UNREPORTED

IN THE COURT OF SPECIAL APPEALS

OF MARYLAND

No. 0347

September Term, 2014

BRIAN BECHTOLD

v.

DEPARTMENT OF HEALTH
& MENTAL HYGIENE, ET AL.

Woodward,
Kehoe,
Arthur,

JJ.

Opinion by Woodward, J.

Filed: April 8, 2016

Appellant, Brian Bechtold, is an inpatient at the Clifton T. Perkins Hospital Center ("Perkins"), having been committed there in 1992 after he was found not criminally responsible for murdering his parents. Appellant has Axis I Schizoaffective Disorder and Axis II Personality Disorder.

Appellant filed a petition in the Circuit Court for Montgomery County on June 27, 2013, requesting release from his inpatient commitment. The court held a jury trial, at which appellant appeared *pro se*. At the close of appellant's case-in-chief, appellee, the Department of Health and Mental Hygiene ("the Department"), moved for judgment, which the court denied. The Department rested without calling any witnesses and renewed its motion for judgment. The court granted the Department's motion as to whether appellant had a mental disorder, but deferred on ruling as to whether appellant would be a danger to himself or the community if he was released. After the jury failed to come to a unanimous verdict, the court granted the Department's motion for judgment in full.

Appellant presents three questions for our review, which we have condensed and rephrased as one question:[1]

[1] Appellant's questions, as stated in his brief, are:

> 1. Did the trial judge err in granting summary judgment by neglecting consideration of a jury's independent view of what value to apply to the credibility of the witnesses as in Bean v. Dept. of Health and Mental Hygiene, 406 MD. 419, 959 A.2d 778 (2008)?
>
> 2. Did the trial Judge err by applying his judgment of the

(continued...)

> Did the trial court err in finding that there was insufficient evidence to support appellant's claim?

For the reasons set forth below, we answer this question in the negative and thus affirm the judgment of the circuit court.

BACKGROUND

In 1992, appellant was found not criminally responsible for two counts of first degree murder and related charges after shooting and killing both of his parents. Thereafter, appellant was committed to Perkins. Appellant has a diagnosis of Axis I Schizoaffective Disorder, Bipolar Type and Polysubstance Dependence, as well as Axis II Personality Disorder, Not Otherwise Specified with Narcissistic and Antisocial Features.

Appellant assaulted Perkins employees twice, once in 1999 and again in 2006, in an attempt to escape Perkins and be transferred to a prison. Since 2006, appellant has had no incidents of active violence. In January 2013, appellant was transferred from the minimum

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[1](...continued)

> Ultimate Merits of the case (E. 16 - E. 18) instead of whether a case existed; see Lipscomb v. Hess, 257 A.2d 178 (Md. 1969) as required by the standard of summary judgment 2-501(a) and contrary to the intent of Byers v. State, 184 Md. App. 499, 966 A.2d 982 (2009)?
>
> 3. Did the trial judge err in isolating the word "danger" from the phrase, "due to a mental disorder or defect"? (E. 14) When Hawkes v. State, No 76, 2013 WL 3794491, at 29 (Md. 2013) directs us to ensure that "no word, clause, sentence, or phrase is rendered surplus - age, superfluous, meaningless, or nugatory". And 3-114(b) clearly does not isolate the word "danger."

security unit to the medium security unit as a consequence of increased paranoia provoked by cancer treatment. In June 2013, appellant's current treating psychiatrist, Dr. Angela Onwuanibe, recommended a transfer back to the minimum security unit, as well as a regional transfer to a less restrictive hospital facility.

On June 27, 2013, appellant filed a Petition for Judicial Release and Trial by Jury in the circuit court. The Department filed its answer on August 26, 2013. Prior to proceeding to trial, appellant made an oral motion to strike his attorneys' appearance, which the court granted. A jury trial was held on February 10 and 11, 2014, during which appellant called five witnesses, including himself. The Department made a motion for judgment at the close of appellant's case, which the court denied. The Department rested without calling any witnesses and renewed its motion for judgment. The court granted the Department's motion in part on the issue of whether appellant had a mental disorder, but deferred its ruling on the issue of whether appellant would be a danger, as a result of a mental disorder, to himself or the community if released.

The jury deliberated for nearly eight hours, but failed to come to a unanimous verdict. At that point, the circuit court granted the Department's motion for judgment in full. On March 25, 2014, the court issued a judgment in favor of the Department. Appellant filed his timely notice of appeal on April 24, 2014. Additional facts will be set forth as necessary to answer the question presented.

STANDARD OF REVIEW

The standard for reviewing the grant of a motion for judgment under Rule 2-519 is *de novo*. *UBS Fin. Servs., Inc. v. Thompson*, 217 Md. App. 500, 514 (2014), *aff'd*, 443 Md. 47 (2015). In doing so, we view the evidence and the reasonable inferences to be drawn from it in the light most favorable to the non-moving party. *Address v. Millstone*, 208 Md. App. 62, 80 (2012), *cert. denied*, 430 Md. 646 (2013). "The case must be submitted to the jury for decision if there is any legally sufficient evidence to support the claim." *Elste v. ISG Sparrows Point, LLC*, 188 Md. App. 634, 647 (2009) (citation omitted), *cert. denied*, 412 Md. 495 (2010).

"Legally sufficient evidence" means that the non-moving party "cannot sustain this burden by offering a mere scintilla of evidence, amounting to no more than surmise, possibility, or conjecture." *Id*. at 647-48. "In other words, where it is manifest to the court upon the plaintiff's own showing and the uncontradicted evidence in the case that there is no rational ground upon which a verdict can be based for the plaintiff, it becomes the duty of the court to direct a verdict for the defendant." *Address*, 208 Md. App. at 80-81 (citation and internal quotation marks omitted). On the other hand, "[i]f there be any evidence, however slight, legally sufficient as tending to prove [the plaintiff's claim,] the weight and value of such evidence will be left to the jury." *Myers v. Bright*, 327 Md. 395, 399 (1992) (citations and internal quotation marks omitted).

DISCUSSION

I. Law

The Eligibility for Release statute provides:

> (a) *In general*. — A committed person may be released under the provisions of this section and §§ 3-115 through 3-122 of this title.
>
> (b) *Discharge*. — **A committed person is eligible for discharge from commitment only if that person would not be a danger, as a result of mental disorder or mental retardation, to self or to the person or property of others if discharged.**
>
> (c) *Conditional release*. — A committed person is eligible for conditional release from commitment only if that person would not be a danger, as a result of mental disorder or mental retardation, to self or to the person or property of others if released from confinement with conditions imposed by the court.
>
> (d) *Burden of proof*. — To be released, a committed person has the burden to establish by a preponderance of the evidence eligibility for discharge or eligibility for conditional release.

Md. Code (2001, 2008 Repl. Vol.), § 3-114 of the Criminal Procedure Article ("CP") (emphasis added).

The procedure for a committed person to apply to a court for release is as follows:

> (1) To apply for release under this subsection, the committed person shall file a petition for release with the court that ordered commitment.
>
> (2) The committed person shall send a copy of the petition for release to the Health Department and the State's Attorney.

> (3) If the committed person requests a trial by jury, the trial shall be held in a circuit court with a jury as in a civil action at law.
>
> (4) The trier of fact shall:
>
> (i) determine whether the committed person has proved eligibility for release by a preponderance of the evidence; and
>
> (ii) render a verdict for:
>
> 1. continued commitment;
>
> 2. conditional release; or
>
> 3. discharge from commitment.
>
> (5) If the trier of fact renders a verdict for conditional release, within 30 days after the verdict, the court shall release the committed person under conditions it imposes in accordance with specific recommendations for conditions under § 3-116(b) of this title.

CP § 3-119(c).

In *Bean v. Department of Health & Mental Hygiene*, a Perkins patient filed a petition with the circuit court requesting conditional release or discharge from his inpatient commitment. 406 Md. 419, 423 (2008).

> Bean, for his part, acknowledged that he ha[d] a mental disorder, but that, in his opinion, his release would not pose any danger to himself or others as a result of the disorder because he would continue to take the required medicine and because he would have the proper support system for his reintegration into the community.

Id. at 424 (footnote omitted).

The Department's forensic psychiatrist agreed that Bean had a mental disorder and that "the medicinal treatments he received under professional supervision had more or less caused his symptoms to subside and improved his behavior." *Id*. at 427. The psychiatrist, however, disagreed that Bean would continue to take the prescribed medications if released unconditionally, because "[o]ver the last, I'd say 30 years, he's refused to take medications on and off in the hospital and out of the hospital. And when he's been out of the hospital, when he stops taking his medications, is when it leads to someone getting hurt." *Id*. at 427 n.6.

The Department moved for judgment on the grounds that Bean did not present any expert testimony on whether he would be a danger to himself or others if released. *Id*. at 426, 428. The trial court denied the Department's motion, and the jury determined that Bean should be conditionally released from inpatient commitment. *Id.* at 428. This Court reversed the trial court's judgment on the ground that Bean was required to produce expert testimony or evidence to satisfy his burden with regard to whether he would be a danger to himself or others if released. *Id*. at 429.

The Court of Appeals, however, reversed our judgment. *Id*. The Court noted that, "[b]ecause Bean acknowledged that he has a specific mental disorder and the Department conceded that the disorder may be managed with medication, the material issue contested before the jury was the factual dispute over whether Bean would take the necessary

medications if granted a conditional release." *Id*. at 432. Accordingly, the Court concluded that

> Bean did not need to present expert medical opinion in support of his desired relief because the principal dispute that needed to be resolved by the jury in this case did not present a complex medical issue, but rather depended on resolving a factual dispute, dependent to a great extent on a credibility assessment of Bean's testimony, a matter within a jury's ken.

Id. at 432-33.

II. Sufficiency of the Evidence

Citing *Bean*, appellant claims that the trial court erred in granting the Department's motion for judgment, because there "was a dispute of material facts," and thus the jury, not the judge, should have adjudicated appellant's claim. According to appellant, the fact that the jury was unable to produce a verdict against him demonstrates that the court should not have granted the Department's motion for judgment.

The Department responds that the trial court correctly granted its motion for judgment, because appellant "presented no evidence to support his contention that he either did not suffer from a mental disorder or that, if released from Perkins Hospital, he would not be dangerous to himself or others." According to the Department, each of the four expert witnesses testified against appellant's release, and the only evidence in favor of appellant's release was offered by appellant himself. The Department argues that appellant "failed to provide evidence beyond his subjective feelings about the future or his speculations about

his intentions and desires," and thus appellant failed to generate a jury question. We agree with the Department and shall explain.

Appellant's four expert witnesses each testified that, in their opinion, appellant would be a danger to himself or others if he was released from Perkins. Appellant's first witness, Dr. Rocha Hebsur, a licensed clinical psychologist at Perkins who was qualified as an expert in clinical psychology, met with appellant on January 13 and 14, 2013, to conduct a risk assessment. Dr. Hebsur testified that

> one of the most important reasons [that appellant has remained at Perkins] is that **[he] has continued to be—have been assessed as imminently dangerous to himself, others, and the environment. . . .** He'd demonstrated a history of impulsivity. **He'd demonstrated non compliance with medications. He's also demonstrated threatening and aggressive behaviors towards patients and staff.** Those are just a few. . . .

(Emphasis added).

Dr. Hebsur also mentioned that appellant's "treating psychiatrist at that time [that he was moved from minimum to medium security] wanted to increase his medications to target that paranoia and see if the symptoms improved. And he indicated to her that medication changes was a trigger for violence. Therefore . . . he indirectly threatened and intimidated her." Finally, Dr. Hebsur testified that, "[s]ince [appellant's] transfer, he has not been very open to medication changes to target his thought disorder and his axis 1 symptoms. And that is a big concern given his previous history of violence."

On cross-examination, Dr. Hebsur testified that as a result of her risk assessment, she "concluded that he was at high risk . . . [f]or re-offending again. For committing another violent act." Dr. Hebsur explained the basis of her conclusion as follows:

> It's based on historical factors. Like I said, previous history of violence. He has a history of childhood behavioral problems, a history of substance abuse. He's got a number of non-violent criminal offenses. His relative younger age at his most violent offense is a risk factor. He has employment instability. He has a diagnosis of major mental illness and a personality disorder. He has had prior supervision failures, which means that he has tried to escape from the hospital without approval. And he also falls within the moderate degree of psychopathy.
>
> **Those are some of his historical factors that put him at high risk for violent recidivism.** Clinical factors which are—they're changing. They're dynamic. They change with time and intervention and situations. So that's why we constantly reassess risk—level of risk.
>
> **The clinical factors that put him at high risk for re-offending are his lack of insight into his mental illness and the—and what it takes to manage his mental illness and the associated risk of violence.**
>
> And he has—continues to endorse negative attitudes. He continues to endorse violent thoughts. **And when I asked him what it would take for him to become violent, he said not much.** He fails to take responsibility for his past violent behaviors. He demonstrates a lack of remorse for his victims. Like I said, he lacks insight into his mental illness and the need for comprehensive continual treatment to manage his mental illness and the subsequent risk of violent behavior.
>
> **And this puts him in the high risk range for re-offending if he were released.**

(Emphasis added).

Appellant's second witness, Dr. Cybill Smith Grey, also testified against appellant's release. Dr. Grey, a licensed clinical psychologist at Perkins who was qualified as an expert in clinical psychology, testified that appellant has

> **a persistent pattern of violating the rights of others.** I know that your documented history shows an act of catastrophic violence resulting in the death of others. I know that you have **planned and absconded from supervision in the past**. I know that you have **a history of rule breaking and other criminal activities** outside of the instant offense of murder.

(Emphasis added). Dr. Grey also testified that appellant's disorder "is a disorder that is amenable to treatable [sic] with medication. You've already heard testimony that his medication changes. There are concerns as to whether or not the axis 1, the schizo affective disorder, is being—has ever been sufficiently treated."

The next witness to testify was Dr. Inna Tahler, a forensic psychologist at Perkins. After she was qualified as an expert in forensic psychology, Dr. Tahler testified that she had completed a report for the clinical forensic review board regarding appellant in March 2013 when he was transferred from a minimum security unit to a medium security unit. That report included the following findings:

> Given the concern regarding safety, especially in light of continued symptoms, dangerous comments regarding inability to agree to safe behaviors, therapist concerns and desire for no medication changes, which could help decrease symptoms which exacerbate psychopathic ideas, [appellant] was felt to be inappropriate for [an] open, minimum [security] unit due to potential for serious violence. . . . **It is concerning that he denies ever having had symptoms of his mental illness during his stay at Perkins, despite years of medical records noting the presence of such as well as his**

> **psychotically-motivated violence towards others while in the hospital. Violence, he proudly says, has "worked well" for him in the past and is his "go to" in situations, which he openly discusses. [Appellant] remains at high risk at this time for future dangerousness.**

(Emphasis added).

Dr. Tahler testified at trial in pertinent part:

> What I understand from as a clinical director of the hospital, and upon review of all the information, **[appellant] continues to exhibit subtle, yet active symptoms of a mental illness** that because of their subtlety, and because of him not being so forthcoming about his symptoms, and **reluctance to fold [sic] the treatment recommendations to increase medications**, are difficult to assess.
>
> **And in combination with a past history of violence, and in combination with pervasive personality characteristics, make [appellant] a very high risk for dangerous behavior if released to the community.**

(Emphasis added).

Dr. Tahler also testified:

> **There was a concern that [appellant] was reluctant to change his medication as the psychiatrist and the psychologist and the nurse and the social worker**, because I have met with the whole team, **recognized that he exhibited symptoms of paranoia and suspiciousness.** And they thought that that was not properly medicated. And there have been several discussions about raising [appellant's] medications. However, he has either refused to do so, or he has made indirect threats by statements such as you never know when I can become violent if I am pushed into the corner, I will resort to violence. **And the one thing that makes me violent is discussion about raising medications.**

(Emphasis added).

Last, appellant called Dr. Onwuanibe, his current treating psychiatrist. Appellant asked Dr. Onwuanibe if her treatment plan was "to keep him for life?" Dr. Onwuanibe responded:

> That's a good question, and I don't think that's the plan. **The plan is for us to treat your illness, to be allowed by you to treat your illness, to treat it properly if it's untreated.**
>
> It's untreated. It's untreated in that a lot of times you are extremely smart and intelligent. So a lot of times you are able to keep the symptoms at a minimum and you are able to keep them down. That's why you get referred to as asymptomatic. **But when you get stressed out or when something happens, the full disorder comes back, and you begin once again to feel that boxed in, and then you begin to make those paranoid statements, and it has led to violence.** So the goal is not to keep you in the hospital forever. The goal is to continue to work with you to less restrictive [sic] and to treat your illness. Give us the opportunity to treat this illness.

(Emphasis added)

Later on, Dr. Onwuanibe stated:

> If at any time your risk is lowered and you do continue to work with us in terms of treatment, then like we said earlier, 95 percent of the patients who were admitted around the same [time] as you have left the hospital. **And so, is it possible that you could leave the hospital? Yes, it is possible.**
>
> **You've been here longer than most people in the hospital. That's because of the severity of the risk factors that brought you in, and the dynamic factor, that's the current factor, the everyday factors.**
>
> **You know, we look at your medication and we increase the medication. We know your ambivalence about medication, what you refer to yourself as the application of the insight into understanding the treatment and the illness.**

> **So I can't say when. I hope it will be soon.** I hope it will be soon. We know we can do this. We can do this. We've done it before and I know it.

(Emphasis added).

On cross examination, after she was accepted as an expert in psychiatry, Dr. Onwuanibe testified:

> **My opinion is that [appellant] remains a danger to himself and the life and property of others. Because—not because he's going to hurt himself, but because he perceives threats as a result of his paranoia. He perceives these threats. He has had a long history of paranoia. He does get better [on] occasion, sometimes. He can appear un—asymptomatic, but it is a full disorder.** He was paranoid before he came into the hospital. He was paranoid from the age of 16, which is clearly documented in the record: goes paranoid at age 19, goes off of medication, was paranoid when his parents emergency petitioned him to the hospital for treatment at the ages of 19 and 21 when he was paranoid.
>
> Shortly after he was paranoid about his family, he was paranoid by his own admission, staying a lot of times in his room, and he subsequently committed the instant offense.
>
> He since then has come to the hospital. He's been paranoid about the hospital. He has acted on his paranoia.
>
> ***
>
> **And he continues to be with us in the hospital and he remains paranoid.**
>
> **This put [appellant] at risk. It puts him at risk. The perceived, the persistent perceived threats that when they're not there make [appellant] dangerous.**

(Emphasis added).

Appellant's testimony was the only evidence in support of his position that he would not be a danger, as a result of a mental disorder, to himself or others if released. No expert witness testified that appellant would not pose such danger if released.

Appellant testified to his mental illness that led to the murder of his parents. He then testified to his negative experiences with medication at Perkins, stating that "I took so much medication I slept all day and all night for the next eight months. I began [sic] impotent and incontinent. I was miserable." Appellant explained that he felt like he "was caught in a trap almost," because he understood that he needed to increase his medication in order for his treatment team to accept his progress, but that he was "physically not capable" of increasing his medication, *and did not view it as necessary*. Appellant testified that he tried to escape Perkins in order to be sent to prison, not because he wanted to hurt anybody. Appellant stated that, because his diagnoses have changed "at least five or six times," and because he is not a candidate for release even though he is asymptomatic, he distrusts his treatment team at Perkins.

Appellant explained:

> I'm here today to tell you exactly what those threats are.
>
> **If they try to panel me for medication and drug me to the point where I'm miserable[,] I'm not feeling that it's consensual violence. It's not consensual. I do not want to fight you, but if you hurt me, I can't say I won't fight back. I can't say that. It's not even possible. Not for me.** I can't say that if they drug me to the point where I'm pissing on myself that it's going to be okay. It's not going to be okay. Not for no reason.

If I do something wrong, I can take the consequences.

When I had my assault in 2006, there were a number of factors that were involved with that.

The main factor was that they were putting me on a ward of maximum security for 10 years, 10 years straight I was on maximum security where are the most violent patients, patients who hit you for no reason.

You're locked in a room. Somewhere kind of this court room where all of us are here together and one person, and you don't know who it is, might want to hit you for no reason, and you're like that all day every day.

And what are you going to do about? **You're going to be suspicious, hyper vigilant, you're going to be aggressive, and if you're not you're going to be a punching bag.** And this went on and on for 10 years.

***

I do have a mental illness. I do have an illness that I take medication for every day. I don't have a problem taking medication every day. I feel great. I feel fantastic right now. I can exercise. I can think. I have a personality.

(Emphasis added).

As stated above, in *Bean*,

> Bean, for his part, acknowledged that he ha[d] a mental disorder, but that, in his opinion, his release would not pose any danger to himself or others as a result of the disorder because he would continue to take the required medicine and because he would have the proper support system for his reintegration into the community.

406 Md. at 424 (footnote omitted).

Here, like in *Bean*, appellant concedes that he has a mental disorder, but claims that "his release would not pose any danger to himself or others as a result of the disorder." *See id*. at 424. Unlike *Bean*, however, there was no agreement among the expert witnesses that the risk of violent behavior as a result of appellant's mental disorder "more or less can be controlled by his taking prescribed medication." *Id*. at 432. Indeed, all four expert witnesses testified to the need to increase appellant's medications for better management of the symptoms of his mental illness. For his part, appellant testified that he would "take medications every day," but was "physically not capable" of increasing his medication and saw any increase as unnecessary. In other words, appellant would take the medication that he himself determined was necessary for the treatment of his mental illness.

Thus, whether appellant will pose a danger to himself or to others if released requires an assessment of, at least, his past behavior associated with his diagnosed mental illness, his insight and ability to manage his illness, the effectiveness of the medications, and the potential for appellant's compliance with the prescribed medications. Such assessment, in our view, is "a complicated medical question, necessarily requiring the presentation of expert testimony." *Id*. at 434. Because there was no expert testimony that appellant would not be a danger, as a result of a mental disorder, to himself or to the person or property of others if released, we conclude that there was insufficient evidence for the jury to render a verdict in favor of appellant.

Our conclusion is consistent with the view of the Court of Appeals in *Bean* that "[w]hether expert testimony is required to be adduced by a committed person will depend on the nature of the disputed issues in the proceeding and therefore must be approached on a case-by-case basis." *Id*. Here, in contrast to *Bean*, appellant's subjective belief, no matter how sincerely held, is simply not enough to take his case to a jury. Accordingly, the trial court did not err in granting the Department's motion for judgment at the end of the trial.

JUDGMENT OF THE CIRCUIT COURT FOR MONTGOMERY COUNTY AFFIRMED; APPELLANT TO PAY COSTS.