

Original

NO. 36538-3-II

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

STATE OF WASHINGTON, Appellant

v.

DAVID BARTON SULLIVAN, Respondent

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COURT OF APPEALS
DIVISION II
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STATE OF WASHINGTON
BY DEPUTY

FROM THE SUPERIOR COURT FOR CLARK COUNTY
THE HONORABLE JOHN F. NICHOLS AND JOHN P. WULLE
CLARK COUNTY SUPERIOR COURT CAUSE NO. 06-1-00816-2

BRIEF OF ~~RESPONDENT~~ *Appellant*

Attorneys for Respondent:

ARTHUR D. CURTIS
Prosecuting Attorney
Clark County, Washington

MICHAEL C. KINNIE, WSBA #7869
Senior Deputy Prosecuting Attorney

Clark County Prosecuting Attorney
1013 Franklin Street
PO Box 5000
Vancouver WA 98666-5000
Telephone (360) 397-2261

TABLE OF CONTENTS

I. ASSIGNMENT OF ERROR..... 1

II. STATEMENT OF THE FACTS1

III. ENTRY OF FINDINGS OF FACT AND CONCLUSIONS OF LAW
19

IV. ARGUMENT.....20

V. CONCLUSION29

TABLE OF AUTHORITIES

Cases

<u>All State Ins. Co. v. Raynor</u>	23
<u>In re detention of Marshall</u> , 122 Wn. App. 132, 146 90 P.3d 1081 (2004)	28
<u>Ortwein v. Commonwealth</u> , 76 Pa. 414, 425 (1874).....	25
RCW 10.77.030 (2)	22
-RCW 9A.12.010.....	22
<u>Sherman v. State</u> , 128 Wn.2d 164, 206, 905 P.2d 355 (1995)	29
<u>State v. Baird</u> , 83 Wn. App. 477, 485, 922 P.2d 157 (1996).....	27
<u>State v. Black</u> , 109 Wn.2d 336, 348, 745 P.2d 12 (1987)	23
<u>State v. Box</u> , 109 Wn.2d 320, 322, 745 P.2d 23 (1987).....	22
<u>State v. Crenshaw</u> , 98 Wn.2d 789, 793, 659 P.2d 488 (1983).....	23
<u>State v. Jones</u> , 59 Wn. App. 744, 749-750, 801 P.2d 263 (1990)	23
<u>State v. McDonald</u> , 89 Wn.2d 256, 272, 571 P.2d 930 (1977)	23, 25
<u>State v. Ortiz</u> , 119 Wn.2d 294, 308, 831 P.2d 1060 (1992)	26
<u>State v. Sommerville</u> , 111 Wn.2d 524, 760 P.2d 932 (1988).....	23
<u>State v. Valdobinos</u> , 122 Wn.2d 270, 279, 858 P.2d 199 (1993).....	26
<u>State v. Wilber</u> , 55 Wn. App. 294, 298, 777 P.2d 36 (1989).....	27
<u>State v. Wineberg</u> , 74 Wn.2d 372, 384, 444 P.2d 787 (1968).....	28
<u>Washington State Physicians Ins. v. Fisons Corp.</u> , 122 Wn.2d 299 (1993)	20

I. ASSIGNMENT OF ERROR

At a sanity hearing, the Judge refused to consider all relevant and probative evidence and specifically refused to recognize testimony of the State's expert witnesses. The trial court abused its discretion by refusing to consider the testimony of four State's experts.

II. STATEMENT OF THE FACTS

a. **Statement of Facts- criminal activity**

The underlying facts that led to this tragic homicide are not in dispute. These facts were laid out in an opening statement by the Prosecutor as follows:

But, in general, on April 20, 2006, I believe the evidence that you're going to hear over the next few days will show that Mr. Sullivan, who had been living at home with his parents for many years developed some very negative feelings toward women in general. As a result of these feelings he apparently made a decision to strike out against a woman ornately representing women in general and the slights he perceived to have received at their hands.....

- - hid the knife as he left the house and then walked a fairly short distance from his parents' home to a more populated or commercial area. Apparently he saw a woman initially who he thought might be a likely candidate for an assault and decided against assaulting her principally because of the presence of her children.

He then went into a McDonald's where he came upon the victim in this matter, Anna Savarski. She was sitting by herself with her back to him. According to the witness statements in the case, he drew a knife, approached her, stabbed her once I believe it was in the upper left back, perhaps nicking up her left arm at the same time.

Due to the length of the knife and the fitness [sic] of Ms. Savarski, the knife penetrated her upper chest wall and lacerated the right lower ventricle of her heart causing massive bleeding occurring almost immediately.

There will be some testimony or at least some evidence that she apparently jumped up and climbed over a low wall in an attempt to escape. Mr. Sullivan - - there would also believe be some degree of evidence that he attempted but failed to stab her a second time. She quickly fell to the floor.

Mr. Sullivan at that point left the McDonald's with knife in hand. He was pursued or at least followed from the McDonald's by a couple of employees. A short distance away he cast the knife, I believe, into a field. These individuals were following him. At least one of them had a cell phone and contacted law enforcement officers. They made contact with him a short distance away.

As Mr. Wear will indicate and as you'll hear, Mr. Sullivan was interrogated by law enforcement officers in custody a short time after the events. He made substantial admissions and also made comments indicating that he understood the wrongfulness of the act that he had committed.

-(RP 18, L. 12- P. 20 L. 17)

b. Statement of Fact- procedural history

By way of Amended Information (CP 15) the defendant was charged with Murder in the First Degree and specifically references a

premeditated intent to cause the death of another person. Aggravators were also alleged in the Amended Information.

The defendant pled not guilty by reason of insanity and this matter was then set for a hearing on the defendant's Motion for Acquittal by Reason of Insanity (CP 92).

The hearing was held on June 19 and June 20, 2007. The Closing Argument and the Oral Opinion of the court were done on June 26, 2007. At that time, the trial court indicated that the evidence presented had overcome the presumption of sanity and he found that the defendant was insane at the time that the event took place. (RP 500). Subsequent to that, the court entered Findings of Fact and Conclusions of Law (CP 171). A copy of the Findings of Fact and Conclusions of Law are attached hereto and by this reference incorporated herein. Also, the court filed a Clarification of Finding of Insanity (CP 177) which further elucidated the courts reasoning as to the finding of insanity. A copy of the Clarification of the Finding of Insanity (CP 177) is attached hereto and by this reference incorporated herein.

c. Statement of Facts- Summary of Witnesses Testimony

At the hearing on the defendant's motion for acquittal by reason of insanity which was held in June 2007, the trial court heard testimony from

the following witnesses: Dr. William Sack, M.D.; Dr. Richard Kolbell; Dr. Julie Gallagher, Ph.D.; Dr. Kenneth Muscatel, Ph.D.; Dr. Brian Waiblinger, M.D.; Dr. Robert Howenstine.

Prior to the commencement of testimony from these experts, the parties agreed that the court could review in advance the reports that had been submitted by the various physicians (RP 4-5). The reports were prepared by Dr. Julie Gallagher, Dr. Kenneth Muscatel, Dr. William Sack, and Dr. Richard Kolbell (CP 60, 93, 17, 45).

Dr. William Sack, M.D. a psychiatrist was the first witness to testify for the defense (RP 24). He testified that he met with the defendant, went over the reports and physiological evaluation, and also spoke with the defendant's father (RP 29- 30). He told the court that the defendant was unable to live independently because of mental illness and that he was mildly retarded with an IQ range of 65-70. (RP 32). He described that the defendant had a major mental disease which he described as "schizophrenic process" (RP 32-33).

Dr. Sack discussed with the court the disordered and delusional thinking process of the defendant. He did acknowledge that it showed some intent but that it was delusional thinking. (RP 36). He gave an opinion to the court (RP 46-52) that the defendant was suffering from a mental disease or defect on April 20, 2006 and that because of his

delusional thinking he was unable to perceive the nature and quality of his acts. Concerning the question of whether or not he was able to tell right from wrong with reference to the act the doctor indicated that was more difficult to discern (RP 48).

As related to intent, he indicated that the evidence indicated that the defendant was trying to hurt someone as opposed to kill someone (RP 50). He also indicated, later, that the intent was part of his delusional thinking process. (RP 54).

On cross examination by the State the doctor did acknowledge that the father of the defendant had told him that the defendant was taking his medications on schedule before the attack on the young girl (RP 60). The doctor acknowledged that the defendant acted with intent (RP 61). He also indicated that there is also some evidence that he acted with a premeditated intent (RP 62). Further, he testified that the defendant knew that he was stabbing a human being with a knife. (RP 67). The defendant also knew that this was a sinister act, that he fled the scene after the event, and that he discarded the knife. (RP 68-69). This indicated to the doctor that it appeared that the defendant understood the wrongfulness of this act (RP 69). He further testified on cross that the defendant intended to hurt a woman with a knife. (RP 70).

Dr. Richard Kolbell, a psychologist, testified for the defense at the hearing (RP 78). He told the court what information he had access to, which included reports and other evaluations, and that he also conducted forensic interviews and testing of the defendant (RP 86-88; 107-109). With regard to the M’Naghten test he indicated that “with respect to words like perceive and nature and quality, those are a bit ambiguous to me” (RP 96, L. 19-20).

The doctor indicated that his diagnosis of the defendant was: “the chief diagnosis is Schizophrenia, chronic undifferentiated type, with prominent paranoid delusions, pervasive developmental disorder and mental retardation, mild.” (RP 103, L. 5-8).

He testified that the defendant was hiding the knife when he was going to the McDonald’s and that “it reflects the intent to cover up the knife.” (RP 117, L. 23). The doctor indicated that he did not agree with Dr. Julie Gallagher’s Western State Hospital report (RP 133-137). Concerning the M’Naghten test he indicated that:

Answer (Dr. Kolbell):my opinion, his ability to perceive the quality of his act, and I define quality as the lethality at the time of the assault, was severely impaired and restricted by his mental disease of schizophrenia and his mental defect of mental retardation.

With respect whether he was able to distinguish right from wrong at the moment of the assault, his ability to

appreciate that distinction between right and wrong was severely impaired as a result of his mental disease and defect.

-(RP 139, L. 11-20).

On cross examination by the State, the doctor did acknowledge that the defendant had shown remorse after the fact and that this showed that “he had done something wrong” (RP 142-143; 153). He further indicated that the evidence showed that the defendant was hiding the knife after the event and that he threw the knife away which could indicate that he understood that this had been a wrongful act (RP 151).

The first expert witness called by the State of Washington was Dr. Julie Gallagher, Ph.D. a clinical psychologist at Western State Hospital (RP 158). She was the primary physician who prepared the Western State Hospital report on the defendant which is dated March 5, 2007 (CP 60). A copy of the doctor’s report of March 5, 2007 is attached hereto and incorporated by this reference.

Dr. Gallagher indicated that the team that prepared the report had evaluated the defendant on four different occasions during the 30 days he was there in the hospital and further that there were six separate periods of forensic interviews lasting about ten hours. She referred to the team as the “sanity commission” (RP 166-167). The doctor was asked what the sanity

commission was looking for during these evaluations and she responded as follows:

Well, we reviewed – or I reviewed all of the records. I discussed things with the sanity commission and when I completed my report, I forwarded it to Dr. Howenstine and Dr. Waiblinger for comments. So I just basically put all the information together into a framework looking at his – whether or not he had any symptoms of mental illness before, during and after the offense, and any data there was to indicate his ability to perceive the nature and quality of his actions, and to understand that what he had done was wrong.

–(RP 168, L. 14-23).

The diagnosis that the sanity commission came up with was basically the same as that which the defense experts had also found (RP 173).

Dr. Gallagher told the court, in summary fashion, what it was that the defendant had told the sanity commission.

Answer (Dr. Gallagher): He was able to kind of take us through that evening and what happened. He described getting the knife, putting it in the bag, leaving the house, walking to McDonalds. He said that he saw a woman getting into a car with some kids at a car dealership and thought about stabbing her and decided not to. He described going into the McDonald's, stabbing the victim and getting arrested. And he described his conversation with the police to some degree.

–(RP 174, L. 13-21).

Prior to the homicide the defendant had written some notes. Those notes were discussed with the doctor:

Question (Deputy Prosecutor): Dr. Gallagher, Dr. Kolbell also felt that the notes that were found were that - - I think you referred to found in Mr. Sullivan's room were not reliable. First of all, can you describe for the Court what notes you're talking about and what the content of them was?

Answer (Dr. Gallagher): The notes were on his dresser, I believe, that's what he told me actually, that he had written them before the offense. He couldn't tell me exactly when, but it was close to the time, it sounded like. And I'd have to look here to give you exactly the text is you want.

Q: That would be fine. You know, if you need

--

A: Or if you have copies.

Q: Pardon?

A: Do you have copies?

Q: I don't have copies of those particular notes in front of me.

A: All right. I have them in that box if we need them, but let me find them. I know one of them said, I'm going to kill somebody, and here it is okay. And the other one said, who, who lives by the sword shall die by the sword, here I come, satan's sword, harmless victims.

Q: Were these different notes that you're referring to?

A: Yes, two different ones.

Q: And just to clarify, you indicated that Mr. Sullivan reflected ownership or at least indicated that he created these notes; is that correct?

A: Yes.

Q: And but you weren't sure about time frame prior to the event; is that accurate?

A: Yeah, he wasn't able to articulate that to us.

Q: Okay. Not to any appreciable degree at all?

A: No.

Q: Okay. Why did you and other members of the sanity commission feel that these notes were reliable information, important to your determination of his sanity at the time of the offense?

A: Well, they were clearly - - at least, one that said I'm going to kill somebody and then he did kill somebody, so that seemed significant. And they did reflect psychosis. I would agree with that. But I had no reason to question their reliability. He took ownership of them and said he had written them.

-(RP 177, L. 6- 178, L. 22).

Dr. Gallagher discussed with the court how it was that the sanity commission formulated an opinion as to the defendant's sanity at the time of the act. She indicated as follows:

Answer (Dr. Gallagher): What we do is look for the - - there has to be a nexus between the symptoms and the inability to perceive the nature and quality or inability to know that it was wrong. So, just because someone is delusional doesn't mean they don't understand what they are doing. There are lots of delusional people who do lots of rational things all day.

Not every behavior is in response to a delusion, even when someone is acutely delusional. So we have to find that connection. If in fact someone is insane, we will find that connection. And so we looked at all the data and tried to see if it was there.

Question (Deputy Prosecutor): OK. And what was your opinion?

A: I couldn't find it. I looked as hard as I could, and I couldn't find it.

-(RP 179, L. 11- 25).

The doctor was again asked to describe what the defendant had told her about the activities that evening. He told the doctor. that he was

angry at women (RP 181, L. 5) and that he did not describe anything that would lead them to believe he had been targeting this victim in particular until he saw her there at the McDonald's. He indicated that he saw the woman at the car dealership and decided that he might hit the kids that were with her, so he didn't want to stab her. He told the doctor the he went into the McDonald's and he looked at different people in the McDonald's and decided not to stab someone else and went for this particular victim. He indicated that he did not know this particular victim. (RP 181).

The doctor indicated that it was the sanity commission's finding and their opinion that he did not fit the M'Naghten test. She indicated that there was evidence that he understood the nature and quality of his acts and that he understood that what he had done was wrong. (RP 183; 201-202; 206).

Dr. Gallagher also talked about the presumption of sanity that they use.

Question (Deputy Prosecutor): Based on
presumption of sanity; is that correct?

Answer (Dr. Gallagher): Basically, yes. There
is a presumption of sanity even when somebody has mental
disease or defect, there is still a presumption of sanity until
we can show the nexus between their thinking and what
happened.

—(RP 208, L. 20-24).

Dr. Gallagher also commented on the report from the defense expert, Dr. Kolbell. She indicated that his opinion had no impact on her opinion and that it appeared that he was starting from a presumption of insanity in his report. (RP 209).

The next expert called by the State of Washington was Dr. Kenneth Muscatel, Ph.D. a forensic and neuropsychologist (RP 286). Dr. Muscatel had been contacted and appointed to help the defense when he saw the defendant on August 30, 2006. He indicated that the defense attorneys had supplied him with all of the necessary records for review. (RP 289). He told the Judge that at the conclusion of his examination of the defendant that he found him to be mentally ill but that there was not sufficient evidence to support a conclusion that he was legally insane at the time of the incident. (RP 291-292). Dr. Muscatel testified that “I found no evidence that he didn’t understand the nature and quality of the act in the sense that he knew it was a knife, he knew he put it in a bag, he took it out of the house, went through the basement and left the house... (RP 293, L. 6-10) He also indicated that it appeared that the defendant understood that what he did was wrong when he indicated that “he said immediately afterwards, he said, oh, my god, what have I done? And then was alarmed by his own behavior and discarded the knife in some bushes. So immediately after the event, he seemed to have - - certainly there was

some evidence in what he's told me that he recognized that he had done something terrible and acted accordingly, both to his get away and expressed both regret and remorse about what he did." (RP 294, L. 22 – 295, L. 5).

As a result of this, the doctor specifically looked at the M'Naghten test and testified as follows:

Answer (Dr. Muscatel): Yeah, I was not able to conclude that he met either one of those prongs of that test. It is part of the nature of the narrowness and the specific nature of the legal insanity definition that somebody this mentally ill would still not be able to meet that test, but that is what I concluded.

–(RP 297, L. 7-12).

The court asked Dr. Muscatel some questions dealing specifically with the tape recording of the defendant's confession. Dr. Muscatel indicated that he had reviewed the interview by the police and that it didn't change his ultimate opinion. In fact, he noted "it actually was very similar to when I interviewed him and I was surprised as how little he really had changed." (RP 325, L. 11-13).

The next expert called by the State of Washington was Dr. Brian Waiblinger, M.D. who is a psychiatrist working at Western State Hospital and was part of the sanity commission (RP 327; 331).

The doctor was asked his opinion concerning whether or not the defendant fit the M'Naghten test for criminal insanity. He indicated that he did not fit the test and went on to describe what factors he was taking into consideration when arriving at this opinion:

Answer (Dr. Waiblinger): That's the initial question. Then - - there's the issue of intent, and that sort of gets mixed into this in a certain degree, but it really doesn't have any bearing on sanity. However, he has documented that he had planned to harm someone, in particular a female. And we have some notes indicating that he wanted to kill someone. And other note - - other times he has said that he only intended to harm someone.

We also have the fact that he went through a process of enacting a plan. I mean, he took a knife. He was able to tell us that he took a knife, hid it, either hid from his father's view or was unfortunate enough to not be seen by his father, and left the house, concealed the weapon on the way to the McDonald's.

When he had discussions with us, he talked about why he didn't pick one particular victim, and felt that he might injure the children that were with this woman. And then came to the McDonald's where he ended up stabbing the woman.

So we have in that that his - - he knew that by having a knife, or the way I formulated it, he had the knife. His intent was to harm someone. The inference is that the knife would harm - - cause harm. That's the nature for the way I was looking at the nature of it is the stabbing, so that that would cause some form of harm.

How much damage that would cause, we don't have really information about what he was thinking at the time. We have information after the fact where he was giving some information to police, and also when he was talking with us, that his concern at the time was that he may have killed her or caused serious bodily harm to her.

So, in that regard he perceived the quality or the potential harm that he did cause to her. And that's how I formulated it in my mind.

And the question of whether it was right from wrong, and part of that goes to what I was talking about earlier in the concealment of the weapon. And some of the reports afterwards indicate, you know, from the Police, indicate that he felt that he had done something wrong and may have seriously hurt this person and that he may - - I don't remember if it was go to hell, or something along those lines. He wasn't going to get into heaven for it. That kind of statement indicating that he had made a mistake.

-(RP 338, L. 12 – 340, L. 7).

The doctor. was asked concerning the presumption of sanity and how that fit into his evaluation of the defendant. He indicated as follows:

Question (Deputy Prosecutor): Dr. Waiblinger, were you starting from the position of a presumption of sanity in this particular - -

Answer (Dr. Waiblinger): Correct.

Q: And in your analysis were you looking both for indications that he was - - or evidence that he would have been either sane or insane at the time?

A: Correct. Yeah, either one.

Q: Did you come across indications that he did not understand the nature or quality or the act?

A: There's no evidence that I saw in his testimony or in the record that would indicate that he didn't understand what he was doing, and understand the nature of it, and the quality of it. In other words, that stabbing someone with a knife would cause harm to them.

Q: And then the same issue in regards to understanding right or wrong in reference to this - - the particular act with which he's charged. Did you come across, or identify specific aspects of evidence in your

database that would reflect that he didn't understand right from wrong at the time he committed the act?

A: During his - - after his arrest, or right around the time of his arrest, he made several statements regarding the wrongfulness of the act. And that would support the conclusion that, at that time, or at a proximal relation to that time, that he understood that it was what he was supposed to do.

There is also the issue of the concealment of the weapon, which would suggest that he understood that it was not appropriate to have a knife with him.

He disposed of the bag in the restaurant. And there's some conflicting reports, if I recall correctly, about whether he left briskly or in a normal fashion, and then disposed of the weapon in the bushes.

The disposing of the weapon would suggest, and leaving the premises would suggest that he understood that something bad had happened, or something wrong had happened.

-(RP 342, L. 7 - 343 L. 18).

The court also asked Dr. Waiblinger some questions concerning the presumption of sanity and it was obvious from the Judge's questioning that the Judge was confused:

Question (The Court): Well, if you fail to draw the inference, then you're stuck with the presumption of insanity -

Answer (Dr. Waiblinger): No.

Question: - right?

Answer: you're stuck with the presumption of sanity.

Question: sanity.

Answer: Not insanity.

-(RP 380, L. 1-7).

The last expert called by the State of Washington was Dr. Robert Howenstine, a clinical physiologist working at Western State Hospital (RP 384).

Dr. Howenstine was asked about whether or not he had an opinion as to whether or not the defendant fit the M’Naghten test. He indicated in his opinion the defendant showed an ability to perceive the nature and quality of the acts at the time of the stabbing (RP 397-398) and that the defendant was able to tell the difference between right and wrong at the time of the acts. (RP 399). Dr. Howenstine also indicated to the court that, concerning the ability to tell right from wrong, the defendant, even with his limited cognitive skills, could still discern the wrongfulness of the act. (RP 401-402).

At the close of all the evidence, the defense moved to strike the opinions of the State’s experts indicating that the opinions rendered had not been appropriately done because they weren’t based on reasonable medical certainty. (RP 419). The court indicated that there had been no objection at the time of the testimony and that he questioned whether or not this issue of admissibility had been waived by the defense because they didn’t raise it at the earlier time. (RP 421, L. 15- 422, L. 5).

The court also was questioning the doctor's starting off with a presumption of sanity. He referred to this presumption as "a bias one way or the other" (RP 424, L. 16).

At the time of closing argument, which was held on June 26, 2007, the court again discussed the concept of the experts starting off with a presumption of sanity.

(The court): My concern is not so much the technicalities involved in that as to the actual testimony given by Dr. Gallagher, and I'm going to pick on her, because her testimony's set up an additional burden of proof. Her testimony, and she was very forthright, and I gave her the opportunity to correct her stance. But, she says, nope, I observed my patient, the defendant in this case. I go in there with an understanding that this person is sane. Presumption is sanity. From that I look for evidence to overcome that presumption and find insanity.

That is not the proper basis for testimony. Her testimony has to be based upon what she observed and what her diagnosis is, not that of a fact finder. A fact finder has to look at this with the presumption aspect of it, and she did not do that. And so it is hard to give a great deal of weight to what she said."

-(RP 489, L. 12- 498, L. 12- 499 L. 2).

In fact, what the Judge ultimately does is reflected in his Clarification of Finding of Insanity (CP 177) where he basically discounts and totally ignores all of the State's experts including Dr. Muscatel who was originally hired by the defense. He indicated as part of number 6 of

his clarification that the testimony of the State's witnesses is fatally flawed. The basis for their testimony is that the defendant is presumed sane and the doctor's then weigh the evidence to reach a legal conclusion. As psychologist/ psychiatrist they are charged with the duty to assess the mental condition without a "bias" toward any legal or presumed conclusion. This is further then refined by his ultimate decision as reflected in number 8 of his clarifications where he indicates that the State's witnesses are being totally disregarded; as the trial court indicates he considers it "the lack of any qualified opposition evidence."

III. ENTRY OF FINDINGS OF FACT AND CONCLUSIONS OF LAW

The trial court filed its Findings of Fact and Conclusions of Law on July 3, 2007 (CP 171). The State takes exception to Finding of fact number 2 which reads as follows:

2. The defendant was legally insane at the time of the commission of the acts alleged in the information and is not legally responsible for said act;
-(Findings of Fact and Conclusions of Law, Finding of Fact number 2, CP 171)

The court also filed a Clarification of Finding of Insanity (CP 177). In that document, the court clarified the rulings and referred to it as an aid

in the drafting of any further orders. The State takes exception to numbers 6, 7 and 8 of the Clarification of Finding of Insanity. Those sections read as follows:

6. The testimony of the State's witnesses is fatally flawed. The basis for their testimony is that defendant is presumed sane and the doctors then weigh the evidence to reach a legal conclusion. As physiologists/psychiatrist they are charged with the duty to assess the mental condition without a bias toward any legal or presumed conclusion.

7. Experts may express their opinion on whether a patient meets the legal definition of sanity but not the ultimate legal conclusion that the presumption has been overcome. While ER 704 allows expert opinion on the ultimate issue of fact, they are not permitted to express an opinion that is a conclusion of law. See, Washington State Physicians Ins. v. Fisons Corp., 122 Wn.2d 299 (1993).

8. Ultimately the finding of insanity was based upon the audio and transcription of the interrogation which took place almost immediately after defendant's arrest; the diagnosis of the experts and the lack of any qualified opposition evidence.

-(Clarification of Finding of Insanity, numbers 6, 7 and 8, CP 177).

IV. ARGUMENT

The State maintains that the Judge refused to consider all relevant and probative evidence and specifically refused to recognize testimony of four State's expert witnesses. By doing so, the State submits, the trial court abused its discretion.

There can be no doubt from the record and documentation that the trial court did not pay any attention to the expert witnesses called by the State of Washington. Three of those experts were from Western State Hospital where the defendant was examined and one of them was an expert originally hired by the defense and conducted his own evaluation of the defendant.

The trial court indicated in some of its comments during the taking of testimony, and at the end of the testimony, that it had major concerns with the experts using a presumption of sanity. He did not consider this to be proper. (RP 498). In fact, he referred to the presumption of sanity as a “bias” (RP 424) and that this was not appropriate for the experts to utilize it in formulating their opinions. In the Clarification of Finding of Insanity document (CP 177) the Judge indicated in number 6 that he considered “the testimony of the State’s witnesses is fatally flawed.” He goes on to indicate that that is because of the presumption of sanity. In his clarification number 7 he refers to this as a Conclusion of Law which experts are not permitted to express an opinion about. Finally, in number 8 of that documentation he refers to the testimony of the State’s witnesses as “the lack of any qualified opposition evidence.”

The State submits that there is absolutely nothing in this record that demonstrates that a sanity presumption invalidates the conclusions of experts or justifies the total rejection of what they had to say.

In the State of Washington, a defendant is presumed to be sane. State v. Box, 109 Wn.2d 320, 322, 745 P.2d 23 (1987). A defendant who asserts an insanity defense must prove by a preponderance of the evidence that he was legally insane at the time of the crime. RCW 10.77.030 (2). To establish an insanity defense, a defendant is required to prove:

(1) At the time of the commission of the offense, as a result of mental disease or defect, the mind of the actor was affected to such an extent that:

(a) He was unable to perceive the nature and quality of the act with which he is charged; or

(b) He was unable to tell right from wrong with reference to the particular act charged.

-RCW 9A.12.010

The legal insanity test is “very rigorous.” All State Ins. Co. v. Raynor, 93 Wn. App. 484, 494, 969 P.2d 510, 975 P.2d 517, 980 P.2d 765 (1999); State v. McDonald, 89 Wn.2d 256, 272, 571 P.2d 930 (1977), overruled on other grounds, State v. Sommerville, 111 Wn.2d 524, 760 P.2d 932 (1988). Sanity is presumed, and legal insanity has “a different

meaning and a different purpose” from medical insanity. State v. Crenshaw, 98 Wn.2d 789, 793, 659 P.2d 488 (1983). Accordingly, “The insanity defense is not available to all who are mentally deficient or deranged.” Crenshaw, 98 Wn.2d at 793. Because a verdict of not guilty by reason of insanity is a complete bar to criminal liability, “the defense is available only to those persons who have lost contact with reality so completely that they are beyond any of the influences of the criminal law.” Crenshaw, 98 Wn.2d at 793. Many, if not most, mentally ill persons would not meet the test for legal insanity. All State, 93 Wn. App at 494; McDonald, 89 Wn.2d at 273.

Under ER 704, “The testimony in the form of an opinion or inferences otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact.” State v. Jones, 59 Wn. App. 744, 749-750, 801 P.2d 263 (1990). While it is true that no witness, lay or expert, may testify as to his opinion as to the guilt of a defendant (State v. Black, 109 Wn.2d 336, 348, 745 P.2d 12 (1987)), that is a far cry from what the experts were doing in our particular case. What our Judge referred to as a “bias” by the State’s experts was in fact an acknowledgement by them of the standards that they use all the time and is the standard for the State of Washington: the defendant is presumed sane and the burden of proving insanity is on the defense. Further, there is

absolutely nothing in the evidence to support a contention that this “bias” prevented the experts from arriving at an informed opinion relied on in their scientific communities. It is interesting to note that all of the experts that testified in this case arrived at the same conclusion as to the nature of the underlying mental problems of the defendant. No one was disputing that he suffered from a mental disease or defect at the time of the killing. What was discussed with the Judge, in some detail, was the M’Naghten test for insanity which is codified at RCW 9A.12.010. It was obvious that all the experts, both defense and State, were starting with the concept that the defense had to prove insanity in line with the M’Naghten test. The fact that the experts start with a presumption of sanity does not in any way prevent them from arriving at conclusions and opinions based on what they observed with this defendant. It does not establish a “bias” by experts which totally eradicates and destroys any credibility they may have to the extent that a Judge arbitrarily ignores anything they have to say. But that is exactly what the Judge did in our case. He determined that, because they started with a presumption of sanity, that therefore, their entire testimony was of no value to him and he disregarded all of it. Thus, when he discusses in the clarification of findings of insanity that the State did not produce any “qualified opposition evidence” he is obviously

disregarding all of the testimony from four experts. As stated in State v. McDonald, 89 Wn.2d 256, 271, 571 P.2d 930 (1977):

The presumption of a sanity is as old as the common law and well established in this and every other State. (cites omitted). It is a presumption grounded in common experience and in our society's most basic traditions of free will and personal responsibility. Further, insanity is an affirmative defense in this State for the defendant to plead and prove by a preponderance. This was established before we were a State. (cite omitted). The jury must have more than a reasonable doubt as to a defendant's sanity in order to acquit him. (cite omitted). The requirement has continued to be affirmed by this court (cite omitted) and now it is codified in RCW 9A.12.010 and 10.77.030. As stated by the Pennsylvania Supreme Court, "merely doubtful evidence of insanity would fill the land with acquitted criminals." Ortwein v. Commonwealth, 76 Pa. 414, 425 (1874).

We do not think this requirement of proof in any way emasculates the requirement that the prosecution prove every element of the crime beyond a reasonable doubt. Sanity is not in itself such an element."

-(McDonald, 89 Wn.2d at 271).

The State submits that the actions of the Judge were completely arbitrary and an abuse of his discretion.

The trial courts decision to admit opinion testimony is reviewed for abuse of discretion. State v. Ortiz, 119 Wn.2d 294, 308, 831 P.2d 1060 (1992). A court abuses it's discretion when it bases a decision on untenable grounds or exercises discretion in a manner that is manifestly unreasonable. State v. Valdobinos, 122 Wn.2d 270, 279, 858 P.2d 199

(1993). When considering the admissibility of testimony under ER 702, the appellate court engages in a two part inquiry: (1) does the witness qualify as an expert; and (2) would the witness' testimony be helpful to the trier of fact. Ortiz, 119 Wn.2d at 309.

There is no question but that the four State's experts qualified as experts to testify in a very scientific and detailed discussion of the mental issues and difficulties faced by this defendant. No one at the time of the hearing disputed their credentials or questioned their ability to arrive at a conclusion. Further, this question of the presumption of sanity was not raised by the defense. This was an issue solely raised by the trial court in some of the questioning. In fact, there was concern voiced by the State's experts that one of the defense experts appeared to be starting from a presumption of insanity. As the record demonstrates and was set forth in the Statement of Facts earlier in this brief, the Judge became confused as to what presumption was supposed to be used. Clearly this was something he had never dealt with before. (RP 380, L. 1-7).

An expert opinion addressing an ultimate factual issue is admissible if the opinion is relevant and based on inferences (presumption of sanity) from the physical evidence and the expert's experience. ER 704; State v. Baird, 83 Wn. App. 477, 485, 922 P.2d 157 (1996). That an opinion encompassing ultimate factual issues supports the conclusion that

the defendant is guilty does not make the testimony improper: “it is the very fact that such opinions imply that the defendant is guilty which makes the evidence relevant and material.” State v. Wilber, 55 Wn. App. 294, 298, 777 P.2d 36 (1989).

Concerning the second prong of the test (would the witness’ testimony be helpful to the trier of fact) it is obvious that the mental condition and the M’Naghten test that needed to be applied was an area that required expert testimony. Further, it is obvious that this particular Judge had no experience dealing with this particular subject matter. The testimony from the experts would undoubtedly have been helpful to him. But he considered that the State’s experts were bias and therefore totally disregarded anything they had to say. He did this because he felt that the presumption of sanity was not proper for experts to utilize. (RP 498).

Another way of approaching the same question is found in ER 703 which permits experts to base their opinion testimony on facts or data that is not admissible in evidence if it is of a type reasonably relied upon by experts in a particular field in forming opinions or inferences upon the subject.

The otherwise inadmissible facts or data in an experts’ opinion is admissible for the limited purpose of explaining the basis for the experts opinion but it’s not substantive evidence. In re detention of Marshall, 122 Wn. App. 132, 146 90 P.3d 1081 (2004), affirmed, 156 Wn.2d 150, 125

P.3d 111 (2005). In this regard, then, the trial court may allow the admission of otherwise hearsay evidence and inadmissible facts for the purpose of showing the basis of the experts' opinion. State v. Wineberg, 74 Wn.2d 372, 384, 444 P.2d 787 (1968). This explanation by the expert merely discloses the basis of his opinion in substantially the same manner as if he had answered a hypothetical question. It is an illustration of the kind of evidence which can serve multiple purposes and is admitted for a single, limited purpose only. In other words, the Judge had the ability in our case to utilize this to help elucidate the issues concerning legal insanity. He chose to totally disregard this particular rule of evidence and rather than trying to use a presumption of sanity for a limited purpose he discerned that it was a "bias" and therefore chose to disregard the testimony of four experts in total.

Finally, the State submits that if this matter were to be returned to the trial court level for consideration of the testimony by the State's experts or for further proceedings along those lines, that this Judge be replaced by another Superior Court Judge in Clark County. A Judge should disqualify himself from proceedings in which his impartiality might reasonably be questioned." CJC 3 (D)(1). Whether a Judge's impartiality might reasonably be questioned depends on whether a reasonable person with knowledge of the relevant facts would conclude

that all parties obtained a fair, impartial, and neutral hearing. Sherman v. State, 128 Wn.2d 164, 206, 905 P.2d 355 (1995). The State submits that it is difficult to ascertain from this record that the State would receive a fair, impartial, neutral hearing if this matter were returned to the trial court level.

V. CONCLUSION

The State submits that the trial court has abused its discretion in this matter and that it should be returned to the Superior Court for either re-hearing or re-consideration by another Judge. The actions of the trial Judge were arbitrary and capricious and the record does not support his decision.

DATED this 28 day of March, 2008.

Respectfully submitted:

ARTHUR D. CURTIS
Prosecuting Attorney
Clark County, Washington

By:


MICHAEL C. KINNIE, WSBA#7869
Senior Deputy Prosecuting Attorney

APPENDIX "A"

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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JUL 03 2007

Sherry W. Parker, Clerk, Clark Co.

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IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF CLARK

STATE OF WASHINGTON,)	
)	NO. 06-1-00816-2
Plaintiff,)	
)	
vs.)	
)	FINDINGS OF FACT AND
DAVID BARTON SULLIVAN,)	CONCLUSIONS OF LAW
)	
Defendant.)	

This matter have come before the undersigned Judge of the above-entitled Court on the 26th day of June, 2007, for a hearing on Defendant's Motion for Acquittal by Reason of Insanity, the Plaintiff being represented by his attorney, Gerald L. Wear, the Court having heard the testimony of Dr. William Sack, M.D., Richard Kolbell, Ph.D., Dr. Kenneth Muscatel, Ph.D., Dr. Julie Gallagher, Phs.D., and Dr. Brian Waiblinger, M.D., and being otherwise fully advised in the premises, now, therefore, makes the following:

FINDINGS OF FACT

1. The Defendant committed the acts alleged in the Information;

FINDINGS OF FACT AND
CONCLUSIONS OF LAW - PAGE 1

Gerald L. Wear
Attorney At Law
P.O. Box 185
Vancouver, Washington 98666
(360) 699-0640

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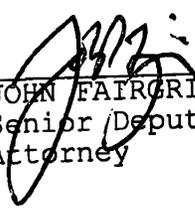
1 DONE IN OPEN COURT this 31st day of July, 2007.

2
3 
4 JUDGE JOHN NICHOLS

5 Presented by:

6 
7 GERALD L. WEAR, WSBA #6315
8 Attorney for Defendant

9 Copy received and approved
10 for entry

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12 JOHN FAIRGRIEVE
13 Senior Deputy Prosecuting
14 Attorney

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FINDINGS OF FACT AND
CONCLUSIONS OF LAW - PAGE 3

Gerald L. Wear
Attorney At Law
P.O. Box 185
Vancouver, Washington 98666
(360) 699-0640

APPENDIX "B"

CLARIFICATION OF FINDING OF INSANITY

2.

FILED

JUL 24 2007

Sherry W. Parker, Clerk, Clark Co.

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON

IN AND FOR THE COUNTY OF CLARK

STATE OF WASHINGTON,)
)
Plaintiff,)
)
)
vs.)
)
DAVID BARTON SULLIVAN)
)
Defendant.)

NO. 06-1-00816-2

**CLARIFICATION OF
FINDING OF INSANITY**

Counsel has requested that the court set forth the bases for the finding of insanity and the rulings on the objections to the state's experts. Thus as further clarification of the court's decision, the following Findings and Conclusions should aid in the drafting of any further Orders.

1. Dr. Sack testified that the defendant suffered from both a mental disease and defect. That as a result of this condition, he was certain that at the time of the murder the defendant was unable to perceive the nature and quality of the act. The doctor was less certain that Sullivan could distinguish right from wrong.

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2. Dr. Kolbell concurred with Dr. Sack as to mental disease and defect but felt that the defendant was impaired as to both the nature and quality and the right from wrong standards. Dr. Kolbell did express some confusion as the distinction of moral wrongness from legal wrong.
3. The State's experts agreed that the defendant suffered from a mental disease and defect but they concluded that there was not enough evidence to overcome the presumption of sanity.
4. The State's experts when voicing their opinions did not phrase their testimony as to a reasonable medical certainty or as to a more probable than not basis. After the State rested the defendant moved to strike this testimony.
5. While defendant's motion is well taken it is not determinative of the court's conclusion. Consequently, the admission of this evidence, even if in error, would be harmless.
6. The testimony of the State's witnesses is fatally flawed. The bases for their testimony is that defendant is presumed sane and the doctors then weigh the evidence to reach a legal conclusion. As physiologists/psychiatrist they are charged with the duty to assess the mental condition without a bias toward any legal or presumed conclusion.
7. Experts may express their opinion on whether a patient meets the legal definition of sanity but not the ultimate legal conclusion that the presumption has been overcome. While ER 704 allows expert opinion on the ultimate issue of fact, they are not permitted to express an opinion that is a conclusion of law. See, *Washington State Physicians Ins. v. Fisons Corp.*, 122 Wn.2d 299 (1993).
8. Ultimately the finding of insanity was based upon the audio and transcription of the interrogation which took place almost immediately after defendant's arrest; the diagnosis of the experts and the lack of any qualified opposition evidence.

Dated this 23 day of July, 2007.


John F. Nichols – Judge Clark County Superior Court

APPENDIX "C"

**WESTERN STATE HOSPITAL
FORENSIC PSYCHOLOGICAL REPORT**



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
WESTERN STATE HOSPITAL
W27-19 • 9601 Steilacoom Blvd SW • Tacoma WA 98498-7213 • (253) 582-8900

MARCH 5, 2007

FORENSIC PSYCHOLOGICAL REPORT

**RE: STATE OF WASHINGTON
vs.
DAVID BARTON SULLIVAN**

**CAUSE NO: 06-1-00816-2
WSH NO: 384052
DOB: 07/16/1977**

The forensic evaluation reflected in this report was conducted pursuant to court order under the authority of RCW 10.77.060. This report was released only to the court, its officers and to others designated in statute and is intended for their use only. Any other use or distribution of this document is not authorized by the undersigned.

NATURE OF EXAMINATION

Reason for Referral

David Barton Sullivan is charged with Murder in the First Degree in Clark County for the murder of Anna Svidersky on April 20, 2006. Pursuant to a Clark County Superior Court order dated September 22, 2006, Mr. Sullivan was committed to Western State Hospital for an evaluation to aid the Court in determining whether the defendant was sane at the time of the acts charged and whether the defendant had the capacity to have the particular state of mind which is an element of the offense charged. As is mandated by RCW 10.77.060, this report will also address the defendant's mental condition, dangerousness to others, likelihood of committing further criminal acts, and any further need for evaluation under RCW 71.05.

Mr. Sullivan's competency to stand trial in this case was previously evaluated by the undersigned in July of 2006. Mr. Sullivan is a client of the Division of Developmental Disabilities and has a longstanding history of Schizophrenia, among many other diagnoses. At that time it was my opinion that Mr. Sullivan's symptoms of mental illness were adequately controlled by medication and did not appear to interfere with his capacity to understand the nature of the proceedings against him or to assist in his own defense. He was subsequently found competent to stand trial.



**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 2 OF 26****Sources of Information**

Mr. Sullivan was re-admitted to the Center for Forensic Services at Western State Hospital on October 18, 2006. He was placed on Ward F5 to undergo psychological, psychiatric, psychosocial, and physical examinations, including 24-hour clinical observations. Brian Waiblinger, M.D., Staff Psychiatrist, and Julie A. Gallagher, Psy.D., Staff Psychologist, comprised the sanity commission. Robert Howenstine, Ph.D., Staff Psychologist and Developmental Disabilities Professional, also participated in this evaluation. This comprehensive evaluation was completed by the undersigned, taking into consideration all of the assessments, consultations, and findings of the entire evaluation team. In addition to reviewing these records, observing the defendant, and consulting with the treatment team, the following information was reviewed and considered in the preparation of this report:

1. Forensic Interviews of the defendant on:
 - 1) July 12, 2006 for approximately 55 minutes
 - 2) July 20, 2006 for approximately 1 hour and 20 minutes
 - 3) October 18, 2006 for approximately 20 minutes
 - 4) November 1, 2006 for approximately 5 hours
 - 5) November 6, 2006 for approximately 2 hours
 - 6) November 14, 2006 for approximately 15 minutes
2. Telephone Interview of Division of Developmental Disabilities case manager, Rob Henrikson, on July 28, 2006
3. Telephone Interview of defense counsel, Thomas Ladouceur, on July 12, 2006
4. Electronic Communication with prosecutor, John Fairgrieve, on July 12, 2006
5. Medical Records, Western State Hospital, Tacoma, Washington, dated:
 - 1) October 18, 2006 – November 15, 2006
 - 2) July 12, 2006 – July 25, 2006
 - 3) January 9, 2002 – November 1, 2002
 - 4) August 23, 1999 – December 24, 1999
 - 5) June 9, 1999 – July 27, 1999
6. Mental Health Records, Clark County Jail, Vancouver, Washington, dated January 29, 2003 through June 16, 2006
7. Medical Records, Kaiser Permanente, Vancouver Medical Office, Vancouver, Washington, dated February 26, 2001 through December 7, 2005
8. Letter from Trish Sowards, Ph.D., to David S. Kurtz, J.D., dated January 8, 2003
9. Forensic Psychological Report by Trish Sowards, Ph.D., Western State Hospital's Inpatient Forensic Evaluation Program, dated November 6, 2002
10. Forensic Psychological Evaluation by Trish Sowards, Ph.D., Western State Hospital's Inpatient Forensic Evaluation Program, dated September 16, 2002

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 3 OF 26**

11. Forensic Psychological Evaluation by Janet Schaeffer, Ph.D., Western State Hospital's Inpatient Forensic Evaluation Program, dated April 23, 2002
12. Forensic Mental Health Evaluation by Thomas M. Danner, Ph.D., Western State Hospital's Inpatient Forensic Evaluation Program, dated January 29, 2002
13. Psychological Assessment by C. Kirk Johnson, Ph.D., Certified Sex Offender Specialist, dated January 15, 2002
14. Medical Records, Southwest Washington Medical Center, Vancouver, Washington, dated December 12 - 17, 1997 and October 22, 2001
15. Medical Records, Vancouver Memorial Hospital, Vancouver, Washington, dated September 15, 2001 through November 5, 2001
16. Medical Records, Columbia River Mental Health Services, Vancouver, Washington, dated May 9, 2000 through March 7, 2001
17. Psychosexual Evaluation by Jon E. Ingram, Ph.D., Therapeutic Strategies, Incorporated, Vancouver, Washington, dated February 15, 2000
18. Forensic Psychological Evaluation by R. Murray Hart, Ph.D., Western State Hospital's Inpatient Forensic Evaluation Program, dated December 2, 1999
19. Psychological Evaluation for Legal Competency by Susan W. Horton, Ph.D., Clinical Psychologist and Developmental Disabilities Professional, dated July 23, 1999
20. Forensic Psychological Evaluation by R. Murray Hart, Ph.D., Western State Hospital's Inpatient Forensic Evaluation Program, dated July 1, 1999
21. Discovery documents provided by the State
22. Mental Health Division Intranet Database
23. DSHS Division of Developmental Disabilities Client Records
24. Washington State Patrol WATCH criminal history record
25. National Crime Information Center (NCIC) Database of Criminal Justice Information

Notification

Prior to each interview, the defendant was informed of the non-confidential nature of the evaluation, the purpose of the evaluation, and the parties who would receive a copy of the forensic report. He was also informed that he had a right to have his attorney present and that he could decline to answer questions. Mr. Sullivan indicated that he understood this notification and agreed to participate in the evaluation. Mr. Sullivan waived his right to have his attorney present for the evaluation but his attorney, Thomas Ladouceur, indicated that he wished to be present for the interviews assessing mental state at the time of the offense. Mr. Ladouceur was present in person or by telephone for all such interviews.

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 4 OF 26****DIAGNOSTIC INFORMATION****Relevant Clinical History**

The following account is based in part on the defendant's self-report and is thus limited by the credibility of the defendant. Where available, collateral information was utilized to supplement his self-report.

Records indicated that Mr. Sullivan was born in Portland, Oregon, the product of a full-term and uncomplicated pregnancy and delivery. He was raised in Vancouver, Washington by his married parents. According to the available records, he reached his developmental milestones within the normal range. Mr. Sullivan reported that when he was six or eight years old he was sexually abused by a female neighbor who was "a little older than him." He reported that he was angry at her "for awhile but I got over it."

Mr. Sullivan graduated from Vancouver High School in 1997 at the age of 20. Records indicated that he was enrolled in special education classes for a learning disability and behavioral problems. He is a client of the Division of Developmental Disabilities. According to his case manager, in 1992 he was tested with the Wechsler Intelligence Scale for Children – Revised and his Full Scale IQ was 68. His Verbal IQ was 73 and his Performance IQ was 67. He was diagnosed with Mild Mental Retardation.

Mr. Sullivan has not held a job for longer than one day. He stated that he receives Social Security entitlements for his mental disability. According to Mr. Sullivan, he has lived with his parents his entire life.

Substance Abuse History

Records indicated that in the past Mr. Sullivan has admitted to using alcohol, marijuana, cocaine, hallucinogenic mushrooms, and methamphetamine. During the current evaluation, he admitted to drinking one bottle of tequila all at once approximately once a year. He stated that he smoked marijuana from age 16 to age 19 and tried methamphetamines on three occasions. He was unclear whether he had ever been enrolled in drug treatment, although his father previously reported that he was in drug rehabilitation in 1995. Criminal history did indicate a charge of Violation of the Uniform Controlled Substance Act on February 7, 1995 that resulted in diversion.

Pre-Offense Psychiatric History

Records indicated that Mr. Sullivan demonstrated delays in socialization skills and performance tasks upon entering kindergarten. As described by a previous evaluator

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 5 OF 26**

who interviewed his mother, "within a few months of beginning school family members noted dramatic changes in behavior. Behaviors included grimacing and muttering to himself. Mr. Sullivan then became mute and withdrawn, evidencing little interest in family members and activities he formerly enjoyed. According to his mother he only engaged in solitary and repetitive behaviors, such as bouncing a ball and playing with on [sic] top. He was never very affectionate, and during the period of his withdrawal he continued to be non-affectionate." Other records also indicated that Mr. Sullivan's father reported to a previous evaluator that between the ages of five and six Mr. Sullivan engaged in headbanging and demonstrated unusual hand movements. Still other records indicated that this began when he was three years old. According to his father, he was seen at the Oregon Health Sciences University and diagnosed with a chemical imbalance. According to the records, he was subsequently diagnosed with a Pervasive Developmental Disorder with Psychotic Features.¹ Other records indicated that Mr. Sullivan's father reported to a previous treatment provider that between the ages of six and eight Mr. Sullivan was diagnosed with prodromal schizophrenia and started on Haldol, an antipsychotic medication, but it was discontinued due to side effects.

Mr. Sullivan reported to a previous evaluator that his first psychiatric hospitalization was at Vancouver Memorial Hospital after a suicide attempt. Records indicated a hospitalization at age 20 from December 12 to 17, 1997 at Southwest Washington Medical Center after he was found wandering on the Interstate 5 bridge and reported thoughts of jumping off the bridge to commit suicide. He was described as "psychotic and disorganized" at intake. He reported auditory hallucinations and these decreased with treatment with Navane, an antipsychotic medication. Discharge diagnoses were Psychosis Not Otherwise Specified and developmental disability.

Mr. Sullivan was first admitted to Western State Hospital on June 9, 1999 for a 15-day forensic evaluation in reference to charges of Unlawful Imprisonment with Sexual Motivation. Signs of mental illness that were observed included odd posturing of his hands and forearms, poor personal hygiene, guardedness, anxious affect, thought blocking, thought derailment, and loose associations. He was observed responding to internal stimuli and admitted to such. He also admitted to ideas of reference, ideas of thought insertion and withdrawal, and mind reading. Paranoid and somatic delusional activity was noted. Mr. Sullivan was diagnosed with Psychosis Not Otherwise Specified

¹ Most records listed the age at diagnosis as six years old but one (Horton, 1999) stated that he was diagnosed in December of 1993, when he would have been 16 years old. Original records documenting this diagnosis were not available as of this writing.

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 6 OF 26**

and Polysubstance Abuse by history. It was noted that Schizophrenia, Chronic, Undifferentiated Type could not be ruled out. He was prescribed Zyprexa, an antipsychotic medication, and Valium, an antianxiety medication, but refused treatment.

Mr. Sullivan's competency to stand trial was evaluated at the end of that hospitalization by R. Murray Hart, Ph.D., at Western State Hospital. Dr. Hart diagnosed Mr. Sullivan with Psychotic Disorder Not Otherwise Specified and Polysubstance Abuse by history. He noted that Schizophrenia could not be ruled out. Dr. Hart documented that Mr. Sullivan demonstrated an understanding of his charges, memory for the events in question, and a basic understanding of guilty and not guilty pleas. He also knew that he was represented by an attorney and demonstrated "a crude understanding of his legal jeopardy." It was the opinion of Dr. Hart that Mr. Sullivan's "signs and symptoms of mental disorder are not of such proportion as to grossly compromise his mental faculties, and thus amount to a mental disease or defect." He opined further that Mr. Sullivan possessed the basic and fundamental capacity to understand the nature of the charge against him and to rationally participate in his own defense.

Mr. Sullivan's competency to stand trial was subsequently evaluated by defense-retained psychologist, Susan W. Horton, Ph.D., in July of 1999. Dr. Horton diagnosed Mr. Sullivan with Major Depressive Disorder, Recurrent, Severe with Psychotic Features and Borderline Intellectual Functioning. She also indicated that she believed that he suffered from Tourette's syndrome. She stated that she did not find a diagnosis of Schizophrenia to be appropriate. Dr. Horton indicated that Mr. Sullivan understood the roles of the professionals present in the courtroom. She stated that he appeared to understand the adversarial nature of the legal process and knew what he was charged with. She noted that he did not understand the range of possible penalties in his case at that time and she expressed concern about his ability to work with his attorney in his defense. Her concerns appeared to focus on his apparent difficulty understanding the consequences of his decisions. She also expressed concern about his capacity to testify relevantly at that time due to his susceptibility to intrusive thoughts.

Mr. Sullivan was subsequently found incompetent to stand trial and admitted to Western State Hospital on August 23, 1999 for 90 days of court-ordered competency restoration. He appeared to have decompensated while incarcerated, appearing more confused and paranoid. He also endorsed symptoms of depression. He was treated with Zyprexa and Valium, and Prozac, an antidepressant medication, was added. His response to treatment was described as "gradual and somewhat incomplete." Residual symptoms included self-isolation, poor hygiene, flat affect, and dysthymic mood. His diagnosis at discharge was Psychotic Disorder Not Otherwise Specified.

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 7 OF 26**

At the conclusion of that 90-day period of competency restoration treatment, Mr. Sullivan was re-evaluated by Dr. Hart. At that time, Dr. Hart diagnosed Mr. Sullivan with Psychotic Disorder Not Otherwise Specified, in Substantial Remission; Depressive Disorder Not Otherwise Specified; and Learning Disorder by history. Dr. Hart documented that Mr. Sullivan demonstrated an awareness of the nature and content of his charges, the roles of the various professionals involved in the legal system, and the adversarial nature of the legal system. He demonstrated an understanding of the purpose of legal proceedings, the pleas available to him, and his legal jeopardy. It was the opinion of Dr. Hart that at that point in time Mr. Sullivan's "mental disorder is sufficiently well controlled by psychotropic medications that he does not have a mental disease or defect, and as before, I see no reason why he would not meet the statutory test of legal competency." Criminal history records indicated that Mr. Sullivan was subsequently found guilty of Assault in the Fourth Degree and sentenced to 365 days in jail per count, with 462 days suspended.²

On February 15, 2000, Mr. Sullivan underwent a Special Sex Offender Sentencing Alternative Evaluation at the Clark County Jail. That evaluation was completed by Jon E. Ingram, Ph.D. Dr. Ingram observed poor hygiene, unusual body movements, poor eye contact, somatic complaints, and disordered thinking. Dr. Ingram documented Mr. Sullivan's self-reported sexual history. He noted that at that time Mr. Sullivan denied ever being the victim of sexual abuse. Mr. Sullivan reported to Dr. Ingram that his first sexual activity occurred when he was 14 years old and involved touching a female cousin four or five years his junior through her clothes, rubbing against her, and masturbating in front of her. He also admitted to having put his finger in his brother's "intestinal tract" when he was ten years old. Mr. Sullivan also related that after age 20 he began going into girls' locker rooms and restrooms and exposing himself and masturbating in front of the girls and women inside. It was the opinion of Dr. Ingram that Mr. Sullivan obtained significant gratification from seeing the fear that he induced in these women.

Mr. Sullivan reported to Dr. Ingram that he sexually fantasized about girls who are eight years old. At that time he reported frequenting a local gymnastics club where he watched young girls and masturbated. He also reported taking pictures of young girls in the community without their knowledge and then masturbating while looking at them. Mr. Sullivan indicated that he believed that it was wrong to have sex with young

² Criminal history records were not completely clear on this, but there was some indication that there may have been more than one charge.

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 8 OF 26**

girls but was unable to explain why it was wrong. Dr. Ingram administered the Sexual Information Scale and concluded that,

Mr. Sullivan has many significant cognitive errors regarding sexual behavior. He seriously minimizes the effect of sexual assault upon children and women; he in part blames victims, including children, for offenses which happen to them; he fails to differentiate legal and appropriate sexual behaviors from illegal and inappropriate behaviors; and he possesses a low degree of knowledge about appropriate and acceptable interpersonal sexual behaviors. On an affective level, Mr. Sullivan demonstrates no empathy and compassion for victims of sexual offending; in fact, he appears to gain some satisfaction or pleasure from the pained reactions of victims of sexual abuse. This pleasure may be sexually arousing to him.

Dr. Ingram diagnosed Mr. Sullivan with Pedophilia, Sexual Attraction to Females, as well as Psychotic Disorder Not Otherwise Specified, and Exhibitionism. He noted that Alcohol Abuse, Cannabis Abuse, and low intellectual functioning could not be ruled out. Dr. Ingram concluded that,

He has shown a clear progression from fairly innocuous actions to serious actions in which he confronted and offended against a very vulnerable victim. Research suggests that such progressions may continue to acts of even more serious personal victimization. Factors which are suggested by research to reduce risk of reoffense are absent in Mr. Sullivan...These factors indicate that his propensity for continued offending is high and that his offending would likely become more serious and intrusive over time.

Regarding dangerousness, Mr. Sullivan poses a significant threat to the safety and welfare of young females as well as women. Of great concern is his disregard for personal safety of others and himself, and his pleasure derived from terrifying and perhaps hurting victims. It is concluded that in his current mental condition and state of untreated sexual deviancy, he presents a substantial threat to community safety.

Dr. Ingram concluded that Mr. Sullivan was untreatable in the community and should be evaluated for civil commitment. None of the available records addressed that recommendation. Mr. Sullivan reported that he received court-mandated treatment

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 9 OF 26**

from Scott Senn, Psy.D., a certified sex offender treatment provider. Attempts to obtain records of that treatment were unsuccessful.

Records indicated that Mr. Sullivan's parole officer subsequently referred him to Columbia River Mental Health Services for outpatient services and vocational assistance. He was first seen there on May 9, 2000. He was diagnosed with Major Depressive Disorder, Recurrent, Mild; Dysthymic Disorder; and Borderline Intellectual Functioning.

Records from Kaiser Permanente indicated that Mr. Sullivan was seen on a weekly basis from September through October of 2001. His mental state appeared to fluctuate significantly during that time. Somatic delusions were documented and there was concern about the possible presence of depression and/or anxiety. His diagnosis was listed as Psychotic Disorder Not Otherwise Specified and he was prescribed the antipsychotic medication Zyprexa. According to the records, in mid-October he began sticking his finger down his throat and stopped taking his Zyprexa. He was switched to another antipsychotic medication, Risperdal.

According to the available records, soon thereafter, on October 22, 2001, Mr. Sullivan was hospitalized at Southwest Washington Medical Center on the basis of grave disability. He presented in the emergency room with complaints that he was infected with anthrax or E. coli. He was described as disorganized and guarded with long latencies and inappropriate sexual comments. He admitted that he had not been taking his medication recently. It was thought that he was experiencing somatic delusions and he was diagnosed with Chronic Paranoid Schizophrenia. He was put back on Zyprexa. Mr. Sullivan was committed to the hospital for 14 days, showed some improvement, and then was released on a 90-day Least Restrictive Alternative (LRA). After his release, Mr. Sullivan was again seen on an outpatient basis at Kaiser Permanente.

Mr. Sullivan was next admitted to Western State Hospital on January 9, 2002 for a 15-day forensic evaluation in reference to a charge of Attempted Kidnapping in the First Degree. This charge stemmed from an incident that occurred on September 19, 2001, when Mr. Sullivan grabbed a 12-year-old girl at a gymnastics club and massaged her arm for six to eight seconds. He then fled. When interviewed by the police, Mr. Sullivan admitted to being sexually aroused during that incident.

Thomas Danner, Ph.D., completed the competency evaluation. Dr. Danner diagnosed Mr. Sullivan with Schizophrenia, Undifferentiated Type, Continuous; Depressive Disorder Not Otherwise Specified; Learning Disorder by History; and Polysubstance Abuse by History. He also noted that Pedophilia, Sexually Attracted to Females could not be ruled

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 10 OF 26**

out. Dr. Danner stated that Mr. Sullivan was aware of the various individuals in the courtroom and their roles. However, he did not know what he was charged with. It was the opinion of Dr. Danner that due to Mr. Sullivan's "difficulty with mental organization, thought derailment, and an inability to clearly focus upon the offense with which he is charged," Mr. Sullivan lacked the capacity to assist in his own defense at that time.

On January 15, 2002, Mr. Sullivan was evaluated at the Clark County Jail by C. Kirk Johnson, Ph.D., Certified Sex Offender Specialist, at the request of his defense attorney. It was the impression of Dr. Johnson that Mr. Sullivan was attempting to minimize the seriousness of his symptoms. Dr. Johnson noted latency in responding, unusual hand movements, blunted affect, diminished attention and concentration, as well as tangential and bizarre speech. He diagnosed Mr. Sullivan with Schizophrenia, Undifferentiated or Paranoid Type and noted that "there may also be a diagnosis of Pedophilia." However, he also noted that Mr. Sullivan was able to discuss the charges against him in a coherent manner. He also observed that Mr. Sullivan appeared to understand the consequences of being found guilty, of being found incompetent, and of being found not guilty by reason of insanity. Dr. Johnson also administered the McArthur Competence Assessment Tool – Criminal Adjudication. Based on the results of that assessment tool, Dr. Johnson concluded that Mr. Sullivan had "substantial deficits in his ability to assist counsel and to reason coherently regarding his legal circumstances. He does appear to have at least a basic understanding of legal concepts and roles."

Mr. Sullivan was subsequently found incompetent to stand trial and returned to Western State Hospital on January 23, 2002 for 90 days of court-ordered competency restoration. Prominent symptoms included anxious affect, poor hygiene, disorganized thoughts, thought derailment, loose associations, and paranoia. Also noted were self-induced vomiting and unusual posturing. He also made sexually inappropriate comments to staff members. Various medications were tried including the antipsychotic medications Geodon, Risperdal, Zyprexa, and Seroquel, as well as the antidepressants trazodone and Prozac. Mr. Sullivan admitted to "cheeking" his medications, as well as vomiting immediately after taking his medications, so it was unclear what effect any medications may have had on him.

At the conclusion of that 90-day period, Mr. Sullivan was evaluated by Janet Schaeffer, Ph.D. Dr. Schaeffer diagnosed Mr. Sullivan with Psychosis, Not Otherwise Specified; Polysubstance Dependence, by History; and Depressive Disorder, Not Otherwise Specified. She also noted that Schizotypal Personality Disorder; Pervasive

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 11 OF 26**

Developmental Disorder Not Otherwise Specified; Obsessive Compulsive Disorder; and Pedophilia, Sexual Attraction to Females could not be ruled out. Dr. Schaeffer noted improvement in Mr. Sullivan's symptoms; however, it was her opinion that his ongoing symptoms of mental disorganization, disturbances of perception, extreme suspiciousness, and vague and latent responses would interfere with his ability to work effectively with counsel at that time.

Mr. Sullivan was again found incompetent to stand trial and was thus re-admitted for another 90-day period of competency restoration that began on June 12, 2002 and ended on September 11, 2002. At the end of that period, Mr. Sullivan was evaluated by Trish Sowards, Ph.D. Dr. Sowards diagnosed Mr. Sullivan with "Schizophrenia, Chronic Undifferentiated versus Paranoid; Paraphilia, Pedophilia, based on his history of inappropriate sexual behavior with minors and his reports of fantasies regarding minors; and history of Psychoactive Substance Abuse," noting that Substance Dependence could not be ruled out. Dr. Sowards went on to say that "on Axis II, Mr. Sullivan would be considered to have a Schizotypal Personality Disorder as, even when stabilized, he continues to show odd and withdrawn behavior and severely impaired social skills, beyond that seen frequently with schizophrenia." Dr. Sowards noted that Mr. Sullivan knew his charge; was able to list potential pleas including guilty, not guilty, not guilty by reason of insanity, the Alford plea, and diminished capacity; and knew the consequences of a not guilty by reason of insanity plea. She stated further that he was able to define the roles of court personnel adequately, adequately defined a plea bargain, and knew that one must enter a guilty plea in order to obtain a plea bargain. Dr. Sowards observed that his memory and concentration were adequate and that he demonstrated "a realistic need to consider his answers from a perspective of legal liability."

Records indicated that Mr. Sullivan's attorney, David Kurtz, disagreed with Dr. Sowards' opinion. In a letter addressed to Mr. Kurtz, Dr. Sowards clarified her opinion as follows,

Mr. Sullivan has a number of mental aberrations, in addition to pedophilia and will never present in a manner similar to the average person. However, he was knowledgeable about his alleged offense, understood his legal peril, was not exhibiting overt symptoms of psychosis, understood the roles of the officers of the court, and could make organized and relevant responses to questions at the time of his discharge.

Mr. Sullivan was found competent to stand trial and was returned to Western State Hospital on October 16, 2002 for a 30-day evaluation of his mental state at the time of

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 12 OF 26**

his attempted kidnapping of a 12-year-old girl. Diagnoses at discharge were: Schizophrenia, Chronic Undifferentiated; Polysubstance Dependence by history; and Depressive Disorder, Not Otherwise Specified. It was noted that Schizotypal Personality Disorder; Pervasive Developmental Disorder Not Otherwise Specified; Obsessive Compulsive Disorder; and Pedophilia, Sexual Attraction to Females could not be ruled out. It was the opinion of Dr. Sowards that Mr. Sullivan,

...clearly understood that his behavior might result in problems for him, as he ran off and attempted to evade apprehension. As Dr. Danner noted in his prior report to the Court, Mr. Sullivan said he had run off because he was scared and acknowledged that he knew what he did was wrong. Thus, he would be considered to have had the capacity to understand the nature and quality of his behavior and the difference between right and wrong in regard to it. He also described planful behavior...thus, he gave every evidence of being able to act with purpose and intent and he would not appear to meet the statutory requirements for diminished capacity.

Criminal history records indicated that Mr. Sullivan was subsequently found guilty of Unlawful Imprisonment with Sexual Motivation and sentenced to 90 days in jail and 12 months of community supervision.

Records indicated that Mr. Sullivan continued to receive outpatient treatment in the community through Kaiser Permanente. He underwent a full mental health evaluation there on October 5, 2004 when he requested that he be taken off of his antipsychotic medications. It was noted that he had been living with his parents for the previous year and "does very little in the home, mostly watches TV, goes on walks with his father and otherwise mostly just hangs out. He does have a couple of friend [sic] with whom he has some limited contact but otherwise he has a fairly limited interactive experience with others." It was noted further that, "Patient states that he discontinued use of Risperdal approximately one year ago and exhibited significant psychotic symptoms as well as insomnia, hyperactivity, pacing, exhibiting repetitive behavior such as opening and closing cabinets in the kitchen and repositioning items in his room such as books or CDs." At the time of the interview he was described as "extremely loose and tangential in his thinking." It was also noted that, "there is evidence of delusional content/thought disorder." His diagnosis was listed as "History of Schizophrenia, Undifferentiated Type versus Delusional Disorder." He was placed on Abilify, another antipsychotic medication; however, further notes revealed that he decompensated on the Abilify and was subsequently placed back on Risperdal.

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 13 OF 26**

Mr. Sullivan was last seen at Kaiser Permanente on December 7, 2005, at which time his diagnoses included Schizophrenia, Undifferentiated Type and Depression. It was noted that he was "reportedly stable" and "seldom ventures away from home alone." His prescribed medications were four milligrams of Risperdal and 40 milligrams of Prozac per day.

Post-Offense Psychiatric History

Mental health records from the Clark County Jail indicated that Mr. Sullivan was first seen by mental health staff on April 21, 2006. He reported to them that he was taking his medication, which he listed as Risperdal and Prozac. It was noted that Mr. Sullivan appeared "very psychotic. Thought process very broken. Unable to tell if he is coming off drugs or is not well." By April 25, 2006, it was noted that he appeared to be "thinking clearer" and was requesting that he be put back on his medications. By April 28, 2006, he had been placed back on his medications and it was noted that he made "eye contact, clear speech, cognitive tracking, cooperative." He was seen on a regular basis during his incarceration. On June 16, 2006, it was documented that he said, "I'm sorry for what I did. I can't believe I did it."

Course of Initial Hospitalization

Mr. Sullivan was admitted to Western State Hospital on July 12, 2006. He was disheveled, with poor hygiene, and spoke in a stilted manner. His eyes darted from side-to-side and he avoided eye contact with the evaluators. Repetitive movements of his hands were observed and he rocked in his seat throughout the intake interview. Mr. Sullivan was alert and oriented to date, place, and situation. Short and long-term memory appeared to be intact and no deficits in attention were noted. He was able to recall three words presented a few minutes earlier, name the current and previous three Presidents of United States, and serially subtract 7 from 100 without difficulty. He was able to identify the commonalities between common objects but had difficulty interpreting common proverbs.

Mr. Sullivan's responses to questions were generally goal-directed but somewhat circumstantial at times. Some vagueness and latency was noted that was consistent with thought blocking. His affect appeared constricted. He reported feeling scared and reported having difficulty sleeping lately due to nightmares. He denied experiencing racing thoughts or a decreased need for sleep. He talked about seeing spirits and having an evil spirit inside of him but further questioning revealed that he was referring to his imagination and his own conceptualization of his behavior, rather than overt hallucinations or delusions. When asked about specific psychotic symptoms, he denied experiencing most of them but his responses became more vague and difficult to

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 14 OF 26**

follow. He appeared to be alluding to some paranoia and possibly auditory hallucinations when stating, "I thought all the inmates came to my house...when the cars drive by...I just hear things...because I can hear them, the things they say about me." He reported that he is diagnosed with Paranoid Schizophrenia but did not know what that meant. He stated that he had been taking his medication and was willing to continue taking it. He was initially prescribed Thorazine, an antipsychotic medication, and Prozac, an antidepressant medication, both of which he reported receiving at the jail. He was later changed from Thorazine to Zyprexa, a newer antipsychotic medication.

Mr. Sullivan's presentation remained the same throughout his hospitalization. He did not regularly attend classes at the Treatment and Recovery Center. He kept to himself on the ward and was not a behavioral management problem for ward staff. He did appear to be responding to internal stimuli at times. He at times refused to take his prescribed medications.

Course of Recent Hospitalization

Mr. Sullivan was re-admitted to Western State Hospital on October 18, 2006. He appeared disheveled and his hygiene was poor. His manner was guarded and his affect was flat. His thought process was goal-directed and concrete. He was aware of the reason for his hospitalization and said, "I hope I pass this thing." When asked what passing would mean, he replied, "NGRI." Mr. Sullivan stated that in the intervening time period he had been on protective custody status in jail and had been taking his medications, which included Prozac and Thorazine. He denied any disturbances in his mood or thinking and stated further that he was not experiencing any side effects from the medication.

Mr. Sullivan was initially prescribed the antipsychotic medication Zyprexa and his antidepressant, Prozac, was continued. Mr. Sullivan refused to take Zyprexa but indicated that he would take Thorazine or Risperdal. His antipsychotic medication was subsequently switched to Risperdal. Mr. Sullivan was compliant with his prescribed medications. He was not a behavioral management problem for ward staff. He attended treatment groups sporadically. Staff observed him laughing inappropriately at times. He required prompting to maintain his personal hygiene.

Mental Status Examination

Mr. Sullivan's presentation was largely consistent with that seen during his previous hospitalization. Mr. Sullivan presented as a man of average build who appeared his stated age. His grooming and hygiene were poor. There were no apparent

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 15 OF 26**

abnormalities in his gait. He demonstrated repetitive movements of his hands and grimaced at times. His eyes darted from side-to-side and he kept his head down, making little eye contact with the evaluators. He was alert and oriented, and his sensorium, or capacity to perceive sensation from his environment, was clear. Mr. Sullivan was cooperative with evaluation procedures but guarded about answering certain questions.

Judging from his verbal presentation, vocabulary, and general fund of knowledge, Mr. Sullivan appeared to function in the borderline range of adult intelligence. His abilities did not appear to be uniform across domains, making it difficult to estimate his level of intellectual functioning. For instance, he was able to serially subtract 7 from 100 at initial intake but could not calculate the change he would receive from 2 dollars if he purchased something that cost 1 dollar and 25 cents. He was able to read a presented passage fluently, though his reading level was not formally tested. He reported that he enjoys reading horror books that he obtains from the library. He also expressed an interest in reading about American history. Mr. Sullivan was able to attend to stimuli and demonstrated no deficits in concentration. He showed a minor deficit in short-term memory, recalling two of three words presented a few minutes earlier. He was able to recall the names of the current and previous four Presidents of the United States. He continued to have difficulty interpreting common proverbs, demonstrating difficulty with abstraction.

When asked about his mood, Mr. Sullivan reported no disturbance. He did not report significant disturbances in sleep, appetite, or energy level. His affective expression was constricted and he appeared anxious. His speech was of normal rate, rhythm, and volume. No signs or symptoms of depression or mania were observed or reported.

Mr. Sullivan's thought process, as evidenced by his speech, was generally goal-directed, though he occasionally provided responses to questions that were not obviously related to the question asked. At no time during the interview did he appear to be responding to, or distracted by, internal stimuli. He denied hearing voices or seeing things that others could not. Mr. Sullivan was specifically asked about beliefs indicative of paranoia, thought control, thought insertion, thought withdrawal, thought broadcasting, grandiosity, and ideas of reference. He denied holding any such beliefs. No overt delusional ideation was elicited during the interviews, though he made reference to bizarre beliefs in the past, such as the belief that his body was shrinking.

Mr. Sullivan's judgment for adult daily living activities, as evidenced by his integration into the ward milieu, appeared adequate. He demonstrated limited insight into his

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 16 OF 26**

mental illness and some insight into his need for ongoing treatment. This appears to be an improvement from previous evaluations.

Clinical Formulation

David Barton Sullivan is a 28-year-old man with a long history of serious mental illness. He has consistently demonstrated the same signs and symptoms of mental illness over the course of many hospitalizations. These have included anxious and dysphoric affect, poor hygiene, odd mannerisms, unusual movements, poverty of thought, tangentiality, and loose associations. When his symptoms have been most acute, Mr. Sullivan has been observed responding to internal stimuli, has reported paranoid delusions, and has demonstrated thought blocking, derailment, and blunted affect, as well as stereotyped behavior. Poor social skills, self-induced vomiting, pacing, inappropriate sexual comments and behavior, and a preoccupation with violent fantasies have also been noted.

Records indicated that Mr. Sullivan was diagnosed with a pervasive developmental disorder in childhood and he continues to demonstrate odd mannerisms, stereotyped behaviors, and limited interpersonal skills. Prior evaluators have wondered whether these traits are better explained in adulthood by a diagnosis of Schizotypal Personality Disorder. His predominant symptoms are quite consistent with Schizotypal Personality Disorder. A review of his records revealed that over the course of his life he has demonstrated all of the necessary symptoms for diagnosis. However, such a diagnosis is ruled out by the presence of a pervasive developmental disorder.

As noted above, Mr. Sullivan has, in the past, demonstrated symptoms of a primary psychotic disorder beyond that which would be explained by a schizotypal personality. These have included both hallucinations and delusions. During the current evaluation period, Mr. Sullivan's primary psychotic symptoms appeared to be fairly well-controlled by medications. Mr. Sullivan has also demonstrated both depressive and obsessive symptoms in the past. These symptoms were not observed during the current evaluation period, most likely because he was taking an antidepressant medication which would treat both types of symptoms.

Mr. Sullivan is a client of the Division of Developmental Disabilities and has been previously diagnosed with Mild Mental Retardation. As noted above, Mr. Sullivan's intellectual abilities appear to vary widely across domains. He has indicated that he is able to take the bus, do some cooking, and enjoys reading. However, he has had difficulty both in school and vocationally and he continues to live with his parents. Interpretation of his functional deficits is complicated by the presence of a primary

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 17 OF 26**

psychotic disorder, as impaired functioning is also seen in those suffering from acute psychosis. However, in light of his previous diagnosis of Mild Mental Retardation, that diagnosis will be continued.

In the past, Mr. Sullivan has been diagnosed with polysubstance abuse. During the current evaluation he reported drinking alcohol once per year. A review of the records seems to indicate that his abuse of substances appeared to have occurred a number of years ago. In the absence of evidence that this is an ongoing problem that interferes with his functioning, a diagnosis of substance abuse will not be given at this time.

Mr. Sullivan has been previously diagnosed with Pedophilia, Sexually Attracted to Females and Exhibitionism. During the current evaluation Mr. Sullivan was extremely reluctant to discuss his sexual history. Nonetheless, the Psychosexual Evaluation completed by Jon E. Ingram, Ph.D., amply documents the basis for these diagnoses.

Diagnosis

Axis I: Schizophrenia, Undifferentiated Type
Pervasive Developmental Disorder Not Otherwise Specified, by History
Pedophilia, Sexually Attracted to Females, by History
Exhibitionism, by History
Depressive Disorder Not Otherwise Specified, by History, in Remission

Axis II: Mild Mental Retardation, by History

Axis III: None

MENTAL STATE AT THE TIME OF THE OFFENSE**Defendant's Account of the Instant Offense**

The court order under which Mr. Sullivan was admitted to Western State Hospital requests an opinion regarding his mental state at the time of the alleged offense. Since Mr. Sullivan's version of these events is both relevant and material to a possible mental state defense and since he informed me that it is his intent to offer his mental state at that time into evidence, his statements are repeated here.

Although Mr. Sullivan's direct statements are quoted here exactly as stated by the defendant, it should be noted that they have been organized for clarity. In addition, discovery documents containing statements made by the defendant closest to the time of the instant offense were reviewed and were relied on most heavily in assessing Mr. Sullivan's mental state at the time of the offense. During the current evaluation, Mr. Sullivan provided the following narrative account of his actions:

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 18 OF 26**

It was at night. My dad gave me a couple cigarettes. I was in the back yard smoking cigarettes. I grabbed the knife out of the kitchen. My dad was cooking. He didn't see me somehow. I put the knife in a bag. I was listening to music, then I left the house around six o'clock. I don't remember what it said on the bag exactly, and then went down to looking for a female, a woman, a lady, anybody, any female, crossed a couple crosswalks, went over to Burton Road and Andresen, went to McDonalds and killed 'em.

...I saw the McDonalds, went to McDonalds. I went there and then she was sitting just minding her own business, waiting for her shift to end. I guess she worked the day shift. I guess swing shift was starting. I pulled the knife out of the bag and stabbed her and killed her.

...I left McDonalds. I dropped the knife in some small bushes by the gas station and right by the Kaady Car Wash, then I jaywalked across the street, then they all surrounded me and the cops got me. I was trying to walk home. It wasn't very far from my house. I tried to run but I stopped.

Mr. Sullivan described actively planning the offense prior to committing it. He said, "I was doing writing, putting two and two together, and trying to figure this whole thing out. I didn't know it was gonna be a mistake." When asked what he had figured out, he replied, "I thought maybe I could get away with it and I didn't get away with it." When asked if anyone had made him do it, he replied, "No. No one. I planned this. I didn't plan, but I did plan. I planned it."

Mr. Sullivan described his behavior prior to the offense, and said that as he walked away from his house he recalled, "I'm thinking I wasn't gonna hurt anybody in my neighborhood." He went on to say that, "I was walking on the streets at night. I was looking for somebody that it could happen to and it turned out to be her." He reported that he initially considered stabbing a woman he saw outside of a car dealership on his way to the McDonalds. He explained,

There was a woman getting into a car with sons, two boys and a woman...I approached her. I almost did but I was almost there. I had the bag with the weapon in it. I just saw them then I just walked away. They didn't see me. They were kind of busy or something. There was

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 19 OF 26**

something that made me not do them. Something like, what was it? I might hit the wrong person.

When asked what he meant when he said "the wrong person," Mr. Sullivan replied, "If it wasn't the woman I would have hit, it would have been the boys."

Mr. Sullivan stated that when he entered the McDonalds, "I was thinking I don't wanna do this. I have no other choice." He described looking around the McDonalds at the various patrons. He said, "I was looking for a female ...I don't know maybe I wanted to even the score, maybe because I don't like what they were doing to me in my neighborhood." He said that he did not recall exactly what he was thinking just prior to stabbing the victim. He said, "I don't know, maybe I was just angry inside. Maybe they pushed me too far." Mr. Sullivan had earlier mentioned that, "I was angry, I was mad." He later added, "It builds up inside. They must have done something to make me angry." He said that he put the knife in the bag, "so I won't look suspicious." He added, "I wanted to hurt somebody. I didn't want to kill somebody."

When asked what would have happened if his father had seen him retrieve the knife, Mr. Sullivan replied, "I wish he did see me. I wouldn't hurt him. He could have talked me out of it." Mr. Sullivan recalled making "those monster noises" as he stabbed the victim. When asked if he knew at the time that he was doing something wrong, he replied, "I did know it was wrong. And I read the Bible inside and I read at least three chapters. It's just a book. Really, it's not like God's gonna stop me from doing something I shouldn't be doing." He later added, "I don't think I can go to heaven after what I did." In a later interview he said, "I guess I didn't have the idea going through my mind that it was the wrong thing to do." When asked if he knew it was against the law at the time he replied, "I'm sure I did know but it just didn't really come through really." He later added, "I guess it didn't really occur to me that I'd get in big trouble for this."

After further questioning, Mr. Sullivan said, "Well, you are still looking for the reason why I killed her, because there was some, they were being mean to me." When asked who he was referring to, he replied, "The ladies were being mean to me." When asked what he meant when he told the police that there was a "devil" inside of him, Mr. Sullivan explained, "I said there was like this evil spirit inside of me making me do things I don't wanna do...I just do things that I can't believe I've done, that I don't wanna do." During our final interview, Mr. Sullivan added that it had recently occurred to him that, "one of the reasons for this is I was taking some over the counter

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 20 OF 26**

medicines – Advil, antibiotics, etc...made me disoriented." He explained that these pills made him sleepy during the day.

Opinion as to Sanity at the Time of the Offense

The requirements for legal insanity in the state of Washington are found within RCW 9A.12.010(1) which states that:

To establish the defense of insanity, it must be shown that at the time of the commission of the offense, as a result of mental disease or defect, the mind of the actor was affected to such an extent that:

- (a) He was unable to perceive the nature and quality of the act with which he is charged; or
- (b) He was unable to tell right from wrong with reference to the particular act charged.

There is substantial data to indicate that Mr. Sullivan was experiencing acute symptoms of psychosis consistent with the diagnosis of Schizophrenia, Undifferentiated Type, prior to, during, and after the instant offense. Mr. Sullivan has a longstanding history of Schizophrenia. Discovery information indicated that the police determined that Mr. Sullivan had not taken his antipsychotic medication since March 20, 2006 and had skipped five days of his antidepressant medication. Notes found in his home that he had written prior to the instant offense were disorganized and bizarre, demonstrating an impaired thought process and possible delusional ideation. Witnesses to the instant offense reported that, "He was babbling. Nothing he said made sense to me." The witness who followed him out of the McDonalds observed him mumbling to himself.

Upon his arrest, the arresting officers observed that Mr. Sullivan was agitated and intermittently crying. They noted that he had difficulty staying on topic and his responses did not always relate to the questions asked. He made statements about a "devil" inside him. They also noted significant latency in his responding and that his eyes were moving rapidly from side-to-side, rarely making eye contact with the officers. In addition, they observed him talking to himself at times. One officer, Officer Scott, specifically expressed concern about his, "mental status."

Furthermore, the transcript of the police's interview with the defendant after the instant offense demonstrated disorganized speech, frequent responses that were not relevant to the questions asked, and significant distractibility, all of which are consistent with psychosis. When the pre-booking/probable cause sheet was completed, the officer who completed it checked the box indicating, "observable mental health problems," as well

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 21 OF 26**

as "signs of suicidal behavior or attempts." He or she also wrote, "Complains of feeling suicidal; bizarre statements." Jail mental health staff subsequently observed that he was "very psychotic." Finally, the letters that Mr. Sullivan wrote to his parents from the jail were bizarre and disorganized. There was no data to indicate that Mr. Sullivan had used drugs of abuse that could affect his mental state on the days surrounding the instant offense.

The presence of symptoms of mental illness does not preclude an awareness of one's actions, however, and the available data indicates that Mr. Sullivan was aware of the nature and quality of his actions. Notes that he wrote prior to the offense included the text, "I'm going to kill somebody," and "Who who [sic] lives by the sword shall die by the sword here I come Satans [sic] sword harmless victims." He told the arresting police officers that he had intended to hurt a young lady. Furthermore, after his arrest he asked them if she was dead. He told the police that, "I stabbed her." He also said, "Oh deadly," and, "I hurt somebody." When the police asked him what he thought could happen to the victim, he replied, "She could have been killed," and, "She could've been dead." He also appeared to refer to the knife as, "a deadly weapon."

There is also substantial data that indicates that Mr. Sullivan was aware of the wrongfulness of his actions. The data indicates that, when approaching the crime scene, Mr. Sullivan attempted to avoid detection by hiding the knife in a bag and then keeping it drawn up inside the sleeve of his coat until the moment he was about to use it. He avoided apprehension by leaving the restaurant when another employee attempted to approach him. Some witnesses described him as leaving the restaurant in a hurried manner, though accounts conflicted. He also disposed of the murder weapon after leaving the restaurant.

More compelling though, are Mr. Sullivan's statements to the police upon his arrest that indicated that he knew that what he had done was wrong. He told the police that he did not want his parents to know what he had done and that he was a bum heading for jail. He said, "I know I did a very, very, very bad thing," and, "Get yourself a shovel, you're in deep sh..." He also demonstrated knowledge of the legal wrongfulness of his actions, stating, "It's a felony...I never get a misdemeanor." In addition, he said, "If this is going to go straight to jail, can I go to...can I have a cigarette first?" Furthermore, when told that the victim had died of her injuries, Mr. Sullivan responded, "I'm not going to heaven. I'm going to hell." He then said, "I can't believe I'm a Charles Manson. God damn," and went on to add, "That was sinister. That was deadly. That was wrong."

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 22 OF 26**

In summary, the weight of the data available to me suggests that Mr. Sullivan was experiencing acute symptoms of Schizophrenia on the day of the instant offense. However, the standard for insanity in Washington State requires not merely the presence of mental illness, but additional specific cognitive deficits. The available data indicates that Mr. Sullivan was both aware of the nature and quality of his actions and was aware that what he was doing was wrong. As such, I cannot support the insanity defense in this case.

Opinion as to Diminished Capacity

Mr. Sullivan is charged with Murder in the First Degree which requires the mental states of intent and premeditation. Intent is defined in RCW 9A.08.010(1)(a) as follows: A person acts with intent or intentionality when he acts with the objective or purpose to accomplish a result which constitutes a crime.

According to the Court in State v. Hoffman (1991) 116 Wn.2d 51, 804 P.2d 577: "Premeditation must involve more than a moment in time; it is defined as the deliberate formation of and reflection upon the intent to take a human life and involves the mental process of thinking beforehand, deliberation, reflection, weighing or reasoning for a period of time, however short."

According to the Court in State v. Atsbeha (2001) 142 Wn.2d 904, to maintain a diminished capacity defense, a defendant must produce expert testimony demonstrating that a mental disorder, not amounting to insanity, impaired the defendant's ability to form the culpable mental state to commit the crime charged. It is not enough that a defendant may be diagnosed as suffering from a particular mental disorder. The diagnosis must, under the facts of the case, be capable of forensic application in order to help the trier of fact assess the defendant's mental state at the time of the crime. The opinion concerning a defendant's mental disorder must reasonably relate to impairment of the ability to form the culpable mental state to commit the crime charged.

Thus the question of capacity to form a given mental state requires analysis of:

- 1) The presence of a mental disorder or extreme intoxication;
- 2) Analysis of what symptoms were likely present at the time of the offense;
- 3) Identification of the mental abilities impaired by the symptoms; and
- 4) The probability and degree to which these impairments may have interfered with the ability to form the requisite mental state.

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 23 OF 26**

As has been described above, there is substantial data to indicate the presence of a serious mental illness at the time of the instant offense. There is no data to indicate the presence of intoxication. The available data indicates that Mr. Sullivan's thought process was somewhat disorganized and it appears likely that he was experiencing both auditory hallucinations and delusional ideation. These symptoms would be expected to impair his ability to engage in linear thought and to distinguish his internal thoughts from the external world. In other words, there is data to suggest that his ability to think rationally was reduced compared to a person without a mental illness.

One would reasonably infer that a disorganized thought process, combined with difficulty distinguishing one's internal thoughts from the external world, would place a person at higher risk for poorly controlled or poorly chosen behavior. Mr. Sullivan's ability to think rationally and to exercise mental control was almost certainly impacted. However, under many circumstances even very impaired individuals will retain the capacity for goal-directed, purposeful, and intentional behavior. While Mr. Sullivan's symptoms would certainly reduce his capacity to rationally consider alternatives, the data suggests that the capacity to form an intent, no matter how poorly chosen, remained intact. There is evidence of planning and preparation for the crime, including the note found at his home stating, "I'm going to kill somebody," the note stating, "Who who [sic] lives by the sword shall die by the sword here I come Satans [sic] sword harmless victims," and the fact that he hid the knife in a bag which he then used to carry it to the scene of the crime. Mr. Sullivan also made multiple statements to the arresting officers indicating that it had been his intention to hurt a woman that night. Furthermore, during the current evaluation, Mr. Sullivan stated that he had planned the offense and that he considered stabbing another woman he saw that night but decided against it, finally settling on the victim.

A jury could certainly infer that the actions taken by the defendant prior to the crime, as well as the statements made afterwards, suggest premeditated intent. It is beyond the scope of this evaluation to offer an opinion as to whether Mr. Sullivan did intend or premeditate the victim's death. His actual intent is properly a question reserved for the jury and I offer no opinion beyond that Mr. Sullivan had the capacity for intentional conduct. I likewise see little data tending to suggest that Mr. Sullivan would have lacked the capacity to form a purpose to kill and act upon that purpose. Thus, if we are examining only the limited question of *capacity* to premeditate or form intent, I am unable to support this defense.

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 24 OF 26****DANGEROUSNESS**

This opinion regarding dangerousness was court-ordered and conducted within the scope of RCW 10.77.060 regarding pre-trial mental health evaluations. An opinion is to be made as to whether the defendant presents a substantial danger to others or presents a substantial likelihood of committing criminal acts jeopardizing public safety or security, unless kept under further control of the court or other persons or institutions.

Cautionary Note: Given the present level of risk assessment technology, and frequently incomplete historical data, mental health professionals can best assist the court in making pre-trial dangerousness assessments by identifying the presence of known risk factors and providing a clinical formulation of how these factors affect a defendant. This assessment does rely considerably on Mr. Sullivan's self-report, and this sets an upper limit on the reliability of any opinions rendered.

Mr. Sullivan's NCIC criminal history record lists the following adult felony conviction: Unlawful Imprisonment with Sexual Motivation (2003); and the following gross misdemeanor conviction: Assault in the Fourth Degree (2000). One juvenile drug offense was also listed. Mr. Sullivan is a Registered Sex/Kidnapping Offender in the state of Washington.

Current practice in violence risk assessment involves the consideration of factors frequently associated with future violence. The HCR-20 is an instrument that organizes such known risk factors, dividing them into three categories: Historical, Clinical, and Risk Management. Not all portions of the HCR-20 could be completed for the evaluation; for example, the Hare Psychopathy Checklist-Revised was not completed. Therefore the HCR-20 was not formally completed and scored, but was used as a guideline for identifying known risk factors.

Historical Risk Factors are relatively stable elements of the individual's life and are unlikely to change. These static or unchanging factors help establish a baseline level of risk. They do not predict individual risk, but evaluate whether a defendant has characteristics similar to offenders in high-risk categories. In Mr. Sullivan's case, the following Historical Risk Factors are present: previous violence, employment problems, substance use problems, major mental illness, early maladjustment, and prior supervision failure. The only historical factors not present were young age at first violent incident, relationship instability, personality disorder, and psychopathy, which was not assessed.

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 25 OF 26**

Clinical Risk Factors describe the individual's current mental state and are considered to be more changeable or amenable to treatment. These dynamic or changeable risk factors interact with a defendant's baseline level of risk, and are associated with shorter-term dangerousness. Mr. Sullivan demonstrated evidence of the following Clinical Risk Factors: limited insight, active symptoms of major mental illness, and impulsivity. Clinical Risk Factors that may have been present or were present to a lesser degree include: negative attitudes and limited response to treatment.

Finally, Risk Management Factors are those that are likely to influence the individual in the future, and are also considered to be changeable. Mr. Sullivan possessed the following Risk Management Factor: stress. Risk Management Factors that may have been present or were present to a lesser degree include: exposure to destabilizers. Factors that currently mitigate Mr. Sullivan's risk of future dangerousness or criminal behavior include: his lack of exposure to young girls and weapons while under the control of the court.

Based upon Mr. Sullivan's documented criminal history, information obtained through interviews and treatment, and a review of risk factors, it is my professional opinion that he is currently at high risk for future danger to others and for committing future criminal acts jeopardizing public safety and security. Mr. Sullivan has an admitted history of violent fantasies, a fascination with violence, and an admitted history of violence against girls under the age of 18. In the past he has also admitted to sexual arousal to young girls as well as sexual arousal to inducing fear in women. His ability to inhibit his impulses appears to be significantly decreased when he experiences psychiatric decompensation and he demonstrates very poor judgment when that occurs. A previous evaluator who evaluated his risk for sexual violence noted "a clear progression from fairly innocuous actions to serious actions in which he confronted and offended against a very vulnerable victim. Research suggests that such progressions may continue to acts of even more serious personal victimization." Should the current charge prove true, it would confirm this escalating pattern of violent behavior. In light of his current charge, I have grave concerns about the safety of young female members of the community were he to be released.

Mr. Sullivan has been charged with sexually motivated crimes in the past. Nothing in this evaluation is intended to assess Mr. Sullivan's risk or potential to commit sexually motivated crimes in the future. It is my recommendation that prior to any decrease in level of security, the court order Mr. Sullivan to undergo a full evaluation by a certified Sex Offender Treatment Provider to fully assess his risk in this specialized area.

**FORENSIC PSYCHOLOGICAL REPORT
RE: DAVID BARTON SULLIVAN****MARCH 5, 2007
PAGE 26 OF 26****DMHP Evaluation**

An opinion is required as to whether the defendant should receive a RCW 71.05 civil commitment evaluation by a designated mental health professional. This opinion is based solely upon the above evaluation under RCW 10.77.060. Other reasons may exist to require a civil commitment evaluation, which fall within the scope of other standards outside the purview of this evaluation.

In response to my direct questions, Mr. Sullivan denied imminent intent to harm himself and similarly denied imminent intent to harm anyone else. Nothing in his recent or overt behavior would suggest that he was less than sincere in this denial. I do not consider him an imminent risk to himself or others at this time. Mr. Sullivan was not a violent behavioral management problem for our ward staff. However, in light of the seriousness of his charge and his prior history of active symptoms of mental illness that exacerbate his risk to others, I recommend evaluation by a designated mental health professional evaluation under RCW 71.05 prior to any release from custody.



Julie A. Gallagher, Psy.D.
Licensed Psychologist
Center for Forensic Services
Inpatient Forensic Evaluation Program
(253) 756-2514

JAG/aib

cc: Presiding Judge, Clark County Superior Court
John P. Fairgrieve, Senior Deputy Prosecuting Attorney
Thomas A. Ladouceur, Defense Counsel
Marlene Burrows, Clark County DMHP
Rita Laurent, Clark County Jail

