IN THE SUPREME COURT OF THE STATE OF NEVADA

WILLIAM POREMBA Appellant, vs. SOUTHERN NEVADA PAVING; and S&C CLAIMS SERVICE, INC., Respondents.	**Supreme Court No.: 66888** Dist. Ct. No.: A-14-698184-C

ANSWER TO PETITION FOR EN BANC RECONSIDERATION

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I. Standard of Review for En Banc Reconsideration

The function of en banc reconsideration is not to review alleged errors for the benefit of losing litigants, *U.S. v. Rosciano*, 499 F.2d 173, 174 (7th Cir. 1974). Thus, en banc reconsideration of panel decision is not favored and ordinarily will not be ordered. NRAP 40A(a). **En banc reconsideration is only available under two very limited circumstances.** *Id.* En banc reconsideration is only available when (1) it is necessary to secure or maintain uniformity of decisions of Nevada's appellate courts, or (2) the proceeding involves a substantial precedential, constitutional or public policy issue. *Id.*[1]

If a petition is brought on the grounds that full court reconsideration is necessary to secure and maintain uniformity of Nevada decisions, the petition must demonstrate that the panel's decision is contrary to prior published Nevada

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[1] It is important to note that although a petition for rehearing and a petition for reconsideration may be viewed as similar they are still different petitions with different exceptions and requirements. For example a petition for rehearing under NRAP 40(c) may be considered if the court has (1) overlooked or misapprehended a material fact in the record or a material question of law in the case or (2) has overlooked, misapplied or failed to consider a statute, procedural rule, regulation or decision directly controlling a dispositive issue in the case. But these rehearing exceptions do not make en banc reconsideration available. Compare NRAP 40(c) with NRAP 40A(c)("En banc reconsideration is available only under the limited circumstances set forth in Rule 40A(a)"). Thus, any petitions for en banc reconsideration based on the overlooking, misapprehension, or failure to consider a question of fact or law would be improper—particularly after these points were already brought to the Panel's attention in a petition for rehearing.

opinions and must include specific citations to those cases. NRAP 40A(c). Or if the petition is based on grounds that the proceeding involves a substantial precedential, constitutional or public policy issue, then the petition must concisely set forth and specify the nature of the issue, demonstrate the impact of the panel's decision beyond the parties involved, be supported by points and authorities, and contain proper supporting argument. *Id.* And **matters presented in the briefs and oral arguments may not be reargued in the petition, and no point may be raised for the first time,** narrowing even further the already limited exceptions allowing en banc reconsideration. *See id.*

Here, the Insurers approach of failing to clearly identify which of the exceptions it was bringing its petition on, at times tacitly relying upon rehearing standards, and then re-arguing its briefing is not tailored to meet the narrow confinements of a petition for reconsideration. The Insurer's petition is a cut-and-paste of its rehearing petition, which was a confusing mess and bare of any substantive citations to many of its arguments (some of which are completely contrary to Nevada law) and ultimately fails to provide any real analysis. Clearly the Insurer's petition does not include specific citations, concisely set forth or specify the nature of the issue, or demonstrate the impact of the panel's decision beyond the litigants involved. Unfortunately, despite the majority or the whole of

the Insurer's petition being inadequate to make reconsideration available, Poremba is unfairly pressed to have to respond lest the Insurer's confusion becomes a trap.

A. The Doctrine of Res Judicata is Contrary to Nevada Law Regarding Reopening Workers Compensation Claims as Already Explained and Held by This Court in *Elizondo v. Hood* and *Jerry's Nugget.*

This Court has already considered, explained, and held that the common law doctrines of issue and claim preclusion[2] do not apply to workers compensation cases, specifically, regarding reopening a workers compensation case. *See Elizondo v. Hood Machine, Inc.*, 129 Nev. Adv. Op. 84, 312 P.3d 479 (2013)(holding it was an error to apply the doctrines of claim and issue preclusion to bar workers requests to reopen their workers' compensation claim pursuant to NRS 616C.390); see also *Jerry's Nugget v. Keith*, 111 Nev. 49, 888 P.2d 921,(Nev. 1995)(holding the terms of the workers compensation statutes control the awarding or denial of benefits, which prevents use of the doctrines of issue and claim preclusion as defenses to reopening a claim if an employee can show a change in circumstance). Issue and claim preclusion would also be inconsistent with NRS 616C.390, which is specifically for *reopening* closed workers compensation claims—the opposite purpose of these common law doctrines. Issue and claim preclusion would also be inconsistent with the entire chapters of NRS 616A to 617

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[2] This Court has adopted the terms of issue and claim preclusion over the use of the term res judicata. *Elizondo v. Hood Machine, Inc.*, 129 Nev. Adv. Op. FN 2 at 84.

because the provisions of Nevada's workers compensation laws are "based on a renunciation of the rights and defenses of employers and employees recognized at common law." NRS 616A.010(3). Thus, given the statutory bar to the common law defenses in workers compensation cases, the holdings in *Elizondo v. Hood* and *Jerry's Nugget*, the use of issue and claim preclusion as defenses in workers compensation cases is contrary to Nevada law and has already been rejected.

Further, beyond the Insurer itself pointing to its faulty res judicata argument as one it has already made in its briefing and oral argument, i.e., it is a re-argument, (Resp. Pet. Reconsideration p. 13:5), it should also be noted that the Insurer's sole citation it relies on is inapposite. The Insurer cites *State v. Indus. Ins. Sys. v. Partlow-Hursh*, 101 Nev. 122, 696 P.2d 462, (1985). However, *Partlow-Hursh* is a short opinion explaining the statutory time period to file a workers compensation appeal is mandatory and jurisdictional. *Id. Partlow-Hursh* does not address, discuss, or even indicate anything about the doctrines of issue or claim preclusion. Thus, the Insurer's reliance on *Partlow-Hursh* to assert that a claimant's second[3] attempt to reopen is barred by res judicata is not only contrary

[3] It is also noteworthy that the *Elizondo v. Hood* decision regarding the inapplicability of issue or claim preclusion in workers compensation cases stemmed from the workers fourth attempt to reopen.

to Nevada law but an inaccurate citation, leaving the Insurer's argument unsupported and bare and is the theme of the Insurer's entire petition.

Lastly, it is dumbfounding at this stage of the case that the Insurer through its res judicata argument still continues to unreasonably insist on ignoring the *new* Dr. Lipshutz Letter showing a change in circumstances and satisfying the requirements of NRS 616C.390, which mandates reopening, and was admitted into evidence at the agency level. Such behavior shows the arbitrariness of the Insurer's position.

B. The Panel's decision does not allow a double recovery or even a triple windfall.

The next example that shows how the Insurer's petition is not tailored to meet the narrow confinements for reconsideration, is the Insurer's re-argument of a double recovery and its re-argument again of double recovery irreverently repackaged as a triple windfall. The Panel has already disagreed with the Insurer's mischaracterized assertion what a double recovery is. Panel Op. p. 3. Double recovery is characterized based not on the event necessitating the compensation, but on the nature of the compensation provided. *Id* at p. 6. Moreover, the Panel clearly stated "[a] worker should not receive funds from two sources to pay for the *same* lost wages or the *same* medical treatment." *Id* at p. 7.

Simply, because of the offset and exhaustion requirements pursuant to NRS 616C.215 and explained in *Chandler*[4] and further clarified by the Panel there is no allowance for double recovery to occur. By merely applying the reduction pursuant to NRS 616C.215 and then requiring exhaustion as explained in *Chandler* before further distributing money which is payable to an employee prevents a double recovery. Here for example, Poremba netted around $34,000 from third party settlement funds. And if we applied these numbers to possible future compensation (determined by statutory calculations) that say for example totals $60,000, then the Insurer would be allowed to reduce the $60,000 "compensation" owed to Appellant by $34,000 and merely pays out $26,000; leaving Poremba to ultimately receive his compensation of $60,000 while the Insurer only pays $26,000 of it. Meaning, Poremba does not take a double recovery and the Insurer pays less than it would have. If anything, based on future reduction, Poremba's third party recovery saved the Insurer from paying out a larger compensation under the workers compensation statutes had Poremba not opted to seek liability from a third-party. In other words based on future reduction provided for in NRS 616C.215, the

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[4] *Employers Ins. Co. of Nevada v. Chandler*, 23 P.3d 255 (Nev. 2001).

Insurer, no matter the outcome, will always have a savings of at least $34,000[5] and Appellant will never take a double recovery.

And as the Panel correctly observed, "Poremba does not appear to be trying to achieve a windfall, but to be properly using the system designed to pay for his workplace injuries." Panel Op. p. 7. But the Insurer still keeps rearguing its double recovery argument and even repackages it again as a triple windfall devoid of any real points and authorities. Not only does this repackaged re-argument insist the court is wrong about what a double recovery is it alleges the court allowed a triple windfall. Such a frivolous argument cannot be taken seriously and again is one that fails to look to the already provided statutory scheme and case law preventing or redressing any legitimate concern that might be hidden in such flippant remarks.

C. The Insurer's TTD hypothetical scenario allowing for continuing wage replacement benefits while the settlement funds are being exhausted is impossible and ignores the statutory scheme and the holdings in *Chandler* and by the Panel in this case.

In the first page of its petition, the Insurer claims the major flaw in the Panel's Opinion is that it "[fails] to account for potential wage replacement benefits, such as temporary total disability benefits (hereinafter "TTD") **while** the

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[5] For simplicity this example did not consider the medical liens negotiated for a reduction and satisfied at the time of settlement or the $14,000 spent on medical treatment by Poremba with these proceeds since, which ultimately will be realized as an additional savings to the Insurer because it did not have to pay these medical expenses.

settlement funds are being exhausted." Resp. Pet. Reconsideration p. 1:8-10 (emphasis added). But beyond providing the term for the acronym, the Insurer never provides a definition of what TTD is, how it operates, where it is found in the statute or any other specific citation, what its interplay is to the holding, or its impact beyond the parties involved, and ignores the other types of wage replacement benefits. The Insurer just makes erroneous conclusory statements and then trivially makes reference to TTD. See Insurer's use of TTD at Resp. Pet. Reconsideration p. 1:9-16, 8:21-23, 11:12-22. How can the Insurer's TTD hypothetical even be accurately addressed when it is so lacking?

Regardless, this Court in its interpretation of NRS 616C.215 held in *Chandler* that an insurer is only entitled to withhold payment of benefits for a work-related injury **until** an employee has exhausted any third-party settlement proceeds. *Chandler* at 258. This would also mean that if an injured worker were to receive a third-party settlement **while** TTD benefits (or any other benefits) were being administered, then the insurer would be entitled to withhold payment of further benefits until the injured worker exhausted the third-party funds. Then, if warranted, re-administration of workers compensation benefits could be resumed **after** third-party funds are appropriately exhausted. Nor did the Panel in its decision change an insurer's ability to withhold payment of benefits until an employee has exhausted third-party funds, rather, the Panel stated:

> A worker should not receive funds from two sources to pay for the same lost wages or the same medical treatment. The worker however should be permitted to use settlement funds for some medical treatment or reasonable lost wages expenses…[a]ccordingly, we conclude that while [the Insurer] is entitled to an offset based on the settlement funds received, that offset must include any reasonable living expense for which the settlement funds were used."

Panel Op. p. 7-8.

Further, beyond already preventing double recoveries, the statutory scheme also provides procedures for situations "[w]hen the insurer determines that a claim should be closed before all benefits to which the claimant may be entitled have been paid." NRS 616C.235(a). Also according to the statute an insurer does not have to pay compensation benefits before the compensation is required to be paid. NRS 616C.155. In certain instances the insurer may seek reconfirmation from the employee with each issued check. NRS 616C.475(6). And the statutes provide a method for an insurer to recover overpayment of benefits to an employee by deducting the amount from future benefits. NRS 616C.155. Thus, when coupled with the offset and exhaustion requirements, these other statutes found within the statutory scheme prevent or resolve the Insurers hypothetical concern.

Therefore, the Insurers hypothetical concerns are unfounded because they can already be addressed by looking to the correct use of the existing case law and the statutory scheme as it already exists. The only reason why these issues have to be addressed is because the Insurer refuses to apply the correct principles of

reasoning and interpretation of what has already been provided, thus, necessitating the Panel to provide the analysis it correctly did. *See* Panel Op. p. 5 ("*Chandler* did not limit how the claimant may exhaust the settlement funds despite [the Insurer's] assertions to the contrary. Accordingly, it is important to clarify *Chandler* and settle this issue moving forward").

D. **The Insurer reliance on a Washington State appellate court decision in its petition is inaccurate and improper.**

First, in its briefing and petition the Insurer cites to an appellate court decision from Washington, *Tobin v. Department of Labor & Industries*, 187 P.3d 780, 145 Wn.App. 607 (Wash.App. Div. 2 2008). (Resp't Br. p. 16). And although the Insurer alleges the Panel's decision conflicts with the Washington decision, it is only contrary published opinions of Nevada appellate courts that may constitute grounds for en banc reconsideration. The Panel's discretion not to entertain the Insurer's incorrect interpretation of *Tobin* in this case is not in conflict with any other opinion from this Court. Thus, en banc reconsideration is unwarranted on this basis.

Regardless, *Tobin* is not contrary to the Panel's reasoning, rather, the Insurer's interpretation of *Tobin* is incorrect and again is essentially a re-argument from its briefs and oral argument. As already brought to the Insurer's attention in Poremba's Reply Brief correcting the Insurer's citations and further explained by

the Panel, in Washington pain and suffering damages are not subject to distribution under the lien statute—which in fairness was the true issue before the *Tobin* court and what it is most cited for (also noting *Tobin* does not address the issue of reopening nor the issue of how third party funds must be exhausted)). *Tobin* at ¶17 (reasoning if the insurer did not compensate *Tobin* for his pain and suffering, it cannot be reimbursed from that portion of the third-party award). Or as explained by the Panel "[t]he *Tobin* court held that the insurer was only entitled to the portion of proceeds from the third-party suit that correlate to the benefits it provided as a worker's compensation insurer." Panel Op. p. 7. This means, that a workers compensation insurer in Washington would only be able to assert a lien to the specific portions of a third-party award that were allocated to cover the same type of benefits provided by the insurer (which are always economic) and not the non-economic damages that the insurer will never contribute to. The Panel also quoted directly from *Tobin* the following:

> [The insurer]'s position would give it an "unjustified windfall" at the [claimants] expense. Under [the insurer]'s interpretation, it would be entitled to share in damages for which it has not provided and will never pay compensation. We do not interpret these statutes to require such a fundamentally unjust result. *[The insurer] did not, and will never, compensate [the claimant] for his pain and suffering, therefore it cannot be "reimbursed" from funds designated to compensate him for his pain and suffering.*

Panel Op. p. 7.

Thus, it is strange why the Insurer would try to rely on *Tobin* to achieve what it says is "[t]he correct approach…and should have been the holding of the Opinion." Resp. Pet. Reconsideration p. 10:20-11:5. An approach and holding which would be that pain and suffering damages from a third-party recovery would not be subject to being offset by the provisions of NRS 616C.215. Because according to *Tobin*, such an offset would result in an unjustified windfall to the insurer at the claimant's expense. And if that is the case then the holding in *Breen*[6] regarding an insurer's lien extending to the total proceeds of a third-party recovery, including non-economic losses (e.g. pain and suffering) is not in conformity with the current standard of interpreting Nevada workers compensation laws to specifically prevent an insurer's unjustified windfall at the expense of injured workers. Compare to NRS 616A(1) and (4), infra.

So, if the Insurer were to have its way and *Tobin* was fully adopted by this Court in Nevada, then the correct reasoning of *Tobin* would abrogate one of the critical holdings in *Breen*. In other words, the Insurer's push for adopting *Tobin* ironically would be inconsistent with a prior published opinion of this Court. Still, Poremba welcomes the Insurer's wish to introduce the reasoning from *Tobin*, particularly that pain and suffering damages are not subject to being offset by the provisions of NRS 616C.215, thus making even less of an offset to

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[6] *Breen v. Caesars Palace*, 102 Nev. 79, 715 P.2d 1070 (1986)

exhaust. But ultimately, we again see how the insurer has tried to twist interpretation of case law to advocate for a fundamentally unjust result for its benefit at the expense of the injured worker.

II. Standard of Interpretation of Nevada's Workers Compensation Laws

The provisions of Nevada's workers compensation laws found in NRS 616A to 617 **must be interpreted to ensure (1) the quick and (2) efficient payment of compensation[7] to injured employees** (3) at a reasonable cost to employers. NRS 616A.010(1). **For the accomplishment of these purposes, these statutes must not be interpreted or construed** broadly or liberally in favor of an injured employee or **in such a manner as to favor the rights and interests of an employer over the rights and interests of an injured employee.** NRS 616A.010(4). Consequently, it is unquestionably clear that the purpose of Nevada's workers compensation laws, in part, are to provide economic assistance to injured workers.

First, it is a revealing that the Insurer believes that "protecting injured workers is not the purpose of workers compensation." Resp. Pet. Reconsideration p. 9:4-5. But again, when you look at the first two elements of NRS 616A.010(1) and NRS 616A to 617 as a whole, it is evident that Nevada's workers

[7] Compensation is defined as "money which is payable to the employee…" NRS 616A.090.

compensation laws are concerned with protecting and providing for injured workers. Thus, it appears the Insurer's arguments are rooted on a terrible belief that is at odds with Nevada's workers compensation laws by favoring the rights and interests of an insurer over the rights and interests of an injured employee and if followed would produce absurd and unreasonable results by denying compensation altogether to a class of injured workers—let alone failing to ensure quick and efficient payment of compensation; whereas the Panel's decision under the above standard of review meets the statutory requirements and produces a logical and reasonable result based on a plain interpretation of the statutes and is in harmony with the statutory scheme as a whole. *Compare with Breen v. Caesars Palace*, 102 Nev. 79, 82, 715 P.2d 1070, 1072 (1986) (a statute should not be construed to "produce an unreasonable result when another interpretation will produce a reasonable result");

A. The Panel's Opinion is in harmony with the standard of interpretation despite dicta from *Breen*.

The only possible inconsistency of the panel's decision is the unfortunate one sentence quote of *Breen* regarding liberal construction. Panel Op. p. 4. It is an unfortunate quote only because it was unnecessary to the determination of the questions involved in the case and it gave the Insurer something to possibly latch

onto to improperly justify asking different judges of the same court to review its re-arguments as a losing litigant due to alleged errors.

But if when this Court looks at the immediately preceding sentence and quotation from *Breen* that the Panel uses, it is clear that the Panel cited to a standard in harmony with the current standard of ensuring the quick and efficient payment of compensation to injured employees and interpreted in manner as to not favor the rights and interests of an employer over the rights and interests of injured employees, i.e., to provide economic assistance to injured workers. That sentence is: "It is unquestionably the purpose of worker's compensation laws to provide economic assistance to persons who suffer disability or death as a result of their employment." Panel Op. p. 4.[8] And under this standard of interpretation the reasoning and result is the same.

Therefore, because the lone sentence in question regarding liberal construction was not necessary for the decision of the case it appears more to be dicta. *See Argentena Consol. Mining Co. v. Jolley Urga Wirth Woodbury & Standish*, 125 Nev. 527, 216 P.3d 779 (2009) (dicta is a statement that is unnecessary to the determination of the questions involved in the case). And dicta is not controlling. *Id.* And because dicta is not controlling, this court is free to rely

[8] The Insurer does not challenge the Panel's use of this sentence.

on the use of the preceding sentence in the Panel's Opinion and leave the Panel's holding in place which is in harmony with the current standard. Alternatively, if this Court were to reconsider, the only change necessary would be to remove or replace the lone sentence in question.

B. Ignoring reasonable living expenses as a reasonable means of using wage replacement benefits produces absurd results.

The Insurer has now finally conceded it has unfairly ignored wage replacement benefits as an acceptable means of showing exhaustion. Resp. Pet. Reconsideration p. 9:22-10:1 and FN 2 p. 10:24-26.[9] But despite conceding that an injured worker can also exhaust his third-party recovery on wage replacement benefits, the Insurer irreverently repackages its original argument damning injured workers from utilizing their life-time reopening rights pursuant to NRS 616C.390 because reasonable living expenses don't count. So, instead of explicitly continuing to argue exhaustion solely on medical expenses, the Insurer reframes its argument as exhaustion solely on medical expenses and wage replacement benefits

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[9] "[I]t is sufficient to note that workers' compensation generally provides two basic types of benefits: (1) accident benefits, i.e., reasonable medical expenses; and (2) wage replacement benefits;" and

"In their Answering Brief, Respondents mentioned several times that Petitioner could only exhaust his third-party settlement funds via medical expenses before worker's compensation benefits are reachable. However, as was explained at oral argument, Respondents do concede that their theory should be expanded to include wage replacement benefits."

but wages replaced cannot be used on reasonable living expenses because the Insurer inequitably interprets them to be a separate category. See generally Resp. Pet. Reconsideration p. 10 ("...and created a third category for reasonable living expenses"). Then what exactly is a wage replacement? And what can it be used for (or why is it even paid to an injured worker) if reasonable living expenses, including housing and food[10] don't count as permissible uses? The rhetorical questions themselves show the absurdity that the Insurer continues to advocate for. This is essentially akin to providing an injured worker two-thirds of his wages pursuant to a relevantly controlling wage replacement provision but explaining to him that he cannot spend it on anything because reasonable living expenses—let alone living expenses in general—is its own separate category that workers compensation statutes does not account for.

Logically, wage replacement benefits replace lost wages (generally two-thirds lost wages). See e.g. 616C.440(1)(a). The Panel was correct in its explanation that "lost wages , naturally, are meant to cover expenses that one's paycheck would normally cover, such as rent or mortgage, utilities and groceries." Panel Op. p. 6. The Panel was also correct in explaining that denying an injured worker from using a system designed to protect injured workers because he used

some of his third-party settlement money to feed himself and his family is patently unjust and not supported by the statute[11]. *Id* at p. 8; see also NRS 616A.010(4) (interpretation may not favor the rights and interests of an employer over those of an injured employee). Thus, the Panel was also correct that any offset must include any reasonable living expenses. Panel Op. p. 8. Any feigned concerns over what is reasonable is already addressed by the Panel in its Opinion, namely, "[w]hether the funds were used for reasonable living expenses is a factual determination best made by the hearing [or appeals officer]." *Id*. Nor does any assertion that the complained of language does not explicitly appear in the provisions of Nevada's workers compensation law have any merit. This Court has recognized in *Breen* that the statutory scheme has statutory gaps that on occasion have to be addressed and where no guidance is given…fundamental fairness must be the guidelines. *Breen* at 84-85. Thus, the Insurer's refusal to accept reasonable living expenses being derived by implication within the explicit group of rights of wage replacement benefits is an untenable position.

C. The Insurers proposition is against public policy, creates a chilling

NRS 616C.215 allows a worker injured by a third-party the option of seeking legal action against the tortfeasor, which in turn allows the insurer to claim

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[10] Examples of reasonable living expenses provided by the Panel in its Opinion include housing and food for a claimant and his family. Panel Op. p. 8.

an offset when an injured worker receives money from a lawsuit against a third-party responsible for the injury. But if the Insurer was to have its way workers injured on the job by a third-party tortfeasor would have reduced motivation to pursue legal action against the at-fault party lest the injured workers should lose out on important workers compensation benefits; particularly, if any third-party award could not even be used on reasonable living expenses.

Here, workers injured by a third-party would forego pursuing or protecting a legal interest against the party who ultimately should be responsible for fear of triggering a greater secondary harm to their other legal interests. The reasoning would be, if I sue third-party tortfeasor, I can't reopen and, therefore, I should not sue. The forced choice would have a chilling effect that would result in at-fault parties escaping responsibility and shifting the entire burden onto the workers compensation system. And under this scenario the insurer would never realize a savings of any offset amount. A policy that encourages preventing an injured worker from reopening his workers compensation case because he spent some of his third-party award on reasonable living expenses might save the insurer some money now specific to that one case. But if such behavior by insurers were to be the status quo then attorney's for injured workers would have to advise their clients not to opt for pursuing litigation against at-fault third-parties; especially in

scenarios where it is clear that a third-party recovery will do less for an injured worker than keeping a workers compensation claim open (e.g., cases involving minimum auto insurance policies held by third-party). Consequently, insurer's overtime in these types of cases would end up being taxed by the entire burden they would be responsible for under workers compensation laws because they would stop realizing offset savings from them. In other words the insurers would pay more money than they normally would in claims involving at-fault third-parties. Clearly the Insurer's argued for position would be against public policy for its chilling effects and because it would not meet the requirements of ensuring the quick and efficient payment of compensation to injured employees at a reasonable cost to employers.

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III. Conclusion

Based upon the foregoing and the record before this Court, revealing the defecincies of the Insurer's arguments and Petition for En Banc Reconsideration, en banc reconsideration Pursuant to NRAP 40A should be denied.

DATED this 15th day of August, 2016.

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CERTIFICATE OF COMPLIANCE

1. I hereby certify that this answer complies with the formatting requirements of NRAP 32(a)(4), the typeface requirements of NRAP 32(a)(5) and the type style requirements of NRAP 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word 2007 in 14 point Times New Roman font.

2. I further certify that this answer complies with the type-volume limitations of NRAP 40A, alternatively allowing an answer to contain up to 4,667 words, because it is proportionately spaced, has a typeface of 14 points or more, and contains 4,586 words.

DATED this 15th day of August, 2016.

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CERTIFICATE OF SERVICE

I certify that on this 15th day of August, 2016, the foregoing ANSWER TO PETITION FOR EN BANC RECONSIDERATION was filed electronically with the Clerk of the Nevada Supreme Court, and therefore electronic service was made in accordance with the master service list as follows:

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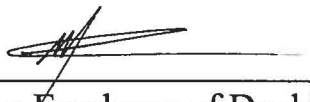

An Employee of Dunkley Law