

COURT OF APPEALS  
DIVISION TWO  
OF THE STATE OF WASHINGTON

STATE OF WASHINGTON )

Respondent, )

v. )

Ronald mendes )

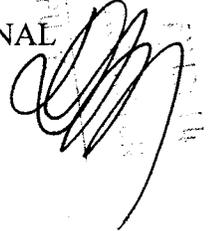
(your name) )

Appellant. )

No. 38642-<sup>9-</sup>II

STATEMENT OF ADDITIONAL  
GROUNDS FOR REVIEW

RECEIVED  
JAN 20 2010  
COURT OF APPEALS  
DIVISION TWO  
SEATTLE, WA



I, Ronald mendes, have received and reviewed the opening brief prepared by my attorney. Summarized below are the additional grounds for review that are not addressed in that brief. I understand the Court will review this Statement of Additional Grounds for Review when my appeal is considered on the merits.

Additional Ground 1 of 2

TESTIMONY by the states witness said for Him/mr Balinger to wake MR SAVOR up when I got there, "ONE" MR SAVOR HAD PLANNED ON ASSAULTING me And did so, two the court Errored by NOT MAKING IT CLEAR ~~HOW~~ How much MR SAVOR HAD of meth AMPHETAMINE And AMPHETAMINE with what His levels were he was NOT sleeping, the COURT Errored IN NOT EXPLAINING why AFTER the first witness ON THE STAND hori Palomo left COURT ROOM SISTER'S of MR SAVOR followed miss Palomo out to HALL WAY AND BEAT Her DOWN IN front of the next witness And T.P.D. Broke IT UP AND STAIed IN COURT ROOM, (3 <sup>Additional Ground 2</sup> TACOMA, TWO Pierce COUNTY) IN front of jury

the COURT Errored by NOT showing JURY my medical condition where AS I Had A HIP ReplACEMENT 5 months AFTER INCIDENT And I Am WAITING for second hip ReplACEMENT And, Im in A wheel-CHAIr Health STATUS Report ENCLOSED I WAS ATTACKED NOT ONCE BUT TWICE from behind, ONE of the STATES witnesses MCKAY BROWN CALled Prosecutorial And said He needed money to make IT to court, He Showed UP hate And WAS PAID by ROSE MARTINELLI, IT seems STRANGE to me my trial Attorney ASKed for ASSISTANCE from His office And JUDGE Denied CO counsel YET MARTINELLI Had Detective threw whole trial

Date: 7/7/09

Signature: Ronald Mendes

pg 2

## ADDITIONAL Grounds 2 of 2

IN closing I told MR BROWN I would BE  
back to talk to MR SAYLOR AT NO TIME did  
He state MR SAYLOR WAS MAD I told them  
I WAS selling A CADILLAC AND would BE  
By later if ANY ONE premeditate ANY  
thing it WAS MR SAYLOR AND MR BROWN  
KNOWING I would HAVE money from SALE of  
CAR, AND knew I WAS disabled AND could  
be subdueD AND BEAT UP EASILY, they were  
ALL USING Drugs THAT WEEKEND BY there own  
testimony AND toxicology tests AND were OUT  
of money AND Drugs So I WAS told by MR Bolinger  
AND MR BROWN, MR SAYLOR NEVER tried to talk  
to me He WAS ON A MISSION, He RAN STRAIGHT  
AT me from Behind AND ATTACKED me NOT ONCE  
BUT twice, Had I NOT been warned BY MR-  
Bolinger to "look OUT Ron" the BACK of my  
Head would HAVE BEEN "Sotaly HIT AND I'm SURE  
with the Amount of force that MR SAYLOR WAS  
coming AT me He would HAVE killed me AND will  
take A polyGRAPH to the fact I knew I WAS  
going to Die if He HIT me

Sincerely Ron menden



HEALTH STATUS REPORT

DE-101

FACILITY WSP	LIVING UNIT D	REFERRED BY S. Nelson	REFERRAL DATE 1-22-09
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**1. PURPOSE**

<input type="checkbox"/> Initial Evaluation <input checked="" type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Mental	<input type="checkbox"/> Change in Status <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Mental	<input type="checkbox"/> Work/School Assignment Clearance <input type="checkbox"/> Food Service <input type="checkbox"/> Barber Shop <input type="checkbox"/> DNR <input type="checkbox"/> Other	<input type="checkbox"/> Transfer/Transportation <input type="checkbox"/> Camp <input type="checkbox"/> Pre-Release <input type="checkbox"/> Work Release	<input type="checkbox"/> Other Classification Specify if other than program review. <input type="checkbox"/> Other Specify
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**2. EVALUATION/TREATMENT IN PROGRESS OR TO BE INITIATED, DEFERRED, OR REEVALUATED:**

Medical (Month, Day, and Year)     Dental (Month, Day, and Year)     Mental (Month, Day, and Year)

**3. INFIRMARY/INPATIENT ADMISSIONS/DISCHARGES:**

Admitted	Date:	Time:	Room:	Bed #	(Optional)	Discharged	Date:	Time:
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**4. RESTRICTIONS/LIMITATIONS**

	Med	Dent	Ment	RESTRICTIONS/LIMITATIONS (Continued)	Med	Dent	Ment
<b>A. Housing Restrictions/Limitations</b>				<b>D. Activities</b>			
(1) No Restrictions/Limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(1) No Restrictions/Limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(2) Single Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(2) Bed rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(3) Lower Bunk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(3) Meals In	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(4) No Stairs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(4) Restricted to Living Area/Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(5) Other - Specify in Comments (5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(5) Other-specific comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(6) Review / Termination Date:				(6) Review / Termination Date:			
<b>B. Assignment/Work/School/Athletics, etc.</b>				<b>E. Transport</b>			
(1) No Restrictions/Limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(1) No Restrictions/Limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(2) No Heavy Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(2) Restrictions/Special Requirements - Specify in Comments (5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(3) No Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>F. Health Care Equipment</b>			
(4) No Vigorous Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(1) No Restrictions/Limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(5) No Prolonged Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(2) Crutches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(6) No Machine Operation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(3) Cane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(7) Other - Specify in Comments (5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(4) Walker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(8) Review / Termination Date:				(5) Wheel Chair	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>C. Dietary</b>				<b>G. Food Service/Barber Shop/DNR</b>			
(1) No Restrictions/Limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(1) No Restrictions/Limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(2) No Concentrated Sweets/Low Fat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(2) Food Service Cleared - No Restrictions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(3) Mechanical Soft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(3) Barber Shop Cleared - No Restrictions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(4) Food Allergy - Specify in Comments (5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(4) DNR Cleared - No Restrictions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(5) Clear Liquid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(5) Restrictions - Specify in Comments (5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(6) Full Liquid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
(7) Health Snack <input type="checkbox"/> Br. <input type="checkbox"/> Lunch <input type="checkbox"/> Din.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
(8) Review / Termination Date:							

**5. COMMENTS**     Medical     Dental     Mental

Low Tier, Wheel Chair  
Foam wedge for Between Legs at night

MEDICAL CARE PROVIDER S. Nelson	DATE 1-22-09	DENTAL CARE PROVIDER	DATE	MENTAL HEALTH CARE PROVIDER	DATE
HEALTH CARE/MGR/AUTHORITY/DESIGNEE (Optional)	DATE	CUSTODY (Optional)	DATE	CLASSIFICATION MANAGER/AUTHORITY (Optional)	DATE

**DISTRIBUTION:**

<input type="checkbox"/> Health Record	<input checked="" type="checkbox"/> Offender	<input type="checkbox"/> Shift Sergeant	<input type="checkbox"/> Laundry	<input type="checkbox"/> Supply Tech
<input type="checkbox"/> Central File	<input checked="" type="checkbox"/> Recreation	<input checked="" type="checkbox"/> Unit Sergeant	<input type="checkbox"/> Dietary	<input type="checkbox"/> Other (1)
<input type="checkbox"/> Counselor/CUS	<input type="checkbox"/> Control			<input type="checkbox"/> Other (1)

State law (RCW 70.02; RCW 70.24.105; RCW 71.05.390) and/or federal regulations (42 CFR Part 2; 45 CFR Part 164) prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.



STATE OF WASHINGTON  
DEPARTMENT OF CORRECTIONS  
WASHINGTON STATE PENITENTIARY

OFFENDER I.D. DATA: MENDES, RONALD  
(name, DOC #, birthdate) 762933  
Housing Unit: D-E101

# INMATE COPY

## WSP REVIEW COMMITTEE DECISION – PATIENT NOTIFICATION

DATE  
June 10, 2009

Referral for left hip resurfacing was reviewed and was:

- Approved, to be scheduled within 90 days. A medical or dental hold will be placed.
- Denied – See Comments
- Deferred – See Comments

Comments:

HEALTH SERVICES STAFF SIGNATURE 	DATE 6/10/09
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Distribution:     **ORIGINAL** – Offender                    **COPY** – Health Record

*State law (RCW 70.02; RCW 70.24.105; RCW 71.05.390) and/or federal regulations (42 CFR Part 2; 45 CFR Part 164) prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.*