NO. ______

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IN THE

SUPREME COURT OF THE UNITED STATES

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ROBERT LEWIS DEAR, JR.,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

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On Petition for Writ of Certiorari to the
United States Court of Appeals for the Tenth Circuit

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**APPENDIX**
**TO**
**PETITION FOR WRIT OF CERTIORARI**

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**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLORADO**
**Judge Robert E. Blackburn**

Case No. 19-cr-00506-REB

UNITED STATES OF AMERICA,

Plaintiff,

v.

ROBERT LEWIS DEAR, JR.,

Defendant.

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## ORDER RE: INVOLUNTARY MEDICATION

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**Blackburn, J.**

The matter before me is the **Motion For *Sell* Hearing** [#128][1] filed December 8, 2021, which is quintessentially a motion for the administration – involuntarily and forcibly if necessary – of antipsychotic and other related medications. The defendant filed a preliminary response [#133]. From August 31 to September 1, 2022, I held a hearing on the motion and took the matter under advisement.

Having judicially noticed all relevant adjudicative facts in the file and record *pro tanto*; having considered the testimony of six expert witnesses presented at the hearing; having considered the other evidence presented at the hearing, including reports prepared by some of the expert witnesses; having considered, but not necessarily accepted, the reasons stated, arguments advanced, and authorities cited by the parties

[1] "[#128]" is an example of the convention I use to identify the docket number assigned to a specific paper by the court's case management and electronic case filing system (CM/ECF). I use this convention throughout this order.

in their papers and during the hearing; and having considered and applied the four ***Sell***[2] factors to the existing, relevant evidence, I enter the following findings of fact, conclusions of law, and orders. Ultimately, I grant the relief requested in the motion.

## I. BACKGROUND

Mr. Dear faces a 68-count indictment which includes possible sentences of life in prison on each of three counts which allege violation of 18 U.S.C. § 248(a)(1) and (b). Those three counts allege, *inter alia*, that Mr. Dear used force in an effort to intimidate a person and class of persons and that use of force by Mr. Dear resulted in the deaths of three people. No doubt, these three counts constitute extremely serious crimes.

The other counts in the indictment also involve serious alleged crimes. These counts are based on the general allegation that Mr. Dear shot at several people outside of a Planned Parenthood Clinic. Excluding the two people allegedly killed outside of the clinic, Mr. Dear allegedly seriously injured three other people by shooting them. Then, Mr. Dear allegedly forced his way into the Planned Parenthood Clinic by shooting through a door. Once inside, he allegedly engaged in an approximately five hour standoff with officials from several public safety agencies. Allegedly, Mr. Dear shot and killed one police officer during the standoff. Some 27 other people in the clinic allegedly were forced to shelter in place inside the clinic as a result of Mr. Dear's actions.

The court ordered the defendant, Robert Dear, to be committed to the custody of the Attorney General, through the United States Bureau of Prisons, for a competency evaluation to be administered at the United States Medical Center for Federal Prisoners at Springfield, Missouri (Springfield). *Order* [#82], p. 5 & *Order* [#100], p.7. Ultimately, I declared Mr. Dear incompetent to proceed to trial. *Order* [#121]. In addition, I ordered

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[2] A reference to ***Sell v. United States***, 539 U.S. 166, 179-81 (2003).

hospitalization and treatment to determine if there is a substantial probability that in the foreseeable future Mr. Dear will attain the capacity to permit proceedings to go forward. *Id*.

Based on subsequent evaluations of Mr. Dear at Springfield, a psychologist and a psychiatrist at Springfield determined that Mr. Dear is unlikely to be restored to competency in the foreseeable future in the absence of the administration of antipsychotic medication. Mr. Dear refuses voluntarily to take antipsychotic medication. As a result, the government filed its **Motion For *Sell* Hearing** [#128] to determine if Mr. Dear should be medicated involuntarily in an effort to restore him to competency. Mr. Dear opposes the motion and the imposition of involuntary medication.

## II. STANDARD OF REVIEW

It is well-settled law that Mr. Dear "possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment." ***U.S. v. Valenzuela-Puentes***, 479 F.3d 1220, 1223 (10th Cir. 2007) (quoting ***Washington v. Harper***, 494 U.S. 210, 221-22 (1990)). In ***Harper***, the Supreme Court of the United States held that "the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest." ***Washington v. Harper***, 494 U.S. at 227.

Prior to the opinion of the Supreme Court in ***Sell v. United States***, 539 U.S. 166 (2003), the government could request an order of involuntary medication for a criminal detainee only on a showing that the defendant was dangerous to himself or others. ***Valenzuela-Puentes***, 479 F.3d at 1223. In ***Sell***, the Supreme Court established a

quadripartite test to determine whether or not it is proper to order involuntarily administered medications to attempt to render a defendant competent to stand trial when the defendant is not a danger to himself or others. Under ***Sell***, the court may order the government to involuntarily administer drugs to a mentally ill, non-dangerous defendant in order to render him competent to stand trial only if the government establishes four things:

> (1) "*important* governmental interests are at stake;" (2) the "involuntary medication will *significantly further*" those interests; (3) the "involuntary medication is *necessary* to further those interests," e.g., less intrusive alternative treatments are unlikely to be effective; and (4) the administration of the medication is "*medically appropriate* " and in the defendant's best medical interests.

***United States v. Chavez***, 734 F.3d 1247, 1249 (10th Cir. 2013) (quoting ***Sell***, 539 U.S. at 180-181) (emphasis in ***Sell***).

Addressing the second ***Sell*** requirement, whether involuntary medication will significantly further governmental interests, a court may find that the second requirement has been satisfied only if it makes two specific subsidiary findings:

> (A) that involuntary medication "is substantially likely to render the defendant competent to stand trial"; and
>
> (B) "that administration of the drugs is substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense . . . ."

***Sell***, 539 U.S. at 181.

"(I)nstances of involuntary medication of a non-dangerous defendant solely to render him competent to stand trial should be 'rare' and occur only in 'limited circumstances.' " ***United States v. Valenzuela–Puentes***, 479 F.3d 1220, 1223 (10th Cir. 2007) (quoting ***Sell***, 539 U.S. at 169, 180). Before undertaking an analysis under

***Sell***, a court first must “consider the applicability of ***Harper*** . . . .” ***Valenzuela–Puentes***, 479 F.3d at 1224; see also ***Sell***, 539 U.S. 181 - 182 (“There are often strong reasons for a court to determine whether forced administration of drugs can be justified on . . . alternative grounds before turning to the trial competence question.”).

To issue an order for involuntary medication under ***Sell***, the “district court must find all necessary underlying facts by clear and convincing evidence.” ***U.S. v. Chavez***, 734 F.3d 1247, 1250 (10th Cir. 2013); see also ***U.S. v. Bradley***, 417 F.3d 1107, 1114 (10th Cir. 2005) (in ***Sell*** hearing, “factual findings . . . ought to be proved by the government by clear and convincing evidence.”) Evidence is clear and convincing when the evidence gives the fact-finder “an abiding conviction that the truth of [the] factual contentions [is] ‘highly probable.’” ***Colorado v. New Mexico***, 467 U.S. 310, 316 (1984) (citing C. McCormick, Law of Evidence § 320, p. 679 (1954)); ***Valenzuela–Puentes***, 479 F.3d at 1228–29 (10th Cir.2007).

## III. FINDINGS OF FACT

1. My findings of fact[3] are based on and supported by clear and convincing evidence. Based on the evidence in the record, each finding of fact is, at minimum, highly probable.

2. Mr. Dear is 64 years old. However, his age is not an impediment to the restoration of competency through the administration of antipsychotic medications and is not likely to exacerbate any of his underlying medical conditions or any of the possible side effects.

3. Mr. Dear suffers from a mental disease or defect rendering him mentally

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[3] Any finding of fact more properly deemed a conclusion of law, or any conclusion of law more properly deemed a finding of fact, shall be as more properly characterized.

incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense. Thus, logically and legally, Mr. Dear is also unable to voluntarily and knowingly waive his right to counsel and exercise his right to proceed pro se. Therefore, Mr. Dear is not presently competent to proceed. *Order* [#121].

4. Mr. Dear suffers from Delusional Disorder, Persecutory Type. This finding is based primarily on the credible and cogent hearing testimony and reports of Lea Ann Preston Baecht, Ph.D., ABPP, a board certified forensic psychologist who has had frequent and fairly recent contact with Mr. Dear in a clinical setting at Springfield. Dr. Preston Baecht evaluated Mr. Dear at Springfield in conjunction with Dr. Robert Sarrazin, Chief of Psychiatry at Springfield. Other experts, including those for the defense, credibly have given Mr. Dear the same or a similar diagnosis.

5. Delusional Disorder is a psychotic disorder recognized by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5 TR, March 18, 2022).

6. All relevant evidence indicates that the symptoms of Mr. Dear's Delusional Disorder are chronic. There is no evidence that those symptoms have abated or decreased spontaneously at any time since at least 2016.

7. Prior to the initiation of proceedings in this case, Mr. Dear was housed at the Colorado Mental Health Institute at Pueblo (CMHI). At CMHI Mr. Dear was treated briefly with olanzapine administered orally and may have received an injection of Haloperidol. On these occasions, Mr. Dear was not treated with therapeutic dosages for a significant period of time. Otherwise, from 2016 to the present, no antipsychotic medication has been administered to Mr. Dear.

8. Mr. Dear suffers from high blood pressure or hypertension. Consistently, he has refused medical treatment for this condition.

9. Mr. Dear suffers from high cholesterol or hyperlipidemia.

10. Mr. Dear suffers from stage three A chronic kidney disease.

11. Mr. Dear claims he suffered a heart attack as the result of a medication administered to him at the CMHI. The medical record, as well as the assessment and opinion of Dr. Matthew Holland, a cardiologist, demonstrate that Mr. Dear has not suffered a heart attack. In addition, there is no competent evidence that Mr. Dear currently suffers from significant cardiovascular disease.

Generally, the QT interval measured by any electrocardiogram (EKG) administered to Mr. Dear was within normal limits. Any aberration involving a prolonged QT interval is attributable to the stress of a serious illness, e.g., pancreatitis, affecting Mr. Dear at the time of the EKG.

12. Mr. Dear does not suffer from an intellectual disability or a neurocognitive disorder, such as dementia.

13. From 2016 to the present, Mr. Dear has assiduously refused to accept medical treatment, including antipsychotic medication, for the symptoms of his Delusional Disorder.

14. Based on the evidence presented in support of and opposition to the motion, it is not known precisely when Mr. Dear began to suffer from Delusional Disorder. More likely than not, Mr. Dear has suffered from Delusional Disorder for at least 10 years and possibly for as many as 30 years. All of the evidence in the record shows Mr. Dear has suffered from Delusional Disorder at least since late 2015. That conclusion is based primarily on the assessments of Mr. Dear at the CMHI and at Springfield, which

assessments began in 2016.

15. On a date not specified in the record, a hearing concerning Mr. Dear and applying the involuntary medication standards of ***Washington v. Harper***, 494 U.S. 210, 221-22 (1990), was conducted at Springfield. The hearing officer concluded that Mr. Dear has a mental illness, but does not present a danger to himself or others in a correctional environment. Given those findings, the hearing officer concluded Mr. Dear is not subject to involuntary medication under the ***Harper*** criteria.

16. When he is in custody in a tightly regulated and highly structured prison-like environment, Mr. Dear does not present a danger to himself or others.

Competency Restoration

17. A competency restoration evaluation of Mr. Dear was conducted at Springfield by Dr. Preston Baecht and Dr. Sarrazin. Dr. Preston Baecht was a staff psychologist at Springfield for 21 years. Dr. Sarrazin has been a psychiatrist at Springfield for 20 years and the Chief of Psychiatry for 18 years. He has worked with competency restorations for 18 of those years.

18. Often, Delusional Disorder can be treated successfully with antipsychotic medication. When successful, such medications minimize but do not eliminate the presence of delusions in the patient's mind. When delusions are sufficiently controlled by antipsychotic medication, a person suffering from Delusional Disorder can be restored to competence.

19. Dr. Sarrazin prepared a Proposed Treatment Plan [#143 - under restriction] for Mr. Dear. The treatment plan includes administration – involuntarily, i.e., forcibly, if necessary – of four different antipsychotic medications. Generally, only one primary medication would be administered at a time. If that medication was well tolerated, did

not cause substantial and unmanageable side effects, and was deemed efficacious, other medications would not be tried. However, if a primary medication was not tolerated well, caused substantial and unmanageable side effects, and/or was deemed ineffective, administration of that medication would be terminated and another antipsychotic medication would be administered.

20. In the experience of Dr. Preston Baecht and Dr. Sarrazin working with psychotic patients at Springfield, antipsychotic medication restores a psychotic patient to competence in at least 70 to 75 percent of the cases in which antipsychotic medication is used.

21. Some published studies reflect a competency restoration rate for psychotic patients treated with antipsychotic medication in the same range experienced by Dr. Preston Baecht and Dr. Sarrazin. However, some published studies reflect a lower competency restoration rate. The results of some published studies are less persuasive because some studies involved fairly small sample sizes, medication trials of less than three months, and/or indications that patients in the study failed to fully comply with the medication regime being studied.

22. In view of their assessments of Mr. Dear at Springfield and their long experience with competency restorations at Springfield, Dr. Preston Baecht and Dr. Sarrazin both conclude that administration of antipsychotic medication to Mr. Dear is substantially likely to restore Mr. Dear to competence. They both estimate credibly that there is at least a 70 percent chance that Mr. Dear would be restored to competency with the use of antipsychotic medication.

23. Dr. George Woods, a neuropsychiatrist, and Dr. Richard Martinez, a professor of forensic psychiatry, each testified at the hearing. They both disagree with

the conclusion that the treatment plan is substantially likely to restore Mr. Dear to competence. I have considered carefully the testimony of Dr. Wood and Dr. Martinez on this point. Given the long experience of Dr. Preston Baecht and Dr. Sarrazin in competence restoration and their personal observations of and interactions with Mr. Dear, I find that their opinions on this issue have a substantially stronger factual and clinical foundation, and, thus, are entitled to greater weight than those opposed to them when assessing Mr. Dear and the likelihood that the treatment plan is substantially likely to restore Mr. Dear to competence.

24. Psychotherapy alone is not likely to be an effective treatment for Delusional Disorder.

25. Antipsychotic medication is not substantially more effective or less effective when administered involuntarily versus voluntarily.

26. The proposed antipsychotic medications paliperidone, aripiprazole, haloperidol, and olanzapine have been shown to be effective treatments for Delusional Disorder.

27. In his Proposed Treatment Plan [#143 - under restriction], Dr. Sarrazin proposes administration of paliperidone, aripiprazole, haloperidol, and/or olanzapine to treat Mr. Dear's Delusional Disorder. Olanzapine is not proposed as a primary medication. Rather, it is proposed as a possible adjunct medication at a low dose. Dr. Sarrazin testified that, in some cases, a low dose of Olanzapine is an effective addition to treatment.

28. In his testimony at the hearing, Dr. Sarrazin proposed to treat Mr. Dear initially with a low dose of an antipsychotic medication with careful monitoring of Mr. Dear's tolerance of the medication, response to the medication, and possible side

effects. Throughout the proposed course of treatment, Mr. Dear would be monitored routinely to assess Mr. Dear's tolerance of the medication, response to the medication, and possible side effects.

29. Based on the evidence in the record concerning the efficacy of these antipsychotic medications, I find that the closely monitored treatment of Mr. Dear with paliperidone, aripiprazole, or haloperidol as the primary medication is substantially likely to render Mr. Dear competent to stand trial. Olanzapine as an adjunct medication at a low dose may aid in this treatment. Most likely, treatment with these medications must continue for at least four months

30. Clear and convincing evidence in the record shows it is substantially likely that the proposed treatment plan will render Mr. Dear competent to stand trial whether Mr. Dear voluntarily complies with the treatment plan or must be medicated involuntarily.

Side Effects of Antipsychotic Medications

31. The more common side effects of antipsychotic medications are restlessness, sedation, drowsiness, apathy, inability to focus, or lack of motivation. At Springfield, when any of these side effects presents in a patient, it is addressed by adjusting the dosage of the antipsychotic medication, changing the time of administration, splitting the dose from once per day to one-half dose twice per day, changing the antipsychotic medication, and/or using a secondary medication to treat the side effects.

32. In some cases, restlessness and sedation can be of sufficient severity that they impact competency. Often, these side effects can be treated, as described above, to ameliorate these side effects.

33. Less common side effects of antipsychotic medication include elevated blood glucose levels, weight gain, elevated cholesterol levels, tremors, shakiness, or stiffness. When necessary, these less common side effects are ameliorated in the same general fashion as the more common side effects.

34. Haloperidol, one of the medications specified in the treatment plan, is a so-called first generation antipsychotic medication. When compared to second generation antipsychotic medications, first generation antipsychotic medications are more likely to cause side effects such as shakiness, unintentional muscle contractions (acute dystonias), and stiffness. However, these side effects respond very quickly and positively to medications known as benzodiazepines.

35. Tardive dyskinesia is a possible, but not a probable, side effect. Tardive dyskinesia manifests as involuntary movements of the jaw, lips, and/or tongue. This is a potential, and possibly permanent, side effect usually is associated with high doses of first generation antipsychotic medications administered over a period of years. This side effect appears in only about five percent of cases using first generation antipsychotics and in about two percent of cases using second generation antipsychotics.

36. Neuroleptic malignant syndrome is a very rare side effect of antipsychotic medication, primarily first generation antipsychotic medication. This side effect appears in less than one percent of cases. Symptoms of neuroleptic malignant syndrome include a high temperature, severe stiffness, muscle break down, and possible kidney damage. Generally, this side effect appears with the first dosages of a new antipsychotic medication or an increased dosage. If this side effect appears, the medication is stopped, and the patient is hospitalized, if necessary.

37. Sudden cardiac death is an extremely rare side effect of antipsychotic medication. This side effect appears in less than one percent of cases. Underlying cardiovascular disease is a contributing factor in sudden cardiac death in people taking antipsychotic medication.

38. None of the foregoing possible side effects – whether described as common, less common, or rare – vitiate the need or efficacy of treatment by antipsychotic medication.

39. If Mr. Dear is given antipsychotic medication at a Bureau of Prisons medical facility, he will be closely monitored in an acute psychiatric care hospital setting.

40. If Mr. Dear is given antipsychotic medication at a Bureau of Prisons medical facility, his blood pressure, blood glucose level, cholesterol level, and weight gain or loss will be routinely and closely monitored. EKGs would be used to assess and monitor the electrical activity of his heart. The creatinine level of Mr. Dear would be monitored to assess his kidney function. In addition, Mr. Dear would be observed routinely and closely to see if he is exhibiting any of the side effects of antipsychotic medication.

Effect of Antipsychotic Medication On Other Medical Conditions

41. There is no reliable evidence that Mr. Dear suffers from significant cardiovascular disease. There is no evidence that administration of antipsychotic medications will have an adverse effect on the cardiovascular health of Mr. Dear, even at his age. Such medications are not contraindicated in even patients who, unlike Mr. Dear, have documented and significant underlying heart disease.

42. Mr. Dear suffers from hypertension. The antipsychotic medications in the proposed treatment plan were selected by Dr. Sarrazin with a goal of eliminating or

minimizing any negative effects on the hypertension of Mr. Dear. Under the proposed treatment plan, the blood pressure of Mr. Dear would be monitored routinely during the course of treatment.

43. Mr. Dear suffers from high cholesterol. Under the proposed treatment plan, the blood cholesterol level of Mr. Dear would be monitored routinely during the course of treatment.

44. Mr. Dear suffers from stage three A chronic kidney disease. The antipsychotic medications specified in the treatment plan are not contraindicated in patients with chronic kidney disease. Under the proposed treatment plan, the renal function of Mr. Dear would be monitored routinely during the course of treatment.

45. If the administration of antipsychotic medication has any significant adverse effect on any of the health conditions listed above, that effect could be effectively extenuated, if not eliminated altogether, by adjusting the dosage of the antipsychotic medication, changing the dosage time, changing the antipsychotic medication, and/or using a secondary medication to treat the adverse effect.

46. Based on the evidence in the record concerning the side effects of the antipsychotic medications at issue, I find that administration of these antipsychotic medications is substantially unlikely to cause side effects that will interfere significantly with Mr. Dear's ability to assist counsel in conducting a trial defense.

47. The proposed treatment plan, including the involuntary administration of the recommended antipsychotic medications, is substantially likely to render Mr. Dear competent to stand trial.

## IV. CONCLUSIONS OF LAW

1. I found all necessary underlying facts by clear and convincing evidence. ***U.S.***

***v. Chavez***, 734 F.3d 1247, 1250 (10th Cir. 2013); see also ***U.S. v. Bradley***, 417 F.3d 1107, 1114 (10th Cir. 2005) (in ***Sell*** hearing, "factual findings . . . ought to be proved by the government by clear and convincing evidence.").

2. Because Mr. Dear does not present a danger to himself or others in a correctional setting, he is not subject to involuntary medication based on the standards stated in ***Washington v. Harper***, 494 U.S. 210, 221-22 (1990).

3. Considering the first ***Sell*** factor, I conclude based on clear and convincing evidence that important governmental interests are at stake in this case. The interest of the government in bringing to trial an individual accused of a serious crime satisfies the first ***Sell*** factor. ***Sell***, 539 U.S. at 180. When considering whether a specific crime is a "serious crime," I have considered, inter alia, "the possible penalty the defendant faces if convicted, as well as the nature or effect of the underlying conduct for which he was charged." ***Valenzuela-Puentes***, 479 F.3d at 1226.

Mr. Dear faces a 68-count indictment. Each count charges a serious crime. Three counts include possible sentences of life in prison for violation of 18 U.S.C. § 248(a)(1) and (b).

All of the crimes in the indictment involve substantial penalties as well as alleged conduct of a particularly violent and heinous nature with pernicious effects. The government has an important interest in bringing a competent Mr. Dear to trial on each of these charges. Additionally, the government has an important interest in seeking to conduct a trial as soon as reasonably practicable to preserve the existence and integrity of all relevant and admissible evidence.

4. Considering the second ***Sell*** factor, I conclude based on clear and convincing evidence that involuntary medication of Mr. Dear under the proposed treatment plan will

significantly further the important governmental interests in bringing this case to trial. As detailed above, and based on clear and convincing evidence, administration of antipsychotic medications to Mr. Dear under the proposed treatment plan is substantially likely to render Mr. Dear competent to stand trial. In addition, and again based on clear and convincing evidence, administration of these medications under the proposed treatment plan is substantially unlikely to have side effects that will interfere significantly with the ability of Mr. Dear to assist counsel in conducting a trial defense when Mr. Dear is competent to stand trial.

5. Considering the third ***Sell*** factor, I conclude based on clear and convincing evidence that involuntary medication of Mr. Dear under the proposed treatment plan is necessary to further the important governmental interests at stake here. There are no alternative, less intrusive treatments which have any real chance of achieving a restoration of competency. For years, Mr. Dear has tendentiously refused medication to treat his Delusional Disorder. Given that history, and based on clear and convincing evidence, involuntary medication of Mr. Dear is the only realistic means by which he is substantially likely to be restored to competence, so he and the government can participate in a fair and lawful criminal trial of the serious charges in this case.

6. Considering the fourth ***Sell*** factor, I conclude based on clear and convincing evidence that involuntary medication of Mr. Dear under the proposed treatment plan is medically appropriate. Such treatment is in the best medical interest of Mr. Dear in light of his psychiatric and medical condition.

Under the proposed treatment plan, and again based on clear and convincing evidence, involuntary medication of Mr. Dear is not substantially likely to engender dangerous and unmanageable side effects. Medication of Mr. Dear is not substantially

likely to exacerbate any of the existing medical conditions of Mr. Dear, including high blood pressure, high cholesterol, and stage three A chronic kidney disease.

Mr. Dear suffers from Delusional Disorder, Persecutory Type, which is a psychotic disorder. In Mr. Dear, the symptoms of this disorder are chronic and likely to persist unless they are treated. The primary symptom of this disorder in Mr. Dear is persistent delusional thoughts that various people and government agencies are constantly persecuting Mr. Dear. Importantly, clear and convincing evidence establishes that involuntary medication of Mr. Dear is substantially likely to mitigate and control this primary symptom. Elimination of delusional thoughts is neither likely nor anticipated. However, quieting or substantially limiting the strength and frequency of his delusional thought is substantially likely. It is in the best medical interest of Mr. Dear to attempt a treatment of this disorder which is substantially likely to ameliorate the primary symptom of the disorder.

The implementation of the reticulated, sequenced, ingravescent treatment regimen using the antipsychotic and other medications and treatment modalities recommended in the proposed treatment plan is medically appropriate, i.e., in Mr. Demetrian's best medical interest in light of his psychiatric condition.

7. In light of the efficacy, the side effects, the possible alternatives, and the medical appropriateness of the proposed course of antipsychotic medication treatment, the government has demonstrated by clear and convincing evidence a need for that treatment sufficiently important to surmount Mr. Dear's protected interest in refusing such treatment.

8. On this evidentiary record, and based on the foregoing findings of fact, which have been established by clear and convincing evidence, the government has satisfied

the quadripartite requirements of ***Sell*** and is entitled to the entry of an order facilitating the involuntary administration of antipsychotic medications to Mr. Dear.

## V. ORDERS

**THEREFORE, IT IS ORDERED** as follows:

1. That the **Motion For *Sell* Hearing** [#128],which is quintessentially a motion for the administration – involuntarily and forcibly if necessary – of antipsychotic and other related medications., is granted on the terms stated in this order;

2. That the treatment plan [#143 - under restriction] is approved and ordered implemented, together with the addition of the other specific augmentative requirements stated in this order;

3. That any medication, test, monitoring, procedure, or assessment required or prescribed by the treatment plan or this order may be administered involuntarily and forcibly if necessary, using the force reasonably necessary in the circumstances;

4. That as soon as practicable, Mr. Dear shall be returned to the United States Medical Center for Federal Prisoners at Springfield, Missouri (Springfield), or another suitable facility (as defined by18 U.S.C. § 4247(a)(2)), for implementation of the treatment plan;

5. That prior to the initiation of the treatment plan, the treatment staff of the BOP shall obtain baseline data on Mr. Dear by EKG, blood test, or other medically appropriate testing for cardiovascular function, electrolytes (including magnesium), renal function, blood pressure, body weight, blood glucose, cholesterol, and lipids;

6. That under the treatment plan, Mr. Dear shall be treated initially with a low dose of one of the three primary antipsychotic medications included in the treatment plan;

7. That throughout the implementation and use of the treatment plan, Mr. Dear shall be monitored carefully to assess his tolerance of any antipsychotic medication administered, his response to the medication, and the possible side effects of the medication;

8. That throughout the implementation and use of the treatment plan, Mr. Dear shall be monitored carefully to acquire and assess data about his cardiovascular condition, electrolytes (including magnesium), and renal function;

9. That throughout the implementation and use of the treatment plan, Mr. Dear shall be monitored carefully to acquire and assess data on his blood pressure, weight gain or loss, blood glucose, cholesterol, and lipids;

10. That an EKG shall be conducted on Mr. Dear within a reasonable time after any increase of the dose of an antipsychotic medication, addition of a new or different antipsychotic medication, or any other significant medical/clinical change in the condition of Mr. Dear which implicates cardiovascular function;

11. That during implementation and execution of the treatment plan, treatment staff of the BOP shall not administer medications known to prolong the QT interval, other than medications specified in the treatment plan;

12. That during implementation and execution of the treatment plan, the serum potassium and magnesium levels of Mr. Dear shall be maintained to the extent medically practicable in the normal range for patients of the same or similar age as Mr. Dear;

13. That during the implementation and execution of the treatment plan, treatment staff of the BOP may, if necessary, involuntarily perform any physical and laboratory assessments and monitoring which are required by this order or are clinically

indicated to monitor for side effects from the administration of any medication used to implement and administer the treatment plan;

14. That pursuant to and subject to the provisions of 18 U.S.C. § 4241(d)(2)(A), Mr. Dear shall remain in the custody of the Attorney General for continued hospitalization and treatment in a suitable facility for such a reasonable period, not to exceed four months, to determine whether there is a substantial probability that in the foreseeable future the defendant will attain the capacity to permit the proceedings to go forward;

15. That by January 19, 2023, counsel for the government shall file a status report to inform the court of the status of Mr. Dear, including a summary of the implementation and execution of the treatment plan;

16. That unless ordered otherwise, implementation and use of the treatment plan shall continue throughout the course of these criminal proceedings; and

17. That under 18 U.S.C. § 3161(h)(1)(A) and (4), the period of delay resulting from these ongoing competency proceedings shall be excluded in computing the time within which trial must commence under 18 U.S.C. § 3161(c).

Dated September 19, 2022, at Denver, Colorado.

**BY THE COURT:**

Robert E. Blackburn
United States District Judge

104 F.4th 145
United States Court of Appeals, Tenth Circuit.

UNITED STATES of America, Plaintiff - Appellee,
v.
Robert Lewis DEAR, Jr., Defendant - Appellant.

No. 22-1303
|
FILED June 10, 2024

**Synopsis**
**Background:** In prosecution arising out of attack on abortion clinic, government moved to medicate defendant involuntarily in order to restore him to competency to stand trial. The United States District Court for the District of Colorado, Robert E. Blackburn, Senior District Judge, granted motion, and defendant filed interlocutory appeal.

**Holdings:** The Court of Appeals, Moritz, Circuit Judge, held that:

district court adequately explained its decision, and

district court did not commit clear error in concluding that government established that proposed treatment was substantially likely to restore criminal defendant to competency.

Affirmed.

**Procedural Posture(s):** Appellate Review; Pre-Trial Hearing Motion.

***146 Appeal from the United States District Court for the District of Colorado, (D.C. No. 1:19-CR-00506-REB-1)**

**Attorneys and Law Firms**

Jacob Rasch-Chabot, Assistant Federal Public Defender (Virginia L. Grady, Federal Public Defender, with him on the briefs), Office of the Federal Public Defender, Denver, Colorado, for Defendant-Appellant.

Marissa R. Miller, Assistant United States Attorney (Cole Finegan, United States Attorney, with her on the brief), Denver, Colorado, for Plaintiff-Appellee.

Before BACHARACH, BRISCOE, and MORITZ, Circuit Judges.

**Opinion**

MORITZ, Circuit Judge.

In the years since his November 2015 attack on a Planned Parenthood clinic in Colorado Springs, Colorado, Robert Dear has repeatedly been found incompetent to stand trial, including by the district court in the proceedings below. But on the government's motion, the district court ordered Dear involuntarily medicated in an attempt to restore his competency. We affirm that order, holding that the district court made sufficiently detailed factual findings and that those findings—which placed greater weight on the government's experts because of their extensive experience restoring competency and their personal experience observing and interacting with Dear—are not clearly erroneous.

## Background

According to the facts alleged in the indictment, Dear arrived at the Colorado Springs Planned Parenthood clinic armed with six rifles, five handguns, a shotgun, propane tanks, and over 500 rounds of ammunition. He immediately began shooting at a car next to his in the parking lot, killing one individual. Dear then shot at others outside the clinic, killing a second individual. From there, Dear forced his way into the building, where he continued to shoot and injure employees, patients, and others gathered in the clinic. Over the course of a five-hour stand-off with law enforcement, Dear killed one officer and injured four others.

The State of Colorado arrested Dear and initially placed him on suicide watch based on statements he made during his intake and because he refused to eat or drink. Soon after, mental-health professionals diagnosed Dear with delusional disorder, persecutory type, and the state ***147** court found Dear incompetent to stand trial. Dear remained in state custody for about four years; upon periodic reexamination, psychiatrists continually found him incompetent to stand trial. [1]

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In December 2019, the federal government indicted Dear on 68 counts. After Dear expressed a desire to represent himself, the government moved for a competency evaluation under 18 U.S.C. § 4241. To obtain this evaluation, Dear was transferred to the United States Medical Center for Federal Prisoners in Springfield, Missouri (Springfield). There, psychiatrist Lea Ann Preston Baecht evaluated Dear and determined that although he remained incompetent due to his delusional disorder, persecutory type, he was substantially likely to be restored to competency through the administration of antipsychotics.

Based on this report, and because Dear refused to take antipsychotic medication voluntarily, the government filed a motion to involuntarily medicate Dear under *Sell v. United States*, 539 U.S. 166, 123 S.Ct. 2174, 156 L.Ed.2d 197 (2003).[2] *Sell* provides that a district court may grant a motion for involuntary medication if the government shows that (1) "important governmental interests are at stake"; (2) "involuntary medication will significantly further those ... interests" (meaning that medication "is substantially likely to render the defendant competent to stand trial" and "is substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel"); (3) "involuntary medication is necessary to further those interests"; and (4) "administration of the drugs is medically appropriate." *Id.* at 180–81, 123 S.Ct. 2174 (emphases omitted). And because of "the vital constitutional liberty interest at stake," the government must prove these prongs "by clear and convincing evidence." *United States v. Bradley*, 417 F.3d 1107, 1113–14 (10th Cir. 2005); *see also Sell*, 539 U.S. at 178, 123 S.Ct. 2174 (stating that "an individual has a 'significant' constitutionally protected 'liberty interest' in 'avoiding the unwanted administration of antipsychotic drugs' " (quoting *Washington*, 494 U.S. at 221, 110 S.Ct. 1028)). To prove a fact by clear and convincing evidence is a heavy burden that equates to showing the fact is "highly probable." *Florida v. Georgia*, 592 U.S. 433, 438–39, 141 S.Ct. 1175, 209 L.Ed.2d 301 (2021) (quoting *Colorado v. New Mexico*, 467 U.S. 310, 316, 104 S.Ct. 2433, 81 L.Ed.2d 247 (1984)).

In August 2022, the district court conducted a three-day *Sell* hearing. Both parties presented expert testimony, which we summarize here and discuss in more detail in our analysis. The government called Preston Baecht, as well as Robert Sarrazin, Springfield's chief of psychiatry, who provided the treatment plan for ***148** Dear.[3] Both had worked at Springfield for over 20 years, and both testified to successfully restoring the competency of over 70% of their patients suffering from delusional disorder. Both had also personally observed and interacted with Dear and estimated a similar, over-70% chance that antipsychotics would restore him to competency. In support, they noted that Dear did not appear to have a history of failed treatment, had previously been functioning in society, and did not appear to have any cognitive disabilities. They additionally determined that neither Dear's duration of untreated psychosis (DUP) of between 10 and 30 years nor Dear's age (in his 60s) meaningfully decreased the likelihood of Dear being restored to competency. Additionally, both Preston Baecht and Sarrazin discussed the existing scientific literature, explaining that despite its limitations, it supported their opinions.

The defense called forensic psychiatrist Richard Martinez; psychiatric pharmacist William Morton Jr.; and neuropsychologist George Woods Jr. Of these three experts, only Martinez had personally examined Dear, once in December 2015, shortly after the alleged attack, and again in February 2016. Martinez and Morton both testified that antipsychotics were unlikely to render Dear competent and discounted the scientific literature discussed by the government's experts. Woods testified that certain facets of Dear's mental illness, such as various negative symptoms and his cognitive skills, indicated that involuntary medication was unlikely to restore Dear to competency.

Two weeks after the *Sell* hearing, the district court granted the government's motion to involuntarily medicate Dear. It concluded that the government's interest in bringing Dear to trial satisfied the first *Sell* prong, particularly in light of the seriousness of the charged crimes and underlying conduct, as well as the severity of the potential penalties. On the second prong, the district court found that involuntary medication would significantly further the government's interest because it was both "substantially likely to render ... Dear competent to stand trial" and "substantially unlikely to have side effects that will interfere significantly with [Dear's] ability ... to assist counsel in conducting a trial defense." R. vol. 1, 50. In making these factual findings, the district court placed greater weight on the government's experts, crediting their significant experience restoring competency to individuals suffering from delusional disorder and their personal observations of and interactions with Dear. On the third prong, the district court reasoned that involuntary medication was necessary because Dear consistently refused medication to treat his delusional disorder and "no alternative, less[-]intrusive treatments" existed that could provide "any

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real chance of achieving a restoration of competency." *Id.* And on the fourth prong, the district court concluded that involuntary medication was medically appropriate and in Dear's "best medical interest ... in light of his psychiatric and medical condition." *Id.* The district court thus permitted the government to pursue its provided treatment plan for up to four months.

Dear then filed this appeal, and the district court stayed its order pending our ruling. [4]

***149 Analysis**

In an appeal from an involuntary-medication order, we review legal conclusions de novo and factual findings for clear error. *See Bradley*, 417 F.3d at 1113–14. Under the basic clear-error standard, "[a] finding of fact is not clearly erroneous unless it is without factual support in the record, or unless the court[,] after reviewing all the evidence, is left with a definite and firm conviction that the district court erred." *United States v. Chavez*, 734 F.3d 1247, 1250 (10th Cir. 2013) (quoting *United States v. Jarvison*, 409 F.3d 1221, 1224 (10th Cir. 2005)). At the same time, the parties agree that in the involuntary-medication context, the clear-error standard incorporates the government's burden of proving the *Sell* prongs by clear and convincing evidence. *See United States v. Valenzuela-Puentes*, 479 F.3d 1220, 1227–28 (10th Cir. 2007) (assessing involuntary-medication fact findings for clear error in light of government's clear-and-convincing burden). Additionally, when reviewing for clear error, "our role is not to re[ ]weigh the evidence." *United States v. Gilgert*, 314 F.3d 506, 515–16 (10th Cir. 2002) (quoting *Concrete Pipe & Prods. of Cal., Inc. v. Constr. Laborers Pension Tr. for S. Cal.*, 508 U.S. 602, 623, 113 S.Ct. 2264, 124 L.Ed.2d 539 (1993)); *see also Obeslo v. Great-West Life & Annuity Ins. Co.*, 6 F.4th 1135, 1148 (10th Cir. 2021) ("The district court 'has the exclusive function of appraising credibility, determining the weight to be given testimony, drawing inferences from facts established, and resolving conflicts in the evidence.' " (quoting *Holdeman v. Devine*, 572 F.3d 1190, 1192 (10th Cir. 2009))).

Dear's appeal focuses exclusively on one portion of *Sell*'s second prong: the district court's finding that medication is substantially likely to restore him to competency. He first argues that the district court legally erred because it "failed to engage in any meaningful analysis of the evidence" or "make sufficient findings in support of its determination." Aplt. Br. 30. Second, he asserts that the district court clearly erred in finding the government met its burden of showing, by clear and convincing evidence, that involuntary medication was substantially likely to restore him to competency. We consider each argument in turn.

On his first point, Dear contends that the district court failed to adequately engage with his evidence below and to make accompanying specific findings. Our caselaw does not provide a definitive standard for the required level of detail in an order directing involuntary medication, but we have stated that "the need for a high level of detail is plainly contemplated by the comprehensive findings *Sell* requires." *Chavez*, 734 F.3d at 1252–53. And indeed, the government does not dispute the basic principle that involuntary-medication orders must include particularized findings. For instance, we held in *Chavez* that details about specific medications and dosages were required for the court to adequately assess potential side effects under *Sell*'s second prong and medical appropriateness under *Sell*'s fourth prong. *Id.* at 1253. Here, of course, the types and dosages of medication are not at issue, but the basic principle holds: orders directing involuntary medication require at least some level of particularized findings. *Id.* at 1252–53.

Relying on two out-of-circuit cases, *United States v. Watson*, 793 F.3d 416 (4th Cir. 2015), and *United States v. Ruiz-Gaxiola*, 623 F.3d 684 (9th Cir. 2010), Dear maintains that the district court failed to conform to this general principle here. In *Watson*, the Fourth Circuit reversed an involuntary-medication order because the district court focused entirely on whether ***150** the treatment plan generally worked for individuals with the defendant's disorder and failed to make "*any* finding assessing the likely success of the government's proposed treatment plan in relation to [the defendant's] particular condition and particular circumstances." 793 F.3d at 424–25 (emphasis added). Similarly, in *Ruiz-Gaxiola*, the Ninth Circuit reversed an involuntary-medication order because the district court "failed to make *any* factual findings relevant to the second prong of the *Sell* test," resting instead on the flawed and conclusory notion that because the treatment plan was designed to restore competency, it was substantially likely to do so. 623 F.3d at 696.

No similar omissions occurred here. For instance, unlike in *Watson*, the district court did not rely solely on the general efficacy of antipsychotics in restoring competency to individuals with delusional disorder; its order included details specific to Dear and his "particular condition and particular circumstances." 793 F.3d at 424–25. And unlike in *Ruiz-*

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*Gaxiola*, the district court here did not "set forth the testimony offered by each side" and then simply choose a side based only on generalized observations. 623 F.3d at 696. Instead, the district court specifically explained that although it had "considered carefully the testimony" of the defense experts, it placed greater weight on the government's experts because "the[ir] long experience ... in competenc[y] restoration and their personal observations of and interactions with ... Dear" gave "their opinions ... a substantially stronger factual and clinical foundation." R. vol. 1, 44.

Dear does not dispute the government's experts' significant experience restoring competency or their personal interactions with him, and both are sound reasons to place greater weight on their testimony. *See Ruiz-Gaxiola*, 623 F.3d at 699–700 (noting that district court wrongly placed more weight on government's experts when record showed that defense expert "had a far superior knowledge base"). Rather, he faults the district court for not additionally explaining why it discounted the defense experts' opinions. But such rationale is implicit in the district court's statements. By emphasizing Preston Baecht's and Sarrazin's personal interactions with Dear and their decades of clinical experience with restoring competency, the district court necessarily discounted the defense experts' lack of such personal interactions and less extensive experience.

To be sure, the district court could have addressed this and other topics in more detail. For instance, even the government acknowledges that the district court's discussion of the scientific literature "was somewhat opaque." Aplee. Br. 62. And the district court could have offered *more* explanation for why it placed greater weight on the government experts' opinions and discounted the defense experts' opinions. But under the circumstances of this case, where (1) the weight placed on competing expert testimonies was dispositive to the district court's resolution of the motion, and (2) the district court clearly explained its assessment of competing expert testimonies, we conclude the district court provided sufficiently comprehensive findings. *See Chavez*, 734 F.3d at 1252–53; *cf. Ruiz-Gaxiola*, 623 F.3d at 696 (faulting district court for merely choosing between competing expert testimonies without explanation).

Dear next argues the district court clearly erred in finding that the proposed treatment is substantially likely to restore Dear to competency. At the outset, the government suggests that we cannot review this factual finding because it rests "in large part [on] its decision to credit the government's experts over [Dear's]" and ***151** "credibility determinations by a factfinder are 'virtually unreviewable.' " Aplee. Br. 33 (quoting *United States v. Virgen-Chavarin*, 350 F.3d 1122, 1134 (10th Cir. 2003)). But Dear correctly points out that the government erroneously conflates credibility determinations with "the weight the district court gave the experts' opinions." Rep. Br. 6. Indeed, the district court explicitly concluded that the government's experts were "entitled to greater *weight*," not that the government's experts were more credible than the defense experts. R. vol. 1, 44 (emphasis added).

Returning to Dear's argument, he suggests that the government's expert testimonies were "exceedingly weak" on findings specific to him. Aplt. Br. 39. We continue to agree that specificity is necessary. Indeed, we have previously acknowledged that "the government cannot merely show that a proposed treatment is 'generally effective' "—instead, it "must prove that a proposed treatment plan, 'as applied to this particular defendant, is substantially likely to render the defendant competent to stand trial.' " *United States v. Seaton*, 773 F. App'x 1013, 1020 (10th Cir. 2019) (quoting *Watson*, 793 F.3d at 424).[5] But we disagree that the district court clearly erred in concluding that the government established as much by clear and convincing evidence.

Dear's appellate briefing emphasizes several factors that he maintains reduce the likelihood of being restored to competency: his duration of untreated psychosis (DUP), his age, and his cognitive abilities. Regarding DUP, the defense experts opined as a general matter that a longer DUP reduced the likelihood of restoring competency, but they offered neither specific studies nor anecdotal treatment experience to support that conclusion. Preston Baecht, on the other hand, initially explained that review of the relevant studies indicated "[in]sufficient data to suggest that [a DUP of 15–30 years] is a strong predictor" of whether someone is substantially likely to be restored to competency. R. vol. 3, 95. She additionally noted that, based on her personal experience, patients with up to 40 years of untreated psychosis had been "successfully restored to competency." *Id.* at 96. Between these two assessments, the district court did not clearly err in placing greater weight on Preston Baecht's opinion, which was more fully explained. *See Seaton*, 773 F. App'x at 1020–21 (concluding district court did not clearly err in finding substantial likelihood of restoring competency where defense expert generally opined that long DUP cut against restoration and government expert proffered personal experience to the contrary and highlighted absence of literature); *cf. United States v. Breedlove*, 756 F.3d 1036, 1041–42 (7th Cir. 2014)

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(finding no clear error where district court placed more weight on government's experts, who personally observed and treated defendant, than on defense expert's testimony that merely questioned one underlying study that government experts discussed in addition to their personal observations).

A similar dynamic played out in the testimony about Dear's age and cognitive abilities. Two defense experts suggested in passing that Dear's age could reduce the chance of restoring his competency. Preston Baecht did not disagree; she acknowledged some studies suggesting that older patients were less likely to be restored, but she noted that this could be due to various other factors, like onset of dementia. Sarrazin also explained that he ***152** would place greater weight on the age factor if Dear were 85, but he did not believe Dear's current age (in his 60s) weighed heavily against the likelihood of restoration. As to cognitive status, both Preston Baecht and Sarrazin testified that although poor cognitive condition could reduce the likelihood of restoring competency, Dear appeared to possess typical cognitive abilities. Both described him as "bright," R. vol. 3, 51, 190, and Sarrazin stated that "nothing" in his interactions with Dear indicated the existence of any "cognitive difficulties," *id.* at 191. To be sure, Woods testified for the defense that Dear did show cognitive symptoms. But the district court did not clearly err in discounting this testimony because unlike Preston Baecht and Sarrazin, Woods never personally interacted with Dear. Indeed, both Preston Baecht and Sarrazin questioned Woods's opinion by citing their personal experiences with Dear. So, on these points as well, the district court did not clearly err in placing greater weight on the government's experts, who did not view Dear's age or cognitive abilities as meaningfully reducing the substantial likelihood that medication would restore his competency. *See Seaton*, 773 F. App'x at 1020 (finding no clear error in district court's finding on substantial likelihood of restored competency where government's experts "persuasively rebutted" defense expert); *cf. Ruiz-Gaxiola*, 623 F.3d at 699–701 (ruling that district court clearly erred in relying on "generalized statements and unsupported assertions of the government's experts, when contrasted with the specific and authoritative rebuttal evidence presented by the defense").

Dear also devotes a significant portion of his clear-error briefing to what he views as the insufficiency of the scientific literature regarding competency restoration for individuals with delusional disorder. In so doing, he highlights two points that the government's experts did not meaningfully disagree with: (1) historically, psychiatrists believed that delusional disorder could not be effectively treated with antipsychotics, and (2) more recent studies questioning that historical view suffer from certain weaknesses. But Dear overlooks Preston Baecht's explanation that the historical evidence also suffered from weaknesses, such as inadequately short trial periods and lack of a specific focus on competency restoration. And in any event, although the district court's discussion of the scientific literature was nonspecific and arguably inconsistent,[6] the court did not base its factual findings on any study. Instead, it relied on the personal experience of the government's experts in restoring competency generally and interacting with Dear specifically. Under these circumstances, we decline to find clear error based on the district court's discussion of the scientific literature. *See Breedlove*, 756 F.3d at 1042 (rejecting argument that district court clearly erred in relying on expert testimony about somewhat flawed scientific research in part because experts' opinions were also based on personal observations of defendant); *United States v. Fieste*, 84 F.4th 713, 727–28 (7th Cir. 2023) (rejecting argument that district court clearly erred by relying on generalized statistics where government's expert testified based on both scientific literature and personal examination); *cf. Watson*, 793 F.3d at 426 (reversing involuntary-medication order in ***153** part because expert's cited studies provided "some evidence that antipsychotic medication may be effective against [d]elusional [d]isorder in general" but were in no way tied to specific defendant).

In sum, given the district court's explanation for placing greater weight on the testimony of the government's experts, who specifically rebutted the views of the defense experts, we are not left with the "definite and firm conviction that the district court erred" in determining that involuntary medication was substantially likely to restore Dear to competency. *Chavez*, 734 F.3d at 1250 (quoting *Jarvison*, 409 F.3d at 1224).

## Conclusion

The district court provided sufficiently particularized findings and did not clearly err in placing greater weight on the government's expert testimony to conclude that involuntary medication is substantially likely to restore Dear to competency. Accordingly, we affirm the district court's order granting the government's motion to involuntarily medicate Dear in an effort to restore his competency. And as a final matter, we grant the government's unopposed motion to file the second supplemental volume of the record under seal. *See*

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*United States v. Dillard*, 795 F.3d 1191, 1205–06 (10th Cir. 2015) (noting that "the privacy interest inherent in personal medical information can overcome the presumption of public access").

**All Citations**

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## Footnotes

1 In August 2017, the state court ordered Dear involuntarily medicated in an attempt to restore him to competency. The Colorado Court of Appeals affirmed, but by that point the involuntary-medication order had expired. The state court conducted additional involuntary-medication hearings in December 2018 and February 2019, but the state court ultimately determined that changes in Dear's underlying physical health rendered involuntary medication not in Dear's best medical interests.

2 The government can also involuntarily medicate individuals who pose a risk of harm to themselves or others under *Washington v. Harper*, 494 U.S. 210, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990). But there is no dispute here that Dear presents no such danger "[w]hen he is in custody in a tightly regulated and highly structured prison-like environment." R. vol. 1, 42.

3 The government also called cardiologist Matthew Holland, who testified that Dear had never had a heart attack and generally discussed the impacts of antipsychotic medications on individuals with cardiovascular disease.

4 We have jurisdiction over this interlocutory appeal under the collateral-order doctrine. *See Sell*, 539 U.S. at 176–77, 123 S.Ct. 2174.

5 We rely on *Seaton* for its persuasive value. *See* Fed. R. App. P. 32.1(a); 10th Cir. R. 32.1(A).

6 The district court noted that "[s]ome published studies" supported the government's experts' estimation as to the likelihood of restoration, that "some published studies reflect[ed] a lower competency restoration rate," and that "some published studies" were less persuasive due to having small sample sizes, being too short, or involving noncompliant patients. R. vol. 1, 43.

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FILED
United States Court of Appeals
Tenth Circuit

**September 20, 2024**

**Christopher M. Wolpert**
**Clerk of Court**

**UNITED STATES COURT OF APPEALS**

**FOR THE TENTH CIRCUIT**

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UNITED STATES OF AMERICA,

Plaintiff - Appellee,

v.

ROBERT LEWIS DEAR, JR.,

Defendant - Appellant.

No. 22-1303
(D.C. No. 1:19-CR-00506-REB-1)
(D. Colo.)

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**ORDER**

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Before **BACHARACH**, **BRISCOE**, and **MORITZ**, Circuit Judges.

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Appellant's petition for rehearing is denied.

The petition for rehearing en banc was transmitted to all of the judges of the court who are in regular active service. As no member of the panel and no judge in regular active service on the court requested that the court be polled, that petition is also denied.

Entered for the Court

CHRISTOPHER M. WOLPERT, Clerk