STATE OF WISCONSIN

IN SUPREME COURT

Appeal Nos. 2024AP1789-CR, 2024AP1799-CR

STATE OF WISCONSIN,

Plaintiff-Respondent,

v.

D.E.C.,

Defendant-Appellant-Petitioner.

PETITION FOR REVIEW

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INTRODUCTION

Following this Court's acknowledgement that Wis. Stat. § 971.14 unconstitutionally allowed forcible medication of incompetent criminal defendants without complying with the mandate set forth in *Sell v. United States*, 539 U.S. 166 (2003),[1] there has been a years-long struggle in Wisconsin over what *Sell* requires.[2] This Court has remained silent regarding the application of *Sell*, while the court of appeals has attempted to clarify how to implement the constitutional requirements.[3]

The court of appeals originally signaled to the State and circuit courts that it was taking seriously the "high level of detail [that] is plainly contemplated

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[1] *State v. Fitzgerald*, 2019 WI 69, ¶2, 387 Wis. 2d 384, 929 N.W.2d 165.

[2] Prior to *Fitzgerald*, there does not appear to have been a serious consideration of *Sell* by the circuit courts in Wisconsin. In fact, the only time *Sell* was cited by a Wisconsin appellate court in a case related to criminal competency was when this Court declined to address the issue later decided in *Fitzgerald*. *See State v. Scott*, 2018 WI 74, ¶12, 382 Wis. 2d 476, 914 N.W.2d 141.

[3] D.E.C. is aware of two cases that reached this Court after *Fitzgerald*. First was *State v. Green*, 2022 WI 30, 401 Wis. 2d 542, 973 N.W.2d 770. There, the Court dealt solely with stays of medication orders and whether time to restore tolled pending appeal. *Id.*, ¶¶2-3. Second was *State v. Anderson*, 2023 WI 44, 407 Wis. 2d 428, 990 N.W. 2d 771, which this Court dismissed as improvidently granted.

by the comprehensive findings *Sell* requires." *United States v. Chavez,* 734 F.3d 1247, 1252 (10th Cir. 2013).

First, the court of appeals made clear that "*Sell* requires an individualized treatment plan that, '[a]t a minimum,' identifies '(1) the specific medication or range of medications that the treating physicians are permitted to use in their treatment of the defendant, (2) the maximum dosages that may be administered, and (3) the duration of time that involuntary treatment of the defendant may continue before the treating physicians are required to report back to the court . . . .'" *State v. Green*, 2021 WI App 18, ¶38, 396 Wis. 2d 658, 957 N.W.2d 583 (quoting *Chavez*, 734 F.3d at 1253). It also held that a treatment plan must be based on a defendant's specific medical condition and history. *Id.*, ¶41.

Most importantly, *Green* reaffirmed this Court's holding in *Fitzgerald*. "Circuit courts are required to determine whether the *Sell* factors have been met before ordering involuntary medication. *Fitzgerald*, 387 Wis. 2d 384, ¶33[]. Courts cannot delegate this responsibility to a treating provider." *Id.,* ¶44.

The next published decision after *Green* was *State v. J.D.B.*, 2024 WI 61, ___ Wis. 2d ___, 13 N.W.3d 525. *J.D.B.* was a comprehensive decision with a number of holdings designed to guide circuit courts in applying *Sell*. *J.D.B.* clarified that a plan based on a medically-informed record was a necessary, not a

sufficient condition for a plan to comply with *Sell*. *J.D.B.*, 2024 WI App 61, ¶¶54-58.[4]

J.D.B. again tried to emphasize to circuit courts their responsibility as gatekeepers in these circumstances. "Because the circuit court determines whether the plan is sufficiently individualized and medically appropriate, the court must be provided a 'complete and reliable medically informed record' from which to make those findings." *Id.*, ¶61 (quoting *Green*, 396 Wis. 2d 658, ¶¶2, 35).

The court of appeals in this case, while acknowledging the holdings and strong language in *Green* and *J.D.B.*, issued a decision that cannot reasonably be harmonized with the rest of the jurisprudence. Rather than reaffirm the State's burden to provide a high level of detail and the courts' role as gatekeepers, the court of appeals signaled the approval of treatment plans based on an incomplete record and where courts defer to the judgment of the State's doctors. In essence, this decision sets Wisconsin back to where it was before *Fitzgerald*.

Because this recommended for publication opinion dilutes the constitutional protections established in *Sell* and deviates from the published opinions in *Green* and *J.D.B.*, this Court should step in and set the course moving forward.

[4] D.E.C. acknowledges this Court's preference for short citations to Callaghan's Official Wisconsin Reports; however, because no such citation currently exists for *J.D.B.*, the public domain citation is used instead.

ISSUES PRESENTED

1. Are circuit courts required to incorporate limitations offered in testimony into their orders approving involuntary medication plans, if such limitations are necessary to make the plans constitutional?

The circuit court upheld the treatment plan as written, and stated that it "is clearly not qualified to say whether one medication or another medication should be applied." (R.84:37; App.46).

The court of appeals held that an otherwise unconstitutional treatment plan can be saved "by interpreting the treatment plan . . . in light of the . . . testimony provided" by the State's doctor, without committing the saving testimony to a written order. *State v. D.E.C.*, Nos. 2024AP1789-CR, 2024AP1799-CR, ¶56 (WI App. Dec. 27, 2024) (recommended for publication) ("Opinion").

2. Does due process require the State to provide supporting information for its involuntary treatment plans at the time a hearing is requested?

This issue was not addressed by the circuit court.

The court of appeals found that D.E.C. forfeited a number of issues related to the medical appropriateness of the plan, despite D.E.C.'s argument that such a finding would shift the burden

to disprove the appropriateness of the plan to defense counsel and create a constitutional crisis where individuals are not adequately represented due to the State's failure to provide support for its treatment plans ahead of the hearing.

CRITERIA FOR REVIEW

The court of appeals' opinion in this case applies the *Sell* factors in a manner that conflicts with other court of appeals decisions and persuasive federal authority. Wis. Stat. § 809.62(1r)(d). The issue of what the State needs to do to meet its burden under *Sell* is a significant question of constitutional law. Wis. Stat. § 809.62(1r)(a); *infra* at 23. This Court has remained silent regarding how to apply the *Sell* factors, and following this decision, Wisconsin courts have unclear guidance on how to apply them; this issue will continue to recur until this court steps in. Wis. Stat. § 809.62(1r)(c)3.

Previously, this Court's guidance was not necessary because the court of appeals' decisions were consistent, and numerous federal courts applied the factors and provided persuasive guidance to Wisconsin courts. *See, e.g. United States v. Evans*, 404 F.3d 227 (4th Cir. 2005); *United States v. Green*, 532 F.3d 538 (6th Cir. 2008) *United States v. Breedlove*, 756 F.3d 1036 (7th Cir. 2014); *United States v. Hernandez-Vasquez*, 513 F.3d 908 (9th Cir. 2008); *Chavez*, 734 F.3d 1247.

Additionally, D.E.C. requests that this Court decide the novel constitutional question of whether due process requires the State to provide facts and data underlying its treatment plans. Wis. Stat. §§ 809.62(1r)(a), (c)2. Alternatively, D.E.C. requests that this Court use its rulemaking authority to ensure due process to defendants in these cases by requiring the State to disclose facts and data underlying its treatment plans at the time of filing. Wis. Stat. § 809.62(1r)(b).

STATEMENT OF THE CASE AND FACTS

Treatment Plan

On July 19, 2024, the Department of Health Services ("DHS") filed a motion requesting that D.E.C.—who was previously found incompetent—be ordered involuntarily medicated to restore him to competency. (R.68).[5] Along with the motion, DHS filed an Individual Treatment Plan authored by doctors Benjamin Title and Marley Kercher. (R.69; App.54-57).

[5] All record citations are to 2024AP001799, unless otherwise noted.

That treatment plan listed the following medications:

The following oral medications are proposed for treatment either in combination or in succession to restore the defendant's competency to stand trial: ☒ See additional materials (attached)

Name of Medication	Purpose	Dose Range
Aripiprazole	Treatment of symptoms of psychosis	</= 30 mg/24hrs
Risperidone	Treatment of symptoms of psychosis	</= 8 mg/24hrs
Paliperidone	Treatment of symptoms of psychosis	</= 12 mg/24hrs
Olanzapine	Treatment of symptoms of psychosis	</= 20 mg/24hrs
Haliperidol	Treatment of symptoms of psychosis	</= 30 mg/24hrs
Fluphenazine	Treatment of symptoms of psychosis	</= 40 mg/24hrs

The following medications are proposed to be given by injection if the defendant is unable or unwilling to take the proposed oral medication:

Name of Medication	Purpose	Dose Range
Aripiprazole LAI (Maintena)	Treat symptoms of psychosis	300-400 mg IM every 4 weeks
Paliperidone LAI (Invega)	Treat symptoms of psychosis	78-234 mg IM every 4 weeks
Haloperidol Decanoate	Treat symptoms of psychosis	100-400 mg IM every 4 weeks
Fluphenazine LAI	Treat symtoms of psychosis	12.5-100 mg IM every 2-3 weeks

(R.69:3; App.56).

Additional names of Medication for : D[redacted] E. C[redacted] – DOB: [redacted]

Haldol, IM	IM back up	</= 10mg /refusal PO dose
Ziprasidone	IM back up	</= 20mg /refusal PO dose
Olanzapine	IM back up	</= 5mg /refusal PO dose
Cogentin	EPS	</= 4 mg / 24 hrs PO
Hydroxyzine	EPS/anxiety/insomnia	</= 400 mg / 24 hrs PO
Diphenhydramine	EPS/insomnia/anxiety	</= 150 mg / 24hrs PO
Benzodiazepine (lorazepam, clonazepam, diazepam)	Agitation/severe anxiety/insomnia	</= 10 mg / 24 hrs PO, IM if available and indicated based on response and within standard of care by peers
Propranolol	Akathisia	</= 80 mg / 24 hrs PO

(R.69:4; App.57).

Testimony

At a hearing on the motion, Dr. Kercher—a psychiatrist at the Wisconsin Resource Center ("WRC")—testified. (R.84:5). After describing D.E.C.'s behaviors and opining that he has schizophrenia, (R.84:7-9), she opined that D.E.C. would be best treated with antipsychotic medications. (R.84:10). Dr. Kercher testified to having at least three discussions with D.E.C. regarding the "indications, benefits, and potential side effects" of medication, which "were largely met with nonresponse." (R.84:7). She did not believe D.E.C. understood the discussions nor could he make an informed choice regarding medication. (R.84:7-8).

Dr. Kercher testified the treatment plan would improve D.E.C.'s disorganized thoughts and decrease his paranoia. (R.84:11). She stated "there is a very high likelihood" that it would render him competent. (R.84:11). She also opined that medications would be in his medical interest by leading to more appropriate behaviors and lesser restrictions at WRC. (R.84:12).

When asked "not necessarily each medication and what it does, but overall how the treatment plan would work," Dr. Kercher explained that two different types of antipsychotics were listed—first and second generation. (R.84:12-13). She stated that second-generation antipsychotics are typically used to treat individuals who are "antipsychotic naïve," i.e. they have not previously been treated with antipsychotics, like D.E.C. (R.84:13). Dr. Kercher noted that one of the

second-generation antipsychotics—aripiprazole—had been offered to D.E.C. (R.84:13). After listing possible side effects of this class of medications, Dr. Kercher opined that the benefits would outweigh any side effects. (R.84:14).

On cross-examination, Dr. Kercher testified that general practice is to begin patients on oral medications to assess tolerability, efficacy, and dosage before switching them to long-acting injectables. (R.84:16). She described this process as involving "robust trials" to see if a medication works before switching medications. (R.84:22, 26). She said "we always start with the lowest possible dose and work upwards to [] achieve a balance of efficacy and tolerability." (R.84:26).

When confronted with the fact that the treatment plan did not discuss trialing medications or placing any restriction on the use of all of the medications listed, Dr. Kercher agreed the plan could be read that way, but that she included more medications to allow staff at WRC flexibility. (R.84:20).

Dr. Kercher conceded she did not have clinical data regarding D.E.C., but said that she:

> would be very deliberative and cautious and careful with administrating medications individually and allowing each trial an adequate time to -- to assess for efficacy and side effects before switching, without careful consideration, to another medication.

(R.84:19-20). At the time of the hearing, she was not recommending trialing any medication other than aripiprazole. (R.84:16, 20).

Dr. Kercher was then asked about specific medications. She first agreed that the FDA label for aripiprazole "states that daily dosages higher than 10 to 15 milligrams are not generally any more effective than [dosages] of 10 to 15[mg.]" (R.84:21). When asked why the treatment plan had a maximum dosage of 30mg, Dr. Kercher stated if an individual had a "suboptimal response" and no side effects, she felt it would be appropriate to go up to the manufacturer-determined maximum dosage. (R.84:21).

When asked a similar question regarding olanzapine, Dr. Kercher noted that she was including the "recommended maximal dosage range" by the manufacturer in the treatment plan. (R.84:25-26).

Trial counsel then asked whether Dr. Kercher was aware that "there's not been any safety testing performed" regarding doses of fluphenazine up to 40mg. (R.84:30). Dr. Kercher testified she was not aware of that—stating that she relied on a "commonly used prescribing textbook that we use, Stahl's" to get the maximum dosage, but did not look at the underlying studies.[6] Dr. Kercher then acknowledged that in her experience, dosages up to 20mg were

[6] Believed to be Stephen M. Stahl, Stahl's Essential Psychopharmacology Prescriber's Guide (Meghan M. Grady, 8th ed. 2024); (App. Br. App.56-57).

usually effective, and she has "rarely used dosage beyond that." (R.84:30-31).

Decision

The court began by outlining the case history as well as Dr. Kercher's testimony regarding D.E.C.'s behaviors and her experience as a psychiatrist. (R.84:36-37; App.45-46). The court then acknowledged it had to consider the *Sell* factors. (R.84:37-38; App.46-47).

The court discussed the charges D.E.C. was facing and found that they were "significant" and that there was an important interest in bringing him to trial. (R.84:39; App.48).

The court then summarized the testimony about how medications are trialed and Dr. Kercher's plan to start with aripiprazole. (R.84:39-40; App.48-49). The court stated it believed it was to D.E.C.'s benefit to have the medication plan as is, because DHS could immediately change medications, if they are harmful. (R.84:40; App.49). The court went on to say how Dr. Kercher was knowledgeable, considering appropriate factors, and planned to treat D.E.C. as an individual. (R.84:40-41; App.49-50).

The court found that medications were likely to improve D.E.C.'s thought processes and symptoms, making them medically appropriate and in his best interest. (R.84:41-42; App.50-51). The court also found that D.E.C. was both not able to understand or apply an understanding of the advantages, disadvantages,

or alternatives to medication to his situation. (R.84:42; App.51). The court found that medications were substantially likely to render him competent and substantially unlikely to undermine the fairness of trial. (R.84:43; App.52).

Finally, the court found that "less intrusive treatments would not achieve the same results and it is medically appropriate in light of his individual medical condition" and ordered involuntary medication in each case. (R.49;[7] R.76; R.84:43; App.40-43, 52).

Appellate Proceedings

D.E.C.'s trial attorney filed a Notice of Motion to Continue Stay in the court of appeals, pursuant to Wis. Stat. § 809.109(7)(b). (R.53;[8] R.79) After briefing, in an order dated September 5, 2024, the court of appeals granted a stay of the medication order pending appeal. (R.89).

Ultimately, the court of appeals upheld the involuntary medication order. The court of appeals relied heavily on Dr. Kercher's testimony to find that the plan appropriately specified the medications to be administered to D.E.C. Opinion, ¶¶40-50, 53-56; (App.21-25, 27-28).

The court went on to find that D.E.C. forfeited a number of arguments regarding whether the plan was

[7] In case 2024AP001789.
[8] In case 2024AP001789.

medically appropriate. Opinion, ¶¶67, 71, 73; (App.32-36). Because those arguments were forfeited, the court of appeals held that the State proved the plan was medically appropriate by clear and convincing evidence. Opinion, ¶78; (App.37-38).

This petition follows.

ARGUMENT

The court of appeals' decision impermissibly allows courts to defer to doctors' judgment in administering medications without ensuring they meaningfully restrict the medications used and implement the plan in a way that is medically appropriate. The decision also approves the violation of a defendant's due process rights by allowing hearings where defense counsel is not given adequate information prior to the hearing and shifting the State's burden onto the defense to disprove the appropriateness of the treatment plan.

Review is warranted to confirm the circuit court's role as gatekeeper and signal to the State that it must provide support for its plans when they are submitted to the court.

I. Testimony that clarifies or limits an involuntary medication plan must be adopted by the court in its order for the plan to comply with *Sell*.

If a circuit court's involuntary medication order does not contain the limitations necessary to that make the treatment plan constitutional, none of the limits that *Sell* requires are in place.

Specificity is critical when it comes to an involuntary treatment plan. Circuit courts must assess "whether a particular medication is substantially likely" to render someone competent without having side effects that hamper that goal. *Green*, 396 Wis. 2d 658, ¶34.

> *Sell*'s discussion of specificity would have little meaning if a district court were required to consider specific drugs at a *Sell* hearing but then could grant the Bureau of Prisons unfettered discretion in its medication of a defendant. While *Sell* appropriately does not direct district courts to micromanage the decisions of medical professionals, reading it as imposing no limits upon the discretion of the treating physicians would render judicial inquiry about specific drugs academic.

United States v. Hernandez-Vasquez, 513 F.3d 908, 916 (9th Cir. 2008). *See also Fitzgerald*, 397 Wis. 2d 384, ¶33; *Green*, 396 Wis. 2d 658, ¶44.

Furthermore, the court's order is what carries the power of law, not the doctor's testimony. *See Chavez*, 734 F.3d at 1252-53 (describing how the court's order, rather than the treatment plan must specify the medications and maximum dosages). Undersigned counsel has admittedly struggled to find

caselaw supporting this very basic legal premise: anything not incorporated into a court's order has no legal force. While few things in the law are self-evident, this seems as close as one can get; anything not ordered by the court is not required to be followed.

Here, the court of appeals repeatedly relied on Dr. Kercher's testimony to find the treatment plan complied with *Sell*, but none of the testimony was converted into the court's order. As such, the court's order, which required D.E.C. to "submit to the administration of medication(s) or treatment as outlined in the treatment plan," (R.76:2; 49:2; App.41, 43), was unconstitutional.

Examples of the court of appeals' reliance on testimony to make the plan sufficiently specific include:

- Noting Dr. Kercher "described how the listed medications would be trialed with D.E.C. This included clarifying testimony, both on direct and cross examination, regarding the overall goal, consistent with the second *Sell* factor, to balance efficacy and tolerability." Opinion, ¶43; (App.22).

- "Further, Dr. Kercher specifically described an intention to first administer aripiprazole to D.E.C. at a low dosage, beginning with the oral formulation, and if that were successful, to not move to any of the other medications." Opinion, ¶47; (App.23).

- Dr. Kercher "provided the circuit court with context to understand how the medical doctors who will administer the medication or medications . . . would reasonably interpret the three grids listing medications to fit D.E.C.'s circumstances." Opinion, ¶49; (App.24).

- "It is true that the treatment plan provides a relatively broad degree of flexibility to the treating doctors, depending on D.E.C.'s reactions to various medications and dosage levels. But Dr. Kercher provided reasons for this and D.E.C. is incorrect in arguing that it reflects 'no meaningful limitation' on the types and amounts of medications that may be administered, **when considered in light of the testimony credited by the circuit court.**" Opinion, ¶50 (emphasis added); (App.24-25).

- Regarding combining medications: "there was no suggestion in Dr. Kercher's testimony that the treatment plan could be reasonably interpreted by doctors at the Wisconsin Resource Center to call for the improper administration of multiple medications at the same time." Opinion, ¶53; (App.27).

- "Further, Dr. Kercher conveyed the idea, which is consistent with a reasonable interpretation of the face of the treatment plan, that doctors would follow the plan to

> allow for the minimum dosages . . . to produce effective and safe outcomes, focusing on one medication at time." Opinion, ¶53; (App.27).

These passages are emblematic of the court of appeals' decision and why it is problematic for two reasons.

A. The treatment plan and order do not require administration of medication in the way Dr. Kercher described.

First, the decision relies entirely on Dr. Kercher's testimony to claim that the medications will be appropriately administered through "robust trials," Opinion, ¶48; (App.24), beginning with low doses and working their way up to an effective dosage. Opinion, ¶47; (App.23-24). Nowhere does the actual order for involuntary medication require "robust trials" with a single medication at a time and beginning with low doses. (R.79). The order only requires DHS to follow the plan, which—despite Dr. Kercher's testimony—allows use of any and all medication "for treatment either in combination or in succession" at any listed dosage. (R.69:3; App.56). There is nothing requiring DHS adhere to Dr. Kercher's testimony.

Similarly, Dr. Kercher testified—and the State conceded in briefing—that before using injectable medication doctors are "required" to complete a trial with oral medication to "assess efficacy and tolerability." (R.84:25); Resp. Br. at 10. The court of appeals response was to indicate there was "a sufficient evidentiary basis to conclude that, through administration as needed of various medications,

doctors would execute the plan in [a] way that" complies with *Sell*. Opinion, ¶54; (App.27).

Again, the order requires compliance with the plan, which in turn says that injectable medication will only be used if D.E.C. "is unable or unwilling to take the proposed oral medication." (R.69:3; App.56). This not only allowed DHS to inject without determining "efficacy and tolerability," but did not allow them to ever switch if D.E.C. was compliant with an oral formulation. Not only was Dr. Kercher's testimony not adopted by the court into an order, the plan DHS was to comply with contradicted Dr. Kercher's testimony.

The court of appeals ignored that the court's order is the only thing holding DHS accountable. No one is overseeing the daily administration of medication. Not the court, not defense counsel. Nothing **requires** or even suggests other doctors will review Dr. Kercher's testimony.

By not converting any of the restrictions describing how medications would be administered into the order, DHS can forcibly administer as many of the listed medications at any of the listed dosages. They are not required to start at the lowest dose of a single medication, titrate up, and do a robust trial before moving on. The court of appeals' decision acknowledges that a plan without these restrictions is not substantially likely to restore a defendant to competency and lacks the specificity *Sell* requires. Opinion, ¶50; (App.24-25).

B. The court of appeals' decision allows circuit courts to order treatment plans that contain no meaningful restrictions.

Second, the court of appeals' decision does exactly what *Sell* prohibits—allows courts to broadly order doctors to only act in a way that is medically appropriate, rather than ordering meaningful restrictions.

"*Sell* requires the **circuit court** to conclude that the administration of medication is medically appropriate, not merely that the medical personnel administering the drugs observe appropriate medical standards in the dispensation thereof." (emphasis in original). *Fitzgerald*, 387 Wis. 2d 384, ¶30. "If courts could render an order for involuntary medication compliant with *Sell* merely by directing the treating providers to comply with the order 'only if the provider determines that the treatment plan approved by the court is medically appropriate,' all medication orders would satisfy *Sell*." *Green*, 396 Wis.2d 658, ¶44.

Here, the court of appeals referenced how doctors would "reasonably" interpret the treatment plan. Opinion, ¶¶49, 53; (App.24, 27). This is a tacit concession that the plain wording of the plan allowed administration of medication contrary to Dr. Kercher's testimony as described. *Supra* at 19-20. Dr. Kercher even acknowledged that the plan reads as though DHS is allowed to administer all medications at once. (R.84:20).

The court of appeals' references to doctors only applying the treatment plan consistent with Dr. Kercher's testimony—absent a court order requiring it—does nothing more than signal to circuit courts that they can abdicate their responsibility to ensure the State complies with *Sell* by ordering DHS to act in a way that is medically appropriate.[9]

This court of appeals decision allowing circuit courts to not place restrictions on DHS is contrary to this Court's opinion in *Fitzgerald*, its own decisions, and federal circuit court decisions.

II. Due process requires the State to provide information supporting its involuntary medication requests before the hearing on the motion.[10]

[9] This is even more concerning because the form order requires DHS to "observe appropriate medical standards" in administering medication. *See* Standard Court Form, CR-206, at 2. The court of appeals' decision here means all plans comply with *Sell* if they use the form, contrary to the language in *Green*. 396 Wis. 2d 658, ¶44.

[10] While not raised directly below, D.E.C. sufficiently flagged for the court of appeals that a decision like the one it made would create the constitutional crisis described herein. As such, due to the significant constitutional and purely legal question posed, D.E.C. believe this Court should exercise its discretion to address this issue, if it believes it is being raised for the first time in the petition for review. *See In the Interest of A.L.W.*, 153 Wis. 2d 412, 416 n.2, 451 N.W.2d 416 (1990); *State v. Minniecheske*, 127 Wis. 2d 234, 240, 378 N.W.2d 283 (1985).

This case demonstrates that due process requires the State to support its requests for involuntary medications with supporting facts and data.

"The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty." *Washington v. Harper*, 494 U.S. 210, 229 (1990). As such, individuals have a "'significant liberty interest' in refusing involuntary medication," *Fitzgerald*, 387 Wis. 2d 384, ¶13 (quoting *Harper*, 494 U.S. at 221), and "only an 'essential' or 'overriding' state interest" can overcome the right to refuse medication. *Sell*, 539 U.S. at 179 (quoting *Riggins v. Nevada*, 507 U.S. 124, 134-35 (1992)). Given the liberty interest at stake, defendants are entitled to due process protections, one of those is notice. *See Vitek v. Jones*, 445 U.S. 480, 494-95 (1980).

Due process requires that notice in these cases be more than a notice of hearing, but also notice of the State's expert's basis for requesting specific medications. This is necessary as there is no ability to conduct discovery in a timely fashion and using cross-examination to discover the underlying facts is inadequate.[11] *See Shibilski v. St. Joseph's Hospital of*

[11] D.E.C. is aware that Wis. Stat. § 907.05 specifically allows testimony without disclosure of underlying facts and data—unless ordered by the court. D.E.C. believes the statute is unconstitutional as applied in these matters, as it interferes with due process as described. D.E.C. proposes this Court could make such a finding, or alternatively, use its rulemaking authority to require disclosure of the underlying facts and data

Marshfield, Inc., 83 Wis. 2d 459, 470, 266 N.W.2d 264 (1978) (noting a right to discovery to the subject matter involved in a pending action). This also implicates a defendant's right to effective counsel. *In re Torrance P., Jr.*, 2006 WI 129, ¶38, 298 Wis. 2d 1, 724 N.W.2d 623 ("the statutory right to counsel includes the right to effective assistance of counsel").

In Wisconsin, when the State requests involuntary administration of medication to restore competency, the court must hold a hearing within 10 days of filing. Wis. Stat. § 971.14(5)(am). Any party may request the hearing be postponed, but the hearing still must be held within 20 days of the request. Wis. Stat. § 971.14(am).

Thus, every defense attorney in Wisconsin is obligated to become well-versed in an untold number of medications—here it was 20, (R.69:3-4; App.56-57)—in less than three weeks. The consequence of not doing so is a hearing by ambush where a doctor from DHS will testify that medications are appropriate without any supporting documentation.

Here, Dr. Kercher testified on cross-examination that she was "not familiar" with the literature regarding why fluphenazine was not recommended for use at the dosage she proposed. (R.84:30). She stated, for the first time, that she relied on a "commonly used prescribing text book . . . , Stahl's" to come up with the maximum dosage. (R.84:30).

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relied upon by the State's experts in this limited class of cases. Wis. Stat. § 751.12(2).

Dr. Kercher claimed up to 40mg was the range specified by the textbook, (R.84:30), but she rarely used doses above 20mg. (R.84:31). On appeal, D.E.C. used an excerpted passage from that textbook in his opening brief to demonstrate that it recommends "augmentation with a mood-stabilizing anticonvulsant" rather than "rais[ing] the dose above normal dosing in partial responders." App. Br. at 23.

The court of appeals found the issue forfeited, despite there being no possibility for defense counsel to have known the source Dr. Kercher based her plan on, or to have reasonably obtained it during the hearing.[12] Opinion, ¶70; (App.34).

This is an enormous and unrealistic burden to place on defense counsel. Especially so, when doctors can cite their sources or give a written explanation how they reached their recommendations ahead of time. The court of appeals left a footnote supporting this stance: "[DHS] would be well advised to include significant details in its plans to provide clarity for everyone involved, including to assist circuit courts in the task of applying the standards under *Sell*." Opinion, ¶51 n.12; (App.26).

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[12] D.E.C.'s attorney appeared by Zoom and Dr. Kercher likely did as well, making exchange of a physical book impossible. Even if both were in-person, the court of appeals' solution would require defense counsel to sift through the nearly 1,000-page textbook and digest what it said, and then formulate cross-examination on a technical topic on the fly.

The court of appeals went on to find D.E.C.'s other similar arguments[13] forfeited, because either the record was insufficiently developed or Dr. Kercher was not given an opportunity to address them. Opinion, ¶¶69-73; (App.34-36). The court of appeals did not fault D.E.C. for not raising his claims as ineffective assistance of counsel, despite the noted lack of impeachment on the issues raised on appeal. Opinion, ¶66; (App.32). In fact, the court of appeals said counsel "was able to pose illuminating questions to Dr. Kercher focusing on the issues that D.E.C. now raises on appeal" and "ably represented" D.E.C. Opinion, ¶77; (App.37). The findings of forfeiture and able representation are internally inconsistent.[14]

This Court should step in and clarify for the State and defense bar what their obligations are for these hearings. It should do so by finding that due

[13] App. Br. at 21-26.

[14] Additionally, the court of appeals refused to rely on the publicly available sources D.E.C. cited when it came to challenging the plan, Opinion, ¶¶67-73; (App.32-36), but willingly relied upon them in order to explain the plan. Opinion, ¶10; (App.7-8). It then used that information to find that the entire page of medications that were not discussed had the "apparent purpose" of dealing with side effects and complications. Opinion, ¶76; (App.37). The use of outside sources only to coverup some insufficiencies, and not acknowledge others, is fundamentally unfair.

This Court may do well to accept review to clarify whether appellate courts are to rely on sources outside the record and apply the forfeiture rule in a way that is consistent and fair to all parties.

process requires the State—who bears the burden—to provide the information needed to evaluate its treatment plan. *See J.D.B.*, 2024 WI App 61, ¶61.

III. This Court should accept review despite the matter being moot.

D.E.C. acknowledges that he has been discharged from this commitment, and is no longer subject to the involuntary medication order in this case. However, numerous exceptions to mootness apply.[15]

Dismissing a moot case "is an act of judicial restraint rather than a jurisdictional requirement." *Sauk Cnty. v. S.A.M.*, 2022 WI 46, ¶19, 402 Wis. 2d 379, 975 N.W.2d 162. Sometimes, "because of their characteristics or procedural posture," issues present "a need for an answer that outweighs our concern for

[15] The court of appeals previously dismissed 2024AP1789-CR as moot, because that case had been dismissed in the trial court while the appeal was pending. Opinion, ¶1 n.2; (App.4). D.E.C. argued below that because the cases were consolidated and dealt with all the same treatment plan and hearing, addressing mootness in only one case was itself a waste of judicial resources, contrary to the principles underlying the doctrine. Reply Br. 4-5; *State ex rel. La Crosse Tribune, v. Circuit Court for La Crosse Cnty.*, 115 Wis. 2d 220, 228, 340 N.W.2d 460 (1983) ("It is generally thought to be in the interest of judicial economy not to continue to litigate issues that will not affect real parties to an existing controversy.").

D.E.C. still believes that this Court should address the merits in both matters, given that there are no separate issues.

judicial economy." *Waukesha Cty. v. S.L.L.*, 2019 WI 66, ¶15, 387 Wis. 2d 333, 929 N.W.2d 140.

Appellate courts recognize exceptions to the mootness doctrine when an issue: "(1) is of great public importance; (2) occurs so frequently that a definitive decision is necessary to guide circuit courts; (3) is likely to arise again and a decision of the court would alleviate uncertainty; or (4) will likely be repeated, but evades appellate review because the appellate review process cannot be completed or even undertaken in time to have a practical effect on the parties." *Outagamie Cnty. v. Melanie L.*, 2013 WI 67, ¶80, 349 Wis. 2d 148, 833 N.W.2d 607. This case meets all four exceptions.

The circumstances in which the State can forcibly medicate individuals against their will is an issue of great public importance, as is ensuring due process for those individuals who are least able to speak out for themselves.

The recent rise in these cases in the court of appeals demonstrates that these issues are coming up frequently. The issue of competency can also come up in any criminal proceeding. Data shows that there were more than 110,000 criminal charges[16] filed in Wisconsin in both 2022 and 2023.[17] Estimates say that

[16] Including only misdemeanor and non-traffic felony cases. Felony traffic cases would increase the numbers further.

[17] Circuit Court Caseload Statistics Dashboard, https://www.wicourts.gov/publications/statistics/circuit/circuitstats.htm (last accessed Jan. 26, 2025).

1.5% to 3.5% of the general population will meet the criteria for a psychotic disorder.[18] Ignoring that individuals in the criminal justice system are almost assuredly more likely to have mental health issues,[19] a conservative estimate is that 1,650-3,850 charges involve a defendant with a psychotic disorder. While not every defendant with a psychotic disorder is untreated and incompetent, the issue is common in circuit courts throughout Wisconsin.

The issue is likely to repeat and evade review in 2024AP1799-CR because that circuit court case remains open, despite D.E.C. being found not competent, not likely to regain and discharged to a Chapter 51 proceeding pursuant to Wis. Stat. § 971.14(6)(b).[20] Because the case remains open, there is a "reasonable expectation" that D.E.C. will be subject to the "same action" again. *Portage Cnty. v. J.W.K.*,

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[18] Jordan Calabrese, Yasir Al Khalili, Psychosis, StatPearls Publishing (May 1, 2023) https://www.ncbi.nlm.nih.gov/books/NBK546579/#:~:text=The%20current%20thinking%20is%20that,psychotic%20symptom%20in%20their%20lifetime.

[19] According to one literature review, the lowest estimate of imprisoned individuals with a psychotic disorder in any study was 6.2%. Helen Gómez-Figueroa, Armando Camino-Proaño, Mental and behavioral disorders in the prison context, Revista Español de Sanidad Penitenciaria (Spanish Journal of Penitentiary Health) (Oct. 6, 2022) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9578298/#.

[20] This information is publicly available on CCAP. This Court may take judicial notice of CCAP records when requested by a party. *See Kirk v. Credit Acceptance Corp.*, 2013 WI App 32, ¶5 n.1, 346 Wis. 2d 635, 829 N.W.2d 522.

2019 WI 54, ¶30, 386 Wis. 2d 672, 927 N.W.2d 509. Until the case is dismissed, D.E.C. can still be prosecuted, Wis. Stat. § 971.14(6)(d), and the court can order him subject to involuntary medication to retain competency. Wis. Stat. § 971.14(5)(d). A decision will inform the circuit court and parties whether a similar treatment plan is constitutional in the future.

The issue is likely to evade review, despite the adoption of expedited timelines for appeal in Wis. Stat. § 809.109, because the State is often not requesting involuntary medication until several months into their 12-month restoration period. Wis. Stat. § 971.14(5)(a)1. Here, despite being subject to the expedited timelines, D.E.C. was found not competent not likely to regain on December 2, 2024, and the court of appeals decision was released December 27th.

Despite the order no longer being in place, there are important reasons for the Court to not apply the mootness doctrine and grant review.

CONCLUSION

For the reasons stated, D.E.C. respectfully requests that this Court grant his petition for review.

Dated this 27th day of January, 2025.

Respectfully submitted,

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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 6,085 words.

CERTIFICATION AS TO APPENDIX

I hereby certify that filed with this petition is an appendix that complies with s. 809.19(2)(a) and that contains, at a minimum: (1) a table of contents; (2) the findings or opinion of the circuit court; (3) a copy of any unpublished opinion cited under s. 809.23(3)(a) or (b); and (4) portions of the record essential to an understanding of the issues raised, including oral or written rules or decisions showing the circuit court's reasoning regarding those issues.

I further certify that if this appeal is taken from a circuit court order or judgment entered in a judicial review or an administrative decision, the appendix contains the findings of fact and conclusions of law, if any, and final decision of the administrative agency.

I further certify that if the record is required by law to be confidential, the portions of the record included in the appendix are reproduced using one or more initials or other appropriate pseudonym or designation instead of full names of persons, specifically including juveniles and parents of juveniles, with a notation that the portions of the record have been so reproduced to preserve confidentiality and with appropriate references to the record.

Dated this 27th day of January, 2025.

Signed:
Electronically signed by
Lucas Swank
LUCAS SWANK
Assistant State Public Defender