

FILED
Court of Appeals
Division II
State of Washington
7/19/2018 11:35 AM

No. 51246-7-II

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

In re the Detention of:

Brian Taylor-Rose,

Appellant.

Clallam County Superior Court Cause No. 12-2-01143-8

The Honorable Judge Brian P. Coughenour

Appellant's Opening Brief

Jodi R. Backlund
Manek R. Mistry
Attorneys for Appellant

BACKLUND & MISTRY

P.O. Box 6490
Olympia, WA 98507
(360) 339-4870
backlundmistry@gmail.com

TABLE OF CONTENTS

TABLE OF CONTENTS i

TABLE OF AUTHORITIES ii

ISSUES AND ASSIGNMENTS OF ERROR..... 1

STATEMENT OF FACTS AND PRIOR PROCEEDINGS..... 2

ARGUMENT..... 6

**The case must be set for trial, because Dr. Franklin provided
prima facie evidence of Mr. Taylor-Rose’s treatment-based
changes. 6**

A. A court “shall set a hearing” if the patient’s condition
has “so changed” through treatment that he no longer meets
commitment criteria. 6

B. Dr. Franklin’s evaluation provides probable cause to
believe Mr. Taylor-Rose has “so changed” through his
participation in treatment that he no longer meets criteria
for commitment..... 7

C. Dr. Franklin’s report is not a collateral attack on the
original commitment order. 8

CONCLUSION 13

TABLE OF AUTHORITIES

WASHINGTON STATE CASES

| | |
|--|-----------|
| <i>Det. of Fox v. State, Dep't of Soc. & Health Servs.</i> , 138 Wn. App. 374, 158 P.3d 69 (2007)..... | 10 |
| <i>Det. of Petersen v. State</i> , 145 Wn.2d 789, 42 P.3d 952 (2002) | 6, 7 |
| <i>In re Det. of Ambers</i> , 160 Wn.2d 543, 158 P.3d 1144 (2007)6, 7, 8, 10, 11, 12, 13 | |
| <i>In re Det. of McGary</i> , 155 Wn. App. 771, 231 P.3d 205 (2010) | 10 |
| <i>In re Det. of Reimer</i> , 146 Wn. App. 179, 190 P.3d 74 (2008)..... | 12 |
| <i>In re Det. of Thorell</i> , 149 Wn.2d 724, 72 P.3d 708 (2003)..... | 9 |
| <i>In re Meirhofer</i> , 182 Wn.2d 632, 343 P.3d 731 (2015) | 9 |
| <i>Matter of Det. of Belcher</i> , 189 Wn.2d 280, 399 P.3d 1179 (2017)..... | 8 |
| <i>State v. Klein</i> , 156 Wn.2d 103, 124 P.3d 644 (2005) | 9 |
| <i>State v. McCuiston</i> , 174 Wn.2d 369, 275 P.3d 1092 (2012) | 7, 11, 12 |

WASHINGTON STATE STATUTES

| | |
|---------------------|-------------|
| RCW 71.09.090 | 6, 7, 8, 10 |
|---------------------|-------------|

ISSUES AND ASSIGNMENTS OF ERROR

1. The trial court erred by denying Mr. Taylor-Rose's petition for an unconditional release trial.
2. The trial court erred by rejecting Dr. Franklin's well-supported and unequivocal opinion that Mr. Taylor-Rose "has so changed through sex offender-specific treatment that he no longer meets the definition of a sexually violent predator."
3. The trial court erred by adopting Finding of Fact No. 1.
4. The trial court erred by adopting Conclusion of Law No. 2.
5. The trial court erred by adopting Conclusion of Law No. 3.

ISSUE 1: Did Mr. Taylor-Rose present *prima facie* evidence that he no longer meets criteria for civil commitment resulting from positive change brought about through his participation in sex offender treatment?

ISSUE 2: Did the trial court err by disregarding Dr. Franklin's well-supported and unequivocal opinion that Mr. Taylor-Rose "has so changed through sex offender-specific treatment that he no longer meets the definition of a sexually violent predator"?

STATEMENT OF FACTS AND PRIOR PROCEEDINGS

Following his civil commitment trial in 2015, Brian Taylor-Rose returned to the Special Commitment Center (SCC) “with a renewed commitment to treatment.” Clerk’s Papers (“CP”) 148.¹ In 2017, Mr. Taylor-Rose petitioned for a release hearing, based on his advancement in treatment. CP 85.

Dr. Karen Franklin evaluated his treatment progress. CP 101-157. In her report, she indicated that “[t]he referral issue is whether Mr. Taylor-Rose has so changed through treatment that he no longer meets civil commitment criteria...” CP 103. In her professional opinion, his participation in treatment had produced a substantial change in his condition, and he no longer qualified for commitment. CP 101-157.

After reviewing the treatment materials, Dr. Franklin found that Mr. Taylor-Rose had diligently participated and had made “good progress.” CP 124-127, 148. She pointed out specific signs from his treatment records showing improvement since his commitment trial. CP 124-127.

¹ He arrived at the SCC in 2012 and has participated in treatment since 2013. CP 123, 148. He entered treatment prior to trial against his attorney’s advice. CP 148. He started the formal phase program in June of 2014. CP 124, 148.

Dr. Franklin formally assessed Mr. Taylor-Rose's treatment-related change using a structured instrument called the Sex Offender Treatment Intervention and Progress Scale (SOTIPS). CP 149. Under SOTIPS, lower scores indicate greater progress and less risk of reoffense. CP 149. Mr. Taylor-Rose's score was 10 out of 42. CP 149.

Dr. Franklin outlined eight "prominent areas of treatment progress as measured by the SOTIPS." CP 149. These include (1) Mr. Taylor-Rose's recognition of the need for change and his active work towards modifying his behavior, (2) his high level of engagement in treatment, (3) his progress understanding issues that contribute to his offending, (4) his recognition and correction of attitudes that lead to offending, (5) his motivation and ability to obey rules, (6) his reduced impulsivity, (7) his demonstrated commitment to sobriety, and (8) the appropriateness of his current sexual interests and behaviors (confirmed by recent PPG² testing, which shows no deviant sexual arousal). CP 141, 146, 149-150.

Dr. Franklin also assessed Mr. Taylor-Rose's risk of reoffense. She used a combination of actuarial instruments and structured professional judgment.³ CP 142. She concluded that his current level of risk "falls in

² Penile plethysmograph.

³ The instruments she relied on include the Static 99R, the Stable 2007, and the Risk for Sexual Violence Protocol (RSVP). CP 142-146.

the average range of sex offenders in the general U.S. population,” approximately 6.5%. CP 148.

Dr. Franklin found it unlikely that he would reoffend, even if he relapsed with drugs or alcohol. CP 148.⁴ Ultimately, she concluded that “he is *not* [likely] to commit predatory acts of sexual violence.” AP 150 (emphasis in original).

Dr. Franklin diagnosed Mr. Taylor-Rose with Borderline Personality Disorder (BPD).⁵ CP 108, 140, 145. She also noted a significant problem with alcohol and controlled substances, stretching all the way back into his childhood. CP 105, 129, 146, 148. She opined that his alcohol and drug use contributed to his offending behavior, and that sobriety reduces his risk. CP 148-150. She questioned other diagnoses he’d been assigned,⁶ but did not suggest that he was wrongly committed or that he never qualified as a sexually violent predator. CP 134-142.

⁴ Furthermore, even if he did reoffend, she predicted “that the offense would likely involve a boundary violation committed while intoxicated, rather than a more severe offense involving force, violence or physical injury.” CP 148. This implies that his risk of predatory sexual violence is even lower than the 6.5% risk of reoffense generally.

⁵ Mr. Taylor-Rose had been diagnosed with that condition as a child. CP 108. Dr. Franklin noted that the condition declines with age and pointed out evidence of gradual progress as he matured. CP 140, 146, 148, 150.

⁶ She based her critique primarily on newly discovered records and other information that had been unavailable or simply overlooked prior to trial. CP 134-137. These records undercut much of the data—Mr. Taylor-Rose’s own uncorroborated statements—used to support the pedophilic disorder diagnosis. CP 134-137, 141-142. Evidence shows that Mr. Taylor-Rose has been an unreliable narrator regarding his own history. This unreliability

After reviewing Mr. Taylor-Rose's treatment records, administering the SOTIPS, and assessing his risk of recidivism, Dr. Franklin concluded that he "has so changed through sex offender-specific treatment that he no longer meets the definition of a sexually violent predator." CP 150. She held this opinion with "a reasonable degree of psychological certainty." CP 150. Mr. Taylor-Rose submitted her report in support of his petition. CP 85, 101-157.

The trial court held a hearing and heard argument on the petition.⁷ RP 1-51. In a memorandum opinion, Judge Brian Coughenour concluded that the petition was a collateral attack on the initial commitment. CP 22-25. The court entered an order denying the petition. CP 26-28.

Mr. Taylor-Rose sought review of that decision. CP 29-31. A Court of Appeals commissioner granted review. Ruling Granting Review, pp. 1, 17.

stems from his childhood tendency to exaggerate, his suggestibility and desire to please interviewers, his poor memory, his past lies (including falsehoods designed to help him enter treatment and avoid prison), and misunderstandings stemming from his below-average intellect. CP 131, 135-136.

⁷ The hearing was combined with Mr. Taylor-Rose's annual review, which is not at issue in this proceeding.

ARGUMENT

THE CASE MUST BE SET FOR TRIAL, BECAUSE DR. FRANKLIN PROVIDED PRIMA FACIE EVIDENCE OF MR. TAYLOR-ROSE'S TREATMENT-BASED CHANGES.

Dr. Karen Franklin unequivocally concluded that Mr. Taylor-Rose has “so changed” through treatment that he no longer qualifies for commitment. CP 150. Her opinion is supported by his treatment records, his psychological and physiological test results, his SOTIPS score (which measures treatment progress), and his low risk of predatory sexual violence. CP 101-157. Under these circumstances, the trial court should have ordered a release hearing. RCW 71.09.090(2)(c)(ii) and (4).

- A. A court “shall set a hearing” if the patient’s condition has “so changed” through treatment that he no longer meets commitment criteria.

To obtain a release hearing, a patient need only show probable cause that his condition has “so changed” through treatment that he no longer qualifies for commitment. RCW 71.09.090(2)(c)(ii) and (4)(b)(ii). Appellate courts review *de novo* “whether evidence meets the probable cause standard.” *In re Det. of Ambers*, 160 Wn.2d 543, 557, 158 P.3d 1144 (2007).

Probable cause requires nothing more than a *prima facie* showing. *Det. of Petersen v. State*, 145 Wn.2d 789, 796-797, 42 P.3d 952 (2002).

The probable cause standard “is not a stringent one.” *State v. McCuiston*, 174 Wn.2d 369, 382, 275 P.3d 1092 (2012).

In assessing probable cause, the court “must assume the truth of the evidence presented; it may not ‘weigh and measure asserted facts against potentially competing ones.’” *Id* (quoting *Petersen*, 145 Wn.2d at 797). The court determines whether the facts, if believed, warrant more proceedings. *Petersen*, 145 Wn.2d at 797.

B. Dr. Franklin’s evaluation provides probable cause to believe Mr. Taylor-Rose has “so changed” through his participation in treatment that he no longer meets criteria for commitment.

Dr. Franklin’s conclusion—that Mr. Taylor-Rose has “so changed” through treatment—requires a hearing on the issue of unconditional release. CP 148-150; RCW 71.09.090(2)(c)(ii); *Ambers*, 160 Wn.2d at 557-558. Mr. Taylor-Rose has met the prima facie standard by “presenting facts which, if believed, warrant further proceedings.” *Id.*, at 557.

In *Ambers*, the patient sought an unconditional release trial based on treatment-related change. *Id*. He provided an expert opinion that his condition had changed, that the change had been brought about (at least in part) through treatment, and that he no longer met criteria for commitment. *Id.*, at 559. The Supreme Court found that this provided probable cause for a full evidentiary hearing: “Because Dr. Abracen indicated *Ambers* no longer meets the definition of an SVP, and because

he stated that this change was due to treatment, we hold that Ambers made the requisite prima facie showing.” *Id.*

Here, as in *Ambers*, Mr. Taylor-Rose has met his burden. *Id.* As in *Ambers*, Dr. Franklin “indicated [that he] no longer meets the definition of an SVP,” and that “this change [is] due to treatment.” *Id.* This opinion is supported by Dr. Franklin’s review of Mr. Taylor-Rose’s treatment records and her assessment of his treatment progress using a structured instrument designed for that purpose. CP 149-150.

The evidence provides probable cause to believe Mr. Taylor-Rose has “so changed” that he no longer qualifies for commitment. Under RCW 71.09.090(2)(c)(ii), the trial court should have set his case for a hearing.

In keeping with *Ambers*, the Court of Appeals must reverse the trial court’s order and remand the case for trial. *Id.*

C. Dr. Franklin’s report is not a collateral attack on the original commitment order.

The Supreme Court has recognized “that psychiatric medicine is an imprecise science and is subject to differing opinions as to what constitutes mental illness.” *Matter of Det. of Belcher*, 189 Wn.2d 280, 292, 399 P.3d 1179, 1185 (2017). The field is subjective and evolving; these characteristics of the profession “may lead to different diagnoses that are based on the very same symptoms, yet differ only in the name

attached to it.” *In re Meirhofer*, 182 Wn.2d 632, 644, 343 P.3d 731 (2015) (quoting *State v. Klein*, 156 Wn.2d 103, 120–21, 124 P.3d 644 (2005)).

Because of this, “there is no ‘talismanic significance’ to any particular diagnosis.” *Belcher*, 189 Wn.2d at 292 (quoting *In re Det. of Thorell*, 149 Wn.2d 724, 762, 72 P.3d 708 (2003)). Thus, a commitment order based in part on pedophilia is not undermined when State experts later decide insufficient evidence supports that diagnosis.⁸ *Meirhofer*, 182 Wn.2d at 644. The Supreme Court upheld the commitment despite the change in diagnosis: “Without more, the change from a diagnosis of pedophilia to a ‘rule out pedophilia’ and hebephilia diagnosis is not sufficient to require a new evidentiary proceeding.” *Id.*, at 644.

Here, as in *Meirhofer*, Dr. Franklin disagreed with diagnoses presented at the initial commitment trial. CP 134-142. She provided her own alternative clinical impressions of Mr. Taylor-Rose’s mental condition. CP 134-142.⁹ This is not a barrier to his request for a hearing, since he also provided evidence of treatment-based change. CP 150.

⁸ Similarly, an insanity acquittee need not be released when the original diagnosis justifying confinement is replaced with another diagnosis. *Klein*, 156 Wn.2d at 119.

⁹ Specifically, she diagnosed him with Borderline Personality Disorder. CP 108, 140, 145. She also noted his problem with alcohol and drug use. CP 105, 129, 146, 148-150.

Furthermore, a patient is entitled to support her or his petition for trial with evidence of a prior diagnostic error. *See In re Det. of McGary*, 155 Wn. App. 771, 785, 231 P.3d 205 (2010). The *McGary* court upheld RCW 71.09.090(4) against an as-applied due process challenge because the statute “does not prevent [a patient] from introducing evidence of an erroneous paraphilia diagnosis at a show cause hearing; it only prevents a finding of probable cause based *solely* on evidence not constituting a change in mental condition due to continuing participation in treatment.” *Id.* (emphasis added); *see also Det. of Fox v. State, Dep't of Soc. & Health Servs.*, 138 Wn. App. 374, 400, 158 P.3d 69 (2007) (A patient seeking a trial “may present both clinical and actuarial data so long as the SVP's case is not based *solely* on his having grown older, getting married, or undergoing a gender change”) (emphasis in original).

Ambers illustrates this principle. In that case, the patient’s expert based his opinion, in part, on updated actuarial tables. *Ambers*, 160 Wn.2d at 558. The patient would not have qualified for commitment under the revised tables. *Id.* Because of this, the State argued that he had not “demonstrated a change in condition due to *treatment*, as required...” *Id.*

The Supreme Court rejected this argument, finding that the detainee “made the requisite prima facie showing.” *Id.*, at 559. The

Ambers court recognized that the expert outlined treatment-based changes, even though he also pointed out revisions to the actuarial tables. *Id.*

Here, as in *Ambers*, Mr. Taylor-Rose did not ask the court to order a hearing based solely on an erroneous diagnosis. CP 85-157. Instead, he presented evidence of positive treatment-based change. CP 101-157. This evidence obligated the court to set the case for a hearing. *Id.*

The trial judge erroneously suggested that Mr. Taylor-Rose's circumstances were "probably closest to those described in *McCuiston*." CP 23 (citing *McCuiston*, 174 Wn.2d at ____). But evidence of Mr. Taylor-Rose's change through treatment distinguishes his case from *McCuiston*.

In *McCuiston*, the detainee did not present evidence of change through treatment – indeed, he had not even participated in treatment. *McCuiston*, 174 Wn.2d at 375. Instead, the patient sought a hearing based on his expert's opinion "that [the State's] evaluators have not presented any evidence that [a] mental abnormality exists, or has ever existed." *Id.*, at 376.¹⁰ The *McCuiston* court described this opinion as "nothing more

¹⁰ The expert went on to criticize the State's evaluators as engaging in "doublespeak" and described "the entire evaluation process" as "a sham created to fulfill legal and legislative agendas." *Id.*, at 376.

than a collateral attack on the original finding...; it does not demonstrate change.” *Id.*, at 382.¹¹

Here, by contrast, Dr. Franklin’s report does “demonstrate change.” *Id.* Unlike the expert in *McCuiston*, she did not collaterally attack the initial commitment order. Instead, she evaluated Mr. Taylor-Rose’s change through treatment, relying on his treatment records and a structured instrument designed to assess progress in treatment (the SOTIPS). CP 149-150.

Commissioner Bears recognized this. She noted that “Dr. Franklin’s report goes beyond the expert declaration submitted in *McCuiston*.” Ruling Granting Review, p. 11. She described the report as “a hybrid report—one that potentially challenges the original commitment grounds but also has an evaluation of progress in treatment.” Ruling Granting Review, p. 11 (citing *Ambers*).

As in *Ambers*, Dr. Franklin’s report includes a discussion of treatment-based change as well as “new” information. CP 134-142. Like the revised actuarial tables in *Ambers*, Dr. Franklin’s diagnosis (BPD) and

¹¹ See also *In re Det. of Reimer*, 146 Wn. App. 179, 190 P.3d 74 (2008). In *Reimer*, the same expert at issue in *McCuiston* provided a report “criticizing the methods mental health professionals use” and focusing on “the flaws inherent in [the] *initial* diagnoses” rather than any evidence of change through treatment. *Id.*, at 197.

her criticism of the pedophilia diagnosis does not negate her conclusions regarding Mr. Taylor-Rose's progress in treatment. *Ambers*, 160 Wn.2d at 558; AP 50-66 CP 134-150.¹²

According to Dr. Franklin, Mr. Taylor-Rose's positive treatment-based change is sufficiently substantial to require a hearing. CP 150. She does not suggest that he receive a trial because of an erroneous diagnosis. CP 101-157. Instead, she provides her professional opinion that he should have a hearing because he has "so changed through sex offender-specific treatment that he no longer meets the definition of a sexually violent predator." CP 150.

This is all that the statute requires. *Id.* The trial court's order must be reversed and the case remanded for trial. *Id.*

CONCLUSION

For the foregoing reasons the Court of Appeals must reverse the Order on Respondent's Petition for Unconditional Release trial. The case must be remanded for trial.

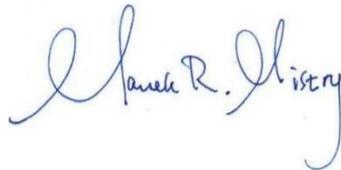
Respectfully submitted on July 19, 2018,

¹² This is so even if Mr. Taylor-Rose would not have been eligible for commitment following review of the recently discovered juvenile records. *See Ambers*, 160 Wn.2d at 558-559.

BACKLUND AND MISTRY

Handwritten signature of Jodi R. Backlund in blue ink.

Jodi R. Backlund, WSBA No. 22917
Attorney for the Appellant

Handwritten signature of Manek R. Mistry in blue ink.

Manek R. Mistry, WSBA No. 22922
Attorney for the Appellant

CERTIFICATE OF SERVICE

I certify that on today's date:

I mailed a copy of Appellant's Opening Brief, postage prepaid, to:

Brian Taylor-Rose
McNeil Island Special Commitment Center
P.O. Box 88600
Steilacoom, WA 98388

With the permission of the recipient(s), I delivered an electronic version of the brief, using the Court's filing portal, to:

Office of the Attorney General
mary.robnett@atg.wa.gov
kristieb@atg.wa.gov
ctjsvpef@atg.wa.gov

I filed the Appellant's Opening Brief electronically with the Court of Appeals, Division II, through the Court's online filing system.

I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF WASHINGTON THAT THE FOREGOING IS TRUE AND CORRECT.

Signed at Olympia, Washington on July 19, 2018.



Jodi R. Backlund, WSBA No. 22917
Attorney for the Appellant

BACKLUND & MISTRY

July 19, 2018 - 11:35 AM

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