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SUPREME COURT

STATE OF WISCONSIN

IN SUPREME COURT

Case No. 2023AP722-CR

STATE OF WISCONSIN,

Plaintiff-Respondent-Petitioner,

v.

N.K.B.,

Defendant-Appellant-Respondent.

PETITION FOR REVIEW RESPONSE

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INTRODUCTION

The State's petition for review concerns the standard under which circuit courts may override, by court order, the right to refuse medication and treatment asserted by pre-trial defendants declared incompetent to stand trial under Wis. Stats. §§ 971.14. However, this standard—repeated in §§ 971.14 and 51.61—already exists, and conforms to this Court's precedent, balances judicial and legislative power, effectuates institutional order, safety, and security, and aligns with similar laws in other jurisdictions.

It is one of two narrow exceptions the legislature designed for the right to refuse treatment. One "unambiguously provides" circuit court authority. That is, "court authorization based upon an evidentiary hearing finding … that the individual is incompetent to refuse medication." And the second recognizes the universal "emergency exception." Medical providers make professional determinations—without court approval—in moments that necessitate immediate, yet temporary, override authority when the smallest of delays are intolerable.

While §§ 971.14 and 51.61 provide statutory authority, the standards may be insufficient for circuit court orders. Indeed, § 971.14 commitments require circuit courts to also satisfy the *Sell* factors. While treatment provider authority remains without court involvement in moments of emergency.

Furthermore, assuming arguendo that the legislature intended to provide authority for circuit courts to order forced treatment under the "necessary

to prevent" exception, the legislature—exercising its policy making power—elected to exclude that authority in § 971.14 commitments after circuit courts issue the commitment order. Again, treatment provider authority remains to react in moments of danger.

The State's petition for review, however, emerges from at least two errors. For one, the State conflates the distinct standards, improperly mixing judicial and extrajudicial authority, and thereby manufactures perturbing scenarios as absurd and unreasonable outcomes.

For the other, the State overgeneralizes off-hand dicta statements. The State clings to the following:

> A court need not consider whether to allow forced medication for [competency to stand trial], if forced medication is warranted for a *different* purpose, … related to the individual's dangerousness, …. There are often strong reasons for a court to determine whether forced administration of drugs can be justified on these alternative grounds *before* turning to the trial competence question.

Sell v. U.S., 539 U.S. 166, 181-82 (2003). But this does not mean all state courts may order involuntary medication based on dangerousness alone. *Sell* recognizes that states typically employ civil proceedings. *Id.* at 182. And long-ago precedent held that federal courts defer to state law for substantive and procedural rights of individuals to refuse treatment. *See Mills v. Rogers,* 457 U.S. 291, 300 (1982). Wisconsin's law distinguishes judicial and extrajudicial authority, and requires specific procedural rights when the court acts.

ARGUMENT

This Court should deny the State's petition for review.

A. The State's petition bodes against valid criteria for review.

First, a critical defect prevents this Court from ruling on the merits of the question in the State's petition. *See* Wis. Stat. § 809.62(3)(b). Specifically, the State raises the question of whether Wis. Stat. § 51.61(1)(g) authorizes circuit courts to override an individual's right to refuse treatment in pretrial commitments under § 971.14.

The critical defect, however, is that neither party raised or relied upon § 51.61(1)(g) as authority for the court to enter its order, nor did the trial court itself rely upon or make the required findings under the language of § 51.61(1)(g). Instead, the trial court merely made an undefined finding of "dangerousness." (39:6, 9). Thus, the record presents a defective vehicle for this Court to travel the roads paved by Wis. Stat. § 51.61(1)(g) for court authority; that is, the merits of the question is not ripe for review.

Second, the State's petition emerges from misstatements of law that once corrected eliminate the propriety of the question that would be before the Court if it grants the petition. *See* Wis. Stat. § 809.62(3)(c). The State mistakes the law by incorrectly asserting the "novelty of the issue presented," and by embroidering the prior holdings of this Court. PFR, 5, 8. Thereby, it obfuscates the well-engrained distinction between judicial and extrajudicial authority to override the right to refuse treatment.

For its novelty assertion, the State distorts longstanding appreciation of the qualified right to refuse treatment. Indeed, thirty-seven years ago this Court recognized that the statutes distinguish between emergency and nonemergency situations. *See State ex rel. Jones v. Gerhardstein,* 141 Wis. 2d 710, 416 N.W.2d 883 (1987). Relevant to this case, the Court recognized that under the legislature's design an "emergency situation" occurs "when the committed individual poses an immediate threat of physical harm to themselves or others." *Id.* at 728. The Court held that the override decision under those circumstances is "professionally determined" within the hospital setting to meet the immediate need and contain the emergency. *Id.* at 737-739.

Removed from immediate emergency, the Court held that the judicial "finding of dangerousness [under § 51.20] is not sufficient" to override the right. *Id.* at 737. Instead, nonemergency situations justify overriding the right to refuse "only pursuant to court authorization based on an evidentiary finding at a hearing that there is probable cause to believe that the individual is incompetent to refuse medication." *Id.* at 735.

For its reliance on precedent, the State embroiders the holdings of this Court. The State incorrectly asserts that "[t]his Court previously held that … [the statutes] authorized a … court to order involuntary medication to address a committee's dangerousness at an institution." PFR, 5. The cases cited by the State do not support its assertion.

For one, *Anthony D.B.* made no such holding. The Court reviewed the circuit court's involuntary

medication order in which the "circuit court found Anthony D.B. … not competent to refuse medication[.]" *State v. Anthony D.B.,* 2000 WI 94, ¶1, 237 Wis. 2d 1, 614 N.W.2d 435. And the Court analyzed the statutory language under the sole source of judicial authority: "Section 51.61 provides patients with the right to make informed decisions regarding medication, except in those circumstances where, following a constitutionally sufficient procedure, the patient is determined to be not competent to refuse medication." *Id.,* ¶15.

For another, the State's citations to *Wood* and *Vitek* fair no better. *See* PFR, 6-7, 16. The State cites these cases for the proposition that the public has an interest in "maintaining safety, security, and functionality with" its mental health institutions." (PFR, 6-7, 16, 19). Nobody doubts these interests exists. But none of those interests establish that the legislature authorized circuit courts to issue involuntary medication orders based upon dangerousness.

All said, the State's petition for review presents a question the record renders not ripe for review, and an answer already exists—the current standard covers every circumstance, and it is clear, well-accepted, and workable.

B. The State misunderstands the individual's right to refuse medication.

Adult mental health consumers in Wisconsin, like most states, possess the right to refuse treatment. *See Winnebago County v. C.S.,* 2020 WI 33, ¶18, 391 Wis. 2d 35, 940 N.W.2d 875; and Wis. Stat. §§ 971.14(2)(f) & 51.61(g); *see also* Catherine E.

Blackburn, The "Therapeutic Orgy"' and the "Right to Rot"' Collide: The Right to Refuse Antipsychotic Drugs Under State Law, 27 Hous. L. Rev. 447 (1990).

An individual's right to refuse treatment, however, "is not absolute." *C.S.,* 2020 WI 33, ¶18. And this Court has recognized "the necessity for statutory authority" before circuit courts "issue an order for involuntary medication." *Anthony D.B.,* 2000 WI 1, ¶24. The legislature elected to enact "two narrow exceptions," establishing Wisconsin's qualified right to refuse treatment, coequally expressed in Wis. Stats. §§ 971.14 and 51.61. *See Id.,* ¶95 (J. Hagedorn, dissenting).

Thus, the issue presented in the State's petition for review fails equally under both statutory sections because the State wishes to legislate the narrow "emergency exception" applicable to treatment providers without court involvement into court authority.

1. The right to refuse treatment arises from common law, constitutional rights, and statutory provisions.

The right to refuse medication and treatment originated in common law, which "over the centuries has always protected individuals from unwanted contacts with their person"; including unwanted personal contact, personal autonomy, and bodily integrity. *See People v. Medina,* 705 P.2d 961, 968 (1985); *Outagamie County v. Melanie L.,* 2013 WI 67, ¶42, 349 Wis. 2d 148, 833 N.W.2d 607 (citations omitted). As common law actions of battery and false imprisonment developed over time laws of informed consent arose. *Johnson by Adler v. Kokemoor,* 199 Wis.

2d 615, 628–29, 545 N.W.2d 495, 500 (1996); *see also Medina,* 705 at 968 (citing *Mills v. Rogers,* 457 U.S. 291, 295 n. 4 (1982) and Prosser WL & Keeton WP, The Law of Torts (5th ed. 1984) § 18 Consent: Emergency Privilege pp. 101). From informed consent, the current right to refuse medication and treatment came to fruition. *See, e.g., Jones,* 141 Wis. 2d at 732.

Constitutional rights bolster the right to refuse treatment. The Supreme Court accepted "the premise that the United States Constitution protects the mentally ill from the unwanted administration of antipsychotic drugs." *U.S. v. Watson,* 893 F.2d 970, 977 (citing *Mills v. Rogers,* 457 U.S. 291, 299 (1982)). Even after committed "patients do retain liberty interests protected by the Constitution … [and] these interests are implicated by the involuntary administration of antipsychotics." *Rogers,* 457 U.S. n. 16. This Court, too, recognized the individual's right to refuse unwanted medical treatment emanates … from the guarantee of liberty in Article 1, Section 1 of the Wisconsin Constitution." *Outagamie County v. Melanie L.,* 2013 WI 67, ¶42, 349 Wis. 2d 148, 833 N.W.2d 607 (citations omitted).

At its core, the right to refuse treatment tethers to the "significant liberty interest in refusing involuntary medication." *State v. Fitzgerald,* 2019 WI 69, ¶13, 387 Wis. 2d 384, 929 N.W.2d 165 (citing *Washington v. Harper,* 494 U.S. 210, 221 (1990); *see also Watson,* 893 F.d at 977 (a long line of caselaw assigns s substantive right to refuse psychotropic medications.). Courts drew parallels from "the substantive right to be free from unwanted bodily restraint [to find] the right to refuse psychotropic medications." *Watson,* 893 F.2d at 977.

But, while constitutional rights may envelope an individual's right to refuse treatment, such a focus is unnecessary to respond to the State's petition in this case. That is because the contours of the right to refuse treatment receives adequate contemplation within Wisconsin's statutory provisions.

Our astute legislature, aware of the practical aspects and competing interests at stake, elected to employ statutory provisions that uniformly encapsulate the contours of the right to refuse medication. In doing so, the legislature balanced competing interests—honoring the individual's right to refuse treatment, respecting the duties and expertise of medical professionals tasked with protecting those from and that are patients under their care (while they navigate legal and ethical consequences), and also furthering the public's interest in institutional order, safety, and security.

The legislature struck this balance by enacting "two narrow exceptions." *C.S.,* 2020 WI 33, ¶95 (J. Hagedorn, dissenting). Each, in substance, uniformly distinguish override authority as judicial or extrajudicial reactions.

The narrow exceptions are: (1) "unless … the court … makes a determination, following a hearing, that the individual is not competent to refuse medication or treatment [(2)] or unless a situation exists in which the medication or treatment is necessary to prevent serious physical harm to the individual or others." *c.f.* Wis. Stat. § 971.14(2)(f) & (4)(b) and 51.61(1)(g)1., 2. & 3.

a. Circuit courts make override determinations under the "incompetent to refuse" statutory exception to ensure continued treatment.

Circuit courts play an essential role in protecting individuals who are unable to care for themselves due to age, illness, or other infirmity. *See Jones,* 135 Wis. 2d at 177; *see also C.S.,* 2020 WI 33, ¶100. But circuit courts are not as qualified to decide medical treatment matters as are physicians or other medical decisionmakers. *See Youngberg v. Romeo,* 457 U.S. 307, 323 (1982). And also, circuit courts are not involved in day-to-day treatment and control of mental health consumers. Thus, circuit courts must hold hearings and afford individuals procedural safeguards prior to issuing involuntary medication orders.

Indeed, under both sections 971.14 and 51.61, circuit courts must conduct an evidentiary hearing that affords the individual whom the court asserts authority over the full panoply of procedural safeguards to conform the hearing to the essentials of due process and fair treatment. *See* Wis. Stat. §§ 971.14(2)(c) & (g), (4)(a), (b), & (c), and 51.20(5).

Circuit courts need the specialized knowledge from treatment professionals, and weigh the institution's allegations to properly exercise their discretion. However, doing so takes time. Time is needed by experts to assess the individual, the individual and their counsel need time to investigate, and hearings may be postponed for good cause. *See* Wis. Stat. §§ 971.14(2)(c) & (g), (4)(a), (b), & (c), and 51.20(5).

Together, the circuit court's need for information and the time delays needed to conduct hearings explains why circuit court authority attends to non-emergency circumstances. In non-emergencies, circuit courts are well-adept at protecting individuals who are incapable of making healthcare decisions. And the court order provides periods of continued treatment independent of an emergency.

The duration of involuntary medication orders further explains circuit court non-emergency authority. Situations "in which the medication or treatment is necessary to prevent serious physical harm to the individual or others," unquestionably justifies immediate response." *See Jones,* 135 Wis. 2d at 739. But that justification dissipates quickly, too. Thus, the "necessity" "justifies forced treatment only so long as the danger exists; it does not justify continued treatment over the person's refusal." *See* Catherine E. Blackburn; The "Therapeutic Orgy"' and the "Right to Rot"' Collide: The Right to Refuse Antipsychotic Drugs Under State Law, 27 Hous. L. Rev. 447, p.36 (1990) (some states statutorily define or limit the period of authority under the emergency exception).

Today, to order involuntary medication of individuals committed under § 971.14, circuit courts must satisfy the statutory "not competent to refuse" requirement, and more. *See, e.g., State v. J.D.B.,* No. 2024AP715-CR, slip. op., ¶64 n.14 (WI App. Sept. 10, 2024) (recommended for publication). For § 971.14 committees, circuit courts must also satisfy the *Sell* factors. *See Fitzgerald,* 2019 WI 69, ¶35.

b. Professionals make override determinations under the "necessary to prevent" statutory exception to effectuate institutional order, safety, and security.

Medical professionals, such as psychiatrists, engage in an important role as public agents to effectuate the public's interest in maintaining institutional order, safety, and security. *See* S. Becker and H. Forman; Implied Consent in Treating Psychiatric Emergencies, 11 Front. in Psych. 127, p. 1 (2020). The public indeed has a legitimate interest in "maintaining institutional safety, security, and functionality." *See State v. Wood,* 2010 WI 17, ¶32, 323 Wis. 2d 321, 780 N.W.2d 63; *see also* Catherine E. Blackburn; The "Therapeutic Orgy"' and the "Right to Rot"' Collide: The Right to Refuse Antipsychotic Drugs Under State Law, 27 Hous. L. Rev. 447, p.4 (1990).

But these public interests are not furthered when circuit court authority is required to override the individual's refusal in moments of immediate necessity; or for "dangerousness" as the State puts it. The legislature exercised its policy making powers to withhold this authority from circuit courts. And as this Response explains, it had good reason for doing so.

All said, Wisconsin's statutory scheme provides appropriate responses tailored to every circumstance—from moments of imminent risks to periods necessary for treatment. The petition for review misses, however, how the legislature ensured complete coverage with its two narrow exceptions. The legislature astutely recognized the need for the

judicial and extrajudicial distinction. And it enacted these exceptions by balancing competing interests to ensure individual rights are honored without sacrificing safety and good psychiatric care.

c. Even if the "necessary to prevent" exception may form the basis of orders, § 971.14 unambiguously excludes it, similar to *K.N.K,* after the commitment order.

While the judicial and extrajudicial distinction appears uniformly throughout the statutory scheme, that means neither that the right to refuse only exists when the legislature references it, nor that the legislature cannot constrain circuit court authority to certain procedural phases.

That is, even if the legislature intended circuit courts to possess the authority to order involuntary medication under the "necessary to prevent" exception, the legislature unambiguously excluded the authority from circuit courts after the court issues the commitment order. Treatment providers, of course, retain the override authority for moments professionally determined to necessitate medication.

This point arose in a guardianship case. *K.N.K. v. Buhler,* 139 Wis. 2d 190, 407 N.W.2d 281 (Ct. App. 1987). The guardian for K.N.K. petitioned the circuit court for protective placement. The circuit court granted the petition, and also ordered involuntary administration of K.N.K.'s medication. *Id.* at 196-97.

K.N.K. appealed, tasking the court of appeals with interpreting the then existing section 51.61 (1985-86). *Id.* Section 51.61(1)(g) then only authorized circuit courts to order involuntary medication "at or after the hearing to determine probable cause for commitment but *prior to* the final commitment order." *Id.* at 205. Thus, the court of appeals concluded that the legislature's intent is "clear and unambiguous," and held "no authority exists for a circuit court to order medication" after the final order. *Id.* at 206.

Within five months of the decision, the legislature "breathed statutory life into the principles" K.N.K. addressed by adding post-order authority for courts under § 51.61. *See Virgil D.,* at 11; *see also Carol J.R. v. Milwaukee County,* 196 Wis. 2d 882, 888-89, 540 N.W.2d 233 (Ct. App. 1995).

Shortly thereafter, the legislature created the "separate involuntary medication provisions … for those committed under ch. 971." *Anthony D.B.,* 2000 WI 94, ¶18. Importantly, the legislature drafted § 971.14 with a provision of similar effect to the pre-*K.N.K.* § 51.61 provisions. Specifically, the legislature chose to exclude reference to the "necessary to prevent" exception in the provision providing post-commitment court authority to issue involuntary medication orders. Wis. Stat. § 971.14(2)(f).

The legislature is presumed to act with full knowledge of the existing law. *See Kindy v. Hayes,* 44 Wis. 2d 301, 314, 171 N.W.2d 324 (1969); and *Reiter v. Dyken*, 95 Wis. 2d 461, 290 N.W.2d 510 (1980). And for § 971.14, the legislature had this issue fresh on its mind.

Therefore—after issuing the § 971.14 commitment order—the legislature unambiguously chose to limit circuit court authority to the "incompetent to refuse" standard. Again, treatment providers retain override authority to react in moments of necessity and danger.

2. Support for distinguishing judicial from extrajudicial authority comes from the statutory scheme, administrative code, and caselaw.

a. Statutory support.

The statutory scheme contextually evidences the judicial and extrajudicial distinction. First, the legislature's use of "or unless" to denote both exceptions is telling. Grammatically, the conjoined conjunction "or unless" denotes two exceptions, each independent and sufficient to invalidate the asserted right. *See* Declerck, R. and Reed, S., May 2, 2000, The semantics and pragmatics of unless. English Language & Linguistics, 4(2), pp. 211. Thus, "has been ordered by the court" connects solely to the "incompetent to refuse" exception.

For another, provisions outlining the elements and duties necessary for circuit court determinations universally express only the "incompetent to refuse" exception. Indeed, the provisions similarly state that "the court shall [determine whether or] make a determination … that the defendant [or individual] is not competent to refuse medication or treatment[.]" *c.f.* Wis. Stat. §§ 971.14(4)(b) and 51.61(1)(g)2. & 3. Thus, again, circuit courts possess authority only under the "incompetent to refuse" exception.

Finally, the "necessary" exception is disconnected from circuit court authority. That is to say, the legislature includes the "necessity" exception to express the qualified right to refuse as a whole, not as tied to circuit court order authority. Section 51.61 proves the point. Subdivision (1)(g)1. offsets the "necessary" exception from any period contemplating court authority—patients have "the right to refuse … except as ordered by the court under sub. 2., or in a situation in which the medication or treatment is necessary to prevent serious physical harm to the patient or others."

Sub. 2. provides the court authority if the patient is "incompetent to refuse" between the period of the "hearing … but prior to the final commitment order." Implicitly, therefore, the "necessity" exception must operate separate from court authority. No reasonably logical basis otherwise exists for the legislature to separate sub. 2. authority.

b. Administrative code support.

The Department of Health Services administrative code further supports the distinction. Indeed, promulgated as patient rights, the administrative code expresses the professionally determined, extrajudicial override authority. DHS 124.06(1)(i) & (j). There, medical professionals receive instruction that "[e]xcept in emergencies, the consent of the patient … shall be obtained before treatment is administered," and receive notice that the "patient may refuse treatment to the extent permitted by law" after the medical professional provides the patient with the disadvantages of going without treatment.

The code, therefore, recognizes that treatment providers possess authority to treat without informed consent during emergency situations. That is, "in a situation in which the medication or treatment is necessary to prevent serious physical harm to the patient or to others." *See Jones,* 141 Wis. 2d at 739 ("This 'implied consent' concept is a standard exception to the informed consent doctrine.") (citing Prosser WL & Keeton WP, The Law of Torts (5th ed. 1984) § 18 Consent: Emergency Privilege pp. 117-118).

c. Caselaw support.

Longstanding precedent of this Court recognizes this distinction. This Court did so in *Jones*.[1] Specifically, the Court explained that the emergency exception references "professionally determined" authority. *Id.* at 739, 741. Whereas the "incompetent to refuse" exception provides circuit court authority. *Id.* at 734, 736 (in nonemergency situations, an override is "only pursuant to a court authorization based on an evidentiary hearing finding that there is probable cause to believe that the individual is incompetent to refuse medication."). Moreover, the Court found that a "finding of dangerousness [under § 51.20] is not sufficient to commence involuntary treatment." *Id.* at 737.

The Court recognized the same in *Rock County v. Virgil D.,* 189 Wis. 2d 1, 15-16, 524 N.W.2d 894 (1994) ("The circuit court must maintain the distinction," whereas the hospital may "medicate him

[1] The *Jones* decision "survived unscathed from a repeal and re-creation of § 51.61(1)(g)3, STATS." *County of Milwaukee v. Carol J.R.,* 196 Wis. 2d 882, 884, 540 N.W.2d 233.

if an emergency arises."); in *Melonie L.,* 2013 WI 67, ¶53 ("In sum, under Wis. Stat. § 51.61, a person has the right to refuse medication unless a court determines that the person is incompetent to make such a decision."); and in *Waukesha County v. M.A.C.,* 2024 WI 30, ¶64, 412 Wis. 2d 462, 8 N.W.2d 365 ("When seeking an involuntary medication order, a county must prove that an individual is incompetent to refuse medication by clear and convincing evidence.).

Wisconsin's longstanding authority to override a patient's right to refuse treatment "is consistent with the law in other jurisdictions." *Jones,* 141 Wis. 2d at 742-45. Most states employ a statutory scheme that differentiates judicial from extrajudicial authority. But all states recognize that it is treatment providers who override the right to refuse treatment in emergency situations without court involvement. *See Jones,* 141 Wis. 2d 710 (1987); *see* also *People v. Medina,* 705 P.2d 961, 971 (Colo. 1985); *Addington v. Texas,* 441 U.S. 418 (1979); Prosser WL & Keeton WP, The Law of Torts (5th ed. 1984) § 18 Consent: Emergency Privilege pp. 117-118); and Catherine E. Blackburn, The "Therapeutic Orgy"' and the "Right to Rot"' Collide: The Right to Refuse Antipsychotic Drugs Under State Law, 27 Hous. L. Rev. 447 (1990).

C. The State's interpretation creates absurd and unreasonable outcomes.

The petition for review cries wolf, while opening the gate for a pride of lions to enter. As the State puts it, the court of appeals' decision leads to "absurd or unreasonable results." PFR, 19. Adding intensity, it claims that the decision "strip[s] Chapter 971.14

committing courts of their authority to address dangerousness and instead require[s] parallel commitment proceedings under Chapter 51." PFR, 19-20. And it proclaims, "our legislature has spoken: the government's interest in maintaining safety and security prevails." PFR, 7.

But none of this is correct. It is hard not to wonder: Does the State really believe that the "necessity to prevent" exception, as it puts it, provides "a mechanism for the government to quickly return to the committing court to address the dangerousness issue[.]" PFR, 19. The State itself recognizes the justifying interest to override the individual's right to review is safety and security.

Returning to the court in moments of imminent or ongoing harm fails to further this interest. Even the smallest of delays in these situations are intolerable. Which is why, the legislature recognizes the treatment provider's authority to professional determine when the situation exists to employ it. And, critically important to individual rights, the professionally determined authority provides a safeguard that ends the significant bodily intrusion when the situation no longer justifies it. Moreover, treatment provider authority operates without court authority. Thus, a dual ch. 51 proceeding is unnecessary unless the desire is to continue treatment after the danger subsides.

Ultimately, the State's belief that the "necessity to prevent" exception provides "a mechanism for the government to quickly return to court," harms individuals, and disservices institutional order, safety, and security.

CONCLUSION

This Court should deny and dismiss the State's petition for review.

Dated this 14th day of November, 2024.

Respectfully submitted,

Electronically signed by Timothy C. Drewa
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CERTIFICATION AS TO FORM/LENGTH

I hereby certify that this petition conforms to the rules contained in s. 809.19(8)(b), (bm) and 809.62(4). The length of this petition is 4,211 words.

Dated this 14th day of November, 2024.

Signed:
Electronically signed by
Timothy C. Drewa
TIMOTHY C. DREWA
Assistant State Public Defender