideas, and paranoia. Later that day, he was placed in seclusion after he became increasingly paranoid. He expressed a belief that the staff were injecting HIV into patients' "blood" and "eyeballs." Mr. Carter demanded to leave and jumped over the nurse's station split door and tried to grab his cell phone. When security approached to escort him out, he barricaded the door to his room and tried to bust out the window to escape. Staff tried to calm him verbally but he continued to escalate, stating they were trying to poison him.

On the following day (July 4th), he walked past the nurse's station and out of an open door to the patio area (used for patient recreation). He scaled the fence surrounding the area and left the premises.

He presented to the Prisma Greenville ED on July 5, 2020 with complaints of being "lightheaded" and that he had "passed out." After medical workup in the ED, he was returned to MIP where he was irritable and demanding. He told staff that his "adoptive mother, Karen" had signed paperwork to have him released from the hospital. Although he denied auditory and visual hallucinations, staff reported he was "obviously responding" to internal distractions. He was frequently seen laughing and smiling inappropriately. On July 6th, he told nursing staff that he saw a demon in his room. He was seen pacing on July 7th and attempted to escape again by trying to bust out his bedroom window. He successfully eloped on July 8th when he forced his body through a glass door.

After he eloped, he went to his father's house. His father called law enforcement to pick him up and take him to the hospital. He was returned to Prisma Greenville ED later in the day on July 8th. While in the ED, he continued to make paranoid statements about his family trying to "take money" from him. He was described as paranoid, delusional, tangential, and responding to internal distractions. He was subsequently sent back to MIP.

When he returned to MIP on July 9th, he was ordered to be observed with one-to-one staff monitoring due to his high risk for elopement. He had a flat affect and was seen smiling inappropriately. He was whispering as if he were talking to someone else. He remained agitated and demanding for several days. He paced the halls and was overheard telling a peer that he was going to try to escape again. Nursing notes record his poor insight and poor compliance with medications. It was noted that when he would ingest the medications, he immediately went to his room to regurgitate them in the toilet. He remained isolative for several more days. Although he would lie in his bed, staff noted he usually was unable to sleep.

By July 18th, he began to interact more with the staff and his peers. He took his medications as prescribed but continued to struggle with insomnia. His difficulties with sleep continued up until his discharge, but he was otherwise described as stable. At the time is discharge, he was prescribed lithium (Lithobid®, a mood stabilizer) and aripiprazole decanoate (Abilify Maintena®, a long-acting injectable antipsychotic). His discharge diagnosis was Bipolar I Disorder, with mood congruent psychotic features.

He presented to the Prisma Greenville ED again on July 27, 2020 with altered mental status. He was pulled over by police after being found driving erratically. He admitted to cannabis use. The officers witnessed him experience a seizure and called EMS for him to be transported to the ED. He was no longer seizing when he reached the ED but was still experiencing some residual symptoms (i.e. he was in a post-ictal state, with vertical nystagmus, and non-responsive to verbal stimuli). He was admitted to the hospital for observation and treatment. His CT scan was negative for an acute intracranial process. He was administered intravenous fluids and antibiotics. His symptoms had resolved by the 29th and he was discharged to home. The etiology of his illness was unknown at the time of his discharge.

According to records from the Greenville County Detention Center (GCDC), he is prescribed aripiprazole (an antipsychotic), olanzapine (Zyprexa®, an antipsychotic), oxcarbazepine (Trileptal®, a mood stabilizer), and trazodone (for sleep). On September 4, 2020, he reported his mood was depressed. He admitted to paranoid and racing thoughts. Mid-October 2020, he continued to report auditory hallucinations from God telling him scripture and that he was going to be famous. His mental health notes from 2021 describe him as stable and doing well.

According to records from the Greenville MHC, he was seen for an initial assessment on July 24, 2020. Mr. Carter was fixated on getting a prescription for a stimulant medication, as he thought he had Attention Deficit/Hyperactivity Disorder (ADHD).

ALCOHOL AND SUBSTANCE USE HISTORY

Mr. Carter reported he tried alcohol when he was "young" but "didn't really like it." He reported he started smoking cannabis when he was 17 years old and smoked "one blunt" daily. He denied he has problems associated with his use. He stated he "was just bored and used." He denied a history of tobacco use, other illicit drug use, or substance abuse treatment.

MEDICAL HISTORY

He reported he has a history of a concussion. He reported he fell backwards while doing box jumps in the high school weight room and hit his head. He was examined by the athletic director, and had subsequent follow ups to monitor his progress.

He denied a history of other serious or chronic physical conditions. He denied a history of seizure or stroke; however, medical records indicate he had a seizure in July 2020.

FAMILY HISTORY

The defendant's mother, Ms. Keshawna Young receives disability benefits for physical and mental health. She has a diagnosis of Bipolar Disorder. She also has paralysis of her left arm. His father, Mr. Kenneth Carter was a painter. He committed suicide

approximately one year ago. The defendant was not aware of substance abuse problems in his family.

SOCIAL HISTORY

Mr. Carter reported he was born in Greenville, South Carolina and raised by his mother and maternal grandmother. He described his childhood as "pretty stable…a pretty normal life." He reported he has one younger brother. He denied a history of abuse, but admitted he was removed from his mother's custody by DSS. He reported he witnessed domestic violence. He stated, "My dad beat my mother and that's how she got paralyzed."

He reported he graduated from Wade Hampton High School in 2020. He was an honor student. He reported he was suspended from school once after one of his friends brought alcohol to school, and they all partook in drinking it. He did not engage in other disruptive behaviors in school and was on the high school football team. Mr. Carter reported he set fire to a playground when he was elementary school aged, but he denied other behaviors associated with a diagnosis of Conduct Disorder.

The defendant reported he worked while he was a high school student. He stated he worked at Sears as a cashier, at a car wash, and in a local hospital doing patient transport. He denied he had problems with his employers. He was accepted into a "Bridges Program" after high school, where he was going to attend Tri County Technical College for one year and then transfer to Clemson University.

He denied he has been married or has children. At the time of his arrest, he and his mother were moving from her home to his grandmother's house.

He stated he has past arrests for Trespassing and Simple Possession.

According to the defendant's maternal grandmother, he was raised by her and his biological mother. She stated he was removed from his mother's home twice by DSS and placed in her custody. She described his childhood as difficult as his father frequently verbally abused him (e.g. telling him that his mother should have had an abortion). She confirmed that he witnessed his father abusing his mother, causing paralysis in her left arm. She stated he was close to both of his parents, despite the abuse from his father.

She reported his father died by suicide while the defendant was incarcerated. She stated his mother had a mental "breakdown" in the past and is treated for mental illness.

She reported he was a good student and planned to go to college after high school. She stated he quit his jobs so that he could focus on school.

MENTAL STATUS EXAMINATION

Mr. Carter presented to the evaluation appropriately dressed in detention center attire. He was well groomed with appropriate hygiene. He made good eye contact. No

abnormal movements were noted. His speech was fluent and clear with normal volume when he spoke. He had a linear and goal-directed thought process. He was cooperative with the evaluation and answered questions appropriately. He was alert and oriented to person, place, time, and situation. He had an average fund of knowledge. He was able to name the current US president and three immediate past presidents. He was able to perform a simple calculation. The defendant was able to repeat three words presented to him and recall all three after a period of distraction. He was able to recall significant past personal information and we find no evidence of clinically significant long- or short-term memory impairment.

Mr. Carter performed well on a test of concentration. He was able to place similar objects into abstract categories and interpret common idioms. His judgement to a hypothetical situation was fair. If he were in a crowded theater and smelled smoke, he would "walk out and see what's going on." The defendant described his mood as "stable...pretty good," and he was observed to have a euthymic (normal) affect (observed expression of mood). He denied current suicidal or homicidal ideations. He denied current auditory or visual hallucinations, and he did not appear to be responding to internal distractions. He did not voice fixed, false beliefs (i.e. delusions).

DIAGNOSTIC IMPRESSION

The defendant has had an approximately one-year history of symptoms of reduced need for sleep, grandiose delusions, rapid speech, fluctuating mood (e.g. irritability to elation), flight of ideas, and increased goal-directed activity. These symptoms are consistent with a manic episode. Although he was using cannabis around that time, cannabis does not commonly cause side effects that are similar to mania. Additionally, he experienced auditory hallucinations, paranoid ideation, and was witnessed responding to internal distractions. These symptoms are consistent with psychosis. His symptoms of mood disorder and psychosis resulted in a need for inpatient psychiatric treatment and a severe decline in his functioning. Since he continued to experience symptoms of psychosis well beyond his mood episode (i.e. mania), he meets criteria for Schizoaffective Disorder, Bipolar Type.

THE ALLEGED INCIDENTS

According to Mr. Carter, he started hearing voices in June 2020. He recalls them telling him that he got a scholarship to Clemson, and that he was going to be rich and famous. After hearing this, he told his boss that he got a scholarship and thus decided to quit his job. He recalls going to Clemson and getting arrested for trespassing on the school president's lawn. He reported he spent a lot of his time walking around the Clemson campus expecting football players to arrive and talk to him. He was hearing voices that he thought were God and Clemson football team members, and these voices were telling him to go to the Clemson campus to find out about his scholarship. Mr. Carter had distanced himself from his family around this time. He believed they were out to get him and harming his little brother. He denied he had thoughts about "Aunt Fran." When asked about his sleep, he stated, "I'm pretty sure I was sleeping fine, but I had really bad

headaches and couldn't concentrate." He felt that his energy was "pretty good" because he spent a lot of time walking around his neighborhood and the Clemson campus. He had a poor appetite and was not eating regularly. He denied he used alcohol but was smoking cannabis daily.

His memory of being admitted to MIP was poor. He recalled going to the ED after he was picked up for trespassing. He remembers a voice telling him that he "shouldn't be there." It also told him that the staff were drinking his blood (after labs were performed). When he was transported to MIP via wheelchair, he had a realization that all Clemson football players had to go through a similar experience before going to college. So, he thought the players and Dabo Sweeney were going to show up and take him from the hospital. This soon changed as he got an overwhelming feeling that he should not be in the hospital and decided to "jump over the fence." He stated, "I get a little mixed up with the first and second time." This quote is discussing his first and second elopement. He described going to his father's house both times and police officers taking him back to MIP. He could not recall exactly what the voices were telling him when he left the hospital. He does not remember exactly how he got to his father's house but knows he walked. He did not recall going to his aunt's house.

After his second elopement and return, he began to engage in consistent treatment, Mr. Carter decided to "try to enjoy myself, because that was the way to go home." At the time of his discharge, he was still hearing voices of Clemson football players telling him "everything will be fine." He also heard voices of "angels" telling him he would be "rich and famous." He was feeling less paranoid about his family and agreed to live with his grandmother.

He noted he was having difficulty sleeping when he was in the hospital and even after his discharge. He denied he had thoughts to harm himself or others.

According to the defendant's account, he was experiencing symptoms of mania and psychosis around the time of the alleged incidents. A review of available medical records and a video police interview reveals evidence of the presence of paranoia, delusional thinking (i.e. fixed, false beliefs), auditory and visual hallucinations. The police interview recorded him laughing and smiling inappropriately and looking around the room. He attempted to mask this when officers were present but these symptoms presented when he was left alone, which is consistent with psychosis (i.e. responding to internal distractions) and likely not feigning, as he tried to conceal his symptoms. Between June and August 2020, he was experiencing command hallucinations and acting on those commands. He thought he was being instructed by the voice of God or angels. He was fearful of hospital staff and his family, whom he thought were out to get him.

CONCLUSION REGARDING CRIMINAL RESPONSIBILITY

S.C. Code § 17-24-10(A) states an individual may be found **not guilty by reason of insanity** if "*at the time of the commission of the act constituting the offense, the defendant, as a result of mental disease or defect, lacked the capacity to distinguish moral*

or legal right from moral or legal wrong or to recognize the particular act charged as morally or legally wrong."

We find sufficient evidence that the defendant has a serious mental illness that would have substantially impaired his ability to distinguish legal or moral right from legal or moral wrong. Mr. Carter related the symptoms of his mental illness to his thinking and actions around that time. His thoughts and behaviors were disorganized. He was actively manic and following commands made by auditory hallucinations. He was also experiencing delusions that made him in fear for his life and safety. Therefore, it is our opinion that he would not have been criminally responsible pursuant to S.C. Code Ann. § 17-24-10 (1976).

10.13.21

Stephanie M. Le, MD
Forensic Psychiatrist

VIOLENCE RISK ASSESSMENT
DIVISION OF FORENSIC PSYCHIATRY
DEPARTMENT OF NEUROPSYCHIATRY AND BEHAVIORAL SCIENCE
UNIVERSITY OF SOUTH CAROLINA SCHOOL OF MEDICINE

DATES OF EVALUATION: April 12, 2023 and April 24, 2023

NAME: Jevon Kenneth Carter

SCDMH #: 1052-3276

DATE OF BIRTH: September 14, 2001

PRESIDING EXAMINER: Richard L. Frierson, M.D., DLFAPA
Alexander G. Donald Professor of Psychiatry
University of South Carolina School of Medicine

REASON FOR REFERRAL

Jevon Kenneth Carter is a 21-year-old African-American male who is referred by Bryan Psychiatric Hospital – Forensic Inpatient Services for an independent violence risk assessment. He has been hospitalized since August 16, 2022 after being adjudicated Not Guilty by Reason of Insanity on charges of Voluntary Manslaughter, Possession of a Weapon During a Violent Crime, and Burglary – First Degree. These index offenses occurred on July 5, 2020 while the defendant was residing in Greenville County. He was evaluated by the South Carolina Department of Mental Health Forensic Evaluation Service on October 4, 2021 and a report was submitted to the court containing an opinion that Mr. Carter would not have been criminally responsible for his actions on or about July 5, 2020. He was adjudicated Not Guilty by Reason of Insanity on these charges on June 8, 2022.

SOURCES OF INFORMATION

1. Court Order signed by the Honorable Perry Gravely on June 8, 2022 containing a finding of Not Guilty by Reason of Insanity and ordering commitment for a period not to exceed 120 days.
2. Prior criminal responsibility and capacity to conform evaluation conducted at the South Carolina Department of Mental Health Forensic Evaluation Service on November 4, 2021.
3. Review of medical records from Prisma Health Greenville Memorial Hospital, dated February 9, 2020 and July 2, 2020.
4. Review of medical records from Marshall Pickens Psychiatric Hospital, dated July 3, 2020 through July 22, 2020.
5. Review of medical records from the Greenville County Mental Health Center.

6. Additional medical records from Prisma Health Greenville Memorial Emergency Department, dated July 27, 2020.
7. Review of medical records from the Greenville County Detention Center, dated September 4, 2020 through September 2, 2021.
8. Review of a high school transcript from Wade Hampton High School for Jevon Carter with a graduation of June 2020.
9. Interview with Jevon Carter by Greenville investigators on August 28, 2020 for two hours and 15 minute duration.
10. Arrest Warrant 2020A2320602678 for Murder.
11. Arrest Warrant 2020A2320602680 for Possession of a Weapon During a Violent Crime.
12. Arrest Warrant 2020A2320602679 for Burglary - First Degree.
13. Greenville City Police Department Incident Report and Supplemental Reports.
14. National Crime Information Center (NCIC) report for the defendant.
15. Psychiatric evaluation by Donna Maddox, MD, dated June 2, 2021.
16. A one-hour and 30-minute clinical forensic interview on April 12, 2023.
17. A one-hour clinical forensic interview on April 24, 2023.
18. Review of medical records from Bryan Psychiatric Hospital Forensic Services, dated August 16, 2022 to the present.

STATEMENT OF NONCONFIDENTIALITY

At the beginning of the evaluation, Mr. Carter was informed of the limitations of confidentiality. He was informed that the evaluator would not be providing psychiatric treatment. He was informed that the purpose of this evaluation was to provide an independent (of SCDMH) violence risk assessment. He was informed that the examiner was a Professor of Psychiatry at the University of South Carolina School of Medicine and that the evaluation was not confidential as it was requested by the Department of Mental Health. He was informed that a report would be submitted to the Department of Mental Health. He indicated that he understood the limitations of confidentiality and he voluntarily agreed to participate in the evaluation.

PERTINENT STATEMENTS REGARDING THE INDEX OFFENSE

Mr. Carter has no history of prior treatment for mental illness until around the time preceding his offenses.

On February 9, 2020, five months before his offenses, he was taken to the Prisma Health Greenville Memorial Emergency Department with a complaint of an altered mental state after he ingested some mushrooms. According to Mr. Carter, a friend from high school found out that mushrooms were available on social media. He reports that the friend obtained the mushrooms and they consumed them at Mr. Carter's house later that evening. He reports that they put on a movie to watch and religious material came up in the movie. He said that he went outside and "freaked out." He reports that he hit

his friend because he thought his friend was out to harm him. He reports that his friend told him to calm down and then called another friend. He reports that his mother was awakened and saw him, asked what he had taken, and then called an ambulance to transport him to the emergency department. They held him for observation, but let him go the next day. He had no further contact with mental health providers until July 2, 2020, approximately three days before the alleged offense.

He reports that during the intervening time he had finished high school. He reports that he had a major stressor which was the death of his long-term girlfriend, Nathalie Ospina, on May 2, 2020 when she died after falling at a local waterfall. He reports the night before they had been to a "makeshift" prom with about 30 people outside at a friend's house. He reported that he and his girlfriend had a good time and came home about 10:00 or 11:00 p.m. He stated that he woke up in the morning and found out that his girlfriend had gone hiking with another friend near a waterfall. He found out later that she had fallen to her death.

Approximately two weeks later he reports experiencing a sudden onset of auditory hallucinations at night. He reports that he had been up that night thinking about school and trying to become a walk-on to the football team at Clemson University. He had planned to enter The Bridge program in the fall (a program where people enter technical college for a year and then transfer into Clemson Unicersity). He reports that he heard the voices of Clemson football players telling him their name and who they were, and they told him to visit the school. He reports sometime in the middle of May he called a friend and told him what he had discovered. He reports that he then went to Clemson and walked on the field and tried to talk to the coaches. He reports that he talked to an athletic trainer who eventually contacted the campus police. They told him that he was trespassing and asked him to leave. Sometime after he graduated in the early part of June he reports that he heard voices telling him that he had an offer to play football at Clemson. He reports that he went back to Clemson another time to the president's house. He states that at the time he thought he was at Dabo Swinney's house. He reports that police were called, detained him, and brought him back to a holding cell and charged him with trespassing. He reports that his family came and picked him up.

By July 2, 2020 he was brought into the Prisma Health Greenville Memorial Hospital Emergency Department. He was described as agitated and delusional. He believed that his high school had hidden a Clemson football scholarship offer letter from him. He was hallucinating and responding to internal stimuli. He was looking at his hands and laughing. He is described as having increased energy and had not slept in one week. He reported that he was communicating with Christ through numbers which had a special meaning. He also claimed to have discovered that there was heroin in cigarettes and HIV in orange juice. It was recommended that he be admitted for psychiatric treatment.

He was admitted on July 3, 2020 to Marshall Pickens Psychiatric Hospital. On admission he claimed to be Ezekiel, the right hand of Christ. He was still focused on a Clemson football offer. He displayed pressured speech, grandiosity, and flight of ideas. He required seclusion because of agitation and he accused staff of injecting people's eyeballs with HIV. He barricaded himself in the room and tried to bust out a window. On July 4, he walked through an open door to a patient recreation area and then scaled the fence. He reports that on July 4, after he left the hospital, he walked to his father's house. He reports that he got into an argument with his father and the father told him he needed to go back to the hospital. He then left his father's house and walked to his aunt's house. He reports that he broke into her house because he believed she was a witch and was doing bad things to harm others. He also reported he believed that she had put a curse on him and was responsible for his girlfriend's death. He reported hearing voices telling him to break into her house. He reports once inside he heard command hallucinations telling him to take her life. He heard his uncle's voice telling him that she could touch people and make them drug addicted. He reported that the voice told him the only way he could be un-addicted was for Jevon to kill her. He reports that he stabbed her with a knife he found in the kitchen while she was sleeping. He reports that he walked to a friend's house, ate some food, and took a shower and passed out.

He woke up in Prisma Health Greenville Memorial Emergency Department with a complaint of lightheadedness and that he had passed out. He alleged that his adoptive mother had signed him out of the hospital, but he was noted to be laughing inappropriately and responding to internal stimuli. He was then re-hospitalized at Marshall Pickens. On July 6 he reported seeing demons in his room. On July 7 he tried to escape by busting through a bedroom window. He once again successfully eloped on July 8 by forcing his body through a glass door. He then went back to his father's house, his father called police, and he was returned to the hospital. On July 9 he was placed on one-to-one observation. He was noted to spit out medication. However, he was doing much better by July 18, but still struggling with getting adequate sleep. He was treated with aripiprazole (Abilify®), an antipsychotic medication, and placed on a long-acting injectable preparation, Abilify Maintena®, and lithium. He received a diagnosis of Bipolar I Disorder, with Mood-Congruent Psychotic Features.

He had an initial assessment at the Greenville Mental Health Center on July 24, 2020. He was scheduled at another time to come back and see the psychiatrist for medication. However, he presented to the Prisma Health Greenville Memorial Emergency Department again on July 27, 2020. He was pulled over by police after being found to be driving erratically. He admitted to cannabis use. Officers reported witnessing him have a seizure and they called EMS for him to be transported to the emergency department. He was no longer seizing when he reached the emergency department, but was still experiencing residual symptoms of a seizure including a postictal state, vertical nystagmus, and unresponsiveness to verbal stimuli. He was admitted to the

hospital for observation and treatment. His brain scan was negative for an acute intracranial process. He was given intravenous fluids and antibiotics and his symptoms resolved by July 29 when he was discharged home.

He was admitted after his arrest to the Greenville County Detention Center on September 4, 2020. He reported depressed mood on admission. He continued to report auditory hallucinations from God telling him scripture and that he was going to be famous. He was treated with aripiprazole (Abilify®), an antipsychotic medication; olanzapine (Zyprexa®), another antipsychotic medication; and oxcarbazepine (Trileptal®), an anti-seizure medication used off-label for mood stabilization. According to the Greenville County Detention Center records, by 2021 he was doing much better and his symptoms appeared to resolve completely. It is noteworthy that in October 2020 his father died from suicide by a self-inflicted gunshot wound to his head.

By the time he was seen on October 4, 2021 for his criminal responsibility evaluation at the Forensic Evaluation Service, he was doing very well in the detention center. He was stable, but still experiencing some grief over the death of his father and girlfriend. He was prescribed aripiprazole (Abilify®) and trazodone, an antidepressant used for sleep. He was noted to have no evidence of ongoing psychotic symptoms. Specifically, there were no hallucinations, delusions, or disorganized thinking.

He was adjudicated on June 8, 2022 and admitted to the Forensic Services division of Bryan Psychiatric Hospital on August 16, 2022.

HOSPITAL COURSE

On admission to the hospital, Mr. Carter was calm and reported a good mood. He understood the reason for his hospitalization. He was not endorsing any symptoms of psychosis, including hallucinations, delusions, paranoia, or ideas of reference. He was able to recall having experienced these symptoms in 2020. He was sleeping well and had a good appetite.

Throughout his nine month hospitalization, he has not experienced psychotic symptoms. He has been compliant with treatment and presented no problems on the inpatient unit. He is described as a model patient. He has been switched to self-monitoring and administration of his medications. In other words, he has to come to the nursing station at the time his medication is due to be taken and ask for his medication, including name and dose, without being prompted by the nurses. He has demonstrated the ability to responsibly manage this task.

He has had no altercations or disputes with other patients. He has also treated the nursing and mental health staff with respect.

CURRENT PRESENTATION

Mr. Carter reports that things are going very well for him in the hospital. He was disappointed that he was not allowed to leave the hospital at his 120-day evaluation hearing. He states that he would like to continue his education and try to get on with his life. He has not experienced psychotic symptoms since early 2021 or late 2020 at the Greenville County Detention Center. During his entire hospitalization he has not experienced hallucinations, delusions, disturbed thought processes, or thought content. He is described as a model patient. He has attended all group activities that had been assigned to him, and he has been cooperative and compliant with taking antipsychotic medications. He denies current psychotic symptoms. He denies a sleep or appetite disturbance. He reports that his mood is good and rates it as a 5 on a scale of 1 to 10, with 1 being severely depressed and 10 being euphoric. He denied suicidal thoughts or homicidal thoughts.

ALCOHOL AND SUBSTANCE USE HISTORY

He denies the use of alcohol. He reports that in high school he would smoke one blunt of cannabis daily. He denies that this caused him problems. He denies failing a urine drug screen or having anyone complain about his cannabis use. He denies being arrested for cannabis. He would not meet diagnostic criteria for Cannabis Use Disorder. He reports that he understands he cannot use cannabis again because it increases his risk of relapse. He also reports that he will be tested regularly if he gets out of the hospital and he will be returned to the hospital if he tests positive for cannabis. He denies other drug use except for the one time experimentation with hallucinogenic mushrooms in February 2020.

MEDICAL HISTORY

He reports a history of one seizure which occurred when he was pulled over by the police for erratic driving. He reports a history of one head injury when he was doing box jumps in a locker room and hit his head. He denies loss of consciousness, however. He has had surgery to a fractured wrist. He denies medication allergies. There is no other history of medical illness.

FAMILY HISTORY

His mother, Keshawna Young, is 43 years of age and is on disability for Bipolar Disorder. His father, Kenneth Carter, died from suicide in October 2020. He worked as a house painter. He had a history of prior suicide attempts. He has a half-brother by his mother and a half-sister by his father. He denies a family history of mental illness besides his mother and his father's depression.

SOCIAL HISTORY

There were no problems with his birth or delivery and he reportedly met his developmental milestones at appropriate ages. He reports he was raised by his mother and grandfather. His father was verbally abusive to his mother and also physically abused his mother, causing a left arm paralysis. His father went to prison for this. Mr. Carter reports he thinks he was in about 4 or 5 year old kindergarten when this happened.

Around age 16 or 17 he reports that the Department of Social Services became involved with his family. His mother had gotten in a car accident and when a DSS worker came to the house they discovered that he was taking care of his 7-year-old brother and that there was a smell of cannabis in the home. He reports that the caseworker had his grandmother pick him up.

He attended Paris Mountain Elementary School, Sevier Middle School, and Wade Hampton High School. He describes that he did very well in school. His transcript would indicate that he was an excellent student. He has one suspension in the 9th grade for drinking alcohol that another person brought to school. He graduated in 2020 and was an honor student.

He has worked as a cashier at a Sears Department Store and at a car wash. He also was an orderly at a local hospital. He had planned after the summer to go into The Bridges program to begin at technical college and then transfer to Clemson University. He has never married, but had a girlfriend throughout high school who died in a tragic accident in May 2020.

According to his National Crime Information Center (NCIC) report, he only has a history of arrests for trespassing at Clemson University and simple possession because he reports he had a grinder in his book bag. He denies a history of prior physical assaults or fights at school. He denies a history of military service.

MENTAL STATUS EXAMINATION

On April 24 he was alert and oriented to person, place, day, date, and time. He was neatly groomed and cooperative with the interview. He made good eye contact. There were no abnormal movements noted. He was able to register three objects and he had no difficulty recalling them after five minutes. He was able to recall significant past personal information and we found no evidence of clinically significant long- or short-term memory impairment. He demonstrated a capacity for abstract reasoning as evidenced by his ability to put similar objects into abstract categories and to interpret a proverb. His ability to concentrate was good as evidenced by his spelling the word *world* backwards very quickly with no deficits. He was able to perform a calculation.

His judgment to a hypothetical situation was very good. His overall intellectual functioning was estimated to be in the high average range.

He rated his mood as "good" and ranked it as a 5 on a scale of 1 to 10, with 1 being severely depressed and 10 being euphoric. He denied suicidal or homicidal ideas. He denied a sleep or appetite disturbance. He denied low energy or poor concentration. He denied auditory or visual hallucinations. He did not report delusional thinking. His thinking was logical and goal-directed without loosening of associations or flight of ideas. We found no evidence of disturbed thought processes or thought content.

DIAGNOSTIC FORMULATION

Mr. Carter has had symptoms of mania including racing thoughts, hyper-religiosity, decreased need for sleep, increased energy, and rapid speech. His initial presentation led to a diagnosis of Bipolar I Disorder at Marshall Pickens. However, once he was incarcerated at the Greenville County Detention Center, his mood symptoms resolved, but he continued to have hallucinations. Because he had psychotic symptoms in the absence of mood symptoms, he would meet the diagnostic criteria for Schizoaffective Disorder, Bipolar Type, rather than just Bipolar Disorder.

VIOLENCE HISTORY

He has no prior history of physical assaults prior to the alleged offense. He denies fights in school. He has never before used a weapon. He has witnessed significant violence in his childhood home between his mother and his father.

FAMILIARITY WITH FIREARMS

Mr. Carter has never owned a firearm. He reports he is not familiar with firearms other than once or twice shooting a pistol under the supervision of his grandfather at his grandfather's house with his grandfather and a cousin present. He was not raised with guns in the household.

VIOLENCE RISK ASSESSMENT

There is little medical evidence that future violent acts could be successfully predicted by mental health professionals. Therefore, despite opinions contained in this report, there is no guarantee that Mr. Carter will or will not behave in a violent manner in the future.

Risk factors for violence can be classified into two different categories. Static risk factors are factors which cannot be modified. In this case, they would include things like

age, gender, history of witnessing violence in the childhood household, and a history of violent acts when psychotic.

Dynamic risk factors are factors which are modifiable and include his history of major mental illness, Schizoaffective Disorder, Bipolar Type, and his initial resistance to treatment prior to incarceration. Another factor would be substance use, although cannabis use is the substance least likely to lead to violent behavior.

In addition to the clinical interview alone, Mr. Carter's risk factors were assessed using the a structured professional judgment instrument, the Historical-Clinical-Risk Management-20 (HCR-20), Version 3. This instrument was designed for use in correctional, civil, psychiatric, and forensic psychiatric settings. This instrument contains a compilation of risk factors that have received empirical support across a wide variety of contexts.

Historical-Clinical-Risk Management 20 (HCR—20), Version 3

Historical Risk Factors (Y=present, P=partially present, N=not present, O=unknown)

H-1.	History of Violence (human)	Y (index offense)
H-2.	History of Other Antisocial Behavior	N
H-3.	Relationship Problems	N
H-4.	Employment Problems	N
H-5.	Substance Use	Y
H-6.	Major Mental Illness	Y
H-7.	Personality Disorder	N
H-8.	Traumatic Experiences	P
H-9.	Violent Attitudes	N
H-10.	Failed Treatment Response	N

Clinical Factors

C-1.	Insight	Y
C-2.	Violent Ideation or Intent	N
C-3.	Symptoms of Major Mental Disorder	N
C-4.	Affective Instability	N
C-5.	Treatment Compliance / Response	Y

Risk Management Factors

R-1.	Professional Services and Plans	Y
R-2.	Living Situation	P
R-3.	Personal Support	Y
R-4.	Compliance	Y
R-5.	Stress/Coping Skills	P

RECOMMENDED INTERVENTIONS TO REDUCE THE RISK OF FUTURE VIOLENCE

Mr. Carter has complied with treatment, has not experienced psychotic symptoms in over a year, and has been described as a model patient. There is no indication for further hospitalization.

1. Mr. Carter should remain on a long-acting antipsychotic medication as a condition for discharge. Failure to take a scheduled dose of this medication should be grounds for re-hospitalization. He should be returned to the hospital for treatment if he misses or refuses a dose of his injectable medication, or if he refuses to attend appoints with his case manager or treating psychiatrist.

2. While not necessarily involved at the time of the alleged offense, Mr. Carter has a history of cannabis use. He does not qualify for a diagnosis of Cannabis Use Disorder because he did not experience impairment from his use. However, now that he has been diagnosed with a major mental illness, further substance use should be prohibited. He was well aware that he should not engage in further cannabis use. He stated he has no desire to use cannabis further. As a safety precaution, I would recommend periodic and unannounced drug screening for at least one year following discharge.

3. SCDMH should ascertain that his name and identifying information has been added to the National Instant Criminal Background Check System (NICS) as required by federal law. There have been reports of individuals found NGRI in other states who were not reported to the FBI/NICS by the courts.

4. Mr. Carter's final discharge plans (i.e. living location), have not been finalized at the time of this report. If he is returned to live with his mother, there needs to be confirmation that there are no firearms in the residence. If he is to be discharged to a community residential care facility (CRCF), he should have the opportunity to tour and approve of the placement facility.

5. Mr. Carter reports a desire to resume his education. This is highly recommended as it is known that a risk for violence and educational level are inversely proportional.

Richard L. Frierson, MD

Richard L. Frierson, MD, DLFAPA
Alexander G. Donald Professor of Psychiatry
Vice Chair for Academic Affairs
University of South Carolina School of Medicine

State of South Carolina
Department of Mental Health

MENTAL HEALTH COMMISSION:
L. Gregory Pearce, Jr., Chair
Elliott E. Levy, MD, Vice Chair
Alison Y. Evans, PsyD
Carl E. Jones, Ph.D.
Bobby H. Mann, Jr.
Crystal A. Smith Maxwell, MD

ACTING STATE DIRECTOR
Robert Bank, MD

Division of Inpatient Services
Forensic Treatment Services
7901 Farrow Road, McClendon Building
Columbia, SC 29203
Information: (803) 935-0505

November 10, 2022

The Honorable Perry H. Gravely
Chief Administrative Judge / General Sessions
Thirteenth Judicial Circuit
Post Office Box 219
Pickens, SC 29671

Re: State v. Carter, Jevon; Case No. 2020A2320602678, 2679, 2680

Dear Judge Gravely:

The defendant in the above captioned case was found Not Guilty by Reason of Insanity of the charge(s) of Voluntary Manslaughter, Possession of a Weapon during a Violent Crime, and Burglary 1st Degree on June 13, 2022, and was committed to the Department of Mental Health by Order soon thereafter.

At this time the Department is recommending that Jevon Carter be discharged under appropriate terms and conditions, please find enclosed a copy of the Report of examination. The Department respectfully requests that a hearing pursuant to §17-24-40(C)(1) be held to determine if Jevon Carter should be discharged pursuant to §44-17-580.

By copy of this letter, I am advising the Solicitor's Office, the Defendant's attorney and the Greenville County Office of Probation, Parole and Pardon Services of this information.

Please contact Logan Royals, Staff Counsel to schedule a hearing at the following address: SCDMH, Office of General Counsel, P.O. Box 485, Columbia, South Carolina, 29202, or you may reach him at (803) 898-8558. Thank you for your assistance with this matter.

Sincerely,

Rashell S. Black
Administrative Coordinator I – Paralegal
rashell.black@scdmh.org
(803) 935-5134
(803) 935-5877 – Fax

1

cc: Andrew Miller, Assistant Solicitor
D. Josev Brewer, Defense Attorney
Melissa Holmes, Director, SCPPPS
Paul B. Wickensimer, Clerk of Court
Logan Royals, Staff Attorney for SCDMH
Davis Rowell, Program Manager, NGRI Outreach Clinic, SCDMH
Lesley Jacobs, Inpatient Movement Coordinator, SCDMH

SCDMH Bryan Psychiatric Hospital Forensic Services
DESIGNATED EXAMINER'S REPORT OF FINDINGS
REQUEST FOR DISCHARGE

PATIENT NAME:	Jevon Carter
HOSPITAL NUMBER:	1052-3276
DATE OF BIRTH:	September 14, 2001
DATE OF ADMISSION:	August 16, 2022
COUNTY OF ORIGIN:	Greenville
ADMITTING COUNTY:	Greenville
HOME ADDRESS:	5 Harrison Ave., Greenville, SC 29617
CORRESPONDENT:	Keshawna Young
CORRESPONDENT ADDRESS:	5 Harrison Ave., Greenville, SC 29617
TELEPHONE NUMBER:	864-772-7457
CHARGES:	Voluntary Manslaughter Possession of a Weapon during a Violent Crime Burglary, First Degree
ADJUDICATION DATE:	June 13, 2022
STATUS OF CHARGES:	NGRI
MAX OUT DATE:	Life

REASON FOR EVALUATION: The purpose of this forensic evaluation is to assist the court in determining whether Jevon Carter requires further hospitalization or whether he can be discharged under court mandated terms and conditions with continued monitoring.

WARNING FOR CONFIDENTIALITY: Prior to the evaluation, Jevon Carter was informed of the nature and purpose of the evaluation. He was specifically informed that the information he revealed would be included in a report submitted to the courts to assist in determining his need for further hospitalization and/or his readiness for discharge. Jevon Carter was informed of the non-confidential nature of this evaluation and he volunteered to participate in the process.

LEGAL STANDARD: 1). Does Jevon Carter at present, lack sufficient insight or capacity to make responsible decisions with respect to his treatment, or 2). Is there a likelihood of serious harm to himself or others if Jevon Carter were to be discharged at this time from the Forensic Inpatient Unit?

INDEX EVENT: Mr. Jevon Carter was adjudicated NGRI on the charges of Voluntary Manslaughter; Possession of a Weapon during a Violent Crime; and Burglary, 1st Degree on June 13, 2022 in Greenville County. Mr. Carter was admitted to Bryan Psychiatric Hospital – Forensics from the Greenville County Detention Center on August 16, 2022.

PENDING CHARGES: Mr. Jevon Carter has no pending charges.

LEGAL HISTORY: Mr. Carter has no legal history.

PSYCHIATRIC DIAGNOSIS: Schizoaffective Disorder, Bipolar Type

PSYCHIATRIC MEDICATIONS:

- Oxcarbazepine 150 mg PO BID
- Aripiprazole 10 mg PO BID
- Trazodone 150 mg qhs

PSYCHIATRIC HISTORY: Mr. Carter is a 21-year-old African American male from Greenville, South Carolina. Mr. Carter has no history of inpatient or outpatient psychiatric treatment prior to July 2020. Per Mr. Carter's Competency to Stand Trial Evaluation (dated October 4, 2021), Mr. Carter was taken to the Prisma Health Greenville Emergency Department by police officers due to agitation, paranoia, and verbalizing delusional beliefs related to his high school hiding his acceptance letter from Clemson University to play football. While in the emergency department he was noted to be responding to internal stimuli (looking at his hands and laughing) and endorsed experiencing a decreased need for sleep, auditory hallucinations from God, increased energy, and an excited mood. Additionally, he made paranoid statements about "heroin being in cigarettes" and "HIV in orange juice". Mr. Carter was transferred from the Prisma Health Greenville Emergency Department to Marshall I. Pickens Psychiatric Hospital on July 3, 2020 for inpatient psychiatric treatment.

According to Mr. Carter's Competency to Stand Trial Evaluation, he was calm and cooperative during the initial admission interview and became tearful when informed he was being admitted to the hospital due to symptoms of psychosis. He displayed pressured speech, grandiosity, flight of ideas, and paranoia. Mr. Carter made statements that he was "Ezekial because I am a disciple, the right hand of Jesus Christ" and proved this by licking the floor of the detention center because the floor of the detention center had "flesh-eating bacteria" on it. He thought the hospital staff was trying to harm him and continued to verbalize that people were hiding his offer letter to play football at Clemson University. Records indicate on the day of admission he was placed in seclusion after he became increasingly paranoid, and expressed a belief that staff was injecting HIV into patients' blood and eyeballs. Mr. Carter became increasingly agitated and demanded to leave the hospital. He "jumped over the nurse's station split door and tried to grab his cell phone". When security approached him, he barricaded the door to his room and attempted to escape by trying to "bust out the window". On July 4, 2020, Mr. Carter "walked past the nurse's station and out of an open door to the patio area (used for patient recreation)". He then was able to scale the fence surrounding the area and eloped from the hospital.

On July 5, 2020, Mr. Carter presented to Prisma Health Greenville Emergency Department with complaints of being lightheaded and passing out. A medical workup was completed and he was returned to Marshall I. Pickens Psychiatric Hospital. He was irritable, demanding, and was observed responding to internal stimuli as evidenced by frequently being seen smiling and laughing to himself. On July 6, 2020 Mr. Carter reported to staff he saw a demon in his room. On July 7, 2020 he was observed pacing in his room and attempted to escape by "trying to bust out his bedroom window". On July 8, 2020, Mr. Carter successfully eloped from Marshall I. Pickens

Psychiatric Hospital when he "forced his body through a glass door". Records indicate that after he eloped he went to his father's home where law enforcement picked him up and transported him back to Prisma Health Greenville Emergency Department. While in the emergency department Mr. Carter made paranoid statements related to his family trying to take his money and was described as "paranoid, delusional, tangential, and responding to internal stimuli".

On July 9, 2020 Mr. Carter was returned to Marshall I. Pickens Psychiatric Hospital and was placed on one-to-one staff observation and monitoring due to his history and high risk for elopement. He remained agitated, had a flat affect, was observed whispering as if he was speaking to someone, and would pace the hallways. It was noted that Mr. Carter would take his prescribed medication and then "immediately went to his room to regurgitate them in the toilet". Records indicate Mr. Carter would isolate from others and lie in his bed but was unable to sleep. By July 18, 2020 Mr. Carter was engaging with staff and was adherent with all prescribed medications. He continued to have difficulty with insomnia but was otherwise described as "stable" at the time of discharge. Upon discharge, Mr. Carter was diagnosed with Bipolar I Disorder, with mood congruent psychotic features and prescribed Lithium and Abilify Maintena.

Per Mr. Carter's Competency to Stand Trial Evaluation, Mr. Carter was seen at the Greenville Mental Health Center for an initial assessment after his inpatient psychiatric hospitalization at Marshall I. Pickens Psychiatric Hospital. Mr. Carter participated in the initial assessment at the mental health center. Records indicate he was "fixated on getting a prescription for a stimulant medication, as he thought he had Attention Deficit/Hyperactivity Disorder (ADHD)". Mr. Carter received no further treatment at the outpatient mental health center.

SUBSTANCE ABUSE HISTORY: Mr. Carter first tried alcohol at the age of 16 years old but did not consume alcohol on a regular basis. He reported his last drink of alcohol was in 2020. Mr. Carter has reported smoking cannabis when he was 17 and smoked one "blunt" daily. Mr. Carter has also tried psychedelic mushrooms one time in February 2020. This resulted in Mr. Carter presenting to the Prisma Health Greenville Emergency Department with an altered mental status. He has denied other illicit drug use or substance abuse treatment.

COURSE OF HOSPITALIZATION: Mr. Carter was admitted to Bryan Psychiatric Hospital – Forensics on August 16, 2022 after being adjudicated NGRI on June 13, 2022 on the charges of Voluntary Manslaughter; Possession of a Weapon during a Violent Crime; and Burglary, 1st Degree. On admission, Mr. Carter was pleasant and cooperative; oriented to person, place, time, and situation; and denied all symptoms of psychosis.

Throughout the course of his hospitalization, Mr. Carter has consistently followed the unit rules; interacts appropriately with staff and peers; and has had no verbal or physical altercations on the unit. Mr. Carter presents as appropriately groomed, and is able to engage in a coherent and linear conversation without voicing paranoid or delusional beliefs. Mr. Carter is adherent with all prescribed medications and has expressed the importance of remaining on medications upon discharge. Mr. Carter received his yellow-band privilege level within one week of admission and

received his green-band privilege four weeks later on September 19, 2022. His green-band has never been demoted. Mr. Carter has been an active participant in treatment by attending all scheduled treatment team meetings, therapeutic groups, and activities on the unit as well as at Building One Treatment Mall. He has attended psychosocial rehabilitation groups to include START Now, Music Processing/Coping Skills, Illness Management, Community Re-Entry, and Alcohol & Other Drugs Group.

Due to Mr. Carter's continued psychiatric stabilization; ability to communication with treatment providers, peers, and staff; and engagement in therapeutic treatment and leisure activities, Treatment Team is recommending Mr. Carter to be discharged to his home in Greenville, South Carolina with his mother, Keshawna Young. Mr. Carter will engage in treatment and services at the Greater Greenville Mental Health Center. In addition, Mr. Carter will be given the opportunity to work with Caroline Caldwell, owner of New Mind Health Care in Greenville, who specialized in community re-entry programming for formerly incarcerated individuals.

DISCHARGE/PLACEMENT AND RECOMMENDED AFTERCARE PLAN: The undersigned believe to a reasonable degree of certainty that Mr. Carter is no longer in need of inpatient hospitalization. However, he is in need of continued mental health treatment and follow-up care, plus treatment for substance abuse. Mr. Carter will need a structured/supervised living environment and must cooperate with all treatment recommendations including:

1. Jevon Carter has been approved for home placement at 5 Harrison Ave., Greenville, SC 29617 and will reside with his mother Keshawna Young.
2. Jevon Carter will comply with the program of care and treatment developed by the Greater Greenville Mental Health Center and the NGRI Outreach Clinic, including keeping all scheduled appointments, participating in scheduled activities, taking all prescribed medications, meeting with his mental health case manager, attending all required treatment programs and groups, complying with scheduled and random urine and/or blood drug and alcohol screens, and attending all appointments with his probation officer as required or ordered by the court.
3. Jevon Carter will sign all required releases to allow communication among professionals providing follow up services.
4. Jevon Carter will not obtain any weapons, guns, or knives, etc. that could potentially harm others.
5. Jevon Carter will not associate with any known felons outside of treatment programs.
6. Jevon Carter will refrain from using any alcoholic beverages or drugs.
7. Jevon Carter will cooperate with the services provided by the Office of Probation, Parole and Pardon. Any drug/alcohol screens done will be reported to the Forensic Outreach Clinic at 803-935-5570. If Jevon Carter does not adhere to the recommendations for his treatment, has a recurrence of symptoms, or violates his court order, he will be referred for reassessment, treatment, and immediate re-hospitalization as deemed clinically appropriate. The chief administrative judge, solicitor, and defense attorney will be notified of re-hospitalization.

Respectfully submitted,

Brittany Csonka, LMSW
Forensic Social Worker
BPH Forensic Services

Jennifer Alleyne, M.D.
Attending Psychiatrist
BPH Forensic Services

R. Chad Pollock, M.D.
Forensic Medical Director
BPH Forensic Services

State of South Carolina
Department of Mental Health

MENTAL HEALTH COMMISSION:
L. Gregory Pearce, Jr., Chair
Elliott E. Levy, MD, Vice Chair
Alison Y. Evans, PsyD
Carl E. Jones, Ph.D.
Bobby H. Mann, Jr.
Crystal A. Smith Maxwell, MD

ACTING STATE DIRECTOR
Robert Bank, MD

Division of Inpatient Services
Forensic Evaluation and Outpatient Services
7901 Farrow Road, Building #6
Columbia, SC 29203
Information: (803) 935-5600

July 7, 2023

The Honorable Alex Kinlaw Jr.
Chief Administrative Judge
Thirteenth Judicial Circuit
305 E. North Street
Greenville, SC 29601

Re: Carter, Jevon
Warrant #: 2020A2320602678, 2679, 2680

Dear Judge Kinlaw:

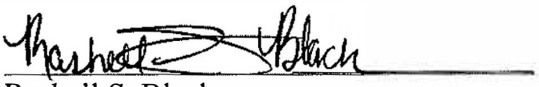
The defendant in the above captioned case was found Not Guilty by Reason of Insanity of the charge(s) of Murder, Possession of a Weapon During the Commission of a Violent Crime, and Burglary 1st Degree on June 13, 2022, and was committed to the Department of Mental Health for treatment pursuant to S.C. Code Ann §17-24-40.

At this time the Department is recommending that Jevon Carter be discharged under appropriate terms and conditions, please find enclosed a copy of the Report of examination. The Department respectfully requests that a hearing pursuant to §17-24-40(C)(1) be held to determine if Jevon Carter should be discharged pursuant to §44-17-580.

By copy of this letter, I am advising the Solicitor's Office, the Defendant's attorney and the Greenville County Office of Probation, Parole and Pardon Services of this information.

Please contact Logan Royals, Staff Counsel, to schedule a hearing at the following address: SCDMH, Office of General Counsel, P.O. Box 485, Columbia, South Carolina, 29202, or you may reach him at (803) 898-8558. Thank you for your assistance with this matter.

Sincerely,



Rashell S. Black
Administrative Coordinator I - Paralegal
(803) 935-5134
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rashell.black@scdmh.org

cc: Andrew Miller, Assistant Solicitor
D. Josev Brewer, Defense Attorney
Paul B. Wickensimer, Clerk of Court
MiKayla Gibbs, Mental Health Coordinator, SCPPS
Logan Royals, Staff Counsel, SCDMH
Lesley Jacobs, Patient Movement Coordinator, SCDMH
Davis Rowell, Program Manager, NGRI Outreach Clinic, SCDMH

SCDMH Bryan Psychiatric Hospital Forensic Services
DESIGNATED EXAMINER'S REPORT OF FINDINGS
REQUEST FOR DISCHARGE

PATIENT NAME:	Jevon Carter
HOSPITAL NUMBER:	1052-3276
DATE OF BIRTH:	September 14, 2001
DATE OF ADMISSION:	August 16, 2022
COUNTY OF ORIGIN:	Greenville
ADMITTING COUNTY:	Greenville
HOME ADDRESS:	5 Harrison Ave., Greenville, SC 29617
CORRESPONDENT:	Cynthia Chapman
CORRESPONDENT ADDRESS:	3 Harrison Ave., Greenville, SC 29617
TELEPHONE NUMBER:	864-772-7457
CHARGES:	Voluntary Manslaughter Possession of a Weapon during a Violent Crime Burglary, First Degree
ADJUDICATION DATE:	June 13, 2022
STATUS OF CHARGES:	NGRI
MAX OUT DATE:	Life

REASON FOR EVALUATION: The purpose of this forensic evaluation is to assist the court in determining whether Jevon Carter requires further hospitalization or whether he can be discharged under court mandated terms and conditions with continued monitoring.

WARNING FOR CONFIDENTIALITY: Prior to the evaluation, Jevon Carter was informed of the nature and purpose of the evaluation. He was specifically informed that the information he revealed would be included in a report submitted to the courts to assist in determining his need for further hospitalization and/or his readiness for discharge. Jevon Carter was informed of the non-confidential nature of this evaluation and he volunteered to participate in the process.

LEGAL STANDARD: 1). Does Jevon Carter at present, lack sufficient insight or capacity to make responsible decisions with respect to his treatment, or 2). Is there a likelihood of serious harm to himself or others if Jevon Carter were to be discharged at this time from the Forensic Inpatient Unit?

INDEX EVENT: Mr. Jevon Carter was adjudicated NGRI on the charges of Voluntary Manslaughter; Possession of a Weapon during a Violent Crime; and Burglary, 1st Degree on June 13, 2022 in Greenville County. Mr. Carter was admitted to Bryan Psychiatric Hospital – Forensics from the Greenville County Detention Center on August 16, 2022.

PENDING CHARGES: Mr. Jevon Carter has no pending charges.

LEGAL HISTORY: Mr. Carter has no legal history.

PSYCHIATRIC DIAGNOSIS: Schizoaffective Disorder, Bipolar Type

PSYCHIATRIC MEDICATIONS:

- Oxcarbazepine 150 mg PO BID
- Aripiprazole injection ER 882mg q4wks
- Trazodone 150 mg qhs

PSYCHIATRIC HISTORY: Mr. Carter is a 21-year-old African American male from Greenville, South Carolina. Mr. Carter has no history of inpatient or outpatient psychiatric treatment prior to July 2020. Per Mr. Carter's Competency to Stand Trial Evaluation (dated October 4, 2021), Mr. Carter was taken to the Prisma Health Greenville Emergency Department by police officers due to agitation, paranoia, and verbalizing delusional beliefs related to his high school hiding his acceptance letter from Clemson University to play football. While in the emergency department he was noted to be responding to internal stimuli (looking at his hands and laughing) and endorsed experiencing a decreased need for sleep, auditory hallucinations from God, increased energy, and an excited mood. Additionally, he made paranoid statements about "heroin being in cigarettes" and "HIV in orange juice". Mr. Carter was transferred from the Prisma Health Greenville Emergency Department to Marshall I. Pickens Psychiatric Hospital on July 3, 2020 for inpatient psychiatric treatment.

According to Mr. Carter's Competency to Stand Trial Evaluation, he was calm and cooperative during the initial admission interview and became tearful when informed he was being admitted to the hospital due to symptoms of psychosis. He displayed pressured speech, grandiosity, flight of ideas, and paranoia. Mr. Carter made statements that he was "Ezekial because I am a disciple, the right hand of Jesus Christ" and proved this by licking the floor of the detention center because the floor of the detention center had "flesh-eating bacteria" on it. He thought the hospital staff was trying to harm him and continued to verbalize that people were hiding his offer letter to play football at Clemson University. Records indicate on the day of admission he was placed in seclusion after he became increasingly paranoid, and expressed a belief that staff was injecting HIV into patients' blood and eyeballs. Mr. Carter became increasingly agitated and demanded to leave the hospital. He "jumped over the nurse's station split door and tried to grab his cell phone". When security approached him, he barricaded the door to his room and attempted to escape by trying to "bust out the window". On July 4, 2020, Mr. Carter "walked past the nurse's station and out of an open door to the patio area (used for patient recreation)". He then was able to scale the fence surrounding the area and eloped from the hospital.

On July 5, 2020, Mr. Carter presented to Prisma Health Greenville Emergency Department with complaints of being lightheaded and passing out. A medical workup was completed, and he was returned to Marshall I. Pickens Psychiatric Hospital. He was irritable, demanding, and was observed responding to internal stimuli as evidenced by frequently being seen smiling and laughing to himself. On July 6, 2020, Mr. Carter reported to staff he saw a demon in his room. On July 7, 2020, he was observed pacing in his room and attempted to escape by "trying to bust out his bedroom window". On July 8, 2020, Mr. Carter successfully eloped from Marshall I. Pickens

Psychiatric Hospital when he "forced his body through a glass door". Records indicate that after he eloped, he went to his father's home where law enforcement picked him up and transported him back to Prisma Health Greenville Emergency Department. While in the emergency department Mr. Carter made paranoid statements related to his family trying to take his money and was described as "paranoid, delusional, tangential, and responding to internal stimuli".

On July 9, 2020, Mr. Carter was returned to Marshall I. Pickens Psychiatric Hospital and was placed on one-to-one staff observation and monitoring due to his history and high risk for elopement. He remained agitated, had a flat affect, was observed whispering as if he was speaking to someone, and would pace the hallways. It was noted that Mr. Carter would take his prescribed medication and then "immediately went to his room to regurgitate them in the toilet". Records indicate Mr. Carter would isolate himself from others and lie in his bed but was unable to sleep. By July 18, 2020, Mr. Carter was engaging with staff and was adherent with all prescribed medications. He continued to have difficulty with insomnia but was otherwise described as "stable" at the time of discharge. Upon discharge, Mr. Carter was diagnosed with Bipolar I Disorder, with mood congruent psychotic features and prescribed Lithium and Abilify Maintena.

Per Mr. Carter's Competency to Stand Trial Evaluation, Mr. Carter was seen at the Greenville Mental Health Center for an initial assessment after his inpatient psychiatric hospitalization at Marshall I. Pickens Psychiatric Hospital. Mr. Carter participated in the initial assessment at the mental health center. Records indicate he was "fixated on getting a prescription for a stimulant medication, as he thought he had Attention Deficit/Hyperactivity Disorder (ADHD)". Mr. Carter received no further treatment at the outpatient mental health center.

SUBSTANCE ABUSE HISTORY: Mr. Carter first tried alcohol at the age of 16 years old but did not consume alcohol on a regular basis. He reported his last drink of alcohol was in 2020. Mr. Carter has reported smoking cannabis when he was 17 and smoked one "blunt" daily. Mr. Carter has also tried psychedelic mushrooms one time in February 2020. This resulted in Mr. Carter presenting to the Prisma Health Greenville Emergency Department with an altered mental status. He has denied other illicit drug use or substance abuse treatment.

COURSE OF HOSPITALIZATION: Mr. Carter was admitted to Bryan Psychiatric Hospital – Forensics on August 16, 2022, after being adjudicated NGRI on June 13, 2022, on the charges of Voluntary Manslaughter; Possession of a Weapon during a Violent Crime; and Burglary, 1st Degree. On admission, Mr. Carter was pleasant and cooperative; oriented to person, place, time, and situation; and denied all symptoms of psychosis.

Throughout the course of his hospitalization, Mr. Carter has consistently followed the unit rules, interacts appropriately with staff and peers; and has had no verbal or physical altercations on the unit. Mr. Carter is always well groomed and can engage in a coherent and linear conversation without voicing paranoid or delusional beliefs. Mr. Carter is adherent to all prescribed medications and has expressed the importance of remaining on medications upon discharge. Mr. Carter received his yellow-band privilege level within one week of admission and

received his green-band privilege four weeks later, on September 19, 2022. His green-band has never been demoted. Mr. Carter has been an active participant in treatment by attending all scheduled treatment team meetings, therapeutic groups, and activities on the unit as well as at Building One Treatment Mall. He has attended psychosocial rehabilitation groups to include START Now, Music Processing/Coping Skills, Illness Management, Community Re-Entry, and Alcohol & Other Drugs Group.

On November 4, 2022, Mr. Carter attended Forensic Review Board (FRB) and was approved for home placement in Greenville, South Carolina with his mother. He was then approved by Administrative Forensic Review Board (AFRB) on November 8, 2022. On December 9, 2022, Mr. Carter attended his scheduled NGRI discharge hearing and was later denied discharge to the community on January 9, 2023 due to the need for extended mental health treatment.

Mr. Carter has continued to participate in all aspects of treatment such as attending scheduled treatment team meetings, therapeutic groups, and activities on the unit as well as at Building One Treatment Mall. Mr. Carter is attending groups on the unit such as Illness Management, Social Skills, Music Processing, and Alcohol & Other Drugs Group. He also attends psychosocial rehabilitation groups, two times weekly, at Building One Treatment Mall, and participates in Emotional Dysregulation Group and Recovery for Life Group. He also engages in activities provided by Activity Therapy such as playing pool, video games, and listening to music as well as attending special events and Fun Friday activities at Building One Treatment Mall. Due to his continued participation in treatment, Mr. Carter has shown insight into symptoms of and how to manage his mental illness. He has demonstrated positive social interactions and developed coping skills to promote healthy living and recovery. Mr. Carter was placed on self-administered medication protocol as of February 9, 2023. He has had no difficulty with presenting to the medication room at the appropriate times, informing the nurse what medication he is to take, opening the blister pack, and taking the medication. Mr. Carter has demonstrated his ability to take responsibility for knowing what medications to take at what time of the day which he will be responsible for once in the community.

Due to Mr. Carter's continued psychiatric stabilization; ability to communicate with treatment providers, peers, and staff; and engagement in therapeutic treatment and leisure activities, Treatment Team is recommending Mr. Carter to be discharged home to Greenville, South Carolina where he will reside with his grandmother, Cynthia Chapman. Mr. Carter will engage in treatment and services at the Greater Greenville Mental Health Center. In addition, Mr. Carter will be given the opportunity to work with Caroline Caldwell, owner of New Mind Health Care in Greenville, who specializes in community re-entry programming for formerly incarcerated individuals.

DISCHARGE/PLACEMENT AND RECOMMENDED AFTERCARE PLAN: The undersigned believe to a reasonable degree of certainty that Mr. Carter is no longer in need of inpatient hospitalization. However, he needs continued mental health treatment and follow-up care, plus treatment for substance abuse. Mr. Carter will need a structured/supervised living environment and must cooperate with all treatment recommendations including:

SCDMH Bryan Psychiatric Hospital Forensic Services
DESIGNATED EXAMINER'S REPORT OF FINDINGS
REQUEST FOR DISCHARGE

1. Jevon Carter has been approved for home placement at 3 Harrison Ave., Greenville, SC 29617 and will reside with his grandmother Cynthia Chapman.
2. Jevon Carter will comply with the program of care and treatment developed by the Greater Greenville Mental Health Center and the NGRI Outreach Clinic, including keeping all scheduled appointments, participating in scheduled activities, taking all prescribed medications, meeting with his mental health case manager, attending all required treatment programs and groups, complying with scheduled and random urine and/or blood drug and alcohol screens, and attending all appointments with his probation officer as required or ordered by the court.
3. Jevon Carter will sign all required releases to allow communication among professionals providing follow-up services.
4. Jevon Carter will not obtain any weapons, guns, or knives, etc. that could potentially harm others.
5. Jevon Carter will not associate with any known felons outside of treatment programs.
6. Jevon Carter will refrain from using any alcoholic beverages or drugs.
7. Jevon Carter will cooperate with the services provided by the Office of Probation, Parole and Pardon. Any drug/alcohol screenings done will be reported to the Forensic Outreach Clinic at 803-935-5570. If Jevon Carter does not adhere to the recommendations for his treatment, has a recurrence of symptoms, or violates his court order, he will be referred for reassessment, treatment, and immediate re-hospitalization as deemed clinically appropriate. The chief administrative judge, solicitor, and defense attorney will be notified of re-hospitalization.

SCDMH Bryan Psychiatric Hospital Forensic Services
DESIGNATED EXAMINER'S REPORT OF FINDINGS
REQUEST FOR DISCHARGE

Respectfully submitted,

Brittany Csonka, LMSW
Forensic Social Worker
BPH Forensic Services

Jennifer Alleyne, M.D.
Attending Psychiatrist
BPH Forensic Services

6/28/23
R. Chad Pollock, M.D.
Forensic Medical Director
BPH Forensic Services

'23 SEP 28 PM2:46
Brice Garrett COC GVL SC

STATE OF SOUTH CAROLINA COUNTY OF GREENVILLE	)	IN THE COURT OF GENERAL SESSIONS THIRTEENTH JUDICIAL CIRCUIT
THE STATE OF SOUTH CAROLINA,	)	INDICTMENT NO: 2021-GS-2305230-31 CASE NO: 2020A2320602678-80
vs.	)	**JEVON CARTER'S POST HEARING MEMORANDUM IN SUPPORT OF SCDMH RECOMMENDATON FOR DISCHARGE FOR DISHCARGE**
JEVON KENNETH CARTER, Defendant.	)	

This matter is before the Court on the request for discharge and Report of the South Carolina Department of Mental Health Service's ("SCDMH"), dated June 28, 2023 (hereinafter "SCDMH Report"), concerning Jevon Kenneth Carter, provided to the Court, by statute, on July 7, 2023. The Court held a hearing on August 30, 2023, and took testimony from two SCDMH witnesses in support of its recommendation that Jevon is no longer in need of hospitalization and that he must, therefore, be discharged as a matter of law. Those witnesses included SCDMH's Dr. Jennifer Alleyne, Attending Psychiatrist, and a second independent examiner, Dr. Richard Frierson, the Alexander G Donald Professor of Psychiatry and Vice Chair for Academic Affairs at the University of South Carolina School of Medicine and the Program Director for the Forensic Psychiatry Fellowship at USC School of Medicine. Both individuals were qualified as experts without objection.

After the hearing, the Court requested briefing from the parties within thirty (30) days.

SUMMARY OF ARGUMENTS THAT JEVON CARTER CAN NO LONGER CONSTITUTIONALLY BE HOSPITALIZED

As will be discussed in greater detail below:

1. Pursuant to S.C. Code 17-24-40(C) and S.C. Code § 44-17-580(A), Mr. Carter is medically and statutorily no longer in need of inpatient hospitalization and should be discharged as recommended;

2. This is the professional and medical judgment of the State of South Carolina through its Department of Mental Health Services, the SCDMH Review Board, Forensic Medical Director, and psychiatrist, Dr. Alleyne. (See Discharge Report, dated July 7, 2023; Testimony of Dr. Alleyne, Aug. 30, 2023 Hearing.)

3. It is also the separate professional and medical judgment of Dr. Richard Frierson, the Alexander G Donald Professor of Psychiatry and Vice Chair for Academic Affairs at the University of South Carolina School of Medicine, and the Program Director for the Forensic Psychiatry Fellowship at USC School of Medicine. (See Frierson Report (attached to SCMH Discharge Report); Testimony of Dr. Firerson, Aug. 30, 2023 Hearing.)

4. Said again, these are the expert opinions and recommendations of *South Carolina* through its own Department of Mental Health and an independent examiner.

5. Importantly, these opinions and recommendations are entirely *uncontested.* The Solicitor's Office has offered *no* witnesses, experts, or evidence to the contrary.

6. Accordingly, the only "clear and convincing evidence" before the Court is that hospitalization is no longer required, *see* S.C. Code § 44-17-580(A).

7. Both Dr. Alleyne and Dr. Frierson concluded, among other things, that Jevon

    a. has sufficient insight and capacity to make responsible decisions with respect to his treatment;

    b. has exhibited no violence or aggression towards himself or others in three years; and

    c. is no longer in need of hospitalization.

    (Discharge Report at 3-5 ; Frierson Rep. at 10.)

8. The South Carolina and United States Supreme Court has expressly ordered that once it has been established that hospitalization is not required, Jevon constitutionally ***must*** be discharged but subject to certain conditions determined by the Court:

"After conducting the hearing, if the Judge determines that the Defendant IS NOT in need of continued hospitalization, ***he shall issue an Order releasing the Defendant*** to the custody of the SCDMH for care and treatment under such terms and conditions as shall be appropriate."

Re: Interagency Protocol for Defendants Found Not Guilty by Reason of Insanity, S.C. S. Ct. Admin. Order 2014-04-21-01 (emphasis added);[1] *see also Vitek v. Jones*, 445 U.S. 480, 493 (1980); *see also Foucha v. Louisiana*, 504 U.S. 71, 77 (1992) ("Thus, the basis for holding Foucha in a psychiatric facility as an insanity acquittee has disappeared, and the State is no longer entitled to hold him on that basis.").

9. Pursuant to S.C. Code §17-24-80(A), the monitoring of Jevon is the responsibility of the Office of Probation, Parole, and Pardon ("PPP"), the Greater Greenville Mental Health Center, the NGRI Outreach Center, and himself;

10. Although Jevon must be released, the Court may order release conditions for the safety of the community and the victim's family. S.C. S. Ct. Administrative Order, dated April 24, 2014, at 3; *see* S.C. Code 17-24-40(D).

11. However, "[a]ny terms and conditions imposed by the chief administrative judge must be **therapeutic in nature, not punitive.**" S.C. Code 17-24-40(D) (emphasis added).

12. SCDMH and the Supreme Court's Administrative Order provide for a number of therapeutic conditions (SCDMH Rep. at 4-5; S.C. S. Ct. Administrative Order, dated April 24, 2014, at 3); *see also* S.C. Code 17-24-40(D)

13. The solicitor's office has offered none.

14. Continued civil commitment under the circumstances would be punitive, rather than therapeutic as statutorily required, and, therefore, unconstitutional.

15. SCDMH's report and recommendations are responsive to ***all*** of Judge Perry Gravely's concerns in his January 9, 20223, Order.

[1] In addition to the procedure outlined in S.C. Code §17-24-40, the South Carolina Supreme Court has issued an extensive Administrative Order that outlines in significant detail the NGRI process both prior to, and post, hospitalization, which the undersigned would recommend to the Court. A copy of the Order has been submitted with this brief.

BACKGROUND

Jevon was arrested on or about August 28, 2020. He was evaluated by SCDMH for criminal responsibility and capacity to conform conduct to the requirements of the law, on July 5, 2021. (SCDMH, NGRI Report, dated Oct. 15, 2021; Order, dated June 13, 2022, at 1.) After a hearing on June 8, 2022, and without objection from the government, the Court adjudicated Mr. Carter Not Guilty By Reason of Insanity ("NGRI"), pursuant to S.C. Code § 17-24-40. (Order, dated June 13, 2022.) Jevon was admitted to the SCDMH on August 16, 2022. On November 10, 2022, the SCDMH rendered a Request for Discharge Report, as required by Section § 17-24-40(B), and relayed to the Circuit Court that Mr. Carter is no longer in need of inpatient treatment pursuant to the standards set forth under S.C. Code § 44-17-580. (See Discharge Report, dated Nov. 10, 2022.) The Court held a hearing, pursuant to S.C. Code § 17-24-40(C)(1), on December 8, 2022 to "decide whether [Jevon] should be hospitalized pursuant to the standard of Section 44-17-580." The Honorable Perry Gravely declined to accept that recommendation, in an Order, dated January 9, 2023. Since that time, Jevon has continued as a "model patient" at the SCDMH. (See Discharge Report, dated July 7, 2023 & Frierson Report at 5.)

SCDMH has met the concerns of Judge Gravely and renewed its independent medical recommendation that Mr. Carter is no longer in need of hospitalization. *Id.* at 4. In addition, SCDMH has secured the separate and independent view of a Dr. Richard Frierson, who has also concluded, "[T]here is no indication for further hospitalization." (Discharge Report, Frierson Report at 10.)

ARGUMENT

The recommendation by SCDMH to discharge Jevon is based on undisputed expert testimony and no surprise. It is what the NGRI process, outlined in S.C. Code § 17-24-40 and by the South Carolina Supreme Court in its Administrative Order, dated April 24, 2014, expressly anticipates. The Solicitor's Office assented to this statutory framework when it originally consented to the NGRI determination, on June 8, 2022. Indeed, the entire point of our NGRI statute and procedure is that an individual, previously suffering from a severe mental health condition, would not be legally characterized as a "prisoner" and would, therefore, be released once hospitalization is no longer required. *See* S.C. Code §17-24-40(C)(2)(c); S.C. S. Ct. Administrative Order, dated April 24, 2014, at 2.

Jevon is not a detainee or prisoner. He is a patient. And, he is legally *not guilty* of any crimes. The South Carolina Supreme Court has emphatically stated, "Defendants adjudicated NGRI are not committed to the South Carolina Department of Corrections and ***are not considered 'prisoners,'*** *as they have* ***not been found guilty of a crime.***" (S.C. S. Ct. Administrative Order, dated April 24, 2014, at 2 (emphasis added).)

As undersigned counsel has emphasized on Jevon's behalf throughout this case, the death of Ms. Frances Mattison was extraordinarily sad and tragic and has obviously been a great sorrow for her family. He is desperately sad and remorseful about it – every day. The case has been additionally tragic for Jevon and Jevon's familial relationship to, and affection for, Ms. Mattison and for the onset of his own personal mental health issues. At all stages, it has been a hard case for everyone involved and impacted. But, the fact of her tragic death cannot constitute a permanent objection to Jevon's release, as the Solicitor's Office asks this Court. Such a view is unconstitutional and would render the entire NGRI procedure moot.

I. The Court Should Accept the Undisputed Recommendation that Jevon Carter is No Longer in Need of Hospitalization and Should Be Released Upon Certain Conditions.

There are two distinct and chronological questions before the Court: First, is Jevon "in need of continued hospitalization"? *See* S.C. Code 17-24-40(C)(2)(c). Second, if he is not, on what conditions should he be released? *See* S.C. Code 17-24-40(C)(2)(c) & (D).

A. The only evidence before the Court is that Jevon no longer needs to be hospitalized.

Any continued hospitalization of Jevon may only occur pursuant to the standard of S.C. Code § 44-17-580, as explicitly outlined throughout S.C. Code § 17-24-40(C). To keep Jevon at SCDMH, the Court would have to find that there is "clear and convincing evidence" that he still "needs involuntary commitment." S.C. Code § 44-17-580(A); *see also Addington v. Texas*, 441 U.S. 418 (1979) ("[An] individual's interest in the outcome of a civil commitment proceeding is of such weight and gravity that due process requires the state to justify confinement by proof more substantial than a mere preponderance of the evidence.")

Very respectfully, there is no evidence whatsoever that he needs further hospitalization.

Indeed, the SCDMH's medical answer to this statutory question – does Jevon need continued hospitalization – is a resounding no. (See generally Discharge Report, dated June 28, 2023.) On June 28, 2023, the SCDMH rendered a Request for Discharge under Section 17-24-40(B) and thereafter, on July 7, 2023, relayed to the Court that Mr. Carter is no longer in need of inpatient treatment pursuant to the standards set forth in S.C. Code §44-17-580.

That standard is a two-pronged inquiry:

Does the patient

(1) have insight or capacity to make responsible decisions with respect to his treatment; and

(2) is there a likelihood of serious harm to himself or others,

S.C. Code § 44-17-580.

Based on both the SCDMH Discharge Report, and the independent violence risk assessment of Dr. Frierson, both prongs have now been satisfied by clear and convincing evidence, indeed more, and involuntary hospitalization is no longer appropriate.

Dr. Jennifer Alleyne has been Mr. Carter's supervising and evaluating psychiatrist and a signatory to the SCDMH report. She is a doctor with the SCDMH. She is not a privately retained expert, and she works directly for the State of South Carolina. She was qualified as an expert and testified in front of this Court at the Discharge Hearing, on August 30, 2023.

The SCDMH report and Dr. Alleyne's in-court testimony demonstrated the following with respect to the recommendation that Jevon is no longer in need of hospitalization and should be discharged:

1. Jevon has sufficient insight and capacity to make responsible decisions with respect to his treatment going forward (Alleyne Testimony; Discharge Report at 3-4);
2. Jevon is not a serious harm to himself or others when properly treated (Alleyne Testimony);
3. Jevon has exhibited *no violence or aggression* during his time at SCDMH, since August 16, 2022 (Alleyne Testimony; see also Discharge Report at 3 ("Mr. Carter . . . has had no verbal or physical altercations on the unit.");

4. Jevon has had *no compliance or disciplinary issues* at the SCDMH, *id.* at 3 ("Mr. Carter has consistently followed unit rules, interacts appropriately with staff and peers . . . .");
5. Jevon exhibited *no violence or aggression* during his time at the Greenville County Detention Center since on or about August 28, 2020 (Alleyne Testimony);
6. Jevon has been on the same medical regimen since, at least, the date of his NGRI evaluation on July 5, 2021, until now (Compare NGRI Report, dated Oct. 13, 2021, at 6 with Request to Discharge, dated July 7, 2023, at 2);[2]
7. Jevon has been fully responsible and compliant with the self-administration of his medical regimen:

   > Mr. Carter was placed on self-administered medication protocol as of February 9, 2023. He has had no difficulty with presenting to the medication room at the appropriate times, informing the nurse what medication he is to take opening the blister pack, and taking the medication. Mr. Carter has demonstrated his ability to take responsibility for knowing what medications to take at what time of day which he will be responsible for once in the community.

   id. at 4;
8. Jevon has good insight into his illness and the treatment regimen for that illness (Alleyne Testimony; see also Discharge Report at 3-4 ("Mr. Carter is adherent with all prescribed medications and has expressed the importance of remaining on medications upon discharge.");
9. His medical regimen effectively rehabilitates his diagnoses and mental illness and can be properly maintained on an outpatient basis (Alleyne Testimony; see also

[2] Jevon has been taking, since admission to the detention center, but at least as of July 5, 2021, Oxcarbazepine ("Trileptal"); Aripiprazole; and Trazadone. (Compare NGRI Report, dated Oct. 13, 2021, at 6 with Request to Discharge, dated July 7, 2023, at 2)

Discharge Report at 3 ("Mr. Carter is always well groomed and can engage in a coherent and linear conversation without voicing paranoid or delusional beliefs.");

10. Jevon advanced through each level of the SCDMH without incident and without the need to repeat a stage (Alleyne Testimony); Discharge Report at 3-4;
11. Jevon has had no disciplinary issues and has been active with his group and individual therapy (Alleyne Testimony; see also Discharge Report at 4 ("Mr. Carter has been active participant in treatment by attending all scheduled treatment team meetings, therapeutic groups, and activities on the unit as well as at Building One Treatment Mall.");
12. Jevon is observed by her or other hospital staff all day and night (Alleyne Testimony);
13. Jevon is one of the most courteous, polite, highest functioning, and well-adjusted individuals she has treated at the Bryan Forensic Unit (Alleyne Testimony);
14. Jevon has expressed repeated remorse for his involvement with Ms. Mattison's death and lives with that, now, sober reality every day (Alleyne Testimony);
15. He has not been deceptive or malingering (Alleyne Testimony);
16. "[T]o a reasonable degree of certainty . . . **Mr. Carter is no longer in need of hospitalization.**" *Id.* (emphasis added).

Likewise, Dr. Frierson with the University of South Carolina School of Medicine, was asked by the SCDMH to perform an independent violence risk assessment. Dr. Frierson was also qualified without objection as an expert and testified in front of this Court at the Discharge Hearing, on August 30, 2023. He has concluded:

> Throughout his nine month hospitalization, [Mr. Carter] has not experienced psychotic symptoms. **He has been compliant with treatment and presented no**

> **problems on the inpatient unit. He is described as a model patient.** He has been switched to self-monitoring and administration of his medications. In other words, he has to come to the nursing station at the time his medication is due to be taken and ask for his medication including name and dose, without being prompted by the nurses, He has demonstrated the ability to responsibly manage this task.
>
> **He has had no altercations or disputes with other patients.** He has also treated the nursing and mental health staff with respect.
>
> (Frierson Rep. at 5.)
> . . .
>
> Mr. Carter has complied with treatment, has not experienced psychotic symptoms in over a year, and has been described as a model patient. **There is no indication for further hospitalization.**
>
> *Id.* at 10 (emphasis added).

Dr. Frierson reiterated all of the above during his testimony and reflected repeatedly on Jevon's interpersonal qualities, compliance, and preparedness for release. Dr. Frierson testified that Jevon should no longer be hospitalized. (Frierson Testimony.)

It is not in Dr. Frierson or SCDMH's best interest to exaggerate or fabricate their view of Jevon's condition or capacity to comply with the proposed release program. The SCDMH has an entire and independent forensic discharge review board hearing that accepts or denies the physician recommendations. Both the physicians in this case and the forensic discharge review board have every incentive and opportunity to conclude differently than they did. SCDMH caries the same, if not more, responsibility for Jevon's future conduct as any entity involved; it rests on their professional and medical expert opinions. In this case, there is no reason to doubt them. They should be considered the controlling opinions in this matter both because they are expert and offered beyond a medical degree of reasonable certainty and also because they are undisputed. To confine him any longer, without evidence to the contrary, which is both clear and convincing, would be a serious civil rights violation. *See Addington v. Texas*, 441 U.S. 418,

424 (1979) ("[An] individual's interest in the outcome of a civil commitment proceeding is of such weight and gravity that due process requires the state to justify confinement by proof more substantial than a mere preponderance of the evidence."); *See Foucha v. Louisiana*, 504 U.S. 71, 77 (1992).

Undoubtedly, it is a very serious crime and a very serious illness. But, the legal standard is *not* whether the underlying crime is sufficiently bad to detain Jevon indefinitely in a hospital out of generalized fears that it might happen again. Not only is that violative of the therapeutic purposes of Section 17-24-40(D), it is unconstitutional. *See Vitek v. Jones*, 445 U.S. 480, 493 (1980). The United States Supreme Court has stated:

> None of our decisions holds that conviction for a crime entitles a State not only to confine the convicted person but also to determine that he has a mental illness and to subject him involuntarily to institutional care in a mental hospital. Such consequences visited on the prisoner are qualitatively different from the punishment characteristically suffered by a person convicted of crime. Our cases recognize as much and reflect an understanding that involuntary commitment to a mental hospital is not within the range of conditions of confinement to which a prison sentence subjects an individual.

Id.

In *Foucha v. Louisiana*, the United States Supreme Court stated that once the mental illness is regulated, "**the State is no longer entitled to hold him on that basis.**" *Foucha v. Louisiana*, 504 U.S. 71, 77 (1992). Indeed, the United States Supreme Court held, in *Foucha*, that the State could not hold the patient once the mental illness was remedied, even where he suffered antisocial personality disorder, had been in "altercations" at the facility, and the treating doctor, himself, was not comfortable stating that he was not a danger to himself and others. *Id.* at 75, 78-80.)

Here, there is *no* evidence that Mr. Carter has committed even a single aggressive act since August 28, 2020, and certainly not since his commitment to the SCDMH over a year ago –

because he has not. And, the only expert evidence is that his medicines fully remediate his mental illness. Accordingly, he must be discharged. *See Foucha v. Louisiana*, 504 U.S. 71, 77 (1992).

As Dr. Alleyne testified, no one knew Mr. Carter was sick before the Summer of 2020; he had had no diagnosis or treatment. His mental health issues did not manifest until the Spring of 2020, when Mr. Carter's genetic predisposition was triggered by the horrific death of his girlfriend who fell from a waterfall in Sunset, South Carolina (at a time when Mr. Carter was not present). (NGRI Report at 3, 8; Frierson Report at 3.) As Drs. Alleyne and Frierson testified, Mr. Carter to that point had been an honor roll student, multi-sport athlete, and was enrolled in the Clemson Bridge program for the Fall of 2020. There was no preexisting context for any violence or aggression in his life. Very shortly after an effective diagnosis and a period of time on appropriate medicines through today, Jevon's mental health diagnoses have been remediated and fully controlled. It is evident by his consistent and good behavior as outlined above, the numerous evaluations in this case, and the total lack of physical or other aggressiveness exhibited by Jevon in well over two years.

This disease was latent in him. It manifested very unexpectedly. But, then it was diagnosed, and now has been treated. This is not a situation where physicians and experts have tried repeatedly to treat his conditions with numerous and repeated violent relapses. For well over two years (and unequivocally over the last year in the SCDMH) he has been responsive to medical treatment and now at the corroboration of experts – designated by the State of South Carolina -- who do this every day. Jevon is quintessentially the kind of individual, receptive to treatment and rehabilitation, for which the NGRI process was designed to benefit.

The fact that the Solicitor's Office raises issues about his condition after release from Marshall Pickens in the Summer of 2020 is not relevant. The present issue before the Court is whether at this moment, today -- after over a year of evaluation with and treatment by the SCDMH -- is he still in need of hospitalization. *See* S.C. Code § 17-24-40(C); *see Foucha v. Louisiana*, 504 U.S. 71, 77 (1992). Respectfully, there is only one expert answer to that question: no.

1. The Solicitor's Office has offered no rejoinder.

The Solicitor's Office has not presented any witnesses or experts of its own. It, therefore, has failed to meet the statutory standard of presenting clear and convincing evidence that Jevon should not be discharged. Instead, it makes two erroneous arguments. First, it contends that the SCDMH did not address Judge Gravely's concerns; this is simply false. Second, the Solicitor's Office attempts to use its disagreement about the *conditions* of discharge to resist the discharge itself, which is not permissible.

a. SCDMH's Discharge Report was responsive to all of Judge Gravely's concerns.

Judge Gravley expressed essentially three concerns in his January 9 Order: (1) the length of Jevon's hospitalization and whether there had been sufficient time to evaluate the genuineness of his compliance; (2) whether Jevon could be trusted to comply with his medical regimen; and (3) whether it was not suitable for Jevon to live with his mother, who has mental health issues and substance abuse issues herself.

All three concerns have been addressed expressly:

1. Length of Time: Jevon has now been under the evaluation and supervision of SCDMH, as of the date of the August 30, 2023, Discharge Hearing for **379 days**. His compliance, affect, and behavior have been perfect. Dr. Alleyne

testified that he is supervised around the clock by staff, medical personal, and physicians. She testified that Jevon is a "model patient" and that he has not been deceptive or manipulative or disingenuous in his compliance and treatment. Indeed, Dr. Frierson was retained to provide an additional assessment, to allay any concerns of the Court, as to the quality of Jevon's condition and compliance; he has fully affirmed SCDMH's recommendation.

2. Medical Compliance: Precisely for Judge Gravely's concerns about medicinal compliance, SCDMH required Jevon to self-administer his medical regimen:

> **Mr. Carter was placed on self-administered medication protocol as of February 9, 2023**. He has had no difficulty with presenting to the medication room at the appropriate times, informing the nurse what medication he is to take opening the blister pack, and taking the medication. Mr. Carter has demonstrated his ability to take responsibility for knowing what medications to take at what time of day which he will be responsible for once in the community.

(Discharge Rep. at 4 (emphasis added).) Dr. Alleyne testified that he has not missed a single dose. And, prior to self-administration, dating to his original admission to SCDMH in August of 2022, he has had zero compliance issues. It is hard to imagine a better medicinal compliance record than one without flaw.

3. Jevon's Mother: In response to Judge Gravely's Order, SCDMH has not recommended that Jevon live with his mother; it has recommended that he live with his grandmother. His grandmother has no criminal record or substance abuse problems. She is not related to the victim's family. She does not live near the victim's family. The fact that Jevon's grandmother lives near his mother (her daughter) does not disregard Judge Gravely's concern. His

concern was not one of geography. Judge Gravely was expressly concerned about whether Jevon's *mother* could provide a suitable environment. That issue is resolved by Jevon living with his grandmother who helped raise him and who is a stable and responsible caregiver.

Very respectfully, the Solicitor's Office suggestion that SCDMH was not responsive to Judge Gravely's concerns is simply untrue.

b. SCDMH evaluation and recommendation are based on expert and sufficient medical evaluation.

Because the Solicitor's Office has no experts of its own, it has tried to suggest that SCDMH has insufficiently evaluated Jevon. In various ways it has implied that the total number of hours of evaluation are somehow small. This is not a good faith allegation. Jevon is literally committed around the clock to the SCDMH facility. He is under constant supervision. If he were violent or noncompliant, there would be records, video, and witnesses to that effect. He is under constant scrutiny. He is also in weekly team meetings, therapeutic groups as well as numerous topical classes, including START Now, Coping Skills, Illness Management, Community Re-Entry, and Alcohol and Drug Group. (Discharge Rep. at 4.) He has been under the care and evaluation of Dr. Alleyne for his entire stay at SCDMH. And, Dr. Frierson testified at the hearing that the quantity and quality of evaluation and programming at the SCDMH was more than sufficient to render an opinion to a reasonable degree of medical certainty that he is no longer in need of hospitalization.

B. The Court should adopt the recommendations for release made by the SCDMH and order any others it deems appropriate.

Once the Court concludes that Jevon is no longer in need of hospitalization, the only remaining issue is under what conditions should he be discharged. *See* S.C. Code 17-24-

40(C)(2)(c) & (D); S.C. S. Ct. Administrative Order, dated April 24, 2014, at 3. Importantly, by that same statute, this is a *therapeutic* moment, not a punitive one. Section 17-24-40(D) states that "[a]ny terms and conditions imposed by the chief administrative judge must be **therapeutic in nature, not punitive**." S.C. Code 17-24-40(D) (emphasis added).

The Solicitor's Office, however, conflates the conditions of release question with the hospitalization one. Because, the Solicitor's Office has no countervailing expert testimony or evidence with respect to the need for hospitalization, it raises various concerns about the *conditions of release* to resist the actual discharge and punitively so. Indeed, that is literally what was allowed by the Solicitor's Office to be implied in open court – that Jevon should "never" be released from the hospital and should feel "lucky" to not be in a correctional facility. But, as stated repeatedly above, that is not what the statutory framework, our Supreme Court, the law, or due process permits. *See Foucha*, 504 U.S. at 77.

Dr. Alleyne and Dr. Frierson have both testified that Jevon is too high functioning for a Community Residential Care Facility (CRCF) and that such a setting would actually expose Jevon to greater risks than being with his grandmother and family and would provide no better assurances for community safety. SCDMH has evaluated his grandmother's home and concluded that it is a suitable and therapeutic environment, indeed precisely because familial love and support is so clinically important to an individual's success. (Alleyne Testimony.) As discussed, Jevon's grandmother has no criminal record and is not related to the victim's family nor does she live near them.

The Solicitor's Office has not offered any conditions that it would recommend.

As to the matter of supervision, pursuant to S.C. Code §17-24-80(A) and the Supreme Court's Administrative Order, the monitoring of Jevon is the responsibility of the Office of

Probation, Parole, and Pardon ("PPP"), the Greater Greenville Mental Health Center, the NGRI Outreach Center, and himself. That is how our General Assembly and Supreme Court have designed the process.

And, it was disingenuous of the Solicitor's Office to act as if there is no procedure for reporting any violations or feign that it somehow does not know it. Indeed, at the hearing, the Solicitor's office suggested that it may never be notified of any violation of the Court's Release Order. But, in the South Carolina Supreme Court's Administrative Order, which undersigned has discussed for years with the Solicitor's Office, the entire procedure is explicitly outlined. (S.C. S. Ct. Administrative Order, dated April 24, 2014, at 5.)

> In the event of alleged violation of the Release Order that involves a community or Defendant safety issue, in the discretion of SCMH employees, SCDMH shall ***immediately report such allege violation to the Sheriff*** of the county where the Defendant is located, with a request to pick up the Defendant and return him to a facility designated by SCDMH. At that time, ***SCDMH legal office shall also notify*** the Defendant, probation officer, ***the prosecuting solicitor***, and defense counsel. ***It is then the duty of the probation officer to notify the Chief Administrative Judge*** [SC Code Ann. 17-24-80(C)]. If the alleged violation does not involve a safety issue for which the Defendant should be immediately taken into custody, then SCDMH should notify the same parties with the exception of he sheriff, and it is then the duty of the probation officer to notify the Chief Administrative Judge, who will determine whether a hearing on the matter is necessary.

Id. (emphasis added).

And, the proposed Outpatient Order previously submitted to the Court incorporates this same procedure, including all notification requirements to the Court and the Solicitor's Office. (Proposed Outpatient Order at 4-5.)

Jevon will, among other things, as outlined in the Discharge Report, Proposed Outpatient Order, and Supreme Court Adminstrative Order,

- reside with his grandmother, who does not live near the victim's family;

- be monitored by Probation, Parole, and Pardon ("PPP"), the Greater Greenville Mental Health Center, the NGRI Outreach Center;
- report monthly to the NGRI outreach clinic and abide by all scheduled appointments and activities;
- participate with Caroline Caldwell of New Mind Health Care, specializing in community reentry programming;
- take all prescribed medications;
- participate in all treatment groups;
- comply with randomized drug testing;
- not possess weapons and firearms;
- not use drugs; and
- not associate with felons[3]

These are literally the conditions expressly outlined for the Court to consider in the statute and more. *See* S.C. Code 17-24-40(D). The Solicitor's Office may disagree with the General Assembly and Supreme Court about the statutory procedure and conditions and wish they were different. But, this is the NGRI framework for South Carolina and the one anticipated when the NGRI determination was originally made.

And, these conditions also represent the expert opinions of the statutorily authoritative agency of the State of South Carolina. SCDMH manages these individuals day on day, year on

[3] The Solicitor's Office has suggested that because Jevon's mother has a felony record that any interaction with her would be a *per se* violation of the proposed order, and mandate that Mr. Carter be readmitted to hospitalization, due to the proposed prohibition of Jevon from interacting with known felons outside of treatment groups. This position should not be taken earnestly. The Court obviously have the legal and practical ability to alter that provision as it sees fit, including a specific carve-out for contract with Jevon's mother. And, Dr. Alleyne testified that this is in fact done precisely because the purpose of such a provision is not to isolate the patient from his family but instead to insulate them from other nefarious criminal activity.

year. The SCDMH has no incentive to, or interest in, carelessly recommending the discharge of Jevon on these conditions – it actually believes that they are therapeutic and sufficient to safeguard the community and Jevon.

To the extent the Court believes some additional conditions are necessary, it has the statutory and administrative ability to order them, including concerning contact with family members of the victim. (S.C. S. Ct. Administrative Order, dated April 24, 2014, at 3); *see* S.C. Code 17-24-40(D). But, any deficiency in the proposed conditions is not a basis to deny release.

And, Jevon's discharge is not anomalous. As Dr. Alleyne testified, there are currently 47 individuals who have been discharged from the SCDMH, living in the community under NGRI supervision, who were originally charged with *murder or attempted murder*.

Jevon's rehabilitation and discharge is the purpose of our NGRI procedure *because he is not a "prisoner."* (S.C. S. Ct. Administrative Order, dated April 24, 2014, at 2.) To continue to hold him, out of preemptive concern for future crime, is illegal. He is literally not a defendant. This discharge decision is not the same as a bond consideration for a pretrial detainee who is facing probable cause for a crime. Jevon has already been adjudicated not guilty. Continued hospitalization in the absence of any active mental illness would be an unconstitutional and dystopian result. *See Foucha*, 504 U.S. at 77.

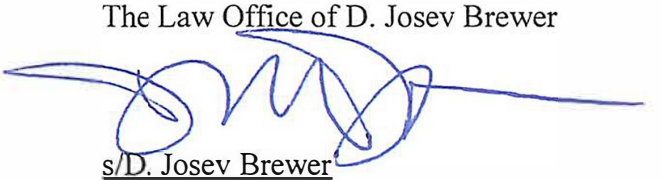
Jevon would respectfully ask that the Court accept the discharge recommendation and plan and find that there is clear and convincing evidence of only one result – that he is no longer in need of hospitalization pursuant to the statutory factors.

CONCLUSION

Based on all of the foregoing, Mr. Jevon Carter is respectfully requesting that the Court accept the expert recommendation and request for discharge of the South Carolina Department of Mental Health. Pursuant to S.C. Code § 44-14-580 and other applicable South Carolina law, he is not in need of further hospitalization.

Respectfully submitted,

The Law Office of D. Josev Brewer



s/D. Josev Brewer
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September 28, 2023
Greenville, South Carolina

STATE OF SOUTH CAROLINA	)	IN THE COURT OF GENERAL SESSIONS
	)	THIRTEENTH JUDICIAL CIRCUIT
COUNTY OF GREENVILLE	)	
	)	
The State of South Carolina,	)	MEMORANDUM OF SCDMH REGARDING
	)	LACK OF NEED FOR HOSPITALIZATION
vs.	)	
	)	Indictment No(s). 2021GS2305230-31
Jevon Kenneth Carter,	)	Case No(s). 2020A2320602678-80
	)	
Defendant.	)	

The South Carolina Department of Mental Health (SCDMH) notified this Court on July 7, 2023 that Jevon Kenneth Carter (Mr. Carter) is no longer in need of hospitalization, as mandated by S.C. Code §17-24-40 (C)(2)(c). A hearing was conducted on August 30, 2023, to determine whether Mr. Carter needs continued hospitalization pursuant to the standard of S.C. Code §44-17-580. During this hearing, the Court requested a brief from each party to further clarify their arguments. The Department respectfully submits this memorandum in support of Mr. Carter's discharge from psychiatric hospitalization and in support of Mr. Carter's continuation of treatment on an outpatient basis.

Facts

Jevon Carter is a twenty-one (21) year old man with a current diagnosis of Schizoaffective Disorder, Bipolar Type.

Jevon Kenneth Carter was found not guilty by reason of insanity (NGRI) on June 13, 2022, on the charges of Voluntary Manslaughter, Burglary 1st Degree, and Possession of a Weapon During a Violent Crime. Pursuant to S.C. Code §17-24-40(A), Mr. Carter was admitted to SCDMH for inpatient care "for a period not to exceed one hundred twenty days" on August 16, 2022. Mr. Carter has been treated by the Department since that time.

Procedural History

On November 10, 2022, the Department rendered a Request for Discharge under §17-24-40 (B) and relayed that Mr. Carter was no longer in need of inpatient treatment pursuant to the standards set forth at §44-17-580. A hearing was held pursuant to S.C. Code §17-24-40(C)(1) on December 8, 2022. The Court denied the Department's recommendation for discharge in a January 9, 2023 "Order for Inpatient Care." Specifically, the Court found that "upon clear and convincing evidence, (Mr. Carter) lacks sufficient insight or capacity to make reasonable decisions with respect to his treatment and that there is a likelihood of harm to himself or others."

Mr. Carter has remained hospitalized under the Court's January 9, 2023 order. In the intervening months, Mr. Carter worked with treatment staff at the Forensic Unit of G. Werber Bryan Psychiatric Hospital to address the findings of the Court.

- Mr. Carter has been on a self-administered medication protocol since February 9, 2023. Under this protocol, Mr. Carter is responsible for approaching staff to provide him with oral medication and administering the correct dosage, as opposed to the typical protocol wherein staff informs patients of medication times unilaterally. This protocol is utilized with patients who are approaching discharge to closely mimic the steps that a patient would take to self-administer medication in their own homes. Such a protocol is incredibly rare in an inpatient psychiatric setting, and to date Mr. Carter is the only current patient of the Forensic Unit on such a protocol.
- Mr. Carter's discharge placement was updated so that he may reside with his grandmother, Ms. Cynthia Chapman, instead of his mother, Ms. Keshawna Young. This update allows Mr. Carter to obtain the benefit of residing within a supportive family

structure while addressing concerns related to Ms. Young's prior interactions with the criminal justice and public health systems.

- SCDMH sought the opinion of a neutral-party expert in the field of forensic psychiatry to gain an impartial opinion on Mr. Carter's readiness for discharge pursuant to the civil commitment standard codified at S.C. Code §44-17-580(A). Dr. Richard Frierson rendered this opinion, and a report of that finding has been provided to the Court as a Violence Risk Assessment.

A Forensic Discharge Review Board (FRB) was held for Mr. Carter on June 23, 2023. Mr. Carter's Request for Discharge was presented by Mr. Carter's treating psychiatrist and treating social worker and approved by the FRB. The recommendation of the FRB was then approved by the SCDMH Deputy Director for Inpatient Services, the Medical Director for the Division of Inpatient Services, and the Director of Forensic Services during a June 27, 2023 administrative review. Accordingly, the approved Request for Discharge was mailed to the Court and parties on July 7, 2023 along with a request for a hearing pursuant to §17-24-40(C)(1).

A hearing was held on August 30, 2023, following the Department's July 7, 2023 notification. SCDMH was represented by Assistant General Counsel Logan Royals. The Department proffered two expert witnesses in support of Mr. Carter's discharge; Dr. Jennifer Alleyne and Dr. Richard Frierson. Mr. Carter was present at the hearing and represented by attorney Josev Brewer. Friends and family appeared in support of Mr. Carter's discharge. The State was represented by Assistant Solicitor Andrew Miller. The victim's family was present and requested that Mr. Carter remain institutionalized for the rest of his life.

Issue

Is Mr. Carter in need of continued hospitalization pursuant to the civil commitment standard of S.C. Code section 44-17-580?

Sources of Law

1. S.C. Code Ann. §17-24-40(C)(2)(b)

   In the event the chief administrative judge finds the person to be in need of hospitalization, the judge must order the person committed to the South Carolina State Hospital.

2. S.C. Code Ann. §17-24-40(C)(2)(c)

   If at a later date it is determined by officials of the State Hospital 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. Within twenty-one days after the receipt of this notice, the chief administrative judge, upon notice to all parties, must hold a hearing to determine whether the person *is in need of continued hospitalization pursuant to the standard of Section 44-17-580.* If the finding of the court is that the person is in need of continued hospitalization, the court must order his continued confinement. 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, as the chief administrative judge considers appropriate for the safety of the community and the well-being of the person. (*Emphasis Added.*)

3. S.C. Code Ann. §17-24-40 (E)

   The chief administrative judge of the circuit in which the trial was held at all times has jurisdiction over the person for the purposes of this chapter.

4. S.C. Code Ann. §44-17-580(A)

   If, upon completion of the hearing and consideration of the record, the court finds upon *clear and convincing evidence* that the person is mentally ill, needs involuntary treatment and because of his condition:

   (1) lacks sufficient *insight or capacity* to make responsible decisions with respect to his treatment; or

   (2) there is a *likelihood of serious harm to himself or others*, the court shall order in-patient or out-patient treatment at a mental health facility, public or private, designated by the Department of Mental Health and may order out-patient treatment following in-patient treatment. If the court finds that the person is not mentally ill and not in need of involuntary treatment, *the court shall dismiss* the

proceedings. (*Emphasis Added*)

5. S.C. Code Ann. §44-22-50 (E)

Patients have a right to the *least restrictive conditions* necessary to achieve the purposes of treatment. The facility shall make *every attempt* to move residents from:

(1) more to less structured living;
(2) larger to smaller facilities;
(3) larger to smaller living units;
(4) group to individual residences;
(5) *segregated from the community to integrated into the community living*;
(6) *dependent to independent living*. (*Emphasis Added.*)

6. Addington v. Texas, 441 U.S. 418, 99 S.Ct. 1804, (1979).

"[An] individual's interest in the outcome of a civil commitment proceeding is of such weight and gravity that due process requires the state to justify confinement by *proof more substantial than a mere preponderance of the evidence.*" (*Emphasis Added*)

6. Vitek v. Jones, 445 U.S. 480, 100 S.Ct. 1254, (1980).

"None of our decisions holds that conviction for a crime entitles a State not only to confine the convicted person but also to determine that he has a mental illness and to *subject him involuntarily to institutional care in a mental hospital*. Such consequences visited on the prisoner are qualitatively different from the punishment characteristically suffered by a person convicted of crime. Our cases recognize as much and reflect an understanding that involuntary *commitment to a mental hospital is not within the range of conditions of confinement to which a prison sentence subjects an individual.*" (*Emphasis Added*)

Discussion

S.C. Code section 17-24-40 (NGRI Statute) governs the procedures by which a former defendant, SCDMH, the parties, and the Court operate when considering the need for hospitalization. Having previously been adjudicated, Mr. Carter participated in a hearing following an initial 120 days of inpatient treatment as anticipated by §40(C)(1). Following that hearing, Mr. Carter was committed to hospitalization with SCDMH as anticipated by §40(C)(2)(b).

SCDMH is later commanded to inform the Court when it determines that the former defendant is no longer in need of treatment at §40(C)(2)(c), and a hearing is then necessitated to determine the former defendant's need for continued hospitalization under the civil commitment standard of S.C. Code §44-17-580. Notably, no reference is made to the terms or finding of the order necessitated by §40(C)(2)(b), and there is nothing within §(C)(2)(c) that mandates that the Court incorporate the findings or reasoning of an order issued under §40(C)(2)(b) when determining if the former defendant remains in need of hospitalization.

While a finding of not guilty by reason of insanity occurs by operation of the criminal justice system, the NGRI Statute specifically incorporates the civil standard used by probate courts at §44-17-580. Under §580, an individual may only be ordered to involuntary inpatient care if they satisfy a two-prong test regarding their need for inpatient care by a clear and convincing evidence standard. Addington explicitly notes that the 14th Amendment *requires* a clear and convincing standard for commitment proceedings. See Addington v. Texas, *supra*, at 432. Thus, an individual that has been found NGRI can only be ordered to remain involuntarily committed to inpatient care if they satisfy either of the two conditions of §580 by clear and convincing evidence.

The two prongs in §580 are whether the individual, because of his mental illness (1) lacks sufficient insight or capacity to make responsible decisions regarding this treatment and (2) is likely to pose a threat of serious harm to himself or others. Both prongs require that the individual either lack insight or pose a risk of serious harm *because of his underlying condition*, and not solely due to other external factors. This reflects the ultimate goal of successfully treating an individual's mental illness, as opposed to merely incapacitating an individual that has a history of making poor decisions or resorting to violence.

Thus, the entity moving to involuntarily commit or continue commitment for an individual alleged to have a mental illness must prove, by clear and convincing evidence, that a person's mental illness prevents them from making responsible decisions regarding their treatment or makes it more likely than not that they pose a likelihood of serious harm to themselves or others. If that movant does not meet that standard, §44-17-580 (A) mandates that the Court *shall* dismiss the proceedings.

In Mr. Carter's case, the State has failed to meet this standard of proof.

During the August 20, 2023 hearing, this Court qualified, without objection, two different experts in the field of forensic psychiatry to provide testimony that Mr. Carter no longer needs hospitalization and is appropriate for discharge under the terms of the proposed order.

Dr. Jennifer Alleyne is the Chief of Forensic Medicine at the Bryan Psychiatric Hospital Forensic Unit, and Mr. Carter's treating psychiatrist. Regarding Mr. Carter's insight, Dr. Alleyne relayed that Mr. Carter understands his illness, the symptoms and the appropriate routes to address any potential symptoms, and his extraordinary compliance with both his oral and intramuscular medications. She explained why these hallmarks of insight illustrate that Mr. Carter's illness can be properly maintained on an outpatient basis. Regarding Mr. Carter's potential for violence, Dr. Alleyne relayed that Mr. Carter has not needed disciplinary intervention, and has demonstrated coping skills to avoid physical confrontations. Finally she explained how proper medication mitigates the risk of violence for Mr. Carter upon discharge.

Dr. Richard Frierson is the Alexander G Donald Professor of Psychiatry and Vice Chair for Academic Affairs at the University of South Carolina School of Medicine, and the Program Director for the Forensic Psychiatry Fellowship at USC Schol of Medicine. Dr. Frierson has no treatment relationship with Mr. Carter, and based his opinions on an independent evaluation of

Mr. Carter. Via written report and testimony, Dr. Frierson agreed that Mr. Carter has shown sufficient insight into his illness to make outpatient treatment appropriate. Moreover, Dr. Frierson specifically evaluated Mr. Carter's risk of future violence utilizing the Historical-Clinical-Risk Management-20, (HCR-2) Version 3, and concluded that further hospitalization is not indicated.

Both Dr. Frierson and Dr. Alleyne testified that there would be absolutely no further therapeutic benefit to Mr. Carter's continued hospitalization or placement at a Community Residential Care Facility (CRCF) upon discharge from Bryan Forensics. Under S.C. Code Ann. §44-22-50(E), patients are entitled to treatment in the least restrictive means possible, and SCDMH is specifically commanded to seek placement in settings that are "integrated into the community" and "independent" as necessary to achieve the purposes of treatment.

The State offered no expert testimony to contradict the recommendation of SCDMH or the expert witnesses. Instead, the State has relied on obfuscations and biases to object to the discharge plan proffered by DMH without offering any tangible alternatives to Mr. Carter's unwarranted and unnecessary hospitalization.

Much has been made of Mr. Carter's proposed residence upon discharge, with the State objecting to Mr. Carter residing with his grandmother (Chapman) due to her geographic proximity to Mr. Carter's mother (Young). The State supposes that because Ms. Young has a felony conviction and a history of chemical dependence, Mr. Carter will be unable to benefit from outpatient mental health services if he is in close geographic proximity to his own mother. This proposition is ripe for confirmation or elaboration by a medical expert, which the State has failed to provide. To the contrary, Dr Alleyne testified that the support of family is beneficial to the treatment of individuals with Schizoaffective Disorder, and that residence with Ms. Chapman

would provide the structure and stability necessary for Mr. Carter to meaningfully benefit from outpatient treatment.

Moreover, the State has contended that a single interaction with Ms. Young would be a *per se* violation of the proposed order, and mandate that Mr. Carter be readmitted to hospitalization, due to the proposed prohibition of Mr. Carter from interacting with known felons outside of treatment groups. This proposition is flawed for several reasons. First, Dr. Alleyne provided context related to the inclusion of that verbiage to prevent patients from participating in gang-related activities. Next, Dr. Alleyne also indicated that clinical judgment would be utilized when determining if readmission is necessary due to Mr. Carter's interactions with known felons, including Ms. Young. Lastly, as Mr. Brewer pointed out, the Court has the legal and practical ability to alter that provision as it sees fit, including a specific carve-out for Ms. Young or deletion of the prohibition altogether.

Perhaps most puzzling, the State has objected to Mr. Carter's discharge out of concern for his medical compliance. As of the submission of this memorandum, Mr. Carter is prescribed one intramuscular injectable medication (Aripiprazole) and two oral medications (Oxcarbazepine and Trazodone) to treat his Schizoaffective Disorder. According to Dr. Alleyne's testimony, Mr. Carter has been compliant with his medical regimen since his admission to the Forensic Unit and he has not endorsed any objections to the medication, based on side effects or otherwise. Moreover, Mr. Carter has demonstrated compliance through medication self-administration protocol by taking responsibility for and complying with medication administration.

The civil commitment standard of §44-17-580(A) calls for an analysis of the individual's insight into their treatment based on a contemporary analysis of the patient's status by two mental health professionals. Here, two expert-qualified forensic psychiatrists have relayed that

Mr. Carter has enough insight into his illness to be treated on an outpatient basis. Notably, both experts testified that they were aware of Mr. Carter's purported medication refusals prior to admission to Bryan, and both still testified to his appropriateness for discharge based on facts that exist at this time. The State's opposition to discharge based on medical compliance is based solely on history prior to Mr. Carter's admission to Bryan Forensics. Here, the State seeks to hold Mr. Carter responsible for alleged past acts, but simultaneously omits any insight or compliance currently demonstrated by Mr. Carter while hospitalized at Bryan. Such an outlook renders commitment for Mr. Carter under the NGRI process as little more than incapacitation instead of meaningful psychiatric treatment. Vitek makes it clear that unnecessary commitment to a psychiatric hospital is not within the realm of punishment for an individual *convicted* of a crime, much less someone that has been found not-guilty. See Vitek v. Jones, *supra*, at 493.

Conclusion

The State has failed to provide any *evidence* to contradict the SCDMH's clinical evidence from multiple sources that Mr. Carter no longer meets the criteria for hospitalization. The State's opposition Mr. Carter's discharge is based solely on *speculation* of what could happen in the future. Could Ms. Young be a bad influence on Mr. Carter? Could Mr. Carter's condition worsen if he refused his medication? Could Mr. Carter refuse to engage in treatment and go on the lam? These are all fair questions, but questions that are properly elucidated by experts in psychiatry. To date, after two hearings, the State has yet to proffer a single expert that opposes Mr. Carter's discharge. More importantly, SCDMH has considered and contextualized these questions for the Court while endorsing Mr. Carter's discharge. Mr. Carter has a right to treatment in the least restrictive means possible under §44-22-50 (E), and the experts from SCDMH have determined that the proposed discharge plan constitutes the least restrictive means

necessary for Mr. Carter to successfully treat his illness. Vague assertions that a person might become sick or violent in the future, contrasted with expert testimony that a person is presently neither and unlikely to become either, cannot properly be deemed clear nor convincing evidence that a person should remain institutionalized. As the Supreme Court explained, "the inquiry involved in determining whether or not to transfer an inmate to a mental hospital for treatment involves a question that is essentially medical. The question whether an individual is mentally ill and cannot be treated in prison "turns on the meaning of the facts, which must be interpreted by expert psychiatrists and psychologists." See Vitek v. Jones, *supra*, at 495-496.

The South Carolina Department of Mental Health is charged with treating former defendants that have been found Not Guilty by Reason of Insanity, and then determining whether that person continues to need hospitalization. S.C. Code 17-24-40. This is a duty that the Department does not take lightly, and a duty that is bolstered by a robust system of reviews, approvals, and outpatient supervision. Mr. Carter's lack of need for hospitalization under the civil commitment standard of §44-17-580 has been opined by his treatment team, discussed and approved by an interdisciplinary group of mental health professionals, and approved by hospital administration. Moreover, the Department elicited the unbiased opinion of a neutral forensic psychiatrist to review whether the Department's discharge plan was appropriate for Mr. Carter, and that psychiatrist agreed that Mr. Carter could be properly treated on an outpatient basis under the terms proffered by SCDMH. Two separate experts were subject to direct and cross examination in support of Mr. Carter's discharge, and both endorsed that he has reached the maximum possible benefit to his hospitalization, and that discharge is appropriate under §44-17-580. To put it simply, SCDMH has determined that Mr. Carter is no longer in need of hospitalization.

Psychiatric hospitals and mental health systems are intended to provide treatment to individuals with mental illnesses. They are not intended to be a branch of the criminal justice system. The means by which an individual is ordered to undergo inpatient psychiatric treatment must be governed by notions of medical necessity and legal mandate, not incapacitation or retribution. The Department respectfully asserts that the State has not met its burden of proof that Mr. Carter remains in need of continued hospitalization by a clear and convincing standard, that mandating that SCDMH continue to hospitalize Mr. Carter forces SCDMH to violate the clear directive of §44-22-50(E), and that continued hospitalization constitutes a violation of Mr. Carter's 14th Amendment rights.

Accordingly, the Department respectfully requests that Mr. Carter be released to outpatient care pursuant to SC Code Ann. §17-24-40(C)(2)(c).

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September 29, 2023

2021GS2305230-31

STATE OF SOUTH CAROLINA	)	IN THE COURT OF GENERAL SESSIONS
	)	THIRTEENTH JUDICIAL CIRCUIT
COUNTY OF GREENVILLE	)	
	)	
The State of South Carolina,	)	INDICTMENTS # 2021GS2305230, -5231
	)	
vs.	)	**BRIEF IN OPPOSITION TO**
	)	**2nd SCDMH PROPOSED ORDER**
JEVON KENNETH CARTER,	)	
Defendant.	)	
	)	

'23 SEP 20 PM4:10
Brice Garrett COC GVL SC

This matter was before the court on August 30, 2023, for a second hearing to establish a manner of treatment pursuant to SC Code §17-24-40(c)(1) after the Defendant was found Not Guilty by Reason of Insanity of Voluntary Manslaughter, Burglary in the 1st Degree and Possession of a Weapon During a Violent Crime. The South Carolina Department of Mental Health (SCDMH) initially submitted a proposed order recommending outpatient treatment on November 10, 2022 and a hearing was held regarding that proposal on December 8 2022. That proposal was denied by Judge Gravely on January 9, 2023 and further inpatient treatment was ordered. The second proposal was submitted on July 7, 2023, and is the basis of the August 30, 2023 hearing. At the hearing SCDMH was represented by Logan Royals, and Dr. Jennifer Alleyne testified in support of the proposed order. The Defendant was present with his attorney, D. Josev Brewer, and the State was represented by Assistant Solicitor Andrew Miller. At the conclusion of the hearing, the Court asked for each side to brief their arguments regarding the proposed order.

Statutory Law

Pursuant to SC Code §17-24-40, when SCDMH submits a report recommending discharge of an NGRI Defendant from inpatient care, the court must hold a hearing "to decide whether the person should be hospitalized pursuant to the standard of §44-17-580." That

standard requires the Court to determine, upon clear and convincing evidence, whether a person is mentally ill, needs involuntary treatment, and either lacks sufficient insight or capacity to make responsible decisions with respect to his treatment or there is a likelihood of serious harm to himself or others.[1]

If the Court "finds the person to be in need of hospitalization, the judge *must* order the person committed to the South Carolina State Hospital."[2] The Court is not required to accept the recommendation of SCDMH regarding hospitalization: "If state hospital officials request a hearing upon their belief the NGRI defendant is no longer in need of hospitalization and the court disagrees with this position, the court 'shall order continued confinement.'"[3]

On the other hand, if the Court finds further hospitalization is not required, the Court "may order the person released upon such terms or conditions, if any, as the judge considers appropriate for the safety of the community and the well-being of the person."[4] Those terms must be therapeutic in nature, rather than punitive, and may include, but are not limited to, continuing to take medication for indefinite time and verifying the use in writing, periodic examination and reviews by psychiatric personnel, and reporting periodically to the probation office.[5] Per the Supreme Court Administrative Order, the Court may also "include provisions for the safety of the community in general and the victim in particular, including 'no contact' strictures, specific housing requirements, and curfew restrictions."[6]

Constitutional Law

The Defense asserted at the hearing on August 30, 2023, that keeping the Defendant in

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[1] SC Code Ann. §44-17-580
[2] SC Code Ann. §17-24-40(C)(2)(b)
[3] *State v. Hudson*, 336 S.C. 237, 247 (1999)
[4] SC Code Ann. §17-24-40(C)(2)(a)
[5] SC Code Ann. §17-24-40(D)
[6] Administrative Order: *Interagency Protocol for Defendants Found Not Guilty by Reason of Insanity*; Supreme Court of South Carolina (2014)

inpatient care longer than an SCDMH doctor recommends is medically necessary would constitute a violation of his constitutional rights. The State strongly disagrees with that assertion. The relevant case law shows that the Defendant can be constitutionally hospitalized as long as the Court finds that the Defendant is both mentally ill and presents a danger.[7]

The Defense is attempting to equate this Defendant's condition with that in *Foucha v. Louisiana*, but unlike the case before the Court, it was uncontested that the defendant in *Foucha* was no longer mentally ill. The defendant in *Foucha* had suffered a temporary, drug induced psychosis, which had been cured during his hospitalization. "Louisiana does not contend that Foucha was mentally ill at the time of the trial court's hearing. Thus, the basis for holding Foucha in a psychiatric facility as an insanity acquittee has disappeared."[8] That is a far cry from the situation at hand, in which it is undisputed that the Defendant is still suffering from a serious chronic mental illness, and temporarily stabilized on medication.

The Defense also cites to *Addington v. Texas* and *Vitek v Jones*[9], however both of those cases are immaterial of the issue before the Court today. *Addington* is purely a civil commitment case, with a far different standard than that for a defendant found NGRI. The Supreme Court in *Jones v. US*[10] clarified that distinction, and in that case upheld a system that even places the burden of proof on the defendant found NGRI to prove that they are no longer mentally ill or a danger to the community. *Vitek* deals with transferring a defendant, without a finding of NGRI or any judicial commitment, from a prison to a mental hospital, and is not relevant to the current issue. The pertinent case law is unambiguous, and South Carolina's statutory framework is clearly constitutional. The Constitution permits an NGRI defendant to be hospitalized as long as

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[7] See *Foucha v. Louisiana*, 504 U.S. 71 (1992); *Jones v. US*, 463 U.S. 354 (1983)
[8] *Foucha v. Louisiana*, 504 U.S. 71, at 78
[9] *Addington v. Texas*, 441 U.S. 418 (1979), *Vitek v. Jones*, 445 U.S. 480 (1980)
[10] *Jones v. US*, 463 U.S. 354 (1983)

the Court finds that he is mentally ill and poses a danger to the community.

SCDMH Proposal Violates the Court's Previous Order

This issue was before the Court previously, on December 8, 2022, when SCDMH submitted a nearly identical Report of Findings and Request for Discharge as the one before the Court today. Two paragraphs were added to the new SCDMH report updating the Defendant's treatment progress, the Defendant's Mother's name was replaced with his Grandmother, and the proposed address of discharge was changed from 5 Harrison Ave. to 3 Harrison Ave. It was established at the second hearing that these residences are approximately twenty feet apart from each other. The Court's previous order found this location to be inappropriate and stated that "IF SCDMH determines that the Defendant should be released at some point in the future, then a more appropriate treatment plan regarding supervision of the Defendant will need to be provided, including the consideration of transitional housing and a more stable environment with appropriate monitoring and supervision."[11] It is clear from the submitted discharge plan and testimony that this Order of the Court was completely disregarded. Per Dr. Alleyne's testimony, no additional monitoring or supervision, at least in any meaningful sense, has been added. She stated that the Defendant's family could monitor him, but that they would not be legally or professionally required to do in any way. This is exactly the same monitoring and supervision that the Court found insufficient at the first hearing, and has not been corrected for the August 2023 hearing. For this reason alone, the current Request to Discharge should be denied.

Defendant Requires Continued Inpatient Treatment

At the August 2023 hearing, uncontroverted testimony from Dr. Alleyne and Dr. Frierson showed that the Defendant is mentally ill and needs involuntary treatment. Therefore the only area of dispute is whether he has sufficient insight to make responsible decisions with respect to

[11] Order for Inpatient Treatment issued by Judge Gravely on January 9, 2023

his treatment, or he presents a likelihood of serious harm to himself or the community.

For the reasons outlined below, the State opposes the recommendations of SCDMH and asserts there is clear and convincing evidence to find both that the Defendant lacks sufficient insight or capacity to make reasonable decisions with respect to his treatment and there is a likelihood of serious harm to himself or others. A finding of either of these factors would require the Court to find further hospitalization necessary.

In the alternative, if the Court finds further hospitalization is not required, the State contends that the terms and conditions proposed by SCDMH are wholly inadequate safeguards for both the safety of the community and the Defendant. In that case, the State would ask the Court to require SCDMH to comply with the Court's previous order, and propose a new plan imposing far more stringent conditions in terms of monitoring to ensure the Defendant's care, treatment, and the safety of the community. Pursuant to the statute, an additional hearing would then be required to determine the Defendant's hospitalization status.[12]

I. The Defendant Lacks Insight or Capacity to Make Responsible Decisions with Respect to His Treatment

The Defendant in this case has a demonstrable track record of non-compliance with treatment when he is not within the care of SCDMH inpatient treatment. At the December 2022 hearing, the State presented clear evidence of prior non-compliance as well as evidence of serious concerns regarding the process and monitoring at SCDMH in this case.

This Defendant has successfully eloped from inpatient care on two separate occasions.. On July 4, 2020, the Defendant, while involuntarily committed to Marshall Pickens Hospital, was able to climb over a wall and escape inpatient care. During the elopement on July 4, 2020, the Defendant committed the underlying offenses. On July 8, 2020, the Defendant again escaped

[12] SC Code Ann. §17-24-40(c)(2)(C)

from inpatient care by running through a glass door. The Defendant attempted to elope from inpatient care on one additional occasion by breaking a window on July 7, 2020.[13] The fact that Defendant tried on three separate occasions, twice successfully, to escape from involuntary commitment shows that he is incapable of making responsible decisions regarding his own care and treatment.

The Defendant has also exhibited an unwillingness to comply with required medications. During inpatient care; nurses noted "his poor insight and poor compliance with medications. It was noted that when he would ingest the medications, he immediately went to his room to regurgitate them in the toilet."[14] During the Defendant's final six months in the Greenville County Detention Center, between February 2022 and July 2022, the Defendant refused medications on fifty separate occasions for a total of eighty-seven missed doses of his prescribed medications. A clear pattern can be seen within the records of the Defendant refusing Oxcarbazepine a total of 46 times during that period.[15] As Dr. Alleyne testified at both hearings, Oxcarbazepine is a mood stabilizer commonly known as Trileptal and is necessary to maintaining the Defendant's stability. According to the testimony of Dr. Alleyne as well as the proposed plan from SCDMH, he is required to take 150mg of Oxcarbazepine by mouth twice per day. Although he has been moved to "self-administer" medications within the hospital, they are still provided to him in the correct dosages at the correct time and monitored by hospital staff. Under the proposed plan, the Defendant would administer that medication at home and there would be no responsible party monitoring that it is properly taken. The State contends that his track record of noncompliance from the Greenville County Detention Center is clear evidence that he lacks sufficient insight with respect to his required treatment and demonstrates a high

[13] Criminal Responsibility and Capacity to Conform Evaluation (p. 5)
[14] Criminal Responsibility and Capacity to Conform Evaluation (p. 5)
[15] Greenville County Detention Center Medication Records

likelihood of noncompliance if daily monitoring by medical staff was suddenly removed.

Dr. Alleyne testified that the Defendant was in compliance with his medications and treatments at SCDMH during his evaluation period. Testimony and evidence admitted at the first hearing revealed that the Defendant was quite aware that he was being monitored for the purpose of determining the need for ongoing hospitalization. The Defendant was aware that in order to achieve his desired outcome he would have to be fully compliant for a set amount of time.[16] As previously noted, during the month prior to his admission to SCDMH, July of 2022, the Defendant refused seventeen medications on eight separate occasions, seven of which were Oxcarbazepine.[17] A clear pattern has emerged of the Defendant refusing medications when he believes his compliance is not being monitored, followed by strict compliance when being evaluated and motivated by the potential to leave a treatment facility, and that provides no reassurance whatsoever that the Defendant would continue to comply with medications if left to fully monitor himself.

There were two periods of time in which the Defendant was discharged to his family members from inpatient care that provide enlightening examples of the Defendant's insight and responsible decision making with respect to his care. The Defendant was initially discharged to his family from Marshall Pickens Hospital on July 22, 2020. On July 27, 2020, a mere five days later, he was "pulled over by police after being found driving erratically. He admitted to cannabis use. The officers witnessed him experience a seizure and called EMS for him to be transported to the ED." [18] He was again discharged to his family on July 29, 2020, and was arrested on the charges of Voluntary Manslaughter, Burglary in the 1st Degree and Possession of a Weapon during a Violent Crime on August 28, 2020. Once Defendant was at the Detention Center, it was

[16] Greenville County Detention Center Mental Health Progress Note dated June 6, 2022
[17] Greenville County Detention Center Medication Records
[18] Criminal Responsibility and Capacity to Conform Evaluation (p. 6)

noted that on "September 4, 2020, he reported his mood was depressed. He admitted to paranoid and racing thoughts. Mid-October 2020, he continued to report auditory hallucinations from God telling him scripture and that he was going to be famous."[19] The first of these incidents display a clear inability to make responsible decisions with respect to his treatment, resulting in a negative interaction with law enforcement within just five days of discharge. No records are available regarding the period between July 29 and August 28, 2020, but it is clearly documented that he was actively experiencing symptoms and was not stabilized by the end of that approximately one-month period.

The July 27, 2020, incident also indicates an immediate return to illegal drug use upon discharge from inpatient care. Per Dr. Alleyne's testimony, drug use, including cannabis, alcohol. or stimulants can have serious negative interactions with the Defendant prescribed medications and would be detrimental to his treatment. Based on this incident, as well as evidence of the proposed environment into which the Defendant would be discharged, the State contends the SCDMH plan would be essentially setting the Defendant up for failure with respect to reasonable decision making regarding his treatment.

II. There is a Likelihood of Serious Harm to the Defendant or Others

The Defendant has been found not guilty by reason of insanity of two offenses that are statutorily categorized as Violent and Most Serious; Voluntary Manslaughter and Burglary in the 1st Degree. The Defendant has now admitted to those acts in addition to stipulating that a jury would likely have found him guilty of those offenses. As the Court is well aware, the underlying incident was truly violent with no known motive. "The fact that a person has been found, beyond a reasonable doubt, to have committed a criminal act certainly indicates dangerousness... Indeed, this concrete evidence generally may be at least as persuasive as any predictions about

[19] *Id.*

dangerousness that might be made in a civil-commitment proceeding.[20]" The violent attack perpetrated by this Defendant in July 2020 is extremely strong evidence of risk of serious harm to the community. The State contends that when that evidence is weighed against the predictive opinions presented by SCDMH, the clear and convincing evidence standard is still met.

The Defendant was incarcerated in the Greenville County Detention Center from August of 2020 until August of 2022, and he has only been in SCDMH care and professionally monitored by their staff for a period of one year prior to the issuance of the proposed plan and order. Dr. Alleyne has now testified twice that she only spent a matter of a few hours total with the Defendant, which the State views as highly inadequate to form an opinion that would outweigh the clear evidence of the Defendant's prior history. The State finds it hard to believe that after only one year in SCDMH care, Dr. Alleyne or anyone else can say with any degree of certainty that the Defendant does not pose a likely risk of serious harm to himself or others. Per Dr. Frierson's Violence Risk Assessment and his testimony, "There is little medical evidence that future violent acts could be successfully predicted by mental health professionals. Therefore, despite opinions contained in this report, there is no guarantee that Mr. Carter will or will not behave in a violent manner in the future."[21]

Previously admitted medical records are illustrative of the potential danger the Defendant poses to himself or other when not properly medicated and monitored; they describe his condition as "dangerously unpredictable" during an incident in which he broke a chair and window, requiring five security guards to finally subdue him.[22] Dr. Alleyne testified the Defendant is currently stabilized, but that she could not guarantee he would maintain stability even if he were to comply with the SCDMH proposed plan, not to mention if he were to deviate

[20] *Jones v. US*, 463 U.S. 354 at 364
[21] Violence Risk Assessment (p. 8)
[22] Marshall Pickens Hospital Records (p.35-36)

from it.

As maintaining stability is more likely if properly medicated, the likelihood of harm in this case relates directly to the Defendant's inability to make responsible decisions with respect to his treatment. "If the Defendant should fail to take his medication, based on his history and evidence presented, the consequences could be severe and could result in violence as shown by his prior killing of his great aunt without any apparent motive."[23]

The clear pattern of refusing medications at the Detention Center illustrates that the Defendant is unlikely to comply with required medications when discharged from SCDMH care. The Defendant exhibited a sudden streak of compliance when he was transported to the hospital from the Detention Center, but only after telling a Counselor at the detention center that he would comply because "I'm going to Columbia for four to six months and then I will get out…I will [comply]. I want to get out."[24] While it certainly is natural for the Defendant to desire going home, it is also apparent that the Defendant intended to essentially play along for a short period of time to obtain a desired result. There is no evidence that the Defendant will comply with his medications when not actively monitored by medical staff on a daily basis. Again, within five days of his discharge on July 22, 2020, the Defendant was expressing symptoms, using recreational drugs, experienced a seizure and had a negative interaction with law enforcement.[25] Based on this record, it is reasonable to anticipate a return to similar circumstances within a short period of discharge from SCDMH care if the Defendant is not closely monitored by medical professionals.

The proposed plan from SCDMH asks the community and the Defendant to take on these risks, with effectively little to no safeguards in place to either ensure compliance or respond to an

[23] Order for Inpatient Treatment issued by Judge Gravely on January 9, 2023
[24] Greenville County Detention Center Mental Health Progress Note dated June 6, 2022
[25] Criminal Responsibility and Capacity to Conform Evaluation (p. 6)

emergency. At the December 8, 2022, hearing, Dr. Alleyne testified that this was a unique case and the first time she has recommended a discharge to a patient's home after an initial one-hundred and twenty day evaluation. The Report of Findings and Testimony presented at the both hearings indicate that the evaluation was focused purely on the Defendant's clinical stability, and it appears an evaluation of the risk to the community was secondary, if considered at all. Given the violent and inherently dangerous nature of the offense in this case and the Defendant's demonstrated danger and potential for violence when symptomatic, the State contends returning him to the community would present an unreasonable risk of serious harm without substantial safeguards, monitoring, and a documented history of prolonged compliance and stability, which are all seriously lacking at this point.

The SCDMH Proposed Order is Inadequate to Ensure Compliance with Medical Treatment and Prevent Serious Harm to the Community and Defendant

According to the Designated Examiner's Report of Findings and Request for Discharge presented by SCDMH to the Court, the Defendant "is no longer in need of inpatient hospitalization. However, he is in need of continued mental health treatment and follow-up care, plus treatment for substance abuse. Mr. Carter will need a structured/supervised living environment and must cooperate with all treatment recommendations…" The report goes on to list the same seven requirements for the Defendant's discharge that were included in the previous discharge proposal. The State contends that these requirements are woefully inadequate to ensure the Defendant's continued success in treatment and curtail the likelihood of serious harm to the community and himself.

I. Home Placement with the Defendant's Grandmother, Cynthia Chapman

The plan and proposed order state that the Defendant has been approved for home placement at 3 Harrison Ave., in Greenville, and reside with his grandmother, Cynthia Chapman.

This was proposed after placement at 5 Harrison Ave. with his mother was found by the Court to be inappropriate. According to Dr. Alleyne's testimony, the Defendant would be free to come and go from the home without monitoring or accountability. It is unclear from the testimony whether the Defendant would be supervised by Ms. Chapman or would "supervise himself" as testified to later in the December 8th hearing. It is clear, however, that Ms. Chapman would bear no responsibility for monitoring him, legally or professionally. There additionally was no meaningful testimony regarding how the living situation would be "structured," and it appears that the Defendant would have no set schedule or structure regarding his whereabouts or the administration of medications. Dr. Alleyne further testified that in any emergency situation, whether at home or in the community, the Defendant would be "responsible for himself." The State contends that arrangement would place both the Defendant and community at an unreasonable risk of serious harm.

If Ms. Chapman is in fact intended to supervise the Defendant, there is ample evidence that would be an unreasonably ineffective precaution. Testimony and evidence show that she was involved with the Defendants' initial discharge from Marshall Pickens Hospital.[26] It was then elicited at the hearing that the Defendant was found by the Greenville Police Department a mere five days later driving under suspension, in possession of marijuana, and requiring medical attention.

Dr. Alleyne also testified that his family would be part of that monitoring and supervision, to again include the Defendant's mother, Ms. Young. Testimony was elicited at both hearings that Ms. Young was convicted of Unlawful Neglect in February 2020, the Defendant being a victim in that case.[27] She was further convicted of Possession of Cocaine in that same

[26] Marshall Pickens Hospital Notes Dated 7/22/20
[27] Certified Prior Conviction for 2018-GS-23-9991

month and was ordered herself to mental health counseling as part of that sentence.[28] Finally, she was convicted of Driving under the Influence, 2nd Offense, in October 2022.[29] Additionally, as part of a prior SCDMH evaluation, it was noted that she "receives disability benefits for physical and mental health. She has a diagnosis of Bipolar Disorder..."[30] Ms. Young has also demonstrated a prior unwillingness to be of assistance during a medical emergency in which the Defendant escaped from Marshall Pickens Hospital.[31] Finally, a recorded jail call was admitted during the December 8th hearing. On that call Ms. Young speaks openly about being under the influence of drugs with the Defendant, indicates she herself has not taken prescribed medications, and that illicit substances had been left on a kitchen table. Although the new plan does not place the Defendant directly in the care of Ms. Young as the first proposal did, it has merely moved him approximately twenty feet next door, as Dr. Alleyne testified.

II. Attendance at all Appointments, Activities and Drug Screens, and Comply with Medications

The proposed order regarding required attendance and participation in treatment appears on the surface to ensure that the Defendant will maintain stability with regard to his treatment, but the supporting testimony made it clear this language is wholly insufficient. No details were provided from SCDMH as to how often any appointments, activities, or drug screens would occur. Dr. Alleyne testified that appointments are usually monthly at the outset, but could not testify to an exact time frame, how noncompliance would be determined, or who would report noncompliance. Further, the Court, Solicitor's Office, and victims would only be notified if he were re-hospitalized, not immediately upon non-compliance. Dr. Alleyne further testified that should the Defendant stop taking his medications, leave the home at 3 Harrison Ave., or have a

[28] Certified Prior Conviction for 2019-GS-23-8020
[29] Certified Prior Conviction for 2022-GS-23-6308
[30] Criminal Responsibility and Capacity to Conform Evaluation (p. 6)
[31] Marshall Pickens Hospital Records (p.37)

symptomatic episode, it likely would not be reported until he missed at least one, if not more monthly meetings. The potential for large gaps of time in monitoring presents an unreasonable risk to both the Defendant and the community. The plan does not include any provisions to ensure the Defendant complies with his medications on a daily basis. To transition from having medication monitored daily by hospital staff, to no daily monitoring, is not a step-down in supervision, but rather a sudden removal of effective monitoring. Other than a relatively short stay in SCDMH care, the Defendant has a demonstrated history of noncompliance with respect to prescribed medications. The State contends that such a sudden removal of essentially all guardrails with respect to medications could likely set the Defendant up for failure and substantially increases the risk of harm to both himself and the community.

III. Execute Releases for Treating Services to Share Information

The State has no objection to this condition in the proposed order. The sharing of information would be necessary to ensure compliance with any treatment plan.

IV. Not Obtain any Weapons, Guns, or Knives etc. That Could Harm Others

The State has no objection to the Defendant being prohibited from obtaining any weapons, and agrees that would be necessary for the safety of the Defendant and the community. Issues arise, however, with how this condition would be enforced. Per Dr. Alleyne's testimony, it is not clear that Probation, Greater Greenville Mental Health, or the NGRI Outreach Clinic would conduct any visits to the home. It seems outrageous to have no protocols for either removing or locking up knives in the home, considering the Defendant's own account of the underlying incident; "He reported hearing voices telling him to break into her house. He reports that once inside he heard command hallucinations telling him to take her life…He reports that he

stabbed her with a knife he found in the kitchen while she was sleeping."[32] It appears that if and when symptoms return, there would be no safeguards against a similar incident within the home.

V. The Defendant will not Associate with any Known Felons Outside of Treatment Programs

This State agrees the Defendant should not associate with any known felons if discharged from inpatient care, as negative outside influences could threaten to derail treatment progress, leading to instability and potential dangers. The issue with this provision is that he would be placed to live next door to a known felon, his own mother. Ms. Young pled guilty to Unlawful Neglect in February 2020.[33] Again, this Defendant and a sibling were the victims listed in the indictment for that offense.

This provision was also an issue at the December 2022 hearing, and the Court previously noted that the "recommendation from SCDMH requires that Defendant not associate with felons, although residing with his mother will violate this directed of the treatment plan and proposed order."[34] This issue has still not been corrected or addressed despite the Courts previous objections, and the Defendant's proposed placement has simply been moved a few feet further away.

VI. Abstain from Drugs and Alcohol, and Comply with Drug Screens

The State has no objection to requiring the Defendant to abstain from drugs and alcohol or comply with drug screens, as it is clear that drugs and alcohol could negatively affect his stability and have serious medical side effects when combined with his required medications. The proposed order and testimony does not, however, establish how this requirement would be monitored or how often drug screens would be administered. The State would also contend that

[32] Violence Risk Assessment (p.4)
[33] Certified Prior Conviction for 2018-GS-23-9991
[34] Order for Inpatient Treatment, January 9, 2023 (p.4)

this order would be setting the Defendant up for failure by placing him in a setting where there is evidence of ongoing drug and alcohol use. As testified to by Dr. Alleyne at the previous hearing, no parties within the residence have been drug tested, and again, within five days of his previous discharge from inpatient care the Defendant was found by law enforcement using illegal drugs.

VII. Non-Cooperation with Treatment, Recurrence of Symptoms, or Violation of the Court Order Results in Referrals for Reassessment, Treatment, and Immediate Re-Hospitalization as Deemed Clinically Appropriate

The State has no objection to the general provisions of this condition, however, as testimony at the hearing showed, many terms are left undefined and unclear in both the plan and proposed order. As mentioned in testimony, a violation of this order is not defined. It is unclear if the Defendant would be considered in violation if he misses a single monthly appointment, or it would require missing multiple appointments. The State also objects to only being notified upon re-hospitalization, as victims and the Court should be notified upon any noncompliance with the Court's order.

Conclusion

The State asserts the Defendant's need for ongoing hospitalization is still proven by clear and convincing evidence as required by SC Code §17-24-40, just as it was at the December 2022 hearing. There is sufficient evidence of both a lack of insight or capacity to make responsible decisions regarding treatment and a likelihood of serious harm to himself or others. Under SC Code §44-17-580 upon finding of either one of those two factors by clear and convincing evidence, the Court shall order further inpatient hospitalization. If at a later date SCDMH finds that the Defendant is no longer in need of further hospitalization, they can propose a new plan and order, and a hearing must once again be conducted at that point in time.

In the alternative, if the Court disagrees with the State's position and finds that the

Defendant is no longer in need of inpatient hospitalization, pursuant to SC Code §17-24-40 the chief administrative judge can order any such terms and conditions as the Court deems appropriate for the safety of the community and the well-being of the person. If that is the case, the State would still ask the Court to deny the proposed order put forth by SCDMH, hold the Defendant in inpatient care temporarily, and require SCDMH to propose a new order that sufficiently addresses the concerns raised at both hearings as well as the Court's previous order.

If the Court disagrees and orders outpatient care, the State would ask that any order include ample "provisions for the safety of the community in general and the victim in particular, including 'no contact' strictures, specific housing requirements, and curfew restrictions."[35] The State believes that close, frequent monitoring would be absolutely essential for the safety of the community and Defendant, and would ask for daily monitoring of his mental health and medications, frequent drug tests, curfews, and GPS monitoring with red zones for the victim's family members.

One innocent member of the community has already lost her life, and while the Defendant's rights must be protected and illness properly treated, the community's rights to be safe from such violent incidents must also be protected. The aforementioned concerns for the health and safety of both the Defendant and community would be far better addressed in an inpatient setting. It is clear that the Defendant is mentally ill, needs involuntary treatment, lacks the insight or capacity to make responsible decisions with respect to his treatment, and presents likelihood of serious harm to himself or others. Therefore, the State is asking the Court to order further inpatient treatment.

Andrew Miller, Bar #102782
Assistant Solicitor, 13th Judicial Circuit

Dated: 9/20/23

[35] Administrative Order: *Interagency Protocol for Defendants Found Not Guilty by Reason of Insanity*; Supreme Court of South Carolina (2014)

The undersigned hereby certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

November 6, 2024

/s Alex Pate

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