FOURTH DIVISION
May 21, 2015

No. 1-13-0884

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IN THE
APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

THE PEOPLE OF THE STATE OF ILLINOIS,	)	Appeal from the
	)	Circuit Court of
Plaintiff-Appellee,	)	Cook County.
	)	
v.	)	No. 10 CR 11998
	)	
JOVAN COOPER,	)	Honorable
	)	James B. Linn,
Defendant-Appellant.	)	Judge Presiding.

JUSTICE COBBS delivered the judgment of the court.
Presiding Justice Fitzgerald Smith and Justice Ellis concurred in the judgment.

O R D E R

¶ 1 *Held*: Sentence of 40 years' imprisonment for first degree murder not excessive.

¶ 2 Following a jury trial, defendant Jovan Cooper was convicted of first degree murder and sentenced to 40 years' imprisonment. On appeal, defendant contends that his sentence is excessive.

¶ 3 Defendant and codefendants Devantae Bolden and Dairion Holmes were charged with first degree murder for, on or about February 4, 2010, allegedly fatally stabbing Andreaus Clark.

¶ 4 In December 2010, the court ordered a behavioral clinical examination (BCX) of defendant's fitness to stand trial at defense counsel's behest based on defendant's extensive psychiatric history and that he was taking medication (Seroquel and Trazodone).

¶ 5 In March 2011, psychologist Dr. Susan Messina of the court's Forensic Clinical Services (FCS) reported that she examined defendant in December 2010 and February 2011 and opined that he was fit to stand trial. Also in March 2011, psychiatrist Dr. Nishad Nadkarni of FCS reported that he examined defendant that month and found him fit to stand trial. Dr. Nadkarni found defendant had a "good" or "strong" understanding of the charges against him, the nature of court proceedings, and the roles of court personnel, and an "adequate capacity" to assist counsel in his defense and maintain an appropriate demeanor in court "if he so chooses." Dr. Nadkarni found "no evidence that the defendant suffers from bona fide major mental illness, or cognitive impairment that would preclude him from [assisting counsel and behaving in court]; any observation to the contrary should be interpreted as volitional on the part of the defendant." Dr. Nadkarni identified defendant's medication: antipsychotics Risperdal and Geodon, mood stabilizer Depakote, and sleep-aid Trazodone.

¶ 6 In May 2011, the court ordered, at defense counsel's behest, another BCX by the "same doctors" of defendant's fitness to stand trial with or without medication due to a subsequent change in medication. In August 2011, Dr. Nadkarni reported that he examined defendant that month and found him fit to stand trial. Except for different medication (antipsychotic Trilafon, mood stabilizer Depakote, and sleep-aid Benadryl) and opining that defendant's volitional symptoms were "the product of malingering and character pathology," the report was substantially identical to Dr. Nadkarni's March 2011 BCX report.

¶ 7 In September 2011, defense counsel told the court that he and defendant "were having difficulty communicating" and expressed skepticism of BCX reports finding defendant fit for trial without medication when he was receiving medication. The court noted that a person can be receiving mental health treatment and yet be fit to stand trial. Nevertheless, in October 2011 the court ordered another BCX.

¶ 8 In November 2011, psychiatrist Dr. Fidel Echeverria of FCS reported that, after examining defendant and reviewing his records, it was his opinion that defendant was legally sane at the time of the alleged offenses. He found "neither subjective reports nor objective documentation" of mental symptoms around the time of defendant's alleged offenses that would have compromised his ability to appreciate the criminality of his conduct.

¶ 9 The evidence at trial revealed that 31-year-old defendant and Clark argued in the street. Clark punched defendant and fled. Defendant pursued Clark after briefly entering a grocery store to clean a bloody gash on his face and possibly take a butcher's knife. Clark fled into a currency exchange. Defendant and codefendants pursued him inside, where codefendants "cornered" and struck Clark while defendant stabbed him. Defendant and codefendants fled. Clark died of multiple stab wounds. A currency exchange employee identified defendant as the assailant in a lineup but did not identify him at trial. A grocery store clerk identified defendant, a previous customer, as one of the men fighting in the street. He also identified the murder weapon – a knife found near the scene with Clark's blood on the blade – as resembling a butcher's knife from his store. Further, he identified defendant on currency exchange security video of the attack. A police detective identified defendant and codefendants on the security video and identified a

jacket worn by the assailant in the video as one in defendant's possession upon his arrest. The jury was instructed on first degree murder alone and found defendant guilty as charged.

¶ 10 In March 2012, at defense counsel's behest, the court ordered a BCX to determine defendant's fitness for sentencing. That month, Dr. Nadkarni reported that he had examined defendant and opined that he was fit for sentencing. Dr. Nadkarni reiterated his earlier findings that defendant has no "bona fide psychiatric or cognitive impairments" rendering him unfit and that any appearance that he does "should be interpreted as volitional on the part of the defendant, and secondary to documented malingering."

¶ 11 On April 2, 2012, defense counsel requested another BCX for fitness by a psychiatrist other than Dr. Nadkarni, and the court so ordered. In May 2012, Dr. Echeverria reported that he conducted the BCX but could not form an opinion as to defendant's fitness because defendant made a "decision not to engage fully in this clinical assessment." Dr. Echeverria opined that this "appeared to have a volitional component" but he could not rule out that it was "also influenced by some symptoms of an untreated or partially treated condition." The court instructed defendant in May 2012 to cooperate with the BCX requested by his counsel. In June 2012, Dr. Echeverria reported that he conducted a BCX and opined that defendant was fit for sentencing. He noted that defendant "is currently not prescribed psychotropic medication nor [is] there any current indication of the need for one to be administered."

¶ 12 In July 2012, defense counsel moved for a fitness hearing, arguing that the records of the jail hospital showed that defendant displayed symptoms of mental illness and was prescribed and administered psychotropic medication in 2012. The court held a fitness hearing in August 2012.

¶ 13 For the fitness hearing and sentencing, defendant submitted his own pre-sentencing report ("Defense PSI"), which included the records of defendant's education from kindergarten through high school and efforts toward receiving a GED degree. The report also included records from his psychiatric treatment in hospitals from 2006 to 2010 and summaries of the examinations underlying the BCXs in the instant case and two 2005 FCS examinations in a prior case.

¶ 14 Dr. Echevarria testified that he evaluated or examined defendant three times. In October 2011, he examined defendant for sanity at the time of the alleged offense as well as fitness to stand trial, and found him both sane and fit. Dr. Echevarria's evaluation included reviewing earlier FCS evaluations. A 2005 psychiatric examination by Dr. Flippen showed that defendant admitted to not being compliant with medication but Dr. Flippen found him fit based on his "goal-directed behavior" while discounting his self-reported auditory and visual hallucinations; she diagnosed him with substance abuse and substance induced psychosis but not mental illness. A 2011 psychological evaluation by Dr. Messina included administering a "M-FAST," a test for malingering; she found the results "highly suggestive of malingering mental illness." Dr. Echevarria himself examined defendant in May 2012 for fitness but could not form an opinion because defendant was uncooperative. When he re-examined defendant in June 2012, defendant was "cooperative, attentive, [and] engaged" and answered questions appropriately. He demonstrated an understanding of the sentence he faced as well as factors in aggravation and mitigation, therefore, Dr. Echevarria found him fit for sentencing, without reference to medication because the jail hospital reported that he was not prescribed any.

¶ 15 On cross-examination, Dr. Echevarria testified that his diagnoses from the June 2012 evaluation were cannabis dependence, cocaine abuse, rule-out substance induced psychosis, and

rule-out malingering. He explained that a "rule out" diagnosis means that the diagnosis in question could not be made with a reasonable degree of psychiatric or psychological certainty or that there was insufficient information to make that diagnosis. He testified that he did not diagnose defendant with malingering to a reasonable degree of certainty. Dr. Echevarria did not perform or order psychological testing for the June 2012 evaluation. He had defendant's medication record from the jail hospital and records from prior treatment outside jail, but not defendant's treatment records from the jail hospital. Dr. Echevarria believed that performing testing or ordering the entire record was unnecessary due to defendant's responsiveness and lack of symptoms in his interview.

¶ 16 The records reviewed indicated that defendant was hospitalized and diagnosed various times in 2006: in July with psychotic, substance abuse, and mood disorders, in October with schizophrenia accompanied by cocaine usage, in November with schizophrenia and paranoia, later that month with schizophrenia and paranoia accompanied by cannabis usage, later again that month with psychotic disorder and poly-substance abuse, later again that month with paranoid schizophrenia, poly-substance abuse, and attention deficit hyperactivity disorder, and later again that month with schizophrenia. He was also hospitalized and diagnosed in 2009: twice in February with schizophrenia, in June with schizoaffective disorder, in July with schizoaffective disorder, and in December with schizophrenia and suicidal ideation. He was also hospitalized and diagnosed in 2010: in January with schizoaffective disorder bipolar type, in February with schizophrenia, again in February with schizophrenia with auditory and visual hallucinations and poly-substance abuse, in March with schizophrenia, and in May with paranoid schizophrenia.

¶ 17 In his evaluation, Dr. Echevarria took the prior psychiatric diagnoses "with a grain of salt" because active substance abuse complicates making such a diagnosis. Although none of the hospitalization records showed a diagnosis of malingering, Dr. Echevarria explained that diagnosing malingering requires a motivation to malinger and that a treating psychiatrist assesses a patient differently than a forensic psychiatrist. He also explained that past treatment or the existence of a mental illness does not resolve whether a defendant is fit now, as mental illness is not synonymous with unfitness. However, an interview does answer whether the defendant is fit or unfit now.

¶ 18 On redirect examination, Dr. Echevarria testified that many of defendant's hospitalizations were for drug-induced psychosis or a positive substance finding. In the June 2012 interview, defendant showed no symptoms of mental illness and denied having any symptoms or indeed any mental illness. On recross examination, Dr. Echevarria admitted that many of his patients who were mentally ill denied having mental illness.

¶ 19 Dr. Nadkarni testified that he evaluated or examined defendant three times. His March 2011 evaluation found defendant fit to stand trial, based on an interview and review of records including prior hospitalizations and FCS evaluations, educational records, and police reports on the instant offense. When Dr. Nadkarni asked defendant why he had been in the jail hospital, he answered that it was for "seeing things and hearing voices." Dr. Nadkarni found this a "vague [and] atypical complaint of psychotic symptoms" because people with *bona fide* mental illness make much more specific reports of hallucinations and demonstrate by their actions that they experience such hallucinations. When Dr. Nadkarni pressed defendant for details of his hallucinations, he became irritated or "couldn't give me a convincing-enough answer," which is a

common response if a patient is malingering. Although defendant was receiving medication in March 2011, Dr. Nadkarni found him fit without reference to medication because his records and interview showed no side effects. His "diagnostic impressions" were of cannabis and cocaine abuse and malingering, with the latter conclusion supported by Dr. Messina's M-FAST test of February 2011 and by jail reports showing that defendant was unhappy with his jail housing division and seeking to be sent to the mental health division.

¶ 20 Dr. Nadkarni evaluated defendant again in August 2011, however, defendant was uncooperative in the brief interview, answering "I don't know" to questions he had properly answered in March, including why he was arrested, what he was charged with, the difference between a felony and misdemeanor, and the roles of his attorney and the judge. Though uncooperative, defendant was calm and appropriately groomed and behaved, with no apparent psychiatric or cognitive impairment and no new issues since March 2011. Thus, Dr. Nadkarni attributed defendant's August 2011 interview responses to malingering. The only new issue he could envision causing such dramatic results in earnest was "head trauma severe enough to put somebody in a coma and give them brain damage," but specifically not any psychiatric impairment. Dr. Nadkarni found defendant fit to stand trial because he did not exhibit any *bona fide* psychiatric or cognitive impairment to understanding the proceedings or cooperating with counsel.

¶ 21 Dr. Nadkarni evaluated defendant again in March 2012 for his fitness for sentencing. The medical, FCS evaluation, and educational records he reviewed for the evaluation indicated that defendant was not receiving psychotropic medication at that time. Defendant was cooperative and calm in the interview and professed to no longer needing medication but again made vague

complaints of "seeing strange stuff, feeling strange stuff, trying to hear voices." Dr. Nadkarni did not press for further details "because he had complained of these things similarly in the past" and showed no signs of *bona fide* mental illness. Defendant gave coherent and correct answers to what a felony is, what he was charged with, who his counsel was, various elements of and personnel involved in criminal proceedings, and the sentence he faced if convicted. Dr. Nadkarni diagnosed defendant with cocaine and marijuana abuse, a history of malingering, anti-social personality disorder, and asthma, and did not diagnose him with any major mental illness such as schizophrenia. He also explained that mental illness does not inherently render a defendant unfit as long as he understands the issues of the pending proceedings.

¶ 22 On cross-examination, Dr. Nadkarni testified that he noted the same prior hospitalizations and diagnoses as described by Dr. Echevarria, including that none diagnosed malingering, and similarly explained that diagnosis of mental illness is "not possible" with the complicating factor of drug and alcohol usage that is not "completely in remission." Dr. Nadkarni noted that clinical treatment relies on a patient's self-reporting, though hospital staff "should" be trained to recognize malingering. For defendant's history of malingering, Dr. Nadkarni pointed to two things: one, the observation by jail hospital personnel that he showed no objective symptoms of major mental illness but wanted to be moved to a different jail division, and two, his descriptions of "psychotic symptoms in a stereotype, stilted and atypical language that is not consistent with my knowledge of *bona fide* major mental illness." Dr. Nadkarni did not review Dr. Messina's M-FAST test of defendant, nor did he interview her. However, he did read Dr. Messina's report that the M-FAST test result was suggestive of malingering, even though she did not diagnose defendant with malingering.

¶ 23 At the time of his evaluation in late March 2012, defendant was not receiving medication. However, he had been receiving psychotropic medications until the middle of that month which was when he withdrew his consent. However, Dr. Nadkarni considered defendant "functioning just fine without those psychotropic medications" as consistent with his history of functioning "just fine" when he was unmedicated previously. Defendant was in the jail hospital psychiatric unit in late January and late February 2012, though Dr. Nadkarni's report did not so reflect. The hospital staff did not diagnose defendant with malingering on either occasion. Dr. Nadkarni explained that any subsequent hospitalizations would not change his diagnosis of malingering due to "self-reported symptomology *** not supported by objective evidence." Dr. Nadkarni reiterated that he did not ask follow-up questions in March 2012 when defendant made vague reports of hallucinations because "if somebody is actually having psychotic symptoms, they are not very cooperative, they look ill, they look as if they are responding to internal stimulation, they can't focus and cooperate very well with questioning," while defendant "showed no evidence of that whatsoever." Dr. Nadkarni disagreed with the jail hospital's 2012 diagnosis of schizophrenia and reiterated his conclusion that defendant does not need treatment for any mental illness.

¶ 24 On redirect examination, Dr. Nadkarni reiterated that he found no objective evidence of mental illness from defendant's prior hospitalizations despite the various diagnoses of mental illnesses because of defendant's drug and alcohol use complicating the diagnosis and because he showed behavioral rather than psychotic symptoms and made "stilted and stereotyped complaints of psychotic symptoms." He also reiterated that a forensic psychiatrist approaches a defendant with "very strong suspicion of malingering" while a treating psychiatrist is "assuming that the

patient is asking for help." He explained that he relied on Dr. Messina's report because he trusted her as a colleague of several years. He opined that diagnosing defendant with malingering or a history of malingering was not a "close call" and maintained his opinion that there was no evidence of *bona fide* mental illness. When defendant was examined in the jail hospital in June 2012, on reports of apparent internal stimulation, he denied any symptoms of psychiatric illness but admitted, with apparent reluctance, to auditory hallucinations and expressed a desire to be readmitted to the psychiatric unit. However, when Dr. Michael Moreno of the jail hospital reported his June 2012 observations of defendant, he did not mention defendant showing signs of auditory hallucinations. Dr. Nadkarni explained that behavioral issues documented in defendant's records were consistent with him having anti-social personality disorder but not having a mental illness.

¶ 25 Dr. Andrea Ward, a psychiatrist at the jail hospital, testified for the defense that she interviewed defendant there four times in the psychiatric unit. In late January 2012, defendant was referred to the psychiatric unit for reasons not recalled by Dr. Ward. He was taking anti-psychotic perphenazine, mood-stabilizer Depakote, and Benadryl for side-effects of the other medication, and Dr. Ward did not change those prescriptions. She again saw defendant in mid-February 2012. At that time, he made "no complaints" and stated that he no longer had schizophrenia and had not taken medication in the prior three weeks. Dr. Ward explained, however, that schizophrenia is a long-term illness that doesn't suddenly end "like a cold." When Dr. Ward saw defendant again two days later, he denied having active symptoms and said he did not want to take medication. Because his behavior was appropriate, and he was not presenting a danger to himself or others, she found "no indication for forced medication" and transferred him

out of the psychiatric unit. In April 2012, when defendant was sent to the psychiatric unit for "inappropriate/bizarre behavior," he "reluctantly acknowledged" auditory hallucinations to Dr. Ward but did not want to discuss the content of the hallucinations. His hygiene was "fair" and he followed basic directions but was "apathetic" and unemotional, which Dr. Ward considered consistent with schizophrenia and indicative of impairment "given his reasons for readmission to the unit and collateral information from the chart." Her notes did not reflect any concern that he was malingering or under the influence of cocaine.

¶ 26 On cross-examination, Dr. Ward explained that her interviews of defendant took no more than 10 minutes each and she never made a diagnostic evaluation of him. Her notes of the four interviews did not reflect any observed responses to internal stimuli or other psychotic symptoms, except for his apathetic mood in the April interview. On redirect examination, she explained that she reviewed defendant's records as well as interviewed him; the lack of observed responses to internal stimuli did not "make [her] believe he did not have schizophrenia;" and patients who are mentally ill often deny that they are ill.

¶ 27 Dr. Michael Moreno, also a psychiatrist at the jail hospital, testified that he interviewed defendant in December 2011, when defendant's diagnosis was schizophrenia and he was prescribed anti-psychotic Prolixin as well as Depakote and Benadryl. After the interview, Dr. Moreno did not change the prescriptions or diagnosis even though defendant did not show any symptoms of schizophrenia in the interview. Dr. Moreno noted that a person with schizophrenia can be asymptomatic with medication. In April 2012, defendant had withdrawn consent to treatment because of side-effects from the anti-psychotic drug Risperdal, the only medication he was prescribed at the time, and was referred to the psychiatric unit because he "had been

exposing himself." Defendant told Dr. Moreno that the Risperdal was "causing him to hear voices." He denied knowing whether he exposed himself, "appear[ed] internally stimulated at times," reported anxiety, albeit with good sleep and appetite, and he hesitated and was unemotional in answering questions. Dr. Moreno explained that auditory hallucinations are not a side-effect of Risperdal but may persist despite taking Risperdal. He found defendant's flat emotions not inconsistent with schizophrenia, and he saw nothing that caused him to suspect malingering. Based on the interview, Dr. Moreno had defendant kept in the psychiatric unit. Dr. Moreno interviewed defendant again the next day. Defendant reported auditory hallucinations but denied they bothered him as they were relatively benign, and he refused his medication of anti-psychotic Zyprexa. His answers to questions remained unemotional and hesitant, and he again appeared internally stimulated "at times." Again, Dr. Moreno saw nothing to change the diagnosis of schizophrenia and therefore he kept defendant in the psychiatric unit and continued his prescriptions.

¶ 28 In June 2012, Dr. Moreno interviewed defendant after he was sent to the psychiatric unit and was reportedly non-compliant with taking medication. Defendant "hesitantly" reported auditory hallucinations and that he was not receiving his medication. He answered questions unemotionally and with hesitation consistent with internal stimulation, and appeared internally stimulated "at times." Dr. Moreno began to consider that defendant was malingering so that he could be housed in the psychiatric unit, but reached no conclusion at that point. When Dr. Moreno interviewed defendant the next day, he was still unemotional but told Dr. Moreno that he wanted to stay in the jail hospital. Dr. Moreno considered defendant's "insight and judgment to not take medication was poor, given that he had been saying over and over again that he was

having symptoms" and he saw nothing that led him to believe that defendant did not have schizophrenia. However, because defendant was "doing fairly well in our unit" despite not taking medication, and was not "suffering to the extent that forced medications were required," Dr. Moreno "felt comfortable" dismissing him from the psychiatric unit with no prescriptions. On discharge, Dr. Moreno assessed defendant's functioning at 51 to 55, or "moderate difficulty" functioning, where a fully-functioning person would score 75.

¶ 29 On cross-examination, Dr. Moreno testified that he never made a diagnostic evaluation of defendant and that he found at the June 2012 discharge that defendant had sufficient "decisional capacity to decline" medication. On redirect examination, he testified that his notes did not specify what he told defendant when he discussed the risks of taking and not taking medication nor did the notes reflect defendant's response to the risk discussion.

¶ 30 Dr. David Kelner, another psychiatrist at the jail hospital, testified that he interviewed defendant in March 2012 after reviewing his records. Although defendant was not in apparent distress, Dr. Kelner saw "oddity of his behavior and affect," examples of which are smiling or laughing at upsetting circumstances or being upset when discussing pleasant matters. However, Dr. Kelner explained, oddity of affect does not by itself indicate mental illness. He was not "100 percent sure" that defendant had schizophrenia, but did nothing to make the diagnosis certain because such certainty was unnecessary to treat defendant as he had already discontinued his medication by withdrawing consent. Dr. Kelner did not make a recommendation as to whether defendant should be housed in the general jail population or a mental health unit.

¶ 31 Dr. Kelner also interviewed defendant in June 2012. Defendant was unkempt and agitated, laughed and smiled inappropriately, apparently responded to auditory hallucinations or

internal stimuli, expressed paranoid and delusional thoughts, delayed in answering questions, and had difficulty relating his thoughts consistently. Dr. Kelner described these symptoms as consistent with "schizophrenia-like illness." Defendant's insight to his condition was poor, and he refused to cooperate when Dr. Kelner tried to administer a cognitive examination. Dr. Kelner therefore had him admitted to the jail hospital.

¶ 32 Defendant offered into evidence, and the court admitted, the Defense PSI including the reports of non-testifying treating psychiatrist Dr. Bharathi Marri. According to Dr. Marri's reports, she interviewed defendant in April and May 2012. She diagnosed defendant with psychotic disorder and schizophrenia, and he told her more than once that he did not want to take medication or be in the jail hospital. The evidence also included a video recording of defendant in a police interview room in June 2010 in which he apparently responds to "external stimuli" (by crying and gesturing) and engages in unusual behavior such as urinating into a cup, staring at food rather than eating it, throwing food on the floor and stepping on it, spanking himself, and running into a wall.

¶ 33 After reviewing the evidence and hearing argument, the court found defendant fit to be sentenced. The court observed defendant "for several years" during this case in addition to reviewing all the evidence. The court noted that a person can be mentally ill and yet be fit for trial or sentencing and that a forensic psychiatrist approaches a person differently than a treating psychiatrist does. The court also noted that "there is some dispute as to whether [defendant] is suffering from some illness or not" and that the instant offense was unusual in that it was hard to ascertain a motive for killing Clark. However, the court found Drs. Echevarria and Nadkarni to be unbiased and credible witnesses that defendant was fit for sentencing.

¶ 34 The pre-sentencing investigation report (PSI) stated that defendant was born in January 1979. He had a juvenile disposition of probation in 1996 for delivery of a controlled substance. He also had criminal convictions from 1996 through 2010 for various theft and criminal trespass offenses, a controlled-substance offense and a cannabis offense, criminal damage to property, escape, assault, battery, aggravated battery, unlawful use of a weapon, and possession of a stolen motor vehicle. His parents' relationship was marred by domestic violence and drug abuse. They separated when he was 11-12 years old, and he then lived with his mother until the instant arrest. His father was physically abusive and thus defendant ran away from home several times. The State brought allegations of abuse and neglect of defendant in 1991 and the circuit court found "abuse/neglect" in 1994. He completed elementary school and attended high school through the 10th grade, was in special education for behavioral and learning disorders, and admitted to multiple suspensions and that he was in no extracurricular activities. He was unemployed at the time of his arrest, received disability income, and previously worked intermittently for no longer than a year. He claimed good physical health and that he was taking no medication when the PSI was prepared. He had prior psychiatric care based on a diagnosis of schizophrenia (as defendant recalled), and was taking psychotropic medication at the time of his arrest. He claimed to have attempted suicide but could not recall when. He admitted to drinking alcohol about once a week, smoking marijuana daily until about three years earlier, and using cocaine daily until about five years earlier, and recalled receiving outpatient substance abuse treatment at some unspecified time. Defendant admitted being a member of the Gangster Disciples gang from about 13 years old until about 32 years old.

¶ 35 At sentencing, the State presented a victim impact statement of Clark's grandmother. According to statement, she raised Clark herself. He was attending college and trying to avoid the violence of "the streets." She had lost another grandson to violence and was experiencing deep and ongoing anxiety from Clark's absence. Thus, she asked the court for "the maximum sentence for this crime." The State argued that defendant's aggravated battery conviction from 2004 was similar to the instant offense, to wit, defendant was begging in a restaurant when an employee tried to get him to leave, but instead he picked up a butcher's knife from the counter and stabbed the employee in the shoulder before the other employees subdued him and he fled. The State argued that defendant presents a danger to the community and should receive a sentence close to the 60-year maximum.

¶ 36 Defense counsel asked the court to consider the fitness hearing evidence and the Defense PSI. The court replied that it was considering it with all prior evidence in its sentencing decision and found that defendant "does have some mental health issues" though not unfit. Counsel argued that defendant acted under a strong provocation – Clark's punch – that was insufficient to justify defendant's response but mitigated it. Counsel also argued that defendant's present and prior violence should be considered in the context of his childhood abuse, as documented by child abuse allegations in 1989 (when he was about 10 years old) and a finding of abuse and neglect in 1992, and domestic violence by defendant's father as referenced in the PSI. Counsel argued that defendant "suffers from intellectual disability" documented by his educational records in the Defense PSI, and noted that a 2010 BCX referenced a head injury when defendant was 17 years old. Counsel concluded that defendant's mental illness and intellectual disability are mitigating factors independent of being found sane and fit, and sought the minimum 20 year

sentence, asserting that it would keep defendant imprisoned until he is 50 years old while a near-maximum sentence effectively constitutes life imprisonment. Defendant declined to address the court personally.

¶ 37 The court stated that it considered "everything that's been presented" including matters "that may have impacted his fitness." The court noted that "it's hard to understand exactly what the provocation was that caused" Clark's death by stabbing. While defendant's history includes diagnoses of and hospitalization for mental illness, it also includes a non-fatal stabbing similar to the instant offense. The court stated that it considered "everything in mitigation that's been presented" and found "substantial significant factors in mitigation" but also noted its "obligation to the public" and found defendant to be "not stable, *** not well, *** prone to commit acts of violence" rendering him "something of a danger to the public." The court sentenced defendant to 40 years' imprisonment and ordered that the mittimus include an attachment notifying the Department of Corrections of defendant's mental health issues so the Department "may treat him as though he was found guilty but mentally ill."

¶ 38 Defendant filed and then amended a motion to reduce his sentence, arguing that the court erred by not changing the verdict to guilty but mentally ill and by finding him fit for sentencing. He also argued that the court disregarded the mitigating factors of his mental illness, intellectual disability, and abusive childhood and that he acted under strong provocation. The court considered modifying the judgment to guilty but mentally ill but decided not to on concerns that the jury was not instructed thereon and issued a verdict of guilty. The court denied the motion to reconsider the sentence, and this appeal timely followed.

¶ 39 On appeal, defendant contends that his 40-year prison sentence is excessive because it does not reflect the mitigating evidence and denies him a realistic opportunity for rehabilitation.

¶ 40 First degree murder is a felony punishable by 20 to 60 years' imprisonment in the absence of any extending factors. 730 ILCS 5/5-4.5-20(a) (West 2012). A sentence within statutory limits is reviewed on an abuse of discretion standard, so that we may alter a sentence only when it varies greatly from the spirit and purpose of the law or is manifestly disproportionate to the nature of the offense. *People v. Snyder*, 2011 IL 111382, ¶ 36. As long as the trial court does not consider incompetent evidence or improper aggravating factors, or ignore pertinent mitigating factors, it has wide latitude in sentencing a defendant to any term within the applicable range. *People v. Jones*, 2014 IL App (1st) 120927, ¶ 56. This broad discretion means that we cannot substitute our judgment simply because we may weigh the sentencing factors differently. *Id.*, citing *People v. Alexander*, 239 Ill. 2d 205, 212-13 (2010).

¶ 41 In imposing a sentence, the trial court must balance the relevant factors, including the nature of the offense, the protection of the public, and the defendant's rehabilitative potential. *Id.*, citing *Alexander*, 239 Ill. 2d at 213. "All penalties shall be determined *both* according to the seriousness of the offense and with the *objective* of restoring the offender to useful citizenship." (Emphasis added.) Ill. Const. 1970, art. I, § 11.[1] The trial court has a superior opportunity to evaluate and weigh a defendant's credibility, demeanor, character, mental capacity, social environment, and habits. *Snyder*, 2011 IL 111382, ¶ 36. The court need not expressly outline its reasoning for sentencing, and we presume that the court considered all mitigating factors on the

[1] Compare defendant's assertion that the "Illinois Constitution makes it essential that defendants are punished in a manner that *will* restore them to useful citizenship." (Emphasis added.)

record absent some affirmative indication to the contrary other than the sentence itself. *Jones*, 2014 IL App (1st) 120927, ¶ 55. Because the most important sentencing factor is the seriousness of the offense, the court is not required to give greater weight to mitigating factors than to the severity of the offense, nor does the presence of mitigating factors either require a minimum sentence or preclude a maximum sentence. *Id.*, citing *Alexander*, 239 Ill. 2d at 214. The court is not required to find significant mitigation in a defendant's troubled childhood, history of mental health or substance abuse issues, or counseling efforts and good behavior in jail. *People v. Holman*, 2014 IL App (3d) 120905, ¶ 75, citing *People v. Ballard,* 206 Ill. 2d 151, 189-90 (2002)(evidence of mental illness may demonstrate dangerousness, and death sentence not precluded by evidence of mental illness, prior abuse, or a troubled childhood).

¶ 42 Here, defendant was convicted of first degree murder for personally stabbing Clark to death. The assistance of codefendants in this offense strongly suggests that the commission of this offense did not result solely from defendant's mental illness. Defendant's long history of criminal convictions includes a similar stabbing, albeit not fatal. Defendant presented for sentencing considerable evidence regarding his mental health, educational record, and childhood abuse. The court expressly found in imposing sentence that defendant was mentally ill and that this constituted mitigation. However, the court also correctly noted that it must balance mitigation with the protection of the public. The trial court does not abuse its discretion by giving the evidence or a sentencing factor a different weight than defendant would prefer, and the record does not support the contention that the court did not adequately credit the mitigating evidence. Under the circumstances, we cannot find that defendant's 40-year sentence is an abuse of the court's sound discretion.

¶ 43 Accordingly, the judgment of the circuit court is affirmed.

¶ 44 Affirmed.