SUPREME COURT NO. 96727-0

NO. 76851-4-I

IN THE SUPREME COURT OF THE STATE OF WASHINGTON

STATE OF WASHINGTON,

Respondent,

v.

GAIL COLEMAN,

Petitioner.

ON APPEAL FROM THE SUPERIOR COURT OF THE
STATE OF WASHINGTON FOR KING COUNTY

The Honorable Susan Amini, Judge

PETITION FOR REVIEW

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A. IDENTITY OF PETITIONER/DECISION BELOW

Gail Coleman requests this Court grant review pursuant to RAP 13.4 of the published decision of the Court of Appeals in State v. Coleman, No. 76851-4-I, filed December 10, 2018. A copy of the opinion is attached as an appendix.

B. ISSUE PRESENTED FOR REVIEW

Did the trial court abuse its discretion in denying G.C.'s petition for unconditional release from commitment when the court's decision is based on erroneous findings regarding the expert risk assessment testimony?

C. STATEMENT OF THE CASE

1. G.C. lives in the community on conditional release after being found not guilty by reason of insanity.

In 2004, appellant G.C. was found not guilty by reason of insanity of attempted murder in the second degree. CP 1-2, 20-21. Believing herself under imminent threat, she shot a grocery store manager who tried to stop her from shoplifting. CP 59. She was diagnosed with chronic, severe paranoid schizophrenia. CP 21. Prior to the incident, she did not take her illness seriously and had stopped taking her prescribed medication. RP 439-41. After acquittal, she was committed to Western State Hospital (WSH). CP 14-19.

G.C.'s condition improved, and, in October 2009, she was conditionally released. CP 49-50. WSH arranged for her to have mental health services and housing through the Downtown Emergency Services Center (DESC).[1] RP 331. A WSH therapist also visits her each month and reports to the court every six months. RP 337-38, 452. A violation of the conditions of her release could result in her return to WSH. RP 340.

2. After nine successful years, G.C. seeks unconditional release.

G.C.'s time in the community has been, by all accounts, an unqualified success. She has consistently taken medication, engaged in treatment, and even participated in a stakeholders group to help improve services for the mentally ill. RP 27, 30, 38-39; CP 71. Dr. Haley Gummelt, a WSH forensic evaluator, testified G.C. understands the seriousness of her condition and the importance of continuing medication and treatment. RP 259-60.

At trial, G.C. reaffirmed her commitment to treatment and medication, regardless of whether court supervision continues, because she does not want to commit another crime or hurt anyone ever again. RP 432-33, 450-51. She seeks unconditional release as the next step in her recovery

[1] DESC provides intensive mental health services through the Program for Assertive Community Treatment (PACT) and less intensive services through the SAGE program. RP 21. At the time of trial, G.C. had graduated to the SAGE program. RP 21-22.

and an acknowledgment that she is no longer a threat to herself or the community. RP 449-50.

She testified that she understands she will always have a mental illness and her symptoms can return. RP 432. If her symptoms were to return, she would go the emergency room or her psychiatrist. RP 455, 465-66. If her medication became less effective, she would reach out for help immediately, and not wait for the symptoms to increase in severity. RP 442. Unlike in 2004, she now understands her illness and the early warning signs of relapse. RP 441, 443-44. She has gained coping skills and a treatment plan that works. RP 441.

DESC will continue to provide mental health and housing services regardless of whether G.C. remains under court supervision. RP 24-25, 55. If DESC should lose its funding or cease to exist, G.C. is aware she can obtain mental health services at Harborview, Navos, Sound Mental Health, and Swedish Hospital. RP 437-38. Her specific backup plan would be to join Harborview's program. RP 498. Treatment would be paid by her Medicaid coverage. RP 502. G.C. knows how to obtain her medication from different pharmacy or the crisis center if she were to lose DESC's medication delivery service. RP 436-37. Regardless of release, she plans to always have a community-based case manager for the rest of her life. RP 487.

3. G.C.'s case managers reported she has done well since her 2009 conditional release.

Since her conditional release, G.C. has been independent in terms of daily living activities such as groceries, cooking, cleaning her apartment, and managing her own money. RP 42, 48. Her social security disability income plus a voucher from the Seattle Housing Authority covers her rent. RP 20, 22-23. She pays the rent herself, consistently and on time. RP 23. She seeks help for other residents when they have problems. RP 23-24.

G.C. has not needed medication monitoring in years. RP 26. She is capable of obtaining her own medication from a pharmacy, but currently has it delivered to her, a month at a time as per DESC's standard protocol. RP 25-26, 198-99. There has never been any sign of reluctance to take her prescribed medication. RP 27. She calls to check on the delivery if there is a holiday or if she fears she might have missed a delivery. RP 27-28. When the maker slightly altered the shape of the pill, G.C. called to verify. RP 29. She called her psychiatrist to check for drug interference before taking an antihistamine when she had a cold. RP 117-18, 194.

According to Heather Riley, a DESC social worker, G.C. did not decompensate even once in the seven and a half years Riley was on her case. RP 30. Even at times of increased stress, Riley never saw any concerning behavior. RP 55-56, 100-01. For example, G.C. weathered a period of

concern that she might lose her housing. RP 80-82, 97. Additionally, she has managed well the transitions to several different mental health providers. RP 125. Riley testified G.C. deals with stress by reaching out to DESC for support. RP 49.

G.C.'s new social worker, Carol Sherwood, agreed G.C. is not resistant to treatment and has good insight into her illness. RP 162. Her previous case manager, Carl Pitlick, also testified that, in the year and a half that he worked on G.C.'s case, he never saw any concerns about her medication or treatment compliance. RP 274. On the contrary, he saw her taking an active role in her own treatment, coming to all meetings, taking all her medication, working well with the hospital and DESC and taking "every step possible in her treatment." RP 275. Pitlick agreed G.C. has "very good insight" into her illness. RP 275. He explained she knows her crime happened because she did not take her medication, knows the medication helps her, and knows when to reach out for help. RP 275. Although she occasionally is lonely or frustrated by the unconditional release process, he testified, G.C. expresses her frustration in healthy ways. RP 288.

4. G.C.'s community psychiatrist supports unconditional release.

G.C.'s DESC psychiatrist, Dr. Craig Jaffe, sees G.C. every six to eight weeks. RP 185, 195. He testified she has never shown any reluctance to

participate in mental health treatment. RP 27. He has prescribed her 3.5 grams of Risperdal daily, a relatively low dose, for the entire time of her conditional release. RP 194-95, 655. He has seen no reason to change her medication or dose because it is so effective for her. RP 194-95. He agreed with the schizophrenia diagnosis based on her history, but in the seven and half years he has worked with G.C., meeting her probably 50 times, he has seen no symptoms. RP 184-85, 193. Jaffe testified G.C. is internally motivated and takes an "unheard of level of responsibility" for her own medication management. RP 188, 194.

Jaffe believed unconditional release would decrease G.C.'s stress level and further increase her motivation by giving her hope. RP 192. He agreed her illness is in remission with medication and could wax or wane in the future; relapse is common. RP 235-36. He could not guarantee she would continue to comply with her medication or that the medication would continue to be effective. RP 237-38. Although medication can stop working, Jaffe testified that, after such a long time, there was no reason to believe that would be the case for G.C. RP 200-01, 238.

Jaffe testified that any future relapse would likely not be sudden; there would be symptoms and markers that would increase in severity over time. RP 239-40. He believes G.C. would tell him or his staff if she felt any symptoms because she has, in the past, come to him with problems without

sugar-coating or minimizing. RP 195, 238. He also testified that treatment refractory illness, the phenomenon wherein a medication stops working, tends to be more common in those whose illnesses are more difficult to treat from the beginning. RP 240. G.C., who has been stable on the same low dose of Risperdal for nearly ten years, does not fit this category. RP 241. He supported her request for unconditional release. RP 242.

5. G.C.'s forensic evaluator found her to be low risk to reoffend.

Dr. Kevin Peterson interviewed G.C. for the first time in 2006 while she was still at WSH. RP 112. At that time, she had incomplete insight into her illness and was struggling to take responsibility for her crime and her mental disorder. RP 112. Ten years later, he evaluated her again and saw significant changes. She showed no signs of the delusions he had seen in 2006. RP 112. She was aware of her disorder, knew it contributed to her crime and was committed to recovery. RP 112-13.

G.C. scored the lowest possible score – low risk – on the risk assessment tool Peterson used, the HCR-20. RP 122, 131. WSH agreed the HCR-20 is the "gold standard" for risk assessment. RP 269. According to Peterson, G.C. now has a high level of insight into her disorder and her need for treatment and medication. RP 127.

The only area of relative weakness Peterson saw was that he would like G.C. to have stronger personal supports, someone she could talk to on a daily basis. RP 128. She talks weekly with her family on the east coast and socializes with other residents of her apartment building. RP 262, 423-25. Peterson noted she has done well despite having few social supports, which shows she has a lot of other resources. RP156. He acknowledged she was on a government program and did not make much money but noted she was nonetheless able to save money and receives family help for unusual expenses. RP 146.

On cross examination, Peterson conceded his finding of low risk was not a finding of zero risk. RP 140. However, no one has zero risk of committing violence. RP 156. He agreed that, "If she stops medication, if she stops treatment, if she stops things that are keeping her oriented and stable, yes, of course, her risk goes up." RP 140. He also agreed G.C.'s illness, though in remission due to medication, is lifelong. RP 135. He also agreed it is common for those with schizophrenia to stop taking medication. RP 141.

6. The WSH evaluator did not opine on G.C.'s risk level.

Dr. Haley Gummelt, a forensic evaluator at WSH also performed a risk assessment for G.C. RP 250, 252. Gummelt offered no opinion on G.C.'s level of risk or her request for release, deferring to the Risk Review Board at WSH. RP 270-72.

Gummelt viewed herself as offering information, not an opinion. RP 270. She reported G.C. "understands and implements the necessary components of treatment." RP 260. She testified G.C. showed understanding of what to do in case of relapse. RP 261.

She agreed G.C.'s illness is "potentially" subject to relapse and that it is "possible" G.C. could become a substantial risk to public safety if she were to become unstable. RP 267-68. Gummelt testified that G.C.'s risk of violence could increase to the point of making her a substantial risk if she were to become mentally unstable. RP 267-68. Her written report states that if the current services ended, G.C.'s risk "may or may not be affected." CP 76.

7. WSH administrators opposed unconditional release.

The community program director at WSH, Jarell Spires, and the interim medical director of WSH's Center for Forensic Services, Dr. Daniel Ruiz Paredes, both opposed G.C.'s request. RP 353, 650. Spires opined G.C. was too reliant on DESC. RP 353-54. He wanted to see a specific contingency plan if DESC's support became unavailable. RP 365. Spires wanted to maintain WSH as a safety net for G.C., so that, if she ever needs services, an immediate bed will be available instead of having to go through a new commitment process. RP 385.

He also wanted to see an update to G.C.'s relapse prevention plan, which was eight or nine years old. RP 378. At trial, she testified she did not believe the plan needed updating because there had been no major changes to her circumstances. RP 463-64. Instead, she presented a list of her accomplishments while on conditional release. RP 408, 469-70.

Ruiz and the WSH risk review board, of which he is the chair, also focused on G.C.'s backup plan. RP 528, 536, 667. Ruiz would not support unconditional release until there was a specific plan in addition to DESC. RP 552. He opined G.C. could become a risk if she were to relapse without a safety net to catch it immediately. RP 552.

He expressed concern that, without WSH supervision, G.C. could be confronted with the state's lack of psychiatric beds that has led to warehousing of the mentally ill in emergency departments as they await treatment. RP 649. He opined that G.C.'s backup plan of going to Harborview is a crisis plan, not a backup plan. RP 670. Since Medicaid does not permit G.C. to have two community health providers at the same time, he opined that a committed person should realize that remaining on WSH conditional release might be the best backup plan. RP 669, 675.

Ruiz testified paranoid schizophrenia is a severe, chronic mental illness that can relapse slowly or acutely, even after long periods of stability. RP 542-44. He testified G.C.'s schizophrenia could become active again

because, even after remission, relapse is more probable than not. RP 543, 555, 639-40. However, he agreed the risk decreases when a person has been stable in the community for a very long time, such as ten years, without problems. RP 658-59. He agreed relapse after 10 years would be "unusual." RP 545.

Ruiz opined that, in case of a relapse, what a person did before, that person is likely to do again. RP 570. Ruiz believed a relapse would make G.C. dangerous because her mental illness led to her prior offense and she lacked insight into the need for a backup plan to prevent relapse. RP 581.

8. After hearing the parties' arguments, the court denied G.C.'s request for unconditional release.

In closing, the state argued G.C. proved only that she was not a substantial danger when she has the structure and support of conditional release. RP 690. The state argued there is no guarantee she will not relapse or that DESC will be there to support her. RP 695. G.C. argued the "substantial risk" standard does not require her to account for every possible future contingency and she met her burden to show she is no longer dangerous. RP 706.

The court found the testimony did not refute the idea that G.C.'s disease could become active again and render her a danger. RP 726. The judge cited Jaffe's and Ruiz' testimony that they could not predict whether

the medication would continue to be effective and that the nature of the illness includes relapse. RP 724-25. The court denied the petition because of the nature of G.C.'s illness. RP 727.

On appeal, G.C. argued the trial court abused its discretion in denying her petition for unconditional release because several of the court's findings of fact were not supported by the record. The Court of Appeals found only two were unsupported and the remaining findings supported the court's decision. State v. Coleman, ___ Wn. App. 2d ___, ___ P.3d ___, 2018 WL 6444975 at *5-6 (2018). G.C. now seeks this Court's review.

D. REASONS WHY REVIEW SHOULD BE ACCEPTED AND ARGUMENT

THE DENIAL OF UNCONDITIONAL RELEASE MUST BE REVERSED BECAUSE IT IS BASED ON FACTUAL FINDINGS THAT ARE UNSUPPORTED BY THE RECORD.

The trial court erred in denying G.C.'s petition for unconditional release because that denial was based on untenable grounds. The court's findings of fact contain seven different assertions regarding G.C.'s risk that are inconsistent with the testimony at trial. Three of these assertions were particularly relevant to the court's decision to deny the petition. While the court has discretion under subsection (4) of RCW 10.77. 200 to deny unconditional released based on the possibility of relapse, that discretion was abused when it was exercised on the untenable grounds of unsupported factual findings. This Court should grant review and reverse because the

Court of Appeals decision is inconsistent with Washington precedent holding that a trial court abuses its discretion when that discretion is based on unsupported factual findings. RAP 13.4(b)(1).

a. The trial court had discretion to order G.C.'s unconditional release from commitment.

When a person is found not guilty by reason of insanity, the person can be committed to the care of the Department of Social and Health Services for mental health treatment for up to the maximum time allowed in a criminal sentence for the offense. RCW 10.77.025. A person can, however, petition for unconditional release at any time. RCW 10.77.200.

Under both Washington law and constitutional due process, the person can only be confined so long as she remains both mentally ill and dangerous. RCW 10.77.110; Foucha v. Louisiana, 504 U.S. 71, 77, 112 S. Ct. 1780, 118 L.Ed.2d 437 (1992). A person acquitted by reason of insanity is presumed to continue to be mentally ill; however, the law does not presume the person continues to be dangerous. State v. Reid, 144 Wn.2d 621, 627, 30 P.3d 465 (2001).

G.C. was acquitted by reason of insanity on charges of attempted second-degree murder, which carries a maximum sentence of life in prison. CP 7-9; RCW 9A.28.020; RCW 9A.32.050. Therefore, the maximum term of her commitment is also life. RCW 10.77.025.

At the trial, G.C. bore the burden to establish by a preponderance of the evidence that she "no longer presents, as a result of a mental disease or defect, a substantial danger to other persons, or a substantial likelihood of committing criminal acts jeopardizing public safety or security, unless kept under further control by the court or other persons or institutions." RCW 10.77.200(2). The court did not find G.C. failed to meet this burden. CP 109-10. Instead, it relied on subsection (4) of the statute. CP 109-110.

Under that subsection, the court "may deny release" if the person's mental illness is in remission but "may, with reasonable medical probability, occasionally become active and, when active, render the person a danger to others." RCW 10.77.200(4). The legislature's use of the term "may" indicates the court has discretion in this matter. State v. Davis, 90 Wn. App. 776, 783, 954 P.2d 325 (1998) (citing Strenge v. Clarke, 89 Wn.2d 23, 28, 569 P.2d 60 (1977)).

b. The court abused its discretion by relying on unsupported factual findings regarding G.C.'s own expert's assessment of her risk.

The Court of Appeals agreed Findings of Fact 20, 22, and 25 were unsupported by the evidence, but found them immaterial to the court's decision. Coleman, ___ Wn. App. 2d at ___, 2018 WL 6444975 at *5-6 (2018). However, the Court of Appeals failed to appreciate that findings 18, 19, were also unsupported and, along with finding 20, misleadingly

overstated the expert testimony pertaining to G.C.'s risk. These unsupported findings falsely made it appear her independent expert agreed with WSH's risk assessment.

Finding of fact 18 states, "Dr. Peterson found [G.C.] at low risk to reoffend so long has she maintains her compliance with medication and the treatment/housing structure of DESC/PACT/SAGE in place." CP 105. This finding misrepresents the substance of Peterson's report and testimony.

A critically disputed issue at trial was whether G.C. could remain stable if the specific organization currently supporting her (DESC) were to cease to exist. Peterson, her independent expert, acknowledged that her continued stability hinged on her continued access to treatment and medication services. RP 133, 140. But critically, he did not testify that her stability was contingent on the availability of DESC or any other specific service provider. RP 133, 140. G.C. testified she knew how and where to access other similar services if DESC were to cease to exist. RP 437-38.

The Court of Appeals wrongly conflated G.C.'s need for treatment/medication/housing assistance in general with her need for DESC in particular. Coleman, ___ Wn. App. at ____, 2018 WL 6444975 at *5-6 (finding Peterson's testimony adequately supported findings of fact 18 and 19). Peterson did not. He acknowledged she could receive the necessary

treatment and medication elsewhere. RP 157-58. The danger would arise only if she were without treatment, not if she were without DESC.

The same problem arises with Finding of Fact 19. Finding of Fact 19 states, "On cross examination Dr. Peterson testified that if [G.C.] loses the treatment/housing structure through PACT and decompensates she will become a substantial danger." CP 105. But Peterson did not specifically link increased risk to the specific programs of DESC, but instead to her treatment and medication in general. RP 140. More importantly, he did not testify that any increase would be so substantial that it would render her a substantial danger. RP 140.

The findings of fact misstate Dr. Haley Gummelt's assessment in much the same way. Finding of Fact 20 states, "Haley D. Gummelt, PhD, at Western State Hospital also conducted a Risk Assessment. Like Peterson, Gummelt also found [G.C.] to be a low risk to reoffend should PACT/SAGE continue case and medication management. Gummelt testified that should she lose this structure and decompensate, [G.C.] will become a substantial risk to public safety." CP 105. This finding is incorrect because Gummelt's testimony was far more limited. Like Peterson, Gummelt agreed G.C.'s risk would increase if she were to become mentally unstable. RP 267. She agreed G.C.'s illness is "potentially" subject to relapse and that it is "possible" she

could become a substantial risk to public safety if she were to become unstable. RP 267-68.

But she did not opine that G.C.'s stability was necessarily contingent on the specific services of DESC. Her written report[2] states that if the current services ended, G.C.'s risk "may or may not be affected." CP 51. She did not opine that mere loss of current services would bring about a substantial risk.

This was a critical issue because the State's primary argument was that G.C. needed WSH supervision as a backup to DESC. RP 365, 528, 536, 552, 667, 670, 695. The State believed G.C.'s backup plan of accessing other mental health services through, for example, Harborview Hospital, was insufficient. RP 670. If G.C.'s own expert Dr. Peterson as well as Dr. Gummelt, also believed she would be dangerous without DESC, that would clearly support the State's position against unconditional release because her backup plan would not keep her and the community safe. But if they merely opined she would be dangerous without treatment and medication in general, that opinion did not support the State's position. Peterson did not denigrate the efficacy of G.C.'s backup plan. The court's factual finding on this point is incorrect and unsupported by the record. The court cannot validly exercise its discretion when it labors under a misapprehension regarding G.C.'s own

[2] Gummelt's written report was admitted as exhibit 3 and is found in the Clerk's Papers at CP 66-77.

expert's opinion about the conditions necessary for her to be safely in the community.

The court's discretion to continue to commit G.C. because of the risk of relapse was just that – discretion. The court also had discretion to find that her backup plan was sufficient to allow her to safely be on her own in the community. Such a conclusion would have been far more likely if the court had correctly assessed Peterson's testimony. Moreover, G.C. was entitled to a decision based on an accurate understanding of her situation.

A court abuses its discretion when its decision is based on untenable grounds. In re Marriage of Horner, 151 Wn.2d 884, 894, 93 P.3d 124 (2004) (quoting In re Marriage of Littlefield, 133 Wn.2d 39, 47, 940 P.2d 1362 (1997)). Factual findings that are unsupported by the record constitute untenable grounds. Id. When the court is faced with a discretionary decision regarding multiple risk assessments, the committed person is entitled to have the court exercise that discretion based on an accurate understanding of those risk assessments.

By affirming a discretionary decision based on an inaccurate recitation of the risk assessment testimony, the Court of Appeals decision is in conflict with Washington cases holding that unfounded factual findings constitute untenable grounds for an exercise of discretion. See, e.g., Horner,

151 Wn.2d at 894 (quoting Littlefield, 133 Wn.2d at 47). This Court should grant review under RAP 13.4(b)(1) and reverse.

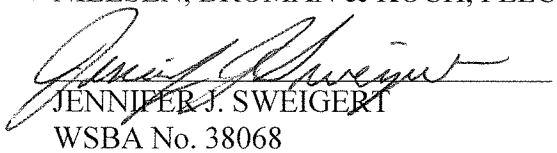
E. CONCLUSION

Because this case stands in conflict with this Court's past precedent, G.C. requests this Court grant review under RAP 13.4 (b) (1).

DATED this 8th day of January, 2019.

Respectfully submitted,

NIELSEN, BROMAN & KOCH, PLLC



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CASE #: 76851-4-I
State of Washington, Respondent v. Gail Yvette Coleman, Appellant
King County, Cause No. 04-1-13163-1 KNT

Counsel:

Enclosed is a copy of the opinion filed in the above-referenced appeal which states in part:

"Accordingly, we affirm."

Counsel may file a motion for reconsideration within 20 days of filing this opinion pursuant to RAP 12.4(b). If counsel does not wish to file a motion for reconsideration but does wish to seek review by the Supreme Court, RAP 13.4(a) provides that if no motion for reconsideration is made, a petition for review must be filed in this court within 30 days.

In accordance with RAP 14.4(a), a claim for costs by the prevailing party must be supported by a cost bill filed and served within ten days after the filing of this opinion, or claim for costs will be deemed waived.

Sincerely,

Richard D. Johnson
Court Administrator/Clerk

khn

Enclosure

c: The Honorable Susan Amini
Gail Yvette Coleman

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

STATE OF WASHINGTON, Respondent, v. GAIL YVETTE COLEMAN, Appellant.	)	No. 76851-4-I PUBLISHED OPINION FILED: December 10, 2018

VERELLEN, J. — An individual found not guilty of a crime by reason of insanity who is committed for treatment or supervision or who has been conditionally released from supervision may petition for final release[1] from custody.[2] We conclude an order granting or denying a petition for final release pursuant to RCW 10.77.200 is appealable as a matter of right under RAP 2.2(a)(13). Gail Coleman has the right to appeal the trial court's denial of her petition for final release.

If only immaterial portions of the findings of fact lack support, it is of no legal consequence. Because sufficient evidence supports the critical findings of fact,

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[1] For clarity, we refer to "final release" rather than the statutory term "release" to avoid any confusion with the statutory provisions governing "conditional release." RCW 10.77.010(3), (20).

[2] RCW 10.77.200.

and those findings in turn support the key conclusions of law, the trial court correctly denied Coleman's petition for final release.

Therefore, we affirm.

FACTS

In 2004, Coleman shot a grocery store manager in the face. The State charged her with second degree attempted murder. The court found her not guilty by reason of insanity in December 2005. After several years in treatment for paranoid schizophrenia at Western State Hospital, Coleman was conditionally released to the community in October 2009. Since then, she has lived in her own apartment and complied with the conditions of her release, all while under the supervision of Western State Hospital. She takes her medications regularly. Her paranoid schizophrenia is in remission when treated with medication. Coleman filed a petition for final release pursuant to RCW 10.77.200 in June 2016. Following a five-day evidentiary hearing in April 2017, the court denied her petition.

Coleman appeals.

ANALYSIS

I. Appealability of Denial of a Final Release Petition

The threshold issue is whether the denial of Coleman's petition is appealable as a matter of right.

RAP 2.2(a) lists superior court decisions appealable as a matter of right.[3] RAP 2.2(a)(13), on which Coleman relies, allows an appeal of "[a]ny final order made after judgment that affects a substantial right."[4] Appeal under this rule requires "a showing of (1) effect on a substantial right and (2) finality."[5] The parties do not dispute the first requirement, so the issue is finality. A final judgment or order "leaves 'nothing else to be done to arrive at the ultimate disposition of the petition.'"[6]

Final release, which used to be called "final discharge,"[7] is the "legal termination of the court-ordered commitment under the provisions of this chapter."[8] A patient may not be released "except by order of a court . . . made after a hearing and judgment of release."[9]

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[3] RAP 2.2(b) and (c) also contain decisions appealable as a matter of right, but those sections are not germane.

[4] RAP 2.2(a)(13).

[5] State v. Howland, 180 Wn. App. 196, 201 n.3, 321 P.3d 303 (2014).

[6] State v. Gossage, 138 Wn. App. 298, 302, 156 P.3d 951 (2007) (quoting In re Det. of Petersen, 138 Wn.2d 70, 98, 980 P.2d 1204 (1999)); rev'd in part on other grounds, 165 Wn.2d 1, 195 P.3d 525 (2008); see also Petersen, 138 Wn.2d at 88 ("'A final judgment is a judgment that ends the litigation, leaving nothing for the court to do but execute the judgment.'" (quoting Anderson & Middleton Lumber Co. v. Quinault Indian Nation, 79 Wn. App. 221, 225, 901 P.2d 1060 (1995))); In re Det. of Turay, 139 Wn.2d 379, 392, 986 P.2d 790 (1999) ("a 'final judgment' is one that settles all the issues in a case").

[7] State v. Reid, 144 Wn.2d 621, 624 n.1, 30 P.3d 465 (2001) (citing LAWS OF 2000, ch. 94, § 16).

[8] RCW 10.77.010(20).

[9] RCW 10.77.120(1).

RCW 10.77.200 governs final release procedures. A person "may petition the court at any time for [their final] release."[10] No section of RCW 10.77 mandates that either the Department of Social and Health Services or the person petition for final release. If a petitioner shows by a preponderance of the evidence that she "is no longer dangerous as a result of mental disease or that [s]he is no longer insane—then the [petitioner] *must* be unconditionally released."[11]

The State points to other sections in chapter 10.77 RCW that govern conditional release to argue against the finality of the court's decision. But final release and conditional release are drastically different.[12] A petition for final release carries the possibility of finality, whereas a petition for conditional release does not.[13] A person petitioning for conditional release remains under the court's jurisdiction regardless of the petition's disposition. A person on conditional release is subject to regular court monitoring, modification of her release conditions, and

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[10] State v. Klein, 156 Wn.2d 102, 114, 124 P.3d 644 (2005); RCW 10.77.200(3), (5). The Department of Social and Health Services may also petition for release. RCW 10.77.200(2).

[11] Reid, 144 Wn.2d at 630; RCW 10.77.200(3), (5).

[12] See id. at 629-30 ("Unlike RCW 10.77.230(3), RCW 10.77.150(2) which references conditional release does not inquire into mental status, only dangerousness.").

[13] At oral argument, the State compared denial of a patient's petition for final release to a motion to dismiss and argued that they are both examples of motions whose appealability depends on the court's decision. But this comparison ignores the fundamental difference that the former is being appealed following a trial on its merits and the other is a threshold determination whether a trial is warranted.

limitations on her liberties.[14] But a successful petition for final release necessarily results in termination of any court jurisdiction over the person, leaving nothing else for the court to do.[15]

The State relies heavily on In re Detention of Petersen to argue against Coleman's right to appeal, but Petersen is inapposite because it addresses interlocutory circumstances akin to a petition for conditional release.[16] In Petersen, our Supreme Court considered whether denial of a probable cause hearing, a statutorily-required hearing prior to an unconditional release hearing, was appealable as a matter of right.[17] The court concluded the decision was not appealable under RAP 2.2(a)(13) because the finding of no probable cause "is not a final order after judgment in light of the court's continuing jurisdiction over the [patient] until their unconditional release."[18] Only discretionary review was available "[i]n light of the nature of the show cause hearing required by

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[14] RCW 10.77.150(3)(d); RCW 10.77.160.

[15] RCW 10.77.010(20); compare RCW 10.77.190(2) (if certain persons "reasonably believe" that a patient is not adhering to the conditions of their release, then a court "shall schedule a hearing . . . to determine whether or not the person's conditional release should be modified or revoked") with RCW 10.77.200(3) (requiring that individuals petitioning for release show a lack of dangerousness and a substantial unlikelihood of criminality).

[16] 138 Wn.2d 70, 76-77, 980 P.2d 1204 (1999), rev'd in part on other grounds, 165 Wn.2d 1, 195 P.3d 525 (2008).

[17] Id. at 88 (citing RCW 71.09.090).

[18] Id.

RCW 71.09.090(2)."[19] But the court strongly suggested that a decision on the merits of unconditional release is appealable as a matter of right:

> [A]lthough we do not now so decide, review of decisions made after a full hearing on the merits under RCW 71.09.090(2) would be reviewable as of right. Such hearings appear to be equivalent to whole new trials with the same procedural protections as the initial commitment trial.[20]

Consistent with the Petersen court's suggestion, RCW 10.77.120(2) presumes the State's ability to appeal adverse rulings on petitions for final release:

> If the [S]tate *appeals* an order of [final] release, such appeal shall operate as a stay, and the person shall remain in custody and be returned to the institution or facility designated by the secretary until a final decision has been rendered in the cause.[21]

An order granting final release ends the court's jurisdiction over the patient, consistent with legislative contemplation of a release order as a final ruling.

The State also compares this case to In re Dependency of Chubb[22] and State v. Howland,[23] but neither is compelling. In Chubb, a parent appealed dependency review orders, not the dependency order or parental rights termination, and our Supreme Court concluded they were not appealable pursuant to RAP 2.2.[24] The dependency review orders were interlocutory because the

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[19] Id. at 95.

[20] Id. at 87 n.13.

[21] RCW 10.77.120(2) (emphasis added).

[22] 112 Wn.2d 719, 773 P.2d 851 (1989).

[23] 180 Wn. App. 196, 321 P.3d 303 (2014).

[24] Chubb, 112 Wn.2d at 721, 724-25.

review hearings occurred automatically as part of an ongoing process.[25] Similarly, in Howland, a trial court's denial of a patient's petition for conditional release was not appealable under RAP 2.2(a)(13) because it was not a final order.[26] Even if the trial court had granted the patient's conditional release petition, it would have retained jurisdiction and disposed only of the petition itself.[27]

Here, Coleman appeals a decision based on a five-day evidentiary hearing on the merits of her petition. Coleman would not be under any court's jurisdiction if her petition were granted. And RCW 10.77.200 does not provide for routine monitoring of Coleman's readiness for release nor does it require a preliminary hearing before a full evidentiary hearing.[28] Moreover, the statute contemplates grant of a release petition as a final, appealable decision.[29]

Similarly, in State v. Gossage, this court concluded a trial court order denying a sex offender's petition for a certificate of discharge was appealable as a matter of right.[30] The court rejected as inapt the State's analogy to Petersen and Chubb.[31] The court upheld the offender's right to appeal because no court would have had continuing jurisdiction over the offender if his petition were

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[25] Id. at 724.

[26] Howland, 180 Wn. App. at 201.

[27] Id. at 202.

[28] See RCW 10.77.200(3) ("The court, upon receipt of the petition for release, shall within forty-five days order a [release] hearing.").

[29] RCW 10.77.120(2).

[30] Gossage, 138 Wn. App. at 301-02.

[31] Id. at 302.

granted and because no statute required routine monitoring to determine whether termination of ongoing court jurisdiction was warranted.[32] The same analysis applies to a petition for final release of a person found not guilty by reason of insanity.

The State contended at oral argument that it may appeal the grant of a final release as a matter of right, implicitly conceding that a decision on a final release petition is a final judgment, but suggested that an unsuccessful petitioner could not appeal as a matter of right the denial of a final release. The State provides no authority for this one-sided approach. An order granting or denying the petition for final release leaves "'nothing else to be done to arrive at the ultimate disposition of the petition.'"[33] Coleman is appealing a final order.

Accordingly, we follow the reasoning in Gossage and conclude that the trial court's order dismissing a petition for final release is appealable as a matter of right pursuant to RAP 2.2(a)(13).[34]

II. Substantial Evidence Supports the Court's Essential Findings of Fact

The main, narrow issue presented by Coleman on the merits is whether we should reverse the court's denial of her petition and remand for reconsideration if, as she contends, 7 of its 58 factual findings are unsupported by the record.[35]

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[32] Id.

[33] Id. (quoting Petersen, 138 Wn.2d at 98).

[34] Because the court's order is appealable under RAP 2.2(a), we do not need to consider Coleman's alternative argument that discretionary review is warranted under RAP 2.3.

Our review is limited to determining whether substantial evidence supports the challenged findings of fact and, in turn, if the supported findings and unchallenged findings support the court's conclusions of law.[36] "Evidence is substantial if it is sufficient to convince a reasonable person of the truth of the finding."[37] "So long as this substantial evidence standard is met, 'a reviewing court will not substitute its judgment for that of the trial court even though it might have resolved a factual dispute differently.'"[38] Even if a trial court relies on erroneous or unsupported findings of fact, immaterial findings that do not affect its conclusions of law are not prejudicial and do not warrant reversal.[39] Unchallenged findings of fact are verities on appeal.[40]

Coleman challenges findings of fact based on testimony given by three doctors who testified at her final release hearing.[41] Dr. Kevin Peterson is an

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[35] Coleman also assigns error to finding of fact 58 but does not argue why it is error. We need not consider an issue that has not been argued by the appellant. RAP 10.3(a)(6); Cowiche Canyon Conservancy v. Bosley, 118 Wn.2d 801, 809, 828 P.2d 549 (1992).

[36] Klein, 156 Wn.2d at 115; In re LaBelle, 107 Wn.2d 196, 209, 728 P.2d 138 (1986).

[37] Klein, 156 Wn.2d at 115.

[38] Blackburn v. State, 186 Wn.2d 250, 256, 375 P.3d 1076 (2016) (quoting Sunnyside Valley Irrig. Dist. v. Dickie, 149 Wn.2d 873, 879-80, 73 P.3d 369 (2003)).

[39] State v. Caldera, 66 Wn. App. 548, 551, 832 P.2d 139 (1992).

[40] Cowiche Canyon, 118 Wn.2d at 808.

[41] Several of the trial court's findings are a summary recitation of the testimony of particular witnesses. Findings of fact that merely purport to summarize testimony of a witness without an indication that the trial court found the testimony credible can be problematic. A finding that a particular witness

independent psychologist who testified on Coleman's behalf. Dr. Haley Gummelt is a psychologist at Western State Hospital who recently evaluated Coleman as part of her petition for final release. Dr. Daniel Ruiz-Parades is an administrator and psychiatrist at Western State Hospital who chairs the committee that makes recommendations regarding final release.

Coleman challenges a portion of finding of fact 18, that "Dr. Peterson found Ms. Coleman at a low risk to reoffend so long as she maintains her compliance with medication and the treatment/housing structure . . . in place." Dr. Peterson assessed Coleman as being a low clinical risk because "she is in treatment" and "connected with a good program."[42] But he noted it is generally very common for individuals experiencing paranoid schizophrenia to stop taking their medication. Dr. Peterson also testified that Coleman could voluntarily opt out of treatment services following release and, if she "stops medication, if she stops treatment, if she stops things that are keeping her oriented and stable, yes, of course, her risk

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testified, "The stop light was red" is not the same as a finding of fact that the stop light was red. A finding of fact should be a determination rather than a mere recitation. See Leschi Imp. Council v. Washington State Highway Comm'n, 84 Wn.2d 271, 283, 525 P.2d 774 (1974) ("'A finding of fact is the assertion that a phenomenon has happened or is or will be happening independent of or anterior to any assertion as to its legal effect.'") (quoting NLRB v. Marcus Trucking Co., 286 F.2d 583, 590 (2nd Cir. 1961)). Trial courts make findings of fact about ultimate facts which "'are the essential and determining facts upon which the conclusions rests and without which the judgment would lack support in an essential particular.'" In re Marriage of Lutz, 74 Wn. App. 356, 370-71, 873 P.2d 566 (1994) (quoting Wold v. Wold, 7 Wn. App. 872, 875, 503 P.2d 118 (1972)). If the trial court chooses to summarize the testimony of a witness, the best practice is to clearly articulate whether the court found that testimony credible.

[42] Report of Proceedings (RP) (Apr. 10, 2017) at 130.

goes up."[43] Because this testimony is sufficient to convince a reasonable person of the truth of the court's finding that Coleman is low risk so long as she takes her medication and continues with treatment and housing services, the finding is supported by substantial evidence.

Coleman objects to finding of fact 19 in its entirety:

> On cross-examination, Dr. Peterson testified that if Ms. Coleman loses the treatment/housing structure . . . and decompensates, she will become a substantial danger. He also testified that Ms. Coleman's chronic paranoid schizophrenia is currently in remission, but may become active[,] rendering Coleman a danger to others.[44]

This particular finding summarizes the testimony of Dr. Peterson. Dr. Peterson testified if Coleman becomes medication noncompliant and decompensates, then "I don't know if she becomes a substantial risk, but the risk increases. . . . She could, in fact, [become extremely dangerous] if somebody wants to be focused on that, yes. . . . If she becomes dangerous, she becomes a substantial risk, yes."[45] Viewed in conjunction with the evidence supporting finding of fact 18, substantial evidence supports finding of fact 19.

Coleman also challenges finding 20:

> Like Dr. Peterson, Dr. Gummelt also found Ms. Coleman to be a low risk to reoffend should [the treatment provider] continue case and medication management. Dr. Gummelt testified that should she lose this structure and decompensate, Ms. Coleman will become a substantial risk to public safety.[46]

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[43] Id. at 140.

[44] Clerk's Papers (CP) at 105.

[45] RP (Apr. 10, 2017) at 133.

[46] CP at 105.

The first sentence is unsupported by the record, and the State concedes the second sentence is inaccurate. Dr. Gummelt did not testify that Coleman's low risk of reoffense was connected to case management. In fact, Dr. Gummelt's written evaluation of Coleman stated, "If [ongoing case and medication management] were to be discontinued or altered, her risk for future violence may or may not be affected."[47] Substantial evidence does not support finding of fact 20.

However, this error does not justify remand. Finding of fact 20 explicitly echoes findings of fact 18 and 19, which are supported by Dr. Peterson's testimony. Even without finding of fact 20, the court could have relied on findings of fact 18 and 19 to reach the same legal conclusion on the same evidentiary basis, albeit one provided by a different expert.[48] Accordingly, the error is immaterial.

Coleman disputes part of finding of fact 22, that "[b]oth Dr. Peterson and Dr. Gummelt were of the opinion that Ms. Coleman lacks personal support in the community, which is a risk factor of concern."[49] Although Coleman is correct that

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[47] CP at 75.

[48] We do not give any more or less weight to the finding based on the testifying expert or their relationship to Coleman. See Klein, 156 Wn.2d at 121 ("We generally do not substitute our judgment with that of the trier of fact regarding issues of conflicting expert testimony.").

[49] CP at 105.

Dr. Gummelt did not share this opinion with Dr. Peterson,[50] this error is immaterial because substantial evidence supports the disputed part of the finding. Dr. Peterson described Coleman's "lack of personal supports" as "a weakness," and noted that Coleman has difficulty engaging with her family because they live far away.[51] In addition, his written evaluation states, "She has attended peer support groups . . . but doesn't socialize outside groups with other patients much."[52] Because this error is immaterial, no relief is warranted.

Coleman objects to finding of fact 25 in which the court again compares Dr. Peterson's and Dr. Gummelt's testimony:

> Dr. Peterson and Dr. Gummelt also expressed concern regarding Ms. Coleman's lack of employment. Both doctors expressed concern [about] whether Ms. Coleman would be able to obtain or maintain employment and simultaneously manage her psychotic symptoms.[53]

Dr. Gummelt evaluated Coleman and wrote, "[I]t is unclear whether she would be able to maintain employment and manage her psychiatric symptoms."[54] Dr. Peterson did not share this concern. As with finding of fact 22, this is an immaterial error because substantial evidence supported the finding as to one

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[50] See CP at 72-73 (evaluating Coleman's relationships and concluding "Ms. Coleman has maintained consistent relationships with her family, despite the fact that they live on the other side of the country. She reported having developed friendships with other clients in her groups and with her neighbors.").

[51] RP (Apr. 10, 2017) at 128.

[52] CP at 62.

[53] CP at 105.

[54] CP at 73.

testifying expert, and that portion of the finding supports the court's conclusion.

The last two objections are to factual findings 54(d) and 54(f), which are based on the testimony of Dr. Ruiz-Parades.

The first finding is "Sooner or later, a person diagnosed with chronic [p]aranoid [s]chizophrenia would relapse."[55] Dr. Ruiz-Parades stated at least four times during his testimony that relapse is common for individuals experiencing paranoid schizophrenia. He stated directly, "It is part of the nature of [chronic paranoid schizophrenia] that almost [every patient] always [has] relapses sooner or later," and that "[t]here are concerns about well-being and safety [b]ecause the nature of the current risks for schizophrenia is one for relapses.[56] Substantial evidence supports this finding.

The second finding states, "The efficacy of medication would change over time and could cause an acute relapse of symptoms."[57] Dr. Ruiz-Parades testified about long-term medication efficacy:

> Another scenario is that the person may become refractory to the medication. And it happens that the Medication A has worked very well for a number of years [but] at some point in time is no longer effective. And so at [that] point in time, it may be necessary to adjust the medications.
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> . . . .
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> . . . [S]ometimes the medication after being taken for several years is no longer effective. The effectiveness of the medication is not guaranteed for life. The fact that Medication A works now [and]

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[55] CP at 109.

[56] RP (Apr. 13, 2017) at 543, 552.

[57] CP at 109.

> has been good for three years, four years, or five years—I have seen many cases in which the medication is[,] the patients decompensate, and we have to change the treatment weekly.[58]

This testimony lets a reasonable fact finder arrive at the same factual determination as the trial court. The finding is supported by substantial evidence.

The court concluded as a matter of law that Coleman "requires continued supervision by [Western State Hospital] and the court."[59] Accordingly, the court denied Coleman's petition. This conclusion was supported by six of the findings of fact discussed above and by the court's unchallenged findings, particularly findings of fact 56 and 57:

> 56. Ms. Coleman's chronic [p]aranoid [s]chizophrenia may, with reasonable medical probability, occasionally become active.
>
> 57. Given Ms. Coleman's history of mental instability and the violent nature of her index offense, when her chronic [p]aranoid [s]chizophrenia becomes active, it will render her a danger to others.[60]

These findings are verities on appeal.[61]

On Coleman's narrow appeal, the court's legal conclusions are supported by findings of fact either unchallenged on appeal or supported by substantial evidence. Accordingly, we decline to reverse and remand for further proceedings.

Coleman also challenges the court's ruling on the grounds that her trial counsel was ineffective in failing to object at trial to the seven findings of fact

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[58] RP (Apr. 13, 2017) at 543-44.

[59] CP at 110.

[60] CP at 109.

[61] Cowiche Canyon, 118 Wn.2d at 808.

above. To prove she received ineffective assistance of counsel, Coleman must show both that her counsel's performance was deficient and that the deficiency prejudiced her.[62]

An appellant is not required to object at trial to findings of fact in order to preserve a challenge to the sufficiency of the evidence. "When findings of fact are made in actions tried by the court without a jury, the question of the sufficiency of the evidence to support the findings may thereafter be raised whether or not the party raising the question has made in the court an objection to such findings."[63] The fact that Coleman's counsel did not object cannot constitute a deficient performance when her counsel had no reason to object.

Accordingly, we affirm.

WE CONCUR:

Andrus, J.

Leach, J.

[62] State v. Grier, 171 Wn.2d 17, 32-33, 246 P.3d 1260 (2011) (citing Strickland v. Washington, 466 U.S. 668, 687, 104 S. Ct. 2052, 80 L. Ed. 2d 674 (1984)).

[63] CR 52(b); see CR 46 ("Formal exceptions to rulings or orders of the court are unnecessary."); Gamboa v. Clark, 180 Wn. App. 256, 266, 321 P.3d 1236 (2014) ("Under CR 46, formal exceptions to a trial court's findings are unnecessary."), aff'd, 183 Wn.2d 38, 348 P.3d 1214 (2015).

NIELSEN, BROMAN & KOCH P.L.L.C.

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