Fifteenth Annual
National Pretrial Competition

Stetson University College of Law
October 6-9, 2022

Competition Problem

State of Stetson

v.

Ashton Campbell

CASE NO: 2022-CR-867

Table of Contents

Stipulations of the Parties

The following has been stipulated to by and between the parties:

1. All exhibits are complete, accurate, and authentic.

2. All transcripts are true and accurate transcriptions of what was said.

3. All reports, affidavits, witness statements, exhibits, and transcripts are complete, accurate, and true copies of the originals.

4. The only antipsychotic drug available for use in the State of Stetson is Haldol (generic is haloperidol). No party may argue that an antipsychotic drug other than Haldol (haloperidol) may be a treatment option for the defendant.

5. Exhibits 1, 2, 3, 4, 5, and 6 are admissible. No objections to these exhibits on any grounds will be entertained by the court.

6. Court Exhibit A and Court Exhibit B are already in evidence, having been admitted at prior proceedings in this matter.

7. The State of Stetson will call Dr. Terry Jackson and Dr. Ellis Ramani as witnesses. Dr. Ellis Ramani has reviewed and is familiar with all documents contained in the Case File and may not deny knowledge of any fact contained within the Case File.

8. The Defense will call Dr. Alex Lee and Pat Griffin, R.N. as witnesses. Dr. Alex Lee has reviewed and is familiar with all documents contained in the Case File and may not deny knowledge of any fact contained within the Case File.

9. Both parties are limited to only the facts contained within the four corners of the Case File, and particularly with respect to the medications and the symptoms, causes, diagnoses, and treatment of the physical and mental illnesses discussed in the Case File.

Petersburg Police Department

102 Freemont Way
Petersburg, Stetson 33713
Main: 727-813-2300
Emergency Dispatch: 911

Incident Report
_X_Narrative
___Supplement

Date of Incident	Time of Incident	Officer Badge Number	Case Number
1-31-22	14:30	417	22-00516
Suspect	**Incident Type**	**Arrest Status**	**Citation Number**
Ashton Campbell	_X_Criminal __ Motor Vehicle __ Violation __ Other	__On-Site __ Warrant _X_Investigation ongoing	N/A

On January 31, 2022, there was a three-alarm emergency call to the Hannah Village Condominium Complex, 17 Plymouth Road, Petersburg, Stetson 33712. Fire, Medical, and Police were all dispatched. By the time emergency services arrived, the units on the right side of the complex were ablaze and there were flames and smoke pouring out of the windows. Luckily, it was midday on a Monday, so not too many people were home. It looked like most of the residents were already outside by the time we arrived. However, it was quickly determined that an elderly couple who lived in Unit 2, Mr. and Mrs. Cole, had not made it out. The Petersburg Fire Department (PFD) attempted rescue (See PFD Report).

I started talking to neighbors who were outside to try to determine what happened. Most people were too shaken up or did not know enough about what occurred to be able to speak with me, but then someone who identified themselves as Dr. Terry Jackson from the University of Stetson came up to me and said, "I know what happened." I asked if Dr. Jackson would accompany me to the police station to give a sworn statement. Dr. Jackson agreed.

Officer Name: Michelle Hernandez (Badge 417)

Officer Signature: *Michelle Hernandez* Date of Incident Report: 01-31-22

Petersburg Police Department

102 Freemont Way
Petersburg, Stetson 33713
Main: 727-813-2300
Emergency Dispatch: 911

Witness Statement

My name is Dr. Terry Jackson, and I am a Professor in the Chemistry Department at the University of Stetson. I have worked with Ashton Campbell for the last 30 years. More than that, he is my friend.

Please know, this must have been a terrible accident. Ashton has not been acting like himself. Something is wrong with him. Ashton would never knowingly or intentionally hurt anyone. He just gets so wrapped up in his work. If only he had been in the lab and not at home. With chemistry, fires can happen, which is why we have fireproof walls around our labs at the University of Stetson.

Anyway, Ashton and I met at the University of Stetson about 30 years ago—in the early 90's—when we were both Ph.D. candidates studying chemistry. He was a year ahead of me and really took me under his wing. We both ended up getting full-time offers to teach in the University's Chemistry Department because two professors retired in the same year. In addition to teaching, we are required to conduct research and publish in our field. To further those requirements, the University looks favorably upon consulting and contract positions, especially with prestigious government agencies like the Center for Disease Control (CDC) and the Department of Defense (DOD).

About 2-and-a-half years ago, around May 2019, Ashton told me that he got a contract working for the DOD. He said he couldn't talk too much about it because of security clearance issues, but that it was related to a chemical weapons defense program the government was studying and developing. He said it was a three-year contract, with a renewal option at the end of the three years if the government was satisfied with his work. He was really excited about this opportunity and said he was thrilled that "his ship was finally coming in." I knew he hadn't published any significant new research findings in the last 7 years, which Dean Pritchett and the Board of Trustees had been consistently hounding him about. It was a little awkward because my research had been a huge success in prior years. I discovered a new chemical compound that was pivotal in the furtherance of stem cell research. Ashton often made comments to me like, "If only I could conduct breakthrough research like you, then Dean Pritchett and the Board would get off my back. They are all over me. It's getting worse by the month. I'm scared they are going to fire me, Terry. I can't lose my job. It's my whole life! And I need to pay the bills – I haven't exactly been a penny pincher over the years. You know I love the slots. Dean Pritchett mentioned needing to see some significant innovative research and related publication 'sooner rather than later.' Can you believe it? He said that to ME – the winner of a McArthur Genius Grant! I really have my back against a wall."

I told Ashton everything would be OK, especially now that he had the DOD contract. I congratulated him on the contract and didn't really think much more about it at the time. Ashton is considered a preeminent chemist, probably one of the best in the country, if not the world, so it was not at all surprising that the DOD would contract him to work on a project. He's brilliant, and he knows it. A little quirky, and quite arrogant, but in the most likeable kind of way. The students like him, and the faculty and administration greatly respect him. He's a delight around campus, always smiling, upbeat, and kind.

Ashton's work is his life. He never married or had kids. I think he would have lived in the chemistry lab if it were permitted. For as long as I have known Ashton, he has lived in the Hannah Village Condominium Complex right on the edge of campus. It's a nice place, I've

been there many times. His condo is always meticulously clean. Ashton is a neat freak. Not me, I'm more of a free spirit. We used to joke that we were like The Odd Couple – I was Oscar, and he was Felix.

I mention this because, knowing how clean and organized Ashton is, I was very surprised to find both him and his apartment dirty and in disarray earlier today. I went over there because I hadn't heard from him in a while. I usually try to respect his privacy and not show up uninvited, but this was different. It wasn't entirely unusual for us to not see each other in person for months at a time due to the Pandemic and his research project, but we always texted, emailed, or spoke on the phone. Although he did forget my birthday last year (it's May 18th), which I thought was weird because we always celebrate each other's birthdays. When I asked him about it, he apologized and said he "forgot." Anyway, Ashton hadn't been in contact with me since before the holidays and hadn't responded to any of my outreach (texts, calls, or emails). He also missed our first faculty meeting of the semester which was very unlike him, especially since this meeting was his first one back following his sabbatical. Wait, I'm sorry, I'm getting ahead of myself. Let me back up.

When the COVID Pandemic hit in March 2020, the University went fully remote – classes, office hours, faculty meetings, etc. were all now taking place on Zoom. Even though the Dean encouraged everyone to turn their cameras on, maybe only 50% of the faculty did so. But Ashton was always one of the people with his camera on – smiling, happy, trying to keep everyone positive and upbeat. He would always use one of those fun "location backgrounds" on Zoom and make jokes about where he was traveling this month. We all got a good laugh out of it – Ashton was very witty. However, about six months into the Pandemic, Ashton stopped using the fake backgrounds during our meetings and I noticed that his apartment looked messy, and he personally looked unkept – his hair wasn't combed, his shirt was wrinkled, and he had bags under his eyes. I guess I didn't think much of it at the time; we were all pretty burned out.

Ashton emailed me in January 2021 and said that he was going on sabbatical to finish his DOD research. He said he was concerned that he had fallen behind on his research due to the Pandemic. He said he needed to show the DOD what he was capable of. He said he was only scheduled to teach one Independent Study that semester and asked if I could cover it for him. I agreed. In hindsight, I probably should have asked more questions, but it seemed totally legitimate at the time. Plus, I wanted the extra financial stipend from the University. Money had been a little tight lately.

Six months went by. We spoke a few times a month via text or email, just checking in to see how things were going. Well, I guess I checked in on him – I was always the one reaching out. Even though Ashton never initiated contact, he would respond and say that his research was very encouraging. He also came to campus many times to use the chemistry lab. I spoke to him while he was there. At first, he seemed like himself, but then things started to change around June 2021. One day when he came to the lab, he seemed very frazzled and disheveled – shirt untucked, wrinkled clothes, unshaven, and moving around and speaking quickly. He said he couldn't find certain chemicals, Bunsen burners, and beakers even though they were where we had always kept them. He accused me of hiding them from him and exploiting the fact that he was on sabbatical to turn the lab into my own personal research facility in an attempt to undermine his research efforts. I was taken aback by this as it was entirely untrue and politely reminded him where the various items were kept – where they had always been kept. I asked him if he was OK and he replied, "Yes, I'm sorry, I guess I'm just having a hard time trusting people lately – I feel like there is no loyalty left in the world. People are too willing to stab their friends in the back just to get ahead." I had no idea what he was talking about, but I did know that I had never known Ashton to forget things, let alone where things were located in the lab that he had personally helped design. He definitely seemed really stressed out. I've been there though – trying to meet a research deadline is incredibly stressful.

The next time I became concerned was about three weeks later, right around July 4, 2021. Ashton showed up at the lab wearing a winter coat and jeans, which made no sense to me

because it was July in Stetson, which is pretty much the hottest time of year. When I asked him why he was wearing a winter coat in the July heat, he said, "It's not July, it's February -- it's freezing in here!" It's true that the air conditioning always pumps really hard in the lab (I often wear multiple layers myself), but it definitely was not February. When I said, "Ashton it's July, not February," he looked confused for a moment (cocked his head to the side and squinted his eyes), but then said loudly, "Are you calling me stupid? I know it's July, I meant it *feels* like February in this ice-cold tundra you call a lab. You're an idiot! I'm out of here!" The incident definitely took me by surprise and concerned me, but it was Ashton – he was always arrogant and quirky. And, again, he was clearly stressed. I thought maybe I had misheard him, so I just let it go.

Over the next six months, I didn't see Ashton in the lab anymore. We still spoke via text message, but as the months passed, Ashton's responses got shorter and shorter. He said he was too busy on the research project to talk, but that he was about to make a breakthrough and would be in touch soon. He said he was planning to return to school in January to teach the students about his new discovery. This was in late December 2021, right before Christmas. My antenna went up when he said that because I thought this DOD project was "top secret." Around that time, I also noticed that certain chemicals and Bunsen burners had gone missing from the chemistry lab. I hadn't seen Ashton take anything, so I didn't want to accuse him by name, but I reported the missing chemicals and burners to the administration, and they told me they would start an investigation.

I didn't hear from Ashton during the holidays or the New Year. He had told me he was returning to teach for the Spring 2022 semester, but I did not see him on campus when classes started about a week-and-a-half ago. And then he missed our first faculty meeting this morning and wasn't returning any of my texts, calls, or emails, so I knew something was very wrong. So, I went over to his apartment today around 1:00pm. He answered the door in his robe, his hair was a mess, and he looked like he hadn't showered in weeks. That was so unlike him. Ashton was always put together, clean-shaven and well-dressed.

Ashton said he was very busy and couldn't talk. He was angry that I had interrupted him on the verge of his breakthrough. I told him I was really worried about him and that I noticed certain chemicals and burners were missing from the lab. He told me he took them because he needed to confirm some of his theories at home and didn't have time to be driving back and forth to campus because it was a "30-minute drive each way." This confused me because it was probably less than a 5-minute drive from his condo to campus, but I was focused on the chemicals and burners at that point. I told him it was dangerous to have those chemicals outside the lab, and he said, "Yes, but I'm the best chemist in the world! I won't let anything happen. You're just jealous that my breakthrough is going to be more significant that yours!" He said he would be back on campus in a couple weeks to reveal his findings and closed the door in my face.

I went straight back to campus and spoke with Dean Pritchett. I told her everything that had just happened, and we were trying to come up with a solution, when I realized it was too late. I heard sirens wailing in the distance and I just knew that something terrible had happened. I rushed back to the Hannah Village Complex and Ashton's condo and the one next to it were on fire. Smoke was pouring out of the windows. This is just awful. But please know this isn't Ashton. Something is very wrong. He needs help.

I hereby attest under penalty of perjury that the above information is true, accurate, and complete.

Witness Name (print): Terry Jackson

Witness Signature: Terry Jackson

Date: 01-31-22

Attesting Officer Name: Michelle Hernandez (417)

Attesting Officer Signature: Michelle Hernandez

Date: 01-31-22

EXHIBIT 1

CITY OF PETERSBURG

Office of Fire Investigation
2 South Way
Petersburg, Stetson 33711
Main: 727-813-2800
Emergency: 911

Date and Time of Incident: January 31, 2022; 14:30
Arson Investigator: Lieutenant Kelly Severide, Rescue Squad 3

On January 31, 2022, Fire Truck 81 and Rescue Squad 3 of the Petersburg Fire Department were dispatched to Hannah Village Condominiums. Upon arrival, firefighters observed the end unit, later identified as Unit 1, fully ablaze with smoke and flames visible through the roof and windows. Residents were scattered outside.

Truck 81 used hoses to try to put out the blaze and Squad 3 took rescue measures. Residents at the scene said they didn't see Mr. and Mrs. Cole, an elderly couple, who lived in Unit 2. They reported that Mr. Cole is wheelchair-bound, and Mrs. Cole is ambulatory, but very infirm.

Squad 3 immediately initiated rescue efforts in Unit 2. The right-side wall of Unit 2 (the shared wall with Unit 1) was on fire and visibility was less than 2 feet due to the smoke. We were able to quickly locate the Cole's in the living room. They were both unconscious. It appeared they were trying to get out of the front door before they collapsed. We extracted them and Paramedics immediately began CPR. They were transported to Petersburg General Hospital. I was later notified that both Mr. and Mrs. Cole were being treated for smoke inhalation but were likely to make a full recovery.

Once Truck 81 was able to put out the fire, I began the arson investigation. Structure collapse and burn patterns evidenced the fire began in the end unit, Unit 1. That theory was confirmed when we entered Unit 1 and found multiple chemical burns. The point of origin, indicated by the most severe burn patterns, was in the kitchen. There was also shattered glass on the floor, indicating high, prolonged heat concentration, also consistent with the point of origin. The owner of Unit 1 is Ashton Campbell

Kelly Severide

Lieutenant, Squad 3; Certified Arson Investigator Report Date: February 1, 2022

EXHIBIT 2

Hannah Village Condominium Complex

EXHIBIT 3

Unit 1 -- Kitchen -- Point of Origin

EXHIBIT 4

PETERSBURG GENERAL HOSPITAL
Emergency Department
75 Collateral Drive
Petersburg, ST 33711

SUMMARY REPORT OF EMERGENCY MEDICAL TREATMENT

DATE/HOUR TREATMENT:	PERFROMED BY: Dr. Paola
01-31-22; 2:50pm	ED Case #: 2022-3077

Patient 1: Robert Matthew Cole Sex: M Age: 85

Patient 2: Barbara Anne Cole Sex: F Age: 83

Home Address: 17 Plymouth Road, Unit 2, Petersburg, ST 33712

Date of Incident: 01-31-22

Time of Admission: 2:50pm

Arrival Method: ( )Walk-in (X)Ambulance

SUMMARY DIAGNOSIS

Both patients presented with coughing and shortness of breath. Medics reported patients were unconscious when located by the Fire Rescue Squad, but medics quickly revived both patients with CPR in the field. Both patients were alert upon arrival and complaining of chest pain. Chest x-rays and bronchoscopies revealed minor inflammation in the respiratory tract and tracheobronchial tree caused by smoke inhalation. Minor bronchoconstriction was present in both patients. No pulmonary edema, thermal burns, or atelectasis were present in either patient. Arterial Blood Gas (ABG) levels were normal. Patients were provided high-dose oxygen and monitored overnight. No complications arose. Patients were discharged after 24-hours.

Jennifer M. Paola

Jennifer M. Paola, M.D.
Chief Physician, Emergency Department
Petersburg General Hospital

SUPERIOR COURT OF STETSON
County of Pinella

WARRANT OF ARREST Stetson General Statutes § 54-2a	

THE PEOPLE OF THE STATE OF STETSON
To any Stetson Police Officer

Warrant No. 654-93
PPD Case # 22-00516

Defendant's Name: Ashton Campbell

Order: A complaint on oath establishing probable cause having been filed with this Court on this date charging the defendant listed above with the crime(s) specified below, you are commanded forthwith to arrest the above-named defendant and bring him before me, or in case of my absence or inability to act, before the nearest and most accessible judge in this county.

Crimes charged: The defendant has been charged with the following crimes:

2 COUNTS: Reckless Arson Causing Physical Injury in violation of Stetson General Statutes § 53a-113. Ashton Campbell recklessly caused the burning of a dwelling that resulted in physical injury to another person(s), to wit: Robert Cole and Barbara Cole, on January 31, 2022.

Night Service Authorization [If checked]
[x] **Felony:** This felony warrant may be executed at any hour of the day or night.
[ ] **Misdemeanor:** Good cause for night service having been established in the supporting declaration, this misdemeanor may be executed at any hour of the day or night.

Bail: [x] $150,000 cash/surety____ [ ] No Bail

February 7, 2022, 10:45am
Date and Time Warrant Issued

The Honorable Omar Prince
Judge of the Superior Court

Arrestee Information

For Identification Purposes Only

Name: Ashton Campbell (no known AKA's)
DOB: 01-08-1952
Last known address(es): 17 Plymouth Road, Unit 1, Petersburg, Stetson 33712
Sex: M Race: C Height: 6'0" Weight: 190lbs Hair Color: Brown Eye Color: Brown
Scars, Marks, Tattoos: Unknown
Vehicle(s) registered to Arrestee: 2018 Honda CRV, Black, Tag LV1597
Other Information: Arrestee is a Professor at University of Stetson. His office is CR-108, Jackson Crummer Hall.

Petersburg Police Department

102 Freemont Way
Petersburg, Stetson 33713
Main: 727-813-2300
Emergency Dispatch: 911

Incident Report
__Narrative
_X__Supplement

Date of Incident	Time of Incident	Officer Badge Number	Case Number
1-31-22	14:30	417	22-00516
Suspect	**Incident Type**	**Arrest Status**	**Citation Number**
Ashton Campbell	_X_Criminal __ Motor Vehicle __ Violation __ Other	__On-Site _X_ Warrant __Investigation ongoing	N/A

On February 7, 2022, Suspect Ashton Campbell was taken into custody at 11:15 am at the University of Stetson. Suspect was in his office when authorities arrived. Suspect was handed a copy of the arrest warrant and was asked to place his hands behind his back. Suspect complied. Suspect was advised of his *Miranda* rights and transported to Petersburg Jail for processing and arraignment the following morning at the Pinella County Courthouse. During transport, unprompted, suspect said, "I did nothing wrong. It was just a common accident. Call the Department of Defense – they'll tell you!"

Officer Name: Michelle Hernandez (417)

Officer Signature: *Michelle Hernandez* Date of Incident Report: 02-07-22

IN THE SUPERIOR COURT OF THE STATE OF STETSON
PINELLA COUNTY JUDICIAL DISTRCT

STATE OF STETSON vs. ASHTON CAMPBELL	DOCKET NO: 2022-CR-867

Long Form Information

COUNT ONE: Reckless Arson Causing Physical Injury

In the Superior Court of the State of Stetson for the Judicial District of Pinella County, the State of Stetson accuses Ashton Campbell of Reckless Arson Causing Physical Injury and charges that in the City of Petersburg on or about January 31, 2022, the said Ashton Campbell recklessly caused the burning of a dwelling that resulted in physical injury to another person, to wit: Robert Matthew Cole, in violation of Stetson General Statutes § 53a-113.

COUNT TWO: Reckless Arson Causing Physical Injury

In the Superior Court of the State of Stetson for the Judicial District of Pinella County, the State of Stetson accuses Ashton Campbell of Reckless Arson Causing Physical Injury and charges that in the City of Petersburg on or about January 31, 2022, the said Ashton Campbell recklessly caused the burning of a dwelling that resulted in physical injury to another person, to wit: Barbara Anne Cole, in violation of Stetson General Statutes § 53a-113.

STATE OF STETSON

Cecil B. Hughes

Cecil B. Hughes, Esq.
Assistant State's Attorney

IN THE SUPERIOR COURT OF THE STATE OF STETSON
PINELLA COUNTY JUDICIAL DISTRCT

STATE OF STETSON	
vs.	DOCKET NO: 2022-CR-867
ASHTON CAMPBELL	

ARRAIGNMENT TRANSCRIPT

February 8, 2022, 9:00 a.m.
Courtroom 12A
Pinella County Courthouse

The Honorable Omar Prince, Presiding

Attorney for Prosecution: Cecil Hughes
Attorney for Defense: Gina Pyle

****

Prosecutor Hughes: The next case is 2022-CR-867.

Judge Prince: Sheriff, please bring the defendant out.

[Sheriff opens door]

Ashton Campbell: This is a matter of national security! It was just an accident! --

Judge Prince: [bangs gavel] ORDER! BE QUIET MR. CAMPBELL!

Ashton Campbell: -- Call the DOD, they will tell you!

Judge Prince: [bangs gavel] ORDER! ORDER! Attorney Pyle you better get your client to calm down right now or we'll do this without him present.

Attorney Pyle: Yes, Your Honor. [Whispers to client]. OK Your Honor. He understands and will remain quiet throughout the proceeding.

Judge Prince: Good. Now, Dr. Campbell, I am going to advise you of the charges against you. You have been charged with two counts of Reckless Arson Causing Physical Injury in violation of Stetson General Statutes § 53a-113. Attorney Pyle of the Public Defender's Office has been appointed to represent you and it is my understanding you had an opportunity to meet with her in lock-up earlier this morning. Attorney Pyle, how does your client plead?

Attorney Pyle: Not Guilty, Your Honor.

Judge Prince: Noted. What's the State's position on bail?

Prosecutor Hughes: Your Honor the defendant has no criminal record. However, the charges against him are serious – two counts of Reckless Arson Causing Physical Injury to two victims. Upon review of the police paperwork, witness statement, and hearing the defendant's comments in court this morning, the State has concerns about the defendant's competency. As such, the State asks that bail remain as set on the Warrant and an Order of No Contact be issued with respect to the Victims who are both present in court today. Further, the State moves for a competency evaluation pursuant to Stetson General Statutes § 54-56d.

Judge Prince: Attorney Pyle?

Attorney Pyle: Your Honor, my client is 70 years old and has no criminal history whatsoever. Not even a speeding ticket. He has a Ph.D. in chemistry and is employed full-time at the University of Stetson. He has lived in Stetson, particularly Petersburg, for most of his adult life. I too have reviewed the police paperwork and I share the State's concerns about competency stemming from mental illness and concur with the request for a § 54-56d evaluation. The defendant does not have a home to return to given the circumstances of this case and has no living family members; therefore, I ask for a nominal bail. I submit that $150,000 is excessive and unnecessary given that he has no criminal record. Further, such a high bail amount will

put him in a restricted unit within the Department of Corrections, which may affect my ability to contact him in a timely manner. I have no objection to the State's request for a No Contact Order with the Victims.

Judge Prince: Alright. Even though Dr. Campbell does not have a criminal record, these charges are significant, and the evidence against him is strong. Although all defendants are presumed competent, that presumption can be overcome, and I share the stated concerns about mental illness and competency given the information we have up until this point. I am going to set bail at $100,000 cash or surety without prejudice and order a § 54-56d evaluation by the Department of Mental Health and Addiction Services. Once we have the results of the evaluation, I will reconsider bail. I am also issuing a No Contact Order with the Victims.

Madame Clerk, I want a return date of approximately 30 days to see where we are. I'll also hear testimony from a representative from the Department of Mental Health and Addiction Services at that time, if necessary, so let's call the case at 2:00pm. Madame clerk?

Clerk of the Court: Four weeks out is March 8th.

Judge Prince: March 8, 2022, at 2:00pm. So ordered. Next case.

****

EXHIBIT 5

Bay Area Cardiologists

February 17, 2022

Dr. Ramani,

I am writing in response to your inquiry about my treatment of Ashton Campbell. With the assistance of Attorney Pyle, Ashton has signed consent forms for me to disclose his medical history.

I first met Ashton Campbell in the year 2000 when he came to me with a concern of "fluttering" in his chest. EKG testing confirmed that Ashton suffered from atrial fibrillation, also known as cardiac arrythmia, and he underwent surgery to have a pacemaker implanted. The surgery was a success, and Ashton's arrythmia has been stable for the last 22 years.

Ashton was diagnosed with early-stage hypertension in 2006. I prescribed him an ACE inhibitor, which has worked successfully to keep his blood pressure within normal limits for the last 16 years.

In 2012, Ashton was diagnosed with Type 2 Diabetes; however, his blood glucose levels were not critical at the time of diagnosis. I was confident we could treat the disease with a regimented change of diet and proper exercise as Ashton did not want to take any more medication or undergo any more surgeries. Ashton assured me he would exercise more often, eat a healthy, low-to-no-carbohydrate diet, and monitor his blood glucose with at-home testing. Annual check-ups to date have confirmed that proper diet and exercise are successfully managing Ashton's Type 2 Diabetes.

I am aware of the charges against Ashton. Attorney Pyle has informed me of the court-ordered competency examination, and the facts underlying the basis for such examination. In my treatment of Ashton, I have not observed any indication that he suffers from any mental disease or illness. However, the last time I saw Ashton in person was March 2019. Due to the Covid Pandemic, and the fact that Ashton's health has been stable for the last decade, we have since only spoken briefly during our annual, now telemedicine, visits. Ashton reported that he was doing, and appeared, well. These telemedicine visits took place in April

2020 and April 2021. They each lasted about 15 minutes, during which I reviewed the results of his annual blood work (all of which were normal).

If the administration of antipsychotic medication is deemed necessary and appropriate, Ashton should be monitored for cardiac complications, although his pacemaker should hopefully mitigate an arrhythmic heartbeat. Further, because antipsychotic medication can increase blood-pressure, his hypertension needs to be closely monitored and his medication regime may need to be reevaluated and/or changed. Finally, regarding his diabetes, given the fact that he is in custody, an alpha-glycosidase inhibitor to help his body break down starchy foods is likely warranted.

Please do not hesitate to reach out to me should you have any questions or concerns.

Regards,

Dr. Emile Marzan, M.D.
Cardiologist
Bay Area Cardiologists
Petersburg, Stetson

EXHIBIT 6

U.S. Department *of* Defense

1600 Defense Pentagon
Washington, DC 20300

February 27, 2022

Prosecutor Hughes:

In response to your inquiry, Dr. Ashton Campbell (DOB 01-08-1952) has never been employed in any capacity by the U.S. Department of Defense. He holds no security clearance and has never been contracted in any capacity to do research on behalf of the Department of Defense.

Sincere regards,

Lloyd R. Artun

Lloyd R. Artun III
Secretary of Defense
United States of America

IN THE SUPERIOR COURT OF THE STATE OF STETSON
PINELLA COUNTY JUDICIAL DISTRCT

STATE OF STETSON	
vs.	CASE NO: 2022-CR-867
ASHTON CAMPBELL	

COMPETENY HEARING I TRANSCRIPT

March 8, 2022, 2:00 p.m.
Courtroom 12A
Pinella County Courthouse

The Honorable Omar Prince, Presiding

Attorney for Prosecution: Cecil Hughes
Attorney for Defense: Gina Pyle

Call to Order. All Rise.

Judge Prince: We're here on Docket # 2022-CR-867. State of Stetson v. Ashton Campbell. Sheriff, please bring Dr. Campbell out. [Sheriff opens door.] Attorney Pyle, your client is aware that I conduct my courtroom in an orderly fashion?

Attorney Pyle: Yes, Your Honor. I spoke to him downstairs and made it clear Your Honor would not tolerate any outbursts. I believe he understands.

Judge Prince: Good. [Dr. Campbell enters courtroom]. Good afternoon, Dr. Campbell.

Mr. Campbell: Good afternoon.

Judge Prince: Madam Clerk, do we have a § 54-56d report from the Department of Mental Health and Addiction Services?

Clerk of the Court: Yes, Your Honor and a copy has been provided to both attorneys.

Judge Prince: Thank you. And is there a representative from the Department of Mental Health and Addiction Services present in the courtroom?

From Gallery: Yes, your honor.

Judge Prince: Come forward Ma'am and the Clerk will swear you in. [Witness sworn]. Mr. Hughes, you moved for the § 54-56d evaluation, so you may now question the witness.

Prosecutor Hughes: Thank you, Your Honor.

DIRECT EXAMINATION BY PROSECUTOR HUGHES:

Q. Good afternoon. Can you please state and spell your first and last name for the record?

A. Mary Simonello. M-A-R-Y S-I-M-O-N-E-L-L-O.

Q. Where do you work?

A. The Department of Mental Health and Addiction Services for the State of Stetson. It's often abbreviated DMHAS – pronounced "De-Mis."

Q. How long have you worked there?

A. 7 years in a full-time position.

Q. What position do you hold with DMHAS?

A. I'm a Licensed Clinical Social Worker. We like our abbreviations; I'm referred to as a "L.C.S.W." for short.

Q. Please describe your educational background that led to that position.

A. I graduated in 2012 with a Bachelor's Degree in Psychology from Stetson State University. I graduated with my Master's Degree in Social Work from the University of South Stetson in 2015. That is when I was hired full-time by DMHAS, but I had worked there part-time during school as part of my fieldwork placement. I completed all my post-graduate supervised fieldwork while working full-time at DMHAS and passed the licensing exam in 2017. I've been working there as a L.C.S.W. ever since.

Q. What do you do as a L.C.S.W. for DMHAS?

A. I am part of a team that evaluates individuals who have been ordered by the court to undergo examinations to determine whether they are competent to stand trial pursuant to Stetson General Statutes § 54-56d. I'm passionate about ensuring that mentally ill individuals get treated fairly by the criminal justice system, and that includes making sure they are competent to stand trial.

Q. What does it mean to be competent to stand trial?

A. A person is competent to stand trial if they understand the nature of the charges against them and are able to assist in their own defense.

Q. Did you evaluate Dr. Ashton Campbell for competency?

A. Yes, our team evaluated him on February 23, 2022, at Petersburg Jail.

Q. Who else was on the team of evaluators?

A. Dr. Fran Storen, Ph.D. in Clinical Psychology and Dr. Ellis Ramani, M.D. in Psychiatry.

Q. Did Dr. Campbell cooperate with your evaluation?

A. To the best of his ability, yes.

Q. What do you mean?

A. For example, it was clear that he was listening to us, and he would respond appropriately, but he was very fidgety – bouncing his right leg up and down at a rapid pace and wringing his hands through one another constantly. He appeared anxious. There

were also times when he would glance around the room with a confused look on his face. At one point he asked what we were doing there. When we reminded him, he told us he wasn't crazy and to call the Department of Defense; they would explain everything.

Q. Did he say anything else about the Department of Defense?

A. Yes. He said he couldn't divulge too much information because we didn't have his level of security clearance, but that he was helping the DOD study and develop a new chemical weapons defense system. He said he was on the verge of a major breakthrough when all this happened. It's all memorialized in my team's report.

Judge Prince: I'm going to mark and admit the DMHAS Report as Court Exhibit A at this time, unless there is an objection from either counsel.

Prosecutor Hughes: No objection.

Attorney Pyle: No objection.

Judge Prince: Thank you. Go ahead, Mr. Hughes.

CONTINUED DIRECT EXAMINATION BY PROSECUTOR HUGHES:

Q. Before we get to the conclusions in your team's report, you mentioned a moment ago that Dr. Campbell listened to your team's questions and responded appropriately. Can you describe what you mean by that?

A. Of course. Dr. Campbell knew who he was and was oriented to season and year -- he knew it was Winter 2022, although he could not recall the exact month or date -- and he knew that he was in jail. He was able to understand his current legal situation in that he was charged with serious crimes and was even able to state them -- "two counts of reckless arson." He said he knew he could go to prison "for a long time" if he was convicted. Dr. Campbell knew who the judge was -- "the man in the black robe" -- and that the role of the judge is to "oversee the trial." Dr. Campbell was also aware that Ms. Pyle is his lawyer and that her job is to "help him." He also knew that the Prosecutor "represents the government."

Q. Well that's a good sign with respect to competency, right?

A. Partially. Dr. Campbell generally understands the court system, knows he is charged with two crimes and what those crimes are, and knows that he faces a prison sentence if convicted, but he doesn't believe he has done anything wrong.

Q. Doesn't every defendant believe that?

A. Well, I can't speak to that, but in this case, Dr. Campbell believes that this was a government sanctioned experiment and that, as a result, the fire was not only not his fault, but that the Department of Defense will produce witnesses on his behalf, or even contact the prosecutor's office to get the charges dismissed entirely.

Q. Understood. How does that inform your team's conclusion?

A. Our conclusion is that as a result of Dr. Campbell's delusion about working for the Department of Defense, he does not understand the nature of the proceedings against him and cannot assist in his own defense.

Q. So what does that mean?

A. It means that, currently, Dr. Campbell is not competent to stand trial, but it is likely he can be restored to competency with psychotherapy and a regime of antipsychotic medication, specifically the drug Haldol.

Q. Is there a substantial probability that Dr. Campbell can be restored to competency within the next 18 months?

A. Yes.

Q. What would be the least restrictive setting in which to attempt to restore Dr. Campbell's competency?

A. Given that he is currently in the custody of the Department of Corrections, the least restrictive setting would be Stetson State Hospital -- Whittier Forensic Wing.

Q. Thank you. Your Honor, I have no further questions.

Judge Prince: Attorney Pyle, do you wish to cross-examine?

Attorney Pyle: No, Your Honor.

Judge Prince: Very well. Ms. Simonello, you are excused and thank you for your time today.

Ms. Simonello: You're welcome.

[Witness steps down]

Judge Prince: Based on Ms. Simonello's testimony and the Report that is in evidence as Court Exhibit A, I find by a preponderance of the evidence that Dr. Campbell is currently not competent to stand trial, but that there is a substantial probability he can be restored to competency within the maximum statutory period, which in this case is 18 months pursuant to Stetson General Statutes § 54-56d(i). Therefore, I order Dr. Campbell committed to the custody of the Department of Mental Health and Addition Services at Stetson State Hospital, Whittier Forensic Wing. I am ordering DMHAS to provide a status update in court 12 weeks from today, which is May 31, 2022. If DMHAS needs more time to treat Dr. Campbell, I expect a letter be written to the Court explaining Dr. Campbell's status and, if necessary, requesting a new court date, not to exceed 26 weeks from today. Upon receipt of any such letter, the court will notify both parties. Finally, given the order of temporary commitment to the custody of DMHAS, bail remains as set. Anything further?

Prosecutor Hughes: No, Your Honor.

Attorney Pyle: No, Your Honor.

Judge Prince: Very good. Madame Clerk please docket this case for 2:00pm on May 31, 2022. Court is in recess.

Sheriff: All Rise.

COURT EXHIBIT A

DMHAS

State of Stetson

Department of Mental Health & Addiction Services
24 Park Street
Petersburg, ST 33712
Tel: (727) 819-2480
Fax: (727) 819-2485

March 2, 2022

Ms. Maria Sanchez
Clerk of the Superior Court
Pinella County Judicial District
235 Cherry Avenue
Petersburg, ST 33719

RE: ASHTON CAMPBELL
DOB: 01/08/1952
DOCKET #: 2022-CR-867

Dear Ms. Sanchez,

Pursuant to an Order from Judge Prince for a Competence to Stand Trial Examination (SGS § 54-56d) dated 02/08/2022, Dr. Ashton Campbell was evaluated on February 23, 2022, for four hours at the Petersburg Jail by a clinical team composed of myself, Dr. Fran Storen, Ph.D., and Mary Simonello, L.C.S.W. Attorney Gina Pyle was present for the evaluation.

Prior to the interview, I gave the defendant a complete physical examination as well as ordered CT and MRI imaging scans of his head to determine if we were dealing with any physical deterioration that may account for his symptoms. I also conducted tests of the defendant's blood and urine to rule out any physical conditions, diseases, medications, or substances that may have been causing his condition. All scans and test results were normal, and the defendant presented in good physical health.

In addition to the information provided by the defendant, the following documents were reviewed:

1. Petersburg Police Department Narrative Incident Report
2. Petersburg Police Department Witness Statement
3. Exhibit 1
4. Exhibit 2

5. Exhibit 3
6. Exhibit 4
7. Arrest Warrant
8. Petersburg Police Department Supplemental Incident Report
9. Long Form Information
10. Arraignment Transcript
11. Exhibit 5
12. Exhibit 6

CONFIDENTIALITY

At the beginning of the interview, the defendant was informed that we were evaluating him pursuant to a court order regarding his competency to stand trial, that a report would be prepared for the court, that testimony may be required, and, therefore, what he said and the records he released would not be confidential. He indicated that he understood the non-confidential nature of this evaluation.

BACKGROUND INFORMATION

The defendant is 70 years old. He was born at McDale Hospital in Tallahassee, Stetson on January 8, 1952, to Larry and Linda Campbell, who are both deceased. The defendant had a younger brother of two years, James Campbell, who is also deceased. The defendant reports that neither his parents nor his brother ever suffered from a mental disease or illness. Until becoming incarcerated, the defendant lived alone in Hannah Village Condominium Complex, Unit 1, for 25 years. He never married and does not have any children.

EDUCATIONAL & EMPLOYMENT HISTORY

The defendant excelled throughout primary and secondary school, having been consistently placed in a gifted program. He received his Bachelor's and Master's Degrees in Chemistry from Bowren University in 1980 and 1984, respectively. In 1995, he obtained his Ph.D. in Chemistry from the University of Stetson and has worked full-time at the University of Stetson ever since. The defendant is described by his colleagues as brilliant, but quite arrogant. He is liked by the students and is respected by the administration. Until the current incident, the defendant has never been the subject of any disciplinary actions and is considered a valued member of the faculty.

PSYCHIATRIC HISTORY

None.

SUBSTANCE ABUSE HISTORY

The defendant reports that he has "Irish in his blood" and likes to end every day with "Jameson on the rocks." He reports that he had been drinking far more than usual when the Covid Pandemic first hit—he can't remember how much or how often—but claims that once he realized he needed to get back on track with his research for the Department of Defense, he "cut down on drinking."

MEDICAL HISTORY

The defendant reports he has had some health issues over the years but can't remember the medical terms for them all. He says he has a "bad ticker," and his doctor can tell us all about it. He says he can't remember his doctor's name at the moment, but it will come to him.

The team is in receipt of a letter from the defendant's treating cardiologist detailing his medical history:

- In 2000, the defendant was diagnosed with atrial fibrillation (aka cardiac arrythmia), an irregular heartbeat. He underwent surgery to have a pacemaker implanted and has not had an arrhythmic event for over 20 years.

- In 2006, the defendant was diagnosed with early-stage hypertension (high blood pressure). He was prescribed an ACE inhibitor that he takes daily, and his blood pressure has since returned to, and remained within, normal limits.

- In 2012, the defendant was diagnosed with Type 2 Diabetes. At that time, he reported he did not want to take any more drugs, so he changed his diet, exercised more often, and monitored his blood-sugar levels with at-home testing. Proper diet and exercise have kept his blood-glucose levels in normal range for the last 10 years.

MENTAL STATUS EXAMINATION

The defendant was polite and cooperative throughout the four-hour interview. He knew his name and was somewhat oriented to time and place: he knew it was Winter 2022, although he could not recall the month or day. He knew he was "in jail." He maintained eye contact while we were speaking with him but would look down at his hands in between questions or during moments of silence. He was constantly wringing his hands through one another and bouncing his right leg up and down at a rapid pace. There was a point during the interview when he asked what we were doing there. When we explained again, he said, "Oh yes, that's right, you think I'm crazy, even though I'm not."

When asked what crimes he is charged with, the defendant replied, "two counts of reckless arson" and said he knew he could go to prison "for a long time," but insisted he wasn't responsible. When asked if he knew who Judge Prince was, he said, "I don't know him personally, but I know he's the man in the black robe and his job is to oversee the trial." When asked who Attorney Pyle was, the defendant said, "My lawyer, and she better help me by calling DOD witnesses to testify on my behalf. I can't divulge too much because you don't have the necessary security clearance, but I was doing research for the DOD on a new chemical weapons defense system. I was on the verge of a major breakthrough that would have saved millions of lives when all this happened. They better not let me take the fall." When asked about the role of the Prosecutor, the defendant said, "he represents the government by bringing these bogus charges."

The defendant described his mood as unhappy, saying things like, "How would you feel if you were in here being told you were crazy when you aren't?" His affect (observed emotional

response) was flat throughout the interview, indicating Depression. He repeatedly said he was sad the DOD had not reached out to us. His speech was understandable, and his thought process was rational except for his repeated assertion that he was working for the DOD. He said he expects the DOD to produce witnesses on his behalf at the trial, but also said, "It might not even get to that point because I'm confident they'll speak to the prosecutor about my role as their test chemist and get this entire mess dismissed in short order." Exhibit 6, a letter from the Department of Defense to Prosecutor Hughes, confirms the defendant has never worked for the Department of Defense. When we confronted the defendant with Exhibit 6, he looked confused at first (cocked his head to the side and squinted his eyes), but then started to laugh and said, "Of course they won't just *tell* the prosecutor I work for them. I'm working on a top-secret assignment. The enemy could be posing as the prosecutor to exploit my research. You need my clearance code. I'll consider giving it to Attorney Pyle. Only she can be trusted."

Consistent with his education and professional experience, the defendant was able to perform high-functioning and complex mathematical equations. Regarding his short-term memory, he was given five words and informed he would be asked to recall and recite them in order after 20 minutes had passed. When asked to recall and recite the words he was previously given and in the same order, he was able to recall the words, but not in the correct order. He told the evaluating team that we should not be focused on "silly recall games," but rather "contacting the Department of Defense."

CAPACITY TO UNDERSTAND PROCEEDINGS

Although the defendant has a sound understanding of the legal process in the abstract, his psychotic mental illness prevents him from applying that information to his own case in a rational way. The defendant's assessment of the evidence and belief that he will prevail at trial is based on his own view of reality, including that he was working for the Department of Defense, that the DOD will produce witnesses to testify on his behalf, and that the case may even be dismissed before trial because the DOD will speak to the prosecutor about his role as their test chemist.

ABILITY TO ASSIST IN HIS OWN DEFENSE

The defendant's psychosis interferes in two ways with his ability to assist in his own defense. First, because his delusions relate to the crime charged, they generate endless requests for his lawyer to call witnesses who do not exist. Second, his delusions make him resistant to the idea of pursuing a defense based on mental illness because he does not believe he is mentally ill.

CONCLUSION

The defendant appears to have developed increasingly severe symptoms of mental illness over the past several years. In 2019, the defendant claimed to have received a three-year contract with the Department of Defense to help study and develop a new chemical weapons system. According to Dr. Terry Jackson, until the last year or so, the defendant was a fun, kind, and outgoing person. He was also meticulously clean, put together, and organized. However, from 2021-2022, the defendant appears to have spiraled into a deep delusional state that affected his ability to carry out his daily responsibilities. The defendant believes he has a high-level security clearance from the

Department of Defense and was on the verge of discovering a breakthrough in our chemical weapons defense system that will save millions of lives. He denied hearing voices or experiencing other perceptual disturbances during the interview. Observation of his physical demeanor corroborates that he does not suffer from auditory or visual hallucinations.

The defendant appears to be suffering from Delusional Disorder – Grandiose Type. Delusional Disorder is characterized in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) as the presence of one or more delusions for a month or longer in a person who, except for the delusions and their behavioral ramifications, does not appear odd and is not functionally impaired.

The defendant has no appreciation or insight into the nature or ramifications of this disorder, and he may be resistant to treatment. As a result, it is the Team's unanimous opinion that he is currently not competent to stand trial because he is not able to understand the nature of the proceedings against him or assist in his own defense. However, there is a substantial probability that he can be restored to competency within the statutory maximum period through mental health treatment in an inpatient setting, including psychotherapy and administration of a regimen of psychiatric medication, specifically the antipsychotic drug Haldol (generic is haloperidol). Although positive treatment results cannot be guaranteed, Haldol is generally able to effectively treat symptoms like those the defendant displays. Specifically, because delusions are caused by the overproduction of dopamine in the brain, Haldol blocks the brain's dopamine receptors, causing the delusions to subside. The least restrictive setting through which to attempt to restore the defendant to competency is Stetson State Hospital, Whittier Forensic Wing.

Ellis Ramani

Dr. Ellis Ramani, M.D.
Chief Psychiatrist
Stetson State Hospital

Fran Storen

Dr. Fran Storen, Ph.D.
Clinical Psychologist
Stetson State Hospital

Mary Simonello

Mary Simonello
Licensed Clinical Social Worker
Stetson State Hospital

EXHIBIT 7

American Psychiatric Association

In conjunction with the Cleveland Clinic and the Mayo Clinic

Delusional Disorder

What is Delusional Disorder?

Delusional Disorder is a type of psychotic disorder. Its main symptom is the presence of one or more delusions for a month or longer in a person who, except for the delusions and their behavioral ramifications, does not appear odd and is not functionally impaired.

A delusion is an unshakable belief in something that's untrue. The belief isn't a part of the person's culture or subculture, and almost everyone else knows this belief to be false.

People with Delusional Disorder often experience non-bizarre delusions. Non-bizarre delusions involve situations that could possibly occur in real life, such as being followed, deceived, or loved from a distance. These delusions usually involve the misinterpretation of perceptions or experiences. In reality, these situations are either untrue or are highly exaggerated.

Non-bizarre delusions are different from bizarre delusions. Bizarre delusions include beliefs that are impossible in our reality, such as believing someone has removed an organ from your body without any physical evidence of the procedure.

People with Delusional Disorder often continue to socialize and function well, apart from the subject of their delusion. Generally, they don't behave in a consistently odd or unusual manner, although there may be times when they appear frustrated, angry, or confused. If untreated, Delusional Disorder can progress to a severe stage, in which someone with Delusional Disorder might become so preoccupied with their delusions that their lives are significantly disrupted.

What are the types of Delusional Disorder?

There are different types of Delusional Disorder, which are determined based on the main theme of the delusions the person experiences. The types of Delusional Disorder include:

- **Erotomanic**: People with this type of Delusional Disorder believe that another person, often someone important or famous, is in love with them. They may attempt to contact the person of the delusion and engage in stalking behavior.
- **Grandiose**: People with this type of Delusional Disorder have an overinflated sense of self-worth, superiority, greatness, intelligence, or identity. They may believe they have a great talent or have made an important discovery even in the face of overwhelming evidence to the contrary.

- **Jealous**: People with this type of Delusional Disorder believe that their spouse or sexual partner is unfaithful without any concrete evidence.
- **Persecutory**: People with this type of Delusional Disorder believe someone or something is mistreating, spying on or attempting to harm them (or someone close to them). People with this type of Delusional Disorder may make repeated complaints to legal authorities.
- **Somatic**: People with this type of Delusional Disorder believe that they have a physical issue or medical problem, such as a parasite or a bad odor.
- **Mixed**: People with this type of Delusional Disorder have two or more of the types of delusions listed above.

What are the symptoms of Delusional Disorder?

The presence of delusions is the most obvious sign of Delusional Disorder, which vary based on the type.

Another characteristic of this condition is that the person often lacks self-awareness that their delusions are problematic. They're unable to accept that their delusions are irrational or inaccurate, even if they recognize that other people would describe their delusions this way.

Anger and violent behavior may be present if someone is experiencing persecutory, jealous or erotomanic delusions.

People with Delusional Disorder also often develop Anxiety and/or Depression as a result of the delusions, as well as may appear confused or distracted as a result of their delusions.

Early symptoms of Delusional Disorder may include:

- Feelings of being exploited.
- Preoccupation with the loyalty or trustworthiness of friends.
- A tendency to read threatening meanings into benign remarks or events.
- Persistently holding grudges.
- A readiness to respond and react to perceived slights.

What causes Delusional Disorder?

Delusions are caused by an overactive neurotransmitter called dopamine in the brain. As with many other psychotic disorders, researchers don't yet know exactly what causes the overproduction of dopamine. Researchers are, however, looking at the role of various factors that may contribute to the development of the condition, including:

- **Genetic factors**: The fact that Delusional Disorder is more common in people who have family members with Delusional Disorder or Schizophrenia suggests there might be a genetic factor involved. Researchers believe that, as with other mental disorders, a tendency to develop Delusional Disorder might be passed on from parents to their biological children.

- **Environmental and psychological factors**: Evidence suggests that Delusional Disorder can be triggered by stress. Alcohol use disorder and substance use disorder can also contribute to the condition. Hypersensitivity and ego defense mechanisms like reaction formation, projection, and denial are some psychodynamic theories for the development of Delusional Disorder. Social isolation, envy, distrust, suspicion, and low self-esteem are also some psychological factors that may lead to a person seeking an explanation for these feelings and, thus, forming a delusion as a solution.

Who does Delusional Disorder affect?

Delusional Disorder most often occurs in middle to late life, with the average age of onset being 45 years.

The persecutory and jealous types of Delusional Disorder are more common in people assigned male at birth (AMAB), and the erotomanic type is more common in people assigned female at birth (AFAB).

People who tend to be socially isolated are more likely to develop Delusional Disorder. These populations include:

- Immigrants who have language barriers.
- People who are deaf.
- People who are visually impaired.
- People who live alone and/or are otherwise isolated from social interaction.

How common is Delusional Disorder?

Although delusions might be a symptom of more common disorders—such as Schizophrenia, narcissistic personality disorder, or late-stage Alzheimer's Disease—Delusional Disorder itself is rather rare. Approximately 0.05% to 0.1% of the adult population has Delusional Disorder.

What is the most common type of Delusional Disorder?

The most common type of Delusional Disorder is the persecutory type — when someone believes others are out to harm them despite evidence to the contrary.

How is Delusional Disorder diagnosed?

Healthcare providers — mainly mental health professionals — diagnose Delusional Disorder when a person has one or more delusions for one month or more that can't be explained by any other condition. The person must also not have the characteristic symptoms of other psychotic disorders, such as Schizophrenia.

If someone is experiencing signs and symptoms of Delusional Disorder, a healthcare provider will perform a complete medical history and physical examination. Although there aren't any laboratory tests to diagnose Delusional Disorder, their healthcare provider might use various

diagnostic tests — such as imaging tests, a urine drug screen and blood tests — to rule out any physical conditions, medications or substances that could be causing the symptoms.

If their healthcare provider finds no physical reason for the symptoms, a consultation with a psychiatrist or psychologist will likely be made. Psychiatrists and psychologists use specially designed interview and assessment tools to evaluate a person for a psychotic disorder. They'll ask questions about the delusions and assess the person's mental status.

The psychiatrist or psychologist may also interview family members and friends so they can provide further details about the person's delusions and a timeline of the symptoms.

As other mental health conditions can cause delusions, mental health professionals carefully assess the person for other symptoms. Delusional Disorder can be misdiagnosed as any of the following conditions:

- Obsessive-compulsive disorder.
- Schizophrenia.
- Delirium/major neurocognitive disorder.
- Bipolar disorder.
- Personality disorders, especially borderline personality disorder and paranoid personality disorder.

The most commonly accepted treatment for all of these conditions is antipsychotic medication.

How is Delusional Disorder treated?

Treatment approaches generally depend on the severity of the disease. The more severe the disease, the more likely antipsychotic medication may be needed. Treatment for Delusional Disorder most often includes antipsychotic medication and/or psychotherapy.

People with Delusional Disorder often don't seek treatment for the condition on their own because most people with Delusional Disorder don't realize their delusions are problematic or incorrect. It's more likely they'll seek help due to other mental health conditions such as Depression or Anxiety.

People with severe symptoms or who are at risk of hurting themselves or others might need to be admitted to the hospital until the condition is stabilized.

Medications for Delusional Disorder

The primary medications used to help treat Delusional Disorder are called antipsychotics (neuroleptics). Medications include the following:

- **First-generation ("typical") antipsychotics**: Healthcare providers have used these medications to treat mental health conditions since the mid-1950s. These medicines work by blocking dopamine receptors in your brain. Dopamine is a neurotransmitter believed to

be involved in the development of delusions. First-generation antipsychotics include chlorpromazine (Thorazine®), fluphenazine (Prolixin®), haloperidol (Haldol®), thiothixene (Navane®), trifluoperazine (Stelazine®), perphenazine (Trilafon®) and thioridazine (Mellaril®).

- **Second-generation ("atypical") antipsychotics**: These newer antipsychotics are also effective in treating the symptoms of Delusional Disorder. They work by blocking dopamine and serotonin receptors in your brain. These drugs include risperidone (Risperdal®), clozapine (Clozaril®), quetiapine (Seroquel®), ziprasidone (Geodon®) and olanzapine (Zyprexa®). These medications are usually better tolerated than first-generation antipsychotics.

First-generation antipsychotics are indicated in the treatment of Delusional Disorder and paranoia associated with personality disorders. Other medications that healthcare providers might prescribe to treat Delusional Disorder include anxiolytics (anti-anxiety medication) and anti-depressants. Anxiolytics might help if the person has a very high level of Anxiety and/or problems sleeping. Antidepressants can help treat Depression, which often occurs in people with Delusional Disorder.

Psychotherapy for Delusional Disorder

Psychotherapy is a term for a variety of treatment techniques that aim to help people identify and change troubling emotions, thoughts, and behaviors. Working with a mental health professional, such as a psychologist or psychiatrist, can provide support, education and guidance to the person and their family.

Through therapy, people with Delusional Disorder can learn to manage their symptoms, identify early warning signs of relapse, and develop relapse prevention plans. Types of psychotherapy include:

- **Individual psychotherapy**: This type of therapy can help a person recognize and correct the underlying thinking that has become distorted.

- **Cognitive behavioral therapy (CBT)**: This is a structured, goal-oriented type of therapy. A mental health professional helps people take a close look at their thoughts and emotions. They'll come to understand how their thoughts affect their actions. Through CBT, they can unlearn negative thoughts and behaviors and learn to adopt healthier thinking patterns and habits.

- **Family-focused therapy**: This therapy can help people with Delusional Disorder and their families. This treatment involves psychoeducation regarding Delusional Disorder, communication improvement training and problem-solving skills training.

Can Delusional Disorder be prevented?

There's no known way to prevent Delusional Disorder. However, early diagnosis and treatment can help decrease the disruption to the person's life, family, and friendships.

What is the prognosis (outlook) for Delusional Disorder?

The prognosis (outlook) for people with Delusional Disorder varies depending on a few factors, including:

- The type of Delusional Disorder.
- The severity and length of the delusions.
- The person's life circumstances, including the availability of support and a willingness to stick with treatment.

Delusional Disorder doesn't usually significantly affect a person's daily functioning, but the severity of the delusions may gradually get worse and progress to a severe psychotic metal illness that does interfere with daily function. Most people with Delusional Disorder can remain employed as long as their work doesn't involve things related to their delusions. Being immersed in the delusions daily can cause the disease to rapidly progress into a deeper delusional state and cause severe psychotic mental illness, especially when combined with other causation events.

The prognosis of Delusional Disorder is better if the person sticks to their treatment plan. More than 50% of people have a full recovery, more than 20% of people report a decrease in symptoms and less than 20% of people report minimal to no change in symptoms.

Unfortunately, many people with this condition don't seek help. It's often difficult for people with mental health conditions to recognize they're not well. They also might be too embarrassed or afraid to seek treatment. Without treatment, Delusional Disorder can be a life-long condition.

What are the possible complications of Delusional Disorder?

If left untreated, Delusional Disorder might lead to:

- Depression and Anxiety, often as a consequence of difficulties associated with the delusions.
- Social isolation.
- Legal issues — for example, stalking or harassing the person involved with the delusion could lead to arrest.
- Self-harm or harm to others. This is more common in the jealous and persecutory types.
- Severe psychosis (a persistent delusional state).

What is the difference between Delusional Disorder and Schizophrenia?

Delusional Disorder is different from Schizophrenia because with Delusional Disorder, unlike Schizophrenia, there aren't any psychotic symptoms other than the delusions. In addition, in contrast to Schizophrenia, Delusional Disorder is relatively rare, and daily functioning isn't nearly as impaired as it is with Schizophrenia.

Schizophrenia is a condition that severely affects a person's physical and mental well-being. This is because it disrupts the proper functioning of multiple neurotransmitters in the brain, interfering

with a person's ability to think and function sensibly, and remember even the most basic aspects of daily living. In essence, all rational thought is lost.

Schizophrenia often causes a person to struggle in virtually every part of their day-to-day life. Schizophrenia often disrupts all relationships (professional, social, romantic, and otherwise). It also causes a person to have disorganized and incoherent thoughts and behave in ways that pose a risk of injury to themselves or others.

The exact cause of Schizophrenia is unknown, but studies suggest it can be the result of genetics (the most significant risk-factor for Schizophrenia is if a parent or other close relative has the disorder) and/or environmental factors such as pregnancy or birth complications (e.g., infection during pregnancy or lack of oxygen during delivery), drug use that results in lasting chemical imbalances in the brain, and significant childhood trauma.

What are the symptoms of Schizophrenia?

Schizophrenia is indicated by the presence of two or more of the following symptoms:

- **Hallucinations**. These are things that don't exist, but you still think you can see, hear, smell, touch or taste them. Auditory (hearing voices) and visual (seeing) hallucinations are the most common symptoms of Schizophrenia.
- **Bizarre Delusions**. These are false beliefs that a person won't change even when there's plenty of evidence that those beliefs do not and cannot exist in reality. For example, believing you are an immortal god, have been implanted with a tracking device despite medical scans showing no device present in your body, or that someone is controlling what you think, say, or do.
- **Disorganized or incoherent speaking.** People with Schizophrenia often have trouble organizing their thoughts while speaking. They often have trouble staying on topic, or it can be so severe that you simply cannot understand them because their sentences are jumbled or incoherent.
- **Disorganized, unusual, or violent movements**. These symptoms can take various forms, from childish and silly movements to abrupt, upset, or violent movements. Violence is very common in people suffering from Schizophrenia because they cannot rationalize their behavior, or that of others. Schizophrenia can also include catatonic behavior, where a person doesn't react as expected to the world around them. They might hold a certain pose (even an uncomfortable one) for hours on end, not respond to people speaking to them, or might start moving around excessively for no obvious reason.

In men, Schizophrenia symptoms typically start in the early to mid-20's. In women, symptoms typically begin in the late 20's. It is uncommon for children to be diagnosed with Schizophrenia and rare for those older than age 45 to be diagnosed with Schizophrenia.

How is Schizophrenia treated?

Antipsychotic medications are the cornerstone of Schizophrenia treatment. They control schizophrenic symptoms by altering the brain's neurotransmitters.

What is the difference between Delusional Disorder and Dementia?

Dementia is a description of the state of a person's mental function and not a specific disease. Dementia is an "umbrella term" describing mental function decline from a previously higher level that's severe enough to interfere with daily living. "Dementia" is the common term for when the brain is suffering physical decline from a physically degenerative illness. A person with Dementia has decline in two or more of these specific difficulties:

- Memory.
- Reasoning.
- Problem-solving skills.
- Language.
- Coordination.
- Mood.
- Behavior.

Dementia develops when the parts of your brain involved with learning, memory, decision-making, or language are affected by infections or diseases, which can be exacerbated by severe alcohol or drug abuse, as well as physical isolation and/or lack of mental stimulation. The most common cause of Dementia is Alzheimer's Disease. Physical indications of Dementia are very often visible in CT or MRI scans when Dementia is in its advanced stages; specifically, atrophy of the brain's medial temporal lobe and significant vascular (blood vessel) deterioration, which inhibits blood flow to certain portions of the brain causing them to decay and manifest Dementia symptoms. In essence, when Dementia is in its advanced stages, you can see the physical decay of the brain through imaging. However, when Dementia is in its early stages, physical symptoms may be difficult to detect through imaging.

Early symptoms of Dementia include:

- Forgetting events or information.
- Repeating comments or questions over a short period.
- Misplacing commonly used items or placing them in unusual spots.
- Not knowing the season, year, or month.
- Having difficulty coming up with the right words.
- Experiencing change in mood, behavior, or interests.

Signs that Dementia is advanced include:

- Consistently forgetting events or information to the point where virtually all short-term memory is lost, as well as developing an inability to remember significant events and make important life decisions.
- Talking and finding the right words becomes consistently more difficult.
- Inability to communicate effectively or clearly with others.
- Social withdrawal and isolation.
- Forgetting to perform common daily tasks, such as brushing your teeth.
- Lessening of rational thinking and the ability to problem-solve.

- Sleep pattern changes: sleeping for prolonged periods of time, or inability to sleep at all.
- Increasing or worsening of anxiety, frustration, confusion, agitation, suspiciousness, sadness, and/or depression.
- Experiencing delusions/hallucinations

Approximately 10% of Americans over the age of 70 suffer from some level of Dementia and about one-third (~3.4%) experience Dementia-related psychosis (delusions/hallucinations) when the Dementia is in its advanced stages. Depression and Anxiety are also common in people living with Dementia. We know that having Depression and Anxiety in addition to Dementia can worsen Dementia symptoms. Antipsychotic drugs may be prescribed to people with Dementia who develop changes such as aggression or psychosis. However, this is usually only after other drugs have been tried, such as anti-depressants and anxiolytics.

IN THE SUPERIOR COURT OF THE STATE OF STETSON
PINELLA COUNTY JUDICIAL DISTRCT

STATE OF STETSON	
vs.	CASE NO: 2022-CR-867
ASHTON CAMPBELL	

COMPETENCY HEARING II TRANSCRIPT

May 31, 2022, 2:00 p.m.
Courtroom 12A
Pinella County Courthouse

The Honorable Omar Prince, Presiding

Attorney for Prosecution: Cecil Hughes
Attorney for Defense: Gina Pyle

Sheriff: Call to Order. All Rise.

Judge Prince: We're here on Docket # 2022-CR-867. State of Stetson v. Ashton Campbell. The defendant is not present due to his temporary commitment at Stetson State Hospital, Whittier Forensic Wing, having been previously found not competent to stand trial. Counsel, please identify yourselves for the record.

Prosecutor Hughes: Cecil Hughes for the State, Your Honor.

Attorney Pyle: Gina Pyle for the defendant, Dr. Campbell, Your Honor.

Judge Prince: I am in receipt of a letter from the Department of Mental Health and Addiction Services dated May 26, 2022. I instructed Madame Clerk to provide both attorneys with a copy of that letter. Did you both receive it, and have you had an opportunity to review it?

Prosecutor Hughes: Yes, Your Honor.

Attorney Pyle: Yes, Your Honor.

Judge Prince: Good. Does either party have an objection to me marking and admitting the May 26th letter as Court Exhibit B at this time?

Prosecutor Hughes: No, Your Honor.

Attorney Pyle: No, Your Honor.

Judge Prince: Good. To summarize, Court Exhibit B says the defendant has refused to take any antipsychotic medication,

which the doctors believe is necessary to restore him to competency. What is the State's position?

Prosecutor Hughes: Well, I am sorry to hear that the defendant is refusing to take the medicine he needs to restore him to competency, but given his refusal, and the State's serious interest in prosecuting the defendant and seeking justice for the Victims, the State concurs with DMHAS and moves for an Order of Involuntary Medication following an evidentiary hearing pursuant to *Sell v. US*, 539 U.S. 166 (2003).

Judge Prince: Attorney Pyle?

Attorney Pyle: The defense opposes the involuntary administration of antipsychotic drugs and agrees an evidentiary hearing pursuant to *Sell* is warranted. Further, pursuant to Stetson General Statutes § 54-56d(j)(1), I ask the court to appoint a Healthcare Guardian who can do an independent review and analysis of Dr. Campbell's medical history, examine him at Whittier, and submit a report to the Court on his behalf.

Judge Prince: I agree that we need to set this case down for a *Sell* hearing. I also want a written memorandum of law from each side on this issue. Attorney Pyle, your request for appointment of a Healthcare Guardian is granted. I am also ordering Dr. Ramani to provide a detailed report to the Court regarding his proposed treatment plan and the potential impact of any side effects of the antipsychotic medication. I am

ordering a similar report from the Healthcare Guardian. Prosecutor Hughes, I presume you intend to subpoena Dr. Ramani for the hearing?

Prosecutor Hughes: Yes, Your Honor. The State also reserves its right to subpoena other witnesses as well and will give defense counsel adequate notice if we intend to do so.

Attorney Pyle: The defense reserves the same right, Your Honor.

Judge Prince: I expect both attorneys to give opposing counsel notice of all witnesses you intend to call, including disclosure of any reports, recommendations, CV's, and/or affidavits, not less than 60 days prior to the date of the hearing so that each counsel may have adequate time to review them and prepare for the hearing as there are serious interests to balance here. Each party's written memorandum of law must be filed with the court on or before September 1, 2022, at 5:00 pm. I am going to set the *Sell* hearing to begin on October 6, 2022, and it will continue daily until all evidence is heard. I will issue a written decision 30 days after the conclusion of the hearing. Anything else before we adjourn?

Attorney Pyle: Actually, yes, Your Honor, I just want to put the Court on notice that I will be going on maternity leave beginning October 1, 2022, so I will not be representing my office at this hearing. However, I will ensure that my

colleagues who take over the case are up to speed and prepared for the hearing on October 6, 2022.

Prosecutor Hughes: I hate to complicate things, Your Honor, but I too have a conflict. I am scheduled for a relatively minor surgery on October 5th and while the recovery shouldn't take more than a couple weeks, I will not be available for the hearing on October 6th. May I respectfully request a continuance until October 24th?

Judge Prince: While I am usually accommodating of counsel's schedules, I want to be very cognizant of the defendant's liberty interests, medical needs, and the interests of the State and the Victims in swift justice. I don't want to continue the hearing date. I know you both have great attorneys in your respective offices. Since you both are aware you have conflicts at this early stage, I am confident you both will be able to get your replacement attorneys up to speed such that they will be able to competently draft the memorandum of law and handle this evidentiary hearing on October 6th. Therefore, this case is continued until the *Sell* hearing on October 6, 2022. We're adjourned [bangs gavel].

Sherriff: All Rise.

COURT EXHIBIT B

DMHAS

State of Stetson

Department of Mental Health & Addiction Services
24 Park Street
Petersburg, ST 33712
Tel: (727) 819-2480
Fax: (727) 819-2485

May 26, 2022

Ms. Maria Sanchez
Clerk of the Superior Court
Pinella County Judicial District
235 Cherry Avenue
Petersburg, ST 33719

RE: ASHTON CAMPBELL
DOB: 01/08/1952
DOCKET #: 2022-CR-867

Dear Ms. Sanchez,

In accordance with Judge Prince's Order on March 8, 2022, Ashton Campbell was transferred from Petersburg Jail to Stetson State Hospital, Whittier Forensic Wing ("Whittier") for continued evaluation, treatment, and a medical determination regarding his ability to attain sufficient competency to stand trial.

Upon transfer, due to Covid-19 precautions, Dr. Campbell was housed in isolation in the triage medical unit. He was provided medication for his hypertension and diabetes, even though he repeatedly stated that he has never taken medication for his diabetes, but rather maintains his blood-sugar levels with healthy diet and exercise. Despite that explanation, he accepted medication for his hypertension and diabetes. However, he denied having any mental illness and refused to take "brain pills."

During his two weeks in isolation, Dr. Campbell slept approximately 20 hours a day. When awake, he would stare blankly at the walls. On the rare occasions he spoke, his affect was flat and measured, and at times he appeared disoriented, confused, and sad. He often asked where he was. During the times he was awake, he would wring his hands through one another constantly and, when sitting up, would also bounce his right leg up and down in a steady, but fast-paced, motion. These symptoms are consistent with Depression and Anxiety. He was offered medication to ease these symptoms but politely declined saying that he wanted to be alert when the Department of Defense called about his discovery.

Following Dr. Campbell's two weeks in isolation, he was admitted into a shared hospital room with another elderly, non-violent patient. Dr. Campbell's mood quickly took a positive turn. He

and his roommate became friendly and spoke often. Dr. Campbell's roommate had been taking, and successfully responding to, oral antipsychotic medication. When medical staff would bring Dr. Campbell's roommate his medication, Dr. Campbell would look at the pills. At the beginning of May, I heard Dr. Campbell ask his roommate what the pills did, and his roommate responded, "Help my brain, hurt my body. I hate how they make me feel, but it's better than the highs and lows, I guess. Doc tells me to take them, so I do. I just want to get out of here." Dr. Campbell nodded in response but said nothing else. At the time, I was hopeful this exchange would give Dr. Campbell some insight into his own mental illness and that antipsychotic medication can help him. Unfortunately, my hope has not come to fruition.

Dr. Campbell has voluntarily engaged in daily, individual psychotherapy with me and Dr. Storen since March 25, 2022. He is always polite and alert, and quickly thrived in our sessions. On April 1, 2022, he agreed to take anti-depressant and anti-anxiety medication (aka anxiolytics) because he said he wanted to be "happier." He also expressed wanting to be "alert," "on his game," and "in control" when needing to speak in detail with the Department of Defense about his discovery. He responded very well to both medications and experienced no side-effects or medical complications. However, to date, he has consistently refused antipsychotic medication, which he calls "brain pills," stating he "does not need them" because he "is not sick in the head." He said we were just jealous of his brilliant discovery and wanted to steal credit for it.

We tried to restore Dr. Campbell to competency over the last 90 days, but to no avail, because he refuses to voluntarily take antipsychotic medication. Given his positive response to anti-depressants and anxiolytics, we have concluded that his quality of life would benefit greatly from antipsychotic medication beyond simply restoring his capacity to stand trial. Delusions are caused by overactive dopamine in the brain. Antipsychotic medication would likely eliminate the defendant's delusions entirely by preventing the dopamine receptors in his brain from being over-stimulated. Because of this, his mental status is substantially unlikely to improve absent the administration of antipsychotic medication and no less intrusive means will obtain the same result. If he is not treated with antipsychotic medication, he may spiral into a deeper delusional state.

Therefore, Stetson State Hospital, Whittier Forensic Unit, requests Judge Prince enter an Order allowing involuntary administration of antipsychotic medication, specifically the drug Haldol (generic is haloperidol), to restore Dr. Campbell's mental competency to stand trial.

Sincerely,

Dr. Ellis Ramani, M.D.

Dr. Ellis Ramani, M.D.
Chief Psychiatrist
Stetson State Hospital

STATE OF STETSON

OFFICE OF THE STATE'S ATTORNEY
Pinella County Judicial District
100 Center Street
Petersburg, Stetson 33719
Tel: 737-565-2900
Fax: 737-656-2933

July 13, 2022

Re: *State v. Ashton Campbell*

Gina,

I hope this letter finds you well. If you have started transitioning the *Campbell* matter to one of your colleagues, please let me know and I will communicate with that person going forward.

In the meantime, I wanted you to know that in addition to Dr. Ramani, the State intends to subpoena Dr. Terry Jackson, whose witness statement is in the police paperwork previously provided to you.

Dr. Ramani's curriculum vitae and report regarding the proposed medical treatment plan and potential side effects of antipsychotic medication are enclosed with this letter.

Please do not hesitate to reach out to me should you have any questions.

Kind Regards,

Cecil

Cecil B. Hughes
Assistant State's Attorney
Office of the State's Attorney
Pinella County Judicial District

DMHAS

State of Stetson

Department of
Mental Health &
Addiction Services
24 Park Street
Petersburg, ST 33712
Tel: (727) 819-2480
Fax: (727) 819-2485

July 11, 2022

Ms. Maria Sanchez
Clerk of the Superior Court
Pinella County Judicial District
235 Cherry Avenue
Petersburg, ST 33719

Treatment Recommendation Report

State of Stetson v. Ashton Campbell, DOCKET #: 2022-CR-867

Dear Ms. Sanchez,

I, Dr. Ellis Ramani, have personally examined and treated the defendant throughout the last four months. I have also conducted tests, including CT scans and MRI's, reviewed the defendant's medical history, reviewed all documents in the possession of DOC and Whittier related to the defendant's arrest, custody, and care, and have reviewed, or will review upon receipt, all documents, exhibits, reports, and affidavits submitted to the court in anticipation of the *Sell* hearing. I adopt and incorporate herein by reference the information contained in all prior reports and letters sent to the Pinella County Superior Court with respect to the case of *State of Stetson v. Ashton Campbell*. My clinical treatment recommendation is as follows.

In the event the defendant continues to refuse oral antipsychotic medication after receiving a copy of a Court Order requiring he submit to such treatment, the proposed treatment plan is for the defendant to be injected with "long-acting antipsychotic medication." The defendant would receive an injection of Haldol (generic is haloperidol) every two weeks with adjustments to the dosing schedule and dosage amount as clinically indicated. Given the defendant's cardiac history, we would start with a very low dose and monitor the defendant's response. Serious cardiac events occur more often at high doses of haloperidol and QT interval prolongation (cardia arrhythmia) is considered a dose-dependent adverse reaction. Depending on the dosage we are able to administer, we hope to see at least some improvement in the defendant's status in 4 weeks, with significant improvement in approximately 8-12 weeks. As the defendant stabilizes and his delusions subside, we will begin additional psychotherapy and hopefully be able to transition the defendant to oral antipsychotic medication once he is able to gain insight and appreciate of the existence and severity of his mental illness.

Haldol is considered a first-generation antipsychotic drug as opposed to more modern second-generation drugs, such as risperidone, aripiprazole, and ziprasidone. The difference between first and second-generation antipsychotics is primarily related to their chemical structure. However, first-generation antipsychotics are indicated in the treatment of Delusional Disorder and paranoia associated with personality disorders. Haldol (or haloperidol) is the only antipsychotic drug available in the State of Stetson.

Clinical studies have found antipsychotic medication, including Haldol, successful in restoring defendants with psychotic disorders to competency, and it is the preferred method of treatment. Specifically, for defendants suffering from Delusional Disorder, the likelihood that a defendant can be restored to competency after court mandated treatment with antipsychotic medication is around 75%. For example, one American Psychiatric Association (APA) study from 2010 found: "Of the 241 defendants who were involuntarily medicated for competency restoration, 44 had Delusional Disorder, and 32 (~73%) of those defendants improved sufficiently for the forensic evaluators to opine that they had been restored to competency after involuntary treatment with antipsychotic medication." Haloperidol was an antipsychotic medication used in this study.

Proposed treatment with antipsychotic medication is unlikely to adversely affect the defendant's cognition, but rather is likely to enhance it. The most common side effects of Haldol include:

• Nausea/Vomiting/ Diarrhea • Dry mouth/Mouth sores • Nervousness/Anxiety • Headache • Drowsiness/Sedation • Dizziness/Lightheadedness • Tremors (shaking) in hands and feet • Risk of developing Diabetes	• Elevations in blood pressure • Sleep problems (insomnia) • Akathisia (sense of restlessness) • Skin rash/Itching • Spontaneous eye movements • Blurred vision • Mood changes • Difficulty urinating

There are some also some rare, but far more serious side effects of Haldol, such as:

- Death in the elderly (over 80 years of age).
- Prolongation of the QT heartbeat interval (irregular/arrhythmic heartbeat, which can lead to heart attack or stroke).
- Tardive Dyskinesia (involuntary body movements that vary from mild, to moderate, to severe in the limbs and/or face).
- Dystonia (severe and prolonged muscle contraction that can cause pain and fatigue)
- Prolonged erection (hours).
- Neuroleptic Malignant Syndrome (NMS) (the body loses its ability to regulate its temperature causing high fever).
- Kidney damage/failure.[1]

[1] Kidney damage/failure is a risk when any drug, prescription or over-the-counter, is taken because kidneys cleanse the blood of toxins and transform the waste into urine.

Approximately 15 percent of patients treated with Haldol suffer from physical side effects ranging from tremors to dystonia. Although there is no centralized database containing specific numbers and percentages of patients treated with Haldol, nor the exact total, severity, and frequency of the side effects they suffer, it is commonly known throughout the medical community that patients who take Haldol suffer some of these side effects, but the vast majority are the common ones. The common side effects are more of a nuisance than they are actually debilitating: they do not entail risk of serious harm, but only inconvenience or discomfort, and do not affect cognition, understanding, or reasoning. Further, not only are the more serious side-effects quite rare, but they can be easily managed by lowering the Haldol dosage, as well as by using other medications to manage the side-effect symptoms.

Although the defendant has pre-existing medical conditions, he is an otherwise healthy 70-year-old man. Until his delusions began to severely affect his daily functioning around 2021, he was active and social. His pacemaker has worked without complication for more than 20 years, and his hypertension and Type 2 Diabetes have been, and continue to be, successfully managed.

Although his blood-pressure has been higher than normal for about a week, it is not life-threatening and is likely caused by the stress of his continued and worsening delusion that the Department of Defense is going to call, appreciate his chemical discovery, and get him released. He has been asking if the DOD has called much more often lately and gets increasingly frustrated when he is told they have not. I constantly show him Exhibit 6 as a reminder that the DOD is not going to call, but he refuses to accept that reality and says the letter "is a forgery."

I intend to adjust the dosage of the defendant's ACE Inhibitor or change his blood-pressure medication to Methyldopa prior to starting him on Haldol, as well as monitor his blood-pressure closely while he is being administered Haldol. The concern with Methyldopa is that it can increase the risk of tremors/inhibit motor function when combined with Haldol. But again, while those side effects are a nuisance, they are not life-threatening. However, we can also consider the use of low-dose epinephrine, which studies have shown lowers blood pressure when combined with Haldol.

Other than the defendant's high blood pressure, his pre-existing medical conditions have not caused any complications for him while he has been in custody, and those conditions will be monitored in conjunction with the administration of Haldol. In fact, we have already been monitoring the defendant's response to the anti-depressants and anxiolytics as both drugs can cause cardiac complications, including arrhythmic heartbeat and high-blood pressure. The defendant has had no adverse reaction to either drug. We started him on the anti-depressants and anxiolytics over two months ago with no adverse reaction. His pacemaker appears to be working well and his blood-pressure did not rise until last week and we are monitoring it. Moreover, there are numerous medications available to treat an arrhythmic heartbeat should his pacemaker need assistance while he is being administered Haldol.

With respect to the defendant's diabetes, it is not a medical concern as he already suffers from the disease, and it is being properly monitored and managed. Antipsychotic drugs can *cause* diabetes to *develop* in someone who does not have it, but I am not aware of any studies that show they make the disease worse. However, I cannot entirely rule it out as a potential risk. But again, we will monitor the defendant closely. If necessary, we can give him an alpha-glycosidase inhibitor, which

we have done previously when his blood-sugar levels get slightly elevated. We can also utilize non-medicinal treatments, such as special diet, to treat the defendant's diabetes while he is being administered Haldol.

The therapeutic effect of antipsychotic medication is to improve thinking. People with psychotic disorders are severely impaired when it comes to the form and content of their thoughts. Treatment of these impairments with antipsychotic medication is likely to enhance, rather than undermine, the fairness of any legal proceeding.

CONCLUSION

The medical treatment of choice for a psychotic disorder, including Delusional Disorder, is antipsychotic medication. It is effective. No drug can be completely safe and side effects are always a risk. Individuals vary greatly in their therapeutic response to psychiatric medications, and in their susceptibility to side effects, so it is important to monitor them regularly, adjust dosage, and provide additional medications or environmental changes to address underlying medical conditions, as necessary. The goal of treatment with antipsychotic medication is to effectively manage symptoms at the lowest possible dose, which is the treatment plan for the defendant.

Because the defendant has no insight into his mental illness, other forms of treatment, including education, environmental stimuli, and psychotherapy, can be effective treatment *supplements*, but alone do not address the cause of the disorder and are therefore highly unlikely to be successful on their own without the additional administration of antipsychotic drugs. The defendant has been engaged in individual psychotherapy with me and Dr. Storen for months with no mitigation of his delusions. If anything, his delusions have become more severe. Other forms of talk-therapy, including Cognitive Behavioral Therapy (CBT), will similarly be unsuccessful because they do not treat the root cause of the problem – overactive dopamine in the defendant's brain. Put simply, he needs antipsychotic medication that will block the dopamine receptors in his brain from being over-stimulated in order to ease the psychotic delusions. Further, the defendant does not appear to have a history of, nor do CT or MRI imaging suggest, head injury, mental impairment, Dementia, or other structural difficulty with the brain that would account for his severe delusional symptoms, which makes for an optimistic prognosis of the use of antipsychotic drugs. Although the defendant does display some symptoms of Dementia (e.g., forgetfulness, confusion), the totality of the circumstances indicates a proper diagnosis of Delusional Disorder.

Treatment with antipsychotic medication is the necessary and medically appropriate intervention choice for the defendant's persistent and worsening condition, and the involuntary administration of such drugs is medically appropriate for the reasons stated herein. It is therefore my medical opinion that there is a substantial likelihood that the defendant could be restored to competency, and his overall lifestyle greatly improved, following involuntary administration of the antipsychotic drug Haldol.

Sincerely,

Dr. Ellis Ramani, M.D.

Dr. Ellis Ramani, M.D.
Chief Psychiatrist, Stetson State Hospital

Dr. Ellis Ramani, M.D.

PROFESSIONAL SUMMARY

Board-certified Psychiatrist with 25 years of experience working with an ethnoculturally diverse population; comfortable working with individuals with severe problems such as suicidality and major mental illnesses. Excellent background in psychopharmacology and interest in responsibly measuring outcomes of new modalities. Adept communicator able to engage with patients and effectively partner with other team members within complex organizational structures.

SKILL HIGHLIGHTS

- Needs assessments
- Treatment plans
- Cultural sensitivity
- Development issues
- PTSD group specialist
- Outreach programming
- Suicide risk assessments
- Evaluation & Progress reports
- Collaborative care
- Medicinal & Therapeutic expertise

PRACTICE EXPERIENCE

- Provide direct clinical services such as psychiatric evaluations, crisis intervention, individual and group psychotherapy, psychopharmacology, and referrals to off-campus agencies and professionals.
- Deliver trainings for professional and paraprofessional staff; consult with staff.
- Perform outreach to help integrate and upgrade Mental Health and Counseling Services in jails and prisons state-wide.
- Prescribe, direct, and administer psychotherapeutic treatments and/or medications to treat mental, emotional, or behavioral disorders.
- Collaborate with physicians, psychologists, social workers, psychiatric nurses, and other professionals to discuss, create, and assess individual treatment plans and progress.

CAREER CHRONOLOGY

Chief Psychiatrist

- Stetson State Hospital
- March 2015 – Present

Staff Psychiatrist

- Stetson State Hospital, Whittier Forensic Unit
- June 2005 – February 2015

Psychiatrist

- Brain Magicians of Greater Tampa – *"Where Medicine Makes the Magic Happen!"*
- Tampa, Stetson
- May 1997 **–** May 2005

EDUCATION AND TRAINING

BayCare University Hospital Orlando, Stetson
Forensic Psychiatric Group

- Residency in Forensic Psychiatry
- May 1995 – May 1997

Stetson State University Tallahassee, Stetson
School of Medicine

- M.D. – Psychiatry – May 1995
- *Cum Laude*

Roggins College Winter Park, Stetson

- Bachelor of Science – May 1991
- Double Major: Biology, Psychology

PROFESSIONAL AFFILIATIONS

- *Theranol Pharmaceuticals*, President (2014-Present); Board Member since 2010.
- *American Psychiatric Association (APA)*, Member since 1997.

PUBLICATIONS

- *Haloperidol: The Gold Standard for Psychotic Illness* (American Journal of Forensic Psychiatry, April 2009).
    - Summary quote from article: "Although the Food and Drug Administration has recently approved many second-generation antipsychotic drugs for the treatment of psychotic mental illness, none of these newer, far-more expensive drugs compare to the efficiency and effectiveness of the first-generation drug, Haloperidol. To quote Thomas Bertram Lance, "If it ain't broke, don't fix it."

- *Cognitive Behavioral Therapy: A Snowflake's Approach to Treating Mental Illness (*American Journal of Psychiatric Medicine, September 2017).
    - Summary quote from article: "It is understandable to not want to subject one's patients to the common, and sometimes severe, side effects of anti-psychotic drugs. But mental illness is a disease of the brain like cancer is a disease of the body. Just like oncologists don't treat cancer with talk-therapy, psychiatrists should not treat mental illness with talk-therapy."

OFFICE OF PUBLIC DEFENDER SERVICES
200 Center Street
Petersburg, Stetson 33707
Tel: 737-562-7300
Fax: 737-562-7355

July 27, 2022

Re: *State v. Ashton Campbell*

Dear Cecil,

I received your letter and attached documentation. Thank you. I have not yet started transitioning the *Campbell* matter but will shortly. Enclosed please find the following:

(1) Report and curriculum vitae of the court-appointed Healthcare Guardian, Dr. Alex Lee, whom we intend to call at the *Sell* hearing.

(2) The affidavit of Pat Griffin, Registered Nurse at Whittier Forensic Hospital, whom we also intend to call at the hearing.

(3) A handwritten note that Dr. Campbell provided to Nurse Griffin.

Speak with you soon.

Sincerely,

Gina

Gina L. Pyle
Assistant Public Defender
Office of Public Defender Services
Judicial District of Petersburg

Healthcare Guardian Report

July 25, 2022

Ms. Maria Sanchez
Clerk of the Superior Court
Pinella County Judicial District
235 Cherry Avenue
Petersburg, ST 33619

RE: *State of Stetson v. Ashton Campbell*

Dear Ms. Sanchez,

I, Dr. Alex Lee, was appointed Healthcare Guardian in the matter of *State of Stetson v. Ashton Campbell*. I have personally examined Dr. Campbell and reviewed all documentation related to this case, Dr. Campbell's medical history, and reviewed the State Psychiatrist's Report and Recommendation.

"Delusional Disorder" is incredibly rare. It is more likely that Dr. Campbell is suffering from Dementia, specifically Dementia-related psychosis. Further, even assuming Dr. Campbell has Delusional Disorder, involuntary administration of antipsychotic medication is neither a necessary nor medically appropriate course of treatment.

A. DEMENTIA

Dementia is a term used to describe symptoms such as memory loss or a decline in a person's thinking and reasoning skills that interfere with daily life. In Dementia, symptoms occur when nerve cells in the brain die. Brain cell death happens to everyone with age, but Dementia is not a normal part of aging. People with Dementia often first lose their short-term memory while their long-term memory (stored in a different part of the brain) remains intact much longer. Isolation can exacerbate Dementia progression. Dementia patients also often become increasingly forgetful, disoriented, uncoordinated, and confused; lose problem-solving skills and the ability to think rationally; and are unable to control their emotions, often reacting angrily or violently. They may also exercise poor judgment or experience agitation, delusions, and hallucinations.

Although CT scans and MRI testing did not reveal any physical signs of Dementia in Dr. Campbell's brain, that does not medically exclude the possibility that he has Dementia, especially given all his documented symptoms. Further, Dr. Campbell suffers from Anxiety and Depression, which are common in Dementia patients. Although anti-psychotic drugs may be prescribed to Dementia patients who develop

psychosis, the American Geriatric Medical Society (AGMS) suggests antipsychotic medications only be used if the Dementia patient:

- has behavioral problems that do not improve with non-drug approaches;
- is threatening to harm themselves or others; and
- the antipsychotic medications are not used for more than 12 weeks.

Dr. Campbell is not threatening harm to himself or others, so he does not meet this criteria and should not be forcibly medicated.

B. "DELUSIONAL DISORDER"

Assuming Dr. Campbell has the incredibly rare disease known as "Delusional Disorder," involuntary antipsychotic medication is neither the necessary nor the appropriate medical treatment for him.

First, unlike for Schizophrenia, Cognitive Behavioral Therapy (CBT) is an approved psychotherapy treatment for Delusional Disorder because it is not as severe a mental illness as Schizophrenia. Delusional Disorder does not *have* to be treated with antipsychotic medication, especially when the disease appears to have been triggered by environmental factors as opposed to genetic factors. CBT is a far less invasive form of treatment than forcibly medicating someone against their will. CBT can help patients understand how their thoughts, which are often created by environmental stimuli, affect their actions. Through CBT, patients can unlearn negative thoughts and behaviors and learn to adopt healthier thinking patterns and habits. Although Dr. Campbell has engaged in individual psychotherapy with Dr. Ramani and Dr. Storen, he should be given a chance to engage in CBT before being forcibly given antipsychotic medication.

Second, while I do not dispute the findings in the APA study that approximately 73% of patients diagnosed with "Delusional Disorder"[2] who were treated with antipsychotic medication were restored to competency, a further study of patients diagnosed with "Delusional Disorder" by the APA indicated that 10%-30% of patients have little or no response to antipsychotic medications, and up to an additional 30% of patients have only a partial response, particularly when severe delusions, defined as significantly interrupting daily life function, have persisted for more than 3 years. Thus, given for how long Dr. Campbell appears to have been suffering from this rare disease and how advanced his disorder appears to be, his prognosis of positively responding to antipsychotic medication likely does not exceed 30%.

[2] It is my opinion based on my training and experience that the patients in these studies were actually suffering from a much more common mental illness, Schizophrenia, which is why the use of antipsychotic medication was largely successful.

Furthermore, not only are the *common* side-effects of antipsychotic drugs painful, distracting, debilitating, and traumatic, but Dr. Campbell has pre-existing medical conditions that put him at a much higher risk of enduring the more *severe* side effects, which are even more painful, distracting, debilitating, and traumatic, as well as potentially fatal.

Dr. Campbell has cardiac arrythmia, diabetes, and hypertension for which he already takes medication. As the human body ages, it reacts to medications differently. This puts older adults (over 60 years of age) at an increased risk of adverse effects from medications. In particular, antipsychotic drugs have been linked to an increased risk of falls, diabetes, and heart disease. Older adults are also more likely to be prescribed multiple medications, increasing the likelihood of negative drug interactions. Higher rates of hospital admission or death have also been reported after the short-term use of antipsychotics in elderly adults (over 80 years of age), suggesting that these drugs should be prescribed with extreme caution.

Although the side effect of cardiac arrythmia is rare, the administration of antipsychotic drugs can double a person's risk of cardiac arrythmia. According to the American Medical Association (AMA), instances of cardiac arrythmia usually occur at a rate of 7 per 10,000 individuals versus occurring at a rate of 10-15 per 10,000 individuals using antipsychotic medication.

Dr. Campbell was diagnosed with atrial fibrillation (chaotic heartbeat caused by a rapid, uncoordinated heart rate) 22 years ago. Atrial fibrillation is associated with serious complications such as stroke. To treat this, Dr. Campbell had a pacemaker implanted to maintain a normal sinus rhythm (heartbeat). It is my opinion that Dr. Campbell's prior diagnosis and use of a pacemaker puts him at higher risk of cardiac complications; however, I cannot say to any degree of medical certainty what the percentage of higher risk is because there are no documented studies of patients with pacemakers having been administered antipsychotic drugs. Thus, administering such drugs poses an unreasonable risk to Dr. Campbell's health.

Dr. Campbell also has Type 2 Diabetes and hypertension. According to research from the National Center for Biotechnology Information (NCBI), an analysis of 438,245 people with severe mental illness found that 11.3% of patients who did not have Type 2 Diabetes prior to treatment with antipsychotic medication developed the disease after receiving such treatment. Furthermore, because dopamine receptors in the brain play a role in the regulation of blood pressure, alterations to this regulatory system that are caused by antipsychotic medication can lead to hypertension. As such, Dr. Campbell's preexisting medical conditions may get significantly worse if he takes antipsychotic medication, which is an unreasonable risk to his health, and potentially his life.

C. CONCLUSION

Dr. Campbell is a single, 70-year-old man whose delusions are likely the result of Dementia not Delusional Disorder, which is incredibly rare. Further, even assuming Dr. Campbell has Delusional Disorder, involuntary antipsychotic medication is not the necessary treatment given the availability of CBT, nor the appropriate medical treatment given his underlying health conditions. If CBT is not successful, then Dr. Campbell should be deemed not competent, not restorable, and further proceedings initiated pursuant to Stetson General Statutes § 54-56d(k).

Dr. Alex Lee, M.D.

Dr. Alex Lee, M.D.
Psychiatrist
Court Appointed Healthcare Guardian
Mind-Body Clinic, Greater Petersburg
115 Burley Way
Petersburg, Stetson 33711

Dr. Alex Lee, M.D.

PROFESSIONAL SUMMARY

A highly personable, competent, and team spirited psychiatrist with more than 20 years of experience working with patients with psychiatric disabilities. A patient-oriented advocate who tirelessly and consistently works with other doctors, nurses, staff, and administrators to deliver the best possible care to every patient.

SKILLS

- Excellent diagnostic and treatment planning abilities, both pharmaceutical and therapeutic.
- Consummate bedside manner, strong interpersonal and relationship-building skills.
- Professional team player working harmoniously with medical staff, administration, patients, and family members to ensure care consistent with standard operating procedures.
- Psychosocial assessment and holistic medicine approach.
- Crisis intervention; facilitating cognitive behavioral therapy sessions; case documentation and discharge planning.

WORK HISTORY

Mind-Body Clinic, Greater Petersburg **Petersburg, Stetson**
Psychiatrist, January 2010-Present

- Private practice providing psychiatric treatment including:
  - Psychiatric evaluation, consultation, and psychopharmacologic treatment for adults, seniors, and geriatric patients.
  - Evaluation and treatment, including pharmaceutical and therapeutic (individual and group therapy) approaches, for patients with psychiatric illnesses such as Major Depression, Bipolar Disorder, Schizophrenia, Obsessive-compulsive Disorder, and Post-traumatic Stress Disorder.
  - Evaluation and treatment of patients with dual diagnoses (mental health and substance abuse) conditions.
  - Consultation, evaluation (including Dementia assessment), and treatment of patients with neuropsychiatric issues.
  - Nursing home visits to treat geriatric patients in the San Naples Valley.
  - Court Appointed Health Care Guardian pursuant to Mind-Body Clinic's Contract with the State of Stetson to provide independent evaluations and recommended treatment plans for patients housed at Stetson State Hospital, Whitter Forensic Unit.

Mental Health America **Miami, Stetson**
Southeast Regional Headquarters
Psychiatrist, May 2005-December 2009

- Cognitive Behavioral Therapy Specialist
  - Performed psychological diagnostic assessments of patients.
  - Reviewed therapy programs to meet patients' needs.
  - Determined therapeutic approaches to improve patients' well-being.
  - Conducted group and individual therapy sessions.
  - Identified areas, and developed best practices, for service improvements.
  - Coordinated with other treating physicians and psychiatrists to ensure comprehensive care.

Winthrop Memorial General Hospital **Tallahassee, Stetson**
Attending Psychiatrist
May 1999 – May 2005

- Treated patients in the Emergency Department and Admitted Patients for psychiatric disorders and disabilities ranging from minor depression to severe psychosis.
- Prescribed medication and also treated patients in a therapeutic setting.
- Managed, trained, and supported a team of 3 resident psychiatrists.

EDUCATION & TRAINING

Residency in Psychiatry
Winthrop Memorial General Hospital **Tallahassee, Stetson**
Specialty areas**:** Clinical and Forensic
May 1997-May 1999

University of Stetson **Gainesville, Stetson**
School of Medicine
M.D. – Psychiatry – May 1997
Magna Cum Laude

University of Tampa **Tampa, Stetson**
Bachelor of Science – May 1993
Double Major: Neuroscience, Psychology

PROFESSIONAL AFFILIATIONS

- *American Psychiatric Association (APA)*, Member since 1997
- *University of Stetson School of Medicine,* Guest Lecturer of Psychiatry

---

PUBLICATIONS

The Real Pandemic! The Over Prescription of Antipsychotic Medication **(Clinical Psychiatry Review, December 2021).**

Summary quote from article: "I'm fed up! The only people benefitting from the prescription of antipsychotic medication are the greedy pharmaceutical companies! Psychiatric patients may feel mentally better, but they suffer physically all while the multi-

millionaires continue to line their pockets. Drug dealers aren't on the street corner anymore, they are in the corner office!"

***Cognitive Behavioral Therapy: Sometimes It Works, Sometimes It Doesn't* (American Journal of Psychiatry, November 2005).**

Summary quote from article: "Proponents of Cognitive Behavioral Therapy (CBT) boast, 'You have considerable power to construct self-helping thoughts, feelings, and actions as well as to construct self-defeating behaviors. You have the ability, if you use it, to choose healthy instead of unhealthy thinking, feeling, and acting.' I agree CBT can be an effective cure for *some* patients, but it can be inappropriately touted as a cure for patients with physically degenerative, or severe psychotic, mental illnesses because a "change in belief system" won't alleviate physical deterioration or severe psychosis. Sometimes with physical deterioration or severe psychosis, medication is a better course of treatment to try to slow the progression of the disease. What CBT can do in those situation though is help patients cope with being chronically ill and manage their emotional reactions better so that they do not waste valuable energy on worrying or feeling guilty about things that they cannot control."

Affidavit of Pat Griffin

My name is Pat Griffin, and I am 34 years old. I am a Registered Nurse (RN), graduated from Stetson State University in 2013, and am currently employed by Whittier Forensic Hospital in the State of Stetson. I have worked at Whittier for 4 years. I don't absolutely love working with mentally ill people all-day, every day, but it pays the bills, and the state benefits are way better than working in private practice. I worked as a nurse in the Emergency Department (ED) at Shady Acres Medical Center in Collier County, Stetson for five years. I really loved getting to work with all the different doctors and treat all different kinds of patients and their various injuries and illnesses, but the pay was barely more than minimum wage, and the benefits were even worse. In addition to cost of living, I've got student debt to pay off, so working there just wasn't sustainable long-term, but I loved it so I made it work as long as I could. The transition to the Forensic Unit at Whittier was relatively easy given that I had experience dealing with different types of people with many different ailments in the ED, but, as I said, working with the mentally ill every day is definitely a different kind of stress. You never know what can happen, or what kind of situation you'll have to deal with at any given moment. It's also really sad because most of the patients are pumped full of antipsychotic meds. The medication does calm many of them down, but I constantly see patients suffering from the side effects: vomiting, diarrhea, mouth sores, drowsiness, tremors, muscle contractions, spikes in blood pressure, and itchy skin rashes. Honestly, it's tough to watch.

Anyway, I think my needing to pay constant attention to what the patients in the Forensic Unit might do at any time is what first drew my attention to Dr. Campbell. He isn't like the other patients. He never yells or acts violently. He is always polite. Honestly, I like being assigned to his room because I always feel safe when I am around him. I am never scared he is going to attack me. Don't get me wrong, I understand why mentally ill patients act violently and I'm pretty used to dealing with it, but Dr. Campbell has been such a breath of fresh air. I was assigned to his room after he had been at Whittier for about a month and have seen him daily ever since.

My daily interaction with him is pretty consistent. Each day I walk in and say, "Hey Dr. C!" He always greets me politely and asks me to remind him of my name. I tell him "Nurse Griffin" and replies, "Oh that's right, I knew that, I'm sorry." He's quiet and doesn't emote much, but

he's always calm. My job is to provide him with his medication, but not what he refers to daily as the "brain pills." He always says, "You better not be bringing me those brain bills." He does not think he is mentally ill, and he will be the first to tell you that. I take his blood pressure every morning and he always whispers in my ear, "I'm not crazy like they keep saying I am." His blood pressure has been high since around July 4th, consistently 145 mm/Hg over 105 mm/Hg. Although that range is not immediately life-threatening, it is concerning. Dr. Campbell still takes an ACE inhibitor, but Dr. Ramani has told me he/she is concerned about Dr. Campbell's high blood-pressure and believes it is stress-induced due to his worsening delusion that the DOD is going to call to ask about his discovery and get him released. Dr. Ramani said he/she intends to adjust the dosage or change the medication entirely.

Each morning when I bring Dr. Campbell his medication, he asks me to show him each pill and explain what it is and what it treats before he will take it. We go through the same routine every day: I provide him the same pills every day for hypertension (red and orange pill), Anxiety (pink pill), and Depression (white pill). He says that even though he doesn't believe he has Anxiety or Depression, he likes that the "happy pills" make him feel less sad and fidgety, so he agrees to take them. He says he wants to be in the best mood possible when the Department of Defense comes to discuss his chemical discovery. He also sometimes asks how "the couple" is and says he is "very sorry."

I also test his blood-sugar twice a day to make sure his glucose levels are appropriate. If his blood-glucose levels are high, which has occurred at least once a week since I have been assigned to his room, I will speak to Dr. Ramani and administer an alpha-glucosidase inhibitor, as directed. Every morning, Dr. Campbell tells me that he used to be able to walk five miles a day and eat healthier to monitor his diabetes without medicine, which is part of the reason he is so disappointed to have to "be in this place where virtually every meal is carb-based." He says he always tries to "avoid the carbs" during his daily meals, but sometimes it's impossible. He is very inconsistent with his hygiene: at least three times a week I need to remind him to take a shower and brush his teeth. He always responds, "I was just about to." His coordination also appears to be declining: he often drops objects like his comb or his toothbrush, and stumbles when walking. Recently, he has gotten very desperate about speaking with the DOD. He used to ask me a few

times a week if the DOD had called for him yet, but since the end of June he has been asking me multiple times a day, in a begging/pleading kind of way, “Did the DOD call for me yet?” I always tell him no, but if they do, I’ll personally bring him the message. He appears very frustrated and keeps asking, “Why haven’t the called yet? I don’t understand!”

Dr. Campbell sleep a lot, at least 12-14 hours a day, but when he is awake, he interacts and gets along well with the other patients. Because he doesn’t pose a threat to others, he is allowed to move freely in and out of his room and interact with staff and other non-violent patients. He visits the library and reads often. Because he is smarter than pretty much everyone else in the Forensic Unit, he teaches basic math and reading skills to many of the patients who are properly medicated and able to interact with him. On two different occasions – once in May and once in June – I heard Dr. Campbell ask other patients about their “brain pills” and “what it's like to have your head messed with like that?” Each time the patients responded that they were “glad the voices are gone” but “feel like crap all the time.” I saw Dr. Campbell respond differently to these patients in May and June. In May, Dr. Campbell nodded his head slowly up-and-down in an agreeable manner and said, “Seems like an interesting trade-off. I don’t hear voices, so maybe I wouldn’t feel so bad. Something to think about. Thanks for your input.” In June, Dr. Campbell firmly shook his head side-to-side as if he were saying “no” and angrily stated, “I’ll never take those damn pills! I’m not crazy. I’m a genius! Probably the best chemist in the world and the DOD knows it!”

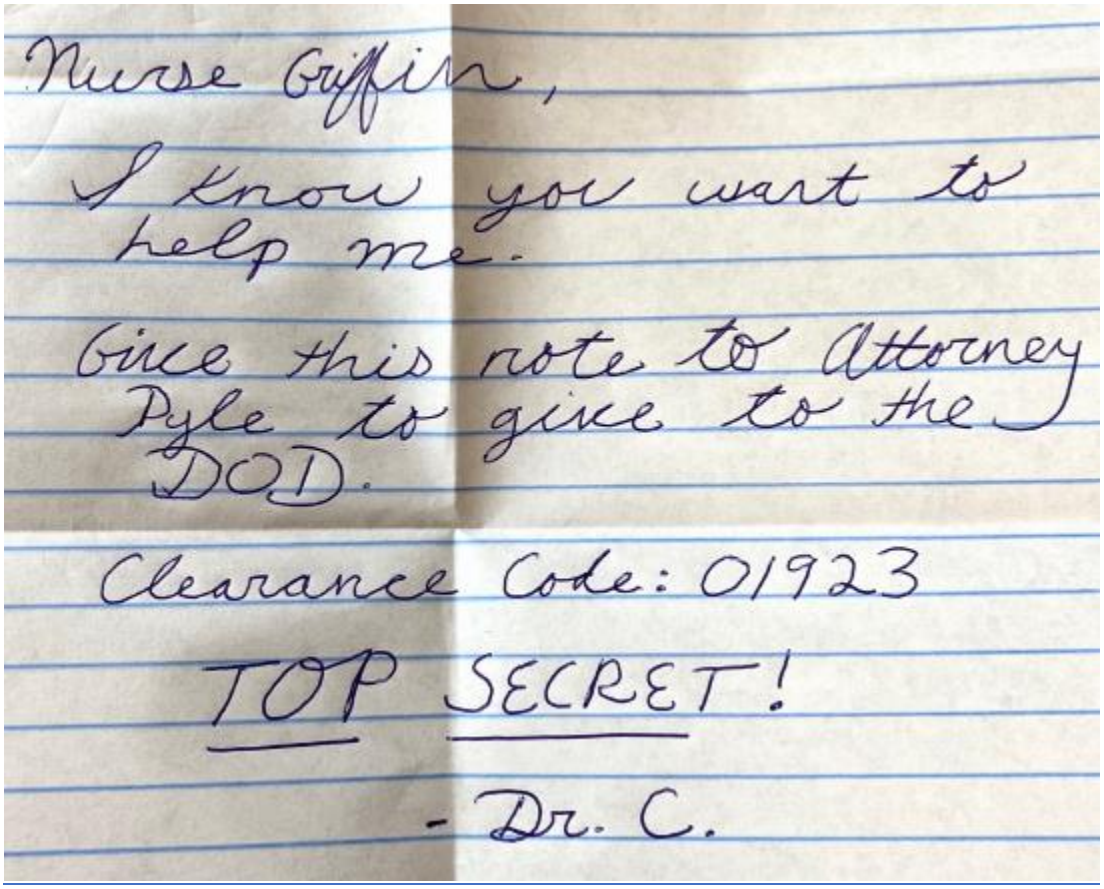
Yesterday morning I entered Dr. Campbell’s room like usual. I gave him his medication, took his blood pressure, and tested his blood-sugar. After I left his room, I went to put my pen back in the side pocket of my scrub pants and I felt something that wasn’t there before. It felt like a small piece of paper. When I pulled it out, I saw that it was a small, handwritten note that said, “Nurse Griffin, I know you want to help me. Give this note to Attorney Pyle to give to the DOD. Clearance Code: 01923. TOP SECRET! - Dr. C.” I knew Attorney Pyle was Dr. Campbell’s lawyer, so I called her and told her about the note. She came and collected it from me.

I attest under penalty of perjury that the above information is true, accurate, and complete.

Pat Griffin Date: July 15, 2022

Pat Griffin, R.N., Stetson State Hospital, Whittier Forensic Unit

EXHIBIT 8



Nurse Griffin,

I know you want to help me.

Give this note to Attorney Pyle to give to the DOD.

Clearance Code: 01923

TOP SECRET!

- Dr. C.

EXHIBIT 9

SAP
STETSON ASSOCIATED PRESS
July 27, 2018

From College Teammates to Business Partners: Theranol Pharmaceuticals Wins Stetson Government Contract

Theranol Pharmaceuticals has won the contract to manufacture and provide all medication to every state-run hospital in the State of Stetson for the next 10 years. The proposed contract has been criticized by corruption watchdog agencies because Stetson's Governor, Ronald DeSatton, and the current President of Theranol Pharmaceuticals, Dr. Ellis Ramani, were college teammates on the Co-Ed Varsity Ultimate Frisbee Team at Roggins College. With this exclusive contract, Theranol Pharmaceuticals stands to make a lot of money over the next decade; a factor likely to be considered by Theranol's Board of Directors when Ramani is up for reappointment as President. Ramani is also an employee of the State of Stetson, but has refused to release his tax returns, so we don't know how much Theranol pays him to run their company. Records released pursuant to Stetson's Campaign Finance Act show that Theranol donated over $1 million to Governor DeSatton's campaign for Governor in 2016. Both Governor DeSatton and Dr. Ramani have denied any wrongdoing. Governor DeSatton had this to say about the contract: "This was a fair bidding process where all proposals were considered. Stetson simply selected the one that made the most financial sense for the patients of our great state." Dr. Ramani had this to say: "Theranol Pharmaceuticals looks forward to partnering with the great State of Stetson over the next decade to provide the best medicine on the market to all the patients in the care of Stetson's State Hospital System." Despite their denials, many Stetson residents are skeptical. One Stetson state employee who spoke on the condition of anonymity had this to say: "The smell of corruption underlying this contract is the same smell that emanates from Stetson's beaches during a red tide: it stinks!"

EXHIBIT 10

PsychMDBlog.com

A platform for discussion of psychological theory and treatment philosophies

Posted May 5, 2016

In what situations do you prescribe antipsychotic medications in your practice? What have been the outcomes of such use?

Posted May 25, 2016

Dr. Kimberly Harrison

I often use anti-psychotic medications for treating patients with conditions ranging from Schizophrenia to Delusional Disorder. I have found them effective at different dosages for patients suffering from many different psychotic disorders.

Reply Posted June 1, 2016

Dr. Roberto Lowery

I have also had success in treating patients with Delusional Disorder, including Jealousy Type, Persecutory Type, and Grandiose Type, with various dosages of antipsychotics.

Reply Posted June 3, 2016

Dr. Alex Lee

I respectfully disagree with this assessment. In my professional opinion, "Delusional Disorder" is a hoax, and the treatment of it with antipsychotic medication cannot be successful. It's the go-to diagnosis when doctors want to medicate a patient using antipsychotic drugs that are appropriate to treat more severe psychotic disorders like Schizophrenia, but the symptoms of Schizophrenia (primarily auditory and visual hallucinations) are not present. Non-schizophrenic delusional mindsets stem from external factors and can be appropriately remedied using CBT and psychotherapy.

Stetson General Statutes
Penal Code

Sec. 53a-113. Reckless Arson Causing Physical Injury.

(a) A person is guilty of Reckless Arson Causing Physical Injury when they recklessly cause the burning of a building or dwelling, as defined in Stetson General Statutes § 53a-100, that results in physical injury or serious physical injury, as defined in Stetson General Statutes § 53a-100, to another person.

(b) Reckless Arson Causing Physical Injury is an unclassified felony with a definite sentencing range of a minimum of 2 years and a maximum of 10 years.

Sec. 53a-38. Sentencing Guideline and Calculation of terms of Imprisonment.

(a) Apply the greatest:

(1) 5-10 years. Shall be considered if the offense (A) created a substantial risk of death or serious bodily injury to any person other than a participant in the offense, and that risk of harm was created knowingly and with an extreme disregard for human life; (B) was committed in an effort to conceal another offense; or (C) involved the destruction or attempted destruction, by the use of an explosive weapon, a dwelling, an airport, an aircraft, a mass transportation facility, a mass transportation vehicle, a maritime facility, a vessel, or a vessel's cargo, a public transportation system, a state or government facility, an infrastructure facility, or a place of public use.

(2) 2-4 years. Shall be considered if the offense (A) created a risk of death, serious bodily injury, or bodily injury to any person other than a participant in the offense; and (B) involved the destruction or attempted destruction of a dwelling by any means.

(3) An offender's criminal record; age; education; upbringing; substance abuse history; mental health history; and any other factor relevant to fashioning an appropriate, individualized sentence shall always be considered.

(b) If a person is convicted and sentenced on more than one count, the sentences shall be calculated as follows: (1) If the sentences are ordered to run "concurrently," the sentence terms merge and the sentence will be satisfied by discharge of the longest term; (2) if the sentences are ordered to run "consecutively," the sentence

terms are added to arrive at an aggregate term and the sentence will be satisfied by discharge of the total aggregate term.

Sec. 53a-100. Definitions.

(a) The following definitions are applicable to this part: (1) "Building" in addition to its ordinary meaning, includes any watercraft, aircraft, trailer, sleeping car, railroad car or other structure or vehicle or any building with a valid certificate of occupancy. Where a building consists of separate units, such as, but not limited to separate apartments, condominiums, offices, or rented rooms, any unit not occupied by the actor is, in addition to being a part of such building, a separate building; (2) "dwelling" means a building that is, or would be, occupied by a person lodging therein at night, whether or not a person is actually present; (3) "night" means the period between thirty minutes after sunset and thirty minutes before sunrise; (4) "physical injury" means bodily pain, illness, or any impairment to the normal functioning of one's physical condition or any bodily organ; (5) "serious physical injury" means bodily injury that creates a substantial risk of death or that causes death, serious permanent disfigurement, or protracted loss or impairment of the function of any bodily member or organ. Losing consciousness may constitute physical injury or serious physical injury, depending on the length of unconsciousness; (6) "explosive weapon" means any explosive or incendiary bomb, grenade, rocket, or mine, that is designed, made, or adapted for the purpose of inflicting serious bodily injury, death, or substantial property damage, or for the principal purpose of causing such a loud noise as to cause undue public alarm or terror.

Sec. 54-56d. Competency to stand trial.

(a) Competency requirement. Definition. A defendant shall not be tried, convicted, or sentenced while the defendant is not competent. For the purposes of this section, a defendant is not competent if the defendant is unable to understand the proceedings against him or her or to assist in his or her own defense.

(b) Presumption of competency. A defendant is presumed to be competent. The burden of proving that the defendant is not competent by a preponderance of the evidence and the burden of going forward with the evidence are on the party raising the issue. The burden of going forward with the evidence shall be on the state if the court raises the issue. The court may call its own witnesses and conduct its own inquiry.

(c) Request for examination. If, at any time during a criminal proceeding, it appears that the defendant is not competent, counsel for the defendant or for the

state, or the court, on its own motion, may request an examination to determine the defendant's competency.

(d) Examination of defendant. Report. If the court finds that the request for an examination is justified and there is probable cause to believe that the defendant has committed the crime for which the defendant is charged, the court shall order an examination of the defendant as to his or her competency. The court may (1) appoint one or more physicians specializing in psychiatry to examine the defendant, or (2) order the Department of Mental Health and Addiction Services to conduct the examination, in which case the clinical team shall consist of a physician specializing in psychiatry, a clinical psychologist, and a licensed clinical social worker. If the examiners determine that the defendant is not competent, the examiners shall then determine whether there is a substantial probability that the defendant, if provided with a course of treatment, will regain competency within the maximum period of any placement order under this section. If the examiners determine that there is not a substantial probability that the defendant, if provided with a course of treatment, will regain competency within the maximum period of any placement order under this section, the examiners shall then determine whether the defendant appears to be eligible for civil commitment to a hospital for psychiatric disabilities pursuant to subsection (k) of this section and make a recommendation to the court regarding the appropriateness of such civil commitment. The examiners shall prepare and sign, without notarization, a written report and file such report with the court within 30 days of the initial competency examination order. On receipt of the written report, the clerk of the court shall cause copies to be delivered immediately to the state's attorney and to counsel for the defendant.

(e) Hearing. Evidence. The court shall hold a hearing as to the competency of the defendant. Any evidence regarding the defendant's competency, including the written report, may be introduced at the hearing. If the written report is introduced, at least one of the examiners shall be present to testify as to the determinations in the report, unless the examiner's presence is waived by the defendant and the state. Any member of the clinical team shall be considered competent to testify as to the team's determinations.

(f) Court finding of competency or incompetency. If the court, after the hearing, finds that the defendant is competent, the court shall continue with the criminal proceedings. If the court finds that the defendant is not competent, the court shall also find whether there is a substantial probability that the defendant, if provided with a course of treatment, will regain competency within the maximum period of any placement order permitted under this section.

(g) Court procedure if finding that defendant will not regain competency. If, at the hearing, the court finds that there is not a substantial probability that the defendant, if provided with a course of treatment, will regain competency within the period of any placement order under this section, the court shall follow the procedure set forth in subsection (k) f this section.

(h) Court procedure if finding that defendant will regain competency. If, at the hearing, the court finds that there is a substantial probability that the defendant, if provided with a course of treatment, will regain competency within the period of any placement order under this section, the court shall order placement of the defendant for treatment for the purpose of rendering the defendant competent.

(i) Placement for treatment. Conditions. The placement of the defendant for treatment for the purpose of rendering the defendant competent shall comply with the following conditions: (1) The period of placement under the order or combination of orders shall not exceed the period of the maximum sentence which the defendant could receive on conviction of the charges against the defendant or 18 months, whichever is less; and (2) the placement shall be either (A) in the custody of the Department of Mental Health and Addiction Services, or (B) the Commissioner of Children and Families; and (3) the court shall order the placement, on either an inpatient or an outpatient basis, which the court finds is the least restrictive placement appropriate and available to restore competency.

(j) Reconsideration of competency. Hearing. Involuntary medication. Appointment and duties of health care guardian.

(1) Whenever any placement order for treatment is rendered or continued, the court shall set a date for a hearing for reconsideration of the issue of the defendant's competency. If the court receives a report that the defendant will not attain competency within the remainder of the period covered by the placement order absent administration of psychiatric medication for which the defendant is unwilling or unable to provide consent, the court shall appoint a health care guardian who shall be a licensed health care provider with training in the treatment of persons with psychiatric disabilities to represent the health care interests of the defendant before the court. The health care guardian shall file a report with the court, which shall set forth such health care guardian's findings and recommendations concerning the administration of psychiatric medication to the defendant, including the risks and benefits of such medication, the likelihood and seriousness of any adverse side effects and the prognosis with and without such medication. The court shall hold a hearing on the matter and, in deciding whether to order the involuntary medication

of the defendant, take into account such health care guardian's opinion concerning the health care interests of the defendant.

(2) If the court finds that the defendant will not attain competency within the remainder of the period covered by the placement order absent administration of psychiatric medication for which the defendant is unwilling or unable to provide consent, after a hearing the court may order the involuntary medication of the defendant if the court finds by clear and convincing evidence that: (A) Important government interests are at stake; (B) Involuntary medication will significantly further those interests; (C) Involuntary medication is necessary to further those interests; and (D) Administering the drugs is medically appropriate.

(k) Release or placement of defendant who will not attain competency.

(1) If at any time the court determines that there is not a substantial probability that the defendant will attain competency within the period of treatment allowed by this section, or if at the end of such period the court finds that the defendant is still not competent, the court shall solicit and consider recommendations by the examiners regarding the appropriateness of civil commitment to the Department of Mental Health and Addiction Services, either on an inpatient or outpatient basis, based on whether the defendant is a significant security, safety or medical risk to the community.

(2) If civil commitment to the Department of Mental Health and Addiction Services is ordered, the court shall order the defendant committed to a hospital for treatment of psychiatric illness and dismiss, with or without prejudice, any charges for which a nolle prosequi is not entered. Notwithstanding the record erasure statute, police and court records and records of any state's attorney pertaining to a charge which is nolled or dismissed without prejudice while the defendant is not competent shall not be erased until the statute of limitations for the prosecution of the defendant expires. A defendant who is not civilly committed shall be released.

(l) Credit for time in confinement on inpatient basis. Actual time spent in confinement on an inpatient basis pursuant to this section shall be credited against any sentence imposed on the defendant in the pending criminal case or in any other case arising out of the same conduct in the same manner as time is credited for time spent in a correctional facility awaiting trial.