No. 318141

COURT OF APPEALS, DIVISION III

OF THE STATE OF WASHINGTON

BEVERLY VOLK, et al., *Appellants*,

v.

JAMES B. DEMEERLEER, et al., *Respondents*.

SUPREME COURT PETITION FOR REVIEW

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I. IDENTITY OF PETITIONER

Petitioners Brian P. Winkler and Beverly R. Volk ("Ms. Volk"), as Guardian for Jack Alan Schiering, a minor, and as Personal Representative of the Estates of Phillip and Rebecca Shiering, deceased, and on behalf of all statutory claimants and beneficiaries (hereinafter "petitioners" or "plaintiffs"), asks this Court to accept review of the Court of Appeal's decisions designated in Part "II" of this petition.

II. COURT OF APPEAL'S DECISION

A copy of the Division III Court of Appeals Published Opinion filed November 13, 2014, is attached in the Appendix at pages A-1. A copy of Division III Court of Appeals Order filed February 3, 2015, is attached in the Appendix at pages A-2.

III. ISSUE PRESENTED FOR REVIEW

Whether expert opinion evidence as to a percentage or range of percentage reduction in the plaintiffs' chance of survival is necessary to maintain a loss of a chance case.

IV. STATEMENT OF THE CASE

In the original complaint, plaintiffs claimed damages for, failure of Spokane Psychiatric Clinic, P.S. ("The Clinic") and Dr. Howard Ashby ("Dr. Ashby") to properly assess Jan DeMeerleer's ("DeMeerleer") mental state; and follow-up on his multiple expressed thoughts of suicide and

homicide; and actions taken on those thoughts, during the period of care and treatment.

In September of 2001, DeMeerler began psychiatric treatment at the Clinic. He related to Dr. Ashby that: he had previously been diagnosed with bipolar disorder ("BPD"); had made one or more legitimate attempts at suicide; and had been civilly committed at a mental institution, all prior to his relocation to Spokane, from the Mid-West. (CP 85-86).

During the course of treatment and therapy with Dr. Ashby and the Clinic, DeMeerleer's marriage failed and caused him distress and homicidal thoughts toward his ex-wife and her new male companion. (CP 87); DeMeerleer caused his family to alert Dr. Ashby that he had homicidal thoughts and had taken action on them by laying in wait with loaded firearms in order to attempt to take retribution on one or more individuals he suspected of damaging one of his vehicles (CP 87-88); and was also known to have extended periods of manic behavior, depression, and mixed affect, especially when it concerned pre and post divorce relationships with his ex-spouse and then with Ms. Schiering. (CP 85-89). During psychiatric sessions with Dr. Ashby, it was DeMeerleer's practice to discuss his mental status, including thoughts of homicide and suicide. However, during the course of treatment, Dr. Ashby never once formally

assessed DeMeerleer for risks of suicide or harm to others. (CP 87-91). DeMeerleer was treated exclusively by prescription medication and clinical counseling sessions. (CP 87-90). In the last clinical visit with Dr. Ashby in April of 2010, DeMeerleer appeared to be in obvious distress, and presented with suicidal thoughts. However, DeMeerleer was not scheduled by Dr. Ashby for follow-up assessment or treatment. (CP 89-90).

In the early morning hours of July 18, 2010, DeMeerleer, a patient of Dr. Ashby and the Clinic for almost nine years, murdered Rebecca Leigh Schiering and her nine year old son, Phillip Lee Schiering, by gunshots to the head, and attempted to murder one of Rebecca Leigh Schiering's other sons, Brian Winkler. DeMeerler did not murder or attempt to murder Rebecca Leigh Schiering's other nine year old son, Jack Alan Schiering. (CP 27-32). Later that day, DeMeerleer was found by a the Sheriff's Department S.W.A.T team in the garage of his house, dead, by an apparent self-inflicted gunshot to his head. This tragic sequence of events is hereinafter referred to collectively as "the Incident."

The amended complaint was filed on May 22, 2012. (CP 27-32). Dr. Ashby and the Clinic moved for summary judgment. (CP 57-59 and 60-62). The plaintiffs responded with competent expert psychiatric testimony, uncontested by opposing expert testimony, that negligence by

errors and omissions in treatment of DeMeerleer by the Clinic and Dr. Ashby was a proximate cause of and/or substantial factor in the causation of the Incident. (CP 82-92). Plaintiffs argued that third parties could recover damages from a treating psychiatrist and clinic, for harm caused by a patient, where: the psychiatrist breached the standard of care in failing to properly assess and follow-up on treatment of a patient for suicidal and homicidal thoughts and actions; and knew or should have known that an the third party was forseeably at risk for harm from the patient. (CP 70-81). Defendant/Respondents argued that such causes of action are not recognized in Washington, under the common law, and even if so, RCW 71.05.120 would bar such a cause of action. (CP 249-59). On June 21, 2013, the trial court granted defendants/respondents summary judgment motion and dismissed plaintiffs/petitioners' claims by entry of judgment, giving rise to this appeal. (CP 274-77).

Undisputed Factual Detail

As of 2001, DeMeerleer was residing in Spokane County. He began treatment with the Clinic on September 13, 2001. (CP 85). DeMeerleer disclosed to Dr. Ashby that he previously had suicidal ideas upon which he acted, and the mitigation of which required extended in-patient psychiatric therapy and treatment. (CP 85-86). DeMeerleer reported that he had played "Russian Roulette" with a loaded firearm,

during the summer of 2001. (CP 86). At the time he began treatment with the Clinic, it was also disclosed he had previously had homicidal ideas. In a written submission believed to be provided to Dr. Ashby as part of a June 27, 2002 session, DeMeerleer assessed his manic mental state to include the following characteristics:

1. Despises lesser creatures; no remorse for my actions/thoughts on other living creatures.
2. Delusional and psychotic beliefs argued to the point of verbal abusive and fighting.
3. No need for socialization; in fact, prefers to psychotically depopulate the world (i.e. "do Your Part" [CYP] terrorist philosophies).
4. Wants to destroy; pounds on computer keyboard, slams phone receiver, swings fists.
5. Has no use for others; everyone else in world is useless.
6. Reckless driving; no fear of danger in any circumstance, even "near misses."
7. Acts out fantasies of sex with anyone available. (CP 86)

DeMeerleer's then-current spouse wrote about DeMeerleer:

1. Makes mistakes on projects (i.e. breaking something) and quickly moves into dangerous rage; actually easily slips into depression

after this type of trigger.

2. Severe lack of sleep coupled with dreams of going on killing or shooting sprees.
3. Drives automobiles very fast (at least 20 to 30 MPH above speed limit) without a seat belt while showing no fear at all when in dangerous situations; applies even with a child in the car.
4. Expresses severe "road rage" at other slower drivers, even as a passenger (he's NOT driving).
5. Has an "all or nothing" attitude; will actually verbally express "Live or Die!" (CP 86-87)

When DeMeerleer expressed suicidal and homicidal ideas on several occasions while being treated by Dr. Ashby, no thorough inquiry was made by Dr. Ashby as to the nature and extent of the ideas, such as: planning; access to weapons; prior attempts; acting out, etc; stress; access to victims; and so forth. (CP 87).

At the time he began clinical treatment with Dr. Ashby, and during treatment, issues of DeMeerleer's sexuality and sexual experimentation were identified by DeMeerleer. (CP 87). A review of the police records confirm that a significant issue in his estrangement from Ms. Schiering was: his interest in pornography; his experimentation with homosexuality and/or bi-sexuality; and Ms. Schiering's disdain for these activities. (CP

87). The Clinic's clinical records and chart notes reflect no inquiry into issues of DeMeerleer's sexuality, even though excessive sexual preoccupation is a well-known symptom of BPD. (CP 87).

During treatment by Dr. Ashby and the Clinic, after the failure of his marriage, DeMeerleer expressed homicidal ideas toward his former spouse and her then-current boyfriend. (CP 87). Subsequently, his family was greatly concerned about his access to firearms, and his acting upon homicidal ideas. (CP 87). His mother sent a letter to Dr. Ashby and the Clinic dated September 24, 2005. (CP 87). The following is an excerpt from that letter:

> 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. (CP 88)

DeMeerleer had been placed on various psychotropic drugs by Dr. Ashby which at times regulated his bi-polar state, and at other times did not. This was due either to efficacy, and/or DeMeerleer's known

penchant for failing to take medications (non-compliance), especially in times of his manic and/or mixed mood states. Based on toxicology results, He was non-compliant with taking his medications at the time of the Incident. (CP 88). Dr. Ashby was aware of DeMeerleer's issues of non-compliance. (CP 88).

During treatment by Dr. Ashby, it was known to him that, after his failed marriage, DeMeerleer struck up an apparent serious relationship with Ms. Schiering and her biological children with the intention of marrying Ms. Schiering and becoming a step-father to her biological children. (CP 85). However, DeMeerleer's coping ability was tested severely by Ms. Schiering's autistic son, Jack, to the extent that he physically attacked Jack by striking the then 9 year old squarely in the mouth with his fist. This caused Ms. Schiering to separate from DeMeerleer. (CP 88).

Dr. Ashby initially appeared to have diagnosed DeMeerleer with a mild form of BPD (cyclothymic personality disorder). (CP 85). Dr. Ashby also considered evaluating DeMeerleer's obsessive compulsive traits, but it is not apparent that this was done. An evaluation may have indicated a concurrent borderline personality disorder, which shares some symptomology with BPD, but is not considered as serious a mental illness as BPD. (CP 85). Generally, in the context of a BPD diagnosis, and

throughout treatment by Dr. Ashby and the Clinic, DeMeerleer frequently appeared to have been mentally unstable. (CP 85). However, no systematic or focused inquiry into his psychiatric symptoms was made, and no solid treatment plan with periodic follow-up was initiated by Dr. Ashby, other than adjustment of medications. (CP 85-86).

DeMeerleer was clinically seen by Dr. Ashby on June 11, 2009, and appeared to be in distress. (CP 88). His medication and medication levels were changed, but no follow-up was scheduled. (CP 88). DeMeerleer also phoned the Clinic on December 1, 2009, in obvious distress due to loss of employment and separation from Ms. Schiering, and specifically expressed his desire to get back into counseling and medication management. (CP 88). The Clinic referred him to local community based medical and mental healthcare, but advised him to come to the Clinic for counseling and a medication check if the referrals didn't work out. (CP 88). He returned to the Clinic on April 16, 2010, appeared to be in the middle of frequent mood cycling, and reported he was mending his relationship with Ms. Schiering. (CP 88). He also stated he was having depression related suicidal ideas. (CP 88-89). Apparently, no focused inquiry was made by Dr. Ashby. Instead, Dr. Ashby relied on DeMeerleer's self-report that he wouldn't act on his suicidal ideas. (CP 89). At DeMeerleer's last appointment, on April 16, 2010, he was noted to

suffer from an unstable mood, as well as having intrusive ideas about suicide. (CP 89). There is no evidence that his suicide risk was assessed at this time. There is also no evidence that any follow-up appointment was made in order to adequately monitor his clinical condition. (CP 89).There is also no evidence that Dr. Ashby or the Clinic ever conducted an evaluation of suicide risk during nine years of treatment. (CP 89-90).

V. ARGUMENT

The Washington Supreme Court may accept a Petition for Review of a decision by the Court of Appeals:

> "(1) if the decision of the Court of Appeals is in conflict with a decision of the Supreme Court...."
>
> RAP 13.4(b)(1).

In the present case, this Court should accept review because the Court of Appeals decision which requires evidence of a percentage or range of percentage of reduction in the chance of survival conflicts with *Herskovits v. Group Health Coop.*, 99 Wn.2d 609, 664 P.2d 474 (1983) and *Mohr v. Grantham*, 172 Wn.2d 844; 262 P.3d 490 (2011). The decision also conflicts with established Washington State constitutional and tort law with respect to the jury's proper function of determining damages.

A. The Court of Appeals Erred When it Affirmed Dismissal of Plaintiffs' Loss of a Chance Claim Because There Was No Opinion Evidence as to the Percentage or Range of Percentage Reduction in the Lost Chance.

In the case at bench, the Court of Appeals wrote:

> "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."
>
> *Volk v. DeMeerler,* 184 Wn. App. 389, 429, 337 P.3d 372 (2014). *See also, Rash v. Providence Health & Servs., 183 Wn. App. 612, 334 P.3d 1154 (2014); Estate of Dormaier v. Columbia Basin Anesthesia,* 177 Wn. App. 828, 313 P.3d 431 (2013).

For the reasons that follow, plaintiffs' respectfully contend percentage or range of percentage evidence is not required in order to maintain a loss of a chance claim.

Washington first recognized a claim for loss of a chance in *Herskovits v. Group Health Coop.,* 99 Wn.2d 609, 664 P.2d 474 (1983). *Herskovits* involved a wrongful death and survival action based on a healthcare provider's failure to diagnose and treat. *Id.* at p. 611. The plaintiffs claimed the decedent incurred a loss of chance of survival. *Id.* at p. 612. The trial court granted summary judgment and the plaintiffs appealed. *Id.* The Supreme Court reversed and remanded the matter for trial.

Neither the lead nor concurring opinion in *Herskovits required* opinion testimony of the sort mandated by the court of appeals in this case. The lead opinion by Justice Dore utilized a substantial factor causation analysis wherein a loss of chance claim could survive even if there was less than a 50% chance the defendant's negligence caused the ultimate harm. *Id.* at 614. Percentage evidence was relevant to the issue of whether the defendant's negligence was a "substantial factor," but such evidence was not required.

The concurring opinion by Justice Pearson argued loss of a chance was a separate harm. *Id.* at 624. Justice Pearson wrote:

> "Therefore, I would hold that plaintiff has established a prima facie issue of proximate cause by producing testimony that defendant probably caused a substantial reduction in Mr. Herskovits' chance of survival."
>
> *Herskovits*, 99 Wn.2d at 634.

Justice Pearson also advocated for a proportional damages approach: With respect to statistical data, he wrote:

> In effect, this approach conforms to the suggestion of Justice Brachtenbach in his dissent at page *640*, footnote 3. The statistical data relating to the extent of the decedent's chance of survival are *considered* to show the amount of damages, rather than to establish proximate cause.
>
> *Id.* at 635, n. 2 (emphasis added).

Justice Pearson used the word "considered," not "required."

In 2011, the Washington Supreme Court adopted Justice Pearson's

plurality opinion.

> "We hold that *Herskovits* applies to lost chance claims where the ultimate harm is some serious injury short of death. We also formally adopt the reasoning of a *Herskovits* plurality. 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. This reasoning of the *Herskovits* plurality has largely withstood many of the concerns about the doctrine, particularly because it does not prescribe the specific manner of proving causation in lost chance cases. Rather, it relies on established tort theories of causation, without applying a particular causation test to *all* lost chance cases. Instead, the loss of a chance is the compensable injury."
>
> *Mohr v. Grantham*, 172 Wn.2d 844, 857, 262 P.3d 490 (2011).

With respect to damages, the court wrote:

> "Treating the loss of a chance as the cognizable injury permits plaintiffs to recover for the loss of an opportunity for a better outcome; an interest that we agree should be compensable, while providing for the proper valuation of such an interest. *Lord v. Lovett*, 146 N.H. 232, 236, 770 A.2d 1103 (2001)...".
>
> *Mohr*, 172 Wn.2d at 858.

The Court's reliance on *Lord v. Lovett* supports the contention that percentage or range of percentage evidence as to the degree of the lost chance is unnecessary. The plaintiff suffered a broken neck in an automobile accident. She alleged the defendants' negligently misdiagnosed her spinal cord injury, failed to immobilize her properly, failed to administer proper steroid therapy and thereby caused her to lose the opportunity of a substantially better recovery. *Lord v. Lovett*, 146

N.H. 232, 233; 770 A.2d 1103, 1104 (2001). The defendants intended to move for dismissal at the close of the plaintiff's case. The trial court permitted the plaintiff to make a pre-trial offer of proof. The plaintiff proffered that her expert would testify the defendants' negligence deprived her of the opportunity for a substantially better recovery. However, the *plaintiff's expert could not quantify the degree to which she was deprived of a better recovery by the defendants' negligence.* 770 A.2d at 1104 (emphasis added). The trial court dismissed the plaintiff's action and the Supreme Court of New Hampshire reversed. *Id.*

The court first examined which approach to take in recognizing a loss of a chance. Specifically, the court considered the traditional tort approach wherein a plaintiff must prove, as a result of the defendant's negligence, the plaintiff was deprived of at least a 51 percent chance of a more favorable outcome than actually obtained. *Id.* at 1105. The second approach the court considered was to relax the standard of proof of causation. Under this approach, the patient would not be precluded from recovering simply because her chance of a better recovery was less than 51 percent. If she could prove the defendant's negligence increased her risk of harm to some degree (the precise degree varying by jurisdiction), her cause of action would survive. *Id.* Under the third and final approach considered by the court, the loss of a chance for a better outcome was

itself the injury for which the negligently injured person may recover. *Id.* at 1105-06. This is the approach the New Hampshire court adopted, as this Court did in *Mohr*. 172 Wn.2d at 857.

Turning to damages, the New Hampshire court addressed the defendants' contention a loss of a chance injury is intangible and not amenable to damages calculation.

> "First, we fail to see the logic in denying an injured plaintiff recovery against a physician for the lost opportunity of a better outcome on the basis that the alleged injury is too difficult to calculate, when the physician's own conduct has caused the difficulty. Second, we have long held that difficulty in calculating damages is not a sufficient reason to deny recovery to an injured party. Third, loss of opportunity is not inherently unquantifiable. A loss of opportunity plaintiff must provide the jury with a basis upon which to distinguish that portion of her injury caused by the defendant's negligence from the portion resulting from the underlying injury. This can be done through expert testimony just as it is in aggravation of pre-existing injury cases."
>
> *Lord v. Lovett*, 146 N.H. 232, 239; 770 A.2d 1103, 1108 (2001) (internal citations omitted).

Based on *Herskovits*, *Mohr* and *Lord,* the plaintiffs' in the case at bench have presented sufficient evidence of a loss of chance injury. They have produced testimony, on a more probable than not basis, that defendant's breach of duty caused a loss of chance. Dr. Knoll's declaration addresses loss of a chance in paragraphs 10, 13, and 14. (CP 55). Specifically, Dr. Knoll testified in relevant part:

> "... 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 (sic) 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."
>
> CP 55, para. 10

Under the authorities presented above, Dr. Knoll's testimony is sufficient and admissible. His opinions are made on a more probable than not basis with reasonable medical certainty. CP 55, para. 6. It is not necessary that loss of a chance be proven to a statistically measurable degree. The court of appeals erred in affirming the trial court's dismissal of the plaintiffs' loss of a chance claim on that basis. Therefore, this Court is requested to accept review and definitively conclude percentage or range of percentage evidence is not required in order to maintain a loss of a chance claim.

This Court's recent opinion in *Grove v. PeaceHealth St. Joseph Hosp., 182* Wn. 2d 136, 341 P3d 261 (2014) supports plaintiffs' argument. In that case, two experts testified for the plaintiff during a medical malpractice trial. Neither expert testified as to a percentage or range of percentage reduction in the chance of survival. Dr. Ghidella opined that Grove would not have suffered permanent injuries or would have had a

better outcome if the standard of care had been met. *Id.* at 140-141. Dr. Adams's testified if the hospital employees had not breached the standard of care, Grove would have had a better chance of avoiding injury or would have suffered less severe injury. *Id.* at 142. Although the primary issue decided by the court was whether the trial court properly granted defendants motion for judgment as a matter of law, *Id.* at 138, the experts' testimony as to loss of a chance absent percentages strongly supports the plaintiffs' argument in the case at bar.

Other jurisdictions do not require percentage evidence. *Borgren v. United States*, 723 F. Supp. 581 (D. Kan. 1989). (Statistical percentage evidence in a loss of a chance case is not required). *Kardos v. Harrison*, 980 A.2d 1014, 1017 (2009). (It is sufficient for the plaintiff to show the chance of survival was reduced as a consequence of the defendant's negligence). Compensating a tort victim for an increase in risk which results from some harm caused by a tortfeasor fits comfortably within traditional damage calculation methods. *Id.* at n. 8. *See also, Pesses v. Angelica*, 214 La. App. *Lexis* 2841 (2014) (Louisiana does not require percentage or range of percentage evidence of loss of a chance); *Thompson v. Sun City Community Hosp.*, 141 Ariz. 597, 688 P.2d 605 (1984) (modified by statute) (percentage evidence not required with respect to causation in loss of a chance case); *Holton v. Mem'l Hosp.*, 176

Ill.2d 95, 679 NE2d 1202 (1997) (no percentage evidence required in loss of a chance case with respect to causation); *James v. United States,* 483 F. Supp. 581 (N. Dist. Cal. 1980) (no percentage evidence required with respect to damages calculation); *Hicks v. United States*, 368 F.2d 626 (4th Cir. 1966) (no percentage evidence required with respect to causation).

In the present case, the court of appeals held the plaintiffs' loss of a chance claim must be supported by an expert opinion as to the percentage or range of percentage reduction in the loss of a chance. This Court should accept review and definitively conclude percentage or range of percentage evidence is not required in order to maintain a loss of a chance claim.

B. Washington Does Not Require Opinion Evidence as to Percentage or Range of Percentages in Similar Contexts.

The jury's function in apportioning causation and damages with respect to a preexisting symptomatic condition is similar to apportioning causation and damages in loss of a chance.

> If your verdict is in favor of the plaintiff, and if you find that:
>
> (1) before this occurrence the [plaintiff] [defendant] had a preexisting [bodily] [mental] condition that was causing pain or disability, and
>
> (2) because of this occurrence the condition or the pain or the disability was aggravated,
>
> then you should consider the degree to which the condition or the pain or disability was aggravated by this occurrence.

> However, you should not consider any condition or disability that may have existed prior to this occurrence, or from which the [plaintiff] [defendant] may now be suffering, that was not caused or contributed to by this occurrence."
>
> WPI 30.17

In a preexisting symptomatic condition case, the goal is to separate the preexisting symptomatic condition from the injury caused by the negligent defendant; and apportion damages accordingly. *Id.* There is no requirement the jury consider percentage or range of percentage opinion evidence. *Id.* The same can be said for a jury's decision apportioning fault, deciding issues of contribution and indemnity, and determining the amount of general damages. The loss of a chance is no different. Percentage or range of percentage evidence of the kind required by the court of appeals is unnecessary.

Additionally, such a requirement encroaches upon the jury's rightful determination of damages.

> "The right of trial by jury shall remain inviolate, but the legislature may provide for a jury of any number less than twelve in courts not of record, and for a verdict by nine or more jurors in civil cases in any court of record, and for waiving of the jury in civil cases where the consent of the parties interested is given thereto."
>
> Washington Constitution, Article 1, Section 21.

The measure of damages is a question of fact within the jury's province. *Sofie v. Fiberboard Corp.*, 112 Wn.2d 636, 645, 771 P.2d 711

(1989). To require expert testimony as to the percentage or range of percentage reduction in the loss of a chance case, as a prerequisite to the jury's determination of damages, impinges upon the jury's proper function.

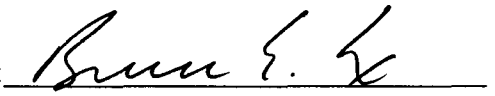
For these reasons, the court is requested to accept review of this matter and conclude evidence as to the percentage or range of percentage reduction in a loss of a chance of case is not required.

VI. CONCLUSION

The plaintiffs' loss of a chance claim in this case was dismissed because there was no evidence of the percentage or range of percentage reduction in the chance of survival. The court is requested to accept review of this matter and definitively conclude opinion evidence as to the percentage or range of percentage reduction in the chance of survival is not required.

RESPECTFULLY SUBMITTED this 5th day of March, 2015.

MICHAEL J. RICCELLI, PS

By: 

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DECLARATION OF SERVICE

I caused to be served a true and correct copy of the foregoing by the method indicated below, and addressed to the following:

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

Dated this 5th day of March, 2015

Holly Eastwood