ORIGINAL

No. 91387-1

SUPREME COURT OF
THE STATE OF WASHINGTON

IN THE COURT OF APPEALS, DIVISION III
OF THE STATE OF WASHINGTON

NO. 318141

BEVERLY VOLK, et al.,
Appellants,

v.

JAMES B. DERMEERLEER, et al.,
Respondents

PETITION FOR REVIEW

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A. IDENTITY OF PETITIONER

Dr. Howard Ashby asks this Court to accept review of parts of the decision as set forth in Part B of this motion.

B. DECISION FOR REVIEW

Dr. Ashby requests review of the Division Three Court of Appeals decision in *Volk v. DeMeerleer, et.al*, Cause No. 31814-1-III, attached as Appendix A.[1] As is set forth herein, in reversing the trial court's summary dismissal of the negligence claim against Dr. Ashby, the Court of Appeals imposed on private-practice psychotherapists providing mental health care in an outpatient setting a generalized, ambiguous duty to protect third persons from "foreseeable harm." This duty was originally established in the context of "in-custody" or "take charge" treatment, and for the reasons set forth below, the Court of Appeals' imposition of such an undefined and amorphous duty on private practitioners is contrary to the public interests of this state, as it infringes on the very purposes of the physician-patient privilege and casts doubt and uncertainty for practitioners regarding the competing interests of protecting patient confidences versus disclosing those confidences to protect against possible or potential harm to third persons. RAP 13.4(b)(4). In the end, a vague duty imposed by the Court

[1]Dr. Ashby filed a motion for reconsideration of the Court of Appeals decision on December 3, 2014. The Court of Appeals issued its decision denying reconsideration on February 3, 2015.

of Appeals discourages persons from seeking the mental health care they need and/or fully disclosing confidences to their provider, and likewise discourages mental health providers from accepting "high risk" patients who may present liability concerns to the practitioner if he or she guesses wrong in attempting to comply with the ill-defined duty to protect.

Specifically, Dr. Ashby seeks review of this case so that the Court can unambiguously identify under what circumstances a psychotherapist in private practice must disclose patient confidences to protect third parties. This Court should accept review to bring Washington in line with the overwhelming number of states that require disclosures only when the patient expresses a specific threat against a readily identifiable person.

Dr. Ashby also asks this Court to accept review of the Court of Appeals decision as it relates to the conclusion that the law "likely recognizes two levels of speculation, one for purposes of summary judgment, and one for the purpose of finding facts after an evidentiary hearing or trial." *Volk*, 337 P.3d at 393. As is set forth herein, the double-standard created by the Court of Appeals is contrary to Washington law, necessitating review pursuant to RAP 13.4(b)(1) and (2).

A copy of the trial court order granting summary judgment is attached as Appendix B. A copy of the declarations from lay witnesses, co-workers and family of Mr. Jan DeMeerleer is attached as Appendix C. A

copy of Dr. Ashby's office notes is attached as Appendix D. A copy of Dr. Ashby's Reply Brief in Support of Summary Judgment and Motion and Memorandum to Strike Dr. Knoll's declaration is attached as Appendix E.

C. ISSUES PRESENTED FOR REVIEW

The Court of Appeals acknowledged that this case presents the "humbling and daunting task of demarcating the duty a mental health professional owe[s] to third parties to protect them from the violent behavior of the professional's outpatient client." *Volk v. Demeerleer*, 337 P.3d 372, 327 (2014). In undertaking this "humbling and daunting task," the Court of Appeals specifically identified the following issues presented by this case: (1) What duty is owed by a mental health professional to protect a third party from the violent behavior of the professional's patient or client; (2) Does a mental health professional owe a duty to protect a third person, when an outpatient, who occasionally expresses homicidal ideas, does not identify a specific target; (3) Does the language of RCW 71.05.120(2) apply by analogy outside the context of an involuntary commitment; and (4) Is a mental health professional's duty of care, when treating a voluntary outpatient, limited to warning someone identified by the patient as a target of an act of violence? *Id.*

Dr. Ashby submits that the Court of Appeals correctly identified the issues but, as suggested in the Court of Appeals' opinion, these issues must

now be resolved by this Court. The scope of the duty owed by a private practice mental health professional to a non-client/third person is a matter of substantial public interest to mental health professionals, mental health clients and the public. As is set forth below, Washington is one of but a few states that has not specifically and directly defined that scope of duty as Dr. Ashby requests herein. This case provides an opportunity to define the duty owed by professionals with clear guidelines/parameters as to when action should be taken for the protection of third parties. Additionally, defining the duty will give mental health patients the security of knowing that the confidences they share with their mental health professionals will not be disclosed absent an actual and imminent threat of harm to an identifiable person. Fundamental to mental health care is the encouragement of patients to share information freely with mental health professionals, and the public interest is served when patients in need of mental health care in fact seek out that care and are forthcoming with their thoughts and feelings without the threat of unnecessary breaches confidence arising from the uncertainty of when the law requires that a third-person be warned about the vague, potential actions of a patient.

Also presented for review is the issue of whether Washington law recognizes "two levels of speculation" depending upon whether the evidence is considered at summary judgment or at trial. Since the

sufficiency of expert causation testimony is frequently a disputed element in tort law, the language from the Court of Appeals case should be addressed pursuant to RAP 13.4(b)(1) and (2).

D. STATEMENT OF THE CASE

Mr. Jan DeMeerleer, who had a bipolar disorder, became a patient of Dr. Ashby in September 2001. Dr. Ashby continued to provide care to Mr. DeMeerleer into 2010. The frequency of office visits was largely driven by Mr. DeMeerleer's life circumstances and the waxing and waning of his disorder. In manic phases of his disorder, he would consider a wide range of "dark" thoughts. However, between 2001 and July 18, 2010, Mr. DeMeerleer did not assault anyone. When Mr. DeMeerleer expressed anger or hostile emotions, he would quickly voice his embarrassment about these thoughts and deny that he would ever act on them. Over nine years, Dr. Ashby and Mr. DeMeerleer developed a close, professional relationship. Assessments were performed by Dr. Ashby in each office visit as Mr. DeMeerleer discussed his recent experiences and feelings.

On April 16, 2010, Mr. DeMeerleer had his last appointment with Dr. Ashby. Mr. DeMeerleer was taking various medications for his disorder, and Dr. Ashby assessed him as being logical, goal oriented, insightful and having intact judgment. Dr. Ashby's note provides in part: "He states when depressed he can get intrusive suicidal ideation, not that he would act on it

but it bothers him. At this point it's not a real clinical problem but we will keep an eye on it."

Separate and very distinct from any thoughts of suicide or self-harm, Mr. DeMeerleer never expressed the slightest suggestion to Dr. Ashby that he could or would harm Rebecca Schiering (his romantic interest) or her children. When Dr. Ashby last saw Mr. DeMeerleer on April 16, 2010, DeMeerleer expressed no intent, plan or desire to harm anyone, including Ms. Schiering and/or her children. As of April 16, 2010, Mr. DeMeerleer's last documented, aggressive or angry thought was approximately 4-5 years old and was wholly unrelated to Ms. Schiering or her family.

On July 18, 2010, Mr. DeMeerleer committed suicide after assaulting one of Ms. Schiering's sons and killing Ms. Schiering and one of her other sons. Uniformly, Ms. Schiering's family, Mr. DeMeerleer's family, Mr. DeMeerleer's co-workers, and Mr. DeMeerleer's friends never thought DeMeerleer would harm Ms. Schiering or her children. *See, Appendix C.* Even Ms. Beverly Volk, Ms. Schiering's mother and primary plaintiff in the lawsuit, thought Mr. DeMeerleer hurting Ms. Schiering or her boys was unforeseeable. Ms. Volk and all other witnesses could not foresee any propensity or suggestion that Mr. DeMeerleer could physically cause harm to the victims.

Based upon the foregoing, the trial court granted Dr. Ashby's summary judgment motion. The Court of Appeals, apparently believing it was compelled to apply *Petersen v. State* to a private practice outpatient setting, reversed the summary dismissal.

E. ARGUMENT WHY REVIEW SHOULD BE ACCEPTED

This Court should accept review of this case because substantial public interests in this state will be furthered by a clear rule from this Court that mental health providers in private practice only have a duty to disclose patient confidences to protect readily identifiable victims from specific threats of harm made by patients. Mental health patients, providers, and the public in general will benefit from a clearly defined duty owed by private-practice, mental health providers to third persons.

This case presents a fact pattern where the psychiatric patient, Mr. DeMeerleer, never expressed actual threats of harm regarding the victims of his assaults. The facts provide an opportunity for this Court to clearly define the legal duty owed to a non-client/third party arising only if the patient expresses (1) an actual threat of harm (2) to a reasonably identifiable person or persons.

1. Washington Is One Of The Few States Not To Have Rejected The Broad and Ambiguous "*Tarasoff*" Duty.

The vast majority of states have specifically defined, whether by legislative enactment or case law, the precise scope of the duty owed by

mental health professionals to protect third persons from the risk of harm posed by the mental health professional's patients. Nearly every state that has addressed the issues presented herein has created bright-line rules imposing a duty on mental health professionals to protect or warn readily identifiable targets of specific and imminent threats of harm. Washington is one of the few states not to have directly and clearly defined the scope of this duty, and as a result, mental health professionals in Washington are left without clear guidance as to when they can or must breach their patients' confidences to warn a potential victim of harm. The nature of a patient report that triggers a need to breach patient confidences is wholly undefined. Similarly, patients in Washington cannot know the parameters of the confidentiality and privilege they share with their mental health providers. The Court of Appeals' decision in this case leaves undefined the scope of the duty to protect or warn third persons as those who may be "foreseeably endangered." The ambiguity, especially in the context of the emotions and thoughts encountered in mental health care, makes practical application of the duty a matter of educated guess work. The absence of a clear and unambiguously defined duty can and will be detrimental to the mental health care system in Washington. This case presents an opportunity to have Washington join the 48 other states that have clear law regarding when a

mental health professional in private practice must take action to protect third persons from potential harm caused by mental health patients.

The Court of Appeals reversed the trial court based upon a finding that *Petersen v. State,* 100 Wash.2d 421, 671 P.2d 230 (1983) was controlling. *See, Volk,* 337 P.3d at 374. In *Petersen*, this Court held that a special relationship existed between a psychiatrist employed at a state mental hospital and a known-to-be-dangerous patient which established a duty of reasonable care in favor of a party injured by the patient. *Petersen,* 100 Wash.2d at 426–28. *Petersen's* "duty to warn" theory originated in *Tarasoff v. Regents of University of California*, 17 Cal.3d 425, 551 P.2d 334 (1976), in which the California Supreme Court held that when a psychotherapist determines, or pursuant to the standards of his or her profession should determine, that a patient presents a serious danger of violence to another, the psychotherapist incurs an obligation to use reasonable care to protect the third person against such danger. 17 Cal.3d 439. While recognizing the "public interest in supporting effective treatment and mental illness and in protecting the rights of patients to privacy (citation omitted), and the consequent public importance of safeguarding the confidential character of psychotherapeutic communication," the *Tarasoff* Court ultimately rejected the argument that

the duty to warn a third person only arises when there is a specific risk of harm to a readily identifiable victim. 17 Cal.3d at 440-41.

Seven years after *Tarasoff*, this Court decided *Petersen v. State*, in which the Court addressed the duty owed by a mental health professional to warn third persons of potential danger in the context of a patient being released from a state hospital. After first recognizing the general rule that ordinarily a person has no duty to protect a third person from harm caused by another, this Court essentially adopted the *Tarasoff* rule:

> Consequently, we conclude Dr. Miller incurred a duty to take reasonable precautions to protect anyone who might reasonably be in danger by Larry Knox's drug related mental problems. At trial Dr. Miller testified that Knox was a potentially dangerous person and that his behavior would be unpredictable. He also testified that if Knox used angel dust again he was likely to continue having delusions and hallucinations, especially if he quit taking the drug Navane. Dr. Miller testified he knew of Knox's reluctance to take Navane and he thought it quite likely Knox would revert to using angel dust again. Nevertheless, Dr. Miller failed to petition the court for a 90 day commitment, as he could have done under RCW 71.05.280 or take other reasonable precautions to protect those who might reasonably be in danger by Knox's drug related mental problems.

100 Wn.2d at 428-29.

The *Petersen* Court observed that after *Tarasoff* was decided, subsequent California decisions "limited the scope of the therapist's duty to readily identifiable victims." *Petersen*, 100 Wn.2d at 428, *citing Thompson v. County of Alameda*, 614 P.2d 728 (1980). Nonetheless, the Court further

sided with those courts that "have required only that the therapist reasonably foresee that the risk engendered by the patient's condition would endanger others." *Petersen*, 100 Wn.2d at 428. As is set forth herein, that position now represents the distinct minority.

In 1985, California adopted Assembly Bill 1133 (1985–1986 Reg. Sess.) in response to the concerns expressed in the *Tarasoff* dissent. "The resulting statutory provision, section 43.92, was expressly not intended to overrule *Tarasoff* and its progeny, 'but rather to limit the psychotherapists' liability for failure to warn to those circumstances where the patient has communicated an 'actual threat of violence against an identified victim [,]'" and to "'abolish the expansive rulings of *Tarasoff* and *Hedlund* ... that a therapist can be held liable for the mere failure to predict and warn of potential violence by his patient.'" (Assem. Com. on Judiciary, Analysis of Assem. Bill No. 1133 (1985 Reg. Sess., May 14, 1985, p. 2.)" *Ewing v. Northridge Hosp. Med. Ctr.*, 120 Cal. App. 4th 1289, 1300-01, 16 Cal. Rptr. 3d 591, 599 (2004). "Civil Code section 43.92 (section 43.92) immunizes psychotherapists from liability for failing to predict, warn of, or protect from a patient's violent behavior, unless the patient communicated to the psychotherapist a threat against an identifiable victim." *Greenberg v. Superior Court*, 172 Cal. App. 4th 1339, 1344, 92 Cal. Rptr. 3d 96 (2009).

California is not the only state to have adopted statutes that limit the liability of mental health care providers to those occasions when a patient makes an actual threat against a reasonably identifiable person. In fact, at least 30 other states have adopted legislation that requires some form of specific threat against a reasonably identifiable person before a duty arises. Other states have case law holding the same. *See Appendix F.* Also of note is the fact that that *Lipari v. Sears Roebuck & Co.,* 497 F. Supp. 185 (D.Neb. 1980), a case substantially relied upon in *Peterson*, was legislatively modified in 1994 so that patient communication of "a serious threat of physical violence against a reasonably identifiable victim or victims" was required before a duty of protection arises.

As the development of the law post *Tarasoff* and *Peterson* makes clear, there is a significant public interest and a recognized need for mental health professionals and patients alike to have clear parameters defining the extent to which client confidences must be kept sacred and the circumstances when the mental health professional can and must disclose such confidences for the protection of others. This Court should accept review of this case and bring Washington in line with the vast majority of states that have directly answered the questions presented herein. Review is appropriate pursuant to RAP 13.4(b)(4) to address the significant public interest raised by the issues presented herein.

2. The *Petersen v. State* Duty Conflicts With Washington's Physician-Patient Privilege.

The purpose of the physician-patient privilege is to enable the patient to secure complete and appropriate treatment by encouraging candid communication between the patient and the physician, free of fear of the possible embarrassment and invasion of privacy engendered by an unauthorized disclosure of information. *See, e.g.,* Louisell & Sinclair, *Reflections on the Law of Privileged Communications—The Psychotherapist-Patient Privilege in Perspective,* 59 Calif. L. Rev. 30, 52 (1971)(noting that psychotherapy requires exploration of patient's innermost fears and fantasies, and effective treatment is dependent upon patient's trust in therapist). In defining when mental health providers must warn others, the potential impact on the physician-patient privilege must be considered. Pursuant to RCW 70.02.020, a health care provider "may not disclose health care information about a patient to any other person without the patient's written authorization." RCW 70.02.050 contains very narrow and specifically defined exceptions to this prohibition. One exception allows for disclosure as follows:

> To any person if the health care provider or health care facility reasonably believes that disclosure will avoid or minimize an imminent danger to the health or safety of the patient or any other individual, however there is no obligation under this chapter on the part of the provider or facility to so disclose.

RCW 70.02.050(d) (emphasis added)

RCW 70.02.050(d) simply cannot be reconciled with the general and ambiguous duty announced in *Petersen v. State* (to "protect anyone who might foreseeably be endangered" by a patient). The mental health professional's duty of confidentiality under the statute can only be breached when there is an "imminent danger" to an individual, but *Petersen* calls for a disclosure (and therefore a breach of confidences) with a merely potential endangerment, including danger to undefined and unknown people.

RCW 71.05.020(20) defines "imminent" as follows:

> "Imminent" means the state or condition of being likely to occur at any moment or near at hand, rather than distant or remote;

Pursuant to RCW 70.02.050(d), mental health professional like Dr. Ashby are prohibited from disclosing any information regarding patients, like Mr. DeMeerleer, unless the professional knows there is a danger to someone that is "likely to occur at any moment." Under the Court of Appeals decision in this matter, mental health professionals in Washington are left to guess at when and what they are ethically permitted and legally required to disclose. Mental health patients in Washington are left to wonder to what degree their confidences can and will be protected from disclosure. Patients will likely withhold their most troubling thoughts and feelings for fear of recrimination, and mental health professionals, as

suggested in the Court of Appeals' opinion, will be forced to practice defensively while erring on the side of disclosing confidences that hint at some undefined endangerment of others. These circumstances can and will have a deleterious effect on Washington's mental health care system.

As the Court of Appeals noted below, without clear guidelines defining the duty, mental health professionals will be quick to seek involuntary commitment of a patient in order to avoid liability, thereby impinging on the freedom and civil rights of the mentally ill. *Court of Appeals decision, p. 30.* The sweeping duty articulated in *Petersen* and the Court of Appeals' application of that duty to the private outpatient setting will compel mental health providers to accept any anger or hostile emotions and/or words of frustration as a basis to report the patient to authorities or notify the public, despite the underlying goal of psychotherapy to invite just such disclosures so that these thoughts and emotions can be addressed therapeutically. At the very least, the extension of possible liability would encourage health care providers to opt in favor of what may be unnecessary confinement for such patients, and concomitantly, decrease the ability of such patients to ultimately successfully integrate into society. At worst, mental health providers may be reluctant to even undertake treatment of those most in need of services.

The sweeping duty to give a generalized warning to the public at large based on non-specific thoughts and emotions expressed in the confines of private therapy, even in the absence of any actual threat of harm toward an identifiable person, creates an unworkable hardship on practitioners, undermines the confidentiality and full disclosure that is fundamental to mental health care, and isolates patients most in need of mental health care without a factually specific basis for doing so. The conflict between the physician-patient privilege and the duty imposed by the Court of Appeals creates a dilemma for mental health professionals, who find themselves caught between potential liability to unknown and unknowable patient victims and to the patient for breach of the physician-patient privilege. The mental health professional is left to over-commit, over-report or refuse to treat those most in need of help. All scenarios are contrary to public policy.

Functionally, without an identifiable victim, the mental health provider has no one to effectively warn. If angry words or hostile emotions from a patient are not directed at a reasonably identifiable victim or victims, the mental health provider is left with the current, ambiguous obligation to warn all members of the public based on nothing more than generalized words and feelings that hint at the endangerment of others. Defining the scope of the duty clearly benefits the public interest in having mental health care patients receive the care they need and warrants review of this case.

3. Washington's Legislature Has Already Attempted To Define The Scope Of Duty Owed.

Similar to what occurred in California, after the Court's decision in *Petersen v. State*, the Washington Legislature in 1987 amended RCW 71.05.120 ("Exemptions from Liability"), which provides:

> (1) No...private agency...shall be civilly or criminally liable for performing duties pursuant to this chapter with regard to the decision of whether to admit, discharge, release, administer antipsychotic medications, or detain a person for evaluation and treatment: PROVIDED, That such duties were performed in good faith and without gross negligence.
>
> (2) This section does not relieve a person from giving the required notices under RCW 71.05.330(2) or 71.05.340(1)(b), or the duty to warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims. The duty to warn or to take reasonable precautions to provide protection from violent behavior is discharged if reasonable efforts are made to communicate the threat to the victim or victims and to law enforcement personnel.

RCW 71.05.120 (emphasis added)

RCW 71.05.120 applies to officers or professionals of public or private agencies. The statute had the practical effect of abrogating *Petersen*. *See*, *Hertog v. City of Seattle*, 138 Wn.2d 265, 293 n. 7, 979 P.2d 400 (1999)("the Legislature statutorily abrogated our holding in *Petersen* in Laws of 1987, ch. 212, §301(1) (codified at RCW 71.05.120(1)), with respect to liability of the State."). In the present case, the Court of Appeals

disagreed, and refused to use the language of the statute "by analogy" to the private/outpatient setting in this case.

Absent from the impossibly broad *Petersen* duty are the requirements imposed by RCW 71.05.120 (actual threat against a reasonably identifiable victim) and RCW 70.02.050(d) (disclosure only to avoid imminent danger). Under *Peterson*, any threat of any nature, no matter how remote, impersonal or attenuated, can arguably be portrayed as creating a duty to breach patient confidences. The anomaly of imposing a more generalized duty to warn in private practice and outpatient circumstances compared to the more narrowly crafted disclosure duties found under RCW 70.20.050 and RCW 71.05.120, cannot be reconciled.

The Court of Appeals' refusal to apply RCW 71.05.120 in this matter conflicts with *Estate of Davis v. State, Dep't of Corr.*, 127 Wash. App. 833, 840-41, 113 P.3d 487 (2005), making review appropriate pursuant to RAP 13.4(b)(2). In *Estate of Davis*, a Stevens County Counseling mental health provider evaluated an individual on community supervision to determine whether he would benefit from counseling. After that initial assessment, Erickson murdered a third party. The decedent's estate sued Stevens County, alleging that the assessment was negligent. Stevens County moved for summary judgment based upon RCW 71.05.120. The estate argued that RCW 71.05.120 did "not apply because Mr. Jones

was not making an assessment under" the involuntary commitment act. *Davis*, 127 Wash.App. at 840. The Court of Appeals disagreed:

> The complaint then alleges Mr. Jones failed to provide assistance or take any action, despite the need to do so. To the extent the estate alleged Mr. Jones was liable because he failed to detain Mr. Erickson, the immunity provision of RCW 71.05.120 applies because the only authority for him to detain Mr. Erickson was under chapter 71.05 RCW.

Davis, 127 Wash.App. at 840-841.

The same is true here. Since Dr. Ashby was not providing in-custody treatment for Mr. DeMeerleer, Dr. Ashby's sole method of "control" over Mr. DeMeerleer would have been an attempt to have him committed, thus invoking the provisions of RCW 71.05. Ironically, if Mr. DeMeerleer had voiced actual threats targeting discrete victims, then any attempt to have Mr. DeMeerleer committed would have insulated Dr. Ashby from liability. The fact that Dr. Ashby did not seek to have Mr. DeMeerleer committed does not make RCW 71.05 inapplicable by analogy.

RCW 71.05.120(2) states that the statute does not relieve a health care provider from the duty to warn "where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims." Missing is any language limiting its application to health care provided in connection with civil commitment proceedings. Rather, it simply clarifies what the "duty to warn" is in Washington and that RCW

71.05.120 should not be interpreted as limiting that duty.

In the context of confinement or decisions to continue confinement, the practitioner owes a duty to warn only when the patient has expressed an actual threat about an identifiable person. There is no rational reason to provide a narrowly defined duty and immunity to a provider who pursues confinement while the private health care provider, seeing a patient in a private office without the powers of custody and control, should be exposed to liability due to a more sweeping duty owed to all members of the general public when no actual threats are made to a readily identifiable victim.

4. The Court Of Appeals "Two Levels Of Speculation" Conclusion With Decisions From This Court And Other Washington Court Of Appeals Decisions.

Dr. Ashby moved to strike the speculative conclusions contained in the declaration of the plaintiffs' liability expert (Dr. James Knoll). The argument was that Dr. Knoll engaged in hindsight analysis looking at the horrific acts on July 18, 2010, and then built a case of assumptions and speculation on what might have been said, done, or expressed in his alternative history of 2010. He speculates (1) that DeMeerleer would have attended additional office visits if suggested or requested, (2) that DeMeerleer would have had homicidal ideation despite the absence of any factually specific evidence in support of this proposition, (3) that DeMeerleer would have expressed this speculated homicidal ideation to

Dr. Ashby, and (4) that DeMeerleer would have been amenable to any treatment offered in response to this hypothetical homicidal ideation. Based upon its "two levels of speculation" analysis, the Court of Appeals found admissible the opinions of Dr. Knoll for purposes of summary judgment.

Case law is clear that expert testimony cannot be speculative in nature. *See, e.g.*, *Davidson v. Municipality of Metropolitan Seattle*, 43 Wn. App. 569, 571, 719 P.2d 569 (1986), *citing*, 5A K. Teglund, Wash. Prac. §291 (1982), at 36. Case law is equally clear that when there is no basis for expert opinion other than theoretical speculation, the expert testimony should be excluded. *Seybod v. Neu*, 105 Wn. App. 666, 676, 19 P.3d 1068 (2001)(finding that expert testimony "must be based on facts in the case and not on speculation and conjecture."); *Fabrique v. Choice Hotels Intern., Inc.*, 144 Wn.App 675, 687, 183 P.3d 1118 (2008); *Griswold v. Kilpatrick*, 107 Wn. App. 757, 27 P.3d 246 (2001); *Queen City Farms, Inc. v. Central National Insurance Company of Omaha*, 126 Wn.2d 50, 103, 882 P.2d 703 (1994); *Bellevue Plaza, Inc. v. City of Bellevue*, 121 Wn.2d 397, 418, 851 P.2d 662 (1993).

In *Rounds v. Nellcor Puritan Bennett, Inc.*, 147 Wn. App. 155, 194 P.3d 274 (2008), the court reaffirmed that, in medical negligence cases, a plaintiff must generally produce competent medical expert testimony establishing that the injury was proximately caused by a failure to comply

with the applicable standard of care, and that expert testimony regarding causation in medical negligence cases must be based upon facts, not speculation or conjecture. *Rounds* is significant because it stands for the proposition that, even where an expert states his opinion in terms of likelihood or probability, the testimony can still be disregarded as speculative or conjectural when it is not supported by the facts.

Case law is also clear that to be considered at summary judgment, evidence must be admissible. *Dunlap v. Wayne,* 105 Wn.2d 529, 536, 716 P.2d 842 (1986). In *Sanchez v. Haddix*, 95 Wn.2d 593, 599, 627 P.2d 1312 (1981), the Court found as follows:

> Where causation is based on circumstantial evidence, the factual determination may not rest upon conjecture; and if there is nothing more substantial to proceed upon than two theories, under one of which a defendant would be liable and under the other of which there would be no liability, a jury is not permitted to speculate on how the accident occurred.

Sanchez, 95 Wn.2d at 599.

The Court of Appeals specifically acknowledged that summary judgment "jurisprudence" directs courts to reject speculation when reviewing summary judgment motions. *Volk*, 337 P.3d at 393. Notwithstanding this recognition, and without citing to any legal authority, the Court of Appeals created "two levels of speculation," one that applies at the summary judgment stage and one at a fact finding hearing or trial. *Id.*

An important purpose of summary judgment is avoiding useless trials. *Cook v. Selland Const. Inc.*, 81 Wn.App. 98, 101, 912 P.2d 1088 (1996); *Johnson v. Rothstein*, 52 Wn.App. 303, 307, 759 P.2d 471 (1988). According to the Court of Appeals' differing types of speculation, speculative expert testimony may create a genuine issue defeating summary judgment, but the very same testimony would apparently be insufficient for a jury verdict. The undefined, but apparently acceptable category of speculation at summary judgment, would obviate the CR 56 objective of avoiding useless trials.

Substantial evidence must support a jury verdict, and substantial evidence must be something that "rises above speculation and conjecture." *Dormaier v. Columbia Basin Anesthesia, PLLC.*, 177 Wn.App. 828, 851-52, 313 P.3d 431 (2013). Similarly, speculation and conjecture are insufficient to survive summary judgment. *Ruff v. County of King*, 125 Wn.2d 687, 707, 887 P.2d 886 (1995); *Miller v. Likins*, 109 Wn.App. 140, 145, 34 P.3d 835 (2001).

The Court of Appeals finding or rationale suggesting differing types of speculation at summary judgment as opposed to trial or evidentiary hearings is an incorrect statement of the law which is also contrary to the jurisprudence of the Supreme Court and other divisions of the Court of Appeals. *See, e.g., Doe v. Puget Sound Blood Ctr.*, 117 Wash. 2d 772, 787,

819 P.2d 370 (1991) ("CR 56(e) requires that the facts set out in the affidavit be material, and second, that those facts be admissible at trial"); *Las v. Yellow Front Stores, Inc.*, 66 Wash. App. 196, 198, 831 P.2d 744 (1992) ("Additionally, any such affidavit must be based on personal knowledge admissible at trial and not merely on conclusory allegations, speculative statements or argumentative assertions"). Discretionary review is therefore warranted pursuant to RAP 13.4 (b)(1) and (2).

F. CONCLUSION

As a result of the functional practicalities of private practice, the psychological therapy underpinnings, and the legislative conflicts, the mental health community needs a clear and more narrowly constructed statement on when a duty is owed to warn non-clients. A decision bringing Washington court authorities into conformity with the Washington legislature's position in RCW 71.05.120(2) and the vast majority of other jurisdictions would curb the "extreme version of duty" reflected in *Petersen* and recognized by the Court of Appeals herein.

The Court of Appeals' decision imposes an impossible burden upon a private psychotherapist of foreseeing harm caused by a patient even though the patient expresses no statement or inclination of specific harm and never identifies the person who should be warned. The expansive duty imposed under the decision would undermine the goals of psychotherapy,

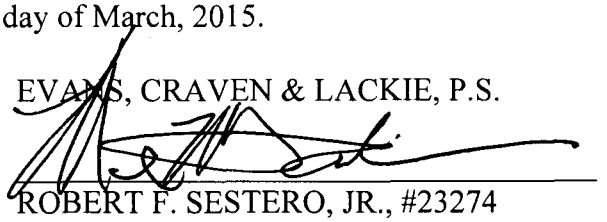
violate patient confidentiality, and create a distinction in the duties owed by mental health providers involved in involuntary commitment proceedings versus private practicing mental health professionals.

While a superficial analysis of *Petersen* and the Court of Appeals decision herein can result in a conclusion that the public as a whole is benefited from imposing a duty on psychotherapists to warn persons who may be "foreseeably endangered" by a mental health patient, the opposite is, in fact, true. Imposition of such an ambiguous duty damages the mental health care system as a whole, having a corresponding negative effect on the public as a whole.

Separate from the larger issue of duty, Respondents did not carry their burden of providing admissible evidence to create an issue of fact on the causation element. Summary judgment in this case should be affirmed based on the speculative conjecture offered by Respondents' expert.

DATED this 16 day of March, 2015.

EVANS, CRAVEN & LACKIE, P.S.



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CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the State of Washington, that on ~~February~~ March 17, 2015, I caused to be delivered to the address below a true and correct copy of Petition for Review of Dr. Howard Ashby:

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DATED this 17 day of ~~February~~ March, 2015.

Shauna L Wade

APPENDIX A

FILED
NOVEMBER 13, 2014
In the Office of the Clerk of Court
WA State Court of Appeals, Division III

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

BEVERLY R. VOLK as Guardian for Jack Alan Schiering, a minor; and as Personal Representative of the Estates of Philip Lee Schiering and Rebecca Leigh Schiering, and on behalf of the statutory beneficiaries of Philip Lee Schiering; and BRIAN WINKLER, individually,	)	No. 31814-1-III
Appellants,	)	PUBLISHED OPINION
v.	)	
JAMES B. DEMEERLEER, as Personal Representative of the Estate of Jan DeMeerleer; HOWARD ASHBY, M.D. and "JANE DOE" ASHBY, husband and wife, and the marital community composed thereof; SPOKANE PSYCHIATRIC CLINIC, P.S., a Washington business entity and healthcare provider; and DOES 1 through 5,	)	
Respondents.	)	

FEARING, J. — We undertake the humbling and daunting task of demarcating the duty a mental health professional owed to third parties to protect them from the violent behavior of the professional's outpatient client. The parties, the mental health care profession, and the residents of Washington State would be better served by the

legislature addressing this question after a comprehensive review of scientific data and statistics and after a thorough airing of the competing interests and policies involved. Since we conclude that the state legislature has not addressed the duty owed in the context of an outpatient client, we follow the Supreme Court precedent of *Petersen v. State*, 100 Wn.2d 421, 671 P.2d 230 (1983). We rule that a question of fact exists as to whether Dr. Howard Ashby and his employer, Spokane Psychiatric Clinic, P.S., owed a duty to protect the general public, including plaintiffs, from violent behavior of patient Jan DeMeerleer.

During the early morning of July 18, 2010, Jan DeMeerleer entered the home of his former girl friend, Rebecca Schiering, and killed her and her son Phillip. He attempted to kill another son, Brian, but left Phillip's twin, Jack, alive. Afterward, DeMeerleer killed himself. Prior to the killings, Jan DeMeerleer received outpatient treatment for his depression and bipolar disorder from psychiatrist Dr. Howard Ashby.

Brian Winkler, individually, and Beverly Volk, as guardian ad litem for Jack Schiering, and as personal representative for the estates of Rebecca Schiering and Phillip Schiering (collectively Schierings) brought suit against Dr. Howard Ashby and the clinic that he worked, Spokane Psychiatric Clinic, P.S., for professional malpractice, loss of chance, and negligence. The trial court dismissed the Schierings' action on summary judgment because Jan never threatened the Schierings in his sessions with Dr. Ashby.

To the extent the Schierings argue Dr. Howard Ashby should have involuntarily committed Jan DeMeerleer, we affirm the trial court's dismissal. We also affirm dismissal of the Schierings' lost chance claim and dismissal of the Schierings' claim of independent negligence against Spokane Psychiatric Clinic, P.S. But because a question of fact exists as to whether Dr. Howard Ashby owed a duty to protect the general public, including the Schierings, we reverse the dismissal of the claim against Howard Ashby for negligence in treating Jan DeMeerleer and the claim against Spokane Psychiatric Clinic, P.S. for vicarious liability and remand for further proceedings.

FACTS

Since the Schierings claim Jan DeMeerleer's psychiatrist committed malpractice, we review DeMeerleer's psychiatric background. In response to the summary judgment motion, the Schierings provided the trial court with some of Dr. Howard Ashby's chart notes. We do not know if all notes were provided.

Jan DeMeerleer was born in 1971 and received his degree in mechanical engineering from Purdue University, where his bipolar disorder and depression first surfaced. He was hospitalized with suicidal thoughts and first diagnosed with the diseases during the summer of 1992. A mental health professional then placed DeMeerleer on Depakote, a medication that treats manic episodes resulting from bipolar disorder. DeMeerleer soon ceased taking the medication. He moved to the Midwest for education and jobs. He imbibed alcohol to treat his depression.

In 1996, DeMeerleer married Amy after living with her for three years. The two first met at a Moscow, Idaho high school where they graduated in 1989.

Jan DeMeerleer next sought treatment for his disorders in 1997, when he once again developed suicidal thoughts. A physician treated DeMeerleer on an outpatient basis and prescribed Depakote again. DeMeerleer ceased his sporadic use of the drug in 1998, because he disliked its side effects. The drug decreased his creativity. He was embarrassed for others to know he took antipsychotic drugs.

Jan and Amy DeMeerleer moved to Spokane in 2000, where their daughter was born that year. Amy, with the daughter, vacated the family home in 2003. The couple divorced in 2004 and agreed to share residential care of the daughter, exchanging her every four days.

Jan DeMeerleer sought psychiatric care from defendant Dr. Howard Ashby beginning September 13, 2001. His wife, Amy, attended Jan's first visit to Ashby. Dr. Howard Ashby obtained a history from his patient, Jan DeMeerleer. Ashby's 2001 intake notes contain the history recited above. The notes also read in part:

> September 13, 2001 Dr. Ashby Jan Demueller [sic] N/P Intake
>
> . . . .
>
> By August of 1998 after sporatic [sic] use [of Depakote] when he stopped it totally, he immediately went into a high and had "great feelings." He describes very much grandiose behavior. Over the past 2 years he has not received treatment and approximately 2 months ago quit his job in a grandiose manipulation and play at work where he basically states he made a fool of himself at work, said stupid things and engineered himself out of

the job in his delusional state thinking this was a grandiose thing to do. He states that earlier this summer he had suicidal ideation and even homicidal ideas, was going to leave the country. He states that in less manic situations he has a tendency to want to feel powerful, manipulates his wife, relatives and friends with stories. He indicates that at work he was so productive and good that at one time they even went along with his desire to be called by some fantastic name because he was so active and "gung ho". He states that last March he was grandiose to the point that he felt "I'm here to show earthlings what they are capale [sic] of". He indicates that as he looks back he recognizes that he was completely out of control.

In August of this year, his wife had to start working because he had quit his job. He started having some depression again and suicidal ideation including playing Russian Roulette. That gun and other weapons have been removed from the home and on Labor Day weekend he had an "intervention" with his family in which he invited them together and finally showed them the records of his previous hospitalization, etc., came clean with everything and asked for their support and help particularly to be able to help his wife when he gets into a manic or depressive swing.

Regarding mania, if he feels suicidal, it's to drive high speeds and hurt himself that way, regarding depression he states he is so immobile that he can't do it although he has had thoughts. He does describe 10 years ago however of being placed in the hospital because he laid down on railroad tracks with the idea of being decapitated.

. . . He was placed in jail at age 20 because of the train having to stop when he was trying to kill himself and was detained in the hospital. Subsequently, at age 21, while in college he was in jail for alcohol, stealing bikes and states it was during one of his out of control episodes during college.

Mental Status Exam: He is logical and goal oriented, somewhat labile [emotionally unstable] . . . . He expresses motivation to get help and to be compliant with medication at this time, however. His mood overall is neutral but again at times he can be very serious but not necessarily depressed but quite intense. Cognition is normal, content is good, judgment is intact. He is not suicidal or homicidal. No obsessions or compulsions. . . . Interaction with wife in this interview was appropriate.

Impression:

Axis I: Bipolar affective disorder with frank manic episodes but also apparently mixed presentations with a response to Depakote in the past but with poor compliance.

> Axis II: A possibility of cyclothymic personality disorder and some obsessive compulsive traits which will all need to be further evaluated as time goes by and he further stabilized.
>
> . . . .
>
> Plan: Reinstitute Depakote, get blood level and baseline labs after he is on 500 mg twice a day for 4 or 5 days. Getting the medication at trough level were all described so he can get the level done appropriately. . . . I feel that having a fairly aggressive dose would be appropriate due to the description and seriousness of his symptoms and the possibility that he was only partially treated and this may have contributed somewhat to his difficulty with compliance. We will have to watch side effects to help with the compliance also. Set up additional appointments not only to monitor medication but to do therapy.

Clerk's Papers (CP) at 238-40. Cyclothymic personality disorder is a mild form of bipolar disorder, with meeker mood swings between depression and hypomania.

Dr. James Knoll, the Schierings' expert, averred in a declaration that he reviewed the clinical records from Spokane Psychiatric Clinic, P.S. In turn, Knoll included information in his declaration concerning Jan DeMeerleer's treatment, not included in the chart notes provided to the trial court. According to James Knoll, Jan DeMeerleer provided the following information, in a written submission, about his mental state when he first met with Dr. Howard Ashby in September 2001:

- Despises lesser creatures; no remorse for my actions/thoughts on other living creatures.
- Delusional and psychotic beliefs argued to the point of verbal abusive and fighting.
- No need for socialization; in fact, prefers to psychotically depopulate the world (i.e. "do Your Part" [CYP] terrorist philosophies).
- Wants to destroy; pounds on computer keyboard, slams phone receiver, swings fists.
- Has no use for others; everyone else in world is useless.

- Reckless driving; no fear of danger in any circumstance, even "near misses."
- Acts out fantasies of sex with anyone available.

CP at 85 (alteration in original).

On September 13, 2001, Amy DeMeerleer described her husband's mental states, according to James Knoll, as follows:

- Makes mistakes on projects (i.e. breaking something) and quickly moves into dangerous rage; actually easily slips into depression after this type of trigger.
- Severe lack of sleep coupled with dreams of going on killing or shooting sprees.
- Drives automobiles very fast (at least 20 to 30 MPH above speed limit) without seat belt while showing no fear at all when in dangerous situations; applies even with child in car.
- Expresses severe "road rage" at other slower drivers, even as a passenger (he's NOT driving).
- Has an "All or Nothing" attitude; will actually verbally express "Live or Die!"

CP at 85-86.

Jan DeMeerleer expressed suicidal and homicidal ideas to psychiatrist Howard Ashby on several occasions after September 2001. But, according to Dr. James Knoll, Dr. Ashby made "no thorough inquiry . . . as to the nature and extent of [DeMeerleer's] ideas, such as: planning; access to weapons; prior attempts; acting out, etc; stress; access to victims; and so forth." CP at 86.

Jan DeMeerleer visited Dr. Howard Ashby on December 2, 2002. Dr. Ashby's notes for that visit read:

> Jan indicate that he had an episode of approximately an hour, hour and a half of having angry, aggressive thoughts, even to the point of suicidal, homicidal thoughts, wouldn't act on them and it went as quickly as it came but on close questioning, he admits that during that period of time he was not checking himself or censoring those thoughts except not letting himself act on them. All told, there are some indications that he was still being responsible, i.e. he didn't want to leave because his daughter was sleeping etc. so there is an element of safety and keeping things under control that continue to be maintained. Mental status exam today is WNL [within normal limits] and he indicates that he is sleeping, doing fine, there is stress with his job as he has two job offers and now just has to wait to see which one comes through but he will be hired on permanently within the next month or two in one of the two jobs. This will be of great help to him.
>
> The last episode he had was in September which was approximately 2 months ago so we will have to keep an eye on this. It lasted about 3 hours, so hopefully the trend is that the medication is keeping things under control.
>
> Plan: Take an extra Risperdal at the earliest onset, also use cognitive behavioral therapy principles that we've discussed prior and reviewed today.

CP at 241.

Jan DeMeerleer saw Dr. Howard Ashby on December 31, 2003. Dr. Ashby's chart notes read:

> Jan missed his last appointment approximately 6 weeks ago, was in the middle of separating from his wife, totally spaced it out. Currently, however, he probably would not have made another appointment until some time in January but his family pressured him to get an appointment today. In the wake of the divorce, he was initially quite depressed, admits to having suicidal ideation, it walked through his mind, as he put it, but he would not take it seriously and has no intent, really feels like he could not do it. It actually bothers him that these kinds of ideas are entertained by

him from time to time. He became congruently upset and tearful because he states that those thoughts are totally untenable and unlike him and not something he would normally consider because of his daughter and other family members. He specifically documents how much support his family is and how much he knows he is cared about.

An additional negative, however, is that he started seeing a woman for approximately a 4 week period which was a very rewarding relationship, however, the last 2 weeks she has backed off and become more aloof indicating that there are a lot of little things about him as she got to know him that she didn't like and this really sent him for a loop because it's basically the same language his wife used, that there was not one thing but a lot of little things that caused her to divorce. We talked about these issues fully as time allowed and he was able to put things into perspective and already had in many ways. Additionally, however, he states that he does want to make some changes in things he knows are reasonable for him to make so we began a review of some target behaviors that he would like to work on.

Impression: Some emotional lability, but he has not had major symptoms that indicate that medication needs to be changed more than he needs psychological support. He has had depressive symptoms and has had some hypomanic behavior but in the context of the recent stresses, I do not see that the disorder itself is raising its head as much as the situation is creating the symptom response. With this in mind we're going to schedule a number of appointments in succession so that we can work on these issues and give him the support that he needs. I do not feel he is a suicidal risk. I also do not feel he is overly depressed or manic, either one which would cause him not to be able to continue to be functional at work, socially or in his family life at this point. Mental status, in that sense was euthymic in the sense of no push of speech, no rapid mood swings, thought content and production were all totally WNL.

CP at 237.

On January 23, 2004, Dr. Howard Ashby met with Jan DeMeerleer. Dr. Ashby's notes read:

Jan is still reeling from his wife divorcing him. He admits that he has had a lot of dark thoughts over the last couple of weeks. Talked about

> this to some friends, they rallied around him and kept him okay. He apologized to them for being so negative, they were actually homicidal/suicidal thoughts. He indicates that reality check was appropriate and he is embarrassed that he had those thoughts and let himself get that carried away. He knows that he would never go there, but just the fact that he was expressing it out loud to other people is an embarrassment to him. We took a step back and looked at this to try to get a sense of perspective that might be helpful. One thing, is that he really does have strong feelings and this in a man who felt that at times he didn't have the ability to have deep feelings about things. Additionally, the fact that he talked with others and then they responded in a way that was appropriate, and as friends would do, was reassuring. As he has a tendency to look at the half empty side of the glass, we worked on this cognitive behavioral principle.
>
> Mood, affect, psychomotor activity, content, insight, etc were all within normal limits. He does openly expresses [sic] the fact that he is in a lot of pain because of the sense of loss, but it is helpful to him that he has liberal visitation with his daughter who allows him to stay centered. The other five days he struggles. We worked on this also, so that he can have some counter statements to help with the tendency for negative interpretations.
>
> Plan: Continue current medication, continue weekly support.

CP at 236.

According to Dr. James Knoll, Jan DeMeerleer, after divorce from Amy, told Dr. Howard Ashby of homicidal thoughts about his ex-wife and her boyfriend. The clinical notes in the record do not confirm such thoughts or reporting to Howard Ashby.

In 2005, Jan DeMeerleer met Rebecca Schiering and immediately fell in love with her. Schiering had three sons, Brian Winkler, and Phillip and Jack Schiering. Phillip and Jack, the younger boys, were twins. Jack experiences autism, bipolar disorder, and mood disorder. DeMeerleer eventually referred to the boys as his "children." CP at 196.

Phillip and Jack often called DeMeerleer "dad." CP at 196. DeMeerleer spoke often of marrying Rebecca Schiering and becoming a stepfather to her three sons.

On September 24, 2005, Gena Leonard, Jan DeMeerleer's mother, wrote to Dr. Howard Ashby expressing concerns about DeMeerleer's depression and homicidal thoughts. The letter read:

> Dr. Ashby:
>
> I am Jan's mother. And . . . I am very concerned about my son. I was in Spokane this past week, responding to a phone call from Jan's "significant other," Rebecca, a young woman who we all greatly admire. Rebecca's "Jan alarm" had gone off per his behavior and she wisely called in the troops . . . i.e., Jan's family. From what I understood of the Wednesday (Sept 21) visit, Jan gave his version of the recent events that prompted his parents and siblings to respond to Rebecca's appeal for help. I am certain you see through Jan's unrealistic reasoning but I am anxious to give you the "side" that we (his family) have experienced and observed.
>
> First of all, we are all concerned over Jan's obsessive occupation with money. . . . The latest events per the "beater" truck Jan was attempting to sell was strictly due to his driving need to get a high price for the vehicle. I believe this helped plunge Jan into a depressive mood. His recent statement of never wanting to see his daughter again, suggesting his companion, Rebecca, move out of his house, and announcing he was going to quit his job screamed depression to me.
>
> We were all extremely concerned that Jan's reaction to vandalism to his "beater" pickup truck was dangerous and unrealistic. Jan placed two powerful guns (a .357 pistol and a shotgun, both with lots of ammunition) into his car and then drove himself to the area where this theft had been perpetrated in order to "wait" for the thieves to return. Jan's two fathers (biological, and step-) and I do have a huge issue with Jan hauling loaded guns around in case he finds the guys who ripped into his truck! Jan assured us that he no longer has visions of suicide but that he has now progressed into a homicidal mode. Believe me, Dr. Ashby, we are NOT comforted by this information! Jan's several guns were removed from his home (by his two fathers) and taken to Moscow.

> The recent events that prompted us to travel to Spokane are difficult to pinpoint since Jan has the ability to cover up his actions via his "stories." He is known in this family for his—to put it bluntly—"bullshit" and we all find it difficult to cut to the real truth. . . . He spends a lot of unhealthy time dwelling on his anger, hurt, and hatred towards his ex-wife and her boyfriend. I am not convinced he truly loved her but I think Jan's sense of absolute possession causes this outrage.

CP at 243.

On July 21, 2006, Dr. Howard Ashby visited with Jan DeMeerleer. Ashby's office notes read:

> Jan indicates that he is having a little bit of a period of time with being down and negative, needing increased sleep, even had some suicidal ideation. He used some extra Risperdal during this period of time and it knocked it right out, so he feels comfortable about keeping things under control. Actually, because of stresses at work, he would like to have a little bit of a manic episode if anything (tongue in cheek). Mood, affect, psychomotor activity; content, insight, etc. are all normal and he is doing well. We don't need to make any medication changes and he is doing a good job of managing things. I indicate to him, however, that if it's not just a minor change, he really should keep in touch with me so we can process it together. He was open to this but reassured me that this episode was not anything that needed to be concerned about.

CP at 235.

We are given no information about Jan DeMeerleer from summer 2006 to summer 2009. According to Dr. James Knoll, Jan DeMeerleer appeared distressed at the Spokane Psychiatric Clinic, P.S., in June 2009. We do not know if DeMeerleer then spoke with Howard Ashby or some other professional at the clinic. The clinic then changed his

medication types and dosages. But, according to Knoll, the clinic did not adequately plan follow-up care.

Rebecca Schiering became pregnant with Jan DeMeerleer's child in the fall of 2009. Both Schiering and DeMeerleer became excited at the prospect of a child together. In December, however, DeMeerleer slapped Schiering's autistic son, Jack, an event that caused estrangement between DeMeerleer and Schiering. Rebecca Schiering, with her children, moved out of DeMeerleer's home. Rebecca Schiering terminated the pregnancy.

In December 2009, Jan DeMeerleer telephoned Spokane Psychiatric Clinic, P.S. in distress over losing his employment and separating from Rebecca. DeMeerleer asked to return to counseling and medication management. The clinic referred him to local community based mental health clinics and told him to call back if the referrals did not succeed.

In January 2010, as the result of Jan DeMeerleer writing to his mother about difficulties with Rebecca Schiering, the mother, Gena Leonard, wrote an e-mail critical of Schiering to DeMeerleer. Schiering read the e-mail and her reading of the message sealed a temporary ending of the relationship between DeMeerleer and Schiering. Schiering concluded that Jan's family unfairly judged her and her sons. Schiering, in turn, did not wish to be part of Jan DeMeerleer's family.

Gene DeMeerleer is the brother of Jan. In January 2010, Gene visited with Jan at their sister's Spokane house. Jan appeared distressed and spoke of Rebecca Schiering's reading of the e-mail written by the brothers' mother. During the talk between the brothers, Jan expressed distress over the apparent ending of his relationship with Rebecca Schiering. Jan expressed no homicidal or suicidal thoughts.

Jan DeMeerleer's last appointment at the Spokane Psychiatric Clinic, P.S. occurred on April 16, 2010, when he again met with Dr. Howard Ashby. DeMeerleer told Ashby that he was mending his relationship with Rebecca Schiering. Dr. Ashby noted he had an unstable mood and intrusive suicidal ideas. But DeMeerleer assured Ashby he would not act on those thoughts. The Spokane Psychiatric Clinic, P.S. notes from April 16 read:

> Jan indicates that his life is stable, he is reconstituting gradually with his fiancé. They are taking marriage classes, he can still cycle many weeks at a time. Right now he is in an expansive, hypomanic mood, but sleep is preserved. He has a bit more energy and on mental status, this shows through as he is a bit loquacious but logical, goal oriented and insight and judgment are intact. He states when depressed he can get intrusive suicidal ideation, not that he would act on it but it bothers him. At this point it's not a real clinical problem but we will keep an eye on it.
>
> Plan: We will continue Risperdal, Depakote and Buproprion [sic].

CP at 234. Risperdal treats symptoms of bipolar disorder. Bupropion is an antidepressant.

As a result of Rebecca Schiering's comments about his family, Jan DeMeerleer had no contact with his mother, Gena Leonard, from January 25 to May 9, 2010, when

Jan gave his mother flowers for Mother's Day. During communications thereafter, Jan expressed to his mother love for Rebecca Schiering and her family. Leonard and DeMeerleer exchanged occasional e-mails after Mother's Day.

During May through July 2010, Jan DeMeerleer and Rebecca Schiering spoke of mending their relationship. DeMeerleer attended a family gathering at his father's cabin during a weekend in late June 2010. DeMeerleer was relaxed and spirited. His humor entertained family members.

On July 11, 2010, Jan DeMeerleer took his daughter to Amy DeMeerleer's home, and he left for New Orleans the following day. According to Amy, Jan appeared normal, other than seeming tired. He spoke positively about Rebecca Schiering and her children. During his trip to New Orleans, Jan sent Amy a number of texts. The texts were "light hearted" and caused Amy no concerns. CP at 156. Amy DeMeerleer saw Jan again on the morning of July 16, 2010, and Jan appeared neither despondent nor manic.

On July 16, 2010, Jan DeMeerleer called his sister, Jennifer Schweitzer, and reported that Rebecca Schiering broke up with him and the relationship was over for good. Schweitzer invited DeMeerleer to dinner that evening. DeMeerleer was depressed when he arrived for dinner. During dinner, he expressed sadness over the termination of the relationship. After dinner, Jan DeMeerleer walked with Jennifer Schweitzer's husband and his mood improved. By the time of leaving Schweitzer's home, DeMeerleer was laughing and normal.

On the morning of Saturday, July 17, 2010, Jan DeMeerleer, at the request of his neighbor, Brent Tibbits, cut down two trees in DeMeerleer's yard. The trees spread roots into the neighbor's yard. DeMeerleer's actions followed a 15 minute conversation with Tibbits. According to Tibbits, DeMeerleer was cooperative, coherent, and logical, and neither angry nor ecstatic.

During his trip to New Orleans in July, Jan DeMeerleer texted Darien Boedcher, a close friend he met at work in 2003. In the text, he told Boedcher how much he was enjoying his time in New Orleans. On the evening of July 17, 2010, DeMeerleer called Boedcher to ask about visiting one another, but Boedcher was out of town. According to Boedcher, DeMeerleer sounded normal during the call.

At 5:00 p.m., July 17, Jan DeMeerleer called his mother, Gena Leonard, and left a message on her phone answering machine. DeMeerleer's tone sounded normal. In the phone message, Jan stated, "'Hello. Long lost son Jan here, trying to get ahold of you. Seeing what's up on a sunny weekend. Hope you guys are out driving your Corvette. That's what you need to be doing. Anyhow, I'll be hanging out here at home. Feel free to give me a call when you get back. Thanks. Bye.'" CP at 172 (emphasis omitted).

Late July 17 or early July 18, 2010, Jan DeMeerleer entered the home of Rebecca Schiering. Present in the home was Rebecca and her three sons. Shortly before 3:00 a.m. on July 18, DeMeerleer entered the room where Brian Winkler, age 17, slept, and DeMeerleer slashed Brian's throat with a knife. Brian struggled with the bigger and

stronger DeMeerleer as DeMeerleer continued the attack on Brian. Brian received additional knife wounds. During the struggle, Brian screamed, awakening the family, which caused DeMeerleer, with a gun in hand, to leave the room and to proceed to Rebecca's room. Brian called for help with his cell phone and fled the home.

Jan DeMeerleer shot Rebecca Schiering as she entered the home hallway. DeMeerleer entered the bedroom of Jack and Phillip and shot Phillip who slept in the top bunk bed. Jack slept in the other bed but was physically unharmed. DeMeerleer left the home and drove away in his car. After observing DeMeerleer leave, Brian returned inside the home and discovered his mother lying in a pool of blood in the hallway. Brian desperately tried to help his wounded mother. He exited the home when police arrived. As he waited outside, Brian observed his mother removed from the house in a body bag. Brian was transported by ambulance to Sacred Heart Hospital. Phillip was also transported by ambulance and died later that day. Police later found DeMeerleer, in his home's garage, dead from a self-inflicted gunshot wound.

Family members, friends, and acquaintances who visited Jan DeMeerleer shortly before the incident gleaned no indication of any plan to kill someone or to commit suicide. Many expressed shock at the deaths. Toxicology reports showed DeMeerleer was not taking his medication at the time of the killings.

PROCEDURE

Brian Winkler, Jack Schiering through his guardian, and the Estates of Rebecca Schiering and Phillip Schiering (collectively the Schierings) sue Jan DeMeerleer's estate for wrongful death, personal injuries, loss of family members, and emotional harm resulting from the killings of Rebecca and Phillip and the attack on Brian. The claims against Jan DeMeerleer are not the subject of this appeal.

The Schierings also sue Howard Ashby and Spokane Psychiatric Clinic, P.S. for professional malpractice. They allege Dr. Ashby did not adequately assess DeMeerleer's suicidal or homicidal risk and provide treatment. The Schierings claim an adequate assessment and better care might have exposed DeMeerleer's homicidal thoughts about Rebecca, Phillip, and Brian. In turn, the Schierings allege Howard Ashby might have prevented the attacks by either mitigating DeMeerleer's dangerousness or warning Rebecca, Phillip, and Brian with enough time for them to protect themselves. The Schierings include an allegation of lost chance of survival.

The Schierings allege Howard Ashby was an employee of Spokane Psychiatric Clinic, P.S. The clinic agrees that Howard Ashby works for it, but denies an employer-employee relationship between the two. The Schierings further allege that Spokane Psychiatric Clinic, P.S. failed to establish or implement "practices, policies, procedures, training, supervision and directives reasonably necessary to provide appropriate medical

care to patients such as Mr. DeMeerleer when presenting with suicidal and/or homicidal ideation." CP at 31.

Howard Ashby and Spokane Psychiatric Clinic, P.S. moved for summary judgment, partly arguing they owed no third-party duty to anyone in general or the Schierings in particular. Ashby filed affidavits of friends and family of Jan DeMeerleer to establish the surprise nature of the assault, homicides, and suicide to argue the lack of foreseeability of the attacks. Howard Ashby wisely filed no affidavit from him or any professional to discuss the standard of care of a psychiatrist, since a battle between experts does not lend itself to winning a summary judgment motion. Instead, Dr. Ashby relied on the undisputed fact that Jan DeMeerleer did not threaten, in the presence of Ashby, Rebecca Schiering or her children.

In opposition to the summary judgment motion, the Schierings filed a declaration of expert, James L. Knoll, IV, M.D. Knoll is a board certified psychiatrist, professor of psychiatry at the State University of New York (SUNY) Upstate Medical University, and editor of *Psychiatric Times*. He specializes in forensic psychiatry. In his declaration, Knoll relates that he reviewed the clinical records of Jan DeMeerleer from Spokane Psychiatric Clinic, P.S., the investigation file of law enforcement, and the autopsy and toxicology reports regarding DeMeerleer. Knoll claims to be familiar with the standard of care of a psychiatrist in the State of Washington based on education, training,

experience, and consultation with a colleague in the State of Washington. According to Knoll, the standard of care in Washington equates to the standard of care nationally.

Dr. James Knoll faults Dr. Howard Ashby, because, despite Jan DeMeerleer's frequent mental instability, Ashby failed to conduct a systematic and focused assessment of DeMeerleer's condition or prepare a treatment plan with periodic follow-up care. Because of his previous homicidal and suicidal ideas, DeMeerleer required extended in-patient psychiatric therapy and treatment.

In his declaration, James Knoll averred:

> During treatment by SPC [Spokane Psychiatric Clinic], DeMeerleer, after the failure of his first marriage, expressed homicidal ideas toward his former spouse and her then-current boyfriend. Subsequently, while in a relationship with Ms. Schiering, it was known that DeMeerleer's family, including his father and mother, were substantially concerned about his access to firearms, and his acting out homicidal ideas.

CP at 86.

According to Dr. Knoll, Dr. Ashby knew of Jan DeMeerleer's penchant for refusing to take prescribed medications and should have taken steps to encourage and monitor use of medications. Knoll criticizes Ashby for failing to provide care, when DeMeerleer called in distress on December 1, 2009, because of loss of employment and separation from Rebecca Schiering. Instead, Spokane Psychiatric Clinic, P.S. referred DeMeerleer to a community-based mental health clinic. Knoll criticizes Ashby for failing to adequately assess Jan DeMeerleer's suicide risk, during the last visit on April

16, 2010, and Ashby's reliance on DeMeerleer's self-report that he would not commit suicide. Ashby should have, at the least, scheduled a follow-up appointment to monitor DeMeerleer's condition.

According to expert witness James Knoll:

> Timely, appropriate, and focused psychiatric inquiry of DeMeerleer during clinical sessions most likely would likely have resulted in him having incurred more appropriate and intensive clinical or institutional psychiatric treatment. This until such time as treatment was demonstrably effective and/or risk of harm to himself had been appropriately mitigated. An adequate suicide risk assessment does not rely solely on the patient's denial of suicidal ideas, but involves an assessment of both the aggravating and mitigating factors in the context of the individual circumstances and patient's clinical status. A psychiatrist simply asking about suicide ideas does not ensure accurate or complete information will be received. It is considered the standard of care for the mental health professional to perform an adequate suicide risk assessment. A systematic assessment of suicide risk is a basic, essential practice that informs the mental health professional about proper treatment and management. It is pertinent that in clinical practice, it is observed that some patients, who first express suicidal ideas in clinical session, are found also to have homicidal ideas during risk assessment for suicide. Also, it is with unfortunate observed frequency that some who are known or believed to be suicidal, commit homicide, concurrent with suicide.

CP at 88-89.

In his declaration, Dr. James Knoll opined:

> . . . Given DeMeerleer's unstable BP, life stressors, past suicide attempts, past actions to realize homicide, noncompliance and "intrusive" suicidal ideas, it was below the standard of care to fail to monitor him in a timely manner. Had SPC met the standard of care, it is patent that DeMeerleer would have been in regularly scheduled clinical follow-up over the summer of 2010. During that period, and prior to the incident, an exchange of e-mails between DeMeerleer and Ms. Schiering reveal the

relationship had crumbled, and that DeMeerleer was emotionally crushed and mentally desperate and unstable. DeMeerleer's SPC records clearly demonstrate that he routinely raised and addressed issues pertaining to his current relationship during clinical sessions. This is evident in his early SPC records, first in his and his then-current spouses' attempts to remain together, and then on to his dark, intrusive homicidal thoughts toward her, and her new interest. DeMeerleer's following relationship with Ms. Schiering was then substituted as a clinical topic. Had DeMeerleer been in clinical session during the summer of 2010, SPC would have been able to inquire about his thoughts and emotions about his current relationship with Ms. Schiering and her children, and any ideas of suicide and/or homicide. Recall that DeMeerleer had disclosed suicidal and homicidal ideas during several prior clinical sessions. Had SPC properly monitored DeMeerleer, resulting in an adequate risk assessment for suicide and/or homicide, intensive clinical or institutional psychiatric treatment, the risk and occurrence of the incident would have been mitigated, and probably would not have occurred, as DeMeerleer's mental distress probably would not have digressed to the level of allowing for an act of suicide and/or homicide.

10. To the extent that DeMeerleer's potential for harm to self or others could not be reasonably mitigated by psychiatric treatment, including institutional treatment, proper inquiry and assessment may have substantiated that Ms. Schiering and her children were foreseeably at risk of harm from DeMeerleer. Had this occurred, given proper caution or warning by SPC directly, through an appropriate intermediary or an subsequent psychiatric services provider to DeMeerleer, Ms. Schiering and her family most likely would have had the opportunity to have: taken reasonable effort to avoid contact with DeMeerleer; seek protection from him; and/or make themselves unavailable to access by DeMeerleer. Failure by SPC to follow-up and treat DeMeerleer appropriately precluded any such opportunity.

11. Considering my review of the referenced materials, and the forgoing, SPC breached the applicable standard of care by failing to exercise the degree of care, skill and learning expected of a reasonably prudent healthcare provider of psychiatric medical services, in the State of Washington, acting in the same or similar circumstances, with respect to the delivery of such psychiatric medical services to DeMeerleer, in various degrees, and at various times during the course of clinical treatment of DeMeerleer (collectively "Breaches"). These Breaches include, but are not

> limited to: failing to perform adequate assessments of DeMeerleer's risk of harming himself, and others when clinically indicated to do so; and failing to adequately monitor DeMeerleer's psychiatric condition, and provide appropriate treatment.
>
> 12. But for the referenced Breaches by SPC, it is unlikely the Incident would have occurred.
>
> 13. The referenced Breaches were, collectively and individually, most likely a causal and substantial factor contributing to and in bringing about the Incident and the resulting harm of loss of life, and other physical and psychological injuries.
>
> 14. The referenced Breaches were, collectively and individually, a causal and substantial factor in contributing to and in bringing about loss of chance of a better outcome of the psychiatric care and treatment of DeMeerleer, and thus a loss of chance that the Incident and the resulting harm wouldn't have occurred.

CP at 89-91. Dr. Knoll does not opine that Spokane Psychiatric Clinic, P.S., independent of Dr. Howard Ashby, violated any standard of care held by a clinic.

The trial court granted Howard Ashby's and Spokane Psychiatric Clinic, P.S.'s summary judgment motion, concluding that they could not have reasonably identified Rebecca, Phillip, or Brian as Jan DeMeerleer's target because he communicated no "actual threats of harm" toward them. CP at 262.

LAW AND ANALYSIS

Mental Health Professional's Duty

The broad issue on appeal is what duty is owed by a mental health professional to protect a third party from the violent behavior of the professional's patient or client. A narrower issue is whether a mental health professional holds a duty to protect a third person, when an outpatient, who occasionally expresses homicidal ideas, does not

identify a target. RCW 71.05.120 provides immunity to the mental health professional in the context of an involuntary commitment of the patient, unless the patient identifies a target of violence or unless the professional is grossly negligent or acts in bad faith. A difficult question for us is whether the language of RCW 71.05.120(2) should be applied by analogy outside the context of an involuntary commitment. Stated differently, a difficult question is whether a mental health professional's duty of care, when treating a voluntary outpatient, is limited to warning someone identified by the patient as the target of an act of violence.

There is no general duty to protect others from the criminal acts of a third party. *Kim v. Budget Rent A Car Sys., Inc.*, 143 Wn.2d 190, 196, 15 P.3d 1283 (2001). An exception to this rule exists, however, if there is a special relationship between the defendant and the victim or the defendant and the criminal. *Petersen v. State*, 100 Wn.2d at 426. Such a duty is imposed only if there is a definite, established, and continuing relationship between the defendant and the third-party criminal actor. *Estate of Jones v. State*, 107 Wn. App. 510, 518, 15 P.3d 180 (2000).

The "special relationship" rule in Washington and other states arises from *Restatement (Second) of Torts* § 315 (1965). This section reads:

> There is no duty so to control the conduct of a third person as to prevent him from causing physical harm to another unless
>
> (a) a special relation exists between the actor and the third person which imposes a duty upon the actor to control the third person's conduct, or

> (b) a special relation exists between the actor and the other which gives to the other a right to protection.

Jan DeMeerleer did not see Dr. Howard Ashby on a regular basis, but rather a hit-and-miss basis. We could question whether Ashby and DeMeerleer had a "definite, established, and continuing relationship." But, we accept that there is a question of fact as to whether this relationship existed. Dr. Ashby impliedly argues that the infrequent visits lessens his obligations, but he does not argue a special relationship is absent.

The leading case in Washington concerning the duty of a mental health professional is *Petersen v. State*, 100 Wn.2d 421. Plaintiff Cynthia Petersen was injured in an automobile accident in Tacoma. Petersen's car was struck by a vehicle driven by Larry Knox. Knox ran a red light while traveling approximately 50 to 60 miles per hour. Knox was under the influence of drugs. Two years earlier, Knox was released on parole for a burglary conviction on the condition he not use illicit drugs. A month before the accident, Knox was involuntarily committed to Western State Hospital after he removed one of his testicles while high on phencyclidine (PCP). Dr. Alva Miller, of Western State Hospital, released Knox early from the commitment because, in Dr. Miller's opinion, Knox had recovered from the drug reaction, was in full contact with reality, and was back to his usual type of personality and behavior. Five days later the car collision occurred.

Cynthia Petersen brought suit against the State of Washington, who operated Western State Hospital, alleging it negligently treated Knox by failing to protect her from

his dangerous propensities. Petersen argued that the failure of Dr. Miller, an employee of the State, to seek either additional confinement or to disclose information about Knox's parole violation was the proximate cause of her injuries. The jury agreed and rendered a verdict in her favor. The jury even ruled that Dr. Miller was grossly negligent. Petersen needed to prove gross negligence because she lacked any expert testimony to show that Miller violated a standard of care. Expert testimony is not needed in a medical negligence action when the plaintiff proves a gross deviation from the standard. *Petersen*, 100 Wn.2d at 437.

On appeal, the State of Washington, in *Petersen v. State*, argued it held no duty to protect Cynthia Petersen from Larry Knox. The high court disagreed. The court ruled that Dr. Miller, the State's employee, incurred a duty to take reasonable precautions to protect anyone who might foreseeably be endangered by Larry Knox's drug-related mental problems. At trial, Dr. Miller testified that Knox was a potentially dangerous person and that his behavior would be unpredictable. He also testified that if Knox used angel dust again he was likely to continue having delusions and hallucinations, especially if he quit taking a prescribed drug. Dr. Miller testified he knew of Knox's reluctance to take the drug, and he thought it quite likely Knox would revert to using angel dust again. Nevertheless, Dr. Miller failed to petition the court for a 90-day commitment, as he could have done under RCW 71.05.280, or to take other reasonable precautions to protect those who might foreseeably be endangered by Knox's drug-related mental problems.

Petersen v. State relied in part on *Kaiser v. Suburban Transp. Sys.*, 65 Wn.2d 461, 398 P.2d 14, 401 P.2d 350 (1965), wherein our state high court allowed a third party to sue a doctor for injuries caused by the doctor's patient. The doctor failed to warn his patient, who he knew was a bus driver, of the side effects of a drug he prescribed. The plaintiff, a bus passenger, was injured when the driver lost consciousness and struck a telephone pole. The court held that, since the doctor knew of the drug's side effects and that his patient was a bus driver, he could reasonably have foreseen the harm. *Kaiser*, 65 Wn.2d at 464. Accordingly, the bus passenger was entitled to present evidence that the doctor's negligence was the proximate cause of her injuries.

All specialties of medicine are both art and science, but psychiatry may be more art than science. The physician in *Kaiser v. Suburban Transportation System*, likely easily diagnosed the nasal condition, readily prescribed the one drug, and should have without much thought warned his patient of the side effect of the drug. Psychiatry is not as routine. Diagnosing whether a patient is a danger to others, particularly when the patient has no history of violence, is problematic. Applying the *Kaiser* rule to a mental health professional is a stretch.

Jan DeMeerleer suffered from bipolar disorder. He had expressed to Dr. Howard Ashby and others both suicidal and homicidal ideas. He attempted suicide once. He never attempted homicide and had a sparse history of violence toward others. The only history of violence is a punch in the mouth to Rebecca Schiering's nine-year-old autistic

son. DeMeerleer admitted homicidal thoughts about his ex-wife Amy and her boyfriend. He never expressed to Dr. Ashby or anyone else any homicidal ideation toward his girl friend, Rebecca Schiering, or her family.

The Schierings claim that, if Dr. Ashby had examined Jan DeMeerleer in compliance with the standard of care, the psychiatrist would have unearthed a homicidal desire toward Rebecca Schiering and thereby would have been able to warn her or others of the oncoming murders. If Howard Ashby treated DeMeerleer in compliance with the standard of care, it would have prevented the murders. The Schierings' expert, Dr. James Knoll supports these claims. Despite any personal views to the contrary, we must assume the veracity of Knoll's testimony. An appellate court does not weigh credibility in deciding a motion for summary judgment. *Jones v. Dep't of Health*, 170 Wn.2d 338, 354, 242 P.3d 825 (2010).

Petersen relied on the seminal case regarding the duty of a psychiatrist to protect against the conduct of a patient, *Tarasoff v. Regents of Univ. of Cal.*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976). In *Tarasoff*, the parents of Tatiana Tarasoff alleged the defendant therapists had a duty to warn their daughter of the danger posed to her by one of the therapists' patients. The patient killed Tatiana. Two months prior to the killing, the patient informed his therapist that he intended to kill a young woman. Although the patient did not name Tatiana as his intended victim, the parents alleged, and

the trial court agreed, that the therapists could have readily identified the endangered person as Tatiana.

The *Tarasoff* court ruled that when a psychotherapist determines, or, pursuant to the standards of the profession, should determine, that a patient presents a serious danger of violence to another, the therapist incurs an obligation to use reasonable care to protect the intended victim against such danger. *Tarasoff*, 17 Cal. 3d at 435. According to the *Tarasoff* court, discharge of the duty may require the therapist to take whatever steps are necessary under the circumstances, including possibly warning the intended victim or notifying law enforcement officials. *Tarasoff*, 17 Cal. 3d at 445.

Tarasoff could be read to limit the duty of the mental health professional to protect others to circumstances where the patient identifies his intended victim or provides enough information about the victim so that the psychiatrist can identify him or her. Nevertheless, the *Tarasoff* decision did not emphasize the identifiability of the victim. Subsequent California decisions limited the scope of the therapist's duty to readily identifiable victims. *See Thompson v. County of Alameda*, 27 Cal. 3d 741, 752-54, 614 P.2d 728, 167 Cal. Rptr. 70 (1980); *Mavroudis v. Superior Court*, 102 Cal. App. 3d 594, 600-01, 162 Cal. Rptr. 724 (1980).

Under *Tarasoff* and its offspring, Dr. Howard Ashby would be granted summary judgment. Jan DeMeerleer never identified Rebecca Schiering or her family members as

a target of violence. The Schierings do not directly argue that the punch to Jack should have alerted Spokane Psychiatric Clinic, P.S. to a homicidal danger toward the family.

The final decision that the *Petersen* court relied on is *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185 (D. Neb. 1980). In *Lipari*, the court emphasized the importance of foreseeability in defining the scope of a person's duty to exercise due care. In that case, a psychiatric patient entered a night club and fired a shotgun into a crowded dining room causing injuries to plaintiff and killing her husband. The *Lipari* court found that the defendant's therapist had a duty to any person foreseeably endangered by the negligent treatment of the psychiatric patient.

Petersen presents the extreme version of the duty imposed on a mental health professional to protect others. The decision is criticized by commentators and rejected by most other states, including California. Commentators protest that the decision places an impossible burden on mental health professionals and unduly interferes in the physician-patient privilege. Patients will withhold thoughts of violence for fear the professional will disclose those thoughts to others. The bond of trust between patient and doctor will dissolve. According to critics of *Petersen*, mental health professionals will be quick to seek involuntary commitment of a patient in order to avoid liability, thereby impinging on the freedom and civil rights of the mentally ill.

Petersen promotes the view that those with special powers, skills, and knowledge gained through the doctor-patient relationship must protect society at large from dangerous persons.

> With their superior knowledge, psychiatrists are expected to identify individuals who are dangerous to themselves or others and to recommend preventive action. This occurs both in the mental health context and within the judicial system where psychiatrists are called upon to assist in making decisions about culpability, competence, incarceration, or rehabilitation.

Fay Anne Freedman, *The Psychiatrist's Dilemma: Protect the Public or Safeguard Individual Liberty?*, 11 U. PUGET SOUND L. REV. 255, 260 (1987-1988) (footnotes omitted). In Washington, we expect psychiatrists to predict whether a sexually violent offender will relapse after treatment. RCW 71.09.055; *In re Det. of Campbell*, 139 Wn.2d 341, 357-58, 986 P.2d 771 (1999); *In re Pers. Restraint of Young*, 122 Wn.2d 1, 56-58, 857 P.2d 989 (1993); *In re Det. of Aguilar*, 77 Wn. App. 596, 601-02, 892 P.2d 1091 (1995). Still, empirical evidence establishes that psychiatry is an ill predictor of violent behavior. Michael A. Norko and Madelon V. Baranoski, *The Prediction of Violence; Detection of Dangerousness*, 8 BRIEF TREATMENT & CRISIS INTERVENTION 73, 77-78 (2008); Mairead Dolan & Michael Doyle, *Violence Risk Prediction: Clinical and Actuarial Measures and the Role of the Psychopathy Checklist*, 177 THE BRIT. J. PSYCHIATRY 303 (2000).

Petersen v. State's duty of care only extends to those "foreseeably endangered" by the patients' mental problems. Nevertheless, Washington decisions place no limitations

as to who is foreseeably endangered. The jury's function is to decide the foreseeability of the danger. *Bernethy v. Walt Failor's, Inc.*, 97 Wn.2d 929, 933, 653 P.2d 280 (1982). Ordinarily, foreseeability is a question of fact for the jury unless the circumstances of the injury "'are so highly extraordinary or improbable as to be wholly beyond the range of expectability.'" *Seeberger v. Burlington N.R.R.*, 138 Wn.2d 815, 823, 982 P.2d 1149 (1999) (quoting *McLeod v. Grant County Sch. Dist. No. 128*, 42 Wn.2d 316, 323, 255 P.2d 360 (1953)); *see also Schooley v. Pinch's Deli Mkt., Inc.*, 134 Wn.2d 468, 478, 951 P.2d 749 (1998).

In *Bader v. State*, 43 Wn. App. 223, 716 P.2d 925 (1986), this division followed the teachings of *Petersen v. State*, 100 Wn.2d 421. Morris Roseberry was arrested for assaulting his mother with a board. He was sent to Eastern State Hospital (ESH) for observation to determine whether he was competent to stand trial. The staff diagnosed him as a paranoid schizophrenic and manic depressive, stating, "Mr. Roseberry is a substantial danger to other persons and presents a likelihood of committing felonious acts jeopardizing public safety or security unless kept under further control by the court or other persons or institutions." *Bader*, 43 Wn. App. at 224. ESH concluded he was competent to stand trial, however. A jury acquitted Roseberry on the ground of insanity and the court released him conditioned upon his taking his prescribed medication, receiving treatment at the Chelan-Douglas Mental Health Center, and not returning to the family home.

Morris Roseberry's sister later informed the mental health center that he was not taking his medication and was talking of seeing the devil in people and how he must kill the devil. His family members felt threatened by his behavior. Roseberry missed several appointments at the center. Eventually, Roseberry showed for an appointment without evidencing any impairment.

Morris Roseberry lived across the street from Hazel Massey. Massey made several complaints to the Wenatchee Police Department about Roseberry's violent behavior toward her, including threats on her life. Four days after his last visit to the mental health clinic, Roseberry purchased a rifle, then shot and killed Massey. He was charged with first degree murder, but found not guilty by reason of insanity and committed to ESH.

In *Bader*, we reversed a summary judgment dismissal in favor of the Chelan-Douglas Mental Health Center. The center's records contained a copy of the court's order of acquittal on the ground of insanity and conditional release. The order stated Roseberry was a substantial danger to others and likely to commit felonious acts jeopardizing public safety. It also listed the conditions of his release, which included taking his medication, contacting the center and following its staff's instructions regarding treatment. The center's records showed it was aware Roseberry missed several of his appointments, was not taking his medication, and was talking of seeing the devil in people and how he must kill the devil. Thus, questions of fact existed as to the

foreseeability of Roseberry doing what he did and what action the center should have taken once it became aware Roseberry was violating the conditions of his court-ordered release. Massey's estate presented an affidavit of an expert, who opined that the center did not act within the standard of care and their actions were grossly negligent and in bad faith.

The Washington Legislature has narrowed the duty created by *Petersen v. State*. In 1987, the legislature enacted a new involuntary treatment act that provides limited immunity to mental health professionals in the context of the involuntary commitment process. This immunity already applied to public and law enforcement officers under a version of the law adopted in 1973. *See Spencer v. King County*, 39 Wn. App. 201, 692 P.2d 874 (1984), *overruled on other grounds*, *Frost v. City of Walla Walla*, 106 Wn.2d 669, 724 P.2d 1017 (1986).

The involuntary treatment act allows commitment of people who are either "gravely disabled" or present a "likelihood of serious harm." RCW 71.05.150. The involuntary commitment process is initiated when a mental health professional receives information alleging that a person presents an imminent likelihood of serious danger to himself or others, or is in imminent danger because of being gravely disabled. RCW 71.05.150. The mental health professional must thoroughly evaluate information received and assess the reliability and credibility of the person providing the information.

The initial detention of an individual may not exceed a 72-hour evaluation period. RCW 71.05.150(2)(a).

For our purposes, the relevant portion of the involuntary treatment act, RCW 71.05.120 reads:

> (1) No officer of a public or private agency, nor the superintendent, professional person in charge, his or her professional designee, or attending staff of any such agency, nor any public official performing functions necessary to the administration of this chapter, nor peace officer responsible for detaining a person pursuant to this chapter, nor any county designated mental health professional, nor the state, a unit of local government, or an evaluation and treatment facility shall be civilly or criminally liable for performing duties pursuant to this chapter with regard to the decision of whether to admit, discharge, release, administer antipsychotic medications, or detain a person for evaluation and treatment: PROVIDED, That such duties were performed in good faith and without gross negligence.
>
> (2) This section does not relieve a person from giving the required notices under RCW 71.05.330(2) or 71.05.340(1)(b), or the duty to warn or to take reasonable precautions to provide protection from violent *behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims.* The duty to warn or to take reasonable precautions to provide protection from violent behavior is discharged if reasonable efforts are made to communicate the threat to the victim or victims and to law enforcement personnel.

(Emphasis added.) The immunity granted by RCW 71.05.120 extends only to third parties and not to the patient. *Spencer*, 39 Wn. App. 201.

We read the two sections of RCW 71.05.120 together to grant immunity to mental health professionals except with five exceptions: (1) the professional performs duties in bad faith; (2) the professional performs duties with gross negligence; (3) the professional

releases a patient before the expiration of an involuntary commitment without notifying the county prosecuting attorney at least thirty days before release pursuant to RCW 71.05.330(2); (4) the professional conditionally releases, for purposes of outpatient treatment, the patient before the expiration of an involuntary commitment without notifying the county prosecuting attorney at least 30 days before release under RCW 71.05.340(b); and (5) the professional fails to warn or take reasonable precautions to provide protection from violent behavior when the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims.

We must decide whether we apply the duty enunciated in *Petersen v. State* or the duty implied by the withholding of immunity under RCW 71.05.120(2). Stated differently, we must decide if a mental health professional has a duty to protect all foreseeable victims or a duty to protect only victims identified by the outpatient.

RCW 71.05.120 by its terms applies only to the performance of "functions necessary to the administration of" chapter 71.05 RCW. The chapter concerns involuntary commitment to a mental health facility. Courts refer to the chapter as the involuntary treatment act. *Poletti v. Overlake Hosp. Med. Ctr.*, 175 Wn. App. 828, 831, 303 P.3d 1079 (2013). The involuntary treatment act is primarily concerned with the procedures for involuntary mental health treatment of individuals who are at risk of harming themselves or others, or who are gravely disabled. *Poletti*, 175 Wn. App. at 832.

The allegations of the Schierings can be read to assert a claim that Spokane Psychiatric Clinic, P.S. was negligent for failing to take steps to involuntarily commit Jan DeMeerleer. Such a claim is ripe for summary judgment and we affirm the trial court to the extent it dismissed this claim.

Dr. James Knoll contends a thorough evaluation and treatment of Jan DeMeerleer may have led to a conclusion that DeMeerleer should receive "institutional treatment." We assume institutional treatment entails involuntary commitment. When the plaintiff claims the mental health professional should have detained the patient, the plaintiff is claiming the professional should have involuntarily committed the patient. *Estate of Davis v. Dep't of Corr.*, 127 Wn. App. 833, 840-41, 113 P.3d 487 (2005). Under such circumstances, RCW 71.05.120 controls and the mental health professional is entitled to immunity under the statute. *Poletti*, 175 Wn. App. at 831; *Estate of Davis*, 127 Wn. App. at 840-41. In *Poletti*, the trial court ruled that plaintiff need only satisfy a negligence standard when presenting evidence that a mental health hospital should have detained a patient. The Court of Appeals reversed, ruling that RCW 71.05.120's immunity applied. The only authority under that the hospital could have detained the patient was under the involuntary treatment act.

Subsection 2 of RCW 71.05.120 imposes an obligation on a mental health professional. It does not provide immunity, but withholds the immunity afforded in subsection 1 in a narrow circumstance. RCW 71.05.120(2) identifies an instance in

which the mental health professional can be found liable—when the patient threatens an identifiable person. It imposes a duty, rather than limiting a duty. But remember the statute applies only within the context of the involuntary commitment process. Subsection 2 does not preclude a broader duty outside the context of involuntary commitment. Should we read the standard as applying outside the involuntary commitment setting? Would the standard make as much sense outside the involuntary commitment background?

One commentator concludes the immunity afforded by RCW 71.05.120 will not be applied outside the context of involuntary commitment. Nevertheless, the commentator does not distinguish between portions or subsections of the statute. 16 DAVID DEWOLF AND KELLER W. ALLEN, WASHINGTON PRACTICE: TORT LAW AND PRACTICE 707-08 (4 ed. 2013) discusses RCW 71.05.120 as follows:

> Similarly, a Washington statute grants limited immunity to mental health professionals and their employers who are responsible for decisions regarding the detention of a mental health patient, so long as they act in good faith and without gross negligence. The limited immunity applies not only to decisions regarding an actual detention, but also to the determination of whether to detain a patient involuntarily. Thus, where a patient voluntarily presented herself for treatment at a hospital, and was later admitted to the psychiatric ward, the statutory standard applied to a claim that the hospital negligently failed to refer the patient for a mental health evaluation. On the other hand, the ordinary negligence standard would apply to claims for negligent treatment that are not based on a decision regarding involuntary detention, such as the evaluation of the patient prior to the time that such a decision is made.

(Footnotes omitted.)

For the purpose of demarcating to whom a duty is owed we discern no reason to differentiate between treating a mental health patient in the context of involuntary commitment and treating a patient outside that context. Under either circumstance, predicting violent behavior and the target of the violent behavior is difficult. Nevertheless, we also discern no purpose in differentiating between applying a negligence or gross negligence standard in these two contexts. But RCW 71.05.120 distinguishes between the two contexts.

In short, the state legislature saw a need to protect mental health professionals within the context of involuntary commitment proceedings. The legislature has not extended those same protections outside that context. So we conclude that the *Petersen* duty applies in our case. There is a question of fact as to whether the clinic violated a duty owed to Rebecca Schiering and her family, except to the extent the Schierings argue that Howard Ashby should have involuntarily institutionalized Jan DeMeerleer.

We now address specific contentions raised by Dr. Ashby and Spokane Psychiatric Clinic, P.S. Howard Ashby focuses on former Justice Phillip Talmadge's concurring opinion in *Hertog v. City of Seattle*, 138 Wn.2d 265, 293 n.7, 979 P.2d 400 (1999) (Talmadge, J., concurring), in which he writes, "the Legislature statutorily abrogated our holding in *Petersen* in LAWS OF 1987, ch. 212, § 301(1) (codified at RCW 71.05.120(1)), with respect to liability of the State." We do not consider a concurring opinion controlling. Also, this appeal does not concern the liability of the State of Washington.

Hertog involved the duty owed by a parole officer, not the duty imposed on a mental health professional with regard to an outpatient.

Dr. Howard Ashby contends that RCW 70.02.050 precluded him from warning Rebecca Schiering of any violent tendency of Jan DeMeerleer, since DeMeerleer never identified Schiering as a potential target of violence. Ashby contends the statute limits any warning to a third party who is a named target of violence. We do not read the statute that narrowly. The statute allows disclosure of health care information:

> (d) To any person if the health care provider or health care facility reasonably believes that disclosure will avoid or minimize an imminent danger to the health or safety of the patient or any other individual, however there is no obligation under this chapter on the part of the provider or facility to so disclose.

RCW 70.02.050(d). The statute also does not expressly preclude disclosure in circumstances where there is no identified victim.

Howard Ashby emphasizes that RCW 70.02.050, enacted in 1991, did not exist when our Supreme Court decided *Petersen v. State*. Nonetheless, the patient-physician privilege existed under another statute at the time of the 1983 *Petersen* decision. RCW 5.60.060(4), that recognizes the privilege, is based on legislation adopted in pre-territorial days. *Petersen* recognized a psychologist-client privilege, RCW 18.83.110, and a privilege in involuntary commitment proceedings, RCW 71.05.390, but ruled that neither privilege overcame the duty to protect third parties.

Dr. Howard Ashby wishes us to hold that he lacked notice that Jan DeMeerleer was an "imminent danger to the health and safety" of others, and, therefore, based on RCW 70.02.050(d), he garnered no duty to protect others. Since we conclude that the statute does not limit the psychiatrist's tort duty, we need not address this argument. Anyway, the Schierings argue and their expert testifies that, if Howard Ashby had met the standard of care and engaged in intensive treatment, Jan DeMeerleer would have disclosed information leading a mental health professional to reasonably believe DeMeerleer was an imminent danger to others.

Howard Ashby contends that the duty to warn third parties arises only if the mental health professional "takes control" of the patient. Washington decisional law does not limit the duty to such circumstances. *Petersen* involved release from involuntary commitment, but did not limit its holding to such circumstances or declare that the duty to protect others applied only when the mental health professional had authority to control the patient. In *Bader*, we reversed summary judgment in favor of the Chelan-Douglas Mental Health Center despite the center never having "control" over the patient. 43 Wn. App. at 227-28.

Amicus contends that three decisions limit the *Petersen* duty to instances of institutional confinement: *Taggart v. State*, 118 Wn.2d 195, 218, 822 P.2d 243 (1992); *Couch v. Dep't of Corr.*, 113 Wn. App. 556, 571, 54 P.3d 197 (2002); and *Osborn* v. *Mason County*, 157 Wn.2d 18, 24, 134 P.3d 197 (2006). *Taggart*, is two consolidated

cases that plaintiffs claimed the Indeterminate Sentence Review Board and individual parole officers were negligent for releasing and supervising parolees. *Taggart* affirmed *Petersen v. State*. The State sought to limit the *Petersen* duty to instances when the criminal actor is released from a mental hospital and argued that a parole officer lacks control over the parolee since the parolee is already in the community. The court declined to make such a distinction. The court declared, "Whether the patient is a hospital patient or an outpatient is not important." *Taggart*, 118 Wn.2d at 223. Thus, *Taggart* supports our ruling not amicus' argument.

In *Osborn v. Mason County*, parents sued because a registered sex offender raped and murdered their daughter. They claimed Mason County failed to warn them of the offender's presence. The Supreme Court held that Mason County had no duty to warn the Osborns because they did not rely on a promise to warn and the daughter was not a foreseeable victim. Although the court mentioned the county's lack of control over the offender, it did not limit the *Petersen* duty.

Couch v. Department of Corrections, addressed the question of whether the department owes a duty of care to prevent future crimes while supervising an offender only for the purpose of collecting money. The court answered no, but made no statement limiting the force of *Petersen*.

Lost Chance

The Schierings also allege that Dr. Howard Ashby's violation of the standard of care reduced Phillip and Rebecca Schiering's chance of survival. Thus, they assert a claim for lost chance, but Dr. Knoll provides no percentage for the lost chance. We dismiss any lost chance claim based on an allegation that Dr. Ashby should have involuntarily committed Jan DeMeerleer, on the basis of immunity under RCW 71.05.120. We further dismiss the lost chance claim in its entirety because the Schierings presented no expert testimony of percentage of lost chance. *Rash v. Providence Health & Serv.*, No. 31277-1-III (Wash. Ct. App. Sept. 16, 2014).

Every Washington decision that permits recovery for a lost chance contains testimony from an expert health care provider that includes an opinion as to the percentage or range of percentage reduction in the chance of survival. *Herskovits v. Grp. Health Coop of Puget Sound*, 99 Wn.2d 609, 611, 664 P.2d 474(1983) (14 percent reduction in chance of survival); *Mohr v. Grantham*, 172 Wn.2d 844, 849, 262 P.3d 490 (2011) (50 to 60 percent chance of loss of better outcome); *Shellenbarger v. Brigman*, 101 Wn. App. 339, 348, 3 P.3d 211 (2000) (20 percent chance that the disease's progress would have been slowed). Without that percentage, the court would not be able to determine the amount of damages to award the plaintiff, since the award is based on the percentage of loss. *See Smith v. Dep't of Health & Hosps.*, 95-0038 (La. 6/25/96); 676 So. 2d 543, 548. Discounting damages by that percentage responds to a concern of

awarding damages when the negligence was not the proximate cause or likely cause of the death. *Mohr*, 172 Wn.2d at 858; *Matsuyama v. Birnbaum*, 452 Mass. 1, 17, 890 N.E.2d 819 (2008). Otherwise the defendant would be held responsible for harm beyond that which it caused. The leading author on the subject of lost chance declares:

> Despite the sound conceptual underpinnings of the doctrine, its successful application depends on the quality of the appraisal of the decreased likelihood of a more favorable outcome by the defendant's tortious conduct.

Joseph H. King, Jr., *"Reduction of Likelihood" Reformulation and Other Retrofitting of the Loss-of-a-Chance Doctrine*, 28 U. MEM. L. REV. 491, 546-47 (1998). This quote promotes accurate calculations and use of percentages.

James Knoll's Testimony

Dr. Howard Ashby contends that the Schierings offered a declaration from an expert witness containing generalities, factually unsupported conclusions and speculation, advocating for a boundless and expansive duty to warn. If we were the trier of fact, we might agree with Dr. Ashby, but our role is not to weigh the credibility of the witness or the validity of expert opinions. Courts do not weigh the evidence or assess witness credibility on a motion for summary judgment. *Am. Express Centurion Bank v. Stratman*, 172 Wn. App. 667, 677, 292 P.3d 128 (2012). Dr. James Knoll is a qualified mental health professional and Ashby does not challenge Knoll's credentials.

Dr. Ashby questions Dr. James Knoll's qualifications to opine about the standard of care imposed on a mental health professional in Washington State. Ashby's questioning fails to recognize that Washington allows a medical professional from another state to testify to the standard of care in Washington. In a medical malpractice suit, a plaintiff must prove the relevant standard of care through the presentation of expert testimony, unless a limited exception applies. *Harris v. Robert C. Groth, M.D., Inc. PS*, 99 Wn.2d 438, 449, 663 P.2d 113 (1983); *Douglas v. Bussabarger*, 73 Wn.2d 476, 479, 438 P.2d 829 (1968); and *Grove v. PeaceHealth St. Joseph Hosp.*, 177 Wn. App. 370, 382, 312 P.3d 66 (2013), *review granted*, 180 Wn.2d 1008, 325 P.3d 913 (2014). The standard of care is the degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he belongs, in the state of Washington. *Hill v. Sacred Heart Med. Ctr.*, 143 Wn. App. 438, 446, 177 P.3d 1152 (2008). A physician licensed in another state may provide admissible testimony that a national standard of care exists and that the defendant physician violated that standard. *Elber v. Larson*, 142 Wn. App. 243, 248, 173 P.3d 990 (2007); *Pon Kwock Eng v. Klein*, 127 Wn. App. 171, 110 P.3d 844 (2005).

Dr. Ashby's criticism also fails to note that Dr. Knoll contacted a Washington mental health professional to consult on the standard of care. One expert may rely on the opinions of another expert when formulating opinions. *State v. Russell*, 125 Wn.2d 24, 74-75, 882 P.2d 747 (1994); *Deep Water Brewing, LLC v. Fairway Res. Ltd.*, 152 Wn.

App. 229, 275, 215 P.3d 990 (2009). Dr. Ashby criticizes Dr. Knoll for failing to identify the Washington State practitioner, but we know of no rule that requires one expert witness to voluntarily identify another expert that he relies in forming opinions. Dr. Ashby could have conducted a deposition of Dr. Knoll to discover the name.

Howard Ashby does not identify the "factually unsupported conclusions" he believes are contained in Dr. Knoll's declaration. Dr. Knoll testifies to the facts, that he based his opinions, and states that he discovered those facts by reviewing Dr. Ashby's records. Dr. Ashby does not isolate any facts declared by Knoll missing from the records.

Summary judgment jurisprudence directs a court to reject "speculation" when reviewing summary judgment motions. *Seven Gables Corp. v. MGM/UA Entm't Co.*, 106 Wn.2d 1, 13, 721 P.2d 1 (1986); *State v. Kaiser*, 161 Wn. App. 705, 718, 254 P.3d 850 (2011). But the law likely recognizes two levels of speculation, one for purposes of summary judgment, and one for purposes of finding facts after an evidentiary hearing or trial. We do not consider Dr. Knoll's testimony speculative for purposes of defending a summary judgment motion. Dr. Knoll relied on facts found in the chart notes of Dr. Ashby. He gives a reasoned explanation for his conclusions. He bases his opinions on reasonable probability.

Imposing a duty on Dr. Ashby, in the setting of our case, entails addressing whether the Schiering family was a foreseeable victim. The family was more foreseeable

as a victim than Cynthia Petersen in *Petersen v. State*, since Larry Knox, the criminal actor in *Petersen*, had no prior connection to Cynthia Petersen. Jan DeMeerleer had a prior connection to Rebecca Schiering and her three sons. DeMeerleer had already slugged one son. According to the evidence before the court on summary judgment, Dr. Ashby knew that Jan DeMeerleer had already threatened to use violence against his former wife and her boyfriend. Dr. Ashby knew DeMeerleer suffered from distress and depression resulting from the breakup with Rebecca Schiering.

Petersen v. State also answers the dissent's position that no liability should attach to Dr. Ashby because there were no threats uttered about the Schierings. Cynthia Petersen was not the subject of prior threats.

Howard Ashby criticizes the declaration of Dr. James Knoll as suggesting that, had Dr. Ashby not violated the standard of care, "it is *possible* that Mr. DeMeerleer *may have* disclosed to Dr. Ashby homicidal thoughts Mr. DeMeerleer *may have* had about Ms. Schiering and/or her children." Br. of Resp't Dr. Howard Ashby at 5. After criticizing Knoll's affidavit, Ashby denounces the testimony as speculation on speculation. Dr. Knoll's opinions are stronger, however, than characterized. James Knoll testified that Spokane Psychiatric Clinic, P.S. should have properly monitored DeMeerleer, performed a risk assessment, and provided intensive clinical or institutional psychiatric treatment. Had Spokane Psychiatric Clinic, P.S.'s conduct conformed to the standard of care, the risk and occurrence of the incident "would have been mitigated," and "probably would

not have occurred," as DeMeerleer's mental distress probably would not have digressed to the level of allowing for an act of suicide or homicide. CP at 90. Knoll further declared that but for the breaches in the standard of care, "it is unlikely the Incident [sic] would have occurred." CP at 91. Dr. Knoll's declaration language meets the requirement that the subject of an expert's affidavit or declaration must be of such a nature that an expert expresses an opinion based on a reasonable probability rather than mere conjecture of speculation. *Davidson v. Mun. of Metro. Seattle*, 43 Wn. App. 569, 571, 719 P.2d 569 (1986).

Dr. Ashby further faults the declaration of James Knoll as being speculative because Knoll testifies that additional treatment "may" have led to Jan DeMeerleer disclosing homicidal thoughts about Rebecca Schiering or her children. Ashby correctly notes that this testimony assumes that Jan DeMeerleer entertained homicidal thoughts about Schiering or her boys before the evening of July 18, 2010. But James Knoll's testimony is not limited to an opinion that more extensive treatment would have allowed Ashby to warn Rebecca Schiering of violent behavior. Dr. Knoll also testifies that extensive treatment would itself have been "demonstrably effective." CP at 88. With intensive treatment, Jan DeMeerleer's "mental distress probably would not have digressed to the level of allowing for an act of suicide and/or homicide." CP at 89.

Howard Ashby criticizes James Knoll for failing to attach to his declaration those clinical records that he reviewed. We are not aware of any rule requiring that the expert

witness attach to a declaration records on which he relies. To the contrary, ER 705 allows an expert to even testify to his opinions without disclosing the underlying basis until asked or ordered by the court.

Liability of Spokane Psychiatric Clinic, P.S.

The parties provide no evidence of the relationship between Spokane Psychiatric Clinic, P.S. and Howard Ashby. We do not know if Ashby is an employee of the clinic, such that the clinic is vicariously liable for the conduct of Howard Ashby. We do not know if Ashby was an independent contractor. In response to Spokane Psychiatric Clinic, P.S.'s summary judgment motion, the Schierings provided no evidence or opinion that Spokane Psychiatric Clinic, P.S. violated a standard of care and was independently negligent. On appeal, the Schierings assign no error to the dismissal of Spokane Psychiatric Clinic, P.S. except to the extent of it's vicarious liability for the conduct of Howard Ashby.

In its brief, Spokane Psychiatric Clinic, P.S. admits that it is vicariously liable for any malpractice of Howard Ashby. In their reply brief, the Schierings admit they have no evidence of direct negligence by the clinic. Based on these concessions, we affirm the trial court's dismissal of the claims asserted by the Schiering family that the clinic failed to establish and implement policies and procedures to prevent the deaths and injuries to the family members. In other words, we affirm the dismissal of any claim against the clinic for independent negligence. Spokane Psychiatric Clinic, P.S. remains subject to

liability to the extent that Howard Ashby is found negligent, and thus the summary judgment ruling in favor of the clinic is reversed to the extent of vicarious liability.

CONCLUSION

We reverse in part, and affirm in part, the summary judgment order in favor of Dr. Howard Ashby. To the extent that the Schierings contend Dr. Ashby should have involuntarily committed Jan DeMeerleer, the dismissal is affirmed. We also affirm the dismissal of the Schierings' claim of lost chance. Otherwise, the summary judgment order for Dr. Howard Ashby is reversed. We reverse in part, and affirm in part, the summary judgment order in favor of Spokane Psychiatric Clinic, P.S. To the extent that the Schierings contend the clinic is independently negligent, the summary judgment order is affirmed. The summary judgment order is reversed to the extent that Spokane Psychiatric Clinic, P.S. is vicariously liable.

We remand for further proceedings consistent with this opinion.

Fearing, J.

I CONCUR:

Lawrence-Berrey, J.

No. 31814-1-III

BROWN, A.C.J. (concurring in part/dissenting in part) — In my view, appellants fail to show Mr. DeMeerleer ever communicated to respondents any actual threat of physical harm concerning these third-party appellants during his treatment. Thus, under current applicable law, I would hold respondents fail to show the necessary foreseeable risk of harm to raise a legal duty to protect appellants. I would affirm the trial court's grant of summary judgment in all respects.[1]

Long before this tragic incident, Mr. DeMeerleer expressed isolated homicidal thoughts about an ex-wife and an unknown prowler. Mr. DeMeerleer never mentioned to respondents any homicidal or threatening thoughts toward appellants. Indeed, on April 16, 2010, Mr. DeMeerleer last saw respondents, telling them he was mending his relationship with Rebecca and would not act on his suicidal ideas. On July 18, 2010 when off his medications, Mr. DeMeerleer shot and killed Rebecca and Phillip, attempted to kill Brian, then killed himself. Family members, friends, and acquaintances who visited Mr. DeMeerleer shortly before the incident gleaned no indication of any plan. Respondents moved successfully for summary judgment, partly arguing they owed no third-party duty. The trial court agreed, reasoning respondents could not have

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[1] For clarity, I use given names.

reasonably identified Rebecca, Phillip, or Brian as Mr. DeMeerleer's target because he communicated no "actual threat of physical violence" toward them. RCW 71.05.120(2).

To prevail in a professional malpractice suit against a mental health care provider, the plaintiff must prove the defendant breached a duty owed to him or her and, thereby, proximately caused damages. *Petersen v. State*, 100 Wn.2d 421, 435, 671 P.2d 230 (1983). At common law, a person owes no duty to control a dangerous person's conduct or protect a foreseeable victim from it unless the person has a special relationship with either the dangerous person or the foreseeable victim. In *Kaiser v. Suburban Transportation System*, 65 Wn.2d 461, 398 P.2d 14, 401 P.2d 350 (1965), our Supreme Court acknowledged a physician-patient relationship may trigger a duty for the benefit of an injured third party.

In 1973, our legislature immunized mental health professionals from civil and criminal liability for performing certain statutory duties "in good faith and without negligence." LAWS OF 1973, 1st Ex. Sess., ch. 142, § 17; LAWS OF 1973, 2d Ex. Sess., ch. 24, § 5. Our legislature increased this standard of care the next year, requiring performance "in good faith and without gross negligence." LAWS OF 1974, 1st Ex. Sess., ch. 145, § 7. Last amended in 2000, this immunity provision now reads,

> (1) No officer of a public or private agency, nor the superintendent, professional person in charge, his or her professional designee, or attending staff of any such agency, nor any public official performing functions necessary to the administration of this chapter, nor peace officer responsible for detaining a person pursuant to this chapter, nor any county designated mental health professional, nor the state, a unit of local government, or an evaluation and treatment facility shall be civilly or criminally liable for performing duties pursuant to this chapter with regard to the decision of whether to admit, discharge, release, administer

> antipsychotic medications, or detain a person for evaluation and treatment: PROVIDED, That such duties were performed in good faith and without gross negligence.

RCW 71.05.120(1).[2]

Historically, the California Supreme Court decided the landmark case of *Tarasoff v. Regents of the University of California*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976). There, a voluntary outpatient told his psychotherapist he planned to kill an unnamed but readily identifiable woman when she returned home from summer travels. *Id.* at 432. The therapist disclosed the plan to law enforcement, who arrested the patient but released him. *Id.* The therapist did not warn the targeted woman or her family. *Id.* at 433. The patient soon killed the targeted woman as planned. *Id.* Applying *Restatement (Second) of Torts* § 315 (1965), the *Tarasoff* court held the therapist-patient relationship triggered a duty for the benefit of the victim and her family. *Id.* at 435-36. Thus, the therapist owed the victim and her family a duty to warn them of the threat the patient posed. *Id.* at 435-36, 438. The *Tarasoff* court ruled:

> When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.

Id. at 431.

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[2] In their opening brief to us, appellants argue RCW 71.05.120(1) applies solely to mental health professionals at public agencies. But in their reply brief to us, appellants properly concede that argument is untenable.

Later California cases decided a psychotherapist owes a duty solely to a person he or she can readily identify as the patient's target. *See Thompson v. County of Alameda*, 27 Cal. 3d 741, 752-54, 614 P.2d 728, 167 Cal. Rptr. 70 (1980); *Mavroudis v. Superior Court*, 102 Cal. App. 3d 594, 600, 162 Cal. Rptr. 724 (1980); 4 STEWART M. SPEISER, CHARLES F. KRAUSE & ALFRED W. GANS, THE AMERICAN LAW OF TORTS § 15:41, at 772-73 (2009). Cases from other jurisdictions similarly hold a psychotherapist owes a duty to any person he or she should reasonably foresee is endangered by the patient's mental condition. *See Semler v. Psychiatric Inst.*, 538 F.2d 121, 124 (4th Cir. 1976); *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185, 194-95 (D. Neb. 1980); *Williams v. United States*, 450 F. Supp. 1040, 1046 (D.S.D. 1978); SPEISER, KRAUSE & GANS, *supra*, § 15:41, at 773-74.

The *Petersen* court adopted the latter approach. *Petersen*, 100 Wn.2d at 427-28. Applying *Tarasoff*, *Lipari*, and *Kaiser*, the *Peterson* court held the therapist involved owed a duty to any person he should have reasonably foreseen was endangered by the patient's drug-related mental problems. *Id.* at 428. The therapist owed the victim a duty to take reasonable precautions protecting her from the threat the patient posed. *Id.*

In 1985, the California Legislature enacted a measure "to limit the liability of psychotherapists under [*Tarasoff*]." *Barry v. Turek*, 218 Cal. App. 3d 1241, 1244, 267 Cal. Rptr. 553 (1990). Two years later, our legislature enacted a similar measure adding a subsection to the then-existing immunity provision that effectively limited the liability of mental health professionals under *Petersen*, *Tarasoff*, and *Lipari*. Under subsection (1), a mental health professional is immune from civil and criminal liability for

performing duties arising from chapter 71.05 RCW regarding a decision to "admit, discharge, release, administer antipsychotic medications, or detain a person for evaluation and treatment" so long as the professional performs the duties "in good faith and without gross negligence." Critical here is subsection (2):

> This section does not relieve a person from . . . the duty to warn or take reasonable precautions to provide protection from violent behavior where the patient has communicated an *actual threat of physical violence* against a *reasonably identifiable victim or victims*. The duty to warn or to take reasonable precautions to provide protection from violent behavior is discharged if reasonable efforts are made to communicate the threat to the victim or victims and to law enforcement personnel.

LAWS OF 1987, ch. 212, § 301(2) (emphasis added) (codified at RCW 71.05.120(2)).

Under subsection (2), a mental health professional still has a duty to "warn or to take reasonable precautions to provide protection from violent behavior" where a patient communicates to the professional an "actual threat of physical violence against a reasonably identifiable victim or victims." In my view, this record fails to show Mr. DeMeerleer communicated to respondents the necessary threat of physical violence toward appellants.

Considering the historical development of RCW 71.05.120, two principles emerge. First, a mental health professional owes the duties specified in subsection (1) to any person he or she should reasonably foresee is endangered by the patient's mental condition. *See* Fay Anne Freedman, *The Psychiatrist's Dilemma: Protect the Public or Safeguard Individual Liberty?*, 11 PUGET SOUND L. REV. 255, 276-77 (1988). Second, a mental health professional owes the duties specified in subsection (2) solely to a person he or she can reasonably identify as the patient's target after the patient

communicates an actual threat of physical violence. *See id.* Thus, RCW 71.05.120(1) and (2) address different duties that should be separately analyzed.

Petersen would be decided the same under subsection (1) because, while the victim was reasonably foreseeable, the psychotherapist was grossly negligent in performing duties arising from chapter 71.05 RCW regarding the decision to discharge the patient or petition for additional commitment. *See* 100 Wn.2d at 424, 428-29, 436-38; Freedman, *supra*, at 277. *Contra Hertog v. City of Seattle*, 138 Wn.2d 265, 292, 293 n.7, 979 P.2d 400 (1999) (Talmadge, J., concurring). But *Petersen* would be decided differently under subsection (2) because, while the psychotherapist was grossly negligent in failing to take reasonable precautions protecting against the threat the patient posed, the patient did not communicate an actual threat of physical violence; thus, the victim was not reasonably identifiable and foreseeable. *See* 100 Wn.2d at 424, 428-29, 436-38; Freedman, *supra*, at 277.

Here, the sole focus is RCW 71.05.120(2) because appellants alleged respondents did not adequately assess Mr. DeMeerleer's suicide risk or plan follow-up care. Appellants allege doing so would likely have resulted in better psychiatric care exposing Mr. DeMeerleer's homicidal thoughts about Rebecca, Phillip, and Brian that would, in turn, have prevented the incident by either mitigating Mr. DeMeerleer's dangerousness or serving as cause to warn and protect them. While these claims are broad enough to allege respondents breached the duties specified in either subsection (1) or (2), appellants reply brief clarified they did not intend to allege respondents breached any duties arising from chapter 71.05 RCW regarding a decision to "admit,

discharge, release, administer antipsychotic medications, or detain a person for evaluation and treatment." RCW 71.05.120(1).[3] Therefore, appellants solely alleged respondents breached the duty to "warn or to take reasonable precautions to provide protection from violent behavior." RCW 71.05.120(2).[4]

In sum, I would hold the trial court correctly reasoned that respondents could not have reasonably identified Rebecca, Phillip, or Brian as Mr. DeMeerleer's targets because he communicated no "actual threat of physical violence" toward them. RCW 71.05.120(2). Because I would affirm the trial court's summary judgment dismissal of appellants' third-party liability claims, I respectfully dissent to the majority decision to reverse the trial court's grant of summary judgment to respondents on the third-party claims. I concur with the majority decisions partly affirming the trial court's dismissal of the other claims.

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[3] Even if the duties specified in RCW 71.05.120(1) applied, I would conclude appellants lack evidence showing respondents performed those duties in bad faith or with gross negligence.

[4] I would reject appellants' attempt to distinguish the duty specified in RCW 71.05.120(2) from the case law. Subsection (2) clearly addresses the same case law duty. *Compare* RCW 71.05.120(2) ("This section does not relieve a person from . . . the duty to warn or take reasonable precautions to provide protection from violent behavior . . . ."), *with Peterson*, 100 Wn.2d at 428 (holding the psychotherapist "incurred a duty to take reasonable precautions to protect"); *Tarasoff*, 17 Cal. 3d at 431 (stating the relevant duty requires the psychotherapist to "use reasonable care to protect" by, for example, "warn[ing]" or "tak[ing] whatever other steps are reasonably necessary under the circumstances"); *Lipari*, 497 F. Supp. at 193 (same). Therefore, subsection (2) logically applies in the same circumstances as case law.

Accordingly, I concur in part and dissent in part.

Brown, A.C.J.

APPENDIX B

SUPERIOR COURT OF WASHINGTON FOR SPOKANE COUNTY

BEVERLY R. VOLK, as Guardian for Jack Alan Schiering, a minor; as Personal Representative for the Estates of Phillip Lee Schiering and Rebecca Leigh Schiering; and on behalf of all statutory beneficiaries of Rebecca Leigh Schiering and Phillip Lee Schiering; and BRIAN P. WINKLER, individually, Plaintiffs, v. JAMES B. DEMEERLEER, as Personal Representative of the Estate of Jan DeMeerleer; HOWARD ASHBY, M.D. and "JANE DOE" ASHBY, husband and wife, and the marital community composed thereof; SPOKANE PSYCHIATRIC CLINIC, P.S., a Washington business entity and health care provider; and DOES 1 through 5, Defendants.	NO. 11-2-00277-7 SECOND AMENDED ORDER ON DEFENDANTS' SUMMARY JUDGMENT MOTIONS

I. BASIS

The Court entertained motions for summary judgment by Defendants Spokane Psychiatry and Howard Ashby, MD on May 31, 2013. The records provided to the Court in advance of the hearing included the following:

- Defendant Dr. Howard Ashby's Motion for Summary Judgment
- Memorandum of Authorities in Support of Defendant Dr. Howard Ashby's Motion for

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400 S Jefferson St Ste 112 Spokane WA 99204-3144
Phone: 509-323-1120 Fax: 509- 323-1222
E-mail: mjrps@mjrps.net

Summary Judgment

- Affidavit of Michael E. McFarland Jr. in Support of Defendant Dr. Ashby's Summary Judgment
- Note for Hearing re: Ashby's SJ
- Joinder in Defendant Dr. Howard Ashby, M.D.'s Motion for Summary Judgment
- Defendant Spokane Psychiatric Clinic's Points and Authorities in Support of Its Joinder in Defendant Dr. Howard Ashby, M.D.'s Motion for Summary Judgment
- Amended Note for Hearing re: Dr. Ashby's Summary Judgment
- Note for Hearing re: Joinder
- Plaintiffs' Response to Defendants Dr. Ashby and Spokane Psychiatric Clinic's Motion for Summary Judgment
- Declaration of James L. Knoll, IV, M.D.
- Proposed Order Denying Defendants' Motion for Summary Judgment
- Spokane Psychiatric Clinic, P.S.'s Reply to Plaintiffs' Response to Spokane Psychiatric Clinic's Motion for Summary Judgment
- Defendant Dr. Howard Ashby's Reply Memorandum in Support of Motion for Summary Judgment
- Defendant Dr. Howard Ashby's Motion to Strike Declaration of James L. Knoll, M.D.
- Defendant Dr. Howard Ashby's Memorandum in Support of Motion to Strike Declaration of James L. Knoll, M.D.
- Declaration of Amy Demeerleer
- Declaration of Darien Boedcher
- Declaration of Gene Demeerleer

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- Declaration of Brent Tibbetts
- Declaration of Gena Leonard
- Declaration of Lawrence Dagnon
- Declaration of Jennifer Schweitzer
- Defendant Dr. Howard Ashby's Motion to Expedite Hearing on Motion to Strike Declaration of James L. Knoll, M.D.
- Defendant Dr. Howard Ashby's Memorandum in Support of Motion to Expedite Hearing on Motion to Strike Declaration of James L. Knoll, M.D.
- Note for Hearing re: Motion to Strike and Motion to Expedite – 04/26/13 @ 9am
- Plaintiffs' Motion to Strike Defendants' Replies; Declarations of Lay Witnesses; to Amend Complaint; and to Continue Hearing
- Memorandum in Support of Plaintiffs' Motion to Strike, to Amend Complaint, and to Continue Hearing
- Motion to Shorten Time
- Declaration of Michael J. Riccelli re: Motion to Shorten Time and in Support of Plaintiff's Motions to Strike, to Amend Complaint, and to Continue Hearing
- Note for Hearing re: Motion to Shorten Time and Motion to Strike, to Amend Complaint, and to Continue Hearing
- Defendant Dr. Howard Ashby's Memorandum in Response to Plaintiffs' "Additional Authority"
- Defendant Dr. Howard Ashby's Memorandum in Opposition to Plaintiffs' Motion to Strike, Motion to Amend Complaint and Motion to Continue Summary Judgment
- Dr. Howard Ashby's office chart regarding Jan DeMeerleer.

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- The Court file and pleadings therein.

II. FINDINGS

Based on the argument of counsel and a review of the record presented by the parties, the Court finds as follows:

1. There are no genuine issues of material fact that preclude summary judgment in favor of Defendants Spokane Psychiatry and Howard Ashby, MD;

2. There are no just reasons for delay of the entry of a final judgment against Defendants Spokane Psychiatry and Howard Ashby, MD. To the contrary, it would cause the parties hardship and/or injustice to delay an appeal of this Order until after resolution of the claims against James DeMeerleer, as Personal Representative of the Estate of James DeMeerleer.

III. ORDER

Based on the foregoing, the Court enters an Order that the Defendants' motions for summary judgment are GRANTED, that any and all of Plaintiffs' claims and causes of action against Defendants Spokane Psychiatry and Howard Ashby, MD are dismissed with prejudice, and that there shall be no award of costs or fees to any party.

The Court further orders that to avoid hardship and/or injustice of the parties, final judgment should be entered as it relates to Plaintiffs' claims against Spokane Psychiatry and Howard Ashby, MD so that immediate appeal can be taken of this Order.

DATED this 6th day of JANUARY, 2014.

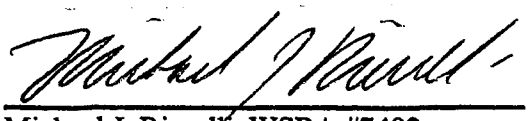
TARI S. EITZEN

THE HONORABLE TARI S. EITZEN

MICHAEL J RICCELLI PS
400 S Jefferson St Ste 112 Spokane WA 99204-3144
Phone: 509-323-1120 Fax: 509- 323-1222
E-mail: mjrps@mjrps.net

Presented by:

Agreed as to form;
Michael J. Ricelli, P.S.



Michael J. Riccelli, WSBA #7492
Attorney for Plaintiffs

Agreed as to Form and Content:
EVANS, CRAVEN & LACKIE, P.S.

Agreed By E-Mail
Michael E. McFarland, Jr., #23000
Attorneys for Defendant Ashby, MD

RANDALL & DANSKIN, P.S.

Agreed By E-Mail
David A. Kulisch, WSBA 18313
Attorney for Defendants

MICHAEL J RICCELLI PS
400 S Jefferson St Ste 112 Spokane WA 99204-3144
Phone: 509-323-1120 Fax: 509- 323-1222
E-mail: mjrps@mjrps.net

APPENDIX C

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

BEVERLY R. VOLK as Guardian for Jack Alan Schiering, a minor; and as Personal Representative of the Estates of Philip Lee Schiering and Rebecca Leigh Schiering, and on behalf of the statutory beneficiaries of Philip Lee Schiering; and BRIAN WINKLER, individually,

Plaintiff(s),

vs.

JAMES B. DEMEERLEER, as Personal Representative of the Estate of Jan DeMeerleer; HOWARD ASHBY, M.D. and "JANE DOE" ASHBY, husband and wife, and the marital community composed thereof; SPOKANE PSYCHIATRIC CLINIC, P.S., a Washington business entity and health care provider; and DOES 1 through 5,

Defendant(s).

No. 11-2-00277-7

DECLARATION OF LAWRENCE DAGNON

I, Lawrence Dagnon, declare under penalty of perjury under the laws of the State of Washington, that the following is true and correct:

I am currently a fifth grade teacher at Warden Elementary School. My wife, Stephanie Dagnon, is also a teacher.

Evans, Craven & Lackie, P.S.
818 W. Riverside, Suite 250
Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

I first met Jan DeMeerleer sometime in November of 2000 while working a second job at Furniture West in Moses Lake. We soon became very close friends. Jan likewise became very good friends with Stephanie. Jan commuted from Spokane to Moses Lake while he worked at Furniture West. After Jan found another engineering job, he continued to work occasionally on a part-time basis (i.e., weekends) at Furniture West. Whenever Jan was in Moses Lake, he would stay with Stephanie and me at our house. After Jan moved to Spokane, we remained very good friends and continued to talk on the phone. In addition, Jan would sometimes come to Moses Lake to visit and we would travel to Spokane to visit him.

At some point around 2005, Jan met Rebecca Schiering. Jan fell head-over-heels in love with Rebecca. Jan absolutely loved Rebecca's children and eventually began referring to them as his "children." Phillip and Jack often called Jan "dad." Jan, Rebecca, and Rebecca's children, came to Moses Lake and visited Stephanie and me, and our children, on several occasions. We likewise went to Spokane with our children and stayed with Jan and Rebecca on several occasions.

On July 17, 2010, at around 5:00 p.m. or 6:00 p.m., I received a phone call from Jan. However, the battery on my cell phone was dead, so the call went straight to voicemail. Eventually, I was able to listen to Jan's voice message. He stated: "Larry, Jan here. Where are you...taking a big shit? What are you doing? You're not picking up when I call lately. Give me a call back when you have a moment." I never talked with Jan after he left that message.

When I learned about the incidents of July 17th – 18th, I was absolutely shocked, as I could not imagine Jan ever taking those actions. The Jan I knew was jovial, hilariously funny and intelligent. He never made any statements at any time that would cause me to believe he was homicidal or suicidal.

Dated this ____ day of February, 2013.

Larry C. Dagnon

LAWRENCE DAGNON

Evans, Craven & Lackie, P.S.
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Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

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

BEVERLY R. VOLK as Guardian for Jack Alan Schiering, a minor; and as Personal Representative of the Estates of Philip Lee Schiering and Rebecca Leigh Schiering, and on behalf of the statutory beneficiaries of Philip Lee Schiering; and BRIAN WINKLER, individually,

Plaintiff(s),

vs.

JAMES B. DEMEERLEER, as Personal Representative of the Estate of Jan DeMeerleer; HOWARD ASHBY, M.D. and "JANE DOE" ASHBY, husband and wife, and the marital community composed thereof; SPOKANE PSYCHIATRIC CLINIC, P.S., a Washington business entity and health care provider; and DOES 1 through 5,

Defendant(s).

No. 11-2-00277-7

DECLARATION OF GENE DEMEERLEER

I, Gene DeMeerleer, declare under penalty of perjury under the laws of the State of Washington, that the following is true and correct:

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Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

I am the brother of Jan DeMeerleer. I have lived in LaGrande, Oregon since graduating from the University of Idaho in 1989.

Between 1989 and 2010, I saw Jan a couple times per year. In addition, we would talk on the phone several times per year.

At some point prior to July 2010, I became aware that Jan was seeing Dr. Howard Ashby for management of his medications. I did not ever meet Dr. Ashby, but Jan spoke very highly about him. Jan advised me on several occasions that he respected Dr. Ashby very much and held him in very high regard.

Early in 2010 (January or February), my wife and I went to Spokane to visit my sister (Jennifer Schweitzer) and her husband (John Schweitzer). While we were there, Jan came over to visit. He was very distressed and proceeded to tell us that Rebecca had read an e-mail our mother (Gena Leonard) sent him about Rebecca Schiering. Jan shared with us that Rebecca had read the e-mail was very upset because she believed that our family were unfairly judgmental about she and her sons. Jan further shared with us that Rebecca wrote a letter that she wanted Jan to share with our family responding to the perceived criticism. Jan read us that letter that evening. Jan told us that he was very upset because Rebecca had made it clear that she did not want to be a part of our family. We spoke with Jan about it for hours that evening. It was clear that Jan loved Rebecca and her children and was upset that it appeared that his relationship with Rebecca and her children may be over. While Jan was clearly upset that evening, he never said anything that would cause me to believe that he was suicidal or homicidal about the situation.

Toward the end of June of 2010, Jan came to our father's cabin to attend a weekend-

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long celebration of my step-daughter's high school graduation. There were approximately 40 to 50 family members and friends that attended the celebration that weekend. Jan brought his daughter (Valerie) and Rebecca's son Philip to the cabin that weekend. Jan spent the weekend participating in all of the activities, laughing and having a good time. Jan seemed entirely "normal" that weekend. He appeared happy, good-natured and relaxed. He participated in conversations with the other guests and was engaged in the group activities. At the end of the family get-together Jan told a story, joking about his failing car wash, which had everyone laughing and smiling. Jan had a great sense of humor and was very entertaining. The weekend ended in lots of laughter and happiness. That was the last time I ever saw Jan.

When I heard about the events of July 18, 2010, I was in complete and utter shock. I had never in my life heard Jan say anything that would cause me to believe that he was homicidal or suicidal. I had known in early 2010 that Jan and Rebecca were having difficulties, but Jan only expressed love for Rebecca and her sons, and never said anything that would have caused me to believe that he would intentionally harm them. In addition, as noted above, when I saw Jan at the end of June 2010, he was happy and joyous, having a good time with family and friends.

Dated this 9 day of January, 2013.

GENE DEMEERLEER

Evans, Craven & Lackie, P.S.
818 W. Riverside, Suite 250
Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

CERTIFICATE OF SERVICE

Pursuant to RCW 9A.72.085, the undersigned hereby certifies under penalty of perjury under the laws of the state of Washington, that on the ____ day of January, 2013, the foregoing was delivered to the following persons in the manner indicated:

Michael J. Riccelli 400 S. Jefferson St. Ste. 112 Spokane, WA 99204-3144 Fax: 509-323-1222	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [ ] VIA EMAIL [ ]
Ian Ledlin Pillabaum, Ledlin, Matthews, Sheldon & Kime 421 W. Riverside Suite 900 Spokane, WA 99201	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [ ] VIA EMAIL [ ]
David Kulisch Randall & Danskin 601 W Riverside Ave Spokane, WA 99201	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [ ] VIA EMAIL [ ]
James McPhee Workland & Witherspoon 601 W. Main Ave., #714 Spokane WA 99201-0677	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [ ] VIA EMAIL [ ]

_____/Spokane, WA _____

(Date/Place)

Evans, Craven & Lackie, P.S.
818 W. Riverside, Suite 250
Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

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

BEVERLY R. VOLK as Guardian for Jack Alan Schiering, a minor; and as Personal Representative of the Estates of Philip Lee Schiering and Rebecca Leigh Schiering, and on behalf of the statutory beneficiaries of Philip Lee Schiering; and BRIAN WINKLER, individually,

Plaintiff(s),

vs.

JAMES B. DEMEERLEER, as Personal Representative of the Estate of Jan DeMeerleer; HOWARD ASHBY, M.D. and "JANE DOE" ASHBY, husband and wife, and the marital community composed thereof; SPOKANE PSYCHIATRIC CLINIC, P.S., a Washington business entity and health care provider; and DOES 1 through 5,

Defendant(s).

No. 11-2-00277-7

DECLARATION OF AMY DEMEERLEER

Evans, Craven & Lackie, P.S.
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Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

Philip Lee Schering, and BRIAN WINKLER, individually

Plaintiff(s),

vs.

JAMES B. DEMEERLEER, as Personal Representative of the Estate of Jan DeMeerleer; HOWARD ASHBY, M.D. and "JANE DOE" ASHBY, husband and wife, and the marital community composed thereof; SPOKANE PSYCHIATRIC CLINIC, P.S., a Washington business entity and health care provider; and DOES 1 through 5,

Defendant(s).

I, Amy DeMeerleer, declare under penalty of perjury under the laws of the State of Washington, that the following is true and correct:

I am the ex-wife of Jan DeMeerleer. We both attended Moscow High School and graduated in 1989. We remained friends throughout college. During the summer of 1992, we ran into each other in Moscow. During this summer, I became aware Jan had been

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Oct. 1998 - Bloomington
Aug 93 - Rt. to School

hospitalized for almost a month and was diagnosed with bipolar disorder.

Sometime later I moved to ~~Minneapolis~~ Bloomington, Minnesota as I transferred jobs. Jan moved with me during this time, and found a job at an engineering firm which he held ~~for approximately a year~~ until Returning to Purdue in the Fall of 93. ~~After a year~~, Jan returned to Purdue University to finish his degree. In 1995, Jan and I moved to Lexington, Kentucky where we remained for five and-a-half years.

On April 27, 1996, Jan and I got married. In May of 2000, we moved to Spokane, Washington and bought a house in Northwoods. Our daughter was born Nov. 7, 2000 ~~shortly thereafter~~ in ~~the fall of 2000~~. In 2003, I moved out of the house and into an apartment with our daughter. Lived in Apt Nov 2003 - Oct 1, 2004 ~~After a few months of living in an apartment, I bought~~ Oct. 1st 2004 bought house a house in the Spokane area where I currently still live. As part of the divorce in Sept. 2004, a parenting plan was entered with the court. Pursuant to the parenting plan, Jan and I each had custody of our daughter for rotating four day period.

When Jan began to see Dr. Howard Ashby, I attended the first ~~few~~ several Sept. 2001 - 1st appt. sessions with him. I recall Dr. Ashby telling Jan that they would meet frequently to begin with, but over time they would eventually meet less frequently, depending on Jan's progression and necessity to see him. Dr. Ashby explained to Jan and I that the goal was to get Jan to a point where he would

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come in on an as needed basis (i.e., when Jan believed he needed to see Dr. Ashby). Dr. Ashby made it clear that Jan was welcome to come in for an appointment whenever Jan felt the need.

He blamed his [illegible] on [illegible]

After Jan and I split up, I would ask on occasion if he was still seeing Dr. Ashby. He would always assure me on each occasion that he indeed was still seeing Dr. Ashby. He also always expressed to me that he had a lot of respect for Dr. Ashby and believed that Dr. Ashby was doing a great job in helping manage Jan's bipolar disorder. * Jan also said [illegible]

On July 11, 2010, Jan brought our daughter to my house, as he was leaving for New Orleans the following day. Jan seemed tired, which he attributed to having been out to dinner the night before with Rebecca and her children. Other than seeming ~~to be~~ a tired, Jan was entirely "normal" that evening. He was not despondent and he was not manic. He gave no indication that he was depressed, angry, frustrated or otherwise emotionally unstable. He talked positively about Rebecca and her children, and did not say anything to indicate that there were any problems between them.

Ashby

During Jan's trip to New Orleans that following week, he sent me a number of texts.

Jan had recently ~~bought~~ aquired a new smart phone thru work and said he was enjoying getting to learn all of its functions. There was nothing unusual about the texts he sent me while on his trip, as all of the texts seemed "light" hearted. There was nothing in any of those texts that caused me to believe that Jan was cycling through a manic or depressed stage, or anything that caused me to believe that Jan was in any way emotionally unstable.

On the morning of July 16, 2010, Jan dropped our daughter off at my home. Just like the evening of July 11, 2010, Jan seemed to be his usual self. He did not appear to be despondent or manic. He gave no indication that he was depressed, angry, frustrated or otherwise emotionally unstable. There was simply nothing about his demeanor that was in any way unusual or concerning. Jan did not "linger" or say any special goodbye to either my daughter or me. We briefly discussed arrangements for Jan to pick up our daughter the following week for his four day rotation. Jan knew I was going out of town that weekend w/ our daughter.

After finding out about the July 18, 2010 murder/suicide, I did a lot of reflecting back on my interactions with Jan in the weeks and months leading up to July 18, 2010. I simply cannot recall Jan having said or done anything during that time (or ever) that would have ever caused me to even remotely suspect that Jan was capable of what happened on July 18, 2010. Jan never made any attempt to contact me or Valerie before July 18th. I feel if he had planned this he would have contacted us to say his goodbyes. I got no texts, letter, email or phone call which

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Jan had never expressed any suicidal or homicidal ideation to me or in my presence. It would have been inconceivable for me to have ever suspected he would take the actions he did on July 18, 2010. As set forth above, I last saw Jan on July 16, 2010. There was absolutely nothing out of the ordinary in Jan's demeanor at that time. He seemed happy, but not manic, and said nothing to indicate any anger he may have had toward Rebecca and/or her children.

Dated this 31 day of December, 2012.

AMY DEMEERLEER

Evans, Craven & Lackie, P.S.
818 W. Riverside, Suite 250
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(509) 455-5200; fax (509) 455-3632

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

BEVERLY R. VOLK as Guardian for Jack Alan Schiering, a minor; and as Personal Representative of the Estates of Philip Lee Schiering and Rebecca Leigh Schiering, and on behalf of the statutory beneficiaries of Philip Lee Schiering; and BRIAN WINKLER, individually,

Plaintiff(s),

vs.

JAMES B. DEMEERLEER, as Personal Representative of the Estate of Jan DeMeerleer; HOWARD ASHBY, M.D. and "JANE DOE" ASHBY, husband and wife, and the marital community composed thereof; SPOKANE PSYCHIATRIC CLINIC, P.S., a Washington business entity and health care provider; and DOES 1 through 5,

Defendant(s).

No. 11-2-00277-7

DECLARATION OF GENA LEONARD

I, Gena Leonard, declare under penalty of perjury under the laws of the State of Washington, that the following is true and correct:

Evans, Craven & Lackie, P.S.
818 W. Riverside, Suite 250
Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

I am the mother of Jan DeMeerleer. I live in Meridian, Idaho with my husband.

On July 17, 2010 at approximately 5:00 pm, I received a message on my answering machine from Jan. His tone sounded completely normal, and there was no indication that anything was wrong. In the message, Jan stated: "*Hello. Long lost son Jan here, trying to get ahold of you. Seeing what's up on a sunny weekend. Hope you guys are out driving your Corvette. That's what you need to be doing. Anyhow, I'll be hanging out here at home. Feel free to give me a call when you get back. Thanks. Bye.*" After learning of the events later that night, I found the most recent photograph I had of Jan and filmed it while the message from Jan played in the background. A true and correct copy of that video (on a DVD) is attached to this Declaration.

Also attached to this Declaration is a true and correct copy of some e-mail correspondence between Jan and me during the time period December 2009 and May 2010.

Jan and I communicated frequently since Rebecca had moved out of his house in November 2009, and Jan shared with me a lot of information about his relationship with Rebecca Schiering and her children. At some point in January 2010, Rebecca apparently read some of my e-mails to Jan in which I expressed some of my thoughts, at Jan's request for my input, about Rebecca, her children and my perceptions of how Rebecca treated Jan. Then, on January 22, 2010, Rebecca wrote a letter to "Jan's relatives" that Jan forwarded to me. As a result of the foregoing, I ceased contact with Jan between January 25, 2010 and May 2010, at which time Jan sent me flowers for Mother's Day. At that point, Jan and I began communicating again.

To the best of my recollection, between May 2010 and July 2010, I had several phone conversations with Jan. Based upon those phone conversations, it was my understanding that he and Rebecca were working on their relationship and that things were getting better between them. At no point between May 2010 and July 2010 did Jan ever make any statements indicating that he was depressed or particularly unhappy. He likewise never made any statements during that period that caused me to believe that he was either suicidal or homicidal. To the contrary, Jan seemed to be "the same old Jan" when we talked during that period of time.

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To say the least, when I learned of the events of July 18, 2010, I was absolutely and totally shocked. Jan had never expressed anything to me that would have ever caused me to believe that he would intentionally harm Rebecca or her children. In fact, he had continually declared that he loved her and her boys very much.

Dated this 14th day of January, 2013.

GENA LEONARD

Evans, Craven & Lackie, P.S.
818 W. Riverside, Suite 250
Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

CERTIFICATE OF SERVICE

Pursuant to RCW 9A.72.085, the undersigned hereby certifies under penalty of perjury under the laws of the state of Washington, that on the ____ day of January, 2013, the foregoing was delivered to the following persons in the manner indicated:

Michael J. Riccelli 400 S. Jefferson St. Ste. 112 Spokane, WA 99204-3144 Fax: 509-323-1222	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [ ] VIA EMAIL [ ]
Ian Ledlin Pillabaum, Ledlin, Matthews, Sheldon & Kime 421 W. Riverside Suite 900 Spokane, WA 99201	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [ ] VIA EMAIL [ ]
David Kulisch Randall & Danskin 601 W Riverside Ave Spokane, WA 99201	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [ ] VIA EMAIL [ ]
James McPhee Workland & Witherspoon 601 W. Main Ave., #714 Spokane WA 99201-0677	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [ ] VIA EMAIL [ ]

_____/Spokane, WA _____

(Date/Place)

Evans, Craven & Lackie, P.S.
818 W. Riverside, Suite 250
Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

---------- Forwarded message ----------
From: **Jan DeMeerleer** <stuntcar2b@gmail.com>
Date: Mon, Jan 25, 2010 at 12:48 PM
Subject: Re: Rebecca is gone; I am crushed
To: Gena Leonard <gewele@gmail.com>

Mom,
I never did tell you that Rebecca had access to my email account as I do hers. We openly share everything. When we discussed on the phone (after you offered your series of opinions) that I was going to pursue Rebecca. That was towards the end of December. And you did indeed stop comments after I asked.
Your other points of view on Rebecca's and I situation were indeed asked for by me in the early moments after she moved out. I was extremely hurt, scared, and confused at the time. I turned to you because I did not have a counselor at the time and you were a person I thought may provide an objective opinion. That was stupid of me because of course you are my mother and will defend me. Rebecca is a good mother because she protects her children from many different types of harms, including me and herself. She stopped doing additive drugs, smoking, and other poor life choices completely for her children. She constantly is updating Jack's psychological/professional care and new medications. She is VERY RESOURCEFUL in this manner. Jack has a better chance of being valuable in society then a huge majority of autistic kids simply because of Rebecca's firm commitment and resourcefulness to him. When I became unhealthy to Jack, Rebecca did one of the hardest things...removing herself and the boys from me. It has proven to be a very good decision while I get help on my emotion management and self-confidence issues. My counselor fully agrees with Rebecca's decision to move out. Kids must ALWAYS come first.
Rebecca further keeps Jack and Phillip (two active boys) with a variety of games and toys and pets and reading and exercising. She keeps a reasonable balance of brain stimulating stuff as well as the typical video games and movies. In fact, she did such a good job with keeping the boys entertained that while we were living together I would frequently become bored as a father because I did not play with their things with them. Meaning they didn't come to me for entertainment often. She kept the entertainment fresh and new with a variety of new books, movies, and video games. The boys have a wonderful home environment and an even better on now with guinea pigs as pets. Rebecca is excellent at creating such a fun, enriching environment at home. Val and I feel the complete loss of this enriching environment now that she is gone. It is a large hole left in our lives that I struggle to fill.

The comments about she and I visiting with the boys and not watching them as well as others would like us to watch them is not descriptive of "bad parents"...it is inappropriate guests. She and I need to be better parental partners in these public events; that is something she and I never really discussed or planned. We can do better.

From here on out because I am still pursuing a relationship with Rebecca (the one I love), it will be good to only talk about positive, constructive viewpoints in our lives. She has to deal with a variety of issues that have boiled up from the past that cause her distrust in ME (Jan). I am not a great spouse in a few regards and she has been very accepting of my occasional distrustful behaviors. Now that all of this family stuff and my personal stuff are forefront in her mind, she has to really come to terms if all she has to accept in our difficult relationship is worth the energy and time. She has a tough decision and is seeing counseling. I will always be her friend at very least.

This will be the last time I discuss personal issues about her and I relationship with family members as unfortunately family only gets one small slice and side of the story, which is usually bad from my momentary concerns. Family rarely if ever hears how I have managed to accept or how we have changed to accommodate new concerns in our relationship. Family is left with old, outdated, harmful information. That puts family in a poor position to make a reasonable, positive view of my spouse. If I really had that much consistent concern with Rebecca, I would not have stayed with her. Trust me in that. She offers me a great variety positive influences that will be hard to live without.

So please do not encourage me to engage in any further personal information about my relationship with Rebecca or whoever may be in the future for me. It is somewhat unhealthy for my family to hear only of negative, momentary concerns about the one I love. I will reserve that for 3rd party, unbiased counseling.

Love,

Jan

On Sun, Jan 24, 2010 at 12:04 AM, Gena Leonard <gewele@gmail.com> wrote:
Sorry about all of that, Jan. I had no idea you did not have a "private" email account. As far as I know, you never informed me of this fact at any time, much less told me on the phone to "back off" while you were sending me emails that certainly appeared to ask for my opinion. Perhaps I missed all of that "somewhere" in the period of time we have, so I thought, been privately discussing your unfortunate situation. You appeared to want input about your sad situation and I thought we were having dialogue concerning your issues via "other opinions." I had no idea that Rebecca was privy to all of this. I do apologize to Rebecca, too, as I had no intention of insulting her. I was simply presenting another point of view. Since the grim situation that you two currently have going on is, apparently, my fault, I shall certainly bow out, apologize to both of you, and leave you to your own "business." I would never have volunteered opinions if I had not been asked for them. Again, I certainly must have grossly misunderstood the whole scenario of the emails and phone conversations. It's one of those "damned if you do and damned if you do not" situations... I'm very sorry for causing such turmoil to the two of you. Best wishes...

----- Original Message -----
From: Jan DeMeerleer
To: Gena Leonard
Sent: Saturday, January 23, 2010 11:42 PM
Subject: Re: Rebecca is gone; I am crushed
Mom,
Rebecca has always had access to my email account. She read your previous emails. I really wanted a relationship with her...but now that's over. I am really crushed and in very deep pain. I don't need any further family opinions about her please. It is not helping me and is only pushing me farther away from you...and has totally driven Rebecca away. She is a kind hearted and generous person that is now out of my life...and it is tearing me up.
Jan

On Fri, Jan 22, 2010 at 8:43 PM, Gena Leonard <gewele@gmail.com> wrote:
Jan, dear!

From the content of Rebecca's email that you forwarded to me this morning, I am guessing you either forwarded my last email to you to her or you used some/most of my comments from my prior emails and phone conversations with you in your conversations with her. Her comments certainly alluded to some of my previous comments to you. Mom is scolding you here... I also seriously don't think that your father, brother, or sister would take the time to comment about her and her children to the extent of her taking things "way out of context" and expanding upon them in her email this morning. Anyway...here's my "take" on all of this:
I believe that Rebecca is (still) angry and will grab at anything to make a Federal Case out of any remarks about her and her boys, particularly if she can put a negative spin on those remarks.

I hope you can get through this latest set-back with minimal discomfort and upset, even though, I think, it has been a long time in coming. I commend you for trying to make "a silk purse out of a sow's ear" per your relationship with Rebecca, but there comes a time when tilting at windmills just isn't doing the deed. It may be time for you to look at this relationship with Rebecca as a "dead end" and move on...

So...how are the counseling sessions going? Have you discussed anything on your current situation with Rebecca? How about the men's group counseling?

So, my dear, do the "chin up" routine and focus on what's IMPORTANT: yourself, your daughter, your job, your counseling, etc. You are always in my thoughts and heart, you know! Keep in touch and let me know what is going on with you, etc.
Love,
Mom

----- Original Message -----
From: Jan DeMeerleer
To: Gena Leonard
Sent: Friday, January 22, 2010 10:47 AM
Subject: Rebecca is gone; I am crushed
To Jan's Relatives,

It hurt to find out that I have been judged to be an awful parent to a couple of wild and mentally deficient children. I have been doing the best I can with what life had dealt me over the last 9 years and while I know I haven't always met with even 75% success it hurt to find that a large majority of you might feel that I wasn't even meeting with 15% success in regards to my children.

I had no idea that I was being judged so very harshly although I can't say I didn't suspect it. I always felt uncomfortable around all of you and I would tell myself that it was a shortcoming in myself that made things that way, all of you were nice people I just needed to relax a little. Now as I look back over the years and our interactions I realize with great embarrassment and shame that my instincts were right and my children and I weren't really welcome we were just something to put up with so that Jan and Valerie could be present.

If it wasn't for Jan's insistence that family events were important and that we as a family should go I would have skipped every wedding and holiday. I know Jack's a screw up out in public, it's easier to stay at home where I can watch him and keep him out of people's hair.

I always thought Phillip was a good enough kid though, a slow reader maybe but caring and pretty fun to be around. However new information tells me that maybe people felt quite strongly otherwise. I was quite surprised to find out that one person even described him as a difficult, mentally challenged child with rage issues. WOW - I mean that really hurts!!!

I just wished I would have trusted my instincts more on this issue and stayed home. I have learned a valuable lesson from this.

Jan and I had hit a rough patch but were working on it and I was feeling pretty hopeful with our progress in January. However in light of a recent letter I have read about me and my children and how people in your family possibly view us I can't imagine how I can ever be around any of you again and even hold my head up and considering how important family is for a person I can't see a way forward for Jan and I with this stumbling block. We have had our set backs and I always felt him and I could work through them but we can't work through this because it really has nothing to do with him and I it's with all of you.

So my apologies for any discomfort our past interactions might have caused. I should have taken the hint, Jack's a difficult kid (he has a diagnosed disability, that doesn't excuse it but it's not like he's some normal child either) I shouldn't have subjected you to him and Phillip. I don't really

take him around others too much and never for too long and while Jan always felt this wasn't the way to handle it I know see that isn't true. I don't want to be a bother to anyone and I don't want my children to be that way either.

Sincerely,
Rebecca Schiering

From: **Gena Leonard** <gewele@gmail.com>
Date: Sun, May 30, 2010 at 7:04 PM
Subject: Re: Recovery
To: Jan DeMeerleer <stuntcar2b@gmail.com>

Thanks for your quick response and your nice apology. Hey, when we screw up, we screw up royally! That's what intelligent people do! Besides, I can certainly understand your need to talk about things, even when they should be discreet subjects. Robert has had a constant task of steering me away from such things for almost 27 years! He is generally very discreet whereas I "say it all"...that must be where you get that tendency! It is difficult to stop and think before speaking out or writing down something that should remain private or be unintentionally hurtful to someone else.

As far as the items you discussed in your email this morning, I have not even related them to Robert, whom I usually do NOT keep secrets from. Per the sensitive issue of the pregnancy, consider it a closed subject here (I won't repeat this, even to Robert). I do know right from wrong per personal issues like that one...that is strictly an issue between you and Rebecca. You can rest assured that no one will hear anything about that from me.
Per Jennifer and Gene and family issues: neither of them has the tendency to "get involved" and do not invite, much less welcome, being pulled into family issues. Jennifer has a tender heart--so does Gene but he covers it up with his silliness--and just cannot handle things that are sensitive per her/his family. She, as well as Gene, has enough on her/his plate with her/his own immediate family and business matters. I do not carry information back and forth among my kids...that much I DO know NOT to do! In short, what you kids tell me "in confidence" is not revealed to any of the other members of our family. The other family members may be aware that there is "trouble in River City" but they never hear any specifics from me about the issue(s). I, too, have a tender heart and that is why I got into trouble trying to get you through the ugliness of last winter's domestic blowup. Hey, one is NEVER too old to learn...! :-)
I appreciate your comments about the new 'Vette, too. We figured we might as well spend the money on something we would enjoy since we cannot make anything in the market, much less get a livable interest rate on CD's or even municipal

bonds, which turn out to be quite risky when one considers all the municipalities and states in financial difficulties.
Do you have tomorrow off work (i.e. holiday)? If so, enjoy it!
Love,
Mom
----- Original Message -----
From: Jan DeMeerleer
To: Gena Leonard
Sent: Sunday, May 30, 2010 4:15 PM
Subject: Re: Recovery

Sweet ride. I do like the gray. Well worth the purchase!

I incorrectly assumed that you speak with Gene and Jennifer regularly and share family issues. So when I went to Gene and Jennifer with Rebecca's letter (because she asked that I give it to my family), I felt it necessary to explain a brief history of what happened so they could get the context of what Rebecca was writing about. I didn't intend on breaking anyone's trust...I was trying to opening communicate.

I do apologize for breaking your trust. I guess when I am hurting or looking for answers I openly communicate too much and say too much to others I care about. My filter isn't working well at those times.

Rebecca mentioned a similar thing about me sharing personal issues about her and I with you. She feels her trust broken as well. I just fucked up across the board. Speaking of which I think I accidently did it again in my last email. Rebecca has not said anything about the pregnancy or abortion to anyone in her family, so I think I should have kept that to myself. I would appreciate it we could keep that secret....

We will talk to you later.

Love, Jan

On Sun, May 30, 2010 at 2:38 PM, Gena Leonard <gewele@gmail.com> wrote:
I do appreciate your efforts to reestablish contact with me per the M-Day card and the phone calls...I just wasn't in the groove to respond at that time. But it's time for me to acknowledge your efforts.
You are correct that I have been avoiding contact with you. Mainly, I haven't known what actually to say to you, Jan, or with what medium to say anything through. It seems that whatever medium I use and whatever words I use get misinterpreted and things end up worse than they were previously. That's the problem with saying or writing words that mean one thing to the author/originator

but another thing to the reader/recipient. Compounding the problem is the fact that the communication has not been kept personal...it has been shared with other persons, either directly involved in the conflict or brought into it at a later date. I seem to excel at issuing words that are not taken in the vein I meant them when writing or speaking them. In your case, I think that you and I both have had misunderstandings over things that were said as well as those things that were not said--much of which was wrongly assumed and definitely misinterpreted by each of us. [e.g. It was apparently and unfortunately interpreted that I do not care for Jack and Phillip, when the exact opposite is the real truth!]

My feelings per you: Mad...NO; Sad, YES; Hurt, QUITE; Puzzled, YES...

OK, so there were huge misunderstandings per the things I said and tried to accomplish to make you feel better about the ugly situation you were in last winter. The really puzzling part that also hurt and made me extremely uncomfortable was when you presented my involvement in your domestic matters to your siblings and their spouses (and children). I had not shared your personal problems with any of them, so I was stunned that you not only shared my comments to you with them, but also with Rebecca. TRUST is something that should govern everything you do, dear Jan. Certainly, TRUST between you and your significant other is extremely important...but so is TRUST between you and your parents, your siblings, your best friend, your child, etc... There should be NO priorities on where you hand out TRUST...it should be an integral part of your nature, your personal relationship personna... I felt that I could no longer TRUST you, dear son, after all of the ugliness of this past winter. That issue (the breakdown of TRUST) is definitely the most hurtful and upsetting part of the whole situation.

My feeling per me: Mad...DEFINITELY...at myself.

I have learned a very valuable and painful lesson: NEVER get involved in a loved one's domestic dispute/problems. The only person who gets beat up is the one who is trying to help his/her loved one. The ole "damned if you do, damned if you don't" issue is at its best/worst in this type of situation. I should have known better but I got "sucked in" via your hurt and emotional turmoil. The best thing you did, per your comments this morning, was to find a counselor and go that route. I am pleased to read that you are continuing the counseling...it DOES make a positive difference, doesn't it? Guess it is the principle of not being able to see the forest for the trees...it takes a neutral, professional party that is outside the forest to get us out of the trees and enable us to see the forest.

You sound like you have your life under control now and I am so pleased to read that. Of course, there will be bad times but that is "life." Like eating an elephant, we have to take life "one bite at a time" (although it seems that we get hammered with humungous or multiple bites at a time, once in a while).
I am attaching some not-so-great photos of our new toy. We got such a great deal on it that we just couldn't leave it on the showroom floor ;-) Actually, our red one was 10 years old (we'd had it over 7 years) and it was starting to indicate that the ring problem, a known problem for that year of 'Vette, was rearing up. What we didn't want was to get into an engine rebuild! Besides, we had been salivating over the Cyber Gray color and Robert was especially enthralled with the Z06 'Vette. For the same price of a regular 'Vette coupe (like the red one with the removable roof), we got the Z06. That was out half of what the original sticker price at the beginning of the 2009 model year for the Z06 stated! This one is, obviously, a 2009 model. The humorous part of this situation is to watch two OLD people relearn a stick shift! Z06's only come in standard transmission and 505 hp! Yep, it has "zip" but we haven't been able to take it on a road trip due to the constantly rainy weather. We do get positive and humorous reactions when we are in this new 'Vette...from OLD ladies who come up to us and comment on how gorgeous it is to guys standing on the street corner giving us the thumbs up signal, and a carful of teens cheering us on! We feel "fancy"!

So...Dear Jan, thank you for your "opening the door" and I hope we can soon have more positive dialog. I PROMISE never to get involved in your (or anyone else's, for that matter!) domestic relationship issues...it's a No-Win situation! And I hope you can understand why I lost TRUST in you and I hope that you will try to repair that issue with me (and Robert, who is very disappointed in you!). WE DO LOVE YOU, you know!

Love,
Mom

----- Original Message -----
From: Jan DeMeerleer
To: Gena Leonard
Sent: Sunday, May 30, 2010 9:47 AM
Subject: Recovery

Hey Mom,

I guess my suspicions are correct that you are mad at me or feeling hurt by me or something of that nature. I am guessing this because you haven't returned my phone calls and the last we talked/emailed was about the Rebecca and me situation a few months ago. Assuming that I hurt you in my communication with you (which was not my intent) concerning the messed up Rebecca situation, let me replay some of the past from my perspective and give you an update on where I am at today.

First and foremost, you need to understand that the Rebecca situation was 100% between Rebecca and I. She and I had issues about parenting Jack, and my explosive behaviors toward him occasionally caused her to not feel secure around me. She and I had sexual issues between us. She and I had basic trust issues between us. And it did not help that right before I hit Jack that she I and were considering having a baby of our own...in fact she was pregnant. We had to make the tough decision among all the chaos of our relationship back then to get an abortion. Her hormones were all over the map and her emotions were similarly all over. It was a perfect storm of shit happening all at once for us.

In December when she moved out and said she thinks an abortion is best, I was crushed. I didn't know where to turn or what to do. I went to you as a sounding board to bounce my thoughts off. Unfortunately, I poorly judged that you could be an unbiased party. Of course you were on my side! I appreciate that of course. At the time though, I really needed more of counseling, 3rd party advise. In fact later into December that is what you focused me upon...to get that counseling help. I really appreciate that because it motivated me to seek the professional help I needed.

However, during our trade of emails back and forth about the Rebecca situation, I allowed you to say some things that although may have some truth to them, they were not totally appropriate to the situation. You were clearly trying to get me to not feel so 100% guilty and responsible for the relationship breakup. Again, unfortunately that is not what I needed. I needed to focus on other personal issues about myself, including the explosive behaviors. I didn't need to hear about other people's issues and characteristics that influence me. The issues were with me and me alone. Always remember, the boys are my kids too....I have raised them for 6 years. Again, I do understand you were just trying to help me and make me feel a little better about the situation. The fact that things were going better between us made her feel nervous that she shouldn't really trust me. So she exercised her long ago mutual email access to check up on me (that mutual

email access between she and I was set up early in our relationship for trust and transparency issues). She wanted to let all the family know that she feels hurt and betrayed by the "secretive feelings" that apparently the whole side of my family feel about her and her kids. She wrote that letter out of pain and loss for what she thought was a relationship in repair between her and I. At that time she could not see how to repair our relationship...her world came down upon her.
So in my viewpoint the end of January 2010 was a test of Rebecca and my relationship and what important things we were missing between us. Mom, I don't blame you for "breaking up our relationship" or anything so pivotal. Your emails and phone conversations/comments were only a catalyst for what was already a rocky relationship. The blame does not fall with your words on the course of my relationship with Rebecca. Never did I think that you had that level of influence over us. Rebecca wrote her letter out of pain and a realization that people view her and her kids differently than she and her family view them. She felt betrayed that people viewed her and her kids so poorly, especially from my family. Outside of her letter, she and I talked more deeply about all the things wrong with our relationship...far beyond the implications of my family viewing her and her kids badly.

That incident in January was also a catalyst to get Rebecca into counseling. I had already started seeing my counselor but she was delaying her start. Through successive counseling, what both she and I realized is that our feelings about the course of our relationship and how we feel about one another and each of our families is totally our choice. We were not victims of circumstance but had an active choice in deciding what truly mattered and what was less important. People in our lives are simply input, but each of us put the meaning and importance of that input to ourselves. We choose how to respond to the input and how to think about the input.

Rebecca and my relationship deteriorated fast in February such that we each wrote emails to one another ending the relationship for good with the caveat that after time goes by and the raw feelings subside we may be able to be friends. I was fed up with trying so hard to show her that I was working on me to improve some much needed areas of my life with little acknowledgement from her. She was still so hurt and mad at me for all the things in the past. So we ended it. Then she went to some more counseling sessions and got a little different perspective on the situation from her counselor. She also found out that I started looking for new women in my life upon the ending of our relationship. I was moving on. That appeared to be a deciding point in her life that I was not coming back and that perhaps some of the feelings she had were not all together as important as our relationship. So in a matter of days her feelings of anger, betrayal, and hurt started to significantly subside. She really does have an uncanny way to getting over things when she sets her mind to it. She and I started talking again.

Now 3 months later she and I are going to counseling together to work on much needed relationship issues. I am still going to personal counseling of course. I have formally received my certificate for completing the nurturing fathers' course, which has made an improvement in how I view and deal with Jack. She and I do talk about the future of our relationship and what it will take to get back to living together or even to marriage. We do have a long ways to go in getting over our own personal issues and how we work together in the relationship. It's a slow course of rebuilding but I think that is the way it needs to be to foster a stronger, healthier relationship of trust, security, and love. We see each other 3 to 4 times a week, and I try to exercise my

improved ways of dealing with Jack every time I am with him. I am gaining more confidence in myself that I won't "crack" under the pressure of his behaviors.

So, Mom... In summary, I do realize you were trying your best to help me several months ago as only a caring mother would. I do realize that it was unfair of me to ask for your unbiased opinion when I should have sought counseling immediately. I do appreciate the support that you provided me and your unflinching advice that I should seek counseling. The counseling has made a good difference in my life. I do not blame you for ruining or significantly affecting my relationship with Rebecca...she and I have many, many more issues than your emails. I do not think badly of you nor am I avoiding you (although I know it has been a long time since we talked last). I have just been focusing so much on my personal rebuilding, my relationship with Rebecca, and of course my work. Now that I am feeling more confident in many aspects of my life, I am trying to reach out to all the others around me that I care for. In essence Mom, I am reaching out to you to regain our relationship back.
I honestly do not know what you are feeling or thinking, but can only guess. I urge you to write me back or call me so we can talk. Take care and give Robert my best and my love.
Love,
Jan

----- Original Message -----
From: Jan DeMeerleer
To: Gena Leonard
Sent: Monday, December 07, 2009 10:26 PM
Subject: Re: clock radio that plays flash drives, etc.

Mom & Robert,

Thanks for the input on Rebecca. I certainly don't think she is trying to use me. That's no in her nature, character, or seeming intentions. Instead she has mentioned a couple of times that she is has not figured out what she wants because she has really not spent any time thinking about us and our future. She also recognizes that at least Phillip still sees and wants me as his only dad. She claims she is so busy at work and with recent civic events (which she is) and this moving out has consumed her emotions and energy for the last week such that she just hasn't had reflection time. She has asked me to give her time to figure out what exactly she wants from us. In the meantime, I told her exactly what I wanted...to continue a loving relationship although in separate houses. Once I told her that, she started offering me hugs and kisses. Essentially, I see her on the fence of wanting something from me and not wanting anything. If I keep inputting positive, loving energy into the relationship as it now stands as well as treating her boys with more tolerance as a dad, she might jump off the fence into the "continue relationship" side. However, if I just pull away and distance myself from her and the boys without continuous communication, she may just read that as moving toward the "no value in a relationship anymore." Funny enough, I think her being on the fence puts ME in the driver's seat for now.

Honestly, Mom, I don't have anyone else (friends, acquaintances, coworkers) to divert time to. My two main guy friends are in Coeur d'Alene and Moses Lake with full families (3 kids each). They are less than convenient to do things with and even talk with from day to day. I am keeping up more frequent phone communication with them, but have not been able to get them to meet me...they just live so far away. So I am using small bits of talking with family (you and Robert, Dad, Jennifer and John) as well as my two friends to fill the hole of time and closeness. But nothing replaces the feeling of the ONE you love...as you know.

So I am hanging on to the remote hopes that something good and positive can come from this split of households. It gives me focus, hope, and still somewhat of a feeling of being special and loved. The "mixed signals" do hurt...but not that much actually. I think I will just have to see how long (weeks) it takes her to place our relationship in her heart and mind. I imagine if I am still getting "mixed signals" in January that I will have a serious sit down discussion with her and push her to a decision. I don't want to ride shotgun on that "relationship choice" fence for too long, but I do want her to truly feel herself out before making a final decision. In the meantime, I will try to see her for a few hours a week and be a dad to the boys and a loving partner to her. I don't know of a better course to get what I need (feeling of some amount of love and closeness) and get her to figure out what she needs.

As far as Christmas goes, I have Val on Christmas and the following weekend and will likely go to Dad's. I don't want to be alone for Christmas either!

Jan

509-944-0586

----- Original Message -----
From: Jan DeMeerleer
To: Gena Leonard
Sent: Saturday, December 12, 2009 7:25 PM
Subject: MP3 player arrived

Mom,

It was good talking to you today. I just wanted you to know that the MP3 player for Val arrived this afternoon. Its looks cool. I didn't know it also had FM tuning...that will be good for her. Thanks again...I'll get it all wrapped up.

I didn't get to go housewares shopping after all. Rebecca called and asked for my help to move her clothes washer and dryer upstairs. I took some time and talked to Brian in private about the situation. He seemed to appreciate the fact that I apologized to him for the situation and that we are working to get things better. Rebecca's mom and brother were there at her house as well...the whole tribe. Though her mom and brother seemed slightly uncomfortable/offish , they certainly did not make me feel uncomfortable. Rebecca and I got to speak briefly about my progress with finding counseling. She seems happy but proceeded to instruct me on all the other things that frustrated her about me. In her mind I am clearly tainted goods. But as I was leaving, she purposely and opening walked up to me and kissed on the lips, saying thank you. She further invited me over tomorrow (Sunday) to put up the Xmas tree (I have all the decorations...yes, she is using me again...I know). I offered to take the boys off her hands for a couples of hours to give her a moment of peace. She is thinking about that offer.... There is an Autism FREE bowling day from 1 to 3pm on Sunday that I thought I'd take the boys to. It may give me some perspective on how bad/challenged some autistic kids can be. Anyhow, that's all the update for now. Essentially, more Jan bring more of my shit, help me move in, and oh by the way here is a gratuitous kiss for all your help. I'm patient....

----- Original Message -----
From: Jan DeMeerleer
To: Gena Leonard
Sent: Monday, December 14, 2009 11:49 AM
Subject: Fwd: tonight

Mom,

Rebecca just wrote me this email below. I take from this that she clearly does not want much of anything from me right now, but more importantly is really unsure if there is any future in our relationship. Again, I am not so worried about the short term anger and such not, but when she says she is also trying to figure out how to let me in her and the boys' lives and make it a healthy positive experience for everyone" I get the distinct feeling that she doubts there is solution to a long term relationship. Just looking for your and Robert's opinion please.

Jan

Forwarded conversation

Subject: **tonight**

From: **REBECCA L SCHIERING** <rebecca2525@msn.com>
Date: Sun, Dec 13, 2009 at 9:59 PM
To: Jan DeMeerleer <stuntcar2b@gmail.com>

I just had to write a quick note before I went to bed. After you left I realized what it is that I'm having a hard time with and its that I can't really trust you just yet.

The majority of my time is spent running around or taking care of stupid shit like trying to email a fucking list for hours and I don't really have time to think. I know I feel very angry at many things not just you, but I don't feel like anything has really changed for the positive between us to start cuddling all night. I feel very hurt and betrayed by not only you hurting Jack but by how I have let your feelings dictate how I feel about my child.

I feel the pressure from you that you want something from me, I feel it intensely from you. But I can't give it just yet, I still feel like my head is reeling from everything that has happened in just 13 days. The epiphany I had last weekend about how ashamed I had come to feel and embarrassed about Jack brought up a lot of anger and hurt at both you and myself for letting things get that way. I had hoped that I was a healthier parent than that. I also am trying to figure out how I let you in our lives and make it a healthy positive experience for everyone. I think short and light bursts of company are what's best right now, every time I see you it just seems like there are just a million unspoken expectations happening and its rough.

Not only has our relationship been hurt but so has the friendship that I felt I had with you and I think that is what is the hardest for me to get past. I don't really like you right now for hurting my kid, fucking up when everything was going really good between us and then expecting things to be ok so quickly. Its just going to take time, I am really angry and I don't have much to give even to myself, I haven't even played guitar in 14 days or a video game. The only thing I've done for myself is listen to a book while getting ready or while going to work.

So ease up on me a little I know your bored, lonely and many other things right now but this is going to take time and 13 days of what has felt like controlled chaos for me isn't going to cut the mustard.

----- Original Message -----
From: Jan DeMeerleer
To: Gena Leonard
Sent: Thursday, December 17, 2009 9:56 AM
Subject: Re: package arrived?

Yep, the clock radio arrived. I already wrapped it up as well as the MP3 player. I'll just have to find out if they work together next week on Xmas.

Thanks for the uplifting thoughts and comments. I am feeling much better. I feel productive (fixed several things around the house yesterday as well as several at the car wash) and more self-assured. Rebecca chastised me in the past and here yesterday for being unproductive and lowly during my unemployment. She claimed NO ONE on this earth could have helped me through my bad time because I just kept letting myself fall into self-pity. I just paused at her comments and said, "Well, honey, unemployment threw me into a mild depression. Go figure. Sorry to burden you with whole situation. When I am depressed, I desperately need to talk through my thoughts with people. You, Rebecca, just didn't want to talk much about our situation. You only wanted action. My mind is my worst enemy and I needed someone strong enough to validate my feelings and boost me up." She just just laughed mockingly at this response.

I am starting counseling tomorrow. My hope is that all through January I will be able to manage twice weekly sessions for "intense psychotherapy." I hope my work schedule will allow that at lunch times. I shared with Rebecca last night that my "master plan" was to periodically give her progress reports so to speak to let her know of improvement, new thoughts, and any revelations. I asked her for increasing amounts of time with her and the boys as I showed positive improvement. She simply emailed back with "do you really think I will be better in 30 days...get real." Obviously, she is not intending to work on her feelings or thoughts about me, the family, and herself in the relationship. It is all still my fault...of course.

My work is being kind in that they are reinstating all of my old benefits as if I never left the company. That means for things like vacation and sick leave I already have 2 years accrued/vested in the company. They didn't have to do that, but I certainly appreciate it!

That's it for now. Talk to you later, Mom....and Robert.

Love,
Jan

----- Original Message -----
From: Jan DeMeerleer
To: Gena Leonard
Sent: Tuesday, January 12, 2010 8:45 AM
Subject: Re: I like it!

Mom & Robert,

That is one funky tree! I need a cool tree in my front yard...I'll have to look around.

Glad you like The Week. I also thought it was concise and well formatted. I enjoy reading it more than Newsweek or US New & World Report. It has a larger variety of subject matter usually. I also ordered myself Scientific American because I am such a tech geek. Can't fight who I am and what I like!

Val still loves her clock radio and MP3 player. It is turned on and jamming Hanna Montana / Miley Cyrus every minute she is home (awake or not). At night I asked her to turn it down so I don't get awakened in the middle of the night by some shrill teenage girl note!

Speaking of Val, she sure had fun with Jacey and Janelle last weekend laying in the hotel room and swimming pool. All the girls stayed up so late that when John, Jenny, and I got back to the room after midnight that we had to force the kids into bed. They just get to caught up in one another...though Janelle acts a little too old for that girl play stuff!

My counseling is still at a slow start. I do so much internal thinking about who I am, what I want to be, and how to get there that the counseling just seems SLOW!!! We are focusing on my low self-confidence as related to the crashes in life due to bipolar episodes and related to dealing with emotions as they come around. We are really just touching the surface and I am wanting to get deeper faster. The counselor, Ed, talks half of the time. It is frustrating for me sometimes to listen to HIS stories as he tries to relate and be relevant to me. I expected to do most of the talking with him just interjecting every now and again. One thing he is clamping down on me as related to my low self-confidence and "story telling" is my exaggerated raise in volume while I explain situations. He sees that as my outlet for emotions that are not addressed and thereby often come out with lies and exaggerations surrounding the elevated volume. It's an interesting observation at least.

The Nurturing Father's class only just started, mostly with administrative paperwork and some name learning among the group. I am the most professional guy there with most of the guys being blue collar workers (what else do you expect in this area)! There is a wide degree of reasons guys are there in the class. Honestly, I am one of the more relevant people that need this class.

In the first class we learned the 3 pillars of parenting: structure, consistency, and modeling. I am great with structure, good with consistency, and only fair with modeling (behaviors). Consistency and modeling are certainly focus areas for me as I deal with my emotions in a more healthy manner. One very interested fact came out of the discussion. My counselor said that one of the surest signs that a child is feeling over-controlled with too little power and freedom is constipation. Jack for years has had terrible constipation such that he clogs toilets every time he does poop. Rebecca actually took to buying a long knife to cut his turds up in the toilet before flushing. Now that Jack is moved out away from me, he is pooping daily with much much smaller sized turds that never clog a toilet. When I told Rebecca of this psychological indicator, she was floored. Jack exhibited the signs of being over controlled and domineered by me to the exact degree my counselor indicated and stopped the constipation once he was free of living under me. This fact alone has really turned the focus on me on the level of power and freedom I gave Jack compared to the other kids. Jack really lived in "fear" of me controlling and punishing him.

Well, I've got to get back to work. Talk to you later.

Love,

Jan

---------- Forwarded message ----------
From: **Jan DeMeerleer** <stuntcar2b@gmail.com>
Date: Wed, Jan 13, 2010 at 2:09 PM
Subject: Re: I like it!
To: Gena Leonard <gewele@gmail.com>

Mom,
Work IS going fine. I am getting integrated on several projects and am remembering most of the internal systems without help. I've only had to ask a half-dozen questions about where to find certain files on the public drives. Actually, these first few weeks have been kind of slow compared to what I was used to. They are fully transitioning me to a $3 million account in February. It will be announced to the customer today...hopefully, they don't get too upset about the change of hands. Two hours from now we will know....
I was complimenting your Monkey Puzzle tree. That is pretty cool and is what is motivating me to look around for some different flora for my front yard. Like you said a nursery should be able to direct me to some good finds...at a good price!
An interesting conversation has started between Rebecca and I. She is now explaining to me that she feels quite judged by my family (you, Dad, Jennifer & John, and even Gene) regarding her and Jack. I guess in my open communications with her in the past about controlling Jack in public and in group situations, I have helped cause her to become embarrassed of Jack and not want to be around my family due to my concerns on his behaviors. Jack acts the same way around her parents and brother as he does around my family (he is clueless to social cues due to his autism), but she does not get the "evil eye" feeling from her family. I believe the main difference in this difference of feeling is that (1) my family has had many, many more group setting events (that Jack performs poorly in largely due to his deficiency mentally), (2) in-laws always appear more judgmental than does your own true blood, and (3) I am more willing to ease up on Jack in front of Rebecca's family than when in front of my family.
DeMeerleer weddings and Fall family reunions have totaled 6 since I met Rebecca. Jack has performed poorly at 3 of those 6 events to the best of my knowledge. Dad's lake house is always a group setting and new areas for Jack to explore, and he used to get into trouble a lot from his inquisitive, exploratory nature. He has done better recently now that he knows the place better and is comfortable around most of the people. The group environment is still an energy shot for him that is tough to quell; he just gets amped up so fast and much in that group setting. Jack has definitely done much, much better at Jennifer's in that he pretty much just goes to Jacey's room and sits and plays with her toys. I believe if you ask Jennifer she would say Jack is pretty well behaved at her house in recent visits. He always does better with a few people present to focus on.
It is interesting that both Amy and now Rebecca complain to me of feeling some level of judgment and guilt when in the presence of my family. I believe that mostly to be my personal fault. I very frequently try to put on a show of "perfect family" for my family and get internally stressed when everything doesn't go as planned. I then take it out on my partner because I am feeling ashamed of something that happened. Again, much of this relates to my LOW SELF-CONFIDENCE. Down deep I know my family members know who I am, but on the surface I am ashamed of the adult that I have become. I want badly for my family to see me normal, adjusted, balanced, and happy. But underneath I feel none of these. I have trouble sometimes even talking to you and Robert and Dad and Jenny and John because of this disparity in "show" versus internal feeling. It feels like a facade because it is. Somehow I have convinced myself that I need to keep up the charade to my family, but routinely sense that my family sees through me. When you and Robert and Gene and Velma visit and stay with Jennifer, it somehow solidifies that fact that I am a fake and really the negative things I see about myself such that no one wants to be around me. All of this feeling I put back into arguments and concerns with my partner every time that a visit happens at our home or someplace else. I always have some complaint or concern...never just happy to have seen the people I love. Rebecca is clearly tired of dealing with this shit.
Finally, it is a weird observation that with Rebecca's family (brother and Mom) I actually back off of the controlling of Jack because I sense that my firm power over him would not be well received. I pretty much let Rebecca, her brother, and mother correct Jack with a few instances of getting myself involved to help out. In my

opinion, Jack has done equal to better in those situations. It may be just the smaller group setting but Jack has never "lost it" in front of Rebecca's mom that I know of. I am really getting a better vantage point that my tight grip on Jack was so over controlling that he was actually acting out in desperate need of some freedom and power. I really struck a poor balance with Jack.
That's all the introspection for now. Talk to you later!
Love,
Jan

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

BEVERLY R. VOLK as Guardian for Jack Alan Schiering, a minor; and as Personal Representative of the Estates of Philip Lee Schiering and Rebecca Leigh Schiering, and on behalf of the statutory beneficiaries of Philip Lee Schiering; and BRIAN WINKLER, individually,

Plaintiff(s),

vs.

JAMES B. DEMEERLEER, as Personal Representative of the Estate of Jan DeMeerleer; HOWARD ASHBY, M.D. and "JANE DOE" ASHBY, husband and wife, and the marital community composed thereof; SPOKANE PSYCHIATRIC CLINIC, P.S., a Washington business entity and health care provider; and DOES 1 through 5,

Defendant(s).

No. 11-2-00277-7

DECLARATION OF DARIEN BOEDCHER

I, Darien Boedcher, declare under penalty of perjury under the laws of the State of Washington, that the following is true and correct:

Evans, Craven & Lackie, P.S.
818 W. Riverside, Suite 250
Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

Jan DeMeerleer was a close friend of mine. I first met him sometime in 2003 or 2004 when both of us worked at ReliOn Inc. When I first met Jan, he had just started off as an independent contractor working for ReliOn Inc. as a manufacturing supervisor, while I worked in Research and Development. We soon became work friends, which progressed to good friends outside of work. Jan disclosed to me early on in our friendship that he had a bipolar disorder. Jan left ReliOn Inc. around 2006 to take a job at Esterline. We remained friends and would get together from time to time thereafter.

Sometime in December of 2009, Jan and I got together to catch up. That evening he had told me that his girlfriend, Rebecca, had recently been pregnant with his child. He explained that they were both very excited about the pregnancy when they first found out. However, shortly thereafter Jan had had an interaction with her son Jack that caused Rebecca to be extremely mad at him. According to Jan, upon witnessing the interaction, Rebecca yelled at him and immediately left with her children. In the following days, she moved her belongings out and told Jan she was going to have an abortion. Jan told me that Rebecca had him take her to a clinic for the abortion, sometime, in early - mid December. He confided to me that it had been a terrible year, but things were looking up since he had been rehired at Esterline after being laid off the year before.

Jan and I met together twice in between December of 2009 and July 17, 2010. Both occasions involved four-wheeling at 7-Mile near Spokane. On both of these outings Jan seemed his normal self, laughing, joking and having a good time. Attached to this Declaration is a true and correct copy of three photographs of Jan taken on one of those outings (April 25, 2010). I am in one of the photographs. Jan's daughter (Valerie) is in all of the photographs.

Evans, Craven & Lackie, P.S.
818 W. Riverside, Suite 250
Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

The week prior to July 17, 2010, Jan and I were texting each other frequently. At the time, Jan was in New Orleans on a business trip. He told me in his texts how much fun he was having in New Orleans. None of the texts he sent me while in New Orleans were unusual in any way. He didn't give me any indication in any of those texts that he was upset or depressed in any way. In fact, his texts were just the opposite – expressions of the fun he was having. There was absolutely nothing in any of those texts which caused me to believe he was in any manner emotionally unstable.

On the evening of July 17, 2010, I received a phone call from Jan at approximately 7:00 p.m. He asked me if I wanted to get together to talk about his trip to New Orleans. I advised him that I was currently on a boat in the middle of Lake Coeur d'Alene and would not be able to get into Spokane until after 9:00 p.m. Jan said that he understood, and that we should get together soon. I told him that I would call him later to schedule something. During that phone conversation, Jan gave no indication that he was distressed or in a depressive state. He sounded his normal self and did not say anything that caused me to believe or consider that he was not emotionally stable.

When I learned about the events that transpired after our conversation on the evening of July 17, 2010 early the next morning, I was absolutely shocked. It seemed inconceivable to me that Jan was capable of such acts. He had never said anything that would cause me to believe that he was capable of homicide or that he was suicidal. Likewise, he never gave me any indication in the time leading up to July 17, 2010 that he was emotionally unstable.

Dated this 8th day of January, 2013.

Evans, Craven & Lackie, P.S.
818 W. Riverside, Suite 250
Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

DARIEN BOEDCHER

CERTIFICATE OF SERVICE

Pursuant to RCW 9A.72.085, the undersigned hereby certifies under penalty of perjury under the laws of the state of Washington, that on the ____ day of January, 2013, the foregoing was delivered to the following persons in the manner indicated:

Michael J. Riccelli 400 S. Jefferson St. Ste. 112 Spokane, WA 99204-3144 Fax: 509-323-1222	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [ ] VIA EMAIL [ ]
Ian Ledlin Pillabaum, Ledlin, Matthews, Sheldon & Kime 421 W. Riverside Suite 900 Spokane, WA 99201	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [ ] VIA EMAIL [ ]
David Kulisch Randall & Danskin 601 W Riverside Ave Spokane, WA 99201	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [ ] VIA EMAIL [ ]
James McPhee Workland & Witherspoon 601 W. Main Ave., #714 Spokane WA 99201-0677	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [ ] VIA EMAIL [ ]

_____/Spokane, WA _____

Evans, Craven & Lackie, P.S.
818 W. Riverside, Suite 250
Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

(Date/Place)

Evans, Craven & Lackie, P.S.
818 W. Riverside, Suite 250
Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

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

BEVERLY R. VOLK as Guardian for Jack Alan Schiering, a minor; and as Personal Representative of the Estates of Philip Lee Schiering and Rebecca Leigh Schiering, and on behalf of the statutory beneficiaries of Philip Lee Schiering; and BRIAN WINKLER, individually,

Plaintiff(s),

vs.

JAMES B. DEMEERLEER, as Personal Representative of the Estate of Jan DeMeerleer; HOWARD ASHBY, M.D. and "JANE DOE" ASHBY, husband and wife, and the marital community composed thereof; SPOKANE PSYCHIATRIC CLINIC, P.S., a Washington business entity and health care provider; and DOES 1 through 5,

Defendant(s).

No. 11-2-00277-7

DECLARATION OF BRENT TIBBETTS

I, Brent Tibbetts, declare under penalty of perjury under the laws of the State of Washington, that the following is true and correct:

Evans, Craven & Lackie, P.S.
818 W. Riverside, Suite 250
Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

I live on East Briant Lane in Spokane, Washington. For approximately 5 years, I lived immediately adjacent to Jan DeMeerleer.

On Saturday, July 17, 2010, I walked over to Jan DeMeerleer's house to talk with him about two trees that he had in his back yard. Years earlier, when he first moved into the house, Mr. DeMeerleer planted two rapidly growing trees in his back yard. The trees' roots had spread to our back yard, and we had numerous shoots coming up throughout our back yard. I had asked Mr. DeMeerleer in the past if he would consider cutting down the trees so that we would stop getting shoots in our back yard. He hadn't done so.

When I approached Mr. DeMeerleer on July 17, 2010, he seemed receptive to my request that he cut down the trees. He walked with me to my back yard to see how many shoots had come up in my yard. Mr. DeMeerleer said that he would cut down his trees. I spent about 15 minutes with Mr. DeMeerleer that morning. We talked about the problem with the tree shoots and made other small conversation.

Shortly after my discussion with Mr. DeMeerleer, he cut down both trees. He then cut up the trees into smaller logs and stacked them under his back porch.

During the 15 minutes I spent with Mr. DeMeerleer the morning of July 17, 2010, he did not seem any different than any of the numerous other times I had had contact with him over the prior approximately 5 years. He did not appear to be despondent or angry. He did not appear to be overly happy, exited, nervous or anxious. He was completely coherent and logical. He did not say anything about Rebecca Schiering. He likewise did not say that he was upset or angry with anybody or anything. He certainly did not say anything that even with the

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benefit of hindsight I could say gave any indication of what he would do later that night.

I simply did not detect anything in Mr. DeMeerleer's conversation or demeanor that caused me to believe that there was anything emotionally wrong with him that day. Mr. DeMeerleer seemed to be just as I had always known him and did not say or do anything that caused me to believe he might be emotionally unstable on that day.

Dated this 10th day of February, 2013.

BRENT TIBBETTS

Evans, Craven & Lackie, P.S.
818 W. Riverside, Suite 250
Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

CERTIFICATE OF SERVICE

Pursuant to RCW 9A.72.085, the undersigned hereby certifies under penalty of perjury under the laws of the state of Washington, that on the ____ day of February, 2013, the foregoing was delivered to the following persons in the manner indicated:

Michael J. Riccelli 400 S. Jefferson St. Ste. 112 Spokane, WA 99204-3144 Fax: 509-323-1222	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [ ] VIA EMAIL [ ]
Ian Ledlin Pillabaum, Ledlin, Matthews, Sheldon & Kime 421 W. Riverside Suite 900 Spokane, WA 99201	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [ ] VIA EMAIL [ ]
David Kulisch Randall & Danskin 601 W Riverside Ave Spokane, WA 99201	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [ ] VIA EMAIL [ ]
James McPhee Workland & Witherspoon 601 W. Main Ave., #714 Spokane WA 99201-0677	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [ ] VIA EMAIL [ ]

_____/Spokane, WA _____

(Date/Place)

Evans, Craven & Lackie, P.S.
818 W. Riverside, Suite 250
Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

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

BEVERLY R. VOLK as Guardian for Jack Alan Schiering, a minor; and as Personal Representative of the Estates of Philip Lee Schiering and Rebecca Leigh Schiering, and on behalf of the statutory beneficiaries of Philip Lee Schiering; and BRIAN WINKLER, individually,

Plaintiff(s),

vs.

JAMES B. DEMEERLEER, as Personal Representative of the Estate of Jan DeMeerleer; HOWARD ASHBY, M.D. and "JANE DOE" ASHBY, husband and wife, and the marital community composed thereof; SPOKANE PSYCHIATRIC CLINIC, P.S., a Washington business entity and health care provider; and DOES 1 through 5,

Defendant(s).

No. 11-2-00277-7

DECLARATION OF JENNIFER SCHWEITZER

I, Jennifer Schweitzer, declare under penalty of perjury under the laws of the State of Washington, that the following is true and correct:

Evans, Craven & Lackie, P.S.
818 W. Riverside, Suite 250
Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

I am the sister of Jan DeMeerleer. I live in Liberty Lake, Washington. In the few years prior to July 2010, I saw Jan every couple months.

In late June 2010, Jan attended a weekend-long family get together at our father's cabin. I also attended the event. Jan brought his daughter and Phillip Schiering with him for the weekend. There were approximately 40 to 50 family members and friends that attended the celebration that weekend. Jan spent the weekend participating in all of the activities, laughing and having a good time. He appeared happy, good-natured and relaxed. There was a lot of laughter that weekend, including laughs and joking around by Jan. He participated in conversations with the other guests and was engaged in the group activities. There was nothing about Jan's behavior that weekend that caused me to believe that he was emotionally unstable. I was aware at the time that Jan had been seeing Dr. Howard Ashby for a number of years. Jan spoke extremely highly of Dr. Ashby. I was also aware that Jan ~~had~~ had for years been taking medication for his bipolar disorder. There was nothing about Jan's behavior during that weekend in late June that led me to believe that Jan was not taking his medication.

On July 16, 2010 Jan called and told me that Rebecca had broken up with him. Jan indicated that his relationship with Rebecca was over for good. He asked if he could come over. I invited Jan to come over for dinner that evening.

Jan was clearly down and sad when he arrived at our house that evening. He talked about the break-up of his relationship with Rebecca and expressed his sadness about the same. After dinner Jan, my husband and I went for a walk. During this walk Jan's mood improved, and by the end of our walk he was laughing and acting normal again. When he left our house for the evening he seemed to be his normal self. During Jan's visit to our house that evening,

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he did not say or do anything that caused me to be even slightly concerned that Jan may have been suicidal or homicidal. While he was clearly upset about his break-up with Rebecca, he did not say anything to indicate that he could or would potentially harm her. Jan likewise said nothing that evening to indicate any anger toward Rebecca's boys. To the contrary, Jan always talked with affection about those boys and that evening expressed sadness that they might be out of his life. Jan did not, however, say anything that caused me any concern that he did not believe his life was worth living.

When I heard about the events of July 18, 2010, I was totally shocked. While I was aware on July 16, 2010 that the relationship between Jan and Rebecca was purportedly over, Jan only expressed love for Rebecca and her sons, and never said anything that would have caused me to believe that he would intentionally harm them. Never in my wildest dreams did I think that Jan would be capable of committing the acts of July 18, 2010.

Dated this 5th day of February, 2013.

Jennifer R Schweitzer

JENNIFER SCHWEITZER

Evans, Craven & Lackie, P.S.
818 W. Riverside, Suite 250
Spokane, WA 99201-0910
(509) 455-5200; fax (509) 455-3632

APPENDIX D

PATIENT Jan Demarchen

MEDICATION

PAGE ____

ACCOUNT NO. ____

DOCTOR ____

00001

DATE		DR	DATE		DR	DATE		DR	DATE		DR	DATE		DR
9/28/07	2/d.		9/28/07	1/d		9/28/07	150 bid		6/11/09	1 tab				
	1		10/5/07	↑ to 2/d			1							
10/22/07	#180+3	A	10/22/07	#180+3		10/22/07	#180+3	A						
5/6/08	1		12/6/07	1	1		1							
1/29/08	#180+0		9/29/08	#180+0		9/29/08	#180+0							
							1							
2/4/09	#180+3		3/4/09	#180+0		2/4/09	#180+3	A						
	1			1/d mostly.			1							
5/27/09	Off Depakote		5/27/09	True lately		5/27/09	Off for awhile							
	Now on Dep. after		6/1/09	Back on 2/d		6/1/09	Back on 1 bid							
	a 2wk manic		6/11/09	#180+0 one		6.15.09	180	B						
	restarted yesterday		3/30/10	#180+3		3/30/10	#180+3	A						
6/1/09	Back on x 1 wk		4/16/10	(gen)		4/16/10	(gen)							
6/11/09	ok compliance													
	↑ 3/d.													
	ER 36 (500)													
2/3/09	Blood level 101													
	(1 ER + 2 reg)													
	500 3/d													
3/30/10	#250+3													
4/16/10	(Gen)													

Rebecca ...

MEDICATION

Walgreens - Argonne + Lincoln 892-1631

PAGE ____

00002

PATIENT Van De Meerleer

ACCOUNT NO. ____

DOCTOR ____

DATE	Depakote	DR	DATE	Risperdal ODT	DR	DATE	Wellbutrin	DR	DATE		DR	DATE		DR
1/3/01	500mg bid		10/10/01	1/d #30 + one		9/27/02	150mg bid.							
1/24/01	Called ...		12/11/01	0.25mg			#60 + ...							
	Salon called ...			1/d #30 + one		10/30/02	#60 + Samples.							
	#120 +			~~1/11/02 ... #15 + 2~~ →		12/2/02	#60 + 2							
7/01	Taking 500mg bid		3/28/02	#15 + 2	A	3/26/03	" + 5							
0/31/01	500mg #60 + 2		6/27/02	0.5mg ½/d n	A	9/24/03	"							
~~/10/02~~	~~#60 + 2~~ Not now		9/27/02	1/d. ~~#30~~	A	3/15/04	"	A						
3/26/02	#60 + 2	A		(1mg #14)										
3/27/02	"	A	10/30/02	...										
0/29/02	... "	A	12/2/02	#30 + 2										
2/2/02	"	A	3/26/03	" + 5										
1/24/03	" + 5	A	9/24/03	"										
9/24/03	"		3/15/04	1mg "										
1/15/04	"	A												
12/8/04	#60 + 0	A	12/8/04	#30 + 0		12/8/04	Generic #60 + 0	A						
1/11/05	#180 + 3	A	1/11/05	... #90 + 3	A	1/11/05	#180 + 3	A						
9/29/05	3/d (...)	A	10/7/05	... 0.25 x14 0.5 x14										
			10/28/05	...										
12/28/05	#180 + 3	A	12/28/05	#90 + 3	A	12/28/05	#180 + 3	A						
10/27/06	Just getting last Refill →			→			→							
2/23/07	... 3/01 #180 + 3		2/23/07	Risperdal 1mg 1d #90 + 3		2/23/07	150mg SR bid #180 + 3	A						

Consent for Release of Confidential Mental Health/Substance Abuse Records

I Jan Richard Demeerleer 10/27/70
Name of patient date of birth

Authorize: Spokane Psychiatric Clinic, P.S
105 W. 8th Ave Suite 6055
Spokane WA 99204
(509) 455-9090 Fax: 747-2118

Mark Chalem, M.D
Howard Ashby, M.D.
David Grubb, M.D
David Bot, M.D.
Jay Schmauch, DO
Rod Peterson, MD

Release To: James B. Demeerleer as personal representative as assigned by the court.
Obtain From: _____

_____
(address) City State Zip Code

_____
(phone number) (fax number)

For the Purpose of: Continued Care Personal Litigation Insurance Claim
(circle) Other Information for Trust estate

To be disclosed: (please initial)

____ Entire record	____ all records from date forward: _____
____ last chart note/notes	____ allow telephone contact
____ lab records	____ psychological/drug testing
____ assessment	____ report/psychiatric evaluation

Other: Clinical notes, medication records, lab reports

RESTRICTIONS: _____

This consent includes authorization to release alcohol, drug abuse, and mental health records obtained in or for the diagnosis, treatment, consultation or evaluation. I understand that I may revoke this consent at any time, except to the extent the action has already been taken in reliance hereon and if not revoked sooner in writing. The consent is valid for 90 days unless revoked in writing prior to the 90 days. You are not required to sign this consent in order to receive treatment, unless this is for a Fitness for Duty Exam or for participating in a medical research study.

Please note when you request records be released to a third party, that party may NOT be subject to redisclosure or privacy regulations.

Patient Signature _____ Date _____

X Parent ~~or Guardian~~ James B. Demeerleer Relationship Father - as personal representative

X Date 6/27/11

Witness Signature _____

File _____ Send out _____ Date _____

April 16, 2010 Dr. Ashby Jan Demeerleer TT-25
Jan indicates that his life is stable, he is reconstituting gradually with his fiancé. They are taking marriage classes, he can still cycle many weeks at a time. Right now he is in an expansive, hypomanic mood, but sleep is preserved. He has a bit more energy and on mental status, this shows through as he is a bit loquacious but logical, goal oriented and insight and judgment are intact. He states when depressed he can get intrusive suicidal ideation, not that he would act on it but it bothers him. At this point it's not a real clinical problem but we will keep an eye on it.

Plan: We will continue Risperdal, Depakote and Buproprion.

7/19/10 - News paper article re Dan allegedly killed friends + 9 y/o son + assaulted 17 y/o son (cut throat) + then killed
5:50pm self. after hrs. so d'll call + report patient incidents to
Ans. as d can't assign Homicide/suicide not being
investigated + will get info re HIPPA & post death issues.

June 11, 2009 Dr. Ashby Jan Demeerleer TT-50
Jan is being seen because of recurrent hypomanic behavior. He got off the medication for a while but is now back on it. He is stabilizing somewhat but he recognizes that he is still having hypomanic symptoms, ie. staying up at night with a lot of plans, but some of this is imposed on him because his work is continuous as it's been announced they are going to do lay offs next week so he is trying to figure out what to do in terms of having a plan B.

Because of his symptoms and the prior lab work, he indicates that 1 gm of Depakote gave him a level of 64 and I feel increasing it by 500 mg would be appropriate and also we have not done lab for quite a while so he will obtain that after he is on the increased dose for 4-5 days and then check a level. Today he had a bit of an awakening. He realized over the last few days he is having expensive thoughts and making some decisions that were not appropriate and he stated that even on the drive here he recognized some things that were inappropriate. It may be that getting back on the Depakote is having some effect but rather than trusting the relatively low blood level we are going to be proactive. Additionally, we will work with sleep. I gave him a prescription for Zolpidem because he states that once he gets to sleep he can sleep through but doesn't want to be hung over so I think this is one of the best things to help with that, but I also mentioned using the antihistamines OTC. Overall, his mental status was not too bad today, there was no real push of speech, he had insight and hopefully he is getting on track and we can stabilize him.

12/1/09 T.C. - unemployed. Separating from Fiance & her sons. Needs to get back in counseling & med management. (wants referral) - given C.M.H.C. & chain clinic given. also → Hen for med V's & counselor if that doesn't work.

February 4, 2009 Dr. Ashby Jan Demeerleer TT-30
Jan indicates that he has been most stable but in November/early December, had a bit of a cycle, notes irritability, being easily frustrated and a bit more argumentative. His wife straightens him out and becomes aware of it, took extra Risperdal during this period of time, is not sure how much it worked but he came through it and it's my perception that this is still the way to handle that and this has worked previously, so he will be a little more conscientious about doing that to minimize any of the episodes. In the last 10 months, is the only time he can think of when times were ragged. His mental status today is totally WNL, has good insight, things are going well in his life both vocationally and family wise.

Plan: Continue Depakote, Risperdal, and Buproprion.

5/27/09 T.C. - Lost job. Not married. Got job back can do things, can't get a grasp things. Sounds depressed. Can't think, can't process. Sleep OK. Resumed 2mg/d recently - P-

6/1/09 - T.C. - Jan - doing better. Talked c Fience - Back to work again today. Pronunciation OK & Eating.

Now - Depakote 500 b.i.d Appt June 11th
Risperdal 2/d.

March 28, 2008 Dr. Ashby Jan Demeerleer TT-25

Jan indicates that he has had some mild cycles in the last 6 months since being seen by him, both depression and a little hypomanic. The hypomanic lasted for a few days and the depression can last for a few weeks but never gets severe. He thinks part of it is because he has not been exercising or been active, kind of changes his life-style to be more "domestic" rather than participating in some of the outdoor things he really loves. He is going to change this and see if it makes a difference. We will leave his medications as is. His mental status today was completely WNL and he will keep in touch if this doesn't turn out right.

9/26/08 - F&C ½ 8am - (2m) I called + left message

9/29/08 - T.C. Deaton - He'll reschedule -

September 28, 2007 Dr. Ashby Jan Demeerleer TT-30
Jan indicates that he continues to do well, has changed jobs, went through that stress without any difficulties so his history really looks good and I'm pleased with how he is doing. He will remain on Wellbutrin, Depakote and Risperdal. Lab needs to be done again although he shows no difficulties with Depakote or Risperdal, which was done 6 months ago.

10/5/07 – TC – Raised voice at work, ↓ sleep, ↑ irritability
c-↑ Risperdal – FU 10/8. (watch for signs of cyclic/a Bipolar Dis. Diagnosis)

February 23, 2007 Dr. Ashby **Jan Demeerleer TT-30**
Jan indicates that he is doing well. Review indicates no problems with any cycling. He is on Depakote 500 mg twice a day, Risperdal 1 mg per day and Bupropion SR 150 mg twice a day. Mood, affect, psychomotor activity, content are all WNL. A review of current stressors, work, etc. is negative and he gives a good report. Lab was done approximately 6 months ago. Triglycerides were high and he had not fasted so the blood sugars were not able to be totally judged so we're going to get it again. I gave him copies of his lab so that when he goes to a primary care physician he can have those available as he indicates that he doesn't go for physicals and doesn't have a PCP at this point and I encouraged him to do so. We will continue the every 4 month schedule for appointments.

October 27, 2006 Dr. Ashby Jan Demeerleer TT-25
Jan indicates that he is doing well. His mood, affect, psychomotor activity, etc. were all WNL. He has appropriate affect which is congruent. He has not repeated his lab so he will do that as he had a high glucose but indicated he forgot it and had some coffee with sugar. We also want to check for triglycerides however. He will stay on the same medications, continue to have a quarterly appointment check.

July 21, 2006 Dr. Ashby Jan Demeerleer TT-30

Jan indicates that he is having a little bit of a period of time with being down and negative, needing increased sleep, even had some suicidal ideation. He used some extra Risperdal during this period of time and it knocked it right out, so he feels comfortable about keeping things under control. Actually, because of stresses at work, he would like to have a little bit of a manic episode if anything (tongue in cheek). Mood, affect, psychomotor activity, content, insight, etc. are all normal and he is doing well. We don't need to make any medication changes and he is doing a good job of managing things. I indicate to him, however, that if it's not just a minor change, he really should keep in touch with me so we can process it together. He was open to this but reassured me that this episode was not anything that needed to be concerned about.

8/25/06 – Lab discussed. Has coffee + sugar so 101 FBS not accurate. Diet D's could acct. for Trig. Will "straighten up" + repeat in 6 wks.

March 31, 2006 Dr. Ashby ***Jan Demeerleer TT-30***
Jan indicates that he is doing well. His mental status is totally consistent with this and we can continue on the same medication. He indicates that he is most likely going to marry his current girlfriend. Family is still a bit tender about his clinical state but as he continues to do well, this should improve.

December 28, 2005 Dr. Ashby Jan Demeerleer TT-25
Jan indicates that he has been stable, is doing well. Mental status is totally WNL.

Plan: Continue current medications.

November 17, 2005 Dr. Ashby Jan DeMeerleer TT-30
Jan is stable with regard to his bipolar symptoms. He and his girlfriend are still talking very seriously. He recognizes that he has high expectations and this is causing problems both in terms of his expectations about how a marriage should work and how her autistic son should be responding to their training and plans. I helped him to be able to put this in perspective but I gave him some tools he can use to assist with this and hopefully that will allow him to reframe some of his expectations so they are not inappropriate and lead to difficulties. He will stay on the same medications.

October 20, 2005 Dr. Ashby Jan Demeerleer TT-50
Jan indicates that he is doing a lot better. He basically is through this cycle. We spent the more part of the interview discussion what to look for to manage these kinds of episodes earlier, to minimize the morbidity etc., and also the interaction between him and his girlfriend and family members and how that can be harolding signs for him.

October 7, 2005 Dr. Ashby Jan Demeerleer TT-55
Jan indicates that in general he is stable, nothing new has happened. As we began to process this recent episode he acknowledges even further the connection between his behavior and the mood change that he had, in this case depressive symptoms. We processed this in light of his history of episodes regularly prior to 2001 and being placed on the current medication regimen and how things are better so he can trust that a little more and can trust that others will not be as taxed by it either. He was open about the fact that despite doing better, he is having difficulty with psychotic thoughts. He can reality test them but he states at the time they seem so real. We talked about Risperdal and we're going to have him take ¼ of a tablet and also ½ tablet 2 weeks each in addition to his 1 mg tablets to see if we can get a feel for what he can tolerate cognitively, but yet get a little more control. He has not done his lab yet as he got a cold and didn't want that to reflect on the CBC. He will get that when things are stable and this will give us a baseline of what 1 mg per day does and then we will check it again sooner than normal if we stay on the higher dose. The other plan would be for him to use higher doses now that he is getting more tuned into mood swings and stay on 1 mg as a base and use 1 ½, which I think we need to use higher because of his admitting that he has the thoughts fairly regularly.

Plan: Continue Depakote, Wellbutrin and Risperdal as discussed above. His mental status today was good. He had good insight, psychomotor activity etc. were WNL.

September 29, 2005 OV 35 Minutes Dr. Ashby **Jan Demeerlear**

Jan indicates that he is more aware that he has been negative and in a depressive mode, although on a scale of 1 to -10, only a 2 or a most a 3. As a result, he has minimized to himself exactly what the connection that had with what is going on, but as he thinks about it he realizes that if he had not been in a negative mode, he probably would not have gone through what he staged which alarmed the family so much. This is the first time he has made a connection between his mood disorder and his recent behavior so the door for his insight is at least opening. He is less intense today, a lot more relaxed because things have smoothed out between him and his significant other. Family members are still pretty alarmed at his behavior. I see no evidence of mania, and his judgment seems to be okay. He had another problem with financial blow, as his computer program went down on him, which has his financial diary for years and years.

We talked about his medication, we are going to increase his Depakote to 1500 mg per day and he has not got the blood level yet, even though I asked him to do it last week. The other medications I will leave the same. We set up an appointment in one week, and then a week and a so after that.

September 21, 2005 30 Minutes Dr. Ashby **Jan DeMeerleer**

Jan came in with his father. He has had a recent episode where he feels that things are just not going well and financially he is getting nickel and dimed. His truck was vandalized – $2500. which set him back emotionally. He had been talking with his girlfriend about the fact that if they were to get married, which they had been talking about that he would have to be able to deal with his mental situation, i.e. being on medication for Bipolar Disorder, etc. She has indicated to him that she feels that she is able to do that. He decided to test this, at least as he describes it and ended up with some erratic behavior, which she reported to his family and they became concerned. As his father was here, I was able to get collateral information and father is concerned about the behavior but there is not other indications of any change in thought and this does somewhat of a context, but it is not satisfactory to chalk it up as a reasonable incident. Rather than looking at it to be a bipolar swing, however, I am wondering if it does not reflect some other aspect of his personality and adaptation, and sense of security in wake of his first relationship ending in divorce.

Mental status: he is goal directed. No obvious manic symptoms are noted. He was very cogent and gave a good reasonable account. Logical and easy to follow. His father indicated that they have not seen any objective signs except for the behaviors that he says he did to test his girlfriend's ability to handle him.

Disposition: He is to stay on the same medications. He will return in a week or two for follow up, to see if there is any kind of a trend that would detract from the fact that he seems psychiatrically stable, even though psychologically there appear to be issues.

July 15, 2005 Dr. Ashby Jan Demeerleer TT-30
Jan indicates that he is doing well. He has a lot of stress at work but is handling that well and has not had any mood swings or episodes, except a couple of weeks ago when he took a vacation for a week, went away, forgot to pack his medication and by the end of the week noticed that he was having difficulty with depression and as a result, had somewhat of a run in with his girlfriend which was stressful, but got back on the medication and continues to be stable.

Mental status exam today is totally WNL.

Plan: Because of some mildly elevated lipids and a high normal glucose, we will get his lab done again to make sure there is not a further drift toward abnormal levels, otherwise he will stay on the same medications and I'll call him when I get the results back.

January 11, 2005 Dr. Ashby Jan Demeerleer TT-25
Jan has not been seen for approximately 8 months. He indicates that he has been emotionally stable, continues on Depakote 500 twice a day, Risperdal 1 mg at HS and Wellbutrin 150 mg twice a day. He has moved on with his life. Divorce issues are pretty much over. He has a significant other that he is seeing regularly and almost to the point of living together. His mood, affect, psychomotor activity, content, etc. are all totally WNL today.

Impression: Stable emotionally.

Plan: Continue current medications, get lab work as we followed up on Depakote information in the past but not on Risperdal. He doesn't have any stigma of any difficulties but we will double check, particularly since the lipid profile problem can be quite occult.

1/25/05 T.C. Lab reported - "ok"

1/27/05 T.C. above message cut off - [illegible] "need to [illegible] lipids".

7/12/05 FTC [illegible] 5pm — I called & left message prior to appt. [illegible] got it. Letter sent - N.C. [illegible]

April 27, 2004 Dr. Ashby Jan Demeerleer TT-60
Jan indicates that he just feels like he is not moving forward and adjusting to his divorce. We processed this fully, looking at all the different ramifications of it, the experiences he is having emotionally, etc. I was able to reinforce by having him compare his current feelings with how he handled situations before, ie. does he have a tendency to be someone who holds grudges and has to get revenge and he indicates that he has never had these kinds of thoughts before, that currently his statement is "if I'm not happy, I can't stop perseverating on the fact that I don't want Amy to be happy. He does admit that he has had fantasies of different negative things but would not act on any of them as he knows better but it scares him that he has had such intense feelings. We talked about what that means in terms of his ability to have feelings and unfortunately we only have strong love feelings when that is torn away from us that we have strong feelings on the other side, either of depression and loss or anger. He showed insight into this as the commitment to continue to be forward looking, to cognitively fight these negative thoughts but he is getting tired of the fact that he feels like he is not making progress but spontaneously did document that intensity as less although frequency is the same and we reviewed the implications of this. His mental status exam otherwise is normal in the sense of mood, affect, content, being logical goal oriented, etc.

Plan: Continue current medication and support.

#3 6/2/04 FTC [illegible] – [illegible] forgot – [illegible]
12/8/04 – T.S. will sched. – 1 month [illegible] called –

March 15, 2004 Dr. Ashby Jan DeMeerleer f/ssn
Jan states that he has been stable over the last number of weeks particularly since our telephone call when there was some question about some behavior. He got all that straightened out and there are no difficulties and his behaviors have not been manic like. Despite this, however, he states that his wife is somewhat guarded and although they both have their daughter and she comes to his house she is not allowing him to know where she is living currently. Work, relationship with his daughter are good. The divorce still hurts. We processed this quite a bit and socially he indicates that he is pretty much shut down but is making efforts to meet people. His mental status is totally WNL, has good insight, doesn't want to make any medication changes even though I would be comfortable with decreasing his Risperdal. We reviewed his lab work which is normal.

January 30, 2004 OV Full Session Dr. Ashby **Jan DeMeerleer**

Jan indicates that he is stable. He has had a good week, because it is the week he has his daughter. He has weekend plans, super bowl weekend, etc. with friends and family, so he feels okay about that and the work week goes reasonably well for him. Last week his wife handed out an olive branch of friendship, had some interaction with her. This may indicate that she feels a little less threatened and able to do things without feeling "boxed in". However, the chances of them getting back together, not only because of her attitude, but things he knows about the situation and he would not be able to trust her again. We talked his ambivalence, tendency for him to be all or nothing in his assessment of things. He finally spontaneously comments that "I guess that there are some good things that can come out of this". What held back on this, was that it appeared that he had the mind set, that unless he was able to have her give him feedback about his contributions to the problems that he would never be able to learn and go on. We talked about this issue that this was not the case and that there were other ways for him to learn and dealing with different then dealing with other concepts and the solution is not always evident of available. He showed insight into this.

Mental status exam today was totally within normal limits, he is stable and will continue on the medications for the Bipolar Disorder.

#2 2/12/04 ETS. F5520 - I called & left message - 2nd miss! 1/2 dose

2/20/04 T.C. w/p. I returned call & indicated I can listen but not talk. She expressed concern that Jan wasn't doing well // above miss consistent & that - as a result of her call I'm prompted to call him again - left message 9:10

2/23/04 T.C. - Dad - Expressed concerns. I. history allegedly: keyed [car] door?, rock through window?, entered BF's house. I asked dad to have him call me - Dad gave me Jan's cell #.

3:40 T.C. to Jan - cell - left message: confronting B.F.
6:10 - T.C. - He denies everything but confronting B.F. (Amy is at his house now) & he talked openly even in the hearing. He indicates he's actually doing better
R apt 3/15 to call earlier if needed

January 23, 2004 OV Full Session Dr. Ashby **Jan DeMeerleer**

Jan is still reeling from his wife divorcing him. He admits that he has had a lot of dark thoughts over the last couple of weeks. Talked about this to some friends, they rallied around him and kept him okay. He apologized to them for being so negative, they were actually homicidal/suicidal thoughts. He indicates that reality check was appropriate and he is embarrassed that he had those thoughts and let himself get that carried away. He knows that he would never go there, but just the fact that he was expressing it out loud to other people is an embarrassment to him. We took a step back and looked at this to try to get a sense of perspective that might be helpful. One thing, is that he really does have strong feelings and this in a man who felt that at times he didn't have the ability to have deep feelings about things. Additionally, the fact that he talked with others and then they responded in a way that was appropriate, and as friends would do, was reassuring. As he has a tendency to look at the half empty side of the glass, we worked on this cognitive behavioral principle.

Mood, affect, psychomotor activity, content, insight, etc were all within normal limits. He does openly expresses the fact that he is in a lot of pain because of the sense of loss, but it is helpful to him that he has liberal visitation with his daughter who allows him to stay centered. The other five days he struggles. We worked on this also, so that he can have some counter statements to help with the tendency for negative interpretations.

Plan: Continue current medication, continue weekly support.

January 9, 2004 Dr. Ashby Jan Demeerleer TT-60
Jan is reasonably stable except for depression, which I think is mainly situational though we need to keep an eye on this. It may be that rather than Depakote, he could do well with something like Trileptal that helps with depression better or have a little more broad spectrum antidepressant rather than Wellbutrin. Also he is only on 150 mg of Wellbutrin which we could increase the dose, ie. this will need to be watched. After reviewing medication, we looked at the psychological aspects of his current stress, ie. the divorce, relationships, and is questioning himself a lot. There are family dynamics that contribute, ie. he describes his brother being favored by his father. He always aligned himself up by standing next to brother so he could be in the limelight but never giving himself over to the particular behaviors or activities that his brother participated in or "accomplished". Additionally, in terms of trying to "find out" about himself, he describes himself as previously being outgoing, not so now, feeling now that he really doesn't know who he is, really bugged into the fact that he is quite controlling, quite all or nothing in his thinking and difficulties with feeling he is vulnerable and that he cannot let those be discovered.

Plan: Between now and our next appointment in 2 weeks is for him to try to experiment with some of the principles we talked about today and get some experience other than with his stereotype feeling that he should not give himself over to vulnerabilities or intimacies or even dealing with small things like getting back in the gym to make friends, reach out to people who have said that they are there for him, ie. he had 3 colleagues who offered to be there for him and he has never taken them up on it.

December 31, 2003 Dr. Ashby Jan Demeerleer TT-30
Jan missed his last appointment approximately 6 weeks ago, was in the middle of separating from his wife, totally spaced it out. Currently, however, he probably would not have made another appointment until some time in January but his family pressured him to get an appointment today. In the wake of the divorce, he was initially quite depressed, admits to having suicidal ideation, it walked through his mind, as he put it, but he would not take it seriously and has no intent, really feels like he could not do it. It actually bothers him that these kinds of ideas are entertained by him from time to time. He became congruently upset and tearful because he states that those thoughts are totally untenable and unlike him and not something he would normally consider because of his daughter and other family members. He specifically documents how much support his family is and how much he knows he is cared about.

An additional negative, however, is that he started seeing a woman for approximately a 4 week period which was a very rewarding relationship, however, the last 2 weeks she has backed off and become more aloof indicating that there are a lot of little things about him as she got to know him that she didn't like and this really sent him for a loop because it's basically the same language his wife used, that there was not one thing but a lot of little things that caused her to divorce. We talked about these issues fully as time allowed and he was able to put things into perspective and already had in many ways. Additionally, however, he states that he does want to make some changes in things he knows are reasonable for him to make so we began a review of some target behaviors that he would like to work on.

Impression: Some emotional lability, but he has not had major symptoms that indicate that medication needs to be changed more than he needs psychological support. He has had depressive symptoms and has had some hypomanic behavior but in the context of the recent stresses, I do not see that the disorder itself is raising it's head as much as the situation is creating the symptom response. With this in mind we're going to schedule a number of appointments in succession so that we can work on these issues and give him the support that he needs. I do not feel he is a suicidal risk. I also do not feel he is overly depressed or manic, either one which would cause him not to be able to continue to be functional at work, socially or in his family life at this point. Mental status, in that sense was euthymic in the sense of no push of speech, no rapid mood swings, thought content and production were all totally WNL.

September 24, 2003 Dr. Ashby Jan Demeerleer f/ssn
Jan is stable with regard to mood. His mental status is totally WNL. After reviewing we spent the rest of this session talking about difficulties he has had in his marriage, probably in the wake of his manic episode, etc. We reviewed this situation so he could at least understand some of the feelings he is having and motivations. He seems to have good insight, isn't making any decisions irrationally and doesn't seem to be inactive so he seems to have a reasonably good balance and will continue to learn as much as he can so he can make the right choice when it needs to be made.

#1 11/19/03 FTC FSSN

July 17, 2003 Dr. Ashby Jan Demeerleer f/ssn
Jan indicates that things are reasonably stable right now with regard to work, his clinical status, etc. His mental status exam is totally WNL and certainly reflects stability clinically. His main concerns at this point are the marital relationship. His wife is in counseling and she continues to work. In the normal course of discussing their relationship, etc. he describes a couple situations that cause me to ask if his wife has a tendency to be shy and he mentioned that she does and that his daughter is exquisitely shy and a couple of other questions led into the possibility of her having a social anxiety/social phobia type of situation that could be adding into or complicating her own psychological issues that she is working on. This would be difficult to approach but I feel strongly enough that she and her counselor need to gather an appreciation of the impact of these anxiety symptoms, such that gaining collateral information from Amy's parents or from Jan, etc. would possibly be an important adjunct. He will see if he can approach this because certainly our motive is not to change the focus on Amy in any means because his manic disorder is the key problem but as is the case in most situations, they are issues that most of us as individuals have and certainly this situation appears to need to be looked at and sees where it fits.

He will stay on the same medication, continue to try to stay clinically stable and nourish the marital relationship as much as possible.

May 15, 2003 Dr. Ashby **Jan Demeerleer f/ssn**
Jan attends by himself. Lab is totally normal except for Metamyelocyte of 1% which is supposed to be 0, which is a transitional form and doesn't appear to be clinically significant. Mental status exam today is WNL. He does acknowledge however that he is under stress because he became aware that his wife is having an affair with an acquaintance at work. It has not progressed to full blown sexual relations but the emotional attachment and relationship had developed significantly. Subsequent to that they went on a vacation to Hawaii which had already been scheduled and he decided it was best to do that and have an opportunity to work through things which they did. He is totally committed to working on things and is handling this reasonably well. His sense is that she is not quite as committed and more vulnerable because of insecurity. At this point she is in counseling herself and they are working on things.

We made changes last time because of the fact that he had some mild difficulties with depressive symptoms and some hypomanic phase during the earlier part of the year. This seems to be stabilized now and we can continue on the same medications.

March 26, 2003 Dr. Ashby **Jan Demeerleer f/ssn**
Jan indicates that for the past month he has had depressive symptoms. In looking back it may be that his feeling good in January was indeed a little bit of a hypomanic period. It was functional however, so I'm not sure if we need to deal with it. He feels like he is coming out of the depression the last couple of days. Prior he had a manic phase, depressive phase, and then a mixed phase so if it holds true to that he could be going into a mixed phase at this point. If that's the case, I want him to take 200 mg of Wellbutrin twice a day and 2 mg of Risperdal to take care of things in both directions and he is to call me in 3 weeks if the results of having to do that are working or not. We will get together again in 6 weeks. His wife attended with him today, it was a good session in terms of working on learning how to manage this in a micro sense at this point.

January 23, 2003 Dr. Ashby **Jan Demeerleer f/ssn**
Jan indicates that he is feeling well and because of this he is worried about whether he is cycling into mania. Sleep is good, energy level is good. He is not having any of the symptoms he had before except that he is having optimistic thoughts about things. In discussing things today and reviewing his situation, he is able to look at both sides of things, his content is appropriate, psychomotor activity is normal, is not off on tangents, is able to look at both the positive and negative and is realistic and I don't see any red flags per presentation or content. We reviewed what he is to look out for as harolding symptoms and to use his wife as an informant and source of collaterol information.

He continues on Depakote 1 gm per day, Risperdal 1 mg per day and Wellbutrin 150 mg SR twice a day. He will continue on these medications and continue visits on a monthly basis.

December 2, 2002 Dr. Ashby Jan Demeerleer f/ssn
Jan indicate that he had an episode of approximately an hour, hour and a half of having angry, aggressive thoughts, even to the point of suicidal, homicidal thoughts, wouldn't act on them and it went as quickly as it came but on close questioning, he admits that during that period of time he was not checking himself or censoring those thoughts except not letting himself act on them. All told, there are some indications that he was still being responsible, ie. he didn't want to leave because his daughter was sleeping etc. so there is an element of safety and keeping things under control that continue to be maintained. Mental status exam today is WNL and he indicates that he is sleeping, doing fine, there is stress with his job as he has two job offers and now just has to wait to see which one comes through but he will be hired on permanently within the next month or two in one of the two jobs. This will be of great help to him.

The last episode he had was in September which was approximately 2 months ago so we will have to keep an eye on this. It lasted about 3 hours, so hopefully the trend is that the medication is keeping things under control.

Plan: Take an extra Risperdal at the earliest onset, also use cognitive behavioral therapy principles that we've discussed prior and reviewed today.

October 30, 2002 Dr. Ashby Jan Demeerleer f/ssn
The first half of the interview was taken up with medication management. No dose changes need to be made but as I had given him samples of Risperdal, he didn't catch onto the fact that the different color was actually a different size, he just thought it was because it was in a different package but it was the same dosage. This is good as he has not used the 1 mg Cogentin, is only on 1/2 mg and I'd like to see if he continues to do well. We reviewed symptoms in the past year and a half or so of treatment and he has been able to keep things under control. We added Wellbutrin last month because of depressive symptoms. He doesn't notice much difference but his wife feels he has come back out of that over the past couple of weeks. It's difficult to tell exactly if this was the Wellbutrin totally responsible for this or not but it appears that it did have a positive influence and we will continue to leave him on the medicine and reassess this.

The second half of the interview was dealt with, psychological issues, questions of the impact of this disorder on their relationship, etc. and even doing a little bit of education about marital interaction in light of the bipolar disorder, stresses etc. They are doing reasonably well, their marriage is strong, they are the parents of an almost 2 year old so this is causing problems and it's nice that his stability is coming along so that it doesn't interact with that stress.

Plan: Continue medication, continue support.

September 27, 2002 Dr. Ashby **Jan DeMeerleer f/ssn**
Jan attends with his wife. Over the past two weeks he has noted some symptoms, in impulsive purchase, some depressive affect, increased sleeping, little less jovial, some unusual responses at work, ie. a person was giving him a compliment about his engineering skills and he stated "I don't want to be that kind of an engineer" and later didn't even know where that statement came from. We're interpreting this as being an indication of difficulties with mood swings. The only change we've made is to decrease the Risperdal so we will increase this. I also feel that adding a little bit of an antidepressant like Wellbutrin prophylactically would be appropriate. Side effects, rational for use, seizures, issues etc. with regard to Wellbutrin was discussed.

Plan: Continue Depakote, continue Risperdal but go back to 1/2 mg a day instead of 1/4 and add Wellbutrin 150 mg a day for 4 days and then twice a day.

August 28, 2002 OV Full Session Dr. Ashby **Jan Demeerleer**

Jan's mental status is within normal limits. He is stressed because he is going to be losing the job he has now in another month. He has not been able to find another engineering job. He is looking into going into financial counseling as a back up. He talked also about stresses this is having on his marital relationship, and I asked whether or not felt his wife was depressed, he had not even considered this, and this seemed to threaten him, because he needs her to be strong, but this could be an issue. They will be spending time together, quality weekend and hopefully they will have some talks and keep things going in a positive direction. In the meantime, this does not appear to be a medication issue. He is stable, not manic, or overly depressed, bit discourage, but appropriate for the situation. Continue current medications. Continue emotional support.

July 26, 2002 Dr. Ashby **Jan Demeerleer f/ssn**
Jan attended with his wife. We did the medication review and assessment of the manic depressive symptoms. Initially this appears to continue to be stable. Lab work doesn't need to be done and mental status is WNL. The latter part of the interview was spent on dealing with the impact of the manic depressive disorder on the marital relationship. Both of them have good insight, there is an increase in confidence coming along as time goes by and he continues to be OK but there is still a lot of aftermath from the significant symptoms he had and the pathology that was inflicted upon the relationship. We identified some areas to work on, some assignments were given and we will review this at his next appointment.

June 27, 2002 Dr. Grubb **Jan Demeerleer f/ssn**
Jan attended with his wife today. He had questions with regard to his ability to know if she was being objective in assessing him and she feels there was signs of difficulties. We reviewed his recent stresses, how he has handled those, the tendency to have depressive symptoms, how much of this was consistent with the context and the quality and quantity of his reaction. After the review, we all agreed that he is bouncing back and his wife's descriptions were actually quite accurate with his and so I think both of them are being quite objective and assessing things appropriately at this time. His thought content, production, goal orientation, etc. were all WNL. Psychomotor activity was normal. I see no evidence of any manic symptoms at this point. He is negative but there's a context of that as he has not been able to find a job and there's a lot of insecurity in the temporary work that he is doing right now.

We reviewed his last lab work. Medication doses etc. and will continue the doses of both the Depakote and the Risperdal. It may be that he doesn't need the Risperdal but because he is still in stressful situations and is bouncing back, if we had to air, I'd air on the side of leaving him on medication that could still be supporting that.

April 26, 2002 Dr. Ashby **Jan Demeerleer 1/2 ssn**
Jan's mental status is WNL. He is stable, has continued to job hunt. Marriage is struggling but he seems to be taking things in stride. Mood is neither euphoric or depressed. He seems to be being kept in reasonable bounds.

Plan: Continue Depakote and Risperdal. No EPS are noted.

May 24, 2002 Dr. Ashby Jan Demeerleer 1/2 ssn
Jan indicates that he continues to do well. He got a job offer but has to turn it down as it's in California and they offered ridiculously low wages for cost of living etc. He was really discouraged two days ago when he found out about work, his wife was upset because she felt he should feel good that he got a job offer but he reacted negatively because of the disappointment and felt it was almost a slap, someone trying to get him to work for practically nothing. He asked her to give him a day, yesterday stated he felt better, was bouncing back and today has totally bounced back, has it in perspective, has a couple of offers including one with his old company but yet these things will not formally come about for a number of months so things are basically still up in the air. Mental status exam is WNL, psychomotor activity, content, etc. are all WNL.

Plan: Continue current medication management, invite his wife to assess him so we can review things with collaterol information.

March 28, 2002 OV Full Session Dr. Ashby JAN DEMEERLEER

Jan attends by himself today, he continues on Depakote a gram a day and Risperdal .25 mg a day. He is stable and has good insight. We talked about work and interaction with wife. We did some work on how to interact with her which should take some stress out their relationship and he is going to experiment with giving her more room because he can be controlling on some levels and will report back.

January 16, 2002 Dr. Ashby **Jan Demeerleer f/ssn**
Jan appears approximately the same as far as the psychomotor activity etc. Content, judgement are good and I do not see any particular red flags for a bipolar disorder. I think his jovialness etc. at this point is more his personality style than evidence of mania. We talked about cognitive behavioral therapy to help with all or nothing thinking and other cognitive distortions. He showed good insight into this and he and his wife will work on it together.

February 26, 2002 Dr. Ashby Jan Demeerleer f/ssn
Jan basically is stable however there is some evidence that he may be getting discouraged. I've asked enough questions to satisfy myself that he is not having difficulty with depression although there is some increased sleep, little less ability to handle stress, some less energy and some difficulty with concentration. My sense is however, that some of this such as the sleep, is some avoidance behavior because of getting discouraged with the job search. We talked about things in a clinical sense although reviewing the legistics of his vocational situation and I think the most important concept for him is that he needs to define for himself when he is doing all he can do and or when the situation is unchangeable so he can either give himself permission to move on or to continue to search after his current goals. On mental status he is goal oriented and has insight etc., psychomotor activity and content are normal.

Plan: Continue current medications, continue support.

February 5, 2002 Dr. Ashby **Jan Demeerleer f/ssn**
Jan is doing reasonably well. He has had two job opportunities that didn't come through. This could be very discouraging and upsetting, however, he is handling this well and neither showing depressive or manic symptoms. He is goal oriented, logical, good insight. We talked about broadening out his view which I think is important for him to do but it's difficult for him because he has a tendency to be a little bit locked on to one path. His wife is now working full time so she is not here but he shows insight into continuing to use her as collateral information on his clinical state.

Plan: Continue medication and support.

December 12, 2001 Dr. Ashby **Jan Demeerleer f/ssn**
Jan indicates that he feels like he is normal, his wife indicates that she observes that he is doing well, seems stable. He is having some difficulty with stress and having to make a job and career decision. Financially they will only be able to handle things through February and decision then are looming because of this. We reviewed the medication and he seems to be doing well on the Depakote and he is also on Risperdal, 1/2 mg per day as that was to be used short term, we will now decrease to 1/4 of a mg per day for a few months and if he remains stable, we will stop the Risperdal and continue Depakote. Lab work was ordered there today. Psychologically, we didn't have much time to go into the problem. He is still working on trying to separate what is his personality and strengths, etc. and what is the artifacts of the disorder and will continue to work on that in subsequent sessions.

December 26, 2001 Dr. Ashby **Jan Demeerleer f/ssn**
Jan indicates he is stable clinically, mental status exam is consistent with this. His mood, affect, content, production, etc. are within normal limits. Psychomotor activity is normal for him. (He can be a little jovial and boisterous at times but this appears to be his personality). I let him talk openly today without structure to test this out and see what kind of content he gets into. He stays realistic, is not grandiose at all and so I'm comfortable with the fact that he is euthymic at this point. He did not get his Depakote level and will follow that up in the next few days.

Plan: Continue current medication, continue emotional support as he is about to have another test of stress with regard to employment.

November 14, 2001 Dr. Ashby **Jan Demeerleer f/ssn**
Jan is doing reasonably stable on the current doses of Depakote 500 mg twice a day and Risperdal 1/2 mg per day. The more part of the session today was spent on psychotherapy. I reviewed lock on, lock out and object relations material as a way of helping him to evaluate his tendency to have all or nothing thinking and opinions about himself and others in this matter which causes difficulties. Of note is that in talking about his personality style, he initially was very upset about this, acknowledged that he wanted to attribute everything to his disorder but we were able to work through this and he sees the benefit of accepting the fact that he can be both rewarding and non rewarding himself let along others and that it's OK to work on problems.

October 31, 2001 Dr. Ashby **Jan Demeerleer f/ssn**
Jan continues on Depakote 500 mg twice a day and Risperdal .5 mg QHS. He attended with his wife. This was a good session in clarifying an education about his disorder. He is still having difficulties with acceptance of having to deal with the disorder, prior he has had insight while been in the throws of it, would be on the medicine for a while then get off the medication and struggle through for years. He is gaining insight through the education during the sessions. He asks good questions, has an outline of things he is working on which helped with the continuity of the sessions so progress continues.

He is not quite as grandiose but yet still can be somewhat expansive but he is showing more insight.

Plan: Continue current efforts.

October 11, 2001 Dr. Ashby **Jan Demeerleer f/ssn**
Jan attended with his wife. He indicates he is not having side effects from the medication anymore, initially had a little nausea from the Depakote. His level was 92 on 500 mg twice a day. He says that prior he was maintained on 750 mg a day so this should be a good level. He notes spikes of hypomanic behavior, is able to describe it, shows insight into the fact that they happen but also is classic in liking the sense of power and happiness etc. that he feels in that state. He uses words such as overly or too much or too big etc. so had some insight into the fact that it's too much but begrudges the fact that he may be losing it. He is noting that he is starting to have some negative / depressive thoughts and begrudges that and feels that if he is not high, he will be depressed rather than the goal of being euthymic.

I educated him about this, despite the fact he has been working with this since the early 90's, over the last 9 years or so, he still has some misconceptions and lack of confidence that he can feel OK without having to feel high all the time. His wife documents that the hypomanic episodes to reaffirms that they are troublesome.

We talked about adjunctive medicine in atypicals or other antiseizure medicine such as Neurontin or Gabitril. I chose the atypical and talked with him about those and directed us towards Risperdal as an initial trial. I'll have him take .25 mg for a few days and then .5 mg and see if this is enough to help with the hypomanic symptoms. Parkinson side effects and the PDR material was reviewed.

September 27, 2001 Dr. Ashby **Jan Demeerleer f/ssn**
Jan met with his wife. He brought a list with problems that he wanted to address today. We spent time mostly talking about medication management, education about the disorder and how it interacted with his history. He also described how he is trying to be more open and had intervention with his family at his invitation.

It's difficult for him to tell where his confidence by nature leaves off and manic confidence and grandiosity begins. He indicates that he is a type A personality and during depressive periods, this would hold him until it was deep enough to them to actually shut him down. He states that this is the first manic episode where he has not liked the mania because it caused anger and irritability, thus his desire to get help and insight into the need for it. As he describes his situation, I'm again impressed with the mixed presentation but I'm not sure about fast cycling.

Plan: He is to gain additional insight into the earliest heralding signs of mood swings so that we can respond to a manic swing with additional PRN medications to keep him from needing to be hospitalized or lose a job, etc. We will continue to work on his list of problems next time.

September 13, 2001 Dr. Ashby ~~John~~ Jan Demueller N/P Intake con't

apparently it was 40.

Plan: Reinstitute Depakote, get blood level and baseline labs after he is on 500 mg twice a day for 4 or 5 days. Giving the medication at ~~try Bif~~ trough level, were all described so he can get the level done appropriately. (He was on 750 mg a day previously and had a blood level of 71. I feel that having a fairly aggressive dose would be appropriate due to the description and seriousness of his symptoms and the possibility that he was only partially treated and this may have contributed somewhat to his difficulty with compliance. We will have to watch side effects to help with the compliance also. Set up additional appointments not only to monitor medication but to do therapy.

9/17/01 ~ T.C. Advised letter to be sent to W.B.O. also he indicates nausea. went on Depakote rather quickly - will watch for trend

previous hospitalization etc., came clean with everything and asked for their support and help particularly to be able to help his wife when he gets into a manic or depressive swing.

Regarding mania, if he feels suicidal, it's to drive high speeds and hurt himself that way, regarding depression he states he is so immobile that he can't do it although he has had thoughts. He does describe 10 years ago however of being placed in the hospital because he laid down on railroad tracks with the idea of being decapitated.

Medical history is unremarkable except for allergy to Amoxicillin. Family history is unremarkable medically. Psychiatrically his brother has admitted that he has hypomanic episodes but has never gotten in enough trouble that he sought treatment and doesn't want it. There is a maternal grandmother who had depression and difficluties with alcoholism. He graduated from high school and engineering degree in college but has had no military experience. He was placed in jail at age 20 because of the train having to stop when he was trying to kill himself and was detained in the hospital. Subsequently, at age 21, while in college he was in jail for alcohol, stealing bikes and states it was during one of his out of control episodes during college.

Mental Status Exam: He is logical and goal oriented, somewhat labile in that at times he will become quite emotional and state that he is not sure if he really means all the things he says, not sure anymore if he is even talking straight, if he really means it, mainly referring to the fact that at times he will be sincere but then will not live up to it and stay with it. He expresses motivation to get help and to be compliant with medication at this time, however. His mood overall is neutral but again at times he can be very serious but not necessarily depressed but quite intense. Cognition is normal, content is good, judgement is intact. He is not suicidal or homicidal. No obsessions or compulsions. No unusual thinking or other evidence of thought disorder is noted. Intellect is above average. Interaction with wife in this interview was appropriate.

Impression:

Axis I:	Bipolar affective disorder with frank manic episodes but also apparently mixed presentations with a response to Depakote in the past but with poor compliance.
Axis II:	A possibility of cyclothymic personality disorder and some obsessive compulsive traits which will all need to be further evaluated as time goes by and he further stabilized.
Axis III:	Allergy to Amoxicillin.
Axis IV:	Stressors include loss of job, symptoms of his disorder.
Axis V:	Adaptive functioning 60, currently earlier this year

September 13, 2001 Dr. Ashby ~~John~~ Demueller N/P Intake

John is a 30 year old married father of one. He indicates that in 1992 he was hospitalized for 2 weeks because of suicidal ideation, was noted to have mixed depression and bipolar symptoms, ie. fast thoughts, increased energy, etc. He was placed on Depakote 500 mg in the morning, 250 mg at night and he indicates that he subsequently moved to Minnesota, went off the medications, was in an engineering program and then subsequently went on to Indiana. He indicates that the period of time when he was drinking, partying to treat depression cycled a lot, had very much highs and lows but was able to maintain functionality. He did not have any of the psychotic thinking he had in the 1992 episode so he convinced himself that he did not need treatment. He was able to land the job in Kentucky in 1995. In 1996 he married, states that at the wedding he was in a drunken stupor and went into a depressive episode after that. Despite this, his wife stayed with him which he indicates he is thankful for (she accompanied him in the interview). In 1997 he again had depressive ideation with suicidal ideation, began skipping work but finally reached out, was treated on an outpatient basis again. He was started on Depakote and did better but complained of the side effects of medication, ie. taking away his creativity, embarassed about medication to the point that if somebody came to visit, he would make sure it was hidden and not able to be seen. He felt he could feel the negative effects of the drugs. Enough questions were asked to see if he cycled through the Depakote or if compliance allowed cycles to happen and it appears to be the latter.

By August of 1998 after sporatic use when he stopped it totally, he immediately went into a high and had "great feelings". He describes very much grandiose behavior. Over the past 2 years he has not received treatment and approximately 2 months ago quit his job in a grandiose manipulation and play at work where he basically states he made a fool of himself at work, said stupid things and engineered himself out of the job in his delusional state thinking this was a grandiose thing to do. He states that earlier this summer he had suicidal ideation and even homicidal ideas, was going to leave the country. He states that in less manic situations he has a tendency to want to feel powerful, manipulates his wife, relatives and friends with stories. He indicates that at work he was so productive and good that at one time they even went along with his desire to be called by some fantastic name because he was so active and "gung ho". He states that last March he was grandiose to the point that he felt "I'm here to show earthlings what they are capale of". He indicates that as he looks back he recognizes that he was completely out of control.

In August of this year, his wife had to start working because he had quit his job. He started having some depression again and suicidal ideation including playing Russian Roulette. That gun and other weapons have been removed from the home and on Labor Day weekend he had an "intervention" with his family in which he invited them together and finally showed them the records of his

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN	10271970JD	10/27/1970	M	39 Y	5099440586	10271970JD	
PHYSICIAN	COLLECT DATE & TIME		DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE
ASHBY MD, HOWARD	04/13/2010 07:18		04/13/2010		663002489218	Final	1

COMMENTS: T1647536:AHEMP2 , ATDIF2, GLU, HFPA; LIPID- 12HRPP

For additional diagnostic criteria, see our Test Directory at www.paml.com

Diagnostic Procedure					
Glucose	108	H	mg/dL	70-99	01
Hepatic Function Panel					
Protein, Total	6.9		g/dL	6.3-8.0	01
Albumin	4.1		g/dL	3.5-5.0	01
Bilirubin, Total	0.3		mg/dL	0.1-1.5	01
Bilirubin, Direct	0.1		mg/dL	0.0-0.2	01
Alkaline Phosphatase	55		U/L	38-110	01
AST	27		U/L	5-40	01
ALT	35		U/L	5-50	01
Lipid Profile					
Cholesterol	191		mg/dL	125-200	01
Triglycerides	262	H	mg/dL	<150	01
HDL	40		mg/dL	>40	01
	For specific risk assessment criteria, see our test directory at (www.paml.com).				
LDL, Calculated	111	H	mg/dL	<100	01
	The LDL goal varies from 70 to 160 depending on the clinical risk category. For specific risk assessment criteria, see our test directory at (www.paml.com).				
Hemogram with Plt					
White Blood Cells	8.8		K/uL	4.0-10.0	17
Red Blood Cells	5.01		M/uL	4.30-5.70	17
Hemoglobin	15.9		g/dL	13.0-17.0	17
Hematocrit	46.0		%	40.0-50.0	17
MCV	91.8		fL	80.0-100.0	17
MCH	31.9		pg	27.0-34.0	17
MCHC	34.7		g/dL	32.0-36.0	17
RDW	13.0		%	11.0-15.0	17
Platelets	256		K/uL	150-400	17
Differential					
Differential Type	Automated				17
Neutrophils	61.8		%	40.0-80.0	17
Lymphocytes	32.1		%	15.0-45.0	17
Monocytes	7.2		%	0.0-12.0	17
Eosinophils	4.9		%	0.0-7.0	17
Basophils	0.9		%	0.0-2.0	17
Neutrophils, Absolute	3.02		K/uL	2.00-7.30	17
Lymphocytes, Absolute	1.57		K/uL	1.00-4.80	17
Monocytes, Absolute	0.63		K/uL	0.00-0.80	17
Eosinophils, Absolute	0.24		K/uL	0.00-0.50	17
Basophils, Absolute	0.02		K/uL	0.00-0.10	17

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN	10271970JD1	10/27/1970	M	38 Y	509-944-0586	10271970JD1	
PHYSICIAN	**COLLECT DATE & TIME**	**DATE OF SERVICE**			**REQUISITION NO.**	**STATUS**	**PAGE**
ASHBY MD, HOWARD	06/26/2009 07:09	06/26/2009			663002014613	Final	1

COMMENTS: F911970:AHEMP2 , ATDIF2, CMPAC, CMPC; GFR- ; LIPID- 12HRPP; VALP- LD 2000 06/25

For additional diagnostic criteria, see our Test Directory at www.paml.com

Depakote, Risperdal. Bupropion, 20 [illegible]

Diagnostic Procedure	Result In Range	Result Out of Range	Units	Reference Range	Site Code
Comprehensive Metabolic Panel					
Sodium	[illegible]		mmol/L	135-145	01
Potassium	4.6		mmol/L	3.5-5.3	01
Chloride	[illegible]		mmol/L	98-109	01
CO2	30		mmol/L	22-31	01
Glucose		104 [illegible]	mg/dL	65-99	01
BUN	12		mg/dL	7-23	01
Creatinine	[illegible]		mg/dL	0.50-1.30	01
	IDMS traceable creatinine				
Calcium	[illegible]		mg/dL	[illegible]	01
Protein, Total	6.9		g/dL	6.3-8.0	01
Albumin	[illegible]		g/dL	[illegible]	01
Bilirubin, Total	0.3		mg/dL	0.1-1.5	01
Alkaline Phosphatase	47		U/L	[illegible]	01
AST	16		U/L	5-40	01
ALT	15		U/L	5-50	01
Anion Gap	7		mmol/L	5-16	01
CMP Calculations					
BUN/Creatinine Ratio		[illegible]	Ratio	[illegible]	01
Globulin	2.5		g/dL	1.8-3.5	01
A/G Ratio	1.8		Ratio	1.1-2.2	01
Estimated GFR (Calc)	>60		ml/min/1.73m2	>60	01
	GFR <60: Chronic kidney disease, if found over a 3 month period. GFR <15: Kidney failure. For African Americans, multiply the calculated GFR by 1.210				
Lipid Profile					
Cholesterol	166		mg/dL	<200	01
Triglycerides		192 [illegible]	mg/dL	<150	01
HDL		30 L	mg/dL	>39	01
	For specific risk assessment criteria, see our test directory at (www.paml.com).				
LDL [Calculated]	98		mg/dL	<100	01
	The LDL goal varies from 70 to 160 depending on the clinical risk category. For specific risk assessment criteria, see our test directory at (www.paml.com).				
Valproic Acid		101 H	ug/mL	50-100	01
	Toxic >150 ug/mL				
Hemogram with Plt					
White Blood Cells	5.9		K/uL	4.0-11.0	17
Red Blood Cells	5.11		M/uL	4.30-5.70	17
Hemoglobin	15.6		g/dL	13.7-16.7	17
Hematocrit	46.8		%	40.0-50.0	17
MCV	91.4		fL	80.0-100.0	17
MCH	30.5		pg	27.0-34.0	17
MCHC	33.3		g/dL	32.0-35.5	17
RDW	12.8		%	11.0-15.0	17
Platelets	150		K/uL	150-400	17

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN	10271970JD1	10/27/1970	M	38 Y	509-944-0586	10271970JD1	
PHYSICIAN	COLLECT DATE & TIME		DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE
ASHBY MD, HOWARD	06/26/2009 07:09		06/26/2009		663002014613	Final	2

COMMENTS: F911970:AHEMP2 , ATDIF2, CMPAC, CMPC; GFR-. ; LIPID- 12HRPP; VALP- LD 2000 06/25

For additional diagnostic criteria, see our Test Directory at www.paml.com

Diagnostic Procedure	Result	Flag	Units	Reference Range	Site Code
Differential					
Differential Type	Automated				
Neutrophils	41.3		%	40.0-80.0	17
Lymphocytes	45.2		%	15.0-50.0	17
Monocytes	10.2		%	0.0-12.0	17
Eosinophils	3.0		%	0.0-5.0	17
Basophils	0.2		%	0.0-2.0	17
Neutrophils, Absolute	2.32		K/uL	2.00-7.50	17
Lymphocytes, Absolute	2.50		K/uL	1.00-3.40	17
Monocytes, Absolute	0.56		K/uL	0.00-0.80	17
Eosinophils, Absolute	0.33		K/uL	0.00-0.50	17
Basophils, Absolute	0.01		K/uL	0.00-0.10	17

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	518801366	10/27/1970	M	37 Y	509-926-3062	518801366	
PHYSICIAN	COLLECT DATE & TIME	DATE OF SERVICE			REQUISITION NO.	STATUS	PAGE
ASHBY MD, HOWARD	02/18/2008 09:33	02/18/2008			663001076416	Final	1

COMMENTS: M16319:AHEMP2 , ATDIF2, CMPAC, CMPC; VALP- LAST DOSE 02172008 AT 2000

For additional diagnostic criteria, see our Test Directory at www.paml.com

Diagnostic Procedure	Result	Flag	Unit	Reference Interval	Lab
Comprehensive Metabolic Panel					
Potassium	4.3		mmol/L	3.5-5.3	01
CO2	27		mmol/L	22-29	01
BUN	10		mg/dL	7-23	01
Calcium	9.2		mg/dL	8.5-10.5	01
Albumin	4.3		g/dL	3.5-5.0	01
Alkaline Phosphatase	50		U/L	38-110	01
ALT	19		U/L	5-50	01
CMP Calculations					
BUN/Creatinine Ratio	7.7		Ratio	7.0-24.0	01
A/G Ratio	1.6		Ratio	1.1-2.2	01
Hemogram with Plt					
White Blood Cells	5.0		K/uL	4.0-11.0	17
Hemoglobin	15.7		g/dL	13.7-16.7	17
MCV	89.8		fL	80.0-100.0	17
MCHC	34.2		g/dL	32.0-35.5	17
Platelets	154		K/uL	150-400	17
Differential					
Differential Type	Automated				
Neutrophils	48.5		%	40.0-80.0	17
Monocytes	8.4		%	0.0-12.0	17
Basophils	0.3		%	0.0-2.0	17
Neutrophils, Absolute	2.42		K/uL	2.00-7.80	17
Lymphocytes, Absolute	1.94		K/uL	1.00-3.40	17
Eosinophils, Absolute	0.20		K/uL	0.00-0.50	17

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End of Report

00056

SPOKANE PSYCHIATRIC CLIINIC
105 W 8TH STE 6055
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ASHBY MD, HOWARD

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(509) 755-8600 (800) 541-7891 FAX (509) 924-0002
CLIENT SERVICES (509) 755-8999 FAX (509) 924-5127
Medical Director: Thomas J Allerding

PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	1380801264	10/27/1970	M	36 Y	926-3062		
PHYSICIAN	**COLLECT DATE & TIME**		**DATE OF SERVICE**		**REQUISITION NO.**	**STATUS**	**PAGE**
ASHBY MD, HOWARD	03/02/2007 07:41		03/02/2007		1000023	Final	1

COMMENTS: F1787:CMPAC , CMPC; LIPID- Patient Fasting

Comprehensive Metabolic Panel

Potassium	4.4		mmol/L	3.5-5.3	01
CO2	27		mmol/L	22-29	01
BUN	11		mg/dL	7-23	01
Calcium	9.2		mg/dL	8.5-10.5	01
Albumin	4.3		g/dL	3.5-5.0	01
Alkaline Phosphatase	64		U/L	38-110	01
ALT	34		U/L	5-50	01

CMP Calculations

BUN/Creatinine Ratio	7.3		Ratio	7.0-24.0	01
A/G Ratio	1.6		Ratio	1.1-2.2	01

Lipid Profile

Triglycerides	354	H	mg/dL	<150	01

For specific risk assessment criteria, see our test directory at (www.paml.com).

The LDL goal varies from 70 to 160 depending on the clinical risk category. For specific risk assessment criteria, see our test directory at (www.paml.com).

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For additional diagnostic criteria, see our Test Directory at www.paml.com

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3/9/07 8:10 left message
3/7/07 11:50 Reported

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Medical Director: Thomas J Allerding

PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	1380801264	10/27/1970	M	35 Y	926-3062		
PHYSICIAN	COLLECT DATE & TIME		DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE
ASHBY MD, HOWARD	08/18/2006 07:45		08/18/2006		1000011	Final	1

COMMENTS: F61563:AHEMP2 , ATDIF2, GLU, HFPA, LIPID- Patient Fasting

Hepatic Function Panel						
Protein, Total	7.2			g/dL	6.3-8.0	01
Bilirubin, Total	0.3			mg/dL	0.1-1.5	01
Alkaline Phosphatase	58			U/L	38-110	01
ALT	27			U/L	5-50	01
Lipid Profile						
Triglycerides	294		H	mg/dL	<150	01
	For specific risk assessment criteria, see our test directory at (www.paml.com).					
	The LDL goal varies from 70 to 160 depending on the clinical risk category. For specific risk assessment criteria, see our test directory at (www.paml.com).					
Hemogram with Plt						
Red Blood Cells	5.34			M/uL	4.30-5.70	17
Hematocrit	47.1			%	40.0-50.0	17
MCH	30.4			pg	27.0-34.0	17
RDW	12.9			%	11.0-15.0	17
Differential						
Differential Type	Automated					17
Lymphocytes	34.0			%	15.0-45.0	17
Eosinophils	3.1			%	0.0-7.0	17
Neutrophils, Absolute	3.57			K/uL	2.00-7.30	17
Monocytes, Absolute	0.71			K/uL	0.00-0.80	17
Basophils, Absolute	0.02			K/uL	0.00-0.10	17

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For additional diagnostic criteria, see our Test Directory at www.paml.com

Continued on next page

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Medical Director: Thomas J Allerding

PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	1380801264	10/27/1970	M	35 Y	926-3062		
PHYSICIAN	COLLECT DATE & TIME		DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE
ASHBY MD, HOWARD	08/18/2006 07:45		08/18/2006		1000011	Final	2

COMMENTS: F61563:AHEMP2 , ATDIF2, GLU, HFPA, LIPID- Patient Fasting

Diagnostic Report

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	1380801264	10/27/1970	M	34 Y	926-3062		
PHYSICIAN	COLLECT DATE & TIME	DATE OF SERVICE			REQUISITION NO.	STATUS	PAGE
HOWARD ASHBY MD	10/20/2005 08:15	10/20/2005			743377	Final	1

COMMENTS: H52217:AHEMP2 , ATDIF2, HFPA; GLU, LIPID- FASTING; VALP- LD @2200 10/19/05

Diagnostic Procedure	Result	Flag	Units	Reference Range	Lab
Glucose					
For additional diagnostic criteria, see our Test Directory at www.paml.com					
Hepatic Function Panel					
Protein, Total			g/dL		
Albumin	4.5		g/dL	3.5-5.0	01
Bilirubin, Total			mg/dL		
Bilirubin, Direct	0.1		mg/dL	0.0-0.4	01
Alkaline Phosphatase			U/L		
AST	21		U/L	5-40	01
ALT			U/L		
Lipid Profile					
Cholesterol	156		mg/dL	<200	01
Triglycerides			mg/dL		
HDL	35	L	mg/dL	>39	01
<40: Low 40 to 59: Normal >59: High HDL Cholesterol greater than or equal to 60 mg/dL is considered a "negative" risk factor, serving to remove one risk factor from the total count.					
LDL (Calculated)			mg/dL		
The LDL goal varies from 70 to 160 depending on the clinical risk category. For specific risk assessment criteria, see our test directory at (www.paml.com).					
Valproic Acid			ug/mL		
Toxic >150 ug/mL					
Hemogram with Plt					
White Blood Cells			K/uL		
Red Blood Cells	5.07		M/uL	4.30-5.70	17
Hemoglobin			g/dL		
Hematocrit	45.6		%	40.0-50.0	17
MCV			fL		
MCH	30.1		pg	27.0-34.0	17
MCHC			g/dL		
RDW	13.2		%	11.0-15.0	17
Platelets			K/uL		
Differential					
Differential Type	Automated				17
Neutrophils	50.4		%	40.0-80.0	17
Lymphocytes	36.1		%	15.0-45.0	17
Monocytes	9.7		%	0.0-12.0	17
Eosinophils	3.5		%	0.0-7.0	17
Basophils	0.3		%	0.0-2.0	17
Neutrophils, Absolute	2.72		K/uL	2.00-7.30	17
Lymphocytes, Absolute	1.95		K/uL	1.00-3.40	17

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	1380801264	10/27/1970	M	34 Y	926-3062		
PHYSICIAN	COLLECT DATE & TIME		DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE
HOWARD ASHBY MD	10/20/2005 08:15		10/20/2005		743377	Final	2

COMMENTS: H52217:AHEMP2 , ATDIF2, HFPA; GLU, LIPID- FASTING; VALP- LD @2200 10/19/05

Diagnostic Procedure	Result	Out of Range	Units	Reference Range	Site
Monocytes, Absolute	0.52		K/uL	0.00-0.80	17
Eosinophils, Absolute	0.01		K/uL	0.00-0.50	17
Basophils, Absolute	0.01		K/uL	0.00-0.10	17

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	1353601259	10/27/1970	M	34 Y	509-926-3062		
PHYSICIAN	COLLECT DATE & TIME		DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE
HOWARD ASHBY MD	01/21/2005 08:52		01/21/2005		510260	Final	1

COMMENTS: F36637:AHEMP2 , AMDIF2, AMY, HFPA, LIPID, VALP; GLU- 14HRSPP

Reported 1/25/05

Test	Result	Flag	Units	Reference Interval	Lab
Glucose	99		mg/dL	65-99	01

0 to 2 days premature 30 to 80 mg/dL
0 to 2 days full term 40 to 90 mg/dL
2 days to 1 month 60 to 105 mg/dL
Adults 65 to 99
ADA diagnostic categories for nonpregnant adults:
Impaired fasting glucose: 100 to 125 mg/dL.
A fasting glucose result of 126 mg/dL or greater indicates diabetes if the abnormality is confirmed on a subsequent day.
A random glucose result of greater than 200 mg/dL indicates diabetes if the abnormality is confirmed on a subsequent day.

Hepatic Function Panel

Test	Result	Flag	Units	Reference Interval	Lab
Albumin	4.8		g/dL	3.5-5.0	01
Bilirubin, Direct	0.2		mg/dL	0.0-0.4	01
AST	20		U/L	5-40	01

Lipid Profile

Test	Result	Flag	Units	Reference Interval	Lab
Cholesterol	185		mg/dL	<200	01

<200: Desirable
200 to 239: Borderline high
>239: High

Test	Result	Flag	Units	Reference Interval	Lab
Triglycerides	153	H	mg/dL	<150	01

<150: Normal
150 to 199: Borderline High
200 to 499: High
>499: Very High

<40: Low
40 to 59: Normal
>59: High
HDL Cholesterol greater than or equal to 60 mg/dL is considered a "negative" risk factor, serving to remove one risk factor from the total count.

Test	Result	Flag	Units	Reference Interval	Lab
LDL [Calculated]	120	H	mg/dL	<100	01

<100: Optimal
100 to 129: Near or above optimal
130 to 159: Borderline High
160 to 189: High
>189: Very High
To calculate 10 year cardiac risk for this patient, go to http://www.paml.com. Click on Testing, then on Ranges/Algorithms and then on Lipid Results.

Continued on next page

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	1353601259	10/27/1970	M	34 Y	509-926-3062		
PHYSICIAN	COLLECT DATE & TIME		DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE
HOWARD ASHBY MD	01/21/2005 08:52		01/21/2005		510260	Final	2

COMMENTS: F36637:AHEMP2 , AMDIF2, AMY, HFPA, LIPID, VALP; GLU- 14HRSPP

Hemogram with Plt						
White Blood Cells	5.7			K/uL	4.0-11.0	17
Hemoglobin	16.7			g/dL	13.7-16.7	17
MCV	90.3			fL	80.0-100.0	17
MCHC	34.0			g/dL	32.0-35.5	17
Platelets	182			K/uL	150-400	17
Differential, Manual						
Bands	6.0			%	0-8	17
Monocytes		13.0	H	%	3-11	17
Basophils	1.0			%	0-2	17
Bands, Absolute		0.34	H	K/uL	0.00-0.24	17
Monocytes, Absolute	0.74			K/uL	0.00-0.80	17
Basophils, Absolute	0.06			K/uL	0.00-0.20	17
WBC Morphology	Normal					17
No. of Cells in Diff	100					17

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	518801366	10/27/1970	M	33 Y	509-926-3062		
PHYSICIAN	COLLECT DATE & TIME		DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE
HOWARD ASHBY MD	03/10/2004 12:51		03/10/2004		126434	Final	1

COMMENTS: W15964:AHEMP2 , AMDIF2, HFPA; VALP- 10; VALP- 04 @ 0700; VALP- LD: 03

3/11/04
Lv. TT Mgmd & pt
on 3/15 appt.

Diagnostic Procedures	Result		Units	Reference Range	Lab
Hepatic Function Panel					
Albumin	4.6		g/dL	3.5-5.0	01
Bilirubin, Direct	0.1		mg/dL	0.0-0.4	01
AST	14		U/L	5-40	01
Valproic Acid	109	H	ug/mL	50-100	01
Toxic >150 ug/mL					
Hemogram with Plt					
White Blood Cells	5.5		K/uL	4.0-11.0	17
Hemoglobin	15.8		g/dL	13.7-16.7	17
MCV	90.3		fL	80.0-100.0	17
MCHC	33.9		g/dL	32.0-35.5	17
Platelets	222		K/uL	150-400	17
Differential, Manual					
Bands	1.0		%	0-8	17
Lymphocytes	27.0		%	21-49	17
Eosinophils	4.0		%	0-7	17
Segs, Absolute	3.25		K/uL	1.80-7.70	17
Lymphocytes, Absolute	1.49		K/uL	1.00-5.00	17
Eosinophils, Absolute	0.22		K/uL	0.00-0.50	17
RBC Morphology	Normal				17
Platelet Morphology	Adequate				17

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	518801366	10/27/1970	M	32 Y	509-926-3062		
PHYSICIAN	COLLECT DATE & TIME		DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE
HOWARD ASHBY MD	04/30/2003 08:30		04/30/2003		961063	Final	1

COMMENTS: W53947:AHEMP2 , AMDIF2, AMY, HFPA; VALP- LD 04/29/03 @ 1900

Hepatic Function Panel						
Protein, Total	7.1		g/dL	6.3-8.0	01	
Bilirubin, Total	0.4		mg/dL	0.1-1.5	01	
Alkaline Phosphatase	50		U/L	38-110	01	
ALT	17		U/L	5-50	01	
Hemogram with Plt						
White Blood Cells	4.8		K/uL	4.0-11.0	17	
Hemoglobin	15.6		g/dL	13.7-16.7	17	
MCV	89.9		fL	80.0-100.0	17	
MCHC	33.9		g/dL	32.0-35.5	17	
Platelets	173		K/uL	150-400	17	
Differential, Manual						
Metamyelocytes	1.0	H	%	0	17	
Monocytes	8.0		%	3-11	17	
Segs, Absolute	2.78		K/uL	1.80-7.70	17	
Monocytes, Absolute	0.38		K/uL	0.00-0.80	17	
RBC Morphology	Normal				17	
Platelet Morphology	Adequate				17	

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PATIENT NAME	PATIENT ID	DOB	SEX		PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN	518801366	10/27/1970	M		926-3052		
PHYSICIAN	COLLECT DATE & TIME		DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE
HOWARD ASHBY MD	06/04/2002 08:20		06/04/2002		671104	Final	1

COMMENTS: T26672:AHEMP2 , AMDIF2, AMY, HFPA; VALP- 03; VALP- 02/2000; VALP- LD=06

Name of Procedure	Result	Flag	Units	Reference Interval	Lab
Hepatic Function Panel					
Protein, Total	7.3		g/dL	6.3-8.0	17
Bilirubin, Total	0.8		mg/dL	0.1-1.5	17
Alkaline Phosphatase	52		U/L	38-110	17
ALT	19		U/L	5-50	17
Hemogram with Plt					
WBC	6.3		K/uL	4.0-11.0	17
HGB	16.7		g/dL	13.7-16.7	17
MCV	89.6		fL	80.0-100.0	17
MCHC	33.8		g/dL	32.0-35.5	17
PLT	176		K/uL	150-400	17
Differential, Manual					
Lymphocytes	34.0		%	21-49	17
Eosinophils	7.0		%	0-7	17
Segs, Absolute	3.2		K/uL	1.8-7.7	17
Monocytes, Absolute	0.5		K/uL	0-0.8	17
Basophils, Absolute	0.1		K/uL	0-0.2	17
WBC Morphology	Normal				17
No. of Cells in Diff	100				17

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6/5/02
BA.

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SPOKANE, WA 1-800-541-7891/1-509-926-2400

THOMAS J. ALLEKOTTE
MEDICAL DIRECTOR

FINAL REPORT

PATIENT	SEX	AGE	DOCTOR	DATE RECEIVED / DATE REPORTED	LABORATORY #
DEMEERLEER, JAN R	M	50	HOWARD ASHBY MD	09/21/01	7493

PATIENT PHONE: 926-3062
(DOB: 7/5/51 SS#: 531-60-3066)

09/22/01

REQUESTS: HEPA VALPROIC COUMAN DRAW

COLLECTED 09/21/01 0830

COMMENTS: LD=9-20-01/2100

CHEMISTRY — J DEMEERLEER 09/21/01

Diagnostic Procedure	Result Low	Result Normal	Result High	Reference Range		REF LAB
Glucose, Fasting				ADULT 65-109 mg/dL; PREGNANT ADULT 65-104 mg/dL		
BUN				7-23	mg/dL	
Creatinine				M 0.7-1.5 F 0.6-1.2	mg/dL	
Uric Acid				M 3.1-8.1 F 2.0-6.7	mg/dL	
Calcium				8.5-10.5	mg/dL	
Phosphorus				2.5-4.8	mg/dL	
Magnesium				1.5-2.4	mg/dL	
Cholesterol				LT 200	mg/dL	
Triglyceride				LT 200	mg/dL	
Total Protein		7.0		6.3-8.0	g/dL	L7
Albumin		4.4		3.5-5.0	g/dL	L7
Globulin				1.8-3.5	g/dL	
A/G Ratio				1.1-2.2		
Total Bilirubin		0.7		0.1-1.5	mg/dL	L7
Direct Bilirubin		<0.1		0-0.4	mg/dL	L7
Indirect Bilirubin				0.3-1.0	mg/dL	
Alkaline Phosphatase		49		Adult 38-110 Child Up to 382	U/L	L7
AST (SGOT)		29		5-40	U/L	L7
ALT (SGPT)		22		5-50	U/L	L7
GGT				5-65	U/L	
LD (LDH)				100-200	U/L	
CK (CPK)				M 25-287 F 20-200	U/L	
Sodium				135-145	mmol/L	
Potassium				3.5-5.0	mmol/L	
Chloride				98-109	mmol/L	
CO_2				22-29	mmol/L	
Iron (Total)				M 35-180 F 30-150	ug/dL	
Iron Binding Capacity				M 230-430 F 250-450	ug/dL	
% Iron Saturation				M 20-55 F 15-50	%	

HEMATOLOGY — J DEMEERLEER 09/21/01

Diagnostic Procedure	Result Low	Result Normal	Result High	Reference Range		REF LAB
WBC		4.4		4-11	K/cL	
RBC		2.48		M 4.3-6.7 F 3.8-5.2	M/uL	
Hemoglobin		L6.3		M 13.7-18.7 F 11.5-15.5	g/dL	
Hematocrit		48.2		M 40-50 F 36-48	%	
MCV		97.9		80-100	fL	
MCH		29.7		27-34	pg	
MCHC		33.7		32.0-35.5	g/dL	
RDW		L2.4		11-15	%	
MPV				7-11.5	fL	

DIFFERENTIAL

Diagnostic Procedure	Result Normal	Reference Range		REF LAB
Granulocytes	47.0	38-70	%	
Lymphocytes	34.0	21-49	%	
Monocytes	9.0	3-11	%	
Eosinophils	L.0	0-7	%	
Basophils	L.0	0-2	%	
Platelet Count	L70	150-400	K/uL	
Morphology	SEE BELOW	Normal		

URINALYSIS — J DEMEERLEER 09/21/01

Diagnostic Procedure	Normal	Abnormal	NORMAL	REF LAB
Specific Gravity			1.001-1.030	
Leukocyte Esterase			Negative	
Nitrite			Negative	
pH			5.0-7.5	
Protein			Negative	
Glucose			Less than 25 mg/dL	
Ketone			Negative	
Urobilinogen			< = 1.0 mg/dL	
Bilirubin			Negative	
Occult Blood			Negative	
Microscopic				

Other Diagnostic Procedures	Result (#)	Units	Reference Range	LT = Less Than GT = Greater Than	REF LAB
Comment for - Normal	NoC morph				
VALPROIC ACID (PEAK OR TROUGH)	92	ug/mL	50-100		01
Variant Lymph, %	4.0	%	0-0		L7
Seg, Abs	2.1	K/uL	1.6-7.7		L7
Lymph, Abs	1.7	K/uL	1.0-3.0		L7
Variant Lymph, Abs	0.2	K/uL			L7
Mono, Abs	0.4	K/uL	0-0.8		L7
Eos, Abs	0.0	K/uL	0-0.5		L7
Baso, Abs	0.0	K/uL	0-0.2		L7
ABC morph	Normal				L7
Platelet Morph	Adequate				L7
Cells Counted	100				L7

500mg bid

OK called 4:45 9/24 left message on machine please repeat

00067

DEMEERLEER, JAN R — * INDICATES RESULT OUTSIDE NORMAL LIMITS — REORDER #0511

[redacted] Pain started Sunday 1/1, no pain Thurs 1/5
appt w/
Dr Reuter
1/19 - Thurs 6pm - started period. 1 wk.
~~Pain in (L) ovary for past week + half~~
1/28 - started period. short

Pain (L) ovary from 1/12 → 1/30

Mood Cycle Chart
Year 2001

		Level	January	February	March	April	May	June	July	August	September	October	November	December
MANIA	Severe	10												
	Moderate	5												
	Mild	2									2			
"WELL"	Normal	0	0							0				
	Mild	-2				-2				-2				
DEPRESSION	Moderate	-5								-5				
	Severe	-10							-10					
	Much	12								11				
	More than usual	10							10					
SLEEP LEVEL	Normal	8		7		??	??							
	Less than usual	6	6	6				6						
	Little	4		4	3									
	Very High	5			5	5								
	Increased	2		2			3							
ACTIVITY LEVEL	Normal	0		0				0						
	Slowed	-2	-2						-2					
	Very Low	-5								-5				
LIFE EVENTS	Deadlines		Lexmark Reynosa		Basement project		Comforter, bar glasses							
	Overworked / overloaded				Large number of quotes at work ("Cold Fusion")									
	Spouse/child disturbances					Hawaii trip failed/Victoria rain								
STRESS EVENTS	Mild "Loss"								No rafting/hiking					
	Moderate "Loss"					10% pay cut at work			Push out wife, kid, house					
	Severe "Loss"				GEA program loss		Pete Lavalle fired		Quit job; death thoughts					
	Increased	5			5		5							
SEXUAL ACTIVITY	Normal	0	0	1		2		2		0				
	Decreased	-5							-2					
MEDICATIONS	Alcohol		Increased while travelling					Increased to evenings & weekends @ 5						
	Lithium													
	Depakote													
	Other													

Mood Cycle Chart
Year 2000

		Level	January	February	March	April	May	June	July	August	September	October	November	December
MANIA	Severe	10												
	Moderate	5												
	Mild	2												
"WELL"	Normal	0												
	Mild	-2												
DEPRESSION	Moderate	-5												
	Severe	-10												
	Much	12												
	More than usual	10												
SLEEP LEVEL	Normal	8												
	Less than usual	6												
	Little	4												
	Very High	5												
	Increased	2												
ACTIVITY LEVEL	Normal	0												
	Slowed	-2												
	Very Low	-5												

LIFE EVENTS	Deadlines					Move to Spokane							Start GEA quoting	
	Overworked / overloaded		New career move announced			Start new job						Long work hours in Mexico		
	Spouse/child disturbances					New furniture purchases							Baby born	
STRESS EVENTS	Mild "Loss"					Argue baby stuff (new ideas)			Purchase Chevy truck			Chevy 4X4 problems: trans/ fuel pump		
	Moderate "Loss"											New ski gear		
	Severe "Loss"													

	Increased	5												
SEXUAL ACTIVITY	Normal	0												
	Decreased	-5												

MEDICATIONS	Alcohol													
	Lithium													
	Depakote													
	Other													

Mood Cycle Chart
Year 1999

		Level	January	February	March	April	May	June	July	August	September	October	November	December
MANIA	Severe	10												
	Moderate	5			5								5	5
	Mild	2			2	2						2		2
"WELL"	Normal	0		0			0	0			0			
	Mild	-2	-2						-2	-2				
DEPRESSION	Moderate	-5												
	Severe	-10												
SLEEP LEVEL	Much	12												
	More than usual	10												
	Normal	8												
	Less than usual	6												
	Little	4												
ACTIVITY LEVEL	Very High	5												
	Increased	2												
	Normal	0												
	Slowed	-2												
	Very Low	-5												
LIFE EVENTS	Deadlines								Sell/give away Olds					
	Overworked / overloaded			RCA ghetto blaster										
	Spouse/child disturbances						Weekend with Eskridges at parents				Elk hunting trip.		New amplifier & receiver	
STRESS EVENTS	Mild "Loss"													
	Moderate "Loss"				Teaching Stef math (blow-up)									
	Severe "Loss"													
SEXUAL ACTIVITY	Increased	5												
	Normal	0												
	Decreased	-5												
MEDICATIONS	Alcohol													
	Lithium													
	Depakote		750 mg daily	750 mg daily	750 mg daily	750 mg daily	750 mg daily	750 mg daily	750 mg daily					
	Other													

Mood Cycle Chart
Year 1998

		Level	January	February	March	April	May	June	July	August	September	October	November	December
MANIA	Severe	10										10		
	Moderate	5									5	5		
	Mild	2								2	2		2	
"WELL"	Normal	0	0				0		0				0	
	Mild	-2						-2						-2
DEPRESSION	Moderate	-5												
	Severe	-10												
	Much	12												
	More than usual	10												
SLEEP LEVEL	Normal	8												
	Less than usual	6												
	Little	4												
	Very High	5												
	Increased	2												
ACTIVITY LEVEL	Normal	0												
	Slowed	-2												
	Very Low	-5												
LIFE EVENTS	Deadlines											Furniture purchases		
	Overworked / overloaded			More furniture purchases					Workbench, Nissan stereo			Home stereo speakers		
	Spouse/child disturbances		Sharon Cheney visit (1st)		Gene visit (1st)					Kara Cheney wedding		Crystal wine glasses		
STRESS EVENTS	Mild "Loss"													
	Moderate "Loss"													
	Severe "Loss"													
	Increased	5												
SEXUAL ACTIVITY	Normal	0												
	Decreased	-5												
MEDICATIONS	Alcohol													
	Lithium													
	Depakote		750 mg daily	750 mg daily	750 mg daily	750 mg daily	750 mg daily	750 mg daily	750 mg daily	750 mg daily				
	Other													

Mood Cycle Chart
Year 1997

		Level	January	February	March	April	May	June	July	August	September	October	November	December
MANIA	Severe	10												
	Moderate	5												
	Mild	2									2	2		
"WELL"	Normal	0							0	0			0	0
	Mild	-2												
DEPRESSION	Moderate	-5												
	Severe	-10												
	Much	12												
	More than usual	10												
SLEEP LEVEL	Normal	8												
	Less than usual	6												
	Little	4												
	Very High	5												
	Increased	2												
ACTIVITY LEVEL	Normal	0												
	Slowed	-2												
	Very Low	-5												
LIFE EVENTS	Deadlines													
	Overworked / overloaded					2nd anniverary			Family reunion trip		Gauley River raft/Olds bury			
	Spouse/child disturbances					Strange allergic reaction					Complete landscpaing			
STRESS EVENTS	Mild "Loss"		Olds timing chain			Laura Hessler leave Lexmark								
	Moderate "Loss"													
	Severe "Loss"					Death thoughts/leave wife								
	Increased	5												
SEXUAL ACTIVITY	Normal	0												
	Decreased	-5												
MEDICATIONS	Alcohol													
	Lithium													
	Depakote						750 mg daily	750 mg daily	750 mg daily	750 mg daily	750 mg daily	750 mg daily	750 mg daily	750 mg daily
	Other													

Mood Cycle Chart
Year 1996

		Level	January	February	March	April	May	June	July	August	September	October	November	December
MANIA	Severe	10												
	Moderate	5									5			
	Mild	2								2		2		
"WELL"	Normal	0		0					0				0	0
	Mild	-2	-2			-2		-2						
DEPRESSION	Moderate	-5				-5	-5							
	Severe	-10												
SLEEP LEVEL	Much	12												
	More than usual	10												
	Normal	8												
	Less than usual	6												
	Little	4												
ACTIVITY LEVEL	Very High	5												
	Increased	2												
	Normal	0												
	Slowed	-2												
	Very Low	-5												
LIFE EVENTS	Deadlines		Move-in house											
	Overworked / overloaded									Maxwell heavy work schedule				
	Spouse/child disturbances					Wedding/bachelor party failure					Stereo system pruchase			
STRESS EVENTS	Mild "Loss"						Tornado							
	Moderate "Loss"			Furnace broke										
	Severe "Loss"													
SEXUAL ACTIVITY	Increased	5												
	Normal	0												
	Decreased	-5												
MEDICATIONS	Alcohol													
	Lithium													
	Depakote													
	Other													

Mood Cycle Chart
Year 1995

		Level	January	February	March	April	May	June	July	August	September	October	November	December
MANIA	Severe	10												
	Moderate	5	5											
	Mild	2		2					2	2				
"WELL"	Normal	0					0	0			0			
	Mild	-2			-2	-2						-2		
DEPRESSION	Moderate	-5											-5	-5
	Severe	-10												
SLEEP LEVEL	Much	12												
	More than usual	10												
	Normal	8												
	Less than usual	6												
	Little	4												
ACTIVITY LEVEL	Very High	5												
	Increased	2												
	Normal	0												
	Slowed	-2												
	Very Low	-5												
LIFE EVENTS	Deadlines													Buy house
	Overworked / overloaded		New job (1st job)		Darrin in Lexington					Gauley River raft				
	Spouse/child disturbances											Broke TV in rage ...Olds transmission		
STRESS EVENTS	Mild "Loss"													
	Moderate "Loss"													
	Severe "Loss"													
SEXUAL ACTIVITY	Increased	5												
	Normal	0												
	Decreased	-5												
MEDICATIONS	Alcohol													
	Lithium													
	Depakote													
	Other													

SAFETY NETWORK

for Jan DeMeerleer Updated 9/8/04

	Contact Name	Relationship to Jan	Phone Number	Email Address	Residence / Mailing Address
1	Howard Ashby	Psychiatrist	[Business] (509) 455-9090	N/A	(Office) 105 W. 8th Street, Suite 6055 Spokane, WA 99204
2	Amy DeMeerleer	Wife	[Home] (509) 926-3062	RAFTFROG@MSN.COM CHINCHILLAFUN@HOTMAIL.COM	8324 E. Briant Lane Spokane, WA 99217
3	Gena Leonard	Mother	[Home] (503) 640-6779	GENALEO@YAHOO.COM	2945 SE Cedar Drive Hillsboro, OR 97123
4	Robert Leonard	Step-father (with Gena)	[Home] (503) 640-6779	GENALEO@YAHOO.COM	2945 SE Cedar Drive Hillsboro, OR 97123
5	Jim DeMeerleer	Father	[Home] (208) 882-2755	DELLAZENE@MOSCOW.COM	2463 Herrington Road Moscow, ID 83843
6	Trudy DeMeerleer	Step-mother (with Jim)	[Home] (208) 882-2755	DELLAZENE@MOSCOW.COM	2463 Herrington Road Moscow, ID 83843
7	George Wray	Father in-law (Amy's dad)	[Home] (208) 882-7132	GTWRAY@UIDAHO.EDU	301 N. Polk Street Moscow, ID 83843
8	Gleanne Wray	Mother in-law (Amy's mom)	[Home] (208) 882-7132	GLEANNE@UIDAHO.EDU	301 N. Polk Street Moscow, ID 83843
9	Jenny Schweitzer	Sister	[Home] (509) 926-7149	ELKNRUT@AOL.COM	1020 N. Drury Court Liberty Lake, WA 99019
10	Jon Schweitzer	Brother in-law (with Jenny)	[Home] (509) 926-7149	ELKNRUT@AOL.COM	1020 N. Drury Court Liberty Lake, WA 99019
11	Gene DeMeerleer	Brother	[Home] (541) 568-4891	THEKING.REDHEAD@VERIZON.NET	1805 Jasper Street Cove, OR 97824
12	Velma	Sister in-law (with Gene)	[Home] (541) 568-4891	THEKING.REDHEAD@VERIZON.NET	1805 Jasper Street Cove, OR 97824
13	Maxwell Eng	Friend since 1987	[Home] (503) 617-6682	ENGBOILERS@HOME.COM	17094 NW Stoller Drive Portland, OR 97229
14	Darrin Oliver	Friend since 1992	[Cellular] (859) 312-0524	DOLIVER1@PRODIGY.NET	1475 N. Highview Lane, Apt. #108 Alexandria, VA 22311
15	Stefanie Boggs	Friend since 1995	[Home] (859) 289-6624	S.P.BOGGS@ATT.NET	426 N. Elm Street Carlisle, KY 40311
16					
17					
18					
19					
20					
21					
22					

Jan's "Manic Depre_ _ion"
Symptom List and Personal Examples

NOTE: Episodes of mania or depression must last at least 2 weeks persistently

MANIA or HYPOMANIA

CLINICAL SYMPTOMS	PERSONAL EXPERIENCES
1 Distinct period of abnormally and persistantly elevated, expansive, or irritable mood.	March-April 2001 work on basement, GE Appliances quoting at work, arguments with VPs at KeyTronic.
2 Inflated self-esteem or grandiosity such that ideas of one's capabilities are exaggerated.	Given codename "Cold Fusion" at KeyTronic because in series of meetings I insisted management to consider me an "unlimited resource."
3 Decreased need for sleep (rested after only 3 hrs).	Wanted to work on basement until 2am and then awoke at 5am While in Mexico, averaged 2 hours sleep per night, worked 15+ hr days.
4 More talkative than usual or pressure to keep talking or pressured, rapid speech.	Consistently told at work to let customer or let management speak. Told by many that I did not respect others because I wanted to interrupt with my ideas and not listen to their ideas or thoughts.
5 Flight of ideas or subjective experience that thoughts are racing such that thought patterns may be difficult for others to follow.	Team at work could not follow my "plans" for quoting GE Appliances. Manager ended arguments with me by repeatedly saying "I just can't follow your thoughts!"
6 Distractibility where attention is too easily drawn to unimportant or irrelevant external stimuli.	Basement project difficult to focus on one item at a time because I was thinking about framing then electrical then sheet rock then dust containment then heating of the basement then chinchilla cage then terrarium then ...
7 Increase in goal-oriented activity (socially, work, school, or sexually) or psychomotor agitation.	Had to qualify new products in Mexico by March 2001 when no one else (not even customer) shared same deadline. Had to land large account (GE Appliances) regardless of cost. Had to finish basement before Easter 2001.
8 Excessive involvement in pleasurable activities which have a high potential for painful consequences, such as engaging in unrestrained buying sprees, sexual indiscretions, foolish business investments (loss of self-control, reckless, impulsive, loss of good judgement).	Basement project fueled spending "needs." Purchased lights, ceiling fans, wood trim (finish material) before framing started. Feel liberated to purchase stereo equipment (now have multiple home stereo systems). Drive recklessly, fast and taking many chances.
9 Mood disturbance sufficiently severe to cause a marked impairment in occupational functioning or in unusual social activities or relationships with others (or to necessitate hospitalization to avoid harm).	Before I resigned, a series of meetings with my manager from April through June 2001 openly discussed my varying work performance, which was marked as insufficient (as well as insubordinate behavior).
10 Never have there been delusions or hallucinations for as long as 2 weeks in the absence of prominent mood symptoms (if delusions or hallucinations do occur than schizophrenia may be prominent)	None to my knowledge.
11 No organic factor has initiated and maintained the disturbance in mood.	No drugs, thyroid disfunction, diabetes, cancers, temporal lobe epilepsy, or other known neurological or blood diseases.
12 Paranoid, or other delusional and psychotic thinking in the manic state	Some thoughts/feelings that everyone around me are idiots and that my purpose is to show the world what humans are really capable of doing!

Jan's "Manic Depre ion"
Symptom List and Personal Examples

NOTE: Episodes of mania or depression must last at least 2 weeks persistently.

DEPRESSION

	CLINICAL SYMPTOMS	PERSONAL EXPERIENCE
1	Depressed or irritable mood most of the day.	June-July 2001 was unhappy day-in and day-out.
2	Markedly diminished interest or pleasure in all, or almost all, activities most of the day.	As Amy repeatably said, I get no pleasure from anything. Every hour was a torture of being...grey was the color or everything. Food did not taste anything more than bland.
3	Significant weight loss when not dieting or weight gain, or decrease or increase in appetite.	Unknown....
4	Insomnia or hypersomnia.	Desired to sleep during work, after work, late in morning. However, would wake up early in morning (classic symptoms!)
5	Psychomotor agitation or retardation.	Ability to process information at work nearly stopped. Spent ~3 hours writing one email message, avoiding phones and meetings. Could not understand simple conversations; required to revist many times.
6	Fatigue or loss of energy.	Totally exhausted after a day of work.
7	Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) and is not merely self-reproach or guilt about being sick.	Knew my reign of "Cold Fusion" has ended at work...failure in my career. Inevitable that all customer accounts I managed would erode. Guilt that I had dragged Amy down with my career; wanted her to leave me. Too worthless to know how to fix stairwell wall in basement.
8	Dimished ability to think or concentrate, or indecisiveness.	Could not make a good "To Do" list and execute to it. Near complete shut-down of basic math and English skills.
9	Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.	Detailed plan to pack camping gear in truck, get $900 in cash, drive north into Canada (so police cannot track me), and go die. Irritated that Val was keeping me in Spokane; thoughts of killing her.
10	No organic factor has initiated and maintained the distubance in mood.	No drugs, thyroid disfunction, diabetes, cancers, temporal lobe epilepsy, or other known neurological or blood diseases.
11	The disturbance is not a normal reaction to the death of a loved one (uncomplicated bereavement).	No recent deaths.
12	Physical aches and pains (headaches, stomach-aches)	None known during severe depression.

9.24.03

PREMERA BLUE CROSS

PPO

An Independent Licensee of the Blue Cross Blue Shield Association

Member

JAN R. DEMEERLEER

Prefix Identification # Suffix

ZKR 100165987 01

Group # 1001588 BCBS 430

Medical HERITAGE PLUS 1

OFFICE VISIT COPAY $15

Rx Group # BCWAPDP

RETAIL RX $5/$15/$30 UP TO 30-DAY SUPPLY

MAIL-ORDER RX $12/$37/$75 UP TO 90-DAY SUPPLY

medcohealth BIN # 610014

Issued 08/01/2003

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I authorize: SPOKANE PSYCHIATRIC CLINIC, P.S.
105 W. 8th Avenue, Suite 6055
Spokane, Wa 99204

_____Release to and/or X Obtain from:

Dr. Platz
Individual, Facility, Hospital, or Organization

Lexington KY
Address City, State, Zip

Concerning myself or the following minor child:

Jan DeMeerleer 10-27-70
Name of patient Date of Birth

For the purpose of: X Continued Care ____Insurance Claim
____Personal ____Litigation ____Other_____

The following information to be disclosed:
____Discharge Summary X Progress Notes ____Psychological Testing
____Social History ____Assessments X Psychiatric Evaluation
____Consultations ____Lab Findings ____History & Physical
____Other_____

This consent includes authorization to release alcohol, drug abuse and mental health records obtained in the course of diagnosis and treatment. I understand that I may revoke this consent at any time except to the extend the action has already been taken in reliance hereon and if not revoked sooner in writing.

TO THE RECEIVING PARTY - This information has been disclosed to you for the sole purpose stated in this consent. Any other use is prohibited.

Jan DeMeerleer 9/13/01
Patient Signature Date

_____ _____
Parent or guardian signature Date

_____ 9/13/01
Witness Signature Date

file_____ send out_____ date sent out_____

Spokane Psychiatric Clinic, P.S.
(509) 455-9090
(509) 747-2118 (FAX)

Mark Chalem, M.D.
Howard Ashby, M.D.
David Grubb, M.D.
David Bot, M.D.
Jay Schmauch, D.O.
Rod Peterson, M.D.

FAXED
JUN 28 2011
PAGE ___ OF ___

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Date: 6/28/11

To: PRMS (Attn Denita)

Fax: 1-703-276-6742

From: Howard B. Ashby M.D.

Total Number of Pages including cover sheet 3

Comments:

Faxto - PRMS
Fax # 703-276-6742
Attn Denita

- Respond ?
- Thursday - last day 6/30. 6/29 ?

claims adj: Rashaan Evans
- Communicate after ?
the

o no receive all pag
55-9090
47-2118

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

CERTIFICATE NUMBER: 2010-007135

DATE ISSUED: 07/21/2010

FEE NUMBER: 0003208063

GIVEN NAMES: JAN RICHARD
LAST NAME: DEMEERLEER

COUNTY OF DEATH: SPOKANE
DATE OF DEATH: JULY 18,2010
HOUR OF DEATH: 03:15 A.M.
SEX: MALE
AGE: 39 YEARS
SOCIAL SECURITY NUMBER: 518-80-1366

HISPANIC ORIGIN: NO, NOT HISPANIC
RACE: WHITE

BIRTHDATE: OCTOBER 27,1970
BIRTHPLACE: MOSCOW, IDAHO

MARITAL STATUS: DIVORCED
SPOUSE:

OCCUPATION: PROJECT MANAGER
INDUSTRY: ENGINEERING
EDUCATION: BACHELOR'S DEGREE
US ARMED FORCES? NO

INFORMANT: JAMES B. DEMEERLEER
RELATIONSHIP: FATHER
ADDRESS: 1055 HERINGTON RD., MOSCOW, IDAHO, 83843

PLACE OF DEATH: HOME
FACILITY OR ADDRESS: 8324 BRIANT LN.
CITY, STATE, ZIP: SPOKANE, WASHINGTON 99217

RESIDENCE STREET: 8324 E. BRIANT LN.
CITY, STATE, ZIP: SPOKANE, WASHINGTON 99217
INSIDE CITY LIMITS? YES
COUNTY: SPOKANE
TRIBAL RESERVATION: NOT APPLICABLE
LENGTH OF TIME AT RESIDENCE: 10 YEARS

FATHER: JAMES B. DEMEERLEER
MOTHER: EUGENIA J. WEBSTER

METHOD OF DISPOSITION: CREMATION
PLACE OF DISPOSITION: FOOTHILLS CREMATORY
CITY, STATE: SPOKANE, WA
DISPOSITION DATE: JULY 22,2010

FUNERAL FACILITY: SPOKANE CREMATION & BURIAL
ADDRESS: 2832 N. RUBY
CITY, STATE, ZIP: SPOKANE WA 99207
FUNERAL DIRECTOR: WILLIAM D ROSSEY

CAUSE OF DEATH:
A. PERFORATING GUNSHOT WOUND TO HEAD
INTERVAL: NOT STATED
B.
INTERVAL:
C.
INTERVAL:
D.
INTERVAL:

OTHER CONDITIONS CONTRIBUTING TO DEATH:

DATE OF INJURY: JULY 18,2010
HOUR OF INJURY: 03:15 A.M.
INJURY AT WORK? NO
PLACE OF INJURY: DECEDENT'S RESIDENCE

LOCATION OF INJURY: 8324 BRIANT LANE

CITY, STATE, ZIP: SPOKANE, WASHINGTON 99212
COUNTY: SPOKANE
DESCRIBE HOW INJURY OCCURRED:
SHOT SELF WITH GUN

STATUS OF DECEDENT, IF A TRANSPORTATION INJURY:
NOT APPLICABLE

MANNER OF DEATH: SUICIDE
AUTOPSY: YES
AVAILABLE TO COMPLETE THE CAUSE OF DEATH? YES
DID TOBACCO USE CONTRIBUTE TO DEATH? NO
PREGNANCY STATUS, IF FEMALE: NOT APPLICABLE

CERTIFIER NAME: SALLY S AIKEN
TITLE: MEDICAL EXAMINER
CERTIFIER
ADDRESS: 5901 N LIDGERWOOD, SUITE 248
CITY,STATE,ZIP: SPOKANE WA 99208
DATE SIGNED: JULY 20,2010

CASE REFERRED TO ME/CORONER: YES
FILE NUMBER: 10-1962
ATTENDING PHYSICIAN:
NOT APPLICABLE

ITEM(S) AMENDED: NONE

NUMBER(S): NONE
DATE(S): NONE

LOCAL DEPUTY REGISTRAR:
PEGGY J WEINORE
DATE RECEIVED: JULY 21,2010

DOH 01-003 (5/99)

THIS IS A CERTIFIED COPY OF THE RECORD ON FILE WITH CENTER FOR HEALTH STATISTICS. CERTIFIED COPIES MUST HAVE THE OFFICIAL SEAL

FILED

AUG 12 2010

THOMAS R. FALLQUIST
SPOKANE COUNTY CLERK

(Clerk's Date Stamp)

SUPERIOR COURT OF WASHINGTON, COUNTY OF SPOKANE

ESTATE OF:	CASE NO. 2010-04-01011-6
JAN DEMEERLEER, Deceased.	**LETTERS TESTAMENTARY** *(LTRTS)*

I. BASIS

1.1 The last will of the decedent(s), late of **Spokane County Washington** was exhibited, proven and recorded in this court on: **August 12, 2010**

1.2 In that will: **JAMES B. DEMEERLEER** is named personal representative.

1.3 The personal representative has qualified.

II. AUTHORIZATION

THIS CERTIFIES: **JAMES B. DEMEERLEER** is authorized by this court to execute the will of the above decedent according to law.

THOMAS R. FALLQUIST, SPOKANE COUNTY CLERK

Dated: August 12, 2010

By Ronelle Seymour,
Deputy Clerk

III. CERTIFICATE OF COPY

State of Washington)
County of Spokane)

As clerk of the superior court of this county, I certify that the above is a true and correct copy of the Letters Testamentary in the above-named case which was entered of record on: **August 12, 2010**

I further certify that these letters are now in full force and effect.

THOMAS R. FALLQUIST, SPOKANE COUNTY CLERK

Dated: **August 12, 2010**

By _____
Deputy Clerk

Spokane Psychiatric Clinic, P.S.
(509) 455-9090
(509) 747-2118 (FAX)

Mark Chalem, M.D.
Howard Ashby, M.D.
David Grubb, M.D.
David Bot, M.D.
Jay Schmauch, D.O.
Rod Peterson, M.D.

FAX
JUN 2 2011
PAGE ___ OF ___

Confidentiality Statement

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Date: 6/28/11

To: PRMS (Attn Denita)

Fax: 1-703-276-6242

From: Howard B. Ashby M.D.

Total Number of Pages including cover sheet 3

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AUG 12 2010

THOMAS R. FALLQUIST
SPOKANE COUNTY CLERK

(Clerk's Date Stamp)

SUPERIOR COURT OF WASHINGTON, COUNTY OF SPOKANE

ESTATE OF: [redacted] Deceased.	CASE NO. **2010-04-01011-6** **LETTERS TESTAMENTARY** *(LTRTS)*

I. BASIS

1.1 The last will of the decedent(s), late of **Spokane County Washington** was exhibited, proven and recorded in this court on: **August 12, 2010**

1.2 In that will: **JAMES B. DEMEERLEER** is named personal representative.

1.3 The personal representative has qualified.

II. AUTHORIZATION

THIS CERTIFIES: **JAMES B. DEMEERLEER** is authorized by this court to execute the will of the above decedent according to law.

THOMAS R. FALLQUIST, SPOKANE COUNTY CLERK

Dated: August 12, 2010

By Ronelle Seymour,
Deputy Clerk

III. CERTIFICATE OF COPY

State of Washington)
County of Spokane)

As clerk of the superior court of this county, I certify that the above is a true and correct copy of the Letters Testamentary in the above-named case which was entered of record on: **August 12, 2010**

I further certify that these letters are now in full force and effect.

THOMAS R. FALLQUIST, SPOKANE COUNTY CLERK

Dated: **August 12, 2010**

By _____
Deputy Clerk

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

CERTIFICATE NUMBER: 2010-007135

DATE ISSUED: 07/22/2010

FEE NUMBER: 0003208063

GIVEN NAMES: [redacted]
LAST NAME: [redacted]

COUNTY OF DEATH: SPOKANE
DATE OF DEATH: July 18,2010
HOUR OF DEATH: 03:15 A.M.
SEX: MALE
AGE: 39 YEARS
SOCIAL SECURITY NUMBER: 518-80-1366

HISPANIC ORIGIN: NO, NOT HISPANIC
RACE: WHITE

BIRTHDATE: OCTOBER 27,1970
BIRTHPLACE: MOSCOW, IDAHO

MARITAL STATUS: DIVORCED
SPOUSE:

OCCUPATION: PROJECT MANAGER
INDUSTRY: ENGINEERING
EDUCATION: BACHELOR'S DEGREE
US ARMED FORCES? NO

INFORMANT: JAMES B. DEMEERLEER
RELATIONSHIP: FATHER
ADDRESS: 1055 HERINGTON RD., MOSCOW, IDAHO, 83843

PLACE OF DEATH: HOME
FACILITY OR ADDRESS: 8324 BRIANT LN.
CITY, STATE, ZIP: SPOKANE, WASHINGTON 99217

RESIDENCE STREET: 8324 E. BRIANT LN.
CITY, STATE, ZIP: SPOKANE, WASHINGTON 99217
INSIDE CITY LIMITS? YES
COUNTY: SPOKANE
TRIBAL RESERVATION: NOT APPLICABLE
LENGTH OF TIME AT RESIDENCE: 10 YEARS

FATHER: JAMES B. DEMEERLEER
MOTHER: EUGENIA J. WEBSTER

METHOD OF DISPOSITION: CREMATION
PLACE OF DISPOSITION: FOOTHILLS CREMATORY
CITY, STATE: SPOKANE, WA
DISPOSITION DATE: JULY 22,2010

FUNERAL FACILITY: SPOKANE CREMATION & BURIAL
ADDRESS: 2832 N. RUBY
CITY, STATE, ZIP: SPOKANE WA 99207
FUNERAL DIRECTOR: WILLIAM D ROSSEY

CAUSE OF DEATH:
A. PERFORATING GUNSHOT WOUND TO HEAD
INTERVAL: NOT STATED
B.
INTERVAL:
C.
INTERVAL:
D.
INTERVAL:

OTHER CONDITIONS CONTRIBUTING TO DEATH:

DATE OF INJURY: July 18,2010
HOUR OF INJURY: 03:15 A.M.
INJURY AT WORK? NO
PLACE OF INJURY: DECEDENT'S RESIDENCE

LOCATION OF INJURY: 8324 BRIANT LANE

CITY, STATE, ZIP: SPOKANE, WASHINGTON 99212
COUNTY: SPOKANE
DESCRIBE HOW INJURY OCCURRED:
SHOT SELF WITH GUN

STATUS OF DECEDENT, IF A TRANSPORTATION INJURY:
NOT APPLICABLE

MANNER OF DEATH: SUICIDE
AUTOPSY: YES
AVAILABLE TO COMPLETE THE CAUSE OF DEATH? YES
DID TOBACCO USE CONTRIBUTE TO DEATH? NO
PREGNANCY STATUS, IF FEMALE: NOT APPLICABLE

CERTIFIER NAME: SALLY S AIKEN
TITLE: MEDICAL EXAMINER
CERTIFIER
ADDRESS: 5901 N LIDGERWOOD, SUITE 248
CITY,STATE,ZIP: SPOKANE WA 99208
DATE SIGNED: July 20,2010

CASE REFERRED TO ME/CORONER: YES
FILE NUMBER: 10-1962
ATTENDING PHYSICIAN:
NOT APPLICABLE

ITEM(S) AMENDED: NONE

NUMBER(S): NONE
DATE(S): NONE

LOCAL DEPUTY REGISTRAR:
PEGGY J WETMORE
DATE RECEIVED: July 21,2010

DOH 01-003 (5/99)

THIS IS A CERTIFIED COPY OF THE RECORD ON FILE WITH THE DEPARTMENT OF HEALTH. CERTIFIED COPIES MUST HAVE THE RAISED SEAL

Spokane Psychiatric Clinic, P.S.
(509) 455-9090
(509) 747-2118 (FAX)

Mark Chalem, M.D.
David Grubb, M.D.
David Bot, M.D.
Jay Schmauch, D.O.
Rod Peterson, M.D.
Leah Edlund, M.D.

Date: 1-17-12

To: Holly

Fax: 703-276-6742

From: Mark Chalem, MD

Total Number of Pages including cover sheet 3

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Fax (509) 747-2118

JAN 17 2012

ICHAEL J RICCELLI PS
Attorney At Law
A Professional Service Corporation

December 29, 2011

Hand Delivered

Mr. Mark Chalem, Registered Agent
Spokane Psychiatric Clinic, P.S.
105 W. 8th Ave., Suite 6055
Spokane, WA 99204

Howard Ashby, M.D.
c/o Spokane Psychiatric Clinic, P.S.
105 W. 8th Ave., Suite 6055
Spokane, WA 99204

NOTICE OF CLAIM
- AND -
REQUEST FOR MEDIATION
(RCW 7.70.110)

DISCLOSURE:

The undersigned, Michael J. Riccelli of Michael J. Riccelli PS, is the attorney for, and providing this notice and request on behalf of, Beverly R. Volk, as Guardian for Jack Alan Schiering, a minor, and as Personal Representative of the Estates of Philip Lee Schiering, and Rebecca Leigh Schiering, and the statutory beneficiaries thereof. The legal representations of Brian P. Winkler and of the Estate of Jan DeMeerleer, and all statutory beneficiaries thereof, have also authorized the undersigned to provide this notice and request, on their behalf. Collectively, the foregoing are referred to as "Claimants."

NOTICE:

Claimants hereby provide you notice of claims for damages resulting from the acts and omissions in healthcare which caused, variously: personal injury; substantial suffering and emotional distress; loss of consortium; destruction of the parent-child relationship; death; and resulting economic damages. Their claims arise from and relate to an incident on July 18, 2010 which took place in Spokane Valley, Washington. The incident involved Jan DeMeerleer (now deceased), who was then, and who had been for some time, a patient of Spokane Psychiatric Clinic, and its employee, ostensible employee and/or agent, Dr. Howard Ashby (collectively

400 S Jefferson St Ste 112 Spokane WA 99204-3144
Phone: (509) 323-1120 Fax: (509) 323-1122
E-mail: mjrps@mjrps.net

"Providers"). On that date, Jan DeMeerler verbally, and by action, assaulted Jack Alan Schiering (then a minor), Brian P. Winkler (a minor), Philip Lee Schiering (a minor), and their mother, Rebecca Leigh Schiering (collectively, hereinafter "the Victims"), causing variously: great bodily harm and injury, severe pain and suffering, and severe emotional distress, to Brian P. Winkler, Philip Lee Schiering and Rebecca Leigh Schiering; severe emotional distress to Jack Alan Schiering; death to Philip Lee Schiering and Rebecca Leigh Schiering; destruction of the parent-child relationship between Rebecca Leigh Schiering and her sons, Philip Lee Schiering, Jack Alan Schiering, and Brian P. Winkler; and substantial economic costs and loss to the estates of Rebecca Leigh Schiering and Philip Lee Schiering. Jan DeMeerleer subsequently committed suicide, prior to which he suffered severe emotional distress, and subsequent to which his child, Valerie DeMeerler, suffered severe emotional distress, and destruction of the parent-child relationship. Further, this resulted in economic costs and loss to the estate of Jan DeMeerler.

A review of certain medical records of Providers' clinical diagnosis and treatment of Jan DeMeerleer reveal that he was suffering from one or more severe psychological condition(s) or affect(s), and was, at the time of the incident, and had been, for several years previously, while under the care and treatment of Providers. These records also reveal that Jan DeMeerleer: was being treated by Providers with multiple psycothropic drugs; had previously attempted suicide; and while under the treatment of Providers, had, on multiple occasions, expressed suicidal and homicidal ideation. The claimants believe that under these circumstances, Providers breached one or more medical standards of care. These include, but are not limited to: failing to perform risk assessment on Jan DeMeerleer; failing to carefully monitor the efficacy and/or risk of prescription psychotropic drugs; failing to provide more appropriate treatment of Jan DeMeerleer under the circumstances; and failing to otherwise worn the Victims of risk of harm from Jan DeMeerler. You are further notified that claimants may institute related litigation in Spokane County Superior Court. Although the provisions of RCW 7.70.100(1) have been rendered inapplicable by the actions of the Washington Supreme Court, claimants do not anticipate initiating any related litigation for 90 days or more after receipt of this notice by the addresses/Providers.

Request for Mediation. This correspondence also constitutes a request for mediation of a dispute related to claims for damages resulting from the occurrence. This request for mediation is made pursuant to RCW 7.70.110, and it is the intent that the running of the statute of limitations, as provided in RCW 4.16.350, be tolled for one year. It is important that any addressee, their risk managers, insurers, representatives, or attorneys contact the undersigned immediately in order to establish whether any other individual health care professionals and/or entities should be given similar notice.

MICHAEL J RICCELLI PS

By: _____
Michael J. Riccelli

\\25701001\DRAFTS\Pleadings\notice of intent final.doc

SPOKANE PSYCHIATRIC CLINIC
105 W 8th Ave Ste 6055
Spokane, WA 99204-2312

PAML (509) 755-8600 (800) 541-7891 FAX (509) 924-0002
CLIENT SERVICES (509) 755-8999 FAX (509) 924-5127

PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN	10271970JD	10/27/1970	M	39 Y	5099440586	10271970JD	
PHYSICIAN	COLLECT DATE & TIME		DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE
ASHBY MD, HOWARD	04/13/2010 07:18		04/13/2010		663002489218	Final	1

COMMENTS: T1647536:AHEMP2 , ATDIF2, GLU, HFPA; LIPID- 12HRPP

For additional diagnostic criteria, see our Test Directory at www.paml.com

Diagnostic Procedure	Result	Flag	Now or Range	Units	Reference Range	Site Code
Glucose	108	H		mg/dL	65-99	01
Hepatic Function Panel						
Protein, Total	6.9			g/dL	6.3-8.0	01
Albumin	3.4			g/dL	3.5-5.0	01
Bilirubin, Total	0.3			mg/dL	0.1-1.5	01
Bilirubin, Direct	0.1			mg/dL	0.0-0.4	01
Alkaline Phosphatase	55			U/L	38-110	01
AST	27			U/L	5-40	01
ALT	35			U/L	5-50	01
Lipid Profile						
Cholesterol	198			mg/dL	<200	01
Triglycerides	262	H		mg/dL	<150	01
HDL	70			mg/dL	>39	01
	For specific risk assessment criteria, see our test directory at (www.paml.com).					
LDL, Calculated	111	H		mg/dL	<100	01
	The LDL goal varies from 70 to 160 depending on the clinical risk category. For specific risk assessment criteria, see our test directory at (www.paml.com).					
Hemogram with Plt						
White Blood Cells	5.8			K/uL	4.0-10.0	17
Red Blood Cells	5.01			M/uL	4.30-5.70	17
Hemoglobin	16.0			g/dL	13.7-17.5	17
Hematocrit	46.0			%	40.0-50.0	17
MCV	91			fL	80.0-100.0	17
MCH	31.9			pg	27.0-34.0	17
MCHC	34.7			g/dL	32.0-36.0	17
RDW	13.0			%	11.0-15.0	17
Platelets	156			K/uL	150-400	17
Differential						
Differential Type	Automated					17
Neutrophils	51.8			%	40.0-80.0	17
Lymphocytes	32.1			%	15.0-45.0	17
Monocytes	10.9			%	3.0-12.0	17
Eosinophils	4.9			%	0.0-7.0	17
Basophils	0.3			%	0.0-2.0	17
Neutrophils, Absolute	3.02			K/uL	2.00-7.30	17
Lymphocytes, Absolute	1.87			K/uL	0.80-3.40	17
Monocytes, Absolute	0.63			K/uL	0.00-0.80	17
Eosinophils, Absolute	0.29			K/uL	0.00-0.50	17
Basophils, Absolute	0.02			K/uL	0.00-0.10	17

Performing Labs
01 PAML 110 W Cliff Ave, Spokane, WA 99204
17 Providence Sacred Heart Medical Ctr, 101 W 8th St, Spokane,WA 99204

End of Report

SPOKANE PSYCHIATRIC CLINIC
105 W 8th Ave Ste 6055
Spokane, WA 99204-2312

Reported 7/7/09 words calm

PAML (509) 755-8600 (800) 541-7891 FAX (509) 924-0002
CLIENT SERVICES (509) 755-8999 FAX (509) 924-5127
Medical Director: Thomas J Allerding

PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN	10271970JD1	10/27/1970	M	38 Y	509-944-0586	10271970JD1	
PHYSICIAN	COLLECT DATE & TIME	DATE OF SERVICE			REQUISITION NO.	STATUS	PAGE
ASHBY MD, HOWARD	06/26/2009 07:09	06/26/2009			663002014613	Final	1

COMMENTS: F911970:AHEMP2 , ATDIF2, CMPAC, CMPC; GFR- ; LIPID- 12HRPP; VALP- LD 2000 06/25

For additional diagnostic criteria, see our Test Directory at www.paml.com

Depakote, Reported. Bgmoore, 26 Jun

Diagnostic Procedure	Result	Flag	Out of Range	Units	Reference Range	Lab Code
Comprehensive Metabolic Panel						
Sodium	144			mmol/L	136-145	01
Potassium	4.6			mmol/L	3.5-5.3	01
Chloride	107			mmol/L	98-109	01
CO2	30			mmol/L	22-31	01
Glucose	104	H		mg/dL	65-99	01
BUN	12			mg/dL	7-23	01
Creatinine	1.10			mg/dL	0.60-1.50	01
	IDMS traceable creatinine					
Calcium	9.4			mg/dL	8.5-10.5	01
Protein, Total	6.9			g/dL	6.3-8.0	01
Albumin	4.4			g/dL	3.5-5.0	01
Bilirubin, Total	0.3			mg/dL	0.1-1.5	01
Alkaline Phosphatase	45			U/L	33-115	01
AST	16			U/L	5-40	01
ALT	15			U/L	5-60	01
Anion Gap	7			mmol/L	5-16	01
CMP Calculations						
BUN/Creatinine Ratio	10.9			Ratio	6-30	01
Globulin	2.5			g/dL	1.8-3.5	01
A/G Ratio	1.8			Ratio	1.2-2.2	01
Estimated GFR (Calc)	>60			ml/min/1.73m2	>60	01
	GFR <60: Chronic kidney disease, if found over a 3 month period. GFR <15: Kidney failure. For African Americans, multiply the calculated GFR by 1.210					
Lipid Profile						
Cholesterol	166			mg/dL	<200	01
Triglycerides	192	H		mg/dL	<150	01
HDL	30	L		mg/dL	>39	01
	For specific risk assessment criteria, see our test directory at (www.paml.com).					
LDL [Calculated]	98			mg/dL	<100	01
	The LDL goal varies from 70 to 160 depending on the clinical risk category. For specific risk assessment criteria, see our test directory at (www.paml.com).					
Valproic Acid	101	H		ug/mL	50-100	01
	Toxic >150 ug/mL					
Hemogram with Plt						
White Blood Cells	5.9			K/uL	4.0-11.0	17
Red Blood Cells	5.11			M/uL	3.80-5.20	17
Hemoglobin	15.6			g/dL	13.7-16.7	17
Hematocrit	46.8			%	39.0-50.0	17
MCV	91.4			fL	80.0-100.0	17
MCH	30.5			pg	27.0-34.0	17
MCHC	33.3			g/dL	32.0-35.5	17
RDW	12.8			%	11.0-15.0	17
Platelets	150			K/uL	150-400	17

Continued on next page

SPOKANE PSYCHIATRIC CLINIC
105 W 8th Ave Ste 6055
Spokane, WA 99204-2312

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CLIENT SERVICES (509) 755-8999 FAX (509) 924-5127
Medical Director: Thomas J Allerding

PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN	10271970JD1	10/27/1970	M	38 Y	509-944-0586	10271970JD1	
PHYSICIAN	COLLECT DATE & TIME	DATE OF SERVICE			REQUISITION NO.	STATUS	PAGE
ASHBY MD, HOWARD	06/26/2009 07:09	06/26/2009			663002014613	Final	2

COMMENTS: F911970:AHEMP2 , ATDIF2, CMPAC, CMPC; GFR- ; LIPID- 12HRPP; VALP- LD 2000 06/25

For additional diagnostic criteria, see our Test Directory at www.paml.com

Diagnostic Procedure	Result	Out of Range	Units	Reference Range	Site Code
Differential					
Differential Type	Automated				
Neutrophils	41.3		%	40.0-80.0	17
Lymphocytes	45.7		%	5.0-45.0	17
Monocytes	10.2		%	0.0-12.0	17
Eosinophils	0.5		%	0.0-7.0	17
Basophils	0.2		%	0.0-2.0	17
Neutrophils Absolute	2.42		K/uL	2.00-7.30	17
Lymphocytes, Absolute	2.50		K/uL	1.00-3.40	17
Monocytes Absolute	0.59		K/uL	0.00-0.80	17
Eosinophils, Absolute	0.33		K/uL	0.00-0.50	17
Basophils Absolute	0.01		K/uL	0.00-0.10	17

Performing Labs

01	PAML 110 W Cliff Ave, Spokane, WA 99204
17	Providence Sacred Heart Medical Ctr, 101 W 8th St, Spokane,WA 99204

End of Report

SPOKANE PSYCHIATRIC CLIINIC
105 W 8TH STE 6055
SPOKANE, WA 99202

PAML
PATHOLOGY ASSOCIATES MEDICAL LABORATORIES

(509) 755-8600 (800) 541-7891 FAX (509) 924-0002
CLIENT SERVICES (509) 755-8999 FAX (509) 924-5127
Medical Director: Thomas J Allerding

PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	518801366	10/27/1970	M	37 Y	509-926-3062	518801366	
PHYSICIAN	COLLECT DATE & TIME		DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE
ASHBY MD, HOWARD	02/18/2008 09:33		02/18/2008		663001076416	Final	1

COMMENTS: M16319:AHEMP2 , ATDIF2, CMPAC, CMPC; VALP- LAST DOSE 02172008 AT 2000

For additional diagnostic criteria, see our Test Directory at www.paml.com

Diagnostic Procedure	Result	Unit	Normal Range	Performing Lab
Comprehensive Metabolic Panel				
Sodium	140	mmol/L	135-145	01
Potassium	4.3	mmol/L	3.5-5.3	01
Chloride	107	mmol/L	98-109	01
CO2	27	mmol/L	22-29	01
Glucose	98	mg/dL	65-99	01
BUN	10	mg/dL	7-23	01
Creatinine	1.3	mg/dL	0.7-1.3	01
Calcium	9.2	mg/dL	8.5-10.5	01
Protein, Total	7.0	g/dL	6.0-8.0	01
Albumin	4.3	g/dL	3.5-5.0	01
Bilirubin, Total	0.5	mg/dL	0.1-1.5	01
Alkaline Phosphatase	50	U/L	38-110	01
AST	20	U/L	5-40	01
ALT	19	U/L	5-50	01
Anion Gap	7	mmol/L	2-16	01
CMP Calculations				
BUN/Creatinine Ratio	7.7	Ratio	7.0-24.0	01
Globulin	2.7	g/dL	1.9-3.7	01
A/G Ratio	1.6	Ratio	1.1-2.2	01
eGFR	74	mL/min	>59	01
Hemogram with Plt				
White Blood Cells	5.0	K/uL	4.0-11.0	17
Red Blood Cells	5.10	M/uL	3.80-5.10	17
Hemoglobin	15.7	g/dL	13.7-16.7	17
Hematocrit	45.8	%	40.0-50.0	17
MCV	89.8	fL	80.0-100.0	17
MCH	30.8	pg	27.0-34.0	17
MCHC	34.2	g/dL	32.0-35.5	17
RDW	13.0	%	11.0-15.0	17
Platelets	154	K/uL	150-400	17
Differential				
Differential Type	Automated			
Neutrophils	48.5	%	40.0-80.0	17
Lymphocytes	38.8	%	19.0-51.0	17
Monocytes	8.4	%	0.0-12.0	17
Eosinophils	4.0	%	0.0-7.0	17
Basophils	0.3	%	0.0-2.0	17
Neutrophils, Absolute	2.42	K/uL	2.00-7.80	17
Lymphocytes, Absolute	1.94	K/uL	1.00-3.40	17
Monocytes, Absolute	0.42	K/uL	0.00-0.80	17
Eosinophils, Absolute	0.20	K/uL	0.00-0.50	17
Basophils, Absolute	0.01	K/uL	0.00-0.10	17

Performing Labs

01	Pathology Associates Medical Laboratories, 110 W Cliff Ave, Spokane, WA 99204
17	Sacred Heart Medical Ctr, 101 W 8th St, Spokane, WA 99204

End of Report

SPOKANE PSYCHIATRIC CLIINIC
105 W 8TH STE 6055
SPOKANE, WA 99202
ASHBY MD, HOWARD

PAML
PATHOLOGY ASSOCIATES MEDICAL LABORATORIES

(509) 755-8600 (800) 541-7891 FAX (509) 924-0002
CLIENT SERVICES (509) 755-8999 FAX (509) 924-5127
Medical Director: Thomas J Allerding

PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	1380801264	10/27/1970	M	36 Y	926-3062		
PHYSICIAN	COLLECT DATE & TIME	DATE OF SERVICE			REQUISITION NO.	STATUS	PAGE
ASHBY MD, HOWARD	03/02/2007 07:41	03/02/2007			1000023	Final	1

COMMENTS: F1787:CMPAC , CMPC; LIPID- Patient Fasting

Diagnostic Procedure	Result	Flag	Our Range	Units	Reference Range	Lab
Comprehensive Metabolic Panel						
Potassium	4.4			mmol/L	3.5-5.3	01
CO2	27			mmol/L	22-29	01
BUN	11			mg/dL	7-23	01
Calcium	9.2			mg/dL	8.5-10.5	01
Albumin	4.3			g/dL	3.5-5.0	01
Alkaline Phosphatase	64			U/L	38-110	01
ALT	34			U/L	5-50	01
CMP Calculations						
BUN/Creatinine Ratio	7.3			Ratio	7.0-24.0	01
A/G Ratio	1.6			Ratio	1.1-2.2	01
Lipid Profile						
Triglycerides	324	H		mg/dL	<150	01

For specific risk assessment criteria, see our test directory at (www.paml.com).

The LDL goal varies from 70 to 160 depending on the clinical risk category. For specific risk assessment criteria, see our test directory at (www.paml.com).

Performing Labs

01 Pathology Associates Medical Laboratories, 110 W Cliff Ave, Spokane, WA 99204

For additional diagnostic criteria, see our Test Directory at www.paml.com

End of Report

3/9/07 8:10 left message
3/7/07 11:50 Reported

SPOKANE PSYCHIATRIC CLIINIC
105 W 8TH STE 6055
SPOKANE, WA 99202

PAML
PATHOLOGY ASSOCIATES MEDICAL LABORATORIES

(509) 755-8600 (800) 541-7891 FAX (509) 924-0002
CLIENT SERVICES (509) 755-8999 FAX (509) 924-5127
Medical Director: Thomas J Allerding

PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	1380801264	10/27/1970	M	35 Y	926-3062		
PHYSICIAN	COLLECT DATE & TIME		DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE
ASHBY MD, HOWARD	08/18/2006 07:45		08/18/2006		1000011	Final	1

COMMENTS: F61563:AHEMP2 , ATDIF2, GLU, HFPA, LIPID- Patient Fasting

Diagnosis Procedure	Current Result	Flag	Previous Result	Units	Reference Range	Site Code
Glucose	101	H		mg/dL	65-99	01
Hepatic Function Panel						
Protein, Total	7.2			g/dL	6.3-8.0	01
Bilirubin, Total	0.3			mg/dL	0.1-1.5	01
Alkaline Phosphatase	58			U/L	38-110	01
ALT	27			U/L	5-50	01
Lipid Profile						
Triglycerides	294	H		mg/dL	<150	01
	For specific risk assessment criteria, see our test directory at (www.paml.com).					
LDL Calculated	The LDL goal varies from 70 to 160 depending on the clinical risk category. For specific risk assessment criteria, see our test directory at (www.paml.com).					
Hemogram with Plt						
Red Blood Cells	5.34			M/uL	4.30-5.70	17
Hematocrit	47.1			%	40.0-50.0	17
MCH	30.4			pg	27.0-34.0	17
RDW	12.9			%	11.0-15.0	17
Differential						
Differential Type	Automated					17
Lymphocytes	34.0			%	15.0-45.0	17
Eosinophils	3.1			%	0.0-7.0	17
Neutrophils, Absolute	3.57			K/uL	2.00-7.30	17
Monocytes, Absolute	0.71			K/uL	0.00-0.80	17
Basophils, Absolute	0.02			K/uL	0.00-0.10	17

Performing Labs

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17	Sacred Heart Medical Ctr, 101 W 8th St, Spokane, WA 99204

For additional diagnostic criteria, see our Test Directory at www.paml.com

Continued on next page

SPOKANE PSYCHIATRIC CLIINIC
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SPOKANE, WA 99202

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(509) 755-8600 (800) 541-7891 FAX (509) 924-0002
CLIENT SERVICES (509) 755-8999 FAX (509) 924-5127
Medical Director: Thomas J Allerding

PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	1380801264	10/27/1970	M	35 Y	926-3062		
PHYSICIAN	COLLECT DATE & TIME		DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE
ASHBY MD, HOWARD	08/18/2006 07:45		08/18/2006		1000011	Final	2

COMMENTS: F61563:AHEMP2 , ATDIF2, GLU, HFPA, LIPID- Patient Fasting

Diagnosis/Procedure	Result	In Range	Out of Range	Units	Reference Range	Site Code

End of Report

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	1380801264	10/27/1970	M	34 Y	926-3062		
PHYSICIAN	COLLECT DATE & TIME	DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE	
HOWARD ASHBY MD	10/20/2005 08:15	10/20/2005		743377	Final	1	

COMMENTS: H52217:AHEMP2 , ATDIF2, HFPA; GLU, LIPID- FASTING; VALP- LD @2200 10/19/05

Diagnostic Procedure	Result	Out of Range	Units	Reference Range	Lab Code
Glucose	90		mg/dL	65-99	01
For additional diagnostic criteria, see our Test Directory at www.paml.com					
Hepatic Function Panel					
Albumin	4.5		g/dL	3.5-5.0	01
Bilirubin, Direct	0.1		mg/dL	0.0-0.4	01
AST	21		U/L	5-40	01
Lipid Profile					
Cholesterol	156		mg/dL	<200	01
HDL	35	L	mg/dL	>39	01
<40: Low 40 to 59: Normal >59: High HDL Cholesterol greater than or equal to 60 mg/dL is considered a "negative" risk factor, serving to remove one risk factor from the total count.					
The LDL goal varies from 70 to 160 depending on the clinical risk category. For specific risk assessment criteria, see our test directory at (www.paml.com).					
Toxic >150 ug/mL					
Hemogram with Plt					
Red Blood Cells	5.07		M/uL	4.30-5.70	17
Hematocrit	45.6		%	40.0-50.0	17
MCH	30.1		pg	27.0-34.0	17
RDW	13.2		%	11.0-15.0	17
Differential					
Differential Type	Automated				17
Lymphocytes	36.1		%	15.0-45.0	17
Eosinophils	3.5		%	0.0-7.0	17
Neutrophils, Absolute	2.72		K/uL	2.00-7.30	17

Continued on next page

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	1380801264	10/27/1970	M	34 Y	926-3062		
PHYSICIAN	COLLECT DATE & TIME		DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE
HOWARD ASHBY MD	10/20/2005 08:15		10/20/2005		743377	Final	2

COMMENTS: H52217:AHEMP2 , ATDIF2, HFPA; GLU, LIPID- FASTING; VALP- LD @2200 10/19/05

Diagnostic Procedure	Result	In Range	Out of Range	Flag	Units	Reference Range	Site Code
Monocytes, Absolute	0.52				K/uL	0.00-0.80	17
Eosinophils, Absolute	0.03				K/uL	0.00-0.50	17
Basophils, Absolute	0.01				K/uL	0.00-0.10	17

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	1353601259	10/27/1970	M	34 Y	509-926-3062		
PHYSICIAN	COLLECT DATE & TIME	DATE OF SERVICE			REQUISITION NO.	STATUS	PAGE
HOWARD ASHBY MD	01/21/2005 08:52	01/21/2005			510260	Final	1

COMMENTS: F36637:AHEMP2 , AMDIF2, AMY, HFPA, LIPID, VALP; GLU- 14HRSPP

Reported 1/25/05

Diagnostic Procedure	Result	Flag	Range	Out of Range	Units	Reference Range	Site Code
Amylase	47				U/L	15-99	01
Glucose	99				mg/dL	65-99	01

0 to 2 days premature 30 to 80 mg/dL
0 to 2 days full term 40 to 90 mg/dL
2 days to 1 month 60 to 105 mg/dL
Adults 65 to 99
ADA diagnostic categories for nonpregnant adults:
Impaired fasting glucose: 100 to 125 mg/dL.
A fasting glucose result of 126 mg/dL or greater indicates diabetes if the abnormality is confirmed on a subsequent day.
A random glucose result of greater than 200 mg/dL indicates diabetes if the abnormality is confirmed on a subsequent day.

Hepatic Function Panel

Albumin	4.8				g/dL	3.5-5.0	01
Bilirubin, Direct	0.2				mg/dL	0.0-0.4	01
AST	20				U/L	5-40	01

Lipid Profile

Cholesterol	185				mg/dL	<200	01

<200: Desirable
200 to 239: Borderline high
>239: High

Triglycerides	153	H			mg/dL	<150	01

<150: Normal
150 to 199: Borderline High
200 to 499: High
>499: Very High

HDL	34	L			mg/dL	>39	01

<40: Low
40 to 59: Normal
>59: High
HDL Cholesterol greater than or equal to 60 mg/dL is considered a "negative" risk factor, serving to remove one risk factor from the total count.

LDL [Calculated]	120	H			mg/dL	<100	01

<100: Optimal
100 to 129: Near or above optimal
130 to 159: Borderline High
160 to 189: High
>189: Very High
To calculate 10 year cardiac risk for this patient, go to http://www.paml.com. Click on Testing, then on Ranges/Algorithms and then on Lipid Results.

Continued on next page

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	1353601259	10/27/1970	M	34 Y	509-926-3062		
PHYSICIAN	COLLECT DATE & TIME	DATE OF SERVICE			REQUISITION NO.	STATUS	PAGE
HOWARD ASHBY MD	01/21/2005 08:52	01/21/2005			510260	Final	2

COMMENTS: F36637:AHEMP2 , AMDIF2, AMY, HFPA, LIPID, VALP; GLU- 14HRSPP

Diagnostic Procedure	Result	Out of Range	Units	Reference Range	Note Code
Hemogram with Plt					
White Blood Cells	5.7		K/uL	4.0-11.0	17
Hemoglobin	16.7		g/dL	13.7-16.7	17
MCV	90.3		fL	80.0-100.0	17
MCHC	34.0		g/dL	32.0-35.5	17
Platelets	182		K/uL	150-400	17
Differential, Manual					
Bands	6.0		%	0-8	17
Monocytes	13.0	H	%	3-11	17
Basophils	1.0		%	0-2	17
Bands, Absolute	0.34	H	K/uL	0.00-0.24	17
Monocytes, Absolute	0.74		K/uL	0.00-0.80	17
Basophils, Absolute	0.06		K/uL	0.00-0.20	17
WBC Morphology	Normal				17
No. of Cells in Diff	100				17

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	518801366	10/27/1970	M	33 Y	509-926-3062		
PHYSICIAN	COLLECT DATE & TIME		DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE
HOWARD ASHBY MD	03/10/2004 12:51		03/10/2004		126434	Final	1

COMMENTS: W15964:AHEMP2 , AMDIF2, HFPA; VALP- 10; VALP- 04 @ 0700; VALP- LD: 03

3/11/04 will report to pt on 3/15 appt.

Diagnostic Procedure	Result In Range	Result Out of Range		Units	Reference Range	Site Code
Hepatic Function Panel						
Protein, Total	[illegible]			g/dL	[illegible]	[illegible]
Albumin	4.6			g/dL	3.5-5.0	01
Bilirubin, Total	[illegible]			mg/dL	[illegible]	[illegible]
Bilirubin, Direct	0.1			mg/dL	0.0-0.4	01
Alkaline Phosphatase	[illegible]			U/L	[illegible]	[illegible]
AST	14			U/L	5-40	01
ALT	[illegible]			U/L	[illegible]	[illegible]
Valproic Acid		109	H	ug/mL	50-100	01
Toxic >150 ug/mL						
Hemogram with Plt						
White Blood Cells	5.5			K/uL	4.0-11.0	17
Red Blood Cells	[illegible]			M/uL	[illegible]	[illegible]
Hemoglobin	15.8			g/dL	13.7-16.7	17
Hematocrit	[illegible]			%	[illegible]	[illegible]
MCV	90.3			fL	80.0-100.0	17
MCH	[illegible]			pg	[illegible]	[illegible]
MCHC	33.9			g/dL	32.0-35.5	17
RDW	[illegible]			%	[illegible]	[illegible]
Platelets	222			K/uL	150-400	17
Differential, Manual						
Segs	[illegible]			%	[illegible]	[illegible]
Bands	1.0			%	0-8	17
Myelocytes	[illegible]			%	[illegible]	[illegible]
Lymphocytes	27.0			%	21-49	17
Monocytes	[illegible]			%	[illegible]	[illegible]
Eosinophils	4.0			%	0-7	17
Basophils	[illegible]			%	[illegible]	[illegible]
Segs, Absolute	3.25			K/uL	1.80-7.70	17
Bands, Absolute	[illegible]			K/uL	[illegible]	[illegible]
Lymphocytes, Absolute	1.49			K/uL	1.00-5.00	17
Monocytes, Absolute	[illegible]			K/uL	[illegible]	[illegible]
Eosinophils, Absolute	0.22			K/uL	0.00-0.50	17
Basophils, Absolute	[illegible]			K/uL	[illegible]	[illegible]
RBC Morphology	Normal					17
WBC Morphology	Normal					[illegible]
Platelet Morphology	Adequate					17
No. of Cells in Diff	100					[illegible]

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN R	518801366	10/27/1970	M	32 Y	509-926-3062		
PHYSICIAN	COLLECT DATE & TIME		DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE
HOWARD ASHBY MD	04/30/2003 08:30		04/30/2003		961063	Final	1

COMMENTS: W53947:AHEMP2 , AMDIF2, AMY, HFPA; VALP- LD 04/29/03 @ 1900

Diagnostic Procedure	Result		Units	Reference Range	Lab
Hepatic Function Panel					
Protein, Total	7.1		g/dL	6.3-8.0	01
Bilirubin, Total	0.4		mg/dL	0.1-1.5	01
Alkaline Phosphatase	50		U/L	38-110	01
ALT	17		U/L	5-50	01
Hemogram with Plt					
White Blood Cells	4.8		K/uL	4.0-11.0	17
Hemoglobin	15.6		g/dL	13.7-16.7	17
MCV	89.9		fL	80.0-100.0	17
MCHC	33.9		g/dL	32.0-35.5	17
Platelets	173		K/uL	150-400	17
Differential, Manual					
Metamyelocytes	1.0	H	%	0	17
Monocytes	8.0		%	3-11	17
Segs, Absolute	2.78		K/uL	1.80-7.70	17
Monocytes, Absolute	0.38		K/uL	0.00-0.80	17
RBC Morphology	Normal				17
Platelet Morphology	Adequate				17

Performing Labs

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CLIENT SERVICES (509) 927-6299 • FAX (509) 924-5127

PATIENT NAME	PATIENT ID	DOB	SEX		PT. PHONE NO.	PT.LAB NO.	
DEMEERLEER, JAN	518801366	10/27/1970	M		926-3052		
PHYSICIAN	COLLECT DATE & TIME		DATE OF SERVICE		REQUISITION NO.	STATUS	PAGE
HOWARD ASHBY MD	06/04/2002 08:20		06/04/2002		671104	Final	1

COMMENTS: T26672:AHEMP2 , AMDIF2, AMY, HFPA; VALP- 03; VALP- 02/2000; VALP- LD=06

Diagnostic Procedure	Result	In Range	Out of Range	Units	Reference Range	Lab
Amylase	67			U/L	16-63	
Hepatic Function Panel						
Protein, Total	7.3			g/dL	6.3-8.0	17
Albumin	4.2			g/dL	3.5-5.0	17
Bilirubin, Total	0.8			mg/dL	0.1-1.5	17
Bilirubin, Direct	0.1			mg/dL	0.0-0.3	17
Alkaline Phosphatase	52			U/L	38-110	17
AST	25			U/L	5-40	
ALT	19			U/L	5-50	17
Lipase	57			U/L	50-160	
Hemogram with Plt						
WBC	6.3			K/uL	4.0-11.0	17
RBC	5.49			M/uL	3.5-5.0	17
HGB	16.7			g/dL	13.7-16.7	17
HCT	49.2			%	40.0-50.0	17
MCV	89.6			fL	80.0-100.0	17
MCH	30.4			pg	27.0-34.0	17
MCHC	33.8			g/dL	32.0-35.5	17
RDW	12.4			%	11.0-15.0	17
PLT	176			K/uL	150-400	17
Differential, Manual						
Segs	50.0			%	38-70	17
Lymphocytes	34.0			%	21-49	17
Monocytes	8.0			%	2-11	17
Eosinophils	7.0			%	0-7	17
Basophils	1.0			%	0-2	17
Segs, Absolute	3.2			K/uL	1.8-7.7	17
Lymphocytes, Absolute	2.1			K/uL	1.0-5.0	17
Monocytes, Absolute	0.5			K/uL	0-0.8	17
Eosinophils, Absolute	0.4			K/uL	0-0.5	17
Basophils, Absolute	0.1			K/uL	0-0.2	17
RBC Morphology	Normal					
WBC Morphology	Normal					17
Platelet Morphology	Adequate					
No. of Cells in Diff	100					17

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6/5/02

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THOMAS J. ALLERDING MD
MEDICAL DIRECTOR

PATIENT	SEX	AGE	DOCTOR	DATE RECEIVED / DATE REPORTED	LABORATORY #
DEMEERLEER, JAN R	M	30	HOWARD ASHBY MD	09\21\01	749351

PATIENT PHONE: 926-3002
(0315.776/518801366)

09\22\01

REQUESTS: HEPA VALPROIC CBCMAN DRAW

COLLECTED 09/21/01 0830

COMMENTS: LD=9-20-01/2100

CHEMISTRY

J DEMEERLEER 09/21/01

Diagnostic Procedure	Result Low	Result Normal	Result High	Reference Range		REF LAB
-Glucose, Fasting				ADULT 65-109 mg/dL; PREGNANT ADULT 65-104 mg/dL		
BUN				7-23	mg/dL	
Creatinine				M 0.7-1.5 F 0.6-1.2	mg/dL	
-Uric Acid				M 3.1-8.1 F 2.0-6.7	mg/dL	
-Calcium				8.5-10.5	mg/dL	
Phosphorus				2.5-4.8	mg/dL	
-Magnesium				1.5-2.4	mg/dL	
-Cholesterol				LT 200	mg/dL	
-Triglyceride				LT 200	mg/dL	
-Total Protein		7.6		6.3-8.0	g/dL	17
Albumin		4.4		3.5-5.0	g/dL	17
Globulin				1.8-3.5	g/dL	
A/G Ratio				1.1-2.2		
Total Bilirubin		0.7		0.1-1.5	mg/dL	17
Direct Bilirubin		<0.1		0-0.4	mg/dL	17
Indirect Bilirubin				0.3-1.0	mg/dL	
Alkaline Phosphatase		49		Adult 38-110 Child Up to 382	U/L	17
AST (SGOT)		29		5-40	U/L	17
ALT (SGPT)		22		5-50	U/L	17
GGT				5-65	U/L	
LD (LDH)				100-200	U/L	
CK (CPK)				M 25-287 F 20-200	U/L	
Sodium				135-145	mmol/L	
Potassium				3.5-5.0	mmol/L	
Chloride				98-109	mmol/L	
CO_2				22-29	mmol/L	
Iron (Total)				M 35-180 F 30-150	ug/dL	
Iron Binding Capacity				M 230-430 F 250-450	ug/dL	
% Iron Saturation				M 20-55 F 15-50	%	

HEMATOLOGY

J DEMEERLEER 09/21/01

Diagnostic Procedure	Result Low	Result Normal	Result High	Reference Range		REF LAB
WBC		4.4		4-11	K/uL	17
RBC		5.48		M 4.3-5.7 F 3.8-5.2	M/uL	17
Hemoglobin		16.3		M 13.7-16.7 F 11.6-15.5	g/dL	17
Hematocrit		48.2		M 40-50 F 35-46	%	17
MCV		87.9		80-100	fL	17
MCH		29.7		27-34	pg	17
MCHC		33.7		32.0-35.5	g/dL	17
RDW		12.4		11-15	%	17
MPV				7-11.5	fL	
DIFFERENTIAL						
Granulocytes		47.0		38-70	%	17
Lymphocytes		39.0		21-49	%	17
Monocytes		8.0		3-11	%	17
Eosinophils		1.0		0-7	%	17
Basophils		1.0		0-2	%	17
Platelet Count		176		150-400	K/uL	17
Morphology	SEE BELOW			Normal		17

URINALYSIS

J DEMEERLEER 09/21/01

Diagnostic Procedure	Normal	Abnormal	NORMAL	REF LAB
Specific Gravity			1.001-1.030	
Leukocyte Esterase			Negative	
Nitrite			Negative	
pH			5.0-7.5	
Protein			Negative	
Glucose			Less than 25 mg/dL	
Ketone			Negative	
Urobilinogen			< = 1.0 mg/dL	
Bilirubin			Negative	
Occult Blood			Negative	
Microscopic				

Other Diagnostic Procedures	Result (*)	Units	Reference Range	LT = Less Than GT = Greater Than	REF LAB
Comment for - Normal	RBC Morph				
VALPROIC ACID (PEAK OR TROUGH)	92	ug/mL	50-100		01
Variant Lymph, %	4.0	%	0-6		17
Seg, Abs	2.1	K/uL	1.8-7.7		17
Lymph, Abs	1.7	K/uL	1.0-5.0		17
Variant Lymph, abs	0.2	K/uL			17
Mono, Abs	0.4	K/uL	0-0.8		17
Eos, Abs	0.0	K/uL	0-0.5		17
Baso, Abs	0.0	K/uL	0-0.2		17
RBC Morph	Normal				17
Platelet Morph	Adequate				17
Cells Counted	100				17

500mg b/d

OK called 4:45 9/24 left message on machine please repeat

104
36

DEMEERLEER, JAN R (*) INDICATES RESULT OUTSIDE NORMAL LIMITS 09/21/01 REORDER #0512

Consent for Release of Confidential Mental Health/Substance Abuse Records

I Jan Richard Demeerleer 10/27/70
Name of patient date of birth

Authorize: Spokane Psychiatric Clinic, P.S
105 W. 8th Ave Suite 6055
Spokane WA 99204
(509) 455-9090 Fax: 747-2118

Mark Chalem, M.D
Howard Ashby, M.D.
David Grubb, M.D
David Bot, M.D.
Jay Schmauch, DO
Rod Peterson, MD

JUN 2011

Release To: James D. Demeerleer - personal representative as assigned by the court.

Obtain From: 1-208-883-4516

(address) City State Zip Code

(phone number) (fax number)

For the Purpose of: Continued Care Personal Litigation Insurance Claim
(circle) Other Information for Jan's estate

To be disclosed: (please initial)

____ Entire record	____ all records from date forward: ____
____ last chart note/notes	____ allow telephone contact
____ lab records	____ psychological/drug testing
____ assessment	____ report/psychiatric evaluation

Other: Clinical notes, medication record, lab reports

RESTRICTIONS: ____

This consent includes authorization to release alcohol, drug abuse, and mental health records obtained in or for the diagnosis, treatment, consultation or evaluation. I understand that I may revoke this consent at any time, except to the extent the action has already been taken in reliance hereon and if not revoked sooner in writing. The consent is valid for 90 days unless revoked in writing prior to the 90 days. You are not required to sign this consent in order to receive treatment, unless this is for a Fitness for Duty Exam or for participating in a medical research study.

Please note when you request records be released to a third party, that party may NOT be subject to redisclosure or privacy regulations.

Patient Signature ____ Date ____

X Parent ~~or Guardian~~ ____ Relationship Father - as personal representative

x Date ____

Witness Signature ____

File ____ Send out ____ Date ____

FAX COVER SHEET

TO	
COMPANY	
FAX NUMBER	15097472118
FROM	. .
DATE	2010-04-07 18:48:00 IST
RE	Refill Request *** URGENT *** (REF # 627554)

COVER MESSAGE

To: Dr. Howard Ashby
From: MIV Ltd.
Toll Free Tel: 1-877-278-5355 Toll Free Fax: 1-877-278-5359
PRESCRIPTION REQUEST FORM - NO. OF MEDICATIONS: 1
***PLEASE RESPOND AND FAX BACK TO 1-877-278-5359 ***
PATIENT INFORMATION
Patient Name: Jan DeMeerleer
Patient Tel: 509-944-0586 Patient D.O.B.: 10/27/1970

FAXED
APR 07 2010
PAGE ____ OF ____

PHYSICIAN INFORMATION
Physician Name: Dr. Howard Ashby
Tel: 509-455-9090
Fax: 15097472118
License No.: _____
MEDICATIONS

Depakote (Generic) 500 mg QTY: 200
Sig 3/d Refills(Circle) 1 2 3 4 5 1yr #270

Physician Signature: _____

*** PLEASE FAX BACK TO 1-877-278-5359 (TOLL-FREE) ***

planetdrugsdirect.com
FAX: 1-800-858-2895
PHONE: 1-888-791-3784

To: Dr. Howard Ashby
Fax: 509-747-2118
Phone:
Date: May 7, 2008
Re: Jan Demeerleer 10/27/70
Order : 325995

>>> We have received a Rx for plain Depakote500mg from the above-named patient. Patient has requested the ER formulation. If this is approved can you please complete the Rx as below?

Please fax this confirmation to 1-800-858-2895 or 1-702-995-6152 ASAP with a Dr. signature. Thank you very much for your time.

1.	Rx Date (M-D-Y):	October 22 2007
2:	Medication Name:	Depakote ER
3.	Medication Strength:	500mg
4.	Dispensing Quantity:	1 #180
5.	Refills:	1 3
6.	Directions:	2/day 1
7.	Generic substitution	Yes (pls allow) /
8.	Dr. Signature: and DEA no.	+ pls sign + AA 7351841

IMPORTANT

FAXED
MAY 07 2008

To: Dr Howard Ashby

Phone:

Re: Jan Demeerleer

Fax : 509 747 2118

Date: 7Dec07

Order #: 305709

FAXED
DEC 0 6 2007

To Whom It May Concern:
We are a mail order pharmacy and we have received a Rx from the above-named patient. Can you please clarify the check list below pertaining to the Rx as detailed. Please fax this confirmation to 1-800-858-2895 or 1-702-995-6152 ASAP with a Dr. signature. Thank you very much for your time.

**********Important Notice, Please Read**********

Please confirm if generic permissable as Rx written DAW

Cust has requested Generic

1.	Rx Date (M-D-Y):	22Oct07
2:	Medication Name:	Risperdal
3.	Medication Strength:	1 mg
4.	Dispensing Quantity:	#180
5.	Refills:	3
6.	Directions:	1 BID
7.	Generic substitution	Yes if available
8.	Dr. Signature: and DEA no.	AA 735 1341

IMPORTANT

This Fax contains information that is confidential and which may be legally privileged. If you are not the intended recipient, you must not read, use, distribute or copy this fax. If you are not the intended recipient, please notify us immediately by phone and destroy this fax. Thank you.

TO Dr Howard Ashby	FAX 15097472118
FROM Planetdrugsdirect .	Re: RD 305709

INCOMING RECORDS
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, Jan DeMeerleer
NAME

ADDRESS

CITY ZIP

HEREBY AUTHORIZE

SPOKANE PSYCHIATRIC CLINIC
105 W. 8th AVENUE, SUITE 6056
SPOKANE, WA 99204
Telephone (509) 455-9090

Affix this reminder to your calendar.

HAS AN APPOINTMENT WITH

APPOINTMENT

Day

Date

Time

ON [redacted] AM

THIS TIME IS RESERVED EXCLUSIVELY FOR YOU. 24 HOURS NOTICE IS NECESSARY IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT.

Fax 747

ADDRESS ZIP 3118

To disclose to: E. Jansen
D. Little, M.D.
R. Mitchell, M.D.
D. Ostrander, M.D
T. Prenger, M.D.
A. Skidmore, M.D.
G.T. Wandschneider, M.D.
L. Weaver, M.D.
T. Wiederhold, ARNP
P. Woolf, M.D.

13102 E. Mission Ave.
Spokane, WA. 99216

Phone: (509) 928-0300

Fax: (509) 922-9241

FAXED
FEB 25 2008

any information you may have regarding my health or care including pertinent x-ray and laboratory findings, drug or alcohol use or abuse, mental illness, AIDS, sexually any information you may have regarding my health or care including pertinent x-ray and transmitted diseases, or immunizations. NOTE: If a patient has reached his or her fourteenth birthday ONLY the patient may authorize disclosure relating to sexual diseases.

I understand that my records are protected under Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise permitted by the regulations. I also understand that I may revoke this consent at any time in writing except to the extent that action has already been taken relative to it. This consent will expire upon completion of the transaction and no later than ninety days from the date signed, unless otherwise stated herein.

Signature Jan DeMeerleer Date 2/22/08

(Parent or Guardian if patient is under 18 yrs.)

Please print the name and date of birth of the individual whose records are to be transferred.

NAME Jan DeMeerleer DATE OF BIRTH 10/27/1970

!!!! PATIENTS: MAIL THIS FORM TO YOUR PREVIOUS DR'S OFFICE!!!!

Check List for Release of Medical Records

Name: Jan DeMeerleer Doctor: Ashby

Date: 2-25-08

1. Check the request to verify that it is valid. ✓
   Name and birth date must match our records ✓
   Did patient sign and date request ✓
   Is request within 90 days of dated form ✓
   Is the patient 13 year or older? Did they sign N/A
   Mailed consent - call and confirm request faxed - OK
   Release to – Check address or fax number with our records ✓
   Give to appropriate doctor for review

2. Pull chart attach request and this form
   Give to the appropriate doctor for review

3. Doctor will review and indicate what records to release
   - Do records include any joint or family sessions? Yes___ No X
   - If yes what precautions need to be taken? _____
   Additional notes to staff _____
   sign off: _____ Date 2/25/08

4. Document what part of the chart was released. (NEVER MORE THEN WHAT IS REQUESTED). Return to doctor if there is a question on this for clarification.

_____

All progress Notes - Notes from date _____ - Medication List - Letter
Number of pages _____

5. Verify fax number by calling before faxing ___
   Verify address of where they are going with our records ___
   Check ID if giving to patient _____

6. Sign and date this form indicating that you: (circle/note)

Faxed Mailed Gave to patient Other _____

Released to other than patient: _____ (insurance, doctor Attorney)

Sign _____ Date 2/25/08

Counseling Center of Spokane, LLC
Sherry Murray, MA, LMHC, CMHS
316 West Boone, Suite 160
Spokane, WA 99201-2346

Telephone (509) 328-3400
Fax (509) 328-5400
www.CounselingCenterofSpokane.com

April 30, 2009

Howard Ashby, PhD
Spokane Psychiatry Clinic
105 West 5th Avenue Suite 6055
Spokane, WA 99204

5/4/09
1:00 – Left message x2 for Jan
No return calls
fax

Re: Jan Demeerleer, DOB 10-27-1970
Ending Counseling

Dear Dr. Ashby:

I am writing to let you know I have ended counseling sessions with your patient, noted above, due to his losing his job, and thus his insurance.

Please feel free to call me at 328-3400 if you have any questions. I look forward to collaborating with you as necessary in this case.

Sincerely,

S. Murray, MA, LMHC
Sherry Murray, MA, CMHS
Licensed Mental Health Counselor

FAXED JUN 15 2009

PAGE 1 OF

FAX COVER SHEET

TO	
COMPANY	
FAX NUMBER	15097472118
FROM	..
DATE	2009-06-15 21:26:22 GMT
RE	Refill Request *** URGENT *** (REF # 443382)

COVER MESSAGE

To: Dr. Howard Ashby
From: MIV Ltd.
Toll Free Tel: 1-877-278-5355 Toll Free Fax: 1-877-278-5359
PRESCRIPTION REQUEST FORM - NO. OF MEDICATIONS: 1
***PLEASE RESPOND AND FAX BACK TO 1-877-278-5359 ***
PATIENT INFORMATION
Patient Name: Jan DeMeerleer
Patient Tel: 509-944-0586 Patient D.O.B.: 10/27/1970

PHYSICIAN INFORMATION
Physician Name: Dr. Howard Ashby
Tel: 509-455-9090
Fax: 15097472118
License No.: _____
MEDICATIONS

Bupropion SR Tabs (Generic) **Promo** 150 mg QTY: 180
Sig 1 TAB 1 D Refills(Circle) (1) 2 3 4 5 1yr

Physician Signature: D Bell MD

*** PLEASE FAX BACK TO 1-877-278-5359 (TOLL-FREE) ***

Dr. Ashby's Office:

9/26/05
mal
BA

Please give this letter to Dr. Ashby for his personal attention.

Thank you.

September 24, 2005

Dr. Howard Ashby
105 West 8th Ste. 6055
Spokane, WA 99204

Re: Jan R. DeMeerleer

Dr. Ashby:

I am Jan's mother. And...I am very concerned about my son. I was in Spokane this past week, responding to a phone call from Jan's "significant other," Rebecca, a young woman whom we all greatly admire. Rebecca's "Jan alarm" had gone off per his behavior and she wisely called in the troops...i.e. Jan's family. From what I understood of the Wednesday (Sept. 21) visit, Jan gave his version of the recent events that prompted his parents and siblings to respond to Rebecca's appeal for help. I am certain you see through Jan's unrealistic reasoning but I am anxious to give you the "side" that we (his family) have experienced and observed.

First of all, we are all concerned over Jan's obsessive occupation with money. He colors his whole lifestyle with this financial spreadsheet he has patterned for himself and his companion. His over-zealous budgeting of his finances greatly restricts his choices, pushing him to bad choices and, we think, loss of life's enjoyments. Every choice Jan makes revolves around money. His obsession with money is even affecting his marriage plans with Rebecca by his insistence that she submit a five-year financial plan to him per her personal accounts and her plans to purchase a business she is currently managing. [I suggested couples counseling for them.] Jan's biological father, whom you met Wednesday, has offered to counsel Jan on practical budget practices but we all know that Jan will ignore this attempt in "realistic finance." Jan is Jan...(and we all love him very much, of course!). The latest events per the "beater" truck Jan was attempting to sell was strictly due to his driving need to get a high price for the vehicle. I believe this helped plunge Jan into a depressive mood. His recent statement of never wanting to see his daughter again, suggesting his companion, Rebecca, move out of his house, and announcing he was going to quit his job screamed depression to me.

We were all extremely concerned that Jan's reaction to vandalism to his "beater" pickup truck was dangerous and unrealistic. Jan placed two powerful guns (a .357 pistol and a shotgun, both with lots of ammunition) into his car and then drove himself to the area where this theft had been perpetrated in order to "wait" for the thieves to return. Jan's two fathers (biological and step-) and I do have a huge issue with Jan hauling loaded guns around in case he finds the guys who ripped into his truck! Jan assured us that he no longer has visions of suicide but that he has now progressed into a homicidal mode. Believe me, Dr. Ashby, we are NOT comforted by this information! Jan's several guns were removed from his home (by his two fathers) and taken to Moscow.

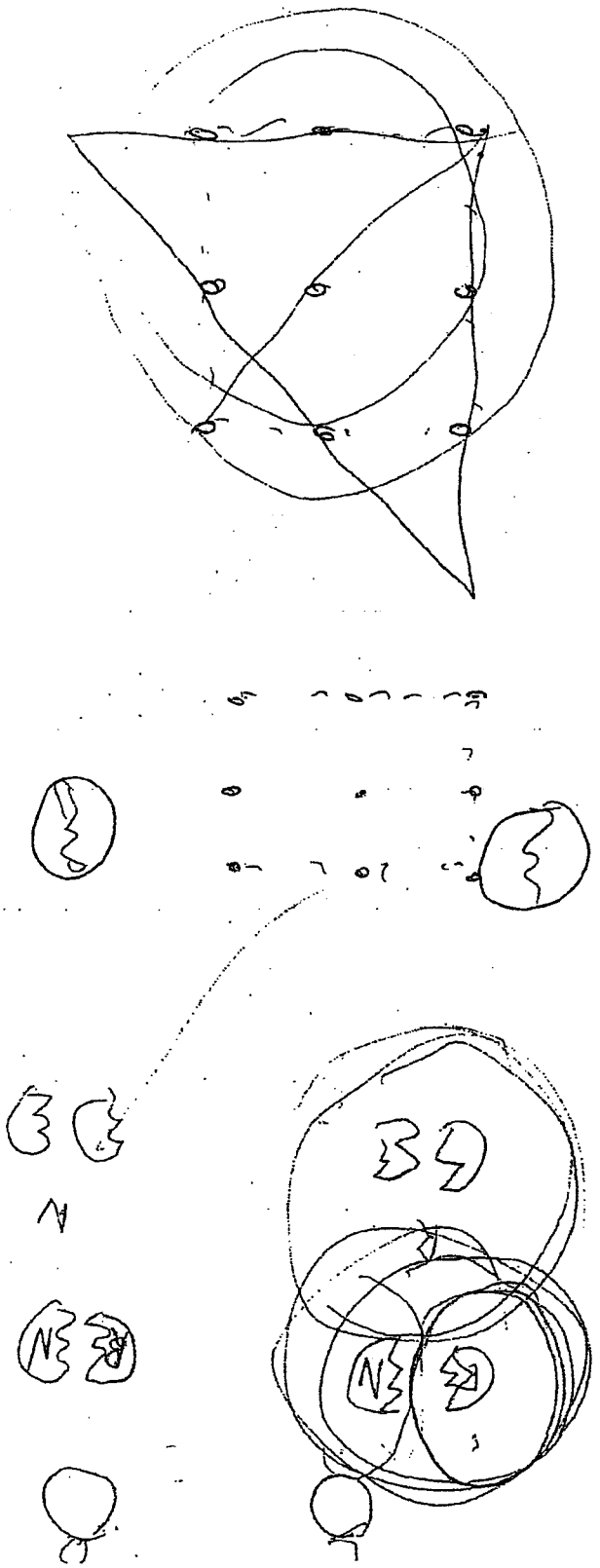
The recent events that prompted us to travel to Spokane are difficult to pinpoint since Jan has the ability to cover up his actions via his "stories." He is known in this family for his—to put it bluntly—"bullshit" and we all find it difficult to cut to the real truth. We TRY to make the point that we all love him no matter what but he has that pounding need to be Mr. Perfect. Frankly, I am extremely proud of my son for everything he has tackled in his life, especially since he is fighting such a debilitating affliction. I tell him so but he just doesn't seem to process this information. Jan is a very driven person...and I wish he would stop and smell the flowers often. He spends a lot of unhealthy time dwelling on his anger, hurt, and hatred towards his ex-wife and her boy friend. I am not convinced he truly loved her but I think Jan's sense of absolute possession causes this outrage.

Dr. Ashby, I wished to put these thoughts down for your consideration in your treatment of my son, Jan. I may be over-concerned on some issues but I want him to have a good life and to be able to enjoy life. I don't see a lot of enjoyment of life going on for Jan. Thank you for "listening"...

Sincerely,

Gena Leonard

Gena Leonard
PO Box 1845
Hillsboro, OR 97123
503-640-6779



Date: 9/5/2002

Order Id : 22486270

Official Request for Medical Records

Faxed 9-6-02

Patient Information:

Patient Name: JAN DE MEERLEER

Patient DOB: 10/27/1970 Patient SSN: 518-80-1366 Patient Number:

Doctor/Facility Information:

SPOKANE PSYCHIATRIC CLINIC
ATTENTION: PHYLLIS/ Medical Records
105 W 8TH AVENUE
SUITE 6055
SPOKANE, WA 99204

509-455-9090

On Behalf of:

736 - Primerica Life Insurance Company
Policy Number: 3281313401-999

Special Instructions:

Copies of all medical records for the past 5 years.
(Please include medical records from DR. HOWARD ASHBY)

PLEASE FAX THIS FORM WITH THE REQUESTED INFORMATION TO OUR AUTHORIZED AGENT:

LabOne Inc.
800 NW Chipman Rd, Suite 5900
PO Box 2340
Lee's Summit, MO 64063

FAX (800) 997-2771

Please call (888) 521-2004 for approval on FEE AMOUNTS over $50.

All medical records are intended for use by agencies listed as authorized agents by the insurance carrier.
All fees associated with the processing of this request will be honored by LabOne Inc. As such, all medical documents are to be released to Lab*One* Inc. ONLY.

22486270

1473 - JC

PRIMERICA LIFE INSURANCE COMPANY
Executive Offices: 3120 Breckinridge Blv uth, Ga. 30099-0001
Application For Life Insurance

SIG

UNDERWRITING AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, Veteran's Administration or government facility, insurance company, the Medical Information Bureau, pharmacy benefit manager, or other organization, institution or person having any records or knowledge about me to provide to Primerica Life Insurance Company, and its reinsurers any such medical or personal information, and to testify as to such information, all to the extent permitted by law.

As part of the Company's regular underwriting procedure, an investigative consumer report may be obtained which will contain personal information concerning an individual's character, habits, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. This information may be obtained through personal interviews with your neighbors, friends, associates and acquaintances. Medical information includes prescription histories, the diagnosis, treatment and prognosis with respect to any physical or mental condition, as well as the use of drugs or alcohol. Although the Company maintains confidentiality of information obtained, the Company may disclose to others without my prior authorization. In the event that a report is obtained, I understand that I may request to be interviewed in connection with the report and to receive a copy of the report and that a right of access and correction exists with respect to all personal information collected. Upon written request to the Company at the address listed above, further detailed information on the nature and scope of the report will be provided. I understand that the information obtained by use of this Authorization will be used to determine eligibility for insurance. I know that I or my legal representative may request to receive a copy of this Authorization. A photographic copy of this Authorization shall be as valid as the original and will be valid for two and one half (2-1/2) years from the date this Application is signed.

Acknowledgements and Authorizations:

This is an Application for a term life insurance policy. Term life insurance provides a death benefit and does not accumulate cash value. Prior to accepting any issued coverage, we will review all policy and disclosure documents in the policy kit. These documents illustrate any premium and benefit changes that occur over the period of coverage.

By choosing to pay premiums through monthly bank draft (Pre-Authorized Checking Plan) We are authorizing Primerica Life Insurance Company to deduct premiums directly from the account indicated on Page 8. (Please refer to the "Authorization To Honor Funds Transfer" on Page 8 and further explanations on Page 13.)

This Application contains an Arbitration Provision that only allows for arbitrators to be used for resolving certain disputes.

By Our signatures below, We acknowledge that We have read, understand, and accept the items of this Application, and received a copy of the Conditional Coverage, Underwriting Authorization, Arbitration Provision and Pre-Authorization Checking Payment Plan descriptions on Pages 11 through 14. We have also received Primerica's Privacy Policy, "Your Privacy is Important To Us."

Dated In: WA (State) on 08 (Month) 20 (Day) 2002 (Year)

Print Name of Proposed Primary Insured	Signature of Proposed Primary Insured
Jan R. DeMeerleer PRIMARY	Jan R. DeMeerleer
Print Name of Spouse (If to be Insured)	**Signature of Spouse (If to be Insured)**
Amy S. DeMeerleer SPOUSE	Amy S. DeMeerleer
Print Name of Owner (If other than Proposed Primary Insured)	**Signature of Owner (If other than Proposed Primary Insured)**
Print Name of Bank Account Owner if Not Included Above	**Signature of Account Owner If Not Included Above**

Symptoms of Mania or Hypomania in Jan DeMeerleer

Jan's Thoughts...

Elated or Slightly High Feeling **(Manic Scale Range: 1 – 3)**

- Still enjoys 6 to 8 hours of sleep at night to feel rested.
- Attentive; remains sensitive and empathetic to other feelings.
- More talkative; engaging in conversation; wants to open conversation about topics.
- More hungry especially for carbohydrates and spicy foods.
- Always optimistic; essentially finds a way to "add water" to half empty glass.
- Enjoys planning future activities, goal setting, etc. with others.
- Feels and acts more competitive especially in sports he already plays.
- Enjoys acting as various animals to get laughter from wife and child.
- Listens to high-energy rock & roll as well as club tunes more loudly.
- Desires to dance to club tunes.
- Desires to use hands to build/fix/improve something (physical labor).
- Desires to feel productive and respected for smart and hard work.
- Drives automobile with more focused attention (looks for faster routes, open lanes).
- Enjoys running numbers game in personal finances (scenarios, planning, budgeting).
- Feels more sexually open and expressive.
- Feels need to express love and affection.

Hypomanic Tendencies **(Manic Scale Range: 4 – 6)**

- Only requires 4 hours of sleep to feel rested with no naps during the day.
- Focuses on and easily angered over weaknesses of people, even those close to me.
- Feels charged and full of life with a desire to verbally express the feeling.
- Wants to debate; argumentative such that own view is the ONLY answer.
- Craves carbohydrates, sweets, and spicy foods with total increased appetite.
- Feels very confident in self; constructive criticism does NOT sink in!
- Somewhat forward and flirtatious with new acquaintances, winning them over by quickly including them in my plans and activities with an aura of sexuality.
- Impatient need for socialization.
- Driving need to win especially in sports he already plays.
- Feels creative by bringing life to drawings, script, designing, and poetry.
- Loses self in blaringly loud high-energy rock & roll as well as club music.
- Occasional fits of rage in which I desire to break things with my hands.
- Prides self in productivity and efficiency; belittles others of their slowness.
- Quickly gets "road rage" at other slower, inattentive drivers.
- Obsesses about money matters in personal finance (over plans then needs to spend).
- Needs sexual activity at least once per day.

Manic Behaviors **(Manic Scale Range: 7 –9)**

- Extremely little sleep possible, perhaps 2 to 3 hours per day at most.
- Despises lesser creatures; no remorse for my actions/thoughts on other living creatures.
- Delusional and psychotic beliefs argued to the point of verbal abusive and fighting.
- Firm belief that I must show others the TRUE nature of the power of the human mind!
- No need for socialization; in fact, prefers to psychotically depopulate the world (i.e. "Do Your Part" [DYP] terrorist philosophies).
- Mind flares with wild thoughts; develops new philosophical and social views.
- Wants to destroy; pounds on computer keyboard, slams phone receiver, swings fists.
- Has no use for others; everyone else in world is useless.
- Reckless driving; no fear of danger in any circumstance, even "near misses."
- Relatively free with spending, especially big ticket items or atypical items.
- Acts out fantasies of sex with anyone available.

Amy's Thoughts and Recollections...

General Hypomanic and Manic States (Manic Scale Range: 4-9)

- Desire to finish a big project in "X" amount of time that is too short of period of time, especially considering he often has never tackled a project like it before.
- Works like there is no tomorrow; no breaks, meals, phone calls, sleep; pure focus.
- Makes mistakes on projects (i.e. breaking something) and quickly moves into dangerous rage; actually easily slips into depression after this type of trigger
- Over buys and over spends on projects, blowing way all previous budgeting.
- Elaborates stories wildly to make the listen more interested or at least to make himself appear more exciting.
- Outright lies to cover up out-of-control actions.
- Cannot see any other option to solving a problem; gets locked on to one issue and delves far too deeply in tangential thoughts.
- Will not accept other suggestions or ideas; in fact, belittles person for coming up with such a simplistic suggestion.
- Severe lack of sleep coupled with dreams of going on killing or shooting sprees.
- Drives automobiles very fast (at least 20 to 30 MPH above speed limit) without seat belt while showing no fear at all when in dangerous situations; applies even with child in car.
- Expresses severe "road rage" at other slower drivers, even as a passenger (he's NOT driving).
- Becomes anti-social in a way that he berates and belittles others (especially wife) in front of group; makes rude and crass comments then pulls within himself.
- Acts totally thankless to others, especially wife; appears to have no use for others.
- Wants to restructure, reorganize, and breathe life into the company he is working for.
- Thinks of himself very highly to the point of exaggerating his importance at work.
- Cannot take one sport on at a time in a day; must engage in multiple sporting activities.
- Cannot just enjoy a leisurely sport (i.e. bike riding); instead acts competitively.
- Has an "All or Nothing" attitude; will actually verbal express "Live or Die!"
- No patience in others that do not have his ability or at least his willinghess; needs to make a decision now or must get going now!
- Very persuasive and manipulative in conversation; clever, smooth, and slick!
- Craves sweets, carbohydrates, desserts, etc.
- Needs immediate socialization when it is convenient for him.
- Acts more sexually exploratory with pornography.
- Listens to stereo loudly in car and at home.
- When irritated, has beady, dangerous eyes (psychotic manic!)
- Paces while caught on the telephone; can't stand to be tied down or idle.
- Becomes less serious about taking and keeping on medication.
- Gets interested in atypical things for him, like "teeny-bopper" TV shows, strange music, door-to-door sales products, etc.

Spokane Psychiatric Clinic, P.S.

105 W. 8th Ave. Suite 6055
Spokane, Washington 99204
(509) 455-9090

Mark L. Chalem, M.D.
Howard B. Ashby, M.D.
David G. Grubb, M.D.
David D. Bot, M.D.
John P. Moulton, M.D.

November 19, 2003

Jan Demeerleer
1055 Herrington Road
Moscow Idaho 83843

Dear Jan:

I had you scheduled for an appointment today at noon. Missed you.

Hope this letter finds you well. Please get rescheduled, or give me a call if there is a problem.

Sincerely,

Howard B. Ashby, M.D.

Demeerleer, Jan

From: Gena Leonard [genaleo@comcast.net]
Sent: Monday, December 29, 2003 3:04 PM
To: Demeerleer, Jan
Subject: RE: Good Morning, Son!

Thanks for your prompt response, dear son. No doubt your father has contacted you by now. I phoned Trudy for your Dr. name, etc. and she, of course, put your dad on the phone. I didn't really want to involve him as he has shown me he does not follow through with "kid things" over the years. The fact that he dropped the ball in November, not checking on your promise of making a Dr. appointment tells me he is only willing to go "so" far. I believe I alarmed him enough this morning to elicit a positive reaction. It may have gone only so far as to check to see if you made an appointment with Dr. Ashby. Believe me, dear son, your support system is warned (including Gene and Fer) so you won't slip through our fingers THIS time! We cannot afford to have you go any further with this crisis you are currently in...we all love you dearly and cannot stand by and see you try to "suffer through it" because we all know that is not the case when you are this far into the crisis.

First of all, I would like to ask you to tell Dr. Ashby that not only are you exhibiting the vehicular negligence symptoms (including driving way too fast and furiously) but you are also sleeping inordinate amounts of time: 10-plus hours per night while you were here. That is also a symptom of rapid cycling, you know. Granted you probably needed the rest but given your other warning signs of "trouble" I can only say that sleeping that long is related.

Now for the inappropriate public behavior that was reported back to me... Fer was very upset over your recent visit to Lenscrafter. It was reported to her via the manager (who waited on you, apparently) that you were "obnoxious and loud," essentially making an ass out of yourself in that facility when you were getting your new glasses. And, you were "all over" Amasa, "making out" in public per the report. This is NOT like you, Jan, as you have tons more class than that! As I stated to both Fer and Trudy: when you start acting like Jim, there is something terribly WRONG!! They both understood completely what I was getting at and agreed 100% with me. Anyway, Fer was totally embarrassed and ready to wring your neck over your "performance" in Lenscrafter. She really got upset when she realized, per my observations of your behavior here, that what she was "seeing" was you in a manic state, out of control. No wonder Amasa is trying to "tame" you! She must be shocked to see you change like that... I still believe you had better discuss your bipolar condition with her NOW. If she cares for you, she will come around and be supportive. If she is superficial and is just taking advantage of your "butt magnet" (via Gene's description of you!) attributes, she will be "out of here." If she cannot handle this, my take is that it is better she bow out of your life now than later when you are even more smitten with her. Like I said in my previous email to you: it is only fair you tell Amasa that what she has witnessed is part of your bipolar syndrome. Jan, being under the stress you have been via this ordeal with Amy, from May to now, is enough to do "a job" on you...and it has.

I am proud of you for following through with my wishes. And, I am offering to come over to support you through this, if you wish. I may show up anyway since I am quite sure you STILL think you have it under control and can handle it. NEWS FLASH TO JAN: you cannot handle this alone....you need to keep close contact with Dr. Ashby and your family members, who LOVE you! So, don't be surprised if old Mom shows up on your doorstep in the next few days...

I will definitely expect to hear from you Wednesday, following your Dr. appointment.

Love,
Ma

-----Original Message-----
From: Demeerleer, Jan [mailto:JDemeerleer@avistalabs.com]
Sent: Monday, December 29, 2003 12:20 PM
To: Gena Leonard
Subject: RE: Good Morning, Son!

Thank you for your continued concern. I am listening and responding appropriately to those "watching/helping me." I have made a doctor's appointment with Dr. Ashby (you had it right) for this Wednesday (12/31/03) at 2:30pm. This was the earliest he could take me without a "hospitalization visit," which I feel is not necessary.

I will let you know the outcome of this first visit regarding follow-up visits and general content of discussion. In preparation for this appointment, I believe I understand everything you have identified as red flags except for the comments about "I also heard that you have been acting out in public places in Spokane.... ...particularly since you have acted out around her (one of the reports I had was your inappropriate actions in a public place with her)." Please, help me understand what this is about...I am not following you. I do not know what situation(s) this refers to.

As far as the Lexus goes, they had to replace both front wheels at $25 a piece. They also replaced the front, right tire free of charge under the road hazard warranty. An alignment was also badly needed! No surprises there. So essentially $100 later the car is back to some state of normal. I guess my personal state of normal will cost a bit more than that!! :o)

Talk to you later, Mom.

Jan

-----Original Message-----
From: Gena Leonard [mailto:genaleo@comcast.net]
Sent: Sunday, December 28, 2003 11:22 PM
To: Demeerleer, Jan
Subject: Good Morning, Son!

Jan:

Just to wish you a "good morning" and also to REMIND you to PLEASE phone your Dr.'s office for an appointment ASAP. And, I MEAN...ASAP. You are cycling rapidly, as I noticed while you were here...and you are basically running out of control. You THINK you are in control but, dear son, you are NOT!

You presented all of this information to us, your family, 2 1/2 years ago, I wish to remind you, and you ASKED for our help. Well, you are now being reminded that you are needing IMMEDIATE attention of your Dr. Please phone his office and ask for an EMERGENCY appointment...NOW! I would like to know your Dr.'s name and phone number...and I will call them to make certain you have made this appointment. AND, I will drive over to Spokane to personally escort you to that appointment. Now I know this constitutes a "threat" but I am very worried about you. If this is the only way I can get you into that Dr.'s office, then I will come over and do so!

Since you left today, I have received reports from other family members that you have been acting "weird," which means you are again hiding the fact you are in deep doo-doo. You must remember we KNOW you and we know when you are trying to pull the wool over our eyes, dear one! In case

no one has told you: you are stressed out and have, understandably, drifted back into your cycling modes. Are you REALLY taking your meds? I did not see you take any while you were here. I also heard that you have been acting out in public places in Spokane. So, even though you think you are under control, you are NOT. No wonder your new girl friend is frustrated and confused...she sees this behavior and doesn't know what to think of you. I can imagine she is being critical of your behavior...but I am also concerned that she is trying to mold you into something you are not. Since she isn't aware of your bipolar affliction, she may be thinking you need some fine tuning...she's partly right but you need more than "fine tuning"...you need your Dr.'s attention! You cannot help this, Jan, and you cannot control it. Don't try to cover it up...get to your Dr. NOW! You are not helping the situation by going out and "partying" (drinking), you know. [And, I think it would be a good time to tell Amasa about your affliction...you either lose her now or later, if you don't 'fess up. Who knows, she may surprise you and become a steady supporter. It is only fair to her...and to you...for her to know about your affliction, particularly since you have acted out around her (one of the reports I had was your inappropriate actions in a public place with her).]

PLEASE call your doctor RIGHT THIS MINUTE for that appointment. If his name is Howard Ashby (that sounds familiar to me), his phone number is (509) 455-9090. Try to get in to see him by this Wednesday (so you can beat the deductible for a new year, for one thing, but the important issue is that you are in a serious crisis now...). Like I stated earlier, this is an emergency, Jan. I am serious about my coming over to monitor you, too, dear one. I nagged at you while you were here for a reason...I sensed you were in trouble per your meds and your bipolar syndrome. You SHOULD be seeing your Dr. once a month during this stressful time in your life, too. Yes, you sleep OK...and long...that's, no doubt, depression kicking in there.

I will keep this nagging up for as long as it takes to get you into your Dr.'s office. I love you and I am very concerned over what I observed and what I am hearing from other family members. Please call for that appointment (or I will) and let me know you did follow through...and then KEEP that appointment or MOM will drag you in there to see your Dr.! You must remember that you have NO CONTROL over your moods so quit trying to cover it up and quit avoiding your doctor, Bird. You are not behaving like our dearest Jan...believe me, and other family members, when we tell you this. Do let your Dr. know that you are acting out inappropriately, from public displays to automotive recklessness.

Love,
Ma

4-19-02

Dear Dr. Ashley, 4/22/02

I had a chance to see Jan and his family in person last weekend, and to ask him face to face how he's doing.

He said he feels at peace for the first time in ages, + that he doesn't need to put on his "facade." And although he and Amy are still working on some issues, they both feel hopeful in that regard. So I just wanted to say how grateful I am that his life seems to be coming together again. Thank you,

Trudy DeMeerleer

(Jan's ex step-mom and good friend)

Spokane Psychiatric Clinic, P.S.

105 W. 8th Ave. Suite 6055

Spokane, Washington 99204

(509)455-9090

Mark L. Chalem, M.D.
Howard B. Ashby, M.D
David G. Grubb, M.D.
David D. Bot, M.D.
John P. Moulton, M.D.

September 14, 2001

Mike Canney
Washington Unemployment Office
Fax # 893-7240

RE: Jan DeMeerleer
DOB: 10-27-70

Dear Mr. Canney:

Jan DeMerrleer first consulted me on 9-13. He is under my care as of that time.

His diagnosis is bipolar affective disorder (manic depressive disorder). This diagnosis was first made in 1992 as part of a hospitalization where he was fully evaluated. He has received treatment off and on since then but more recently has been off medication and per his description. In our initial consultation, he described significant mood swings in the recent past to the point of having manic symptoms in the last year that eventually resulted in him losing his job.

It is my opinion, on 7-18-01 when he quit his job that he was in a manic episode and his behaviors were definitely influenced by his psychiatric disorder. This opinion is based on the description of his situation at the time of his situation.

I hope this information is of value. If I can be of further help to provide information to help him interact with you regarding the effect of his disorder in his recent employment situation, I will be glad to try to clarify things as much as possible in his behalf.

Sincerely,

Howard B. Ashby, M.D.
HBA/tf

9/27/01

Counseling Subject List

- Jan's bursts of rage; changed from irritability to short bursts of rage
- Jan not trust himself nor his own judgment; afraid of overconfidence
  - – confidence is NOT same as judgment
  - – confidence IN judgment eroded by "Napoleon" manic states
  - – it is OK to be confident in self; simply be watchful of manic threshold
- Jan needs to define his own personality separate from illness
- Jan's need for continual love and affection due to lack in upbringing
- Jan's sense of "loss" due to failed goals (naive goal setting, inflexible, etc)
- Jan's desire for sexual exploration
- Amy, Jan, & family need a PLAN for future intervention
- Amy's guilt and anger for not being proactive enough about Jan's illness
- Amy's feeling of a false sense of emotional strength; truly feels weak
- Amy's feeling that NO foundation exists in life at present
- Amy's feeling of inadequacy in other's eyes (i.e. college, career, etc.)
- Amy's lack of sexual desire especially with Jan's apparent selfish desires
- Amy's constant need for CONTROL in many aspects of life

PATHOLOGY ASSOCIATES
MEDICAL LABORATORIES
SPOKANE, WA. 1-800-5[illegible] 7891/1-509-755-8600 FI[illegible] REPORT

THOMAS J. ALLERDING MD
MEDICAL DIRECTOR

PATIENT: DEMEEKLEEK, JAN R | SEX: F | AGE: 31 | DOCTOR: HOWARD ASHBY MD | DATE RECEIVED: 01\02\02 | DATE REPORTED: 01\03\02 | LABORATORY #: 162055

PATIENT PHONE: 509-926-3062
(0315.128*/518801366)

REQUESTS: HEPA CBCMAN VALPROIC AMY DRAW

COLLECTED 01/02/02 0925

COMMENTS: LD 01-01-2002 @ 1900

CHEMISTRY

J DEMEEKLEEK 01/02/02

Diagnostic Procedure	Low	Result	High	Reference Range		REF LAB
Glucose, Fasting				ADULT 65-109 mg/dL; PREGNANT ADULT 65-104 mg/dL		
BUN				7-23	mg/dL	
Creatinine				M 0.7-1.5 F 0.6-1.2	mg/dL	
Uric Acid				M 3.1-8.1 F 2.0-6.7	mg/dL	
Calcium				8.5-10.5	mg/dL	
Phosphorus				2.5-4.8	mg/dL	
Magnesium				1.5-2.4	mg/dL	
Cholesterol				LT 200	mg/dL	
Triglyceride				LT 200	mg/dL	
Total Protein		7.2		6.3-8.0	g/dL	17
Albumin		4.1		3.5-5.0	g/dL	17
Globulin				1.8-3.5	g/dL	
A/G Ratio				1.1-2.2		
Total Bilirubin		0.9		0.1-1.5	mg/dL	17
Direct Bilirubin		0.1		0-0.4	mg/dL	17
Indirect Bilirubin				0.3-1.0	mg/dL	
Alkaline Phosphatase		43		Adult 38-110 Child Up to 382	U/L	17
AST (SGOT)		26		5-40	U/L	17
ALT (SGPT)		24		5-50	U/L	17
GGT				5-65	U/L	
LD (LDH)				100-200	U/L	
CK (CPK)				M 25-287 F 20-200	U/L	
Sodium				135-145	mmol/L	
Potassium				3.5-5.0	mmol/L	
Chloride				98-109	mmol/L	
CO_2				22-29	mmol/L	
Iron (Total)				M 35-190 F 30-150	ug/dL	
Iron Binding Capacity				M 230-430 F 250-450	ug/dL	
% Iron Saturation				M 20-55 F 15-50	%	

HEMATOLOGY

J DEMEERLEER 01/02/02

Diagnostic Procedure	Low	Result	High	Reference Range		REF LAB
WBC		5.9		4-11	K/uL	17
RBC		5.53		M 4.3-5.7 F 3.8-5.2	M/uL	17
Hemoglobin			17.0	M 13.7-16.7 F 11.6-15.5	g/dL	17
Hematocrit		48.8		M 40-50 F 35-46	%	17
MCV		88.2		80-100	fL	17
MCH		30.7		27-34	pg	17
MCHC		34.8		32.0-35.5	g/dL	17
RDW		12.9		11-15	%	17
MPV				7-11.5	fL	
DIFFERENTIAL						
Granulocytes		57.0		38-70	%	17
Lymphocytes		30.0		21-49	%	17
Monocytes		6.0		3-11	%	17
Eosinophils		2.0		0-7	%	17
Basophils					%	
Platelet Count		1178	(176 last cnt.)	150-400	K/uL	17
Morphology		SEE BELOW		Normal		17

URINALYSIS

J DEMEERLEER 01/02/02

Diagnostic Procedure	Normal	Abnormal	NORMAL	REF LAB
Specific Gravity			1.001-1.030	
Leukocyte Esterase			Negative	
Nitrite			Negative	
pH			5.0-7.5	
Protein			Negative	
Glucose			Less than 25 mg/dL	
Ketone			Negative	
Urobilinogen			< = 1.0 mg/dL	
Bilirubin			Negative	
Occult Blood			Negative	
Microscopic				

Other Diagnostic Procedures	Result (*)	Units	Reference Range	LT = Less Than GT = Greater Than	REF LAB
Comment for - RBC Morph					
Normal					
Band, %	5.0	%	0-8		17
Seg, Abs	3.5	K/uL	1.8-7.7		17
Band, Abs	0.3*	K/uL	0-0.7		17
Lymph, Abs	1.8	K/uL	1.0-5.0		17
Mono, Abs	0.4	K/uL	0-0.8		17
Eos, Abs	0.1	K/uL	0-0.5		17
WBC Morph	Normal				17
Platelet	Adequate				17
Morph					
Cells Counted	100				17
VALPROIC ACID (PEAK OR TROUGH)	55	ug/mL	50-100		01
AMYLASE	43	U/L	16-108		01

OK 1/3/02 [illegible] with negative [illegible]

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DEMEEKLEEK, JAN R (*) INDICATES RESULT OUTSIDE NORMAL LIMITS 01/02/02 REORDER #0512

September 14, 2001

Jan DeMeerleer
8324 E. Briant Lane
Spokane, WA 99217

Dr. Howard Ashby
105 W. 8th Avenue, Suite 6055
Spokane, WA 99204

Dear Dr. Ashby:

As per our phone conversation, I am authorizing release of information from your office to the Washington Unemployment office representative, Mike Canney. In a written letter to Mike Canney, I ask that you include the following information:

- initial date and description of my mental condition diagnosis
- your recent diagnosis of my mental condition
- confirmation that I am under your professional care and on medication
- your analysis of my state of mind when I quit my job at KeyTronicEMS Corporation on July 18, 2001

Mike Canney asked to receive a fax copy of this letter by Tuesday (9/18/01) at the latest. His fax number is 893-7240. If you need to speak to Mike Canney for any reason, he may be contacted at telephone number 893-7211.

Mike Canney will be using this information to make a decision as to whether or not to honor unemployment insurance benefits to me. Mike Canney first contacted me by telephone on Friday, September 14, 2001.

Thank you for your time and assistance, Dr. Ashby.

Respectfully,

Jan DeMeerleer

Jan DeMeerleer
518-80-1366

MICHAEL J RICCELLI PS
Attorney At Law
A Professional Service Corporation

December 29, 2011

Hand Delivered

Mr. Mark Chalem, Registered Agent
Spokane Psychiatric Clinic, P.S.
105 W. 8th Ave., Suite 6055
Spokane, WA 99204

Howard Ashby, M.D.
c/o Spokane Psychiatric Clinic, P.S.
105 W. 8th Ave., Suite 6055
Spokane, WA 99204

NOTICE OF CLAIM
- AND -
REQUEST FOR MEDIATION
(RCW 7.70.110)

DISCLOSURE:

The undersigned, Michael J. Riccelli of Michael J. Riccelli PS, is the attorney for, and providing this notice and request on behalf of, Beverly R. Volk, as Guardian for Jack Alan Schiering, a minor, and as Personal Representative of the Estates of Philip Lee Schiering, and Rebecca Leigh Schiering, and the statutory beneficiaries thereof. The legal representations of Brian P. Winkler and of the Estate of Jan DeMeerleer, and all statutory beneficiaries thereof, have also authorized the undersigned to provide this notice and request, on their behalf. Collectively, the foregoing are referred to as "Claimants."

NOTICE:
Claimants hereby provide you notice of claims for damages resulting from the acts and omissions in healthcare which caused, variously: personal injury; substantial suffering and emotional distress; loss of consortium; destruction of the parent-child relationship; death; and resulting economic damages. Their claims arise from and relate to an incident on July 18, 2010 which took place in Spokane Valley, Washington. The incident involved Jan DeMeerleer (now deceased), who was then, and who had been for some time, a patient of Spokane Psychiatric Clinic, and its employee, ostensible employee and/or agent, Dr. Howard Ashby (collectively

400 S Jefferson St Ste 112 Spokane WA 99204-3144
Phone: (509) 323-1120 Fax: (509) 323-1122
E-mail: mjrps@mjrps.net

"Providers"). On that date, Jan DeMeerler verbally, and by action, assaulted Jack Alan Schiering (then a minor), Brian P. Winkler (a minor), Philip Lee Schiering (a minor), and their mother, Rebecca Leigh Schiering (collectively, hereinafter "the Victims"), causing variously: great bodily harm and injury, severe pain and suffering, and severe emotional distress, to Brian P. Winkler, Philip Lee Schiering and Rebecca Leigh Schiering; severe emotional distress to Jack Alan Schiering; death to Philip Lee Schiering and Rebecca Leigh Schiering; destruction of the parent-child relationship between Rebecca Leigh Schiering and her sons, Philip Lee Schiering, Jack Alan Schiering, and Brian P. Winkler; and substantial economic costs and loss to the estates of Rebecca Leigh Schiering and Philip Lee Schiering. Jan DeMeerleer subsequently committed suicide, prior to which he suffered severe emotional distress, and subsequent to which his child, Valerie DeMeerler, suffered severe emotional distress, and destruction of the parent-child relationship. Further, this resulted in economic costs and loss to the estate of Jan DeMeerler.

A review of certain medical records of Providers' clinical diagnosis and treatment of Jan DeMeerleer reveal that he was suffering from one or more severe psychological condition(s) or affect(s), and was, at the time of the incident, and had been, for several years previously, while under the care and treatment of Providers. These records also reveal that Jan DeMeerleer: was being treated by Providers with multiple psycothropic drugs; had previously attempted suicide; and while under the treatment of Providers, had, on multiple occasions, expressed suicidal and homicidal ideation. The claimants believe that under these circumstances, Providers breached one or more medical standards of care. These include, but are not limited to: failing to perform risk assessment on Jan DeMeerleer; failing to carefully monitor the efficacy and/or risk of prescription psychotropic drugs; failing to provide more appropriate treatment of Jan DeMeerleer under the circumstances; and failing to otherwise worn the Victims of risk of harm from Jan DeMeerler. You are further notified that claimants may institute related litigation in Spokane County Superior Court. Although the provisions of RCW 7.70.100(1) have been rendered inapplicable by the actions of the Washington Supreme Court, claimants do not anticipate initiating any related litigation for 90 days or more after receipt of this notice by the addresses/Providers.

Request for Mediation. This correspondence also constitutes a request for mediation of a dispute related to claims for damages resulting from the occurrence. This request for mediation is made pursuant to RCW 7.70.110, and it is the intent that the running of the statute of limitations, as provided in RCW 4.16.350, be tolled for one year. It is important that any addressee, their risk managers, insurers, representatives, or attorneys contact the undersigned immediately in order to establish whether any other individual health care professionals and/or entities should be given similar notice.

MICHAEL J RICCELLI PS

By _____
Michael J. Riccelli

\\25701001\DRAFTS\Pleadings\notice of intent final.doc

Amy(X) ; Rebecca Fiancé ⊖ Seizures

Drug Hx — on Both Li + Depakote

MEDICATION

walgreens — argonne + brand 892-1637 SR

PAGE ____ 133

PATIENT Van De Meerleer

ACCOUNT NO. ________

DOCTOR ________

DATE	Depakote	DR	DATE	Risperdal 0.5	DR	DATE	Wellbutrin	DR	DATE		DR	DATE		DR
/13/01	500mg bid		10/10/01	1/d #30+one		9/27/02	150mg bid.							
/24/01	Called ⊃ lost script		12/13/01	0.25mg,			#60+0							
	Sabo called to make sure			1/d #30+ one		10/30/02	#60+Samples,							
	to insured got [illegible]		11/4/02	0.5 #15+2		12/2/02	#60+2							
	#120+													
27/	taking 500mg		3/28/02	#15+2	A	3/26/03	" +5							
/31/01	500mg #60+2		6/27/02	0.5mg ½/d "	A	9/24/03	"							
/6/02	#60+2 ~~[illegible]~~		9/27/02	1/d. ~~#30~~	A	3/15/04	"	A						
/26/02	#60+2	A		(1mg #14)										
/27/02	"	A	10/30/02	Just starting — [illegible] [1mg #7]										
/30/02 script	"	A	12/2/02	#30+2										
/2/02	"	A	3/26/03	" +5										
26/03	" +5	A	9/24/03	"										
/24/03	"		3/15/04	1mg "										
/15/	"	A												
2/8/04	#60+0	A	12/8/04	#30+7		12/8/04	Generic #60+0	A						
/11/05	#180+3	A	1/11/05	#90+3	A	1/11/05	#180+3	A						
/29/05	3/d (lowest [illegible])		10/7/05	Cold 0.25 x14 0.5 x14										
			10/20/05	∅ used [illegible] — [illegible]										
/28/05	#180+3	A	12/28/05	#90+3	A	12/28/05	#180+3	A						
/27/06	Just getting last Refill →			→			→							
/23/07	500mg 2/d. #180+3		2/23/07	Risperdal 1mg 1d #90+3		2/23/07	150mg SR bid #180+3	A						

PATIENT Jan Demeester

MEDICATION

PAGE 134

ACCOUNT NO.

DOCTOR

DATE		DR	DATE		DR	DATE		DR	DATE		DR	DATE		DR
9/28/07	2/d.		9/28/07	1/d		9/28/07	150 mg bid		6/1/09	1 mg				
	1		10/5/07	1 tab 2mg/d			1			#90				
10/22/07	#180+3 A		10/22/07	#180+3		10/22/07	#180+3 A							
5/6/08	" Now		12/6/07	"	"		1							
1/2	mail order received		9/29/08	#180+0		9/29/08	#180+0							
	#180+0 (Rec'd Last Feb 08)						1							
2/4/09	#180+3		2/4/09	#180+0		2/4/09	#180+3 A							
	1			1/2 mostly.			1							
5/27/09	Off Depakote		5/27/09	Tone Lately		5/27/09	Off for awhile							
	Now on Dep. after		6/1/09	Back on 2/d		6/1/09	Back on 1 bid							
	a 2wk wash.		6/11/09	#180+0 ONE		6.15.09	180 #(60+0)	B						
	Restarted yesterday		3/30/10	#180+3		3/30/10	#180+3	A						
6/1/09	Back on x 1 wk		4/16/10	(Seen) now on 2/d		4/16/10	(Seen)							
6/1	D.C. compliance.													
	↑ 3/d.													
	ER #36 (500 mg)													
	Now Reg.													
2/7/09	Blood Level 101													
	(1 ER + 2 Reg)													
	Reg 500 mg 3/d													
3/30/10	#240+3													
8/27/10	#270+3 Ext													
10/16/10	(Seen) using 2/d (Script for 180, 150,													

Mailed 6.30-11

Telephone Message

Chalem Bot

Ashby Schmauch

Grubb Peterson

Date: 6/24/11 Time:

Received by: (Ina)

Caller: JAMES B. DEMEERLEER

Phone: 1055 HERRINGTON Rd.

Message: MOSCOW, ID. 83843

1-208-882-2755

6/27/11 10:45 - Busy

11:00 - left message

2:45 - " " will try again 7/28

Consent for lease of Confidential Mental E. lth/Substance Abuse Records

I Jan Richard Demeerleer 10/27/70
Name of patient date of birth

Authorize: Spokane Psychiatric Clinic, P.S
105 W. 8th Ave Suite 6055
Spokane WA 99204
(509) 455-9090 Fax: 747-2118

Mark Chalem, M.D
Howard Ashby, M.D.
David Grubb, M.D
David Bot, M.D.
Jay Schmauch, DO
Rod Peterson, MD

Release To: James B. Demeerleer - personal representative as assigned by the court.

Obtain From: _____

(address) City State Zip Code

(phone number) (fax number)

For the Purpose of: Continued Care Personal Litigation Insurance Claim
(circle) Other Information for Jan's estate

To be disclosed: (please initial)

_____ Entire record
_____ last chart note/notes
_____ lab records
_____ assessment
Other: Clinical notes, medication record, lab reports

____ all records from date forward: _____
____ allow telephone contact
____ psychological/drug testing
____ report/psychiatric evaluation

RESTRICTIONS: _____

This consent includes authorization to release alcohol, drug abuse, and mental health records obtained in or for the diagnosis, treatment, consultation or evaluation. I understand that I may revoke this consent at any time, except to the extent the action has already been taken in reliance hereon and if not revoked sooner in writing. The consent is valid for 90 days unless revoked in writing prior to the 90 days. You are not required to sign this consent in order to receive treatment, unless this is for a Fitness for Duty Exam or for participating in a medical research study.

Please note when you request records be released to a third party, that party may NOT be subject to redisclosure or privacy regulations.

Patient Signature _____ Date _____

X Parent ~~or Guardian~~ James B. Demeerleer Relationship Father - as personal representative

X Date 6/27/11

Witness Signature _____

File _____ Send out _____ Date _____

TELEPHONE MESSAGE

☐ Dr. Chalem
☑ Dr. Ashby
☐ Dr. Grubb
☐ Dr. Bot
☐ Dr. Moulton

☐ _____ ☐ _____

Date 8/21 Time 11:16

Received By Tara

Caller Jim DeMeerleer

Phone (208) 882-4114

Message: Re: Son (JAN) Bi-Polor manic-depressant Wants to talk to you about this. ? an appt.

TELEPHONE MESSAGE

☐ Dr. Chalem
☐ Dr. Ashby
☐ Dr. Grubb
☐ Dr. Bot
☐ Dr. Moulton

☐ _____ ☐ _____

Date 8-21-01 Time 2:33

Received By Phyllis

Caller Jim DeMeerleer

Phone 208-882-4114

Message: RE: Son

~~possible~~ NP

Please Call

7/20 Noon

8/22 — Gone 4:50,

8/28/01 10:30 8/27 — 1:10 — Gone - back 9:00 Am

Date: 9/12/01 Account # 138649

Doctor Ashby

Name of Patient: Jan DeMeerleer 944-0586 9/05 9/09

Address: ~~3317~~ ~~8324 E. Briant Lane~~

City Spokane State WA Zip Code 99217

Date of Birth 10-27-70 Social Security # 518-80-1366

Phone: ~~Cell 926-3867~~ Cell ~~(509) 868-8437~~ 9/02 N.J.

Parent or Spouse ~~Amy DeMeerleer~~ OK Dad 509

Employer: None Work Phone: —

Insurance Name: N/A

Social Security Number of Policy Holder: N/A

Policy/Group N/A

Claim Number: N/A Date of Injury: N/A

Fees are payable at the time of service. Please check to see if we bill your insurance. If referral or authorization is required for your insurance, you will be responsible for obtaining the referral. Also, please note the length of time the referral is good for and/or the number of sessions. This will be your responsibility.

We require at least 24 hours notice if you need to change an appointment or to cancel. You will be charged in full for missed appointments.

Please ask any questions you have regarding this information.

I have read the above and agree to and understand the above billing, referral and cancellation policies.

Signature Jan DeMeerleer

Appointment Schedule: (Full session) 40 - 45 minutes
Half session 20 - 25 minutes
1/4 Session 10 - 15 minutes

Drs are on call for themselves during the week and can be reached by calling 455-9090 at anytime. On weekends the doctor on call can be reached at this same number.

Spokane Psychiatric Clinic, P.S.

Receipt of Notice Privacy Practices

My signature on this form indicates that I have received a Notice of Privacy Practices from the Spokane Psychiatric Clinic.

Jan DeMeerleer
Signature

3/26/03
Date

June 28, 2011 Dr. Ashby Jan Demeerleer RE: Recent Fax of Death Cert. 11:20
Letter of testimony of Jan's father having been designated as personal representative to execute Jan's will.

I called PRMS (Donita, who will review the documents so I can release clinical notes to father).

12:20 - message left for dad regarding coordinating the above and expectation of being able to release records without further documentation (ie, current information should be state of Washington and HIPPA compliant)

6/29/11 - ok/appropriate to release records. Dad signed release. above documents in chart. Records mailed to father -

April 16, 2010 Dr. Ashby Jan Demeerleer TT-25
Jan indicates that his life is stable, he is reconstituting gradually with his fiancé. They are taking marriage classes, he can still cycle many weeks at a time. Right now he is in an expansive, hypomanic mood, but sleep is preserved. He has a bit more energy and on mental status, this shows through as he is a bit loquacious but logical, goal oriented and insight and judgment are intact. He states when depressed he can get intrusive suicidal ideation, not that he would act on it but it bothers him. At this point it's not a real clinical problem but we will keep an eye on it.

Plan: We will continue Risperdal, Depakote and Buproprion.

7/19/10 – Newspaper article re Dan allegedly killed Pierce + 9 y/o son + assaulted 17 y/o son (cut throat) + then killed self. after hrs. so I'll call + report patient incidents to Ans. as I can't image Homicide/suicide not being investigated + will get info re HIPPA & post death issues.
5:50pm

June 11, 2009 Dr. Ashby Jan Demeerleer TT-50
Jan is being seen because of recurrent hypomanic behavior. He got off the medication for a while but is now back on it. He is stabilizing somewhat but he recognizes that he is still having hypomanic symptoms, ie. staying up at night with a lot of plans, but some of this is imposed on him because his work is continuous as it's been announced they are going to do lay offs next week so he is trying to figure out what to do in terms of having a plan B.

Because of his symptoms and the prior lab work, he indicates that 1 gm of Depakote gave him a level of 64 and I feel increasing it by 500 mg would be appropriate and also we have not done lab for quite a while so he will obtain that after he is on the increased dose for 4-5 days and then check a level. Today he had a bit of an awakening. He realized over the last few days he is having expensive thoughts and making some decisions that were not appropriate and he stated that even on the drive here he recognized some things that were inappropriate. It may be that getting back on the Depakote is having some effect but rather than trusting the relatively low blood level we are going to be proactive. Additionally, we will work with sleep. I gave him a prescription for Zolpidem because he states that once he gets to sleep he can sleep through but doesn't want to be hung over so I think this is one of the best things to help with that, but I also mentioned using the antihistamines OTC. Overall, his mental status was not too bad today, there was no real push of speech, he had insight and hopefully he is getting on track and we can stabilize him.

12/1/09 T.C. – unemployed. Separating from
Fiance & her sons. Needs to get back in counseling
& med management. (wants referral) – gave C.M.H.C.
& chase clinic gave. also [illegible] for med [illegible]
& counselor if that doesn't work.

/ 4, ?–?9 Dr. Ashby Jan Demeerleer TT-30

:ates ...at he has been most stable but in November/ea[illegible] ... cember, had a
:ycle, notes irritability, being easily frustrated and a bit m[illegible] ... ırgumentative.
straightens him out and becomes aware of it, took extra[illegible] ... erdal during
od of time, is not sure how much it worked but he came [illegible] ... gh it and it's
eption that this is still the way to handle that and this ha[illegible] ... ·ked previously,
ll be a little more conscientious about doing that to mini[illegible] ... any of the
;. In the last 10 months, is the only time he can think of w[illegible] ... ı times were
His mental status today is totally WNL, has good insigh[illegible] ... gs are going
is life both vocationally and family wise.

ɔntinue Depakote, Risperdal, and Buproprion.

/09 T.C. – Lost job. Not mar[illegible] ... Got job.
Can't do things, can't get a grasp [illegible] ... Sounds dep.
Can't think, can't process. 8[illegible] ... OK – Risperd[illegible]
P–

9– T.C. – Jan – doing better. Ta[illegible] ... [illegible]rience – [illegible]
to work again today. Processing OK [illegible] ... [illegible]ting.

[illegible] – Depakote 500 bid ... Thru 11[illegible]
Risperdal 2/d.

March 28, 2008 Dr. Ashby Jan Demeerleer TT-25
Jan indicates that he has had some mild cycles in the last 6 months since being seen by him, both depression and a little hypomanic. The hypomanic lasted for a few days and the depression can last for a few weeks but never gets severe. He thinks part of it is because he has not been exercising or been active, kind of changes his life-style to be more "domestic" rather than participating in some of the outdoor things he really loves. He is going to change this and see if it makes a difference. We will leave his medications as is. His mental status today was completely WNL and he will keep in touch if this doesn't turn out right.

9/26/08 - FLC ½ 50mg - (2m) I called + left message ~~KC~~ X

9/29/08 - T.C. Deaton - He'll reschedule - KC

September 28, 2007 Dr. Ashby Jan Demeerleer TT-30
Jan indicates that he continues to do well, has changed jobs, went through that stress without any difficulties so his history really looks good and I'm pleased with how he is doing. He will remain on Wellbutrin, Depakote and Risperdal. Lab needs to be done again although he shows no difficulties with Depakote or Risperdal, which was done 6 months ago.

10/5/07 – TC. – Raised voice at work, ↓ sleep, ↑ c-↑ Response – RTC 10/8. (watch for signs of cycling a Bipolar Dis. Diagnosis)

February 23, 2007 Dr. Ashby **Jan Demeerleer TT-30**
Jan indicates that he is doing well. Review indicates no problems with any cycling. He is on Depakote 500 mg twice a day, Risperdal 1 mg per day and Bupropion SR 150 mg twice a day. Mood, affect, psychomotor activity, content are all WNL. A review of current stressors, work, etc. is negative and he gives a good report. Lab was done approximately 6 months ago. Triglycerides were high and he had not fasted so the blood sugars were not able to be totally judged so we're going to get it again. I gave him copies of his lab so that when he goes to a primary care physician he can have those available as he indicates that he doesn't go for physicals and doesn't have a PCP at this point and I encouraged him to do so. We will continue the every 4 month schedule for appointments.

October 27, 2006 Dr. Ashby Jan Demeerleer TT-25
Jan indicates that he is doing well. His mood, affect, psychomotor activity, etc. were all WNL. He has appropriate affect which is congruent. He has not repeated his lab so he will do that as he had a high glucose but indicated he forgot it and had some coffee with sugar. We also want to check for triglycerides however. He will stay on the same medications, continue to have a quarterly appointment check.

July 21, 2006 Dr. Ashby Jan Demeerleer TT-30

Jan indicates that he is having a little bit of a period of time with being down and negative, needing increased sleep, even had some suicidal ideation. He used some extra Risperdal during this period of time and it knocked it right out, so he feels comfortable about keeping things under control. Actually, because of stresses at work, he would like to have a little bit of a manic episode if anything (tongue in cheek). Mood, affect, psychomotor activity, content, insight, etc. are all normal and he is doing well. We don't need to make any medication changes and he is doing a good job of managing things. I indicate to him, however, that if it's not just a minor change, he really should keep in touch with me so we can process it together. He was open to this but reassured me that this episode was not anything that needed to be concerned about.

8/25/06 – Lab discussed. Has coffee + sugar so 101 FBS not accurate. Diet D's could acct. for Trig. He'll "straighten up" + repeat in 6 wks.

March 31, 2006 Dr. Ashby ***Jan Demeerleer TT-30***
Jan indicates that he is doing well. His mental status is totally consistent with this and we can continue on the same medication. He indicates that he is most likely going to marry his current girlfriend. Family is still a bit tender about his clinical state but as he continues to do well, this should improve.

December 28, 2005 Dr. Ashby Jan Demeerleer TT-25
Jan indicates that he has been stable, is doing well. Mental status is totally WNL.

Plan: Continue current medications.

November 17, 2005 Dr. Ashby Jan DeMeerleer TT-30
Jan is stable with regard to his bipolar symptoms. He and his girlfriend are still talking very seriously. He recognizes that he has high expectations and this is causing problems both in terms of his expectations about how a marriage should work and how her autistic son should be responding to their training and plans. I helped him to be able to put this in perspective but I gave him some tools he can use to assist with this and hopefully that will allow him to reframe some of his expectations so they are not inappropriate and lead to difficulties. He will stay on the same medications.

October 20, 2005 Dr. Ashby Jan Demeerleer TT-50
Jan indicates that he is doing a lot better. He basically is through this cycle. We spent the more part of the interview discussion what to look for to manage these kinds of episodes earlier, to minimize the morbidity etc., and also the interaction between him and his girlfriend and family members and how that can be harolding signs for him.

October 7, 2005 Dr. Ashby Jan Demeerleer TT-55
Jan indicates that in general he is stable, nothing new has happened. As we began to process this recent episode he acknowledges even further the connection between his behavior and the mood change that he had, in this case depressive symptoms. We processed this in light of his history of episodes regularly prior to 2001 and being placed on the current medication regimen and how things are better so he can trust that a little more and can trust that others will not be as taxed by it either. He was open about the fact that despite doing better, he is having difficulty with psychotic thoughts. He can reality test them but he states at the time they seem so real. We talked about Risperdal and we're going to have him take ¼ of a tablet and also ½ tablet 2 weeks each in addition to his 1 mg tablets to see if we can get a feel for what he can tolerate cognitively, but yet get a little more control. He has not done his lab yet as he got a cold and didn't want that to reflect on the CBC. He will get that when things are stable and this will give us a baseline of what 1 mg per day does and then we will check it again sooner than normal if we stay on the higher dose. The other plan would be for him to use higher doses now that he is getting more tuned into mood swings and stay on 1 mg as a base and use 1 ½, which I think we need to use higher because of his admitting that he has the thoughts fairly regularly.

Plan: Continue Depakote, Wellbutrin and Risperdal as discussed above. His mental status today was good. He had good insight, psychomotor activity etc. were WNL.

September 29, 2005 OV 35 Minutes Dr. Ashby **Jan Demeerlear**

Jan indicates that he is more aware that he has been negative and in a depressive mode, although on a scale of 1 to -10, only a 2 or a most a 3. As a result, he has minimized to himself exactly what the connection that had with what is going on, but as he thinks about it he realizes that if he had not been in a negative mode, he probably would not have gone through what he staged which alarmed the family so much. This is the first time he has made a connection between his mood disorder and his recent behavior so the door for his insight is at least opening. He is less intense today, a lot more relaxed because things have smoothed out between him and his significant other. Family members are still pretty alarmed at his behavior. I see no evidence of mania, and his judgment seems to be okay. He had another problem with financial blow, as his computer program went down on him, which has his financial diary for years and years.

We talked about his medication, we are going to increase his Depakote to 1500 mg per day and he has not got the blood level yet, even though I asked him to do it last week. The other medications I will leave the same. We set up an appointment in one week, and then a week and a so after that.

September 21, 2005 30 Minutes Dr. Ashby **Jan DeMeerleer**

Jan came in with his father. He has had a recent episode where he feels that things are just not going well and financially he is getting nickel and dimed. His truck was vandalized – $2500. which set him back emotionally. He had been talking with his girlfriend about the fact that if they were to get married, which they had been talking about that he would have to be able to deal with his mental situation, i.e. being on medication for Bipolar Disorder, etc. She has indicated to him that she feels that she is able to do that. He decided to test this, at least as he describes it and ended up with some erratic behavior, which she reported to his family and they became concerned. As his father was here, I was able to get collateral information and father is concerned about the behavior but there is not other indications of any change in thought and this does somewhat of a context, but it is not satisfactory to chalk it up as a reasonable incident. Rather than looking at it to be a bipolar swing, however, I am wondering if it does not reflect some other aspect of his personality and adaptation, and sense of security in wake of his first relationship ending in divorce.

Mental status: he is goal directed. No obvious manic symptoms are noted. He was very cogent and gave a good reasonable account. Logical and easy to follow. His father indicated that they have not seen any objective signs except for the behaviors that he says he did to test his girlfriend's ability to handle him.

Disposition: He is to stay on the same medications. He will return in a week or two for follow up, to see if there is any kind of a trend that would detract from the fact that he seems psychiatrically stable, even though psychologically there appear to be issues.

July 15, 2005 Dr. Ashby Jan Demeerleer TT-30
Jan indicates that he is doing well. He has a lot of stress at work but is handling that well and has not had any mood swings or episodes, except a couple of weeks ago when he took a vacation for a week, went away, forgot to pack his medication and by the end of the week noticed that he was having difficulty with depression and as a result, had somewhat of a run in with his girlfriend which was stressful, but got back on the medication and continues to be stable.

Mental status exam today is totally WNL.

Plan: Because of some mildly elevated lipids and a high normal glucose, we will get his lab done again to make sure there is not a further drift toward abnormal levels, otherwise he will stay on the same medications and I'll call him when I get the results back.

January 11, 2005 Dr. Ashby Jan Demeerleer TT-25
Jan has not been seen for approximately 8 months. He indicates that he has been emotionally stable, continues on Depakote 500 twice a day, Risperdal 1 mg at HS and Wellbutrin 150 mg twice a day. He has moved on with his life. Divorce issues are pretty much over. He has a significant other that he is seeing regularly and almost to the point of living together. His mood, affect, psychomotor activity, content, etc. are all totally WNL today.

Impression: Stable emotionally.

Plan: Continue current medications, get lab work as we followed up on Depakote information in the past but not on Risperdal. He doesn't have any stigma of any difficulties but we will double check, particularly since the lipid profile problem can be quite occult.

1/25/05 T.C. Lab reported - "ok"

1/27/05 - T.C. above message cut off - reviewed "need to check lipids"

#4 7/12/05 FTC 1/2 55m - I called & left message prior to appt. ? if got it. Letter sent - N.C. Warned

April 27, 2004 Dr. Ashby Jan Demeerleer TT-60
Jan indicates that he just feels like he is not moving forward and adjusting to his divorce. We processed this fully, looking at all the different ramifications of it, the experiences he is having emotionally, etc. I was able to reinforce by having him compare his current feelings with how he handled situations before, ie. does he have a tendency to be someone who holds grudges and has to get revenge and he indicates that he has never had these kinds of thoughts before, that currently his statement is "if I'm not happy, I can't stop perseverating on the fact that I don't want Amy to be happy. He does admit that he has had fantasies of different negative things but would not act on any of them as he knows better but it scares him that he has had such intense feelings. We talked about what that means in terms of his ability to have feelings and unfortunately we only have strong love feelings when that is torn away from us that we have strong feelings on the other side, either of depression and loss or anger. He showed insight into this as the commitment to continue to be forward looking, to cognitively fight these negative thoughts but he is getting tired of the fact that he feels like he is not making progress but spontaneously did document that intensity as less although frequency is the same and we reviewed the implications of this. His mental status exam otherwise is normal in the sense of mood, affect, content, being logical goal oriented, etc.

Plan: Continue current medication and support.

#3 6/2/04 FTC FSSN – T. Redacted – Redacted

12/8/04 – T.C. will schd. – 1 month sooner called –

March 15, 2004 Dr. Ashby Jan DeMeerleer f/ssn
Jan states that he has been stable over the last number of weeks particularly since our telephone call when there was some question about some behavior. He got all that straightened out and there are no difficulties and his behaviors have not been manic like. Despite this, however, he states that his wife is somewhat guarded and although they both have their daughter and she comes to his house she is not allowing him to know where she is living currently. Work, relationship with his daughter are good. The divorce still hurts. We processed this quite a bit and socially he indicates that he is pretty much shut down but is making efforts to meet people. His mental status is totally WNL, has good insight, doesn't want to make any medication changes even though I would be comfortable with decreasing his Risperdal. We reviewed his lab work which is normal.

January 30, 2004 OV Full Session Dr. Ashby **Jan DeMeerleer**

Jan indicates that he is stable. He has had a good week, because it is the week he has his daughter. He has weekend plans, super bowl weekend, etc. with friends and family, so he feels okay about that and the work week goes reasonably well for him. Last week his wife handed out an olive branch of friendship, had some interaction with her. This may indicate that she feels a little less threatened and able to do things without feeling "boxed in". However, the chances of them getting back together, not only because of her attitude, but things he knows about the situation and he would not be able to trust her again. We talked his ambivalence, tendency for him to be all or nothing in his assessment of things. He finally spontaneously comments that "I guess that there are some good things that can come out of this". What held back on this, was that it appeared that he had the mind set, that unless he was able to have her give him feedback about his contributions to the problems that he would never be able to learn and go on. We talked about this issue that this was not the case and that there were other ways for him to learn and dealing with different then dealing with other concepts and the solution is not always evident of available. He showed insight into this.

Mental status exam today was totally within normal limits, he is stable and will continue on the medications for the Bipolar Disorder.

#2 2/12/04 ETC. FSSW - I called & left message - 2nd miss 1
½ day

2/20/04 T.C. WTP. I returned call & indicated I can listen but y talk. She expressed concern that Jan would do/say meth // about miss conduct & that - as a result of her call is prompted to call him again - left message 9:10

2/23/04 T.C. - Dad - Expressed concerns. A. Holland
allegedly: kayed door?, Rock-thru window?, entered BF's house-
& asked dad to have him call me - Dad gave me Jans cell #.

3:40 T.C. to Jan - cell - left message - confronting BF.
6:10 - T.C. - He denies everything but confronting BF.
Carry is at his house now) & he talked openly even re
Rx hearing. He indicates he's actually doing better
Rx appt 3/15 & to call earlier if needed.

January 23, 2004 OV Full Session Dr. Ashby **Jan DeMeerleer**

Jan is still reeling from his wife divorcing him. He admits that he has had a lot of dark thoughts over the last couple of weeks. Talked about this to some friends, they rallied around him and kept him okay. He apologized to them for being so negative, they were actually homicidal/suicidal thoughts. He indicates that reality check was appropriate and he is embarrassed that he had those thoughts and let himself get that carried away. He knows that he would never go there, but just the fact that he was expressing it out loud to other people is an embarrassment to him. We took a step back and looked at this to try to get a sense of perspective that might be helpful. One thing, is that he really does have strong feelings and this in a man who felt that at times he didn't have the ability to have deep feelings about things. Additionally, the fact that he talked with others and then they responded in a way that was appropriate, and as friends would do, was reassuring. As he has a tendency to look at the half empty side of the glass, we worked on this cognitive behavioral principle.

Mood, affect, psychomotor activity, content, insight, etc were all within normal limits. He does openly expresses the fact that he is in a lot of pain because of the sense of loss, but it is helpful to him that he has liberal visitation with his daughter who allows him to stay centered. The other five days he struggles. We worked on this also, so that he can have some counter statements to help with the tendency for negative interpretations.

Plan: Continue current medication, continue weekly support.

January 9, 2004 Dr. Ashby Jan Demeerleer TT-60
Jan is reasonably stable except for depression, which I think is mainly situational though we need to keep an eye on this. It may be that rather than Depakote, he could do well with something like Trileptal that helps with depression better or have a little more broad spectrum antidepressant rather than Wellbutrin. Also he is only on 150 mg of Wellbutrin which we could increase the dose, ie. this will need to be watched. After reviewing medication, we looked at the psychological aspects of his current stress, ie. the divorce, relationships, and is questioning himself a lot. There are family dynamics that contribute, ie. he describes his brother being favored by his father. He always aligned himself up by standing next to brother so he could be in the limelight but never giving himself over to the particular behaviors or activities that his brother participated in or "accomplished". Additionally, in terms of trying to "find out" about himself, he describes himself as previously being outgoing, not so now, feeling now that he really doesn't know who he is, really bugged into the fact that he is quite controlling, quite all or nothing in his thinking and difficulties with feeling he is vulnerable and that he cannot let those be discovered.

Plan: Between now and our next appointment in 2 weeks is for him to try to experiment with some of the principles we talked about today and get some experience other than with his stereotype feeling that he should not give himself over to vulnerabilities or intimacies or even dealing with small things like getting back in the gym to make friends, reach out to people who have said that they are there for him, ie. he had 3 colleagues who offered to be there for him and he has never taken them up on it.

December 31, 2003 Dr. Ashby Jan Demeerleer TT-30
Jan missed his last appointment approximately 6 weeks ago, was in the middle of separating from his wife, totally spaced it out. Currently, however, he probably would not have made another appointment until some time in January but his family pressured him to get an appointment today. In the wake of the divorce, he was initially quite depressed, admits to having suicidal ideation, it walked through his mind, as he put it, but he would not take it seriously and has no intent, really feels like he could not do it. It actually bothers him that these kinds of ideas are entertained by him from time to time. He became congruently upset and tearful because he states that those thoughts are totally untenable and unlike him and not something he would normally consider because of his daughter and other family members. He specifically documents how much support his family is and how much he knows he is cared about.

An additional negative, however, is that he started seeing a woman for approximately a 4 week period which was a very rewarding relationship, however, the last 2 weeks she has backed off and become more aloof indicating that there are a lot of little things about him as she got to know him that she didn't like and this really sent him for a loop because it's basically the same language his wife used, that there was not one thing but a lot of little things that caused her to divorce. We talked about these issues fully as time allowed and he was able to put things into perspective and already had in many ways. Additionally, however, he states that he does want to make some changes in things he knows are reasonable for him to make so we began a review of some target behaviors that he would like to work on.

Impression: Some emotional lability, but he has not had major symptoms that indicate that medication needs to be changed more than he needs psychological support. He has had depressive symptoms and has had some hypomanic behavior but in the context of the recent stresses, I do not see that the disorder itself is raising it's head as much as the situation is creating the symptom response. With this in mind we're going to schedule a number of appointments in succession so that we can work on these issues and give him the support that he needs. I do not feel he is a suicidal risk. I also do not feel he is overly depressed or manic, either one which would cause him not to be able to continue to be functional at work, socially or in his family life at this point. Mental status, in that sense was euthymic in the sense of no push of speech, no rapid mood swings, thought content and production were all totally WNL.

September 24, 2003 Dr. Ashby Jan Demeerleer f/ssn
Jan is stable with regard to mood. His mental status is totally WNL. After reviewing we spent the rest of this session talking about difficulties he has had in his marriage, probably in the wake of his manic episode, etc. We reviewed this situation so he could at least understand some of the feelings he is having and motivations. He seems to have good insight, isn't making any decisions irrationally and doesn't seem to be inactive so he seems to have a reasonably good balance and will continue to learn as much as he can so he can make the right choice when it needs to be made.

#1 11/19/03 FTC FSSN

July 17, 2003 Dr. Ashby Jan Demeerleer f/ssn
Jan indicates that things are reasonably stable right now with regard to work, his clinical status, etc. His mental status exam is totally WNL and certainly reflects stability clinically. His main concerns at this point are the marital relationship. His wife is in counseling and she continues to work. In the normal course of discussing their relationship, etc. he describes a couple situations that cause me to ask if his wife has a tendency to be shy and he mentioned that she does and that his daughter is exquisitely shy and a couple of other questions led into the possibility of her having a social anxiety/social phobia type of situation that could be adding into or complicating her own psychological issues that she is working on. This would be difficult to approach but I feel strongly enough that she and her counselor need to gather an appreciation of the impact of these anxiety symptoms, such that gaining collateral information from Amy's parents or from Jan, etc. would possibly be an important adjunct. He will see if he can approach this because certainly our motive is not to change the focus on Amy in any means because his manic disorder is the key problem but as is the case in most situations, they are issues that most of us as individuals have and certainly this situation appears to need to be looked at and sees where it fits.

He will stay on the same medication, continue to try to stay clinically stable and nourish the marital relationship as much as possible.

May 15, 2003 Dr. Ashby **Jan Demeerleer f/ssn**
Jan attends by himself. Lab is totally normal except for Metamyelocyte of 1% which is supposed to be 0, which is a transitional form and doesn't appear to be clinically significant. Mental status exam today is WNL. He does acknowledge however that he is under stress because he became aware that his wife is having an affair with an acquaintance at work. It has not progressed to full blown sexual relations but the emotional attachment and relationship had developed significantly. Subsequent to that they went on a vacation to Hawaii which had already been scheduled and he decided it was best to do that and have an opportunity to work through things which they did. He is totally committed to working on things and is handling this reasonably well. His sense is that she is not quite as committed and more vulnerable because of insecurity. At this point she is in counseling herself and they are working on things.

We made changes last time because of the fact that he had some mild difficulties with depressive symptoms and some hypomanic phase during the earlier part of the year. This seems to be stabilized now and we can continue on the same medications.

March 26, 2003 Dr. Ashby **Jan Demeerleer f/ssn**
Jan indicates that for the past month he has had depressive symptoms. In looking back it may be that his feeling good in January was indeed a little bit of a hypomanic period. It was functional however, so I'm not sure if we need to deal with it. He feels like he is coming out of the depression the last couple of days. Prior he had a manic phase, depressive phase, and then a mixed phase so if it holds true to that he could be going into a mixed phase at this point. If that's the case, I want him to take 200 mg of Wellbutrin twice a day and 2 mg of Risperdal to take care of things in both directions and he is to call me in 3 weeks if the results of having to do that are working or not. We will get together again in 6 weeks. His wife attended with him today, it was a good session in terms of working on learning how to manage this in a micro sense at this point.

January 23, 2003 Dr. Ashby **Jan Demeerleer f/ssn**
Jan indicates that he is feeling well and because of this he is worried about whether he is cycling into mania. Sleep is good, energy level is good. He is not having any of the symptoms he had before except that he is having optimistic thoughts about things. In discussing things today and reviewing his situation, he is able to look at both sides of things, his content is appropriate, psychomotor activity is normal, is not off on tangents, is able to look at both the positive and negative and is realistic and I don't see any red flags per presentation or content. We reviewed what he is to look out for as harolding symptoms and to use his wife as an informant and source of collaterol information.

He continues on Depakote 1 gm per day, Risperdal 1 mg per day and Wellbutrin 150 mg SR twice a day. He will continue on these medications and continue visits on a monthly basis.

December 2, 2002 Dr. Ashby **Jan Demeerleer f/ssn**
Jan indicate that he had an episode of approximately an hour, hour and a half of having angry, aggressive thoughts, even to the point of suicidal, homicidal thoughts, wouldn't act on them and it went as quickly as it came but on close questioning, he admits that during that period of time he was not checking himself or censoring those thoughts except not letting himself act on them. All told, there are some indications that he was still being responsible, ie. he didn't want to leave because his daughter was sleeping etc. so there is an element of safety and keeping things under control that continue to be maintained. Mental status exam today is WNL and he indicates that he is sleeping, doing fine, there is stress with his job as he has two job offers and now just has to wait to see which one comes through but he will be hired on permanently within the next month or two in one of the two jobs. This will be of great help to him.

The last episode he had was in September which was approximately 2 months ago so we will have to keep an eye on this. It lasted about 3 hours, so hopefully the trend is that the medication is keeping things under control.

Plan: Take an extra Risperdal at the earliest onset, also use cognitive behavioral therapy principles that we've discussed prior and reviewed today.

October 30, 2002 Dr. Ashby Jan Demeerleer f/ssn
The first half of the interview was taken up with medication management. No dose changes need to be made but as I had given him samples of Risperdal, he didn't catch onto the fact that the different color was actually a different size, he just thought it was because it was in a different package but it was the same dosage. This is good as he has not used the 1 mg Cogentin, is only on 1/2 mg and I'd like to see if he continues to do well. We reviewed symptoms in the past year and a half or so of treatment and he has been able to keep things under control. We added Wellbutrin last month because of depressive symptoms. He doesn't notice much difference but his wife feels he has come back out of that over the past couple of weeks. It's difficult to tell exactly if this was the Wellbutrin totally responsible for this or not but it appears that it did have a positive influence and we will continue to leave him on the medicine and reassess this.

The second half of the interview was dealt with, psychological issues, questions of the impact of this disorder on their relationship, etc. and even doing a little bit of education about marital interaction in light of the bipolar disorder, stresses etc. They are doing reasonably well, their marriage is strong, they are the parents of an almost 2 year old so this is causing problems and it's nice that his stability is coming along so that it doesn't interact with that stress.

Plan: Continue medication, continue support.

September 27, 2002 Dr. Ashby **Jan DeMeerleer f/ssn**
Jan attends with his wife. Over the past two weeks he has noted some symptoms, in impulsive purchase, some depressive affect, increased sleeping, little less jovial, some unusual responses at work, ie. a person was giving him a compliment about his engineering skills and he stated "I don't want to be that kind of an engineer" and later didn't even know where that statement came from. We're interpreting this as being an indication of difficulties with mood swings. The only change we've made is to decrease the Risperdal so we will increase this. I also feel that adding a little bit of an antidepressant like Wellbutrin prophylactically would be appropriate. Side effects, rational for use, seizures, issues etc. with regard to Wellbutrin was discussed.

Plan: Continue Depakote, continue Risperdal but go back to 1/2 mg a day instead of 1/4 and add Wellbutrin 150 mg a day for 4 days and then twice a day.

August 28, 2002 OV Full Session Dr. Ashby **Jan Demeerleer**

Jan's mental status is within normal limits. He is stressed because he is going to be losing the job he has now in another month. He has not been able to find another engineering job. He is looking into going into financial counseling as a back up. He talked also about stresses this is having on his marital relationship, and I asked whether or not felt his wife was depressed, he had not even considered this, and this seemed to threaten him, because he needs her to be strong, but this could be an issue. They will be spending time together, quality weekend and hopefully they will have some talks and keep things going in a positive direction. In the meantime, this does not appear to be a medication issue. He is stable, not manic, or overly depressed, bit discourage, but appropriate for the situation. Continue current medications. Continue emotional support.

July 26, 2002 Dr. Ashby **Jan Demeerleer f/ssn**
Jan attended with his wife. We did the medication review and assessment of the manic depressive symptoms. Initially this appears to continue to be stable. Lab work doesn't need to be done and mental status is WNL. The latter part of the interview was spent on dealing with the impact of the manic depressive disorder on the marital relationship. Both of them have good insight, there is an increase in confidence coming along as time goes by and he continues to be OK but there is still a lot of aftermath from the significant symptoms he had and the pathology that was inflicted upon the relationship. We identified some areas to work on, some assignments were given and we will review this at his next appointment.

June 27, 2002 Dr. Grubb **Jan Demeerleer f/ssn**
Jan attended with his wife today. He had questions with regard to his ability to know if she was being objective in assessing him and she feels there was signs of difficulties. We reviewed his recent stresses, how he has handled those, the tendency to have depressive symptoms, how much of this was consistent with the context and the quality and quantity of his reaction. After the review, we all agreed that he is bouncing back and his wife's descriptions were actually quite accurate with his and so I think both of them are being quite objective and assessing things appropriately at this time. His thought content, production, goal orientation, etc. were all WNL. Psychomotor activity was normal. I see no evidence of any manic symptoms at this point. He is negative but there's a context of that as he has not been able to find a job and there's a lot of insecurity in the temporary work that he is doing right now.

We reviewed his last lab work. Medication doses etc. and will continue the doses of both the Depakote and the Risperdal. It may be that he doesn't need the Risperdal but because he is still in stressful situations and is bouncing back, if we had to air, I'd air on the side of leaving him on medication that could still be supporting that.

April 26, 2002 Dr. Ashby **Jan Demeerleer 1/2 ssn**
Jan's mental status is WNL. He is stable, has continued to job hunt. Marriage is struggling but he seems to be taking things in stride. Mood is neither euphoric or depressed. He seems to be being kept in reasonable bounds.

Plan: Continue Depakote and Risperdal. No EPS are noted.

May 24, 2002 Dr. Ashby **Jan Demeerleer 1/2 ssn**
Jan indicates that he continues to do well. He got a job offer but has to turn it down as it's in California and they offered ridiculously low wages for cost of living etc. He was really discouraged two days ago when he found out about work, his wife was upset because she felt he should feel good that he got a job offer but he reacted negatively because of the disappointment and felt it was almost a slap, someone trying to get him to work for practically nothing. He asked her to give him a day, yesterday stated he felt better, was bouncing back and today has totally bounced back, has it in perspective, has a couple of offers including one with his old company but yet these things will not formally come about for a number of months so things are basically still up in the air. Mental status exam is WNL, psychomotor activity, content, etc. are all WNL.

Plan: Continue current medication management, invite his wife to assess him so we can review things with collaterol information.

March 28, 2002 OV Full Session Dr. Ashby JAN DEMEERLEER

Jan attends by himself today, he continues on Depakote a gram a day and Risperdal .25 mg a day. He is stable and has good insight. We talked about work and interaction with wife. We did some work on how to interact with her which should take some stress out their relationship and he is going to experiment with giving her more room because he can be controlling on some levels and will report back.

February 26, 2002 Dr. Ashby **Jan Demeerleer f/ssn**
Jan basically is stable however there is some evidence that he may be getting discouraged. I've asked enough questions to satisfy myself that he is not having difficulty with depression although there is some increased sleep, little less ability to handle stress, some less energy and some difficulty with concentration. My sense is however, that some of this such as the sleep, is some avoidance behavior because of getting discouraged with the job search. We talked about things in a clinical sense although reviewing the legistics of his vocational situation and I think the most important concept for him is that he needs to define for himself when he is doing all he can do and or when the situation is unchangeable so he can either give himself permission to move on or to continue to search after his current goals. On mental status he is goal oriented and has insight etc., psychomotor activity and content are normal.

Plan: Continue current medications, continue support.

January 16, 2002 Dr. Ashby Jan Demeerleer f/ssn
Jan appears approximately the same as far as the psychomotor activity etc. Content, judgement are good and I do not see any particular red flags for a bipolar disorder. I think his jovialness etc. at this point is more his personality style than evidence of mania. We talked about cognitive behavioral therapy to help with all or nothing thinking and other cognitive distortions. He showed good insight into this and he and his wife will work on it together.

February 5, 2002 Dr. Ashby Jan Demeerleer f/ssn
Jan is doing reasonably well. He has had two job opportunities that didn't come through. This could be very discouraging and upsetting, however, he is handling this well and neither showing depressive or manic symptoms. He is goal oriented, logical, good insight. We talked about broadening out his view which I think is important for him to do but it's difficult for him because he has a tendency to be a little bit locked on to one path. His wife is now working full time so she is not here but he shows insight into continuing to use her as collateral information on his clinical state.

Plan: Continue medication and support.

December 12, 2001 Dr. Ashby **Jan Demeerleer f/ssn**
Jan indicates that he feels like he is normal, his wife indicates that she observes that he is doing well, seems stable. He is having some difficulty with stress and having to make a job and career decision. Financially they will only be able to handle things through February and decision then are looming because of this. We reviewed the medication and he seems to be doing well on the Depakote and he is also on Risperdal, 1/2 mg per day as that was to be used short term, we will now decrease to 1/4 of a mg per day for a few months and if he remains stable, we will stop the Risperdal and continue Depakote. Lab work was ordered there today. Psychologically, we didn't have much time to go into the problem. He is still working on trying to separate what is his personality and strengths, etc. and what is the artifacts of the disorder and will continue to work on that in subsequent sessions.

December 26, 2001 Dr. Ashby **Jan Demeerleer f/ssn**
Jan indicates he is stable clinically, mental status exam is consistent with this. His mood, affect, content, production, etc. are within normal limits. Psychomotor activity is normal for him. (He can be a little jovial and boisterous at times but this appears to be his personality). I let him talk openly today without structure to test this out and see what kind of content he gets into. He stays realistic, is not grandiose at all and so I'm comfortable with the fact that he is euthymic at this point. He did not get his Depakote level and will follow that up in the next few days.

Plan: Continue current medication, continue emotional support as he is about to have another test of stress with regard to employment.

November 14, 2001 Dr. Ashby **Jan Demeerleer f/ssn**
Jan is doing reasonably stable on the current doses of Depakote 500 mg twice a day and Risperdal 1/2 mg per day. The more part of the session today was spent on psychotherapy. I reviewed lock on, lock out and object relations material as a way of helping him to evaluate his tendency to have all or nothing thinking and opinions about himself and others in this matter which causes difficulties. Of note is that in talking about his personality style, he initially was very upset about this, acknowledged that he wanted to attribute everything to his disorder but we were able to work through this and he sees the benefit of accepting the fact that he can be both rewarding and non rewarding himself let along others and that it's OK to work on problems.

October 31, 2001 Dr. Ashby **Jan Demeerleer f/ssn**
Jan continues on Depakote 500 mg twice a day and Risperdal .5 mg QHS. He attended with his wife. This was a good session in clarifying an education about his disorder. He is still having difficulties with acceptance of having to deal with the disorder, prior he has had insight while been in the throws of it, would be on the medicine for a while then get off the medication and struggle through for years. He is gaining insight through the education during the sessions. He asks good questions, has an outline of things he is working on which helped with the continuity of the sessions so progress continues.

He is not quite as grandiose but yet still can be somewhat expansive but he is showing more insight.

Plan: Continue current efforts.

October 11, 2001 Dr. Ashby **Jan Demeerleer f/ssn**
Jan attended with his wife. He indicates he is not having side effects from the medication anymore, initially had a little nausea from the Depakote. His level was 92 on 500 mg twice a day. He says that prior he was maintained on 750 mg a day so this should be a good level. He notes spikes of hypomanic behavior, is able to describe it, shows insight into the fact that they happen but also is classic in liking the sense of power and happiness etc. that he feels in that state. He uses words such as overly or too much or too big etc. so had some insight into the fact that it's too much but begrudges the fact that he may be losing it. He is noting that he is starting to have some negative / depressive thoughts and begrudges that and feels that if he is not high, he will be depressed rather than the goal of being euthymic.

I educated him about this, despite the fact he has been working with this since the early 90's, over the last 9 years or so, he still has some misconceptions and lack of confidence that he can feel OK without having to feel high all the time. His wife documents that the hypomanic episodes to reaffirms that they are troublesome.

We talked about adjunctive medicine in atypicals or other antiseizure medicine such as Neurontin or Gabitril. I chose the atypical and talked with him about those and directed us towards Risperdal as an initial trial. I'll have him take .25 mg for a few days and then .5 mg and see if this is enough to help with the hypomanic symptoms. Parkinson side effects and the PDR material was reviewed.

September 27, 2001 Dr. Ashby **Jan Demeerleer f/ssn**
Jan met with his wife. He brought a list with problems that he wanted to address today. We spent time mostly talking about medication management, education about the disorder and how it interacted with his history. He also described how he is trying to be more open and had intervention with his family at his invitation.

It's difficult for him to tell where his confidence by nature leaves off and manic confidence and grandiosity begins. He indicates that he is a type A personality and during depressive periods, this would hold him until it was deep enough to them to actually shut him down. He states that this is the first manic episode where he has not liked the mania because it caused anger and irritability, thus his desire to get help and insight into the need for it. As he describes his situation, I'm again impressed with the mixed presentation but I'm not sure about fast cycling.

Plan: He is to gain additional insight into the earliest heralding signs of mood swings so that we can respond to a manic swing with additional PRN medications to keep him from needing to be hospitalized or lose a job, etc. We will continue to work on his list of problems next time.

apparently it was 40.

Plan: Reinstitute Depakote, get blood level and baseline labs after he is on 500 mg twice a day for 4 or 5 days. Giving the medication at ~~try off~~ proven level, were all described so he can get the level done appropriately. (He was on 750 mg a day previously and had a blood level of 71. I feel that having a fairly aggressive dose would be appropriate due to the description and seriousness of his symptoms and the possibility that he was only partially treated and this may have contributed somewhat to his difficulty with compliance. We will have to watch side effects to help with the compliance also. Set up additional appointments not only to monitor medication but to do therapy.

9/17/01 ~ TC. Renewal letter to be sent to W&B.
also he indicated nausea. went on Depakote
take quantity - will watch for trend

previous hospitalization etc., came clean with everything and asked for their support and help particularly to be able to help his wife when he gets into a manic or depressive swing.

Regarding mania, if he feels suicidal, it's to drive high speeds and hurt himself that way, regarding depression he states he is so immobile that he can't do it although he has had thoughts. He does describe 10 years ago however of being placed in the hospital because he laid down on railroad tracks with the idea of being decapitated.

Medical history is unremarkable except for allergy to Amoxicillin. Family history is unremarkable medically. Psychiatrically his brother has admitted that he has hypomanic episodes but has never gotten in enough trouble that he sought treatment and doesn't want it. There is a maternal grandmother who had depression and difficluties with alcoholism. He graduated from high school and engineering degree in college but has had no military experience. He was placed in jail at age 20 because of the train having to stop when he was trying to kill himself and was detained in the hospital. Subsequently, at age 21, while in college he was in jail for alcohol, stealing bikes and states it was during one of his out of control episodes during college.

Mental Status Exam: He is logical and goal oriented, somewhat labile in that at times he will become quite emotional and state that he is not sure if he really means all the things he says, not sure anymore if he is even talking straight, if he really means it, mainly referring to the fact that at times he will be sincere but then will not live up to it and stay with it. He expresses motivation to get help and to be compliant with medication at this time, however. His mood overall is neutral but again at times he can be very serious but not necessarily depressed but quite intense. Cognition is normal, content is good, judgement is intact. He is not suicidal or homicidal. No obsessions or compulsions. No unusual thinking or other evidence of thought disorder is noted. Intellect is above average. Interaction with wife in this interview was appropriate.

Impression:

Axis I:	Bipolar affective disorder with frank manic episodes but also apparently mixed presentations with a response to Depakote in the past but with poor compliance.
Axis II:	A possibility of cyclothymic personality disorder and some obsessive compulsive traits which will all need to be further evaluated as time goes by and he further stabilized.
Axis III:	Allergy to Amoxicillin.
Axis IV:	Stressors include loss of job, symptoms of his disorder.
Axis V:	Adaptive functioning 60, currently earlier this year

September 13, 2001 Dr. Ashby ~~John~~ Dan Demueller N/P Intake

John is a 30 year old married father of one. He indicates that in 1992 he was hospitalized for 2 weeks because of suicidal ideation, was noted to have mixed depression and bipolar symptoms, ie. fast thoughts, increased energy, etc. He was placed on Depakote 500 mg in the morning, 250 mg at night and he indicates that he subsequently moved to Minnesota, went off the medications, was in an engineering program and then subsequently went on to Indiana. He indicates that the period of time when he was drinking, partying to treat depression cycled a lot, had very much highs and lows but was able to maintain functionality. He did not have any of the psychotic thinking he had in the 1992 episode so he convinced himself that he did not need treatment. He was able to land the job in Kentucky in 1995. In 1996 he married, states that at the wedding he was in a drunken stupor and went into a depressive episode after that. Despite this, his wife stayed with him which he indicates he is thankful for (she accompanied him in the interview). In 1997 he again had depressive ideation with suicidal ideation, began skipping work but finally reached out, was treated on an outpatient basis again. He was started on Depakote and did better but complained of the side effects of medication; ie. taking away his creativity, embarassed about medication to the point that if somebody came to visit, he would make sure it was hidden and not able to be seen. He felt he could feel the negative effects of the drugs. Enough questions were asked to see if he cycled through the Depakote or if compliance allowed cycles to happen and it appears to be the latter.

By August of 1998 after sporatic use when he stopped it totally, he immediately went into a high and had "great feelings". He describes very much grandiose behavior. Over the past 2 years he has not received treatment and approximately 2 months ago quit his job in a grandiose manipulation and play at work where he basically states he made a fool of himself at work, said stupid things and engineered himself out of the job in his delusional state thinking this was a grandiose thing to do. He states that earlier this summer he had suicidal ideation and even homicidal ideas, was going to leave the country. He states that in less manic situations he has a tendency to want to feel powerful, manipulates his wife, relatives and friends with stories. He indicates that at work he was so productive and good that at one time they even went along with his desire to be called by some fantastic name because he was so active and "gung ho". He states that last March he was grandiose to the point that he felt "I'm here to show earthlings what they are capale of". He indicates that as he looks back he recognizes that he was completely out of control.

In August of this year, his wife had to start working because he had quit his job. He started having some depression again and suicidal ideation including playing Russian Roulette. That gun and other weapons have been removed from the home and on Labor Day weekend he had an "intervention" with his family in which he invited them together and finally showed them the records of his

9/13.

Jan Demeulen. 30 y/o Married. pro. 1 child

92 Hosp. x2wks SE – (college
Bipolar – mixed/Rapid cycling
Depakote 500/250.

~~married~~ ⇒ minnesota – went off meds.
Internship – back to school (93)
Engineering – ~~Indiana~~ Indiana (purdue)
Drinking/partying – Depression – cycle –
(Hypomania) Highs & lows. psychotic thinking that had before
Grad. Job – Kentucky – (95)
96 – married – Drunken stupor. → Depression
97 – Dep – SE – mood – skipping work – No interest –
Now not admitting of hurt & disorders or at least causes by self – (Kentucky ...) (Out pt) Reached out for help –
Depakote restarted ⇒ Better...
successful at work
98 – Aug – D/c after sporadic use.
Immediately went into high –
Spending "Great" feelings

2000 May –

2001 – Now fast cycling – ~~Tra~~ – not so Rapid.
& loved the mania. Fool of self at work, said stupid things etc.
This summer "all over," SE, Homicidal ideas, leave country, drop hints – reveal [illegible] power of manipulating wife, relatives, friends of "Stories" –
Ex – ~~March~~ ... here to show exactly what [illegible] are capable of.
"Grandeous,"

[illegible]

wife -
TMMY

Any ✗ [illegible] [illegible]

Depressed — SZ — Russian Roulette - [illegible] gun.

In mania — driving high speed - "[illegible]"

Depression - "[illegible]"

Intervention - ∅ except for family — cycled out enough — to realize need for Rx.

Labor Day — called family together — People know — "NETWORK"

[illegible] Embarrassed. Feel [illegible] Stifle me (b care)

Med — ∅ meds.

[illegible] A - amoxicillin —

∅ illness —

Fam — cancer = ∅ DM, thyroid dz.

[illegible] — Bro. [illegible] — Not [illegible]

MGM — Depression - [illegible]

EtOH — ∅

[illegible] / [illegible] / ∅ military /

Jail — [illegible] (91) [illegible] Hospital

EtOH — can be a problem → treat c̄ EtOH at times

Rise with cycle -

21 B.D. — EtOH [illegible] Bikes [illegible]

Drugs — ∅

Tobacco — ∅ .

PATIENT: JAN DEMEERLEER

DATE OF ADMISSION: 5-11-92

DATE OF DISCHARGE: 5-23-92

LENGTH OF STAY: 12 days.

REASON FOR ADMISSION: Jan is a 21 year old, single, Caucasian male from Moscow, Idaho admitted voluntarily to River Crest Hospital. He was referred by a family friend, Dr. Sally Fredericks for evaluation and treatment of depression and suicidal ideation. Jan had been developing increasingly severe agitation and depression since approximately October 1991 when he was away at Purdue University. He began experiencing thoughts and made several abortive attempts at suicide in October 1991. Since that time he reported that he had been "struggling" to sort out a variety of philosophical and other types of questions. He began to see himself as increasingly worthless, and his thoughts of suicide had increased progressively. Throughout this time he was also experiencing periods of intense psychomotor hyperactivity during which he would go up to 6 days without sleep. During these times he was bombarded with rapid, confused, and tangential ideas and felt driven to accomplish high levels of activities, both academically and extracurricularly. There was no history of significant alcohol or drug abuse.

PHYSICAL AND LABORATORY EVALUATION: At the time of admission, the patient underwent a physical examination conducted by Diana Kottkey, RNC. No acute physical problems warranting intervention were noted. Chlamydia and gynecoccal urethral cultures, as well as HIV testing were recommended.

Laboratory screening upon admission included a chem 26, CBC, urinalysis, thyroid panel, TSH level and urine drug screen. Results of all admission laboratory tests were within normal limits with the exception of a positive on urine drug screen, which was cannabis, which was later confirmed as negative. HIV testing was negative, and urethral cultures for Chlamydia and gonorrhea were also negative.

CONSULTATIONS AND SPECIAL STUDIES: Patient completed a Millon Clinical Multiaxial Inventory which was scored and interpreted by Roy Anderson, Ph.D. Most notable was the patient's intense dysthymia and emotional lability, as well as elated sense of self importance and mistrust of others.

HOSPITAL COURSE: Problem 1. "Depression."

Based upon the patient's description of symptoms over the past several months, as well as his clinical presentation at the time of admission,

it was my impression that he was experiencing a mixed bipolar state, with rapidly shifting moods, and the simultaneous occurrence of intense dysthymia, associated with physical hyperactivity, racing thoughts, grandiosity, and a drive of overachievement.

Based upon the patient's reluctance to take medication, which might interfere with his intellectual functioning, we agreed that a therapeutic trial of mood stabilizer such as Valproate would be indicated as being a medication that would be relatively unlikely to cause undue side effects. Treatment was begun with Depakote and the dosage titrated to 750 mgms daily. On this dose, patient obtained a therapeutic blood level of 71 micrograms per milliliter. He tolerated this without side effects.

Over the course of the patient's hospitalization he showed a gradual slowing of his psychomotor hyperactivity with a lessening of his pressured speech, flight of ideas, and tangentiality. His emotional lability and intense dysphoria also gradually waned, such that by the time of discharge he was no longer experiencing prominent symptoms of depression or suicidal ideation. We engaged in numerous discussions with regard to the nature of bipolar disorder and the recognition of early symptoms suggestive of relapse. We engaged in extensive discussions with regard to his medication and the expected benefits and possible side effects of this.

DISCHARGE DIAGNOSES:
Axis I: Bipolar disorder, mixed type.
Axis II: Narcissistic personality traits.
Axis III: No active medical illnesses.

DISCHARGE MEDICATIONS: Depakote 500 mgms each morning and 250 mgms each evening.

PHYSICAL AND DIETARY RESTRICTIONS: None.

DISPOSITION AND RECOMMENDATIONS: Patient was discharged to return to his family's home in Moscow. Arrangements for a weekly outpatient visit with myself were arranged with initial followup appointment scheduled for 5-29-92.

Richard D. Marciniak, M. D.

D 6-16-92
T 6-17-92
vls

PATIENT: JAN DEMEERLEER

DATE OF ADMISSION: 5-11-92

IDENTIFYING INFORMATION: Jan is a 21 year old, single, Caucasian male from Moscow, Idaho admitted voluntarily to River Crest Hospital. This is his first ever psychiatric admission.

REASON FOR ADMISSION: Jan was referred to River Crest Hospital for evaluation and treatment of depression and suicide ideation by a family friend, Dr. Sally Fredericks. By history he had been developing increasingly severe dysphoria since approximately October 1991 while away at Purdue University for his junior year. His first thoughts and aborted attempts at suicide occurred shortly after his first birthday in October 1991. Since that time he states that he has been "struggling" to sort out the variety of "questions and conflicts" in his life with little or no success. He has seen himself increasingly as worthless and a failure, and his thoughts of suicide have increased progressively, with increasingly elaborate planning. In addition to his feelings of "depression" he describes various symptoms of psychomotor activation including periods of up to 6 days without sleep, being bombarded with very rapid, confused, and tangential thoughts and ideas, and the feelings have driven this toward accomplishing supranormal levels of activities such as being an all A student, while also having a very active social life, while also being the president of various academic societies, etc. A great deal of Jan's dysphoria centers around his perception of himself as a failure for not being able to accomplish the many very high goals that he has set for himself.

Jan denies any significant or ongoing alcohol abuse or other drug use. He admits to having an "occasional beer or two" generally on weekends and on social situation. This has not apparently changed appreciably in the last several weeks or months. He has however essentially dropped out of school in March of 1992, thereby not completing any of his courses during the current semester. He kept his decision to withdraw from classes secret both from his family and friends. The immediate precipitant to this admission occurred over a period of several days prior to the hospitalization. He had returned to the Moscow area unknown to his family and had gathered up his camping equipment. He had hiked at least 10 miles into the Selway Bitteroot wilderness area where his plan was to give himself approximately one week to "come up with answers" to his various life conflicts and if he was unsuccessful in doing so, then planned to shoot himself. Prior to his departure into the woods he wrote several long and detailed suicide notes to various family members and friends, and mailed them from Lewiston.

PATIENT: JAN DEMEERLEER

MENTAL STATUS EXAMINATION: At the time of admission, Jan presented as alert and completely oriented. He showed no deficits of immediate, short term, or long term memory. His cognitive abilities were excellent and his verbal skills superior. He presented himself in a highly intellectualized manner, preferring to deal with even painful emotional issues in a verbalized and intellectualized way. His predominant mood was dysphoric, primarily depressive, and his affect generally constricted to this predominant mood. His thought processes were very rapid, almost pressures at times, and notably tangential. His thought content was remarkable for both feelings of self deprecation and feelings of worthlessness and failure, but also statements suggesting a potentially over inflated view of certain accomplishments while at school. He presented his various suicidal plans in great detail and in very elaborate, romanticized, and grandiose terms.

He denied any hallucinations or delusional beliefs.

INITIAL IMPRESSION: Jan is a young man who appears at the present time to be suffering from a mixture of both manic psychomotor activation associated with intense dysphoria and depression, thereby qualifying as a "mixed bipolar disorder." His dysphoric mania has been gradually escalating over a period of approximately 6 monthsd. His suicidal preoccupations have become extremely intense. Although he denies hallucinations or delusions, I have some suspicions as to possibly underlying psychosis, based upon both his apparent thought disorder, as well as an almost delusional romanticized view of death and suicide

PROVISIONAL ADMITTING DIAGNOSES:

Axis I:	Bipolar disorder-mixed type.
Axis II:	Deferred.
Axis III:	No active medical illness.
Axis IV:	Psychosocial stressors--severe
Axis V:	Current level of functioning 15, highest level of functioning in the past year 85.

ASSETS: Jan is extremely intelligent and verbally very skilled with active interests in participating in psychotherapy. Also,. his intellect allows him to understand the concepts of a biochemically based emotional disorder and thereby accept the need for psychotropic medications. Family support is also a positive asset for this young man.

PATIENT: JAN DEMEERLEER

INITIAL TREATMENT PLAN: 1. Patient will complete both Millon and MMPI psychological profiles to assist in diagnosis of possible underlying psychotic symptoms.

2. Patient will particpate in individual psychotherapy with the goal being to further explore his depressive and manic symptoms as well as identifying more clearly the various personal and family conflicts which are so deeply troubling to him and involved intimately with his current dysphoria and suicidal thinking.

3. Patient will be treated initially with a mood stabilizing agent of Valproic Acid. This is chosen based on evidence of its potential advantage in both rapidly cycling mixed bipolar patients.

4. For the time being we will avoid the use of antidepressants due to the possible destabilizing affect on the patient's mood. We will observe for stabilization of the mood, and lessening of depression on Depakote alone at this time.

5. Anticipated length of stay 2 weeks.

Richard D. Marciniak, M. D.

D/T 5-13-92
vls

MEDICATION INSTRUCTIONS

PATIENT NAME: Jan Deneerlee DATE: 5-22 92

PHYSICIAN NAME: Manchual

MEDICATION: De-Dakate	MEDICATION:
DOSE OR FREQ: 250mg	DOSE OR FREQ:
SPECIAL INSTRUCTIONS: Take one tablet at 7.30 am and two tablets at 5:30pm #11 Sluthou	SPECIAL INSTRUCTIONS:
MEDICATION:	MEDICATION:
DOSE OR FREQ:	DOSE OR FREQ:
SPECIAL INSTRUCTIONS:	SPECIAL INSTRUCTIONS:
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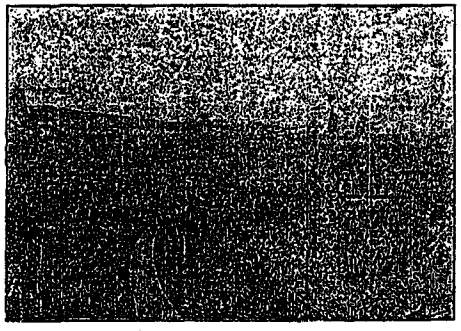
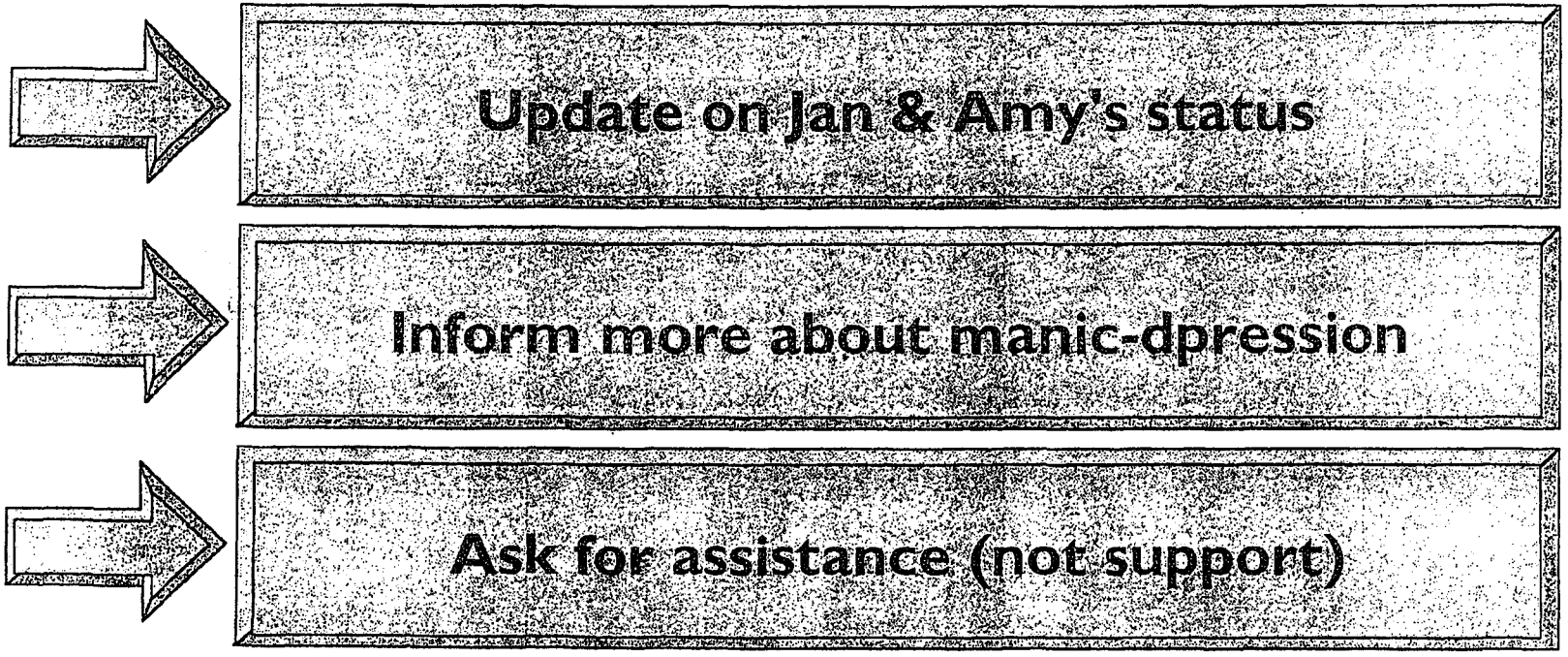
SPECIAL INSTRUCTIONS:	SPECIAL INSTRUCTIONS:

Jan's Manic-Depression

Family Update & Assistance



Meeting Objectives



History

- 1991-1992 severe mania and depressive episodes with many suicide attempts (drugs, knives, cars, trains, buildings)
- May 1992 hospitalized after suicide attempt
- October 1992 left with Amy to Minneapolis
- March 1993 took self off of medication
- Managed illness throughout years of college, 1st job, new house, wedding, etc.
- April 1997 breakdown in depression included suicide thoughts and leaving Amy
- May 1997 entered into psychotherapy with medication
- August 1998 took self off of medication
- Managed illness throughout job fluctuations, new job, moving closer to family, new house, new baby girl, etc.
- July 2001 breakdown in depression including suicide plans and leaving Amy & Val

Problem Statement

- Manic depression (bipolar disorder) is a diabolical, insidious medical condition that affects not only mood but sleep, activity level, concentration, rate and content of thought, sexual prowess, self-esteem.
- Lack of knowledge as well as the insidious nature of bipolar disorder combine to form a lethal combination.
- A list of bipolar symptoms alone is not sufficient knowledge; it does not capture the human experience.
- Medication, psychotherapy, and family understanding (not just family support without careful understanding the disorder) are the best arsenal to provide relief from the crippling symptoms of bipolar disorder.
- Manic depression is NOT curable; it is only treatable.
- Even on medication, one experiences truncated levels of the manic and depressive states. It is not uncommon for one to go off medication a number of times, testing one's limitations.

Potential Help

- Maintenance medication, like Depakote (Sodium Valporate) and Lithium Cabonate.
- Periodic psychotherapy to ease me into reality, help me fight the battles of myself, and learn who Jan is.
- Family understanding and open discussion of the bipolar disorder on a CONTINUAL basis.
- Family help to sort which feelings, actions, and personality traits are symptoms of the disorder and which are the core of Jan.
- Family help to keep me on medication for MAINTENANCE.

Recommended Strategy for Family Understanding

- Group meeting to open up discussion within family.
- Summarize Jan's research and personal experience to define "manic depression."
- Encourage each family member to read more about the illness and ask me knowledgable questions.
- Entertain idea of family members meeting with psychotherapist or local support group to enhance understanding.
- Continual discussion of management of disorder and support for maintenance of medication and therapy. Get involved!

Next Steps

- Family group meeting on September 2, 2001
- Appointment with psychiatrist on September 13, 2001.
- What next????

APPENDIX E

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

BEVERLY R. VOLK as Guardian for Jack Alan Schiering, a minor; et. al.,

Plaintiff(s),

vs.

JAMES B. DEMEERLEER, as Personal Representative of the Estate of Jan DeMeerleer; et. al.,

Defendant(s).

No. 11-2-00277-7

DEFENDANT HOWARD ASHBY'S REPLY MEMORANDUM IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT

I. INTRODUCTION

Plaintiffs' negligence claims against Dr. Howard Ashby are premised entirely upon the legal duty defined by the Supreme Court in *Peterson v. State*, 100 Wn.2d 421, 671 P.2d 230 (1983). That duty was adopted from *Tarasoff v. Regents of Univ. of Cal.*, 17 Cal.3d 425, 551 P.2d 334 (1976). The flaw with Plaintiffs' reliance upon *Peterson v. State*, and the reason the Court must dismiss Plaintiffs' claims, is that the duty of care announced in *Peterson v. State* (duty to "protect anyone who might foreseeably be endangered" by a patient) is no longer the applicable duty in Washington. Rather, just as in California and numerous other states, the Washington legislature recognized the impossibly broad and ambiguous duty placed upon mental health care providers to "protect anyone who might foreseeably be endangered" by a patient, and therefore adopted a standard requiring a duty to protect only when "the patient has

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communicated an actual threat of physical violence against a reasonably identifiable victim or victims." Contrary to Plaintiffs' arguments, *Peterson v. State* simply did not impose a duty on mental health providers to "warn" potential victims of the risks posed by patients. In fact, no Washington court has ever held that a psychiatrist has a general duty to "warn" potential victims of crimes about the alleged dangers posed by patients. Instead, the "duty to warn" only arises when there is a specific threat directed at a reasonably identifiable person. Plaintiffs have not come forward with any evidence that Jan DeMeerleer ever communicated to Dr. Ashby "an actual threat of physical violence against a reasonably identifiable victim or victims," making summary judgment proper.

II. AUTHORITIES AND ARGUMENT

A. *Peterson v. State* Does Not Define The Applicable Standard of Care.

In opposition to summary judgment, Plaintiffs cite at length to *Peterson v. State*. Indeed, it is the only case upon which Plaintiffs rely to support the imposition of some duty on Dr. Ashby's part to third persons. As previously briefed by Dr. Ashby, the duty announced in *Peterson v. State* was taken directly from *Tarasoff v. Regents of Univ. of Cal.* As also previously briefed by Dr. Ashby, subsequent to *Tarasoff*, not only did California decisions limit the scope of a therapist's duty to readily identifiable victims, but the California legislature adopted Assembly Bill 1133 (1985–1986 Reg. Sess.), which statutorily limits a therapist's duty to warn to occasions when "the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims." Washington soon followed suit.

Peterson v. State was decided in 1983. RCW 71.05.120 was amended in 1987 to limit the duty owed by mental health care providers to those occasions where a "patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims." To resolve Dr. Ashby's Motion for Summary Judgment, this Court must decide the applicable standard of care, and specifically, whether the general and ambiguous duty announced in *Peterson v. State* (to "protect anyone who might foreseeably be endangered" by a patient) or the statutory duty identified in RCW 71.05.120(2) (to warn or

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commit if a "patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims") applies. For the reasons set forth herein, Dr. Ashby submits that it is the later.

1. RCW 71.05.120 abrogated the holding of *Peterson v. State*.

Former Justice Phillip Talmadge specifically noted in his concurring opinion in *Hertog v. City of Seattle*, 138 Wn.2d 265, 293 n.7, 979 P.2d 400 (1999) that "the Legislature statutorily abrogated our holding in *Petersen* in Laws of 1987, ch. 212, § 301(1) (codified at RCW 71.05.120(1)), with respect to liability of the State." Justice Talmadge makes it clear that the duty announced in *Peterson v. State* was abrogated[1] with respect to liability of the state. Plaintiffs nonetheless argue that *Peterson v. State* is applicable to the instant case because: (1) RCW 71.05.120 applies only to "the state;" and (2) RCW 71.05.120 only applies to civil commitment hearings. Plaintiffs are incorrect on both accounts.

2. RCW 71.05.120 applies to private actors.

First and foremost, Plaintiffs' argument is contrary to the language of the statute, which makes it clear that it applies to private actors:

> (1) No officer of a public or **private agency**, nor the superintendent, professional person in charge, his or her professional designee, or **attending staff of any such agency**, nor any public official performing functions necessary to the administration of this chapter, nor peace officer responsible for detaining a person pursuant to this chapter, nor any county designated mental health professional, nor the state, a unit of local government, or an evaluation and treatment facility shall be civilly or criminally liable for performing duties pursuant to this chapter with regard to the decision of whether to admit, discharge, release, administer antipsychotic medications, or detain a person for evaluation and treatment: PROVIDED, That such duties were performed in good faith and without gross negligence.

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[1] **ab·ro·gate:** 1. to abolish by formal or official means; annul by an authoritative act; repeal: to abrogate a law; 2. to put aside; put an end to. *Random House Dictionary*. To "repeal or do away with." *Oxford Dictionary - United States, 2013.*

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Second, if the abrogation of *Peterson v. State* applied only to state mental health providers, Washington would be in the unique and unworkable position of having two separate standards of care for private versus public health care providers. It would also call into question the constitutionality of RCW 71.05.120, as state mental health providers would be given far greater rights and protections than private mental health providers. "Our constitutional guaranties to equal protection mean that 'all persons similarly situated should be treated alike.'" *O'Hartigan v. Dep't of Pers.*, 118 Wash. 2d 111, 121, 821 P.2d 44, 50 (1991), citing *Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 439, 105 S.Ct. 3249, 3254, 87 L.Ed.2d 313 (1985); *In re Knapp*, 102 Wash.2d 466, 687 P.2d 1145 (1984). There is simply no rational basis for concluding that state health care providers are to be afforded greater rights and protections than private health care providers.

3. RCW 71.05.120 is not limited to civil commitment proceedings.

Plaintiffs next argue that RCW 71.05.120 only applies "when dealing with commitment of individuals to, and release from mental health facilities." *Response, pg. 6.* Plaintiffs' interpretation of RCW 71.05.120 is too narrow, as is best evidenced by the facts of this case. In summary form, Plaintiffs allege that Dr. Ashby did not perform an adequate risk assessment on Mr. DeMeerleer and did not properly "monitor" him. This begs the question of what actions Dr. Ashby could have taken if, as Plaintiffs' expert speculates, a "more proper and/or formal risk assessment" had revealed that Mr. DeMeerleer was experiencing suicidal and/or homicidal ideations and therefore presented a risk of harm to third parties. Dr. Ashby's only options in such a situation, as it relates to any duty owed to a third person, would be to (1) have Mr. DeMeerleer involuntarily committed; or (2) warn anyone who may be the identifiable victim of Mr. DeMeerleer's homicidal ideations.[2] Any decision Dr. Ashby would have made as it relates to whether or not to have Mr. DeMeerleer involuntarily committed makes RCW 71.05.120 directly applicable.

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[2] While Dr. Knoll opines that Dr. Ashby should have more thoroughly "assessed" and "monitored" Mr. DeMeerleer, he ultimately concludes that had Dr. Ashby not engaged in these "breaches," he would have discovered Mr. DeMeerleer's alleged homicidal ideations and either had Mr. DeMeerleer committed or taken action to warn Ms. Schiering. *See, Declaration, pg. 9.*

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Plaintiffs' argument that RCW 71.05.120 is not applicable to this case was rejected by *Estate of Davis v. State, Dep't of Corr.*, 127 Wash. App. 833, 840-41, 113 P.3d 487 (2005). In that case, a Stevens County Counseling mental health provider (Jones) evaluated an individual (Erickson) on community supervision to determine whether he would benefit from counseling. After that initial assessment, Erickson brutally murdered a third party (Davis). Davis's estate sued Stevens County, alleging that the Jones's assessment of Erickson was negligent. Stevens County moved for summary judgment based upon RCW 71.05.120. The estate argued that RCW 71.05.120 did "not apply because Mr. Jones was not making an assessment under this chapter." *Davis*, 127 Wash.App. at 840. The Court of Appeals disagreed:

> Mr. Jones testified he was not making an assessment under this chapter. The estate's amended complaint, however, alleges Mr. Jones evaluated Mr. Erickson for the purpose of providing mental health assistance and supervision. The complaint then alleges Mr. Jones failed to provide assistance or take any action, despite the need to do so. To the extent the estate alleged Mr. Jones was liable because he failed to detain Mr. Erickson, the immunity provision of RCW 71.05.120 applies because the only authority for him to detain Mr. Erickson was under chapter 71.05 RCW.

Davis, 127 Wash.App. at 840-841.

The same is true in this case. To the extent Plaintiffs allege that Dr. Ashby should have had Mr. DeMeerleer involuntarily committed,[3] the case falls squarely within the provisions of RCW 71.05 and provides Dr. Ashby with immunity from Plaintiffs' claims.[4]

The second section of RCW 71.05.120 goes on to state that the statute does not relieve a health care provider from the duty to "warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims." There is no langauge contained in this provision limiting its application to health care provided in connection with

---

[3] Dr. Knoll suggests that absent the "breaches," Mr. DeMeerleer could have been admitted for "intensive clinical or institutional psychiatric treatment." *Declaration, pg. 9.*

[4] Immunity is lost under RCW 71.05.120 only upon a showing of bad faith or gross negligence. Plaintiffs have alleged neither.

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civil commitment proceedings. Rather, it simply clarifies what the "duty to warn" is in Washington and that RCW 71.05.120 should not be interpreted as limiting that duty.

4. *Peterson v. State* does not hold that a mental health provider has a duty to warn third parties about risks posed by patients.

Citing to *Peterson v. State*, Plaintiffs argue that it has been "long settled law in Washington that a psychiatrist may have liability for the harm caused by third parties as a result of the actions of his or her patient." *Response, pg. 4. Peterson v. State* is distinguishable on its facts, and contrary to Plaintiffs' position herein, it does not stand for the proposition that a psychiatrist has a general duty to warn third parties if the psychiatrist believes that a patient poses a risk of danger to others. The facts of *Peterson v. State* are of note.

In *Peterson*, the plaintiff was injured by a patient of a state psychiatric hospital who had been released five days earlier. On these facts, the Court answered two questions:

> First, does a state hospital psychiatrist have a duty to seek additional confinement of a patient who remains potentially dangerous after initial hospitalization? Second, under the specific circumstances of this case, was Dr. Miller required, or even allowed, to disclose information about the violation by Knox of the conditions of his parole to the Superior Court or to Knox's probation officer?

Petersen v. State, 100 Wash. 2d at 425.

While the Court answered the first question affirmatively, that holding was "abrogated" with the adoption of RCW 71.05.120 (see above). As it relates to the second question, the Court rejected the argument that the psychiatrist had a duty to warn others of the patient's potential dangerous propensities.

> "**We agree with defendant that Dr. Miller was prohibited from disclosing information about the violation by Knox of the conditions of his parole to the Superior Court or to Knox's probation officer.**"

Petersen v. State, 100 Wash. 2d at 431-32.

According to the Court, the psychiatrist was precluded by the patient confidentiality provisions from "warning" others about the patient's dangerous propensities. *Id.* As is set forth

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in the following section, Dr. Ashby is likewise precluded by statute from disclosing any patient confidences absent more than a general concern that a patient may present a risk of danger to third parties.

Peterson v. State simply does not stand for the broad proposition that a psychiatrist has a duty to warn anyone who might be foreseeably endangered by a patient. Rather, the Court merely held that a psychiatrist can be held liable for not protecting third parties from a dangerous patient by not seeking additional involuntary commitment. As set forth above, RCW 71.05.120 was enacted in response to *Peterson v. State* and provides Dr. Ashby with immunity from any claim that he should have had Mr. DeMeerleer involuntarily committed. With respect to any assertion that Dr. Ashby should have warned Ms. Schiering that Mr. DeMeerleer presented a risk of harm, Dr. Ashby, just like the psychiatrist in the *Peterson* case, was statutorily precluded from sharing any of Mr. DeMeerleer's health care information absent a reasonable belief that Ms. Schiering and her children were in "imminent danger" (see below). As set forth herein, Plaintiffs have not produced any evidence suggesting that Dr. Ashby had a reasonable belief that Ms. Schiering or her children were in "imminent danger."

5. RCW 70.02.020 precludes the imposition of the *Peterson v. State* duty.

Any duty owed by Dr. Ashby to warn anyone about suicidal and/or homicidal ideations must be considered in connection with RCW 70.02 ("Health Care Information and Access and Disclosure"). Pursuant to RCW 70.02.020, a health care provider such as Dr. Ashby "may not disclose health care information about a patient to any other person without the patient's written authorization." RCW 70.02.050 contains very narrow and specifically defined exceptions to this prohibition. One exception allows for such disclosures:

> To any person if the health care provider or health care facility reasonably believes that disclosure will avoid or minimize an imminent danger to the health or safety of the patient or any other individual, however there is no obligation under this chapter on the part of the provider or facility to so disclose.

RCW 70.02.050(d) (emphasis added)

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RCW 70.02.050(d) makes it absolutely clear that the general and ambiguous duty announced in *Peterson v. State* ("protect anyone who might foreseeably be endangered" by a patient) simply does not require a psychiatrist to disclose health care information based solely upon the risk that a third party might be foreseeably endangered. Rather, before a health care provider can even consider making any type of disclosure, there must be an "imminent danger" to an individual. "Imminent" is defined as "likely to occur at any moment; impending." *Random House Dictionary*. RCW 71.05.020(20) ("Mental Illness") defines "imminent" as follows:

> "Imminent" means the state or condition of being likely to occur at any moment or near at hand, rather than distant or remote;

Pursuant to RCW 70.02.050(d), Dr. Ashby would have been prohibited from disclosing any information regarding Mr. DeMeerleer unless Dr. Ashby knew that there was a danger to someone that was "likely to occur at any moment." This prohibition precludes the imposition of the generalized and ambiguous duty announced in *Peterson v. State* to a "duty to warn" case, and supports the duty as identified in RCW 71.05.120, which only requires a warning if the patient has "communicated an actual threat of physical violence against a reasonably identifiable victim or victims." RCW 71.05.120 and RCW 7.02.050 have to be read in conjunction with each other, just as the Court did in *Peterson v. State*. Just as the Court made clear in *Peterson v. State*, patient confidentiality requirements prohibits the imposition of liability for failing to report generalized concerns of safety risks posed by patients. Instead, legislature has made it absolutely clear that liability for failing to "warn" must be based upon a showing that Mr. DeMeerleer communicated to Dr. Ashby an actual threat of physical violence against Ms. Schiering and her children.

6. The *Tarasoff* duty has been almost universally rejected.

California and Washington are not the only states to have adopted statutes that limit the liability of mental health care providers to those occasions when a plaintiff makes an actual threat against a reasonably identifiable person. A review of how other states have responded to

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Tarasoff only clarifies the intent of RCW 71.05.120. The following is a sampling of how other states have statutorily limited the duty of mental health providers.

> There shall be no cause of action against a mental health provider nor shall legal liability be imposed for breaching a duty to prevent harm to a person caused by a patient, unless...: (1) The patient has communicated to the mental health provider an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such threat.

Ariz. Rev. Stat. Ann. § 36-517.02 (emphasis added)

> (a) Except as provided in subsection (d) of this section, no cause of action shall lie against a mental health services provider, nor shall legal liability be imposed, for inability to prevent harm to person or property caused by a patient unless: (1) The patient has communicated to the mental health services provider an explicit and imminent threat to kill or seriously injure a clearly identified victim or victims, or to commit a specific violent act or to destroy property under circumstances which could easily lead to serious personal injury or death, and the patient has an apparent intent and ability to carry out the threat;

Del. Code Ann. tit. 16, § 5402 (emphasis added)

> A mental health professional has a duty to warn a victim if a patient has communicated to the mental health professional an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such a threat.

Idaho Code Ann. § 6-1902 (emphasis added)

> (b) There shall be no liability on the part of, and no cause of action shall arise against, any person who is a physician, clinical psychologist, or qualified examiner based upon that person's failure to warn of and protect from a recipient's threatened or actual violent behavior except where the recipient has communicated to the person a serious threat of physical violence against a reasonably identifiable victim or victims. Nothing in this Section shall relieve any employee or director of any residential mental health or developmental disabilities facility from any duty he may have to protect the residents of such a facility from any other resident.

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IL ST CH 405 § 5/6-103 (emphasis added)

> (1) No monetary liability and no cause of action shall arise against any mental health professional for failing to predict, warn of or take precautions to provide protection from a patient's violent behavior, unless the patient has communicated to the mental health professional an actual threat of physical violence against a clearly identified or reasonably identifiable victim, or unless the patient has communicated to the mental health professional an actual threat of some specific violent act.

Ky. Rev. Stat. Ann. § 202A.400 (emphasis added)

> (b) A cause of action or disciplinary action may not arise against any mental health care provider or administrator for failing to predict, warn of, or take precautions to provide protection from a patient's violent behavior unless the mental health care provider or administrator knew of the patient's propensity for violence and the patient indicated to the mental health care provider or administrator, by speech, conduct, or writing, of the patient's intention to inflict imminent physical injury upon a specified victim or group of victims.

Md. Code Ann., Cts. & Jud. Proc. § 5-609 (emphasis added)

> If a patient communicates to a mental health professional who is treating the patient a threat of physical violence against a reasonably identifiable third person and the recipient has the apparent intent and ability to carry out that threat in the foreseeable future, the mental health professional has a duty to take action as prescribed in subsection (2). Except as provided in this section, a mental health professional does not have a duty to warn a third person of a threat as described in this subsection or to protect the third person.

Mich. Comp. Laws Ann. § 330.1946 (emphasis added)

> A mental health professional has a duty to warn of or take reasonable precautions to provide protection from violent behavior only if the patient has communicated to the mental health professional an actual threat of physical violence by specific means against a clearly identified or reasonably identifiable victim.

Mont. Code Ann. § 27-1-1102 (emphasis added)

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> A physician licensed under this chapter has a duty to warn of, or to take reasonable precautions to provide protection from, a client's violent behavior when the client has communicated to such physician a serious threat of physical violence against a clearly identified or reasonably identifiable victim or victims, or a serious threat of substantial damage to real property.

N.H. Rev. Stat. Ann. § 329:31 (emphasis added)

> A therapist has no duty to warn or take precautions to provide protection from any violent behavior of his client or patient, except when that client or patient communicated to the therapist an actual threat of physical violence against a clearly identified or reasonably identifiable victim. That duty shall be discharged if the therapist makes reasonable efforts to communicate the threat to the victim, and notifies a law enforcement officer or agency of the threat.

Utah Code Ann. § 78B-3-502 (emphasis added)

Statutes from other states containing nearly identical language are identified in Appendix A to this memorandum. As can be seen, the majority of states have, like Washington and California, adopted statutes limiting the duty of a mental health professional to protect others to situations when the patient communicates a specific threat of actual harm to a reasonably identifiable person.

In states where no such statute exists, case law has almost universally either rejected *Tarasoff* and adopted the same standard as contained in the above-identified statutes, or held that patient-therapist confidentiality statutes preclude a duty to warn absent a threat to a reasonably identifiable victim. *See, e.g., Emerich v. Philadelphia Ctr. for Human Dev.*, 554 Pa. 209, 720 A.2d 1032, 1035 (1998) (a duty to warn in this context exists "only where a specific and immediate threat of serious bodily injury has been conveyed by the patient to the professional regarding a specifically identified or readily identifiable victim"); *Peck v. Counseling Serv. of Addison Cnty., Inc.*, 146 Vt. 61, 499 A.2d 422, 426 (1985) ("A mental patient's threat of serious harm to an identified victim is an appropriate circumstance under which the physician-patient privilege may be waived"); *Nasser v. Parker*, 249 Va. 172, 455 S.E.2d 502, 504 (1995) (rejecting *Tarasoff*); *Cole v. Taylor*, 301 N.W.2d 766, 768 (Iowa 1981)

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("We have not adopted the rationale in *Tarasoff*."); *Gregory v. Kilbride*, 150 N.C. App. 601, 565 S.E.2d 685, 692 (2002) ("Thus, unlike the holding in *Tarasoff,* North Carolina does not recognize a psychiatrist's *duty to warn* third persons"); *Santana v. Rainbow Cleaners*, 969 A.2d 653, 666 (R.I. 2009) (finding the imposition of "a *Tarasoff*-type duty" unjust, and could "result in the overcommitment of patients as mental health professionals operated under the increased fear of potential liability"); *Bishop v. S. Carolina Dep't of Mental Health*, 331 S.C. 79, 502 S.E.2d 78, 82 (1998) ("if the Department [Mental Health] knew or should have known a specific threat was made by mother, the Department had a duty to warn the threatened third party of mother's release"); *Jacobs v. Taylor*, 190 Ga. App. 520, 379 S.E.2d 563 (1989) (Psychiatrists who treated mental patient cannot be held liable for failing to warn members of public of generalized threats made by patient during his treatment, and could not be held liable when patient killed two victims who were not acquainted with him); *Doe v. Marion*, 373 S.C. 390, 645 S.E.2d 245, 251 (2007) (summary dismissal affirmed because "[p]etitioner's claim fails to allege a specific threat against James Doe necessary to create a duty to warn").

Courts and legislatures have recognized the necessity of protecting physician-patient confidences, as well as the inability of physicians to predict the future. The ambiguous nature of the duty announced in *Tarasoff* puts physicians in the impossible position of trying to determine when a patient may pose a risk of danger to others such that the provider can and should violate the patient's confidences. This is especially true for mental health providers, who deal on a regular basis with patients whose mental conditions could potentially make them a risk to themselves or others. It is precisely because of this dilemma that so many states, including Washington, have abandoned the *Tarasoff* duty in favor of a bright line rule imposing a duty only when a specific threat of harm against an identifiable victim is made.

B. There Is No Evidence That Jan DeMeerleer Ever Communicated To Dr. Ashby An Actual Threat To Harm Plaintiffs.

Once the Court finds that the duty of a psychiatrist to warn in the state of Washington is only triggered by the communication of an actual threat, summary judgment is proper, as there is no evidence that Mr. DeMeerleer ever communicated such a threat to Dr. Ashby.

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C. RCW 70.02.020 Precludes A General Duty To Warn.

Even if the Court is unwilling to find that the duty of a mental health professional in Washington is defined by RCW 71.05.120, summary judgment is nonetheless proper pursuant to RCW 70.02.020. RCW 71.02 (Public Health - Uniform Health Care Act) was enacted in 1991, eight years after *Peterson v. State*. *See*, 1991 Wash. Legis. Serv. Ch. 335 (S.H.B. 1828). The statute defines when a health care provider is even authorized to "warn" third persons about a patient.

The mandatory language of RCW 70.02.020 precludes a health care provider from disclosing "health care information about a patient to any other person without the patient's written authorization." There is no discretion in this mandatory language. Instead, the legislature has defined specific situations pursuant to which a physician can disclose health care information about a patient. Relevant to this case is subsection (1)(d), which authorizes the disclosure of such information when the health care provider reasonably believes that the patient poses an "imminent danger" to the health and safety of an "individual." Dr. Ashby submits that this limited exception to the requirement not to disclose patient health care information squarely rejects a *Tarasoff* general duty to warn. The *Tarasoff* duty to "protect anyone who might foreseeably be endangered" by a patient simply cannot be squared with the prohibition from disclosing health care information absent a belief of an imminent danger to the health and safety of an individual. While this exception does not contain the identical language of RCW 71.05.120 (threat of physical violence against a reasonably identifiable victim), the practical affect is the same – it rejects the *Tarasoff* duty to warn anyone who might foreseeably be endangered. Instead, it permits a disclosure/warning to those occasions were an individual or individuals are in "imminent danger." Clearly, that requires more than a patient who "might foreseeably" endanger the public.

Further, it is of no small significance that this limited exception to the requirement for physicians not to disclose health care information includes the following language: "...however, there is no obligation under this chapter on the part of the provider of facility to so disclose." Pursuant to this statute, even when a health care provider knows that a patient

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presents an "imminent danger" to the health or safety of an individual, the provider has no duty/obligation to disclose that information. That language simply cannot be reconciled with the *Tarasoff* duty that a health care provider must protect third parties whenever a patient "might" forseeably endanger the public.

RCW 70.02.020(1)(d) does not create a duty ("obligation") to report a reasonable concern about imminent danger. However, it creates the *minimum* that must be known to a health care provider before the provider can share any patient health care information. In this case, Plaintiffs have not produced any evidence that Dr. Ashby had reason to believe that Plaintiffs were in "imminent danger" from Mr. DeMeerleer. Instead, Plaintiffs rely upon the Declaration of James Knoll for the proposition that more thorough assessments, or closer monitoring "may have substantiated" that "Ms. Schiering and her children were foreseeably at risk." *Declaration of Knoll, pg. 9.* As a matter of law, this does not establish a reasonable belief of "imminent danger," mandating the dismissal of Plaintiffs' claims.

D. Even Under The Abandoned *Tarasoff* Standard, Dr. Knoll's Speculative Declaration Does Not Preclude Summary Judgment.

To prove medical negligence, a plaintiff must establish that the doctor failed to use reasonable care and that the failure was a proximate cause of the plaintiff's injury. RCW 7.70.040. Proximate cause in a medical negligence case requires evidence establishing that but for the failure to observe the standard of care, the injury would not have occurred. *Harbeson v. Parke-Davis, Inc.*, 98 Wn.2d 460, 475-76, 656 P.2d 483 (1983). This requires a showing that "but for" the defendant's actions, the claimant would not have been injured. *Tyner v. DSHS,* 141 Wn.2d 68, 82, 1 P.3d 1148 (2000). The evidence establishing cause in fact must 'rise above speculation, conjecture, or mere possibility.' *Reese v. Stroh,* 128 Wn.2d 300, 309, 907 P.2d 282 (1995).

In his declaration, Dr. Knoll opines that Dr. Ashby violated the applicable standard of care by allegedly failing to "perform an adequate assessment" and failing to "adequately monitor DeMeerleer's psychiatric condition." *Declaration, pgs. 9-10.* While that testimony is sufficient to establish an issue of fact on the element of "breach," Dr. Knoll's testimony falls

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well-short on the requisite "but for" causation requirement. Indeed, recognizing their inability to establish "but for" causation, Plaintiffs make the unique, but improper, argument that Dr. Ashby's alleged negligence resulted in a "loss of chance" for Plaintiffs (see below).

In his declaration, Dr. Knoll states that had Dr. Ashby performed an "adequate assessment" and "adequately monitored" Mr. DeMeerleer, Dr. Ashby "may have substantiated that Ms. Schiering and her children were foreseeably at risk of harm from DeMeerleer." *Declaration, pg. 9* (emphasis added). This testimony simply does not meet the "but for" requirement necessary to establish medical negligence. Instead, Dr. Knoll can only say that if the alleged breaches had not occurred, Dr. Ashby *may have* discovered that Mr. DeMeerleer may have been having suicidal/homicidal ideations, and with that information may have been able to take measures to prevent the incident. Pursuant to well-established law, Dr. Knoll's testimony that had the alleged breaches not occurred, the "risk and occurrence of the Incident would have been mitigated, and probably would not have occurred." *Declaration, pg. 9*. It is likewise insufficient to establish merely that the alleged breaches were a "substantial factor" in causing the incident in question, or that but for the alleged breaches, "it is unlikely the Incident would have occurred." Rather, to oppose summary judgment, Plaintiffs were required to come forward with evidence that "but for" the alleged breaches, the incident would not have occurred – not that the risks of the incident would have been "mitigated" and "probably" or "likely" would not have occurred.

In addition to the absence of the necessary "but for" testimony, Dr. Knoll's opinions are not based upon identifiable facts, but are instead are based upon conclusory allegations and pure speculation.[5] To preclude summary judgment, an expert's affidavit must amount to more than speculation and conjecture. *Guile v. Ballard Community Hospital*, 70 Wn.App. 18, 25, 851 P.2d 689, *review denied sub nom*, *Guile v. Crealock*, 122 Wn.2d 1010, 863 P.2d 72 (1993). *See also Griswold v. Kilpatrick*, 107 Wn.App. 757, 762, 27 P.3d 246 (2001). Put another way, mere conjecture or speculation by an expert cannot raise a genuine issue of material fact. *Halvorson v. Ferguson*, 46 Wn.App. 708, 712, 735 P.2d 675 (1986). The issue

[5] Dr. Ashby has filed a separate Motion to Strike the declaration of Dr. Knoll.

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that is the subject of an expert's affidavit or declaration must be of such a nature that an expert can express an opinion based on "a reasonable probability rather than mere conjecture of speculation." *Davidson v. Municipality of Metropolitan Seattle*, 43 Wn.App. 569, 719 P.2d 569 (1986). "Presumptions may not be pyramided upon presumptions nor inference upon inference." *Davidson, supra*, at 575, quoting *Prentiss Packing and Storage Company v. United Pacific Insurance Company*, 5 Wn.2d 144, 164, 106 P.2d 314 (1940).

To survive summary judgment, Plaintiffs were required to come forward with evidence creating a question of fact on the issue of causation. Dr. Knoll's declaration is insufficient in that regard, as he is simply unable to testify that but for the alleged breaches, the incident in question would not have occurred. Summary judgment is therefore proper.

E. The Loss of Chance Doctrine Is Inapplicable In This Case And Does Not Substitute For The "But For" Causation Requirement.

Unable to establish that "but for" the alleged negligence of Dr. Ashby, the murders would not have occurred, Plaintiffs argue that the facts of this case present an "avenue of recovery" pursuant to the "loss of chance" doctrine. In support of this theory, Plaintiffs rely upon the testimony of Dr. Knoll that the alleged breaches were a "causal and substantial factor" in contributing to and in bringing about loss of chance "that the Incident and resulting harm wouldn't have occurred." *Declaration, pg. 10.* The "loss of chance" theory is an "avenue of recovery," not an independent cause of action allowing Plaintiffs to avoid the "but for" causation requirement of a negligence action. Plaintiffs cannot escape their failure to establish the necessary "but for" causation requirement of a negligence claim with a "substantial factor" test of a "loss of chance" theory of recovery.

In *Herskovits v. Group Health Coop. of Puaet Sound,* 99 Wn.2d 609, 664 P.2d 474 (1983) a doctor negligently failed to diagnose the plaintiff's lung cancer in a timely fashion. This negligent diagnosis deprived him of a chance to pursue therapy that might have extended his life. However, even with prompt therapy his survival probably would not have been extended. *Herskovits*, 99 Wn.2d at 612. In such circumstances a strict application of the "but for" test would mean that the defendant would not be liable, despite clear proof of negligence,

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so long as he could establish that the patient probably would have suffered the same injury anyway. The Supreme Court rejected that argument, as the plaintiff had submitted evidence that the negligence caused a reduction in the possibility of a 5–year survival from 39 percent o 25 percent. *Id.* Similarly, in *Mohr v. Grantham,* 172 Wn.2d 844, 262 P.3d 490 (2011), the plaintiffs presented evidence that but for the alleged negligence of the defendant, the plaintiff would have had a 50 %to 60% chance of a better outcome. *Mohr,* 172 Wn.2d at 860.

Herskovits and *Mohr* simply recognize that the loss of a chance of a better outcome is a compensable injury. However, the plaintiff still must prove the elements of the underlying negligence claim, including the requirement of establishing that "but for" the negligence, the plaintiff would not have experienced the loss of chance. "Under this formulation, a plaintiff bears the burden to prove duty, breach, and that such breach of duty proximately caused a loss of chance of a better outcome." *Mohr v. Grantham*, 172 Wash. 2d 844, 857, 262 P.3d 490, 496 (2011); *See also, Rounds v. Nellcor Puritan Bennett, Inc.*, 147 Wash. App. 155, 166, 194 P.3d 274, 279 (2008) ("Because Ms. Rounds fails to make out a prima facie case on causation, we do not need to discuss if her loss of chance theory applies on the issue of damages").

Appling the loss of chance theory to this case would mean that Ms. Scheiring and her children would have sustained the injuries in question (death and bodily harm) even in the absence of any alleged negligence, and that the alleged negligence merely increased the risk of those injuries. Clearly, the "loss of chance" doctrine is inapplicable to this case.

In addition, Plaintiffs have not presented any evidence that "but for" Dr. Ashby's alleged negligence, they experienced a quantifiable loss of chance. In both *Herskovits* and *Mohr*, the plaintiffs presented expert medical testimony establishing a quantifiable loss of a chance of a better outcome. Plaintiffs have not, and cannot because of the inapplicability of the doctrine to these facts, identify any quantifiable "loss of chance" proximately caused by the alleged negligence of Dr. Ashby. Summary judgment is therefore appropriate.

III. CONCLUSION

There is not a single Washington case that has imposed a duty on a psychiatrist to "warn" anyone about the alleged dangerousness of a patient. *Peterson v. State* squarely

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rejected such a duty. Subsequent to the *Peterson v. State* decision, the Washington legislature enacted RCW 71.05.120, which defines the duty owed by psychiatrists to warn third parties about patients. That statute is the only law in this state which defines that duty, and clearly requires an actual threat toward a reasonably identifiable person.

Plaintiffs have failed to produce any evidence that Mr. DeMeerleer communicated to Dr. Ashby an actual threat of harm against Ms. Schiering and her children. In the absence of such a threat, Dr. Ashby had no legal duty to protect Ms. Schiering and her children. In fact, absent concern that Mr. DeMeerleer presented an "imminent danger" to Ms. Schiering and her children, Dr. Ashby could not have taken any action to "warn" Ms. Schiering of the potential danger of Mr. DeMeerleer. Summary judgment is therefore proper.

DATED this 22 day of April, 2013.

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By _____
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CERTIFICATE OF SERVICE

Pursuant to RCW 9A.72.085, the undersigned hereby certifies under penalty of perjury under the laws of the state of Washington, that on the 22 day of April, 2013, the foregoing was delivered to the following persons in the manner indicated:

Michael J. Riccelli 400 S. Jefferson St. Ste. 112 Spokane, WA 99204-3144 Fax: 509-323-1222	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [X] VIA EMAIL [X]
Ian Ledlin Pillabaum, Ledlin, Matthews, Sheldon & Kime 1235 N. Post St. Spokane, WA 99201	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [X] VIA EMAIL [X]
David Kulisch Randall & Danskin 601 W Riverside Ave Spokane, WA 99201	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [X] VIA EMAIL [X]
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4-22-13 /Spokane, WA Shawna L Wade

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APPENDIX A

(a) There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a licensed marriage and family therapist in failing to predict and warn of and protect from a patient's violent behavior except where the patient has communicated to the marriage and family therapist a serious threat of physical violence against a reasonably identifiable victim or victims.

Ala. Code § 34-17A-23

(a) A psychologist or psychological associate may not reveal to another person a communication made to the psychologist or psychological associate by a client about a matter concerning which the client has employed the psychologist or psychological associate in a professional capacity. This section does not apply to
(1) a case conference with other mental health professionals or with physicians and surgeons;
(2) a case in which the client in writing authorized the psychologist or psychological associate to reveal a communication;
(3) a case where an immediate threat of serious physical harm to an identifiable victim is communicated to a psychologist or psychological associate by a client;

Alaska Stat. Ann. § 08.86.200

A physician, social worker, psychiatric nurse, psychologist, or other mental health professional and a mental health hospital, community mental health center or clinic, institution, or their staff shall not be liable for damages in any civil action for failure to warn or protect any person against a mental health patient's violent behavior, and any such person shall not be held civilly liable for failure to predict such violent behavior, except where the patient has communicated to the mental health care provider a serious threat of imminent physical violence against a specific person or persons.

Colo. Rev. Stat. Ann. § 13-21-117

Communications between a patient and a psychiatrist, as defined in s. 394.455, shall be held confidential and shall not be disclosed except upon the request of the patient or the patient's legal representative. Provision of psychiatric records and reports shall be governed by s. 456.057. Notwithstanding any other provision of this section or s. 90.503, where: (1) A patient is engaged in a treatment relationship with a psychiatrist; (2) Such

patient has made an actual threat to physically harm an identifiable victim or victims; and (3) The treating psychiatrist makes a clinical judgment that the patient has the apparent capability to commit such an act and that it is more likely than not that in the near future the patient will carry out that threat, the psychiatrist may disclose patient communications to the extent necessary to warn any potential victim or to communicate the threat to a law enforcement agency.

Fla. Stat. Ann. § 456.059

A client has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made for the purpose of diagnosis or treatment of the client's mental or emotional condition, including substance addiction or abuse, among the client, the client's psychologist, and persons who are participating in the diagnosis or treatment under the direction of the psychologist, including members of the client's family.

(d) Exceptions

(6) Prevention of crime or tort. There is no privilege under this rule as to a communication reflecting the client's intent to commit a criminal or tortious act that the psychologist reasonably believes is likely to result in death or substantial bodily harm.

Haw. Rev. Stat. § 626-1

Sec. 1. A mental health service provider is immune from civil liability to persons other than the patient for failing to:
(1) predict; or
(2) warn or take precautions to protect from;
a patient's violent behavior unless the patient has communicated to the provider of mental health services an actual threat of physical violence or other means of harm against a reasonably identifiable victim or victims, or evidences conduct or makes statements indicating an imminent danger that the patient will use physical violence or use other means to cause serious personal injury or death to others.

Ind. Code Ann. § 34-30-16-1

A. When a patient has communicated a threat of physical violence, which is deemed to be significant in the clinical judgment of the treating psychologist or psychiatrist, or marriage and family therapist, or licensed professional counselor, or social worker, against a clearly identified victim or victims, coupled with the apparent intent and ability to carry out such threat, the psychologist, licensed under R.S. 37:2351 through 2369, the medical psychologist, licensed under R.S. 37:1360.51 through

1360.72, the psychiatrist, licensed under R.S. 37:1261 through 1291, or the social worker, credentialed under R.S. 37:2701 through 2723, treating such patient and exercising reasonable professional judgment, shall not be liable for a breach of confidentiality for warning of such threat or taking precautions to provide protection from the patient's violent behavior.

B. A psychologist's, psychiatrist's, or marriage and family therapist, or licensed professional counselor, or social worker's duty to warn or to take reasonable precautions to provide protection from violent behavior arises only under the circumstance specified in Subsection A of this Section.

La. Rev. Stat. Ann. § 9:2800.2

(1) There shall be no duty owed by a licensed mental health professional to take reasonable precautions to warn or in any other way protect a potential victim or victims of said professional's patient, and no cause of action imposed against a licensed mental health professional for failure to warn or in any other way protect a potential victim or victims of such professional's patient unless: (a) the patient has communicated to the licensed mental health professional an explicit threat to kill or inflict serious bodily injury upon a reasonably identified victim or victims and the patient has the apparent intent and ability to carry out the threat, and the licensed mental health professional fails to take reasonable precautions as that term is defined in section one; or (b) the patient has a history of physical violence which is known to the licensed mental health professional and the licensed mental health professional has a reasonable basis to believe that there is a clear and present danger that the patient will attempt to kill or inflict serious bodily injury against a reasonably identified victim or victims and the licensed mental health professional fails to take reasonable precautions as that term is defined by said section one.

Mass. Gen. Laws Ann. ch. 123, § 36B

Subd. 2. Duty to warn. The duty to predict, warn of, or take reasonable precautions to provide protection from, violent behavior arises only when a client or other person has communicated to the licensee a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim. If a duty to warn arises, the duty is discharged by the licensee if reasonable efforts, as defined in subdivision 1, paragraph (c), are made to communicate the threat.

Minn. Stat. Ann. § 148.975

The hospital records of and information pertaining to patients at treatment facilities or patients being treated by physicians, psychologists (as defined

in Section 73-31-3(e)), licensed master social workers or licensed professional counselors shall be confidential and shall be released only: (a) upon written authorization of the patient; (b) upon order of a court of competent jurisdiction; (c) when necessary for the continued treatment of a patient; (d) when, in the opinion of the director, release is necessary for the determination of eligibility for benefits, compliance with statutory reporting requirements, or other lawful purpose; or (e) when the patient has communicated to the treating physician, psychologist (as defined in Section 73-31-3(e)), master social worker or licensed professional counselor an actual threat of physical violence against a clearly identified or reasonably identifiable potential victim or victims, and then the treating physician, psychologist (as defined in Section 73-31-3(e)), master social worker or licensed professional counselor may communicate the threat only to the potential victim or victims, a law enforcement agency, or the parent or guardian of a minor who is identified as a potential victim.

Miss. Code. Ann. § 41-21-97

(1) No monetary liability and no cause of action shall arise against any psychologist for failing to warn of and protect from a client's or patient's threatened violent behavior or failing to predict and warn of and protect from a client's or patient's violent behavior except when the client or patient has communicated to the psychologist a serious threat of physical violence against a reasonably identifiable victim or victims.

Neb. Rev. Stat. § 38-3132

Any person who is licensed in the State of New Jersey to practice psychology, psychiatry, medicine, nursing, clinical social work or marriage counseling, whether or not compensation is received or expected, is immune from any civil liability for a patient's violent act against another person or against himself unless the practitioner has incurred a duty to warn and protect the potential victim as set forth in subsection b. of this section and fails to discharge that duty as set forth in subsection c. of this section.

b. A duty to warn and protect is incurred when the following conditions exist:

(1) The patient has communicated to that practitioner a threat of imminent, serious physical violence against a readily identifiable individual or against himself and the circumstances are such that a reasonable professional in the practitioner's area of expertise would believe the patient intended to carry out the threat; or

(2) The circumstances are such that a reasonable professional in the practitioner's area of expertise would believe the patient intended to carry out an act of imminent, serious physical violence against a readily identifiable individual or against himself.

N.J. Stat. Ann. § 2A:62A-16

There is no monetary liability on the part of and no cause of action may arise against any licensee in failing to warn of and protect from a patient's threatened violent behavior or failing to predict and warn of and protect from a patient's violent behavior except if the patient has communicated to the licensee a serious threat of physical violence against a reasonably identifiable victim or victims.

N.D. Cent. Code Ann. § 43-53-11

A mental health professional or mental health organization may be held liable in damages in a civil action, or may be made subject to disciplinary action by an entity with licensing or other regulatory authority over the professional or organization, for serious physical harm or death resulting from failing to predict, warn of, or take precautions to provide protection from the violent behavior of a mental health client or patient, only if the client or patient or a knowledgeable person has communicated to the professional or organization an explicit threat of inflicting imminent and serious physical harm to or causing the death of one or more clearly identifiable potential victims, the professional or organization has reason to believe that the client or patient has the intent and ability to carry out the threat, and the professional or organization fails to take one or more of the following actions in a timely manner:

Ohio Rev. Code Ann. § 2305.51

All communications between a licensed psychologist and the individual with whom the psychologist engages in the practice of psychology are confidential. At the initiation of the professional relationship the psychologist shall inform the patient of the following limitations to the confidentiality of their communications. No psychologist, colleague, agent or employee of any psychologist, whether professional, clerical, academic or therapeutic, shall disclose any information acquired or revealed in the course of or in connection with the performance of the psychologist's professional services, including the fact, circumstances, findings or records of such services, except under the following circumstances:

the patient has communicated to the psychologist an explicit threat to kill or inflict serious bodily injury upon a reasonably identified person and the patient has the apparent intent and ability to carry out the threat.

Okla. Stat. Ann. tit. 59, § 1376

(12) Information obtained in the course of diagnosis, evaluation or treatment of an individual that, in the professional judgment of the health care services provider, indicates a clear and immediate danger to others or to society may be reported to the appropriate authority. A decision not to disclose information under this subsection does not subject the provider to any civil liability.

Or. Rev. Stat. Ann. § 179.505

If any person subject to the proceedings under this chapter has communicated a serious threat of serious physical injury against a reasonably identifiable victim, the person with knowledge of the threat may disclose the threat to the potential victim or to any law enforcement officer, or both. No cause of action may arise under this chapter against the person who, in good faith, discloses the threat to a potential victim or law enforcement officer pursuant to the provisions of this subdivision.

S.D. Codified Laws § 27A-12-29

Privileged communications between a patient and a licensed physician when practicing as a psychiatrist in the course of and in connection with a therapeutic counseling relationship, regardless of whether the therapy is individual, joint, or group, may be disclosed without consent of the patient if:

(A) Such patient has made an actual threat to physically harm an identifiable victim or victims; and
(B) The treating psychiatrist makes a clinical judgment that the patient has the apparent capability to commit such an act and that it is more likely than not that in the near future the patient will carry out the threat.

Tenn. Code Ann. § 24-1-207

In judicial proceedings, whether civil, criminal, or juvenile, in legislative and administrative proceedings, and in proceedings preliminary and ancillary thereto, a patient or client, or his guardian or personal representative, may refuse to disclose or prevent the disclosure of confidential information, including information contained in administrative records, communicated to a person licensed or otherwise authorized to practice under this act, or to persons reasonably believed by the patient or client to be so licensed, and their agents, for the

purpose of diagnosis, evaluation or treatment of any mental or emotional condition or disorder. The psychologist shall not disclose any information communicated as described above in the absence of an express waiver of the privilege except in the following circumstances:

(iv) Where an immediate threat of physical violence against a readily identifiable victim is disclosed to the psychologist;

Wyo. Stat. Ann. § 33-27-123

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

BEVERLY R. VOLK as Guardian for Jack Alan Schiering, a minor; et. al.,

Plaintiff(s),

vs.

JAMES B. DEMEERLEER, as Personal Representative of the Estate of Jan DeMeerleer; et al,

Defendant(s).

No. 11-2-00277-7

DEFENDANT HOWARD ASHBY'S MEMORANDUM IN SUPPORT OF MOTION TO STRIKE DECLARATION OF JAMES L KNOLL, M.D.

I. INTRODUCTION

In opposition to Dr. Howard Ashby's Motion for Summary Judgment, Plaintiffs have submitted the Declaration of James L. Knoll. In his declaration, Dr. Knoll opines that had Dr. Ashby performed a more thorough risk analysis, and/or had Dr. Ashby more closely "monitored" Jan DeMeerleer, Dr. Ashby "may have" discovered that Mr. DeMeerleer presented a risk of harm to Rebecca Schiering and her children. Dr. Knoll's opinions in that regard are based entirely on speculation and conjecture and are therefore inadmissible.

The fact is that nobody, including Mr. DeMeerleer's family and friends, as well as Ms. Schiering's own mother,[1] saw any indication that Mr. DeMeerleer presented a risk of murdering Ms. Schiering and her children. In fact, as set forth in the declarations of Amy

[1] Bev Volk testified that prior to July 18, 2010, she would never have conceived that Mr. DeMeerleer would ever kill Rebecca Schiering and/or Phillip Schiering. *Deposition of Beverly Volk, pgs. 63-64.*

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DeMeerleer, Brent Tibbets, Darien Boedecher, Gena Leonard, Gene DeMeerleer, Jennifer Schweitzer and Larry Dagnon, in the days and hours leading up to the murders of Ms. Schiering and Phillip Schiering, Mr. DeMeerleer was acting "normal," and said and did nothing that would have or could have predicted that he would commit the crimes in question. To the contrary, the evidence shows that something happened on July 18, 2010 that caused Mr. DeMeerleer to "snap." Mr. DeMeerleer gave no one any foreshadowing that he would engage in the crimes just hours after discussing and planning for the future with friends and family. For Dr. Knoll to now opine that had Dr. Ashby taken additional or different actions in the months leading up to July 18, 2010, he would have somehow been able to prevent these crimes is nothing but speculation and conjecture. The Court should therefore strike Dr. Knoll's declaration in its entirety.

II. FACTS

Jan DeMeerleer committed the crimes in question on July 18, 2010. Mr. DeMeerleer had last seen Dr. Ashby on April 16, 2010. *Declaration of Knoll, pgs. 6-7.* When Mr. DeMeerleer presented to Dr. Ashby for the last time on April 16, 2010, Mr. DeMeerleer reported some "depression related suicidal ideas." *Declaration of Knoll, pg. 7.* However, Mr. DeMeerleer reported that he would not act on those ideas. *Id.* Mr. DeMeerleer did not report any homicidal ideations on April 16, 2010.[2]

In his declaration, Dr. Knoll opines that on April 16, 2010, Dr. Ashby should have performed a more thorough suicide assessment, and should have thereafter "adequately monitored his clinical condition." *Id.* Although Dr. Ashby did not see Mr. DeMeerleer between April 16, 2010 and July 18, 2010, Dr. Knoll speculates that during that time period, Mr. DeMeerleer's condition was "worsening." *Declaration of Knoll, pg. 8.* Dr. Knoll likewise suggests that during this period of time, Mr. DeMeerleer was in "apparent psychological distress." *Id.* According to Dr. Knoll, because of this alleged worsening of Mr. DeMeerleer's condition, and his alleged "psychological distress," Dr. Ashby should have had regularly-scheduled clinical follow-ups during the summer of 2010. *Id.*

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[2] While Dr. Knoll states that Mr. DeMeerleer had homicidal ideations in the past, he fails to note that the last of those was in 2005, five years before the murders.

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Dr. Knoll opines that had Dr. Ashby conducted regular follow-up appointments with Mr. DeMeerleer during the summer of 2010, Dr. Ashby:

> ...would have been able to inquire about his thoughts and emotions about his current relationship with Ms. Schiering and her children, and any ideas of suicide and/or homicide.

Declaration of Knoll, pg. 8.

According to Dr. Knoll, had Dr. Ashby conducted regular follow-up appointments with Mr. DeMeerleer during the summer of 2010, Dr. Ashby "may have substantiated that Ms. Schiering and her children were foreseeably at risk of harm from DeMeerleer." *Id. at pg. 9.*

Dr. Knoll renders these opinions without any information or knowledge about Mr. DeMeerleer's mental and emotional status during the summer of 2010. Dr. Knoll has absolutely no information or facts regarding Mr. DeMeerleer's actions, thoughts, emotions, behaviors, statements, ideations, etc. at any point between April 16, 2010 and July 18, 2010. Instead, Dr. Knoll simply speculates that during this period of time, Mr. DeMeerleer's condition was "worsening" and that he was in "psychological distress." Dr. Knoll further speculates that Mr. DeMeerleer may have been experiencing suicidal and/or homicidal ideations during that time, and that Dr. Ashby may have been able to discover the same. In the absence of any foundational basis for these conclusions, it is pure inadmissible speculation.

Submitted with this Motion are declarations from Mr. DeMeerleer's family and friends. These declarations are submitted to show just how speculative Dr. Knoll's conclusions and opinions are about Mr. DeMeerleer's mental and emotional status during the period of time between April 16, 2010 and July 18, 2010. As is set forth in those declarations, Mr. DeMeerleer was not in a state of "psychological distress," and his condition was not "worsening." Instead, in the months and weeks preceding July 18, 2010, Mr. DeMeerleer was his "normal" self, having attended a family reunion (with Phillip) at the end of June. Just hours before the crimes, Mr. DeMeerleer was talking about future plans with both family and friends. Dr. Knoll lacks any foundation for his conclusion that Mr. DeMeerleer's condition was "worsening," or that at any point prior to the actual murders, Mr. DeMeerleer was experiencing any homicidal ideation. It is thus pure speculation for Dr. Knoll to conclude that

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with additional assessment and monitoring, Dr. Ashby "may have" discovered that Ms. Schiering and her children were in danger.

III. LAW/ANALYSIS

Expert testimony is admissible only when the witness qualifies as an expert, the opinion is based on an explanatory theory generally recognized in the scientific community, and the testimony would help the trier of fact. *State v. Greene*, 139 Wash.2d 64, 73–74, 984 P.2d 1024 (1999), *cert. denied*, 529 U.S. 1090, 120 S.Ct. 1726, 146 L.Ed.2d 647 (2000). ER 702 also permits admission of qualified expert testimony when scientific, technical, or other specialized knowledge will help the trier of fact understand the evidence or determine a fact in issue. *State v. Phillips*, 123 Wash. App. 761, 765, 98 P.3d 838, 841 (2004).

"Expert opinions lacking an adequate foundation should be excluded." *Katare v. Katare*, 175 Wash. 2d 23, 39, 283 P.3d 546, 554 (2012), *citing Walker v. State*, 121 Wash.2d 214, 218, 848 P.2d 721 (1993); *See also*, *Safeco Ins. Co. v. McGrath*, 63 Wn.App. 170, 177, 817 P.2d 861 (1991) (conclusory or speculative expert opinions lacking an adequate foundation are not admissible). "An opinion which lacks proper foundation or is not helpful to the trier of fact is not admissible under ER 701 or 702." *City of Seattle v. Heatley*, 70 Wash. App. 573, 579, 854 P.2d 658, 661 (1993). In fact, it is an abuse of discretion for a court to admit expert testimony that lacks an adequate foundation. *Walker v. State*, 121 Wash.2d 214, 218, 848 P.2d 721 (1993).

To preclude summary judgment, an expert's affidavit must amount to more than speculation and conjecture. *Guile v. Ballard Community Hospital*, 70 Wn.App. 18, 25, 851 P.2d 689, *review denied sub nom*, *Guile v. Crealock*, 122 Wn.2d 1010, 863 P.2d 72 (1993). *See also Griswold v. Kilpatrick*, 107 Wn.App. 757, 762, 27 P.3d 246 (2001). Put another way, mere conjecture or speculation by an expert cannot raise a genuine issue of material fact. *Halvorson v. Ferguson*, 46 Wn.App. 708, 712, 735 P.2d 675 (1986). The issue that is the subject of an expert's affidavit or declaration must be of such a nature that an expert can express an opinion based on "a reasonable probability rather than mere conjecture of speculation." *Davidson v. Municipality of Metropolitan Seattle*, 43 Wn.App. 569, 719 P.2d 569 (1986). "Presumptions may not be pyramided upon presumptions nor inference upon

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inference." *Davidson, supra*, at 575, quoting *Prentiss Packing and Storage Company v. United Pacific Insurance Company*, 5 Wn.2d 144, 164, 106 P.2d 314 (1940).

At the end of June 2010, Mr. DeMeerleer attended a family reunion, at which he participated "in all of the activities, laughing and having a good time." *Declaration of Gene DeMeerleer*. Mr. DeMeerleer "seemed entirely 'normal' that weekend" and was "happy, good-natured and relaxed." *Id.*

The week prior to the murders, Mr. DeMeerleer was on a business trip in New Orleans. *Declarations of Darrin Boedecher and Amy DeMeerleer*. Mr. DeMeerleer's texts were lighthearted and "normal," giving no indication that Mr. DeMeerleer was emotionally unstable. *Id.*

Two days prior to the murders, Mr. DeMeerleer dropped his daughter off at his ex-wife's home. Mr. DeMeerleer seemed his "usual self," with no indication of mania or despondency. *Declaration of Amy DeMeerleer*. Mr. DeMeerleer "gave no indication that he was depressed, angry, frustrated or otherwise emotionally unstable." *Id.* He made no special good-byes to either Ms. DeMeerleer or his daughter. *Id.* That night, Mr. DeMeerleer shared with his sister that Ms. Schiering had broken up with him. *Declaration of Jennifer Schweitzer*. Although sad about the same, Mr. DeMeerleer did not say or do anything to cause Ms. Schweitzer to believe that Mr. DeMeerleer was suicidal or homicidal. *Id.*

The day of the murders,[3] Mr. DeMeerleer interacted with his next door neighbor, agreeing to remove a tree that was spreading shoots into the neighbor's yard. *Declaration of Brent Tibbits*. Not only did Mr. DeMeerleer cut down the tree, he cut the tree up into firewood and stacked it below his deck. *Id.* Mr. DeMeerleer's presentation was normal, and he gave no indication that he was emotionally unstable. *Id.*

Later that evening, Mr. DeMeerleer made phone calls to his mother (Gena Leonard), Mr. Boedecher and his friend Larry Gagnon.

Mr. DeMeerleer called Mr. Gagnon at around 5:00 p.m. that evening. *Declaration of Larry Gagnon*. Unable to reach Mr. Gagnon, Mr. DeMeerleer left a message asking Mr.

[3] The murders occurred in the early morning hours of July 18, 2010.

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Gagnon to return his call when he received the message. *Id.* At around the same time, Mr. DeMeerleer called Ms. Leonard, leaving a message advising her that he would be "hanging out" at his home and asking her to call when she got the message. *Id.* Mr. DeMeerleer sounded "normal," giving Ms. Leonard no indication that anything was wrong with Mr. DeMeerleer. *Id.* Approximately 2 hours later (7:00 p.m.) Mr. DeMeerleer called Mr. Boedecher, wanting to get together to talk about Mr. DeMeerleer's trip to New Orleans. *Declaration of Darien Boedecher.* When advised that Mr. Boedecher was unavailable, Mr. DeMeerleer suggested that they get together at a later time. *Id.* There was nothing about Mr. DeMeerleer's speech that caused Mr. Boedecher to believe that Mr. DeMeerleer was emotionally unstable. *Id.*

Dr. Knoll's opinions are all premised upon the theory that Mr. DeMeerleer was in a state of "psychological distress," and that his condition was "worsening" between April 16, 2010 and July 18, 2010. However, Dr. Knoll identifies no basis or foundation for these conclusions. Instead, he merely speculates that because Mr. DeMeerleer engaged in the acts in question on July 18, 2010, he must have been in a state of psychological distress in the weeks and days preceding July 18, 2010. With that assumption, Dr. Knoll contends that absent the alleged "breaches" by Dr. Ashby, Dr. Ashby "may have" been able to substantiate that Ms. Schiering and her children were in danger. As the foregoing declarations make clear, Dr. Knoll's opinions are purely speculative.

Experts must have a sufficient factual foundation for his or her opinion, *Queen City Farms, Inc. v. Cent. Nat'l Ins. Co. of Omaha,* 126 Wash.2d 50, 104, 882 P.2d 703 (1994), and conclusory or speculative expert opinions that lack an adequate foundation are inadmissible. *Safeco Ins. Co. v. McGrath,* 63 Wash.App. 170, 177, 817 P.2d 861 (1991). There is no evidence in this case that Mr. DeMeerleer had any homicidal ideations about Ms. Schiering and her children until the very moment he committed the crimes in question. Dr. Knoll's opinion that Mr. DeMeerleer "may have" had homicidal ideations that "may have" been discovered by Dr. Ashby lacks any foundation, and is nothing more than inadmissible speculation and conjecture. That inadmissible testimony cannot be used to defeat Dr. Ashby's Motion for Summary Judgment and should be stricken.

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IV. CONCLUSION

Speculation and conjecture are not admissible and cannot defeat summary judgment. Dr. Knoll's opinions are based upon the speculative belief that Mr. DeMeerleer was in a state of "psychological distress" between April 16, 2010 and July 18, 2010. Dr. Knoll has no foundation for these conclusions, making his opinions inadmissible speculation and conjecture which should be stricken.

DATED this 22 day of April, 2013.

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By _____
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CERTIFICATE OF SERVICE

Pursuant to RCW 9A.72.085, the undersigned hereby certifies under penalty of perjury under the laws of the state of Washington, that on the 22 day of April, 2013, the foregoing was delivered to the following persons in the manner indicated:

Michael J. Riccelli 400 S. Jefferson St. Ste. 112 Spokane, WA 99204-3144 Fax: 509-323-1222	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [X] VIA EMAIL [X]
Ian Ledlin Pillabaum, Ledlin, Matthews, Sheldon & Kime 1235 N. Post St. Spokane, WA 99201	VIA REGULAR MAIL [ ] VIA CERTIFIED MAIL [ ] VIA FACSIMILE [ ] HAND DELIVERED [X] VIA EMAIL [X]
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4-22-13 /Spokane, WA Shauna L Wade

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APPENDIX F

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Ala. Code §34-17A-23; Ariz. Rev. Stat. Ann. §36-517.02; Alaska Stat. Ann. §08.86.200; Ark. Code Ann. §20-45-202; Colo. Rev. Stat. Ann. §13-21-117; Del. Code Ann. tit. 16, §5402; Fla. Stat. Ann. §456.059; Haw. Rev. Stat. §626-1; Idaho Code Ann. §6-1902; IL ST CH 405 §5/6-103; Ind. Code Ann. §34-30-16-1; Ky. Rev. Stat. Ann. §202A.400; La. Rev. Stat. Ann. §9:2800.2; Md. Code Ann., Cts. & Jud. Proc. §5-609; Mass. Gen. Laws Ann. ch. 123, §36B; Mich. Comp. Laws Ann. §330.1946; Minn. Stat. Ann. §148.975; Miss. Code. Ann. §41-21-97; Mont. Code Ann. §27-1-1102; Neb. Rev. Stat. §38-3132; N.H. Rev. Stat. Ann. §329:31; N.J. Stat. Ann. §2A:62A-16; N.D. Cent. Code Ann. §43-53-11; Ohio Rev. Code Ann. §2305.51; Okla. Stat. Ann. tit. 59, §1376; Or. Rev. Stat. Ann. §179.505; S.D. Codified Laws §27A-12-29; Tenn. Code Ann. §24-1-207; Utah Code Ann. §78B-3-502; Wyo. Stat. Ann. §33-27-123.

See, e.g., *Jacobs v. Taylor*, 190 Ga. App. 520, 379 S.E.2d 563 (1989) (Psychiatrists who treated mental patient cannot be held liable for failing to warn members of public of generalized threats made by patient during his treatment, and could not be held liable when patient killed two victims who were not acquainted with him); *Cole v. Taylor*, 301 N.W.2d 766, 768 (Iowa 1981) ("We have not adopted the rationale in *Tarasoff*."); *Jacoby v. Brinckerhoff*, 250 Conn. 86, 96, 735 A.2d 347, 352 (1999)("To protect the integrity of the therapeutic relationship, we held that a duty to disclose the substantial risk of such an act of violence would arise only if the third person was an identifiable victim or a member of a class of identifiable victims"); *Brown v. Kellogg*, 340 P.3d 1274, 1276 *cert. denied*, 339 P.3d 841 (2014)("In the second instance, a doctor who is aware of specific threats to the life of an individual can potentially be liable for failing to disclose those threats to the authorities or to the person threatened"); *Gregory v. Kilbride*, 150

N.C. App. 601, 565 S.E.2d 685, 692 (2002) ("Thus, unlike the holding in *Tarasoff,* North Carolina does not recognize a psychiatrist's *duty to warn* third persons"); *Emerich v. Philadelphia Ctr. for Human Dev.,* 554 Pa. 209, 720 A.2d 1032, 1035 (1998) (a duty to warn in this context exists "only where a specific and immediate threat of serious bodily injury has been conveyed by the patient to the professional regarding a specifically identified or readily identifiable victim"); *Santana v. Rainbow Cleaners*, 969 A.2d 653, 666 (R.I. 2009) (finding the imposition of "a *Tarasoff*-type duty" unjust, and could "result in the overcommitment of patients as mental health professionals operated under the increased fear of potential liability"); *Bishop v. S. Carolina Dep't of Mental Health*, 331 S.C. 79, 502 S.E.2d 78, 82 (1998) ("if the Department [Mental Health] knew or should have known a specific threat was made by mother, the Department had a duty to warn the threatened third party of mother's release"); *Thapar v. Zezulka*, 994 S.W.2d 635, 639 (Tex. 1999) (no duty even if a threat made); *Counseling Serv. of Addison Cnty., Inc.*, 146 Vt. 61, 499 A.2d 422, 426 (1985) ("A mental patient's threat of serious harm to an identified victim is an appropriate circumstance under which the physician-patient privilege may be waived"); *Nasser v. Parker*, 249 Va. 172, 455 S.E.2d 502, 504 (1995) (rejecting *Tarasoff*).