**PHYSICIAN'S MEDICATION ORDERS AND SERVICE NOTES**

**Patient's Name and I.D. #** Kimmie Heaton # 9113536

**Medications Prescribed and Physician's Service Notes**

**CURRENT MEDICATIONS:** None.

**LAB REPORTS:** None.

**CHIEF COMPLAINTS:** Initial evaluation for this 20 year old brought in by the jail for evaluation of depressive symptoms as well as hearing voices.

**HISTORY OF PRESENT ILLNESS:** Reveals that the client has been incarcerated during the past several months after an incident in which she shot and killed her husband in an early morning incident when they were on their paper route. The client describes having had a conflictual relationship with her husband over a period of many months in which the client had left her husband three times, but returned each time. The client described her husband as being somewhat persistent and controlling and would frequently stalk her and she would then consent to return home. The client described that her husband did have a drinking problem, but was not physically abusive. The client reported that her husband reminded her of her father who was also a very controlling individual. The client ultimately decided that the only escape she would have would be to kill her husband and requested that her cousin bring her a gun which she took on the morning of the paper route and shot and killed her husband and also shot herself. The client was quite tearful when talking about the incident and reported that she wished it had never happened. The client even before the incident with the husband describes depressive symptoms of insomnia, anorexia, mood swings, crying spells and loss of energy level. Subsequent to the incident the client also has reported increasing crying spells two to three times a day, difficulty sleeping at night, changes in appetite, changes in energy level, occasional suicidal ideation, but no intent and no plan at this time.

**PAST HISTORY:** Reveals that the client reportedly has no history of violence in the past, denies any cruelty to animals or fire setting. The client denies any other legal problems also. The client did describe a difficult childhood in which she was abandoned by her mother at age 13 or 14 years of age. The client lived with her father for a while and then went to live with her mother after the mother remarried. The mother had remarried an alcoholic abusive spouse and again left this spouse and left the client again. The client at this time then returned home to live with her father until she married. The client also described an incident where she had been molested by an uncle who had touched her inappropriately. The client reported that she had never reported this to anyone, but she also had a cousin to whom this had happened. The client states that she is unsure what will happen. She reports that the family of her deceased husband is asking for the death penalty, but she said that she has been informed that there is not enough evidence to support that. The client at this point reports that she does not know what will happen.

**PAST PSYCHIATRIC HISTORY:** Reveals that the client reportedly has had no significant medical problems. The client however has had a past psychiatric history. The client had been hospitalized twice at Marshall Pickens for depression and suicidal gesture and also hearing voices. The client on the second hospitalization at Marshall Pickens was then transferred to the Hall Institute where she stayed for six weeks. The client reportedly was treated with Desipramine, Imipramine and Trilafon. Subsequent to that the client had sporadic outpatient visits, but has had no consistent mental health follow up.

(continued from page 1)

**PAST MEDICAL HISTORY:** Again reveals no significant medical problems. No hospitalizations. The client however does report having endometriosis. The client is reportedly allergic to no medications. The client's social work history reveals that she had graduated from High School and worked odd jobs as well as doing the paper route with her husband. The client reports that she has contact with her step father, her mother and her brother with whom she reportedly has a close relationship.

**MENTAL STATUS EXAM (CURRENT):** Reveals client to be alert and oriented, dressed in orange uniform of the jail and in handcuffs. The affect is noticeably depressed, brightens very little. Client quite tearful throughout the interview when talking about the incident with her husband and about her being in jail. The client reported occasional suicidal ideation, but denies any present suicidal ideation or intent. She denies any plan. The client denies any homicidal ideation. Thought processes appear logical and coherent. However, the client does describe auditory hallucinations of muffled voices which at times disturb her. The client denies any visual hallucinations, tactile hallucinations or paranoid ideations or other evidence of thought disorder. The client does report having occasional flashbacks of incidents that happened to her in her childhood, especially when her mother abandoned her and the incident with her uncle. Again the client describes difficulty sleeping at night, changes in appetite and energy level, frequent crying spells. Memory functioning appears to be good. Insight appears to be fair. Judgement however appears to be somewhat impaired. When client was asked why she shot her husband she could not give a clear reason other than feeling that this was her only escape from him. The client when asked about the incident of next door neighbors house burning replied appropriately that she notify the neighbors and help them get out and call the police. When given the incident of finding a letter on the side walk the client reported that she would open the letter and read it rather than putting it in the mail box. Also when asked about if she saw someone drop money on the sidewalk and she found it she reported that what she would do depended on how badly she needed the money. The client appeared to have a very subjective sense of morality of right and wrong at this point in time. The client's three wishes: to change everything in her life, to be happy (the client describes that she can not remember the last time that she had been happy).

**IMPRESSION:** Major Depression with Psychotic Features.

**PLAN/RECOMMENDATIONS:**

1. Recommend that the client be given a trial of Paxil 10 mgs a day for a week and then 20 mgs a day.
2. It is recommended that she consider taking the Risperdal for the hallucinations, although client is reluctant to do this. The client was given a neuroleptic consent form to review and this was reviewed with her. The client again requested more time to think about this. She was given information about the Risperdal.
3. The client is to be rechecked in one month or sooner if needed.

James E Ford MD

**James E. Ford, M.D.**
**Physician's Signature & Date**

11-4-97

**10/14/97**
**Date Of Visit**

SCDMH FORM
MAY 86(REV APR 91) C-168c

wpb

**PHYSICIAN'S MEDICATION ORDERS AND SERVICE NOTES**

**Patient's Name and I.D. #** Kimmie Heaton #9113536

**Medications Prescribed and Physician's Service Notes**

**CURRENT MEDICATIONS:**
1. Paxil 20 mgs in the morning, 10 at night.
2. Clonidine 0.1 mg 1/2 tab in the morning, 1/2 at night.

**LAB REPORTS:** No recent labs.

**CHIEF COMPLAINTS:** Med check follow up for this soon to be 21 year old female with a diagnosis of major depression with psychotic features, although psychotic features are resolving.
Axis II - R/O Antisocial Personality.
Axis III - No DX.

**PROGRESS:** Reveals that the client continues to be incarcerated on the charge of murdering her husband. The client is scheduled to go to trial in the not to distant future. The client reports having run out of her Paxil during the past two weeks and can tell a increase in her depression and anxiety. However, the client does report that the Clonidine has helped her with her angry and aggressive outburst. The client has had no further specific behavior problems in jail. The client however does continue to report flashbacks about the incident of killing her husband, also incidences when she was abused as a child.

**MENTAL STATUS EXAM (CURRENT):** BP-110/70. P-92 and regular. The client is alert and oriented, neatly dressed and groomed. Affect slightly depressed and anxious, but brightens easily. The client denies any SI/HI. Thought processes are logical and coherent. The client denies any hallucinations, delusions or paranoid ideations at this point. However, the client does report the flashbacks of previous trauma. Insight appears good. Judgement good. There is no evidence of abnormal movements. No EPS.

**IMPRESSION:** Axis I- Major Depression with Psychotic Features improving ~~psychotic~~ features. Also additional diagnosis of ~~P~~TSD.
Axis II - Antisocial Personality.
Axis III - No DX.

**PLAN/RECOMMENDATIONS:**
1. Continue the Paxil 20 mgs in the morning, 10 mgs at night. Clonidine 0.1 mg 1/2 tab b.i.d.
2. Recheck in one month or sooner if needed.

James E Ford, MD
**James E. Ford, M.D.**
**Physician's Signature & Date**

1-13-98
**12/30/97**
**Date Of Visit**

SCDMH FORM
MAY 86(REV APR 91) C-1682

**PHYSICIAN'S MEDICATION ORDERS AND SERVICE NOTES**

**Patient's Name and I.D. #** Kimmie Heaton #9113536

**Medications Prescribed and Physician's Service Notes**

**CURRENT MEDICATIONS:**
1. Paxil 20 mg tablets 1/2 tab or 10 mgs in the morning and then a whole tab or 20 mgs at bedtime.
2. Clonidine 0.1 mg 1/2 tab b.i.d.

**LAB REPORTS:** No recent labs.

**CHIEF COMPLAINTS:** Med check follow up for this 21 year old today with a DX of Major Depression with Psychotic Features.

**PROGRESS:** Reveals that the client has had a good response to the Paxil. The client describes fewer depressive symptoms, fewer mood swings, fewer periods of irritability. The client reports getting along better with inmates as well as staff at the local jail. Client denies any side effects of medication at this point. The client reports sleeping well at night. Appetite is good. Client however is concerned about weight gain and reports that she does not always have the opportunity to exercise. The client did describe an incident several weeks ago when she was falling asleep that she felt that there was someone in the jail cell with her that was kneeling down and praying beside her bed. The client wondered if this might have been an angel and startled her when she woke up and the figure had disappeared. The client did question about the subject of angels.

**MENTAL STATUS EXAM (CURRENT):** Reveals the client to be alert and oriented, again dressed in orange jumpsuit and in handcuffs from the jail. Affect somewhat subdued, but does brighten. There is no SI/HI. Thought processes appear logical and coherent. The client denies any present hallucinations, delusions, paranoid ideations or other evidence of thought disorder. Insight appears improved. Judgement improved.

**IMPRESSION:** Axis I - Major Depression with Psychotic Features resolving.
Axis II - No DX.
Axis III - No DX.

**PLAN/RECOMMENDATIONS:**
1. Continue present medications. Paxil 20 mgs 1/2 tab or 10 mgs in the morning, whole tab or 20 mgs at night. Clonidine 0.1 mg 1/2 tab b.i.d.
2. Recheck in 6 weeks or sooner if needed.

James E Ford, MD

**James E. Ford, M.D.**
**Physician's Signature & Date**

1-29-98

**1/20/98**
**Date Of Visit**

SCDMH FORM
MAY 86(REV APR 9[illegible]

**PHYSICIAN'S MEDICATION ORDERS AND SERVICE NOTES FOR CHILDREN**

**Patient's Name and I.D#** Kimmie Heaton #9113536

Medications Prescribed and Physician's Service Notes

**CURRENT MEDICATIONS:**
Paxil 20 mg 1/2, 10 mg, in the morning, whole tab 20 mg, at bedtime
Clonidine 0.1 mg 1/2 tab at bed bid
**LAB REPORTS/INFORMATION:**
No recent labs.
**CHIEF COMPLAINT:**
Med check follow up for this 21 year old with a diagnosis of major depression with psychotic features.
**PROGRESS:**
Client reports that during the past month that she has experienced episodes of dysphoria possibly on a twice a week basis. She reports that the periods of dysphoria last for approximately one day. Client also reports mood swings. Reports that at times she is active, energetic, not depressed and then within a matter of a few hours, she is depressed. Again, client reports having these episodes several times a week. Client reports overall sleeping well at night and appetite good, in fact too good. Client reports some concern about medication causing her to eat too much and gain weight. Client reports that she is involved in a regular pattern of exercise but again is concerned about her weight. Client reports no recent episodes of seeing the angels in her room. Other than the weight gain, client denies any side effects to medication.
**PHYSICAL FINDINGS: Wt.** 135 lbs. **Ht.** **BP.** 118/80 **Pls.** 92 regular

**MENTAL EXAM (CURRENT):**
Client is alert and oriented, neatly dressed and groomed. Client wearing glasses today. Affect appears slightly depressed but does brighten. Client denies any suicidal or homicidal ideation. Thought processes are logical and coherent. Again client denies any recent hallucinations, delusions, paranoid ideation or other evidence of thought disorder. Insight appears fair, judgement fair. On exam, no evidence of abnormal, involuntary movements.
**IMPRESSION:**
Axis 1: Major depression with psychotic features, psychotic features resolving, depression continuing
Axis 2: No diagnosis
Axis 3: No diagnosis
**RECOMMENDATIONS:**
Continue Clonidine 0.1 mg 1/2 tab bid. Taper the Paxil. Client is to take 1 tab at night for 3 nights, 1/2 tab at night for nights and then discontinue. Will be started on Wellbutrin SR, 150 mg 1 tablet in the morning. Client is to be checked in 1 month or sooner if needed. Noted that the change in the Paxil to Wellbutrin was made because of the client's concern about the weight gain. Client reports that this has created a great deal of anxiety and stress for her.

James E. Ford, MD
**Physician's Signature And Date**

3-10-98
**Date of Visit**

lmd

# PHYSICIAN'S MEDICATION ORDERS AND SERVICE NOTES

**Patient's Name and I.D#** Kimmie Heaton #9113536

Medications Prescribed and Physician's Service Notes

**CURRENT MEDICATIONS:**
Clonidine 0.1 mg 1/2 tab bid
Wellbutrin SR 150 mg 1 tab q am

**LAB REPORTS/INFORMATION:**
No recent labs

**CHIEF COMPLAINTS:**
Med check follow up for this --- year old with major depression with psychotic features.

**PROGRESS:**
It is noted on the last visit that the medication was changed from the Paxil to the Wellbutrin because of side effects of the Paxil, specifically weight gain. Also client having periods of dysphoria. Client reports a good response to Wellbutrin. Client reports not feeling as depressed, having fewer mood swings. Client did report one episode of dysphoria with a crying spell several weeks ago but none since that time. Client reports overall sleeping well at night, appetite good, energy level good. Client denies any significant depressive symptoms at this point. Client denies any psychotic symptoms. Client reports no recent episodes of seeing angels in her room.
**WEIGHT: 132 lbs. Loss of 3 lbs. BP: 110/70 Pulse: 88 regular**

**MENTAL STATUS EXAM (CURRENT):**
Client is alert and oriented, neatly dressed and groomed. Again wearing the orange jumpsuit from the jail and the shackles. Affect appeared much less depressed today. Brightened easily. Client denied any SI/HI. Thought processes are logical and coherent. No evidence of thought disorder. Client again denies any hallucinations, delusions, or paranoid ideation. Insight again appears fair, judgement fair. On exam no evidence of abnormal movements.

**IMPRESSION:**
Axis 1: Major depression with psychotic features resolving. Depression improving
Axis 2: No diagnosis
Axis 3: No diagnosis

**RECOMMENDATIONS:**
Continue Clonidine 0.1 mg 1/2 tab bid. Continue Wellbutrin SR 150 mg 1 in the morning. Recheck in 1 month or sooner if needed.

James E Ford, MD 4-20-98
**James E. Ford, MD** **4-6-98**
**Physician's Signature And Date** **Date of Visit**

SCDMH FORM
MAY 86(REV APR 91) C-168C lmd

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May 5, 1998

FAX 864-833-4587

Claude H. Howe, III, Esq.
509 North Broad Street
Clinton, South Carolina 29325

Re: Kimmie Lee Heaton

Dear Mr. Howe:

Based upon psychiatric examination and psychological testing here and review of prior medical records it is my conclusion that your client has a serious mental illness.

The medical records show that she was first seen at the local mental health center on May 30, 1991. On June 8, 1991 she was admitted to the Marshall Pickens Psychiatric Hospital with severe depression with suicidal ideas as well as hearing voices. She was treated with appropriate medication, Prozac and Trilafon. After three weeks as an inpatient she was discharged for follow-up in the local mental health center but she did not respond well to outpatient treatment. On September 20, 1991 she was again admitted to the Marshall Pickens Hospital with worse depression, more hallucinations and more suicidal thoughts. On September 28, 1991 she was transferred to the William S. Hall Psychiatric Institute where she remained until November 15, 1991. Her diagnosis there was Major Depression with psychotic features. After release from the Hall Institute she was followed at the mental health center until she dropped out of treatment in 1993.

Examination here on December 12, 1997 revealed depression as the most obvious clinical feature. However, psychological testing with the Personality Assessment Inventory and the Minnesota Multiphasic Personality Inventory (MMPI) revealed more peculiarities in her thinking, impairment in judgement and magical thinking or delusional ideas. In short, her contact with reality is fragile.

It should be noted that this young woman's early life was chaotic. She was the product of rape but was subsequently adopted when her mother married Mr. Shipes. That marriage was unstable; the patient recalls lots of fights between her parents and when she was a teenager her mother abandoned the family. The record shows that her mother also has a long history of psychiatric illness.

BTW

A TRUE COPY OF ORIGINAL fax
Barbara T. Wasson
BARBARA T. WASSON
Laurens County CCCP & GS

In summary, this defendant has a chronic mental illness, which requires treatment with antidepressants and antipsychotic medication. At the time of the incident she was not being treated. As a consequence her thinking, judgement and behavior were significantly impaired.

Ms. Heaton is intelligent and insightful. Whatever the outcome of her legal charges she needs continued treatment with medication and counseling. If this can be provided in a stable, consistent environment she can become a productive citizen.

I hope that this information will be helpful; if you have questions please contact me.

Thank you for asking me to see your client and please accept my best personal wishes.

Yours very truly,

Harold C. Morgan, M.D.
Diplomate, American Board of Psychiatry and Neurology
Diplomate, American Board of Forensic Psychiatry
Clinical Professor of Psychiatry
University of South Carolina School of Medicine

HCM/jg