IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
WESTERN DIVISION

NO. 5:09-HC-2075-FL

UNITED STATES OF AMERICA,	)	
	)	
Petitioner,	)	
	)	
v.	)	ORDER
	)	
DAVID ARLON [redacted]	)	
	)	
Respondent.	)	

This matter is before the court for determination of whether respondent David Arlon [redacted] ("respondent") no longer is a sexually dangerous person and thereby can be released from his civil commitment under the Adam Walsh Act, pursuant to 18 U.S.C. § 4247(h). Upon evidentiary hearing held June 25, 2019, and for the reasons set forth below, the court finds respondent has established by a preponderance of the evidence that he will not be sexually dangerous to others if released under a prescribed regimen of medical, psychiatric, or psychological care or treatment.

STATEMENT OF THE CASE

On June 8, 2009, petitioner initiated this proceeding by filing certification of a sexually dangerous person and petition as to respondent, which stayed respondent's release from Federal Bureau of Prisons's ("BOP") custody. See 18 U.S.C. § 4248(a). At the time of certification, respondent was serving 135 months' term of imprisonment following convictions for: 1) interstate transportation and shipment of a visual depiction of minors engaging in sexually explicit conduct (two counts); 2) possession of items shipped in interstate commerce which contain visual depictions of minors engaging in sexually explicit conduct; 3) interstate travel with intent to engage in a sexual

act with a minor; and 4) attempt to entice a minor to engage in sexual activity by use of a facility and means of interstate commerce.

On March 30, 2012, the court held respondent's commitment hearing, and found by clear and convincing evidence that respondent was a sexually dangerous person. Respondent was civilly committed to the custody of the United States Attorney General. On September 7, 2018, respondent moved for discharge hearing pursuant to 18 U.S.C. § 4247(h). Petitioner did not oppose respondent's request for hearing, but moved to reopen discovery for a period of 90 days prior to hearing. On November 8, 2018, the court granted petitioner's motion for discovery, and set deadlines for prehearing discovery, submission of expert reports, and final prehearing disclosures.

On June 13, 2019, respondent filed motion in limine to place burden of proof on petitioner at discharge hearing. After briefing, the court denied the motion, finding respondent bears the burden of proof by preponderance of the evidence at the discharge hearing.

The court held the discharge hearing on June 25, 2019. The court received into evidence all exhibits in the joint trial notebook, including respondent's treatment and court records, the parties' expert reports, transcripts of prehearing depositions, and BOP annual review reports regarding respondent's sexual dangerousness. The court granted the parties' consent motion to qualify Dr. Joseph Plaud, Ph.D., Dr. Luis Rosell, Psy.D., and Dr. Justin Rigsbee, Ph.D. as expert witnesses pursuant to Federal Rule of Evidence 702. The court denied petitioner's request to qualify Dr. Kara Holden as Rule 702 expert in sex offender treatment, but permitted Dr. Holden to testify as fact witness concerning respondent's treatment. The following witnesses testified at hearing: 1) respondent; 2) Dr. Plaud; 3) Dr. Rosell; 4) Dr. Holden; 5) Dr. Brandi Kohr; 6) Dr. Rigsbee; 7) Dr. Laura Sheras; and 8) Dr. Trisha Rae Smithson. The court also granted the parties' joint motion to

admit de benne esse videotaped deposition of Carynne Williams, M.S.W. in lieu of live testimony. After closing arguments, the court took the matter under advisement.

STATEMENT OF THE FACTS

The court derives the following description of respondent's background from the court's order committing respondent as a sexually dangerous person, the experts' reports, respondent's presentence investigation report, and other documentary evidence. Reference also is made to respondent's testimony at the discharge hearing.

A. Personal History

Respondent was 70 years old at the time of hearing. He was born in Fayetteville, Arkansas, and he has two older siblings, a sister 19 years his senior and a brother 17 years his senior. (Resp't Ex. 4 at 3-4).[1] The family lived in a rural part of Arkansas, and respondent was socially isolated during his formative years. (Resp't Ex. 2 at 2). Respondent reported his father was emotionally abusive, and his mother was overprotective and "smothering." (Id.). Respondent's father passed away when he was 15 years old from a cerebral brain hemorrhage. (Resp't Ex. 4 at 4). His mother died in 1985 from heart disease. (Id.). Respondent is not close to his siblings. (Id.).

Respondent's pre-incarceration work history includes employment as a janitor, construction worker, and as hospital orderly. (Resp't Ex. 2 at 3; Resp't Ex. 4 at 4). Respondent has been continuously incarcerated or civilly committed for the past 20 years.

Respondent has historical mental health problems, including diagnosed mood disorders and "serious suicidal ideation." (Id.). Currently, respondent takes Prozac and Buspar to treat his

[1] Unless otherwise specified, page numbers specified in citations to the record in this order refer to the page number of the document designated in the court's electronic case filing (ECF) system, and not to page numbering, if any, specified on the face of the underlying document.

depression and other mood issues. (Gov't Ex. 8 at 12).[2]

Respondent has numerous physical health issues, including stage I chronic kidney disease, rheumatoid arthritis, high cholesterol, cataracts, esophageal reflux, essential hypertension, chronic or unspecified peptic ulcer with hemorrhage and perforation, and chronic obstructive pulmonary disease. (Resp't Ex. 4 at 4). Respondent also received treatment for skin cancer in March 2018. (Gov't Ex. 8 at 12). Respondent reports he cannot currently maintain an erection as a result of his health issues. (Resp't Ex. 4 at 5). At hearing, respondent testified he has not been able to successfully masturbate since 2014, and that his libido has "decreased tremendously." Treatment records, however, reflect that respondent began taking Naltrexone in January 2017 due to heightened sexual thoughts and self-reported frequent erections. (Resp't Ex. 4 at 11).

B. Sexual and Relationship History

Respondent reports that he is bisexual. (Id.). At age 20, he had his first sexual experience with an 18 year-old female. (Id.). He also reports one instance of sexual abuse when he was five years old, in which a 13 year-old female sat on top of him and rubbed her genitals on respondent's exposed genitals. (Resp't Ex. 2 at 2).

In 1969 (age 21), respondent married Annette M. (Resp't Ex. 4 at 5). They had two sons during the marriage, who were adopted by their stepfather when Annette remarried. (Id.). Respondent's oldest son from this marriage is one of his victims. (Id. at 6). In 1982 (age 33), respondent divorced Annette and married Frances J. (Id. at 5). Frances had a daughter with disabilities from a previous marriage, and respondent and Frances were her primary caregivers.

[2] Petitioner labeled its exhibits "Government Exhibit [#]" in the joint trial notebook, and thus citations to petitioner's exhibits herein correspond to that format. Textual references to "petitioner's exhibits" are synonymous with and refer to citations formatted "Gov't Ex. [#]."

(Resp't Ex. 2 at 7). As discussed below, respondent sexually molested his stepdaughter for approximately twelve years. (Id.). Respondent and Frances divorced in 2007. (Resp't Ex. 4 at 5).

C. Offense History

The court's March 30, 2012, order committing respondent contains the following description of respondent's offense history. Respondent admits that he committed these offenses.

> At the evidentiary hearing, [respondent] testified that he fondled the penis of his oldest son when the child was approximately nine years old.[3] He also admitted that he had sexual contact with a nephew and three nieces when they were children. However, [respondent] claimed that he was relatively close in age to these family members at the time the contact occurred. [Respondent] further admitted at the evidentiary hearing that he molested his step-daughter from his second marriage.[4] He testified that he believed that his stepdaughter had been "coming on" to him since she was five years old.
>
> In July 1999, [respondent] came under the scrutiny of the Federal Bureau of Investigation after a confidential witness reported having encountered him online in an adult chat room utilized by individuals who enjoy conversing about sexual relationships with children. On [August 23, 1999], the confidential witness informed investigators that she reached an agreement for the sale of an eight-year-old girl, "Stacy," to [respondent] so that he could have a sexual relationship with the child. In exchange for the child, [respondent] agreed to pay the confidential witness $100 plus child pornography.
>
> Pursuant to this agreement, [respondent] traveled from Arkansas to Memphis, Tennessee to pick up Stacy. He was arrested in Memphis. A search of his vehicle revealed a loaded .22 caliber revolver, a teddy bear, condoms, lotions, and hundreds of images of child pornography. The child pornography included several sexually-explicit images involving a prepubescent female.
>
> In relation to these events, [respondent pleaded] guilty in the United States District Court for the Western District of Tennessee on [December 6, 2000,] to several charges including interstate transportation of visual depictions of minors

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[3] Dr. Rosell reports this abuse took place over a period of approximately three years. (Resp't Ex. 2 at 3). In treatment, respondent disclosed that he molested his son over 700 times. (Gov't Ex. 9 at 2566).

[4] According to Dr. Rosell, this abuse consisted of fondling and oral sex beginning when his stepdaughter was 12 years old and lasting for 12 years. (Resp't Ex. 2 at 7). Respondent also engaged in sexual intercourse with her after she turned 17. (Id.).

> engaged in sexually explicit conduct; possession of items shipped in interstate commerce which contain visual depictions of minors engaging in sexually explicit conduct; interstate travel with intent to engage in a sexual act with a minor; and attempt to entice a minor to engage in sexual activity by use of a facility and means of interstate commerce. He was sentenced to [135 months' imprisonment] and a three-year term of supervised release.

(Gov't Ex. 11 at 1-3 (citations omitted)).

In addition to the foregoing, in 1977 respondent exposed himself to an eight-year-old female. The federal presentence report states respondent forced the victim to touch his penis. (Resp't Ex. 2 at 4). Respondent denies forcing the victim to touch him, but admits exposing himself. (Id.). Respondent was convicted of sexual abuse in the 1st degree, and the state court sentenced him to probation and ordered counseling, which respondent successfully completed. (Resp't Ex. 4 at 6).

D. Commitment Order

On March 30, 2012, the court found petitioner established by clear and convincing evidence that respondent is a sexually dangerous person. (Gov't Ex. 11 at 10). All experts agreed, and the court so found, that respondent had committed prior acts of child molestation, and that he suffered from pedophilic disorder. (Id. at 4-5). As to his volitional impairment, the court credited petitioner's experts' opinions finding respondent would have serious difficulty refraining from child molestation if released. (Id. at 7). As petitioner's experts explained, respondent's behavior while incarcerated suggested he planned to continue molesting children if released. (Id. at 7-8). For example, before the commitment hearing, respondent stated there was nothing better than having sex with an eight-year-old girl, and requested pictures of prepubescent children. (Id. at 8). He also stated he "would" attempt to molest a child if he were not incarcerated. (Id.). The court also noted respondent had denied committing contact-based offenses, had never participated in sex offender treatment, and that his testimony generally "demonstrate[d] that he has little insight into or ability

to manage his pedophilic disorder." (Id. at 9-10). Finally, the court emphasized that age did not appear to be a protective factor where respondent's ongoing sexual preoccupation with prepubescent children was evident well past age 60. (Id. at 8).

At hearing, respondent admitted to maintaining pen-pal relationships with a child molester and a woman with a young child before his commitment. Respondent candidly testified he maintained these pen pals because he wanted to continue molesting children after his release.

E. Commitment History

Respondent has been housed in the Maryland unit at the Federal Correctional Institution in Butner, North Carolina since his March 30, 2012, commitment. Respondent has not been charged with any disciplinary infractions since the court committed him. However, in November 2013, BOP officials searched respondent's cell and confiscated pictures of children and scantily-clad women, a list of female pen pals, and lists of sexually-explicit movies and websites. (Gov't Ex. 9 at 2639).[5] BOP staff have not confiscated any additional inappropriate sexual material from respondent's cell since the November 2013 search.[6] Respondent testified that he has had one pen pal since his civil commitment, and he has not discussed children with her. He stopped corresponding with her in 2014.

F. Sex Offender Treatment

Respondent enrolled in the BOP's Commitment and Treatment Program ("CTP") on May

[5] Page numbers specified in citations to petitioner's exhibit 9 refer to the Bates-stamped page number designated by the parties, and not to page numbering, if any, specified on the face of the underlying document.

[6] In October 2015, treatment staff confiscated a map of the Philippines and a letter detailing the cost of living in the Philippines from respondent's cell. (Gov't Ex. 9 at 2640). These materials, however, did not contain any sexually inappropriate content.

3, 2012. (Gov't Ex. 9 at 2639). The CTP employs the Good Lives Model treatment program. (Gov't Ex. 15.1 at 9:03-9:09).[7] The program consists of four phases: orientation, evaluation, and treatment planning (phase one); basic skills and treatment fundamentals (phase 2); advanced skills and treatment integration (phase 3); and community reintegration preparation and planning (phase 4). (Id. at 46:13-48:20; see also Gov't Proposed Findings (DE 113) at 8).

At hearing, respondent testified he has been continuously enrolled in the CTP since May 2012, with exception of one six-month period in 2016. He has progressed to phase three. Respondent participated in phase two from November 2012 to August 2017, and he completed numerous therapy groups in phase two. After his promotion to phase three, respondent participated in sex offense history, grief and loss, and advanced intimacy groups. Currently, respondent attends two weekly treatment groups, community meetings four days a week, and monthly individual appointments with his primary therapist. Respondent testified he completes all his homework and always attends his therapy appointments.

Respondent's treatment progress, however, has been problematic. In July 2014, CTP staff expelled respondent from a sexual self-management group after he admitted to deliberately masturbating to fantasies about sexually molesting one of his prior victims. (Gov't Ex. 9 at 2639). He was readmitted to the group, but in January 2015 staff expelled him again after he failed to complete required sexual arousal logs and demonstrated substantial denial of deviant sexual thoughts. (Id. at 2640). Respondent also testified that he was suspended from the CTP after he verbally attacked a treatment peer in 2016. Respondent, however, has been enrolled in the CTP continuously since the 2016 suspension.

[7] Citations to petitioner's exhibit 15 refer to the page and line numbers on the face of the deposition transcript.

At hearing, respondent acknowledged that he currently has cognitive distortions, including that his stepdaughter enticed him to sexually molest her. Respondent also admitted that he spoke to his individual therapist about viewing child pornography upon release. He acknowledged he has an addiction to child pornography and that he will need continued treatment to avoid viewing it, which is why he raised the issue with his therapist. Respondent candidly admitted he continues to struggle with attraction to prepubescent children, but he believes he has now developed sufficient control to avoid acting on such attraction.

Five CTP treatment providers also testified at hearing concerning respondent's progress in the treatment program.

1. Dr. Kara Holden

Dr. Holden, respondent's assigned CTP therapist, testified that treatment staff are concerned that respondent has not made sufficient progress in treatment. Dr. Holden explained that respondent's release plans do not include engaging with a support network, which can be an important protective factor. Respondent's behavior during the program also evidences that respondent has difficulty building supportive relationships. She also has concerns about respondent's ongoing sexual preoccupation, as reflected in respondent's recent comments suggesting his stepdaughter enticed him, and the fact respondent continues to watch television programming depicting children in revealing clothing. Respondent also viewed one movie depicting the rape of a child.

Dr. Holden noted that respondent has not shown acceptance of responsibility or concern for others, and he maintains offense-supportive beliefs. Dr. Holden noted one concerning clinical encounter within the past three months where respondent stated he views children as useless objects.

Dr. Holden also explained that respondent presents his cognitive distortions as "truth" and he becomes defensive when challenged about them. Although Dr. Holden agreed respondent attends group and completes his assignments, she testified he demonstrates limited motivation and he has "internalized" the concepts. When respondent discusses his release plan with Dr. Holden, he does not discuss treatment strategies for preventing further offending and does not appear motivated to attend outpatient treatment. As a result of the foregoing treatment issues, respondent has not been promoted to phase four and therefore has not addressed relapse prevention planning issues.

2. Dr. Brandi Kohr

Dr. Kohr is a therapist in the CTP program, and is a member of respondent's treatment team. She has treated respondent in both group and individual therapy sessions since she began working in the program in 2016. Dr. Kohr testified respondent rejoined the treatment program in 2016, but noted he did so because his attorney told him he needed to rejoin in order to be released. She did not believe respondent was intrinsically motivated to rejoin the program. She acknowledged, however, that respondent was promoted from phase two to phase three after he rejoined the CTP.

Dr. Kohr noted that around the time of his promotion to phase three, respondent was "really, really, into [the CTP]." However, respondent's participation "vacillated" and she testified respondent currently appears "detached" from the program. Dr. Kohr also noted that even when respondent was engaged in treatment, he only appeared to grasp the concepts at an intellectual level. She noted that respondent's ongoing cognitive distortion that his stepdaughter enticed him has not been amenable to treatment.

Dr. Kohr also testified about a concerning clinical encounter that occurred approximately two weeks before the instant discharge hearing. Respondent was informed about a disturbing crime,

and empathized with the perpetrator but showed no empathy toward the victim. In that same encounter, respondent was not able to articulate a reasonable release plan, or explain precisely how he would prevent himself from reoffending. Dr. Kohr noted respondent's inability to articulate a viable release plan also has been an "ongoing" issue. Like Dr. Holden, Dr. Kohr testified that developing a comprehensive relapse prevention plan is part of phase four of the CTP, and respondent has not completed that phase.

3. Dr. Laura Sheras

Dr. Sheras is a treatment provider with the CTP program, and she has treated respondent in both group and individual therapy sessions. In 2018, Dr. Sheras facilitated a sex offense history group in which respondent's peers confronted him after he expressed interest in contacting his stepdaughter.[8] Dr. Sheras noted that "[q]uestioning from the group revealed that [respondent] wanted to contact her because he still fantasized about a relationship with her and was stating he wanted to 'apologize' for the past as an excuse to contact her." (Gov't Ex. 9 at 2570). Dr. Sheras also noted respondent lacked insight into how contacting the victim could re-traumatize her. Respondent also admitted during the group session that he generally has no empathy for his victims. However, at the conclusion of the group, respondent stated that he would not further attempt to contact his stepdaughter, and the record does not reflect that he ever did so.

4. Dr. Trisha Smithson

Dr. Smithson is a treatment provider with the CTP program, and she has treated respondent in both group and individual therapy sessions. She testified that in July 2015, respondent showed her a journal in which he wrote letters to some of his victims, and then responded to them from the

[8] As respondent testified at hearing, he also requested assistance from his counsel's investigator to contact his stepdaughter.

victims' perspectives. She noted that respondent was not directed to complete such an assignment by his treatment team, and she had concerns respondent was considering contacting one his prior victims. Finally, Dr. Smithson noted an ongoing issue with respondent is that he wanted to resume a relationship with his stepdaughter.

5. Carynne Williams, M.S.W.[9]

Williams is a treatment provider in the CTP, and she was respondent's primary clinician from 2017 until February 2019. Williams testified that respondent's motivation for treatment recently has been "lackluster." Respondent, for example, has not significantly participated in recent group therapy sessions, and he has failed to complete several assignments. She confirmed respondent isolates himself on the unit, and thus does not demonstrate ability to engage with a support network.

Williams also is concerned that respondent currently denies sexual preoccupation, that he uses sex as coping, or that he exhibits offense-supportive beliefs. Williams noted respondent recently attempted to masturbate to one of his victims, which shows that he is sexually preoccupied. As to offense-supportive beliefs, Williams recounted one clinical encounter in which respondent stated he believed his stepdaughter was attempting to sexually entice him by showing him that she drew in crayon on her panties.

Williams also noted concerns about respondent's comments about child pornography. In 2017, respondent informed Williams that he "will always" have the desire to watch child pornography and that he has limited willpower when it comes to viewing child pornography. In February 2019, respondent informed her that "viewing child pornography is better than a hands-on

[9] As noted, Williams testified by de bene esse deposition.

offense" and he would "allow" himself to view child pornography upon release. (See also Gov't Ex. 9 at 2556).

G. Release Plans

Respondent does not have a firm release plan, and he has not secured housing. He has expressed interest in living "off the grid" in Mexico or rural Arkansas, and has stated that he believes he can refrain from sexually offending by isolating himself. (Gov't Ex. 9 at 2552). Respondent also filed motion in his sentencing court requesting that the court confirm his term of supervised release expired during his commitment. Mot. for Termination of Supervised Release, United States v. [redacted] No. 2:00-CR-20102-JPM-1 (E.D. Tenn. July 2, 2013). At hearing, respondent's counsel reported that the United States Probation Office's position is respondent no longer is subject to supervised release.

At close of hearing, respondent argued that he should be released on conditions, which can include required sex offender treatment, limitations on internet use, and GPS monitoring. Respondent noted that because petitioner opposes release (even on conditions), the BOP will not begin efforts to find a housing placement or arrange for outpatient sex offender treatment unless the court orders them to do so. Accordingly, respondent maintains that the BOP (in consultation with counsel) can arrange a suitable release plan in the event the court orders respondent released on conditions. Respondent also testified at hearing that he will comply with all release conditions imposed by the court, including restrictions on internet use and sex offender treatment.

COURT'S DISCUSSION

A. The Adam Walsh Child Protection and Safety Act

The Adam Walsh Child Protection and Safety Act of 2006 ("Adam Walsh Act"), Pub. L. No.

109-248, § 302, 120 Stat. 587, 619-22 (codified in 18 U.S.C. §§ 4241, 4247, and 4248), established a program for civil commitment of individuals in the custody of the BOP, and others, who are determined to be "sexually dangerous person[s]." 18 U.S.C. § 4248(d). An individual committed under the Act may request discharge hearing pursuant to 18 U.S.C. § 4247(h), provided the motion is not filed within 180 days of a court determination that he is sexually dangerous. At the discharge hearing, respondent must demonstrate by a preponderance of the evidence that he no longer is a sexually dangerous person, or will not be sexually dangerous if released under a prescribed regimen of medical, psychiatric, or psychological care or treatment. 18 U.S.C. §§ 4247(h), 4248(e); see United States v. Maclaren, 866 F.3d 212, 217 (4th Cir. 2017) (noting respondent must make "evidentiary showing" to secure discharge under § 4247(h)); United States v. Barrett, 691 F. App'x 754, 755 (4th Cir. 2017) (explaining "when a person who has been civilly committed as sexually dangerous petitions for relief from his civil commitment under 18 U.S.C. § 4247(h), he bears the burden of showing by a preponderance of the evidence that he is no longer sexually dangerous within the meaning of 18 U.S.C. § 4247(a)(5)-(6)."); United States v. Wetmore, 812 F.3d 245, 248 (1st Cir. 2016) (same).[10]

A "sexually dangerous person" is one "who has engaged or attempted to engage in sexually

[10] The United States Court of Appeals for the Fourth Circuit has not definitively resolved whether § 4247(h) permits release on conditions requiring medical, psychiatric, or psychological care or treatment. See United States v. Wooden, 887 F.3d 591, 610 n.8 (4th Cir. 2018). Section 4247(h) permits civil detainees to apply for "discharge" from various forms of federal civil commitment, but it does not address whether conditional discharge is permitted. See 18 U.S.C. § 4247(h). Section 4248(e) permits conditional discharge for Adam Walsh Act detainees if the BOP initiates the discharge request. 18 U.S.C. § 4248(e). In Maclaren, the Fourth Circuit stated § 4247(h) "complements" the discharge procedure set forth in § 4248(e), and thus suggested that a § 4248 detainee may request conditional discharge under § 4247(h). 866 F.3d at 216-17. The court also notes that construing § 4247(h) to permit conditional discharge is consistent with the purpose of the Adam Walsh Act to protect the public from persons who have a history of inability to control their sexual attraction to children. See United States v. White, 927 F.3d 257, 261 (4th Cir. 2019) (noting "core" purpose of the Adam Walsh Act to "protect the public from sexual sexually dangerous persons"). Furthermore, the parties agree that § 4247(h) permits conditional discharge.

violent conduct or child molestation and who is sexually dangerous to others." 18 U.S.C. § 4247(a)(5). The phrase "sexually dangerous to others" means that "the person suffers from a serious mental illness, abnormality, or disorder as a result of which he would have serious difficulty in refraining from sexually violent conduct or child molestation if released." 18 U.S.C. § 4247(a)(6).

Thus, at the initial commitment hearing, petitioner must show that respondent 1) has previously "engaged or attempted to engage in sexually violent conduct or child molestation"; 2) currently "suffers from a serious mental illness, abnormality, or disorder"; and 3) "as a result of" such condition, "would have serious difficulty in refraining from sexually violent conduct or child molestation if released." 18 U.S.C. §§ 4247(a)(5), (6), 4248(d); see also United States v. Comstock, 560 U.S. 126, 130 (2010). To obtain discharge pursuant to § 4247(h), respondent therefore must show by a preponderance of the evidence that one of the foregoing conditions no longer applies, or would not apply if the court released him on a prescribed regimen of medical, psychiatric, or psychological care and treatment. See 18 U.S.C. § 4248(e); Maclaren, 866 F.3d at 217; Barrett, 691 F. App'x at 755. "The burden of showing something by a 'preponderance of the evidence,' . . . simply requires the trier of fact 'to believe that the existence of a fact is more probable than its nonexistence before he may find in favor of the party who has the burden to persuade the judge of the fact's existence." Concrete Pipe & Prods. of California, Inc. v. Constr. Laborers Pension Tr. for S. California, 508 U.S. 602, 622 (1993) (alterations omitted) (quoting In re Winship, 397 U.S. 358, 371–72 (1970) (Harlan, J., concurring)).

B. Prong One - Prior Acts of Child Molestation or Sexually Violent Conduct

Respondent does not contest prong one is satisfied, and his history, set forth above,

affirmatively demonstrates respondent has engaged in prior acts of child molestation. Accordingly, respondent is not entitled to discharge based on absence of prong one.

C. Prong Two - Serious Mental Illness or Disorder

Prong two addresses whether respondent currently suffers from a serious mental illness, abnormality, or disorder. 18 U.S.C. § 4247(a)(6); Comstock, 560 U.S. at 130. The second prong thus requires examination of the psychiatric diagnoses proffered by the experts. Such diagnoses, however, are "merely the starting point for the court to consider the true thrust of the § 4247(a)(6) inquiry – whether, on a case-specific basis, the respondent's underlying condition constitutes a serious functional impairment." United States v. Caporale, 701 F.3d 128, 137 n.4 (4th Cir. 2012).

All experts diagnosed respondent with pedophilic disorder, and opined this disorder constitutes a serious functional impairment.[11] Respondent does not contest these findings. Accordingly, the court finds respondent has not established by a preponderance of the evidence that he no longer suffers from a serious mental illness, abnormality, or disorder, as defined in the Act.

D. Prong Three – Serious Difficulty Refraining From Sexually Violent Conduct or Child Molestation

To meet his burden on prong three, respondent must prove by a preponderance of the evidence that he no longer would have serious difficulty refraining from sexually violent conduct or child molestation if released. 18 U.S.C. §§ 4247(h), 4248(e); Maclaren, 866 F.3d at 217; Barrett, 691 F. App'x at 755. "[T]he 'serious difficulty' prong of § 4248's certification proceeding refers to the degree of the person's 'volitional impairment,' which impacts the person's ability to refrain from acting upon his deviant sexual interests." United States v. Hall, 664 F.3d 456, 463 (4th Cir.

[11] Dr. Rigsbee also diagnosed respondent with antisocial personality disorder. The court, however, credits Dr. Plaud and Dr. Rosell's opinions that antisocial personality disorder is not present in this case. (See Resp't Ex. 2 at 13; Resp't Ex. 4 at 16-18).

2012) (quoting Kansas v. Hendricks, 521 U.S. 346, 358 (1997)). In other words, "civil commitment statutes [that] have coupled proof of dangerousness with the proof some additional factor, such as a 'mental illness' or 'mental abnormality' . . . serve to limit involuntary civil confinement to those who suffer from a volitional impairment rendering them dangerous beyond their control." Kansas, 521 U.S. at 358

In evaluating the third prong, the court considers the following factors: 1) history of acting on pedophilic urges or deviant sexual interests; 2) continued high-risk behavior; 3) failures while on supervision; 4) resistance to treatment; 5) continued deviant thoughts; 6) cognitive distortions; 7) actuarial risk assessments and dynamic risk factors; 8) impulsiveness; and 9) historical offenses. See United States v. Wooden, 693 F.3d 440, 459, 462 (4th Cir. 2012). The court also examines respondent's age, offense-free time in the community, ability to comply with institutional rules, commitment to controlling deviant behavior, respondent's testimony regarding volitional control, and supervised release conditions. Hall, 664 F.3d at 464-67.

The parties and experts dispute whether respondent would have serious difficulty refraining from child molestation or sexually violent conduct if released under conditions. There is no dispute, however, that many of the Wooden factors support a finding of volitional impairment. Respondent has a lengthy history (both while incarcerated and in the community) of acting on his deviant sexual interests. Similarly, his historical offenses establish that he lacked volitional control when he was last in the community. As discussed further below, respondent undoubtedly continues to display cognitive distortions[12] and deviant sexual attraction. Finally, although respondent has progressed

[12] Cognitive distortions refer to thinking patterns that "allow sex offenders to explain their actions in a way to manage the impressions of others and in a way to make themselves more socially palatable." Wooden, 693 F.3d at 452 n.5 (quotation omitted).

to phase three of the CTP program, his motivation for treatment has been uneven at times.

The primary issue is whether respondent's age, declining health, actuarial scores, participation in sex offender treatment, and lack of disciplinary infractions outweigh the factors set forth above. To address these issues, the court summarizes the experts' testimony concerning volitional impairment.

1. Dr. Justin Rigsbee

Dr. Rigsbee, a BOP forensic psychologist, testified as petitioner's expert witness. Dr. Rigsbee completed an annual forensic report in March 2019, and opined respondent remains a sexually dangerous person. (Gov't Ex. 8 at 17). Respondent declined Dr. Rigsbee's offer to participate in a clinical interview, and thus Dr. Rigsbee's report and testimony are based on records review, observation of respondent's hearing testimony, and his training and experience. (Id. at 3).

Dr. Rigsbee testified respondent would have serious difficulty refraining from child molestation if released. Dr. Rigsbee acknowledged respondent's actuarial score on the Static 99-R[13] reflects a low risk of reoffense. However, Dr. Rigsbee identified numerous dynamic risk factors which increase the risk of reoffense in this case: 1) resistance to treatment; 2) sexual preoccupation; 3) offense-supportive beliefs; 4) cognitive distortions; 5) poor problem solving; 6) grievance thinking; and 7) resistance to rules and supervision.

To illustrate resistance to treatment and rules/supervision, Dr. Rigsbee testified about two concerning incidents that occurred when respondent was in treatment. As discussed above, respondent attempted to contact his stepdaughter, one of his victims, despite his treatment provider

[13] The Static 99R is an actuarial tool that measures risk of committing another sex offense by examining "static" risk factors that are not amenable to change over time. See Hall, 664 F.3d at 464. Dr. Rigsbee scored respondent a two, which corresponds to an average risk of reoffense, and an approximate 5.6% risk of reoffense in five years if respondent is compared to the routine sample group. (Gov't Ex. 8 at 15-16).

instructing him not to do so. Respondent also became confrontational when his peers attempted to hold him accountable by suggesting his plan was a symptom of his ongoing pedophilia. As noted above, respondent also stated that he planned to view child pornography after release as a means to avoid committing a hands-on offense. According to Dr. Rigsbee, these behaviors and statements reflect that respondent is resistant to treatment, and will have difficulty complying with release conditions.[14]

Dr. Rigsbee also found evidence of sexual preoccupation. Dr. Rigsbee noted respondent has watched television programs depicting minors in revealing clothes, made statements that he plans to view child pornography upon release, and attempted to contact his stepdaughter. Dr. Rigsbee also noted that respondent is taking Prozac and Buspar to control his sexual urges, and he would "not expect" respondent to need medication to control sexual urges at his age. Respondent also recently attempted to masturbate to one of his prior victims, which according to Dr. Rigsbee reflects ongoing sexual preoccupation.[15] On cross examination, Dr. Rigsbee acknowledged that one of the defining features of pedophilic disorder is sexual urges directed to prepubescent children, and that the condition is considered chronic. Dr. Rigsbee thus agreed that some of the evidence of sexual preoccupation is explained by respondent's pedophilic disorder. Dr. Rigsbee, however, expected that respondent would show better ability to manage these thoughts given the amount of time he has spent in treatment.

Dr. Rigsbee also testified that respondent has shown offense-supportive attitudes and cognitive distortions in the CTP, as reflected in his numerous statements suggesting his stepdaughter

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[14] Dr. Rigsbee also relied on the CTP treatment providers' notes and testimony, summarized above, documenting respondent's resistance to treatment.

[15] As noted above, respondent reports that he was not able to achieve an erection at the time.

enticed him. As noted, respondent continues to have this distortion/offense-supportive belief despite years of sex offender treatment. Dr. Rigsbee also testified respondent's inability to form a viable release plan and his statements that he will avoid offending by isolating himself reflect poor problem solving.

Dr. Rigsbee acknowledged that advanced age is associated with lower rates of sex offense recidivism. According to Dr. Rigsbee, however, the recidivism rate for offenders over 70 years old is not zero and thus some "atypical offenders" recidivate despite their advanced age. Dr. Rigsbee believes respondent fits the "atypical" pattern based on the dynamic risk factors and his behavior in treatment set forth above. He also noted that respondent was 50 years old at the time he committed his index offense, which itself indicates respondent does not fit the typical pattern with respect to age. Dr. Rigsbee did not find evidence suggesting any of respondent's current health conditions would decrease his risk of recidivism. Finally, Dr. Rigsbee testified respondent's participation in sex offender treatment is not a protective factor because respondent continues to struggle with his cognitive distortions and sexual preoccupation despite years of treatment, he has been unable to "internalize" the treatment concepts, and he has shown inconsistent motivation to engage in treatment.

In sum, Dr. Rigsbee opined that respondent would remain sexually dangerous even if released on conditions. He noted that respondent needs to formulate a better release plan, and also needs to continue working on his sexual preoccupation and challenging his cognitive distortions and offense-supportive beliefs. Dr. Rigsbee also emphasized that respondent recently stated he would view child pornography upon release, which is the same behavior that preceded his index offense.

2. Dr. Joseph J. Plaud, Ph.D.

Dr. Plaud testified as respondent's expert, and opined respondent would not be sexually dangerous if released on conditions. Dr. Plaud's evaluation was based on clinical interview, extensive records review, and his training and experience conducting hundreds of sex offender evaluations. (See Resp't Ex. 4 at 12).

Dr. Plaud emphasized respondent is in an age group associated with the lowest rates of sexual recidivism, and his scores on the Static-99R reflect a low risk of reoffense. His report refers to seven peer-reviewed research studies showing rates of recidivism between approximately zero and five percent for offenders over age 70. (Id. at 2). According to Dr. Plaud, the foregoing research data is applicable to offenders, like respondent, who committed an offense at age 50.

Dr. Plaud also noted that he was one of the expert witnesses who testified at respondent's initial commitment hearing, and he opined respondent is less sexually dangerous today than when he was committed. He noted that the court's primary reasons for committing respondent – ongoing sexual preoccupation, lack of sex offender treatment, and lack of insight – are not applicable today. Respondent's sexual preoccupation appears to have declined, according to Dr. Plaud, as evidenced by respondent's lack of disciplinary infractions (including no writings to pen pals) or other inappropriate sexual behavior, and his self-reports that he rarely masturbates.

Dr. Plaud also noted respondent also has now participated in extensive sex offender treatment for approximately seven years, progressing to phase three of a four-phase program. Dr. Plaud acknowledged that respondent has struggled with internalizing some treatment concepts, and his motivation has fluctuated, but testified that many treatment participants have the same issues. Dr. Plaud explained that respondent is not sophisticated and has an avoidant, or "schizotypal"

interpersonal style that makes group treatment in particular challenging for him. Dr. Plaud emphasized that the treatment providers and Dr. Rigsbee only know about some of the risk factors discussed above because respondent has been forthcoming about them during treatment. According to Dr. Plaud, that demonstrates respondent is making progress in treatment. He emphasized respondent still needs sex offender treatment, but opined that his treatment needs can be resolved on an outpatient basis, particularly assuming respondent will be required to attend such treatment as a condition of release. And as to lack of insight, Dr. Plaud noted respondent now admits to a number of his offenses and cognitive distortions, although Dr. Plaud acknowledged that respondent has made some problematic statements during treatment.

Dr. Plaud also addressed some of the Dr. Rigsbee's findings. He noted that even assuming sexual preoccupation is present, it does not standing alone establish respondent is an outlier with respect to the research showing recidivism rates substantially decline after age 70. Dr. Plaud agreed with Dr. Rigsbee that respondent has significant cognitive distortions, but similarly testified there is no research suggesting cognitive distortions predict sexual recidivism or that the age research data does not apply to persons who have distortions.

Dr. Plaud also addressed respondent's statements that he intended to view child pornography upon release. Dr. Plaud acknowledged that the research literature shows a limited correlation between viewing child pornography and sexual recidivism for offenders who have a history of contact-based offenses. In Dr. Plaud's view, however, respondent's ability to view child pornography can be managed through release conditions. Dr. Plaud also testified that even if respondent views child pornography, his risk of committing child molestation or sexually violent conduct remains low given the protective factors in this case.

As to respondent's attempts to contact his prior victim, Dr. Plaud did not consider this behavior a significant risk factor because respondent may have been attempting to "atone" for his past behaviors.[16] Dr. Plaud also noted that respondent's release conditions can prohibit contact with prior victims.

Dr. Plaud testified respondent's progress in the CTP program suggests he will comply with release conditions. Dr. Plaud noted respondent has been in inpatient treatment for approximately seven years. And despite numerous negative reviews and problems during the CTP, he is still participating in treatment. In Dr. Plaud's view, the fact respondent has persevered in the program for seven years supports the view that respondent will continue to attend sex offender treatment even if released. Dr. Plaud also emphasized that respondent's lack of disciplinary infractions and the fact he successfully completed a term of probation in 1977 also suggest that he will comply with release conditions in the community.

Dr. Plaud also explained that respondent's offense history primarily involves family victims, and opined that strict conditions on release should prevent him from accessing the types of victims he has offended against in the past. Dr. Plaud acknowledged respondent's index offense involved an attempt to purchase a child over the internet, but noted that respondent's internet activity also can be modified through conditions. Dr. Plaud noted that if respondent had an extensive history of offending against stranger victims or impulsive offending, then he might be at greater risk to recidivate regardless of conditions. But respondent's offense pattern should be manageable on conditions.

In sum, Dr. Plaud testified the protective factors in this case, including respondent's age,

[16] As noted above, respondent's treatment providers believe respondent attempted to contact the victim in order to start a new sexual relationship with her.

participation in sex offender treatment, and his lack of disciplinary infractions, establish respondent will not be sexually dangerous to others if released on conditions.

3. Dr. Luis Rosell, Psy.D.

Dr. Rosell also testified as respondent's expert, and opined respondent would not be sexually dangerous if released on conditions. Dr. Rosell's evaluation was based on clinical interview, extensive records review, and his training and experience conducting hundreds of sex offender evaluations. (See Resp't Ex. 2 at 2).

Dr. Rosell agreed with much of Dr. Plaud's analysis. Dr. Rosell testified that respondent's participation in intensive sex offender treatment, although admittedly "rocky" at times, is a protective factor in this case. He stated the research literature shows individuals who engage in sex offender treatment have lower recidivism rates than offenders who do not participate in treatment. Dr. Rosell emphasized that the evidence of cognitive distortions in this case all came from respondent's self-disclosures, which indicates compliance with treatment.

Dr. Rosell testified that research has consistently shown the risk of recidivism for persons over age 70 is low, and Dr. Rosell did not detect anything in respondent's clinical profile that suggests such research would not apply in this case. He testified data showing risk of recidivism substantially decreases after age 70 holds true even if the offender committed an offense after age 50. Dr. Rosell also scored respondent a two on the Static 99-R.[17] He noted that is an average actuarial score and is not associated with a significantly increased risk of recidivism.

Dr. Rosell considered the dynamic risk factors and issues identified the court's order committing respondent, including sexual preoccupation, cognitive distortions, and lack of insight.

[17] Dr. Rosell scored respondent a one on the Static-99R in his report, but acknowledged at hearing that respondent validly can be scored a two.

Dr. Rosell agreed with Dr. Plaud that respondent's sexual preoccupation has decreased since he has been committed, as evidenced by his lack of disciplinary infractions and his self-reported decrease in sexual fantasies.

As to cognitive distortions and lack of insight, Dr. Rosell testified that respondent was able to articulate how he harmed his victims, which shows improved insight. Notably, respondent informed Dr. Rosell that he likely should not have been released after his term of incarceration ended because he had not participated in sex offender treatment at that time. Dr. Rosell acknowledged that respondent needs additional sex offender treatment to continue working through some of his cognitive distortions and other issues identified by the CTP clinicians. However, Dr. Rosell believed respondent has shown ability to manage his cognitive distortions while in treatment, and respondent can be safely discharged to outpatient treatment to continue working through these issues. Dr. Rosell also agreed with Dr. Plaud's testimony that there is no data showing cognitive distortions standing alone increase risk of recidivism or that presence of cognitive distortions makes respondent an outlier with respect to the research showing offenders at his age are at low risk of reoffense.

As to the child pornography issue, Dr. Rosell testified that respondent's admission that he will have difficulties preventing himself from viewing it is a sign of treatment progress. As a treatment provider, Dr. Rosell is more concerned when a patient is overconfident about his ability to refrain from sexually offending after release. Thus, Dr. Rosell did not consider respondent's comments about viewing child pornography were a significant risk factor.

Dr. Rosell also disagreed with Dr. Rigsbee that respondent's attempts to contact his prior victim and to masturbate to fantasies about a victim evidence continued sexual preoccupation and

dangerousness. Dr. Rosell explained that it is common for offenders to have fantasies about their victims and engage in masturbation as a response. Additionally, Dr. Rosell noted respondent disclosed it to a treatment provider, which shows respondent is progressing in treatment. As to his attempts to contact a prior victim, Dr. Rosell noted the victim is now an adult and he would be more concerned about attempts to contact a minor.

In sum, Dr. Rosell testified the protective factors in this case, including respondent's age, participation in sex offender treatment, and his lack of disciplinary infractions, establish respondent will not be sexually dangerous to others if released on conditions. Dr. Rosell also noted that respondent understands if he commits another sexual offense or views child pornography, he will likely spend the rest of his life in prison, which is a significant external motivator to comply with conditions of release.

4. Analysis

While this is a close case, the court finds respondent has established by a preponderance of the evidence that he will not be sexually dangerous to others if released on conditions. The court found Dr. Plaud and Dr. Rosell's opinions on the volitional impairment prong to be more well-reasoned and persuasive than Dr. Rigsbee's opinion. The court adopts their findings with respect to the volitional impairment prong, and finds that such evidence outweighs petitioner's evidence of volitional impairment.[18]

The court did not find persuasive Dr. Rigsbee's testimony or petitioner's arguments that respondent is an "outlier" with respect to the data showing risk of recidivism substantially decreases at respondent's age. In the past six years of respondent's commitment, he has not demonstrated

[18] The court also finds such evidence outweighs the Wooden factors discussed above that support a finding of volitional impairment.

inability to control his pedophilic urges. He has not corresponded with pen pals about sexual abuse of children, he has not attempted to contact prepubescent children, and he has not possessed any inappropriate sexual materials. And where respondent previously engaged in this behavior while incarcerated, the fact that he has not done so for at least six years shows that his volitional control has improved. See United States v. Antone, 742 F.3d 151, 167-68 (4th Cir. 2014).

Petitioner also argues respondent's age is not a protective factor because his index offense occurred when he was 50 years old. As Dr. Plaud and Dr. Rosell testified, however, the research showing lower risk of recidivism after age 70 holds true regardless of whether an offender committed an offense in his fifties. The court credits this testimony over Dr. Rigsbee's opinion.

Dr. Rigsbee relied on respondent's comments that he intended to view child pornography upon release, his recent attempt to masturbate to a prior victim, and the fact that he watches inappropriate television programming in support of his opinion that respondent remains sexually dangerous despite his age. Dr. Rigsbee also noted that respondent is taking medication to decrease his sexual arousal, which he would not expect if respondent's libido had decreased with age. The court agrees that respondent remains sexually attracted to prepubescent children. The issue, however, is whether respondent has attained volitional control over those sexual urges. As set forth above, there is no current evidence that respondent remains volitionally impaired, and the research data in this area suggests respondent's risk of recidivism is exceptionally low. Dr. Rigsbee did not provide the court with any research data showing that continued sexual thoughts about children or attempts to masturbate renders this research inapplicable.[19]

[19] As Dr. Plaud and Dr. Rosell testified, respondent's age is a protective factor for a number of reasons, including that his health is deteriorating, and that as people age they develop more control over their deviant thinking patterns or cognitive distortions. Thus, even assuming respondent's sexual drive remains high despite his age, factors beyond reduced libido may explain why recidivism rates decrease with age.

The parties also dispute whether respondent's progress in the CTP program is a protective factor. As set forth above, respondent has progressed to phase three, but he has made numerous comments in treatment reflecting ongoing cognitive distortions, continued sexual attraction to prepubescent children, and lack of empathy for his victims. He also has struggled completing assignments and he has not been able to articulate a viable release plan.

The court agrees with Dr. Rigsbee that respondent's progress in the CTP program is not encouraging. At the same time, the court credits Dr. Rosell's opinion that neither the treatment providers or petitioner would know about these issues if respondent had not voluntarily disclosed them during treatment. The fact that respondent has admitted his ongoing struggle with desire to view child pornography and his cognitive distortions shows that he is attempting to make some progress in treatment. Respondent's interpersonal and communication style also may account for some of his struggles in the CTP program. Accordingly, while respondent's participation in the program has not been impressive, the fact remains that he has engaged in inpatient sex offender treatment for the past seven years, and he will be subject to strict conditions requiring additional treatment upon release.[20] The court cannot say that respondent's difficulties in the CTP program establish that respondent lacks volitional control at this time.

The court also has fully considered Dr. Rigsbee's dynamic risk factor analysis, and the presence of respondent's strong cognitive distortions. The court agrees that most of the risk factors Dr. Rigsbee identified are present, which increases the risk of recidivism in this case. Respondent also does not dispute that he continues to suffer from cognitive distortions. As Dr. Plaud and Dr.

[20] Petitioner also argues respondent's motivation to participate in the CTP program is driven by his interest in discharge from civil commitment. Assuming that is true, the same external motivation will be present after respondent's release. If respondent does not comply with the terms of his release requiring sex offender treatment, his conditional release may be revoked and he may have to return to the CTP. See 18 U.S.C. § 4248(f).

Rosell persuasively testified, however, the age data and the fact that respondent has not shown current inability to control his sexual impulses outweighs the limited evidence that these dynamic risk factors increase risk of recidivism.

Finally, the court addresses respondent's attempts to contact his stepdaughter and his statements about viewing child pornography. The court is troubled by respondent's attempts to contact his stepdaughter, particularly in light of his admitted attempt to masturbate to fantasies about her.[21] The court notes, however, that respondent agreed that he would not contact her after his treatment peers challenged him, and there is no evidence in the record that he did so. Respondent thus is amenable to treatment interventions addressing this issue. Accordingly, respondent's attempts to contact his stepdaughter, while concerning, do not outweigh the evidence of volitional control set forth above.

As noted, respondent recently informed his primary therapist that he will "allow himself" to view child pornography if released. Respondent candidly testified at hearing that he is addicted to child pornography. The fact that he disclosed his urge to view child pornography to his primary therapist suggests he is amenable to treatment intervention in this area. Respondent also agreed to abide by conditions limiting his access to the internet if he is released. The court agrees with Dr. Plaud that the child pornography issue can be addressed on an outpatient basis assuming appropriate restrictions and probation monitoring are in place.

In sum, the court finds Dr. Plaud and Dr. Rosell's volitional control analyses are the more well-reasoned and persuasive opinions in this case. Accordingly, the court will order respondent released on conditions.

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[21] The court does not agree with Dr. Plaud's opinion that respondent was attempting to "antone" for his past offenses when he attempted to contact her.

The court emphasizes respondent's release is "conditional." In the event respondent fails to comply with any conditions of release, the provisions of 18 U.S.C. § 4248(f) will apply. Section 4248(f) provides that upon notice to the court having jurisdiction over respondent that respondent has failed to comply with conditions of release, respondent

> may be arrested, and, upon arrest, shall be taken without unnecessary delay before the court having jurisdiction over him. The court shall, after a hearing, determine whether [respondent] should be remanded to a suitable facility on the ground that he is sexually dangerous to others in light of his failure to comply with the prescribed regimen of medical, psychiatric, or psychological care or treatment.

18 U.S.C. § 4248(f). Thus, in the event respondent fails to comply with conditions of release, he may be arrested and committed again to the custody of the Attorney General as a sexually dangerous person. The court expects respondent to strictly comply with conditions of release.

CONCLUSION

Based on the foregoing, the court finds by a preponderance of the evidence that respondent will not be sexually dangerous to others if released under a prescribed regimen of medical, psychiatric, or psychological care or treatment. The court GRANTS respondent's motion for discharge (DE 85), but STAYS respondent's release from his civil commitment pending court approval of a conditional release plan. Petitioner and counsel for respondent are DIRECTED to file conditional release plan within the next 60 days. After the parties file the conditional release plan, the court will consider the plan, and approve it, direct modifications to it, or reject it.

SO ORDERED, this the 5th day of August, 2019.

LOUISE W. FLANAGAN
United States District Judge