IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

Docket No. 20-0750

CHRISTOPHER MORRIS, individually and as Administrator of the ESTATE OF AMY CHRISTINE WADE,

Plaintiff Below, Petitioner,

v.

Case No. 20-0750
(On Appeal from Circuit Court of Ohio County, Civil Action No. 20-C-140)

STEVEN CORDER, M.D; MELANIE BASSA, M.A.; MARTHA DONAHUE, N.P.; NORTHWOOD HEALTH SYSTEMS, INC.; MID-VALLEY HEALTHCARE SYSTEMS, INC.; and JOHN DOES 1-5,

Defendants Below, Respondents.

PETITIONER'S REPLY BRIEF

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I. First Assignment of Error: The Circuit Court Erred by Failing to Find a Special Relationship Under *Moats*

Respondents insist that West Virginia law does not recognize liability "for suicides in noncustodial settings," and accuses Petitioner of attempting to "expand the duties and expectations" of West Virginia's mental health professionals. [Jt. Br. of Resp., at 6.] But the reality is that Respondents have grossly misread *Moats v. Preston County Comm'n*, 206 W. Va. 8, 521 S.E.2d 180 (1999). *Moats* did not draw a dividing line between suicides occurring in custodial versus noncustodial settings. Instead, *Moats* recognized—as syllabus law—that liability arises whenever a special relationship exists between the parties "giving rise to a duty to prevent the decedent from committing suicide." *Moats*, Syl. Pt. 6, in part. Where, as here, the patient was being treated as an outpatient on a regular, long-term basis by a mental health professional, a special relationship under *Moats* exists.

In *Moats*, this Court acknowledged that suicide historically was treated as an intentional, immoral act that barred liability. See also Alex B. Long, *Abolishing the Suicide Rule*, 113 N.W. U.L. Rev. 767 (2019). Modern courts, however, have tempered this rule—embracing our greater understanding of mental illness and promoting greater protection for those suffering from mental illness. According to *Moats*, the modern trend is to extend liability to all cases "where the defendant is found to have caused the suicide or where the defendant is found to have had a duty to prevent the suicide from occurring." 206 W. Va. at 16, 521 S.E.2d at 188. For support, *Moats* cited a New Hampshire case, *McLaughlin v. Sullivan*, 123 N.H. 335, 461 A.2d 123 (1983). To understand the nature and scope of the duty under *Moats*, we must take a closer look at *McLaughlin*.

Like *Moats*, *McLaughlin* acknowledged the common law rule barring liability for suicide. Like *Moats*, *McLaughlin* also recognized two exceptions to the common law rule—where someone

has *caused* a suicide and where someone has a *duty to prevent* a suicide from occurring. But when does this duty arise? *McLaughlin* answers: "[t]his duty has been imposed as a matter of law...on essentially two classes of defendants, both of whom are held to have a special relationship with the suicidal individual." Significantly, this duty covers not only those having actual custody, but also mental health professionals who have the expertise to diagnose mental illness and to prevent any potential suicide:

> Specifically, this duty has been imposed on: (1) institutions such as jails, hospitals and reform schools, having actual physical custody of and control over persons; see Note, Custodial Suicide Cases: An Analytical Approach to Determine Liability for Wrongful Death, 62 B.U.L.Rev. 177 (1982); Schwartz supra, at 245–55; Annot., 11 A.L.R.2d at 775–802; Annot., 79 A.L.R.3d 1210 (1977); and (2) persons or institutions such as mental hospitals, psychiatrists and other mental-health trained professionals, deemed to have a special training and expertise enabling them to detect mental illness and/or the potential for suicide, and which have the power or control necessary to prevent that suicide. See Comment, 1978 Ariz.St.L.J. at 581–83; Comment, supra 12 Loy.L.A.L.Rev. at 987–995; Schwartz, supra, at 245–55; Annot., 11 A.L.R.2d at 775–802, Annot., 17 A.L.R.4th 1128 (1982).

McLaughlin, 123 N.H. at 338, 461 A.2d at 125.

Importantly, this duty on the part of mental health professionals ***is not limited to custodial settings***. See, e.g., *Kockelman v. Segal*, 61 Cal.App.4th 491, 501, 71 Cal.Rptr.2d 552, 558 (1998)("[P]sychiatrists owe a duty of care, consistent with standards in the professional community, to provide appropriate treatment for potentially suicidal patients, whether the patient is hospitalized or not....Indeed, it would seem almost self-evident that doctors must use reasonable care with ***all*** of their patients in diagnosing suicidal intent and implementing treatment plans.") (emphasis in original); *Edwards v. Tardif*, 240 Conn. 610, 618 n.7, 692 A.2d 1266, 1270 n.7 (1997)("[T]he circumstances in which a physician may be liable for a patient's suicide are not limited only to when the patient is in the physician's custody. Instead, the relevant inquiry is whether a defendant failed to provide reasonable treatment for the patient and that failure proximately resulted in the patient taking his or her life."); *Perez v. United States*, 883 F. Supp.

2d 1257, 1286, 1297 (S.D. Fl. 2012) (imposing liability on an outpatient mental health provider, noting that "this duty applies whether the patient is being seen in a hospital or in an outpatient environment"); *Peterson v. Reeves*, 315 Ga.App. 370, 375, 727 S.E.2d 171, 175 (2012)(specifically rejecting a rule that would relieve a mental health professional of liability where "a patient is not hospitalized at the time of a suicide attempt"); *Hoeffner v. The Citadel*, 311 S.C. 361, 368, 429 S.E.2d 190, 194 (1993)(finding, in an outpatient case, that a mental health professional is liable whenever "departure from the standards of their profession proximately causes their patient's suicide"); V. Schwartz, *Civil Liability for Causing Suicide: A Synthesis of Law and Psychiatry*, 24 Vand.L.Rev. 217, 246 (1971)(asserting that a physician's liability for a patient's suicide resulting from the failure to provide adequate treatment should not be limited to custodial care).

Kockelman provides a helpful example. The patient in *Kockelman* treated with a mental health professional, Dr. Segal, as an outpatient for a year and a half. Dr. Segal prescribed a variety of medications, but the patient's condition deteriorated. The patient missed work, stayed in bed, and was described as being "more depressed than ever." On one occasion, he reported that he was too depressed to keep his appointment. Dr. Segal increased the patient's medication and discussed electroconvulsive therapy, possibly on an inpatient basis. However, no steps were taken to schedule this treatment. Eventually, the patient committed suicide by overdosing on one of the medications Dr. Segal had prescribed.

Like Respondents here, Dr. Segal argued that a mental health professional can only be liable for a suicide occurring in a custodial setting. Because the patient was being treated on an outpatient basis, Dr. Segal claimed there was no duty to prevent his suicide. The court firmly

rejected this argument, noting that the duty of care applies regardless of whether the patient is being treated as an inpatient or an outpatient:

> [W]e have found no precedent supporting the defendants' position that a licensed professional psychotherapist owes no duty of care to a potentially suicidal patient solely because the patient is seen on an outpatient basis rather than confined in a hospital. Existing case law provides that a psychotherapist or other mental health care provider has a duty to use a reasonable degree of skill, knowledge and care in treating a patient, commensurate with that possessed and exercised by others practicing within that specialty in the professional community. [citations omitted] "If those who are caring for and treating mentally disturbed patients know of facts from which they could reasonably conclude that the patient would be likely to self-inflict harm in the absence of preventative measures, then those caretakers must use reasonable care under the circumstances to prevent such harm from occurring." [citation omitted.] ***This duty exists whether the patient is hospitalized at the time or not.***

Kockelman, Cal.App.4th at 505, 71 Cal.Rptr.2d at 561 (emphasis added).

Petitioners, then, are not asking for an expansion of the applicable duty of care. Properly understood, *Moats* adopts the same rule set forth in *McLaughlin* and faithfully applied in cases across the country. In fact, this Court anticipated *Moats* when it decided *Martin v. Smith*, 190 W. Va. 286, 438 S.E.2d 318 (1993) six years earlier. The patient in *Martin* was released from a psychiatric unit for a day visit at his mother's home. The psychiatrist, Dr. Smith, failed to give any instructions to the mother or otherwise provide security precautions. During the visit, the patient took a gun and fatally shot himself. The jury returned a verdict against Dr. Smith, which this Court affirmed.

Respondents treat *Martin* dismissively, suggesting that Dr. Smith's failures occurred "while the patient was in the facility, allowing the patient to leave without clear safeguards." [Jt. Br. of Resp., at 15.] Thus, according to Respondents, *Martin* is simply another custodial care case. But *Martin* is surely more than that. Critically, Dr. Smith released his patient from custody. The very premise of Respondents' argument is that the act of suicide breaks the chain of causation

unless it occurs in a custodial setting. But in *Martin* the patient committed suicide in his mother's home. Nevertheless, this Court affirmed—foreshadowing *Moats* and rejecting the kind of custodial/noncustodial distinction Respondents are advocating.

Respondents repeatedly cite *Hull v. Nasher-Alneam*, No. 18-1028, 2020 WL 882087 (W. Va. Feb. 24, 2020), claiming that it reinforces its view of *Moats*. *Hull*, however, is easily distinguishable. Dr. Nasher was an ***orthopedic*** specialist. The patient in *Hull* was referred to Dr. Nasher for orthopedic complaints, including chronic pain and sleeplessness. The patient was prescribed pain medication, which allegedly led to addiction, depression, and suicide. But clearly, as an orthopedist, Dr. Nasher was not a mental health professional "deemed to have a special training and expertise enabling [him] to detect mental illness and/or the potential for suicide." *McLaughlin*, 123 N.H. at 338, 461 A.2d at 125. Therefore, the case did not trigger either of the exceptions recognized by *Moats/McLaughlin*. The trial court's dismissal of the case should have been affirmed on that basis.

Instead, *Hull* emphasized the custodial/noncustodial distinction. But in doing so, *Hull* misapplied the syllabus law from *Moats*. It was not this Court's intention in *Moats* to require custodial care as a mandatory requirement in suicide cases. It may be true, as stated in *Moats*, that these cases "generally" arise in custodial settings. However, they can also arise in other settings—as this Court's citation to *McLaughlin* clearly affirms. Because *Hull* contradicts *Moats* on this point, *Moats* controls. Syl. Pt. 5, *State v. McKinley*, 234 W. Va. 143, 764 S.E.2d 303 (2014)("while memorandum decisions may be cited as legal authority, and are legal precedent, their value as precedent is necessarily more limited; where a conflict exists between a published opinion and a memorandum decision, the published opinion controls").

Thus, under *Moats*, the question of whether the patient was being treated as an inpatient or an outpatient is not dispositive. The relevant question is whether, under the facts and circumstances, a special relationship existed between the mental health professional and the patient that would give rise to a duty of care. Here, Petitioner alleged that Respondents treated Amy Wade for multiple mental health issues over a 10-year time period. [JA0004 at ¶¶16-17.] Petitioner also alleged that beginning in February 2018, Wade's condition declined rapidly and she reported "auditory hallucinations and threatening visual hallucinations." [JA0005 at ¶¶25-26.] Furthermore, in June, 2018, Wade experienced suicidal ideations and later became so panicked that she went to the hospital for emergency treatment. [JA0006 at ¶¶29-30.] Despite this, Respondents failed, *inter alia*, to make any adjustments to Wade's medications, to consult with any specialists, or to arrange for inpatient care at one of the facility's crisis stabilization units. [JA0006-7 at ¶¶32-37.]

Taken together, these facts clearly establish that a special relationship existed, giving rise to a duty of care. The trial court's dismissal of Petitioner's complaint was error. Reversal is, therefore, warranted.

Even aside from the common law duty of care under *Moats*, there is also a statutory duty of care arising under the Medical Professional Liability Act, W. Va. Code §55-7B-1 *et seq.* Specifically, W. Va. Code §55-7B-3(a)(1) provides that every health care provider in West Virginia must "exercise that degree of care, skill and learning required or expected of a reasonable, prudent health care provider in the profession or class to which the health care provider belongs acting in the same or similar circumstances." This language creates an independent, statutory duty, as explained by the Florida Supreme Court in *Chirillo v. Granicz*, 199 So.3d 246 (Fla. 2016). *Chirillo* found that, under Florida law, there was no common law duty to prevent suicide in an

outpatient scenario. However, "the nonexistence of one specific type of duty does not mean that [the mental health professional] owed the decedent no duty at all." Looking at its own malpractice law, Fla. Stat. 766.102, *Chirillo* found that "there still existed a statutory duty...to treat the decedent in accordance with the standard of care." In applying the statutory duty, "the foreseeability of the decedent's suicide [was] a matter of fact for the jury to decide in determining proximate cause." 199 So.3d at 251-52.

The language of Fla. Stat. 766.102 is similar to the language of West Virginia's counterpart, W. Va. Code §55-7B-3(a)(1). Regardless of whether a common law duty exists, the MPLA is the source of a statutory duty that applies broadly to all health care providers practicing in this state. Respondents complain this represents a "drastic departure from conventional holdings." [Jt. Br. of Resp., at 10.] But Petitioner is asking this Court to apply the plain text of W. Va. Code §55-7B-3(a)(1)—nothing more.

The statutory duty under W. Va. Code §55-7B-3(a)(1) provides an alternative ground supporting Petitioner's claim. For this reason, too, the trial court's dismissal order should be reversed.

II. Second Assignment of Error: The Circuit Court Erred by Failing to Properly Apply General Negligence Principles

Under his second assignment of error, Petitioner alleges that the trial court erred by failing to apply the analysis required for determining whether he had asserted a *prima facie* case of negligence.

Respondents focus their attention on two aspects of this analysis: duty and causation. According to Respondents, the question of whether a duty exists under West Virginia law was definitively answered by *Moats*. Suicide, it says, must be treated differently because we are

incapable of understanding "[t]he true landscape of the conscious and unconscious mind." [Jt. Br. of Resp., at 12.]

First of all, as we have seen, *Moats* is not limited to suicides occurring in custodial settings. The duty under *Moats* arises anytime a special relationship exists, which includes outpatients who have a long-term relationship with a mental health professional. Beyond that, Respondents' argument proves too much. If we cannot possibly plumb the depths of the suicidal mind, then why is there any duty at all? Unfortunately, Respondents are harkening back to the prejudices of a bygone era. Suicide no longer carries a moral stigma. Furthermore, we have a far greater understanding of mental illness today and a far greater ability to help those afflicted with mental illness. If a mental health professional is treating a patient who poses a foreseeable risk of suicide, then it is irrelevant whether that treatment is being provided on an inpatient or outpatient basis. The duty remains the same in both settings.

Respondent also argues that "a patient's decision to end his or her life is a superseding, intervening cause." [Jt. Br. of Resp., at 12.] However, under well-settled law, an intervening cause relieves the tortfeasor of liability only in situations where the intervening acts are "not reasonably foreseeable by the original tortfeasor at the time of his negligent conduct." Syl. Pt. 9, in part, *Harbaugh v. Coffinbarger*, 209 W. Va. 57, 543 S.E.2d 338 (2000). Respondents draw an arbitrary and unrealistic line, claiming that custodial suicides are foreseeable but noncustodial suicides—as a matter of law—are not. Again, *Moats* does not establish this kind of custodial/noncustodial distinction. The issue of proximate cause in any suicide case is a fact-driven inquiry that ordinarily should be left to the jury. See, e.g., *Hoeffner,* 311 S.C. at 368, 429 S.E.2d at 194 (1993)(the question in all suicide cases is whether the mental health professional's "departure from the standards of their profession proximately cause[d] their patient's suicide");

Kockelman, 61 Cal.App.4th at 505, 71 Cal.Rptr.2d at 561 (in an outpatient case, it was for the jury to decide whether the defendant's negligence, if any, "was a proximate cause of [the patient's] death"); *Peterson*, 315 Ga.App.at 376, 727 S.E.2d at 176 (in all malpractice cases involving suicide, "questions regarding proximate cause are undeniably a jury question.")

Relatedly, Respondents point to specific facts in Petitioner's complaint that allegedly support their intervening cause defense. For example, Respondents say that Wade expressed suicidal ideations at her June 11 appointment, but did not express a plan, and that she denied suicidal ideations at her follow-up appointment on June 20. [Jt. Br. of Resp., at 14.] In making this argument, Respondents totally ignore Wade's emergency room visit before the June 20 appointment and their failure to make any inquiry regarding that visit. In truth, however, none of these facts really matters. At this stage, we are only reviewing Petitioner's complaint for legal sufficiency. See, e.g., *Camden-Clark Mem. Hosp. Corp. v. Tuan Nguyen*, 240 W. Va. 76, 79 n.8, 807 S.E.2d 747, 750 n.8 (2017)("A Rule 12(b)(6) motion to dismiss tests the legal sufficiency of a complaint, and an inquiry as to the legal sufficiency is essentially limited to the content of the complaint."). Petitioner has alleged all of the elements necessary for a claim of negligence.[1] It is up to the jury to resolve disputed issues of fact and to decide if, in fact, Respondents' negligence was a proximate cause of Wade's suicide.

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[1]It is also worth noting that intervening cause is an affirmative defense in West Virginia. *Sydenstricker v. Mohan*, 217 S.E.2d 552, 559 n.13, 618 S.E.2d 561, 568 n.13 (2005)("As with all other affirmative defenses, it is [the defendant's] burden to prove intervening cause by a preponderance of the evidence."); *Skaggs v. Elk Run Coal Co.*, 198 W. Va. 51, 76 n.29, 479 S.E.2d 561, 586 n.28 (1996)("the defendant must bear the burden of persuasion on the affirmative defense[] of superseding cause"). Ordinarily, it is not the plaintiff's burden to anticipate an opponent's defenses and to proactively counter those defenses in the complaint. The plaintiff is only required to set forth the elements of his claim. See, e.g., *Harrison v. Davis*, 197 W. Va. 651, 478 S.E.2d 104 (1996)(recognizing the "inherent problem" of using a motion to dismiss for purposes of raising an affirmative defense). Here, the trial court erred by resolving the proximate cause issue against Petitioner as a matter of law based solely on the allegations contained in Petitioner's complaint.

Thus, the trial court erred in two respects: (1) by concluding that no duty existed because the patient, Wade, was being treated on an outpatient basis, and (2) by concluding, as a matter of law, that Wade's suicide was a superseding, intervening cause. If the court had properly applied the analytical framework for negligence, it would have concluded that Petitioner had, indeed, stated a valid claim for negligence under West Virginia law. Its failure to do so constitutes reversible error.

III. Third Assignment of Error: The Circuit Court's Order, as Applied, Treated Medical Malpractice Victims Unequally in Violation of the Equal Protection Clause

Under the third and final assignment, Petitioner alleges that the trial court's dismissal order violates equal protection by imposing an additional pleading requirement on those seeking to recover for a suicide caused by a mental health professional—i.e., an allegation that the suicide occurred in a custodial setting. In other words, the order treats victims of medical malpractice unequally by requiring all medical malpractice claimants to comply with the MPLA, but requiring claimants seeking recovery from a mental health professional to also specifically allege that that their treatment was "custodial."

Initially, Respondents complain that Petitioner failed to raise this constitutional issue before the trial court, resulting in a waiver. Petitioner's equal protection argument focuses on the practical effects of applying the trial court's order—something that was not knowable until after the August 26, 2020 order was entered. In any event, this Court has stressed that the raise-or-waive rule, "though important, is a matter of discretion." Where "the facts of the case are sufficiently developed to permit meaningful review, and the issue [is] fully briefed by both parties," this Court may proceed to address the issue. *Horton v. Professional Bureau of Collections of Maryland*, 238 W. Va. 310, 313, 794 S.E.2d 395, 398 (2016).

Respondents agree that *Robinson v. Charleston Area Medical Center, Inc.*, 186 W. Va. 720, 414 S.E.2d 877 (1991) and the rational basis test are applicable here. In defending the trial court's order, Respondents once again argue that "noncustodial suicide cases are different." Specifically, Respondents posit that the losses in noncustodial suicide cases "result from a volitional act that no one—not families, not health care providers—can detect, diagnose [or] prevent in noncustodial settings." Thus, they conclude that the custodial/noncustodial distinction is justified as a means of "enforcing the duty of self-care and precluding liability where duty cannot and does not lie." [Jt. Br. of Resp., at 19-20.]

Unfortunately, Respondents can cite nothing to support this rationale. Respondents themselves admit that the legislature's intent when enacting the MPLA was to curb "the cost of liability insurance." [Jt. Br. of Resp., at 19.] In setting forth its findings and purposes, the legislature says absolutely nothing about suicide cases. W. Va. Code §55-7B-1. Even *Moats* itself does not engage in the kind of line drawing Respondents are advocating. Furthermore, *Moats* most assuredly does not say that mental health professionals are incapable of diagnosing suicidal tendencies and taking steps to prevent suicide in outpatient settings. Respondents have, instead, created this rationale from whole cloth.

The upshot of the trial court's order is that suicide victims are burdened with a procedural hurdle that does not exist for other victims of medical malpractice. Not only must a plaintiff in a suicide case meet all of the MPLA's procedural requirements, he must go further by affirmatively pleading and proving that the suicide occurred in a hospital or some other custodial setting. There is no rationale for making this distinction or for laying on the plaintiff the burden of asserting it in his complaint. Those suffering from mental health issues are among our state's most vulnerable.

It seems not only unfair, but also cruel and heartless, to have them labor under a heavier pleading burden than any other malpractice victim.

Because the trial court's order treats medical malpractice victims unequally without a rational basis, that order is unconstitutional and, therefore, unenforceable. For this additional reason, the August 26, 2020 dismissal order should be reversed.

IV. Conclusion

For the reasons set forth herein, Petitioner respectfully asks this Court to reverse the August 26, 2020 dismissal order and to remand the case for further proceedings.

PETITIONER, CHRISTOPHER MORRIS, individually and as Administrator of the ESTATE OF AMY CHRISTINE WADE

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Defendants Below, Respondents.

CERTIFICATE OF SERVICE

I hereby certify that on this 2nd day of March, 2021, I served a true and correct copy of the **PETITIONER'S REPLY BRIEF** on the following individuals, via electronic mail:

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