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SC Court of Appeals

STATE OF SOUTH CAROLINA

IN THE COURT OF APPEALS

Appeal from Spartanburg County
J. Derham Cole, Circuit Court Judge
Appellate Case No. 2014-000764

THE STATE,

Respondent,

vs.

STEPHANIE IRENE GREENE,

Appellant.

INITIAL BRIEF OF RESPONDENT

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases:

Other Authorities:

STATEMENT OF ISSUES ON APPEAL

I.

Direct evidence and substantial circumstantial evidence established that Appellant's infant died from respiratory failure caused by morphine intoxication and that the morphine came from Appellant's breast milk.

II.

The trial court did not err in denying the motion for directed verdict where evidence supports that Appellant's infant died under circumstances manifesting an extreme indifference to human life because the dangers of controlled substances are well-known, and Appellant's actions indicated knowledge and a conscious disregard of those dangers.

III.

No double jeopardy violation occurred and the trial court was not required to instruct the jury to choose between multiple charges where neither unlawful neglect of a child nor involuntary manslaughter are lesser included offenses of homicide by child abuse.

IV.

The trial court did not err in following the established procedure of allowing the prosecution to open its closing argument on the law and argue last on the facts, and following the established procedure is not a due process violation. The allegation of a due process violation is so conclusory as to constitute abandonment on appeal and any purported error is harmless under the facts of this case.

STATEMENT OF THE CASE

Appellant Greene was indicted by the Spartanburg County grand jury for homicide by child abuse, involuntary manslaughter, and unlawful conduct towards a child. Greene was tried by jury on March 31 through April 3, 2014, and found guilty as charged. On April 4, 2014, the Honorable J. Derham Cole, Sr., sentenced Greene to concurrent sentences of twenty years' imprisonment for homicide by child abuse and five years' imprisonment for both unlawful conduct towards a child and involuntary manslaughter.

STATEMENT OF FACTS

On November 13, 2010, Appellant Greene's infant child, Alexis, was already dead when officers and medical personnel responded at approximately 6:00 a.m. The death was the result of intoxication by morphine in combination with other medications. Evidence indicates the morphine and other substances were ingested by Alexis through Greene's breast milk. Due to Greene's efforts to conceal information from her treating physicians, the doctor prescribing the extended release morphine, known as MS Contin, was unaware that Greene was breastfeeding.

The first witness for the State was Terri Carter, an investigator for the Spartanburg County Coroner's Office. Carter and fellow investigator Ellen Holmes responded to a call to Greene's residence concerning the death of an infant on November 13, 2010. By the time Carter arrived at Greene's residence at around six a.m., Greene's infant child, Alexis, was already in the ambulance laying in a stretcher. Tr. p. 43.

Holmes interviewed Greene while Carter inspected the house. Carter noticed Greene was stumbling, slurred her words, spilled her coffee, her eyes were not focused, and she seemed cognitively unsound. Her husband was also present during the interview and needed to tell Greene to sit up. However, as the interview progressed over time, Greene became more alert and focused. Then at a later point in the interview, Greene left the room to use the restroom. Shortly after she returned, Greene's speech became slurred again, and she was clumsy once more. Tr. pp. 43-46.

Walking into the master bedroom, Carter observed numerous pill bottles covering the dresser. Carter published some of the warnings on the labels of these pill bottles that warned

about taking the pills while pregnant or breastfeeding. Tr. pp. 50-53. Carter photographed the bottles, including the front and back of the bottles. Carter cataloged the medications found on the dresser and checked to see the number of pills remaining in each bottle, the dates the prescriptions were made available, and the dosage instructions found on the bottles. These tabulations were memorialized in a pill chart that was admitted into evidence. Tr. pp. 50-56; State's Exhibit No. 60.

Notably, the label for the morphine pills indicated it originally contained 90 pills and the instructions allowed for one pill every eight hours. The prescription was filled on October 20, 2010. Accordingly, eighteen pills should have been left in the bottle, but only twelve remained. The morphine pill bottle was six pills short. Tr. p. 59, p. 65, State's Exhibit Nos. 7, 8, 60.

Even more hydrocodone pills were missing. The prescription was filled November 4, 2010, with ninety pills and was to be taken three times a day. Nine days later, only twenty-seven pills should have been missing, but instead there were forty-eight missing. State's Exhibit No. 60, Tr. pp. 59-60. The pill count was short for Baclofen and Gabapentin as well. Tr. pp. 63-64.

The 911 tape was admitted into evidence. It documents Greene's attempts under the direction of the operator to administer CPR to her daughter. She had trouble remembering how to administer CPR, which is surprising given she is a former nurse. The operator directed her to administer thirty compressions at a time, counting out loud. At times, Greene fails to count out loud and her voice trails off, usually when reaching the mid and upper teens in the count. State's Exhibit No. 33.

Ellen Holmes was the investigator from the Coroner's Office who interviewed Greene and her husband at their home the day Alexis was found dead. She testified she responded at 6:16 a.m, November 13, 2010. Alexis was already in the back of the EMS vehicle. The baby was dressed in an oversized red turtle neck shirt and wore a wet diaper. Alexis was only six-and-a-half weeks old. Alexis was "extremely" pale and cold to the touch. Mild lividity had set in on her back. Tr. pp. 86-87. Holmes noticed Greene "had a very flat affect, slurred speech, almost incomprehensible at times. Her eyes were very heavy and glassy. . . . [W]hen she walked it was a very unsteady gait." Tr. p. 87, lines 19-22. Holmes testified that Greene seemed intoxicated, but when Holmes asked Greene if she had taken any medications that morning, Greene claimed she had not. Tr. pp. 87-88.

Greene told Holmes that on Wednesday (Alexis died on Friday night/Saturday morning), Alexis was congested, and the doctor's office recommended a vaporizer and baby rub. Alexis was not running a temperature. According to Greene, she woke up at 4:30 a.m. (her husband said 5:00 a.m.) Saturday to find Alexis unresponsive. Tr. pp. 89-90. Greene admitted to Holmes that she used to be a nurse. She told Holmes about breastfeeding times. Tr. p. 90.

The interview was recorded. Tr. p. 88; State's Exhibit No. 34. During the interview, Greene's speech was markedly slurred evidencing her intoxicated state. She explained she called Alexis' physician, Dr. Bridges, on Thursday night about Alexis' upper respiratory system. Dr. Bridges said she did not need to bring Alexis in for a visit. State's Exhibit No. 34 (00:15 – 1:00). After following Dr. Bridges' recommendations to use a vaporizer and baby rub, Alexis seemed to do better. Greene and her husband described Alexis as bright-

eyed and Thursday night, she nursed all night long. Greene told Holmes that Alexis was attached to Greene's breast the whole night, feeding when needed. State's Exhibit No. 34 (2:00 – 3:30; 9:20 – 9:45). Friday, she remained bright-eyed and they did not notice anything out of the ordinary. Greene breastfed Alexis that evening. State's Exhibit No. 34 (4:45 – 6:15). Greene told Holmes she started supplementing breastfeeding with formula for the last week because Greene's blood pressure spiked and she started taking blood pressure medication. **Greene was concerned about the blood pressure medication affecting Alexis** and she claimed she spoke with the lactation expert about the blood pressure medication and her other medications. State's Exhibit No. 34 (13:45 – 14:30).

This prompted Holmes to ask about the other medications, and Greene slowly and deliberately listed several medications, but MS Contin was not one of them. State's Exhibit No. 34 (15:00 – 17:30). Greene told Holmes she was taking Amlodipine, Baclofen, Vicoprofen, Pristiq, Keppra, and Klonopin. The other medications found, which Greene did not tell Holmes about, were Requip, Durotan, Savella, Soma, alert tabs, and Morphine. Tr. p. 91.

On the extended form provided by Holmes for Greene to fill out, Greene was asked to list medications she took during her pregnancy. Greene listed MS Contin. However, Greene did not tell Holmes that she took MS Contin while breastfeeding. Greene was asked several times about her prescriptions. Tr. pp. 91-92.

RN Elaine Olsen worked at Piedmont Women's Healthcare. She testified that on March 25, 2010, she received a call from Greene informing Nurse Olsen that Greene took a home pregnancy test on March 20, 2010, that tested positive. An appointment was scheduled

for April 12, 2010, but Greene never came to the appointment. Tr. pp. 116-117. An ultrasound was also scheduled for March 26, 2010, but Greene did not show up for that appointment either. Tr. p. 123. Prior to that, Greene was last seen in August 2009. Tr. p. 118.

Vera Andrus is an LPN for Carolina OBGYN. She took down the initial information from Greene on May 10, 2010. This was after Greene took a pregnancy test during a visit to Dr. Nichols on May 7, 2010. Nurse Andrus testified that she asked Greene about the medications Greene was taking. Tr. pp. 97-98, p. 100. Nurse Andrus explained the reason why it was important to ask patients about their medications as follows:

> It's important to know that because we want to know anything that the baby has been exposed to during pregnancy. And if those medications shouldn't be taken during pregnancy, then we need to advise the patient, you know, to have her stop or to stop or to wean off them.

Tr. p. 98, lines 15-19. Nurse Andrus testified that each time a patient comes in, the patient is asked if there are any changes to their medications. Tr. p. 98, lines 20-23.

Nurse Andrus testified she asked Greene for a list of medications she was currently taking or had taken since her last period. Greene told her Soma, Vicoprofen, Clonazepam, Keppra, Lortab, Neurontin, Claritin, Benadryl, Savella, and a prenatal vitamin. Tr. p. 99, lines 6-11. Greene did not tell Nurse Andrus she was taking morphine or MS Contin. Greene also did not tell Nurse Andrus she was taking morphine or MS Contin when she came in for a follow up visit. Tr. p. 99, lines 15-25.

Emile Marks Horne is a labor and delivery nurse who testified for the State. She testified that on September 27, 2010, Greene complained during triage about headaches and

intermittent contractions. Greene was treated and then admitted into the hospital. Nurse Horne testified that Greene reported she was taking some medications, but she did not mention that she took MS Contin, Vicoprofen, or Neurontin. Greene delivered Alexis the next day. She was given Nubain for headaches and Motrin and Percocet at discharge. Tr. pp. 109-112.

SLED forensic toxicologist Quintus Leon Young, II, testified that he performed an initial screen from Alexis' blood and it tested positive for benzodiazepines, cocaine metabolite, opiates and salicylates. Tr. p 141 This prompted Young to perform a more comprehensive screen which indicated Alexis' blood contained .52 mg/liter of morphine. Young testified this was within lethal levels. Young's testing also indicated the blood sample contained .19 mg/liter of acetaminophen, .03 mg/Liter Methorphan, .03 mg/liter Benadryl, .04 mg/L Metherphanan, and .01 mg/L Clonezepam. Tr. pp. 141-144. This prompted further testing. Young received and tested samples of Alexis' brain and liver tissue. These tests further confirmed the lethal ranges of morphine in Alexis' body. The sample from the brain tested at .54 mg/liter, and the liver sample indicated a morphine level of .56 mg/liter. Tr. p. 144; pp. 147-148. Young confirmed that the combination of morphine and other medications could have a synergistic effect on each other. Tr. p. 148.

Dr. Suzanne Kovacs, Greene's primary physician, testified she treated Greene from November 2007 into 2010. Dr. Kovacs testified she never knew Greene was pregnant or had a child and was breastfeeding. Dr. Kovacs adjusted Greene's medications during an April 30, 2010 visit, changing the prescription from a Duragesic patch to a prescription for MS contin. The Duragesic patch was originally prescribed for pain on March 11, 2010. This was

based on Greene reporting that the patch was falling off or not working. Dr. Kovacs referred Greene to a gynecologist to have a contraceptive device known as a Mirena removed. Greene never told Dr. Kovacs that she was pregnant when changing medications. At the time of the April 30 visit, Greene had minimal weight gain from the previous visit: she weighed 133.9 pounds compared to 131 pounds the previous visit. Tr. pp. 163-168.

Dr. Kovacs gave Greene further prescriptions for MS Contin on May 27, 2010, June 28, 2010, July 27, 2010, August 26, 2010, and October 15, 2010. On October 29, 2010, Greene was given a new prescription for Klonopin. Tr. pp. 168-169; p. 171, lines 4-8; p. 174, lines 10-13.

Dr. Kovacs testified she was unaware of any prescriptions that her other doctors, Dr. Kooistra or Dr. Bridges, gave Greene. Dr. Kovacs testified that Greene was supposed to be off the prescriptions from Dr. Kooistra at that point in time. Greene never told Dr. Kovacs about the other doctors' prescriptions. Tr. pp. 170-171. Dr. Kovacs did not know about Dr. Kooistra's prescription for Klonopin from July 3, 2010. Dr. Kovacs also did not know about the August 5, 2010 prescriptions from Dr. Kooistra for Vicophen and Klonopin. Tr. p. 171. Likewise, Dr. Kovacs did not know that Dr. Bridges had prescribed Darvocet on June 30, 2010, July 23, 2010, and August 23, 2010. Tr. pp. 173-174.

Dr. Kovacs testified she would not have prescribed morphine or any pain medication during pregnancy had she known Greene was pregnant. She would have let the gynecologist or obstetrician issue any prescriptions. Tr. p. 171, lines 20-24; p. 176.

Dr. Kovacs did not know Greene was breastfeeding. Dr. Kovacs was unaware that Dr. Kooistra gave Greene a prescription for Baclofen, Vicoprofen, Neuroton, and Klonopin

on November 4, 2010. Dr. Kovacs testified she would not have gave Greene a prescription for Klonopin on October 29, 2010, if she had known that Dr. Kooistra gave Greene another prescription for Klonopin five days later. Tr. pp. 172-173.

Dr. Kovacs did not know Greene was pregnant, had a child, and lost the child until Dr. Kovacs was visited by law enforcement in 2011. Tr. pp. 174-176. Greene did not even tell Dr. Kovacs during visits subsequent to Alexis' death. Tr. p. 175, lines 4-6.

Dr. Kovacs confirmed that in 1998 Greene suffered a car accident and suffered from pelvic pain. She also suffered a skull fracture in the accident and suffered from seizures. Tr. pp. 177-178.

Dr. Carol Kooistra, a neurologist, testified she first saw Greene in 2006 when Greene was pregnant. Greene was referred to her for a seizure disorder. Dr. Kooistra did not prescribe any narcotics during Greene's 2006 pregnancy. She testified she tries to avoid prescribing medications of any sort during pregnancy. She did not prescribe any pain medication during the pregnancy, only medicine for the seizure disorder (Levetiracetam, aka Keppra). Tr. pp. 209-210. Greene signed a narcotic pain medication contract with Dr. Kooistra's office on January 5, 2006. Tr. p. 209, lines 20-25; p. 211, lines 4-7; State's Exhibit No. 59. One of the contract terms is as follows:

> I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician at Carolina Neurology. Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted in the hospital.

Tr. p. 212, lines 4-9; State's Exhibit No. 59. The second page of the contract contains the

relevant laws on the matter – S.C. Code sections 44-53-390 and 395. Tr. p. 212, lines 20-25; State's Exhibit No. 59, page 2. The contract further reads as follows:

> I understand that if I violate any of the above conditions my controlled substance prescriptions and/or treatment at Carolina Neurology may be ended immediately. If the violation involved obtaining controlled substances from another individual as described above or the concomitant use of nonprescription or illicit or illegal drugs I may also be reported to my physician, medical facilities and other appropriate authorities.

Tr. p. 213, lines 8-15, State's Exhibit No. 59. In the contract, Greene indicated she had a college degree and a Bachelor of Science in nursing. Tr. p. 213, lines 16-21.

Dr. Kooistra saw Greene on February 16, 2010, and did not see her again until November 4, 2010. There were two scheduled appointments in between that were no shows: May 13, 2010, and August 25, 2010. Instead, Greene requested her prescriptions by phone. Dr. Kooistra testified she was willing to issue the prescription on August 5, 2010, anticipating Greene would make her August 25, 2010 appointment. Greene requested a prescription by phone for Soma on October 28, 2010. Dr. Kooistra declined the request since she had not seen Greene since February. Subsequently, Greene came to her November 4, 2010 appointment. At that appointment, Greene did not tell Dr. Kooistra that between visits she became pregnant and gave birth or that she was currently breastfeeding. Tr. pp. 213-215.

When Dr. Kooistra asked why she had not made any of her appointments since February, Greene claimed "she had been in a severe depression and had been unable to leave her house." Tr. p. 215, lines 14-16.

Greene never told Dr. Kooistra she was pregnant in March 2010. However, Greene

continued to receive prescriptions for Vicoprofen, Soma, Klonopin, and Gabapentin. Tr. pp. 215-216. Dr. Kooistra did not know Greene was seeing an OBGYN and did not know that Dr. Kovacs was prescribing MS Contin. Tr. p. 216.

On November 4, 2010, Dr. Kooistra prescribed Klonopin, unaware that Dr. Kovacs wrote a prescription for Klonopin on October 29, 2010. Tr. pp. 219-220. She was unaware Dr. Bridges was also prescribing medicines. Tr. p. 220. On redirect, Dr. Kooistra published the medication guide for MS Contin that advises the following:

> Pregnant or planning to become pregnant. MS Contin may harm your baby, unborn baby. Tell your healthcare provider if you are breastfeeding. MS Contin passes into breast milk and may harm your baby. Tell your healthcare provider if you are taking prescription or over-the-counter medicines, vitamins or herbal supplements.

Tr. p. 235, lines 4-9.

On cross-examination, when Dr. Kooistra was asked: "And the American Academy of Pediatric finds nothing wrong with taking morphine while breastfeeding?" Dr. Kooistra answered, "So I've read." However, Dr. Kooistra clarified that she has not researched the issue closely. Tr. pp. 231-232.

Doctor Kelly Ann Bridges is a doctor with Carolina OBGYN and treated Greene. When she saw Greene for the first time on June 30, 2010, Greene was twenty-six weeks pregnant. Greene advised her she was taking Vicoprofen. She changed Greene's medication to Darvocet because Vicoprofen is dangerous during pregnancy. Greene did not tell Dr. Bridges that she was taking morphine during that visit or the other two visits in August and September 2010. Dr. Bridges testified her office asks what medications the patient is taking

at every visit. Greene was given additional prescriptions for Darvocet on July 23 and August 23, 2010. Dr. Bridges gave prescriptions for Motrin and Percocet on September 29, 2010. Tr. pp. 236-241. Dr. Bridges testified she would not have prescribed Darvocet if she knew Greene was taking morphine and other drugs, "[b]ecause you could potentially overdose on narcotics if you're combining those medications. It could be dangerous." Tr. p. 242, lines 5-11.

Reviewing the office records, Dr. Bridges testified the last time Greene visited Carolina OBGYN was November 4, 2010, for a six week postpartum exam with Dr. John Nichols. Nothing in the records of that visit indicated Greene informed Dr. Nichols that she was taking morphine. Tr. pp. 242-243.

Wendy Bell, an expert in forensic toxicology involving drugs and alcohol, testified for the State. She reviewed SLED toxicologist Quintus Young's report. She testified that every phase of testing in the laboratory is triple-checked to ensure correct results. Tr. p. 253. Bell testified as follows on the accuracy of her laboratory:

> Our laboratory is an accredited laboratory, and as such we have to go into rigorous testing. We have outside agencies come in and look at our protocols and make sure that we're performing them properly and that they're scientifically valid.
>
> We also participate in . . . proficiency testing programs where they send us samples every year and we have to accurately report them. And if not, then we're cited. We have to undergo corrective action to find out why. And we haven't had any of those . . . particularly for opiates. We've been highly reliable in our opiate results.

Tr. p. 266, lines 12-22.

The results of the testing were as follows:

Acetaminophen: .19 mg/Liter;

Diphenhydramine (antihistamine): .03 mg/Liter;

Chlorpheniramine (antihistamine): .06 mg/Liter;

Methorphan DM: .03 mg/Liter;

Methorphanan: .04 mg/Liter;

Morphine: .52 mg/Liter;

Clonazepam (benzodiazepine): .01 mg/Liter.

Tr. pp. 257-259 (emphasis added).

Bell noted there is limited pediatric information on the type of medications involved. Tr. p. 260. Bell testified the effects of drugs like Klonopin with morphine will act together synergistically. She explained the medications "are central nervous system depressants, which means it's going to slow the respiratory system, the breathing, the heart rate. And they can act together synergistically to have affects on each other." Tr. p. 260, lines 8-12.

Bell testified "a lot of these drugs aren't prescribed for children because their livers have not fully developed yet. So it's very, very difficult for them to metabolize this type of medication." Tr. p. 260, lines 19-22. Bell noted, "Children under ten months old cannot tolerate high levels of narcotics" and noted a lot of literature supports that proposition. Tr. p. 261, lines 10-15.

Investigator William Robert Gary testified he responded to Greene's house on the day of the incident. Alexis was in the ambulance parked in front of the house. Investigator Gary passed Greene sitting on the porch, unaware she was the victim's mother. Greene "was sitting there smoking a cigarette, drinking coffee." Tr. p. 286, lines 11-19.

Investigator Gary checked on the victim. When he returned inside the house, the investigators with the coroner's office had already begun the interview. Investigator Gary noted Greene was slow in her speech. "Everything she was doing was slow." Tr. p. 287, lines 20-22. Investigator Gary testified Greene appeared to be under the influence of something. Greene denied taking any medications since she found Alexis. Tr. pp. 287-288.

Investigator Gary interviewed Greene on June 24, 2011. Investigator Gary spoke with Greene about her omitting information from her doctors about either her pregnancy or the drugs she was taking, Greene claimed they were covering themselves by not documenting it. Greene claimed her sister dropped some medication and claimed one of children could have picked up the pills and given it to the baby. Later in the interview, Investigator Gary inquired if the reason she did not tell doctors about being pregnant and breastfeeding was because of her morphine addiction and the awareness that the doctors would not give her the medication if they knew. Her response was the only time she showed emotion during the interview, and she answered "that was part of it." Tr. pp. 293-294; p. 302 (direct quote, tr. p. 294, lines 22-23).

Greene claimed she was not taking the pills while she was pregnant, but filled the prescriptions because her insurance covered it. She claimed her husband locked up the medication and gave her three days' worth of medication at a time. Of course, Investigator Gary was skeptical about this since he had seen the pill bottles sitting on the dresser. In response, Greene said that by that point, her husband trusted her enough to leave them out, but still kept some locked up. Tr. p. 295.

Investigator Gary testified as follows about his conversation with her about

breastfeeding Alexis:

> She said she supplemented a good bit with formula and that she didn't breastfeed a lot, you know, which hearing her talk about before with her talk about that there'd be nights that Alexis would just – she'd lay in the bed and she'd stay latched on all night and feed as she wanted to, to me that's not – it was – if you're doing that, I don't know how you're not breastfeeding a lot.

Tr. p. 297, lines 14-20. Investigator Gary testified the investigators confronted Greene about how she filled out the lists of medications she was on at the doctors' offices and omitted morphine, contradicting her claim that they removed or omitted records themselves. Toward the end of the interview, Greene broke down crying and admitted they would stop prescribing morphine to her if they knew about her pregnancy or other medications. Tr. pp. 299-300. Greene admitted to Investigator Gary that she and her husband discussed the possibility that Alexis' death could be from the drugs. Greene admitted the morphine levels in the coroner's report were high. Tr. pp. 300-301.

On cross-examination, Investigator Gary agreed that Greene claimed she spoke with a lactation nurse at the hospital, however, there were no notes in the hospital records. Greene also claimed to have researched the issue online on her computer. Tr. p. 303.

Kaushik Kotecha, who at the time of Alexis' death was employed by the State Bureau of Drug Control, part of the Department of Health and Environmental Control (DHEC), testified. Without objection, he was qualified as an expert in the field of pharmacy. Following time as a uniformed police officer, Kotecha went to pharmacy school and has been a licensed pharmacist for twenty-five years. His duties with DHEC included both law enforcement and regulatory enforcement of drug control laws. Tr. pp. 307-310.

Kotecha testified as follows about morphine: "The problem with morphine of course you have – I usually when I was practicing pharmacy, I would tell them that this is very strong drug. . . . Sometimes you'd be unstable on your feet." Tr. p. 315, lines 10-15. Kotecha testified that MS Contin is a continuous release form of morphine. Tr. p. 316. Looking at State's Exhibit No. 7, the bottle for morphine sulfate ER, Kotecha testified that it is an extended release morphine. When asked if he would recommend morphine sulfate ER for someone who was breastfeeding, Kotecha responded, "I certainly would have had additional questions and I would want to talk to the doctor if I knew they were breastfeeding." Tr. p. 317, lines 17-19. Likewise, Kotecha indicated that if he was aware someone was being prescribed medication containing Hydrocodone while breast feeding, he would double check with the prescribing physician. Tr. pp. 317-318.

Kotecha published to the jury the warnings contained on the pill bottle photographed in State's Exhibit Nos. 9 and 10, which advise: "DO NOT TAKE MEDICATION IN 3RD TRIMESTER OF PREGNANCY." Tr. p. 318. The warnings for Clonezapam advise in part as follows: "Do not use if pregnant or suspect you are pregnant or breastfeeding." Tr. p. 318, lines 20-23; State's Exhibit No. 12. The warnings on a bottle of Keppra pills likewise warns about discussing use with a doctor if pregnant. Tr. p. 319; State's Exhibit No. 14. Another drug found was Ropinirole, used for restless leg syndrome. It likewise warns that breastfeeding is not recommended while using the drug. Tr. p. 320, State's Exhibit No. 20.

Kotecha explained about how substances may have a synergistic effect on each other. Kotecha testified that the combination of all these drugs together could cause a baby to stop breathing. Kotecha noted that the hydrocodone pills were originally prescribed for 90 pills

on November 4, 2010, and on November 13, 2010, there were only 42 remaining. Tr. p. 324.

Referring to the pill chart prepared by the Coroner's investigators, he noted that if she took the appropriate doses of morphine since the prescription was filled on October 20, 2010, only seventy-two pills should have been taken. However, only twelve pills remained. Tr. pp. 323-324. Eighteen pills should have been remaining, so six pills were missing.

Kotecha was present during the June 2011 interview. During the interview, Greene admitted she was addicted to pain killers. She admitted she lied to doctors to avoid losing her prescriptions. Greene was upset and wanted to know what was going to happen to her. Tr. pp. 325-326.

On cross-examination, Kotecha admitted that with the exception of one prescription, all the prescriptions were from one pharmacy, the Inman CVS. Tr. pp. 329-330. On redirect examination, Kotecha noted that Greene used two different names to fill her prescriptions, Stephanie Greene and Stephanie Neet. Tr. p. 340. Greene said she used Rite-Aid once because it had a drive-thru. That prescription was the October 20, 2010 prescription for MS Contin. Tr. pp. 340-341.

Dr. David Eagerton testified as an expert in forensic toxicology and pharmacology. Dr. Eagerton is an assistant professor at the Presbyterian College School of Pharmacy. Dr. Eagerton received a Ph.D. in pharmacology in 1992. Dr. Eagerton was the chief forensic toxicologist with SLED for approximately twelve years until he retired in 2009 and became a professor. Dr. Eagerton had testified as a forensic toxicologist and pharmacologist between eighty and a hundred times by the time of trial. Dr. Eagerton was qualified as an expert without objection. Tr. pp. 343-345.

Dr. Eagerton testified that Alexis had toxic levels of morphine. He also noted Clonazepam or Klonopin is a benzodiazepine that is very potent. Dr. Eagerton testified these medicines can have a synergistic effect on each other. Tr. pp. 346-350.

Dr. Eagerton published FDA warnings about MS Contin from the Medication Guide, approved by the U.S. Food and Drug Administration, which provides the following warnings:

> **Tell your healthcare provider if you are:**
>
> - **pregnant or planning to become pregnant.** MS Contin may harm your unborn baby.
> - **breastfeeding.** MS Contin passes into the breast milk and may harm your baby.

States Exhibit No. 67; Tr. p. 354, line 20 – p. 355, line 1 (emphasis in original).

Dr. Eagerton noted that while studies indicated treatment with morphine for short periods of time for acute pain might not be dangerous, the studies, even prior to 2010-2011, did not recommend use of the sustained release morphine products. Tr. pp. 357-358. Specifically, Dr. Eagerton noted:

> [I]f you look at the fine print they – they talk about sustained release and . . . continued use of these products. It . . . drops it down to an . . . uncertain level or an unsafe level, and they don't . . . recommend it even prior to these studies.

Tr. p. 358, lines 6-10.

Dr. Eagerton noted that infants livers are not fully developed, specifying on cross-examination that they do not reach adult level liver function until towards six months of age. Tr. pp. 360-361; p. 400.

Dr. Eagerton testified that "the lethargy, maybe trouble breathing. . . . I don't know

how to interpret that exactly, but . . . there were some symptoms that were conveyed that were consistent with morphine toxicity." Tr. p. 361, lines 15-18. "[I]f you can't metabolize it, then the drug may build up in your body and you become – you have a toxic dose whenever you wouldn't normally have a [toxic] dose." Tr. p. 361, line 2 – p. 362, line 2.

Dr. Eagerton agreed on cross-examination that a 2000 article listed morphine as safe to take while breastfeeding. Tr. p. 375, lines 4-7. Dr. Eagerton testified as follows on cross-examination:

> Q: Okay. But you don't have any basis for saying that it came through breast milk.
>
> A: Had to get into the baby somehow.
>
> Q: That's not my question. You have no basis for saying that number came into the baby through breast milk.
>
> A: I don't know that I'd say I have no basis. I'd say the basis is the mother is taking MS Contin, which is morphine. She is breastfeeding. We know that based on the literature we've already talked about that at least small amounts certainly do pass through into the breast milk. . . .

Tr. p. 383, line 16 – p. 384, line 2. Counsel conceded "some of it." Tr. p. 3. Commenting on the amount of morphine necessary to kill someone, Dr. Eagerston testified as follows:

> [W]e in forensic toxicology aren't concerned with the amount that people can survive on. We're – we're concerned with the amount it takes to kill one person. . . . And people can die at much lower levels, and people can survive. I can't really predict that. I can only say as a forensic toxicologist that this is a lethal level or this is consistent with a lethal level, this is consistent with a toxic level. I can't tell you specifically what levels somebody's going to survive with and what level's going to kill somebody.

Tr. p. 385, lines 8-19.

Dr. Eagerton talked about the blood-brain barrier on cross-examination, agreeing with defense counsel that it keeps some drugs from getting to the brain. Dr. Eagerton agreed with defense counsel that heroine and oxycontin pass through the blood-brain barrier quicker than morphine, but noted that morphine passes through the blood-brain barrier in a pretty good concentration. Tr. pp. 393-394.

Dr. Eagerton noted that taking morphine **acutely** while breastfeeding may be perceived as acceptable because "you don't get that good penetration into this, into the brain." Tr. p. 396, lines 2-10. But "[o]nce it gets in the brain it – there are receptors there. These – these opioid receptors there that are responsible for the actions of the drug are going to bind to it, and it's going to stay there longer than just regular blood." Tr. p. 396, lines 11-15. Speaking further on the significance of morphine levels in the brain, Dr. Eagerton commented as follows:

> So the other thing is whenever you take a . . . portion of brain, obviously, from a dead person, you can measure levels of drugs throughout different areas of the brain. You're going to get different levels.
>
> So the levels of the drug in the brain are not that impressive to me. Specifically to me my interpretation of those is that they're just consistent with a large amount of morphine being in that – this little baby's body. . . . So that's consistent with that high overdose level, lethal level, of morphine.

Tr. p. 396, line 21 – p. 397, line 5.

Dr. Eagerton was asked to consider other modes of delivery than breast milk for explaining the morphine level in Alexis. Dr. Eagerton noted the lack of needle marks on Alexis and discounted the possibility of morphine being injected. Dr. Eagerton also

discounted the possibility that the baby swallowed the pill, agreeing there would likely be pill remnants in her stomach. Although the pill could be crushed up, Dr. Eagerton opined this would have killed the baby in thirty to sixty minutes. Instead, Dr. Eagerton opined: "I think what we see here is – is more of a chronic type exposure, which is more consistent with through the breast milk. Or it could be some combination of both. I don't know." Tr. pp. 398-399 (direct quote, p. 399, lines 8-11). Defense counsel claimed in his question posed to Dr. Eagerton that no literature supported his opinion. Dr. Eagerton disagreed, explaining the following:

> I believe that if we take the reports that we have where it comes through in small levels that means if it – if you're getting a small dose of it you gotta to take it longer over a period of time.
>
> If we've got evidence that the – these little babies, this six-and-a-half-week-old – probably can't metabolize and get rid of the morphine as fast, so therefore it's going to build up in its body. So that would suggest the more chronic type exposure. And I believe that's what the literature that we've already gone over – in my opinion that's what it points to.
>
> Does it come out and out and say that? No. I don't believe I've seen any literature that says that. But for everything there's got to be a first.

Tr. p. 399, line 16 – p. 400, line 4.

On redirect, Dr. Eagerton published a portion of LactMed pertaining to the use of morphine, as follows:

> Epidural morphine given to mothers for postcesarean section analgesia results in trivial amount of morphine in their colostrum and milk. Intravenous or oral doses of maternal morphine in the immediate postpartum period results in higher milk levels than with epidural morphine. . . . Maternal use of oral narcotics during breastfeeding can cause infant drowsiness, central nervous system depression and even

death.

Tr. p. 404, line 18 – p. 405, line 1.

Dr. John David Wren was admitted as an expert in forensic pathology. He performed the autopsy on Alexis. At the time of the autopsy, he observed that Alexis was normally developed and of normal weight. Some rigor mortis and liver mortis had set in. Dr. Wren found no evidence of trauma. Dr. Wren testified that Alexis did not have any of the tell-tale signs of SIDS. He observed her lung was congested. Dr. Wren observed nothing physically wrong with Alexis. Tr. pp. 415-429.

Dr. Wren testified about the drug levels in Alexis' blood. Acetaminophen levels were .19 mg/Liter, which was in the high end of therapeutic levels. Tr. pp. 428-426. Chlorpheniramine levels were .06 mg/Liter. Dr. Wren testified that therapeutic levels are .01 to .04 mg/Liter. So the Chlorpheniramine level was above therapeutic levels and needed to be taken into account. Tr. p. 431. The dextromethorphan metabolite was .04 mg/Liter and therapeutic levels are .007 to .021 mg/Liter, indicating Alexis had elevated levels of this drug. As to morphine, the level was .52 mg/Liter. Dr. Wren testified therapeutic levels were .001 to .200 mg/Liter according to his references. Toxic levels would be from .30 to 2.5 mg/Liter. Lethal levels are from as low as .20 mg/Liter to 7.2 mg/Liter. Tr. p. 432. Dr. Wren testified there are reported deaths with levels as low as .20 mg/Liter. Tr. p. 432.

Dr. Wren confirmed, "It's well known that infants and children do react differently to medications than adults, and it takes some – infants are much more susceptible to any drugs than others. . . . They don't need as much and they're more susceptible to effects of them." Tr. p. 434, lines 14-20.

Dr. Wren concluded that Alexis died as a result of respiratory insufficiency secondary to synergistic drug intoxication. Dr. Wren explained, "I could just as easily have said morphine intoxication, lawyers like to split hairs, and so I included them all." Tr. p. 433, lines 18-22. Dr. Wren noted "all of these drugs essentially lead to respiratory depression." Tr. p 433, lines 15-16.

Dr. Wren also concluded the morphine was administered orally, as there were no signs of injection. Tr. pp. 434-435. As to the determination of blood levels, Dr. Wren noted lethal levels were found in the blood, brain, and liver, and he noted the level and sort of testing employed by SLED was "kind of hard to mess up [by] an experienced operator." Tr. p. 436, lines 6-8.

The defense presented Dr. Steven Bernard Karch as an expert in the effect of drugs on the human body. He claims to have written over a hundred peer reviewed articles, but he has not performed an autopsy in forty-five years. He earned an undergraduate degree from Brown University, then studied at Stanford, but left before earning any degree to go to medical school at Tulane. After getting his M.D., he did a fellowship at the Royal London Hospital in neuropathology. From there he worked at the only heart transplant lab in the world during the 1980's and 1990's. Dr. Karch then worked one day a week for the San Francisco Medical Examiner for roughly a decade. Dr. Karch authored the "Pathology of Drug Abuse, Fourth Edition." Tr. pp. 485-492.

Dr. Karch disagreed that a lethal amount of morphine could pass through breast milk, although he agreed a toxic level sufficient to make a child sick could be achieved. He testified that he thought it has happened. Dr. Karch claimed the American Academy of

Pediatrics did not even list morphine as being dangerous for women who are breastfeeding. Tr. pp. 492-494. In contrast to other witnesses, Dr. Karch claimed a one-month-old baby would already have developed an 80% normal metabolism rate.[1] Tr. p. 497.

However, Dr. Karch noted the American Academy of Pediatrics recommended starting with nonsteroidal medications like aspirin or ibuprofen and not starting with morphine. Tr. p. 494, lines 5-10. **Dr. Karch admitted a baby could have achieved a morphine level as high as .52 mg/Liter from breast milk,** noting a case where a baby had a blood level of 84 nanograms from a mother on morphine. That baby did not happen to die. Tr. pp. 504-505.

Dr. Karch confirmed "the mode of death for morphine is to stop respiration." Tr. p. 510, lines 20-21. Dr. Karch testified as follows on the cause of death:

> Q: All right. Yet you said in this case where 52 mg – nanograms of morphine – you would believe that that could have been a cause of death if that number is accurate.
>
> A: If the number is accurate and if the baby was intolerant. I don't – I have no way of proving what the mother's drug usage was or was not during that period.

Tr. p. 511, lines 5-10.

Dr. Karch testified he did not know of any medical group that advises against taking morphine while breastfeeding because of dangers to the child. Tr. p. 513, lines 22-25. Dr. Karch testified as follows on what physical traits a baby would develop if the baby was slowly building up morphine in their system:

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[1] See The Transfer of Drugs and Therapeutics Into Human Breast Milk: An Update on Selected Topics, 132, PEDIATRICS, Official Journal of the American Academy of Pediatrics, e796, e801 (September 2013) ("Clearance of morphine is decreased in infants younger than 1 month and approaches 80% of adult values by 6

> The baby would start to go south. It wouldn't nurse. It would be lethargic. Its color might not be too good.
>
> The best example I know of – and even though it's codeine and not morphine, or initially, but codeine turned into morphine – was the baby went off its feed and the mother was concerned that the baby just wouldn't take the breast milk.

Tr. p. 515, lines 17-23. In that case, the child was being purely breastfed. The child would not gain weight and was taken to the doctors. Tr. p. 516. Based on that case, Dr. Karch testified that if a baby was on morphine, he would expect the baby would not gain weight. Tr. p. 519, lines 8-19.

Holmes was recalled as a reply witness for the State. She testified that the medical records indicated Alexis was 7 lbs., 2 oz. when born. In her second week, Alexis weighed 7 lbs., 11 oz. At the time of death, Alexis only weighed 7 lbs., 6 oz. So Alexis lost five ounces since her two week check-up. Holmes also testified that when she saw Alexis the day she died, she was "extremely pale, very pale, all over." Tr. p. 525, lines 11-15.

The weight loss is confirmed by Greene's interview with the Coroner's Office where she admits that she had noticed Alexis had lost a lot of weight and was going to ask the doctor to weigh Alexis at an upcoming visit. State's Exhibit No. 34 (circa 11:30).

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months of age.").

ARGUMENT

I.

Direct evidence and substantial circumstantial evidence established that Appellant's infant died from respiratory insufficiency caused by morphine intoxication and that the morphine came from Appellant's breast milk.

Greene argues that the trial court should have granted a directed verdict on all three charges because there was insufficient evidence that a lethal dose of morphine (and other narcotics) passed through Greene's breast milk and killed Alexis. Direct evidence establishes Greene was taking morphine and other drugs likely to have a synergistic effect in concert with MS Contin. Direct evidence establishes Greene was breastfeeding Alexis. Direct evidence also establishes Alexis had a lethal dose of morphine in her system when she died. Scientific evidence establishes that morphine can pass through breast milk and that infants lack the capacity to process morphine in their system. Greene's expert, Dr. Karch, agreed that levels of morphine as high as .52 mg/Liter, the amount found in Alexis, could pass through breastmilk. Further, to the extent it may be argued that cause and effect is not supported by direct evidence, abundant circumstantial evidence supports the verdicts in all three charges.

When considering a motion for directed verdict, the trial court is concerned with the existence of evidence, not its weight. State v. Walker, 349 S.C. 49, 53, 562 S.E.2d 313, 315 (2002). In reviewing the denial of a motion for a directed verdict, the reviewing court must view the evidence in the light most favorable to the State. Id. If there is any direct evidence or any substantial circumstantial evidence reasonably tending to prove the guilt of the

accused, an appellate court must find that the case was properly submitted to the jury. State v. McGowan, 347 S.C. 618, 622, 557 S.E.2d 657, 659 (2001). The appellate court may reverse the trial court's denial of a motion for a directed verdict only if there is **no** evidence to support the trial court's ruling. State v. Lindsey, 355 S.C. 15, 20, 583 S.E.2d 740, 742 (2003) (emphasis added).

Ultimately, the question is whether, in view of the evidence in the light most favorable to the State, a rational trier of fact could find all the elements beyond a reasonable doubt. State v. Robinson, 310 S.C. 535, 539, 426 S.E.2d 317, 318 (1992) (finding any rational trier of fact could have found all the elements of the crime beyond a reasonable doubt in affirming the denial of a motion for directed verdict and citing Jackson v. Virginia, 443 U.S. 307 (1979)).

The United States Supreme Court noted the following:

> [T]he relevant question is whether, after viewing the evidence in the light most favorable to the prosecution, *any* rational trier of fact could have found the essential elements of the crime beyond a reasonable doubt. . . . This familiar standard gives full play to the responsibility of the trier of fact fairly to resolve conflicts in the testimony, to weigh the evidence, and to draw reasonable inferences from basic facts to ultimate facts.

Jackson, at 319 (emphasis in original).

"Direct evidence is based on personal knowledge or observation and . . . , *if true* proves a fact without inference or presumption." State v. Phillips, 411 S.C. 124, 133, 767 S.E.2d 444, 448 (Ct. App. 2014) (citation and internal quotation marks omitted, emphasis in original). In the instant case, Greene admitted to investigators she was addicted to pain

killers, including morphine, and she was breastfeeding Alexis. A bottle of nearly empty MS Contin prescribed for her was found on her dresser. Dr. Kovacs testified she gave Greene this prescription (under false pretenses). Forensic testing established Alexis had toxic levels of morphine in her system when she died. These facts are all clearly established by direct evidence and when considered with unrefuted scientific evidence that morphine will pass through breast milk, the evidence sufficiently establishes cause of death. So contrary to Greene's arguments, this is not a purely circumstantial evidence case. Id. (noting "the existence of 'any direct evidence' proving the defendant's guilt requires the denial of a directed verdict motion.").

In any event, the circumstantial evidence itself is substantial, and in conjunction with the aforementioned direct evidence, easily provides sufficient evidence for the court to deny directed verdict. "Circumstantial evidence . . . is proof of a chain of facts and circumstances from which the existence of a separate fact may be inferred." Id. The United States Supreme Court made the following observation concerning circumstantial evidence:

> Admittedly, circumstantial evidence may in some cases point to a wholly incorrect result. Yet this is equally true of testimonial evidence. In both instances, a jury is asked to weigh the chances that the evidence correctly points to guilt against the possibility of inaccuracy or ambiguous inference. In both, the jury must use its experience with people and events in weighing the probabilities. If the jury is convinced beyond a reasonable doubt we can require no more.

Holland v. United States, 348 U.S. 121, 137-38 (1954) *cited with approval in* Jackson, at 317 n.9.

Our Supreme Court recently articulated the following concerning the standard of

review for purely circumstantial evidence cases:

> The trial court should grant the directed verdict motion when the evidence merely raises a suspicion that the accused is guilty as suspicion implies a belief or opinion as to the guilt based upon facts or circumstances which do not amount to proof. On the other hand, a trial judge is not required to find that the evidence infers guilt to the exclusion of any other reasonable hypothesis.

State v. Hepburn, 406 S.C. 416, 753 S.E.2d 402, 409 (2013) (quoting State v. Cherry, 361 S.C. 588, 593, 606 S.E.2d 475, 478 (2004) (citations and internal quotations omitted)); see also State v. Richburg, 250 S.C. 451, 459, 158 S.E.2d 769, 772 (1968) ("When the evidence is susceptible of more than one reasonable inference, questions of fact must be submitted to the jury.").

In the instant case, direct and circumstantial evidence reasonably indicates Greene was addicted to morphine and other pain killers. She was taking numerous medications, keeping all her doctors in the dark about the full extent of her medications. She was breast feeding Alexis. Medical testimony establishes that morphine and other medications pass through breast milk. Alexis was found with not only lethal amounts of morphine in her system, but also varying amounts of several other medications that Greene was taking. The presence of numerous other substances in Alexis is strong substantial circumstantial evidence establishing that the lethal levels of morphine passed through Greene's breast milk to Alexis rather than some already difficult to believe theory of accidental ingestion or forced ingestion.

The State presented expert testimony establishing that a child of Alexis' age will have difficulty metabolizing morphine because the liver will not be fully developed yet. Dr.

Eagerton testified that some of the respiratory issues reported were consistent with morphine toxicity. Dr. Eagerton opined that the evidence was most consistent with a chronic exposure to morphine. Dr. Wren concluded the death was the result of respiratory insufficiency secondary to synergistic drug intoxication, and noted "all of these drugs essentially lead to respiratory depression." Tr. p. 433 (direct quote, Tr. p. 433, lines 15-16). Greene's own expert, Dr. Karch, testified he would expect an infant to not nurse and have difficulty gaining weight if the infant was slowly building up morphine in her system. This was consistent with the weight loss reported by Greene and confirmed by evidence establishing that Alexis lost five ounces since her second-week checkup. Dr. Karch also admitted that the levels of morphine as high as .52 mg/Liter can be passed through to a child through breast milk.

Accordingly, abundant direct and circumstantial evidence establishes the cause of death was morphine and other substances which passed through Greene's breast milk to Alexis, who died of respiratory insufficiency due to chronic, lethal levels of morphine in conjunction with other narcotics. The trial court did not err in denying the motions for directed verdict.

Note that unlawful conduct towards a child does not require the death of a child. Under the offense of unlawful conduct towards a child, the following is proscribed:

> (A) It is unlawful for a person who has charge or custody of a child, or who is the parent or guardian of a child, or who is responsible for the welfare of a child as defined in Section 63-7-20 to:
>
> (1) Place the child at unreasonable risk of harm affecting the child's life, physical or mental health, or safety; or
>
> (2) do or cause to be done unlawfully or maliciously any

bodily harm to the child so that the life or health of the child is endangered or likely to be endangered; or

(3) wilfully abandon the child.

S.C. Code Ann. § 63-5-70. In the instant case, evidence proves that her ingestion of numerous pain killers, including MS Contin, without informed supervision by a physician constituted unlawful conduct towards a child as it exposed Alexis by breastmilk to an unreasonable risk of harm to her health, and as events proved, to her life. The danger could have been avoided by disclosure of her medications and appropriate preventive steps by the trained physicians; or Greene could have used formula to feed Alexis while Greene fed her addiction. Accordingly, even if this Court were to determine causation was not proved despite the aforementioned direct and substantial circumstantial evidence presented, evidence supports the unlawful conduct charge so as to deny directed verdict on that charge.

II.

The trial court did not err in denying the motion for directed verdict where evidence supports that Appellant's infant died under circumstances manifesting an extreme indifference to human life because the dangers of controlled substances are well-known, and where Appellant's actions demonstrated knowledge of the dangers and a conscious disregard of those dangers.

Largely depending on her own view of the evidence, Greene argues that the trial court erred in denying directed verdict because there was no evidence her infant's death occurred under circumstances manifesting an extreme indifference to human life. However, the record is replete with instances of Greene actively avoiding informed supervision by physicians – she obtained several pain killers, especially morphine, without her prescribing physicians being aware she was pregnant and later breastfeeding. The dangers inherent in using controlled substances without supervision of a physician are well known and the potential to harm a breastfeeding child when the mother is using medications is also well-known. Evidence supports the trial court's denial of directed verdict.

A person is guilty of homicide by child abuse if (1) the person causes the death of a child while committing child abuse or neglect; and (2) the death occurs "under circumstances manifesting an extreme indifference to human life." S.C. Code Ann. §16-3-85(A)(1). "Child abuse or neglect" is defined under the homicide by child abuse statute as "an act or omission by any person which causes harm to the child's physical health or welfare[.]" S.C. Code Ann. § 16-3-85(B)(1).

"To prove a defendant guilty of homicide by child abuse, the State must demonstrate 'the death occur[red] under circumstances manifesting an extreme indifference to human

life.'" State v. Phillips, 411 S.C. 124, 767 S.E.2d 444 (Ct. App. 2014) (quoting section 16-3-85). "Extreme indifference is in the nature of a culpable mental state and therefore is akin to intent." State v. Jarrell, 350 S.C. 90, 98, 564 S.E.2d 362, 367 (Ct. App. 2002) (citation, ellipses, and internal quotation marks omitted). "In this state, indifference in the context of criminal statutes has been compared to the conscious act of disregarding a risk which a person's conduct has created, or a failure to exercise ordinary or due care." Id. The meaning of extreme indifference to human life in the context of a homicide by child abuse case is consistent with recklessness and indifference in reckless homicide cases. State v. McKnight, 352 S.C. 635, 645, 576 S.E.2d 168, 173 (2003). Thus, extreme indifference to human life can similarly be equated to "'a conscious failure to exercise due care or ordinary care or a conscious indifference to the rights and safety of others or a reckless disregard thereof.'" Id. (quoting State v. Tucker, 273 S.C. 736, 739, 259 S.E.2d 414, 415 (1979)).

In the instant case, Greene went to great lengths to maintain her prescriptions to narcotics, including morphine, during her pregnancy and while she was breast feeding because, as she confessed, she was afraid she would lose these prescriptions. During the interview the day Alexis died, Greene disclosed only some of her medications and critically omitted mentioning morphine, indicating an awareness of wrongdoing. Greene also admitted that after Alexis' death she and her husband discussed whether breastfeeding Alexis while on morphine could have caused the death. While Greene attempts to minimize her conduct by claiming she was not doctor shopping because she mainly used only one pharmacy, she kept each doctor in the dark about either her pregnancy and breastfeeding, and about the prescriptions from the other doctors. She used two different names to pick up her

prescriptions. Greene cancelled medical appointments so Dr. Kovacs and Dr. Kooistra would not learn she was pregnant. She omitted morphine from the list of medications she provided to nurses and never made Dr. Bridges aware she was taking morphine and other pain medications while she was pregnant or at her post-partum appointment. Greene was aware of the dangers of medication during pregnancy generally – she claims the reason she used formula was to minimize the possible danger to Alexis from Greene's blood pressure medicine. In this same interview, she omits mentioning she was taking morphine, although she lists several other medications. "As a general rule, any guilty act, conduct, or statements on the part of the accused are admissible as some evidence of consciousness of guilt." State v. McDowell, 266 S.C. 508, 515, 224 S.E.2d 889, 892 (1976).

Greene also misses the mark in claiming medical experts have not found it dangerous for mothers breastfeeding their children while taking morphine. Dr. Eagerton noted the distinction Greene fails to acknowledge in her brief between short term use of morphine for acute treatment of pain and long term use of sustained release morphine.[2] Dr. Eagerton testified that even prior to 2010-2011, long term use of morphine during breastfeeding was not recommended and was viewed as unsafe or uncertain. Tr. p. 358, lines 6-10.

The risks of using morphine, or more precisely, multiple pain killers and other controlled substances while breastfeeding without informed supervision by physicians is obvious to a layperson. Phillips observed the following: "Federal law requires a patient to obtain a prescription for medication that cannot be bought over-the-counter because these medications are 'not safe for use except under the supervision of a practitioner licensed by

[2] Bell noted mothers dosed with MS Contin and had their breast milk tested in studies were not chronic users,

law to administer such drug[s].'" Phillips, 411 S.C. at 136, 767 S.E.2d at 450 (quoting 21 U.S.C. § 353(b)(1)(A) (2013)). "By any standard the delivery of a controlled substance to a child, not under the direction of a physician in regard to dosage, is an act that is inherently dangerous." State v. Taylor, 626 A.2d 201, 202 (R.I. 1993).

Further, Greene's self-serving claims to interviewers that she researched the risks of her medications helps prove rather than diminish her reckless mental state. Avoiding the supervision of a physician and relying on her own rationale in the haze of addiction does not remove her mental culpability leading to her own infant's death. Further, evidence strongly suggests that Greene was taking more than the prescribed amount of morphine and other narcotics that contributed towards Alexis' death. See Borg-Warner Corp. v. Flores, 232 S.W.3d 765, 770 (Tex. 2007) ("One of toxicology's central tenets is that 'the dose makes the poison.' This notion was first attributed to sixteenth century philosopher-physician Paracelsus, who stated that '[a]ll substances are poisonous – there is none which is not; the dose differentiates poison from a remedy.'" (citations omitted and brackets in original)).

"A parent has a specific and undelegable duty to serve the best interests of her child and should make every effort not to knowingly place her child in harm's way." Jarrell, 350 S.C. at 99, 564 S.E.2d at 367. Even if the effects of the use of controlled substances by a breast-feeding mother on her child may not be precisely known, their potential harm is something to which the public is well aware. See Whitner v. State, 328 S.C. 1, 10, 492 S.E.2d 777, 782 (1997) ("Although the precise effects of maternal crack use during pregnancy are somewhat unclear, it is well documented and within the realm of public

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meaning they did not fit with the profile of Greene, an obvious chronic user. Tr. p. 271, lines 7-19.

knowledge that such use can cause serious harm to the viable unborn child."). This is why the law-abiding population, conscious of their duty to their children, would not take medications while breastfeeding without supervision from their physicians. Here, Greene took numerous medications based on prescriptions obtained under false pretenses, and she used more than the significant prescribed amounts, all while breast-feeding her child. She was aware of the dangers of controlled substances to Alexis; if believed, it was her concern about blood pressure medication that caused her to resort to formula (Apparently, it was not Alexis' disquieting loss of weight).

Just as the public is aware of the danger of a mother's crack use to an unborn child, the general public is also certainly aware that taking medications while breastfeeding poses the risk of harm to a child. In the instant case, the record is replete with actions and admissions by Greene that shows she attempted to use morphine and other pain killers without informed supervision by doctors and pharmacists in disregard of the very obvious dangers resulting from a lack of supervision. Her past experience as a nurse makes her actions even more egregious, as she should have been on notice of the significant risk she put Alexis in due to her unsupervised intake of multiple pain killers. This is sufficient proof of extreme indifference to survive a motion for directed verdict. State v. Tuckness, 257 S.C. 295, 299, 185 S.E.2d 607, 608 (1971) ("The question of criminal intent with which an act is done is one of fact and **is ordinarily for jury determination except in extreme cases**[.]" (emphasis added)). Accordingly, the trial court did not err.

III.

No double jeopardy violation occurred, and the trial court was not required to instruct the jury to choose between multiple charges where neither unlawful neglect of a child nor involuntary manslaughter are lesser included offenses of homicide by child abuse.

Greene alleges the jury should have been instructed that it could only convict on one of the three charges because in Greene's view, the three charges constitute double jeopardy. Contrary to Greene's position, the familiar "same elements" test is the proper test and conviction for the three charges did not constitute double jeopardy.

"The Double Jeopardy Clause protects against a second prosecution for the same offense after acquittal or conviction, and protects against multiple punishments for the same offense." State v. Easler, 327 S.C. 121, 489 S.E.2d 617 (1997). The proper manner of determining if two charges constitutes the same offense is application of the "same elements" test under Blockburger v. United States, 284 U.S. 299 (1932).

Our United States Supreme Court has declared:

> If the same act or transaction constitutes a violation of two distinct statutory provisions, the test to be applied to determine whether there are two offenses or only one, is whether each provision requires proof of a fact which the other does not. In subsequent applications of the [Blockburger] test, we have often concluded that two different statutes define the same offense, typically because one is a lesser included offense of the other.

Rutledge v. United States, 517 U.S. 292, 298 (1996) (internal quotation marks and citations omitted); see also State v. Norton, 286 S.C. 95, 332 S.E.2d 531 (1985) (noting that when a single act combines requisite elements of two distinct offenses, the defendant may be

indicted and punished for each offense). Ultimately, the existence of double jeopardy depends on whether the legislature intended to create one crime or more than one. Missouri v. Hunter, 459 U.S. 359, 365-68 (1983).

Greene asserts that Blockburger is controlling, but interprets the United States Supreme Court decisions to be more than the simple "same elements" test. Instead, Greene claims the test is whether the multiple offenses are proved by the same evidence. Greene relies heavily on Rutledge to advance this assertion, but contrary to Greene's analysis, Rutledge does not depart from the same elements test.

In Rutledge, the court was determining whether conspiracy to distribute a controlled substance was a lesser included offense of the continuing criminal enterprise offense (CCE). The Rutledge court noted that conspiracy required an agreement while CCE required the charged to act "in concert" with five or more individuals in a supervisory position within the enterprise. Id. at 298. The Rutledge court noted the Government's argument, that "in concert" was a different element than the agreement required to prove conspiracy, was previously rejected in a plurality opinion in Jeffers v. United States, 432 U.S. 137 (1977). Id. at 298-99. Deciding to resolve any lingering doubt, the Rutledge court declared as follows: "For the reasons set forth in Jeffers, and particularly because the plain meaning of the phrase 'in concert' signifies mutual agreement in a common plan or enterprise, we hold that **this element of the CCE offense requires proof of a conspiracy** that would also violate [the conspiracy statute]." Id. at 300. In other words, the greater offense, CCE, required proof of an agreement, same as the lesser offense of conspiracy. Therefore, Rutledge did apply the same elements test.

It seems that in reality, Greene wants to apply what amounts to the "same conduct" test abandoned in Grady v. Corbin, 495 U.S. 508 (1990) that was overruled by United States v. Dixon, 509 U.S. 688 (1993). This Court should decline to do so.

Applying the same elements test, our Supreme Court found that involuntary manslaughter is not a lesser included offense of homicide by child abuse. McKnight v. State, 378 S.C. 33, 51-52, 661 S.E.2d 354, 363 (2008).

Further, unlawful conduct towards a child is not a lesser included offense of homicide by child abuse. A person commits homicide by child abuse, as a principle, if the person "(1) causes the death of a child under the age of eleven while committing child abuse or neglect, and the death occurs under circumstances manifesting an extreme indifference to human life." S.C. Code §16-3-85.

For purposes of the statute, the following definitions are set out:

> (1) "child abuse or neglect" means an act or omission by any person which causes harm to the child's physical health or welfare;
>
> (2) "harm" to a child's health or welfare occurs when a person:
>
> (a) inflicts or allows to be inflicted upon the child physical injury, including injuries sustained as a result of excessive corporal punishment;
>
> (b) fails to supply the child with adequate food, clothing, shelter, or health care, and the failure to do so causes physical injury or condition resulting in death; or
>
> (c) abandons the child resulting in the child's death.

Under the offense of unlawful conduct towards a child, the following is proscribed:

> (A) It is unlawful for a person who has charge or custody of a child, or who is the parent or guardian of a child, or who is responsible for the welfare of a child as defined in Section 63-7-20 to:
>
> (4) Place the child at unreasonable risk of harm affecting the child's life, physical or mental health, or safety; or
>
> (5) do or cause to be done unlawfully or maliciously any bodily harm to the child so that the life or health of the child is endangered or likely to be endangered; or
>
> (6) wilfully abandon the child.

S.C. Code Ann. § 63-5-70.

Greene does not assert that one offense is a lesser included offenses of the other, and it is clear that they each require elements the other does not. Homicide by child abuse occurs only when a child dies, while unlawful conduct towards a child does not require physical harm at all to the child. On the other hand, unlawful conduct towards a child is only committed by a person who has a parental or custodial type of authority over the child, or is responsible for the child under S.C. Code Ann. § 63-7-20. Indeed, S.C. Code Ann. § 63-7-20(16), in its definition of "Person responsible for a child's welfare," excludes specifically "[a] person whose only role is as a caregiver and whose contact is only incidental with a child, such as a babysitter or a person who has only incidental contact but may not be a caretaker, . . ." Homicide by child abuse is not limited in this fashion. Indeed a babysitter could be guilty of homicide by child abuse, unlike the unlawful conduct statute. Accordingly, neither charge is a lesser included offense of the other.

Likewise, involuntary manslaughter requires the death of a person without regards to the age of the victim, while unlawful conduct towards a child requires no physical harm

towards the child, but requires the victim be a child. See State v. Northcutt, 372 S.C. 207, 215, 641 S.E.2d 873, 877 (2007) (finding homicide by child abuse is not a lesser included offense of murder where the element of death of a child under eleven years of age is not a required element of murder).

"The lesser offense is included in the greater only if each of its elements is always a necessary element of the greater offense." Easler, 327 S.C. at 134, 489 S.E.2d at 624 (internal quotation marks and citations omitted). In the instant case, each of the three offenses includes elements not required by the other two offenses. None of the three are lesser included offenses of the other, and no double jeopardy violation occurred.

IV.

The trial court did not err in following the established procedure of allowing the prosecution to open its closing argument on the law and argue last on the facts, and following the established procedure is not a due process violation. The allegation of a due process violation is so conclusory as to constitute abandonment on appeal, and any purported error is harmless under the facts of this case.

Greene claims the trial judge should have required the State to open on the law and the facts and be allowed to only offer a reply argument after Greene's closing argument. Greene in her statement of issues claims the current, established practice violates the due process clause of the South Carolina Constitution and the Fourteenth Amendment of the federal constitution.[3] However, Greene does not make this assertion in the body of the brief and fails to argue at all how this practice violates due process. Greene cites no authority for the proposition that the due process clause is implicated. See State v. Tyndall, 336 S.C. 8, 16-17, 518 S.E.2d 278, 282-83 (Ct. App. 1999) (argument was deemed abandoned where a single conclusory statement in the appellant's brief left un-argued the purported error being raised); State v. Porter, 389 S.C. 27, 35, 698 S.E.2d 237, 241 (Ct. App. 2010) (requiring an appellant to cite authority in "specific support of his assertion").

Further, due process is not implicated, and the procedure is reasonable and does not require alteration. Historically, the right to the final closing argument has followed the party with the burden of proof. Stein Closing Arguments § 1:6: Right to open and close; order of

[3] Below, defense counsel requested that the State open in full on the law and the facts, the defense would argue, and then the State be restricted to merely replying to the defense's argument. Defense counsel argued that by following the established practice, the State would get to "sandbag" the defense, and defense counsel would be unable to know before he argued what was the State's theory of the facts. Tr. pp. 533-536.

argument (2011-2012 ed.) ("Generally, the right to make opening and closing follows the person having the burden of proof."); Nicole Velasco, Taking the "Sandwich" Off of the Menu: Should Florida Depart from Over 150 years of Its Criminal Procedure and Let Prosecutors Have the Last Word?, 29 Nova L.Rev. 99, 112 (2004) ("At common law, the widely accepted rule in the United States is that the party with the burden of proof has the right to open and conclude final argument before the jury.").

In criminal trials in South Carolina, a solicitor is entitled to open and close the closing arguments to the jury unless the defendant has not offered any evidence. State v. Rodgers, 269 S.C. 22, 24, 235 S.E.2d 808, 809 (1977). The initial closing argument must include a discussion of the law if demanded by the defendant; however, the solicitor is not required to open his initial closing with any argument on the facts although he may do so as a matter of discretion. State v. Lee, 255 S.C. 309, 318, 178 S.E.2d 652, 656 (1971) *overruled on other grounds by* State v. Belcher, 385 S.C. 597, 685 S.E.2d 802 (S.C. Oct 12, 2009); Rodgers, 269 S.C. at 25, 235 S.E.2d at 809.

However, unlike the vast majority of jurisdictions, current South Carolina practice sets the order of closing arguments in criminal cases according to the evidence received at trial. See State v. Brisbane, 2 Bay 451 (S.C. 1802) (As a matter of practice, when a criminal defendant calls no witnesses, he has "the **privilege** of concluding to the jury.") (emphasis added); see also State v. Gellis, 155 S.E. 849, 855 (1930) ("It is evident from the more recent decisions of this court that the rule is that if a defendant offers any evidence on trial of the case, the state is not deprived of its general right to the opening and concluding arguments.");

State v. Crowe, 258 S.C. 258, 188 S.E.2d 379, 384 (1972) (same); State v. Mouzon, 321 S.C. 27, 467 S.E.2d 122, 125 (Ct. App. 1995) (same).

In this case, Greene chose to present three defense witnesses. Therefore, under longstanding state procedure, Greene was not entitled to have last closing argument to the jury nor was he entitled to require the solicitor to open on both the facts and the law. Greene asserts the trial judge's adherence to the longstanding practice in South Carolina violated due process, although there is no explanation for this claim, beyond a vague allegation of the opportunity for sandbagging.

In rejecting an equal protection challenge, the Florida Supreme Court explained the rationale of their rule that is similar to the practice in South Carolina:

> In all criminal proceedings, the prosecution takes the offensive at the outset, building through its witnesses a "case" for defendant's guilt. In most instances, defense counsel is limited to the defensive tactic of cross-examination to show the weakness of the State's evidence, and to create a reasonable doubt in the minds of the jury. Occasionally the defense will be in a position to take the offensive itself by calling witnesses to build its own case for innocence. In those instances where such an offensive tactic is possible, the defense receives a more balanced exposure before the jury, and is more adequately able to offset the impression created in the minds of the jurors by the prosecution's presentation. But what of those situations where the circumstances do not give the defendant the option of presenting his own case? In our judgment it was precisely to counterbalance the weight of the State's offensive in such cases that the Legislature, and later this Court, created an exception to the common law rule that the party with the burden of proof is entitled to the concluding argument before the jury. As we view the Rule, it is intended as an aid to those defendants entitled to avail themselves of it, rather than as a limitation upon those desiring to call defense witnesses.

Preston v. State, 260 So.2d 501, 504 (Fla. 1972).[4]

Totally denying a criminal defendant the opportunity for closing argument constitutes a denial of the defendant's basic right to make his defense. Herring v. New York, 422 U.S. 853, 858-859 (1975). While the right to make a closing argument cannot be circumvented, the order of argument is vastly different, particularly since argument is not evidence. See, e.g., Ex parte Morris, 367 S.C. 56, 624 S.E.2d 649, 653 (2006), *quoting* S.C. Dept. of Transp. v. Thompson, 357 S.C. 101, 590 S.E.2d 511, 513 (Ct. App. 2003) ("'[a]rguments made by counsel are not evidence'"); Sosebee v. Leeke, 293 S.C. 531, 362 S.E.2d 22, 24 (1987) ("the solicitor's closing argument is not evidence"). There is no constitutional **right** to a certain order or scope of argument.

The order of closing arguments is a matter of state procedural rule or practice rather than substantive law. State v. Huckie, 22 S.C. 298, 299 (1885) (alleged error in denying defendant final closing argument was "not a matter of error as to express law, but of practice"). The United States Supreme Court has consistently held the States are free to shape their own rules of procedure. See, e.g., United States v. Scheffer, 523 U.S. 303, 316 (1998), *quoting* Chambers v. Mississippi, 410 U.S. 284, 302 (1973) ("we thus stressed that the ruling did not 'signal any diminution in the respect traditionally accorded to the States in the establishment and implementation of their own criminal trial rules and procedures.'").

Significantly, Greene did not lose her right to make a closing argument; rather, she

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[4] In 2007, Florida changed its rules to eliminate a defendant's right to make a final closing argument. See In re Amendments to the Florida Rules of Criminal Procedure–Final Arguments, 957 So.2d 1164 (Fla. 2007). Florida's new rule provides, in pertinent part, as follows: "In all criminal trials, excluding the sentencing phase of a capital case, at the close of all the evidence, the prosecuting attorney shall be entitled to an initial closing argument and a rebuttal closing argument before the jury or the court sitting without a jury." Id. at 1167.

merely chose to forfeit the opportunity to present her argument last. See Herring, 422 U.S. at 857-64 (a *total denial* of the opportunity to present a closing argument to the trier of fact is a denial of the basic right of the accused to make his defense).

The order of closing arguments is a matter of state procedural preference which does not offend equal protection or any other constitutional right. Sheffer. The trial judge and the parties below had the right to rely on well-established precedent and longstanding practice – a practice that never deprives any defendant of the opportunity to present a closing argument. That practice was followed in Greene's case. There was no error.

In any event, even if the order of argument in Greene's case is deemed error, the error was harmless under the facts of Greene's case. Our Supreme Court has previously concluded that denial of the right to last closing argument "is not the kind of error that would affect the entire conduct of the trial from beginning to end" and is "subject [to a] harmless error analysis." State v. Mouzon, 326 S.C. 199, 485 S.E.2d 918 (1997). In Mouzon, the Supreme Court concluded that pursuant to state procedure the defendant was entitled to the right to last closing because he in fact did not present evidence. Further, the court concluded the error was not harmless as Mouzon concentrated "on the murder charge and was acquitted of murder; he did not focus on the conspiracy charge and was convicted." Id. at 205, 485 S.E.2d at 922. The court noted the prosecution "devoted a significant amount of attention to the issues of drug dealing and conspiracy. If Mouzon had been allowed to argue last, then he could have more adequately addressed the issue of conspiracy to distribute crack cocaine." Id.

Greene's case is distinguishable from Mouzon. First, according to well-settled state

procedural practice, Greene lost the opportunity to present the last argument when she introduced evidence in the form of three defense witnesses. Second, the focus in Greene's case remained on one event – the death of Alexis based on toxic levels of morphine in her body and brain. The State's theory was clearly that death resulted from Greene's breast milk, which contained morphine. Third, and perhaps most significantly, defense counsel failed to proffer a proposed "rebuttal" argument to illustrate how his closing argument would have been different had the solicitor opened in full prior to the defense argument. Indeed, Greene failed to show the trial court how she might have been "sandbagged" as she claims.

In sum, Greene failed to demonstrate prejudice even assuming the trial judge erred. See State v. Hariott, 210 S.C. 290, 298, 42 S.E.2d 385, 388 (1947) ("It is a rule of practically universal application in appellate procedure that an accused cannot avail himself of error as a ground for reversal where the error has not been prejudicial to him."); see also Smith v. State, 375 S.C. 507, 523, 654 S.E.2d 523, 532 (2007) (finding errors in closing argument "do not automatically require reversal if they are not prejudicial to the defendant, and the appellant has the burden of proving he did not receive a fair trial because of the alleged improper argument.").

CONCLUSION

For all of the foregoing reasons, the judgment and conviction of the lower court should be affirmed.

Respectfully submitted,

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April 22, 2015

STATE OF SOUTH CAROLINA

IN THE COURT OF APPEALS

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SC Court of Appeals

Appeal From Spartanburg County
J. Derham Cole, Circuit Court Judge

STATE OF SOUTH CAROLINA, Respondent

v.

STEPHANIE I. GREENE, Appellant.

PROOF OF SERVICE

I, Norma Bigbee, certify that I have served the within **Initial Brief of Respondent and Designation of Matter** on Appellant by depositing two copies of the same in the United States mail, postage prepaid, addressed to: C. Rauch Wise, Esquire, 305 Main St., Greenwood, SC 29646.

I further certify that all parties required by Rule to be served have been served.

This 22ND day of April, 2015.

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ALAN WILSON
ATTORNEY GENERAL

RECEIVED
APR 22 2015
SC Court of Appeals

April 22, 2015

VIA HAND DELIVERY
The Honorable Jenny A. Kitchings
Clerk, South Carolina Court of Appeals
Post Office Box 11629
Columbia, SC 29211

Re: **State v. Stephanie I. Greene**
Appellate Case No: 2014-000764

Dear Ms. Kitchings:

Enclosed please find the original of the **Initial Brief of Respondent and Designation of Matter** in the above matter for filing in your office. By copy of this letter we are serving opposing counsel with this brief today.

Sincerely,

David Spencer
Senior Assistant Attorney General
Bar No: 68571

DS/nb
Enclosures

cc: C. Rauch Wise, Esquire (2 copies enclosed)
Trisha Allen, Victim Services (1 copy enclosed)