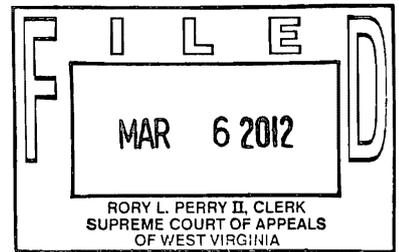


**SUPREME COURT OF APPEALS
OF WEST VIRGINIA**



STATE OF WEST VIRGINIA,

Plaintiff below/Respondent,

v.

APPEAL NO.: 11-1618

JAMES ROBERTSON,

Defendant below/Petitioner.

**ON APPEAL FROM THE CIRCUIT COURT OF
RALEIGH COUNTY, WEST VIRGINIA**

BRIEF OF PETITIONER JAMES ROBERTSON

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I.
ASSIGNMENTS OF ERROR

ASSIGNMENT OF ERROR #1: The Circuit Court erred when it ordered the placement of the appellant, who is within the Circuit Court’s jurisdiction by reason of the provisions of W. Va. Code § 27-6A-4, in a privately owned facility situated in the State of South Carolina in which psychiatric services are provided to forensic patients and inmates in a maximum security setting because the transportation clause contained in the provisions of Section 5 of Article III of the West Virginia Constitution, W. Va. Cons., Art. III, § 5, bars such a placement if it is forced over the objection of the appellant.

ASSIGNMENT OF ERROR #2: The Circuit Court erred when it ordered the placement of the appellant, who is within the Circuit Court’s jurisdiction by reason of the provisions of W. Va. Code § 27-6A-4, in a privately owned facility situated in the State of South Carolina in which psychiatric services are provided to forensic patients and inmates in a maximum security setting because the provisions of W. Va. Code § 27-6A-5 required the placement of the appellant, when his release into the community was revoked, in the “least restrictive setting appropriate to manage the acquittee and protect the public” rather than in the most restrictive setting imaginable.

ASSIGNMENT OF ERROR #3: The Circuit Court erred when it ordered the placement of the appellant, who is within the Circuit Court’s jurisdiction by reason of the provisions of W. Va. Code § 27-6A-4, in a privately owned facility situated in the State of South Carolina in which psychiatric services are provided to forensic patients and inmates in a maximum security setting because the statutory authorization for transfer of “mentally disordered offenders,” as set forth in the “Interstate Compact on the Mentally Disordered Offender,” W. Va. Code § 27-15-1, to facilities in another state requires a contract with the sovereign authority of the receiving state

who is then an agent of the State of West Virginia and not with a privately owned facility that is not subject to regulation or control by the State of West Virginia.

II. **STATEMENT OF CASE**

1. Background.

The appellant James Robertson was indicted on the charge of first degree arson.¹ On February 22, 2002, the appellant entered his plea of “not guilty by reason of mental illness” before the Circuit Court of Raleigh County, West Virginia, with the Honorable John A. Hutchison, Judge of the 10th Judicial Circuit, West Virginia (the “Circuit Court”), presiding.² In support of the plea, the Circuit Court found:

That the defendant has been evaluated and found not criminally responsible due to mental illness, including schizophrenia, paranoid type The Court finds the defendant presently competent but further finds, by a preponderance of the evidence, based upon the psychiatric and psychological evaluations of the defendant, the defendant’s psychiatric history and the representations of the State, defense counsel, and the defendant personally, that he lacked criminal responsibility at the time of the first degree arson with which he stands charged.³

The Circuit Court concluded:

[U]pon review of the entire record and the representations of the State and the defendant, and the prior voluntary admissions of the defendant, that there is a factual basis whereby the state could prove, at trial, that the defendant, in fact, committed the felony of first degree arson as charged in this Indictment, but that he lacked criminal responsibility due to this mental illness or incapacity, and that he was then and remains now a danger to himself and others as a result of such mental illness.⁴

¹ Appendix, p. 1. The undersigned counsel did not represent the appellant in these matters and has not seen the charging documents. The undersigned counsel’s understanding is that the appellant believed that he was in danger from other tenants of an apartment building in which he resided and, in a paranoid delusional state, he started a fire in his apartment that was subsequently extinguished without harm to any person.

² Appendix, p. 2, 3.

³ Appendix, p. 1, 2.

⁴ Appendix, p. 2, 3.

As a result of the findings and conclusions, the Circuit Court accepted the appellant's plea and found him to be "NOT GUILTY BY REASON OF MENTAL ILLNESS OR INCAPACITY of the felony of FIRST DEGREE ARSON charged in the Indictment."⁵

Pursuant to the provisions of W. Va. Code §27-6A-3 and W. Va. Code §27-6A-4, in effect on the date of his disposition, the Circuit Court then ordered that the appellant was to be "committed as an inpatient [sic] to a mental health facility under the authority of the West Virginia Department of Health and Human Resources, presently being Sharpe Hospital."⁶ The Circuit Court retained jurisdiction over the appellant "for a period of twenty (20) years from this date [*i.e.*, February 10, 2021]... being the maximum he could have received if convicted...."⁷

After his transfer to the custody of the West Virginia Department of Health and Human Resources ("DHHR"), the appellant was placed at the William R. Sharpe, Jr. Hospital ("Sharpe"). As a result of difficulties in the management of the appellant at Sharpe, the DHHR placed the appellant at the Forensic Evaluation Unit which was comprised of four cells that were located at, and leased from, the South Central Regional Jail in South Charleston, West Virginia. The Forensic Evaluation Unit was managed by a private health care contractor. On the date of October 5, 2005, the Circuit Court ordered a forensic examination of the appellant.⁸ The Circuit Court's order noted that the appellant "was incarcerated at the South Central Regional Jail's Forensic Unit...."⁹ The Circuit Court's order noted that the transfer to the Forensic Evaluation Unit was "to protect the safety of other patients at Sharpe Hospital."¹⁰

The Circuit Court made the following findings in its ordering of a forensic examination:

⁵ Appendix, p. 2.

⁶ Appendix, p. 2.

⁷ Appendix, p. 2.

⁸ Appendix, p. 4.

⁹ Appendix, p. 4.

¹⁰ Appendix, p. 7.

On June 10th, 2005, this Court received correspondence from Sharpe Hospital indicating that [:] “when Mr. Robertson first came to Sharpe, he was believed to be suffering from Schizophrenia, or some such major mental illness. This was based on an extensive review of the record. Later, his diagnosis was changed to BiPolar Disorder, and finally, with continued evaluation, Antisocial Personality Disorder became the primary diagnosis.”¹¹

Sharpe Hospital states that it is “not designed to manage individuals such as Mr. Robinson, a person for whom no classic mental illness appears, and who makes more effort to harm others than improve himself.”¹²

The Court then ordered that the appellant was to undergo an evaluation “to determine past and current competency as required by statute.”¹³

While the order requiring the forensic examination was entered on the date of October 5, 2005, the examinations were not completed until August 3, 2006.

In the report of his psychological evaluation of the appellant, David A. Clayman, Ph. D., made the following observations:

James Robertson was transferred from Sharpe Hospital to the South Central Regional Jail on 5/17/06 where he was to await this evaluation and where he remains as of the date of this report [*i.e.*, August 3, 2006]. ... When admitted this time, he was on no psychotropic medications and has not been prescribed any since. ... Throughout this admission, his general behavior has been acceptable, although, he has needed to be calmed down and redirected. There has been no evidence of any psychopathology necessitating anything but verbal or behavioral intervention.¹⁴

In the “Historical Review & Discussion” section of the report on his psychological evaluation of the appellant, Dr. Clayman observed:

To make the determination that Mr. Robertson has no Axis I disorder is misleading as compared to understanding that the symptoms may have abated or even be in remission. This would

¹¹ Appendix, p. 7.

¹² Appendix, p. 8.

¹³ Appendix, p. 12.

¹⁴ Appendix, p. 18.

explain why Mr. Robertson has been able to go without any medications since his admission to the FEU [Forensic Evaluation Unit]. All evaluating entities seem to agree that the primary driving force to Mr. Robertson's dysfunctional pattern is the array of behaviors associated with Antisocial Personality Disorder and that his aggressive, inappropriate and disruptive behaviors are generally associated with ongoing, deeply engrained personality traits. His ability to assert control when given external constraints and redirection as well as his diatribes against Sharpe Forensic staff reflect the personality issues not any acute mental illness.¹⁵

Dr. Clayman concluded, therefore:

At the time of this evaluation, he [the appellant] was not suffering from any mental disease or defect such that he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law. Any aberrant acts, at this time, would be associated with the characteristics of Antisocial Personality Disorder with paranoid, borderline and narcissistic traits but not any acute mental illness.

From the description of his background and the information in the criminal investigation report, it does appear that Mr. Robertson was in a manic state at the time of the crime on or about February 10, 2001. ... Based upon his distorted perceptions and impaired judgment, he took actions that he felt were defensible in light of the alleged harassment of him by his neighbors. His underlying personality characteristics were catalysts for this precipitous and out of control action. He does not appear to have been aware of the wrongfulness of his actions, but behaved in a way that he might have been able to maintain control if some external pressure had been asserted. ...

At the time of this evaluation, Mr. Robertson clearly evidenced the pervasively maladaptive characteristics of Antisocial Personality Disorder with many other negative traits. The diagnostic formulation by staff at Sharpe Hospital is not accurate in that Mr. Robertson has a history of aberrant behaviors that supports the classification of Bipolar Affective Disorder-Manic with Psychotic Features in Remission. Even if he remains out of manic or hypomanic states, his enduring personality traits will put him in danger of responding to situations in a volatile manner that is likely to bring him to the attention of authorities. In such a situation, his actions would not be dismissed or mitigated as a result of a mental disease or defect. Rather, it would be a

¹⁵ Appendix, p. 20.

volitional action based upon his misinterpretation of social cues, failure to get his way through intimidation and low frustration tolerance. Given the right circumstances, including use of drugs or alcohol, he could precipitate an acute psychotic state that would med the criteria for Mania.¹⁶

Dr. Clayman then summarized:

Although it is probable that Mr. Robertson was suffering from psychotic distortions of thinking when he committed the criminal act in 2001, he has not evidenced this level of disturbance in about two years. It does not mean that he has no mental problem, but it is “dormant” at this time. This explains why he has not had to be medicated for his aggressiveness which has abated when environmental restraint, limit setting and redirection have been used. His inability to sustain adaptive functioning is grounded [in] his deeply engrained maladaptive pattern of behavior over which he has control if he chooses to use it. He is an extreme risk to act out again when he is living outside of the structure of the hospital or jail setting.¹⁷

On the date of December 6, 2006, the Circuit Court entered its *Order finding Defendant James Robertson Mental[ly] Ill and a Danger to Himself or Others and Denying Motion of William R. Sharpe Hospital to Release Defendant.*¹⁸ The Circuit Court’s order reflected that “this matter comes on for final ruling regarding the motion of the Department of Health and Human Resources and William R. Sharpe Hospital, to release James Robertson from his current confinement in that facility.”¹⁹ The Court’s findings included the following:

During the year 2005, while at William R. Sharpe Hospital, James Robertson became involved in a number of violent confrontations with patients and/or staff. During this same period of time, the resident psychiatrist and psychologist reviewed Mr. Robertson and opined in their reports that Mr. Robertson, in fact, did not suffer from a mental illness as contemplated by the statute but suffered from a disorder. The difference being, a mental illness is subject to

¹⁶ Appendix, p. 21

¹⁷ Appendix, p. 21, 22.

¹⁸ Appendix, p. 24 – 29.

¹⁹ *Id.*

treatment and potential cure and a disorder is not treatable and not curable.²⁰

From and after that time, the Department of Health and Human Resources has aggressively sought release of Mr. Robertson and a finding from this Court that he does not suffer from a mental illness but from a Personality Disorder and therefore is improperly housed at William R. Sharpe Hospital.²¹

The Court concluded that, based upon its findings and its review of the evaluations performed in accord with its October, 2005 order:

[T]he Defendant James Robertson is mentally ill. The revised diagnosis of the staff of Sharpe Hospital notwithstanding, and the argument of counsel for DHHR notwithstanding, it is clear that at best, by the clear and convincing evidence in this case is that James Robertson suffers from a mental illness.²²

The reports of Mark Casdorff and Dr. Clayman indicate that the mental illness is in remission and it is in remission because of the limitations and treatment provided by Sharpe Hospital. ... Clearly, in this case, Mr. Robertson cannot be held any longer than the maximum period of sentence he could have received for the crime for which he was found not guilty for reason by reason [sic] of mental incapacity or if he is cured. In this case it is clear, based upon the substantial evidence in this matter that James Robertson has not been cured. His symptomatology has decreased and his violent outburst as his psychotic events have all but disappeared but based upon a reasonable interpretation of the reports available to this Court, that is because of his treatment including environmental restraints, the limits set by Shape [sic] Hospital and any behavioral modification or redirection that may have been incorporated with his stay. It is likewise clear that for a substantial amount of time, Mr. Robertson has not required medication to maintain his sanity. However, it is clear that based upon his other conduct, he remains a significant danger to himself and to others if he is not managed appropriately.²³

Accordingly, the Circuit Court maintained its jurisdiction over the appellant and sustained its commitment of the appellant to DHHR's custody.

²⁰ Appendix, p. 25.

²¹ Appendix, p. 25.

²² Appendix, p. 26, 27.

²³ Appendix, p. 27.

From that point, however, the DHHR's custodial placement of the appellant consisted principally of continuing to house the appellant in the jail cell at the South Central Regional Jail, which it operated as a Forensic Evaluation Unit, rather than at its facility in Weston, West Virginia.

On the date of May 30, 2007, Janice L. Woofers, in her capacity as the Statewide Forensic Coordinator for the State of West Virginia Department of Health and Human Resources ("DHHR"), replied to the appellant's request that he "be removed from the Southern Regional Jail²⁴ and be sent to a proper treatment facility"²⁵ as follows:

The length of your stay at the Southern Regional Jail depends solely upon you. It is your responsibility to follow the rules and regulations of the forensic evaluation unit. When you choose to cooperate with the FEU staff, you will then be one step closer to transitioning back to William R. Sharpe, Jr. Hospital. ...²⁶

On June 2, 2008, Robert W. Keefover, in his capacity as the Clinical Director for Sharpe Hospital, delivered to the Circuit Court his correspondence in "response to your [*i.e.*, Judge Hutchison's], correspondence dated May 14, 2008 which expresses your increasing concern regarding Mr. Robertson's mental health, treatment or lack of treatment and copies of letters that Mr. Robertson has sent to you."²⁷ The clinical director wrote that:

The overwhelming prevailing opinion among multiple examiners is [sic] that James Robertson's behavior springs from personality issues rather than a major (Axis I) psychiatric illness. He has an antisocial (psychopathic) character disorder that manifests in ongoing manipulative and disruptive behavior. ... He has not required any psychotropic medication since his last status update to the court, nor has he had any symptoms exhibiting an active major mental illness as reflected in Dr. Mark Casdorff's status update dated May 28, 2008....²⁸

²⁴ The correct designation of the facility is the South Central Regional Jail in South Charleston, West Virginia.

²⁵ Appendix, p. 30.

²⁶ Appendix, p. 30.

²⁷ Appendix, p. 32.

²⁸ Appendix, p. 32.

It remains the opinion of the clinical staff of William R. Sharpe, Jr. Hospital and the Internal Forensic Service Review Board that Mr. Robertson's behavior stems from personality issues, rather than a mental illness that requires medication and therapy. He requires the behavioral management available at our FEU. As an acute care hospital for those with an acute mental illness we do not feel it is safe for Mr. Robertson to be returned to Sharpe until he has shown a willingness to comply with the behavior plan being maintained at our FEU. We are not permitted to use medication solely for behavior control and thus feel his return to Sharpe Hospital at this time would be unsafe for our psychiatric patients, staff and himself.²⁹

After the Circuit Court's inquiry and the DHHR's response, the appellant remained at the Forensic Evaluation Unit in the South Central Regional Jail facility.

The undersigned counsel and Gary A. Collias, at the request of the federal court pursuant to the provisions of 28 U.S.C. § 1915(e)(1), jointly represented the appellant in the federal civil actions that he had filed *pro se* in the United States District Court in and for the Southern District of West Virginia due to his continued placement at the Forensic Evaluation Unit despite his objections. An amended complaint was filed on the date of December 16, 2008, bearing the civil action number 2:08-cv-01249 and the caption *James Buford Robertson, an individual, plaintiff, v. West Virginia Department of Health and Human Resources, a state agency; William R. Sharpe, Jr. Hospital, a state mental health facility; Robert W. Keefover, M.D., in his individual and official capacity; Janice L. Woofter, in her individual and official capacity; John McKay, in his individual and official capacity; and JOHN DOES I through III, inclusive, in their individual and official capacities, defendants* (the "federal civil action").³⁰ The gravamen of the amended complaint was that the appellant had been housed in the Forensic Evaluation Unit for almost four

²⁹ Appendix, p. 33.

³⁰ Appendix, pp. 34 – 47.

(4) years at the time of the filing of the amended complaint.³¹ Again, the Forensic Evaluation Unit was a pod of cells at the South Central Regional Jail that was leased to the DHHR.

Allegations were made that:

Nonetheless, the DHHR and the Hospital have permanently housed James at the Jail such that James has been treated as a prisoner rather than a patient, which is his proper status under the law.

The independent forensic psychologist who examined James stated in his report that “it is noted that the FEU is not a treatment facility and does not have the ability to provide all of Mr. Robertson’s clinical patient needs.”

The FEU is not a facility that can provide treatment to James that meets the basic constitutional rights of involuntarily committed patients to reasonable care by adequately trained medical services providers and to non-restrictive confinement conditions.

Specifically, the FEU staff consists of a nurse who is provided by the Jail’s medical care provider and not by the Hospital’s specialized mental health services providers.

No psychiatrists or psychologists are present at the FEU who are retained by the Hospital.

James is rarely visited at the FEU by staff from the Hospital.

Indeed, the FEU’s staff has required the services of the Jail’s psychiatrist in order to provide emergency services to James.

The FEU is not intended to be administered by the Regional Jail but the reality is that correctional officers maintain oversight of, and influence the management of, the FEU.

Indeed, the Regional Jail administrator has ordered at times that James be maintained outside of his cell in hand cuffs, a belly chain and shackles.

These conditions cannot meet the constitutional requirement of the least restrictive confinement.³²

³¹ Appendix, p. 39.

³² Appendix, p. 40.

In addition to monetary damages, the relief sought was an “order preliminarily and permanently enjoining the defendants from continuing the actionable conduct set forth in the complaint....”³³

In the course of the resolution of the federal civil action, an evaluation of the appellant was done. In a report bearing the date of March 3, 2010, Cheryl A. Hill, M.D., Ph. D., proffered the following opinions:

At the time of my evaluation, Mr. Robertson met DSM-IV TR criteria for the following diagnoses: *posttraumatic stress disorder, chronic and personality disorder, not otherwise specified.*

Mr. Robertson has several risk factors for future dangerousness and has a higher risk for future violence than the general population. Beginning a process of transitioning him to a less restrictive environment than the Forensic Evaluation Unit (FEU) would be appropriate.³⁴

Dr. Hill elaborated as follows:

During his tenure at the FEU Mr. Robertson has continued to exhibit agitated behavior but he has demonstrated an ability to control his behavior with prompting and has responded well to the behavior plan developed by Dr. Clayman and his staff. Dr. Clayman also notes that Mr. Robertson has been co-operative with treatment and is making a genuine effort to learn alternative coping skills.

At this time transitioning Mr. Robertson to a less restrictive environment than the FEU would be appropriate. I do not recommend that he return to Sharpe Hospital; given his history with this institution this would be likely to fail. It may be appropriate to begin by allowing Mr. Robertson supervised trips into the community to allow him the opportunity to demonstrate safe behavior outside of the restrictive environment of the FEU.

If he is granted conditional release this should include a strong behavior plan with concrete consequences which are consistently enforced. I interviewed Dr. Clayman and he expressed his willingness to make a long term commitment to Mr. Robertson’s

³³ Appendix, p. 47.

³⁴ Appendix, p. 48.

treatment and is willing to oversee his progress and compliance in the event that he is transitioned to a less restrictive environment.³⁵

Based upon this evaluation, the parties to the federal civil action negotiated a resolution that included the elements of a *Community Placement and Treatment Plan* in which the DHHR committed resources to the appellant's placement in the community.³⁶

On the date of April 29, 2010, the Circuit Court entered its order providing for the transition of the appellant from the Forensic Evaluation Unit into an apartment in the Charleston, West Virginia community.³⁷ The Circuit Court order was filed with the United States District Court in compliance with the District Court's order regarding the resolution of the federal civil action.³⁸ Subsequently, the federal civil action was dismissed.

After six (6) years of effective incarceration at the Forensic Evaluation Unit, the appellant was placed into the community into an apartment in Charleston, West Virginia. Supervision was provided in accordance with the Circuit Court order and the adopted *Community Placement and Treatment Plan*.

2. Circumstances Giving Rise to the Order from Which the Appeal is Taken.

Unfortunately, the appellant began to suffer from psychotic episodes after a period of four to six months of living in the apartment. On the date of March 17, 2011, another tenant of the apartment building reported to Dr. Clayman that she heard the appellant yelling from his apartment in the direction of a tenant in another apartment that he, the appellant, was going to burn down the building.

³⁵ Appendix, p. 59.

³⁶ Appendix, pp. 60 – 64.

³⁷ Appendix, pp. 65 - 72.

³⁸ Appendix, pp. 73 – 82.

As a result of these episodes, the appellant was admitted by order of the Circuit Court upon the request of Dr. Clayman, who was implementing the *Community Placement and Treatment Plan*, to the Mildred Mitchell Bateman Hospital (“Bateman Hospital”).

The Circuit Court ordered that a multi-disciplinary team be convened for the purpose of considering the future placement of the appellant. The team included the undersigned counsel for the appellant, the counsel for DHHR, the DHHR’s statewide forensic coordinator, Dr. Robert Miller, who was the psychiatrist on staff at the Bateman Hospital, and Dr. Clayman, who had been providing services under the *Community Placement and Treatment Plan*. The subsequent report of the multi-disciplinary team provided the Circuit Court with the following options:

- 1) Mr. Robertson remain in the hospital indefinitely;
- 2) Mr. Robertson be released to the community;
- 3) Mr. Robertson be placed in a facility outside the state.³⁹

The report indicated that the multi-disciplinary team, with the exception of counsel for the appellant, was recommending that the appellant be placed in the out of state facility. Counsel for the appellant supported either another attempt to implement the *Community Placement and Treatment Plan* or that the appellant be released and discharged as he was not mentally ill. On the date of September 21, 2011, a *Placement Hearing* was held in the Circuit Court.

At the *Placement Hearing*, the DHHR counsel represented to the Court that it was the DHHR’s position that “Mr. Robertson be sent to GEO Care, a facility in South Carolina.”⁴⁰

DHHR’s counsel described the facility as follows:

It is a facility in Columbia, South Carolina. ... It is a treatment facility. They have individuals there who have issues similar to Mr. Robertson. They have a multi-disciplinary team put together for each patient there. That multi-disciplinary team addresses the issues. If this court were to send him there, the MDT in South Carolina would meet with the caregivers and the individuals here

³⁹ Appendix, p. 83.

⁴⁰ Appendix, p. 88, 89.

who are most intimately familiar with Mr. Robertson's care and his issues and common goals established. It is a cognitive-therapy approach and, in addition to that, there is also opportunity for getting GEDs and training and that kind of thing.⁴¹

The facility presents itself, however, as a maximum security detention facility.⁴² It is co-joined with a prison hospital. And, indeed, the treatment facility includes both convicted inmates and forensic patients such as the appellant.

Mr. Robertson objected to the placement in the out of state facility. Because of his objection, counsel argued that the placement would violate the provisions of Article 3, Section 5 of the West Virginia Constitution, W. Va. Const. Art. 3, Sec. 5, in that "no person shall be transported out of or forced to leave the state for any offense committed within the same."

The response of the DHHR was:

It is DHHR's position that we have a duty to treat Mr. Robertson. It is also DHHR's position that there is no facility in the state of West Virginia who can effectively treat Mr. Robertson. Dr. Miller has talked to me, and I believe to Mr. Eddy, as well, and has indicated in the MDT's that Mr. Robertson has reached his maximum capacity while at Bateman Hospital.⁴³ ... It's simply the Department's position, bottom line, we don't have a facility in the state to take care of him. ... You can keep him at Bateman and, I mean, they will do the best that they can. And I think Dr. Miller has done the best that he can to assist Mr. Robertson in his issues, but Dr. Miller has repeatedly said: He has reached maximum capacity.⁴⁴

The DHHR called as its first witness, Robert Miller, M.D. who was a member of the appellant's MDT and a medical services provider at Bateman Hospital. Dr. Miller testified as follows:

In the hospital, he's not been psychotic. So what we deal with on a daily basis is his personality pathology, which essentially is not amenable to treatment.⁴⁵

⁴¹ Appendix, p. 89, 90.

⁴² Appendix, p. 93.

⁴³ Appendix, p. 94, 95.

⁴⁴ Appendix, p. 99, 100.

⁴⁵ Appendix, p. 107.

Dr. Miller further testified that:

Well, what I've stated is that it's been my observation that Mr. Robertson is currently difficult to treat in an inpatient setting, and that I really have very little to offer him, other than daily maintenance and management. And actually, I've said two things; one is that he either needs to be in a more restricted environment or he needs to be simply sent home, that where he is right now is likely to continue to be ineffective, and I would think that anything that would be intermediate would also be ineffective. So, I've taken polar positions. One is to do more or to do nothing.⁴⁶

Under cross-examination, Dr. Miller acknowledged that Mr. Robertson would not be sent to the South Carolina facility for treatment, but would be sent for "behavioral management."⁴⁷ Dr. Miller further testified that the crux of the behavioral management was the imposition of consequences. Disturbingly, Dr. Miller then acknowledged that an advantage of the privately-owned facility in South Carolina was:

I mean, we don't have a forensic hospital. We have two state psychiatric facilities where we manage forensic individuals, I think very successfully. But at the same time, by being a hospital, we have rules that are imposed upon us that involve civil liberties. And what I think would happen in South Carolina is those liberties are likely not going to apply.⁴⁸

In response to questions from the Circuit Court, Dr. Miller gave his opinion that:

My primary diagnosis is Axis II, the antisocial personality disorder. I have been given records evidence and discussed with Dr. Clayman and have become convinced that there are periods when Mr. Robertson gets paranoid. However, he does not have schizophrenia or bipolar disorder or delusional disorder. Within the DSM-IV, it is discussed and well-known that individuals with severe personality pathology can become psychotic transiently under stress. In order to reflect that as an Axis I, his diagnosis is psychotic disorder not otherwise specified.⁴⁹

⁴⁶ Appendix, p. 106, 107.

⁴⁷ Appendix, p. 112.

⁴⁸ Appendix, p. 117.

⁴⁹ Appendix, p. 121, 122.

Dr. Miller further opined that, if released without conditions:

It would be my prediction that within six months he'll be charged with terroristic threats and be before you looking at the correctional system.⁵⁰

The DHHR then called Dr. Clayman. Dr. Clayman explained the lack of options with respect to the treatment of the appellant:

I don't think we can make accommodations in the existing facility. ... Pretera, none of the behavioral health centers will take him in a group home because of his history. They can't manage him. So the behavioral health system, Your Honor, is not even to be considered. The community behavioral health system isn't to be considered. There are no group homes; we don't have them. I do not have the resources right now, unless DHHR wants to come up with an enormous amount of money to have him share an apartment or have a duplex where my person would be in one side and he would be on the other. And it can't be just be checking in at night, it's day-long. Getting him out of his apartment, doing stuff, having structure, being willing to deal with him when he's being combative and being argumentative. We don't have anything in the community or in the state to handle that kind of stuff.⁵¹

Dr. Clayman further explained that James should not be maintained at the hospital for the reason that:

James is bright. He has a good heart. He's got good components to him. That's piece number one. Bright is important, and not developmentally disabled is important, because he's with people there. He is not actively, at this point, AXIS I. ... He's there with, in quotes, "mentally-ill" people, who have an active AXIS I diagnosis, and we're in a preventive model. He's got to learn behaviors.... [T]hat he can't make threats, he can't say the MF word to people, he can't tell them that he's the one that's setting the rules, he can't tell them that every time something happens, he's going to call his attorney and make threats that people don't have to go along with him. He can't do that or he's going to be like – as Dr. Miller said – within a very short period of time he'll be coming back under the adjudicative system.⁵²

⁵⁰ Appendix, p. 122, 123.

⁵¹ Appendix, p. 139, 140.

⁵² Appendix, p. 141.

Dr. Clayman's opinion was, therefore:

He's not mentally ill right now. A psychiatric hospital is not appropriate. And so the judge hears this in context, a psychiatric hospital for James, the way he is, is no more appropriate than a psychiatric facility is for PTSD vets. ... They need their environment, they need their lives straightened out, they need more than we can give them in a facility that we have in West Virginia.⁵³

With respect to Dr. Clayman's monitoring of the appellant during his community placement, Dr.

Clayman acknowledged in response to cross-examination that:

Q. First of all, on those occasion in which had the psychotic episodes and he required treatment, it's my understanding that once medication was administered or whatever, he came out of the psychotic state:

A. He did on those occasions, from the acute psychotic state.⁵⁴

During cross-examination, the following discourse occurred regarding alternative placements:

Q. [Y]ou testified, I believe, and it is in fact the case, that no group facility could be found for Mr. Robertson; is that correct?

A. That's what we learned.

Q. And, primarily, that related to the fact that DHHR has contracts with private entities that provide those group homes, and those private entities have the right, under their contracts, to basically refuse to take patients?

A. That's all – yes. As far as one-half of the argument, yes, you're correct.

...

Q. ... Apparently, by statute, they can't force the private contractor to take a patient?

A. Apparently.⁵⁵

Dr. Clayman was then asked, and he then answered, the following questions:

⁵³ Appendix, p. 142.

⁵⁴ Appendix, p. 145.

⁵⁵ Appendix, p. 147, 148.

Q. Well, in previous hearings, it's been established that for the period of time that he was at the forensic evaluation unit in the South Central Regional Jail, he had, in fact, no AXIS I manifestations and, in fact, went without medication for a long period of time?

A. Correct.

Q. What is it about the community placement, versus the FEU setting, would you attribute to the reason why he deteriorated?

A. Well, you've got to go three steps. If you take the FEU, where he showed no episodes, and pretty much since he's been at Bateman, he's had a couple of things where they've used medication to calm his agitation and calm him down, but there's only a couple of mentions of psychotic thought or delusional thinking or whatever. He was in a structured setting, where there was very structured things to battle against, and he didn't have to fill and occupy his time and take care of things. ... The similarity between Bateman and the FEU, he had places to fight and it was not this having to fill his day-to-day living with empty space, and that's what happened in the community.⁵⁶

Dr. Clayman was then asked, and he answered the following question:

Q. I mean really, what's the difference between sending James to this facility in South Carolina versus housing him at the FEU at the South Central Regional Jail?

A. Well, first of all, I'm not familiar enough with the programming down there to characterize it in any way. What I have been told is that it's much more open, there's much more activities. There is no program at the FEU. There is programming at this facility. There is open space at this facility. There is recreation at this facility. There is structure at this facility and there is the capacity to combine both psychosocial and medical/psychiatric treatment to give him the best chance of doing things that won't get him in trouble in the future.⁵⁷

⁵⁶ Appendix, p. 150, 151.

⁵⁷ Appendix, p. 151, 152.

The DHHR's counsel called Georgette Bradstreet, the DHHR's statewide forensic coordinator, to testify regarding the facility in South Carolina. Ms. Bradstreet provided the following information:

There's GEO Group, and GEO Group, under the auspice of GEO Group, they have private prisons, as well as private mental health and general health treatment. The facility in Columbia, South Carolina is actually two facilities together. One is a psychiatric hospital; the other one is a medical treatment facility. The medical treatment facility is primarily inmates. There are some forensic patients there; however, most of them are inmates. These inmates have cancer, they have catastrophic illness that requires them to be in a facility, whereas their needs cannot be met in a prison facility. The other part is the psychiatric hospital.⁵⁸

Ms. Bradstreet explained her perception of the difference in the out-of-state facility and the state's psychiatric hospitals:

The units at Bateman and Sharpe Hospital have a very diverse milieu. There are actually psychotic people; there are MR folks. There are people with dementia. It's a completely mixed bag of people. The units that I visited in GEO, most – well, it appeared to me that the people were very high functioning and I actually talked to some of the patients, and you don't have those walking victims that James likes to terrorize. They're much more functional than the people at Bateman and Sharpe.⁵⁹

With respect to the population of the psychiatric facility, Ms. Bradstreet's testimony was that the facility was comprised of one-third inmates who were not segregated from the forensic patients.⁶⁰

Ms. Bradstreet was also asked about a "transitional living facility" at Sharpe hospital and the appellant's utilization of the facility. Ms. Bradstreet's response was:

It's a 12-bed building that's on the same property as Sharpe is. One-half is kind of a group home atmosphere. The other half is more of an independent living atmosphere. There are apartments

⁵⁸ Appendix, p. 166.

⁵⁹ Appendix, pp. 167, 168.

⁶⁰ Appendix, p. 179.

in the second half that have a stove, a refrigerator, and the people who live there usually have a job that they go to, and then they cook for themselves and take care of their basic daily needs.⁶¹

Ms. Bradstreet then provided her explanation for why the appellant was not considered a candidate for residency at the facility:

First of all, Mr. Robertson, as Dr. Clayman and Dr. Miller both testified, Mr. Robertson makes his own rules. There are very specific rules to living in the transitional facility. You must get up, you must, you know, do all these different things. And James' history shows us that he does not follow rules. He makes his own rules. The other reason I would give is, once again, there are a couple lower-functioning people or gentlemen in that facility who would be – who James would have a great potential to victimize.⁶²

Under cross-examination, however, Ms. Bradstreet admitted that in the two and one-half years that she served as the statewide forensic coordinator, the admission of the appellant into the transitional living facility was never discussed.⁶³

Counsel for the appellant called as a witness Beverly Crews who is employed as a registered nurse at Mildred Mitchell Bateman Hospital.⁶⁴ Ms. Crews' position was shift supervisor for the hospital's forensic floor.⁶⁵ Ms. Crews' testimony generally provided that the appellant was manageable within the hospital and that issues that arose with the appellant were experienced with other patients as well.⁶⁶ The final question on direct examination was answered as follows:

Q. Do you believe that you could continue to manage your unit if Mr. Robertson were part of the population?

A. Yes.⁶⁷

⁶¹ Appendix, p. 170.

⁶² Appendix, pp. 170, 171.

⁶³ Appendix, p. 182.

⁶⁴ Appendix, p. 191.

⁶⁵ Appendix, p. 191.

⁶⁶ Appendix, pp. 191 – 200.

⁶⁷ Appendix, p. 199 – 200.

The hearing concluded with the Court's pronouncement that:

Noting the exception and objection of Mr. Eddy on behalf of Mr. Robertson, I believe that the least restrictive alternative is GEO Care [in Columbia, South Carolina]. I find that there is no reasonable, available treatment program in the state of West Virginia, and I further find, based upon all the evidence presented to me here today, that he needs secure – a secure facility, because he cannot conform his conduct to the requirements of the law and cannot conform his conduct to the requirements – to any requirement that would lead me to believe that he would not be a danger to himself and/or the public if I placed him in a less secure facility.⁶⁸ ... I order that Mr. Robertson be returned to the custody of the Department of Health and Human Resources to be held at Bateman Hospital until such time as the ICPC information can be completed and the transfer made.⁶⁹

On the date of September 30, 2011, the Circuit Court endorsed its final order on the matter which was then entered by the Office of the Clerk of the Circuit Court of Raleigh County, West Virginia, on the date of October 19, 2011.⁷⁰ This appeal is taken from that order.

III. SUMMARY OF ARGUMENT

Argument #1: Because the appellant objected to his placement in the out of state facility, the provisions of the “transport clause” contained in Section 5 of Article III of the West Virginia Constitution, W. Va. Const. Art. III, §5, bars his transportation from this state. The constitutional provision states that no “person” shall be “transported” or “forced” from this state for any offense committed in this state. The appellant is a person within the Court’s jurisdiction because he committed acts that constituted an offense against the state for which he was found not guilty by reason solely of mental illness. If he is placed in the out of state facility over his objection, he is being forced to do so because of the offense he committed in this state. And, again, this violates the transport clause.

⁶⁸ Appendix, pp. 219, 220.

⁶⁹ Appendix, pp. 222.

⁷⁰ Appendix, pp. 225 – 228.

Argument #2: The appellant's release was revoked because he decompensated mentally. The provisions of W. Va. Code § 27-6A-5 dictate that the appellant should be placed in a mental health facility that is the "least restrictive setting appropriate to manage the acquittee and protect the public." The placement in the out of state facility is the most restrictive setting possible and is made only because the State of West Virginia cannot, or will not, place the appellant into any group homes or its transitional living facility or will not dedicate resources to impose the structure needed in a community placement.

Argument #3: The provisions of W. Va. Code § 27-15-1, which are designated as the "Interstate Compact on the Mentally Disordered Offender," authorizes the transfer of forensic patients only to the custody of another sovereign state and does not authorize the transfer of forensic patients to privately owned facilities in another state who are not subject, therefore, to the laws and regulations of the State of West Virginia and who are not designated statutorily as agents of the State of West Virginia.

IV. **STATEMENT REGARDING ORAL ARGUMENT AND DECISION**

Oral argument is deemed to be necessary because the issues presented in the appeal are seemingly matters of first impression for which court precedent is not available and, therefore, oral argument would aid in the decisional process. Moreover, the appellant's circumstances cannot be adequately and fully described in writing considering the elongated period of time surrounding his proceeding and the Court may desire further inquiry regarding these circumstances. The argument would be most appropriate under the provisions of Rule 20 of the Revised Rules of Appellate Procedure because the issue of the application of the transportation clause to forensic patients is both a matter of first impression and a matter of fundamental public importance. Moreover, the application of the transportation clause in the order of the Circuit

Court raises a constitutional question and may additionally give rise to issues under the Equal Protection Clause of the United States Constitution.

V.
ARGUMENT

1. The Final Order Transferring the Appellant from a Mental Health Facility in the State of West Virginia to a Maximum Security Facility in South Carolina in which Psychiatric Services are Provided Violated the Bar set forth in the Transportation Clause of the West Virginia Constitution against Transporting or Forcing a Person from Leaving the State of West Virginia because of an Offense the Person Committed in the State of West Virginia.

The following syllabus point was made with respect to the “transportation clause” found in the provisions of Section 5 of Article III of the West Virginia Constitution, W. Va. Cons., Art. III, § 5:

The clause “[n]o person shall be transported out of, or forced to leave the State for any offense committed within the same,” of *W. Va. Const.* art. III, § 5, prevents a prisoner convicted under West Virginia law from involuntarily serving any portion of a state sentence beyond the West Virginia borders.

Ray v. McCoy, Syl. Pt. 1, 174 W. Va. 1, 321 S.E.2d 90 (1984). Notably, the analysis of this matter does not require a determination of whether the transportation of the appellant to South Carolina is “punishment” for the appellant’s intractable personality disorders, although it may be readily apparent that it is.

If the transportation clause applies, the question is whether the appellant is being “forced” to leave the State of West Virginia, whatever the purpose for the transfer. As the Court has opined:

We cannot interpret *W. Va. Const.* art. III, § 5 as limited to forbidding banishment as a punishment for a crime. The transportation clause states that, “No person shall be transported out of, or forced to leave the State for any offense committed within the same” We emphasize the use of the word “forced” and hold that this article prevents a prisoner convicted under West

Virginia law from involuntarily serving any portion of her sentence beyond the West Virginia borders.

Ray, supra at 92. The appellant in this matter has not consented to his transfer to a facility outside the State of West Virginia. Indeed, the appellant, whose competency at the time of his placement hearing was undisputed, objected to the transfer.

Admittedly, the appellant has not been convicted of a criminal act. The appellant is within the Court's jurisdiction by reason of the appellant's plea of not guilty to criminal charges by reason of a mental illness. And, in *Ray, supra*, the Court's construction and application of the transportation close spoke to the prevention of a person "convicted" under the laws of the State of West Virginia from involuntarily serving any portion of the "sentence" outside the boundaries of the State.

The constitutional clause does not expressly refer, however, to a conviction and does not make reference to a prisoner. Instead, the clause is broadly worded to state that "no person" shall be transported out of the state. The clause further states that the prohibited reason for the transfer is if it is for an "offense committed" within the state.

Indeed, one can envision the situation in which a person is threatened to be charged with, and prosecuted for, a crime unless that person leaves the jurisdiction. The clause would prohibit this type of law enforcement activity because it applies to any person who is in this position because of an offense that was committed. This stereotypical example of forced banishment would not be precluded by the constitutional bar if the clause was considered only applicable to "prisoners" who stand "convicted" of a crime. Accordingly, the seemingly restrictive language of *Ryan, supra*, should not be applied in this analysis.

The appellant is in the jurisdiction of the Circuit Court for the very reason that he committed an offense against the state. Indeed, the order accepting the plea of not guilty by reason of mental illness contains the recitation that “that there is a factual basis whereby the state could prove, at trial, that the defendant, in fact, committed the felony of first degree arson as charged in this Indictment.”⁷¹ Accordingly, every action in the underlying proceeding that is taken with respect to the appellant is taken for the very reason that the appellant was charged with an offense against the State. The Transportation Clause covers the appellant, therefore, because he is a person who is able to be transported by the Circuit Court because he was found to have committed an offense against the State of West Virginia.

The placement of the appellant in the South Carolina facility is thereby prohibited if it is involuntary. The Circuit Court seemingly agreed with this analysis when the judge stated that “Mr. Eddy is correct that the reason he is here --- the seminal conduct was criminal.”⁷²

The Circuit Court then analyzed, however, whether the transfer of the appellant was, in fact, involuntary. The Circuit Court stated:

But he’s not – Mr. Robertson is not competent right now. I have not made the appropriate findings that indicate that he is now competent. So he is incompetent. He is in the custody of the Department of Health and Human Resources, who is required to treat him and provide him with treatment. He is not competent to make his own decisions with regard to these issues. I mean, if that were the case – if he were “competent” now, he could refuse the placement, he could refuse the treatment, he could refuse everything else. He can’t refuse the placement, because he’s still under my jurisdiction; he’s incompetent. He’s incompetent and, therefore, I have to look at it from a treatment standpoint. It’s not a punitive action that we’re contemplating here today. We are not contemplating penalizing him for his criminal conduct. What we

⁷¹ Appendix, p. 2.

⁷² Appendix, p. 213.

are looking at is finding an appropriate treatment place to deal with the issues that have rendered him incompetent.⁷³

In the final order from which this appeal is taken, the Circuit Court made the following finding:

The Defendant has no standing to object to his involuntary transportation to a treatment facility in another state as violation [sic] the provisions of the transportation clause as set forth in Section 5 of Article 3 of the West Virginia Constitution because the Defendant is within the Court's jurisdiction pursuant to his plea of not guilty to a criminal offense by reason of mental illness which, as a matter of law, makes him incompetent to make decisions regarding his treatment, including imposing an objection to the Court's decision regarding his treatment in an out-of-state facility.⁷⁴

Essentially, the Circuit Court determined that the transportation clause was not violated because the transfer was not involuntary, notwithstanding the appellant's objections.

The Circuit Court was in error, however, in determining that the appellant was incompetent. The Circuit Court expounded that, because the appellant was within the Circuit Court's jurisdiction, the appellant was necessarily incompetent. The reality is, however, that the appellant is within the Circuit Court's jurisdiction because the disposition of his charges was that he was not guilty by reason of mental illness. The appellant was deemed to be competent, but he was deemed to be suffering from a mental illness at the time of the commission of the offense. And, indeed, at the hearing of this matter, the undisputed testimony was that the appellant was both competent and in remission from any mental illness.

The Circuit queried why the transfer of the appellant would be any different than the transfer of juveniles to out of state facilities. In the matter of a juvenile, the juvenile is considered incompetent, as a matter of law, due to the juvenile's age. Accordingly, the governing statutes require the formation of a multi-disciplinary team which makes

⁷³ Appendix, p. 217.

⁷⁴ Appendix, p. 226.

recommendations regarding the interests of the juvenile, including the possibility of transfer to an out of state facility. *See, generally, E.H. v. Matin*, 201 W. Va. 463, 498 S.E.2d 35 (1997). Moreover, the Circuit Court is statutorily granted the “authority to make facility-specific decisions governing juvenile placements.” *Id.* at 40.

But, with respect to the issue of consenting to a transfer under the transportation clause, the most significant element is that the determination of the infant’s best interests is deemed to be the responsibility of others and not the infant.

The appellant has no such legal disability, however. The appellant is, for all practical purposes, competent to make decisions regarding the location of his detention.

Indeed, the distinction between a prisoner and a forensic patient in this fashion would violate the Equal Protection provisions of the United States Constitution. Restated, if a prisoner can refuse to consent to his transfer while he is within the jurisdiction of the Circuit Court, then no rational basis exists for treating a forensic patient any differently by reason of his commitment to the Circuit Court’s jurisdiction due to the commission of an offence against the state.

For these reasons, the Circuit Court erred, as a matter of law, when it ordered a transfer of the appellant to a facility in another state notwithstanding the appellant’s objection to the transfer.

2. The Circuit Court’s Final Order Provides for a Placement that is Inconsistent with the Statutory Directive that the Appellant be Placed in the Least Restrictive Setting and the Placement Constitutes, Essentially, Punishment for the Appellant’s Intractable Personality Traits.

In 2007, the provisions of Sections 3, 4 and 5 of Article 6A of Chapter 27 of the West Virginia Code, W. Va. Code § 27-6A-3, 4, and 5, were enacted. Section 5 was an amended

version of the previous Section 4 governing the release or discharge of individuals from the Circuit Court's jurisdiction under the proceeding sections governing the disposition of a defendant who was found to be incompetent or who was found to be not guilty by reason of mental illness.

Significantly, Section 5, as enacted in 2007, provides an express reference to the release of individuals from a mental health facility into a less restrictive environment. The previous enactment contemplated the release of the individual into the community by discharge of the individual from the court's jurisdiction and was silent regarding the release into lesser restrictive settings than an inpatient hospital facility. Accordingly Section 5 seemingly addresses the issue of the potential overcrowding of forensic units in mental health hospitals by authorizing release into lesser restrictive facilities. Restated, if the Circuit Court's only choice was to release a defendant into the community or to maintain the defendant in the hospital setting, caution would result in the continued hospitalization of most defendants.

Specifically, Section 5, as enacted in 2007, provides as follows:

If upon consideration of the evidence the court determines that an acquitee may be released from a mental health facility to a less restrictive setting, the court shall order, within fifteen days of the hearing, the acquitee be released upon terms and conditions, if any, the court considers appropriate for the safety of the community and the well-being of the acquitee. **Any terms and conditions imposed by the court must be protective and therapeutic in nature, not punitive.** When a defendant's dangerousness risk factors associated with mental illness are reduced or eliminated as a result of any treatment, the court, in its discretion, may make the continuance of appropriate treatment, including medications, a condition of the defendant's release from inpatient hospitalization. The court shall maintain jurisdiction of the defendant in accordance with said subsection [W. Va. Code § 27-6A-4(e)][emphasis added].

W. Va. Code § 27-6A-5(a). Accordingly, Section 5 contemplates that the circuit court does not have to discharge the defendant from its jurisdiction. Instead, the circuit court is authorized, and directed, to consider release of the defendant into less restrictive settings combined with appropriate conditions for this release without discharge of the defendant from its jurisdiction.

As set forth in the statement of the facts in this matter, the resolution of the appellant's federal civil action against the DHHR regarding his effective incarceration in the cells constituting the Forensic Evaluation Unit at the South Central Regional Jail was to be resolved by the DHHR's support of the appellant's release from his inpatient hospitalization pursuant to the provisions of the *Community Placement and Treatment Plan*, dated April 1, 2010.⁷⁵ The Court approved the release of the appellant on these conditions.⁷⁶

Unfortunately, the appellant experienced psychotic episodes while on release, resulting in his hospitalization at the Bateman facility. Under Section 5, the legislation contemplated the situation in which a defendant violated a term of the condition of release, requiring as follows:

Upon notice that an acquitee released on the condition that he or she continues appropriate treatment does not continue his or her treatment, the prosecuting attorney responsible for the charges brought against the acquitee at trial shall, by motion, cause the court to reconsider the acquitee's release and upon a showing that the acquitee is in violation of the conditions of his or her release, the court may reorder the acquitee to a mental health facility designated by the department which is the least restrictive setting appropriate to manage the acquitee and protect the public.

W. Va. Code § 27-6A-5(a). The notable limitation is that the revocation of release is to be to the "least restrictive setting appropriate to manage the acquitee and protect the public."

In this matter, the revocation of the appellant's release was attributable to his decompensation mentally. Dr. Clayman and Dr. Miller testified that due to the stress of the

⁷⁵ Appendix, pp. 60 - 64.

⁷⁶ Appendix, pp. 65 - 72.

appellant's personality disorders, the appellant's mental illness came out of remission. Accordingly, his recommitment to an inpatient mental health facility was not the result of his violating conditions of the *Community Placement and Treatment Plan*, but was, essentially, medically necessary.

As the medical services providers further testified, the appellant's psychosis was dissipated almost immediately by medication and the appellant was, again, without mental illness.

At this point, however, the appellant was not released from the Bateman hospital in accordance with the *Community Placement and Treatment Plan*. Instead, the hospitalization was continued.

The appellant's hospitalization was then fraught with issues of the appellant's management. Dr. Miller and Ms. Bradstreet described the appellant as victimizing certain of the other forensic patients. While the nurse who was in charge of certain shifts at the hospital testified that the appellant was no less manageable than other patients, Dr. Miller and Ms. Bradstreet testified that the appellant was no less than a "terrorist."

The most significant testimony was, however, that the hospital setting was not an appropriate setting for the appellant. The appellant was competent, was not mentally ill, and was not subject to treatment.

Dr. Miller and Dr. Claymen testified, however, that if the appellant were returned to an apartment into the community, he would quickly decompensate again due to the pressure of his personality disorders and the lack of the structure that was found in the hospital.

The further testimony was that no other setting was available for the appellant's management in the State of West Virginia. The candid assessment was that the behavioral health

community was devoid of any facilities for the appellant other than the forensic unit at the hospital, which was also not appropriate. When questioned about the commitment of resources to monitoring the appellant if he returned to the apartment in which he had been previously released, the testimony was that it was impractical or expensive to do so.

Accordingly, the South Carolina facility was then identified and arrangements were made for the appellant's admission to the facility. And, as described, the facility is a detention facility that provides medical services to both inmates of prison facilities and forensic patients who constitute its detainees.

The facility is, without question, the most restrictive setting possible. The facility is a maximum security facility. The facility is a prison, in effect, that provides medical psychiatric services. The appellant's room is a cell.

And, notably, the placement of appellant into the South Carolina facility is solely for the purpose of managing the appellant. The belief is that the appellant will not be able to "victimize" any person within the population because the population consists of individuals with similar personality traits of the appellant. Dr. Miller expressly stated that the appellant's admission into the facility was for behavioral management and not for treatment.

The statutory charge is, however, that the appellant is not to be punished by reason of the manifestation of his illness. Instead, his disposition is to be for therapeutic purposes. If his hospitalization is not required for treatment, then he is to be in the "least" restrictive setting, not the "most" restrictive setting, for his management and for the protection of the public.

The appellant has not been categorized as an escape risk. Instead, the issue is the prevention of his decompensation into mental illness if he is again placed into the community. Structure is needed by the appellant. The hospital is not the appropriate setting because the

appellant does not require treatment or medication with his mental illness in remission and because the appellant is perceived as victimizing certain elements of the hospital forensic population.

The DHHR cannot place the appellant into any of the group homes within the behavioral health community because the group homes have the right to refuse placement and have done so with regard to the appellant. The DHHR refuses to consider the appellant's placement into its Transitional Living Facility in Weston, West Virginia, due, apparently, to Ms. Bradstreet's determination that the appellant will not abide by the rules, even though the placement has never been tried.⁷⁷

Accordingly, the DHHR proclaims that the only setting available is the South Carolina facility. However, the placement is effectively equal to the placement of the appellant back into the Forensic Evaluation Unit at the South Central Regional Jail, except that, perhaps, the staff at the South Carolina facility is considered better able to manage the appellant.

Simply stated, the Circuit Court's placement of the appellant into the South Carolina facility is in violation of the governing statute because it is not done for therapeutic purposes, but, instead, is punishment for his intractable personality traits.

The appellant was released from the inpatient hospitalization because it was determined that the appellant's mental illness was in remission and the dangerousness associated with the mental illness was diminished. The appellant's mental decompensation as a result of his intractable personality disorders required treatment. However, treatment stabilized the appellant.

⁷⁷ The record set forth in the Appendix makes reference to the difficulties that exist between the appellant and the Sharpe facility that makes placement back at the Sharpe facility problematic. However, the Transitional Living Facility is separated from the hospital facility and is managed separately. The appellant has never been considered for this placement.

The issue should be the manner in which to release the appellant so that he does not decompensate again, not to punish the defendant for his submission to his illness. The warehousing of the appellant in the maximum security facility in South Carolina is not consistent with the statutory directive that, if a release is revoked, the “least restrictive setting” be determined for the management of the defendant and the protection of the community. Instead, the DHHR should be charged with obtaining the agreement of the various private facilities to house the appellant or should permit the appellant an opportunity to reside within its operated Transitional Living Facility in Weston, West Virginia. The DHHR should not be permitted the opportunity to warehouse the appellant for another six (6) year period in a prison structure as it did before the resolution of the appellant’s federal civil action.

3. The Interstate Compact on the Mentally Disordered Offender does not Authorize the Transfer of the State of West Virginia’s Obligations as a Custodian of the Appellant to a Privately Owned Facility outside the Regulatory Control of the State of West Virginia.

The statutory authorization for the transfer of the defendant to the South Carolina facility was proffered by the DHHR to be the provisions of Section 1 of Article 15 of Chapter 27 of the West Virginia Code, W. Va. Code § 27-15-1, which is identified as the “Interstate Compact on the Mentally Disordered Offender.” The salutary policy of the compact for the party states is stated to be the “common action to improve their programs for the care and treatment of mentally disordered offenders.” W. Va. Code § 27-15-1, Article I(a). The purpose is stated as follows:

[To] authorize negotiation, entry into, and operations under contractual arrangements among any two or more of the party states for the establishment and maintenance of cooperative programs in any one or more of the fields for which specific provision is made....

W. Va. Code § 27-15-1, Article I(b). The procedure is declared to be:

Whenever the duly constituted judicial or administrative authorities in a state party to this compact, and which has entered into a contract pursuant to Article III, shall decide that custody, care and treatment in, or transfer of a patient to, a facility within the territory of another party state, or conditional release for aftercare in another party state is necessary in order to provide adequate care and treatment or is desirable in order to provide an appropriate program of therapy or other treatment or is desirable for clinical reasons, said officials may direct that the custody, care and treatment be within a facility or in a program of aftercare within the territory of said other party state, the receiving state to act in that regard solely as agent for the sending state.

W. Va. Code § 27-15-1, Article IV(a).

In this matter, the DHHR has not contracted with the State of Carolina pursuant to the foregoing compact. Instead, the DHHR has contracted with a private facility that is situated in the State of Carolina. Accordingly, the DHHR has released a person within its custody to a facility outside its sovereign boundaries without any agreement with the representatives of the sovereign whose boundaries encompass the private facility. Moreover, the contract with the facility was not presented to the Court for review of the provisions to determine what measures were adopted to ensure that the private facility would comply with the dictates of the laws and regulations of the State of West Virginia.

Accordingly, the DHHR had no authority to transfer a patient within its custody to a facility that is outside its regulatory reach and without arrangement to make certain that another sovereign regulator would abide by, and honor, its role as an agent of the State of West Virginia in these circumstances and exercise control over the facility to which the appellant is transferred.

VI. **CONCLUSION**

For the reasons that have been set forth, the Court is requested to vacate the final order of the Circuit Court ordering the transfer of the appellant to the facility in the State of South

Carolina and to direct the Circuit Court to enter its order regarding the proper placement of the appellant in the most appropriate setting within the State of West Virginia.

RESPECTFULLY SUBMITTED,

JAMES ROBERTSON
By Counsel

A handwritten signature in black ink, appearing to read "Dana F. Eddy", written over a horizontal line.

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CERTIFICATE OF SERVICE

I, Dana F. Eddy, counsel for the appellant James Robertson, do hereby certify that I have caused to be served upon the counsel of record in this matter a true and correct copy of the accompanying *Brief of Petitioner James Robertson* on this 6th day of March, 2012, by depositing the copy in the United States mail in a postage paid envelope with the following addresses:

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