

NO. 48666-1-II

**COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON**

ALICE KARANJAH,

Respondent,

v.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES,

Appellant.

APPELLANT'S RESPONSE BRIEF

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I. INTRODUCTION

Ivan was a vulnerable adult who lived at an assisted living facility.¹ Alice Karanjah was a caregiver at that facility. Late one night, Ivan grabbed the wrist of another caregiver and would not let go. Ms. Karanjah responded to the call for assistance, but after successfully getting Ivan to voluntarily release his grip, she then forcibly held Ivan's arms behind his back and pushed him over 200 feet into his room, causing an injury to his wrist.

These actions were contrary to the explicit instructions Ms. Karanjah's supervisors gave her on how to take care of severely demented residents like Ivan, particularly since he posed no immediate threat to any person. The Resident and Client Protection Program, the division of the Department of Social and Health Services (Department) that investigates incidents of alleged vulnerable adult abuse in long-term care facilities, made a finding that Ms. Karanjah physically abused Ivan. This finding was upheld twice by the Department Board of Appeals, only to be reversed by the Pierce County Superior Court both times.

Ms. Karanjah seeks to justify her conduct with reference to what a vulnerable adult *might* do instead of what he was actually doing. She

¹ In order to protect the privacy of vulnerable adults involved in this matter, Ivan will be referred to by his first name only. No disrespect is intended. See RCW 74.34.095. Ivan passed away before this matter went to hearing. CP 479.

seeks to use Ivan's very dementia against him and put him, and other vulnerable adults with dementia, in perpetual risk of restraint for the purposes of "protection." This Court should affirm the Department's finding that Ms. Karanjah abused Ivan. This Court should decide that a caregiver's privilege to take what is otherwise certainly unlawful action only extends to those who must act to prevent imminent harm. Otherwise, vulnerable adults will be at risk on a daily basis from the excessive use of restraints used, purportedly, for their own good.

II. RESTATEMENT OF THE ISSUES

1. Whether the finding that Ivan was physically abused is supported by substantial evidence where each finding of fact challenged by Ms. Karanjah is directly supported by eye-witness testimony.

2. Whether physical abuse of a vulnerable adult is defensible where there was no imminent risk of harm to any person.

3. Whether the Department's final agency order is arbitrary and capricious where each challenged finding of fact was supported by eye-witness testimony and where the Department relied on case law to come to its decision.

4. Whether Ms. Karanjah should be awarded attorney's fees where the Department's action was substantially justified because it investigated in response to a complaint, had a statutory duty to so

investigate, had a duty to liberally construe the law to favor the protection of vulnerable adults, and depended explicitly on case law in making its decision.

III. COUNTER STATEMENT OF THE CASE

A. Pioneer Place, Ivan, and Alice Karanjah

Pioneer Place Alzheimer's Residence (Pioneer Place) is an assisted living facility, located in Tacoma, Washington. CP 340. Pioneer Place is separated into two buildings, a higher functioning unit and a lower functioning unit. CP 461. Pioneer Place specializes in dementia care, and its residents are fairly advanced in their dementia. *Id.*

In order to accommodate residents with such extensive needs, Pioneer Place trains its caregiving staff. CP 472. Some of the training was state required and some of the training Pioneer Place conducted as a best practice. *Id.* Caregivers receive dementia and mental health training, which spans three to four days. CP 472, 474. There is also a new staff orientation, which specifically advises on how to approach a resident exhibiting difficult behaviors. CP 472. The training also emphasizes empathy and attempts to teach how to look "through the eyes of someone with dementia." *Id.* Cory Ellis, RN, LPN, was the Director of Nursing at Pioneer Place at the time relevant for this appeal, but was not employed by Pioneer Place at the time of her testimony. CP 460, 472. She testified

that, “[C]ompared to other facilities I’ve been at, and I’ve been at quite a few hospitals and what not, Pioneer has a pretty good training program.” CP 473.

Ivan was a resident of Pioneer Place in the lower functioning unit. CP 463. Ivan had vascular dementia and an unsteady gait. CP 463-64. Ms. Ellis noted that “he was difficult” and “combative.” CP 463. Leticia “Letty” Simmons, LPN, and a medication technician, however, noted that Ivan “was not physically assaultive,” but rather “physically resistive” to care. CP 329. Ivan was also uncomfortable with caregivers approaching him from behind. CP 325. Ivan might pick up a vase with flowers in it to drink or put a cardboard box over his head instead of a shirt. CP 463-64. On one occasion, he struck Ms. Simmons on the shoulder with a photo album while she was trying to change his socks. CP 329. Pioneer Place staff were afraid of him. CP 327.

When Ivan exhibited combative behavior, staff were trained to walk away and re-approach later. CP 325, 327, 329, 402, 464. Ms. Ellis told the Department of Health that “[two] minutes later the patient could be in a different mindset and not even remember (being upset.)” CP 327.

Alice Karanjah was a caregiver at Pioneer Place. CP 464. At the time relevant to this appeal, Ms. Karanjah had a “nursing assistant registered” or “NAR” credential from the Department of Health. CP 229.

A NAR has no scope of practice of his or her own—everything a NAR does must be done with the supervision of a Licensed Practical Nurse or Registered Nurse. CP 390. The only training required for the NAR credential is seven hours of HIV/AIDS training. *Id.* The job duties of a NAR generally include personal hygiene, toileting, and transferring patients. CP 391.

B. The January 3, 2011 Incident

On January 3, 2011, at about one a.m., Ms. Karanjah responded to a call for assistance from another caregiver, Jalissa Harris. CP 418. Ms. Harris was in a soiled utility room, which is where used adult diapers were kept. *Id.* Ivan had a hold on Ms. Harris's wrist. CP 498. Ms. Karanjah sang to Ivan, talked to him softly, and asked him to let Ms. Harris go. CP 418-19, 498. Ivan responded to Ms. Karanjah's request and let Ms. Harris go. *Id.* Ivan had been touching the used adult diapers, and had feces on his hands. CP 424. After Ivan released Ms. Harris, Ms. Karanjah took Ivan's wrists behind his back and interlocked them. CP 467. Still keeping Ivan's wrists locked behind his back, Ms. Karanjah started pushing Ivan to his room, two hundred feet away down the hall and around two corners. CP 216, 467.

At some point between the soiled utility room and Ivan's room, Ivan got his hands free of Ms. Karanjah's grip. *See* CP 399. Ivan was

screaming and Ms. Karanjah continued to push Ivan from behind, controlling him by holding on to fistfuls of his shirt. CP 398. Ivan was flailing his arms out to the side of his body. CP 399. He was digging in his heels, trying to slow Ms. Karanjah down, but Ms. Karanjah was successful in overcoming his resistance. *Id.* Ms. Karanjah and Ivan were moving somewhat faster than Ivan's normal gait. *Id.*

When they got to the door of Ivan's room, Ivan reached out for the door jamb in an attempt to stop moving. CP 400. Because Ms. Karanjah continued to push Ivan forward, however, Ivan hit his wrist against it instead. CP 401. Ms. Karanjah put Ivan in his room with the lights off. CP 485. She closed the door and walked away. *Id.* She had an irritated look on her face. CP 326.

Angela Varney, another caregiver at Pioneer Place, witnessed the last 20 seconds or so of the incident. CP 399-400. She saw Ivan smack his wrist against the door jamb and checked Ivan for injuries. CP 401. She saw that his wrist was red and swollen. CP 485. She reported the incident to her supervisor, Ms. Simmons, and together they applied ice to Ivan's wrist and gave him pain killers. CP 486.

Ms. Karanjah's testimony at the hearing differed from the other evidence in the record. *See* CP 420-24, 499-500. According to Ms. Karanjah, she held Ivan by the forearm and wrist, walking slowly with

him side-by-side. CP 421-22. Ivan was never pushed, never hit his wrist against the door frame, and never yelled. *Id.* Ms. Karanjah also never described Ivan as being violent after he let go of Ms. Harris in the soiled utility room. *Id.*

C. The Department of Health Determined That Ms. Karanjah Violated Nursing Assistant Regulations

The Department of Health (DOH) investigated Ms. Karanjah for her involvement in the January 3 incident. *See* CP 213-225. DOH made four factual allegations against Ms. Karanjah, including that Ms. Karanjah “took [Ivan’s] hands, and pushed him down the hall and into his room where she left him alone and closed the door.” CP 312. Ms. Karanjah did not admit to these allegations, but did acknowledge that if they were proved they would constitute unprofessional conduct under the nursing assistant rules. *Id.* The DOH matter was resolved via a stipulation to informal disposition, resulting in a one-year probation of Ms. Karanjah’s NAR credential. CP 314.

D. Procedural History

Ms. Ellis made a call to the Department abuse hotline to report the January 3, 2011 incident regarding Ivan and Ms. Karanjah. CP 352. On April 17, 2012, after reviewing the DOH investigative file, the Resident and Client Protection Program made a finding that Ms. Karanjah

physically abused Ivan. CP 337. Ms. Karanjah requested an administrative hearing. CP 344. Evidence was presented at the hearing that Ms. Karanjah's actions went contrary to her training and the best practices for dealing with vulnerable adults with dementia. *See, e.g.*, CP 469. The ALJ affirmed the Department's finding of physical abuse in an Initial Order filed on January 2, 2013. CP 268. Ms. Karanjah requested review from the Department's Board of Appeals (Board), a *de novo* administrative appellate body. CP 253; *see also* WAC 388-02-0600. The Board affirmed the ALJ's initial order in a Review Decision and Final Order filed on September 17, 2013.

Ms. Karanjah then petitioned the Pierce County Superior Court for judicial review under RCW 34.05.570. CP 543. The superior court reversed and remanded the matter back to the Department, finding two basic errors. CP 546-49. First, the superior court did not find substantial evidence that Ms. Karanjah injured or physically mistreated Ivan, and remanded the case back to the Department for additional fact-finding on those two issues. CP 547-48. Second, the court determined that the Department did not properly apply the law in *Brown v. Dept. of Social and Health Services*, 145 Wn. App. 177, 185 P.3d 1210 (2008), and the case was remanded to apply that law. CP 546, 548.

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The parties jointly moved to conduct additional fact-finding to comply with the superior court's order. CP 174-75. Another administrative hearing was held on November 5, 2014. CP 373. The ALJ again affirmed the Department's finding that Ms. Karanjah physically abused Ivan. CP 608-623. Ms. Karanjah again petitioned for review to the Board. CP 2. The Board again found that Ms. Karanjah physically abused Ivan. CP 21.

In making its decision, the Board specifically found that where Ms. Karanjah's testimony conflicted with other evidence in the record, Ms. Karanjah was not credible. CP 7-8. The Board found that Ivan injured his wrist when it was struck against the door jamb. CP 10. It also found that Ms. Karanjah caused Ivan physical pain and mental anguish. CP 11. Pursuant to the remand order, the Board also applied the law in *Brown*, holding that *Brown* was distinguished from Ms. Karanjah's case. CP 20. "There simply was not the necessary immediacy of defensive action in this case that the Court of Appeals found was present in the *Brown* case." *Id.*

Ms. Karanjah petitioned for judicial review to the Pierce County Superior Court a second time. CP 574. The superior court reversed, finding that the Board order was in error of law, not supported by substantial evidence, and was arbitrary and capricious. CP 530-31. The court also awarded Ms. Karanjah \$25,000 in attorney's fees. CP 535, 538-39. This appeal followed.

IV. ARGUMENT

This Court should affirm the Board's decision finding that Ms. Karanjah physically abused Ivan. Each challenged finding of fact is supported by substantial evidence in the record, which shows that Ms. Karanjah forcibly shoved Ivan 200 feet down a hallway and through his doorway, injuring his wrist. Contrary to her arguments, Ms. Karanjah's actions are not excused by *Brown* or otherwise. Moreover, finding that these actions amounted to physical abuse was not arbitrary and capricious. In any event, the Department's actions in fulfilling its statutory obligations of protecting vulnerable adults were substantially justified, and therefore the grant of attorney fees under the Equal Access to Justice Act should be reversed.

A. Standard of Review

This is a petition for judicial review of a final agency order under RCW 34.05.570(3). The Court reviews only the final agency action, here the final order issued by the Board on April 1, 2015. CP 2-21. There are limited grounds upon which an appellant can challenge a final agency order. RCW 34.05.570(3). Ms. Karanjah is challenging the final order on the grounds that the Department erroneously interpreted the law, that a lack of substantial evidence supports the Board's findings, and that the Board's order is arbitrary and capricious. Respondent's Opening Brief

(Opening Brief) at 3. It is Ms. Karanjah's burden to prove these grounds. RCW 34.05.570(3). The Court can affirm the agency action on any theory adequately supported by the administrative record. *Heidgerken v. Dep't of Nat. Res.*, 99 Wn. App. 380, 388, 993 P.2d 934 (2000).

1. Questions of Law Are Reviewed *De Novo*

Questions of law are reviewed *de novo*, except that agency interpretations of law are given deference where the agency has expertise. *City of Redmond v. Central Puget Sound Growth Mgmt. Hearings Bd.*, 136 Wn.2d 38, 46, 959 P.2d 1091 (1998). "Where an administrative agency is charged with administering a special field of law and endowed with quasi-judicial functions because of its expertise in that field, the agency's construction of statutory words and phrases and legislative intent should be accorded substantial weight when undergoing judicial review." *Overton v. Economic Assistance Authority*, 96 Wn.2d 552, 555, 637 P.2d 652 (1981). In this matter, the Department is due some deference from the Court. The Department is responsible for protecting vulnerable adults and it is also responsible for licensing the assisted living facility where Ivan resided. *See* Chapter 74.34 RCW; *see also* Chapter 18.20 RCW. The Department has quasi-judicial functions in both of these capacities. *See* Chapter 388-71 WAC; *see also* Chapter 388-78A WAC. The Department has expertise in interpreting statutes regarding assisted living facilities,

and for protecting vulnerable adults in general, and in that regard, should be given deference in its interpretation of the law. *See Goldsmith v. Dep't of Soc. and Health Servs*, 169 Wn. App. 573, 584, 280 P.3d 1173 (2012).

2. The Department Is Due Significant Deference On Its Findings Of Fact

The substantial evidence standard is “highly deferential to the agency fact finder.” *Beatty v. Washington Fish and Wildlife Comm'n*, 185 Wn. App. 426, 449, 341 P.3d 291 (2015). On judicial review, the Court does not substitute its judgment for the agency as to the credibility of witnesses or the relative weight of conflicting evidence. *Id.* Rather, the court only grants relief if the agency’s decision “is not supported by evidence that is substantial when viewed in light of the whole record before the court.” RCW 34.05.570(3)(e). The evidentiary standard applicable to a finding that a person abused a vulnerable adult is a preponderance of the evidence. *Kraft v. Dept. of Social and Health Servs.*, 145 Wn. App. 708, 714, 187 P.3d 798 (2008); WAC 388-02-0485; CP 12. Unchallenged findings of fact are treated as verities on appeal. *Postema v. Pollution Control Hearings Bd.*, 142 Wn.2d 68, 100, 11 P.3d 726 (2000).

3. The Arbitrary and Capricious Standard Is A High Burden To Meet

Finally, the “arbitrary and capricious” standard is only met if there is room for but one decision based on the administrative record. “Where

there is room for two opinions, action is not arbitrary and capricious even though one may believe an erroneous conclusion has been reached.” *Heinmiller v. Dep’t of Health*, 127 Wn.2d 595, 609, 903 P.2d 433 (1995). To set aside an agency order as arbitrary and capricious, Ms. Karanjah must put forth a “clear showing of abuse” of discretion. *ARCO Products Co. v. Washington Utilities and Transp. Comm’n*, 125 Wn.2d 805, 812, 888 P.2d 728 (1995).

B. All Challenged Factual Findings Are Supported By Substantial Evidence

Before the challenged findings of fact are addressed, the Department notes what is *unchallenged*. It is a verity on appeal that Ms. Karanjah restrained Ivan by holding his wrists behind his back and shoving him the 200 feet to his room. *See* Opening Brief at 11 n.9.

Substantial evidence also shows that Ms. Karanjah both injured Ivan and physically mistreated him. These findings of fact were based on eye-witness testimony and Ms. Karanjah’s argument that the evidence should be re-weighed in her favor is contrary to the Administrative Procedure Act.

1. Substantial Evidence Shows Ms. Karanjah Injured Ivan

The Board found that “Ivan’s wrist was injured when he slammed it into the doorjamb of his room” and that Ms. Karanjah caused the injury.

CP 10-11. This finding is based on the eye-witness testimony of Ms. Varney. *Id.* The Board's decision to find her credible should not be reversed by this Court.

Ms. Varney testified at the first hearing that she saw Ivan strike his wrist against the door jamb of his room. CP 401, 485. She specifically testified that immediately afterwards Ivan had a red bump on his wrist that swelled quickly. CP 485. Ms. Varney's 2012 testimony did not explicitly explain how Ivan's wrist struck the door jamb. *See* CP 485. On remand, Ms. Varney was recalled as a witness to explain. *See* CP 400. Ms. Varney testified that she saw Ms. Karanjah pushing Ivan for about 20 seconds. CP 399-400. During that whole time, Ivan was flailing his arms to the side of his body and slightly above his head. CP 399-400. When they approached the door to Ivan's room, Ivan reached for the door jamb, in an apparent effort to stop himself from moving forward. CP 400. Ms. Varney specifically testified that Ms. Karanjah caused Ivan to strike his wrist against the doorjamb.

Q: So if Ms. Karanjah had not been pushing him from behind, he wouldn't have struck his wrist on the doorframe?

A: No.

CP 401.

///

Ms. Varney's testimony is corroborated by other evidence in the record. Ms. Varney's written statement taken the day of the incident notes that she "looked at his left wrist and noticed some swelling on the outside bone. He was in pain." CP 345. Ms. Simmons faxed an injury report to Ivan's physician, noting redness and swelling on Ivan's wrist. CP 209. Ivan's physician wrote back, "Injury noted." *Id.* An incident report was filled out, noting the injury and documenting that continuing observation would be required. CP 210. Progress notes were taken documenting the progression of the injury to Ivan's wrist. CP 211-12. Ms. Simmons told DOH that she "confirmed redness around [Ivan's] left wrist." CP 330. While there were no breaks in the skin, she did apply a wet rag and give him Tylenol for the pain. *Id.*

This evidence is more than substantial for a factual finding that Ms. Karanjah caused Ivan injury. Ms. Karanjah takes issue with it, noting several reasons that a finder of fact might decide that it is less than credible. *See* Opening Brief 40-42. But this kind of evidence weighing is reserved for the trier of fact. An appellate court does "not substitute [its] judgment for that of the agency regarding witness credibility or the weight of the evidence." *Smith v. Employment Security Dept.*, 155 Wn. App. 24, 35, 226 P.3d 263 (2010). The Board found Ms. Varney's account particularly credible, and accordingly gave it more weight. CP 8-10.

There is no basis to overturn the Board's finding that Ms. Karanjah caused Ivan an injury.

2. The Law Of The Case Doctrine Does Not Preclude A Factual Finding That Ms. Karanjah Caused Ivan Injury

Ms. Karanjah's argument that the Board should hold to its finding of fact made in 2013 that Ivan was injured when Ms. Karanjah "released" him at the "foot of his door"² is unsupported by the law or common sense. The Board is not bound by the law of case doctrine to ignore evidence, specifically called for by the remand order of a superior court, and persist in a false version of events.

Ms. Karanjah erroneously claims that the Board erred by reversing itself contrary to the law of the case doctrine. *See* Opening Brief at 39 n.18. The law of the case doctrine refers to a reviewing court's ability to reverse itself when it reviews the same matter a second time. *See Lutheran Day Care v. Snohomish Cty.*, 119 Wn.2d 91, 113, 829 P.2d 746 (1992).³ The law of the case doctrine is discretionary, not mandatory. *Folsom v. Cty. of Spokane*, 111 Wn.2d 256, 264, 759 P.2d 1196 (1988). Furthermore, the doctrine only applies when it is "applied to the same facts, shown by the same evidence." *Perrault v. Emporium Dep't Store*

² Ms. Karanjah quotes this phrase twice and in emphasized text. Opening Brief at 39 nn.18 & 41. It appears nowhere in the record, and certainly not on page seven of the 2013 final order where she says it does. *See* CP 236.

³ The term also has two other meanings, not applicable here. *See Lutheran Day Care*, 119 Wn.2d at 113.

Co., 83 Wn. 578, 582, 145 P. 438 (1915). Courts do not apply the doctrine of the law of the case where the evidence has changed materially. See *Highlands Plaza, Inc. v. Viking Inv. Corp.*, 2 Wn. App. 192, 197-98, 467 P.2d 378 (1970).

First, the Board was under a mandate from the Pierce County Superior Court to find additional facts regarding whether Ms. Karanjah injured or physically mistreated Ivan. CP 549. The remand for further proceedings is specifically authorized in statute. RCW 34.05.574(1). On remand, the parties agreed to hold another evidentiary hearing to take evidence in order to fulfill the Superior Court's mandate. CP 174-75. Whether and how Ivan's wrist came into contact with the door frame is directly relevant to whether Ivan was injured or physically mistreated. The Board cannot be barred from finding additional facts when it was under the explicit instruction from the Superior Court to do exactly that, and the parties stipulated to the gathering of additional evidence.

Second, this application of the law of the case doctrine—that an appellate body will not reverse itself the second time a matter is before it—would be unconstitutional if applied to an administrative agency. The law of the case doctrine is a discretionary, prudential doctrine, developed by the judicial branch to govern itself. *Highlands Plaza*, 2 Wn. App. at 198. Forcing an executive agency to take a discretionary act violates

separation of powers. *Shaw v. Clallam County*, 176 Wn. App. 925, 934-35, 309 P.3d 1216 (2013).

Third, the finding that Ms. Karanjah complains of does not even contradict the 2013 order. The basic elements of the finding, that Ms. Karanjah caused Ivan to strike his wrist against the door frame, remain. *Compare* CP 400-01 *with* CP 485. Even if the law of the case doctrine applies it should not bar this kind of clarification of previous holdings.

Finally, there was a change of the evidence. The law of the case doctrine only applies “to the same facts, shown by the same evidence.” *Perrault*, 83 Wn. at 582. There was different evidence before the Board and it was entitled to use that evidence to make additional findings of fact.

3. Substantial Evidence Shows That Ms. Karanjah Physically Mistreated Ivan

The Board found that Ms. Karanjah physically mistreated Ivan in its Conclusion of Law 12. CP 17. This finding is well-supported by substantial evidence in the record. It is unchallenged that Ms. Karanjah approached Ivan from behind, restrained his limbs, and pushed him from behind. As witnesses showed in their testimony, this constituted physical mistreatment.

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First, Ms. Ellis, RN, LPN and Pioneer Place's Director of Nursing at the time of the incident, was very clear that treating Ivan in the way Ms. Karanjah did was not appropriate. CP 467-69. She explained that taking Ivan's limbs, walking him from behind, and pushing him were all contrary to Pioneer Place's standards of practice and Ms. Karanjah's training. CP 468-69. She further explained that the standards are there in order to promote appropriate levels of dignity and respect for the residents. CP 468. She testified that, to her, Ms. Karanjah's conduct appeared "as though it was a form of punishment." CP 468. Ms. Ellis was clear that if Ivan was not approachable, then Ms. Karanjah should have walked away and reapproached him later. CP 469.

Ms. Simmons, as part of an earlier DOH investigation, explained appropriate techniques for approaching Ivan if he was approachable. CP 217. Ms. Simmons agreed that approaching from the back is always inappropriate for an Alzheimer's patient. *Id.* "Direct eye-contact is vital to re-directing them." *Id.* She explained that grabbing an Alzheimer's patient's wrist is also never appropriate. *Id.* Rather, "hold your hands out and the patient will place their hands on yours and follow you." *Id.* These are very basic caregiving principles and were known to Ms. Karanjah. *Id.* Ms. Simmons emphasized that resistive and combative behavior is "compounded" by failing to follow these principles. *Id.*

Ms. Varney testified that a person with Alzheimer's must always be approached from the front. CP 487. Even when a resident with Alzheimer's is approached from the front, if the caregiver then moves to the back, the resident will forget who is there. *Id.*

Ms. Paula Sanz, RN, and program manager for the Resident and Client Protection Program, testified from her lengthy experience working with people with dementia. *See* CP 454-55. She explained that approaching a person with Alzheimer's from behind causes them to become fearful and anxious. CP 455. "They don't understand what's happening." CP 454. Because of that, it is important to obtain cooperation and "not force them to do anything." CP 454-55.

Against this testimony no evidence was presented to show that taking Ivan's wrists behind his back and shoving him from behind was an accepted practice. No evidence was presented that showed it was necessary to prevent harm to Ivan or others to restrain him in this way. At the hearing, Ms. Karanjah did not seek to justify these actions as necessary under the circumstances. Rather, her position at the hearing was that she *did not* take these actions. *See* CP 65-66. But the Board found her not credible. CP 8. And, those facts that Ms. Karanjah once contested are now verities on appeal because they were not challenged. The evidence is unanimous that Ms. Karanjah physically mistreated Ivan when she took

his hands behind his back, restrained him by holding on to his wrists, and shoved him to his room. The Board's finding of physical mistreatment is not error.

4. The Board's Characterizations of Ms. Karanjah As Annoyed and Overly Assertive Are Legitimate Inferences Based On The Evidence

Ms. Karanjah also complains about Board characterizations of her action as "frustrated" and "overly-assertive." Opening Brief at 43. Both of these characterizations are legitimate inferences from the evidence.

First, Ms. Varney told DOH that Ms. Karanjah had an irritated look on her face. CP 326. Evidence that Ms. Karanjah herself put in the record indicates that Ivan was generally a difficult resident, and was especially difficult that night. *See* CP 497. The evidence was also unanimous that the way Ms. Karanjah forced Ivan to his room was outside of the procedures and practices of Pioneer Place and outside of Ms. Karanjah's training. *See, e.g.* CP 469. It is a reasonable inference from all of this evidence that the reason Ms. Karanjah ignored her training was because she was frustrated at the way that Ivan was behaving. Instead of taking the slow approach Ms. Simmons described (CP 217) or, if Ivan was not approachable, walking away and trying again in a minute or two as Ms. Ellis recommended (CP 469), Ms. Karanjah simply forced Ivan to
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his room. That solved her immediate problem, but at the expense of Ivan's dignity and physical autonomy.

Ms. Karanjah also objects to "fact-finding" that she was "overly-assertive." Opening Brief at 43. As indicated above, Ms. Ellis, Ms. Simmons, Ms. Varney and Ms. Sanz all provided evidence that Ms. Karanjah's way of handling Ivan was inappropriate. It was inappropriate because it was too forceful and, synonymously, overly-assertive. The Board did not err in describing her as frustrated and overly assertive.

5. Substantial Evidence Shows Ms. Karanjah Did Not Seek Assistance To Clean Ivan's Hands

The Board found that Ms. Karanjah "did not notify other staff members that [Ivan's] hands needed to be cleaned." CP 11. This finding is directly supported by Ms. Varney's eye-witness testimony and should not be overturned.

Ms. Varney testified that after Ms. Karanjah shoved Ivan into his room, she closed the door and walked away. CP 485. Ms. Karanjah testified that she first called to Ms. Varney so that she would assist Ivan. CP 500. The Board determined that Ms. Varney was more credible. CP 8. Again, an appellate court does "not substitute [its] judgment for that of the agency regarding witness credibility or the weight of the evidence."

Smith, 155 Wn. App. at 35. There is no basis to overturn the finding of fact that Ms. Karanjah did not seek assistance in cleaning Ivan’s hands.

C. Ms. Karanjah’s Conduct Was Physical Abuse Under Former RCW 74.34.020(2)(b)

By taking Ivan into an arrested position, shoving him into his room, and forcing his wrist into violent contact with the doorjamb, Ms. Karanjah physically abused Ivan under former RCW 74.34.020(2)(b). She physically abused Ivan because she restrained him, because she shoved him from behind, and because she caused his wrist to come into violent contact with the door frame, causing him injury.

The Abuse of Vulnerable Adults Act, chapter 74.34 RCW was amended while this case was pending. *See* Laws of 2015, ch. 268.⁴ On January 3, 2011, the definition of “abuse” was, in relevant part:

“Abuse” means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. . . . Abuse includes . . . physical abuse . . . which [has] the following meaning[]:

. . .
(b) “Physical abuse” means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse

⁴ The House Bill Analysis that Ms. Karanjah cites is not persuasive authority. First, the bill it analyzes, House Bill 1726, never became law. *See* <http://app.leg.wa.gov/billinfo/summary.aspx?bill=1726&year=2015> (last accessed August 4, 2016). Rather, its companion bill, Senate Bill 5600 was enacted by the legislature. Laws of 2015, ch. 268. Second, the passage Ms. Karanjah quotes refers to a section of the bill that was not enacted. *See* SB 5600, 64th Leg., § 2. As originally conceived, Senate Bill 5600 would have enacted a new affirmative defense to the abuse of a vulnerable adult. *Id.* This defense was not enacted into law. Laws of 2015, Ch. 268. The passage Ms. Karanjah quotes is clear—it is in the “summary of bill” section, not the “background” section. *See* Opening Brief, Appendix 1, at 2.

includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.

Former RCW 74.34.020(2) (2010). The recent amendments did not substantively change the umbrella definition of “abuse,” except to add a new category of abuse: “improper use of physical restraint.” Laws of 2015, Ch. 268 § 1. Under the new law, “physical abuse” no longer includes the use of restraints. RCW 74.34.020(2)(b). Rather, the abuse of a vulnerable adult via the use of restraints is a category of abuse separate from “physical abuse.” RCW 74.34.020(2)(e).

Here, by restraining Ivan, shoving him from behind, and causing his wrist to come into violent contact with the door frame, Ms. Karanjah’s conduct met every element of the definition of “physical abuse” in former RCW 74.34.020(2)(b). Physical abuse of a vulnerable adult has three essential elements:

- A willful action
- That inflicts injury or physical mistreatment
- On a vulnerable adult.

See former RCW 74.34.020(2)(b). “Willful” is not defined in statute, but the Department has defined it in rule to mean, “the deliberate, or

nonaccidental, action or inaction by an alleged perpetrator that he/she knows or reasonably should have known could cause a negative outcome, including harm, injury, pain or anguish.” WAC 388-78A-2020.⁵

The facts establishing that Ms. Karanjah caused Ivan injury and physical mistreatment are discussed above. This element of physical abuse is supported by substantial evidence and there is no basis to reverse the finding. In satisfaction of the third element, Ivan was a vulnerable adult, which was specifically found by the Board and is not contested on appeal. CP 16; *see also* former RCW 74.34.020(16)(d).

Ms. Karanjah’s conduct was also willful. It was no accident that she took Ivan by the wrists and forced his arms behind his back. *See* CP 400-01, 467. Ms. Karanjah could not have accidentally shoved Ivan from behind. *See* CP 399. These were deliberate acts on Ms. Karanjah’s part. And, Ms. Karanjah knew, or should have known, that these actions “could cause a negative outcome, including harm, injury pain or anguish.” She received explicit training on how to deal with residents with dementia. CP 366. Her conduct went outside of that training. CP 468-69. She should have known that pushing Ivan from behind could cause him harm.

⁵ This definition is taken from the rules regarding assisted living facilities. *See* Chapter 388-78A WAC. It is applicable here because the Department was operating under rules allowing it to enforce chapter 74.34 RCW against caregivers in assisted living facilities when it made its finding against Ms. Karanjah. *See* Former WAC 388-78A-3400 (2012). The definition of “willful” in WAC 388-78A-2020 is very similar to the definition in WAC 388-71-0105 applicable to Adult Protective Services generally.

And, given what Ivan was doing, it is hard to believe that Ms. Karanjah did not know Ivan was in distress. Ivan was digging in his heels and screaming in Spanish. CP 398-99. He was flailing his arms in an attempt to stop moving forward. CP 399. When he got to his room, he tried to stop himself by grabbing hold of the door jamb. CP 400. At the beginning of the interaction, Ms. Karanjah simply asked Ivan to let go of Ms. Harris and he complied. CP 419, 498. By the time Ms. Varney witnessed the occurrence, about 200 feet later (CP 216), Ivan's mental state had devolved to where he was confused, anxious, and violent. *See* CP 402. Ms. Karanjah should have been able to conclude that her actions were causing distress to Ivan.

Ms. Karanjah incorrectly argues that her conduct was not willful because she did not intend to hit Ivan's wrist on the door jamb. Opening Brief at 45. The act must be willful, but the injury or anguish caused by it need not be. Former RCW 74.34.020(2)(b) requires "the willful action of inflicting bodily injury or physical mistreatment." Not "the willful action *to inflict* bodily injury or physical mistreatment." *See* Former RCW 74.34.020(2)(b). The definition of "abuse" is even clearer. There, the language is "the willful action or inaction *that inflicts* injury . . ." Former RCW 74.34.020(2). It is enough that Ms. Karanjah "knew or should have known" that her actions posed an unacceptable risk of harm to Ivan. *See*

WAC 388-78A-2020 (defining “willful”). Because she was specifically trained that grabbing him, approaching him from behind and shoving him were all inappropriate, she should have known that her actions could result in harm to Ivan. *See, e.g.*, CP 469. Because Ivan made his distress perfectly clear, she should have known that her actions were in fact causing Ivan distress. *See Goldsmith*, 169 Wn. App. at 585 (holding conduct was willful where son “know or should have known” that repeated yelling matches with his elderly father caused him “considerable stress.”). Ms. Karanjah’s conduct was willful. *See* CP 399.

Ms. Karanjah also abused Ivan under former RCW 74.34.020(2)(b) because she restrained him. It is physical abuse of a vulnerable adult to use chemical or physical restraints unless the restraints are used consistently with licensing requirements. Former RCW 74.34.020(2)(b). In assisted living facilities, restraints are prohibited. WAC 388-78A-2660. This is in contrast to other licensed settings where restraints may be used within certain parameters. *See, e.g.*, WAC 388-76-10655 (allowing the use of physical restraints in adult family homes); *see also* WAC 388-97-0620 (allowing the use of chemical and physical restraints in nursing homes). In fact, in the regulatory definition of physical abuse applicable to assisted living facilities, the exception for the use of restraints used “consistently with licensing requirements” does not appear. WAC 388-78A-2020

(defining “physical abuse”). This is because restraints can never be used in an assisted living facility consistently with licensing requirements. *See* WAC 388-78A-2660. The assisted living facility regulations also define restraint, in part, as “any method or device used to prevent or limit free body movement.” WAC 388-78A-2020 (defining “restraint”). By holding Ivan’s wrists behind his back, and holding onto his shirt, she certainly prevented his body from moving freely and consequently restrained him. While exigent circumstances may sometimes justify such restraint, as discussed below, Ms. Karanjah was reacting to no such circumstances on January 3, 2011. Consequently, Ms. Karanjah physically abused Ivan.

1. *Brown* Created A Defense Analogous To The Necessity Defense Or A Defense Of Self-Defense Or Defense Of Others

The court in *Brown* held that when a caregiver “intervenes in the presence of danger,” conduct which would otherwise be abuse under RCW 74.34.020 is not necessarily unlawful. *Brown*, 145 Wn. App. at 183. The decision in *Brown* does not give caregivers like Ms. Karanjah license to prophylactically restrain vulnerable adults whenever they subjectively believe that such restraint may be “protective.” The facts of *Brown* illustrate that the court was applying established principles analogous to the defenses of necessity and self-defense.

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“The common law has long recognized the existence of a defense of necessity.” *State v. Diana*, 24 Wn. App. 908, 914, 604 P.2d 1312 (1979). The defense has several elements, generally going to the point that if illegal action is necessary to avoid some greater evil, the actor has a defense. *Id.* at 914 (quoting Model Penal Code, §3.02 (Proposed Official Draft A, 1962)). The defense is not available where there is a legal alternative to the alleged conduct. *Id.* at 913. And, the belief that the illegal conduct is necessary must be reasonable. *See State v. Jeffrey*, 77 Wn. App. 222, 224, 889 P.2d 956 (1995). While the necessity defense is generally applied as a defense to criminal charges, it has been extended to civil cases. *See Texas Dept. of Public Safety v. Moore*, 175 S.W.3d 270, 273 n.2 (Tex. App. 2004) (applying the law of the necessity defense to an administrative driver’s license revocation); *see also U.S. v. Cannibus Cultivators Club*, 5 F.Supp.2d 1086, 1101-03 (N.D. Cal. 1998) (applying the law of the necessity defense to an action for a civil injunction).

The defense of self-defense or the defense of others is similar to the defense of necessity. It is also rooted in the common law (*see State v. Acosta*, 101 Wn.2d 612, 626, 683 P.2d 1069 (1984)), but has been codified into statute in Washington. *See* RCW 9A.16.020. Most analogous to this case, and to *Brown*, is RCW 9A.16.020(6), which provides a defense for the use of force against a mentally incompetent person. To be entitled to

this defense, the defendant must have a reasonable belief that the person to be protected is in imminent danger. *State v. Jarvis*, 160 Wn. App. 111, 121-22, 246 P.3d 1280 (2011). The defense is limited to the use of “force used in self-defense is limited to what a reasonably prudent person would find necessary under the conditions as they appeared to the defendant.” *See State v. Walden*, 131 Wn.2d 469, 474, 932 P.2d 1237 (1997).

Although the *Brown* opinion did not explicitly reference these legal doctrines, the law it applied is highly analogous to these two defenses. *Brown* involved a caregiver, Ms. Brown, and a vulnerable adult, L., who suffered from various mental impairments. *Brown*, 145 Wn. App. at 180. One day when Ms. Brown was caring for L. and other vulnerable adults, L. became agitated. *Id.* She attempted to kick another vulnerable adult, S., who was a fragile diabetic. *Id.* S. tried to walk away, but L. continued her aggression, yelling at S., and threatened to kill him. *Id.* Another staff person attempted to redirect L., but L. struck her and knocked her glasses to the ground calling her names. *Id.* At this point, Ms. Brown intervened for the first time. *Id.* She physically turned L. around and pushed her onto her bed. *Id.* Ms. Brown held L. down for a short period of time. *Id.* After a few moments, and L. had calmed down, L. went outside and observed Ms. Brown speaking with S. *Id.* L. again became aggressive toward S. *Id.* Ms. Brown got in between the two, attempting to

calm L. down. *Id.* L. refused to be calm and started to hit and scratch Ms. Brown, all the while threatening to kill S. *Id.* Ms. Brown instructed another staff person to call 911, while L. grabbed Ms. Brown's wrists. *Id.* at 181. Ms. Brown released herself from L.'s grip and, in the process, caused L. to fall to the ground. *Id.* L. got up immediately and, again, attacked S. *Id.* Ms. Brown "grabbed L. with both hands and put her foot and leg behind L.'s legs, and then pushed L. onto the grass." *Id.* Ms. Brown restrained L. until L. agreed to calm down. *Id.* Ms. Brown escorted L. into L.'s apartment where Ms. Brown helped L. with her hair in further attempts to calm her down. *Id.* "L. and Ms. Brown exited the apartment, holding hands." *Id.* Ms. Brown went to the hospital where she was treated for her injuries. *Id.*

The court held that Ms. Brown did not physically abuse L. The court's analysis was not long:

Both the definition of "abuse" and "physical abuse" require a willful action to inflict injury. Further, "abuse" may entail "unreasonable" confinement. Here, substantial evidence shows Ms. Brown did not willfully injure L.; nor did she unreasonably confine her. No Washington case is directly on point, but in Alaska, which has a similar [Abuse of Vulnerable Adults Act], the Supreme Court noted, "[I]f the harm results from improper action, we label the action abuse." *R.J.M. v. State*, 946 P.2d 855, 863 n.9 (Alaska 1997). Here, no improper action is shown. *Ms. Brown properly intervened in the presence of danger to herself, her co-workers, and another vulnerable adult resident.* Her

actions were protective, not injurious or ill-intended, thus they were warranted and not abusive.

Id. at 183 (emphasis added).⁶

The reasoning in *Brown* tracks the analysis of both the necessity defense and the defense of self-defense or the defense of others. Ms. Brown’s conduct was proper because Ms. Brown “intervened in the presence of danger,” in other words her conduct was necessary to prevent an imminent harm. *See Brown*, 145 Wn. App. at 183. Ms. Brown’s conduct was proportional to the danger posed because it was “protective” and “warranted.” *Id.* Ms. Brown had no reasonable alternative and so her actions were not “ill-intended.” *Id.*

Ultimately, Ms. Brown was faced with the imminent danger that L. would hurt somebody (and in fact, L. did hurt Ms. Brown). *See id.* at 181. She did only what was necessary to prevent that harm. She released L. as soon as L. calmed down—twice. *Id.* Because she had to do what she did to avoid a greater evil, she did not abuse L.—that is the rule from *Brown*.

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⁶ The Alaska case cited by the *Brown* court was not an interpretation of Alaska’s act prohibiting abuse of vulnerable adults. *See R.J.M. v. State*, 946 P.2d 855, 857, 946 P.2d 855 (1997). The case was actually about the proper interpretation of the state’s laws about dependent children, and focused on the distinction between neglect and abuse. *Id.* The case had nothing to do with exigent circumstances or what makes a given act proper or improper. *See id.* at 863. *R.J.M.* provides no help in determining what is “improper” under *Brown*.

2. The *Brown* Defense Is Unavailable To Ms. Karanjah Because Ms. Karanjah Faced No Immediate Danger

In contrast to the *Brown* case, there was no imminent threat that required Ms. Karanjah to take Ivan's hands behind his back and force him to his room. Even when Ivan had a hold on Ms. Harris's wrist, Ms. Karanjah got him to let go by asking him—no force was necessary. CP 498. Then, without any further provocation from Ivan, Ms. Karanjah took Ivan's hands behind his back and forced him to his room. *See* CP at 467. Ms. Karanjah herself never articulated any particular threat posed by Ivan. *See* CP 419-21, 498-500.

The fact that Ivan was combative by the time he reached his room does not justify Ms. Karanjah's conduct. *See* CP 402. Ms. Karanjah caused Ivan's distress when she took Ivan's hands behind his back and pushed him the 200 feet to his room. Ms. Simmons was clear that grabbing a resident from behind aggravates combative behaviors. CP 217. Ms. Ellis testified that what Ms. Karanjah did would cause Ivan to be aggressive. CP 468. Ms. Karanjah cannot leverage this reaction to her initial abuse into a retroactive license to abuse. *Cf. Diana*, 24 Wn. App. at 914 (defense of necessity is not available when a defendant causes the circumstances which pose a danger).

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Ms. Karanjah acknowledges that there is no evidence that Ivan was an immediate threat requiring her to take his arms behind his back and push him to his room. *See* Opening Brief at 31-34. She attempts to justify her conduct by pointing to Ivan's previous combative behaviors and generally disruptive presence in the assisted living facility, including other incidents that took place on the morning of January 3, 2011. *Id.* But, like the defense of necessity and the defense of self-defense or the defense of others, *Brown* requires "intervention in the presence of danger" in order for the defense to apply. *Brown*, 145 Wn. App. at 183. Ms. Karanjah does not, and cannot, point to any particular harm that was avoided. *See* Opening Brief at 31-34. She only states that she prevented "violence or other dangerous or problematic resident behavior." *Id.* at 33. Without a requirement of immediacy, this argument would justify "protective" restraint of a resident like Ivan at any time.

Ms. Karanjah pins her argument on the difference between the words "defend" and "protect." Opening Brief at 32. First, "protect" does mean defense in the face of an attack. The first definition of "protect" listed in the dictionary is "to cover or shield from that which would injure, destroy, or detrimentally affect." Webster's Third International Dictionary 1822 (Merriam-Webster 2002). Second, "defend" and "protect" are synonymous. *Id.* at 591, 1822 (defining "defend" and "protect"). The court

in *Brown* spent no time defining or articulating what it meant by “protective.” *Brown*, 145 Wn. App. at 183. Extending the *Brown* defense to the prophylactic use of force would be an unwarranted departure from generally applicable legal principles. It has long been the law that in order to be privileged to do what is otherwise illegal the actor must have a compelling and immediate reason. *See Jarvis*, 160 Wn. App. at 121-22. Those principles should not be overturned based on the slight differences between otherwise synonymous words.

Ms. Karanjah also had options that Ms. Brown never had. She could have walked away and re-approached Ivan at a later time. In fact, that is what she was trained to do if Ivan was not approachable. CP 469. If Ivan was approachable, as Ms. Karanjah’s initial interaction with him suggests, then she had the full arsenal of techniques that Ms. Simmons explained to DOH. *See* CP 217. This also precludes application of the defense in *Brown*.

Because there was no immediate danger that required Ms. Karanjah to restrain Ivan and shove him to his room she abused him under former RCW 74.34.020(2)(b). The Board’s Final Order applied the law correctly and it should be affirmed.

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3. The Abuse of Vulnerable Adults Act Must Give Vulnerable Adults More Protection Than The Assault Statutes

It would be absurd if the Abuse of Vulnerable Adults Act gave Ivan less protection than the criminal prohibition on assault. Yet, that is exactly what Ms. Karanjah argues for when she argues that she may restrain Ivan for generally protective purposes without any immediate necessity. Because such a result is at odds with the clear legislative intent behind the Abuse of Vulnerable Adults Act, Ms. Karanjah's argument should be rejected.

Assault means, among other things, "an unlawful touching with criminal intent." *State v. Keend*, 140 Wn. App. 858, 866-67, 166 P.3d 1268 (2007). An unlawful touching is one that is "harmful or offensive regardless of whether it results in injury." *State v. Osman*, 192 Wn. App. 355, 378, 366 P.3d 956 (2016). The intent required is merely the intent to commit the act. *Keend*, 140 Wn. App. at 866. There is no requirement that the defendant intend some further result such as substantial bodily harm. *Id.* There is no requirement that the defendant act with malice or ill-will. *Jarvis*, 160 Wn. App. at 119. Absent justification or excuse, taking a person's arms behind their back and shoving them forward would constitute assault.

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If what was proved at hearing in this matter were proved beyond a reasonable doubt according to the rules of criminal procedure, then Ms. Karanjah would have been convicted of assault in the fourth degree. *See* RCW 9A.36.031. If that were the case, she would be obligated to use RCW 9A.16.020(6) in order to present the argument she now makes under *Brown*. But under the law set out in *Jarvis*, this defense would not justify her conduct because there was no compelling and immediate reason to restrain Ivan. *See Jarvis*, 160 Wn. App. at 121-22. There, the court held that applying the defense to a situation not involving imminent harm “would be giving those with custody of the mentally disabled broad license to assault their charges” and “undermine the protection that the assault statutes offer to such individuals.” *Id.* at 121.

The Abuse of Vulnerable Adults Act was enacted by the legislature in order to give vulnerable adults additional protections when compared with the general population. *See* RCW 74.34.005. It would be wholly incongruent with the statutory scheme if what constitutes assault under RCW 9A.36.031 did not constitute the physical abuse of a vulnerable adult. Yet, that is Ms. Karanjah’s argument. This Court should reject it and affirm the Board’s Review Decision and Final Order finding that Ms. Karanjah physically abused Ivan.

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4. There Is A Serious Risk Of Excessive Use Of Restraint If Restraints Are Allowed For “Protective” Purposes

If caregivers are allowed to use restraint against a vulnerable adult whenever such restraint might be “protective” against a hypothetical future harm, vulnerable adults will be at the mercy of their caregivers. It is easy to manufacture a reason that a vulnerable adult might come to harm if allowed to be free. Vulnerable adults are vulnerable because they cannot care for themselves. *See* RCW 74.34.020(21)(a). Washington has enacted specific laws and rules prohibiting the use of prophylactic restraints. *See* RCW 74.34.020(2)(e); WAC 388-78A-2660; WAC 388-76-10655; WAC 388-97-0620. The *Brown* decision should not be used to invalidate them.

All residents of long-term care facilities are there voluntarily. RCW 11.92.190. Ivan needed the kind of care that Pioneer Place provided—called “domiciliary care” (*see* RCW 18.20.020(5))—but he was not a prisoner. He was not even a “patient”—he was a “resident.” *See* RCW 18.20.020(10). Pioneer Place was his *home*. *See* CP 18, 478. Assisted living facilities are required to “care for residents in a manner and in an environment that maintains or enhances each resident’s dignity and respect in full recognition of his or her individuality.” RCW 70.129.140.

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Restraints range in type from the manual restraint that Ms. Karanjah used on Ivan (*see* RCW 74.34.020(17)) to mechanical restraints that strap a vulnerable adult down or prevent a vulnerable adult from getting out of bed. *See* RCW 74.34.020(14) (defining “mechanical restraint”). Restraints also include chemical restraints, which are drugs used for the explicit purpose of managing a vulnerable adult’s behavior. RCW 74.34.020(3).

While restraints are allowed in some settings,⁷ there are always strict rules regarding their application. In adult family homes for instance, physical restraints may only be applied by a licensed medical professional and a licensed professional must be on-site to supervise their use. WAC 388-76-10655. Nursing homes may only apply restraints when there is a physician’s order directing their use. WAC 388-97-0620. Under the recent amendments to the Abuse of Vulnerable Adults Act, the improper use of restraint is a form of vulnerable adult abuse and includes the use of restraints whenever the restraint is not medically authorized. RCW 74.34.020(2)(e).

Despite these legal prohibitions, physical restraints are nonetheless broadly used to control the behavior of vulnerable adults. Cory W. Brooks, *Skilled Nursing Homes: Replacing Patient Restraints with Patient Rights*,

⁷ Restraints are not allowed in assisted living facilities. *See* WAC 388-78A-2660(3).

45 S.D. L. REV. 606, 612 (2000). Restraints are quick and easy, where appropriate caregiving can be hard.

Studies show that restraints have certain appeals, such as an immediate impact on behavior, easy application without much training, ready accessibility and administrative sanction. Restraints are used to punish patients or out of frustration, or because of insufficient staffing, staff attitudes and also administrative pressures to avoid possible litigation.

Id. at 615. Despite being used for the putative purpose of protecting vulnerable adults, restraints have a range of negative impacts. *Id.* at 615-16. These include demoralization, fear, injuries and even death. *Id.* Vulnerable adults are sometimes injured by trying to escape from restraints. *Id.*

Accordingly, if caregivers are allowed to use restraints to prevent hypothetical future harms, restraints could be used to stop a dementia patient from getting out of bed, from getting a snack from the kitchen, and from going to the bathroom by him or herself on the theory that that he or she might wander. Restraints could be used to escort a vulnerable adult, like Ivan, from place to place on the theory that the vulnerable adult might become combative on the trip. Restraints could be used in settings and in places that the policy of Washington has declared they should not be. Such use is not “proper” under *Brown*.

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5. Ms. Karanjah's Nursing Credential Did Not Allow Her To Abuse Ivan

Ms. Karanjah is not protected by her NAR credential for two reasons. First, there is no exception for the abuse of a vulnerable adult by restraint as long as those restraints are consistent with NAR licensing requirements. Second, even if there were, Ms. Karanjah violated the nursing rules when she abused Ivan.

a. There Is No Exception To Physical Abuse For Nursing Licensing Rules

There is no exception in former RCW 74.34.020(2)(b) for the use of restraint consistent with nursing regulations. Rather, when the statute excepts "restraints used consistently with licensing requirements" it is referencing *facility* licensing requirements such as for adult family homes and nursing homes.⁸ These facilities have specific licensing requirements for the use of restraints. *See* WAC 388-76-10655; *see also* WAC 388-97-0620. The nursing assistant regulations, however, barely reference restraints at all and do not provide any specific instructions for their use. *See* Chapter 246-841 WAC. Consequently, Ms. Karanjah cannot seek refuge behind her NAR credential for her violation of former RCW 74.34.020(2)(b).

⁸ This interpretation is validated by the recent amendments to Chapter 74.34 RCW, where the "improper use of restraint" is defined, in part, as restraints used "inconsistent with federal or state licensing or certification requirements for *facilities*." Laws of 2015, ch. 268, § 1 (emphasis added).

b. Ms. Karanjah Violated The Nursing Regulations And Cannot Be Protected By Them

Even if the nursing regulations could provide a defense for a violation of the Abuse of Vulnerable Adults Act, they are of no help to Ms. Karanjah here. Ms. Karanjah actually *violated* the nursing assistant regulations by abusing Ivan. Accordingly, she cannot claim that they provide her a defense.

First, a nursing assistant must follow the instructions of his or her supervising nurse. CP 390; *see also* WAC 246-841-400; *see also* RCW 18.88A.020(8). Ms. Ellis was Ms. Karanjah's supervising nurse with both LPN and RN licenses; she oversaw the care of all residents at Pioneer Place. CP 462. Ms. Ellis testified that Ms. Karanjah's actions regarding Ivan were outside of Pioneer Place's instruction. CP 469. By failing to follow the directions of her supervising nurse, Ms. Karanjah went outside of her scope of practice as a nursing assistant and violated the nursing assistant regulations.

Second, DOH has already determined that Ms. Karanjah violated the rules. *See* CP 312. DOH determined that the facts of this case "constitute grounds for discipline under RCW 18.130.180(4), (7) and WAC 246-841-400(4)(a), (c), and (6)(g)." *Id.* RCW 18.130.180(4) prohibits "incompetence, negligence, or malpractice which results in

injury to a patient or which creates an unreasonable risk that a patient will be harmed.” WAC 246-841-400(4) has to do with the care of cognitively impaired patients. WAC 246-841-400(6)(g) requires a nursing assistant to promote a patient’s “right to be free from abuse, mistreatment, and neglect.” In other words, by taking Ivan’s arms behind his back and pushing him to his room, DOH determined that Ms. Karanjah committed incompetence, negligence or malpractice which caused an injury or created an unreasonable risk of injury. *See* RCW 18.130.180(4). It also determined that Ms. Karanjah inappropriately cared for a patient with cognitive impairments and violated Ivan’s right to be free from *abuse*. *See* WAC 246-841-400(4), (6)(g). Rather than undermine the Board’s final order, the nursing assistant regulations and DOH’s determination reinforce the Board’s conclusion.

6. Ms. Karanjah Had Choices Other Than Whether To Abuse Ivan Or Neglect Him

As discussed previously, Ms. Karanjah had training on how to handle difficult behaviors. If Ivan was approachable, then Ms. Karanjah should have used the techniques explained to DOH by Ms. Simmons. *See* CP 217. If Ivan was not approachable, then Ms. Karanjah should have observed Ivan to make sure he was safe and approached again after some time had passed. CP 469.

Ms. Karanjah incorrectly argues that using the techniques approved by her superiors posed an unacceptable risk that Ivan would be neglected. Opening Brief at 35-36. She does so without referencing the statutory definition of neglect. *Id.* That definition states in part:

“Neglect” means (a) a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or (b) an act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult’s health, welfare, or safety

RCW 74.34.020(15). The pattern of conduct prong of the definition cannot apply, because there is no evidence that this situation occurred with any frequency. In order to be considered neglect, therefore, failing to force Ivan’s arms behind his back and force him to his room would have to constitute a “clear and present danger” to Ivan’s “health, welfare or safety” and “demonstrate[] a serious disregard of [the] consequences” to him. *See id.* But by following the training set out by Ms. Karanjah’s supervisors, both licensed nurses who were primarily responsible for Ivan’s care, Ms. Karanjah would in no way be seriously disregarding the consequences to Ivan. Rather, she would have been following the instructions laid down to help preserve Ivan’s safety and well-being. *See* CP 467-69.

Also, and as discussed above, Ms. Karanjah had options beyond either restraining Ivan and shoving him to his room or doing nothing at all. Ms. Karanjah was not faced with a Hobson's choice (*see* CP 217, 469), and the specter of neglect does not justify Ms. Karanjah's abuse.

7. The Prevention Of The Spread Of Infectious Materials Does Not Justify Ms. Karanjah's Abuse Of Ivan

Finally, Ms. Karanjah attempts to use the assisted living facility and nursing assistant regulations requiring the prevention of the spread of infectious substances to justify her conduct. *See* Opening Brief at 36-38. While preventing the spread of infectious substances is important, assisted living facilities and nursing assistants must also, of course, prevent the abuse of residents. *See, e.g.*, WAC 388-78A-2660(7); *see also* WAC 246-841-400(6)(g). If a caregiver is to justify manually restraining a resident and shoving him from behind, the countervailing evil must be sufficiently serious. *Cf. Diana*, 24 Wn. App. at 914. A little bit of feces on Ivan's hands does not meet that threshold.

First, while it is a verity on appeal that Ivan did have feces on his hands (CP 5-6), the amount could not have been very much. Ms. Varney testified that she observed no feces on Ivan's hands when she inspected his wrist, despite being in a good position to see it. CP 401.

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Second, it is within a nursing assistant's regular duties to deal with and clean human waste. *See* CP 391. Whatever Ivan might have done, could be cleaned up afterwards. And if Ivan ever presented an actual imminent danger of, for instance, eating feces or bringing feces into another resident's room, Ms. Karanjah (or Ms. Harris or Ms. Varney) could have dealt with the situation as it arose. Only when an intervention in the actual presence of danger is required—not a hypothetical future danger—does *Brown* justify what would otherwise be abuse. *See Brown* 145 Wn. App. at 183.

Finally, Ms. Karanjah's conduct does not show concern about the spread of waste. After forcing Ivan to his room she shut the door on him and just walked away. CP 485. She did not clean his hands or even ask Ms. Varney to take care of him. *Id.* In fact, by taking Ivan *out* of the soiled utility room where the waste was secure, Ms. Karanjah actually promoted the spread of infectious material throughout Pioneer Place. *See* CP 621; *see also* WAC 388-78A-2920 (requiring assisted living facilities to have a soiled utility room for the purpose of storing soiled linens).

While there might be circumstances where the spread of infectious material justifies restraining a vulnerable adult—where actual imminent harm can be shown—these facts do not make out that case. Ms. Karanjah abused Ivan and the Board's Final Order should be affirmed.

D. The Board's Order Is Not Arbitrary And Capricious

For the reasons stated above, the Board's order was not arbitrary and capricious. Agency action is only arbitrary and capricious where it is unreasoning and made in disregard of the facts and circumstances. *Heinmiller*, 127 Wn.2d at 609. Here, the Board appropriately found that Ms. Karanjah injured and mistreated Ivan on the basis of credible, eye-witness testimony. It correctly applied the law to the facts and required that in order for the defense in *Brown* to apply, there must have been some imminent threat of harm posed by Ivan. Because Ms. Karanjah acknowledges there was no such threat, taking Ivan's arms behind his back, shoving him to his room and causing his wrist to come into violent contact with the door jamb constituted physical abuse of a vulnerable adult.

E. Ms. Karanjah Is Not Entitled To Attorney's Fees

In order for this Court to award Ms. Karanjah attorney's fees and costs associated with bringing this appeal pursuant to RCW 4.84.350, the Equal Access to Justice Act, this Court must find: 1) Ms. Karanjah is a qualified party; 2) Ms. Karanjah prevailed on her appeal; and 3) The Department was not substantially justified in its actions.

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For the reasons given in this brief, Ms. Karanjah should not prevail on her appeal. In any event, the Department had a reasonable basis in both law and fact to find Ms. Karanjah physically abused Ivan, in violation of former RCW 74.34.020(2)(b). Because the Department's decision had a reasonable basis in fact and law, sufficient to satisfy a reasonable person, the agency was substantially justified in its actions. *Silverstreak, Inc. v. Dep't of Labor & Indus.*, 159 Wn.2d 868, 892, 154 P.3d 891 (2007); *H&H P'ship v. State*, 115 Wn. App. 164, 171, 62 P.3d 510 (2003).

This case is very similar to the *Silverstreak* case, in which the Washington State Supreme Court did not award fees. *Silverstreak*, 159 Wn.2d at 892. There the court held that four factors established that the agency was substantially justified in its action: 1) the agency received a complaint that it 2) had a statutory duty to investigate where 3) it had a duty to liberally construe the statute in favor of workers and 4) the agency relied heavily on favorable Washington case law. Here, all these same factors go to show that the Department's action was substantially justified. First, the Department only investigated Ms. Karanjah once it received a complaint. CP at 451. Second, the Department has a statutory duty to investigate such complaints. RCW 74.34.063. Third, the Department has a duty to put the interests of vulnerable adults above the interests of care givers in order to protect vulnerable adults. *Bond v. Dept. of Social and*

Health Servs., 111 Wn. App. 566, 575, 45 P.3d 1087 (2002). Fourth, the Department relied on the *Brown* case to the extent that it requires a caregiver to intervene in the presence of danger. *See* CP 20.

Even if the Department's actions are found ultimately to be erroneous, the Department should not be chilled from investigating incidents like this in the future by awarding attorney's fees. *See Raven v. Dep't of Social and Health Services*, 177 Wn.2d 804, 833, 306 P.3d 920 (2013). "When balancing the needs of vulnerable adults entrusted to state care and the interests of even well-meaning caregivers who fail to provide necessary and adequate supervision over their charges, DSHS must give priority to the safety of these vulnerable adults." *Bond*, 111 Wn. App. at 575. Awarding attorney's fees in this case will make the Department less likely to aggressively pursue cases where caregivers manually restrain, shove and injure vulnerable adults. The Court should deny Ms. Karanjah's request for an award of attorney's fees and costs under RCW 4.84.350.

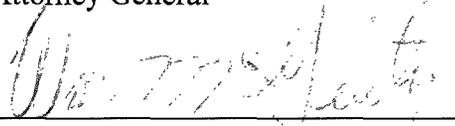
V. CONCLUSION

This case is about what circumstances constitute an excuse from the operation of otherwise valid law. Ms. Karanjah claims that she can take actions that would undoubtedly be abusive under normal circumstances because she was dealing with a resident who was unpredictable and disruptive. This Court should find that the privilege to

take a willful action that causes injury or physical mistreatment to a vulnerable adult only extends to cases of true necessity. There was no necessity to restrain Ivan and shove him to his room. Ms. Karanjah, therefore, abused Ivan and the Board's final order should be affirmed.

RESPECTFULLY SUBMITTED this 19th day of August, 2016.

ROBERT W. FERGUSON
Attorney General

A handwritten signature in cursive script, appearing to read "William McGinty", is written over a horizontal line.

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CERTIFICATE OF SERVICE

I certify that on the date indicated below, I served a true and correct copy of the foregoing document on all parties or their counsel of record as follows:

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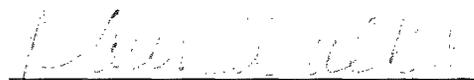
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I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

EXECUTED this 19th day of August, 2016 at Olympia, WA.



DAWN WALKER

WASHINGTON STATE ATTORNEY GENERAL

August 19, 2016 - 4:26 PM

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