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IN THE COURT OF APPEALS FOR THE STATE OF WASHINGTON  
DIVISION TWO

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IN RE THE PERSONAL RESTRAINT PETITION OF:

LIA Y. TRICOMO,

Petitioner.

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**AMENDED PERSONAL RESTRAINT PETITION AND REPLY**

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Judgment in Thurston County Superior Court No. 13-1-00655-7  
The Hon. Gary Tabor, Presiding

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**A. INTRODUCTION**

Lia Yera Tricomo seeks relief from a Thurston County judgment for murder, three counts of assault and taking and riding a motor vehicle, for killing her former mental health counselor who abused his position of trust to have an illicit sexual relationship with her. In a timely pro se Personal Restraint Petition, Ms. Tricomo raised challenges based on double jeopardy, prosecutorial misconduct, ineffective assistance of counsel, and the failure of the trial court to consider the effect of the drug Paxil on Tricomo's behavior.

After the State responded to the pro se PRP, Ms. Tricomo obtained counsel, who is filing this pleading as both a reply and an amended petition. The issue raised in this pleading is the ineffectiveness of Ms. Tricomo's trial counsel when he failed to provide the sentencing court with an appropriate expert to render an opinion about the effect of Paxil on Ms. Tricomo's behavior.

While an amended petition is not necessarily required, as this pleading does not really raise new issues, the Court should consider the claims raised in this pleading in conjunction with the closely related claims that Ms. Tricomo has already raised pro se. Counsel will file a

separate motion regarding amendments to PRPs and the interplay with the non-jurisdictional “time-bar” statute in RCW 10.73.090. *See In re Pers. Restraint of Davis*, 188 Wn.2d 356, 362 & n.2, 395 P.3d 998 (2017), *abrogated on other grounds in State v. Gregory*, 192 Wn.2d 1, 427 P.3d 621 (2018). Because of the new facts brought up in this pleading (i.e. the opinion of an appropriate expert about the effects of Paxil), the State should be given the opportunity to file a new response, to which Ms. Tricomo will file a reply.

**B. STATUS OF PETITIONER**

Petitioner Lia Tricomo applies for relief from restraint as defined in RAP 16.4(b). Ms. Tricomo challenges the judgment in Thurston County Superior Court No. 13-1-00655-7 for one count of second degree murder, three counts of assault in the second degree and one count of taking and riding a motor vehicle without permission. The judgment was entered on January 28, 2015. CP 213-22; Ex. 3 at 13-22.<sup>1</sup> The Hon. Gary Tabor was the judge (now retired).

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<sup>1</sup> After Ms. Tricomo filed her PRP, upon the State’s motion, the Court transferred the Clerk’s Papers and transcripts from the direct appeal to this file. Additional documents are being submitted in a separate filing of exhibits which are successively paginated.

Ms. Tricomo is currently incarcerated at the Washington State Corrections Center for Women in Gig Harbor, Washington (DOC No. DOC # 348594), serving determinate sentences of 357 months for the murder conviction, 70 months on the three assault counts and 12 months on the taking and riding count, the sentences to be served concurrently. CP 213-22.

Mr. Tricomo appealed the convictions and sentence, raising three issues: (1) double jeopardy regarding the assault counts, (2) the guilty plea was invalid because Ms. Tricomo was not informed of the correct maximum sentence, and (3) the trial court erred when refusing to consider evidence Ms. Tricomo's mental state, including the effect of Paxil, at sentencing. COA No. 47238-4-II. This Court affirmed the convictions and sentences in an unpublished opinion (as amended on June 1, 2016). Ex. 4 at 23-35. Ms. Tricomo filed a petition for review, but the Supreme Court denied review on November 2, 2016 (Sup. Ct. No. 93379-1). Ex. 5 at 36-37. The mandate issued on January 5, 2017. Ex. 6 at 38-40.

On December 29, 2017, Ms. Tricomo filed a pro se, handwritten PRP. This PRP was timely, filed within one year of the issuance of the mandate. She also has not filed any other challenges to the judgment and

thus there are no issues regarding successive petitions. Ms. Tricomo also has no other sentences to serve when she completes the sentences in this case.

As noted, in her pro se PRP, Ms. Tricomo raised challenges based on double jeopardy, prosecutorial misconduct, ineffective assistance of counsel, and the failure of the trial court to consider the effect of the drug Paxil on her behavior. The State responded to Ms. Tricomo's claims. Ms. Tricomo then obtained counsel, who, on July 25, 2018, appeared and moved to stay consideration of the PRP pending further investigation. The Court granted the motion to stay and Ms. Tricomo, through counsel, is now filing this amended pleading.

**C. JURISDICTION**

This Court has jurisdiction under article IV, section 30 of the Washington Constitution, RAP 16.3(c) and RAP 16.5(a).

**D. STATEMENT OF GROUNDS FOR RELIEF**

**1. *Statement of Facts***

**a. **General Factual Background****

Ms. Tricomo had a very challenging upbringing, characterized by the instability of being raised by parents in a cult (the Unification Church),

poverty, transiency, and sexual abuse (molestation as a child in Japan, inappropriate sexualized comments from her father, and a violent rape as a teenager). As a result, Ms. Tricomo has been variously diagnosed as suffering from depression with psychotic features (reports of hallucinations), bipolar disorder, borderline personality disorder, and substance dependence. Ms. Tricomo has attempted suicide numerous times, including at attempts in custody. Still, Ms. Tricomo was (after a number of failed attempts) able to complete college and received a degree from the Evergreen State University in Olympia. She is also a talented violinist, and has played for a series of regional orchestras. CP 53-55, 57-58, 60-80, 82-96, 98-120, 136-45, 147-63; Ex. 14 at 145.

Ms. Tricomo began mental health counseling at Behavioral Health Resources (“BHR”) in Olympia in 2010. In November of 2011, Ms. Tricomo, who was 26 years of age, was assigned to counselor John Alkins (then 57 years old). Alkins was Ms. Tricomo’s counselor for about a year until he was terminated from BHR due to his misconduct with other female patients. Ex. 7 at 41-45. The records of Mr. Alkins’ sessions with Ms. Tricomo are not particularly notable except that she seemed very upbeat with him and he spent an unusual amount of time with her –

sessions often lasting two to three hours, whereas typically other therapists' sessions were only for one hour. *See, e.g.*, Ex. 8 at 46-74; Ex. 11 at 101-16. After Mr. Alkins was terminated from BHR in the fall of 2012, Ms. Tricomo was assigned to other therapists, including Lyn Hertz, who was Ms. Tricomo's therapist up until the homicide. Ex. 11 at 101-16.

In late March 2013, Ms. Tricomo attempted suicide, and ended up in the emergency room at St. Peter Hospital in Olympia. The doctor prescribed her a new antidepressant, paroxetine (also known as "Paxil"), and was discharged the same day.<sup>2</sup> Ex. 9 at 75-97. On April 3, 2013, Ms. Tricomo was seen at the Seamar Community Health Center as a follow up to her hospital visit, where Dr. Fatima Shah renewed the prescription for Paxil. Ex. 10 at 97-100. The next day, she was seen by her therapist, Lyn Hertz, who encouraged her to stay on the new antidepressant. Ex. 11 at 114.

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<sup>2</sup> In 2010, Ms. Tricomo was once prescribed Paxil during a prior civil commitment, CP 154, but she went off that medication, taking Prozac and Seroquel intermittently, Ex. 10 at 100 CP 136, 142, until she was prescribed Paxil again at St. Peter Hospital in March 2013. Ex. 9 at 77.

Ms. Tricomo did not appear at her appointment with Hertz on April 11, 2013. Ex. 11 at 115. On April 25, 2013, Ms. Hertz noted Ms. Tricomo's concerns about anger:

Lia brought up several issues of concern. Discussed and processed her ambivalence about the medication she is on. Looked at what she identifies as the root cause of her anger; She is angry that she is alive. She does not plan to harm herself, and in fact, talked about ways she used to inflict pain on herself. She does not want to do that anymore and does not want to take her life. However, she still in not happy about being alive. On the other hand, Lia is excited about an upcoming audition has for a job with the Spokane Symphony. . . .

. . . .

Lia does not like the way the medication makes her feel, even though she knows she feels calmer and happier, She expressed confusion about the experience of being happier. It is uncomfortable and unfamiliar. It seems to also take away her energy for acting out in anger.

Ex. 11 at 116.

A few weeks after she began taking Paxil, Ms. Tricomo needed to find a place to live. She had been communicating with her old counselor, John Alkins, and he suggested that Ms. Tricomo come and stay with him.

CP 56.

On April 29-30, 2013, Ms. Tricomo brought some of her belongings to Mr. Alkins' house, and she and Mr. Alkins drank a lot of

vodka and ate pasta. Mr. Alkins' blood alcohol level was .16 at the time of the autopsy.<sup>3</sup> Mr. Alkins wanted to have sex with Ms. Tricomo, suggesting that they have a "father-daughter" relationship. He also stated that he was into "golden showers." They had oral sex. Ms. Tricomo tied Mr. Alkins up, but he did like it so she untied him. She then cut his throat with a razor knife, a knife that she had brought with her to cut bondage ropes if need be. Even though his throat was cut, Mr. Alkins got dressed and wandered around the house for some time, not wanting to call 911 (apparently due to his compromised situation). Ms. Tricomo said she cut him a few more times. Ultimately, Alkins went up to his bedroom and Tricomo then strangled him to death. Tricomo stayed in the house overnight, thought about ways of trying to steal from his accounts, and ended up taking his car. Ms. Tricomo called the crisis line and then called her therapist, Ms. Hertz, who called the police. A few hours later, after going to her AA meeting, someone took Ms. Tricomo to St. Peter Hospital, and she was then arrested. Ms. Tricomo fully confessed to the police, noting at times that the effect of the new medication she was taking. CP 4-6, 68-69, 83-84, 91-96; Ex. 13 at 125, 128, 137, 140, 141-42.

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<sup>3</sup> Ex. 12 at 118.

**b. Proceedings in Superior Court**

On May 3, 2013, the State charged Ms. Tricomo in Thurston County Superior Court, No. 13-1-00655-7, with murder in the first degree and attempted murder in the first degree. CP 7. On November 6, 2014, the State amended the information to charge Ms. Tricomo with murder in the second degree, three counts of assault in the second degree, and taking a motor vehicle without permission. Represented by the public defenders (first, Robert Jimerson, and then, Patrick O'Connor),<sup>4</sup> Ms. Tricomo pled guilty. CP 25-26; RP (11/6/14) at 1-6. For the murder count, the parties agreed on an offender score of “8” with a standard range sentence of 257 to 357 months in prison. Although the plea agreement allowed the State to ask for the high end of the range, the agreement allowed the defense to argue for a lesser sentence, and did not rule out the court imposing an exceptionally low sentence.<sup>5</sup>

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<sup>4</sup> Mr. O'Connor substituted in for Mr. Jimerson on January 2, 2014. CP 24.

<sup>5</sup> Although the State's sentencing memo claimed that the defense was limited to asking for a sentence of no lower than 257 months, the low end of the range, CP 128, the plea agreement contains no such limitation, stating that the prosecutor would seek 357 months but that “Defense is free to argue for a lesser sentence.” CP 30. During the plea colloquy, the court repeated that the prosecutor was going to argue for 357 months but:

(continued...)

Sentencing took place on January 28, 2015. The State asked for 357 months, while the defense asked for 257 months. RP (1/28/15) 50, 82. Judge Gary Tabor imposed the top end of the standard range – 357 months – for the murder conviction. RP (1/28/15) 95.

**c. Issues about Paxil**

Not only did Ms. Tricomo tell the police in her confession about how Paxil had made her feel, Ex. 13 at 125, 128, 137, 140, 141-42, but when Ms. Tricomo was in jail awaiting trial, she also told the psychiatric staff that she believed Paxil was a cause of her behavior. A 9/9/13 jail psych note states: “Paxil, made her want to kill people, had horrible withdrawal,” and the jail psychiatrist decided to take her off Paxil: “She was dx with major depressive disorder there, but will err on side of caution, particularly as she describes problems with Paxil and historically being on mood stabilizers with antidepressants for the most part.” Ex. 14 at 146-47.

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<sup>5</sup>(...continued)

you understand that you are not agreeing that that is what the court should order and that, in fact, Mr. O’Connor will be able to argue that the court should impose a lesser sentence on your behalf.

RP (11/6/14) 8. The plea agreement further made it clear that whatever the parties’ recommendations, the court had the power to impose an exceptional sentence below the range if the court found sufficient mitigating circumstances. CP 30.

Ms. Tricomo's supporters in the community also thought Paxil was significant, and her ex-boyfriend's mother, Justine Turpin, repeatedly wrote to Ms. Tricomo's lawyers asking them to investigate the role of Paxil, sending them articles, and even offering to pay privately for a psychiatrist. Ex. 21 at 182-213. Ms. Tricomo herself filed a pro se motion with the court asking for a public defender other than Mr. Jimerson to be assigned and asking that the new lawyer retain both a psychologist and a psychiatrist. CP 23.

Prior to pleading guilty, the defense had Ms. Tricomo evaluated by a psychologist, Dr. David Dixon, for "diminished capacity." Copies of two versions of Dr. Dixon's resume/cv are at Ex. 17 at 160-67. Dr. Dixon tangentially addressed Paxil in his report. He noted that Ms. Tricomo reported that her last dose of Paxil was earlier the day of the incident and that she got violent if she missed a dose. He concluded that the Paxil and the vodka decreased her ability to control her impulses, and that "Use of and withdrawal from Paxil at the time of the alleged crime may have diminished her ability to form intent, a requisite mental state. Paxil withdrawal exacerbated her mood disorder into a manic state with psychosis." CP 78.

Dr. Delton Young, the State's psychologist, had a different conclusion. Not only did he not find diminished capacity but disagreed with Dr. Dixon about Paxil: "But there was no withdrawal: she was taking the medication every day (including on April 29th) as prescribed. It is possible that the medication generated aversive side effects (e.g., feeling "nothing"); but it is more likely that the psychotic symptoms stemmed from alcohol abuse in a psychologically vulnerable individual." CP 94.

Ms. Tricomo's attorney, Mr. O'Connor, also hired a mitigation investigator, Ms. Dhyana Fernandez. Her expertise was described as conducting "thorough social-history investigations" by reviewing records and interviewing witnesses, and compiling a history of the client. CP 50; *see* Ex. 19 at 174-78 (c.v.). Ms. Fernandez submitted a report to the court before sentencing (after the reports of the psychologists had been completed). In her report, Ms. Fernandez included an entire section about the effects of Paxil, and cited to a number of articles linking Paxil to violent behavior, articles she found on the Internet. CP 50-51, 56-57.

The State objected to consideration of Ms. Fernandez's report, both in general and specifically related to her lack of expertise regarding the effects of the medication Paxil. CP 132-33. Judge Tabor agreed to

consider most parts of Ms. Fernandez's report, but he refused to consider the portion of Ms. Fernandez's report dealing with Paxil because of her lack of expertise on the issue:

So what I want to make clear is that I'm going to consider the background information about Ms. Tricomo that's provided in Ms. Fernandez' report. I am, however, disregarding the section that appears at page 4 of her report. It begins there regarding Paxil. I don't find that she has any expertise in that particular area and she basically only sets forth a number of articles suggesting that they may have some relevance, but I'm not considering her report in that regard . . . .

RP (1/28/15) 39.

On direct appeal, in response to a claim that the trial court erred when excluding information about Paxil, this Court affirmed:

The trial court ruled that it would disregard the expert's discussion of medication, because "I don't find that [the expert] has any expertise in that particular area and she basically only sets forth a number of articles suggesting that they may have some relevance." VRP (Jan. 28, 2015) at 39. Tricomo fails to provide any argument as to how the trial court erred. Therefore, we do not consider this argument.

Ex. 4 at 34.

Thus, there is no question that Ms. Fernandez was not a qualified expert to discuss the effect of Paxil on Ms. Tricomo's behavior. Neither were Dr. Young and Dr. Dixon – both psychologists without a medical

background. *See* Exs. 16 & 17.<sup>6</sup> Mr. O'Connor did not consult any expert with medical or psychiatric expertise, and relied solely on Dr. Dixon and Dhyana Fernandez's reports at sentencing. Ex. 20 at 181.

Dr. Manuel Saint Martin is a qualified expert. He is a psychiatrist with practices in both Los Angeles and New York City. Ex. 2 at 6-12. He has reviewed the records connected with this case and has concluded that Paxil in fact caused Ms. Tricomo's violent behavior toward Mr. Alkins:

Ms. Tricomo was prescribed paroxetine to combat depression. Paroxetine is a selective serotonin antidepressant medication that has been in clinical use in the US since 1996. Postmarketing studies have revealed that paroxetine produces adverse effects of agitation, anger and acting on dangerous violent impulses. These adverse effects include suicidal and homicidal behavior. The adverse effects are more common in adolescents and young adults and in patients who have a history of bipolar disorder. Paroxetine's adverse effects are documented in the Federal Drug Administration (FDA) medication guide published in June 2012.

Ms. Tricomo is in the latter two categories of persons whom paroxetine can cause serious adverse effects of violence and suicide. She has a diagnosis of bipolar disorder and a history of severe suicidal thoughts and urges to harm people. Individuals who are prescribed antidepressants such as paroxetine require close monitoring

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<sup>6</sup> As a current psychiatric expert (Dr. Manuel Saint Martin) has stated: "I reviewed Dr. Dixon's and Dr. Young's resumes and neither have experience in the behavioral effects of psychiatric medications (also known as psychopharmacology)." Ex. 1 at 3.

in the initial weeks of treatment to make sure that they do not experience the serious adverse side effects of suicide and violence.

In Mr. Tricomo's case, it is medically probable that using paroxetine accentuated her impulsive and violent behavior. There is a stronger causal link in the records between her psychiatric condition and paroxetine use than there is for alcohol and marijuana causing her violent behavior. The record review indicates that Ms. Tricomo was prescribed paroxetine on March 25, 2013, by Dr. Anurag Jindal of St. Peter Hospital following a suicide attempt the night before. She was evaluated by Dr. Fatimah Shah of Sea Mar Community Health Centers on April 3, 2013, and she was still taking paroxetine. Dr. Shah gave Ms. Tricomo a new prescription for Paxil and a refill. Ms. Tricomo had been taking paroxetine for sufficient time for both its beneficial and adverse effects to emerge.

Ms. Tricomo voiced her concerns of increasing angry feelings a few days before the offense. Ms. Tricomo attended a therapy session at BHR on April 4, 2013, and she was encouraged to stay on the antidepressant. On April 25, 2013, Ms. Tricomo told her therapist, Ms. Hertz, that she felt that paroxetine was causing her to feel angry and although it improved her depression, she was ambivalent about continuing the medication. Psychiatrists who are acting as prescribers rely on the therapists for feedback about how the patient is responding to the medication especially when the medication has been recently started. The records do not indicate that this adverse effect was communicated to Dr. Shah, the psychiatrist prescribing paroxetine to Ms. Tricomo.

On April 30, 2013, Ms. Tricomo called BHR's crisis line to report that she felt aggressive and suicidal and that she had urges to harm someone. She had already committed the offense.

Ms. Tricomo later called Ms. Hertz and reported that she had killed someone. When Ms. Tricomo was interviewed by the homicide detectives, she mentioned twice that she was reacting to paroxetine and that she wanted to discontinue the medication. While the former may be viewed as self-serving and excusing her conduct, the latter statement of feeling numb is a symptom that is reported in individuals who engage in impulsive behavior induced by antidepressant medication. It is improbable that Ms. Tricomo would have known this fact at the time she was interviewed. Furthermore, based on the chronology of events in the day following the offense and Ms. Tricomo's custodial interview, it cannot be concluded with reasonable certainty that she formed the intent to cause the victim's death.

At the time she committed the offense, Ms. Tricomo was not withdrawing from paroxetine. This medication has a duration of 21 hours in the body and she had taken it on the morning of the offense. Furthermore, the adverse effects of paroxetine occur when the individual is on the medication-not when they are withdrawing from it. Ms. Tricomo had been on the medication continuously for at least one month. Thus, she was not withdrawing from it. The records subsequent to the offense indicate that she had withdrawal symptoms combined with suicidal thoughts and psychosis. She was prescribed Zyprexa (an anti-psychotic medication) and Celexa (a serotonin antidepressant) for these symptoms.

Ms. Tricomo's treatment subsequent to her incarceration at the jail and the DOC indicated that the doctors concluded that paroxetine was linked to her violent impulses and they refrained from prescribing it. In 2018, Ms. Tricomo expressed a desire to resume taking paroxetine, but the treatment team at the DOC thought that she did not have sufficient appreciation of the risks of adverse effects. Thus, the doctors treating Ms. Tricomo

immediately after the offense and to the present also believe that paroxetine causes her impulsive violent behavior.

Ex. 1 at 3-5.

Dr. Saint Martin's conclusions were based in part on what experts with the Washington State Department of Corrections itself believes to be the case. For instance, on April 19, 2018, a Department of Corrections' psychiatrist wrote a treatment note about her conversations with Ms.

Tricomo and Paxil:

We discussed at length her history of being on paroxetine, which she recalls very positively in terms of decreased depression, but admits it does give her feelings of wanting to kill people. Well before her crime when she was suicidal and depressed and sent by BHR to WSH, they put her on a combination of paroxetine and VPA. When on that combination she didn't have thoughts of wanting to kill others, but when she got out she stopped the VPA as it was causing GI upset. Without the VPA she had cravings to drink on paroxetine alone, and did drink heavily, So it is hard to know if without alcohol the paroxetine would have the same effect.

Ex. 15 at 150. The psychiatrist noted, "Discussed situation with PT, who will meet with the patient to discuss how we would respond if she does have homicidal thoughts on the paroxetine." Ex. 15 at 151.

Then, on June 18, 2018, the psychiatrist wrote:

She asked to resume paroxetine, despite acknowledging that it made her want to kill people but

decreased depression. Her PT and I have reviewed her records, At the time of her initial assessment she refused to give consent to outside record release, She engaged in some reckless behavior in MSU, was infracted and taken to SEG, where she stated she would harm herself. . . .

We shared our concerns that she has an underlying bipolar diathesis and that paroxetine had possibly triggered an irritable manic state, leading to her crime, Despite having reported episodes of elevated mood and increased energy, increased goal directed behavior, she now denies any history of such symptoms, She was willing to sign a release for BHR. She clearly has her heart set on going back on paroxetine, the risks of which she did not appear to appreciate, She has been on all mood stabilizers but lithium, did not want to consider it. She did accept a drug information sheet on lithium. . . .

Ex. 15 at 153. Thus, the DOC itself believes that prescribing Paxil to Ms. Tricomo was too risky, even in the confined and regulated environment of a prison.

## **2. *Argument Why Restraint is Unlawful***

### **a. Summary of Claim**

Ms. Tricomo's restraint is unlawful under RAP 16.4(c)(2), (3), (5) & (7). Ms. Tricomo was denied the right to counsel in violation of the Sixth Amendment to the United States Constitution (as applied to the states through the Due Process and Privilege and Immunities Clauses of the Fourteenth Amendment) and in violation of article I, sections 3 and 22

of the Washington Constitution. By failing to hire the appropriate expert on Paxil, Mr. O'Connor's performance as Ms. Tricomo's attorney fell below prevailing professional norms and caused Ms. Tricomo actual prejudice. *See Strickland v. Washington*, 466 U.S. 668, 104 S. Ct. 2052, 80 L.Ed.2d 674 (1984).

**b. Paxil's Effect on Ms. Tricomo's Behavior Should Have Been Considered by the Judge When Determining the Sentence to Impose on Ms. Tricomo**

The parties in this case agreed to a standard sentencing range of 257 to 357 months in prison for the murder conviction. Although the State was to ask for 357 months, the written plea agreement specifically allowed the defense to ask for a lesser sentence, with no limits placed on the power of the court to impose an exceptional sentence. CP 30. In contrast to a sentence for first degree murder, where a court could not impose less than 20 years, RCW 9.94A.540, the court here had the power to impose an exceptionally low sentence, even on its own motion, on a variety of grounds under RCW 9.94A.535(1)(a), (e), (g), (h) & (j),<sup>7</sup> grounds that

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<sup>7</sup> RCW 9.94A.535 provides in part:

(1) Mitigating Circumstances - Court to Consider  
The court may impose an exceptional sentence below the

(continued...)

would have centered on Mr. Alkins' predatory behavior of taking advantage of Ms. Tricomo's vulnerable mental status.<sup>8</sup>

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<sup>7</sup>(...continued)  
standard range if it finds that mitigating circumstances are established by a preponderance of the evidence. The following are illustrative only and are not intended to be exclusive reasons for exceptional sentences.

(a) To a significant degree, the victim was an initiator, willing participant, aggressor, or provoker of the incident. . . .

. . .

(e) The defendant's capacity to appreciate the wrongfulness of his or her conduct, or to conform his or her conduct to the requirements of the law, was significantly impaired. Voluntary use of drugs or alcohol is excluded. . . .

. . .

(g) The operation of the multiple offense policy of RCW 9.94A.589 results in a presumptive sentence that is clearly excessive in light of the purpose of this chapter, as expressed in RCW 9.94A.010.

(h) The defendant or the defendant's children suffered a continuing pattern of physical or sexual abuse by the victim of the offense and the offense is a response to that abuse. . . .

. . .

(j) The current offense involved domestic violence, as defined in RCW 10.99.020, and the defendant suffered a continuing pattern of coercion, control, or abuse by the victim of the offense and the offense is a response to that coercion, control, or abuse.

<sup>8</sup> As Ms. Tricomo's mental health counselor, Alkins would clearly would have known of Ms. Tricomo's vulnerabilities, including her prior sexual abuse, suicide attempts, anger and violent behavior, and substance abuse problems, and yet still invited her into his home, provided her with alcohol and wanted to use her for his own sexual gratification.

With regard to Ms. Tricomo’s mental state, Dr. Saint Martin states that the medication that Tricomo was prescribed just a month before the murder, Paxil, “produces adverse effects of agitation, anger and acting on dangerous violent impulses. These adverse effects include suicidal and homicidal behavior. The adverse effects are more common in adolescents and young adults and in patients who have a history of bipolar disorder.” Ex. 1 at 3-4. In other words, Ms. Tricomo’s violent eruption toward her former therapist was a result of a prescription drug given to her because of her suicide attempt. This certainly would be the type of information that a judge imposing a discretionary sentence should have considered.<sup>9</sup>

Traditionally, a court is allowed to consider a wide array of information to make an informed sentencing decision, with the goal being that “the punishment should fit the offender and not merely the crime.”

*Williams v. New York*, 337 U.S. 241, 247, 69 S. Ct. 1079, 93 L. Ed. 1337 (1949) (quoted in *State v. Herzog*, 112 Wn.2d 419, 424, 771 P.2d 739

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<sup>9</sup> On direct appeal, this Court held, “Tricomo provides no authority suggesting that during sentencing, where the defendant does not request an exceptional sentence below the standard range based on mitigating circumstances, the trial court should readdress and reestablish a defendant’s culpability for an offense that the defendant has pleaded guilty to.” Ex. 4 at 35. However, here, Ms. Tricomo is not arguing that the trial court should “readdress and reestablish” culpability – rather, when determining where in a range to impose a sentence or whether to impose a sentence below the range, a person’s relative culpability (relative to others committing the same offense) is certainly important to consider.

(1989)). The desire to allow sentencing judges access to all relevant information is tied to a key cornerstone of modern sentencing jurisprudence under the Eighth Amendment and article I, section 14 -- that state-imposed punishment should be proportionate to the crime. *See State v. Bassett*, 192 Wn.2d 67, 83, 90-91, \_\_\_ P.3d \_\_\_ (2018) (discussing proportionality and article I, section 14). Generally, proportionality is driven by a defendant’s mental state: “American criminal law has long considered a defendant’s intention -- and therefore his moral guilt -- to be critical to ‘the degree of [his] criminal culpability,’ . . . and the Court has found criminal penalties to be unconstitutionally excessive in the absence of intentional wrongdoing.” *Enmund v. Florida*, 458 U.S. 782, 800, 102 S. Ct. 3368, 73 L. Ed. 2d 1140 (1982) (quoting *Mullaney v. Wilbur*, 421 U.S. 684, 698, 95 S. Ct. 1881, 44 L. Ed. 2d 508 (1975)); RCW 9.94A.010(1) & (2) & (3).<sup>10</sup>

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<sup>10</sup> As David Boerner, the author of the Sentencing Reform Act of 1981, explained:

Allowing variations from the presumptive sentence range where factors exist which distinguish the blameworthiness of a particular defendant’s conduct from that normally present in that crime is wholly consistent with the underlying principle. Certainly the fact that the substantive law treats these circumstances as complete defenses establishes the legitimacy of their use in determining relative degrees of blame-worthiness for purposes of imposing punishment.

(continued...)

Thus, the issue of whether Ms. Tricomo deserved to be sentenced to such a long time in prison for killing Mr. Alkins could really only have been decided with full information about her mental state – was she a “manipulating, calculated, cold-blooded killer, that showed no mercy or remorse, nor accepts any responsibility of the crime, and should sentenced accordingly and harshly, to the fullest extent of the law,” as Mr. Alkins’ brother claimed, Ex. 16 at 158, or was she a damaged individual who had been prescribed a drug, Paxil, that caused her to be violent toward someone who knowingly took advantage of her and wanted to use her as a sexual object? That was essentially what the judge needed to resolve when exercising discretion when imposing a sentence on Ms. Tricomo.

Indeed, at the sentencing hearing, the prosecutor argued for the maximum sentence because of what she considered to be Ms. Tricomo’s lack of remorse in the time after the murder, RP (1/28/15) 49-50, presenting the testimony of the main investigating detective who asked for a higher end sentence because “[w]hen we interviewed Ms. Tricomo in this case, at no point in time during that interview did she ever show any

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<sup>10</sup>(...continued)  
D. Boerner, *Sentencing in Washington* 9-23 (1985).

signs of remorse.” RP (1/28/15) 53. Yet, as Dr. Saint Martin states “the latter statement of feeling numb is a symptom that is reported in individuals who engage in impulsive behavior induced by antidepressant medication.” Ex. 1 at 4.<sup>11</sup> Ms. Tricomo’s very behavior and demeanor after she killed Mr. Alkins was actually mitigating, rather than aggravating, reflecting the effects of the drug she was prescribed, rather than being an inherently evil person.

To be sure, crimes committed as a result of a person’s voluntary use of drugs or alcohol is not necessarily mitigating. *See* RCW 9.94A.535(1)(e) (excluding voluntary use of drugs and alcohol from statutory mitigating factor). But although Ms. Tricomo ingested Paxil of her own free will, her use of this drug, prescribed by doctors after she tried to commit suicide and loosely monitored by her therapist, was not “voluntary” in the same sense that another person would commit crimes while under the voluntary influence of alcohol or illegal street drugs. *See, e.g., Kaiser v. Suburban Transp. Sys.*, 65 Wn.2d 461, 466, 398 P.2d 14 (1965) (“We do not think that one who innocently takes a pill, which is

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<sup>11</sup> Ms. Tricomo told the investigating officer, “I feel nothing on this medication. I don’t, I don’t feel like, I don’t...all I feel is, uh,...feel numb. I feel numb.” Ex. 13 at 140.

prescribed by a doctor, can be convicted of a crime under this statute and thus be negligent per se unless he has knowledge of the pill's harmful qualities. To hold otherwise would be to punish one who is not culpable.”). *See also State v. Hutsell*, 120 Wn.2d 913, 917-23, 845 P.2d 1325 (1993) (while cocaine dependence does not support an exceptional sentence, involuntary intoxication is mitigating).

Given Paxil's possible side effect of causing someone like Ms. Tricomo (younger, bipolar) to act more violently than she would without the drug, certainly the drug's effect is a clear mitigating factor<sup>12</sup> that should have been considered by the judge when deciding what sentence to impose – which sentence within the standard range to impose or even whether to impose an exceptionally low sentence. In this case, however, the judge never got accurate information about the effect of Paxil because the defense did not retain a proper expert, and, upon the State's motion, the judge excluded Ms. Fernandez's opinions and research because she was not qualified.

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<sup>12</sup> And, as noted, even the supposed “lack of remorse” used by the State to seek a high-end sentence could have been a result of the “numbness” that someone using the medication would end up feeling.

**c. Ms. Tricomo Was Denied Effective Assistance of Counsel**

People accused of crimes are entitled to the assistance of counsel under the Sixth and Fourteenth Amendments and article I, section 22. This right to counsel is understood to be the right to effective counsel. *Strickland v. Washington*, 466 U.S. at 685-686. While counsel is not expected to perform flawlessly, counsel is required to meet an objectively reasonable minimum standard of performance. *Id.* at 688. Evidence of ineffective assistance includes the failure to conduct appropriate investigations. *Strickland*, 466 U.S. at 691.

Related to the failure to investigate is the failure to consult or retain an appropriate expert.<sup>13</sup> “We can certainly defer to a trial lawyer’s decision against calling witnesses if that lawyer investigated the case and

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<sup>13</sup> See, e.g. *Hinton v. Alabama*, \_\_\_ U.S. \_\_\_, 134 S. Ct. 1081,1088, 188 L. Ed. 2d 1 (2014) (“Criminal cases will arise where the only reasonable and available defense strategy requires consultation with experts and introduction of expert evidence.”) (internal quotations omitted); *State v. A.N.J.*, 168 Wn.2d 91, 112, 225 P.3d 956 (2010) (“depending on the nature of the charge and the issues presented, effective assistance of counsel may require the assistance of expert witnesses to test and evaluate the evidence against a defendant.”); *In re Pers. Restraint of Brett*, 142 Wn.2d 868, 880-82, 16 P.3d 601 (2001) (failure of counsel to investigate client’s medical condition); *State v. Thomas*, 109 Wn.2d 222, 229-32, 743 P.2d 816 (1987) (reversal based upon failure of defense counsel to retain expert with proper credentials); *State v. Maurice*, 79 Wn. App. 544, 552, 903 P.2d 514 (1995) (“We are persuaded that counsel’s performance was deficient. Given Mr. Maurice’s insistence that a mechanical malfunction caused him to lose control of his pickup, his attorney’s failure to have the vehicle inspected by a mechanic before trial cannot be justified.”).

made an informed and reasonable decision against conducting a particular interview or calling a particular witness. . . . But courts will not defer to trial counsel’s uninformed or unreasonable failure to interview a witness.” *State v. Jones*, 183 Wn.2d 327, 340, 352 P.3d 776 (2015).<sup>14</sup>

The Sixth Amendment’s right to counsel unquestionably extends to sentencing hearings, long understood to be a “critical stage” of a prosecution. *United States v. Yamashiro*, 788 F.3d 1231, 1234-35 (9th Cir. 2015). Thus, the Sixth Amendment guarantees the right of effective assistance of counsel at non-capital sentencing, which is measured by the two-part test set out in *Strickland*. See *Lafler v. Cooper*, 566 U.S. 156, 165, 132 S. Ct. 1376, 182 L. Ed. 2d 398 (2012); *Glover v. United States*, 531 U.S. 198, 202-04, 121 S. Ct. 696, 148 L. Ed. 2d 604 (2001); *Daire v. Lattimore*, 812 F.3d 766, 767 (9th Cir. 2016) (en banc). “Even though sentencing does not concern the defendant’s guilt or innocence, ineffective assistance of counsel during a sentencing hearing can result in *Strickland* prejudice.” *Lafler*, 566 U.S. at 165.

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<sup>14</sup> See *In re Pers. Restraint of Owens*, 197 Wn. App. 1058 (32694-2-III, 1/31/17) (unpub.) (granting collateral relief where trial attorney failed to consult a domestic violence expert); *In re Pers. Restraint of Gonzales Guzman*, 199 Wn. App. 1007 (No. 75296-1-I, 5/22/17) (unpub.) (remanding for reference hearing where defense counsel failed to obtain expert in baby assault case) (both cited as non-binding authority).

Under *Strickland*, to show prejudice, petitioners need not prove that “counsel’s deficient conduct more likely than not altered the outcome in the case,” but rather only must demonstrate there is a “reasonable probability that, but for counsel’s unprofessional errors, the result of the proceeding would have been different.” *Strickland*, 466 U.S. at 693-694. Prejudice under *Strickland* involves the same analysis as “materiality” under *Brady v Maryland*, 373 U.S. 83, 83 S. Ct. 1194, 10 L.Ed.2d 215 (1963). See *Kyles v. Whitley*, 514 U.S. 419, 434, 115 S. Ct. 1555, 131 L.Ed.2d 490 (1995) (adopting *Strickland* standard in *Brady* context). In other words, the test is whether the deficient representation put the entire case in a different light, such that confidence in the judgment is undermined. See *Kyles v. Whitley*, 514 U.S. at 435; *In Pers. Restraint of Stenson*, 174 Wn.2d 474, 493, 276 P.3d 286 (2012).

Applying these tests, it is apparent that Ms. Tricomo’s attorney, Patrick O’Connor, was ineffective. He never consulted a qualified medical expert to assess the effect of Paxil on Ms. Tricomo’s behavior. Ex. 18 at 181.<sup>15</sup> Although Mr. O’Connor engaged a psychologist, Dr.

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<sup>15</sup> Even one of Ms. Tricomo’s supporters in the community recognized the importance of Paxil, Ex. 21 at 182-213, and Ms. Tricomo herself wanted her lawyer to hire a psychiatrist in addition to a psychologist. CP 23.

Dixon, to examine diminished capacity, not only is a psychologist not a medical doctor who is qualified to render an opinion about the effect of medication on behavior, Ex. 1 at 3, but as the State's psychologist, Delton Young, pointed out,<sup>16</sup> Dr. Dixon clearly was wrong – the issue was not Ms. Tricomo's withdrawal from Paxil, since she took the medication on the day in question. CP 94. In fact, as Dr. Saint Martin notes, the issue was the impact of the newly prescribed medication on Ms. Tricomo's behavior – causing her to be angry and violent -- during a time when she should have been subject to close psychiatric monitoring, in the month or so after she was prescribed the medication at the hospital, although her counselor never apparently relayed the information about the effect of Paxil to the prescribing doctor. Ex. 1 at 4. This evidence – the link between Paxil and violence – was never presented properly to the judge in this case.

Mr. O'Connor attempted to submit to the sentencing judge citations to Internet research about the violent effects of Paxil compiled by someone with even less qualifications than the two psychologists – a mitigation investigator, Ms. Fernandez. While Ms. Fernandez actually

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<sup>16</sup> Dr. Young too is only a psychologist who is not qualified to address the medical issues involving medication. Ex. 1 at 168-73.

may have been a wonderful investigator,<sup>17</sup> who was able to compile records and set out a good chronology of the traumas suffered by Ms. Tricomo before she was preyed on by Mr. Alkins, the trial court ruled:

So what I want to make clear is that I'm going to consider the background information about Ms. Tricomo that's provided in Ms. Fernandez' report. I am, however, disregarding the section that appears at page 4 of her report. It begins there regarding Paxil. I don't find that she has any expertise in that particular area and she basically only sets forth a number of articles suggesting that they may have some relevance, but I'm not considering her report in that regard . . . .

RP (1/28/15) 39.

The failure to consult with a proper expert regarding the impact of Paxil is, therefore, self-evidently prejudicial. Judge Tabor made it clear that he would not consider Ms. Fernandez's opinions about Paxil because of her lack of expertise. At this point, effective counsel should have asked for a continuance to obtain a proper expert to educate the judge about Paxil's effect of causing people to act violently. This is not a case where counsel decided not to pursue a particular strategy (looking at the effect of medication) for tactical reasons. Rather, this is a case where counsel tactically tried to introduce through Ms. Fernandez evidence about Paxil

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<sup>17</sup> See Ex. 19 for Fernandez's c.v.

causing violence, but failed to retain the proper expert to support that tactical decision and did nothing when the judge ruled that Ms. Fernandez's research was inadmissible.

The first case in Washington to adopt the two-part *Strickland* test, *State v. Thomas*, 109 Wn.2d 222, 743 P.2d 816 (1987), is almost on-point. In *Thomas*, the defendant raised a claim of ineffective assistance of counsel arguing that her lawyer failed to competently present a diminished capacity defense based on voluntary intoxication to a charge of attempting to elude a police vehicle. Counsel tried to call as an expert witness about Ms. Thomas' mental state an alcohol counselor trainee, and the trial court barred the testimony because of her lack of qualifications. The Supreme Court held that counsel was ineffective for not proffering a properly credentialed expert and that such a failure caused prejudice:

Thomas offered substantial lay testimony regarding her intoxicated condition and blackouts. Her testimony regarding blackouts was very damaging to her credibility because it suggested that there is a conscious component to her blackouts. The prosecutor attempted to capitalize on this testimony. Therefore, expert testimony explaining blackouts may have proved crucial to her defense. To hold as the Court of Appeals that "there simply is no showing that there was an expert who could have offered testimony helpful to Thomas" begs the question. [*State v. Thomas*, 46 Wn. App. 723,] at 727, [732 P.2d 171 (1987)]. Arguably, many alcohol counselors could have testified, as

defense counsel proposed, as to alcohol's effect on the brain and could have assisted the jury in explaining blackouts. See ER 702. Accordingly, we cannot say that trial counsel's deficiency in failing to discover his expert's lack of qualifications to explain blackouts and their effects did not prejudice Thomas. This reaffirms that our confidence in the outcome of Thomas' trial is undermined.

*State v. Thomas*, 109 Wn.2d at 232.

Similarly, in *In re Pers. Restraint of Brett*, 142 Wn.2d 868, 16 P.3d 601 (2001), the Supreme Court granted relief when counsel failed to retain a proper expert to render an opinion about fetal alcohol syndrome in the sentencing phase of a capital case:

The only expert sought by counsel to evaluate Brett's fetal alcohol effect was a psychologist wholly unqualified to render a medical diagnosis of Brett. Dr. Stanulis informed defense counsel of this fact immediately. However, neither Dane nor Foister moved for the appointment of a qualified expert.

*Brett*, 142 Wn.2d at 881.<sup>18</sup>

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<sup>18</sup> The Supreme Court relied *Caro v. Calderon*, 165 F.3d 1223 (9th Cir. 1999), where counsel was aware of the defendant's extraordinary acute and chronic exposure to neurotoxicants, yet failed to consult either a neurologist or a toxicologist, both being experts on the effects of chemical poisoning. *Caro*, 165 F.3d at 1226. Finding that counsel was ineffective, the Ninth Circuit held:

Counsel have an obligation to conduct an investigation which will allow a determination of what sort of experts to consult. Once that determination has been made, counsel must present those experts with information relevant to the conclusion of the expert.

*Caro*, 165 F.3d at 1226. Accord: *State v. Fedoruk*, 184 Wn. App. 866, 879-85, 339 P.3d (continued...)

In this case, one of Ms. Tricomo's supporters repeatedly told her lawyers that she thought Paxil was something that should have been investigated, Ex. 19 at 182-213, while Ms. Tricomo's own written allocution was focused on this factor as well. CP 208-12. Judge Tabor himself recognized: "There are issues about taking anti-depressant drugs, Paxil, and that this may somehow have affected your view of life." RP (1/28/15) 93. But solely because the defense did not proffer any witness with the proper credentials, such as a psychiatrist, Judge Tabor not only excluded Ms. Fernandez's evidence about the effect of Paxil, but then he was deprived of key information about the link between the drug and aggressive and violent behavior.

Had defense counsel not submitted Ms. Fernandez's lay opinions about Paxil, but had he retained a qualified expert on the effect of medication on behavior, given what Dr. Saint Martin now says to be the case, there is a reasonable probability that Judge Tabor may have treated Ms. Tricomo more leniently. For instance, Judge Tabor stated:

It is clear, Ms. Tricomo, that you had a very difficult upbringing. There were lots of situations that cause

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<sup>18</sup>(...continued)  
233 (2014) (finding counsel to be ineffective when counsel knows defendant has history of mental illness and does not retain an expert to explore diminished capacity defense).

sympathy for you, that you had to endure those situations. There is certainly the fact that you have mental issues. Some of those, in this Court's opinion, are self-created. The choice to consume alcohol. You've had periods of sobriety, but you've often had periods in which you said I'm just going to drink because I can and to amounts that are just astounding to the Court.

RP (1/28/15) 93. Yet, now it is clear that alcohol was not the factor that caused Tricomo's violence toward Alkins:

In Mr. Tricomo's case, it is medically probable that using paroxetine accentuated her impulsive and violent behavior. There is a stronger causal link in the records between her psychiatric condition and paroxetine use than there is for alcohol and marijuana causing her violent behavior.

Ex. 1 at 4.

Thus, rather than sentencing someone who voluntarily consumed a large amount of alcohol and someone who "self-created" mental health issues, Judge Tabor would have been sentencing someone who was prescribed a medication after a recent suicide attempt, a medication that causes violent behavior. In other words, Ms. Tricomo's violent outbursts toward her abuser was not the result of some personality defect, but was organically caused by a medication prescribed to her by doctors who should have been more closely monitoring her behavior and moods. Such evidence, had it been provided to Judge Tabor, could only have

diminished Ms. Tricomo's moral culpability<sup>19</sup> and should have led to a lesser sentence, either the low end of the standard range or even an exceptionally low sentence. Evidence about the link between Paxil and violent behavior would have placed the entire case in a different light.<sup>20</sup>

Accordingly, Ms. Tricomo's attorney's failure to retain the proper expert – a psychiatrist – to assess the impact of Paxil on Ms. Tricomo's behavior caused prejudice and is grounds for relief. Ms. Tricomo's rights to counsel and effective assistance of counsel, guaranteed by the Sixth and Fourteenth Amendments and article I, section 22, were violated.

**E. REQUEST FOR RELIEF**

Ms. Tricomo is under restraint as defined by RAP 16.4(a) & (b).

The restraint is unlawful because the judgment was entered in violation of

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<sup>19</sup> Such evidence may not have been sufficient to be a complete legal defense to a murder charge, but certainly is the type of evidence that a judge would consider when exercising discretion about the length of a sentence. *Even a day less in custody is constitutionally significant. See Glover v. United States*, 531 U.S. at 203 (“Authority does not suggest that a minimal amount of additional time in prison cannot constitute prejudice. Quite to the contrary, our jurisprudence suggests that any amount of actual jail time has Sixth Amendment significance.”). Thus, even if there is a reasonable probability that evidence of Paxil would have led Judge Tabor to impose any sentence less than 357 months, Ms. Tricomo can make out *Strickland*-prejudice, although actually such evidence reasonably should have led to a significant reduction in the amount of incarceration imposed in this unique case.

<sup>20</sup> One has to assume that Judge Tabor's mind was not made up ahead of time and that he would not have simply ignored pertinent scientific evidence about the effect of a prescribed drug on a person's behavior.

the laws and constitutions of Washington and the United States, material facts exist which have not been previously heard which in the interest of justice require vacation of the convictions,<sup>21</sup> there are other grounds for collateral attack and other grounds for challenging the legality of restraint or petitioner. RAP 16.4(c)(2), (3), (5), & (7). Ms. Tricomo has no other adequate remedies except to file this Personal Restraint Petition. RAP 16.4(d).

Pursuant RAP 16.7(a)(5), Mr. Tricomo asks that this Court enter an order vacating the judgment in Thurston County Superior Court No. 13-1-00655-7, and remanding for a new sentencing hearing. Alternatively, the Court should remand the case for reasonable discovery and a reference hearing if required, and then vacate the judgment.

**F. STATEMENT OF FINANCES**

Mr. Tricomo was already determined to be indigent in this matter, although she now has retained counsel.

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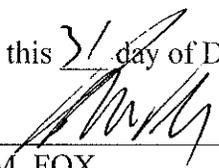
<sup>21</sup> In this regard, evidence of Mr. O'Connor's ineffectiveness of not hiring the proper expert is "newly discovered" and properly is a ground for relief under RAP 16.4(c)(3).

**G. OATH**

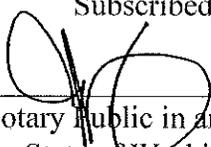
STATE OF WASHINGTON )  
 ) ss  
COUNTY OF KING )

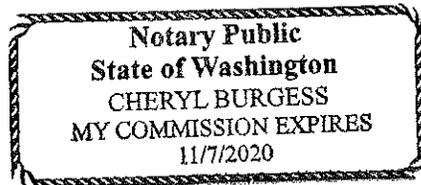
After being first duly sworn, on oath, under penalty of perjury under the laws of the State of Washington, I verify this petition and I depose and say: That, I am the attorney for the petitioner, that I have read the petition, know its contents, and I believe the petition is true.

Signed this 31 day of December 2018, at Seattle, Washington

  
\_\_\_\_\_  
NEIL M. FOX  
WSBA NO. 15277

Subscribed and sworn to before me this 31 day of December 2018.

  
\_\_\_\_\_  
Notary Public in and for  
the State of Washington, residing at Seattle



**STATUTORY APPENDIX**

RAP 16.4 provides:

(a) Generally. Except as restricted by section (d), the appellate court will grant appropriate relief to a petitioner if the petitioner is under a "restraint" as defined in section (b) and the petitioners restraint is unlawful for one or more of the reasons defined in section (c).

(b) Restraint. A petitioner is under a "restraint" if the petitioner has limited freedom because of a court decision in a civil or criminal proceeding, the petitioner is confined, the petitioner is subject to imminent confinement, or the petitioner is under some other disability resulting from a judgment or sentence in a criminal case.

(c) Unlawful Nature of Restraint. The restraint must be unlawful for one or more of the following reasons: (1) The decision in a civil or criminal proceeding was entered without jurisdiction over the person of the petitioner or the subject matter; or (2) The conviction was obtained or the sentence or other order entered in a criminal proceeding or civil proceeding instituted by the state or local government was imposed or entered in violation of the Constitution of the United States or the Constitution or laws of the State of Washington; or (3) Material facts exist which have not been previously presented and heard, which in the interest of justice require vacation of the conviction, sentence, or other order entered in a criminal proceeding or civil proceeding instituted by the state or local government; or (4) There has been a significant change in the law, whether substantive or procedural, which is material to the conviction, sentence, or other order entered in a criminal proceeding or civil proceeding instituted by the state or local government, and sufficient reasons exist to require retroactive application of the changed legal standard; or (5) Other grounds exist for a collateral attack upon a judgment in a criminal proceeding or civil proceeding instituted by the state or local government; or (6) The conditions or manner of the

restraint of petitioner are in violation of the Constitution of the United States or the Constitution or laws of the State of Washington; or (7) Other grounds exist to challenge the legality of the restraint of petitioner.

(d) Restrictions. The appellate court will only grant relief by a personal restraint petition if other remedies which may be available to petitioner are inadequate under the circumstances and if such relief may be granted under RCW 10.73.090, .100, and .130. No more than one petition for similar relief on behalf of the same petitioner will be entertained without good cause shown.

RCW 9.94A.010 provides:

The purpose of this chapter is to make the criminal justice system accountable to the public by developing a system for the sentencing of felony offenders which structures, but does not eliminate, discretionary decisions affecting sentences, and to:

(1) Ensure that the punishment for a criminal offense is proportionate to the seriousness of the offense and the offender's criminal history;

(2) Promote respect for the law by providing punishment which is just;

(3) Be commensurate with the punishment imposed on others committing similar offenses;

(4) Protect the public;

(5) Offer the offender an opportunity to improve himself or herself;

(6) Make frugal use of the state's and local governments' resources; and

(7) Reduce the risk of reoffending by offenders in the community.

RCW 9.94A.535 provides in part:

The court may impose a sentence outside the standard sentence range for an offense if it finds, considering the purpose of this chapter, that there are substantial and compelling reasons justifying an exceptional sentence. Facts supporting aggravated sentences, other than the fact of a prior conviction, shall be determined pursuant to the provisions of RCW 9.94A.537.

Whenever a sentence outside the standard sentence range is imposed, the court shall set forth the reasons for its decision in written findings of fact and conclusions of law. A sentence outside the standard sentence range shall be a determinate sentence.

If the sentencing court finds that an exceptional sentence outside the standard sentence range should be imposed, the sentence is subject to review only as provided for in RCW 9.94A.585(4).

A departure from the standards in RCW 9.94A.589 (1) and (2) governing whether sentences are to be served consecutively or concurrently is an exceptional sentence subject to the limitations in this section, and may be appealed by the offender or the state as set forth in RCW 9.94A.585 (2) through (6).

(1) Mitigating Circumstances - Court to Consider

The court may impose an exceptional sentence below the standard range if it finds that mitigating circumstances are established by a preponderance of the evidence. The following are illustrative only and are not intended to be exclusive reasons for exceptional sentences.

(a) To a significant degree, the victim was an initiator, willing participant, aggressor, or provoker of the incident.

(b) Before detection, the defendant compensated, or made a good faith effort to compensate, the victim of the criminal conduct for any damage or injury sustained.

(c) The defendant committed the crime under duress, coercion, threat, or compulsion insufficient to constitute a complete defense but which significantly affected his or her conduct.

(d) The defendant, with no apparent predisposition to do so, was induced by others to participate in the crime.

(e) The defendant's capacity to appreciate the wrongfulness of his or her conduct, or to conform his or her conduct to the requirements of the law, was significantly impaired. Voluntary use of drugs or alcohol is excluded.

(f) The offense was principally accomplished by another person and the defendant manifested extreme caution or sincere concern for the safety or well-being of the victim.

(g) The operation of the multiple offense policy of RCW 9.94A.589 results in a presumptive sentence that is clearly excessive in light of the purpose of this chapter, as expressed in RCW 9.94A.010.

(h) The defendant or the defendant's children suffered a continuing pattern of physical or sexual abuse by the victim of the offense and the offense is a response to that abuse.

(i) The defendant was making a good faith effort to obtain or provide medical assistance for someone who is experiencing a drug-related overdose.

(j) The current offense involved domestic violence, as defined in RCW 10.99.020, and the defendant suffered a continuing pattern of coercion, control, or abuse by the victim of the offense and the offense is a response to that coercion, control, or abuse.

(k) The defendant was convicted of vehicular homicide, by the operation of a vehicle in a reckless manner and has committed no other previous serious traffic offenses as defined in RCW 9.94A.030, and the sentence is clearly excessive in light of the purpose of this chapter, as expressed in RCW 9.94A.010. . . .

RCW 9.94A.540 provides in part:

(1) Except to the extent provided in subsection (3) of this section, the following minimum terms of total confinement are mandatory and shall not be varied or modified under RCW 9.94A.535:

(a) An offender convicted of the crime of murder in the first degree shall be sentenced to a term of total confinement not less than twenty years.

U.S. Const. amend. VI provides:

In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury of the state and district wherein the crime shall have been committed, which district shall have been previously ascertained by law, and to be informed of the nature and cause of the accusation; to be confronted with the witnesses against him; to have compulsory process for obtaining

witnesses in his favor, and to have the assistance of counsel for his defense.

U.S. Const. amend. VIII provides:

Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted

U.S. Const. amend. XIV, § 1 provides in part:

No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Wash. Const. art. I, § 3 provides:

No person shall be deprived of life, liberty, or property, without due process of law.

Wash. Const. art. I, § 14 provides:

Excessive bail shall not be required, excessive fines imposed, nor cruel punishment inflicted.

Wash. Const. art. 1, § 22 (Amendment 10) provides in part:

In criminal prosecutions the accused shall have the right to appear and defend in person, or by counsel, to demand the nature and cause of the accusation against him, to have a copy thereof, to testify in his own behalf, to meet the witnesses against him face to face, to have compulsory process to compel the attendance of witnesses in his own behalf, to have a speedy public trial by an impartial jury of the county in which the offense is charged to have been committed and the right to appeal in all cases . . . .

**DECLARATION OF SERVICE**

I, Neil M. Fox, certify and declare as follows:

On the 31st day of December 2018, I served a copy of this pleading on all parties, by filing it through the Portal and thus a copy will be delivered electronically.

I certify or declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Dated this 31st day of December 2018, at Seattle, Washington.

s/ Neil M. Fox

\_\_\_\_\_  
WSBA No. 15277

Attorney for Petitioner

**LAW OFFICE OF NEIL FOX PLLC**

**December 31, 2018 - 1:17 PM**

**Transmittal Information**

**Filed with Court:** Court of Appeals Division II  
**Appellate Court Case Number:** 51741-8  
**Appellate Court Case Title:** In re the Personal Restraint Petition of Lia Yera Tricomo  
**Superior Court Case Number:** 13-1-00655-7

**The following documents have been uploaded:**

- 517418\_Motion\_20181231131458D2745535\_8172.pdf  
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Other - Exhibits in support of PRP  
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- 517418\_Personal\_Restraint\_Petition\_20181231131458D2745535\_4544.pdf  
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Personal Restraint Petition - Other  
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IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON  
DIVISION TWO

IN RE THE PERSONAL  
RESTRAINT PETITION OF:

LIA Y. TRICOMO,

Petitioner.

) CAUSE NO. 51741-8-II

) EXHIBIT 1

EXHIBIT 1

Report of Dr. Manuel Saint Martin

EXHIBIT 1

Law Office of Neil Fox, PLLC  
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# MANUEL SAINT MARTIN, M.D., J.D. PSYCHIATRY AND LAW

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December 24, 2018

Neil M. Fox,  
Attorney at Law  
Law Office of Neil Fox, PLLC  
2125 Western Ave. Suite 330  
Seattle WA 98121

## **PSYCHIATRIC REPORT:**

State of Washington v Lia Yera Tricomo, Case No.: 13-1-00655-7

Dear Mr. Fox;

I reviewed the medical records and discovery documents concerning the case of Lia Yera Tricomo in order to address the issue of her treatment with the antidepressant paroxetine (also known as Paxil) and her mental state for the primary offense of second degree murder. The following are my conclusions.

## **RECORD REVIEW:**

1. Declaration of Dhyana Fernandez.
2. Employment records from Behavioral Health Resources (BHR) regarding Mr. John Alkins.
3. Undated transcription of recorded statement of Ms. Tricomo taken by Thurston County Sheriff's Office.
4. Transcription of recorded statement of Timothy Zola, MD, of St. Peter's Hospital taken by Thurston County Sheriff's Office dated April 30, 2013.
5. Felony judgment and sentence re: State of Washington v Lia Yera Tricomo, Case No.: 13-1-00655-7 filed January 28, 2015.



6. Department of Corrections (DOC) Central file and medical/psychiatric records.
7. DOC chemical dependency treatment records.
8. Psychological report by David Dixon, PhD, dated April 30, 2013 (wrong dated as he evaluated her last on April 15, 2014).
9. Forensic mental health report by Phyllis Knopp, PhD, dated May 19, 2011.
10. Forensic mental health report by Marilyn Ronnei, PhD, and Judith Kirkeby PhD, dated July 9, 2013.
11. Psychological evaluation dated August 20, 2014, by Delton Young, PhD.
12. Statement of defendant on guilty plea.
13. Treatment records from Behavioral Health Resources.

#### **DISCUSSION:**

Ms. Tricomo's diagnoses are bipolar disorder, borderline personality disorder and alcohol dependence. In the months preceding the offense, she was experiencing a depressive episode brought on by life stressors. Ms. Tricomo had a history of multiple suicide attempts, frequent suicidal and homicidal thoughts on and off medication and acting out violently. The chronology of Mr. Tricomo's psychiatric treatment with paroxetine (Paxil) in the month preceding the offense indicates that she had an adverse medication reaction, namely aggressive and violent behavior. In the days preceding the offense, Ms. Tricomo's violent and suicidal thoughts were more prominent. Thus, the conclusion is that paroxetine was responsible for Mr. Tricomo's aggressive and violent behavior resulting in Mr. Alkin's death.

The issue of paroxetine's effect on Ms. Tricomo's neurobiological state was not addressed during her criminal proceeding because she was only examined by psychologists. Dr. Dixon and Dr. Young discussed the role of paroxetine in Ms. Tricomo's offense and arrived at opposing conclusions. I reviewed Dr. Dixon's and Dr. Young's resumes and neither have experience in the behavioral effects of psychiatric medications (also known as psychopharmacology). Dr. Ronnei and Dr. Kirkeby addressed the singular issue of Ms. Tricomo's competency to stand trial and their opinion was valid. Ms. Tricomo required a psychiatric evaluation to address the issue of paroxetine's effect on her mental state during the commission of the crime, but she never had one during the criminal proceedings.

Ms. Tricomo was prescribed paroxetine to combat depression. Paroxetine is a selective serotonin antidepressant medication that has been in clinical use in the US since 1996. Post-marketing studies have revealed that paroxetine produces adverse effects of agitation, anger and acting on dangerous violent impulses. These adverse effects include suicidal and homicidal behavior. The adverse effects are more common in adolescents and young adults and in patients



who have a history of bipolar disorder. Paroxetine's adverse effects are documented in the Federal Drug Administration (FDA) medication guide published in June 2012.

Ms. Tricomo is in the latter two categories of persons whom paroxetine can cause serious adverse effects of violence and suicide. She has a diagnosis of bipolar disorder and a history of severe suicidal thoughts and urges to harm people. Individuals who are prescribed antidepressants such as paroxetine require close monitoring in the initial weeks of treatment to make sure that they do not experience the serious adverse side effects of suicide and violence.

In Mr. Tricomo's case, it is medically probable that using paroxetine accentuated her impulsive and violent behavior. There is a stronger causal link in the records between her psychiatric condition and paroxetine use than there is for alcohol and marijuana causing her violent behavior. The record review indicates that Ms. Tricomo was prescribed paroxetine on March 25, 2013, by Dr. Anurag Jindal of St. Peter Hospital following a suicide attempt the night before. She was evaluated by Dr. Fatimah Shah of Sea Mar Community Health Centers on April 3, 2013, and she was still taking paroxetine. Dr. Shah gave Ms. Tricomo a new prescription for Paxil and a refill. Ms. Tricomo had been taking paroxetine for sufficient time for both its beneficial and adverse effects to emerge.

Ms. Tricomo voiced her concerns of increasing angry feelings a few days before the offense. Ms. Tricomo attended a therapy session at BHR on April 4, 2013, and she was encouraged to stay on the antidepressant. On April 25, 2013, Ms. Tricomo told her therapist, Ms. Hertz, that she felt that paroxetine was causing her to feel angry and although it improved her depression, she was ambivalent about continuing the medication. Psychiatrists who are acting as prescribers rely on the therapists for feedback about how the patient is responding to the medication especially when the medication has been recently started. The records do not indicate that this adverse effect was communicated to Dr. Shah, the psychiatrist prescribing paroxetine to Ms. Tricomo.

On April 30, 2013, Ms. Tricomo called BHR's crisis line to report that she felt aggressive and suicidal and that she had urges to harm someone. She had already committed the offense. Ms. Tricomo later called Ms. Hertz and reported that she had killed someone. When Ms. Tricomo was interviewed by the homicide detectives, she mentioned twice that she was reacting to paroxetine and that she wanted to discontinue the medication. While the former may be viewed as self-serving and excusing her conduct, the latter statement of feeling numb is a symptom that is reported in individuals who engage in impulsive behavior induced by antidepressant medication. It is improbable that Ms. Tricomo would have known this fact at the time she was interviewed. Furthermore, based on the chronology of events in the day following the offense and Ms. Tricomo's custodial interview, it cannot be concluded with reasonable certainty that she formed the intent to cause the victim's death.

At the time she committed the offense, Ms. Tricomo was not withdrawing from paroxetine. This medication has a duration of 21 hours in the body and she had taken it on the morning of the offense. Furthermore, the adverse effects of paroxetine occur when the individual is on the medication-not when they are withdrawing from it. Ms. Tricomo had been on the medication continuously for at least one month. Thus, she was not withdrawing from it. The



records subsequent to the offense indicate that she had withdrawal symptoms combined with suicidal thoughts and psychosis. She was prescribed Zyprexa (an anti-psychotic medication) and Celexa (a serotonin antidepressant) for these symptoms.

Ms. Tricomo's treatment subsequent to her incarceration at the jail and the DOC indicated that the doctors concluded that paroxetine was linked to her violent impulses and they refrained from prescribing it. In 2018, Ms. Tricomo expressed a desire to resume taking paroxetine, but the treatment team at the DOC thought that she did not have sufficient appreciation of the risks of adverse effects. Thus, the doctors treating Ms. Tricomo immediately after the offense and to the present also believe that paroxetine causes her impulsive violent behavior.

I certify or declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

December 26, 2018, Los Angeles, CA

A handwritten signature in black ink that reads "Manuel M.D., J.D." with a stylized flourish at the beginning.

Manuel Saint Martin, M.D., J.D.  
Diplomate, American Board of Psychiatry and Neurology



---

# MANUEL SAINT MARTIN, M.D., J.D. PSYCHIATRY AND LAW

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## CURRICULUM VITAE

### EDUCATION

- Undergraduate:** Stanford University, Stanford, CA 1979
- Medical School:** State University of New York at Buffalo, Buffalo, NY; M.D. 1982
- Law School:** Southwestern University School of Law, Los Angeles, CA; J.D. 1989
- Internship:** Cedars-Sinai Medical Center, Los Angeles, CA; General Surgery 1982 to 1983
- Residencies:** Cedars-Sinai Medical Center, Los Angeles, CA; General Surgery 1983 to 1984  
  
LAC/USC Medical Center, Los Angeles, CA; General Psychiatry 1984 to 1987
- Clinical Practice:** Private clinical psychiatry practice from 1987 to present with offices in Los Angeles, California and Forest Hills, New York, treating a variety of child, adolescent and adult psychiatric disorders using medications, brief supportive therapy, and individual therapy. Criminal and civil forensic psychiatry practice in Oklahoma, New York, Nevada, California and other states.
- Legal Practice:** Legal practice in California, New York and New Jersey consisting of civil litigation, medical malpractice and health care law, probate and bankruptcy.

**APPOINTMENTS** Psychiatric Expert for the Federal District Courts: Central District of California, Northern District of California, and the District of Nevada

Psychiatric Expert for Orange County Superior Court, Criminal Division

Special Deputy Trial Counsel, Office of Trials, State Bar of California



Expert Medical Reviewer for the California Medical Board

## **TEACHING**

2000 to present: Professor and Medical Director, York College, Department of Health Sciences, City University of New York. Oversee the medical education of physician assistants. Attend departmental meetings, contribute to ongoing program development, recruit and visit clinical rotation sites. Monitor each student's overall performance in the program. Teach a class on psychiatry and behavioral sciences covering the diagnosis and management of common psychiatric illness and substance abuse/dependence. Prepare and grade examinations, monitor student performance in the class.

2000 to 2010: Adjunct Assistant Professor, Touro College Manhattan Campus PA Program. Instruct about 30 students in a psychiatry class consisting of the management and diagnosis of common psychiatric illness and substance abuse/dependence, and test their competence.

1993 to present: Adjunct Assistant Professor, Western University of Health Sciences PA Program. Teach 96 students psychiatry consisting of common psychiatric illness and substance abuse/dependence, and test their competence. Lecture students on professional responsibility and medical ethics.

Clinical preceptor for two to three students per year to learn psychiatric skills with actual patients in an office setting during a four week module. Provide a yearly scholarship award to a graduating physician assistant student interested in pursuing psychiatry and substance dependence as a clinical career.

2002 to present: Clinical Preceptor Midwestern University, Glendale, Arizona. Teach clinical psychiatric skills to two to three students in office and forensic settings, and evaluate their competence during a six week module.

1996 to 2003: Adjunct Faculty, Long Island University Physician Assistant Program. Instruct students in psychiatry and behavioral medicine covering the common psychiatric illnesses and substance abuse/dependence, and test their competence. Teach physician assistant students medical ethics course to familiarize students with legal and ethical responsibilities of clinical practice.

## **LICENSES**

### **States:**

California Medical License No. G51685  
New York State Medical License No. 156748  
Nevada Medical License No. 8068 (inactive)



Oklahoma Medical License No. 20933 (inactive)

**DEA:** California Certificate BS5684724  
New York Certificate BM1810159

**Certification:** Board Certified by the American Board of Psychiatry and Neurology in 1989 with lifetime certification.

**Legal:** Admitted to practice law in the states of California, New York, and New Jersey; and the Federal Courts of the Central District of California, New Jersey and Eastern District of New York.

### **MEMBERSHIPS**

California State Bar Association  
Langston Bar Association  
Queens County Medical Society  
New York State Bar Association  
Physician Assistant Education Association  
National Council of La Raza

### **LANGUAGES**

Bilingual in English and Spanish

### **PUBLICATIONS**

*Daubert* and Defense Mental Health Issues, CJA Defense Journal, Vol. 2 No. 1 March 1995

Representing Psychiatrically Ill Clients in Dissolution and Custody Proceedings, Family Law News and Review Vol. 15, No. 2 Spring 1994

Evolving Legal and Ethical Trends in Allied Health Care, The Association of Schools of Allied Health Professionals 29th Annual Conference, Charleston South Carolina, October 1996

Assessing and Avoiding Violence in Medical Settings: Practical Considerations, Dietitian Today May 1999

Quoted in Los Angeles Times, Friday January 9, 1998, If Fit for Trial Suspect [Kaczynski] Could Defend Himself, page A20

Mentioned in US v. Murdoch 98 F 3d 472, 478 (9<sup>th</sup> Circ. 1996)

Mentioned in Littlejohn v. Trammell, 704 F 3d 817 (10<sup>th</sup> Circ. 2013)

Running Amok: a modern perspective on a culture bound syndrome. The Primary Care Companion to the Journal of Clinical Psychiatry, pages 66-70, 1999



**PRESENTATIONS** Medical Liability of Managed Care Organizations. American Association of Legal Nurses, Orange CA, January 1997

Handling Psychiatric Issues in General Liability Claims. AIG Claims Services, Costa Mesa, CA October 1997

Preparation for EBT (Deposition) of the Psychiatric Expert. Law Office of Creedon & MCorry, Garden City NY, April 1998

Assessing Dangerousness and Preventing Violence in Medical Settings. Touro College of Health Sciences, Dix Hills, New York, June 1997

Managing Violence in Health Care Settings. American Academy of Physician Assistants, Anaheim, CA, May 2001

Medicine 101 For Judges, and Attorneys, The American Bar Association Nationwide, April 2012



## CASES

### Death Penalty Cases--Trial

People v. Juan Mendez, Case No.: 00 CR 903, Illinois 2004 (Evaluated)

State of Oklahoma v. Alfred Mitchell, Case No.: CS 91 91-206 (Testified)

People v. Ingracia Nuñez, Case No.: 01 CR 6487, Illinois, 2004 (Evaluated)

### Death Penalty Cases-Appeal

State of Oklahoma v. Clarence R Goode, 2010 OK CR 10, June 9, 2010 (Evaluated)

Danny Keith Hooks v. Randall G Workman, Case No. 07-6152, May 25, 2010 (Evaluated)

Steven Michael Cox v. EK McDaniel, et. al., Case No.: CV N 98 482 DWH (PHA) Nevada, 2000 (Evaluated)

State of Oklahoma v. Rocky E Dodd, Case No.: F-97-26, January 06, 2000 (Evaluated)

State of Oklahoma v. James Pavatt, Case No.: D-2003-1186 (Evaluated)

Billy Ray Riley v. State of Nevada, 107 Nev. 205, 808 P 2d 551, January 8, 1997 (Evaluated)

State of Oklahoma v. Michael Dewayne Smith, Case No.: 09-CV-293 (Evaluated)

State of Nevada v. Ricardo Sandoval, Case No.: CR04-1150, NV 2005 (Evaluated)

Cyril Wayne Ellis v. Ron Ward, Warden, Case No.: CIV-97-1386-R (Evaluated)

State of Arizona v. Sergio Sanchez Mendivil, Arizona 2005 (Evaluated)

Vincent Allen Johnson v. State of Oklahoma, Case No.: PC-97-261, 1998 OK CR 13 (Evaluated)

Darrin Lynn Pickens v. Gary Gibson, Warden, 206 F.3d 988, Oklahoma 2000 (Evaluated)

State of Nevada v. Jose Echeverria, Case No.: 51042, Nevada (Evaluated)

State of Oklahoma v. Emmanuel Littlejohn, Case No.: D-2000-1609, 85 P.3d 287, February 12, 2004 (Testified)

### Habeas--Non-Death Penalty

Hugo Garcia v. James Yates, Warden, et al. Case No.: 07-CV-00048 DMS (Testified)

USA v. Vincent DePasquale, Case No. CV-N-00-209 EAR (PHA) Nevada (Testified)



Enrique Nava v. Hedgpeth Case No.: CV 095-08387-DSF(P) California (Testified)

### **Criminal—Competency**

USA v. Michael Duong, Case No.: 10-863-SVW (Evaluated)

USA v. Chandra Deniece King, Case No.: 2:09 CR00058 (Evaluated)

People v. Varish Yadav, Case No.: EE907273 (Evaluated)

US v. Ortiz-Payan, Case No.: CR07-1233-TUC-DCB (HCE) (Testified)

USA v. Jeffrey Choi, Case No.: DR-11-884-DMG (Testified)

### **Criminal—Trial**

People v. Alfredo Cortez Sandoval, Case No.: C1077075 (Evaluated)

USA v. Hamad Riaz Samana, Case No.: CR 05214-CJC (Evaluated)

People v. Danmei Boss, Case No.: GA071626 (Testified)

People v. Young Choi, Case No.: 8BF00019 (Evaluated)

USA v. Peter Kessal, Case No.: SA CR 08-207 DOC (Testified)

People v. Dong Gu Lee, Case No.: OS03007 (Testified)

People v Brandon Kim, Case No.: BA071852 (Testified)

DOJ v. Verdugo Valley Skilled Nursing and Wellness Centre LA2009311083 (Testified for prosecution)

CA DOJ v. Del Rosa Villa Case No.: RV2009101757 (Ongoing for prosecution)

USA v. Martin Luman, Case No.: 09-1256-JFW (Testified)

Department of Defense v. Gabriel Abraham, Case No.: ISCR 11-00193 (testified)

CA DOJ v. Elaine James, MD, Case No.: 09-2012-221315 (ongoing)

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

IN RE THE PERSONAL  
RESTRAINT PETITION OF:

LIA Y. TRICOMO,

Petitioner.

) CAUSE NO. 51741-8-II

) EXHIBIT 3

EXHIBIT 3

Judgment and Sentence, Thurston County Sup. Ct. No. 13-1-00655-7

EXHIBIT 3

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10

FILED  
SUPERIOR COURT  
THURSTON COUNTY, WA

2015 JAN 28 AM 10: 50

SUPERIOR COURT OF WASHINGTON  
COUNTY OF THURSTON

STATE OF WASHINGTON, Plaintiff,

vs.

LIA YERA TRICOMO,

Defendant.

No. 13-1-00655-7

FELONY JUDGMENT AND SENTENCE (FJS)

SID: WA25371849  
If no SID, use DOB: 11/24/1985  
PCN: 767140185 BOOKING NO. C0179274

Prison (non-sex offense)

I. HEARING

1.1 A sentencing hearing was held on January 28, 2015 and the defendant, the defendant's lawyer and the deputy prosecuting attorney were present.

II. FINDINGS

There being no reason why judgment should not be pronounced, the court FINDS:

2.1 CURRENT OFFENSE(S): The defendant was found guilty on November 6, 2014  
by  plea  jury-verdict  bench trial of

COUNT	CRIME	RCW	DATE OF CRIME
I	MURDER IN THE SECOND DEGREE	9A.32.050(1)(a)	APRIL 29, 2013
II	ASSAULT IN THE SECOND DEGREE - SUBSTANTIAL BODILY HARM	9A.36.021(1)(a)	APRIL 29, 2013
III	ASSAULT IN THE SECOND DEGREE - SUBSTANTIAL BODILY HARM	9A.36.021(1)(a)	APRIL 29, 2013
IV	ASSAULT IN THE SECOND DEGREE - SUBSTANTIAL BODILY HARM	9A.36.021(1)(a)	APRIL 29, 2013
V	TAKING MOTOR VEHICLE WITHOUT PERMISSION IN THE SECOND DEGREE	9A.56.075(1)	APRIL 29, 2013

as charged in the FIRST AMENDED information.

Additional current offenses are attached in Appendix 2.1.

The court finds that the defendant is subject to sentencing under **RCW 9.94A.712**.

A special verdict/finding for use of **firearm** was returned on Count(s) \_\_\_\_\_, RCW 9.94A.602, 9.94A.533.

A special verdict/finding for use of **deadly weapon other than a firearm** was returned on Count(s) \_\_\_\_\_, RCW 9.94A.602, 9.94A.533.

A special verdict/finding for **Violation of the Uniform Controlled Substances Act** was returned on Count(s) \_\_\_\_\_, RCW 69.50.401 and RCW 69.50.435, taking place in a school, school bus, within 1000 feet of the perimeter of a school grounds or within 1000 feet of a school bus route stop designated by the school district; or in a public park, public transit vehicle, or public transit stop shelter; or in, or within 1000 feet of the perimeter of a civic center designated as a drug-free zone by a local government authority, or in a public housing project designated by a local governing authority as a drug-free zone.

- A special verdict/finding that the defendant committed a crime involving the manufacture of methamphetamine, including its salts, isomers, and salts of isomers, **when a juvenile was present in or upon the premises of manufacture** was returned on Count(s) \_\_\_\_\_ . RCW 9.94A.605, RCW 69.50.401, RCW 69.50.440.
- The defendant was convicted of **vehicular homicide** which was proximately caused by a person driving a vehicle while under the influence of intoxicating liquor or drug or by the operation of a vehicle in a reckless manner and is therefore a violent offense. RCW 9.94A.030.
- This case involves **kidnapping** in the first degree, kidnapping in the second degree, or unlawful imprisonment as defined in chapter 9A.40 RCW, where the victim is a minor and the offender is not the minor's parent. RCW 9A.44.130.
- The court finds that the offender has a **chemical dependency** that has contributed to the offense(s). RCW 9.94A.607.
- For the crime(s) charged in Count \_\_\_\_\_, **domestic violence** was pled and proved. RCW 10.99.020.
- Other current convictions listed under different cause numbers used in calculating the offender score are (list offense and cause number):

None of the current offenses constitute same criminal conduct except: \_\_\_\_\_

2.2 CRIMINAL HISTORY (RCW 9.94A.525):

CRIME	DATE OF SENTENCE	SENTENCING COURT (County & State)	DATE OF CRIME	A or J Adult, Juv.	TYPE OF CRIME
1 ASSAULT 3	4-12-11	THURSTON CO.	10-22-09	A	NV
2					
3					

- Additional criminal history is attached in Appendix 2.2.
- The defendant committed a current offense while on community placement (adds one point to score). RCW 9.94A.525.
- The court finds that the following prior convictions are one offense for purposes of determining the offender score (RCW 9.94A.525):

- The following prior convictions are not counted as points but as enhancements pursuant to RCW 46.61.520:

None of the prior convictions constitutes same criminal conduct except \_\_\_\_\_

2.3 SENTENCING DATA:

COUNT	OFFENDER SCORE	SERIOUSNESS LEVEL	STANDARD RANGE	ENHANCEMENTS*	TOTAL STANDARD RANGE	MAXIMUM TERM
I	8	serious violent	257-357m	none	257-357m	life
II	8	violent	53-70m	none	53-70m	10yrs
III	8	violent	53-70m	none	53-70m	10yrs
IV	8	violent	53-70m	none	53-70m	10yrs
V	5	non-violent	4-12m	none	4-12m	5yrs

\* (F) Firearm, (D) Other deadly weapons, (V) VUCSA in a protected zone, (VH) Veh. Hom, see RCW 46.61.520, (JP) Juvenile present. [ ] Additional current offense sentencing data is attached in Appendix 2.3.

2.4 [ ] EXCEPTIONAL SENTENCE. Substantial and compelling reasons exist which justify an exceptional sentence:  
[ ] within [ ] below the standard range for Count(s) \_\_\_\_\_.  
[ ] above the standard range for Count(s) \_\_\_\_\_.  
[ ] The defendant and state stipulate that justice is best served by imposition of the exceptional sentence above the standard range and the court finds the exceptional sentence furthers and is consistent with the interests of justice and the purposes of the sentencing reform act.  
[ ] Aggravating factors were [ ] stipulated by the defendant, [ ] found by the court after the defendant waived jury trial, [ ] found by jury by special interrogatory.  
Findings of fact and conclusions of law are attached in Appendix 2.4. [ ] Jury's special interrogatory is attached. The Prosecuting Attorney [ ] did [ ] did not recommend a similar sentence.

2.5 ABILITY TO PAY LEGAL FINANCIAL OBLIGATIONS. The court has considered the total amount owing, the defendant's past, present and future ability to pay legal financial obligations, including the defendant's financial resources and the likelihood that the defendant's status will change. The court finds that the defendant has the ability or likely future ability to pay the legal financial obligations imposed herein. RCW 9.94A.753.  
[ ] The following extraordinary circumstances exist that make restitution inappropriate (RCW 9.94A.753):  
\_\_\_\_\_

2.6 For violent offenses, most serious offenses, or armed offenders recommended sentencing agreements or plea agreements are [ ] attached [ ] as follows: \_\_\_\_\_

III. JUDGMENT

3.1 The defendant is GUILTY of the Counts and Charges listed in Paragraph 2.1 and Appendix 2.1.

3.2 [ ] The court DISMISSES Counts \_\_\_\_\_ [ ] The defendant is found NOT GUILTY of Counts \_\_\_\_\_

IV. SENTENCE AND ORDER

IT IS ORDERED:

4.1 Defendant shall pay to the Clerk of this Court:

JASS CODE

RTN/RJN

\$ RESERVED Restitution to: victim's family (Peter Alkins, Mike Alkins, Mary Gehring)  
\$ \_\_\_\_\_ Restitution to: \_\_\_\_\_

\$ \_\_\_\_\_ Restitution to: \_\_\_\_\_  
(Name and Address--address may be withheld and provided confidentially to Clerk of the Court's office.)

PCV

\$ 500.00 Victim assessment RCW 7.68.035  
\$ \_\_\_\_\_ Domestic Violence assessment RCW 10.99.080

CRC

\$ 200.00 Court costs, including RCW 9.94A.760, 9.94A.505, 10.01.160, 10.46.190  
Criminal filing fee \$ \_\_\_\_\_ FRC  
Witness costs \$ \_\_\_\_\_ WFR  
Sheriff service fees \$ \_\_\_\_\_ SFR/SFS/SFW/WRF  
Jury demand fee \$ \_\_\_\_\_ JFR  
Extradition costs \$ \_\_\_\_\_ EXT  
Other \$ \_\_\_\_\_

PUB \$ \_\_\_\_\_ Fees for court appointed attorney RCW 9.94A.760  
 WFR \$ \_\_\_\_\_ Court appointed defense expert and other defense costs RCW 9.94A.760  
 FCM/MTH \$ \_\_\_\_\_ Fine RCW 9A.20.021; [ ] VUCSA chapter 69.50 RCW, [ ] VUCSA additional fine  
 deferred due to indigency RCW 69.50.430  
 CDF/LDI/FCD \$ \_\_\_\_\_ Drug enforcement fund of Thurston County RCW 9.94A.760  
 NTF/SAD/SDI \$ \_\_\_\_\_ Thurston County Drug Court Fee  
 CLF \$ \_\_\_\_\_ Crime lab fee [ ] suspended due to indigency RCW 43.43.690  
 \$ 100.00 Felony DNA collection fee [ ] not imposed due to hardship RCW 43.43.7541  
 RTN/RJN \$ \_\_\_\_\_ Emergency response costs (Vehicular Assault, Vehicular Homicide only, \$1000  
 maximum) RCW 38.52.430  
 \$ \_\_\_\_\_ Other costs for: \_\_\_\_\_  
 \$ 800.00 TOTAL RCW 9.94A.760

The above total may not include all restitution or other legal financial obligations, which may be set by later order of the court. An agreed restitution order may be entered. RCW 9.94A.753. A restitution hearing may be set by the prosecutor or is scheduled for \_\_\_\_\_.

[ ] RESTITUTION. Schedule attached.

[ ] Restitution ordered above shall be paid jointly and severally with:

	<u>NAME of other defendant</u>	<u>CAUSE NUMBER</u>	<u>(Victim's name)</u>	<u>(Amount-\$)</u>
RJN	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

The Department of Corrections (DOC) or clerk of the court shall immediately issue a Notice of Payroll Deduction. RCW 9.94A.7602, RCW 9.94A.760(8).

All payments shall be made in accordance with the policies of the clerk of the court and on a schedule established by DOC or the clerk of the court, commencing immediately, unless the court specifically sets forth the rate here: Not less than \$ \_\_\_\_\_ per month commencing \_\_\_\_\_ RCW 9.94A.760.

The defendant shall report as directed by the clerk of the court and provide financial information as requested. RCW 9.94A.760(7)(b).

The financial obligations imposed in this judgment shall bear interest from the date of the judgment until payment in full, at the rate applicable to civil judgments. RCW 10.82.090. An award of costs on appeal against the defendant may be added to the total legal financial obligations. RCW 10.73.160.

[ ] In addition to the other costs imposed herein, the court finds that the defendant has the means to pay for the cost of incarceration and is ordered to pay such costs at the rate of \$50.00 per day, unless another rate is specified here: (JLR) RCW 9.94A.760.

4.2 DNA TESTING. The defendant shall have a biological sample collected for purposes of DNA identification analysis and the defendant shall fully cooperate in the testing. The appropriate agency shall be responsible for obtaining the sample prior to the defendant's release from confinement. RCW 43.43.754.

[ ] HIV TESTING. The defendant shall submit to HIV testing. RCW 70.24.340.

4.3 The defendant shall not have contact with Peter Atkins, Mary Gehling, Miles (name, DOB) including, but not limited to, personal, verbal, telephonic, written or contact through a third party Alkhonda Brooks, Guy Gehling, Atkins, Brooke Bell

for life years (not to exceed the maximum statutory sentence).

[ ] Domestic Violence No-Contact Order or Antiharassment No-Contact Order is filed with this Judgment and Sentence.

4.4 OTHER: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4.5 CONFINEMENT OVER ONE YEAR. The defendant is sentenced as follows:

(a) CONFINEMENT. RCW 9.94A.589. Defendant is sentenced to the following term of total confinement in the custody of the Department of Corrections (DOC):

357 months on Count 1      70 months on Count 4  
70 months on Count 2      12 months on Count 5  
70 months on Count 3      \_\_\_\_\_ months on Count \_\_\_\_\_

Actual number of months of total confinement ordered is: 357 months (Cts II, III, IV & V concurrent to Ct I)  
(Add mandatory firearm and deadly weapons enhancement time to run consecutively to other counts, see Section 2.3, Sentencing Data, above.)

[ ] The confinement time on Count(s) \_\_\_\_\_ contain(s) a mandatory minimum term of \_\_\_\_\_.

NON-FELONY COUNTS:

Sentence on counts \_\_\_\_\_ is/are suspended for \_\_\_\_\_ months on the condition that the defendant comply with all requirements outlined in the supervision section of this sentence.

\_\_\_\_\_ days of jail are suspended on Count \_\_\_\_\_  
\_\_\_\_\_ days of jail are suspended on Count \_\_\_\_\_

All counts shall be served concurrently, except for the portion of those counts for which there is a special finding of a firearm or other deadly weapon as set forth above at Section 2.3, and except for the following counts which shall be served consecutively: \_\_\_\_\_

The sentence herein shall run consecutively with the sentence in cause number(s) \_\_\_\_\_

but concurrently to any other felony cause not referred to in this Judgment. RCW 9.94A.589.

Confinement shall commence immediately unless otherwise set forth here: \_\_\_\_\_

The defendant shall receive credit for time served prior to sentencing if that confinement was solely under this cause number. RCW 9.94A.505. The time served shall be computed by the jail unless the credit for time served prior to sentencing is specifically set forth by the court: \_\_\_\_\_



[ ] The defendant shall enter into and complete a certified domestic violence program as required by DOC or as follows: \_\_\_\_\_

[ ] The defendant shall not use, possess, manufacture or deliver controlled substances without a valid prescription, not associate with those who use, sell, possess, or manufacture controlled substances and submit to random urinalysis at the direction of his/her CCO to monitor compliance with this condition.

[ ] The defendant shall comply with the following additional crime-related prohibitions: \_\_\_\_\_

Other conditions may be imposed by the court or DOC during community custody, or are set forth here: \_\_\_\_\_

The conditions of community supervision or community custody shall begin immediately unless otherwise set forth here: \_\_\_\_\_

4.7 [ ] **WORK ETHIC CAMP.** RCW 9.94A.690, RCW 72.09.410. The court finds that the defendant is eligible and is likely to qualify for work ethic camp and the court recommends that the defendant serve the sentence at a work ethic camp. Upon completion of work ethic camp, the defendant shall be released on community custody for any remaining time of total confinement, subject to the conditions below. Violation of the conditions of community custody may result in a return to total confinement for the balance of the defendant's remaining time of total confinement. The conditions of community custody are stated above in Section 4.6.

4.8 **OFF LIMITS ORDER** (known drug trafficker) RCW 10.66.020. The following areas are off limits to the defendant while under the supervision of the county jail or Department of Corrections: \_\_\_\_\_

## V. NOTICES AND SIGNATURES

5.1 **COLLATERAL ATTACK ON JUDGMENT.** Any petition or motion for collateral attack on this Judgment and Sentence, including but not limited to any personal restraint petition, state habeas corpus petition, motion to vacate judgment, motion to withdraw guilty plea, motion for new trial or motion to arrest judgment, must be filed within one year of the final judgment in this matter, except as provided for in RCW 10.73.100. RCW 10.73.090.

5.2 **LENGTH OF SUPERVISION.** For an offense committed prior to July 1, 2000, the defendant shall remain under the court's jurisdiction and the supervision of the Department of Corrections for a period up to 10 years from the date of sentence or release from confinement, whichever is longer, to assure payment of all legal financial obligations unless the court extends the criminal judgment an additional 10 years. For an offense committed on or after July 1, 2000, the court shall retain jurisdiction over the offender, for the purpose of the offender's compliance with payment of the legal financial obligations, until the obligation is completely satisfied, regardless of the statutory maximum for the crime. RCW 9.94A.760 and RCW 9.94A.505(5). The clerk of the court is authorized to collect unpaid legal financial obligations at any time the offender remains under the jurisdiction of the court for purposes of his or her legal financial obligations. RCW 9.94A.760(4) and RCW 9.94A.753(4).

5.3 **NOTICE OF INCOME-WITHHOLDING ACTION.** If the court has not ordered an immediate notice of payroll deduction in Section 4.1, you are notified that the Department of Corrections or the clerk of the court may issue a notice of payroll deduction without notice to you if you are more than 30 days past due in monthly payments in an amount equal to or greater than the amount payable for one month. RCW 9.94A.7602. Other income-withholding action under RCW 9.94A.760 may be taken without further notice. RCW 9.94A.7606.

5.4 RESTITUTION HEARING.

[ ] Defendant waives any right to be present at any restitution hearing (sign initials): \_\_\_\_\_.

5.5 Any violation of this Judgment and Sentence is punishable by up to 60 days of confinement per violation. RCW 9.94A.633.

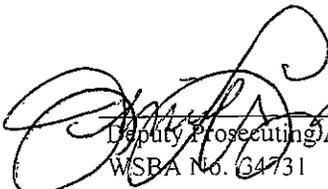
5.6 FIREARMS. You must immediately surrender any concealed pistol license and you may not own, use or possess any firearm unless your right to do so is restored by a court of record. (The clerk of the court shall forward a copy of the defendant's driver's license, identicard, or comparable identification to the Department of Licensing along with the date of conviction or commitment.) RCW 9.41.040, 9.41.047.

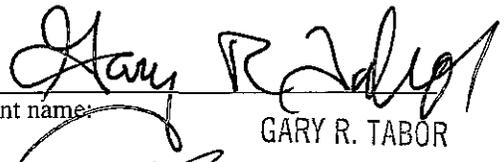
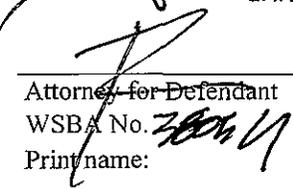
5.7 [ ] The court finds that Count \_\_\_\_\_ is a felony in the commission of which a motor vehicle was used. The clerk of the court is directed to immediately forward an Abstract of Court Record to the Department of Licensing, which must revoke the defendant's driver's license. RCW 46.20.285.

5.8 If the defendant is or becomes subject to court-ordered mental health or chemical dependency treatment, the defendant must notify DOC and the defendant's treatment information must be shared with DOC for the duration of the defendant's incarceration and supervision. RCW 9.94A.562.

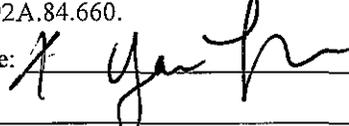
5.9 OTHER: Bail previously posted, if any, is hereby exonerated and shall be returned to the posting party.

DONE in Open Court and in the presence of the defendant this date: 1-28-15.

  
Deputy Prosecuting Attorney  
WSBA No. 64731  
Print name: JENNIFER L. LORD

  
Judge/Print name: \_\_\_\_\_  
GARY R. TABOR  
  
Attorney for Defendant  
WSBA No. 300611  
Print name: \_\_\_\_\_

VOTING RIGHTS STATEMENT: RCW 10.64.140. I acknowledge that my right to vote has been lost due to felony conviction. If I am registered to vote, my voter registration will be cancelled. My right to vote may be restored by: a) A certificate of discharge issued by the sentencing court, RCW 9.94A.637; b) A court order issued by the sentencing court restoring the right, RCW 9.92.066; c) A final order of discharge issued by the indeterminate sentence review board, RCW 9.96.050; or d) A certificate of restoration issued by the governor, RCW 9.96.020. Voting before the right is restored is a class C felony, RCW 92A.84.660.

Defendant's signature:  \_\_\_\_\_.

I am a certified interpreter of, or the court has found me otherwise qualified to interpret, the \_\_\_\_\_ language, which the defendant understands. I translated this Judgment and Sentence for the defendant into that language.  
Interpreter signature/Print name: \_\_\_\_\_

I, \_\_\_\_\_, Clerk of this Court, certify that the foregoing is a full, true and correct copy of the Judgment and Sentence in the above-entitled action now on record in this office.

WITNESS my hand and seal of the said Superior Court affixed this date: \_\_\_\_\_.

Clerk of the Court of said county and state, by: \_\_\_\_\_, Deputy Clerk

**IDENTIFICATION OF DEFENDANT**

SID No. WA25371849  
 (If no SID take fingerprint card for State Patrol)

Date of Birth 11/24/1985

FBI No. 158092FD4

Local ID No. \_\_\_\_\_

PCN No. 767140185

Other \_\_\_\_\_

Alias name, DOB: \_\_\_\_\_

**Race:**

- Asian/Pacific Islander       Black/African-American       Caucasian  
 Native American       Other: \_\_\_\_\_

**Ethnicity:**

- Hispanic       Non-Hispanic  
 Male       Female

**FINGERPRINTS:** I attest that I saw the same defendant who appeared in court on this document affix his or her fingerprints and signature thereto. Clerk of the Court, Deputy Clerk, [Signature] Dated: 01-28-15

**DEFENDANT'S SIGNATURE:** [Signature]

Left four fingers taken simultaneously

Left Thumb

Right Thumb

Right four fingers taken simultaneously



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

IN RE THE PERSONAL )  
RESTRAINT PETITION OF: ) CAUSE NO. 51741-8-II  
LIA Y. TRICOMO, ) EXHIBIT 4  
Petitioner. )  
\_\_\_\_\_)

EXHIBIT 4  
Slip Opinion, COA No. 47238-4 -II

EXHIBIT 4

Law Office of Neil Fox, PLLC  
2125 Western Ave. Ste. 330  
Seattle, Washington 98121  
206-728-5440

April 26, 2016

**IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON**

**DIVISION II**

STATE OF WASHINGTON,

Respondent,

v.

LIA YERA TRICOMO,

Appellant.

No. 47238-4-II

UNPUBLISHED OPINION

LEE, J. — Lia Yera Tricomo pleaded guilty to second degree murder, three counts of second degree assault, and second degree taking a motor vehicle without owner’s permission. Tricomo appeals, arguing that her convictions violate double jeopardy, her plea was not entered voluntarily, and that the trial court erred in not considering evidence at sentencing. We disagree and affirm.

**FACTS**

Tricomo and the victim, her former counselor, had a sexual encounter at the victim’s home in the upstairs bedroom. Following the sexual encounter, Tricomo repeatedly slit the victim’s throat with a razor knife. Tricomo acknowledged that she brought the knife to the upstairs bedroom in preparation to kill the victim. For several hours after having his throat slit, the victim “walked around the house,” attempting to stop the bleeding. Clerk’s Papers (CP) at 5. Tricomo, concerned that the victim would attempt to leave the house, struggled with the victim over the razor knife at the entryway. The victim’s wrists were cut in the struggle. The victim then went

back upstairs to the bedroom, and Tricomo strangled him with an electrical extension cord, killing him.

The State charged Tricomo with second degree murder and three counts of second degree assault.<sup>1</sup> At the plea hearing, the trial court informed her that the applicable maximum term of confinement for the second degree murder charge was a life sentence, the “standard range of actual confinement was 257 to 357 months,” and the State would recommend a sentence of 357 months. Verbatim Report of Proceedings (VRP) (Nov. 6, 2014) at 7. Tricomo acknowledged that she understood.

At sentencing, Tricomo offered an expert report that included a discussion of the effects of Tricomo’s medication. The trial court ruled that it would consider the expert’s report for purposes of background information, but that it would disregard the expert’s discussion of medication because “I don’t find that [the expert] has any expertise in that particular area and she basically only sets forth a number of articles suggesting that they may have some relevance.” VRP (Jan. 28, 2015) at 39. The trial court reviewed letters from individuals in support of Tricomo, two reports from Western State Hospital, and portions of Tricomo’s expert’s report. The trial court noted that the “issue before me today is not whether or not Ms. Tricomo had the ability to form a specific intent to kill. That’s been established by her pleading guilty to this charge.” VRP (Jan. 28, 2015) at 92. Ultimately, the court sentenced Tricomo to 357 months, which was within the standard sentencing range. Tricomo appeals.

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<sup>1</sup> The State also charged Tricomo with second degree taking a motor vehicle without the owner’s permission. The morning after Tricomo strangled the victim, she left the victim’s home in the victim’s vehicle. The conviction for second degree taking a motor vehicle is not at issue in this appeal.

## ANALYSIS

### A. DOUBLE JEOPARDY

Tricomo argues that double jeopardy bars her convictions for three counts of second degree assault, and her convictions for second degree assault and second degree murder. Tricomo did not raise the double jeopardy argument below, but a constitutional challenge may be raised for the first time on appeal. *State v. Adel*, 136 Wn.2d 629, 631-32, 965 P.2d 1072 (1998); *see accord State v. Reeder*, 181 Wn. App. 897, 925-26, 330 P.3d 786 (2014), *review granted in part*, 337 P.3d 325, *aff'd*, 184 Wn.2d 805, 365 P.3d 1243 (2015).

Both the federal and state double jeopardy clauses protect against multiple punishments for the same offense. U.S. CONST. amend. V; WASH. CONST. art. I, § 9; *State v. Hart*, 188 Wn. App. 453, 457, 353 P.3d 253 (2015). Generally, a guilty plea will insulate the defendant's conviction from collateral attack. *State v. Knight*, 162 Wn.2d 806, 811, 174 P.3d 1167 (2008). A guilty plea waives “constitutional rights that inhere in a criminal trial, including the right to trial by jury, the protection against self-incrimination, and the right to confront one's accusers.” *Knight*, 162 Wn.2d at 811 (quoting *Florida v. Nixon*, 543 U.S. 175, 187, 125 S. Ct. 551, 160 L. Ed. 2d 565 (2004)). But claims that go to “the very power of the State to bring the defendant into court to answer the charge brought against him,” like the double jeopardy clause, are not waived by guilty pleas. *Knight*, 162 Wn.2d at 811 (quoting *Blackledge v. Perry*, 417 U.S. 21, 30, 94 S. Ct. 2098, 40 L. Ed. 2d 628 (1974)); *see Menna v. New York*, 423 U.S. at 62, 96 S. Ct. 241, 46 L. Ed. 2d 195 (1975). After a defendant pleads guilty, “the double jeopardy violation must be clear from the record presented on appeal, or else be waived.” *Knight*, 162 Wn.2d at 811.

We review alleged violations of double jeopardy de novo. *State v. Villanueva-Gonzalez*, 180 Wn.2d 975, 980, 329 P.3d 78 (2014). Different double jeopardy analyses apply depending on whether the convictions at issue were under the same statutory provision or different statutory provisions. *Villanueva-Gonzalez*, 180 Wn.2d at 980. Where a defendant has multiple convictions under the same statutory provision, we apply the “unit of prosecution” analysis. *Villanueva-Gonzalez*, 180 Wn.2d at 980. But when a defendant has convictions under different statutes, we apply the same evidence analysis.<sup>2</sup> *State v. Calle*, 125 Wn.2d 769, 777, 888 P.2d 155 (1995).

1. Three Counts of Second Degree Assault

Tricomo was convicted of three counts of second degree assault pursuant to RCW 9A.36.021. Because the second degree assault convictions arise from the same statutory provision, we apply the “unit of prosecution” analysis. *Villanueva-Gonzalez*, 180 Wn.2d at 980-81.

Tricomo argues that her acts constituted a single criminal episode driven by the singular intent to kill the victim. Tricomo argues that because her acts were a single criminal episode, she could only be convicted of one count of assault, or two at the most, but definitely not three.

Tricomo was charged, in relevant part, with three counts of second degree assault<sup>3</sup> stemming from the events of one evening. Count II charged second degree assault based on the “use of a razor knife to inflict neck wounds.” CP at 25. Count III charged second degree assault

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<sup>2</sup> The same evidence test mirrors the federal “same elements” standard adopted in *Blockburger v. United States*, 284 U.S. 299, 304, 52 S. Ct. 180, 76 L. Ed. 306 (1932); *State v. Gocken*, 127 Wn.2d 95, 107, 896 P.2d 1267 (1995).

<sup>3</sup> RCW 9A.36.021(1)(a), (c).

based on the “use of a razor knife to inflict facial wounds.” CP at 25. And count IV charged second degree assault based on the “use of a razor knife to inflict hand wounds.” CP at 25.

Tricomo pleaded guilty as charged and agreed that the trial court could rely on the State’s statement of probable cause and police reports to find the facts necessary to establish a factual basis for her plea. The trial court found that a sufficient factual basis existed in the record before it to accept the plea.

a. Count III (facial wounds)

The statement of probable cause does not include any information about count III, the assault charge based on infliction of facial wounds. And, the record does not contain any police reports. It is the appellant’s burden to provide a sufficient record for us to review. *See State v. Gomez*, 183 Wn.2d 29, 34, 347 P.3d 876 (2015). Because a double jeopardy violation is not clear from the record presented on review, we hold that Tricomo waived her challenge to count III, the second degree assault conviction based on the use of a razor knife to inflict facial wounds. *Knight*, 162 Wn.2d at 811.

b. Count II (neck wounds) and Count IV (hand wounds)

Tricomo argues that “it is clear from the facts” that her acts “constituted a single criminal episode driven by the singular intent to kill” the victim. Br. of Appellant at 9. Tricomo also acknowledges that the facts may support two assault counts. But the record shows that the two assaults were separate courses of conduct.

Assault is a course of conduct crime, which “helps to avoid the risk of a defendant being ‘convicted for every punch thrown in a fistfight.’” *Villanueva-Gonzalez*, 180 Wn.2d at 985 (quoting *State v Tili*, 139 Wn.2d 107, 116, 985 P.2d 365 (1999)). Thus, if multiple assaultive acts

constitute only one course of conduct, then double jeopardy protects against multiple convictions. *Villanueva-Gonzalez*, 180 Wn.2d at 985. There is no bright-line rule for when multiple assaultive acts constitute one course of conduct. *Villanueva-Gonzalez*, 180 Wn.2d at 980-81. In determining whether multiple assault acts constitute one course of conduct, we consider the length of time over which the acts occurred, the location of the acts, the defendant's intent or motivation for the assaultive acts, whether the acts were uninterrupted, and whether there was an opportunity for the defendant to reconsider her acts. *Villanueva-Gonzalez*, 180 Wn.2d at 980-81. No single "factor is dispositive, and the ultimate determination should depend on the totality of the circumstances, not a mechanical balancing of the various factors." *Villanueva-Gonzalez*, 180 Wn.2d at 985.

Here, the assaultive acts occurred over several hours and in different places in the victim's home. According to Tricomo, there were hours in between the act of slitting the victim's throat and cutting the victim's wrists. Further, Tricomo's account of the events indicate that her motivation for the two attacks was different. Tricomo stated that she brought the knife with her into the upstairs bedroom "as preparation to kill" the victim, but that she cut the victim's wrists because the victim was attempting to take the knife from her. CP at 5. And, she had considerable time to reconsider her actions. For instance, she had time to reconsider during the "hours" the victim spent walking around the house after she slit his throat in the upstairs bedroom and before she cut his wrists during the struggle at the entryway. See CP at 5. Considering the totality of the circumstances, the assault that resulted in neck wounds was a separate course of conduct from the assault that resulted in wrist wounds. Therefore, Counts II and IV do not violate double jeopardy.

2. Second Degree Murder and Second Degree Assault

Tricomo was charged with second degree murder under RCW 9A.32.050(1)(a), and three counts of second degree assault under RCW 9A.36.021(1)(a) and (c). Tricomo contends that the murder and assaults “arose from a single course of conduct and constitute the same offense.” Br. of Appellant at 10. Tricomo misconstrues the double jeopardy analysis for multiple convictions under separate statutes.

To determine if a defendant’s convictions under different statutes violate double jeopardy, we apply the same evidence test. *Calle*, 125 Wn.2d at 777; *Villanueva-Gonzalez*, 180 Wn.2d at 980-81. The same evidence analysis asks whether the convictions were the same in law and in fact. *Calle*, 125 Wn.2d at 777; *accord Villanueva-Gonzalez*, 180 Wn.2d at 980-81. “If there is an element in each offense which is not included in the other, and proof of one offense would not necessarily also prove the other, the offenses are not constitutionally the same and the double jeopardy clause does not prevent convictions for both offenses.” *Calle*, 125 Wn.2d at 777 (quoting *State v. Vladovic*, 99 Wn.2d 413, 423, 662 P.2d 853 (1983)).

Tricomo was charged with second degree murder under RCW 9A.32.050(1)(a), one count of second degree assault under RCW 9A.36.021(1)(a), and two counts of second degree assault under RCW 9A.36.021(1)(c). A person commits second degree assault under RCW 9A.36.021 when:

- (1) . . . he or she, under circumstances not amounting to assault in the first degree:
  - (a) Intentionally assaults another and thereby recklessly inflicts substantial bodily harm; or
  - . . . .
  - (c) Assaults another with a deadly weapon.

Because assault is not defined in the criminal code, courts have turned to the common law for its definition. *State v. Elmi*, 166 Wn.2d 209, 215, 207 P.3d 439 (2009); *State v. Kier*, 164 Wn.2d 798, 806, 194 P.3d 212 (2008). Three definitions of assault are recognized in Washington: (1) an unlawful touching (actual battery); (2) an attempt with unlawful force to inflict bodily injury upon another, tending but failing to accomplish it (attempted battery); and (3) putting another in apprehension of harm. *Elmi*, 166 Wn.2d at 215.

A person commits second degree murder under RCW 9A.32.050(1)(a) when:

With intent to cause the death of another person but without premeditation, he or she causes the death of such person or of a third person.

Tricomo's convictions for second degree murder and second degree assault are legally different. Proof of second degree assault does not necessarily prove second degree murder because a person can assault another person without actually causing death. Second degree murder, on the other hand, requires proof of intent to cause death, and actual death. Therefore, the convictions are not the same in law.

Also, Tricomo's convictions for second degree assault and second degree murder are factually different. As discussed above, Tricomo's assault convictions arise from her acts of assaulting the victim with a razor knife. But Tricomo's second degree murder conviction arises from her strangling the victim with an electrical extension cord.

Thus, Tricomo's murder and assault convictions are not the same in law and in fact. While it is true that the convictions are based on Tricomo's actions from a particular day, they are based on different laws and actions. Tricomo's double jeopardy challenge fails.

B. CONSEQUENCES OF GUILTY PLEA

Tricomo argues that she should be able to withdraw her guilty plea because she was misinformed about the maximum sentence in her guilty plea. We disagree.

Due process requires that a defendant's guilty plea be made knowingly, voluntarily, and intelligently. *State v. Kennar*, 135 Wn. App. 68, 72, 143 P.3d 326 (2006). CrR 4.2 precludes a trial court from accepting a guilty plea without first determining that the defendant is entering the plea voluntarily, competently, and with an understanding of the nature of the charge and the consequences of the plea. *Kennar*, 135 Wn. App. at 72.

Here, Tricomo pleaded guilty to second degree murder. At the plea hearing, the trial court informed her that the applicable maximum term of confinement was a life sentence and the "standard range of actual confinement was 257 to 357 months," with the State recommending a sentence of 357 months. VRP (Nov. 6, 2014) at 7. Tricomo acknowledged that she understood. The court then sentenced Tricomo within the standard range.

Tricomo contends that her plea was not made knowingly, voluntarily, and intelligently because the trial court misinformed her of the applicable maximum sentence for the offense with which she was charged. Tricomo asserts that the applicable maximum sentence was the top end of the standard range, not the statutory maximum sentence declared by the legislature. Citing *Blakely v. Washington*, 542 U.S. 296, 124 S. Ct. 2531, 159 L. Ed. 2d 403 (2004), Tricomo claims that the trial court misinformed her when it told her that life imprisonment was the applicable maximum sentence for second degree murder.

*Kennar* rejected Tricomo's precise argument. *Kennar*, 135 Wn. App. at 72. In *Kennar*, the court held that "CrR 4.2 requires the trial court to inform a defendant of both the applicable

standard sentence range and the maximum sentence for the charged offense as determined by the legislature.” *Kennar*, 135 Wn. App. at 75. The *Kennar* court, noting that *Blakely* is a sentencing case, not a plea-entry case, held:

Because a defendant’s offender score and standard sentence range are not finally determined by the court until the time of sentencing, the Sixth Amendment concerns addressed in *Blakely* do not apply until that time. Thus, when *Kennar* entered his guilty plea, the maximum peril he faced was, in fact, life in prison. He was correctly informed of this by the trial court. His plea was knowingly, intelligently, and voluntarily entered. There was no error.

*Kennar*, 135 Wn. App. at 76.

Similarly here, at the time of her plea, Tricomo was informed of the maximum sentence and the standard sentence range for the charged offense. *Kennar* controls, and Tricomo’s plea was entered knowingly, intelligently, and voluntarily.

C. EVIDENCE AT SENTENCING

Tricomo argues that the trial court erred in refusing to consider relevant evidence at sentencing. We disagree.

“As a general rule, the length of a criminal sentence imposed by a superior court is not subject to appellate review,” as long as the sentence is within the standard range.<sup>4</sup> *State v. Williams*, 149 Wn.2d 143, 146, 65 P.3d 1214 (2003). Tricomo was sentenced within the standard range. However, even if we consider whether the trial court erred in not considering Tricomo’s evidence, her argument fails.

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<sup>4</sup> We may review the sentence where a defendant requests an exceptional sentence below the standard range if the court abused its discretion by either refusing to exercise its discretion or relied on an impermissible basis for refusing to impose an exceptional sentence. *State v. Khanteechit*, 101 Wn. App. 137, 138, 5 P.3d 727 (2000). Here, however, Tricomo did not request an exceptional sentence below the standard range and was sentenced within the standard range.

In Tricomo’s sentencing brief, Tricomo asked the court to consider evidence regarding her background, urging the court to sentence her at the low end of the standard range. Tricomo argues that “the court refused to consider any opinion as to the appropriate sentence.” Br. of Appellant at 18. Tricomo fails to provide any authority suggesting that the sentencing court is required to consider an expert’s opinion about “the appropriate sentence” where the defendant does not request an exceptional sentence. “Where no authorities are cited in support of a proposition, the court is not required to search out authorities, but may assume that counsel, after diligent search, has found none.” *DeHeer v. Seattle Post-Intelligencer*, 60 Wn.2d 122, 126, 372 P.2d 193 (1962). Thus, Tricomo’s argument fails.

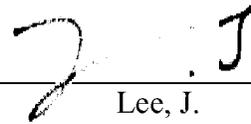
Tricomo next argues that the trial court erred by not considering the experts’ opinions about the effects of Tricomo’s medications. The trial court ruled that it would disregard the expert’s discussion of medication, because “I don’t find that [the expert] has any expertise in that particular area and she basically only sets forth a number of articles suggesting that they may have some relevance.” VRP (Jan. 28, 2015) at 39. Tricomo fails to provide any argument as to how the trial court erred. Therefore, we do not consider this argument. RAP 10.3; *Cowiche Canyon Conservancy v. Bosley*, 118 Wn.2d 801, 809, 828 P.2d 549 (1992).

Finally, Tricomo argues that she should have been able to present more evidence about her culpability for the crimes because the sentencing court should be concerned with whether the punishment is proportional to the culpability. Culpability is determined by the charge and conviction. *See State v. Johnson*, 180 Wn.2d 295, 306, 325 P.3d 15 (2014). And the legislature, in determining the sentencing range, accounts for culpability and dangerousness. *State v. Jordan*, 180 Wn.2d 456, 460, 325 P.3d 181 (2014). Tricomo provides no authority suggesting that during

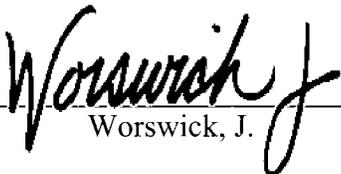
sentencing, where the defendant does not request an exceptional sentence below the standard range based on mitigating circumstances, the trial court should readdress and reestablish a defendant's culpability for an offense that the defendant has pleaded guilty to. Again, Tricomo's argument fails. *See DeHeer*, 60 Wn.2d at 126.

We affirm.

A majority of the panel having determined that this opinion will not be printed in the Washington Appellate reports, but will be filed for public record in accordance with RCW 2.06.040, it is so ordered.

  
\_\_\_\_\_  
Lee, J.

We concur:

  
\_\_\_\_\_  
Worswick, J.

  
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Bjorgen, C.J.

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

IN RE THE PERSONAL )  
RESTRAINT PETITION OF: ) CAUSE NO. 51741-8-II  
LIA Y. TRICOMO, ) EXHIBIT 5  
Petitioner. )

EXHIBIT 5  
Denial of Review, Supreme Court No. 93379-1

# THE SUPREME COURT OF WASHINGTON

STATE OF WASHINGTON,	)	No. 93379-1
	)	
Respondent,	)	<b>ORDER</b>
	)	
v.	)	Court of Appeals
	)	No. 47238-4-II
LIA TRICOMO,	)	
	)	
Petitioner.	)	
_____	)	

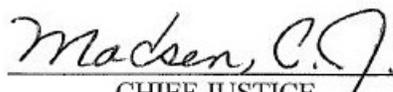
Department II of the Court, composed of Chief Justice Madsen and Justices Owens, Stephens, González and Yu, considered at its November 1, 2016, Motion Calendar whether review should be granted pursuant to RAP 13.4(b) and unanimously agreed that the following order be entered.

IT IS ORDERED:

That the Petition for Review is denied.

DATED at Olympia, Washington, this 2<sup>nd</sup> day of November, 2016.

For the Court

  
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CHIEF JUSTICE

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

IN RE THE PERSONAL )  
RESTRAINT PETITION OF: ) CAUSE NO. 51741-8-II  
LIA Y. TRICOMO, ) EXHIBIT 6  
Petitioner. )

EXHIBIT 6  
Mandate, COA No. 47238-4-II

EXHIBIT 6

Law Office of Neil Fox, PLLC  
2125 Western Ave. Ste. 330  
Seattle, Washington 98121  
206-728-5440

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Mandate  
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FILED  
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THURSTON COUNTY, WA

2017 JAN 10 AM 10:03

Linda Myhre Enlow  
Thurston County Clerk

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

STATE OF WASHINGTON,  
  
Respondent,  
  
v.  
  
LIA TRICOMO,  
  
Appellant.

No. 47238-4-II

MANDATE

Thurston County Cause No.  
13-1-00655-7

The State of Washington to: The Superior Court of the State of Washington  
in and for Thurston County

This is to certify that the opinion of the Court of Appeals of the State of Washington, Division II, filed on April 26, 2016 became the decision terminating review of this court of the above entitled case on November 2, 2016. Accordingly, this cause is mandated to the Superior Court from which the appeal was taken for further proceedings in accordance with the attached true copy of the opinion.



IN TESTIMONY WHEREOF, I have hereunto set  
my hand and affixed the seal of said Court at  
Tacoma, this 5th day of January, 2017.

Derek M. Byrne  
Clerk of the Court of Appeals,  
State of Washington, Div. II

CASE #: 47238-4-II

State of Washington, Respondent v. Lia Tricomo, Appellant  
Mandate – Page 2

Hon. Gary Tabor

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

IN RE THE PERSONAL  
RESTRAINT PETITION OF:

LIA Y. TRICOMO,

Petitioner.

) CAUSE NO. 51741-8-II

) EXHIBIT 7

EXHIBIT 7  
DSHS Report 6/5/13

EXHIBIT 7

Law Office of Neil Fox, PLLC  
2125 Western Ave. Ste. 330  
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206-728-5440



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
Aging and Disability Services  
Behavioral Health and Service Integration Administration  
Division of Behavioral Health and Recovery  
P.O. Box 45330, Olympia, WA 98504-5330

June 5, 2013

John Masterson, CEO  
Behavioral Health Resources  
3857 Martin Way E  
Olympia, WA 98506-5218

RCW 42.56.360(2) / RCW 70.02.020

Dear Mr. Masterson:

**SUBJECT: Critical Incident Investigation**

On May 14, 2013, the Department of Social and Health Services (DSHS), Division of Behavioral Health and Recovery (DBHR) conducted an on-site investigation of the recent critical incident involving the homicide of a former Behavioral Health Resources employee (John Alkins) allegedly by a current client of the agency (██████████). The investigation included a review of any actions taken by the agency prior to and following the incident. In particular, the investigation focused on why the agency did not notify the Department of Health (DOH) when John Alkins was terminated for inappropriate conduct and repeated violations of professional boundaries.

The investigation was conducted by Victoria Roberts, Office Chief, Tony O'Leary, Compliance Manager, and Pete Marburger, Supervisor, Mental Health Licensing and Certification Section. In addition, Mark Freedman and Linda Smythe from the Thurston-Mason Regional Support Network (T-M RSN) participated in the investigation.

Present from Behavioral Health Resources were: John Masterson, Chief Executive Officer; Ronald (Sandy) Ward, Director of Human Resources; Traci Crowder, Chief of Performance Management; and Darren Nealis, Clinical Director of Outpatient Services. The investigation team was informed that Stacy Sanders, who oversees all clinical functions of the agency, was out on medical leave and not available.

**PROCESS OF THE INVESTIGATION:**

RCW 42.56.360(2) / RCW 70.02.020

The investigation consisted of a:

- Group interview with the Behavioral Health Resources staff to discuss the incident and actions taken by the agency prior to and following the incident.
- Review of clinical records for any clients who were treated by John Alkins and were identified as possible victims of inappropriate conduct, including that of ██████████.
- Review of the private investigator's report regarding the allegations of inappropriate conduct and violations of professional boundaries on the part of John Alkins.
- Review of the personnel record of John Alkins, along with all other staff that had been terminated in the past two years, including former supervisors Sherry Waller and Rita Szantay.
- Review of documentation of all communication between Behavioral Health Resources and the Department of Health (DOH) related to John Alkins.

## Critical Incident Investigation

Page 2

- Review of documentation related to the clinical and administrative supervision of John Alkins.
- Review of all policies and procedures related to staff recruitment, hiring, training, supervision, and discipline.
- Review of all policies and procedures related to mandatory reporting to outside agencies.
- Exit interview with the Behavioral Health Resources staff to discuss findings and corrective actions.

### **SUMMARY OF THE EVENTS RELATED TO THE CRITICAL INCIDENT:**

John Alkins had been employed by Behavioral Health Resources since 1993. From 1993 to 2011, he worked as a children's therapist/case manager, but was laid off as a result of budget cuts in 2011. He was subsequently "bumped" into a position as a case manager for adults. His personnel record did not indicate any significant problems until May 2012. However, it was verbally discussed with the investigation team that in 2007 or 2008, there had been a complaint from a client's mother that John Alkins had inadvertently exposed himself to her and her child during a session (he had apparently been wearing shorts with no underwear). However, there is no documentation of this event or subsequent disciplinary action.

On May 2, 2012, a female client complained that he frequently touched her on her back, arm and leg at the end of a session, and had "blown her a kiss" as she was exiting his vehicle. The agency investigated and determined that the complaint was unsubstantiated but noted that during that general time period, three other female clients had requested transfers to another clinician.

An internal memo from Stacy Sanders to John Alkins, dated June 7, 2012, indicated that on May 8, 2012, a meeting was held with Mr. Alkins to discuss the specific complaint and the transfer requests. Although there was no formal disciplinary action taken at the time, he was instructed to review "BHR Human Resources Policy #HR-5.6, Professional Behavior and Personal Boundaries" and sign and return an attestation statement by June 22, 2012. There is no follow up documentation to ensure that this was done. There is also no indication in his personnel record of any subsequent training or additional supervision related to professional boundaries.

On August 12, 2012, another client called the Crisis Clinic and reported that John Alkins had given her a hug, and asked the Crisis Clinic if it was "OK", stating that it made her uncomfortable. The complaint was referred to Traci Crowder, who discussed the matter with Sherry Waller, John Alkins' supervisor at the time. Sherry Waller then reportedly discussed the matter with DOH and was advised to investigate and report back to DOH if it was determined that there were grounds for DOH to take action against his credential. The client who had complained was then asked to provide the agency with a written statement.

On September 12, 2012, John Alkins was placed on administrative leave pending the outcome of an investigation. Behavioral Health Resources retained Rebecca Dean, an independent investigator who specializes in workplace and employment issues. On November 15, 2012, Ms. Dean submitted a report stating that it was "highly likely" that John Alkins engaged in frequent touching with clients and frequently discussed his own personal issues with them.

On December 12, 2012, John Alkins' employment with Behavioral Health Resources was terminated and his clients were re-assigned to other clinicians. He held an active DOH credential as an Agency Affiliated Counselor. WAC 246-810-017(c) required that the agency report his termination to DOH. However, the agency did not do so until May 2, 2013, after the current incident had been reported in the media.

On April 30, 2013, John Alkins was found dead in his home, the victim of an apparent homicide. A current Behavioral Health Resources client, [REDACTED], was arrested the next day and charged with the murder. According to stories in The Olympian and other media outlets, [REDACTED] had been involved in a sexual relationship with him and had moved into his home the day before. [REDACTED] had been on John Alkins' caseload while he was employed at Behavioral Health Resources, but was not one of the clients who had complained about his behavior.

**FINDINGS:**

1. The agency failed to follow their own policies and procedures related to incident reporting and management. Specifically, Procedure GAA-400.15. This is true for the current incident as well as the previous efforts noticed in this report. Furthermore, none of the previous incidents were reported as required by WAC 388-865-0400.
2. The agency failed to follow up on the May 8, 2012, meeting. A review of John Alkins' personnel record found that the complaints of inappropriate conduct and violations of professional boundaries had been documented in the form of an e-mail to him outlining the concerns and corrective actions required. However, there was no documentation of subsequent follow-up prior to his being placed on administrative leave and ultimately terminated. His performance evaluations did not address any areas of concern related to professional boundaries, and the personnel record does not reflect any action taken as a result of requests by multiple clients to be re-assigned to other clinicians.
3. The agency failed to notify DOH of Mr. Alkin's termination. It is the opinion of the investigation team that role definition and accountability is unclear in several areas, specifically regarding incident reporting and communication with outside agencies. While all parties acknowledged that John Alkins' termination from the agency and its circumstances should have been reported to DOH for possible action against his credential as well as to T-M RSN as a reportable incident under their contract (who in turn would have reported to DBHR), staff could not describe who, specifically, was responsible for taking that action.
4. The agency failed to meet the requirements of WAC 399-865-405(1). For a period of nearly three years (5/25/10 - 3/22/13), the individual in charge of clinical oversight for the agency did not have an active DOH credential. While clinical oversight may not be a direct service, it is still considered a clinical activity.

In addition to the above findings, the review team identified the following areas of concern:

1. The review of the personnel records for other staff whose employment had been terminated over the past two years, including that of John Alkins' former supervisor, did not document or otherwise address any areas of concern nor any progressive discipline prior to their termination. In addition, performance evaluations were not current and the most recent version (from 2010-2011) for John Alkin did not reflect or address any areas of concern.  
RCW 42.56.360(2) / RCW 70.02.020
2. The clinical records review for the two clients who had complained about John Alkins' conduct, as well as that of [REDACTED], did not provide sufficient documentation to justify the services provided, nor did the documentation support the goals and objectives in the clients' treatment plans.
3. There is not a common framework for incident management and quality management processes. Incident management is an essential feature of quality management and there should be increased coordination, for example, using data from incident reports to establish and track trends and implement corrective actions.

## Critical Incident Investigation

Page 4

The investigation team found that in general, Behavioral Health Resources acted appropriately in its response to several clients who had complained about John Alkins' inappropriate conduct and violations of professional boundaries. Furthermore, there does not appear to be any causal relationship between any action the agency did or did not take and the (alleged) homicide of John Alkins.

### **CORRECTIVE ACTION:**

Within 30 days of receipt of this report, please provide DBHR with the following:

- A description of actions taken by the agency to ensure that policies and procedures related to incident reporting and management are followed. The description should include clarification of roles and responsibilities, how required information is provided to T-M RSN in a timely manner, and how adherence to policies and procedures is addressed and tracked through the agency's quality management process.
- A copy of the agency's policies and procedures that delineate the process through which DOH will be notified in the case of future occurrence of staff misconduct, as well as who will be responsible for ensuring that this action occurs.
- A description of actions taken by the agency to ensure that all staff are provided with clear performance expectations, including annual performance evaluations, and that any progressive disciplinary action taken toward a staff person is followed up on. The description should outline clear roles and responsibilities with regard to the clinical and administrative supervision of staff, including but not limited to performance evaluation and progressive discipline.
- A description of actions taken by the agency to ensure that all staff persons providing clinical services, both directly to clients and through supervision or oversight, hold an active DOH credential in accordance with RCW 18.19.030 and WAC 388-865-0405(1).
- A check or money order in the amount of one thousand (1,000) dollars payable to the Division of Behavioral Health and Recovery, in accordance with WAC 388-865-0103.

DBHR wishes to thank Behavioral Health Resources for its cooperation and transparency in the investigation. Should you have any questions or concerns, please contact me by telephone at 360-725-1039 or via email at [anthony.oleary@dshs.wa.gov](mailto:anthony.oleary@dshs.wa.gov).

Sincerely,

Tony O'Leary, LMHC  
Compliance Manager

cc: Jane Beyer, Assistant Secretary, Behavioral Health and Service Integration Administration  
Chris Imhoff, Director, DBHR  
Mark Freedman, Thurston-Mason Regional Support Network  
Agency File

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

IN RE THE PERSONAL )  
RESTRAINT PETITION OF: ) CAUSE NO. 51741-8-II  
LIA Y. TRICOMO, ) EXHIBIT 8  
Petitioner. )

EXHIBIT 8

Selected BHR Treatment Notes by Alkins

EXHIBIT 8

Law Office of Neil Fox, PLLC  
2125 Western Ave. Ste. 330  
Seattle, Washington 98121  
206-728-5440

## Behavioral Health Resources Individualized Treatment Plan

Client name: <u>Lia Tricomo</u>	ID#: <u>3029092</u>
Primary Clinician: <u>John Atkins</u>	
I was provided education on my diagnosis of: <u>Major Depressive Disorder</u>	
Client initials: <u>LT</u>	
Is transportation an issue? <input type="checkbox"/> Yes <input type="checkbox"/> No <u>pursuing bass pass</u>	
If yes, client was given information on transportation resources. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Any issues relating to my age, culture, or disabilities that need to be considered when developing my treatment plan: <u>None identified</u>	

Life Domains:				
1. Emotional/Mental Health	4. Housing	7. Safety	10. Finances/Income	13. Transportation
2. Social/Recreational	5. Educational/Vocational	8. Legal	11. Food	14. Work/Employment
3. Relationships	6. Cultural/Spiritual	9. Health/Dental	12. Addictions	15. Other
Date listed	Life Domain	Target Date/Revised Target Date:	Date Completed:	Outcome Code:
<u>11/28/11</u>	<u>1,8</u>	<u>4/30/11</u>		
Problem/Need <u>#1</u>	I want help with: <u>"regulating my emotions", because my moods fluctuate so much.</u> <u>Work with my counselor on mood management.</u>			
Measurable Outcome	I will know I have reached this goal when I: <u>have only 1 minor anger outburst a month, and 1-2 times a week I feel depressed. That I am getting along with people inside and outside my family as a result and staying clear of legal problems.</u> <u>Currently experiences 3-4 depressive episodes a week resulting and self-isolating, and 1-2 major anger outbursts a month impairing social and personal relationships.</u>			
Services	<input checked="" type="checkbox"/> Case management <input checked="" type="checkbox"/> Individual therapy <input type="checkbox"/> Group therapy <input type="checkbox"/> EPSDT <input type="checkbox"/> Family therapy <input type="checkbox"/> Medication management <input type="checkbox"/> Collateral contacts <input type="checkbox"/> Referral to _____ <input type="checkbox"/> Other (describe) _____			
Who Is Involved	<input checked="" type="checkbox"/> Client <input type="checkbox"/> BHR medical staff <input type="checkbox"/> DDD <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Housing Authority <input checked="" type="checkbox"/> Clinician <input type="checkbox"/> Primary care physician <input type="checkbox"/> DCFS <input type="checkbox"/> Foster Care Agency <input type="checkbox"/> Adjunct Therapist <input type="checkbox"/> Family <input type="checkbox"/> School <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Other (describe) _____			

Date listed	Life Domain	Target Date/Revised Target Date:	Date Completed:	Outcome Code:
Problem/Need <u>#</u>	I want help with:			
Measurable Outcome	I will know I have reached this goal when I:			
Services	<input type="checkbox"/> Case management <input type="checkbox"/> Individual therapy <input type="checkbox"/> Group therapy <input type="checkbox"/> EPSDT <input type="checkbox"/> Family therapy <input type="checkbox"/> Medication management <input type="checkbox"/> Collateral contacts <input type="checkbox"/> Referral to _____ <input type="checkbox"/> Other (describe) _____			
Who Is Involved	<input type="checkbox"/> Client <input type="checkbox"/> BHR medical staff <input type="checkbox"/> DDD <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Housing Authority <input type="checkbox"/> Clinician <input type="checkbox"/> Primary care physician <input type="checkbox"/> DCFS <input type="checkbox"/> Foster Care Agency <input type="checkbox"/> Adjunct Therapist <input type="checkbox"/> Family <input type="checkbox"/> School <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Other (describe) _____			

Outcome codes: (1) Goal Achieved    (2) Goal Discontinued at Client request

Date listed	Life Domain	Target Date/Revised Target Date:	Date Completed:	Outcome Code:
Problem/Need #	I want help with:			
Measurable Outcome	I will know I have reached this goal when I:			
Services	<input type="checkbox"/> Case management <input type="checkbox"/> Individual therapy <input type="checkbox"/> Group therapy <input type="checkbox"/> EPSDT <input type="checkbox"/> Family therapy <input type="checkbox"/> Medication management <input type="checkbox"/> Collateral contacts <input type="checkbox"/> Referral to _____ <input type="checkbox"/> Other (describe) _____			
Who Is Involved	<input type="checkbox"/> Client <input type="checkbox"/> BHR medical staff <input type="checkbox"/> DDD <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Housing Authority <input type="checkbox"/> Clinician <input type="checkbox"/> Primary care physician <input type="checkbox"/> DCFS <input type="checkbox"/> Foster Care Agency <input type="checkbox"/> Adjunct Therapist <input type="checkbox"/> Family <input type="checkbox"/> School <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Other (describe)			

Date listed	Life Domain	Target Date/Revised Target Date:	Date Completed:	Outcome Code:
Problem/Need #	I want help with:			
Measurable Outcome	I will know I have reached this goal when I:			
Services	<input type="checkbox"/> Case management <input type="checkbox"/> Individual therapy <input type="checkbox"/> Group therapy <input type="checkbox"/> EPSDT <input type="checkbox"/> Family therapy <input type="checkbox"/> Medication management <input type="checkbox"/> Collateral contacts <input type="checkbox"/> Referral to _____ <input type="checkbox"/> Other (describe) _____			
Who Is Involved	<input type="checkbox"/> Client <input type="checkbox"/> BHR medical staff <input type="checkbox"/> DDD <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Housing Authority <input type="checkbox"/> Clinician <input type="checkbox"/> Primary care physician <input type="checkbox"/> DCFS <input type="checkbox"/> Foster Care Agency <input type="checkbox"/> Adjunct Therapist <input type="checkbox"/> Family <input type="checkbox"/> School <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Other (describe)			

Outcome codes: (1) Goal Achieved (2) Goal Discontinued at Client request

I have worked with my primary clinician in developing my treatment plan. I understand I can request to review my treatment plan at any time.

Client Signature \_\_\_\_\_ Date 11/28/11

Parent/Guardian Signature (for children under 13 years old) \_\_\_\_\_ Date \_\_\_\_\_

Natural Supports Signature (if requested by client) \_\_\_\_\_ Date \_\_\_\_\_

Clinician Signature John Ullman BA Date 11/28/11

Supervisor Signature [Signature] Date 12/7/11

Special Population Consultant Signature (For In House Consults Only) \_\_\_\_\_ Date \_\_\_\_\_

Appearance:	<input type="checkbox"/> Within No Limits <input checked="" type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled	Good Hygiene <input type="checkbox"/> Poor Hygiene
	<input type="checkbox"/> Other:	
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other	
Mental Status:	Affect: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Mood: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Thought Process: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Orientation: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Behavior: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:

Danger to:  None  Self  Other  Property Plan:

ASSESSMENT (Overall impression):  Needing IMMEDIATE Attention  Decompensating  Stable  Improved

Modification to Tx Plan  No  Yes If Yes, Identify Change:

Service Focus Related to Goal # (1): Met with Lia regarding tendencies towards sadness and irritability, and to promote creative outlets.

Service Focus Related to Goal # :

Service Focus Related to Goal # :

Other Services Provided Not Related to Treatment Plan:

Describe Client Involvement: Lia reports being more positive minded and getting along with others better recently, and in better mood. Engaged in therapeutic creative music playing, which worked well as a healthy mode of self expression and stress reduction.

Plan Focus For Next Session: Goal #1.

Provider Signature/Credentials: *John Alkham BA*

Date of Service: 12/16/11 Service Duration: Hours 1:15 minutes SAL Code: 24

Time of Service: 15:00 Location: 9  ERS/DT Contact

Client Name: Lia Tricomo

Progress Note



Appearance:	<input type="checkbox"/> Within Normal Limits <input checked="" type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:	
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other	
Mental Status:	Affect: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Mood: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Thought Process: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Orientation: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Behavior: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:

Danger to:  None  Self  Other  Property Plan:  
 ASSESSMENT (Overall impression):  Needing IMMEDIATE Attention  Decompensating  Stable  Improved

Modification to Tx Plan  No  Yes If Yes, Identify Change:

Service Focus Related to Goal # 1 met with Lia in regards to mood management for depression and interpersonal relationships.

Service Focus Related to Goal # \_\_\_\_\_:

Service Focus Related to Goal # \_\_\_\_\_:

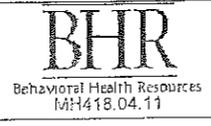
Other Services Provided Not Related to Treatment Plan:

Describe Client Involvement: Positive mood and cheerful. Happily announced she had a successful music session playing her violin with a drummer & guitarist, when plans to continue. Still in the process of sorting out her relationship with B/F. Talked about wishes and goals as affirmations for the New Year.

Plan Focus For Next Session: Goal #1.

Provider Signature/Credentials: *John Pelkina BA*  
 Date of Service: 1/6/12 Service Duration: Hours 2:10 minutes SAL Code: 24  
 Time of Service: 15:00 Location: 9  EPSDT Contact

Client Name: Lia Tricomo  
 Progress Note



Appearance:  Within Normal Limits  Well-Groomed  Disheveled  Good Hygiene  Poor Hygiene  
 Other:

Attitude:  Guarded  Cooperative  Uncooperative  Other

Mental Status:	Affect: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Mood: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Thought Process: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Orientation: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Behavior: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:

Danger to:  None  Self  Other  Property Plan:

ASSESSMENT (Overall impression):  Needing IMMEDIATE Attention  Decompensating  Stable  Improved

Modification to Tx Plan  No  Yes If Yes, Identify Change:

Service Focus Related to Goal # 1: Met with Lia regarding mood management for depression and anger issues.

Service Focus Related to Goal # :  
:

Service Focus Related to Goal # :  
:

Other Services Provided Not Related to Treatment Plan:

Describe Client Involvement: Lia came in ready to talk, and that after some soul searching and priorities identification that she broke up with boyfriend and currently feeling better about herself. Shared how she and her mom managed without power in last week's snow storm.

Plan Focus For Next Session:  
Goal #1,

Provider Signature/Credentials: John Albino BA  
Date of Service: 1/27/12 Service Duration: Hours 2:01 minutes SAL Code: 24  
Time of Service: 15:30 Location: 9  EPSDT Contact

Client Name: Lia Tricomo  
Progress Note 51  
BHR Behavioral Health Resources MH418.7/07

Appearance:	<input type="checkbox"/> Within Normal Limits <input checked="" type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene	
	<input type="checkbox"/> Other:	
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other	
Mental Status:	Affect: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Mood: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Thought Process: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Orientation: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Behavior: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:

Danger to:  None  Self  Other  Property Plan:

ASSESSMENT (Overall impression):  Needing IMMEDIATE Attention  Decompensating  Stable  Improved

Modification to Tx Plan  No  Yes If Yes, Identify Change:

Service Focus Related to Goal # 1 *Met with Lia regarding mood management and stress coping skills.*

Service Focus Related to Goal # \_\_\_\_\_:

Service Focus Related to Goal # \_\_\_\_\_:

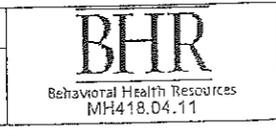
Other Services Provided Not Related to Treatment Plan:

Describe Client Involvement: *Positive mood and goal oriented. Is playing her violin on a regular basis and <sup>has</sup> been accepted into Olympia Chamber Orchestra, with a performance early March. Talked about the*

Plan Focus For Next Session: *sadness of her teenage years and poor relationship with her estranged father.*

Provider Signature/Credentials: *John Alkine BA*  
 Date of Service: *2/10/12* Service Duration: Hours *2*:*28* minutes SAL Code: *24*  
 Time of Service: *15:00* Location: *9*  EPSDT Contact

Client Name: *Lia Tricomo*  
 Progress Note



Appearance:	<input type="checkbox"/> Within Normal Limits	<input checked="" type="checkbox"/> Well-Groomed	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Clean Hygiene	<input type="checkbox"/> Poor Hygiene
	<input type="checkbox"/> Other:				
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other				
Mental Status:	Affect:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Mood:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Thought Process:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Orientation:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Behavior:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
Danger to:	<input type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Other <input type="checkbox"/> Property Plan:				
ASSESSMENT (Overall impression):	<input type="checkbox"/> Needing IMMEDIATE Attention <input type="checkbox"/> Decompensating <input type="checkbox"/> Stable <input checked="" type="checkbox"/> Improved				
Modification to Tx Plan	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:				
Service Focus Related to Goal #	1: Met with Lia in regards to mood management and healthy expression.				
Service Focus Related to Goal #	:				
Service Focus Related to Goal #	:				
Other Services Provided Not Related to Treatment Plan:					
Describe Client Involvement:	Lia arrived in cheerful and enthusiastic mood. She is approaching her 1 year sobriety anniversary. Mood has been mostly positive and stable since break-up with ex-boyfriend. Talked more about her teenage years feeling unloved by her father.				
Plan Focus For Next Session:	Goal #1.				
Provider Signature/Credentials	John Alkins BA				SAL Code: 24
Date of Service: 2/17/12	Service Duration: Hours	2	minutes	17	
Time of Service: 15:00	Location:	9			<input type="checkbox"/> EPSDT Contact
Client Name:	Lia Tricomo				 Behavioral Health Resources MH418.04.11
	Progress Note				

Appearance:	<input type="checkbox"/> Within Normal <input checked="" type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Poor Hygiene	
	<input type="checkbox"/> Other:	
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other	
Mental Status:	Affect: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Mood: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Thought Process: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Orientation: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Behavior: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:

Danger to:  None  Self  Other  Property Plan:

ASSESSMENT (Overall impression):  Needing IMMEDIATE Attention  Decompensating  Stable  Improved

Modification to Tx Plan  No  Yes If Yes, Identify Change:

Service Focus Related to Goal # 1: *Met with Lia regarding mood management and healthy expressive outlets.*

Service Focus Related to Goal # \_\_\_\_\_:

Service Focus Related to Goal # \_\_\_\_\_:

Other Services Provided Not Related to Treatment Plan:

Describe Client Involvement: *Lia arrived in positive mood and energetic. She has recently decided to quit drinking coffee and switching to a variety of teas. Is very focused on her violin music and preparation for upcoming performance. Planning to get auto insurance and drivers license.*

Plan Focus For Next Session: *Goal #1*

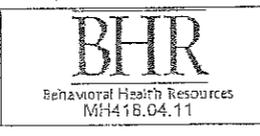
Provider Signature/Credentials: *John Albino BA*

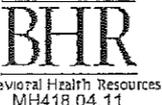
Date of Service: *2/24/12* Service Duration: Hours *2:25* minutes SAL Code: *24*

Time of Service: *15:00* Location: *9*  EPSDT Contact

Client Name: *Lia Tricomo*

**Progress Note**



Appearance:	<input type="checkbox"/> Within Normal <sup>ts</sup>	<input checked="" type="checkbox"/> Well-Groomed	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Good Hygiene	<input type="checkbox"/> Poor Hygiene
	<input type="checkbox"/> Other:				
Attitude:	<input type="checkbox"/> Guarded	<input checked="" type="checkbox"/> Cooperative	<input type="checkbox"/> Uncooperative	<input type="checkbox"/> Other	
Mental Status:	Affect:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Mood:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Thought Process:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Orientation:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Behavior:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
Danger to: <input checked="" type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Other <input type="checkbox"/> Property Plan:					
ASSESSMENT (Overall impression): <input type="checkbox"/> Needing IMMEDIATE Attention <input type="checkbox"/> Decompensating <input type="checkbox"/> Stable <input checked="" type="checkbox"/> Improved					
Modification to Tx Plan <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:					
Service Focus Related to Goal # <u>1</u> : <i>Met with Lia regarding mood management and positive emotional outlets.</i>					
Service Focus Related to Goal # _____:					
Service Focus Related to Goal # _____:					
Other Services Provided Not Related to Treatment Plan:					
Describe Client Involvement: <i>Lia arrived in cheerful mood saying she is able to her mother's car insurance policy by paying into it. She is excited about her Chamber Orchestra concert tomorrow and concentrating on keeping in a good mental state to not get too nervous.</i>					
Plan Focus For Next Session: <i>Goal #1.</i>					
Provider Signature/Credentials: <i>John Alkiewicz BA</i>					
Date of Service: <i>3/2/12</i>		Service Duration: Hours <i>1:46</i> minutes		SAL Code: <i>24</i>	
Time of Service: <i>15:00</i>		Location: <i>9</i>		<input type="checkbox"/> EPSDT Contact	
Client Name: <i>Lia Tricomo</i>					
Progress Note					

Appearance:	<input type="checkbox"/> Within Normal Limits <input checked="" type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene	
	<input type="checkbox"/> Other:	
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other	
Mental Status:	Affect: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Mood: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Thought Process: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Orientation: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Behavior: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:

Danger to:  None  Self  Other  Property Plan:

ASSESSMENT (Overall impression):  Needing IMMEDIATE Attention  Decompensating  Stable  Improved

Modification to Tx Plan  No  Yes If Yes, Identify Change:

Service Focus Related to Goal # 1: *Met with Lia regarding mood management and effective personal expression.*

Service Focus Related to Goal # \_\_\_\_\_:

Service Focus Related to Goal # \_\_\_\_\_:

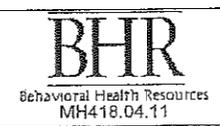
Other Services Provided Not Related to Treatment Plan:

Describe Client Involvement: *Lia was in a positive, but serious mood today. She shared more about her past 5 or so years and how she moved to Olympia, and a series of problematic and harmful relationships.*

Plan Focus For Next Session: *Goal #1.*

Provider Signature/Credentials: *John Albina BA*  
 Date of Service: *3/9/12* Service Duration: Hours *2*:18 minutes SAL Code: *24*  
 Time of Service: *15:00* Location: *9*  EPSDT Contact

Client Name: *Lia Trizomo*



Appearance:	<input type="checkbox"/> Within Normal Limits <input checked="" type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:	
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other	
Mental Status:	Affect: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Mood: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Thought Process: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Orientation: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Behavior: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
Danger to:	<input checked="" type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Other <input type="checkbox"/> Property Plan:	
ASSESSMENT (Overall impression):	<input type="checkbox"/> Needing IMMEDIATE Attention <input type="checkbox"/> Decompensating <input type="checkbox"/> Stable <input checked="" type="checkbox"/> Improved	
Modification to Tx Plan	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:	
Service Focus Related to Goal#	<u>1</u> : Met with Lia regarding mood management.	
Service Focus Related to Goal#	_____:	
Service Focus Related to Goal#	_____:	
Other Services Provided Not Related to Treatment Plan:		
Describe Client Involvement:	Lia was happy to announce she got a driver's license and drove here today. Talked about goal of finishing college in the Fall, and eventually become a music instructor. Talked more about her past and the move to Olympia.	
Plan Focus For Next Session:	Goal #1.	
Provider Signature/Credentials	John Atkins BA	
Date of Service:	3/16/12	
Service Duration:	Hours 2:28 minutes	
Time of Service:	15:00	
Location:	9	
SAL Code:	24	
<input type="checkbox"/> EPSDT Contact		
Client Name:	Lia Tricorno	
Progress Note		

Appearance:	<input type="checkbox"/> Within Normal I's <input checked="" type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:	
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other	
Mental Status:	Affect: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Mood: <input checked="" type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable	Comments: <i>Serious</i>
	Thought Process: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Orientation: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Behavior: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:

Danger to:  None  Self  Other  Property Plan:

ASSESSMENT (Overall impression):  Needing IMMEDIATE Attention  Decompensating  Stable  Improved

Modification to Tx Plan  No  Yes If Yes, Identify Change:

Service Focus Related to Goal # 1: *Met with Lia regarding emotional regulation and mood management.*

Service Focus Related to Goal # \_\_\_\_\_:

Service Focus Related to Goal # \_\_\_\_\_:

Other Services Provided Not Related to Treatment Plan:

Describe Client Involvement: *Lia talked about her frustration with having road blocks set in place by the college before allowed to re-enroll and graduate. Talked about the benefits of being able to finish what she started for sense of accomplishment and respect for her mother. Emotionally fragile today.*

Plan Focus For Next Session: *Goal #1.*

Provider Signature/Credentials: *John Atkins BA*

Date of Service: *3/30/12* Service Duration: Hours *2*:08 minutes

SAL Code: *24*

Time of Service: *15:00* Location: *9*

EPSDT Contact

Client Name: *Lia Trizomo*

Progress Note



Appearance:	<input type="checkbox"/> Within Normal Limits	<input type="checkbox"/> Well-Groomed	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Good Hygiene	<input type="checkbox"/> Poor Hygiene
	<input type="checkbox"/> Other:				
Attitude:	<input type="checkbox"/> Guarded <input type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other				
Mental Status:	Affect:	<input type="checkbox"/> Remarkable	<input type="checkbox"/> Unremarkable	Comments:	
	Mood:	<input type="checkbox"/> Remarkable	<input type="checkbox"/> Unremarkable	Comments:	
	Thought Process:	<input type="checkbox"/> Remarkable	<input type="checkbox"/> Unremarkable	Comments:	
	Orientation:	<input type="checkbox"/> Remarkable	<input type="checkbox"/> Unremarkable	Comments:	
	Behavior:	<input type="checkbox"/> Remarkable	<input type="checkbox"/> Unremarkable	Comments:	

Danger to:  None  Self  Other  Property Plan:

ASSESSMENT (Overall impression):  Needing IMMEDIATE Attention  Decompensating  Stable  Improved

Modification to Tx Plan  No  Yes If Yes, Identify Change:

Service Focus Related to Goal # 1 :  
*Met with Lia to complete 180-day review and update crisis plan.*

Service Focus Related to Goal # \_\_\_\_\_:

Service Focus Related to Goal # \_\_\_\_\_:

Other Services Provided Not Related to Treatment Plan:

Describe Client Involvement:  
*Co-operative and well focused on her goal setting and progress made.*

Plan Focus For Next Session:

Provider Signature/Credentials: *John Albin BA*  
 Date of Service: *4/13/12* Service Duration: Hours *1*:*45* minutes  
 Time of Service: *15:00* Location: *9* SAL Code: *24*  
 EPSDT Contact

Client Name: *Lia Tricomo*  
**Progress Note**



Appearance:	<input type="checkbox"/> Within Normal Limits <input checked="" type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene	
	<input type="checkbox"/> Other:	
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other	
Mental Status:	Affect: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Mood: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Thought Process: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Orientation: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Behavior: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:

Danger to:  None  Self  Other  Property Plan:

ASSESSMENT (Overall impression):  Needing IMMEDIATE Attention  Decompensating  Stable  Improved

Modification to Tx Plan  No  Yes If Yes, Identify Change:

Service Focus Related to Goal # 1: *Met with Lia regarding mood management and healthy outlets of expression.*

Service Focus Related to Goal # \_\_\_\_\_:

Service Focus Related to Goal # \_\_\_\_\_:

Other Services Provided Not Related to Treatment Plan:

Describe Client Involvement: *Calm and well focused. Fully engaged in creative expression activity, being thoughtful and articulate.*

Plan Focus For Next Session: *Goal #1 - 180 day review.*

Provider Signature/Credentials *John Velina BA*

Date of Service: *4/6/12* Service Duration: Hours *3* minutes *02*

SAL Code: *24*

Time of Service: *15:45* Location: *9*

EPSDT Contact

Client Name: *Lia Tricomo*

Progress Note

Appearance:	<input type="checkbox"/> Within Normal Limits <input checked="" type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:	
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other	
Mental Status:	Affect: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Mood: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Thought Process: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Orientation: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Behavior: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:

Danger to:  None  Self  Other  Property Plan:

ASSESSMENT (Overall impression):  Needing IMMEDIATE Attention  Decompensating  Stable  Improved

Modification to Tx Plan  No  Yes If Yes, Identify Change:

Service Focus Related to Goal # 1: *Met with Lia regarding mood management and healthy emotional outlets.*

Service Focus Related to Goal # \_\_\_\_\_:

Service Focus Related to Goal # \_\_\_\_\_:

Other Services Provided Not Related to Treatment Plan:

Describe Client Involvement: *Lia has been accepted back to finish college degree after submitting a qualifying essay. Making healthy choices, and applying herself to various positive endeavors including performing with chamber orchestra next weekend, and out of state trip with her family.*

Plan Focus For Next Session:

*Goal #1.*

Provider Signature/Credentials

*John Atkins BA*

Date of Service: *4/18/12*

Service Duration: Hours *2*:09 minutes

SAL Code: *24*

Time of Service: *17:00*

Location: *9*

EPSDT Contact

Client Name:

*Lia Tricomo*

Progress Note

**BHR**

Behavioral Health Resources  
MH418.04.11

Appearance:	<input checked="" type="checkbox"/> Within Normal Limits <input type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:			
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other			
Mental Status:	Affect:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:
	Mood:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:
	Thought Process:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:
	Orientation:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:
	Behavior:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:
Danger to:	<input checked="" type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Other <input type="checkbox"/> Property           Plan:			
ASSESSMENT (Overall impression):	<input type="checkbox"/> Needing IMMEDIATE Attention <input type="checkbox"/> Decompensating <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Improved			
Modification to Tx Plan	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:			
Service Focus Related to Goal #	<u>1</u> : Met with Lia regarding mood management for depression and agitation, and promote healthy, creative outlets.			
Service Focus Related to Goal #	_____:			
Service Focus Related to Goal #	_____:			
Other Services Provided Not Related to Treatment Plan:	 			
Describe Client Involvement:	Said her orchestra performance went well, and that her mother attended. Is accepted back in school to finish her B.A. degree, and feeling very positive about herself right now.			
Plan Focus For Next Session:	Goal #1,			
Provider Signature/Credentials	<i>John Alkino BA</i>			
Date of Service:	5/4/12	Service Duration: Hours	2:00 minutes	SAL Code: 24
Time of Service:	16:00	Location:	9	<input type="checkbox"/> EPSDT Contact
Client Name:	Lia Tricomi			
<b>Progress Note</b>				 Behavioral Health Resources MH418.04.11

Appearance:	<input type="checkbox"/> Within Normal   <input checked="" type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:	
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other	
Mental Status:	Affect: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Mood: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Thought Process: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Orientation: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Behavior: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:

Danger to:  None  Self  Other  Property Plan:

ASSESSMENT (Overall impression):  Needing IMMEDIATE Attention  Decompensating  Stable  Improved

Modification to Tx Plan  No  Yes If Yes, Identify Change:

Service Focus Related to Goal # 1: *met with Lia regarding mood management and emotional coping skills*

Service Focus Related to Goal # \_\_\_\_\_:

Service Focus Related to Goal # \_\_\_\_\_:

Other Services Provided Not Related to Treatment Plan:

Describe Client Involvement: *Lia has been very health conscious and experimenting with alternative diets. Has been more social lately. Her orchestra is performing tomorrow and again in June. Her mood has continued positive and stable. She is thinking about the job market.*

Plan Focus For Next Session: *Goal #1.*

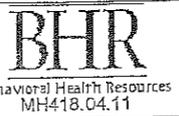
Provider Signature/Credentials: *John Atkins BA*

Date of Service: *5/11/12* Service Duration: Hours *2:00* minutes SAL Code: *24*

Time of Service: *11:00* Location: *9*  EPSDT Contact

Client Name: *Lia Tricorno*

**Progress Note**



Appearance:	<input type="checkbox"/> Within Normal	its <input checked="" type="checkbox"/> Well-Groomed	<input type="checkbox"/> Disheveled	<input type="checkbox"/> od Hygiene	<input type="checkbox"/> Poor Hygiene
	<input type="checkbox"/> Other:				
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other				
Mental Status:	Affect:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Mood:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments: somewhat depressed	
	Thought Process:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Orientation:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Behavior:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	

Danger to:  None  Self  Other  Property Plan:

ASSESSMENT (Overall impression):  Needing IMMEDIATE Attention  Decompensating  Stable  Improved

Modification to Tx Plan  No  Yes If Yes, Identify Change:

Service Focus Related to Goal # 1: Met with Lia regarding mood and stress management.

Service Focus Related to Goal # \_\_\_\_\_:

Service Focus Related to Goal # \_\_\_\_\_:

Other Services Provided Not Related to Treatment Plan:

Describe Client Involvement: Lia was somewhat emotionally fragile today, feeling isolated and minimal natural supports. Gave her praise and encouragement for her recent accomplishments reminding her of her abilities.

Plan Focus For Next Session: Goal #1

Provider Signature/Credentials: John Atkins BA

Date of Service: 5/18/12 Service Duration: 2:20 minutes SAL Code: 24

Time of Service: 15:00 Location: 9  EPSDT Contact

Client Name: Lia Tricomo  
Progress Note



Appearance:	<input type="checkbox"/> Within Normal Limits <input checked="" type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:		
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other		
Mental Status:	Affect:	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Mood:	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Thought Process:	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Orientation:	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Behavior:	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
Danger to:	<input checked="" type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Other <input type="checkbox"/> Property Plan:		
ASSESSMENT (Overall impression):	<input type="checkbox"/> Needing IMMEDIATE Attention <input type="checkbox"/> Decompensating <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Improved		
Modification to Tx Plan	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:		
Service Focus Related to Goal #	<u>1</u> : Met with Lia regarding mood and stress management.		
Service Focus Related to Goal #	_____:		
Service Focus Related to Goal #	_____:		
Other Services Provided Not Related to Treatment Plan:	_____		
Describe Client Involvement:	Lia was more calm and positive minded today, Engaged in relaxation and mindfulness activity. She is thinking a lot about planning her future. She plans to go out of town to attend a music festival this weekend.		
Plan Focus For Next Session:	Goal #1.		
Provider Signature/Credentials	John Alkine BA		
Date of Service:	5/25/12	Service Duration: Hours	2:25 minutes
Time of Service:	15:15	Location:	9
			<input type="checkbox"/> EPSDT Contact
Client Name:	Lia Tricorno		
	Progress Note		

Appearance:	<input type="checkbox"/> Within Normal? <input checked="" type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:	
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other	
Mental Status:	Affect: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Mood: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Thought Process: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Orientation: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Behavior: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:

Danger to:  None  Self  Other  Property Plan:

ASSESSMENT (Overall impression):  Needing IMMEDIATE Attention  Decompensating  Stable  Improved

Modification to Tx Plan  No  Yes If Yes, Identify Change:

Service Focus Related to Goal # 1: *Met with Lia regarding mood management and emotional coping skills building.*

Service Focus Related to Goal # \_\_\_\_\_:

Service Focus Related to Goal # \_\_\_\_\_:

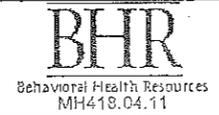
Other Services Provided Not Related to Treatment Plan:

Describe Client Involvement: *Lia was visibly tense about needing to prepare for dress rehearsal and performance tomorrow. Engaged in activity of centering thoughts, relaxing the mind and healthy ways of emotional release and restoration.*

Plan Focus For Next Session: *Goal #1.*

Provider Signature/Credentials: *John Alkins BA*  
 Date of Service: *6/1/12* Service Duration: *Hours 2:45* minutes SAL Code: *24*  
 Time of Service: *15:00* Location: *2*  EPSDT Contact

Client Name: *Lia Tricomo*  
**Progress Note**



Appearance:	<input type="checkbox"/> Within Normal Limits <input checked="" type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:		
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other		
Mental Status:	Affect:	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Mood:	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Thought Process:	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Orientation:	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Behavior:	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
Danger to:	<input checked="" type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Other <input type="checkbox"/> Property    Plan:		
ASSESSMENT (Overall impression):	<input type="checkbox"/> Needing IMMEDIATE Attention <input type="checkbox"/> Decompensating <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Improved		
Modification to Tx Plan	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:		
Service Focus Related to Goal #	<u>1</u> : <i>Met with Lia regarding mood management of sadness and agitation.</i>		
Service Focus Related to Goal #	_____:		
Service Focus Related to Goal #	_____:		
Other Services Provided Not Related to Treatment Plan:			
Describe Client Involvement:	<i>Calm and relaxed. Preparing to start summer quarter of school for 8 weeks to finish her B.A. Has ambitious goal of applying for a position with The Oregon Symphony. Engaged in creativity and expressive relaxation exercise.</i>		
Plan Focus For Next Session:	Goal #1,		
Provider Signature/Credentials	<i>John Atkins BA</i>		
Date of Service:	6/8/12	Service Duration: Hours	2:15 minutes    SAL Code: 24
Time of Service:	15:00	Location:	9 <input type="checkbox"/> EPSDT Contact
Client Name:	<i>Lia Tricomo</i>		
Progress Note			

Appearance:	<input type="checkbox"/> Within Normal its <input checked="" type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> od Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other
Mental Status:	Affect: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable Comments:
	Mood: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable Comments:
	Thought Process: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable Comments:
	Orientation: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable Comments:
	Behavior: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable Comments:
Danger to:	<input checked="" type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Other <input type="checkbox"/> Property Plan:
ASSESSMENT (Overall impression):	<input type="checkbox"/> Needing IMMEDIATE Attention <input type="checkbox"/> Decompensating <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Improved
Modification to Tx Plan	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:
Service Focus Related to Goal # <u>1</u> :	<i>met with Lia regarding mood and stress management.</i>
Service Focus Related to Goal # _____:	
Service Focus Related to Goal # _____:	
Other Services Provided Not Related to Treatment Plan:	
Describe Client Involvement:	<i>Lia is trying to figure out the logistics of getting to her college credit music lessons, feeling isolated out at her mom's place, and feeling she's being a burden. Was stressed and angry over hidden costs involved in auto body repair through insurance.</i>
Plan Focus For Next Session:	<i>Thinking alot about her future. Self-critical at times. Goal #1.</i>
Provider Signature/Credentials	
Date of Service:	<i>6/15/12</i> Service Duration: Hours <i>2:55</i> minutes SAL Code: <i>24</i>
Time of Service:	<i>14:30</i> Location: <i>9</i> <input type="checkbox"/> EPSDT Contact
Client Name:	<i>Lia Tricoma</i>
Progress Note	



Appearance:	<input type="checkbox"/> Within Normal <input type="checkbox"/> Other:	its <input checked="" type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene
Attitude:	<input type="checkbox"/> Guarded <input type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other	
Mental Status:	Affect:	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable Comments:
	Mood:	<input checked="" type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable Comments: <i>serious minded</i>
	Thought Process:	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable Comments:
	Orientation:	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable Comments:
	Behavior:	<input checked="" type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable Comments: <i>self-critical</i>
Danger to: <input checked="" type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Other <input type="checkbox"/> Property Plan:		
ASSESSMENT (Overall impression): <input type="checkbox"/> Needing IMMEDIATE Attention <input type="checkbox"/> Decompensating <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Improved		
Modification to Tx Plan <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:		
Service Focus Related to Goal # <u>1</u> : <i>met with Lia regarding mood management for stress and depression.</i>		
Service Focus Related to Goal # _____:		
Service Focus Related to Goal # _____:		
Other Services Provided Not Related to Treatment Plan:		
Describe Client Involvement: <i>Lia reported she had gotten so that she was feeling trapped and isolated out at her mom's house, and made an impulsive call to her ex-boyfriend and moved in with him. She was having bad allergies to mold there, geographically isolated, and read negative things about herself in her mom's diary.</i>		
Plan Focus For Next Session: <i>Goal #1.</i>		
Provider Signature/Credentials: <i>John Alkima BSA</i>		
Date of Service: <i>6/22/12</i>	Service Duration: Hours <i>2</i> :00 minutes	SAL Code: <i>24</i>
Time of Service: <i>15:00</i>	Location: <i>9</i>	<input type="checkbox"/> EPSDT Contact
Client Name: <i>Lia Tricomo</i>		 Behavioral Health Resources MH418.04.11
Progress Note		

Appearance:  Within Normal Li  Well-Groomed  Disheveled  G<sup>r</sup> Hygiene  Poor Hygiene  
 Other:

Attitude:  Guarded  Cooperative  Uncooperative  Other

Mental Status:	Affect: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Mood: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Thought Process: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Orientation: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Behavior: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:

Danger to:  None  Self  Other  Property Plan:

ASSESSMENT (Overall impression):  Needing IMMEDIATE Attention  Decompensating  Stable  Improved

Modification to Tx Plan  No  Yes If Yes, Identify Change:

Service Focus Related to Goal # 1: *met with Lia regarding mood management for depression.*

Service Focus Related to Goal # \_\_\_\_\_:

Service Focus Related to Goal # \_\_\_\_\_:

Other Services Provided Not Related to Treatment Plan:

Describe Client Involvement: *Lia reported that she had a bout of depression and hopelessness last week, feeling futile and unsuccessful. Her companion [redacted] whom she is staying with helped bring her out of it. She has been back at her mom's past 2 days helping her mom who had a bad bee sting on her face.*

Plan Focus For Next Session: *Goal #1*

Provider Signature/Credentials: *John Alkins BA*

Date of Service: *7/6/12* Service Duration: Hours *1:30* minutes SAL Code: *24*

Time of Service: *15:10* Location: *9*  EPSDT Contact

Client Name: *Lia Tricomo*

Progress Note

  
 Behavioral Health Resources  
 MH418.04.11

Appearance:	<input type="checkbox"/> Within Normal Limits	<input checked="" type="checkbox"/> Well-Groomed	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Good Hygiene	<input type="checkbox"/> Poor Hygiene
	<input type="checkbox"/> Other:				
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other				
Mental Status:	Affect:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Mood:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Thought Process:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Orientation:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Behavior:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
Danger to:	<input checked="" type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Other <input type="checkbox"/> Property Plan:				
ASSESSMENT (Overall impression):	<input type="checkbox"/> Needing IMMEDIATE Attention <input type="checkbox"/> Decompensating <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Improved				
Modification to Tx Plan	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:				
Service Focus Related to Goal #	1: met with Lia regarding mood management for depression.				
Service Focus Related to Goal #	_____:				
Service Focus Related to Goal #	_____:				
Other Services Provided Not Related to Treatment Plan:					
Describe Client Involvement:	Client was in a thoughtful, somewhat introspective mood. She has been working on paying attention to stress triggers, and we talked about being mindful of not pushing herself too hard with self-imposed expectations that lead to self criticism and sense of defeat.				
Plan Focus For Next Session:	Goal #1.				
Provider Signature/Credentials	John Alkins BA				
Date of Service:	7/13/12	Service Duration:	Hours 2:25	minutes	SAL Code: 24
Time of Service:	15:20	Location:	9		<input type="checkbox"/> EPSDT Contact
Client Name:	Lia Tricomi				 Behavioral Health Resources MH418.04.11
Progress Note					

Appearance:	<input type="checkbox"/> Within Normal Limits	<input checked="" type="checkbox"/> Well-Groomed	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Good Hygiene	<input type="checkbox"/> Poor Hygiene
	<input type="checkbox"/> Other:				
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other				
Mental Status:	Affect:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Mood:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Thought Process:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Orientation:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Behavior:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
Danger to: <input checked="" type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Other <input type="checkbox"/> Property Plan:					
ASSESSMENT (Overall impression): <input type="checkbox"/> Needing IMMEDIATE Attention <input type="checkbox"/> Decompensating <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Improved					
Modification to Tx Plan <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:					
Service Focus Related to Goal # <u>1</u> : <i>met with Lia regarding mood management for depression.</i>					
Service Focus Related to Goal # _____:					
Service Focus Related to Goal # _____:					
Other Services Provided Not Related to Treatment Plan:					
Describe Client Involvement: <i>Lia reports she has been in stable mood lately. Feels better that she is no longer over extending herself towards professional violinist audition. Took a restful trip to the mountains with her mother.</i>					
Plan Focus For Next Session: <i>Goal #1.</i>					
Provider Signature/Credentials: <i>John Alkema BA</i>					
Date of Service: <i>7/20/12</i>		Service Duration: Hours <i>1:25</i> minutes		SAL Code: <i>24</i>	
Time of Service: <i>15:00</i>		Location: <i>9</i>		<input type="checkbox"/> EPSDT Contact	
Client Name: <i>Lia Trizomo</i>					
Progress Note					

Appearance:	<input type="checkbox"/> Within Normal Li	<input checked="" type="checkbox"/> Well-Groomed	<input type="checkbox"/> Disheveled	<input type="checkbox"/> C Hygiene	<input type="checkbox"/> Poor Hygiene
	<input type="checkbox"/> Other:				
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other				
Mental Status:	Affect:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Mood:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Thought Process:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Orientation:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	
	Behavior:	<input type="checkbox"/> Remarkable	<input checked="" type="checkbox"/> Unremarkable	Comments:	

Danger to:  None  Self  Other  Property Plan:

ASSESSMENT (Overall impression):  Needing IMMEDIATE Attention  Decompensating  Stable  Improved

Modification to Tx Plan  No  Yes If Yes, Identify Change:

Service Focus Related to Goal # 1 :

Service Focus Related to Goal # \_\_\_\_\_ :

Service Focus Related to Goal # \_\_\_\_\_ :

Other Services Provided Not Related to Treatment Plan:

Describe Client Involvement: *Lia has been focused on getting the most out of her violin lessons that serve as her last quarter of college and to graduate w/ B.A. Putting alot of effort into making living at her B.F.'s place feel like a family household. Seeking sense of family belonging.*

Plan Focus For Next Session: *Goal #1*

Provider Signature/Credentials: *John Alkimo BA*  
 Date of Service: *7/27/12* Service Duration: Hours *2:45* minutes SAL Code: *24*  
 Time of Service: *15:00* Location: *9*  EPSDT Contact

Client Name: *Lia Tricomo*  
 Progress Note



Appearance:	<input type="checkbox"/> Within Normal Limits <input checked="" type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:	
Attitude:	<input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other	
Mental Status:	Affect: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Mood: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Thought Process: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Orientation: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Behavior: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:

Danger to:  None  Self  Other  Property Plan:

ASSESSMENT (Overall impression):  Needing IMMEDIATE Attention  Decompensating  Stable  Improved

Modification to Tx Plan  No  Yes If Yes, Identify Change:

Service Focus Related to Goal # ①: Met with Lia in regards to mood management for depression and agitation.

Service Focus Related to Goal # :

Service Focus Related to Goal # :

Other Services Provided Not Related to Treatment Plan:

Describe Client Involvement: Lia arrived in cheerful mood. She reports she has been getting well at B/F's place and been able to sustain a positive mood, concentrating on her school project.

Plan Focus For Next Session:

Goal #1.

Provider Signature/Credentials

*John Alkema BA*

Date of Service: 8/17/12

Service Duration: Hours 1:25 minutes

SAL Code:

24

Time of Service: 15:00

Location: 9

EPSDT Contact

Client Name:

Lia Tricomo

Progress Note

**BHR**

Behavioral Health Resources  
MH4 18.7/07

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

IN RE THE PERSONAL RESTRAINT PETITION OF:	)	CAUSE NO. 51741-8-II
LIA Y. TRICOMO,	)	EXHIBIT 9
Petitioner.	)	
	)	
	)	
	)	
	)	
	)	

EXHIBIT 9  
St. Peter Hospital, 3/25/13

WSP PROVIDENCE ST PETER HOSPITAL  
 413 Lilly Rd NE  
 Olympia, WA 98506-5133  
 Inpatient Record

TRICOMO, LIA Y  
 MRN: 60001270277  
 DOB: 11/24/1985, Sex: F  
 Acct #: 330000200546  
 Adm: 3/25/2013, D/C: 3/25/2013

**Admission Information**

Arrival Date/Time:	03/25/2013 1215	Admit Date/Time:	03/25/2013 1215	IP Adm. Date/Time:	None
Admission Type:	Emergency	Admission Source:	Non-healthcare Facility	Admit Category:	None
Means of Arrival:	Car	Primary Service:	Emergency Medicine	Secondary Service:	None
Transfer Source:	None	Service Area:	Phs Washington Montana	Unit:	Wsp Emergency Center
Admit Provider:	None	Attending Provider:	Anurag Jindal, MD	Referring Provider:	None

**Account Information**

Hospital Account	Primary Payor	Affiliated Recurring Accounts	Combined from HAR
330000200546 - TRICOMO, LIA Y	MEDICAID WASHINGTON [203]	None	None

**Discharge Information**

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	Home Or Self Care	Home	None	Wsp Emergency Center

**Admission Diagnoses / Reasons for Visit (ICD-9-CM)**

Code	Name	Comments
311	Depressive disorder, not elsewhere classified	
V62.84	Suicidal ideation	

**Allergies as of 3/25/2013**

Review Complete On: 3/25/2013 By: Amanda L Harvell, RN

No Known Allergies
--------------------

**Immunizations as of 3/25/2013**

Never Reviewed

No immunizations on file.
---------------------------

**Medical**

Past Medical History

Date

Comments

Source

as of 3/25/2013	Depression [226092]			Provider
-----------------	---------------------	--	--	----------

**ED Records**

**ED Arrival Information**

Expected	Arrival	Acuity	Means of Arrival	Escorted By	Service	Admission Type	Arrival Complaint
-	3/25/2013 12:15	Emergency	Car	Self	Emergency Medicine	Emergency	suicidal thoughts pg 239

**ED Events**

Date/Time	Event	User	Comments
03/25/13 1215	Patient arrived in ED	CROSSEN, MERIDITH M	
03/25/13 1215	Patient expected in ED	CROSSEN, MERIDITH M	
03/25/13 1221	Triage Started	HARVELL, AMANDA L	
03/25/13 1223	Triage Completed	HARVELL, AMANDA L	
03/25/13 1225	Patient roomed in ED	ARGERIS, STEPHANIE R	To room P 3
03/25/13 1253	Registration Completed	OWENS, KERRY L	
03/25/13 1312	Assign Attending	JINDAL, ANURAG	JINDAL, A assigned as Attending
03/25/13 1312	Assign Physician	JINDAL, ANURAG	
03/25/13 1526	Remove Attending	EKLUND, JEFF S	JINDAL, A removed as Attending
03/25/13 1530	Assign Attending	JINDAL, ANURAG	JINDAL, A assigned as Attending
03/25/13 1530	Assign Physician	JINDAL, ANURAG	
03/25/13 1538	Team Member Removed	BRENNAN, MICHAEL G	BRENNAN, M removed as Mental Health Specialist
03/25/13 1547	Patient discharged	SALAZAR, MELISSA L	
03/25/13 1547	Patient departed from ED	SALAZAR, MELISSA L	

**ED Disposition**

Discharge	Lia Y Tricomo discharge to home/self care.
	Condition at discharge: Good

**After Visit Summary**

**Printed AVS Reports**

PROVIDENCE ST PETER HOSPITAL

Printed on 1/25/2014 14:14

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After Visit Summary (continued)

Printed AVS Reports (continued)

**EMERGENCY CENTER**

413 Lilly Rd Ne  
Olympia WA 98506-5133  
Phone: 360-493-7389

**Tricomo, Lia Y**  
MRN: 60001270277

Department: **PROVIDENCE ST PETER  
HOSPITAL EMERGENCY  
CENTER**  
Date of Visit: **3/25/13**

Your diagnosis was Mood problem.  
You were seen by Anurag Jindal, MD.

**Your Medications**

**Start Taking**

**PAROXETINE (PAXIL) 20 MG TABLET**

**Take 1 tablet by mouth every morning for 15 days.  
If you get giddy you can stop taking this  
medication and wait to be seen at BHR**

**YOU ARE THE MOST IMPORTANT FACTOR IN YOUR RECOVERY**

Follow these instructions carefully. Take your medicines as prescribed. Most important, see a doctor again as discussed. If you have problems that we have not discussed or your condition worsens, call or visit your doctor IM MEDIATELY. If you cannot reach your doctor, return to the Emergency Department.

WHERE YOU GO FOR YOUR CARE MATTERS.

For most medical problems, you should go to your regular health care provider first. You get the best care because they know you and your medical history.

DOCTORS OFFICE OR CLINIC

The best place to get care is a doctor's office or clinic for common illnesses, minor injuries, and routine health exams. Your doctor can also help you manage your health over time. You should make an appointment with your doctor's office for:

\* Common illnesses such as colds, flu, ear aches, sore throats, migraines, fever or rashes

\* Minor injuries such as sprains, back pain, minor cuts and burns, minor broken bones, or minor eye injuries

\* Regular physicals, prescription refills, vaccinations, and screenings



After Visit Summary (continued)

Printed AVS Reports (continued)

- \* A health problem where you need advice

URGENT CARE CLINICS

When your doctor is not available, urgent care clinics provide attention for non-life threatening medical problems or problems that could become worse if you wait. Urgent care clinics provide walk-in appointments and are often open seven days a week with extended hours. When your regular doctor or health care provider is not available, you should go to an urgent care clinic for:

- \* Common illnesses such as colds, the flu, ear aches, sore throats, migraines, fever, rashes
- \* Minor injuries such as sprains, back pain, minor cuts and burns, minor broken bones, or minor eye injuries

HOSPITAL EMERGENCY ROOMS

You should use a hospital emergency room for very serious or life threatening problems. Hospital emergency rooms are not the place to go for common illnesses or minor injuries. If you are experiencing any of the following symptoms, don't wait! Call 911 or get to your nearest hospital emergency room.

- \* Chest pain
- \* Severe abdominal pain
- \* Coughing or vomiting blood
- \* Severe burns
- \* Deep cuts or bleeding that won't stop
- \* Sudden blurred vision
- \* Difficulty breathing or shortness of breath
- \* Sudden dizziness, weakness, or loss of coordination or balance
- \* Numbness in the face, arm, or leg
- \* Sudden, severe headache (not a migraine)
- \* Seizures
- \* High fevers
- \* Any other condition you believe is life threatening



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After Visit Summary (continued)

Printed AVS Reports (continued)

Discharge Instructions

Providence St. Peter Hospital  
Emergency Center / Crisis Services  
Disposition Form

Lia Y Tricomo is a 27 y.o. year old, Caucasian, female, who comes to the ER by private car. The patient is referred to the Crisis Services Department by Anurag Jindal, MD for a mental health evaluation.

**Impression:**

1. Depression
2. Transient Suicidal thoughts, resolved
3. Not psychotic

**Consultation:**

Case consult with ER Physician Anurag Jindal, MD and Psychiatrist Dr. Chappell who concur with the disposition and plan of care.

**Disposition:**

1. Discharge to self with no harm agreement:

(A) As a part of my treatment program and in conjunction with the plan set up with the Providence St. Peter Hospital Crisis Services Counselor, I, Lia Y Tricomo agree to the following terms:

- 1) I will refrain from all threats and/or acts of harm to myself, others, animals or property.
- 2) If at any time I should feel depressed or anxious to the extent that I am unable to resist suicidal, assaultive or destructive impulses, I agree to call the **Crisis Clinic at (360) 586-2800** or **Crisis Resolution Services at (360) 754-1338**; or I will go directly to the nearest Emergency Room.

(B) I agree to seek counseling and will contact a therapist or agency on the next business day.

(C) I agree to abide by this agreement until contact is made with my therapist and my suicidal/assaultive/destructive thoughts and behaviors have been addressed.

2. Home.

**3. Follow-up with BHR**

**Discharge Note:**



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After Visit Summary (continued)

Printed AVS Reports (continued)

- Lia Y Tricomo received all belongings at discharge.
- Lia Y Tricomo was considered for the PSPH Partial Hospitalization Program.
- 
- 

Patient Signature: \_\_\_\_\_

Date &

Time: \_\_\_\_\_

ED Notes

ED Notes signed by Michael G Brennan, MA at 03/25/13 1538

Author:	Michael G Brennan, MA	Service:	Emergency Medicine	Author Type:	Counselor
Filed:	03/25/13 1538	Note Time:	03/25/13 1352		

PSPH CSC Evaluation

Primary Provider: None: "I don't have one"

Psychiatric Provider: None

Insurance: Provider One

Referred by: Self

Brought to Hospital by: "I was at the DOC checking in and told them what was going on and they gave me a ride."

Evaluation Start: 13:50

County of Residence: Thurston

Active RSN Client? Yes: BHR. My CM is Lynn Hertz. "I haven't seen her since the 7th as I was in jail."

**Current Problem (onset, precipitant, symptoms, behavior):** Ms. Lia Tricomo is a 27 y/o, never married, Caucasian, female, who comes to the ER reporting recent thoughts to harm herself and hoping to get some medications. She states that she has been struggling lately with a guy who reported that she had assaulted him by going too far when they were doing sex play. She has now been ostracized by many of her friends and is very lonely. Further, she is estranged from family and room-mates. Lia reports that she was on prozac before, but it made her angry; and that paxil worked well, but that when she got 30 mg she became giddy and childlike. She asserts she can be safe and will follow-up with her BHR providers.

**Contact Person:** Primary Emergency Contact: Tricomo, Ami, Home Phone: 360-292-3748 Sister: Tricomo, Ami, Home Phone: 360-292-3748

**Previous Psychiatric Hospitalizations:** Yes: total - about 8. First at 23 y/o. Most recent: 25 y/o.

**Hospital(s):** BHR ETU, CSTU, St. John's in Longview, Harrison in Bremerton, and WSH.

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ED Notes (continued)

**Hospitalized within the last year?** no

**Drug/Alcohol Involvement:** Alcohol: Recently - daily. beer. Usually between three to five drinks. Last drink was last night at 11pm. No MJ. No illegal drugs. No medication abuse.

**Previous CD Treatments:** No detox. Inpatient: x1 - PSPH 2012. Outpatient - completed outpatient tx with the DOC: 2012.

**Family Psychiatric History:** Great uncle: depression and committed suicide. Maternal grandfather was alcoholic and very abusive- he seemed very depressed.

**Outstanding Legal Problems:** DOC for 3rd degree assault on law enforcement. DOC ends in August. DV s charge against my sister: 4th degree assault. This is in diversion.

**Recent Stressful Life Events:** I am being accused of assaulting a guy (Leaf) I barely knew. He is slandering my name. He is telling my friends who no longer will talk with me. I feel humiliated by this and am afraid. I think someone will tell the police about this and I will be charged. Then I will have to do five years. She reports that Leaf reports that Lia violated pre-determined boundaries.

**Current Visit Chief Complaint:**

**Chief Complaint**

Patient presents with

- Suicidal Thoughts

**Past Medical History:** has a past medical history of Depression.

**Home Medications:**

**Allergies:** Review of patient's allergies indicates no known allergies.

**Appearance:** Neat

**Hygiene:** good

**Eye Contact:** good

**Speech:** WNL

**Affect:** Full

**Mood:** Fearful, Anxious, Depressed and Hopeless, lonely: "I miss my circle of friends, whom I have had to separate due to this guy's accusations."

**Cooperation:** Attentive and Cooperative

**Biological/Vegitative Signs of Depression:** Increased guilt  
**Appetite:** reduced



ED Notes (continued)

**Weight:** Reduced

**Sleep:** Decreased: difficulty falling asleep, frequent waking, nightmares, vivid dreams, difficulty returning to sleep, night sweats, not rested when wakes.

**Psychomotor:** Unchanged

**Energy:** Decreased

**Insight:** Recognizes problem

**Judgement:** Fair

**Memory - Long Term:** Fair

**Memory - Short Term:** Fair

**Concentration:** fair

**Thought Content:** Appropriate, suicide is really prevalent in my mind and I am stuck on it. My thoughts about it are messing up my music work: violin.

**Hallucinations:** None

**Thought Process:** normal

**Level of Consciousness:** Alert

**Orientation:** Fully Oriented

**Suicidality:** Ideation past, Ideation current and Family history

**Current Plan:** Tying self to something heavy and dropping into water; ideally I would use a gun, but I have no access.

**Attempts Where Fully Expected to Die:** 4 - 1 OD on tylenol, tried to hang myself at WSH, this time I tried to hang myself.

**Harmed Self When Thinking About Suicide w/o Expectation of death:** Never

**History of Self Harm When Not Thinking of Suicide:** Yes: because of emotional pain.

**Other History of Self-Harm:** Enjoys getting with people for sexual bdsm play.

**Assaultive History:** Yes, charges see above

**Homicidality:** none

**Weapons:** No

**Information Provided By:** patient

**Evaluation Completed By:** Michael Brennan, MA, LMHC

Signed by Michael G Brennan, MA on 3/25/2013 15:38



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**ED Notes (continued)**

**ED Notes signed by Melissa L Salazar, RN at 03/25/13 1520**

Author:	Melissa L Salazar, RN	Service:	Emergency Medicine	Author Type:	Registered Nurse
Filed:	03/25/13 1520	Note Time:	03/25/13 1500		

Pt evaluated by CSC.

Signed by Melissa L. Salazar, RN on 3/25/2013 15:20

**ED Provider Notes signed by Anurag Jindal, MD at 03/25/13 1515**

Author:	Anurag Jindal, MD	Service:	Emergency Medicine	Author Type:	Physician
Filed:	03/25/13 1515	Note Time:	03/25/13 1457		

**EMERGENCY DEPARTMENT ENCOUNTER**

**CHIEF COMPLAINT**

**Chief Complaint**

Patient presents with

- Suicidal Thoughts

**HPI**

Lia Y Tricomo is a 27 y.o. female who presents to the emergency department reporting suicidal ideation and depression ongoing for the last few weeks. She states that she is depressed because this guy she met on the internet has been spreading false rumors about her. She states that she has not been able to stop crying. She states that she tried to strangle herself last night with a nylon rope but could not go through with it. She states that she "could not pass out" and gave up. She denies any problems of difficulty in breathing or hoarseness of voice. She has been able to swallow food without any problems. She has a parole officer she could and asked to be brought to the ER for evaluation. She thinks that she needs to be prescribed some antidepressants. She states that she was hospitalized for mental health issues in February of 2010. She has not been on any medications on a regular basis. She denies any hallucinations. She denies any homicidal ideation. She states that she has been drinking almost every night for the last 5 nights. Prior to attempting to strangle herself last night she states she drank 5 beers. She denies having had any alcohol or recreational drugs today.

**PAST MEDICAL HISTORY**

**Past Medical History**

Diagnosis

Date

- Depression

**SURGICAL HISTORY**

History reviewed. No pertinent past surgical history.

**CURRENT MEDICATIONS**

No current outpatient prescriptions on file.

**ALLERGIES**

No Known Allergies



ED Notes (continued)

**FAMILY HISTORY**

History reviewed. No pertinent family history.

**SOCIAL HISTORY**

History

Social History

- Marital Status: Single
- Spouse Name: N/A
- Number of Children: N/A
- Years of Education: N/A

Social History Main Topics

- Smoking status: Current Everyday Smoker -- 0.5 packs/day for 10 years
- Smokeless tobacco: Never Used
- Alcohol Use: Yes
- Drug Use: No
- Sexually Active:

Other Topics

Concern

- None

Social History Narrative

- None

**REVIEW OF SYSTEMS**

**Constitutional:** Denies fever, chills, weight loss or weakness

**Eyes:** Denies photophobia or discharge or blurred vision.

**HENT:** Denies sore throat or ear pain.

**Neck:** No neck pain

**Respiratory:** Denies cough or shortness of breath.

**Cardiovascular:** Denies chest pain, palpitations or swelling.

**GI:** Denies abdominal pain, nausea, vomiting, or diarrhea.

**GU:** Denies dysuria, frequency of urination or hematuria.

**Musculoskeletal:** Denies back pain, myalgias and arthralgias.

**Skin:** Denies rash.

**Neurologic:** Denies headache, dizziness, focal weakness or sensory changes.

**Endocrine:** Denies polyuria or polydypsia.

**Lymphatic:** Denies swollen glands

**Psychiatric:** Reports depression, but denies suicidal ideation or homicidal ideation.

All systems negative except as marked.

**PHYSICAL EXAM**

**VITAL SIGNS:** (first vital signs): Temp: 37 °C (98.6 °F) Pulse: 74 Resp: 18 SpO2: 100 % BP: 120/68 mmHg

**Constitutional:** Well developed, Well nourished, No acute distress, Non-toxic appearance.

**HENT:** Normocephalic, Atraumatic, Bilateral external ears normal, Oropharynx moist, No oral exudates, Nose normal.

**Neck:** Normal range of motion, No tenderness, Supple, No stridor.

**Eyes:** PERRL, EOMI, Conjunctiva normal, No discharge.



**ED Notes (continued)**

**Respiratory:** Normal breath sounds, No respiratory distress, No wheezing, No chest tenderness, no accessory muscle use.

**Cardiovascular:** Normal heart rate, Normal rhythm, No murmurs, No rubs, No gallops, pulses bilaterally equal and symmetrical in all 4 extremities.

**GI:** No distention

**Musculoskeletal:** Good range of motion in all major joints. No major deformities noted.

**Skin:** Warm, Dry, No rashes, petechiae or purpura

**Lymphatic:** No cervical lymphadenopathy noted.

**Neurologic:** Alert & oriented x 3. Moves all 4 extremities well; normal speech.

**Psychiatric:** Affect normal, Judgment normal, Mood normal.

**CONSULTATIONS**

Crisis services were asked to consult on this patient.

**ED COURSE & MEDICAL DECISION MAKING**

Pertinent Labs & Imaging studies reviewed. (See chart for details)

Medications and Allergy list reviewed.

Nurses note and old records reviewed

EMS Note reviewed: N/A

Nursing Home records reviewed: N/A

Patient presented to the emergency department with complaints of depression. She attempted to strangle herself yesterday. She does not have any evidence of laryngeal injury or any difficulty with swallowing or speech. She appears to be well. She is not actively suicidal and does not have a plan at present time. She is being cleared medically for evaluation by crisis services. She doesn't have any ulcerations or acute psychosis.

Last Set of Vital Signs: Temp: 37 °C (98.6 °F) Pulse: 74 Resp: 18 SpO2: 100 % BP: 120/68 mmHg

**FINAL IMPRESSION**

1. Depression

**DISPOSITION**

As per crisis services.

Portions of this chart may have been created with voice recognition software. Occasional wrong-word or "sound-alike" substitutions may have occurred due to the inherent limitations of voice recognition software. Read the chart carefully and recognize, using context, where these substitutions have occurred.

Anurag Jindal, MD  
03/25/13 1515



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Adm: 3/25/2013, D/C: 3/25/2013

**ED Notes (continued)**

Signed by Anurag Jindal, MD on 3/25/2013 15:15

**ED Notes signed by Melissa L Salazar, RN at 03/25/13 1310**

Author: Melissa L Salazar, RN      Service: Emergency Medicine      Author Type: Registered Nurse  
Filed: 03/25/13 1310      Note Time: 03/25/13 1308

Pt states here for suicidal attempt w/ plan. Pt states last noc attempted to hang herself. Pt has slightly red mark noted to anterior neck. States her neck is slightly sore. Voice and speech is clear. No drooling noted. Airway intact. resp even and unlabored. Pt does not appear to be in any distress. Skin wnl. Lungs clear to auscultation. Pt sitting on bed with blankets covering herself. Pt appears to have good hygiene. Makes good eye contact w/ RN.

Signed by Melissa L Salazar, RN on 3/25/2013 13:10

**Care Plan Notes**

**Plan of Care signed by Onbase Scan Wamt at 03/26/13 1503**

Author: Onbase Scan Wamt      Service: (none)      Author Type: (none)  
Filed: 03/26/13 1503      Note Time: 03/26/13 0000

Scan on: 03/26/2013 1419 by: Onbase Scan Wamt [ONBASEWAMT] - Discharge Instruction

Signed by Onbase Scan Wamt on 3/26/2013 15:03

**Other Notes**

**Miscellaneous signed by Onbase Scan Wamt at 03/26/13 1415**

Author: Onbase Scan Wamt      Service: (none)      Author Type: (none)  
Filed: 03/26/13 1415      Note Time: 03/25/13 0000      Trans ID: OBO6929064  
Trans Available  
Status:

Scan on: 03/25/2013 1253 by: Onbase Scan Wamt [ONBASEWAMT] - Consent to Treat

Signed by Onbase Scan Wamt on 3/26/2013 14:15

**ED Triage Notes signed by Amanda L Harvell, RN at 03/25/13 1225**

Author: Amanda L Harvell, RN      Service: Emergency Medicine      Author Type: Registered Nurse  
Filed: 03/25/13 1225      Note Time: 03/25/13 1221  
Related Original Note by: Amanda L Harvell, RN filed at 03/25/13 1222  
Notes:

Having suicidal thoughts and tried to strangle herself last night. States breathing okay and slightly sore to neck but otherwise no medical complaints. States can be safe while in lobby.

Signed by Amanda L Harvell, RN on 3/25/2013 12:25

**ED Triage Notes signed by Amanda L Harvell, RN at 03/25/13 1222**

Author: Amanda L Harvell, RN      Service: Emergency Medicine      Author Type: Registered Nurse  
Filed: 03/25/13 1222      Note Time: 03/25/13 1221      Note Status: Revised  
Related Addendum by: Amanda L Harvell, RN filed at 03/25/13 1225  
Notes:



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**Other Notes (continued)**

Having suicidal thoughts and tried to strangle herself last night. States breathing okay and slightly sore to neck but otherwise no medical complaints.

Signed by Amanda L Harvell, RN on 3/25/2013 12:22



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**Medication Orders**

**PARoxetine (PAXIL) 20 mg tablet [31432903]**

Expired

Ordering User: Anurag Jindal, MD 03/25/13 1518  
Authorized by: Anurag Jindal, MD  
Electronically signed by: Anurag Jindal, MD 03/25/13 1518

Ordering Provider: Anurag Jindal, MD  
Frequency: QAM 03/25/13 - 15 Days

**Laboratory Orders**

No orders found

**Imaging Orders**

No orders found

**Procedure Orders**

No orders found

**Other Orders**

No orders found

**Clinical Lab Results**

**Lab Results**

No matching results found

**Radiology Results**

**Radiology Results**

No matching results found

**ECG/EMG Results**

**ECG/EMG Results**

No matching results found

**Cardiac Results**

**All Results**

No matching results found

**Pathology Reports**

**Pathology Results**

No results found

**All Results**

No results found

**All Meds and Administrations**

(There are no med orders for this encounter)

**Multi-Disciplinary Problems (Active)**

There are no active problems.



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Multi-Disciplinary Problems (Active) (continued)

Patient Education

None

Discharge Instructions

Tricomo, Lia Y (MR # 60001270277)

Date	Status	User	User Type	Discharge Note
03/25/13 1526	Pended	Michael G Brennan, MA	Counselor	Original
Note:				

Providence St. Peter Hospital  
Emergency Center / Crisis Services  
Disposition Form

Lia Y Tricomo is a 27 y.o. year old, Caucasian, female, who comes to the ER by private car. The patient is referred to the Crisis Services Department by Anurag Jindal, MD for a mental health evaluation.

**Impression:**

1. Depression
2. Transient Suicidal thoughts, resolved
3. Not psychotic

**Consultation:**

Case consult with ER Physician Anurag Jindal, MD and Psychiatrist Dr. Chappell who concur with the disposition and plan of care.

**Disposition:**

1. Discharge to self with no harm agreement:

(A) As a part of my treatment program and in conjunction with the plan set up with the Providence St. Peter Hospital Crisis Services Counselor, I, Lia Y Tricomo agree to the following terms:

- 1) I will refrain from all threats and/or acts of harm to myself, others, animals or property.
- 2) If at any time I should feel depressed or anxious to the extent that I am unable to resist suicidal, assaultive or destructive impulses, I agree to call the **Crisis Clinic at (360) 586-2800** or **Crisis Resolution Services at (360) 754-1338**; or I will go directly to the nearest Emergency Room.

(B) I agree to seek counseling and will contact a therapist or agency on the next business day.

(C) I agree to abide by this agreement until contact is made with my therapist and my suicidal/assaultive/destructive thoughts and behaviors have been addressed.

2. Home.

**3. Follow-up with BHR**



**Discharge Note:**

- Lia Y Tricomo received all belongings at discharge.
- Lia Y Tricomo was considered for the PSPH Partial Hospitalization Program.
- 
- 

**Discharge Medications**

There are no discharge medications for this patient.

Lia Y Tricomo

Lia Y Tricomo does not have an active treatment plan of type ONCOLOGY TREATMENT in this episode.

**All Flowsheet Data (03/25/13 0000-03/25/13 2359)**

**Custom Formula Data**

Row Name	03/25/13 1222
<b>OTHER</b>	
BMI (Calculated)	19.4 -AH
BSA (Calculated - sq m)	1.59 sq meters -AH
BSA (Calculated - sq m)	1.59 sq meters -AH
BMI (Calculated)	19.4 -AH
IBW/kg (Calculated) Male	64.58 kg -AH
Low Range Vt 6cc/kg MALE	387.48 mL -AH
Adult Moderate Range Vt 8cc/kg MA	516.64 mL -AH
Adult High Range Vt 10cc/kg MALE	645.8 mL -AH
% Ideal Body Weight Male	84.29 -AH
IBW/kg (Calculated) FEMALE	59.3 kg -AH
Low Range Vt 6cc/kg FEMALE	355.8 mL -AH
Adult Moderate Range vt 8cc/kg FEMALE	474.4 mL -AH
% Ideal Body Weight Female	91.79 -AH
Weight change in grams since last filed entry	0 grams -AH
Percent Weight Change Since Birth	0 -AH
IBW/kg (Calculated)	59.3 -AH
Low Range Vt 4cc/kg	237.2 mL -AH
Low Range Vt 6cc/kg	355.8 mL -AH
Adult Moderate Range Vt 8cc/kg	474.4 mL -AH
Adult High Range Vt 10cc/kg	593 mL -AH
Recorded by	[AH] Amanda L Harvell, RN 03/25/13 1223
<b>BMI (Adult)</b>	
BMI (kg/m2)	19.41 -AH
Recorded by	[AH] Amanda L Harvell, RN 03/25/13 1223



WSP PROVIDENCE ST PETER HOSPITAL  
 413 Lilly Rd NE  
 Olympia, WA 98506-5133  
 Inpatient Record

TRICOMO, LIA Y  
 MRN: 60001270277  
 DOB: 11/24/1985, Sex: F  
 Acct #: 330000200546  
 Adm: 3/25/2013, D/C: 3/25/2013

All Flowsheet Data (03/25/13 0000--03/25/13 2359) (continued)

Row Name	ED from 3/25/2013 in PROVIDENCE ST PETER HOSPITAL EMERGENCY CENTER				
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Facility E/M

Crisis Intervention Psych/Social Crisis -SS  
 Nursing 1-2 Assessments -SS  
 Assessments  
 Recorded by [SS] Susan J Slade  
 03/28/13 0530

Triage Complete

Row Name	03/25/13 1224				
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Full Triage Completed

Full Triage Completed YES -AH  
 Recorded by [AH] Amanda L Harvell,  
 RN 03/25/13 1224

Anthropometrics

Row Name	03/25/13 1222				
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Anthropometrics

Weight Change 0 % -AH  
 Percent  
 Recorded by [AH] Amanda L Harvell,  
 RN 03/25/13 1223

Ready for BH

Row Name	03/25/13 1337				
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Safety/BH Needed

Place on Safety/BH? Yes -AJ  
 Recorded by [AJ] Anurag Jindal, MD  
 03/25/13 1337

Brief Assessment

Row Name	03/25/13 1224				
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Cognitive, Perceptual, Neuro

Orientation oriented x 4 -AH  
 Mood/Behavior flat affect -AH  
 Recorded by [AH] Amanda L Harvell,  
 RN 03/25/13 1224

Skin

Skin color consistent with  
 Color/Characteristics ethnicity -AH  
 Skin Moisture dry -AH  
 Recorded by [AH] Amanda L Harvell,  
 RN 03/25/13 1224

Respiratory

Rhythm/Pattern (Respiratory) unlabored -AH  
 O2 Device (Oxygen Therapy) room air -AH  
 Recorded by [AH] Amanda L Harvell,  
 RN 03/25/13 1224

Vital Signs

Row Name	03/25/13 1222				
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Vitals

Temp 37 °C (98.6 °F) -AH  
 Pulse 74 -AH  
 Resp 18 -AH  
 BP 120/68 mmHg -AH  
 SpO2 100 % -AH  
 Temp src Tympanic -AH  
 Heart Rate Source Monitor -AH  
 BP Method Automatic -AH  
 BP Location Left arm -AH  
 Patient Position Sitting -AH  
 Recorded by [AH] Amanda L Harvell,



All Flowsheet Data (03/25/13 0000-03/25/13 2359) (continued)

Vital Signs (continued)

Row Name	03/25/13 1222
	RN 03/25/13 1223
<b>Height and Weight</b>	
Height	1.676 m (5' 6") -AH
Height Method	Stated -AH
Weight	54.432 kg (120 lb) -AH
Weight Method	Stated -AH
Recorded by	[AH] Amanda L Harvell, RN 03/25/13 1223
<b>Oxygen Therapy</b>	
O2 Device (Oxygen Therapy)	room air -AH
Recorded by	[AH] Amanda L Harvell, RN 03/25/13 1223
<b>Pain/Comfort</b>	
Observed/Reported Pain	Yes -AH
Recorded by	[AH] Amanda L Harvell, RN 03/25/13 1223

Acuity

Row Name	03/25/13 1223
<b>Acuity</b>	
Patient Acuity	Emergent -AH
Recorded by	[AH] Amanda L Harvell, RN 03/25/13 1223
<b>Short Triage</b>	
Short Triage Completed	YES -AH
Recorded by	[AH] Amanda L Harvell, RN 03/25/13 1223

Arrival Documentation

Row Name	03/25/13 1221
<b>Triage Start</b>	
Triage Start	Start -AH
Recorded by	[AH] Amanda L Harvell, RN 03/25/13 1221

Abuse/Neglect Screening

Row Name	03/25/13 1223
<b>Screening</b>	
We ask all patients, do you feel safe in your living/school environment?	Denies concerns -AH
Recorded by	[AH] Amanda L Harvell, RN 03/25/13 1223
<b>Abuse Screen (Adult, OB)</b>	
* Do You Feel That You Are Treated Well By Your Partner/Spouse/Family Member?	yes -AH
Recorded by	[AH] Amanda L Harvell, RN 03/25/13 1223

Departure Condition

Row Name	03/25/13 1547
<b>Departure Condition</b>	
Mobility at Departure	Ambulatory -MS
Patient Teaching	Discharge instructions reviewed; Medications discussed; Patient verbalized understanding; Follow-up care reviewed -MS
Departure Mode	By self -MS



WSP PROVIDENCE ST PETER HOSPITAL  
 413 Lilly Rd NE  
 Olympia, WA 98506-5133  
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 Acct #: 330000200546  
 Adm: 3/25/2013, D/C: 3/25/2013

All Flowsheet Data (03/25/13 0000-03/25/13 2359) (continued)

Departure Condition (continued)

Row Name	03/25/13 1547				
Recorded by	[MS] Melissa L Salazar, RN 03/25/13 1547				

User Key

(r) = User Recd, (t) = User Taken, (c) = User Cosigned

Initials	Name	Effective Dates	Provider Type	Discipline
AJ	Anurag Jindal, MD	03/15/12 - 07/07/13	Physician	
SS	Susan J Slade	-	-	-
AH	Amanda L Harvell, RN	03/02/12 -	Registered Nurse	Nurse
MS	Melissa L Salazar, RN	03/02/12 -	Registered Nurse	Nurse

Flowsheet Notes

No notes of this type exist for this admission.

Hospital Account-Level E-Signatures:

There are no hospital account-level e-signatures.

Encounter-Level Documents - 03/25/2013:

Scan on 3/26/2013 0:00 by Onbase Scan Wamt (below)



WSP PROVIDENCE ST PETER HOSPITAL  
413 Lilly Rd NE  
Olympia, WA 98506-5133  
Inpatient Record

TRICOMO, LIA Y  
MRN: 60001270277  
DOB: 11/24/1985, Sex: F  
Acct #: 330000200546  
Adm: 3/25/2013, D/C: 3/25/2013

Encounter-Level Documents - 03/25/2013: (continued)

Tricomo, Lia Y (MR # 60001270277)

Encounter Date 03/25/2013

**PROVIDENCE ST PETER HOSPITAL  
EMERGENCY CENTER**  
413 Lilly Rd Ne  
Olympia WA 98506-5133  
Phone 360-493-7389

Tricomo, Lia Y  
MRN 60001270277

Department **PROVIDENCE ST PETER HOSPITAL EMERGENCY  
CENTER**  
Date of Visit 3/25/13

I have received a copy of my discharge instructions from Providence Health & Services

Patient Signature

*Lia Y Tricomo*

Date & Time

*3/25/13*

TRICOMO LIA Y  
DOB 11/24/85 F 27 YRS  
MRN 60001270277  
CSN 10040472350  
3/25/2013 EMERGENCY



Scan on 3/25/2013 0:00 by Onbase Scan Wamt (below)



Encounter-Level Documents - 03/25/2013: (continued)

**1. CONSENT FOR SERVICE**  
I acknowledge my attending physician is responsible for directing my care and has advised me of the need for services such as nursing care, diagnostic tests, anesthesia, medical or surgical treatments, disposal of removed tissue, services for any newborn if appropriate, and any other necessary medical service. By signing below I give my consent to all such services instructed by my attending physician, his/her assistants or designees.  
I understand my physician may order an operation or procedure, and give my consent after receiving adequate advice as to the benefits and risks of such operation or procedure. In the event a healthcare worker is exposed to my blood or body fluid in a manner posing a risk for transmission of a blood-borne infection, I give my consent to be tested for infections such as HIV, Hepatitis B and Hepatitis C at no cost to me, so the healthcare worker may be treated promptly. In such situations, I authorize release of applicable information to the healthcare worker and his/her healthcare provider.

**2. USE AND DISCLOSURE OF INFORMATION**  
I have received and read the "Notice of Privacy Practices" and authorize Providence Health and Services (PH&S) to use and disclose information about me and my health to diagnose and treat me, to obtain payment for my care and for PH&S business operations.

**3. PH&S TEACHING FACILITIES**  
I acknowledge PH&S has teaching facilities, and consent to supervised residents and students being involved with my care. I acknowledge I may refuse care by a resident or student at any time, and that such refusal will not result in any reduction of the quality of care provided.

**4. NURSING CARE**  
I acknowledge PH&S offsite hospital facilities do not provide general duty nursing care and release PH&S from all liability for special duty services that may be arranged by me/my legal representative.

**5. HEALTH PLAN OBLIGATION**  
I acknowledge I am individually obligated to pay the full charges of all services rendered to me by PH&S if I belong to a health plan that does not have a contract with PH&S at the time services are provided.

**6. ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION**  
**Medicare / Medicaid and Other Government Programs:** I authorize PH&S to receive direct payments for any benefits to which I may be eligible under Medicare, Medicaid or any other government program, and authorize PH&S to release relevant information about me and my healthcare necessary to receive payment under the applicable government program(s). I understand and accept my responsibility to pay any deductible and/or co-insurance under such program(s).  
**Medicare Notice:** I understand I may receive a bill from PH&S for self-administered drugs not covered by Medicare Part A, B and C, and may request an itemized statement containing the national drug codes necessary for me to bill my Part D carrier.  
**Insurance:** I consent to assign to PH&S all insurance company coverage benefits to which I am entitled for services rendered by PH&S, and authorize PH&S to release relevant information about me and my healthcare to receive such payment. I understand and accept I am responsible for paying any co-payments and/or deductibles required under my insurance plan(s).

**7. Right to Revoke Consent:** I acknowledge I have the right to revoke consent to treatment at any time effective immediately, and may also revoke authorization for the release of information about me and my healthcare to relevant government programs and insurance company(s). I understand and accept such revocation must be in writing and is effective only when it is received by the Medical Record Department at PH&S. I understand and accept if my revocation results in denial of payment to PH&S, I am responsible to pay for the care provided by PH&S.

**8. CHARITY CARE AND UNINSURED PATIENT DISCOUNTS**  
I acknowledge PH&S offers charity care, discounts for uninsured patients and prompt pay hardship discounts to qualifying individuals, and understand that I may request information regarding discounts where appropriate.



3COA



Page 1 of 2

Patient  
Identification:

TRICOMO, LIA Y  
DOB: 11/24/85 F 27 YRS  
MRN: 60001270277  
CSN: 10040472350

3/25/2013 EMERGENCY

**CONSENT FOR SERVICE - ENGLISH**  
Form Number: 8560-01-NH-01 (03/20/12)



Encounter-Level Documents - 03/25/2013: (continued)

**9. FINANCIAL RESPONSIBILITY**  
I understand and accept: PH&S will bill the Charge Master rates in effect when services are provided; I may request a price estimate for such services; I agree to pay for such services; and I acknowledge and accept my personal responsibility for payment in full for billed charges even where PH&S has been assigned benefits from government programs and insurance companies. I acknowledge failure to meet my financial obligations to PH&S will result in the referral of account(s) to professional collection agencies and consent to PH&S or its designees obtaining a copy of my credit report or any other publicly available data related to my ability to pay. I understand that PH&S, its affiliates, agents or designees may contact me using pre-recorded/artificial voice messages and/or automatic dialing services at any telephone number I provide to PH&S. In the event of any dispute regarding payment, I agree to pay all collection costs and attorneys' fees whether or not a case is filed in court. I understand I may receive separate bills from PH&S and/or from treating physicians such as radiologists, pathologists, anesthesiologists and emergency room physicians, and accept my responsibility to pay these in accordance with the payment terms set by those providers. If I am entitled to any personal injury settlement, judgment or other payment I agree to take any and all actions to assign or have paid to PH&S balances owed by me.

**10. PERSONAL BELONGINGS AND VALUABLES**  
I agree that PH&S is not responsible for my personal belongings and valuables brought into a PH&S facility, and agree to send such items home with my family or other responsible party if possible. I accept full responsibility and hold PH&S harmless for any loss, theft or damage for personal belongings or valuables retained at a PH&S facility.

**11. SAFE ENVIRONMENT**  
I acknowledge that weapons or other dangerous objects, illegal drugs and medications not prescribed by my healthcare provider are not permitted on PH&S premises, and accept the rights of PH&S to search individuals and rooms upon reasonable cause and to confiscate any such items.

**12. PHOTOGRAPHS**  
I agree to allow PH&S to take, reproduce and use photos, video tape, video monitoring / recording, or audio recording for the purpose of diagnosis, testing, medical evaluation, care or treatment (including invasive procedures), patient safety or medical education, and to preserve clinical information. I understand that this material may be treated as a part of my medical record and that PH&S privacy policies apply.

**13. PATIENT RIGHTS AND RESPONSIBILITIES**  
I acknowledge that I have received and read the "Patient Rights and Responsibilities" notice provided by PH&S.

**14. NONDISCRIMINATION POLICY**  
I acknowledge PH&S prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

**AUTHORIZATION FOR TREATMENT AND FINANCIAL RESPONSIBILITY STATEMENT**  
By signing this document I certify I am of lawful age and legally competent. I accept and agree to be legally bound by the terms and conditions contained herein.

Signature of Patient: *[Handwritten Signature]* Date of Signature: 3/25/13

Signature of Patient Representative / Agent: *[Handwritten Signature]* Relationship to Patient: \_\_\_\_\_

PH&S Representative present when consent for service document executed  
Note: If patient is unable to sign, indicate reason(s) for inability to sign

Name of interpreter (if used to explain document to patient): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_



**CONSENT FOR SERVICE - ENGLISH**  
Form Number: 8560-01-NH-01 (03/20/12)

Page 2 of 2

Patient  
Identification:

TRICOMO, LIA Y  
DOB: 11/24/85 F 27 YRS  
MRN: 60001270277  
CSN: 10040472350

3/25/2013 EMERGENCY



Order-Level Documents:

There are no order-level documents.

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

IN RE THE PERSONAL )  
RESTRAINT PETITION OF: ) CAUSE NO. 51741-8-II  
LIA Y. TRICOMO, ) EXHIBIT 10  
Petitioner. )

EXHIBIT 10  
SeaMar Treatment Record 4/3/13

EXHIBIT 10

Law Office of Neil Fox, PLLC  
2125 Western Ave. Ste. 330  
Seattle, Washington 98121  
206-728-5440



**SEA MAR**  
Community Health Centers  
Clínica de la Comunidad

**ADULT MEDICAL HISTORY**

BELLINGHAM  EVERSON  MARYSVILLE  MT. VERNON  PUYALLUP  SEATTLE  TACOMA  THURSTON  VANCOUVER

NAME Lia Yera Tricomo DATE OF BIRTH 11/24/85 DATE 4/3/13

PLEASE HELP US BY ANSWERING THE FOLLOWING QUESTIONS ABOUT YOUR MEDICAL HISTORY:

	YES	NO	PLEASE LIST:	UPDATES (Q 5 YRS)	
HOSPITALIZATIONS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>Depression</u>		
OPERATIONS	<input type="checkbox"/>	<input type="checkbox"/>			
MAJOR ILLNESS/TRAUMA	<input type="checkbox"/>	<input type="checkbox"/>			
CHILDHOOD ILLNESSES	<input type="checkbox"/>	<input type="checkbox"/>			
RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>			
LONG TERM MEDICATIONS	<input type="checkbox"/>	<input type="checkbox"/>			
MEDICINE THAT YOU TAKE	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>Paroxetine Hydrochloride</u>		
ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	TO WHAT?		
HABITS: ALCOHOL	<input checked="" type="checkbox"/>	<input type="checkbox"/>	HOW MUCH? <u>1</u>		
SMOKING	<input checked="" type="checkbox"/>	<input type="checkbox"/>	HOW MANY CIGARETTES? <u>6</u>		
COFFEE	<input checked="" type="checkbox"/>	<input type="checkbox"/>	HOW MUCH? <u>3 cups</u>		
OTHER DRUGS	<input type="checkbox"/>	<input type="checkbox"/>			
DATE OF LAST PHYSICAL EXAM?			<u>August 2011</u>	PROVIDER	DATE
LAST TETANUS BOOSTER	<input type="checkbox"/>	<input type="checkbox"/>			
FOR WOMEN:	YES	NO			
HAVE YOU HAD A MAMMOGRAM?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	WHEN?		
NUMBER OF PREGNANCIES?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	ABORTIONS? (TYPE)	PROVIDER	DATE
DATE OF LAST PAP SMEAR?			<u>January 2011</u>		

HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD ONE OR MORE OF THE FOLLOWING?

	YES	NO	PLEASE SPECIFY WHO:	UPDATES (Q 5 YRS)	
ALLERGIES/ASTHMA	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>father</u>		
SEIZURES (EPILEPSY)	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
STROKE (CVA)	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
CANCER	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
DIABETES MELLITUS	<input type="checkbox"/>	<input type="checkbox"/>			
RHEUMATOID ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>			
MENTAL RETARDATION	<input type="checkbox"/>	<input type="checkbox"/>			
ALCOHOLISM	<input type="checkbox"/>	<input type="checkbox"/>			
PSYCHIATRIC PROBLEMS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>father</u>		
SICKLE CELL ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>			
HEART DISEASE	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>mother</u>		
HIGH BLOOD PRESSURE	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
HEART ATTACK (MI)	<input type="checkbox"/>	<input type="checkbox"/>			

PLEASE TELL US ABOUT YOUR PRESENT SITUATION:

	YES	NO	COMMENTS	UPDATES (Q 5 YRS)	
EMPLOYED	<input type="checkbox"/>	<input checked="" type="checkbox"/>	TYPE OF WORK:		
MARITAL STATUS:			SPIRITUAL BELIEFS THAT MAY AFFECT YOUR MEDICAL CARE		
SINGLE	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
MARRIED	<input type="checkbox"/>	<input type="checkbox"/>			
DIVORCED	<input type="checkbox"/>	<input type="checkbox"/>			
ARE YOU SEXUALLY ACTIVE?	Y <input checked="" type="checkbox"/>	N <input type="checkbox"/>			
DO YOU HAVE SEX WITH	if yes:				
WOMEN	<input type="checkbox"/>	<input type="checkbox"/>			
MEN	<input type="checkbox"/>	<input type="checkbox"/>			
BOTH	<input checked="" type="checkbox"/>	<input type="checkbox"/>			

PLEASE SIGN: [Signature] DATE 4/3/13  
 PARENT AND/OR GUARDIAN: [Signature] DATE 4/3/13  
 PROVIDER: \_\_\_\_\_ DATE \_\_\_\_\_

MED 100 (REV. 02/05)

## History & Physical Report #8

**Lia Y. Tricomo**

4/3/2013 2:38 PM

Location: SEA MAR OLYMPIA MEDICAL

Patient #: 000383407

DOB: 11/24/1985

Single / Language: English / Race: White

Female

The patient is a 27 year old Female.

Assessment & Plan (Michelle Carter, MA; 4/3/2013 2:39 PM)

Unspecified Diagnosis

Current Plans

| Immunization Admin (90471)

Immunization, Viral Hepatitis B (V05.3)

Current Plans

| Immunization: HEP B VACCINE ADULT IM (90746)

Signed electronically by Michelle Carter, MA (4/3/2013 2:42 PM)

### **Procedures**

**Immunization Admin (90471)** Performed: 04/03/2013 (Final, Reviewed)

**HEP B VACCINE ADULT IM (90746)** Performed: 04/03/2013 (Final, Reviewed)

# History & Physical Report #7

**Lia Y. Tricomo**

4/3/2013 1:59 PM

Location: SEA MAR OLYMPIA MEDICAL

Patient #: 000383407

DOB: 11/24/1985

Single / Language: English / Race: White

Female

History of Present Illness (Fatima Shah, DO; 4/3/2013 2:27 PM)

The patient is a 27 year old female is here for an office visit. Patient comes to clinic for follow up of er. The patient describes symptom/s as Depression. The symptoms have been improving. To help the symptoms, the patient is currently using paroxetine. Patient was identified by date of birth and name. The patient was screened for the risk of depression with the following two questions: Over the last 2 weeks have you felt down depressed or hopeless? yes . Over the past 2 weeks have you felt little interest or pleasure in doing things? yes. Note for "Office Visit-Established Patient/MA intake": Michelle Carter MA  
Olympia Medical

Note: Went to ER ST. Peter's on 3/28 due to she was suicidal and at the ER pt was given Paxil. She had not been compliant with her antidepressant. She was given PROZAC in the past but med did not match with her well and quit taking medication.

Allergies (Michelle Carter, MA; 4/3/2013 2:03 PM)

**No Known Drug Allergies.** 04/03/2013

**NO KNOWN ALLERGIES.** 05/11/2010

Social History (Michelle Carter, MA; 4/3/2013 2:03 PM)

**Tobacco Status.** Current every day smoker.

Review of Systems (Fatima Shah, DO; 4/3/2013 2:29 PM)

**General:** Present- Fatigue. Not Present- Chills, Fever and Night Sweats.

**Psychiatric:** Present- Anxiety, Change in Sleep Pattern, Depressed Mood, Depression, Fatigue and Fearful.

Vitals (Michelle Carter, MA; 4/3/2013 2:06 PM)

4/3/2013 1:59 PM

**Weight:** 118 lb **Height:** 66 in

**Body Surface Area:** 1.58 m<sup>2</sup> **Body Mass Index:** 19.05 kg/m<sup>2</sup>

**Pain Level:** 0/10

**Temp.:** 98.2° F (Oral) **Pulse:** 60 (Regular) **Resp.:** 16 (Unlabored)

**BP:** 90/70 (Sitting, Left Arm, Standard)

Michelle Carter MA

Olympia Medical

Physical Exam (Fatima Shah, DO; 4/3/2013 2:29 PM)

The physical exam findings are as follows:

Note: Head: Normocephalic and Atraumatic

EYES: PERLA, EOMI

EARS: Both TMs are intact with clear EACs

NOSE: Normal appearing nasal mucosa with no signs of erythema and hypertrophy

THROAT: thyriod midline, no lymphadenopathy

HEART: Regular rate and rhythm, no murmurs

LUNGS: CTA, no rales, rhonchi and wheezes

ABD: Soft, non tender, non distended with normal bowel sounds in all quadrants, neg hepatosplenomegaly

NEURO: Alert and oriented x3, Motor and sensory systems are grossly intact.

EXT: Normal bipedal pulses, Neg clubbing and cyanosis and edema

Assessment & Plan (Fatima Shah, DO; 4/3/2013 2:37 PM)

Depressive disorder, rcr, severe (296.33)

**Impression:** Pt is already going to Counseling with BHR at the Martin way and she was going for counseling once a week for the last a few months.

Pt was advised to continue Counseling at BHR.

Pt likes the sisiter and I had asked pt to spend more tiem wiht her sister.

Current Plans

I Paxil 20MG, 1 Tablet at bedtime, #30, 04/03/2013, Ref. x1. Active.

Signed electronically by Fatima Shah, DO (4/3/2013 2:39 PM)

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

IN RE THE PERSONAL  
RESTRAINT PETITION OF:

LIA Y. TRICOMO,

Petitioner.

) CAUSE NO. 51741-8-II

) EXHIBIT 11

EXHIBIT 11

Selected BHR Treatment Records Winter/Spring 2013

# BHR

Behavioral Health Resources

Legal Last Name <b>Tricomo</b>	Legal First Name <b>Lia</b>	Legal Middle Name <b>(AKA)</b>
Address: Mail/Street <b>#A NE 1269 Bigelow Ave Oly 98506</b>		County of Residence <input checked="" type="checkbox"/> (34) Thurston <input type="checkbox"/> (23) Mason <input type="checkbox"/> Other
Telephone <b>357 3854</b>	DOB & Age <b>11-24-85</b>	Gender <input checked="" type="checkbox"/> (1) F <input type="checkbox"/> (2) M
MH PCP: <input type="checkbox"/> BHR <input type="checkbox"/> PSPH <input type="checkbox"/> CRS <input type="checkbox"/> Other: MH CM <b>Sherri Walker</b>	<input type="checkbox"/> None	Referred From / Phone <b>Self</b>
DDD Enrolled? <input type="checkbox"/> Y <input checked="" type="checkbox"/> N		DDD CM

Date / Time **11/4/13 2135** Sign each entry

**I'm really angry and I'm afraid I'll hurt my boy friends. It agreed not to hurt the Boyfriend. Agree to have her mom come pick her up and take home but stay @ mom's for a while. Agreed to call back if she needs to.**

*[Signature]*

Staff ID	Date	Service Code	Start Time	Duration	Location	Recip Code	# Recip	County/Ref	RU
0P90	1/14/13	201 Crisis Telephone	21:35 am/pm	: 5 "	T-E&T / CSTU	1	1	16	2550-CSTU After Hrs
	/ /	201 Crisis Telephone	: am/pm	:	T-E&T / CSTU			16	2550-CSTU After Hrs
	/ /	201 Crisis Telephone	: am/pm	:	T-E&T / CSTU			16	2550-CSTU After Hrs
	/ /	201 Crisis Telephone	: am/pm	:	T-E&T / CSTU			16	2550-CSTU After Hrs
	/ /	201 Crisis Telephone	: am/pm	:	T-E&T / CSTU			16	2550-CSTU After Hrs

### Recipient Codes

- |                        |                           |
|------------------------|---------------------------|
| (1) Client Only        | (4) Client & Collaterals  |
| (2) Collateral Only    | (5) Client & Family       |
| (3) Family Member Only | (6) Ct, Family, & Collat. |

CID <b>3029092</b> <input checked="" type="checkbox"/> AC/CC/New
Entered By/Date <i>[Signature]</i> 1/30/13

Active  
M-W

**Crisis Telephone Contact - After Hours**  
3436 Mary Elder Road NE, Olympia, WA, 98506  
(360) 528-2590 ♦ Fax: (360) 528-2596

<b>Appearance:</b>	<input checked="" type="checkbox"/> Within Normal limits <input type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:
<b>Attitude:</b>	<input checked="" type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other
<b>Mental Status:</b>	<b>Affect:</b> <input checked="" type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable Comments: anxious
	<b>Mood:</b> <input checked="" type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable Comments: depressed
	<b>Thought Process:</b> <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable Comments:
	<b>Orientation:</b> <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable Comments:
	<b>Behavior:</b> <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable Comments:
<b>Danger to:</b> <input type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Other <input checked="" type="checkbox"/> Property Plan: By her report, she has destroyed property recently.	
<b>ASSESSMENT (Overall impression):</b> <input type="checkbox"/> Needing IMMEDIATE Attention <input type="checkbox"/> Decompensating <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Improved	
<b>Modification to Tx Plan</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:	
<b>Service Focus Related to Goal:</b> First session with this client who transferred from another therapist here. She notes that she wants "anger management". She states she knows she has a problem with it. Explored what she means by this and allowed client to talk about how much she hurt her ex boyfriend's apartment and his things.  Discussed connection between anger and the urge to hurt others. She notes she never hurts herself or her things.  Made plan for working on and learning to control violent behavior.	
<b>Service Focus Related to Goal:</b>	
<b>Service Focus Related to Goal:</b>	
<b>Other Services Provided Not Related to Treatment Plan:</b>	
Describe Client Involvement: Lia presents with somewhat flat affect, and has a matter of fact attitude about her choices and her lifestyle. She is concerned about housing; she has to leave her boyfriend's house and cannot live with her mom anymore. She notes she has no real friends ("nobody likes me because of my violent temper") She hopes to gain employment but has little hope of it being successful. She agreed to use her music to help keep her calm. She agreed that she would like counseling weekly to work on her issues.  She also noted that she will call me if she can't make it in next week. She hopes she will not "fail" another "pee test" and be arrested.	
<b>Plan Focus For Next Session:</b> Anger management.	
Provider Signature/Credentials	<i>Lyn Hunt MA</i>
Date of Service: 1/18/13	Service Duration: Hours 1 : 00 minutes
Time of Service: 10:00	Location: 9
Client Name: Lia Tricomo	<input type="checkbox"/> EPSDT Contact

<b>Progress Note</b>	 Behavioral Health Resources MH418.04.11
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## Behavioral Health Resources Individualized Treatment Plan

Client name: Lia Tricomo

ID#: 3029092

Primary Clinician: Lyn Hertz

I was provided education on my diagnosis of: **Major Depressive Disorder, Borderline Personality Disorder** Client

initials:   *LT*  

Is transportation an issue?  Yes  No

If yes, client was given information on transportation resources.  Yes  No

Any issues relating to my age, culture, or disabilities that need to be considered when developing my treatment plan:

**Life Domains:**

- |                            |                           |                  |                     |                     |
|----------------------------|---------------------------|------------------|---------------------|---------------------|
| 1. Emotional/Mental Health | 4. Housing                | 7. Safety        | 10. Finances/Income | 13. Transportation  |
| 2. Social/Recreational     | 5. Educational/Vocational | 8. Legal         | 11. Food            | 14. Work/Employment |
| 3. Relationships           | 6. Cultural/Spiritual     | 9. Health/Dental | 12. Addictions      | 15. Other _____     |

Date listed	Life Domain	Target Date/Revised Target Date:	Date Completed:	Outcome Code:
1/24/13	1,2,3	6/30/13		
Problem/Need #1	I want help with: "Anger Management; I really need to learn to control my anger. It gets me in a lot of trouble."			
Measurable Outcome	I will know I have reached this goal when I: "When I can go for at least a week with no major anger outbursts. When I can control my emotions." Lia will learn and practice at least two new skills to manage her anger.			
Services	<input type="checkbox"/> Case management <input checked="" type="checkbox"/> Individual therapy <input type="checkbox"/> Group therapy <input type="checkbox"/> EPSDT <input type="checkbox"/> Family therapy <input type="checkbox"/> Medication management <input type="checkbox"/> Collateral contacts <input type="checkbox"/> Referral to <input type="checkbox"/> Other (describe)			
Who Is Involved	<input checked="" type="checkbox"/> Client <input type="checkbox"/> BHR medical staff <input type="checkbox"/> DDD <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Housing Authority <input checked="" type="checkbox"/> Clinician <input type="checkbox"/> Primary care physician <input type="checkbox"/> DCFS <input type="checkbox"/> Foster Care Agency <input type="checkbox"/> Adjunct Therapist <input type="checkbox"/> Family <input type="checkbox"/> School <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Other (describe)			

Date listed	Life Domain	Target Date/Revised Target Date:	Date Completed:	Outcome Code:
1/24/13	8	6/30/13		
Problem/Need #2	I want help with: <b>Mood management and emotion regulation.</b>			
Measurable Outcome	I will know I have reached this goal when I: <b>Lia will be able to relax knowing that she is in control of her emotions. At least three times a week, Lia will recognize and be able to act from her goals of staying calm rather than from her emotions or moods.</b>			
Services	<input type="checkbox"/> Case management <input checked="" type="checkbox"/> Individual therapy <input type="checkbox"/> Group therapy <input type="checkbox"/> EPSDT <input type="checkbox"/> Family therapy <input type="checkbox"/> Medication management <input type="checkbox"/> Collateral contacts <input type="checkbox"/> Referral to <input type="checkbox"/> Other (describe)			
Who Is Involved	<input checked="" type="checkbox"/> Client <input type="checkbox"/> BHR medical staff <input type="checkbox"/> DDD <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Housing Authority <input checked="" type="checkbox"/> Clinician <input type="checkbox"/> Primary care physician <input type="checkbox"/> DCFS <input type="checkbox"/> Foster Care Agency <input type="checkbox"/> Adjunct Therapist <input type="checkbox"/> Family <input type="checkbox"/> School <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Other (describe)			

Outcome codes: (1) Goal Achieved    (2) Goal Discontinued at Client request

Appearance:	<input checked="" type="checkbox"/> Within Normal <input type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:
Attitude:	<input checked="" type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other
Mental Status:	Affect: <input checked="" type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable Comments: anxious
	Mood: <input checked="" type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable Comments: depressed
	Thought Process: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable Comments:
	Orientation: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable Comments:
	Behavior: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable Comments:
Danger to:	<input type="checkbox"/> None <input checked="" type="checkbox"/> Self <input type="checkbox"/> Other <input checked="" type="checkbox"/> Property Plan: agreed to safety plan
ASSESSMENT (Overall impression):	<input type="checkbox"/> Needing IMMEDIATE Attention <input checked="" type="checkbox"/> Decompensating <input type="checkbox"/> Stable <input type="checkbox"/> Improved
Modification to Tx Plan	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:
Service Focus Related to Goal: Lia is experiencing increased depression and admits to thoughts of harming herself. Discussed her history of this and how she has helped herself in the past. Secured commitment for her safety and plan for what she will do if she is worried about it.	
Explored her inability to be alone and how this triggers her depressive and suicidal thoughts. Made plans for being with safe people.	
Validated her choice of new housing situation. It sounds safe calm and quiet.	
Service Focus Related to Goal:	
Service Focus Related to Goal:	
Other Services Provided Not Related to Treatment Plan:	
Describe Client Involvement: Lia did not go to her probation appointment before this meeting as she said she needed to do. She will go right after this. Lia presents with worry for her safety and anxiety about being alone. She came up with the idea of asking her recently ex- boyfriend to stay the week with her until she moves into her new housing.	
She continues to have problems with anger, but this week she is turning the anger in on herself.	
Plan Focus For Next Session: Anger management.	
Provider Signature/Credentials <i>Lisa Hartman MA</i>	
Date of Service: 1/24/13	Service Duration: Hours 1 : 00 minutes SAL Code: 410
Time of Service: 1:00	Location: 9 <input type="checkbox"/> EPSDT Contact
Client Name: Lia Tricomo	

Progress Note	 Behavioral Health Resources MH418.04.11
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<b>Appearance:</b>	<input type="checkbox"/> Within Normals <input type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:		
<b>Attitude:</b>	<input type="checkbox"/> Guarded <input type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other		
<b>Mental Status:</b>	<b>Affect:</b>	<input type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable	Comments:
	<b>Mood:</b>	<input type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable	Comments:
	<b>Thought Process:</b>	<input type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable	Comments:
	<b>Orientation:</b>	<input type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable	Comments:
	<b>Behavior:</b>	<input type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable	Comments:
<b>Danger to:</b>	<input type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Other <input type="checkbox"/> Property    Plan:		
<b>ASSESSMENT (Overall impression):</b>	<input type="checkbox"/> Needing IMMEDIATE Attention <input type="checkbox"/> Decompensating <input type="checkbox"/> Stable <input type="checkbox"/> Improved		
<b>Modification to Tx Plan</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:		
<b>Service Focus Related to Goal:</b>			
<b>Service Focus Related to Goal:</b>			
<b>Service Focus Related to Goal:</b>			
<b>Other Services Provided Not Related to Treatment Plan:</b>			
<b>Describe Client Involvement:</b>	Client did not come for her scheduled appt.		
<b>Plan Focus For Next Session:</b>			
<b>Provider Signature/Credentials</b>	<i>[Handwritten Signature]</i>		
<b>Date of Service:</b> 1/31/13	<b>Service Duration:</b> Hours 0 : 0 minutes	<b>SAL Code:</b> 410	
<b>Time of Service:</b> 1:00	<b>Location:</b> 9	<input type="checkbox"/> EPSDT Contact	
<b>Client Name:</b> Lia Tricomo			

Appearance:	<input checked="" type="checkbox"/> Within Normal Limits ; <input type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:	
Attitude:	<input checked="" type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other	
Mental	Affect: <input checked="" type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable	Comments: <i>Anxious</i>
	Mood: <input checked="" type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable	Comments: <i>depressed</i>
Status:	Thought Process: <input checked="" type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable	Comments:
	Orientation: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	Behavior: <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:

Danger to:  None  Self  Other  Property Plan:

ASSESSMENT (Overall impression):  Needing IMMEDIATE Attention  Decompensating  Stable  Improved

Modification to Tx Plan  No  Yes If Yes, Identify Change:

Service Focus Related to Goal # \_\_\_:

*Lia is having a relatively calm spell. She is still having anger outbursts, but not as many as usual.*

Service Focus Related to Goal # \_\_\_: *Processed two different experiences - sudden anger that she feels she has no control over and her enjoyment of inflicting pain on others.*

Service Focus Related to Goal # \_\_\_: *Worked on her goal of reducing the sudden anger. Used mindfulness skills to increase awareness of physical changes in order to gain control and understand that there are seconds between cause and effect. Encouraged leaving and using exercise as good alternatives to her violent anger.*

Other Services Provided Not Related to Treatment Plan: *stand that there are seconds between cause and effect. Encouraged leaving and using exercise as good alternatives to her violent anger.*

Describe Client Involvement: *Lia expressed strong motivation to gain control of her anger. "I don't want it to get me in trouble anymore."*

Plan Focus For Next Session: *Anger Management*

Provider Signature/Credentials: *Liz Heitz MA*

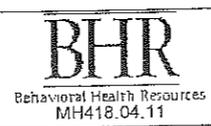
Date of Service: *2/14/13* Service Duration: Hours *1* minutes *00* SAL Code: *410*

Time of Service: *2:00* Location: *9*  EPSDT Contact

Client Name: *Lia Trilomo*

Progress Note

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Date listed	Life Domain	Target Date/Revised Target Date:	Date Completed:	Outcome Code:
Problem/Need #	I want help with:			
Measurable Outcome	I will know I have reached this goal when I:			
Services	<input type="checkbox"/> Case management <input type="checkbox"/> Individual therapy <input type="checkbox"/> Group therapy <input type="checkbox"/> EPSDT <input type="checkbox"/> Family therapy <input type="checkbox"/> Medication management <input type="checkbox"/> Collateral contacts <input type="checkbox"/> Referral to <input type="checkbox"/> Other (describe)			
Who Is Involved	<input type="checkbox"/> Client <input type="checkbox"/> BHR medical staff <input type="checkbox"/> DDD <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Housing Authority <input type="checkbox"/> Clinician <input type="checkbox"/> Primary care physician <input type="checkbox"/> DCFS <input type="checkbox"/> Foster Care Agency <input type="checkbox"/> Adjunct Therapist <input type="checkbox"/> Family <input type="checkbox"/> School <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Other (describe)			

Date listed	Life Domain	Target Date/Revised Target Date:	Date Completed:	Outcome Code:
Problem/Need #	I want help with:			
Measurable Outcome	I will know I have reached this goal when I:			
Services	<input type="checkbox"/> Case management <input type="checkbox"/> Individual therapy <input type="checkbox"/> Group therapy <input type="checkbox"/> EPSDT <input type="checkbox"/> Family therapy <input type="checkbox"/> Medication management <input type="checkbox"/> Collateral contacts <input type="checkbox"/> Referral to <input type="checkbox"/> Other (describe)			
Who Is Involved	<input type="checkbox"/> Client <input type="checkbox"/> BHR medical staff <input type="checkbox"/> DDD <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Housing Authority <input type="checkbox"/> Clinician <input type="checkbox"/> Primary care physician <input type="checkbox"/> DCFS <input type="checkbox"/> Foster Care Agency <input type="checkbox"/> Adjunct Therapist <input type="checkbox"/> Family <input type="checkbox"/> School <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Other (describe)			

Outcome codes: (1) Goal Achieved    (2) Goal Discontinued at Client request

I have worked with my primary clinician in developing my treatment plan. I understand I can request to review my treatment plan at any time.

Client Signature *[Signature]* Date 2/14/13

Parent/Guardian Signature (for children under 13 years old) \_\_\_\_\_ Date \_\_\_\_\_

Natural Supports Signature (if requested by client) \_\_\_\_\_ Date \_\_\_\_\_

Clinician Signature \_\_\_\_\_ Date \_\_\_\_\_

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

Special Population Consultant Signature (For In House Consults Only) \_\_\_\_\_ Date \_\_\_\_\_

## Behavioral Health Resources Individualized Treatment Plan

Client name: <b>Lia Tricomo</b>	ID#:
Primary Clinician: <b>Lyn Hertz</b>	
I was provided education on my diagnosis of: <b>Major Depression</b> Client initials: <i>LH</i>	
Is transportation an issue? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
If yes, client was given information on transportation resources. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Any issues relating to my age, culture, or disabilities that need to be considered when developing my treatment plan:	

Life Domains:				
1. Emotional/Mental Health	4. Housing	7. Safety	10. Finances/Income	13. Transportation
2. Social/Recreational	5. Educational/Vocational	8. Legal	11. Food	14. Work/Employment
3. Relationships	6. Cultural/Spiritual	9. Health/Dental	12. Addictions	15. Other _____
Date listed	Life Domain	Target Date/Revised Target Date:	Date Completed:	Outcome Code:
<i>2/20/13</i>	<i>1, 2, 7, 8</i>	<i>6/30/13</i>		
Problem/Need #1.	I want help with: " <b>Anger Management: I really want to learn to control my emotions. It's really hurting my life.</b> "			
Measurable Outcome	I will know I have reached this goal when I: <b>Learn and use skills to to manage intense negative emotions. Lia will refrain from lashing out in anger for a week at a time. Current: two to three times a week.</b>			
Services	<input type="checkbox"/> Case management <input checked="" type="checkbox"/> Individual therapy <input type="checkbox"/> Group therapy <input type="checkbox"/> EPSDT <input type="checkbox"/> Family therapy <input type="checkbox"/> Medication management <input type="checkbox"/> Collateral contacts <input type="checkbox"/> Referral to <input type="checkbox"/> Other (describe)			
Who Is Involved	<input checked="" type="checkbox"/> Client <input type="checkbox"/> BHR medical staff <input type="checkbox"/> DDD <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Housing Authority <input checked="" type="checkbox"/> Clinician <input type="checkbox"/> Primary care physician <input type="checkbox"/> DCFS <input type="checkbox"/> Foster Care Agency <input type="checkbox"/> Adjunct Therapist <input type="checkbox"/> Family <input type="checkbox"/> School <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Other (describe)			

Date listed	Life Domain	Target Date/Revised Target Date:	Date Completed:	Outcome Code:
Problem/Need #	I want help with:			
Measurable Outcome	I will know I have reached this goal when I:			
Services	<input type="checkbox"/> Case management <input type="checkbox"/> Individual therapy <input type="checkbox"/> Group therapy <input type="checkbox"/> EPSDT <input type="checkbox"/> Family therapy <input type="checkbox"/> Medication management <input type="checkbox"/> Collateral contacts <input type="checkbox"/> Referral to <input type="checkbox"/> Other (describe)			
Who Is Involved	<input type="checkbox"/> Client <input type="checkbox"/> BHR medical staff <input type="checkbox"/> DDD <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Housing Authority <input type="checkbox"/> Clinician <input type="checkbox"/> Primary care physician <input type="checkbox"/> DCFS <input type="checkbox"/> Foster Care Agency <input type="checkbox"/> Adjunct Therapist <input type="checkbox"/> Family <input type="checkbox"/> School <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Other (describe)			

Outcome codes: (1) Goal Achieved    (2) Goal Discontinued at Client request

Date listed	Life Domain	Target Date/Revised Target Date:	Date Completed:	Outcome Code:
Problem/Need #	I want help with:			
Measurable Outcome	I will know I have reached this goal when I:			
Services	<input type="checkbox"/> Case management <input type="checkbox"/> Individual therapy <input type="checkbox"/> Group therapy <input type="checkbox"/> EPSDT <input type="checkbox"/> Family therapy <input type="checkbox"/> Medication management <input type="checkbox"/> Collateral contacts <input type="checkbox"/> Referral to <input type="checkbox"/> Other (describe)			
Who Is Involved	<input type="checkbox"/> Client <input type="checkbox"/> BHR medical staff <input type="checkbox"/> DDD <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Housing Authority <input type="checkbox"/> Clinician <input type="checkbox"/> Primary care physician <input type="checkbox"/> DCFS <input type="checkbox"/> Foster Care Agency <input type="checkbox"/> Adjunct Therapist <input type="checkbox"/> Family <input type="checkbox"/> School <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Other (describe)			

Date listed	Life Domain	Target Date/Revised Target Date:	Date Completed:	Outcome Code:
Problem/Need #	I want help with:			
Measurable Outcome	I will know I have reached this goal when I:			
Services	<input type="checkbox"/> Case management <input type="checkbox"/> Individual therapy <input type="checkbox"/> Group therapy <input type="checkbox"/> EPSDT <input type="checkbox"/> Family therapy <input type="checkbox"/> Medication management <input type="checkbox"/> Collateral contacts <input type="checkbox"/> Referral to <input type="checkbox"/> Other (describe)			
Who Is Involved	<input type="checkbox"/> Client <input type="checkbox"/> BHR medical staff <input type="checkbox"/> DDD <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Housing Authority <input type="checkbox"/> Clinician <input type="checkbox"/> Primary care physician <input type="checkbox"/> DCFS <input type="checkbox"/> Foster Care Agency <input type="checkbox"/> Adjunct Therapist <input type="checkbox"/> Family <input type="checkbox"/> School <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Other (describe)			

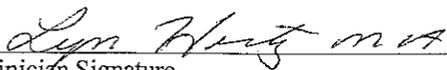
Outcome codes: (1) Goal Achieved (2) Goal Discontinued at Client request

I have worked with my primary clinician in developing my treatment plan. I understand I can request to review my treatment plan at any time.

Client Signature  Date 2/20/13

Parent/Guardian Signature (for children under 13 years old) \_\_\_\_\_ Date \_\_\_\_\_

Natural Supports Signature (if requested by client) \_\_\_\_\_ Date \_\_\_\_\_

Clinician Signature  Date 2/20/13

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

Special Population Consultant Signature (For In House Consults Only) \_\_\_\_\_ Date \_\_\_\_\_

<b>Appearance:</b>	<input checked="" type="checkbox"/> Within Normal Limits <input type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:		
<b>Attitude:</b>	<input checked="" type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other		
<b>Mental Status:</b>	<b>Affect:</b>	<input checked="" type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable	Comments: anxious
	<b>Mood:</b>	<input checked="" type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable	Comments: depressed
	<b>Thought Process:</b>	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	<b>Orientation:</b>	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	<b>Behavior:</b>	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
<b>Danger to:</b>	<input checked="" type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Other <input checked="" type="checkbox"/> Property    Plan:		
<b>ASSESSMENT (Overall impression):</b>	<input type="checkbox"/> Needing IMMEDIATE Attention <input type="checkbox"/> Decompensating <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Improved		
<b>Modification to Tx Plan</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:		
<b>Service Focus Related to Goal:</b> Lia does not endorse suicidal ideation today. She also notes pride that she had one example of managing her anger recently. She notes that she allowed herself to cry rather than lash out and hurt someone or something.			
<b>Discussed future goals and the motivation she has to learn to control her anger. Lia knows that gaining financial stability is important for her success. She believes she can achieve this with her "career" goal.</b>			
<b>Service Focus Related to Goal:</b>			
<b>Service Focus Related to Goal:</b>			
<b>Other Services Provided Not Related to Treatment Plan:</b>			
Describe Client Involvement: Lia presents with more upbeat mood today. She has a concert this weekend and is happy to be playing again. She talked about goals of housing, job and increased stability. She was very pleased to say she did not get angry at her sister recently.			
<b>Plan Focus For Next Session: Anger management.</b>			
Provider Signature/Credentials <i>Lyn Hartman</i>			
<b>Date of Service:</b> 2/20/13		<b>Service Duration:</b> Hours 1 : 00 minutes	<b>SAL Code:</b> 410
<b>Time of Service:</b> 4:00		<b>Location:</b> 9	<input type="checkbox"/> <b>EPSDT Contact</b>
<b>Client Name:</b> Lia Tricomo			

<b>Appearance:</b>	<input checked="" type="checkbox"/> Within Normal Limits <input type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:	
<b>Attitude:</b>	<input checked="" type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other	
<b>Mental Status:</b>	<b>Affect:</b>	<input checked="" type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable    Comments: agitated
	<b>Mood:</b>	<input checked="" type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable    Comments: depressed
	<b>Thought Process:</b>	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable    Comments:
	<b>Orientation:</b>	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable    Comments:
	<b>Behavior:</b>	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable    Comments:
<b>Danger to:</b>	<input checked="" type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Other <input checked="" type="checkbox"/> Property    Plan:	
<b>ASSESSMENT (Overall impression):</b>	<input type="checkbox"/> Needing IMMEDIATE Attention <input type="checkbox"/> Decompensating <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Improved	
<b>Modification to Tx Plan</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:	
<b>Service Focus Related to Goal:</b> Lia worked to identify why she was in a "bad mood." She knows that she had a very busy week and has several positive experiences. She also had a cold most of the week. She finally was able to identify that her mood is related to lack of sexual release. Explored her relationship to her sexuality and her anger issues.		
<b>Validated her commitment to following all probation requirements. She sees this as important for her future success, not as punishment.</b>		
<b>Service Focus Related to Goal:</b>		
<b>Service Focus Related to Goal:</b>		
<b>Other Services Provided Not Related to Treatment Plan:</b>		
<b>Describe Client Involvement:</b> Lia was open to exploration of her moods and actions. She had two very positive concerts this week and is happy about upcoming events. She talked about her sexuality and its role in her life. She again expressed her motivation to gain control of her anger issues. However, she also notes having "fun" fighting with her sister.		
<b>Plan Focus For Next Session:</b> Anger management.		
<b>Provider Signature/Credentials</b> <i>Lyn Hartman</i>		
<b>Date of Service:</b> 2/28/13	<b>Service Duration:</b> Hours 1 : 00 minutes	<b>SAL Code:</b> 410
<b>Time of Service:</b> 1:00	<b>Location:</b> 9	<input type="checkbox"/> <b>EPSDT Contact</b>
<b>Client Name:</b> Lia Tricomo		

<b>Progress Note</b>	 <small>Behavioral Health Resources MH418.04.11</small>
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<b>Appearance:</b>	<input checked="" type="checkbox"/> Within Normal Limits <input type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:		
<b>Attitude:</b>	<input checked="" type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other		
<b>Mental Status:</b>	<b>Affect:</b>	<input checked="" type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable	Comments: calm
	<b>Mood:</b>	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	<b>Thought Process:</b>	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	<b>Orientation:</b>	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	<b>Behavior:</b>	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
<b>Danger to:</b>	<input checked="" type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Other <input type="checkbox"/> Property    Plan:		
<b>ASSESSMENT (Overall impression):</b>	<input type="checkbox"/> Needing IMMEDIATE Attention <input type="checkbox"/> Decompensating <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Improved		
<b>Modification to Tx Plan</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:		
<b>Service Focus Related to Goal:</b>	Lia needed to come in later than original time scheduled in order for her to secure bus money. Discussed financial problems and processed how she deals with this level of poverty.		
<b>Service Focus Related to Goal:</b>	Discussed anger issues; Lia denies any problem this week. Discussed health and nutrition and its relationship to mood.		
<b>Service Focus Related to Goal:</b>			
<b>Service Focus Related to Goal:</b>			
<b>Other Services Provided Not Related to Treatment Plan:</b>			
<b>Describe Client Involvement:</b>	Lia is very tired today due to her extreme activities this weekend. She slept for most of three days following. She is still tired and states that she has little resources for adequate nutrition.		
	She is looking forward to a job next week; She hopes to be playing in the orchestra for the Oliver production. She is a bit worried about having "messed up" and hopes she passes her drug test next week.		
	Lia had her violin with her today; she played at a coffee shop in order to get bus money to come here. She played a few pieces while she was here.		
<b>Plan Focus For Next Session:</b>	Anger management. Mood management		
<b>Provider Signature/Credentials</b>	<i>Lyn Huntz &amp; MHC</i>		
<b>Date of Service:</b> 3/7/13	<b>Service Duration:</b> Hours	: 40 minutes	<b>SAL Code:</b> 410
<b>Time of Service:</b> 3:30	<b>Location:</b> 9	<input type="checkbox"/> EPSDT Contact	
<b>Client Name:</b> Lia Tricomo			

<b>Progress Note</b>	
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<b>Appearance:</b>	<input checked="" type="checkbox"/> Within Normal Limits <input type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:	
<b>Attitude:</b>	<input checked="" type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other	
<b>Mental Status:</b>	<b>Affect:</b>	<input checked="" type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable    Comments: calm
	<b>Mood:</b>	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable    Comments:
	<b>Thought Process:</b>	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable    Comments:
	<b>Orientation:</b>	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable    Comments:
	<b>Behavior:</b>	<input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable    Comments:
<b>Danger to:</b>	<input checked="" type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Other <input type="checkbox"/> Property    Plan:	
<b>ASSESSMENT (Overall impression):</b>	<input type="checkbox"/> Needing IMMEDIATE Attention <input type="checkbox"/> Decompensating <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Improved	
<b>Modification to Tx Plan</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:	
<b>Service Focus Related to Goal: Completed review of progress and need to alter or change treatment plan. Validated Lia's assertion that she does not have anger issues currently. Discussed the addition of anti-depressants to her therapy and how well she is doing on them. Discussed pros and cons and encouraged her to stay on them for longer than just a month or two. Reminded her that they do not act like aspirin and need to be taken as prescribed. Lia says she would like to work toward gaining employment. Agreed to this as a valid treatment goal.</b>  <b>Discussed guilt she feels over missing a job interview. Processed different approaches she could take to reconcile this.</b>  <b>Explored the similarities and differences she experiences with physical and emotional pain.</b>		
<b>Service Focus Related to Goal:</b>		
<b>Service Focus Related to Goal:</b>		
<b>Other Services Provided Not Related to Treatment Plan:</b>		
<b>Describe Client Involvement: Lia is quite mellow and is enjoying the break she feels from her usual intensity. She did discuss concerns about "getting bored" with it and the temptation she will feel to return to her normal high intensity. She was able to think about her goals and use her goals as guidelines for her intensity vs. mellow states.</b>		
<b>Plan Focus For Next Session: Mood stability. Work toward employment.</b>		
<b>Provider Signature/Credentials</b> <i>Lyn Hunt, LMSW</i>		
<b>Date of Service:</b> 4/4/13	<b>Service Duration:</b> Hours 1 : 00 minutes	<b>SAL Code:</b> 410
<b>Time of Service:</b> 1:00	<b>Location:</b> 9	<input type="checkbox"/> <b>EPSDT Contact</b>
<b>Client Name:</b> Lia Tricomo		

<b>Progress Note</b>	 Behavioral Health Resources MH418.04.11
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Appearance:	<input type="checkbox"/> Within Norm Limits <input type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:		
Attitude:	<input type="checkbox"/> Guarded <input type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other		
Mental Status:	Affect:	<input type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable	Comments:
	Mood:	<input type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable	Comments:
	Thought Process:	<input type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable	Comments:
	Orientation:	<input type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable	Comments:
	Behavior:	<input type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable	Comments:
Danger to:	<input type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Other <input type="checkbox"/> Property    Plan:		
ASSESSMENT (Overall impression):	<input type="checkbox"/> Needing IMMEDIATE Attention <input type="checkbox"/> Decompensating <input type="checkbox"/> Stable <input type="checkbox"/> Improved		
Modification to Tx Plan	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:		
Service Focus Related to Goal:			
Service Focus Related to Goal:			
Service Focus Related to Goal:			
Other Services Provided Not Related to Treatment Plan:			
Describe Client Involvement:	Client did not show for her scheduled and confirmed appt.		
Plan Focus For Next Session:			
Provider Signature/Credentials:	<i>Ryan Henry, L.M.H.C.</i>		
Date of Service:	4/10/13	Service Duration: Hours 0 : 0 minutes	SAL Code: 410
Time of Service:	4/11/13 2:21 1:00	Location: 9	<input type="checkbox"/> EPSDT Contact
Client Name:	Lia Tricomo		

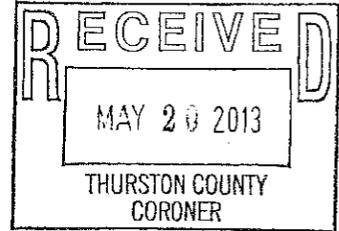
<b>Progress Note</b>	 Behavioral Health Resources MH418.04.11
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<b>Appearance:</b>	<input checked="" type="checkbox"/> Within Norms <input type="checkbox"/> Well-Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good Hygiene <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Other:	
<b>Attitude:</b>	<input checked="" type="checkbox"/> Guarded <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other	
<b>Mental Status:</b>	<b>Affect:</b> <input checked="" type="checkbox"/> Remarkable <input type="checkbox"/> Unremarkable	Comments:
	<b>Mood:</b> <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	<b>Thought Process:</b> <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	<b>Orientation:</b> <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
	<b>Behavior:</b> <input type="checkbox"/> Remarkable <input checked="" type="checkbox"/> Unremarkable	Comments:
<b>Danger to:</b>	<input checked="" type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Other <input type="checkbox"/> Property Plan:	
<b>ASSESSMENT (Overall impression):</b> <input type="checkbox"/> Needing IMMEDIATE Attention <input type="checkbox"/> Decompensating <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Improved		
<b>Modification to Tx Plan</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Identify Change:		
<p><b>Service Focus Related to Goal:</b> Lia brought up several issues of concern. Discussed and processed her ambivalence about the medication she is on. Looked at what she identifies as the root cause of her anger; She is angry that she is alive. She does not plan to harm herself, and in fact, talked about ways she used to inflict pain on herself. She does not want to do that anymore and does not want to take her life. However, she still in not happy about being alive.</p> <p>On the other hand, Lia is excited about an upcoming audition has for a job with the Spokane Symphony.</p> <p>Also discussed relationship issues and how she handles them.</p>		
<b>Service Focus Related to Goal:</b>		
<b>Service Focus Related to Goal:</b>		
<b>Other Services Provided Not Related to Treatment Plan:</b>		
Describe Client Involvement: Lia does not like the way the medication makes her feel even though she knows she feels calmer and happier. She expressed confusion about the experience of being happier. It is uncomfortable and unfamiliar. It seems to also take away her energy for acting out in anger.		
<b>Plan Focus For Next Session:</b> Mood stability. Work toward employment.		
Provider Signature/Credentials <i>Lyn Healy, MHC</i>		
<b>Date of Service:</b> 4/25/13	<b>Service Duration:</b> Hours 1 : 00 minutes	<b>SAL Code:</b> 410
<b>Time of Service:</b> 1:00	<b>Location:</b> 9	<input type="checkbox"/> <b>EPSDT Contact</b>
<b>Client Name:</b> Lia Tricomo		





TOXICOLOGY LABORATORY  
WASHINGTON STATE PATROL  
2203 Airport Way South Suite 360 Seattle, WA 98134  
(206) 262-6100 FAX No. (206) 262-6145



TOXICOLOGY REPORT

Attention: Gary Warnock  
Agency: Thurston Co Coroner  
Address: 2000 Lakeridge Dr SW MS-40947  
Olympia, WA 98502

Tox Case #: ST-13-03974 Case Type: Death Investigation Report Date: 5/13/2013

Agency Case #: 13-0801-04 JA Subject Name: John P. Alkins

Evidence: The following evidence was submitted to the Laboratory by Michael Ashton of the Thurston Co Coroner on 5/3/2013 via Campus Mail:  
(1) ST-13-03974-A: VGray, Blood - Central  
(2) ST-13-03974-B: VRed, Urine

Volatile Analysis Results:

ST-13-03974-A: Blood - Central

ST-13-03974-A was tested by Headspace - Gas Chromatography for the presence of acetone, ethanol, isopropanol, and methanol on the date(s) indicated below. The following average result was obtained:

Ethanol 0.16 ± 0.014 g/100mL (k=3, 99.7% confidence level) 05/06/13, 05/09/13

Drug Analysis Results:

ST-13-03974-B: Urine

ST-13-03974-B was tested by Bayer Ketodiatix for the presence of glucose and ketones on 05/09/2013. The following result(s) was obtained:

None Detected

ST-13-03974-B was tested by Enzyme Multiplied Immunoassay Technique (EMIT) for the presence of amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine metabolite, methadone, opiates, phencyclidine (PCP), propoxyphene, and tricyclic antidepressants on 05/09/2013. The following result(s) was obtained:

None Detected

ST-13-03974-B was tested by Spectrophotometry for the presence of acetaminophen and salicylates on 05/09/2013. The following result(s) was obtained:

None Detected

COMMENTS

All testing was performed by the Forensic Scientist listed below except as otherwise indicated. The Forensic Scientist has technically reviewed all relevant pages of testing documentation in the case record.



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

IN RE THE PERSONAL  
RESTRAINT PETITION OF:

LIA Y. TRICOMO,

Petitioner.

) CAUSE NO. 51741-8-II

) EXHIBIT 13

EXHIBIT 13

Thurston County Sheriff's Office – Tricomo Transcribed Statement



## THURSTON COUNTY SHERIFF'S OFFICE

Suspect  
 Victim  
 Witness

Case #: 13-2336  
 Date:  
 Time:

NAME: Lia Yera Tricomo  
 DATE OF BIRTH: 11-24-85  
 ADDRESS:  
 INTERVIEWING OFFICER: Det Simper  
 INTERVIEW LOCATION: Thurston County Sheriff's Office  
 ALSO PRESENT:

1 Q Actually right, right there is good. So, a little bit more comfortable here than there, and  
 2 we're not gonna have as many interruptions as just people coming and, and poking their  
 3 heads in and listening to your business. It's better this way, so...  
 4 A Mm hmm  
 5 Q But, just so you know, um, we record our interviews. Okay?  
 6 A Mm hmm  
 7 Q And that's, that's for your protection as well as our protection. It just, it's just so every  
 8 knows what's going on in here. Okay? You understand that?  
 9 A Mm hmm  
 10 Q Oh. Yeah?  
 11 A (no verbal response)  
 12 Q Okay. Is that okay with you?  
 13 A Uh huh.  
 14 Q Okay.  
 15 A Makes a really high pitched sound.  
 16 Q I turned it off.  
 17 A Oh.  
 18 Q I turned it off because it was, it was making this (undistinguishable) I heard  
 19 (undistinguishable) until you, until you mentioned it, I was kind of...zoning it out.

- 1 So...we'll just, uh,...so he, he was trying to actually, your honor, track down some food  
2 for you. Okay?
- 3 A Thank you.
- 4 Q (King: I'll be right back back). Okay. Looks like he found some food, so he's gonna run  
5 down and grab it. Okay? So you, you, I heard you talking to Detective King about school.  
6 You went here locally?
- 7 A Uh huh.
- 8 Q Where, where to?
- 9 A Evergreen (sounds like).
- 10 Q Okay. You a current student or did you, um,...
- 11 A I graduated.
- 12 Q Oh, you did. How long ago was that?
- 13 A Last summer.
- 14 Q Okay. What was your degree in?
- 15 A Bachelor of Arts.
- 16 Q Okay. Cool. And so did you come to this area to go to Evergreen or had you, um,...lived  
17 in this area prior to that?
- 18 A No, I came to go to the (undistinguishable).
- 19 Q Okay. Where are you from originally?
- 20 A Bremerton.
- 21 Q Okay. So still within, you know, not too far away. Probably made it nice going to college  
22 since you were still fairly close to where you, where you grew up, (undistinguishable)  
23 half a country away or something, you know, several states away.
- 24 A (undistinguishable)
- 25 Q (King: (undistinguishable) two sandwiches. (undistinguishable) get started on one of  
26 those). Yeah. So while, while you're eating that, we just have some preliminary stuff I  
27 have to, I have to take care of. Okay? Um,...I have a Miranda card. Okay? And it's your  
28 rights. And we, we do this for everybody that we interview. Okay. So I need to read those  
29 to you. So if you just bear with me really quick.
- 30 A (undistinguishable)
- 31 Q What's that?
- 32 A Oh, okay.
- 33 Q Oh, I, no, I don't want to interrupt your, your eating your sandwich. So I was just  
34 gonna...
- 35 A Well, I thought you were gonna read...
- 36 Q I, I will. It won't take but a couple...

- 1 A Oh.
- 2 Q ...couple seconds. So like I said, we do this for everybody we interview. And it's just so  
3 everybody knows what their rights are. Okay? You have the right to remain silent.  
4 Anything you say can be used against you in a court of law. You have the right at this  
5 time to talk to a lawyer and have him present with you while you're being questioned. If  
6 you cannot afford to hire a lawyer, one will be appointed to represent you before any  
7 questioning if you wish. You can decide at any time to exercise these rights and not  
8 answer any questions or make any statements. Do you understand each of these rights  
9 I've explained to you?
- 10 A Um,...I don't...
- 11 Q Would you like me to read them again?
- 12 A (no verbal response)
- 13 Q I can do that.
- 14 A Um,...I don't know. I don't know. Yeah. I, I understand.
- 15 Q You understand them?
- 16 A Mm hmm
- 17 Q Okay. And, um, having these rights in mind, do you wish to continue talking with us?
- 18 A What?
- 19 Q With these rights in mind, do you wish to con-, continue talking with, um,...
- 20 A Oh.
- 21 Q ...myself and Detective King?
- 22 A I don't know. Um, sure, yeah.
- 23 Q Okay. Cool. Like I said, just preliminary stuff we have to take care of. And now that  
24 that's out of the way, uh, go ahead and eat. Uh, open your sandwich. Not quite sure what  
25 kind of sandwich it is.
- 26 A Egg and cheese (sounds like).
- 27 Q (King): Is that not gonna work?
- 28 A Um, I don't know.
- 29 Q Well, start with the juice and think about it. Is the one below it maybe a little bit  
30 different?
- 31 A No, the same.
- 32 Q The same?
- 33 A Yeah.
- 34 Q Like egg salad?
- 35 A (undistinguishable). Ooh, smells. (undistinguishable) I'm sorry.

1 Q (Simper): Oh, you don't like, you don't like it?  
2 A I'm sorry.

3 Q No, don't, you don't have to apologize. Like I said, we don't know what, what's in the  
4 bag. It's just...  
5

6 Q (King): What you get.  
7

8 Q (Simper): ...it's what we get. Can probably try to track down something else if that's not  
9 gonna work for you.  
10

11 Q (King): you can try the cookie, too. I'm sure that's probably pretty good.  
12

13 Q (Simper): Can't go wrong with a cookie.  
14

15 Q (King): If not, I'll eat the cookie.  
16

17 Q (Simper): How long has it been since you ate?  
18 A (undistinguishable)

19 Q Okay.  
20 A Okay.

21 Q All right. Feeling a little bit better? Got some juice in you?  
22 A Yeah.

23 Q Okay. Well,...Detective King and I, obviously we, we just need your side of, of, of the  
24 story, of what happened out there. Okay?  
25 A Yeah. Yeah.

26 Q What's that?  
27 A Did you go there?

28 Q Yeah, I, I did go there. I did.  
29 A Oh. (undistinguishable)

30 Q You don't have to apologize to me. Really, you don't. Okay? I,...you don't have to  
31 apologize. We'll just throw that out there. Okay? We just, we're here to talk to you and,  
32 and get your side of what, what really truly happened. And this is your, your time to, to  
33 paint that picture for us and tell that story. Okay? Okay. So let's kinda start with,  
34 um,...the living arrangements. How long you been living at that house?  
35 A That was the first (undistinguishable)

- 1 Q What's what?  
2 A That was the first day.
- 3 Q What was the first day?  
4 A Um, (undistinguishable)
- 5 Q When did you move in?  
6 A Today.
- 7 Q Yesterday. Okay. Where were you living before that?  
8 A I was living, um, on Eastside Street.
- 9 Q Okay. So you moved in yesterday.  
10 A Yep.
- 11 Q And...how did you come to know this, this individual?  
12 A I think he was my, uh, case worker at BHR.
- 13 Q Okay. And how long had he been your case worker at BHR?  
14 A Um,...nine months.
- 15 Q Okay.  
16 A And then he got, he had to, uh, have a...he, he was, uh,...he was, uh,...fired for  
17 unprofessional conduct.
- 18 Q And do you know what that unprofessional conduct was?  
19 A He told me that it was, uh, some lady accused him of, uh,...being sexual with her,  
20 touching her.
- 21 Q Okay. So you say he was your case worker for about nine months. When did that stop?  
22 When was he terminated from there?  
23 A When, well, see what happened, I, uh,...uh, last September...wait...well, he said that we  
24 hadn't seen each other for...six months.
- 25 Q Oh, okay. Well, that would be about right. As far as the timeframe goes. How did, did  
26 you reach out to him or did he contact you?  
27 A Yeah.
- 28 Q He did, he contacted you?  
29 A (undistinguishable)
- 30 Q And when was that?  
31 A Um, no. I con-, I, I contacted him.
- 32 Q Oh, okay.  
33 A Yeah.
- 34 Q Was that by phone? Email? How was it?

- 1 A Mm...um,...I called him...because I wanted to give him back his amp (sounds like),  
2 because he let me borrow his amp. And, uh, I wanted my book back, because he  
3 borrowed one of my books.
- 4 Q Okay. And so what became of that conversation?  
5 A Um, I was (undistinguishable) in the, uh,...just, you know,...um,...I don't know.
- 6 Q Okay. No big deal.  
7 A I'm...
- 8 Q We'll stick on...  
9 A ...he, well, he called me...
- 10 Q ...stick on (undistinguishable)  
11 A He calls me a lot of times after he found out my phone number.
- 12 Q Oh, did he?  
13 A Yeah.
- 14 Q What was he talking about?  
15 A Um, how much he likes me and how special our time together was. And, uh,...
- 16 Q (King): What kind of timeframe was that over?  
17 A Um,...let's see. Um, I would say...oh, yeah, I remember. It was when I started taking my  
18 medication.
- 19 Q And when was that around?  
20 A Huh?
- 21 Q When do you think that was?  
22 A It was March...27<sup>th</sup> of something. I went to the hospital.
- 23 Q So about the same time...  
24 A And he prescribed that medication. And then I told him that I went to the hospital and I  
25 started taking my...taking medication. And I was telling him how...um,...nasty it made  
26 me feel at first, and it wasn't really...working.
- 27 Q So was it, so he contacted you in March.  
28 A No, I called him, after I got out of the hospital.
- 29 Q Okay. Okay. And how did you come across his phone number? Did you still have it  
30 or...?  
31 A Um, it's in the phone book.
- 32 Q (Simper): So, had you guys been, um, socializing between then, uh, when you contacted  
33 him and now?  
34 A (no verbal response)

- 1 Q Before you moved in, were you, you guys socializing?  
2 A Yeah. I mean, we were socializing when we were, uh,...um,...having our sessions. He'd  
3 call my mom's phone and...
- 4 Q Okay.  
5 A ...(undistinguishable) you know I'm not supposed to do this, but...
- 6 Q What was the extent of your relationship with him?  
7 A Um, we recorded music together. But, I could tell he really, really likes me.
- 8 Q Okay.  
9 A Yeah. Like, like sexually, you know. I just, you know, because he's such a good  
10 musician, I just, I just felt like, uh, I should be nice. And also he was kind  
11 of...manipulating me, um, saying that...well, I wasn't, I was obviously not manipulated  
12 by him. You know, because I, I know when people are manipulating me. But, he thought  
13 I was stupid and that's...he, he, yeah. He thought I was stupid and so he thought he was  
14 manipulating me...by saying that I (undistinguishable) in the sessions with him that he  
15 told DOC...whatever he's supposed to say how...I'm getting in trouble (sounds like).
- 16 Q Okay. And if you hear that buzzing downstairs, it's just the doors downstairs, they have  
17 to hit that button to make the, uh, the door open. So it's, that's that noise if it startles you  
18 or anything like that. (undistinguishable) just brought that up before it becomes an issue.  
19 So...you said he likes you, you could tell he liked you sexually?  
20 A (No verbal response)
- 21 Q Okay. Um, at any point, did you have a sexual relationship with him?  
22 A Last night.
- 23 Q Was that the first time?  
24 A (no verbal response)
- 25 Q Okay. And then you said yesterday was the first day you moved in there.  
26 A (no verbal response)
- 27 Q Okay. So now that we kinda got that background down, let's just, uh, fast-forward to  
28 yesterday, when you moved in. How did, how did you moving in get brought up?  
29 A He brought it up.
- 30 Q He did?  
31 A (no verbal response)
- 32 Q And did he offer it to you?  
33 A (no verbal response)
- 34 Q Okay. What, were there conditions to you moving in?  
35 A I couldn't tell BHR, because I was still a client there.
- 36 Q Okay.

- 1 A Um,...that's it. He said he wanted to do it family style and share (undistinguishable).  
2 Have no boundaries.
- 3 Q And what did that mean to you?  
4 A I was totally very, very uncomfortable with it, very uncomfortable with it. I don't know  
5 what the fuck I was thinking moving in with him.
- 6 Q Okay.  
7 A (undistinguishable) I don't know what else...
- 8 Q Were you gonna pay rent or anything like that?  
9 A Yeah.
- 10 Q Okay.  
11 A I just feel hopeless (sounds like).
- 12 Q Okay. So you moved in yesterday, um, how'd your day go yesterday? When, right after  
13 you moved in? Tell me, just, uh, basically I'll let you just talk about your day yesterday?  
14 A I was drinking. I was drinking (undistinguishable) vodka, I don't know, I started drinking  
15 it and I made him pasta. And, uh,...(undistinguishable) and like (undistinguishable) said  
16 he wanted to do it family style. (undistinguishable)
- 17 Q Now, so you're sa-, you, you said he wanted to do it family style. So what does that mean  
18 to you? In your, in your words, just explain it to me.  
19 A I don't know about the creepy shit. Creepy. Yeah. What does it mean to me? Incestuous.
- 20 Q Oh, okay. So what time of day did this, this happen at?  
21 A What happened?
- 22 Q What, what you're saying.  
23 A Oh.
- 24 Q You're, you're saying that, uh, incestuous, the family style.  
25 A Oh.
- 26 Q What...  
27 A Very early in the day.
- 28 Q Oh, okay. Do you, you have any idea what time and...  
29 A Six.
- 30 Q And do you know how much you'd had to drink at that point?  
31 A Probably about a quarter of...the bottle.
- 32 Q And you were, you were drinking vodka, is what you said.  
33 A (No verbal response)
- 34 Q Okay. So just, I'll let you go ahead and talk from there as to what, what occurred.

- 1 A Mm...what?
- 2 Q I'm sorry.
- 3 A (undistinguishable) I'm spaced out.
- 4 Q No, no problem. I'll rephrase my question.
- 5 A What happened...I don't, my god.
- 6 Q So just starting about 6:00. Why don't you go ahead and tell me about what hap-, starting  
7 from 6:00 last night.
- 8 A 6:00 last night.
- 9 Q Just kinda go through what happened.
- 10 A Um,...um,...(whispering). I'm sorry, this medication is...
- 11 Q You don't have, you don't have to apologize.
- 12 A It's...this medication.
- 13 Q (King): what if we skip back a little bit and start over. You were making pasta.
- 14 A I, I made pasta.
- 15 Q You were drinking vodka.
- 16 A I was drinking vodka like first thing I came to the house. Then he came over at  
17 like...3:30 to my house and picked me up and then...um, I loaded up his car  
18 and...uh,...um, I loaded up his car, we went to a liquor store, got vodka and then...went  
19 to his house, it was around 4:00, 4, 4:15. And then I,...took like...three or four swigs of  
20 vodka. And, uh, and then I unpacked the car, and he was (undistinguishable). Anyway, I,  
21 I don't really remember what he was doing. But, um, I was, uh,...I unpacked the car. And  
22 then, and then that took like ten, twenty minutes. So maybe he mentioned the family style  
23 thing (undistinguishable). And then...
- 24 Q We don't need to really worry about the time so much.
- 25 A Oh.
- 26 Q It's, if that's, and if, if it's...
- 27 A Yeah.
- 28 Q ...(undistinguishable) to keep track of the time...
- 29 A Mm hmm
- 30 Q ...let's just forget about that time. Okay? I mean, we know that, okay, we're up to 6:00  
31 last, last night. So let's forget about the time. And let's just move forward with, with what  
32 happened, without...narrowing it down to specific times. Because that probably will  
33 make it easier for you to discuss.
- 34 A Okay.
- 35 Q Okay? Fair enough?
- 36 A Okay.

- 1 Q So he brought up...what you called, uh, the family, family style. So how did that  
2 progress?
- 3 A Uh,... we were, uh, (undistinguishable) baby girl. Um,...(undistinguishable) we were  
4 listening to his music. Um, we were listening to his music that he played back in the 70s.  
5 And it was really loud. And...I told him how good he was. And he said...we were eating  
6 and, uh, he said, he touched me. He touched my boobs and, um,...then he took my pants  
7 off and then, then licked me (sounds like). And...um,...and then I um,...gave him a blow  
8 job and, um,...at that time, I don't know. Like...a crazy amount of alcohol. I drank a  
9 crazy amount of alcohol. And then I asked him if he wanted to get tied up. And he said  
10 yeah. And we went upstairs, and he (undistinguishable)...went upstairs and we, uh,...um,  
11 I was trying to tie his legs down to the, um,...like (undistinguishable) and you know, he  
12 didn't like it (sounds like). You know. Some reason I,...put a basically, put a razorblade  
13 hiding in the room. And, uh,...what the fuck, I don't understand. I don't understand  
14 what...um, then I cut his throat...open. Yeah. Bled a lot. It was...(undistinguishable) he  
15 wanted to know why...I was doing that.
- 16 Q And what'd you tell him?
- 17 A I said that, um, I said that he was a creep.
- 18 Q And did you, did you feel that way?
- 19 A (no verbal response)
- 20 Q How did you feel that way?
- 21 A (undistinguishable) really creepy.
- 22 Q So you're saying that you, you hid the razorblade? Is that what you said?
- 23 A (no verbal response)
- 24 Q And, and where did you hide that?
- 25 A Chair, I think, behind a pillow.
- 26 Q (King): is it in his room?
- 27 A Yeah
- 28 Q And was, was it a razorblade that you...brought with or...
- 29 A Yep, I used it to sharpen my pencils.
- 30 Q So it was in your property?
- 31 A (no verbal response)
- 32 Q (Simper): And you described that, like a, was it a loose razorblade or was it actually in...
- 33 A It was in a...like a switch knife.
- 34 Q Oh, so like one of the folding razorblades. Okay.
- 35 A Yeah.
- 36 Q Do you remember what color it was?
- 37 A Silver.

- 1 Q Okay.  
2
- 3 Q (King): Like for opening boxes?  
4 A Yeah (whisper).
- 5 Q Okay.  
6
- 7 Q (Simper): Okay. So, he was asking you why.  
8 A (undistinguishable)
- 9 Q And you told him...  
10 A Why are you trying to kill me?
- 11 Q Do you remember how you, how you cut him?  
12 A That.
- 13 Q So you reached across?  
14 A Yep.
- 15 Q So from his...  
16 A (undistinguishable)
- 17 Q Okay.  
18 A By the carotid (undistinguishable)
- 19 Q Okay. You remember how many times?  
20 A Six maybe.
- 21 Q Okay. Can you describe the motion that you used?  
22 A Like that (sounds like).
- 23 Q And where were you positioned at the time?  
24 A Um, uh,...I think he was laying on the bed.
- 25 Q He, he was laying on the bed?  
26 A No, no. Uh, I don't remember.
- 27 Q Okay. That's fine.  
28
- 29 Q (King): Because you said, you said you had him tied up, but he didn't like that. Right?  
30 A Yeah. I let him go.
- 31 Q Oh, okay. So he wasn't tied up at that time?  
32 A Hm mm.
- 33 Q (Simper): And what were you using to tie him up?

- 1 A I was using a nylon cloth rope (sounds like).
- 2 Q Okay. You know what color it was?
- 3 A Pink (sounds like).
- 4 Q Okay.
- 5 A Um,...
- 6 Q (King): and was that yours or was that his?
- 7 A It was mine.
- 8 Q (Simper): Did he ask you anything else or did he say anything else?
- 9 A He told me to go to bed.
- 10 Q He told you to go to bed?
- 11 A Mm hmm
- 12 Q After you've done, you've done that?
- 13 A Yeah.
- 14 Q Okay. And what did you say?
- 15 A I said okay.
- 16 Q And did you?
- 17 A No.
- 18 Q What did you do?
- 19 A Uh,...I said I wanted to sleep with him. He just said no. And uh,...and when I,...I, I, I
- 20 was just, he was bleeding for so long that I just...
- 21 Q When you say for so long, how long do you think it was?
- 22 A Hours. He was bleeding for hours.
- 23 Q (King): And did he stay in his room while he was bleeding or...?
- 24 A No. He went all over the house. Trying to stop the bleeding.
- 25 Q How come he wouldn't call or go to the hospital?
- 26 A I don't know. I was asking him why...he wasn't (undistinguishable) crying for help, like
- 27 if I was him I would be screaming (undistinguishable) and defending myself. And...
- 28 Q (Simper): Did he answer you?
- 29 A Hmm?
- 30 Q Did he answer you when you asked him that?
- 31 A No.
- 32 Q Okay. He didn't say anything?
- 33 A He just said, kept saying go to bed, Yera.

- 1 Q Why did, why do you think he didn't call anyone?  
2 A He was afraid he was gonna get in trouble for having me move in with him.
- 3 Q And how did you feel as he's wandering around?  
4 A I was...terrified.
- 5 Q Why were you terrified?  
6 A He was bleeding.
- 7 Q Did you try to help him stop it?  
8 A No.
- 9 Q Why not?  
10 A I don't know.
- 11 Q Did you feel like you need...  
12 A I thought it was really a really bad wound and I just knew he was (undistinguishable).
- 13 Q Okay.  
14 A But, he...
- 15 Q Did he say anything else to you besides go to bed?  
16 A No.
- 17 Q And you said you'd asked him if you could sleep with him. Right? And why was that?  
18 A I don't know. I don't know.
- 19 Q So you said he was bleeding for what you described as hours. What's, what's going on  
20 through this time?  
21 A I was following him around and...
- 22 Q Do you remember why you were following him?  
23 A I think to make sure (undistinguishable). (whispering)
- 24 Q Are you sure it wasn't what?  
25 A (undistinguishable) handcuffs (sounds like).
- 26 Q Why didn't you want him to leave?  
27 A I don't know.
- 28 Q Okay. I'm gonna...go back a step.  
29 A It was just like, it was just like...a nightmare. It was like a dream.
- 30 Q Okay.  
31 A I don't understand.
- 32 Q I just, I want to ask you a question about that, uh, that razorblade. You said you'd hidden  
33 it. Did, you took that knife in there...beforehand?

- 1 A (no verbal response)
- 2 Q What was the reason for that?
- 3 A Um,...well, it's, it was to have something to cut the rope (undistinguishable) um, got  
4 stuck or something, (undistinguishable) basically...you know, the rope and...
- 5 Q Was there another reason you, that you took the knife in there?
- 6 A I think so.
- 7 Q What's that?
- 8 A I, I think I wanted to cut him (sounds like).
- 9 Q Really? Was that something that you were thinking about beforehand?
- 10 A Yeah.
- 11 Q Okay.
- 12 A Yes.
- 13 Q What, what prompted you to feel that way?
- 14 A (undistinguishable) he touched me (undistinguishable)
- 15 Q Okay. Was that something that you wanted?
- 16 A No.
- 17 Q Okay. Did you try to stop him?
- 18 A No.
- 19 Q Why not?
- 20 A Because I was drunk (sounds like).
- 21 Q Okay. So you don't remember where you grabbed that knife from?
- 22 A From my backpack.
- 23 Q And that was in your room?
- 24 A Mm hmm
- 25 Q Okay. All right. So let's fast forward. I'm sorry I keep jumping around. I just have  
26 questions that pop up. I want to ask them before I forget them. So...fast forward to...after  
27 you're following him around, making sure he doesn't leave...what happened after that?
- 28 A Like, (undistinguishable) he was laying, um, he was laying on his bed. And,  
29 uh,...(whispering) what happened...and I, um, grabbed a cord and....um,...tied it around  
30 his neck and...um,...(whispering) he died (sounds like).
- 31 Q Do you know what kind of cord it was?
- 32 A It was a, uh, extension cord.
- 33 Q Remember what color it was?
- 34 A Green.

- 1 Q Okay. Can you describe how you tied that?  
2 A Just wrapped it around and...
- 3 Q And when...  
4 A ...like this.
- 5 Q You made a motion with your hands. Can you do that again, kinda show me how, how  
6 you did that?  
7 A Like this.
- 8 Q You did it kinda quick, I was trying to follow.  
9 A Like that. That.
- 10 Q And then you pulled it.  
11 A Yeah.
- 12 Q Okay.  
13 A (undistinguishable)
- 14 Q Did you put any other pressure on him...  
15 A (undistinguishable)
- 16 Q ...on his body?  
17 A (no verbal response)
- 18 Q Was he saying anything?  
19 A No. He couldn't. I cut his windpipe off.
- 20 Q Okay.  
21
- 22 Q (King): Was he laying face down on the bed when, when you did this or was...?  
23 A He was laying (undistinguishable)
- 24 Q (Simper): Okay. And then what, what happened after that?  
25 A Um,...he threw the rope (undistinguishable) like hanging out on the roof.  
26 (undistinguishable) out on the roof and...um, like in the house and...
- 27 Q Do you, you remem-...  
28 A I was...um,...I kind of, uh, got, drank some more in his bed.
- 29 Q Okay. What was going through your mind at that point? What were you thinking?  
30 A I was thinking that I'm gonna get in really big trouble.
- 31 Q Where did the knife go at that point?  
32 A On the floor (undistinguishable).
- 33 Q Is it still there?

- 1 A No. Um,...
- 2 Q Where is it now?
- 3 A In my backpack.
- 4 Q And that backpack is...?
- 5 A My backpack. In my property.
- 6 Q Oh, at the, from the hospital.
- 7 A Yeah.
- 8 Q Okay. All right.
- 9
- 10 Q (King): What about the clothes that you were wearing?
- 11 A What?
- 12 Q The clothes that you were wearing? I'm guessing if you were trying to help him out, they
- 13 must've had some blood on them and stuff. Did you try cleaning those or...?
- 14 A Mm...no.
- 15 Q What'd you do with the clothing? Did you change or...?
- 16 A No, I went to bed with the clothes on.
- 17 Q Are they the same ones in your property or...?
- 18 A No.
- 19 Q So what'd you do with them then?
- 20 A (undistinguishable) they're on my floor. In my room.
- 21 Q Okay.
- 22 A Yeah.
- 23 Q (Simper): What color, do you remember what color of clothes they were?
- 24 A Um...black tank top with a purple blouse, (undistinguishable) and I was wearing
- 25 black...Carharts (sounds like).
- 26 Q Okay. So you said after this all happened, you drank some more. And you think you went
- 27 to bed. What time did you wake up this morning?
- 28 A 12:30 (sounds like).
- 29 Q Oh, this afternoon?
- 30 A Yeah.
- 31 Q Okay. What'd you do when you woke up?
- 32 A Woke up, smoked a cigarette, (undistinguishable) I think I called crisis line, I don't
- 33 remember...oh, I checked my messages. Checked my messages. Tried to use John's
- 34 phone, because there's no reception at the house. But, um, I used the...I used

- 1 the...cordless phone, called the crisis line. I know I called from...Lynn, I mean, I called  
2 crisis line again. And they put me through to Lynn. I told her what happened.
- 3 Q Did she encourage you to do anything?  
4 A Told me to go to the hospital.
- 5 Q And did you?  
6 A No.
- 7 Q What did you do at that...  
8 A Not right away, I didn't. Huh?
- 9 Q What'd you do at that, after that...the phone call?  
10 A The phone call...(undistinguishable) and, um, took a shower. I took a shower first,  
11 oh...(undistinguishable). Drank some more. And, uh,...then I went to a AA meeting.
- 12 Q And how'd you get there?  
13 A I drove his car.
- 14 Q Okay. And after the AA meeting?  
15 A I went to the hospital.
- 16 Q Okay.  
17 A Uh, people at the AA meeting told me to go to the hospital.
- 18 Q Did you say anything at the AA meeting about what happened?  
19 A Hm mm.
- 20 Q No? Okay. What, what were you thinking about this whole...thing that had transpired the  
21 night before? Were you trying to process this?  
22 A Process...(undistinguishable) I feel terrible (sounds like) what it was so I can, I can  
23 (undistinguishable) deeply if I just (undistinguishable) (whispering). I can't believe it. I  
24 don't understand. I don't understand. I don't understand.
- 25 Q So when you asked him if he wanted to be tied up...  
26 A Yeah.
- 27 Q What was your intent in tying him up?  
28 A Killing him. I don't know. I don't understand. I,...I'm sorry.
- 29 Q Is that what you wanted to do?  
30 A Oh, I,...I don't know. I don't, I don't know. I don't know.
- 31 Q (King): What were your feelings toward him at that point?  
32 A Contempt.
- 33 Q For what?  
34 A For...because I didn't want him (undistinguishable) trapping me in the house and...

- 1 Q And why do you think he was gonna do that?  
2 A I felt trapped.
- 3 Q (Simper): Did he try to get out of the house?  
4 A No.
- 5 Q Are you sure?  
6 A Mm hmm.
- 7 Q There's a lot of blood downstairs.  
8 A Mm hmm. He was trying to stop the bleeding.
- 9 Q And there was blood on the door. Downstairs.  
10 A Yeah.
- 11 Q Why is that?  
12 A Um,...he was trying to...stop me...from cutting him.
- 13 Q So aside from the initial cut upstairs, did...  
14 A He was trying to take the knife away, because I was following him around  
15 (undistinguishable)
- 16 Q Aside from cutting him upstairs, did you cut him anywhere else in the house?  
17 A Uh,...no. Yeah. Yeah, in the...I think near the door. He was trying to take the knife away  
18 from me. And, uh, I cut, I cut his hand and his, uh, wrist. And I just...went like that so  
19 that he wouldn't take the knife away from me.
- 20 Q (King): and what was he saying to you?  
21 A He was saying...stop.
- 22 Q (Simper): And why didn't you stop?  
23 A Because I thought he was gonna...I don't know (whispering). I don't know why  
24 I,...fucking paxil.
- 25 Q So aside from cutting him upstairs and down by the door downstairs, did you cut him  
26 anywhere else?  
27 A (no verbal response)
- 28 Q (King): And where was it again on his body that you remember cutting him?  
29 A On the wrist.
- 30 Q And then where else did you say earlier upstairs?  
31 A That's it. He went, he went into the bathroom...tried to stop the bleeding.
- 32 Q (Simper): did he ever pick up the phone?  
33 A No.
- 34 Q Did he ever call for help?

- 1 A Huh uhh. (sounds like).
- 2 Q Did he ever cry for help?  
3 A (undistinguishable)
- 4 Q (King): Later that night, when you, before you put the cord around his throat, were you  
5 guys both sleeping in the same bed?  
6 A Sleeping?
- 7 Q Or were you laying in his bed?  
8 A I was laying in his bed when...
- 9 Q And was he asleep at the time or...?  
10 A No. No.
- 11 Q Was he talking to you still?  
12 A Huh uhh. He was telling me to leave and go to bed (sounds like).
- 13 Q And when you put the cord around his throat, did he do anything or...?  
14 A No.
- 15 Q I mean, did he see you doing it or...?  
16 A No.
- 17 Q So was his head turned away from you then?  
18 A (no verbal response)
- 19 Q And when you did it, what, what happened?  
20 A Some...choking (sounds like).
- 21 Q What do you mean he was joking?  
22 A He was choking.
- 23 Q Oh, okay. So was he grabbing at you at all?  
24 A No.
- 25 Q Was he trying to grab the cord?  
26 A (no verbal response)
- 27 Q (Simper): How did you know he was dead?  
28 A He stopped trying to breath (sounds like).
- 29 Q How did you know that?  
30 A He wasn't breathing.
- 31 Q So when you woke up, did you go check on him this morning?  
32 A (no verbal response)
- 33 Q What did you do?

1 A Um,...(undistinguishable)...I went online. Um,...

2 Q What'd you surf online?

3 A What did I surf online? Nothing. I just went to...random...like PIN numbers, stuff and I  
4 couldn't get into his accounts.

5 Q PIN numbers for what?

6 A (undistinguishable)

7 Q Why'd you want that?

8 A I don't know. I was thinking about running. But,...um,...

9 Q How much money were you able to get?

10 A None (sounds like). Somebody gave me 11 bucks at the AA meeting.

11 Q What about the money out of his wallet?

12 A He didn't have any money.

13 Q He didn't?

14 A No.

15 Q Okay.  
16

17 Q (King): Did you check?

18 A Mm hmm

19 Q What'd his wallet look like?

20 A It's brown.

21 Q Where'd you leave it at after you were done looking?

22 A Put it in the hallway.

23 Q And where was he laying at when you left?

24 A Um,...on the...walk in...he was basically dead on the left side (sounds like).

25 Q On the floor or on the bed?

26 A On the bed.

27 Q When was he laying on the floor?

28 A Hmm?

29 Q Was he laying on the floor at all?

30 A Oh, one time, yeah.

31 Q When was that?

32 A I think that's, uh, when I cut him. I think that's when I cut him. He was laying on the  
33 floor.

- 1 Q So was that earlier in the day? Or was that toward the end of the night?  
2 A (undistinguishable)
- 3 Q (Simper): So when you were tying him up...um,...was he clothed?  
4 A No.
- 5 Q Were you clothed?  
6 A Yes.
- 7 Q Okay. And were you guys in the act of, uh,...any sexual activity at that point, aside from  
8 you just tying him up?  
9 A No.
- 10 Q Okay.  
11 A I think he put his clothes on, after he went downstairs.
- 12 Q (King): Is that after you cut him the first time?  
13 A (no verbal response)
- 14 Q (Simper): So when you, when you get, make those motions the first time with the  
15 knife...how many times did you cut him that first...time?  
16 A Five or six.
- 17 Q Okay. And at any other time did you cut his throat again?  
18 A I don't think so.
- 19 Q So why didn't you run?  
20 A I...don't know. Don't (undistinguishable) money.
- 21 Q How angry were you at him?  
22 A I wasn't.
- 23 Q Describe, if it wasn't anger, describe the feeling.  
24 A Nothing. I feel nothing on this medication. I don't, I don't feel like, I don't...all I feel is,  
25 uh,...feel numb. I feel numb.
- 26 Q (King): Earlier though you said you felt a certain way about the things that he was doing  
27 to you.  
28 A Yeah.
- 29 Q Can you describe that?  
30 A Contempt.
- 31 Q And why do you think that?  
32 A This medication makes me like, makes me really....aggressive. And, uh,...very irrational  
33 (sounds like). I have bad, very bad dreams (sounds like) too.
- 34 Q (Simper): But, let's be honest here.

- 1 A It's like explosive (undistinguishable)
- 2 Q Put yourself, you say you took this medicine about a month ago?  
3 A (no verbal response)
- 4 Q So let's push you, let's go back a month. Okay? Say you had moved in with...with him  
5 without that medication in your system.  
6 A I wouldn't. I don't think I would.
- 7 Q Would what?  
8 A I don't think I would've moved in with him. I think I would've called  
9 (undistinguishable). (undistinguishable) the medication's (undistinguishable).
- 10 Q Okay.  
11 A (undistinguishable).
- 12 Q What's that?  
13 A He should keep (undistinguishable) off of it.
- 14 Q (King): When's the last time you took it?  
15 A This morning.
- 16 Q And did you take it the day before?  
17 A Mm hmm. I did.
- 18 Q (Simper): Well, let's look at your...  
19 A Because I get, I, I get really like...(undistinguishable) bad and...
- 20 Q Let's look at your arms. I see some bruises there.  
21 A Mm hmm
- 22 Q And some scratches.  
23 A Mm hmm
- 24 Q Can you describe where those came from?  
25 A I believe this is from...him trying to take the knife away from me. (undistinguishable) uh,  
26 he was trying to take the knife away from me.
- 27 Q Okay. When you woke up this morning, did you at any point, attempt to hide or conceal  
28 any evidence?  
29 A No.
- 30 Q Did it cross your mind to?  
31 A No.
- 32 Q (King): What were your thoughts then in the morning?  
33 A (undistinguishable)

- 1 Q (Simper): On your floor in your bedroom, I saw that, uh,...horse riding, uh, thing, with  
2 the pink handle. What's that for?  
3 A It's for, um,...it's for playing. To play for, uh, sexual play.
- 4 Q Okay. Was that used at all last night?  
5 A Um,...
- 6 Q No?  
7
- 8 Q (King): Was that yours or his?  
9 A It's mine.
- 10 Q (Simper): So aside from him, uh, you said he touched your breasts and licked you. Aside  
11 from...uh, and...just, I don't mean to be vulgar here. But, when you say...  
12 A (undistinguishable) can I have a cigarette?
- 13 Q Gonna try and track one down for you in a minute. Okay?  
14 A Mm hmm
- 15 Q Can't promise you, because I don't smoke and he doesn't smoke. But, if I can...  
16 A In my property...
- 17 Q Oh, then probably make that happen. Okay? You said he licked you. I don't mean to be  
18 vulgar, but I just want to make sure that we're on the same page here. Can you describe  
19 where he licked you?  
20 A On the, uh,...on the, uh,...clitoris and...
- 21 Q Okay.  
22 A ...my...
- 23 Q And aside from...  
24 A ...(undistinguishable)
- 25 Q ...aside from that oral sex, did you guys have intercourse?  
26 A (no verbal response)
- 27 Q No?  
28 A No.
- 29 Q You said you gave him oral sex though.  
30 A (no verbal response)
- 31 Q Okay. Aside from that, was there any other sexual activity?  
32 A No.
- 33 Q Okay. Is there anything else that you're, you're thinking of right now that you want to  
34 talk about to us?

- 1 A So...can I be taken off, um, tapering off this medication (sounds like)?
- 2 Q Yeah, neither one of us are medication pros. I don't...
- 3
- 4 Q (King): But, we can put you in touch with somebody that will.
- 5
- 6 Q (Simper): But, unfortunately, I, I don't even know the first thing about medication or  
7 how...so wrong person to ask, I'm sorry. I just don't have the answer for you. Um,...how  
8 do you feel right now?
- 9 A (undistinguishable)
- 10 Q How do you feel about the incident that happened last night?
- 11 A Feels like a nightmare. A nightmare. Horror flick (sounds like). Except I can't feel...this  
12 fucking medication, it's making me not (undistinguishable) and not feeling. I can't feel.  
13 (undistinguishable) feel (whispering).
- 14 Q Did you call anybody and tell them about what happened last night? Besides the crisis  
15 line?
- 16 A No.
- 17 Q Detective King, you have anything else you want to ask?
- 18
- 19 Q (King): Yeah, the...
- 20 A I can't feel.
- 21 Q So you drove his silver Hyundai around?
- 22 A (no verbal response)
- 23 Q When you parked it downtown, what's inside of it that belongs to you?
- 24 A Nothing.
- 25 Q It's all his stuff in there?
- 26 A (no verbal response)
- 27 Q Did you take anything out of the vehicle?
- 28 A No.
- 29 Q Did anybody else, like friends or anything ride around in it with you?
- 30 A No.
- 31 Q Um,...back to the bedroom next to the side of the bed that he was on, there was a large  
32 pool of blood. Did he lay there for a while?
- 33 A No.
- 34 Q Did he pass out?

1 A No.

2 Q Or he just lay there?

3 A Lay there

4 Q And that was right after you cut him the first time?

5 A Yeah.

6 Q So describe that to me.

7 A (no verbal response)

8 Q Was he laying on the floor when you cut him?

9 A I don't remember.

10 Q (Simper): Is there anything in your property right now in your bags that's with you, is  
11 there anything that belongs to him in there?

12 A Yeah, there are a pack of, uh,...cloves.

13 Q Well, like a pack of smo-, cigarettes, like smoking cloves?

14 A Yeah. But, I don't smoke cloves.

15 Q What else is his?

16 A That's it.

17 Q Okay. Detective King, do you have anything else you can think of?

18

19 Q (King): So you're sure the knife is in your backpack?

20 A (no verbal response)

21 Q And how come you took it with you?

22 A So I can open my veins.

23 Q What do you mean you wanted to open up your veins?

24 A I wanted to kill myself...want to kill myself.

25 Q Do you still feel that way?

26 A Yes.

27 Q Okay. All right. Well, is there anything else before we, uh,...stop our interview, is there  
28 anything else you want to talk about right now?

29 A Um,...no.

30 Q Okay. We can go ahead and conclude this statement. The time now is 0131 hours.

31

32

33 Ending Time: 0131



TRICOMO, LIA (DOB: 11/24/1985 ID: 6364)

Sep 09, 2013 Mon 09:22 AM

CC Psychiatric evaluation MN

HPI PAST PSYCHIATRIC HOSPITALIZATIONS: BHR three times, last time 2011. Also been to WSH as well.  
PAST OUTPATIENT TREATMENT: Was at BHR, saw Dr Truschel  
PAST PSYCHIATRIC MEDICATIONS: Paxil, made her want to kill people, had horrible withdrawal. Risperdal, Prozac, Depakote, Seroquel, Trazodone all caused horrible side effects.  
SUICIDE ATTEMPTS: Tired to cut neck in early August here in jail. Made lots of attempts six times seriously, different each time. Some other attempts "im just being emotional." Overdose, hanging. Has also cut wrists "just for fun." At times feels like killing herself, with plans, wants to give meds a chance, won't act on plans. Thinks of hanging herself with sheets. No homicidal ideation but fears in anger she could kill someone. Has "happened before." MH problems started in 2010.  
CURRENT SYMPTOMS: Feeling depressed, having visions, anxious. Been in here for four months without meds. Tried to chew arm open, had lots of hallucinations withdrawing from Paxil, not as bad now.

ROS MOOD: "tired and spaced out" today because she keeps herself on night schedule because the day staff is "mean," afraid of "messing up." Is in the "hole." Hard time not losing her temper. Stays up at night, so will be tired and "mellow" during day. Mood is "anxious," has court today. In past highs lasted longest two days, would have too much energy, be too happy, engage in impulsive behaviors, need much less sleep. Lows can last months, with anhedonia, low energy and motivation, sleep alot. Can get very emotional if gets heart broken, loses job, and that has lead to suicide attempt.  
SLEEP: Sleeping during day, lots  
ANXIETY: Always anxious, but is also set off by the officers and her issues with how they treat her. Trying hard "not to think about what happened." Is very scared of hallucinations she has of people involved with the incident that lead to her arrest. Has nightmares. Seeing the people in her cell (that aren't there), makes her feel suicidal, not eat for days. Feels at times that "this has happened" before. Relives also past car accident. Hypervigilant, easily angered.  
THOUGHT DISORDER SX: see anxiety sx. Sees and hears people involved with the incident, sees blood on hands and smells blood on hands.  
OTHER: Issues with abandonment.

PMH CURRENT: denies  
PAST: asthma in past, allergic to peanuts, thinks that was the real reason for the breathing problems in past.  
SURGICAL HX: had wisdom teeth removed  
HOSPITALIZATIONS: for asthma  
PREGNANCY HX: no chance she is pregnant, discussed avoiding unplanned pregnancy because some meds are teratogenic.

SH CHILDHOOD: "Loving." Parents were married until she was an adult. Has one sister. In contact with family.  
TRAUMA: No other traumas besides incident that lead to arrest, other than hitting a parked car at 55mph. No childhood trauma, trouble started after parents divorced when she was 21  
RELATIONSHIP: Single, never married, no kids. Was living with room mates before arrest.  
SUBSTANCES: Was using alcohol, Paxil made her crave alcohol, would get headache if did not drink. Drank "more than nine" in a few hours for about a month. Before that only drank a

Printed By: Charge Nurse, RN 1/6/2015 10:04:22 AM

couple of drinks a day. "I'll never drink again." Hx of marajuana use, but not problematic.  
EDUCATION: Graduated college with bachelors degree.  
EMPLOYMENT: Was working at Captial Playhouse, was a pit musician, was a soloist. This was a side job, used to do it for a living, got in car accident. Things 'got very difficult after that." On disability since 2011.

FH PSYCHIATRIC: Denies  
SUBSTANCES: Mom's dad died from cirrhosis from drinking alcohol.

Allergies symbicort, peanuts

Meds PAXIL TABLET 20 MG, 1 tab AM

PE

A/P APPEARANCE/BEHAVIOR: white scrubs, chains, blood shot eyes. Guarded, did not seem to trust our info would not end up in court.  
SPEECH: Normal rate, rhythm and volume  
MOOD/AFFECT: depressed, at times incongruent smiling  
THOUGHT PROCESS/CONTENT: endorsed auditory and visual hallucinations, linear logical future oriented  
SUICIDAL IDEATION/HOMICIDAL IDEATION: suicidal ideation and plan, no intent, no homicidal ideation  
INSIGHT/JUDGEMENT: fair  
COGNITION: intact

ASSESSMENT: Read WSH forensic eval after meeting with client. She was dx with major depressive disorder there, but will err on side of caution, particularly as she describes problems with Paxil and historically being on mood stabilizers with antidepressants for the most part. The zyprexa could also help with the very vivid flashbacks and impulsivity, anger issues. Hallucinations seem tied to flashbacks, but will watch for additional evidence of psychosis.

DIAGNOSIS:  
# POSTTRAUMATIC STRESS DIS (309.81):  
# BORDERLINE PERSONALITY (301.83): and antisocial personality traits  
# BIPOLAR DISORDER UNSPEC (296.80): vs major depressive disorder, recurrent

DISCONTINUE: PAXIL TABLET 20 MG.  
PRESCRIBE: OLANZAPINE 15 MG, one half at hs for four nights then one at hs, # 30, RF: 1.  
Discussed impressions and treatment recommendations. Reviewed risks and benefits of the medication. Verbalizes an understanding and consents to take medication. She knows zyprexa could increase wt, blood sugar, lipids, cause movt disorders, etc.

Before starting zyprexa or within first two days of starting, get fasting comp metabolic panel, CBC, lipids, HgbA1C

See me in two weeks.

TRICOMO, LIA (DOB: 11/24/1985 ID: 6364)  
Coded: Medium Complexity > 99203

Sep 09, 2013 Mon 09:22 AM

*Electronically Signed By: Marne Nelson, NP*

Printed By: Charge Nurse, RN 1/6/2015 10:04:22 AM

Amazing Charts

Page 3 of 3

The information on this page is confidential.  
Any release of this information requires the written authorization of the patient listed above.

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

IN RE THE PERSONAL  
RESTRAINT PETITION OF:

LIA Y. TRICOMO,

Petitioner.

) CAUSE NO. 51741-8-II

) EXHIBIT 15

EXHIBIT 15

Selected Department of Corrections Psych Records

EXHIBIT 15

Law Office of Neil Fox, PLLC  
2125 Western Ave. Ste. 330  
Seattle, Washington 98121  
206-728-5440



OFFENDER I.D. DATA: **TRICOMO, LIA**  
(Name, DOC#, DOB) **348594 11/24/1985**

**PSYCHIATRIC PROGRESS NOTE**

DATE	FACILITY/UNIT
04/19/2018	WCCW-MSU

**Allergies:** symbicort

**Interim General History (comment on function):**

Patient last seen 1/26/18, she was not taking chlorpromazine regularly with resultant increase in paranoid thoughts and irritability. She was afraid it was causing her to have a weak grip, but she was working on hand exercises. She was going to try taking the chlorpromazine regularly. It has since been discontinued as she was not taking it.

**Interim Medical and Psychiatric History (include lab results):**

She is feeling very down, the break up of a "fantasy" relationship has hit her hard, as is the amount of time she has to do. She is feeling hopeless at times, but is very focussed on not losing all the things she has gained by working hard, particularly her guitar and participating as a musician in programs, as well as having a means to listen to music. She uses meditation several times a day to "get away" from the feelings she is experiencing, but still finds much of the day is merely painful. We discussed at length her history of being on paroxetine, which she recalls very positively in terms of decreased depression, but admits it does give her feelings of wanting to kill people. Well before her crime when she was suicidal and depressed and sent by BHR to WSH, they put her on a combination of paroxetine and VPA. When on that combination she didn't have thoughts of wanting to kill others, but when she got out she stopped the VPA as it was causing GI upset. Without the VPA she had cravings to drink on paroxetine alone, and did drink heavily. So it is hard to know if without alcohol the paroxetine would have the same effect. She understands that we are all concerned about her depression, but also don't want her to harm others.

**Mental Status Examination (MSE):**

- Level of Consciousness:  Alert & Oriented     Somnolent/sedated     Confused/disoriented  
 Other:
- Behavior/Attitude/Appearance:  Unremarkable  
 Other:
- Psychomotor:  Within normal limits  
 Agitated     Hyperactive     Fidgety     Retardation  
 Other:
- Speech:  Within normal limits  
 Slowed     Lags/latency     Pressured     Articulation abnormal  
 Other:
- Affect/Mood:  Within normal limits     Anxious     Sad  
 Tearful     Excited     Flat     Labile/irritable  
 Other:
- Thought:  Within normal limits  
 Thought disorder     Racing     Ruminative     Perseverative  
 Other:

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



OFFENDER I.D. DATA: **TRICOMO, LIA**  
(Name, DOC#, DOB) **348594 11/24/1985**

**PSYCHIATRIC PROGRESS NOTE**

DATE	FACILITY/UNIT
04/19/2018	WCCW-MSU

- Content:  Within normal limits  Delusional  Obsessions  
 Guilt  Ideas of reference  Insertion/broadcasting  
 Other:
- Hallucinations:  None  Auditory  
 Command:  Responding to internal stimuli  Visual  
 Other:
- Cognitive:  Within normal limits  Poor memory  
 Poor attention/concentration  Impulse dyscontrol  
 Other:
- Vegetative symptoms:  None  Increased sleep  Decreased sleep  
 Increased appetite  Decreased appetite  Increased energy  Decreased energy  
 Other:

Comment on vegetative symptoms:

Homicidal/Suicidal Ideation Assessment: no report of self harm or suicidal thoughts, but feels hopeless at times

MSE Comments:

**Diagnoses:**

- Mixed Personality Disorder
- Cyclothymia

**Response to Treatment (include adverse or side effects):**

increased depression in setting of loss of relationship

**Plan:**

- Current medication(s): none
- No medication change
- Medication change (specify):

Target symptoms:

Referral/Follow-up: 4 weeks to discuss medication again.

Other (labs, etc.): Discussed situation with PT, who will meet with the patient to discuss how we would respond if she does have homicidal thoughts on the paroxetine.

Kathryn Hall, MD, psychiatrist 4  
PRACTITIONER'S PRINTED NAME AND TITLE

SIGNATURE

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



OFFENDER I.D. DATA: **TRICOMO, LIA**  
(Name, DOC#, DOB) **348594 11/24/1985**

**PSYCHIATRIC PROGRESS NOTE**

DATE	FACILITY/UNIT
04/19/2018	WCCW-MSU

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



OFFENDER I.D. DATA: TRICOMO, LIA
(Name, DDC#, DDB) 348594 11/24/1985

PSYCHIATRIC PROGRESS NOTE

Table with 2 columns: DATE (06/18/2018) and FACILITY/UNIT (WCCW-COA)

Allergies: symbicort

Interim General History (comment on function):

Patient last seen 5/9/18, she was feeling depressed over the breakup of a "fantasy" relationship, and now is facing the reality of the incarceration. She asked to resume paroxetine, despite acknowledging that it made her want to kill people but decreased depression.

Interim Medical and Psychiatric History (include lab results):

We shared our concerns that she has an underlying bipolar diathesis and that paroxetine had possibly triggered an irritable manic state, leading to her crime. Despite having reported episodes of elevated mood and increased energy, increased goal directed behavior, she now denies any history of such symptoms.

Mental Status Examination (MSE):

- Level of Consciousness: [X] Alert & Oriented, [ ] Somnolent/sedated, [ ] Confused/disoriented
Behavior/Attitude/Appearance: [X] Unremarkable
Psychomotor: [X] Within normal limits, [ ] Agitated, [ ] Hyperactive, [ ] Fidgety, [ ] Retardation
Speech: [X] Within normal limits, [ ] Slowed, [ ] Lags/latency, [ ] Pressured, [ ] Articulation abnormal
Affect/Mood: [ ] Within normal limits, [ ] Anxious, [X] Sad, [ ] Tearful, [ ] Excited, [X] Flat, [ ] Labile/irritable
Thought: [X] Within normal limits, [ ] Thought disorder, [ ] Racing, [ ] Ruminative, [ ] Perseverative
Content: [X] Within normal limits, [ ] Delusional, [ ] Obsessions, [ ] Guilt, [ ] Ideas of reference, [ ] Insertion/broadcasting

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OFFENDER I.D. DATA: **TRICOMO, LIA**  
(Name, DOC#, DOB) **348594 11/24/1985**

**PSYCHIATRIC PROGRESS NOTE**

DATE	FACILITY/UNIT
06/18/2018	WCCW-COA

- Hallucinations:  None  Auditory  
 Command:  Responding to internal stimuli  Visual  
 Other:
- Cognitive:  Within normal limits  Poor memory  
 Poor attention/concentration  Impulse dyscontrol  
 Other:
- Vegetative symptoms:  None  Increased sleep  Decreased sleep  
 Increased appetite  Decreased appetite  Increased energy  Decreased energy  
 Other:

Comment on vegetative symptoms:

Homicidal/Suicidal Ideation Assessment: no report of self harm or suicidal thoughts, but feels hopeless at times

MSE Comments:

**Diagnoses:**

Mixed Personality Disorder  
Cyclothymia

**Response to Treatment (include adverse or side effects):**

reporting ongoing depressed mood. concern remains triggering mania with irritability/homicidall ideation

**Plan:**

- Current medication(s): none  
 No medication change  
 Medication change (specify):

Target symptoms:

Referral/Follow-up: 6 weeks

Other (labs, etc.):

Kathryn Hall, MD, psychiatrist 4  
PRACTITIONER'S PRINTED NAME AND TITLE

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

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

IN RE THE PERSONAL )  
RESTRAINT PETITION OF: ) CAUSE NO. 51741-8-II  
LIA Y. TRICOMO, ) EXHIBIT 16  
Petitioner. )

EXHIBIT 16

Peter Andrew Alkins, Victim Impact Statement (from superior court file)

State v. Tricomo

Case Number 13-1-00655-7

FILED  
SUPERIOR COURT  
THURSTON COUNTY, WA

2015 JAN 28 AM 11:40

### Victim Impact Statement

Victim: John Philip Alkins

Submitted: Peter Andrew Alkins

01-18-2015

Your Honorable Judge Tabor,

My name is Peter Andrew Alkins, older brother of John Philip Alkins.

#### Impact of Crime

It was on the evening of April 30<sup>th</sup> 2013, while cleaning up the kitchen with the eleven o'clock news in the background; I realized the breaking news story was about my brother John, and that he had been brutally attacked and murdered. I rewound the DVR to view it again and in disbelief went into shock and woke up Rhonda and called my sister and a few close friends. Our lives had been changed forever. We waited all night for the deputies and coroner to arrive. It was now dawn. We were briefed and told not to go near the crime scene, until it had been cleaned up because it was the most gruesome and bloody crime scene they had ever encountered in their professional careers.

I had just spoken with John on several occasions recently, before his murder, as he was concerned about my losing my job earlier that week, after fifteen years, because of, a recent diagnosis of Parkinson's disease. He reassured me that we are in a new stage of life now and there was plenty of other opportunities to explore, and music to create. He then mentioned a temporary roommate situation, which he was helping out a violinist who needed a place to stay for a couple of weeks and practice to prepare for an audition with the Spokane Symphony. He seemed happy to help and was excited about the musical collaborations. He inspired me to focus on creating new music opportunities, and not pining over my lost career due to health changes. After all, we had been creating professional music together since 1974 when I transferred to TESC as a major in audio engineering and acoustics and have been involved as an engineer/producer for most of John's productions for over 40 years.

Those good times with my brother were soon to end. Then this nightmare happens to all of us: My Father, a retired Episcopal Reverend now at age 92, myself, Rhonda, my daughter Kelly, John's son Miles, Miles' family, my sister Mary, and her family,

and all our friends and their family's who have been so devastated by this heinous crime.

How could it be, that my younger brother, who was such a gentle spirit and talented musician, who always helped people, and couldn't hurt any creature, be taken in such a violent manner? The prolonged suffering, torturing, taunting, and the gruesomeness have given me nightmares for twenty months, and they continue today, and for how long? I can't sleep for more than a few hours nightly, and have been in counseling to help cope with the loss and horror of it all. The images in my minds eye flash back on how he was attacked and suffered so much, and for so long. I avoid or pre-filter most television and news programs to minimize my exposure to seeing violence.

After the crime scene was cleared, I began the clean up and moved all of his belongings out for sale or storage. The task was gruesome, large patches of carpet were missing to remove bloodstains. In areas near the doors, the wood was removed because it was so blood soaked, as my brother tried to escape the violence. The stench of death lingered. With Lia Tricomo's confession, describing her version of events, the weeks of sorting and moving his belongings out of the house, the scenario just played over and over in my head, as it still does today.

The stress of the crime and legal proceedings has exasperated my Parkinson's disease, as noted in increased severity of my tremors. My doctors have increased some of my Parkinson's medications, and prescribed anti-anxiety medications to help me cope with the tremendous grief and feelings of outrage, despair and hopelessness.

John was not only my brother, but also my best friend. We talked several times each week, and I miss those caring calls so much. He was a dedicated father to Miles, and it hurts me so much to see Miles lose his father at such a critical time of his development. Miles also lost his wonderful waterfront home in which he grew up in on Eld Inlet, and enjoyed so much quality time with his father on the beach. Seeing John's only son Miles suffer with overwhelming sadness, and develop difficulties in high school because of how his life was changed forever on that fateful night in April of 2013. Having to deal with students whispering behind his back about bits of sensationalist, often incorrect information The Olympian and other media sources reported. To make matters worse, we were advised not to speak to the media and tell our story as it may affect the trial. Our story couldn't be told until after the legal proceedings are over, and in the absence of our story, the rumor mill has caused so much damage to my brother's reputation, and has been so hurtful to our family.

John will never get to see Miles grow up and embrace his dreams. Never compose another note of beautiful music. Never be able to share life's stories, or laugh with family and friends.

The long-term effect on Tricomo's murder of my brother is, that now my family lives with fear. Fear, that an unexpected act of violence will harm us. That she, or other

violent criminals might hurt us, or our children without any warning, perhaps while we are trying to help a stranger, or just walking down the street, or sleeping in our bedroom at night. Her violent acts will never leave our memories of John and because of that, leaves fear and worry in our hearts....forever.

At present, Lia's family and family friends have launched an all out smear campaign to rewrite history, and spread blatant, and disturbing false allegations that are purposely meant to skew public opinion, and this court. One such example, is attorney Elaine Thomas claiming that John was a sexual predator and was terminated from BHR for sexual misconduct. Those are simply lies. They have also lashed out against the legal system, including the defense and prosecution, as well as the judge. This is only a spiteful attempt to hide the truth that the defendant is a manipulating, calculated, cold-blooded killer, that showed no mercy or remorse, nor accepts any responsibility of the crime, and should be sentenced accordingly and harshly, to the fullest extent of the law.

### Financial Impact

While the emotional impact and personal loss has been so devastating, the financial consequences should be also considered. There were funeral and celebration of life expenses, a memorial marker, the cost of hiring an attorney to help the family navigate and understand this complex legal system that was cast upon us. There were legal and administration expenses incurred by the probate process. Counseling services were also needed to cope with the overwhelming grief that occurs from a violent murder of a beloved family member. The expenses incurred from moving and cleaning John's household, not to mention the damage that was done to John's landlord's property, and the stigma of the violent crime that occurred in that quaint waterfront home. There was a vast amount of time over the last twenty months involved with court appearances, and scheduled meetings with the prosecutors, which has required long distance travel for some of our family members, and time taken off work for others.

### Sentencing

In sentencing the defendant, Your Honor, I would like you to impose the maximum penalty allowed by the sentencing guidelines, of twenty-nine years and 9 months or greater. This was a particularly violent and brutal crime, the rampage went on for hours and hours. John suffered and was tortured for hours and hours. The defendant had multiple opportunities to change the course of history, but chose to languish in her bizarre, violent and deliberate assaults, and prevented my brother from escaping and finding help. I will always be haunted by the notion that my brother John was eventually strangled to death by an extension cord, and had his hands between the cord and his neck in a desperate and final last chance to save himself. The defendant has a manipulative, violent history and the maximum time imposed would be a just punishment for such a particularly senseless, violent and brutal and bizarre crime. She has manipulated the system long enough, she has played the poor me card for far too long. She has showed no mercy or remorse, nor accepts any

responsibility of the crime, as evident by her taking the Alford Plea to avoid pleading guilty.

John was not her first victim of violence. Before she murdered John, she has assaulted two police officers, assaulted her sister, held a knife to her own mother's throat, and threatened to kill her boyfriend with a hatchet. In addition she has made threatening jesters to mental health evaluators visiting her in jail by asking them if "they were afraid to work in a jail", and then slipped her hands through the handcuffs. There will be no rehabilitation during her prison time, as her violent history suggests, she is at high risk to commit other extreme violence and the community would be safer with her incarcerated for the maximum amount of time permitted by law of twenty-nine years and nine months, or longer if you can include the aggravating circumstances.

In summary, my brother John tried to help Tricomo, with music and a place to stay while she was homeless. Because of her evil intentions she killed him in cold-blooded murder. The plea deal was her bargain, she effectively gets away with first-degree murder and the high end of the sentence scale is still too lenient, especially with all the aggravators. No matter what sentence she receives, her family and friends still have an opportunity to write to her and speak to her via phone calls as well as personal visits. *Our family will never have that opportunity to ever see or hear from John again, forever.*

I will leave this court today to visit my elderly father whom will soon be 93. It is my prayer that he will know with certainty that justice was served by not allowing her to hurt someone else, ever.

Sincerely,

A handwritten signature in cursive script that reads "Peter Andrew Alkins". The signature is written in dark ink and is positioned above the printed name.

Peter Andrew Alkins

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

IN RE THE PERSONAL  
RESTRAINT PETITION OF:

LIA Y. TRICOMO,

Petitioner.

) CAUSE NO. 51741-8-II

) EXHIBIT 17

EXHIBIT 17

Dr. David Dixon – Resume (from Internet)  
C.V. (from trial counsel file)

EXHIBIT 17

Law Office of Neil Fox, PLLC  
2125 Western Ave. Ste. 330  
Seattle, Washington 98121  
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Phone: (425) 260-5530

Office: 2105 112th Avenue NE, Suite 200, Bellevue, WA 98004-2945

Web: [www.NWForensicPsychology.com](http://www.NWForensicPsychology.com)

### Education

Ph.D. Clinical Psychology: APA-approved  
California School of Professional Psychology  
Berkeley, California, 1997-1982

M.S. Psychology, Alcoholism and Substance Abuse  
Washington State University, 1976

B.S. Psychology, Summa Cum Laude, Phi Beta Kappa  
Washington State University 1974

### Licensure and Certification

Licensed Clinical Psychologist #1108, State of Washington, 35 years' experience.

Certificate of Proficiency in Treatment of Alcohol and other Psychoactive Substance Use Disorders #AD003306, granted February 1997.

International Critical Incident Stress Foundation Certification, granted October 1998.

### Clinical Expertise

#### Forensic Psychology Practice, Serving King County and surrounding counties, 1992 to Present

Independent expert witness in predominately criminal felony cases. Deemed an expert in court more than 800 times.

Evaluated and examined approximately 5000 inmates in the two King County Correctional Facilities in Seattle and Kent for the State Superior and Federal District Courts, ongoing.

Consult and evaluate regarding competency, diminished capacity, mitigating circumstances, and insanity.

Consult with Family Courts of the State of Washington, giving second opinion evaluations in parenting and custody cases.

Retained and admitted as an expert in Washington State cases involving personal injury and family law.

### United States Department of Defense, 2010 to Present

Consult and serve as expert witness in cases involving federal and corporate employees.

Assess individuals with high security clearance.


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## Private Practice, 1980 to Present

Clinical Psychology and Behavioral Medicine, Bellevue, WA; Outpatient general clinical and medical psychology. Preferred provider for many HMOs, PPOs, and EAPs; Consulting service to primary care physicians, and 7 inpatient and outpatient alcohol drug treatment programs.

Individual, couple, group psychotherapy and psycho-diagnostic assessment.

Treatment of adolescent and adult alcohol and chemical dependency, ADD/ADHD and depression, Marital and individual psychotherapy, Chronic pain disorder, Sexual dysfunction, Parent/adolescent problems, and Critical Incident Stress Debriefing (CISD).

## Papers and Publications

*Settled Insanity: Conundrums of Forensic Psychology* by David M. Dixon, 2014. Found at [NWForensicPsychology.com](#).

*Psychology in the Courtroom* by David M. Dixon. Found at [NWForensicPsychology.com](#).

*Diminished Capacity* by David M. Dixon. Found at [NWForensicPsychology.com](#).

*Defining Competency to Stand Trial* by David M. Dixon. Found at [NWForensicPsychology.com](#).

*What to Look For in a Forensic Expert* by David M. Dixon. Found at [NWForensicPsychology.com](#).

*Forensic Psychological Evaluation and Assessment: Psychology in the Classroom* by David M. Dixon. Found at [www.CounselingWashington.com](#).

*What's a Parent Like Me Doing With A Kid Like You?* by David M. Dixon, publication pending.

Dixon, D.M. (1982) Prognostic Indices for Predicting Outcome with Inpatient Alcohol Abuse, Doctoral dissertation, California School of Professional Psychology, Berkeley, California.

## Media

Forensic psychology commentary for The Discovery Investigative Channel Wicked Series "Payback".

Forensic psychology commentary on The Colton Harris Moore Story for Japanese TV documentary "The Twelve Most Interesting Stories Around the World in 2010".

## References

Lloyd G. Edwards, Attorney at Law, Bellevue, WA.

Steve Karimi, Attorney at Law, Seattle, WA.

Kris Jensen, [JensenLegal.com](#).

## Prior Teaching Appointments

Bellevue Community College and Shoreline Community College: *Introduction to Counseling and Advanced Counseling of Substance Abuse*.

University of Washington: *Alcohol and Drug Abuse in Medical Practice*.

Seattle Pacific University: *Psycho-pharmacology*.

Overlake Hospital Medical Center: *Alcohol and Drug Abuse in Medical Practice*.

**How helpful is this web page to you?**

not helpful ★ ★ ★ ★ ★ very helpful



SOCIAL NETWORKS

David Dixon, Ph.D.

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Clinical and Forensic Psychologist  
2105 112<sup>th</sup> Ave. NE, Suite 200  
Bellevue, WA 98004-2945

### Licensure and Certifications

- License Clinical Psychologist #1108, State of Washington
- Certificate of Proficiency in Treatment of Alcohol and Other Psychoactive Substance Use Disorders #AD003306, granted 2/1/1997
- International Critical Incident Stress Foundation Certification, granted 10/31/98

### Education

- Ph.D.** Clinical Psychologist: APA approved program California School of Professional Psychology, Berkeley, CA, 1977-1982
- MS** Psychology, Alcoholism and Substance Abuse, Washington State University, Pullman, WA, 1976
- BS** Psychology, Summa Cum Laude, Phi Beta Kappa

### College Experience and Training

**1992 to present: Psychological Forensic Exams and independent expert witness** in felony cases. Evaluation of inmates in the King County Correctional Facility of Kent Regional Justice Center. Consultation regarding competency, diminished capacity and mitigating circumstances.

**1990 to present: Employee Assistance Consulting Psychologist.** Specialty in focus and training in Critical Incident Stress Debriefing for companies, organizations and agencies. Debriefing dealing with natural, accidental, suicidal, homicidal death and violence in the workplace.

**1984 to present: Private Practice:** Clinical Psychology and Behavioral Medicine, Bellevue, Washington. Outpatient general clinical psychology and medical psychology. Individual, couple, group psychotherapy and psycho-diagnostic assessment. Preferred provider for many HMOs, PPOs, and EAPs. Clinical director and supervisor of Northwest Behavioral Medical Group (1984-1990) a private psychological service unit. General mental health and medical psychology practice. Clinical focus: psychological evaluations referred by court and medical community, treatment of adolescent and adult alcohol and chemical dependency (cocaine, marijuana, heroin, and prescription drug abuse), ADD/ADHD and depression. Practice includes marital and individual psychotherapy, chronic pain disorders, sexual dysfunction, parent/adolescent problems, and Critical Incident Stress Debriefing (CISD).

Consulting service to primary care physicians, inpatient and outpatient alcohol drug treatment programs (CareUnit Hospital of Kirkland, Highline-Riverton Hospital, Milam Recovery Center, Residence XII, Snoqualmie Valley Hospital, First Step, Inc. Square One and Chinook Center).

Involved with medical/psychology issues and treatment, case consultation, patient evaluation and staff training. Held Allied staff privilege at Fairfax and Associate staff privilege at the CareUnit Hospital.

**1991 to present: Consultative Examiner, US Office of Disability Insurance, Washington and Idaho.** Providing cognitive and psychological assessment of organic, intellectual and personality factors in Eastern and Western Washington and Idaho.

**1983 to 1984: Psychological Resident, Behavioral Medicine Associates, Bellevue, Washington.** General consulting medical and clinical psychology. Specialty interest areas: alcohol and chemical dependency, adolescent, adult, individual, couple and group psychotherapy, assessment and treatment of chronic pain and disability disorders.

**1977 to 1983: Northern California Psychological Services, San Francisco. Consulting services:** performing psychological and neuropsychological consultations (interview and psychological test battery) for the alcohol and substance abuse rehabilitation units at St. Mary's Hospital and Medical Center, Hayward Vesper Hospital, Merrit Hospital and Doctor's Hospital. Performing individual, couple and group psychotherapy. Workshop delivery and staff in-service training for: East Texas Community Mental Health, Southwest Community Mental Health, Addiction Intervention Motivation System, Mendocino County Mental Health, Moraga School District, and Southwestern School for Behavioral Health Studies at the University of Arizona.

**September 1980 to August 1981: Intern, Department of Psychiatry, US Public Health Service Hospital, San Francisco, California.** Providing consultation to medical service. Diagnosing, assessing and treating general hospital patients with psychiatric complications. Consultation cases included chronic pain, depression, death and dying, confusion, delirium and dementia, toxic and alcohol withdrawal syndrome, hallucination and delusion, suicide attempts, extreme manifestation of anxiety, psychosomatic medicine issues, and sexual deviance. Psychotherapy and emergency psychiatric intervention was provided at patient Community Mental Health Clinic connected with the hospital.

**September 1977 to August 1978: Clinical Psychology Intern, San Francisco General Hospital,** in the general medical clinic, psychiatric and prison wards: staff rounds, consultation to medical and nursing staff, psychological testing and individual psychotherapy.

**November 1976 to September 1977: Chief alcoholism Therapist at Alta Bates Hospital CareUnit, Berkeley California.** Clinical director and administrator of a general hospital inpatient and out-patient alcohol and drug addiction treatment unit. Involved in group, individual and family therapy, videotaped feedback, relaxation therapy, assertiveness and sexuality training, emergency room consultation, education and in-service training for medical and nursing staff.

**1976: "Roving Therapist," *Comprehensive Care Corporation*, Newport Beach, California.** Traveling to twenty-four CareUnit programs through the United States serving as a program consultant and liaison between corporate headquarters and satellite units located in general hospitals. Primary function was delivering direct patient care: group therapy, education, family, marital and individual counseling. Secondary function involved problem solving and troubleshooting on the units, staff relations, interviewing job applicants, in-service training of medical and clinical staff and community presentations.

**1975: Psychologist II, *Cascadia Juvenile Center*, State of Washington.** Master's level position doing psychological evaluations, assessments, and testing of an adolescent population of multiple offenders (sexual and aggressive assaults) referred from all counties in the state for psychological evaluation.

**1975: Addictions counselor Intern, *Alberta Alcoholism and drug Abuse Commission*, Calgary, Alberta, Canada.** Intake assessments, individual counseling, group, marital and family therapy, industrial and court referral work.

**1973 to 1974: Psychology Intern, *Veteran's Administration Hospital*, Alcohol Treatment Program and Neuro-psych Units.** Conducting group therapy, developing videotaped "social skill and assertiveness training" program, and serving as a research assistant.

**1972 to 1973: *Sex Information Center*, Washington State University, Pullman, Washington.** Directing a clinic providing information and counseling to students on birth control, family planning, pregnancy, abortion issues, and sexuality problems.

**1971 to 1972: *Volunteer, Tacoma Crisis Clinic*, Tacoma, Washington,** serving as a crisis phone answerer in a large urban crisis clinic and suicide prevention center.

### Teaching Experience

**1988 to 1992: Bellevue Community College, Bellevue, Washington.** Instructor: Introduction to Counseling" and "Advanced Counseling of Substance Abuse."

**1986 to 1987: Shoreline community college, Seattle, Washington.** Instructor: "Introduction to Counseling" and "Advanced Counseling of Substance Abuse."

**1986: University of Washington Family Medicine Program, Seattle, Washington.** "Alcohol and Drug Abuse in Medical Practice."

**1985: Seattle Pacific University, Seattle Washington,** "Psycho-pharmacology." Overlake Hospital Medical Center, Bellevue, Washington, physician CME, "Alcohol and Drug Abuse in Medical Practice." State of Washington, Children's Services and Bureau of Alcohol and

Substance Abuse (BASA) Instructor of state-wide training seminars on "Adolescent Chemical Dependency: Evaluation and Treatment."

**1984 to 1985: Guest Lecturer, Washington Teen Institute, Washington State.**

**1977 to 1981: Instructor and Chief Therapist, Addiction Intervention Motivating System (AIMS) San Jose and Los Altos, California.** Teaching classes and supervising counselors who led group sessions for an impaired driver program for second offenders in Santa Clara County.

**1976: Instructor, Highline Community College, Seattle Washington "Alcohol and Drug Abuse."**

**1975: Summer School on Alcohol and Drugs, University of Calgary, Calgary, Alberta, Canada.**

**1974 to 1975: US Department of Health, Education and Welfare, College of Idaho, Caldwell, Idaho.**

### Honors and Awards

Teaching Grant: \$9,000.00. National Institute of Alcoholism and Abuse, 1978-1979.

Teaching Grant: \$5,000.00 National Institute of Alcoholism and Alcohol Abuse, 1975-1976

Graduation honors – Washington State University

Phi Beta Kappa

Phi Kappa Phi

Summa cum Laude

Beta Theta fraternity

John Reilly Scholarship – 1974

### Papers and Publications

Dixon, D.M., "*What's a Parent Like Me Doing With Kid Like You?*"; publication pending.

Dixon, D.M., "*Prognostic Indices for Predicting Outcome with Inpatient Alcohol Abuse*," doctoral dissertation, California School of Professional Psychology, Berkeley, California (1982).

Dixon, D.M. "*Forensic Psychological Evaluation and Assessment: Psychology in the Courtroom*," CounselingSeattle.com (2005).

Legal Cases Evaluated and/or Testified

Parties Involved	Number	Type
State v. Anderson	041057031KNT	Animal violation felony
State v. Silva	041121678KNT	Robbery first degree
State v. Poorbear	041091817SEA	Robbery first degree
State v. Dixson	031027153KNT	Robbery first degree
State v. Folk	041122658KNT	Assault first degree
State v. Sawyer	048026247	child molesting 1st degree superior / juvenile
State v. McClurg	038052622	Child molesting first degree
State v. Wilson	031027517KNT	Robbery second degree
State v. Schaller	041103591SEA	Murder first degree
State v. Forest	041097726SEA	Robbery first degree
State v. Smalis	021076510SEA	Attending a pursuing police officer
State v. Abdullahi	0480669	Arson second degree, superior / juvenile
State v. Grant	041006399SEA	Robbery first degree
State v. Ganga	041110102KNT	Assault second degree
State v. Sutherland		Murder first degree
State v. Key	041090861SEA	Assault with a deadly weapon second degree
Girton v. Ross	Kirkland Municipal Court	
State v. Comslast	041104731SEA	Burglary first degree
State v. Humiston		Assault with weapon first degree
State v. Hite	01101409KNT	VUCSA
State v. Wilborg	031078251SEA	Robbery first degree
State v. Smith	00C102SEA	
State v. Boyle	018030576	Attempted robbery first degree juvenile
State v. Hicks	99100666KNT	Rape first degree
State v. Campo	03-C-10452SEA	Assault second degree
State v. Coffey	04804921	animal cruelty
State v. Coleman	051003665SEA	Assault second degree
State v. Parker	041062736SEA	Burglary second degree
State v. Wilson	031027517KNT	Robbery second degree
State v. Sutherland		Murder first degree
State v. Barnes	04-1-01689-1SEA	Rape first degree
State v. Nastase	05-1-06090-1KNT	Assault second degree
State v. Rogers	05-1-04684KNT	

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

IN RE THE PERSONAL  
RESTRAINT PETITION OF:

LIA Y. TRICOMO,

Petitioner.

) CAUSE NO. 51741-8-II

) EXHIBIT 18

EXHIBIT 18

Dr. Delton Young – Curriculum Vitae

## **DELTON W. YOUNG, PhD, ABPP**

Diplomate, American Academy of Forensic Psychology  
Interlake Psychiatric Associates, PL  
1300 114<sup>th</sup> AVE NE #115 BELLEVUE, WA 98004  
TEL 425-336-0212 FAX 425-462-8894  
EMAIL: drdwyoung@comcast.net WEBSITE: drdeltonyoung.com

### EDUCATION

- Ph.D. Center for the Study of Psychological Development. Graduate School of Education and Human Development, University of Rochester, 1982.
- M.S. Clinical Psychology. Eastern Washington University, 1975.
- B.S. Chemistry/Physics. Central Washington State College, 1970.

### ACADEMIC APPOINTMENTS

- Clinical Assistant Professor.** Department of Psychiatry and Behavioral Sciences, University of Washington School of Medicine. 1997-2001.
- Clinical Instructor in Psychology.** Department of Psychiatry and Behavioral Sciences, University of Washington School of Medicine. 1996-1997.
- Clinical Instructor in Psychology.** Dept. of Psychiatry, Harvard Medical School. 1985-1994.
- Post-Doctoral Fellow.** Adolescent/Family Psychology. Harvard Medical School/McLean Hospital. 1984-85.
- Post-Doctoral Fellow.** Adolescent Clinical Psychology. Harvard Medical School/McLean Hospital. 1982-84.
- Psychology Intern.** Department of Psychology. Oregon State Hospital. 1980-81.

### CURRENT FORENSIC PRACTICE (1994-2016)

- Juvenile:** Competency to Stand Trial, Legal Capacity/Diminished Capacity, Juvenile Decline/Waiver to Adult Court, Insanity Defense, Competency to Waive *Miranda* Rights; Mitigation, Risk Assessment.
- Torts:** Evaluation for emotional damages in civil litigation.
- Criminal:** Evaluations for Competency to Stand Trial, Insanity Defense, Diminished Capacity, Competency to Waive *Miranda* Rights, Mitigation at Sentencing.
- Family Law:** Parenting Evaluations, Psychological Evaluation of Parents, Dependency, Termination of Parental Rights, Re-Integration.
- Education:** Independent Evaluations for school districts for educational planning and IEP's
- Testimony:** 1994-2016: at trials, depositions, hearings--in juvenile, family, criminal, education, personal injury. Qualified as expert in King, Snohomish, Pierce, Yakima, Skagit, Whatcom, Kittitas, Benton/Franklin, Thurston, Grant Counties, and Federal Courts.

PROFESSIONAL EXPERIENCE

**Assistant Psychologist:** McLean Hospital, Boston, 1985-1992;

**Associate Psychologist:** McLean Hospital, Boston, 1992-1994:

- Clinical practice: Individual and family therapies, psychodiagnosis, in-patient administration
- Consultant: to clinical treatment reviews (in-patient, day program and out-patient) at adolescent half-way houses, group homes, and schools.
- Supervisor: of Psychology post-doctoral fellows and Psychiatry residents on individual psychotherapy, family therapy, and psychological evaluation.
- Principal Investigator: Family Assessment Project (grant-supported research). Developed adolescent-family assessment methods and clinical service.

**Post-Doctoral Fellow.** Adolescent and Family Treatment and Study Center (1/2 time). Individual and family therapy, psychodiagnostics and research development on family-oriented, in-patient adolescent program. McLean Hospital, 1984-1985.

**Post-Doctoral Fellow.** Adolescent Clinical Psychology. Individual/family therapy, psychodiagnosis (adolescents and adults). Seminars in psychotherapy, adolescent development and psychopathology, psychodiagnosis. McLean Hospital, 1982-1984.

**Staff Psychologist.** Psychodiagnosis of adolescents and adults. Individual, group therapy. Consultation to case conferences. Program evaluation. Oregon State Hospital, 1981-82.

**Clinical Psychology Intern.** (11-month, 1900-hour internship). Supervised experience in diagnostic assessment, individual and group therapy. Rotations in general psychiatric Service and child/adolescent treatment program. Oregon State Hospital, 1980-1981.

PROFESSIONAL TRAINING AND PUBLIC SPEAKING

The Nature and Quality of Malingering. Invited address to the Washington Institute for Mental Health Research and Training, Western State Hospital. May, 2009

Mental Health Evaluation of Juveniles for Decline of Jurisdiction Hearings. Invited address to the Washington State Legislature, Human Services Committee, Olympia, February, 2009

Collaboration Between Attorneys and Mental Health Experts: Beyond the Basics. Panelist for one-day conference, TeamChild, Seattle October, 2008

Judgment and Risk-Taking in Adolescence: Implications of Psychological and Brain-Imaging Research. Invited address to the Washington State Truancy/Becca Conference, 5/05

Mental Status Examination and Psychopathology. Friends of Youth. March, 2006.

The Growth of Judgment from Adolescence to Adulthood: Implications for Juvenile Justice. Invited address to the Washington State Legislature, Juvenile Justice and Family Law Committee, Olympia, January, 2005.

Mood Disorders in Adolescence. Friends of Youth, Griffin Home Staff. Renton September, 2003

Maturity of Judgment: The Ongoing Development from Adolescence to Adulthood. Invited address to the Washington State Legislature, Juvenile Justice and Family Law Committee, Olympia, February, 2003

Risk Assessment for Violence in Psychiatric Patients: Recent Research and Methods. Eastside Psychiatric Group, Kirkland, Jan., 2003

Emotional Abuse of Children: Family Dynamics and Assessment, Title 26 Family Law GAL Training Program, WSBA, Seattle, March 2002

Panel, Attachment Disorders Conference, Seattle Psychoanalytic Assn., 2001

Antisocial Development in Children/Adolescents, Friends of Youth, Issaquah 2001

PROFESSIONAL TRAINING AND PUBLIC SPEAKING, cont.

Psychological Testing in Custody Evaluations, Snohomish County Bar Association, Family Law Interest Group, 2001  
Assessment of Antisocial Youth, Trainings Sponsored by Seattle Crisis Clinic, 1999-2000  
Assessment of Violence Risk in Juveniles, Trainings for Seattle Children's Home, 1999-2000  
Psychological Development of Antisocial Youth, WA Council of Mental Health Centers, 1999  
Antisocial Development, trainings for Friends of Youth staff, Renton, 1997-2001  
Violence in Youth, parent group presentations, Mountlake Terrace High School, 1996  
Raising Healthy Adolescents, Rotary Club, Mountlake Terrace, 1996  
Curbing Violence Among Youth, Senator Patty Murray Community Forum, Tacoma, 1996  
Families of Borderline Personality Disorder Adolescents, McLean Hospital/Harvard Medical School, Grand Rounds, 1992  
Adolescent-Family Development, Public Schools, Belmont, MA 1990-91

PUBLICATIONS: Books and Professional Journal Articles

- Young, D. (1999). *Wayward Kids: Understanding and Treating Antisocial Youth*. Northvale, NJ: Jason Aronson, Inc. (Psychology textbook on antisocial development and treatment).
- Young, D. (1999). WISC-III third factor. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 1207.
- Young, D. (1997) Using DSM-IV: A Clinician's Guide to Psychiatric Diagnosis [Invited book review]. *American Journal of Psychotherapy*, 51, 124-125.
- Young, D. & Gunderson, J. (1995). Family images of borderline adolescents. *Psychiatry: Interpersonal and Biological Processes*, 58, 164-172. Presented at Grand Rounds, Harvard Medical School and McLean Hospital.
- Young, D. & Childs, A. (1994). Family images of hospitalized adolescents: The failure to generate shared understandings. *Psychiatry: Interpersonal and Biological Processes*, 57, 258-267.
- Young, D. (1994). Behaviors and attributions: Family views of adolescent psychopathology. *Journal of Adolescent Research*, 9, 427-441.
- Young, D. (1994). Images of the family's adolescent: Clinical application of an empirical method. *Family Therapy*, 21, 117-127.
- Young, D. & Klein, A. (1992). Family images of the adolescent: An empirical method for clinical assessment. *Journal of Family Psychology*, 6, 139-152.
- Young, D. (1991). Family factors in failure of psychotherapy. *American Journal Psychotherapy*, 45, 495-499.
- Young, D. (1985). Reliability of videotape-assisted recall in counseling process research. *Counselor Education and Supervision*, 24, 360-364.
- Banaka, W. & Young, D. (1985). Impact of an adventure camp on chronic psychiatric patients: Functional levels and deinstitutionalization. *Hospital and Community Psychiatry*, 36, 746-758.

Nielsen, G. & Young, D. (1982). Multipli-acting out adolescents: Developmental correlates and response to secure treatment. *International Journal of Offender Therapy and Comparative Criminology*, 26, 195-206.

Young, D. (1981). Meanings of counselor nonverbal gestures: Fixed or interpretive? *Journal of Counseling Psychology*, 27, 447-452.

#### OTHER PUBLICATIONS

Young D. & LaRue, C. (1998). Aggression in a middle class high school: Prevalence, effects and protective factors. Unpublished research manuscript.

Young, D. (2010). Mental Health Malingering in Legal Contexts. *King County Bar Bulletin*, February.

Young, D. (2003). Varieties of Thought Disorder in the Criminal Context. *WSBA Bar News*, March.

Young, D. (2002). *Miranda* Waivers in Juveniles: Validity and Assessment. *WSBA Bar News*, March.

Young, D. (2001). Psychological testing in parenting evaluations. *King County Bar Bulletin*, February.

Young, D. (1999). Handguns in America. *Seattle Times* [Editorial page article]. December 20, B5.

Young, D. (1999). Experts' predictions of dangerous behavior. *King County Bar Bulletin*. June.

Young, D. (1998). Post-traumatic stress disorder: Current insights. *King County Bar Bulletin*. June.

Young, D. (1996). Development means more than growth. *Seattle Sunday Times* [Editorial page article]. December 8, C1.

Young, D. (1995). Suburban Disconnect. *Seattle Post-Intelligencer* [Editorial page feature article], Nov. 12, E1.

Young, D. (1995). Youth violence in the suburbs. *Seattle Post-Intelligencer* [Editorial page article], July 27, A17.

Young, D. (1995). Gangs a Poor Substitute for Family, Community. *Seattle Post-Intelligencer* [Editorial page article], Nov. 12, E1-2.

#### PROFESSIONAL AFFILIATIONS

American Academy of Forensic Psychology  
American Psychological Association  
Washington State Psychological Association

LICENSURE: Washington (#1580, 1992); Oregon (#802, 1992); Massachusetts (Inactive; #3516, 1984)

RELATED EXPERIENCE

Director and Chief Guide. Oregon State Hospital Adventure Camps. Planned and directed experimental mountaineering outings for psychiatric patients. 1972 and 1980-1981.

Professional Mountain Guide and Instructor. Planned and directed mountaineering treks and climbing expeditions in Asia, Africa, South America and Alaska. Directed mountaineering program, U.S. 1971-1983.

REFERENCES: Provided on request.

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

IN RE THE PERSONAL )  
RESTRAINT PETITION OF: ) CAUSE NO. 51741-8-II  
LIA Y. TRICOMO, ) EXHIBIT 19  
Petitioner. )

EXHIBIT 19  
Dhyana Fernandez – Curriculum Vitae

EXHIBIT 19

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Dhyana Fernández  
Mitigation Specialist and Sentencing Advocacy  
2422 Columbia St SW  
Olympia, Wa. 98501

Office: 360-524-2037  
Cellular: 206-769-1801  
Email: [dhyana@goldenprairie.org](mailto:dhyana@goldenprairie.org)

Oregon private investigator license #76017

## **EXPERIENCE**

### **2001 – Present      Mitigation Specialist**

In 2001, I resumed work as a mitigation specialist working privately as a court-appointed mitigation specialist on cases primarily in the Chicago area. I began to develop an area of expertise in cases involving foreign nationals and the special obstacles (logistical, cultural, safety concerns, difficulties locating witnesses, problems in overcoming issues of trust) that are presented in these cases.

I have been appointed to conduct comprehensive bio-psycho-social history investigations in 34 state capital cases in 12 different states. I have also been appointed in an additional 14 federal capital cases in 12 different states. Of those 14 federal cases, the death penalty was not authorized in 13 cases. In the authorized case, I commenced work after authorization had been sought. The client later sought and received substitution of counsel and I was unable to see that case through to a penalty phase. In sixteen of these cases (state and federal), my clients were foreign nationals from the countries of Mexico, Colombia, Honduras, Ecuador, and El Salvador. Accordingly, I conducted mitigation investigation in each of those countries as well as the island of Puerto Rico. I have been the mitigation specialist in multiple capital cases where the client was intellectually disabled and therefore focused on adaptive deficit behavior investigations and interviews with retrospective reporters. I have performed diverse research for use in mitigation reports and have helped prepare for various aspects of evidentiary hearings, including sentencing hearings.

### **1999 – 2006      Northwestern University Feinberg School of Medicine**

<http://psychiatry.northwestern.edu/research/health-disparities/index.html>

Worked as field and institutional interviewer in Psycho-Legal Studies (Department of Psychiatry and Behavioral Sciences). Responsible for locating and interviewing community youth and young adults for longitudinal research study with a sample size of 1,849 subjects identified at the Cook County Juvenile Temporary Detention Center.

Engaged in aggressive field tracking of participants in high-crime sections of Chicago. Sought assistance through family, friends, and other sources to locate subjects. Also searched for participants using online databases, court searches and state agencies. Worked to maintain high participation rates. Kept detailed records for data-entry and administrative purposes.

Conducted face-to-face interviews in varied settings, including institutions (Cook County Jail, Illinois Department of Corrections, Department of Children and Family Services Placement Agencies, Chicago Housing Authority) public housing, and participants' homes. Traveled statewide to various institutions for administration of interviews.

Obtained informed consent of research participants and maintained strict confidentiality standards. Protocols used included computer-assisted mental health diagnostic screens: CDISC, DIS, and WMH CIDI. Also screened for alcohol and substance abuse, family functioning, community, sex and risk behavior. Also administered various cognitive instruments and collected urine samples for drug testing.

The study's findings have shaped public health policy around the country. Results have been cited in Supreme Court amicus briefs, congressional hearings, and Surgeon General reports, examples of which can be found here:

- <http://www.wardrounds.northwestern.edu/winter-2010-11/features/unlocking-health-disparities/>
- [http://www.nytimes.com/2012/11/05/us/chicago-project-follows-what-happens-to-juveniles.html?hp&\\_r=0](http://www.nytimes.com/2012/11/05/us/chicago-project-follows-what-happens-to-juveniles.html?hp&_r=0)
- <http://www.apa.org/monitor/2013/02/detained.aspx>

### **1995 – 2006                      Criminal Defense Investigation**

Performed fact investigations of criminal cases primarily in Cook County, Illinois. Worked in cooperation with private criminal defense attorneys. Located and interviewed witnesses and generated related memoranda. Also testified in court cases, conducted process service, record collection, photography, and development of graphics for trial use.

### **1992 – 1995                      Texas Appellate and Education Resource Center**

Employed as a post-conviction capital case investigator on Texas capital cases. I developed defendant social histories for mitigation purposes which included multiple and extensive interviews with client, immediate and extended family members, friends, community members, teachers, neighbors, correctional officers, and clergy. Produced memoranda, collected records and prepared life chronologies and life history narratives in combination with field interviews. Located and interviewed jurors, conducted fact investigation, performed paralegal duties, all as part of intensive work-up in cases with pending execution dates.

**1990**                      **Cook County Public Defender**

Conducted pre-trial mitigation investigation in a capital case in which the death penalty was sought. The case resulted in a 40-year sentence.

**EDUCATION**

- 1995    Master of Arts  
          Department of Radio, Television, Film  
          University of Texas  
          Field thesis research done in Buenaventura, Valle de Cauca Colombia, SA
- 1989    Bachelor of Arts  
          Department of Communications  
          Loyola University of Chicago

**TRAININGS ATTENDED and FACULTY**

- 1993    National Resource Center Training
- 1997    Life in the Balance – National Legal Aid and Defender Association
- 1998    Life in the Balance – National Legal Aid and Defender Association
- 2001    National Center on Wrongful Convictions – Investigator Training
- 2003    Life in the Balance – National Legal Aid and Defender Association
- 2004    National Association Sentencing Advocates Death Penalty Mitigation  
          Institute Training
- 2004    Mexican Capital Legal Assistance Program: Seminar for Defense Attorneys  
          Representing Mexican Nationals in San Francisco
- 2005    National Association of Sentencing Advocates Death Penalty Mitigation  
          Institute
- 2006    Cook County Public Defender: One Team One Voice Mitigation Training
- 2007    **Faculty** at Mexico Capital Litigation Assistance Program Mitigation  
          Specialist Training in Houston
- 2008    **Faculty** at Federal Capital Defense Strategy Session in Phoenix
- 2009    CACJ/CPDA Death Penalty Defense Conference Monterey
- 2010    Washington Association of Criminal Defense Lawyers Capital Case Brainstorming at  
          Gonzaga Law School
- 2010    Santa Clara Death Penalty College
- 2011    Washington Association of Criminal Defense Lawyers training on Victim Outreach in  
          Capital Cases in Seattle
- 2012    Federal Death Penalty Resource Counsel Authorized Case Training; Cincinnati
- 2013    Mexican Capital Litigation Assistance Program Mitigation Training; Houston
- 2013    **Faculty** with Michael Iaria at Washington Association of Criminal Defense Lawyers  
          CLE: “The Measure of a Life, or Why Mitigation Isn't Just for Capital Cases”
- 2014    Federal Death Penalty Authorized Case Training: Louisville. March 2014
- 2014    Providing Assistance to Defense Teams for Their Mexican National Clients: Santa Fe

## **PROFESSIONAL ASSOCIATIONS**

NLADA National Legal Aid and Defender Association  
NASAMS National Alliance of Sentencing Advocates and Mitigation Specialists  
WACDL Washington Association of Criminal Defense Lawyers  
WDA Washington Defenders Association

## **REFERENCES**

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### **Mandy Welch**

Burr & Welch  
Former Litigation Director and Executive Director, Texas Resource Center  
mandy@burrandwelch.com

*Additional references available upon request*





3. The State retained forensic psychologist Delton Young who critiqued Dr. Dixon's report. Dr. Young concluded that Ms. Tricomo did not suffer from diminished capacity.

4. Both Dr. Dixon and Dr. Young discussed the possible effect of the medication Paxil or withdrawal from Paxil on Ms. Tricomo's behavior on April 29, 2013. The mitigation investigator, Dhyana Fernandez, who I retained did mention the effect of Paxil when she wrote her report to the court for Ms. Tricomo's sentencing hearing. For Ms. Tricomo's sentencing hearing, I did not retain or consult with a psychiatrist or an additional expert regarding the possible effects of Paxil on Ms. Tricomo's behavior on April 29, 2013. Instead, I relied on Dr. Dixon's report and Ms. Fernandez's mitigation report in support of the defense recommendation for sentencing.

I certify or declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

12/20/18  
DATE AND PLACE

  
PATRICK O'CONNOR

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

IN RE THE PERSONAL )  
RESTRAINT PETITION OF: ) CAUSE NO. 51741-8-II  
LIA Y. TRICOMO, ) EXHIBIT 21  
Petitioner. )  
\_\_\_\_\_)

EXHIBIT 21  
Justine Turpin Correspondence

RECEIVED

JUN 19 2013

OFFICE OF  
ASSIGNED COUNSEL

for Robert Dimerson

Re: Lia Tricomo

Fr: Justine Turpin  
(friend)

cc: Mrs. Tricomo (mother)

Behalf of.  
Lia Truono

June 19, 2013

(Paxil)

Lia is not guilty: Paxil has  
Paxil caused this before.

Dear Mr. Jenson:

Paxil is a very dangerous  
drug. Lia should have never been  
prescribed Paxil. People that have  
been suicidal should never take Paxil.  
It was shown + Glaxo Smith Kline was  
found guilty before in Cheyenne Wyoming.

People on Paxil don't know  
what they are doing.

Enclosed are information from the  
web + there is more. Lia is innocent

Sincerely,

Justine Turpin

360-359-9631

~~Justine Turpin @ checentral.com~~  
justine.turpin@checentral.com

In lawsuits against Glaxo - Smith Kline  
they have been responsible for  
these suicides + deaths - J.T.

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## Paxil® Dangers – Consult an Attorney for Legal Advice

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Paxil® (paroxetine) is a type of antidepressant, known as a selective serotonin reuptake inhibitor (SSRI), that works to relieve depression by blocking the reabsorption of serotonin within the brain. Paxil® is prescribed to treat depression, generalized anxiety disorder, social anxiety disorder, panic disorder, and obsessive compulsive disorder.

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### Paxil Side Effects

As with any drug, there are side effects associated with Paxil®. Side effects of Paxil® include:

- Nausea
- Dizziness
- Drowsiness
- Insomnia
- Diarrhea
- Decreased sexual interest (men)
- Increased sexual interest (women)
- Suicidal tendencies

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- Birth defects

In addition to these side effects, Paxil® use has been associated with severe withdrawal symptoms when patients stop taking the drug.

## Dangers of Paxil®

Since Paxil® was introduced to consumers, various side effects have been associated with use of the medication.

### Paxil® Use During Pregnancy

Two separate studies have found an increased risk of birth defects linked with Paxil® use. According to the studies, babies exposed to Paxil® during the first trimester of pregnancy have an increased risk of heart problems.

### Paxil® Withdrawals

Individuals who have used Paxil® for an extended period of time have experienced withdrawals when they stopped using the medication. The withdrawal symptoms can include depression, suicidal thoughts, anxiety, and nausea.

## Possible FDA Recall?

The FDA has not issued a recall of Paxil®, nor has it issued any warnings about the risk of side effects. However, several patients have filed a class action suit in California against the manufacturer of Paxil®, claiming that adequate warnings about the addictive nature of the drug were not provided.

In addition, a jury in Wyoming found that Paxil® was to blame for a murder/suicide incident involving a Wyoming man and his family.

## Consult a Lawyer

If you or a loved one has been harmed by Paxil®, you should contact a Paxil® attorney to find out whether you are eligible for compensation for your injuries.

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Paxil® - Dangerous Side Effects

The possible adverse side effects of Paxil® use include suicidal tendencies and an increased rate of birth defects. Consult an attorney if you have suffered any of the side effects associated with Paxil®.

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2

# McMan's Depression and Bipolar Web

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## Antidepressants - The Dark Side

The dangers may be remote, but they are real.

by John McManamy



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Early in 2000, in a non-jury trial, a Connecticut judge acquitted Christopher DeAngelo, an insurance agent, of robbing a bank after his lawyer successfully argued that his client's state of mind was due to the Prozac he had been taking at the time. Listed in the manufacturer's warning as an "infrequent" adverse reaction is "akathisia," which may cause an unsuspecting victim to become mentally restless and lose all inhibitions about his actions.

In October 1999, Pfizer, makers of Zoloft, settled for an undisclosed sum with the estate of Brynn Hartman, who had shot her husband comedian Phil Hartman dead, and then killed herself. Ms Hartman had been taking Zoloft at the time of the murder/suicide. According to the lawsuit, Ms Hartman had complained to friends that she felt as if she were going to "jump out of her skin."

Until recently, Eli Lilly, makers of Prozac, had managed to settle all of its 200 or so civil claims out of court. But that changed in 2000:

In 1992, Bill Forsyth, a retiree living in Hawaii, was prescribed Prozac for his anxiety and depression. The next day, he called his doctor to say he felt 200 percent better. The day after, however, he requested to be taken to a psychiatric hospital, where doctors continued giving him the drug. Eleven days later, he returned home, stabbed to death his wife of 37 years, then impaled himself on a kitchen knife.

Eli Lilly won the case, but possibly lost a long-term war, for the company was obliged to make public incriminating internal documents dating back to 1978.

According to company minutes, Eli Lilly had full knowledge of what its top-selling drug could do to some people. In the company's own words, back in 1978: "There have been a fairly large number of reports of adverse reactions ... Another depressed patient developed psychosis ... Akathisia and restlessness were reported in some patients."

In another meeting, it was noted that, "some patients have converted from severe depression to agitation within a few days; in one case the agitation was marked and the patient had to be taken off [the] drug."

The minutes also revealed that during the approval process, Eli Lilly's trial subjects were put on tranquilizers to counter the akathisia (and presumably skew the drug trial findings in their favor), though no warning was given when the drug came on the market in the US. In Germany, however, Eli Lilly was obliged to put this caveat on its package insert:

"For his/her own safety, the patient must be sufficiently observed, until the antidepressive effect of Fluctin [Prozac] sets in. Taking an additional sedative may be necessary."

The documents also reveal that Eli Lilly excluded from scrutiny at-risk subjects in a so-called suicide study requested by the FDA, as well as 76 out of 97 suicides.

Meanwhile, in 2001, a Wyoming jury has returned a verdict in a wrongful death suit against GlaxoSmithKline (formerly SmithKline Beecham), makers of Paxil, with damages amounting to \$6.4 million. On Feb 13, 1998, Donald Scheil, 60, took two Paxil tablets, then shot to death his wife, daughter, and grand-daughter before killing himself. Unpublished data from SmithKline revealed that its own investigators had attributed a variety of side effects to the drug, including akathisia (tumor), mania, psychosis, aggression, and attempted suicides. Dr David Healy, who has published studies on Prozac (but not Paxil) side effects, testified as an expert witness, along with Harvard psychiatrist Terry Maltzberger.

This is the first successful wrongful death suit in the US involving SSRIs. The plaintiffs in the Forsyth and Tobin cases were represented by the same legal team, Vickery and Waldner of Houston, Texas. Andrew Vickery told this writer what was different about taking a drug company to court this time around:

"We had additional experts in Tobin. We tried SKB on a 'failure to test' theory in addition to failure to warn. In Tobin we wised up and emphasized that homicide and



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suicide are 'multifactorial' and 'biological' phenomena.' These and other tactical changes made a big difference."

In October 2002, BBC aired on its flagship current affairs program, Panorama, a no-holds barred documentary on Paxil (marketed as Seroxat in the UK). Right off, with reporter Shelley Joffre's allusion to the medication's "darker side," you knew this was no industry-sponsored symposium:

In quick succession, we hear from two patients, one who cannot get off the drug and the other who mutilated himself while on the drug, followed by David Healy MD who testified in a successful wrongful death suit brought against the drug's manufacturer, and attorney Andrew Vickery who brought that wrongful death suit. Then Joffre cuts to the chase:

"The Maudsley Hospital in London runs a national information service for people taking psychiatric medicines. Trouble coming off Seroxat is the number one complaint from callers. Doctors too report far more withdrawal problems from patients on Seroxat than on any other drug."

**Paxil Side Effects**

According to Davis Taylor, Chief Pharmacist at the Maudsley Hospital: "If a patient is to stop taking Seroxat suddenly, then usually they would quite soon become quite anxious. They may feel very dizzy and unsteady on their feet. Often people experience electric shock sensations. They may also have a fever and feel generally unwell and they also may experience mood changes or very vivid nightmares for example."

Thanks to the wrongful death suit brought against manufacturer GlaxoSmithKline, Dr Healy gained access to some quarter million documents in the company's archives. He told Panorama that according to GSK's own studies, often on healthy volunteers, that one in four experienced mental agitation while on the drug, and in some instances up to 85 percent had withdrawal problems when they halted.

**More on Paxil**

At about the same time the documentary aired, the Prescription Medicines Code of Practice Authority in the UK ruled that GSK had breached the industry's code of practice by playing down Paxil's side effects. Meanwhile, in the US, Paxil's most

recent TV ad leaves out its previous claim about the drug not being habit-forming.

**Number One**

According to the World Health Organization reported in The Guardian, Paxil tops the list for drugs in terms of difficulty to quit followed by Effexor at number two, Zoloft at number four, and Prozac at number seven. The benzodiazepines Ativan and Valium come 11th and 13th.

**Walk, Don't Run**

If you are on Paxil, please do not panic. Mental agitation or anxiety from SSRIs usually occurs in the first few days, if at all, then recedes. If the agitation or anxiety persists, it is advisable to notify your doctor or psychiatrist. If the drug is working for you, it is sensible to stay on it. If the drug is being prescribed to you for the first time, it is advisable, as with any medication, to express any concerns to your doctor or psychiatrist. Should you no longer need to stay on the drug, following is a "reprint" from a recent Newsletter:

In December 2001, GSK changed Paxil's label, encouraging physicians to recommend "a gradual reduction in the dose rather than abrupt cessation." Paxil washes out of the system more quickly than other SSRIs when stopped. In recent clinical trials, GSK decreased the daily dose by 10 mgs a week (doses can range from 10 to 60 mg a day), then stopped treatment after reducing the dose to 20 mgs. The Washington Post reports Frederick Goodwin MD, former head of the NIMH, as in favor of an even more gradual taper, "dropping the dose every four or five days by as little as possible, even if that means cutting pills in half."

**On The Paxil Label**

According to the manufacturer's product information, of patients who gradually weaned off Paxil 2.3 percent experienced abnormal dreams, two percent experienced a tingling sensation (paresthesia), and 7.1 percent experienced dizziness. According to GSK, the majority of cases were mild and did not require medical intervention.

**Paxil Lawsuits**

Not since the tobacco lawsuits have law firms been so eagerly licking their litigious chops. A Google search turns up dozens of law firms in the US, Canada, and the UK that have already been filed on behalf of individuals or classes of individuals or are touting for business. The claims generally allege withdrawal symptoms or suicidal gestures and the failure of GSK to issue appropriate warnings.

In July 2003, the FDA has advised that no one under age 18 should be prescribed Paxil for depression, owing to the risk of suicide. Three studies found the drug did not help for pediatric depression, and an analysis of the data showed a three times greater risk of suicidal thoughts and attempts among mostly teens taking the drug vs those on a placebo. There were no deaths in the studies.

The warning follows similar action by the Medicines and Healthcare Products Regulatory Authority in the UK, where the drug is marketed as Seroxat.

Children and teens already on the drug should not suddenly stop the drug, the FDA cautioned, as a long tapering period is required to avoid withdrawal effects.

Prozac is the only antidepressant FDA approved to treat depression in children.

**Final Word**

If soon after beginning antidepressant treatment you start feeling uncharacteristically hyper, call your doctor at once and stop taking the medication while you still have your wits about you. Your doctor may adjust your dose or switch medications to get you on something that works for you. If you are experiencing anxiety or agitation in the early going, the effect is usually temporary, but it won't hurt to keep your doctor informed.

If, after reading this, you feel you are ready to flush your pills down the toilet - hold on. If you have been taking antidepressants for some time, then you will need to be gradually weaned off of them under a doctor's supervision over a period of weeks or months.

If an antidepressant has harmed you or your family, you may have cause for a legal action, but this is something you would need to take up with a lawyer who specializes in these kinds of cases.

Updated Feb 11, 2008

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But Is It Depression?

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Summary:

<http://www.guardian.co.uk/Archive/Article/0,4273,4236200,00.html>

'Four people dead is four too many'

**Don Schell was taking a Prozac-type antidepressant when he killed his wife, daughter and granddaughter, then turned the gun on himself. His son-in-law sued the drugs company - and won £5m. Sarah Boseley meets him**

Sarah Boseley  
Guardian Unlimited

Thursday August 9, 2001

Tim Tobin was an ordinary guy with a wife and a baby daughter living in small town America and that was just fine. He and his family were simple, normal people, he says. They didn't want to be anything different. He and Deb, his wife and their nine-month-old baby, Alyssa, lived in Montana, but they spent a lot of time over the Wyoming border with Deb's parents, Don and Rita Schell, in the small oil town of Gillette. Alyssa was the first grandchild and everybody adored her.

It was the life they wanted. Tim and Deb expected to bring up their children in Montana, just as they had been brought up themselves - close to generations of people they held dear. But it all went shockingly wrong.

In February 1998, Deb and the baby were staying with her parents in Gillette. Deb was there for a break and stayed for two weeks because she got ill while she was there. Meanwhile, her father Don was feeling low. He had suffered occasional bouts of depression in the past and it had happened again. The doctor put him on an antidepressant called Paxil (Seroxat in the UK) - a drug in the same class as Prozac.

Two days later, Don Schell, the non-violent family man and doting grandfather, took a .22 calibre pistol and a 357 magnum in the middle of the night and shot dead the three people in the world dearest to him - his wife Rita, his daughter Deb and baby Alyssa. Then he killed himself. The following afternoon Tim Tobin found the scene of carnage that will stay with him as long as he lives.

For a while, he says, he was out of his head. Once he was able to think rationally again, he and Rita's sister and other family members tried to work out what had happened. Their conclusion was that Don must have been affected

<http://ssrstories.com/show.php?item=240>

6/19/2013

by the medication he was on. Nothing else made sense.

They sued GlaxoSmithKline, the British drug giant that makes Paxil, and won a historic victory in June. The jury awarded \$6.4m (£4.7m), but it wasn't for the money that the family put itself through the trauma of the court case. It was to clear Don's name and to tell the world that there could be problems for some people with the class of antidepressants to which Paxil belongs, known as selective serotonin reuptake inhibitors (SSRIs).

In that, Tobin admits he is disappointed. "I really just did want to win, to say, OK, the drugs did do it - what's everyone going to do now? And of course, there's been nothing. I honestly believe until it's somebody of importance it will be very difficult to get any changes. Here I am, a simple man from Montana. I'm not exceptionally rich or famous or anything. Who's going to listen to me?"

Tobin is 33 now - a tall, gentle soul with an occasional quiet, self-deprecating laugh. After the death of his wife and daughter, he too wanted to die. He now has an inside track on the depression that sometimes overtook Don and feels more able to assess the chances of his father-in-law having been turned into a suicidal killer by it. He is certain it could not have happened without the drug.

"To go from a state where you are in serious depression and would hurt yourself to becoming a person who would do this to his wife and daughter and his granddaughter - a nine-month-old baby girl who can't take care of herself - he would have had to be so completely out of his mind and there was just no way."

Tim and Deb lived with the Schells for five months in Gillette, where Don and Rita had been since their marriage, before moving to Billings, a four-hour drive away. They still spent a lot of time together. "We were always very close and after Deb got pregnant even more so. This was the first grandchild on both sides. Everybody was involved and excited. My brother took a 48-hour bus ride so he could be there when the baby was born. That was how the whole family was."

Don was retired, but had a job for a few hours every day working as a pumper for the oil company, checking on the oil wells to make sure everything was running smoothly. He was a slightly reserved man, Tobin says, except with his family. "He was a bit of a father figure to me. I enjoyed spending time with him."

When Don was depressed, he says, he didn't act odd. Depression, says Tobin, "is a normal part of life anyway... If anything, he became more loving with his family when he was down because we'd all stick by him and he'd get very, very appreciative of that because we'd all say, 'It's OK.'"

"Deb and I were both overly protective parents. I would never have left my nine-month-old daughter there - or Deb for that matter - in a situation I felt might get bad." Tobin had never seen Schell become violent. "He raised

his voice. He liked things a certain way. But the most you can say is that he'd get irritable at times - and you can say that about anybody.

"He loved Alyssa. We used to laugh about it because he'd hold Alyssa and we'd say you know you've got to put her down at some point. He was just really the proud grandfather. He'd fuss over her and everything, and he'd ignore us."

When he starts to tell of what happened on that February night, Tobin's voice slips into a low monotone. There are things he doesn't want to recall. He spoke to his wife on the phone on Thursday evening. When he drove down to join them as planned the next afternoon, they were already dead.

"I last heard from Deb the night before it happened. We talked at least once a day. Deb asked me to bring some stuff down for her and I said, 'Do me a favour and call me in the morning to remind me.' I didn't hear from her, but didn't think anything of it and left early from work to get down there.

"I got there somewhere around 4pm and there was no one answering the door at the house. I thought they were out running errands. So I left and spent a couple of hours trying to find them. Finally I checked the garage and saw the cars were in there and noticed a light was on upstairs. "

A neighbour called the police. An officer arrived who said he was not permitted to force the door, so Tobin and the neighbour broke a window at the back. "I said, 'You'll just have to arrest me, then, because I'm going in.' And of course he understood - he wasn't going to arrest me. Then we ran upstairs. That's when I found everybody.

"I don't remember much until I got back to Billings a few days later. It's all a blur. I've had nightmares over what I saw. But I don't really remember, and I don't spend a lot of time trying to remember. I went to a therapist because I was in a pretty bad shape. I really felt like killing myself. My brother quit his job and moved in to babysit me because I was in such a mess. I was worthless. I was totally worthless."

Tobin went from wanting to kill himself to taking chances with his life - travelling across Australia, New Zealand and South America, mountain climbing, bungee jumping and hang-gliding. The worst that could happen had happened. Death held no fears for him any more. In the end, he found he just wanted to go home.

"My life has moved on. I don't live that thing every day. It's just that it's always there, as if there's a scab over it, and every now and then you reach a point where the scab breaks off and you have to deal with this painful, lonely time because there aren't that many people that understand it.

"I have to live that for the rest of my life. It's not every day, but my daughter's birthday comes around, our anniversary, or if I see a little girl who looks like my daughter I have a real hard time. I remember the way Deb smelled - the perfume she used to wear. I smell it every now and then and it really brings me back to ground zero for a while. I guess the thing is that I

feel that way and then I bounce back a lot quicker than I did before."

Glaxo's representative in court, Ian Hudson, who now works for the Medicines Control Agency in the UK, argued that the occasional suicide or killing by somebody on Paxil is not sufficient evidence that there is a problem with the drug, considering the millions who take it. Tobin is outraged. Virtually all drugs can cause a bad reaction of some sort in a few people, he says. However small the effect is, there is no excuse for not investigating what is happening. "I don't think they've taken a proper look at the whole thing," he says. "We're talking about people's lives. Whether we are statistically significant or not, four people dead is too many as far as I'm concerned."

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**Robert Jimerson - Lia Tricomo**

**From:** <webservice@co.thurston.wa.us>  
**To:** <jimersr@co.thurston.wa.us>  
**Date:** 6/17/2013 12:16 PM  
**Subject:** Lia Tricomo

\*\*\*\*\*

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\*\*\*\*\*

**Subject:** Lia Tricomo

**Sender Name:** justine turpin

**Sender Email:** justineturpin@cheerful.com

**Sent:** 6/17/2013 12:16:00 PM

**Sender Message:** This message regards Lia Tricomo. I wrote a 5 page letter to you on 6/13/2013 regarding the innocence of Lia. Over the weekend I found out that she was on a drug at the time of the incident. This was most likely a drug prescribed for her. Neither my son nor I knew she was prescribed a drug. Now I realize she is totally innocent. Information about the drug was not in any newspaper or Web articles about her. Lia should be freed. What has been done to her is so wrong. She is the victim here. She wasn't Liable for her actions. Do we lock up people on Date Rape Drugs?? Please let me know what I can do to help? The public and the judge has been totally misinformed about this case. sincerely, Justine Turpin

attention: attorney jensen  
re: Lia Tricomo

8/16/2013

I will be sending you a book on Paril  
Withdrawal, but have enclosed the book "Tonic  
Psychiatry." Prozac and Paril have similar  
actions on the brain, but paril with drawal  
can be much more serious. The books are by Peter  
Breggin, MD. He explains that behavior that looks  
like recitivism can appear when actually it  
is a totally new behavior brought on by the  
with drawl of Paril.

On page "A" of the packet please make  
note of the "flattering of emotional responses."  
that occurs on Paril.

I believe that Lia can not properly  
depend herself at this point. She is being  
held in a dark cell the past 2 weeks and on  
a limited diet. She doesn't have books or qualified  
psychiatric help.

She really needs a quality psychiatrist  
to defend her like Dr. Peter Breggin.  
a few years from now with all the  
new information on drug reactions + with drawal  
her treatment will be considered barbaric.

Sincerely,  
Justine Turpin



August 13, 2013

# THE HUFFINGTON POST

## FDA Warns that Paxil Makes Depressed Adults Suicidal

Getting the FDA to move forward by presenting it with scientific data is like using a peacock feather to tickle a sleeping giant tortoise on its shell. Many people die before the agency opens its eyes and then it barely reacts at all.

Bloated with conflicts of interest, under the best of conditions the FDA is barely able to drag itself along the ground. Slowly, oh, so slowly, it inches its way toward the obvious conclusion it can never quite reach: Antidepressants cause suicide; therefore, they aren't antidepressants at all. These drugs don't cure depression--and they frequently cause or worsen it. Regarding the most dreadful risk of depression, suicide, so-called antidepressants put depressed people of all ages at much greater risk of killing themselves.

### The FDA Confirms Antidepressant-Induced Suicidality in Adults

So, after years of prodding by me and more lately by a handful of other professionals, what new point in its journey has the FDA tortoise reached? In a May 2006 release in collaboration with the manufacturer GlaxoSmithKline (GSK), the FDA has acknowledged the antidepressant Paxil causes a statistically significant increased rate of suicidality in depressed adults as measured in controlled clinical trials (1). The results are based on a re-analysis of all adult controlled clinical trials that compared Paxil with placebo.

Buried in the FDA/GSK release is an astounding fact: **Depressed people are 6.4 times more likely to become suicidal while taking an antidepressant than while taking a sugar pill (2).**

No other antidepressants were mentioned in the FDA's warning but all SSRI antidepressants share a common profile of adverse mental and behavioral effects, including Paxil, Prozac, Zoloft, Celexa, Luvox, and Lexapro. Several other relatively new antidepressants have also been implicated in producing similar psychiatric abnormalities, including Wellbutrin, Effexor, Serzone, and Cymbalta. All of the newer antidepressants can produce stimulation or activation with the potential for increased agitation, anxiety, mood instability, disinhibition, irritability, aggression, hostility, mania, and crashing into depression and suicide. They can also cause a flattening of emotional responses, including a loss of caring, that can unleash dangerous actions (3, 4).

It is hard to cheer the FDA when in books and scientific reports, I've been warning about the risk of antidepressant-induced suicide (and violence) for fifteen years, starting in 1991 with *Toxic Psychiatry*. My most comprehensive scientific review of the subject was published in 2003 (4). In more recent years, other professionals have also joined the fray, especially Harvard psychiatrist Joseph Glenmullen. Scientific reviews confirmed that antidepressants cause suicidality in children and adults (5), but the FDA delayed acting on mounting evidence. To this day, the agency waffles about the importance of the antidepressant suicide risk. Thus far it has focused only on Paxil in regard to adult suicide and it has hinted that the risk may be slight when it is catastrophic. It also continues to avoid facing evidence that the drugs cause violence.

A few weeks before the FDA and GSK published their recent admission that Paxil can make adults more suicidal, I published a special report in *Ethical Human Psychology and Psychiatry* in which I released previously suppressed data indicating that GSK had manipulated its research results to hide the risk of Paxil-induced suicidality (6) (available on [www.breggin.com](http://www.breggin.com); also see previous blog). I based my observations on suppressed company data that I had discovered during a three-day investigation inside the drug company's secret files, working as a medical expert in a murder-suicide product liability case against the company. Simultaneously, I published on my website the original product liability report with all the scientific data that I had unearthed during those three days. More than a year earlier, I had informed the FDA at two of its public hearings that I possessed this sealed smoking gun. They never responded to me directly. Perhaps they are responding to me now.

### The Struggle to Enlighten the Public, the Profession and the FDA

Beginning with the widespread use of Prozac in the early 1990s, the struggle to gain public and professional recognition of antidepressant-induced suicide and violence has a long and stormy history. Drug advocates accused critics of Prozac of taking away a "lifesaving" treatment from depressed patients. Ironically, these same drug advocates would never be able to prove that Prozac or any other antidepressant can reduce the suicide rate; but the evidence has mounted, ultimately proving that these drugs can increase suicide and violence.

The struggle peaked in 1994 when I testified against Eli Lilly in a case of Prozac-induced suicide and mass murder. My testimony, in effect, was that the perpetrator, Joseph Wesbecker, hadn't gone "postal," he'd gone "Prozacal." After the drug company won a split jury decision, the judge realized that the trial had been fixed. The plaintiffs had been paid off by the drug company to conduct a fake trial that was rigged to end in favor of the drug company. The outraged judge voided the verdict. I have documented these events, including the judge's conclusions, in numerous sources including *Brain-Disabling Treatments in Psychiatry* (Springer, 1997).

The Prozac-soaked media simply ignored this bombshell. There were no headlines, "Drug Company Fakes Trial; Data Reveals that Prozac Causes Suicide and Violence." If either the media or the FDA had examined the data I generated for that legal case, followed by the fixing of the trial, it might not have taken twelve more years for the government and GSK to acknowledge

that Paxil causes suicidality in children *and* adults. Meanwhile, the FDA and the antidepressant manufacturers continue to deny that the drugs also cause violence. Because of this delay, many lives continue to come to tragic ends because of this delay.

#### Continued Obfuscation

The FDA and GSK continue to obfuscate the true risk in their May 2006 announcement concerning Paxil-induced suicidality in depressed adults. They emphasize the supposedly slight increase in suicidality among young adults (through age thirty) who take Paxil for a variety of conditions, including for depression, panic attacks, anxiety and obsessive-compulsive disorder. Far more important is the statistically significant increase in suicidality in all ages of depressed adults. It's worth restating that depressed people getting Paxil were 6.4 times more likely to display suicidal thoughts and behavior than depressed people taking a sugar pill. In regard to suicide--the most devastating risk associated with antidepressants--it is safer for depressed persons to stay off the drug!

The FDA allowed the Paxil manufacturer to soft pedal the results by claiming, for example, that the results could be compounded by the fact that suicide is an aspect of "psychiatric illnesses." This is nonsense--and every scientist knows it. Since both groups were depressed, and since they differed only in the substances they were given to take, Paxil and not depression was the cause of this astronomical increase in suicidality.

If depression had caused the increased suicidality, then the placebo patients--who lacked the supposed benefit of an antidepressant effect--would have suffered a much higher rate of suicidality than the Paxil patients. Instead, they had a much lower rate. In other words, because the antidepressants were supposed to be helping the depressed patients, the relative ineffectiveness of the sugar pill should lead to more suicidality than the drug, not less. The FDA, the drug company, and the media ignored this important fact. Conventional assumptions would have predicted increased suicidality on placebo instead of increased suicidality on Paxil. It's a complete reversal of the expected outcome, underscoring the seriousness of finding increased suicidality on the drug.

#### The Real-Life Risk Is Much Greater than Describe

It's nothing short of a miracle that GSK-sponsored clinical trials have demonstrated the increased risk of suicidality from antidepressants. If not a miracle, it's a confirmation that the risk is enormous--far more so than indicated by the studies. Keep in mind that controlled clinical trials are planned by the drug companies, supervised by the drug companies, and carried out by paid lackeys of the drug companies. Keep in mind that all the data analysis is done at drug company headquarters by drug company execs. Keep in mind that the trials are constructed in order to prove the usefulness of the drug and to minimize its adverse effects such as suicidality. Keep in mind that the controlled clinical trials are very short, usually 4-6 weeks long, and that prescreening excludes suicidal and psychotic patients from participating in the studies.

In real-life medical practice, the rate of drug-induced suicidality will be much higher than in the research-oriented controlled clinical trials. In actual practice, many patients are already suicidal when they are started on the drug, increasingly the likelihood that the drug will push them over into self-injurious behavior. In actual practice, compared to controlled clinical trials used for research, busy doctors provide much less supervision or monitoring, the patients are almost never tested or evaluated for suicidality, multiple drugs are often given at once, and the doctors know little about looking for adverse effects on the mind.

If Paxil increased the rate of suicidality by more than six times in the drug company's controlled clinical trials, it may be doing so by sixty times in actual practice. We can't determine exactly how much greater the risk will be in clinical practice but it will be astronomically greater.

#### And the Antidepressants Don't Even Work

Meanwhile, a comprehensive review of all studies of antidepressant drugs submitted for approval to the FDA showed that when the studies are taken as a whole, antidepressants don't work (7). A drug company may perform twenty studies in an attempt to show efficacy. Exemplified by the case of Prozac, as I described in *Talking Back to Prozac* (1994), as long as two studies show a positive effective, the FDA will approve the drug. If a drug company cannot massage their self-generated data sufficiently to obtain a positive result in two out of twenty clinical trials, the company's paid consultants and employees don't deserve to stay employed. And of course, they won't stay employed if they fail to meet the company's needs to promote new products.

Of course, many people feel helped by antidepressants, as well as many other psychiatric and even recreational drugs. The placebo effect is enormous. In addition, the artificial euphoria or emotional flattening produced at times by antidepressants may provide temporary relief at the cost of rationality and effective dealing with life.

It's time to say again what I've been saying for too many years on end. The antidepressants aren't antidepressants. They are more likely to make a person worse than better. More tragically, these toxic agents push many people over the brink into suicide and violence.

It's astonishing as I approach my 70th birthday that the FDA is beginning to catch up with what I've been saying for decades in regard to the limits of drugging children and adults to control their emotions and behavior. It's gratifying but also a little frustrating. No, I don't have a biochemical imbalance, I am outraged that my profession has consistently tried to foist off self-serving mythology as science and that so many people have been damaged or killed by the effects of the false biochemical diagnoses and toxic medications.

Meanwhile, the antidepressants are very difficult to stop taking. Withdrawal from antidepressants can lead to "crashing," with agitation, violence and suicide. Withdrawal from these noxious drugs should be done slowly with experienced clinical supervision. These drugs are not only unsafe to start--they are dangerous to stop.

**The best approach to antidepressants: Don't start taking them.**

Endnotes:



1. Dear Healthcare Professional: Important Prescribing Information [for Paxil]. By John E. Kraus, M.D., GlaxoSmithKline, Philadelphia, Pennsylvania, May 2006. Available on [www.fda.gov](http://www.fda.gov).
2. Among depressed adults taking Paxil, 0.32% displayed suicidal thoughts or behaviors compared to 0.05% among depressed adults taking placebo.
3. Breggin, P. (2006). Recent regulatory changes in antidepressant labels: Implications for activation (stimulation) in clinical practice. *Primary Psychiatry*, 13, 57-60. (PDF file)
4. Breggin, P. (2003). Suicidality, violence and mania caused by selective serotonin reuptake inhibitors (SSRIs): A review and analysis." *Ethical Human Sciences and Services* 5:225-246. Simultaneously published in the *International Journal of Risk and Safety in Medicine*, 16, 31-49, 2003/2004. (PDF file)
5. For a review of increased suicidality in adults taking Paxil, see: Aursnes, I., Tvette, I., Gassemyr, J., and Natvig, B. (2005). Suicide attempts in clinical trials with paroxetine randomised against placebo. *BMC Medicine*, 3:14. For suicidality in children, see: Jick, S., Dean, A., and Jick, H. (1995). Antidepressants and suicide. *British Medical Journal*, 310, 215-218.
6. . Breggin, P. (2006). Court filing makes public my previously suppressed analysis of Paxil's effects. *Ethical Human Psychology and Psychiatry*, 8, 77-84. (PDF file)
7. For the review demonstrating lack of efficacy in antidepressant studies conducted for FDA approval, see: Antonuccio, D., Burns, D., and Danton, W. (2002). Antidepressants: A triumph of marketing over science? *Prevention & Treatment*, 5, Article 25, 1-17. For a study of the lack of efficacy demonstrated by Prozac studies submitted to the FDA, see Breggin, P. and Breggin, G., *Talking Back to Prozac*, New York: St. Martin's Press, 1994.

Dr. Breggin's latest book is *Medication Madness: A Psychiatrist Exposes the Dangers of Mood-Altering Medications* (2008) and his revised and updated website is [Breggin.com](http://Breggin.com).

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What your doctor may not know

# Psychiatric Drug Facts

with Dr. Peter Breggin

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## Paxil Withdrawal Case Settled in California

A California lawsuit against Glaxo SmithKline (GSK) charged the drug company with failing to warn the public about the dangers of Paxil withdrawal. Glaxo SmithKline (GSK), the manufacturer of the antidepressant Paxil, resolved the suit in January 2002. The results of the resolution, including any settlement by defendant Glaxo SmithKline, were not announced. The outcome was described as a resolution rather than a settlement.

Psychiatrist Peter Breggin, M.D. was the plaintiff's medical expert and worked closely with the attorneys in formulating the suit. According to Dr. Breggin, there is published and clinical evidence that all of the SSRIs can cause serious withdrawal reactions. Paxil, because of its intense impact and short duration of action, causes the most severe withdrawal reactions.

Paxil is an antidepressant of the SSRI class that also includes Prozac, Zoloft, Celexa and Luvox. The suit charged that Paxil causes serious withdrawal problems of many kinds, resulting in a widespread societal problem when many individuals find themselves unable to stop taking the drug.

The Paxil withdrawal suit was brought in San Jose, California on August 19, 2000 as a "Complaint for Injunctive Relief Under Business and Professions Code" (Nguyen & Farber, plaintiffs vs. SmithKline Beecham Corporation, Case No: CV791998).

[Legal brief for the resolved Paxil withdrawal suit](#)

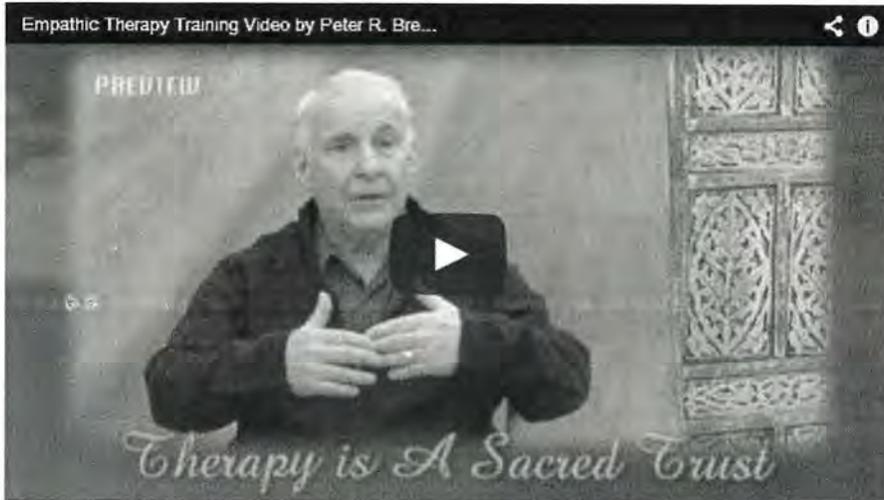


### PSYCHIATRIC DRUG WITHDRAWAL

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#### WARNING!

Most psychiatric drugs can cause withdrawal reactions, sometimes including life-threatening emotional and physical withdrawal problems. In short, it is not only dangerous to *start* taking psychiatric drugs, it can also be dangerous to *stop* them. Withdrawal from psychiatric drugs should be done carefully under experienced clinical supervision. Methods for safely withdrawing from psychiatric drugs are discussed in Dr. Breggin's new book, [Psychiatric Drug Withdrawal: A Guide for Prescribers, Therapists, Patients, and Their Families](#).

*Dangerous to stop  
taking Paxil*

search...

Prozac Turned  
Teen into  
murderer -  
Judge agrees with  
psychiatrist  
Peter M.P.

"Judge Agrees Prozac Made Teen a Killer." Provincial court judge Robert Heinrichs listened to expert psychiatric testimony for the defense by Peter R. Breggin, MD and weighed it against testimony for the prosecution by a Canadian psychiatrist.

On September 16, 2011 the judge issued his opinion in regard to a sixteen-year-old who stabbed his friend to death. The judge determined, "His basic normalcy now further confirms he no longer poses a risk of violence to anyone and that his mental deterioration and resulting violence would not have taken place without exposure to Prozac." Also consistent with Dr. Breggin's lengthy report and testimony, the judge observed, "He has none of the character of a perpetrator of violence. The prospects for rehabilitation are good."

This was the first criminal case in North America where a judge specifically found that an antidepressant was the cause of a murder.

In his written opinion in the case of "Her Majesty the Queen v. C.J.P." (Citation #2011 MBPC 62), Judge Heinrichs concluded, "Breggin's explanation of the effect Prozac was having on C.J.P.'s behavior both before that day and in committing an impulsive and inexplicable violent act that day corresponds with the evidence." He also found, "there is clear medical and collateral evidence that the Prozac affected his behaviour and judgment, thereby reducing his moral culpability" (p. 20). The judge's complete opinion is available at Dr. Breggin's professional website, [http://breggin.com/index.php?option=com\\_content&task=view&id=295](http://breggin.com/index.php?option=com_content&task=view&id=295)

The case involved a teenage high school student with no prior history of violence who, while chatting in his home with two friends, abruptly stabbed one of them to death with a single wound to the chest. The boy had been taking Prozac for three months, during which time his behavior deteriorated. He became impulsive and unpredictable, and suicidal. He also began to talk at times as if fantasizing about violence. He seemed to become a different person to his distraught parents. Dr. Breggin testified that his primary physician and his parents alerted the prescribing psychiatrist of the boy's deteriorating condition, but the clinic continued the medication and then increased it. Seventeen days after the increase in dosage, the teen committed the violence.

Starting approximately 2005 to the present, the FDA-approved labels for all antidepressants as found in the annual *Physician Reference* includes the following information under the section WARNINGS-Clinical Worsening and Suicide Risk:

"All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.

The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric."

This list of adverse effects—"anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania"—is a prescription for violence. The teen in this case suffered from all these dangerous effects which worsened during the time of his exposure to Prozac.

The Canadian drug regulatory agency, Health Canada, has warned that Prozac is not authorized for use in children and that it carries a "self-harm or harm to others." According to a warning issued



by the drug manufacturer, Eli Lilly, and Health Canada:

"There are clinical trial and post-marketing reports with SSRIs and other newer anti-depressants, in both pediatrics and adults, of severe agitation-type adverse events coupled with self-harm or harm to others. The agitation-type events include: akathisia, agitation, disinhibition, emotional lability, hostility, aggression, depersonalization. In some cases, the events occurred within several weeks of starting treatment."

Dr. Breggin wrote in his report and testified that the boy's symptoms were consistent with a Prozac (fluoxetine) Induced Mood Disorder with Manic Features and that he would not have committed the violence if he had not been given the antidepressant. He also testified that the teen had improved dramatically when removed from the Prozac after a few months in jail and that he was no longer a danger to himself or others. He brought numerous independent scientific studies to court confirming that a large percentage of those exposed to the newer antidepressants will develop these hazardous adverse drug reactions. He also noted that the observations are even the wording of his own earlier scientific publications had been included into the information now found in the official FDA-approved labels. Dr. Breggin's scientific articles concerning antidepressants can be found on his website on his 'Antidepressants information' page.

The original hearing was to determine whether or not the 17-year-old should be sentenced as a minor, in which case his maximum jail time would be limited to four years. The prosecution wanted him tried as an adult. On September 16, 2011, Judge Heinrichs decided that the boy would be tried as a minor and that his deterioration and violent behavior was caused by Prozac. On November 4, 2011 the judge will determine how much of the remaining four years the teenager will serve.



The judge's decision represents an enormous step forward in recognizing that the newer antidepressants can cause violence.

Digging deeper? See these links, including scientific reference: Dr. Breggin:

[Antidepressant-Induced Suicide, Violence and Mania](#)

[Intoxication Anosognosia \(Medication Madness\)](#)

[Suicidality, Violence and mania caused by SSRIs: A Review](#)

[Brain-Disabling Treatments in Psychiatry \(2008\): Drugs, Electroshock, and the Psychopharmaceutical Complex](#)

[The Canadian judge's written opinion is available here.](#)

## Evidence of Birth Defects from Paxil, Zoloft and other SSRI Continues to Mount

Birth defects from the SSRI antidepressants, including Paxil, Zoloft and others are being further documented.

Recently a former executive of GlaxoSmithKline, testified that the company admitted that its SSRI, Paxil was the likely cause of a defect reported in 2001 and to the company.

Bloomberg reported:



Sept. 18 (Bloomberg) -- Officials of GlaxoSmithKline Plc, the U.K.'s largest drugmaker, said in 2001 that a birth defect in the fetus of a woman taking its Paxil antidepressant likely was linked to the drug, according to court testimony.

After analyzing a 2001 e-mail from a Paxil user who aborted her fetus because it had a heart defect, Glaxo officials noted in company files they were "almost certain" the drug was related to the problem, Jane Nieman, a former Glaxo drug-safety executive, told a Pennsylvania jury.

"I don't know who made that assessment, but it's there," Nieman testified in a videotaped deposition played yesterday for jurors. Nieman's testimony came in the trial of another Paxil user's lawsuit over birth defects suffered by her now 3-year-old son.

The state-court trial in Philadelphia is the first of more than 600 cases alleging Glaxo knew Paxil caused birth defects and hid those risks to increase profits. The drug, approved for U.S. use in 1992, generated about \$942 million in sales last year, 2.1 percent of Glaxo's total revenue.

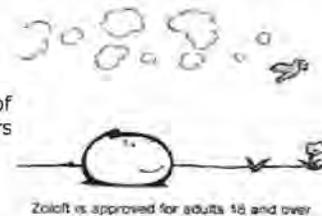
The family of Lyam Kilker claims Glaxo withheld information from consumers and regulators about the risk of birth defects and failed to properly test Paxil. Lyam's mother, Michelle David, blames Paxil for causing her son's life-threatening heart defects.

Separately, patient advocacy law firms are increasingly providing information via the internet and television advertisements to those who may have children suffering from birth defects from in-utero exposure to an SSRI. Here is one website with extensive information about the potential birth defects. The [Zoloft Cent](#) states in part:

Researchers in the United States and Europe have linked SSRI drugs like Zoloft to serious birth defects like skull deformities, defects of the brain and spine, heart defects, lung defects, abdominal defects, club foot and facial cleft deformities.

In many cases, scientists found that SSRI drugs such as Zoloft increased the risk of severe birth defects by as much as 600%.

Unfortunately, Zoloft has been taken by hundreds of millions of people and the makers of the drug gave no warning about the serious health risks like Zoloft birth defects. They have continued to sell it to patients around the world earning billions of dollars per year.



If you took Zoloft and have given birth to a child with birth defects, it is important to speak with a lawyer as soon as possible. The time to recover for your child's condition is limited.

For further information on SSRI related birth defects see:

["Exposure to SSRI Antidepressants In Utero Causes Birth Defects, Neonatal Withdrawal Symptoms, and Brain Damage"](#) by Pete Breggin MD and Ginger R. Breggin, *Ethical Human Psychology Psychiatry*, 10, 5-9, 2008

**New Study: Women Taking Antidepressants While Pregnant have**

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**Background Science**

SSRI's including Prozac, Paxil, Zoloft, Luvox and Celexa block the removal of serotonin from the synapse or space between neurons. Other antidepressants, such as Effexor, can also block this reuptake of serotonin causing similar effects. These drugs can cause suicide, violence and other criminal acts through several mechanisms, including the following:

(1) SSRI-induced mania, sometimes (but not always) with psychotic features, such as hallucinations or delusions. During drug-induced mania, the individual can make elaborate plans, including robberies or embezzlement. However, the plans are often outlandish and doomed to failure due to obviously poor judgment. Drug-induced mania can cause many expressions of disinhibited or out-of-control behavior, including sexual acting out, road rage, buying sprees and shoplifting. Drug-induced mania, even when seemingly not intense, can ruin marriages and destroy careers.

All of the features of mania are not required in order to meet the diagnosis of Antidepressant-Induced Mood Disorder with Manic Features: If the individual's mood is "elevated, euphoric, or irritable," the necessary criteria are met.

(2) SSRI-induced depression or worsening of depression. In a seemingly paradoxical effect, antidepressants can cause or worsen depression. In controlled clinical trials for Prozac that were conducted by the manufacturer, Eli Lilly and Company, depressed patients taking Prozac attempted suicide more frequently than depressed patients taking placebo (sugar pill) or older antidepressants.

(3) SSRI-induced severe anxiety and agitation, especially in a patient already suffering from depression with anxiety and agitation;

(4) SSRI-induced obsessions and compulsions that motivate violence toward oneself or others.

(5) SSRI-induced akathisia, an internal sensation of agitation or discomfort that drives a person to move about, and also to lose impulse control. During akathisia, the inner experience of agitation includes many unusual physical feelings, such as electricity in the head or body. The person suffering from akathisia typically feels compelled to move the feet when sitting, to stand, or to pace. Akathisia is known to increase the risk of suicide and violence.

*Was this a Compiment ?*

**Severe Adverse Effects After One or Two Doses**

Dr. Breggin stated that physicians and patients are not aware that many severe adverse drug effects can surface after the first or second dose of any SSRI antidepressant. Because the "therapeutic effect" of any antidepressant usually takes several weeks or more to develop, some doctors fail to realize that toxic effects can develop beginning with the first dose. These doctors are not likely to warn patients and their families about adverse events occurring after one or two doses. Furthermore, these doctors may discount the patient's report when these early reactions occur. They may urge the patient to continue taking the drug so that the patient ends up developing an unnecessarily severe reaction.

Dr. Breggin is a medical expert in cases in which SSRI antidepressants, including Prozac, Paxil, Zoloft, Celexa and Luvox, have caused suicidal and violent behavior in individuals while taking the drug rather than during withdrawal. In some cases, it can be difficult to determine if the adverse drug effect is caused by direct drug toxicity, by drug withdrawal, or by both.

Dr. Breggin is also involved in a variety of other suits relating to harmful effects of the SSRIs. This website contains additional relevant materials, including >discussions of other lawsuits, and details about how the SSRI antidepressants can cause mania, psychosis, depression, violence, and suicide.

Brief filed in Paxil withdrawal suit

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## GSK Updates the Paxil Label

In December, in an event that may have been in part motivated by the Paxil withdrawal suit, GSK finally updated its label for Paxil with a specific mention of the danger of Paxil withdrawal reactions. One of the attorneys who filed the suit, Don Farber of San Rafael, California, told Dr. Breggin that it is highly likely that the suit influenced both the drug company and the FDA to strengthen the label in regard to Paxil withdrawal effects. Farber and his colleague Vince Nguyen voluntarily dismissed the suit when the new label was issued on December 14, 2001.

The revised label uses the industry-favored term "discontinuation" instead of withdrawal. Discontinuation is a euphemism for withdrawal that is used to circumvent the negative connotations associated with addiction, dependency and withdrawal syndrome. By using the term discontinuation instead of withdrawal, the drug company obscures the potential severity of these symptoms and their tendency to force patients to continue taking the drug.

The updated label can be found on the company website ([www.GSK.com](http://www.GSK.com) under Products).

In the Precautions section of the new label, GSK cites clinical trial data confirming the existence of several withdrawal symptoms, including abnormal dreams, paresthesia [abnormal sensations], and dizziness. According to the label, since the marketing of Paxil, other withdrawal symptoms have been reported in association with the discontinuation of the drug. These post-marketing reports include "dizziness, sensory disturbances (e.g., paresthesias such as electric shock sensations), agitation, anxiety, nausea and sweating." However, the company claims that the reactions reported since the start of marketing "may have no causal relationship to the drug" and are "generally self-limiting."

Dr. Breggin stressed the importance of the "anxiety" and "agitation" mentioned in the label as reported in association with Paxil withdrawal. He observed that anxiety and agitation can contribute to aggressive, violent or suicidal behavior. Aggressive behavior is especially likely to result when a drug causes or increases agitation and anxiety in individuals already suffering from psychiatric disorders such as anxiety, depression, panic, stress, and obsessions or compulsions. Dr. Breggin also stated that there is a growing body of clinical and research literature demonstrating irritability and aggression during withdrawal from Paxil. However, the updated label makes no mention of any danger of aggressive, violent or suicidal behavior during Paxil withdrawal. \*

Dr. Breggin was gratified to see the company update its label to specifically mention withdrawal reactions. However, he described the updated label as grossly inadequate in regard to the range, intensity and persistence of Paxil withdrawal reactions, including the danger of aggressive, violent, or suicidal behavior, and an overall worsening of the patient's mental condition.

## Longstanding Concerns About SSRI Withdrawal Effects

Dr. Breggin was among the first to warn about the dangers of SSRI withdrawal in his book *Talking Back to Prozac* (with Ginger Breggin, St. Martin's Press, 1994) and in two more recent books, *Brain-Disabling Treatments in Psychiatry* (Springer Publishing Company, 1997, revised 2008) and *The Antidepressant Fact Book* (Perseus Books, 2001). Dr. Breggin and co-author David Cohen, Ph.D. also discuss the overall problem of drug withdrawal in *Your Drug May Be Your Problem: How and Why to Stop Taking Psychiatric Medications* (Perseus Books, 1999, revised 2007). These books should be consulted for documentation and further discussion of the issues surrounding the SSRI antidepressants such as Paxil, Prozac, Zoloft, Celexa and Luvox.

Dr. Breggin is currently a medical expert in other cases related to Paxil withdrawal. In a criminal case, a young man physically assaulted a female friend while he was undergoing withdrawal from Paxil. The young man had no previous history of violence. The assault was extremely out of character.

Dr. Breggin is also actively involved in treating patients who have experienced serious difficulty withdrawing from Paxil and other SSRI antidepressants. Headaches, nausea, dizziness, painful internal sensations, and various manifestations of emotional distress can make it difficult to withdraw from these medications. Some patients experience very lengthy withdrawal periods lasting several months or more.

## Direct Toxic Effects Caused by SSRIs

In 1994 Dr. Breggin developed and provided the scientific basis for a large series of combined product liability cases alleging violence and suicide caused by Prozac. The court combined the cases in order to facilitate the discovery process. It facilitated one organized effort for evaluating secret materials obtained from the company. In his role as the medical expert for the combined cases, Dr. Breggin reviewed internal documents from Eli Lilly & Company, the manufacturer of Prozac, and also interviewed FDA officials, examined FDA materials, and reviewed and analyzed the scientific literature. In a more recent suit product liability suit against Eli Lilly & Company, Dr. Breggin once again had the opportunity to examine internal documents, this time at the corporate headquarters. As far as Dr. Breggin is aware, all of the individual Prozac product liability suits in which he has agreed to be an expert have been settled or remain active.

(K)



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[Wow, I'm an American! How To Live Like Our Nation's Heroic Founders.](#)

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potential to cause withdrawal reactions. Earlier in this chapter, I described a patient with such severe withdrawal symptoms that she felt compelled to resume taking the drug. The PDR further states, "it is not possible to predict on the basis of this limited experience the extent to which [Prozac] will be misused, diverted, and/or abused once marketed." That is, the drug may yet turn out to be habit-forming or addictive.

Prozac & Serotonin  
Returns to Brain

### Murder and Suicide Associated with Prozac

Newspaper and scientific reports are pointing to an association between Prozac and compulsive self-destructive and murderous activities in a growing number of patients. \* In "Murder Trials Introduce Prozac Defense" in the February 7, 1991, *Wall Street Journal*, Amy Dockser Marcus reports, "A spate of murder trials in which defendants claim they became violent when they took the antidepressant Prozac are imposing new problems for the drug's maker, Eli Lilly & Co." An article by Natalie Angler on the same day in the *New York Times* declared in its headline, "Suicidal Behavior Tied Again to Drug: Does Antidepressant Prompt Violence?"<sup>9</sup> On February 28, 1991, a "Donahue" TV talk show put together a group of individuals who had become compulsively self-destructive and murderous after taking Prozac and the clamorous telephone and audience response confirmed the problem.

The clinical literature also displays a growing number of reports of compulsive suicidal behavior in people taking Prozac. An article by Mar-chatry described six cases of obsessive, violent suicidal thoughts after starting Prozac,<sup>10</sup> and more recently a variety of individual case reports have reinforced these initial observations. I am personally familiar with several cases of compulsive suicidal or violent feelings developing after taking Prozac. Recently I presented a seminar on Prozac and its dangers at the psychiatric grand rounds of a hospital. After I concluded, one of a highly responsible corporate executive had unexpectedly become very violent one week after starting to take Prozac. The patient had no prior history of violence and described the impulse as taking him over. He had to be subdued by several men after he attacked a stranger without provocation during a minor quarrel.

### How Prozac Could Cause Seemingly Paradoxical Reactions

As noted in chapter 7, some researchers believe they have found an association between diminished or sluggish activity of serotonin and impulsive acts such as suicide and murder.<sup>11</sup> While Prozac is supposed to enhance serotonin neurotransmission, the brain in fact reacts to the first dose by *reducing serotonin activity*, including that to the emotion-regulating centers. Researchers for the pharmaceutical company itself, Eli Lilly, first described this reaction before the drug was even named. In *Life Sciences* (1974), Ray Fuller and colleagues from the Lilly Research Laboratories reported that one dose of Prozac (then called Lilly 110140) caused a marked drop in serotonin nerve activity for more than twenty-four hours. They suggested that this was the result of a "compensatory mechanism" in reaction to initial overstimulation. As further documented by Claude de Montigny and his team in the December 1990 *Journal of Clinical Psychiatry* and by Pierre Blier et al. in the 1988 *Navy-Schmiedeberg's Archives of Pharmacology*, Prozac and similar drugs initially cause a *suppression* of serotonergic neurotransmission that gradually returns to normal over a three-week period. In a phone call interview with me in early 1991, Montigny agreed that this compensatory sero-nergic *shutdown* mechanism could possibly account for the out-of-control destructive reactions to initially taking the drug, but he considered the suggestion "speculative." However, it is no less speculative than the drug company's claim that Prozac alleviates depression by enhancing sero-nergic neurotransmission.

Prozac can also produce a relative shutdown of serotonergic neurotransmission during long-term use through another mechanism called down-regulation. When neurotransmitter systems are overstimulated, some of them tend to become relatively nonreactive. One way this occurs is through a reduction in the density of the receptors for the neurotransmitter. Prozac-induced down-regulation occurs<sup>12</sup> and is even mentioned in the 1991 USP DI *Drug Information for the Health Care Provider*, but without indicating the potentially disastrous outcomes associated with it.

### Prozac as a Stimulant

There are still other ways of understanding how Prozac could produce both murderous and suicidal behavior. Prozac often affects individuals as if they are taking stimulants, such as amphetamine, cocaine, or PCP. When testing a drug for amphetamine-like or stimulant qualities in animal research, the two main criteria are an energizing effect and an appetite

\* See chapter 7 for my criticism of directly associating particular biochemical alterations with specific behaviors.

*Assigned Counsel: When I talked with Lia 11/23/2013 she was having misgivings about her complaints to Wash State Bar. Her Pro Bono Counsel Elaine Thomas allows to want her to remain with Mr. Jameson. Lia has not heard from Assign. Counsel for well over a month.*

The following is a list of expert witnesses that Lia Tricomo needs for her trial. All of them will need to be screened for qualifications, credentials, educational background, whether they are authors of books dealing with the subject they are testifying about, or testified in court on the same subject before Lia's Trial. *This is a partial list of expert witnesses*

1. A Forensic Psychologist or Psychiatrist to deal with her inability to tell right from wrong at the time of the incident because of the drug Paxil. This requires careful testing and psychological examination.
2. An Expert in Paxil most likely a Psychiatrist of the caliber of Dr. Peter Breggin will be needed as it is now well known that Paxil is connected to violence and especially when a person is being withdrawn from the drug. Paxil withdrawal stimulates some areas of the brain while at the same time decreasing activity in other parts of the brain. It will take an expert, just in this area, to explain this complicated process to the jury.
3. An Expert in Depression, a person with at least a PHD in this area will be needed to explain how improperly treated or untreated depression leads to alcohol and drug abuse. It appears that Lia Tricomo was not being treated properly by her BHR counselor for months before this incident.
4. It needs to be explained that this incident is not recidivism. This is a totally separate incident from previous incidences that required care at Western State. For a year she was not involved in Domestic Violence and was seeking psychological help. This incident was the result of improper withdrawal of the drug Paxil. Although a juror might be led to see this incident as being the result of alcoholism, that is most unlikely. Also, Lia was left unable to resist the temptation of alcohol due to the Paxil withdrawal reaction. She was left with no self-control because of the abrupt Paxil withdrawal.
5. It needs to be carefully explained that Mr. Altman was a predator. Lia's life was in danger. I think you can talk to Lia's pro Bono attorney Elaine Thomas about this. (If he would give up his own life, surely she was in danger of losing hers.)
6. Someone needs to examine Lia's traumatic life and how improper Psychiatric help has led her to this point. Her severe reaction to previous drugs needs to be outlined. At one point a drug reaction was improperly diagnosed and she was sent to Western State for this reaction and missed court dates. The reaction was akathisia which is an unpleasant sensation of inner restlessness with an inability to sit still caused by a drug that was administered to Lia previously. Lia has suffered terribly. This will require another Psychiatric expert.

I think Lia is evaluating her choices. She has been left alone for over a month with no advice from her assigned counsel. She now understands the hardships in that area. She needs counseling from the assigned counsel's office and then from her family and friends and pro bono attorney. If there is no money for the trial and experts she needs, everyone needs notification, *so we can figure out how to get her help.*

Sincerely, Justine Turpin 360-357-9631 905 Quince St. N.E., Oly

Washington 98506/

**RECEIVED**

NOV 22 2013

OFFICE OF  
ASSIGNED COUNSEL

*Justine Turpin 11/25/2013  
(I am a friend of Lia Tricomo and told her I would drop this off + talk with you about some problems.)*

**Robert Jimerson - Lia Tricomo**

**From:** <webservice@co.thurston.wa.us>  
**To:** <jimersr@co.thurston.wa.us>  
**Date:** 9/11/2013 1:19 PM  
**Subject:** Lia Tricomo

\*\*\*\*\*

Please note the following: This e-mail message was generated using the Thurston County E-mail Web Application. The 'Sender Email' address in the message body is as entered by the user and may not be valid. **The 'From' e-mail address in the message header cannot be replied to.**

\*\*\*\*\*

**Subject:** Lia Tricomo

**Sender Name:** justine turpin

**Sender Email:**

**Sent:** 9/11/2013 1:19:04 PM

**Sender Message:** Lia writes that there is so much noise in the Jail at night from other inmates that she is unable to sleep and then sleeps some during the day. Until things quiet down at night, as it seems they have been bringing in ladies with severe problems, I don't think she is able to handle contributing to her defense. The person you saw in May was not the real Lia. Paxil withdrawal is a terrible thing and I have sent for a text book on Psychiatric Drug Withdrawal and hope it has some specifics on Paxil as this is the worst. I don't think she can view the photos of what happened just yet and in such a state. Now we are beginning to see how truly caring she is and so sorry about what happened. I guess some psychologist said she was competent and I know the criteria for that is very loose. At the very least she needs a caring empathetic person with her as this could be psychologically stunning and we don't want to lose Lia Forever. I will try to talk to Lia about her pro bono attorney Elaine Thomas a little more this Saturday. Perhaps she will want her with her, but maybe not. I have had to view 11 bodies in my life and we do get somewhat toughened by things and forget how fragile people can be. I know I wrongly brought up some subjects Lia could not handle. Sincerely, Justine Turpin

**Robert Jimerson - Lia Tricomo**

---

**From:** <webserver@co.thurston.wa.us>  
**To:** <jimersr@co.thurston.wa.us>  
**Date:** 11/7/2013 8:56 PM  
**Subject:** Lia Tricomo

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\*\*\*\*\*

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\*\*\*\*\*

**Subject:** Lia Tricomo

**Sender Name:** Justine Turpin

**Sender Email:** justineturpin@cheerful.com

**Sent:** 11/7/2013 8:55:46 PM

**Sender Message:** This total message will be comprised of 3 messages: Lia Tricoma is in need of 4-6 expert witness for her Trial. She needs and expert witness in the field of Paxil and abrupt Paxil withdrawal. She needs a witness in the field of mental depression and how it leads to alcohol and street drugs if it is left untreated or improperly treated. She needs a psychologist to address the jury in the problems a person can have with a traumatic life and many medication reactions and mistakes. also the problems of having a predator for a psychological counselor and the methods of such people

**Robert Jimerson - Lia Tricomo**

---

**From:** <webserver@co.thurston.wa.us>  
**To:** <jimersr@co.thurston.wa.us>  
**Date:** 11/7/2013 9:08 PM  
**Subject:** Lia Tricomo

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\*\*\*\*\*

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\*\*\*\*\*

**Subject:** Lia Tricomo

**Sender Name:** Justine Turpin

**Sender Email:** justineturpin@cheerful.com

**Sent:** 11/7/2013 9:08:15 PM

**Sender Message:** continuation of message re Lia Yera Tricomo. Lia Needs an expert that can explain how abrupt Paxil withdrawal can leave a person with the inability to tell right from wrong and with no self control and thus the inability to refuse alcohol when this is made readily available. She also needs a expert witness in Post traumatic stress and how her responses when arrested would be very abnormal and an expert in Jurisprudence to respond to the jury about the Judges remarks in the newspaper that she had "no remorse" thus sullyng the jury pool. A careful evaluation of who is treating her with drugs that cause tardive dyskinesia needs to be done. Already remarks have been made on a nationwide website about what the judge said and what should be done to Lia. There has been no rebuttal. Can she now receive a fair trial at all. done to make sure there is no conflict of interest. More will be added to this e-mail.





1           5.       Exhibit 15 are some of Ms. Tricomo's medical records I obtained from the  
2 Department of Corrections.

3           6.       Exhibit 17 contains Dr. David Dixon's resume found on the internet and his  
4 curriculum vitae which I found in the files of the Thurston County Office of Assigned  
5 Counsel. My office staff tried to obtain a current c.v. from Dr. Dixon's office but we have  
6 been unable to obtain one.

7           7.       Exhibit 18 is the curriculum vitae that Dr. Delton Young sent to me in response  
8 to a recent request.

9           8.       Exhibit 19 is the curriculum vitae of Dhyana Fernandez which I found in the  
10 files of the Thurston County Office of Assigned Counsel.

11          9.       Exhibit 21 are copies of some correspondence from Justine Turpin to Ms.  
12 Tricomo's attorneys that I found in the files of the Thurston County Office of Assigned  
13 Counsel.

14           I certify or declare under penalty of perjury under the laws of the State of Washington  
15 that the foregoing is true and correct.

16           Dated this 31<sup>st</sup> day of December 2018, at Seattle, WA.

17           s/ Neil M. Fox  
18           \_\_\_\_\_  
19           WSBA No. 15277  
20  
21  
22  
23  
24  
25  
26  
27  
28

**DECLARATION OF SERVICE**

I, Neil M. Fox, certify and declare as follows:

On the 31st day of December 2018, I served a copy of this pleading on all parties, by filing it through the Portal and thus a copy will be delivered electronically.

I certify or declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Dated this 31st day of December 2018, at Seattle, Washington.

s/ Neil M. Fox

\_\_\_\_\_

WSBA No. 15277

Attorney for Petitioner

**LAW OFFICE OF NEIL FOX PLLC**

**December 31, 2018 - 1:17 PM**

**Transmittal Information**

**Filed with Court:** Court of Appeals Division II  
**Appellate Court Case Number:** 51741-8  
**Appellate Court Case Title:** In re the Personal Restraint Petition of Lia Yera Tricomo  
**Superior Court Case Number:** 13-1-00655-7

**The following documents have been uploaded:**

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This File Contains:  
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*The Original File Name was Exhibits.pdf*
- 517418\_Personal\_Restraint\_Petition\_20181231131458D2745535\_4544.pdf  
This File Contains:  
Personal Restraint Petition - Other  
*The Original File Name was Amended PRP and Reply 123118.pdf*

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SEATTLE, WA, 98121  
Phone: 206-728-5440

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