SUPPLEMENTAL APPENDIX

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DISTRICT I

December 6, 2023

To:

Lucas Swank
Electronic Notice

Jennifer L. Vandermeuse
Electronic Notice

Katie R. York
Electronic Notice

Anne Bensky
Wisconsin Department of Health Services
P.O. Box 7850
1 West Wilson Street
Madison, WI 53707-7850

You are hereby notified that the Court has entered the following order:

2023AP715-CR State of Wisconsin v. J. D. B. (L.C. # 2022CF3407)

Before Donald, P.J.

J.D.B. filed a notice of appeal on April 25, 2023, seeking to challenge an order for the involuntary administration of medication. Briefing is nearly complete; only the reply brief remains to be filed. J.D.B., by Attorney Katie R. York and Attorney Lucas Swank, now moves to supplement the appellate record with a competency report filed in the circuit court on June 27, 2023, approximately one month after the record was transmitted here. *See* WIS. STAT. RULE 809.15(3) (2021-22)[1] (providing that "[a] party who believes that the record ... does not accurately reflect what occurred in the circuit court may move the court in which the record is located to supplement or correct the record"). The State, by Assistant Attorney General Jennifer

[1] All references to the Wisconsin Statutes are to the 2021-22 version unless otherwise noted.

L. Vandermeuse, opposes the motion. Upon review of the motion, the response, and the record, the motion will be denied.

J.D.B.'s opening brief addressed the question of whether the appeal was moot.[2] The State's response brief also addressed mootness, and the State's arguments in that regard included a statement describing the content of the record. J.D.B. now seeks to supplement the record with the June 27, 2023 competency report "to establish that [the State's] claim is inaccurate." The State's objection to supplementation emphasizes that the record as it appears now "accurately reflects what occurred in the circuit court." *See* ***id.*** The State adds that, if this court grants the motion to supplement the record, then the State "requests that the Court order that the [supplement] is made part of the record solely for the purpose of assessing the parties' mootness arguments."

We do not normally permit the record to be supplemented with materials that postdate the notice of appeal. *See* ***Verex Assur., Inc. v. AABREC, Inc.***, 148 Wis. 2d 730, 734 n.1, 436 N.W.2d 876 (Ct. App. 1989). We are an error-correcting court rather than a fact-finding court, *see* ***Lange v. LIRC***, 215 Wis. 2d 561, 572, 573 N.W.2d 856 (Ct. App. 1997), and we therefore normally do not consider new evidence on appeal, *see* ***Van Deurzen v. Yamaha Motor Corp. USA***, 2004 WI App 194, ¶6, 276 Wis. 2d 815, 688 N.W.2d 777. J.D.B suggests that this consideration is not significant here, given the nature of the report that he seeks to include in the record. We disagree. Notwithstanding J.D.B.'s contrary assertion, it is not clear that the

[2] The issue of mootness appears to have arisen because J.D.B's order of commitment expired, as reflected in the circuit court's docket. *See* ***Kirk v. Credit Acceptance Corp.***, 2013 WI App 32, ¶5 n.1, 346 Wis. 2d 635, 829 N.W.2d 522 (providing that this court may take judicial notice of entries in the circuit court's electronic docket).

reliability of the information in the report "cannot reasonably be questioned."[3] Further, this court is satisfied that interests of judicial efficiency dictate proceeding under the record as it existed when it reached the court of appeals without the necessity of parsing later-added content that might be considered for one purpose but not another.

Deadlines in this matter have been tolled since J.D.B. filed the motion to supplement the record. *See* WIS. STAT. RULE 809.14(3)(b). The court on its own motion will now establish a deadline for J.D.B. to file a reply brief.

Upon the foregoing,

IT IS ORDERED that the motion to supplement the record with the June 27, 2023 competency report is denied.

IT IS FURTHER ORDERED that the deadline for J.D.B. to file a reply brief is extended through December 15, 2023. *See* WIS. STAT. RULE 809.82(2)(a).

Samuel A. Christensen
Clerk of Court of Appeals

[3] The portion of the competency report at issue appears under an italicized heading. According to that heading, the text that follows is a summary of an evaluation authored by a third party and dated April 11, 2023. As described in that summary, the April 11, 2023 evaluation included a description of an event occurring on an unspecified date after April 24, 2023.

STATE OF WISCONSIN

COURT OF APPEALS

DISTRICT I

Case No. 2023AP000715-CR

STATE OF WISCONSIN,

Plaintiff-Respondent,

v.

J.D.B.,

Defendant-Appellant.

MOTION TO SUPPLEMENT THE RECORD

The defendant-appellant, Jared[1], by counsel, Acting State Public Defender Katie R. York and Assistant State Public Defender Lucas Swank, moves the Court pursuant to Wis. Stat. § 809.15(3) for an order supplementing the record with the following items:

(1) The competency examination report authored by Jeffrey M. Washelesky, Psy.D filed in the circuit court on June 27, 2023.[2]

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[1] To promote readability and taking guidance from Wis. Stat. § 809.81(8), this motion refers to J.D.B. as "Jared," a pseudonym, rather than redacting his name pursuant to the Court's August 9, 2023 order.

[2] A redacted copy of this report is attached as Appendix A.

Under Wis. Stat. § (Rule) 809.15(3), "[a] party who believes that the record . . . does not accurately reflect what occurred in the circuit court may move the court in which the record is located to supplement or correct the record." The following is shown to the Court in support of this motion:

1. The circuit court ordered Jared be subject to involuntary medication on April 24, 2023. (R.23).

2. Jared filed a Notice of Appeal on April 25, 2023. (R.24).

3. Jared filed a Motion for Emergency Temporary Relief and Request for Briefing Schedule to stay the involuntary medication order on April 26, 2023.

4. This Court ordered the involuntary medication order temporarily stayed on April 26, 2023, and set a briefing schedule.

5. After briefing, this Court granted a stay of the involuntary medication order pending appeal on June 8, 2023.

6. The record on appeal in this matter was compiled and submitted to the Court on June 1, 2023.

7. The report sought to be admitted was e-filed in the circuit court on June 27, 2023—after the record on appeal was sent up.

8. In its response brief, the State, in part, argues that this appeal is moot because "[t]he record does not show that [Jared] ever received medication involuntarily, pursuant to the April 24 order." Resp. Br. at 20.

9. The June 27th report by Dr. Washelesky indicates that:

> According to CCAP, in a hearing on 04/24/2023, the OTT [(Order to Treat)] was granted. [Jared] then received one injectable dose before his attorney filed a motion to stay the OTT pending appeal, which was also granted. As such, aside from the one injectable dose he received, [Jared] has not been subject to the provisions of an OTT during his current course of hospitalization.

Appendix A at 5-6.

10. As such, supplemental court filings demonstrate that—contrary to the State's assertion—Jared did receive involuntary medication pursuant to the order at issue on appeal.

11. The information contained within the June 27th report was not initially discovered, as that report is not itself related to the litigation at hand. It was only discovered while drafting the reply brief (to confirm the State's assertion that Jared had never been subject to involuntary medication).

12. Given the nature of the emergency litigation involved in these cases, evidence is unlikely to be available in the record regarding if an individual was actually medicated involuntarily—especially in instances where a gap exists between the order and a stay. Jared is fortunate any exists at all.

13. Part of the State's argument is that the appeal is moot because Jared was never medicated while the involuntary medication order was in place—meaning the liability for the costs of care do not exist in this case. Resp. Br. at 20. Supplementing the record is necessary to establish that this claim is inaccurate.

14. Information about whether a defendant has been subjected to involuntary medication is normally not included in the record and can only be inferred from the existence of the order itself. In cases where the order is stayed shortly after being entered, the inference gets more and more difficult to make—as demonstrated by the State's brief. As such, in instances where the record can be supplemented—especially with sources whose reliability cannot reasonably be questioned—supplementing the record should be permitted.

15. For the foregoing reasons, Jared believes that supplementing the appellate record with the enumerated circuit court documents will more accurately "reflect what occurred in the circuit court," *see* Rule 809.15(3), and assist the Court in resolving the issues on appeal. Moreover, the interests of justice support supplementing the record so that the Court has all available relevant information in deciding the mootness issue.

16. Finally, undersigned counsel requests this Court extend the deadline for filing the reply brief until 3 days after the record is supplemented.

WHEREFORE, Jared respectfully asks the Court for an order supplementing the record with the June 27th competency examination report authored by Jeffrey M. Washelesky, Psy.D. Undersigned counsel also requests the Court extend the deadline for filing appellant's reply brief until 3 days after the record is supplemented.

Dated this 17th day of November, 2023.

Respectfully submitted,

Electronically signed by Katie R. York
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Mr. J.D.B.
Defendant-Appellant

APPENDIX A

Tony Evers
Governor

Kirsten L. Johnson
Secretary

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06/27/2023

The Honorable Milton L. Childs
Circuit Court Judge, Branch No. 2
Milwaukee County 1st Judicial District Courthouse
901 N. 9th Street
Milwaukee, WI 53233-1425

Regarding: [redacted]
Date of Birth:
Case Number:

Dear Judge Childs:

IDENTIFYING INFORMATION

Mr. [redacted] is a 20-year-old man who is currently charged with Battery or Threat to Judge, Prosecutor, or Law Enforcement Officer, in connection to events that are alleged to have occurred on or about 08/23/2022.

On 10/12/2022, in the Milwaukee County Circuit Court, the Honorable Milton L. Childs determined Mr. [redacted] was not competent to proceed to trial, but was likely to be restored to competency within the statutory period. These determinations were made in consideration of a Forensic Evaluation authored by Deborah L. Collins, Psy.D., ABPP, dated 09/19/2022. Therefore, pursuant to the court order and Wisconsin State Statute (WSS) 971.14(5), Mr. [redacted] has continued to reside in the Forensic Program at Mendota Mental Health Institute (MMHI) since 01/25/2023 for inpatient care and treatment to his competency to proceed to trial. His current Order of Commitment for Treatment expires on 10/11/2023.

According to WSS 971.13(1), "No person who lacks substantial mental capacity to understand the proceedings or assist in his or her own defense may be tried, convicted, or sentenced for the commission of an offense so long as the incapacity endures." The current competency to proceed to trial evaluation focused on obtaining relevant information about the defendant's current clinical and psychological condition, his functional abilities associated with his participation in trial, his ability to assist and participate in his defense, and finally, if these competency-related capacities have been adequately restored.

STATEMENT OF NON-CONFIDENTIALITY

Mr. [redacted] was informed that he was being evaluated for his competency to proceed to trial. He was notified of the evaluation procedures, how the information would be utilized, and the limits to confidentiality. Specifically, he was told that the evaluation was legally required, and that if he did not participate in the interview or testing, this information would be included in the report to the Court and any testimony that might follow. In addition, he was informed that the report would not be confidential and that copies of it would be sent to the Court, his attorney, and the district attorney. He did not demonstrate an understanding of this information, and he did not participate in any of the attempted interviews.

SOURCES OF INFORMATION

1. Attempted direct evaluation and interviews at various times on 06/15/2023 and 06/19/2023
2. Administration of the Independent Living Skills (ILS), by Amanda Hellestad, OTR/L, on 05/30/2023
3. Administration of the Wechsler Adult Intelligence Scale – Fourth Edition (WAIS-IV) on 06/13/2023
4. Milwaukee County Circuit Court records
    a. Criminal Complaint, dated [redacted]/2022
    b. Order of Commitment for Treatment (Incompetency), dated 10/12/2022
    c. Amended Order of Commitment for Treatment (Incompetency) with Order to Treat (OTT), dated 04/24/2023
5. State of Wisconsin Department of Justice Criminal History, dated 10/12/2022
6. Consolidated Court Automation Program (CCAP) for Wisconsin Circuit Courts, accessed 06/19/2023
7. Milwaukee County Jail records, various dates
8. Milwaukee Public Schools records, various dates
9. Medical and Mental Health records
    a. Milwaukee Behavioral Health Division (BHD) records, various dates
    b. Wraparound Milwaukee records, various dates
    c. Aurora Psychiatric Hospital records, various dates
    d. Children's Hospital Wisconsin records, various dates
    e. Columbia St. Mary's records, various dates
    f. Froedtert Hospital records, various dates
    g. Rogers Behavioral Health records, various dates
    h. St. Francis Hospital records, various dates
    i. Outpatient Competency Restoration Program (OCRP) Initial Assessment and Discharge Summary, dated 10/19/2022 and 01/25/2023, respectively
10. Previous Forensic Evaluations and Letters to Court
    a. Authored by Deborah L. Collins, Psy.D., ABPP, dated 09/19/2022
    b. Authored by Sergio Sanchez, Psy.D., dated 01/05/2023
    c. Authored by Ana Garcia, Ph.D., dated 03/28/2023
    d. Authored by Mitchell Illichmann, M.D., dated 04/11/2023
11. Mendota Mental Health Institute (MMHI) Electronic Health Records, dated 01/25/2023 through 06/27/2023

It should be noted that records from Winnebago Mental Health Institute (WMHI), Aurora St. Luke's, Ascension St. Joseph, and Ascension Wheaton Franciscan were requested but not received by the time this report was written. Additionally, records from Aurora Sinai Medical Center were requested but no records were available. If additional information is received at a later time that would alter the opinion(s) contained in this report, an addendum to the report will be submitted.

RELEVANT BACKGROUND INFORMATION

The below information was obtained from available records, observations of Mr. [redacted] *collateral contacts, and consultations with his treatment team, as cited.*

Developmental and Social History

Mr. [redacted] previously reported he was born in Milwaukee, Wisconsin where he was raised by his biological mother. His father died when Mr. [redacted] was 7 years old. He has four siblings of which he is the middle (i.e., third of five). He has denied a history of abuse or neglect. He has never been married and does not have children. Just prior to his 12th birthday, Mr. [redacted] sustained a self-inflicted gunshot wound to the head (see medical history), which impacted his functioning post-injury. At the time of his most recent arrest, he resided with his mother.

Re: [redacted]
Case No.: [redacted]

Educational and Occupational History

According to a previous evaluation, Mr. [redacted] discontinued his education in the 11th grade due to the belief he already graduated. Prior to this, he had poor attendance throughout his academic years, and he did not attend the entirety of the 2019-2020 school year, though he partially attended (i.e., 74.4%) the 2020-2021 school year (virtual education due to COVID). Regarding his academic functioning, prior to his head injury, Mr. [redacted] was described as functioning in the average to low average range in reading and the above average range in math. He was able to read and understand academic work, answer comprehension questions about what he had read, had nice handwriting, did well in math, and was willing to participate in class. His mother believed that if he attended school every day, he would have "no problem getting back to where he was academically." She reported that post-injury, he was able to learn and remember things. However, he was less patient and became agitated more quickly. Mr. [redacted]'s Individualized Education Plan (IEP) reflects he was ultimately released from occupational therapy services as he "no longer require[d] occupational therapy to access his special education curriculum. He demonstrate[d] functional performance of school-related tasks, and his academic needs are addressed by other services providers." Further, Mr. [redacted] was described as an "advocate for himself and asks questions when he needs to gain clarification on things he is uncertain about." Standardized test scores from the 2018-2019 academic year reflect his reading was in the low average range and math was in the average range of academic functioning. Mr. [redacted] does not have a history of employment. His primary source of income is Social Security due to his cognitive and physical impairments, including paralysis.

Medical History

As stated above, Mr. [redacted]s medical record is notable for a self-inflicted gunshot wound to his head (right parietal lobe) four days prior to his 12th birthday (i.e., 11/20/2014). His mother previously indicated in an IEP that prior to the injury Mr. [redacted] did not want to go to school. He reportedly picked up a gun to make a point that he really did not want to go to school, and she believed that he did not intend for the gun to go off. He was hospitalized from 11/20/2014 through 01/07/2015. He underwent a decompressive craniotomy (i.e., removal of a portion of the skull to allow room for brain swelling) on 11/20/2014, with an external drain placement on 01/02/2015. He also underwent skull repair on 01/15/2015. Sequelae from this incident included left-sided weakness. He underwent neuropsychological testing while inpatient following his initial injury and was described as "doing well cognitively but decline in visual spatial tasks and visual spatial memory was moderately to severely impaired in some tests; evidence of visual field cut, and attention neglect of left side were noted." In the community, Mr. [redacted] participated in both physical and occupational therapy to address his physical deficits and left sided neglect. An occupational therapy assessment conducted at MMHI during his last review period (e.g., January through March 2023) suggested no midline or sided neglect at that time. He has also been diagnosed with diabetes and hypertension, and he is prescribed medication to prevent seizures that can be resultant from head injuries.

Substance Use and Treatment History

Mr. [redacted] has consistently denied the use of illicit/psychoactive substances. There is no indication he has ever been diagnosed with a substance use disorder or participated in substance use treatment.

Psychiatric History

Mr. [redacted] has been psychiatrically hospitalized on several occasions secondary to suicidal ideation and past attempts. He has attempted suicide at least five times including via a gunshot wound to the head and multiple intentional overdoses (three in 2020). Hospitalizations have occurred at Rogers Behavioral Health, St. Mary's Hospital, Aurora Psychiatric Hospital, and the Milwaukee County Behavioral Health Division. When asked during a hospitalization at Aurora Psychiatric Hospital in 2020 about his repeated suicide attempts, he replied, "I was bored. I don't like living." His most recent psychiatric hospitalization

was on 01/03/2022, after he physically attacked his sister. His family reported he stopped taking his psychiatric medication in the preceding weeks. Following Mr. [redacted] arrest, he was brought to Aurora Health Care due to his expression of homicidal thoughts; however, he was not admitted for psychiatric treatment.

In addition to having a history of depression and suicidal ideation, Mr. [redacted] has heard voices, including command hallucinations, which urged him to shoot himself and he has struggled with thought disorganization. He also has a longstanding delusion that his sister was spitting in his eyes and in his food. His medical records reflect that he has a history of medication non-compliance while living in the community. His previous diagnoses have included *Schizoaffective Disorder, Major Depressive Disorder with Psychotic Features, Unspecified Anxiety Related Disorder, Impulse Control Disorder,* and *Traumatic Brain Injury with Deficits in Cognition*.

Prior to his admission to MMHI, while detained in Milwaukee County Jail, Mr. [redacted] was placed on suicide precautions after he expressed suicidal ideation related to his incarceration. He was housed on the Special Needs Unit. He was described by jail staff as disoriented and slow to respond to questions. Jail staff believed that he was experiencing symptoms of psychosis including thought blocking, poverty of thought, and auditory hallucinations. He was placed on suicide watch again on 09/27/2022, after expressing suicidal ideation related to his incarceration. He was prescribed Depakote (for seizures), fluoxetine (an antidepressant), olanzapine (an antipsychotic), and hydroxyzine (for sleep). He often refused to accept his psychiatric medications while he was detained.

Legal History

According to the State of Wisconsin Department of Justice Criminal History and the Consolidated Court Automation Program (CCAP) for Wisconsin Circuit Courts, Mr. [redacted]'s current pending charge is his only known involvement with the criminal justice system.

PREVIOUS FORENSIC EVALUATIONS AND JAIL-BASED TREATMENT TO COMPETENCY

Authored by Deborah L. Collins, Psy.D., ABPP, dated 09/19/2022

Mr. [redacted]'s competency to proceed to trial related to his current criminal complaint was initially evaluated by Dr. Collins on 09/07/2022 (report dated 09/19/2022) pursuant to the provisions of WSS 971.14(2). According to Dr. Collins, Mr. [redacted] reportedly presented with significant difficulty sustaining attention, he was repeatedly distracted, his productivity was limited, and he struggled to offer relevant historical information. He also reportedly presented with thought disorganization, and he appeared to be responding to internal stimuli. Dr. Collins stated, "Mr. [redacted]'s speech and cognitive abilities were compromised by an impediment presumably related to [his] self-inflicted gunshot would […] resulting in permanent brain damage." In totality, Dr. Collins diagnosed Mr. [redacted] with *Schizophrenia* and *Major Neurocognitive Disorder Due to a Traumatic Brain Injury*.

Mr. [redacted] was reported to demonstrate brief and cursory recollections of the allegations against him, but comments he made related to his allegation were not self-preserving. He was reportedly unconcerned about his legal situation, and when Dr. Collins attempted to explain possible dispositional outcomes, Mr. [redacted] "stared off and then digressed into commentary about Christianity, a matrix and being 'no age at all.'" It was Dr. Collins's opinion that Mr. [redacted] lacked substantial mental capacity to understand the proceedings against him or assist in his own defense but was likely to be restored to trial competency. Dr. Collins indicated Mr. [redacted]'s deficits derived from both his TBI and his acute symptoms of mental illness. Dr. Collins also noted an accurate appraisal of Mr. [redacted]'s restorability was difficult to ascertain due to a lack of records.

Re: [redacted]
Case No.: [redacted]

Jail-Based Competency Restoration Program
As Mr. [redacted] awaited admission to MMHI to be treated to competency, he was seen the Jail-Based Competency Restoration (JBCR) program for four sessions. During these contacts, Mr. [redacted] was minimally productive and often responded with silence to questions asked of him. He appeared to be internally preoccupied and reported experiencing visual hallucinations (e.g., a hand coming through the wall). He was non-adherent with his prescribed psychiatric medications at the time of these contacts.

Authored by Sergio Sanchez, Psy.D., dated 01/05/2023
Mr. [redacted]'s competency to proceed to trial related to his current criminal complaint was re-evaluated by Dr. Sanchez on 12/28/2022 and 12/31/2022 (report dated 01/05/2023) pursuant to the provisions of WSS 971.14(5). According to Dr. Sanchez, on 12/28/2022, security staff at the Milwaukee County Jail informed the evaluator that Mr. [redacted] refused to participate in the scheduled interview. Dr. Sanchez then left the facility, and approximately 30 minutes later he was contacted by jail staff and informed Mr. [redacted] now agreed to participate. Upon Dr. Sanchez's return to the jail, Mr. [redacted] again refused to meet with the evaluator. On 12/31/2022, Dr. Sanchez again attempted to meet with Mr. [redacted], but he was informed by security staff that Mr. [redacted] did not respond when he was informed that he had a scheduled visit. Dr. Sanchez did not offer a diagnosis in his evaluation. He opined Mr. [redacted] continued to lack substantial mental capacity to understand the proceedings against him or assist in his own defense but was likely to be restored to trial competency. It was reported, "Mr. [redacted]'s deficits and symptoms of a TBI and major mental illness continue to significantly impair his ability to engage in a meaningful and reciprocal dialogue."

Authored by Ana Garcia, Ph.D., dated 03/28/2023
Following his admission to MMHI, Mr. [redacted]'s competency to proceed to trial related to his current criminal complaint was evaluated by Dr. Garcia on 03/27/2023 (report dated 03/28/2023) pursuant to the provisions of WSS 971.14(5). According to Dr. Garcia, Mr. [redacted] reportedly presented with notably poor hygiene. He often paused before responding and it was unclear whether this was due to impaired processing speed, lack of knowledge, or disengagement from the interview. Mr. [redacted] ultimately told the evaluator he would "not follow unit rules" and he then rubbed his groin. The interview was subsequently terminated following this. Dr. Garcia diagnosed Mr. [redacted] with *Unspecified Schizophrenia Spectrum and Other Psychotic Disorder* and a provisional *Unspecified Neurocognitive Disorder*. She also administered the Test of Malingered Memory (TOMM) in her evaluation. His performance on the TOMM did not reflect the presence of feigned memory impairment.

Mr. [redacted] was reported to demonstrate some cursory factual knowledge about court, but he had not demonstrated, in any context, an expressed understanding or appreciation for the charge he faced. It was the opinion of the evaluator that it was possible acute symptoms of psychosis were precluding his rational approach to his defense. It was Dr. Garcia's opinion that Mr. [redacted] continued to lack substantial mental capacity to understand the proceedings against him or assist in his own defense but was likely to be restored to trial competency.

Authored by Mitchell Illichmann, M.D., dated 04/11/2023
On 04/11/2023, Mr. [redacted]'s treating psychiatric provider at the time submitted a request for an Involuntary Order of Medication Administration (Order to Treat or OTT). Dr. Illichmann indicated Mr. [redacted] met criteria for a schizophrenia spectrum illness, and that he has consistently declined his offered antipsychotic medication since 04/03/2023. According to CCAP, in a hearing on 04/24/2023, the OTT was granted. Mr. [redacted] then received one injectable dose before his attorney filed a motion to stay the

Re: [redacted]
Case No.: [redacted]

OTT pending appeal, which was also granted. As such, aside from the one injectable dose he received, Mr. [redacted] has not been subject to the provisions of an OTT during his current course of hospitalization.

HOSPITAL COURSE SINCE ADMISSION AND CURRENT PSYCHIATRIC MEDICATION

As stated, Mr. [redacted] has continued to reside in the Forensic Program at MMHI since 01/25/2023 for inpatient care and treatment to his competency to proceed to trial pursuant to the provisions of WSS 971.14(5). He was initially admitted to the maximum-security Admission Treatment Unit (ATU) where he was required to complete a period of quarantine. When Mr. [redacted] was first admitted to MMHI he indicated that he was unaware of the reason for his admission. He typically replied with "I don't know" to most questions or he declined to answer questions all together. He offered minimal background history other than to provide the treatment team with his mother's telephone number. During his brief time on ATU, Mr. [redacted] generally isolated in his room and did not engage with his treatment providers. He did endorse ongoing auditory hallucinations, visual hallucinations, and delusions including that someone was spitting on him. He did not bathe while on ATU and claimed that he "stays clean magically." Mr. [redacted] had one incident of restraint and seclusion on ATU. On 02/09/2023, he did not comply with staff directives to wear his mask while under quarantine and he swore and spit at staff. He then threatened, "I will shoot that dude in the head 15 times." A code was called, and a spit mask was applied. He initially agreed to walk back to his room but ultimately had to be secured to a gurney for transport. During another incident, which did not result in his seclusion, after eating dinner he got up from the table and started running out of the dayroom. Staff ultimately were able to direct him to his room.

On 03/02/2023, Mr. [redacted] was transferred from ATU to a less restrictive maximum-security unit, the East Admission Medical Unit (EAMU). On EAMU, Mr. [redacted] continued to isolate, and he refused to meet with the treatment team for his transfer staffing. He was noted to urinate and defecate in his room and refused to leave his room to allow it to be cleaned. He once said, "Get the fuck out bitch" and continued to lay in bed while staff cleaned his room. On 03/07/2023, Mr. [redacted] told a nurse, "I just wanna go home. I've been here weeks. I'm supposed to go home. I was admitted the 25th of January." The next day, he was observed defecating in his room on top of his sweatshirt. He was asked to remove the soiled sweatshirt from his room and dispose of his feces into the toilet. Mr. [redacted] took his sweatshirt, with the feces in it, and left it on bathroom floor. He then left the bathroom and ignored staff. He was later observed shadow boxing in his room. During the month of April 2023, Mr. [redacted] engaged in several rule violations (e.g., swinging at staff, refusing to shower after continuously defecating on himself, etc.) and was uncooperative with staff. It was the previous evaluator's opinion these behaviors were volitional and not a product of cognitive deficits, because he appeared able to follow unit rules when he was motivated to do so.

Since his last competency to proceed to trial evaluation was submitted (report dated 03/28/2023), Mr. [redacted] was transferred from the maximum-security East Admission Medical Unit (EAMU) back to the maximum-security Admission Treatment Unit (ATU). His transfer was secondary to ongoing issues related to defecating on himself and increasing agitation. Specifically, Mr. [redacted] was observed smearing feces in his room, he then hit staff in the face with his feces, and he spit and kicked other staff members. He continued to throw feces at staff's faces throughout the interaction. Upon return to ATU, Mr. [redacted] met with his treatment team to discuss his reason for transfer and his ongoing restoration to competency. During that meeting, Mr. [redacted] initially was mute, but after several prompts from staff he minimally engaged. He reported he "doesn't like" his medication because they "taste nasty," but he also claimed they "make [him] grow facial hair." He did not report any acute perceptual disturbances at that time, but he described the voices he hears as his "friends." Approximately one week later, he met with his treatment team again and reported being "depressed" about being at MMHI. Throughout the entirety of that interaction, he was observed rocking back and forth in his chair, and he offered a number of unintelligible responses. He was asked about his ongoing defecation, and he reported he "does not like using toilets other

people use." He then stated he is "supposed to live in water, the ocean," and that people "can poop in the ocean." During that same meeting, he agreed to work with his occupational therapist to devise an incentive plan for him to discontinue defecating on himself. Although this was beneficial at first, Mr. [redacted] has continued to defecate on himself almost daily since that time.

Throughout much of Mr. [redacted]'s remaining hospitalization, he continued to defecate and smear his feces in his room. Further, he has increasingly been more defiant with showering or changing clothes after he defecates on himself. He has demonstrated ongoing irritability, and he appears to have a significantly low frustration tolerance. It even appears as though some of his defecation is in response to real or perceived stressors. His psychiatric provider indicates his defecation appeared driven by regression, frustration, and anxiety about his prolonged hospitalization. It was noted he had a limited understanding of why he was a MMHI, which increased his frustrations. Since early June 2023, Mr. [redacted] has almost entirely disengaged from staff. His motivation to participate in offered programming, or even daily check-ins with his psychiatric provider is significantly limited. His responses to questions from his treatment team has significantly decreased, as has his general day-to-day engagement with unit staff. Of the 79 groups offered to him since he was transferred back to ATU, he only attended or partially attended 18 groups. The groups he attended were mostly occupational therapy groups focused on relaxation, recreation, spirituality, and movies/music. During those groups, he required prompting from facilitators and assistance with completing group tasks. A review of group notes reflects Mr. [redacted] often declined to attend groups, or he was room restricted due to continued defecation and was ineligible to participate.

Mr. [redacted]'s psychiatric provider diagnosed him with *Unspecified Schizophrenia Spectrum and Other Psychotic Disorder* and *Mild Intellectual Disability*. He is currently prescribed divalproex sodium (a mood stabilizer) 1,000 milligrams at night for agitation, fluoxetine (an antidepressant) 20 milligrams at night for anxiety, hydroxyzine (an antihistamine) 20 milligrams at night for anxiety, and paliperidone (an antipsychotic) 15 milligrams at night for psychosis. He is also prescribed medications for physical ailments such as amlodipine (for hypertension), cholecalciferol (for Vitamin D deficiency), and ferrous sulfate (for iron deficiency). Despite having a stayed OTT, Mr. [redacted] has largely been compliant with his psychiatric medications. He is sporadically, though mostly, compliant with his physical medications.

SUMMARY OF ADAPTIVE FUNCTIONING AND INTELLECTUAL TESTING

The test interpretations presented below are based on the use of empirically validated instruments, but they do not stand alone or in isolation from other information about Mr.[redacted] The undersigned used clinical judgment aided by clinical interviews and psychological test interpretation for presentation here.

Independent Living Skills (ILS)

Mr. [redacted] was administered the Independent Living Skills (ILS) by Amanda Hellestad, OTR/L, on 05/30/2023. The ILS is a standardized assessment of competence in instrumental activities of daily living that can be used to determine the degree of independence of a person and can be used to make recommendations for appropriate living situations. Mr.[redacted] was given target situations in which he had to problem solve, demonstrate knowledge, and/or perform certain tasks related to independent living. It is comprised of five subscales: Memory/Orientation, Managing Money, Managing Home and Transportation, Health and Safety, and Social Adjustment. In addition, two factors: problem-solving and performance/information may be derived from some of the subscale items. The ILS gives information about a person's ability to attend to tasks, to follow verbal directions and visual demonstrations, to problem solve, and determine the level of independence for community placement. Information from the ILS ranges from the Full Scale Score to the individual item scores and is a global indicator of living independently (high-functioning), semi-independently (moderate functioning), or dependently (low functioning).

Re: [redacted]
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Mr. [redacted] was cooperative during the entire evaluation process. He benefited from being able to read the questions he needed to answer. It should also be noted that Mr. [redacted] often talked about his superpowers and needed prompts to answer the questions as if he did not have superpowers. He appeared to be putting forth his best effort and was calm during all testing.

Results of testing placed Mr. [redacted]'s Full Scale Standard Score at 55, which is the lowest Full Scale score possible for this assessment. His score indicates that Mr. [redacted]'s level of functioning is low and is dependent upon others regarding his living situation. His individual subscale scores are as follows and please note 20 is the lowest score possible for each subscale:

Subscales	Standard Score	Level of Independence
Memory/ Orientation	31	**Low** (Dependent)
Managing Money	20	**Low** (Dependent)
Managing Home and Transportation	20	**Low** (Dependent)
Health and Safety	20	**Low** (Dependent)
Social Adjustment	20	**Low** (Dependent)

Factor	Standard Score	Level of Independence
Problem Solving	20	**Low** (Dependent)
Performance/ Information	24	**Low** (Dependent)

The subscale scores in all areas indicate that Mr. [redacted] will require assistance and is unable to live independently in the community at this time. The factor scores also indicate that Mr. [redacted] does not have the various knowledge, abilities, and problem-solving skills necessary for independent living.

According to Mr. [redacted]'s occupational therapist, the results of testing reflect Mr. [redacted] does not exhibit the capacity of sufficient living skills in order to live independently in the community. It was recommended that he receive a 24 hour supervised and structured living environment, especially for physical/health and home safety, in order to be successful in the community. This type of environment will assist in structuring his full daily activity routine including interactions with peers and medication management. There are many areas of daily and routine living skills in which Mr. [redacted] has deficits in. He would benefit from a predictable routine. Additionally, driving was not recommended, and assistance with transportation is required. It was also recommended he have a payee.

Intellectual Functioning

Mr. [redacted]'s current level of intelligence and cognitive functioning was measured with the Wechsler Adult Intelligence Scale – Fourth Edition (WAIS-IV), which was administered according to standard procedures and is considered to be a valid representation of Mr. [redacted]'s current cognitive functioning. The WAIS-IV is an individually administered test which measures overall cognitive functioning in adults from ages 16 to 90 years old while also assessing cognitive strengths and weaknesses. Typically, 10 to 15 subtests are administered to calculate four index scores and a Full Scale Intelligence Quotient (FSIQ). The Full Scale IQ score is considered to be the score to best represent general intellectual functioning and is comprised of four indices, the Verbal Comprehension Index (VCI), the Perceptual Reasoning Index (PRI), the Working Memory Index (WMI), and the Processing Speed Index (PSI). Each index score of the WAIS-IV is obtained from subtests and has a mean (or average) of 100 with a standard deviation of 15. Similarly, to the index scores, the subtests each have a mean and standard deviation which are 10 and 3, respectively. Mr. [redacted] obtained the following scores:

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WAIS-IV Score Profile			
Index/Subtest	**Scaled Score**	**Percentile**	**Descriptor**
Verbal Comprehension Index (VCI)	**72**	**3**	**Borderline**
Similarities	5		
Vocabulary	5		
Information	5		
Perceptual Reasoning Index (PRI)	**73**	**4**	**Borderline**
Block Design	6		
Matrix Reasoning	3		
Visual Puzzles	7		
Working Memory Index (WMI)	**77**	**6**	**Borderline**
Digit Span	5		
Arithmetic	7		
Processing Speed Index (PSI)	**63**	**< 0.1**	**Extremely Low**
Symbol Search	1		
Coding	1		
Full Scale Intelligence Quotient (FSIQ)	**63***	**1**	**Extremely Low**
General Ability Index (GAI)	**70**	**2**	**Borderline**
* FSIQ was not interpretable as a unitary construct based on the variation of scores among the indexes			

Due to too much variation in his index scores, Mr. [redacted]'s FSIQ is not interpretable. The General Ability Index (GAI) score is a measurement generated from the six subtest scores within the VCI and PRI and is considered a good estimate of an individual's overall intellectual functioning when the FSIQ is not interpretable. Mr. [redacted] obtained a GAI score of 70 which places him in the 1st percentile rank. This suggests his general level of cognitive ability fell within the Borderline range when compared with same-age peers. Although scores can fluctuate across time and repeated administrations, there is a 95% likelihood he would score between 63 and 74 points if tested again under similar conditions.

The VCI is representative of Mr. [redacted]'s ability to recall and articulate factual and verbal knowledge in addition to applying it to a verbal reasoning task. The VCI measures language development, general fund of knowledge, vocabulary, and ability to elaborate on verbal information and is comprised of the Similarities, Vocabulary, and Information subtests. Mr. [redacted]'s score on the VCI was a 72 which fell in the Borderline range when compared to his peers and places him in the 3rd percentile. There were no significant differences between the subtests suggesting this score is a valid representation of Mr. [redacted]'s ability to recall and articulate factual and verbal knowledge in addition to applying it to a verbal reasoning task. There is a 95% likelihood he would score between 67 and 79 points if tested again under similar conditions.

The PRI is designed to assess an examinee's visual-motor coordination, visual processing, spatial reasoning, and problem-solving abilities. The PRI is also an indicator of mental visualization of images, nonverbal reasoning, and ability to quickly interpret and organize visual information. The subtests used to obtain this score are Block Design, Matrix Reasoning, and Visual Puzzles. Mr. [redacted]'s score on the PRI was a 73 which fell in the Borderline range when compared to his peers and places him in the 4th percentile. There were no significant differences between the subtests suggesting this score is a valid representation of Mr. [redacted]'s visual-motor coordination, visual processing, spatial reasoning, and problem-solving abilities. There is a 95% likelihood he would score between 68 and 81 points if tested again under similar conditions.

The WMI is designed to measure the ability to hold information in immediate memory, as well as sustain attention, concentration, and use mental control. The WMI measures a respondent's skills in short term

rote and working memory, cognitive flexibility, and mental manipulation from immediate memory. The WMI score is composed of the Digit Span and Arithmetic subtests. Mr. [redacted]'s score on the WMI was a 77 which fell in the Borderline range when compared to his peers and places him in the 6th percentile. There were no significant differences between the subtests suggesting this score is a valid representation of Mr. [redacted]'s working memory, cognitive flexibility, and mental manipulation ability. There is a 95% likelihood he would score between 72 and 85 points if tested again under similar conditions.

The PSI is designed to measure the ability to observe and quickly process non-verbal visual information. The PSI also measures the ability to carry out precise motor movements, level of motivation, and capacity to concentrate on specific tasks. The PSI is composed of the Symbol Search and Coding subtests. Mr. [redacted]'s score on the PSI was a 50 which fell in the Extremely Low range when compared to his peers and placed him in the <0.1 percentile. There were no significant differences between the subtests suggesting this score is a valid representation of Mr. [redacted]'s ability to observe and quickly process non-verbal visual information. There is a 95% likelihood he would score between 47 and 63 points if tested again under similar conditions.

Notably, all four of Mr. [redacted]'s index scores are considered normative weaknesses when compared to peers his age. His working memory index, his short-term memory, and visual processing abilities are considered personal strengths (i.e., compared to his own scores in other areas). In contrast, his processing speed and fluid reasoning are considered personal weaknesses. Furthermore, his processing speed is also considered a High Priority Concern.

MENTAL STATUS EXAMINATION AND BEHAVIORAL OBSERVATIONS

On each of the attempted interview days and times, the undersigned met with Mr. [redacted] at his door on his unit of residence at MMHI. As Mr. [redacted] declined to participate in any of the attempted interviews, a full mental status examination could not be completed. Below are limited behavioral observations made.

Mr. [redacted] is a 20-year-old man who appeared his chronological age. He is of below average height and average build. During each of the attempted interview times on 06/15/2023, Mr. [redacted] was asleep in his room. He was approached at his room door at various times of day (e.g., 9:30AM and 1:00PM). At each of those times, he did not respond, verbally or non-verbally, to any of the undersigned's inquires. He was informed another interview would be attempted on a later date when he was more alert. On the morning of 06/20/2023, during a treatment team meeting prior to the undersigned's next scheduled interview with Mr. [redacted], it was reported Mr. [redacted] was room restricted (i.e., could not leave his room) because he defecated on himself two days prior, had continued to defecate on himself, and refused to change clothes or shower since that time. As such, and in consideration of all of the information known about Mr. [redacted]'s clinical presentation throughout his course of hospitalization, the undersigned elected to forgo the third attempted interview.

CLINICAL FINDINGS (DSM-5)

It is the undersigned's opinion, to a reasonable degree of professional certainty, that Mr. [redacted]'s *Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5)* diagnoses are as follows:

Intellectual Disability (Intellectual Developmental Disorder), Moderate
Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

According to the *DSM-5,* Intellectual Disability (Intellectual Developmental Disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in

conceptual, social, and practical domains. The following three criteria must also be met: (1) deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing; (2) deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community; (3) and the onset of intellectual and adaptive deficits occurs during the developmental period. The severity level (i.e., mild, moderate, severe, profound) are defined on the basis of adaptive functioning, and not IQ scores, because it is adaptive functioning that determines the level of support required. Of note, in acquired forms, the onset may be abrupt following illnesses such as meningitis or encephalitis, or following a traumatic brain injury (TBI) during the developmental period.

Mr. [redacted] sustained a self-inflicted gunshot wound to the head when he was approximately 12 years old, which resulted in a hospitalization from November 2014 through January 2015. During that time, he underwent a decompressive craniotomy and a skull repair. He subsequently demonstrated left-side weakness and neglect, and a decline in visual spatial tasks and visual spatial memory. Results of his most recent intellectual assessment reflect he has a General Ability Index of 70, which places his intellectual functioning in the Borderline range. Results from adaptive functioning assessment reflect Mr. [redacted] does not exhibit the capacity of sufficient living skills in order to live independently in the community. It was recommended that he receive a 24 hour supervised and structured living environment, especially for physical/health and home safety, in order to be successful in the community. In totality, Mr. [redacted] has demonstrated notable deficits in both intellectual and adaptive functioning, to include behavioral dysregulation and low frustration tolerance, following a self-inflicted gunshot wound approximately eight years ago. As such, Mr. [redacted] meets criteria for *Intellectual Disability (Intellectual Developmental Disorder).* The specifier *'Moderate'* was applied to reflect the level of impairment in Mr. [redacted]'s adaptive functioning (e.g., ongoing assistance to complete conceptual tasks of day-to-day life, less-complex spoken language, limited decision-making abilities and social judgment, and considerable support/teaching from others regarding hygiene, elimination, employment, transportation, and money management).

According to the *DSM-5,* Schizophrenia Spectrum and Other Psychotic Disorders are defined by abnormalities in one of more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms. Mr. [redacted] has a history of experiencing delusions and perceptual disturbances, and he has historically been treated with antipsychotic medication. However, at this present time, little is known about Mr. [redacted]'s symptoms of severe mental illness, to include the onset, severity, and duration. For that reason, the diagnosis of *Unspecified Schizophrenia Spectrum and Other Psychotic Disorder* is the most appropriate diagnosis at this time. This diagnosis applies to presentations in which symptoms characteristic of a schizophrenia spectrum and other psychotic disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet full criteria for any of the disorders in the schizophrenia and other psychotic disorder diagnostic class.

COMPETENCY ASSESSMENT

Wisconsin State Statute (WSS) 971.13(1) states: "No person who lacks substantial mental capacity to understand the proceedings or assist in his or her own defense may be tried, convicted, or sentenced for the commission of an offense so long as the incapacity endures."

During his last competency evaluation, Mr. [redacted] was asked why he was admitted to MMHI. He replied, "I've been here since January." He then declined to elaborate on his response. He was provided with

education about his treatment to competency commitment. When asked what it means to be competent to stand trial he replied, "know stuff about court." He stated that a defendant was, "a public defender or lawyer," and he was then provided with education in this domain. He stated that when he is in the courtroom he should behave "good," but was unfamiliar with the concept of contempt of court. He, however, responded correctly to yes or no questions regarding courtroom etiquette. Mr. [redacted] indicated that the role of the Judge was to "judge people, who is guilty and who is not guilty." He was further aware of the Judge's authority in the courtroom and their role in sentencing. He stated that a jury was "12 people who judge people and see if the suspect is guilty." He indicated that a witness was "evidence." He then paused and said to the evaluator, "I'm not going to follow y'all's rules. I'm a witch." He then put his hands on his lap, began smiling, and rocked his body slightly. The evaluator requested that he put his hands on the table and he refused. Efforts to reengage him in the interview were unsuccessful. Given his inappropriate behavior, the interview was terminated.

For the purposes of the current evaluation, Mr. [redacted] did not participate despite multiple attempts made by the undersigned. A review of his most recent MMHI records does not reflect Mr. [redacted] has a factual or rational understanding or appreciation for his current legal situation. He has continued to demonstrate issues related to memory and behaviors, and he has continuously defecated on himself and neglected his own hygiene for the majority of his current hospitalization. Presently, he appears to have very limited frustration tolerance, he has almost entirely disengaged from his treatment team/unit staff, and he continues to require significant assistance/prompts from staff to complete basic day-to-day functions (e.g., shower). It is very likely that if Mr. [redacted] were to return to Court at this time, he would likely remain mute and significantly struggle to assist his attorney in formulating a rational, self-preserving legal strategy.

OPINION AND RATIONALE

Wisconsin State Statute (WSS) 971.14(3)(d) states: "If the examiner reports that the defendant lacks competency, the examiner [shall render] an opinion regarding the likelihood that the defendant, if provided treatment, may be restored to competency within the [statutory] period."

Mr. [redacted] currently meets diagnostic criteria for *Intellectual Disability (Intellectual Developmental Disorder), Moderate* and *Unspecified Schizophrenia Spectrum and Other Psychotic Disorder*. Available records indicate Mr. [redacted] has a history of a self-inflicted gunshot wound to the head when he was approximately 12 years old. There was a decline in functioning post-injury. Complicating his clinical presentation is the co-morbid psychosis he experiences. He has been diagnosed with varying psychotic disorders in the past, to include Schizophrenia. However, based on his current clinical presentation (i.e., a lack of motivation or engagement, minimal verbal responses to questions asked, etc.), gathering information about his symptom onset, severity, and duration has been fruitless. He has a history of medication non-compliance within the community, and he was recently granted an OTT during his MMHI hospitalization. The OTT was stayed upon appeal, but Mr. [redacted] has been largely compliant with his psychiatric medication regimen since at least mid-April. He has been admitted to MMHI for competency restoration services for approximately five months. Since his admission, he has continued to demonstrate impaired functioning, cognitive impairment, difficulty maintaining appropriate behaviors, poor hygiene, and he has continuously defecated on himself, smeared his feces, or used his feces as weapons against staff. He has not demonstrated any consistent awareness of why he was admitted to MMHI, he has not demonstrated an understanding of his current legal situation, and he fails to appreciate the significance of his pending charge and the possible dispositional outcomes. At this time, his observable symptoms of psychosis appear well-managed on his medication regimen. However, his cognitive and functional impairments remain significant barriers to his competency to proceed.

*At this time, it is the opinion of the undersigned, to a reasonable degree of professional certainty, that Mr. [redacted] **continues to lack substantial mental capacity** to understand the proceedings against him and assist in his own defense, and he is **not likely to be restored to competency** within the statutory period.*

As stated above, Mr. [redacted] meets diagnostic criteria for *Intellectual Disability (Moderate)*, and his low level of intellectual/cognitive functioning is acting, and will likely always act, as an impediment to his ability to apply his limited knowledge of the competency issues rationally and adequately to any future legal situation/proceedings. Mr. [redacted]'s intellectual functioning also interferes with his capacity to adequately assist his attorney in his own defense, as he does not, and likely never will, appreciate the nature of the legal proceedings in which he is involved. Therefore, he will not be able to plan an effective defense strategy with his attorney, no matter how much training/treatment is provided to him. Furthermore, given that the clinical condition of *Intellectual Disability (Moderate)* does not change over time, it is the undersigned's opinion that Mr. [redacted] will be unable to attain adjudicative competence within the statutory period.

RECOMMENDATIONS

Wisconsin State Statute 971.14(5)(b) requires that "any competency report indicating that a defendant has not made such progress that attainment of competency is likely within the remaining commitment period shall include the examiner's opinion regarding whether the defendant is mentally ill, alcoholic, drug dependent, developmentally disabled or infirm because of aging or other like incapacities." As stated, Mr. [redacted] has a history of psychosis with co-morbid neurocognitive deficits secondary to a self-inflicted gunshot wound to the head when he was approximately 12 years old. At this time, he continues to report acute symptomatology related to his serious thought disorder (i.e., perceptual disturbances, delusional ideation), and he continues to demonstrate significantly impaired functioning (i.e., repeated defecation on self, refusal to change clothes/shower, requires consistent prompts from staff, lack of engagement with his treatment team, etc.). Since he was admitted to MMHI approximately five months ago, Mr. [redacted] has continued to demonstrate functional impairment, a low frustration tolerance, and physical violence. Of significant concern is that Mr. [redacted] has physically harmed or attempted to physically harm various staff members at MMHI, and he required the use of seclusion and restraint on numerous occasions due to his physical aggression, agitation, and secondary to continued defecation/smearing of feces. He has been mostly complaint with his psychiatric medication regimen, and most of his acute symptoms of psychosis appear to be well-managed. As stated above, he continues to meet diagnostic criteria for *Intellectual Disability (Intellectual Developmental Disorder), Moderate* and *Unspecified Schizophrenia Spectrum and Other Psychotic Disorder*, which independently and in conjunction grossly impairs his judgment, behavior, capacity to recognize reality, evaluative capacity, risk of harm to self and others, and ability to meet the ordinary demands of life.

When a Court determines it is unlikely a defendant will become competent within the remaining commitment period, it may choose to proceed under WSS 971.14(6)(b) and petition for examination pursuant to s. 51.20 (i.e., involuntary commitment for treatment). As Mr. [redacted] has demonstrated persistent physical aggression, threats of violence, and other unsafe behaviors within one of the highest security maximum-security units at MMHI, he will likely remain dangerous to himself and others if he were released back to the community. As such, it is recommended the Court consider pursuing conversion to civil commitment. Additionally, given Mr. [redacted]'s current level of functioning, which significantly impacts his behaviors, evaluative capacity, and risk of harm to himself and others, the Court may also choose to pursue appointment of guardianship pursuant to WSS 54.10 under the procedures specified in s. 48.9795. Of note, however, is that guardianship is non-emergent and can be pursued as and if needed. The ATU clinical team has already reached out to Milwaukee County Corp Counsel in regard to this matter.

Re: [redacted]
Case No.: [redacted]

If you have any further questions, please do not hesitate to contact the undersigned at jeffrey.washelesky@dhs.wisconsin.gov or (608) 301-1489. Please note, the undersigned is unavailable to testify on Fridays.

Respectfully submitted,

Jeffrey M. Washelesky, Psy.D.

Jeffrey M. Washelesky, Psy.D.
Licensed Psychologist
Mendota Mental Health Institute

cc: MMHI Admissions
James C. Griffin, District Attorney
Mary Garvin Guimont, Defense Attorney
Katy Ruth York, Defense Attorney
Lucas Swank, Defense Attorney

STATE OF WISCONSIN

C O U R T O F A P P E A L S

DISTRICT I

Case No. 2023AP715-CR

STATE OF WISCONSIN,

Plaintiff-Respondent,

v.

J.D.B.,

Defendant-Appellant.

RESPONSE TO MOTION TO SUPPLEMENT THE RECORD

The State of Wisconsin opposes J.D.B.'s motion to supplement the appellate record in this matter. J.D.B. asks to supplement the record with the competency examination report authored by Dr. Jeffrey M. Washelesky, which was filed in the circuit court on June 27, 2023. But J.D.B. has not shown that the June 27, 2023 report is essential to resolution of the mootness issue. Grounds for the State's opposition are as follows.

1. On April 25, 2023, J.D.B. filed a notice of appeal, seeking this Court's review of an order for involuntary medication issued on April 24, 2023.

2. This Court granted a temporary stay of the involuntary medication order on April 26, 2023.

3. The record on appeal in this matter was compiled and submitted to the Court on June 1, 2023.

4. This Court granted a stay of the involuntary medication order on June 8, 2023, pending a decision from this Court resolving the appeal.

5. The competency report, with which J.D.B. now seeks to supplement the record, was filed in circuit court on June 27, 2023.

6. J.D.B. filed his merits brief in this Court on August 11, 2023, arguing (as relevant here) that his case was not moot because he was still liable for the costs of care related to his commitment. (J.D.B.'s Br. 42.)

7. The State filed its response brief on October 30, 2023. Responding to the mootness argument noted directly above, the State asserted:

> J.D.B. has not argued that prevailing on appeal would relieve him of liability for the cost of his medication. (J.D.B.'s Br. 42.) Even if he had argued that, there is no authority for that proposition. Wisconsin Stat. § 46.10(2) renders a person committed under § 971.14(2) and (5) "liable for the cost of the care, maintenance, services and supplies in accordance with the fee schedule established by the department under s. 46.03(18)." In turn, Wis. Admin. Code § DHS 1 (Uniform Fees, Liability and Collections) sets the relevant fee schedule. But § DHS 1 does not reveal a fee structure showing it is possible to separate out liability for medication that is rendered involuntarily. And more to the point, this Court stayed the order for involuntary medication on June 8, 2023. The record does not show that J.D.B. ever received medication involuntarily, pursuant to the April 24 order.

(State's Br. 19–20.)

8. J.D.B. now moves to supplement the record with the June 27, 2023 report, because the report includes this line:

> According to CCAP, in a hearing on 04/24/2023, the OTT [Order to Treat] was granted. [J.D.B.] then received one injectable dose before his attorney filed a motion to stay the OTT pending appeal, which was also granted. As such, aside from the one injectable dose he received, [J.D.B.] has not been subject to the provisions of an OTT during his current course of hospitalization.

(Mot. to Supp. at 12–13.)[1]

9. The State opposes J.D.B.'s request to supplement as unnecessary, for at least two reasons. First and foremost,

[1] When citing to J.D.B.'s motion to supplement and his appendix, the State uses page numbers located in the upper right corner of the document.

this report is not evidence that J.D.B. is liable for the cost of any medication rendered involuntarily. Therefore, the report does nothing to undermine the State's argument that this case is moot.

10. Second, as a general matter, the report should not be part of the appellate record. The report was issued more than two months after the subject order for involuntary medication was entered. The record on appeal was transmitted on June 1, 2023. For the purpose of briefing this appeal, the record "accurately reflect[s] what occurred in the circuit court." Wis. Stat. § (Rule) 809.15(3). J.D.B. does not argue that the report, absent the two sentences noted directly above, is relevant to the mootness issue that the parties are briefing.

11. For these reasons, the State opposes supplementing the record with the report. That said, for the purposes of this appeal, the State does not dispute that the June 27, 2023 report contains the statement noted in paragraph 8 above. The State does not agree that this

statement is evidence that J.D.B. is liable for costs associated with any involuntary medication he received.

12. If this Court grants J.D.B.'s motion to supplement the record with this report, the State respectfully requests that the Court order that the report is made part of the record solely for the purpose of assessing the parties' mootness arguments. The State would object to use of this report for the purpose of making new arguments on reply.

Dated this 28th day of November 2023.

Respectfully submitted,

JOSHUA L. KAUL
Attorney General of Wisconsin

Electronically signed by:

Jennifer L. Vandermeuse
JENNIFER L. VANDERMEUSE
Assistant Attorney General
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March 28, 2023

The Honorable Milton L. Child
Circuit Court Judge, Branch 2
Milwaukee County Courthouse
901 North 9th Street
Milwaukee, WI 53233-1425

Re: J[redacted] B[redacted]
DOB: 11/24/2002
Case No.: 22-CF-3407

Dear Judge Child:

Pursuant to the court order dated October 11, 2022, and WSS 971.14(5), Mr. B[redacted] was admitted on January 25, 2023, to the Forensic Program at Mendota Mental Health Institute (MMHI) for treatment for and evaluation of his competence to proceed. According to Wisconsin State Statute §971.13, "no person who lacks substantial mental capacity to understand the proceedings or assist in his or her own defense may be tried, convicted, or sentenced for the commission of an offense so long as the incapacity endures." Mr. B[redacted] a 20-year-old man, is facing the charges of Battery to a Law Enforcement Officer.

STATEMENT OF NONCONFIDENTIALITY

At the time of admission, and again at the time of this writer's competency evaluation interview with Mr. B[redacted] he was informed that he was being evaluated for his competence to proceed. He was also told that the evaluation was legally required, and that if he chose not to participate, this information would be included in the report to the Court and any testimony that might follow. In addition, he was informed that the report would not be confidential and that copies of it would be sent to the Court, his attorney, and the district attorney. He indicated that he understood the above information and agreed to participate in the interview.

SOURCES OF INFORMATION

1. Review of Mr. B[redacted] records, including:
    a. Mr. B[redacted] Criminal Record according to the Crime Information Bureau (CIB) and Consolidated Court Automation Programs (CCAP) for Wisconsin, access date 3/02/2023
    a. Current Criminal Complaint against Mr. B[redacted]
    b. Competency Examination authored by Deborah Collins, Psy.D., ABPP dated 9/19/2022
    c. Competency Examination authored by Sergio Sanchez, Psy.D., dated 1/05/2023
    d. Records from the Milwaukee County Jail
    e. Records from the Jail Based Competency Restoration (JBCR) program
    f. Records from the Milwaukee Public Schools
    g. Records from Rogers Behavioral Health, (RBH)
    h. Records from St. Mary's Hospital
    i. Records from Milwaukee County Behavioral Health Division (BHD)
    j. Records from Aurora Psychiatric Hospital

k. Records from Children's Hospital of Wisconsin
l. Records from Froedtert Hospital
m. Records from St. Francis Hospital
n. Mr. B[redacted] records generated during his admission to MMHI

2. Consultation with:
   a. Mitchell Illichmann, M.D., Mr. B[redacted] attending psychiatrist
   b. MMHI direct care staff who have worked with Mr. B[redacted] during this admission
3. Direct observation and evaluation of Mr. B[redacted] including:
   a. Participation in his interdisciplinary transfer staffing on 3/10/2023
   b. Participation in his weekly treatment plan reviews
   c. Observation of his participation in restoration to competency groups
   d. Administration of the Test of Memory Malingering (TOMM) on 3/08/2023
   e. Administration of the Weschler Adult Intelligence Scale Fourth Edition (WAIS-IV) on 3/22/2023 & 3/24/2023
   f. Competency Interview on 3/27/2023

RELEVANT HISTORY

Social History

Mr. B[redacted] was born in Milwaukee, Wisconsin and raised by his biological mother. Mr. B[redacted] father died when he was seven years old. He is the third of his mother's five children. He has one brother and three sisters. Mr. B[redacted] denied a history of abuse or neglect. He is single, never married, and he does not have any children. At the time of his arrest, Mr. B[redacted] lived with his mother.

Educational/Employment Histories

Mr. B[redacted] progressed through the 11th grade and then withdrew, allegedly due to his belief that he had already graduated. He subsequently failed to continue attending school. In the 9th and 10th grades he attended South Division High School and then attended Bay View High School virtually (during the height of the COVID-19 pandemic). Mr. B[redacted] schooling was marked by poor attendance as he attended school 56% of the time when he was in the 8th grade, 80.3% in 9th grade, 49.1% in 10th grade, he did not attend school for the entirety of the 2019-2020 school year, and 74.4% attendance in virtual school during the 2020-2021 school year.

Prior to his head injury, Mr. B[redacted] was described as functioning in the average to low average range in reading and the above average range in math. He was able to read and understand academic work, answer comprehension questions about what he had read, had nice handwriting, did well in math, and was willing to participate in class. His mother had indicated in his IEP that prior to the injury he did not want to go to school. He picked up a gun to make a point that he really did not want to go to school, and she believed that he did not intend for the gun to go off. His mother believed that if he attended school every day, he would have "no problem getting back to where he was academically." She reported that after his accident, he was able to learn and remember things. However, he was less patient and become agitated more quickly. Mr. B[redacted] IEP suggested that he was released from occupational therapy services as "J[redacted] no longer requires occupational therapy to access his special education curriculum. He demonstrates functional performance of school-related tasks, and his academic needs are addressed by other services providers." Further, Mr. B[redacted] was described as an "advocate for himself and asks questions when he needs to gain clarification on things, he is uncertain about." His most recent standardized test scores from the 2018-2019 academic year indicated that his reading is in the low average range and math was in the average range of academic functioning.

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Mr. B[redacted] does not have a history of employment. His primary source of income is Social Security due to his cognitive and physical impairments, including paralysis.

Medical History
Mr. B[redacted] medical record is notable for a self-inflicted gunshot wound to his head (right parietal lobe) just prior to his 12th birthday (November 20, 2014). He was hospitalized from November 20, 2014, to January 7, 2015. He underwent a decompressive craniotomy (removal of a portion of the skull to allow room for brain swelling) on November 20, 2014, with an external drain placement on January 2, 2015. He underwent skull repair on January 15, 2015. Sequelae from this incident included left-sided weakness. He underwent neuropsychological testing while inpatient following his initial injury and was described as "doing well cognitively but decline in visual spatial tasks and visual spatial memory was moderately to severely impaired in some tests; evidence of visual field cut, and attention neglect of left side were noted." In the community, Mr. B[redacted] engaged in both physical and occupational therapy to address his physical deficits and left sided neglect. An occupational therapy assessment conducted at MMHI suggested no midline or sided neglect at present. He has also been diagnosed with diabetes, hypertension, and is prescribed medication to prevent seizures that can be resultant from head injuries.

Substance Use History
Mr. B[redacted] denied a history of abusing alcohol, illicit drugs, or prescription medication. He has never been diagnosed with a substance use disorder nor participated in substance abuse treatment.

Psychiatric History
Mr. B[redacted] has been psychiatrically hospitalized on several occasions due to his suicidal ideation and past attempts. He has attempted suicide at least five times including via a gunshot wound to the head and overdose (three in 2020). Hospitalizations have occurred at Rogers Behavioral Health, (RBH), St. Mary's Hospital, Aurora Psychiatric Hospital, and the Milwaukee Count Behavioral Health Division (BHD). When asked during a hospitalization at Aurora Psychiatric Hospital in 2020 about his repeated suicide attempts, he replied, "I was bored. I don't like living." His most recent psychiatric hospitalization was on January 3, 2022, after he attacked his sister. His family reported that he had stopped taking his psychotropic medication in the preceding weeks. Following Mr. B[redacted] arrest, he was brought to Aurora Health Care due to his expression of homicidal thoughts; however, he was not admitted for psychiatric treatment.

In addition to having a history of depression and suicidal ideation, Mr. B[redacted] has heard voices, including command hallucinations which urged him to shoot himself and he has struggled with thought disorganization. He also has a longstanding delusion that his sister was spitting in his eyes and in his food. His medical records suggest that he had poor medication compliance when living in the community. His previous diagnoses have included Schizoaffective Disorder, Major Depressive Disorder with psychotic features, Unspecified Anxiety Related Disorder, Impulse Control Disorder, and Traumatic Brain Injury with deficits in cognition.

Legal History
The pending charges are Mr. B[redacted] first within the criminal justice system.

Jail Behavior
Mr. B[redacted] was booked into the Milwaukee County Jail on August 27, 2022. Upon his booking, he was placed on suicide precautions after he expressed suicidal ideation related to his incarceration. He was housed on the Special Needs Unit. He was described by jail staff as disoriented and slow to respond to questions. Jail staff believed that he was experiencing symptoms of psychosis including thought blocking, poverty of thought, and

auditory hallucinations. He was placed on suicide watch again on September 27, 2022, after expressing suicidal ideation related to his incarceration. He was prescribed Depakote (for seizure disorder), fluoxetine (antidepressant medication), Olanzapine (antipsychotic medication), and hydroxyzine (to aid in sleep). He often refused to accept his psychotropic medication.

As Mr. B[redacted] awaited transfer to MMHI to be treated to competency, he was seen the Jail Based Competency Restoration (JBCR) program. During these contacts, Mr. B[redacted] was minimally productive and often responded with silence to their questions. He appeared to be internally preoccupied and reported experiencing visual hallucinations (a hand coming through the wall). He was non-adherent with his prescribed psychotropic medications at the time of their contacts.

Previous Competency Examination

Mr. B[redacted] competence to proceed was first assessed by Deborah Collins, Psy.D., ABPP and documented in a report dated September 19, 2022. During that evaluation, Mr. B[redacted] was described as having difficulty sustaining his attention, was distracted, and limited in his productivity in the discussions. At times, he smiled or giggled out of context suggesting that he was internally preoccupied. During the competency interview, he digressed into commentary about Christianity, a matrix, and being "no age at all." He further failed to demonstrate a rational appreciation of his charges to assist in his defense. He was opined to be incompetent but likely to be restored.

Mr. B[redacted] competence to proceed was next evaluated by Sergio Sanchez, Psy.D., and documented in a report dated January 5, 2023. Mr. B[redacted] refused to participate in this evaluation. Based on Mr. B[redacted] failure to make progress during JBCR sessions, he was opined to be incompetent but likely to be restored.

HOSPITAL COURSE

Mr. B[redacted] was admitted to a maximum-security forensic unit (Assessment Treatment Unit - ATU) on January 25, 2023, to be treated and evaluated for his competence to proceed. During his interdisciplinary intake interview, he indicated that he was unaware of the reason for his admission. He typically replied "I don't know" or declined to answer questions. He offered minimal background history other than to provide the treatment team with his mother's telephone number.

During his brief time on ATU, Mr. B[redacted] generally isolated in his room and did not engage with his treatment providers. He did endorse ongoing auditory hallucinations, visual hallucinations, and delusions including that someone was spitting on him. He did not bathe while on ATU and claimed that he "stays clean magically." Mr. B[redacted] had one incident of restraint and seclusion on ATU. On February 19, 2023, he did not comply with staff directives to wear his mask while under quarantine and he swore and spit at staff. He then threatened, "I will shoot that dude in the head 15 times." A code was called, and a spit mask was applied. He initially agreed to walk back to his room but ultimately had to be placed on a gurney for transport. During another incident, which did not result in his seclusion, after eating dinner he got up from the table and started running out of the dayroom. Staff ultimately were able to direct him to his room.

On March 2, 2023, Mr. B[redacted] transferred to a less restrictive maximum-security unit (East Admission Medical Unit – EAMU). On EAMU, Mr. B[redacted] continued to isolate and refused to meet with the treatment team for his transfer staffing. He was noted to urinate and defecate in his room and refused to leave his room to allow it to be cleaned. He once said, "get the fuck out bitch" and continued to lie in bed while staff cleaned his room. On March 7th he told a nurse, "I just wanna go home. I've been here weeks. I'm supposed to go home. I was admitted the 25th of January." The next day, he was observed defecating in his room on top of his sweatshirt. He was asked to remove the dirty sweatshirt from his room and dispose of his feces into the toilet. Mr. B[redacted] took his sweatshirt,

with the bowel movement in it, and left it on bathroom floor. He then left the bathroom ignoring staff. He was later observed shadow boxing in his room.

While Mr. B[redacted] is generally disengaged from his environment, there have been instances where he had more prolonged interactions with others. On March 25th Mr. B[redacted] was noted to be much more talkative and social after he was rewarded for following staff directions by being able to use the PlayStation game on the unit. One peer commented that Mr. B[redacted] spoke more in the hour of playing PlayStation than in the past few weeks combined. The next day, a nurse approached him and asked whether he wanted to play cards. He replied, "I don't play cards or board games. I like video games." The nurse stated that she did not know if they had those on EAMU. He replied, "They do. I played last night for an hour." He told the nurse that patients had to be a level three to use the PlayStation. He then agreed to play the card game War with the nurse. She noted that he knew which cards were the higher value. He was described as slow but eventually did respond when the spoke. The nurse had to briefly leave the game and take a phone call. Upon return, Mr. B[redacted] stated, "I have 38 cards. I win." Mr. B[redacted] was also able to complete a visitor request form with relevant pertinent information about the visitor.

Mr. B[redacted] has ambulated independently on EAMU. The physical therapist assessed that he did not require one-to-one monitoring or standby assist when transferring (e.g., from a chair/bed to standing position). He was observed ambulating effectively and even running at times. Standby assist was recommended when outdoors due to the ice/snow on the unit patio.

Mr. B[redacted] is currently diagnosed with a Major Neurocognitive Disorder and Unspecified Schizophrenia Spectrum mand Other Psychotic Disorder. He is currently prescribed paliperidone (antipsychotic medication) and fluoxetine (antidepressant medication) in addition to medications to prevent seizures.

Mr. B[redacted] attended 3 of 6 competency groups during this admission. These groups serve the dual purpose of treatment and evaluation. During groups that Mr. B[redacted] did attend, he was noted to initially decline to participate or respond to the facilitator's questions. When he ultimately did respond to questions, he was able to define several legal terms including the roles of the defense attorney and jury and the concepts of a plea bargain and a misdemeanor. He was able to read information presented in group aloud albeit with a soft volume of voice. His responses were not universally accurate as he confused perjury with contempt of court.

SUMMARY OF PSYCHOLOGICAL TESTING

Test of Memory Malingering (TOMM)

The Test of Memory Malingering (TOMM) was administered to Mr. B[redacted] This is a standardized instrument designed to detect feigned memory impairment. Examinee responses are compared to a norming group of individuals who had traumatic brain injuries and/or dementia. That is, even individuals with severe memory and cognitive deficits tend to perform well on this assessment. The implication is that individuals performing worse than this norming group are feigning their deficits. The TOMM was administered to Mr. B[redacted] due to the medicolegal context of this evaluation, as defendants may be motivated to feign cognitive or psychological impairments to potentially delay or avoid prosecution. Mr. B[redacted] performance on the TOMM did not suggest the presence of malingering.

CURRENT CLINICAL PRESENTATION

Mr. B[redacted] is a 20-year-old male who appears consistent with his chronological age. He is short in stature and is of proportionate weight. His hygiene was poor, and he completed his self-cares only with prompts from staff. At

the time of interview, he wore hospital provided clothing that he wore neatly. He ambulates with an obvious limp due to his left sided weakness. He, however, ambulated without assistance.

Mr. B[redacted] was oriented to person, place, time, and situation. His speech was soft in volume and mumbled, which was assessed to be volitional and not the product of his head injury given that he chose to speak in a normal tone and well-articulated at other times. Mr. B[redacted] often paused before responding and it was unclear whether this was due to his delayed processing speed, lack of legal knowledge, or disengagement from the interview. He ultimately disengaged from the interview by telling this examiner that he would not follow unit rules and he then appeared to rub his groin.

Mr. B[redacted] mood was euthymic, and his affect was congruent. He did not present as grandiose or euphoric or with other symptoms that might be suggestive of a current manic or hypomanic episode. He did endorse auditory hallucinations during this admission, but he did not appear to be internally preoccupied during the interview. His thought processes were logical and organized.

COMPETENCY EVALUATION

At the onset of the interview, Mr. B[redacted] was asked why he was admitted to MMHI. He replied, "I've been here since January." He then declined to elaborate on his response. He was provided with education about his treatment to competency commitment. When asked what it means to be competent to stand trial he replied, "know stuff about court." He stated that a defendant was, "a public defender or lawyer," and he was then provided with education in this domain. He stated that when he is in the courtroom he should behave "good," but was unfamiliar with the concept of contempt of court. He, however, responded correctly to yes or no questions regarding courtroom etiquette.

Mr. B[redacted] indicated that the role of the Judge was to "judge people, who is guilty and who is not guilty." He was further aware of the Judge's authority in the courtroom and their role in sentencing. He stated that a jury was "12 people who judge people and see if the suspect is guilty." He indicated that a witness was "evidence." He then paused and said to this evaluator, "I'm not going to follow ya'll's rules. I'm a witch." He then put his hands on his lap, began smiling, rocked his body slightly. This examiner requested that he put his hands on the table and he refused. Efforts to reengage him in the interview were unsuccessful. Given his inappropriate behavior, the interview was terminated.

CLINICAL FINDINGS

It is my opinion to a reasonable degree of professional certainty that Mr. B[redacted] meets criteria for the following DSM-5-TR diagnoses:

Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
Unspecified Neurocognitive Disorder (provisional)

Unspecified Schizophrenia Spectrum and Other Psychotic Disorder is a major mental disorder that is characterized by disturbances in thought and perception, which can include delusions, hallucinations, disorganized speech and behavior, and negative symptoms including diminished emotional expression or avolition. Mr. B[redacted] has been documented to experience hallucinations, delusions, and thought disorganization. Patients diagnosed with this condition are typically prescribed psychotropic medications, specifically anti-psychotics, to reduce the intensity of their hallucinations and assist with organizing their thoughts.

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Unspecified Neurocognitive Disorder is diagnosed when an individual experiences a decline from a previous level of cognitive functioning, but the course or etiology of these deficits is unclear. In Mr. B[redacted] case, he suffered a head injury that led to left sided weakness and a notable change in his distress tolerance. Academic records did not suggest a significant shift in his cognitive capacity following his injury; however, his academic performance did worsen due to truancy and poor effort.

OPINION

It is also my opinion, to a reasonable degree of professional certainty that at the present time Mr. B[redacted] lacks substantial mental capacity to understand the proceedings and assist in his own defense.

Furthermore, it is this writer's opinion that Mr. B[redacted] needs treatment and, if provided such, is likely to be restored to competency within the statutory period. Further, in my opinion treatment should continue to occur in an inpatient facility designated by the Department of Health Services.

BASIS FOR OPINION

Mr. B[redacted] a 20-year-old man, is facing the charges of Battery to a Law Enforcement Officer. His history is notable for a self-inflicted gunshot wound to his head (right parietal lobe) just prior to his 12th birthday (November 20, 2014). Sequelae from this incident included left-sided weakness. He underwent neuropsychological testing while inpatient following his initial injury and was described as "doing well cognitively but decline in visual spatial tasks and visual spatial memory was moderately to severely impaired in some tests; evidence of visual field cut, and attention neglect of left side were noted." In the community, Mr. B[redacted] engaged in both physical and occupational therapy to address his physical deficits and left sided neglect. An occupational therapy assessment conducted at MMHI suggested no midline or sided neglect at present. Mr. B[redacted] was initially opined to be incompetent due to his symptoms of psychosis including expressing thoughts that were bizarre and tangential. Indeed, upon admission to MMHI, Mr. B[redacted] endorsed ongoing auditory hallucinations, visual hallucinations, and delusions including that someone was spitting on him. At MMHI, he has been treated with an antipsychotic and antidepressant medication. At present, Mr. B[redacted] continues to endorse auditory hallucinations and espouse odd beliefs. Cognitively, Mr. B[redacted] has demonstrated the ability to learn and recall information. He has followed unit procedures when motivated to do so. He also has engaged in several rule violations and has been uncooperative with staff. These behaviors are viewed as volitional and not the product of confusion or cognitive deficits.

During the current competency examination, Mr. B[redacted] inappropriate behavior precluded a complete assessment of his understanding of legal terms. During the interview, expressed an understanding of appropriate courtroom behavior, the roles of pertinent courtroom personnel, and has expressed an understanding of the role of his counsel during competency groups. During groups, he expressed an understanding of the concepts of a plea bargain and a misdemeanor. These strengths notwithstanding, Mr. B[redacted] has not, in any context, expressed an understanding or appreciation of his charges or plea options. His odd statements raise concern that symptoms of psychosis could be precluding his rational approach to defense. There is insufficient data to indicate that the symptoms that initially precluded his competence have since abated with treatment. As such, it is this examiner's opinion that Mr. B[redacted] is incompetent to proceed. Regarding restorability, there a numerous medication changes that can be made in an effort to treat his symptoms of psychosis. Moreover, Mr. B[redacted] would benefit from continued competency remediation sessions to improve his understanding of pertinent legal concepts.

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If you have any further questions, please do not hesitate to contact me at (608) 301-1570.

Respectfully submitted,

Ana Garcia, Ph.D.
Licensed Psychologist
Mendota Mental Health Institute

cc: James Griffin, District Attorney
Ashley Fard, Defense Attorney
MMHI Admissions