**BEFORE THE**
**WEST VIRGINIA INTERMEDIATE COURT OF APPEALS**



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| **NICHOLAS A. GHAPHERY, D.O.,** | : | |
| **As Personal Representative of** | : | |
| **the Estate of Austin Ghaphery,** | : | **Intermediate Court No. 22-ICA-150** |
| **Plaintiff Below, Petitioner,** | : | (Case No. CC-35-2019-C-182) |
| | : | |
| **v.** | : | |
| | : | |
| **WHEELING TREATMENT CENTER,** | : | |
| **LLC and JOHN SCHULTZ, M.D.,** | : | |
| **Defendants Below, Respondents** | : | |

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# PETITIONER'S REPLY BRIEF

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**Patrick S. Cassidy, Esq.**
**WV State Bar No. 671**
**CASSIDY LAW, PLLC**
**The First State Capitol**
**1413 Eoff Street**
**Wheeling, WV 26003-3582**
**Phone: (304) 232-8100**
**Fax: (304) 232-8200**
**pcassidy@walslaw.com**
**Counsel for Petitioner,**
**Nicholas A. Ghaphery, D.O.,**
**as Personal Representative of the**
**Estate of Austin Ghaphery**

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## INTRODUCTION

To read Respondents' Response, it would seem that the order of the court from which this appeal was taken held that there were no genuine issues of material fact for the jury on questions of negligence or causation, as they spend much of their Response in trying to convince this Court to sustain the court's grant of summary judgment below on such grounds as proximate cause, contributory negligence, intervening cause, etc., notwithstanding the court below made no such finding in granting them summary judgment below, and all of Petitioner's related assignment of errors relate solely to the court's erroneous ruling that a duty of care did not exist as a matter of law when Austin Ghaphery was assessed for admission to Wheeling Treatment Center's (WTC) MAT Program, because no patient-healthcare provider relationship was established between Austin and Respondent upon which liability can be based.

Notwithstanding, because many of Respondents' arguments (relevant or not to the order appealed from) include several misrepresentations of fact to the effect that Plaintiff has not been able to provide evidence countering what Respondents now want to present as certain "undisputed" facts, Petitioner feels compelled in his response to reply to even those arguments ancillary to Petitioner's assignment of errors.

## I. RESPONDENTS' MISAPPREHEND THE NATURE OF PETITIONER'S ASSIGNMENTS OF ERROR

Petitioner asserts five separate assignments of error; not four as stated by Respondents. (See pgs. 1-2 of Petitioner's Brief). These five Assignments of Error are interrelated in that they all address the fundamental question of whether Respondents owed Austin any duty to conduct their assessment to determine whether he was eligible for the MAT Program and/or their suicide risk assessment in accordance with the standards of care applicable to healthcare providers working in the field of addiction medicine during Austin's visit to WTC of September 28, 2017. The Circuit Court's grant of summary judgment in favor of Respondents rests upon the finding

that no patient-healthcare provider relationship was established between Austin and Respondents upon which liability can be based (JA 886-888, Vol. 2). This key finding may be seen as forming the basis for all of Petitioner's related Assignments of Error.

## II. REPLY TO RESPONDENTS' ARGUMENT

Respondents open their brief with a colossal misstatement of the nature of this appeal by arguing that granting the Petition and remanding this matter for trial would somehow "force healthcare professionals to accept as patients and treat all persons who present for evaluation regardless of whether they *should* properly be treated by that particular healthcare professional and/or whether that healthcare professional's scope of practice permits treatment of that individual's condition(s)." (Resps'. Br. at p. 6). By way of additional hyperbole, Respondents argue that granting this Petition would extend the ambit of liability of healthcare professionals beyond that already provided for under law in West Virginia and somehow infringe upon the constitutional autonomy of healthcare providers to voluntarily enter into (or not enter into) physician-patient relationships (*Id.*). The Court will note that Respondents' opening argument does not even address the relatively narrow legal question presented by the instant Petition; i.e. whether WTC Staff and Dr. Schultz rendered healthcare services to Austin such as to come under a duty to provide such services in accordance with the standard of care provided for under the MPLA. Petitioner's sole contention on the "duty" issue is that once WTC Staff and Dr. Schultz agreed to provide healthcare services to Austin by conducting a pre-admission initial assessment to determine whether he met the criteria for admission to the MAT Program and/or by conducting a suicide risk assessment to determine whether he was at an enhanced risk for self-harm they came under a duty to conduct such assessments in accordance with the standard of care required of reasonable and prudent healthcare providers working in their field as provided for under the MPLA. The specific conduct required by those standards of care and

whether the Respondents complied with those standards are questions of fact for a jury to determine, but the question of whether the Respondent healthcare providers were under a duty to comport themselves in accordance with the applicable standards is a question of law governed by the MPLA.

**A. Respondents misconstrue their legal duty under the MPLA**

Throughout the Respondents' brief, they argue that because they had no duty to accept Austin into the MAT Program, the manner in which they performed the diagnostic assessment of whether Austin met the criteria for admission is "immaterial" (Resps.' Br. at p. 9). Respondents assert that the definition of "patient" as set forth in the MPLA is not dispositive of whether Austin was owed a duty of care (Resps'. Br. at p. 9); but they offer no explanation as to how Austin can be their patient upon his receipt of healthcare services under the terms of the MPLA, yet be found to have not established a healthcare provider-patient relationship for purposes of requiring them to owe the duty of care provided for under the same Act. The Circuit Court, too, acknowledged that Austin was "technically a patient" when he received his pre-admission initial assessment at the facility, but that despite his receipt of healthcare services somehow a healthcare provider-patient relationship was not established sufficient to require Respondents' to meet the duty provided for under the MPLA (JA 866-888 at p. 887, Vol. 2), under the authority of *Gooch v. W.Va. Dept. of Pub. Safety*, 195 W.Va. 357, 465 S.E.2d 28 (W.Va. 1995) distinguished at pages 16-17 of Petitioner's Brief. Respondents argue that under the MPLA, however, whether a healthcare provider continues to see a person following the provision of healthcare is not determinative of the person's status as a "patient" for purposes of pursuing a claim arising out of the healthcare services which were actually received.

The MPLA provides that "patient" means "a person who receives or should have received healthcare from a licensed healthcare provider under a contract, express or implied"

W.Va. Code §55-7B-2(m). Accordingly, Austin's status as a "patient" under the MPLA is dependent upon whether he received "healthcare" from WTC Staff and Dr. Schultz. The MPLA defines "healthcare" as "any act, service or treatment provided under…a healthcare facility's plan of care, medical diagnosis or treatment." (my emphasis) W.Va. Code §55-7B-2(c)(1).

Respondents' Brief turns a blind eye to the fact that Austin's pre-admission initial assessment was required under its own screening policy (JA 436, Vol. 1; JA 855, Vol. 2) and that the purpose of such assessment is to determine whether the person undergoing the assessment meets the criteria for admission to the MAT Program (i.e. whether the assessed individual meets the diagnosis for opioid use disorder, is diagnosed as "high risk", or is otherwise diagnosed as meeting the criteria for admission to an MAT Program. C.S.R. 69-11-21.8). Also disregarded by Respondents are the West Virginia Regulations pertaining to the operation of MAT Programs which expressly required Austin's pre-admission initial assessment to be performed in order to determine whether he met the criteria for his admission to the MAT Program; and that the determination of such his admission eligibility be made using accepted medical criteria such as those listed in the latest approved version of the Diagnostic and Statistical Manual for Mental Disorders. (my emphasis) 69 C.S.R. 11 §69-11-21.2 (JA 855, Vol. 2). Because Austin's pre-admission initial assessment encompassed a "medical diagnosis", the services provided to Austin by Respondents in connection with such assessment fall within the definition of "healthcare" under W.Va. Code §55-7B-2(c)(1). Thus, as a person who received "healthcare" from the Respondent healthcare providers under an express or implied contract it is clear that Austin was a "patient" under W.Va. Code §55-7B-2(m); and once Respondents agreed to provide healthcare services to Austin a healthcare provider-patient relationship was established such that the Respondent healthcare providers came under a duty to provide such healthcare services accordance with the standard of care provided for under the MPLA.

Respondents' argument that so long as Austin was not ultimately admitted to the MAT Program they may "wrongly" or "negligently" assess Austin with impunity because they did not "agree to provide *any* medical service to the decedent" (Resps' Br. at p. 10), rings hollow in a case where the undisputed facts show that Austin's pre-admission initial assessment and suicide risk assessment are both diagnostic exercises falling squarely within the purview of the MPLA's express definition of healthcare. The pre-admission initial assessment required the Respondents to use "accepted medical criteria" to determine whether Austin met the criteria for admission to the MAT Program. These are clearly healthcare services that Respondents agreed to provide (and did in fact provide) to Austin. Likewise, the Respondents performance of a suicide risk assessment to determine whether Austin was at an enhanced risk for harm is an essentially diagnostic endeavor such as to fall within the purview of "healthcare."

The Respondents continuously misstate Petitioner's theory of liability as one which would mandate "Respondents to accept anyone as a patient" (Resps'. Br. at p. 10). The instant Petition, however, seeks no such ruling. Rather Petitioner contends that when Austin was assessed to determine whether he met the criteria for admission to the MAT Program and when he received a suicide risk assessment, Respondents were under a duty to conduct such assessments in accordance with the standard of care provided for under the MPLA. The questions of what conduct is required by the standard of care and whether Respondents complied with such standard remains a factual issue for a jury to consider. Respondents' assertion that Petitioner's action must fail because "a determination was made that the individual was not a qualifying candidate for the type of treatment which they offer" (Resps'. Br. At p. 10) also misses the mark quite widely. The propriety of Respondents' conduct in performing Austin's pre-admission initial assessment may not be unilaterally declared by Respondents as it is a question of fact for a jury to consider.

A healthcare providers' statutory duty under the MPLA is to conduct the healthcare services which they provided in a manner consistent with the applicable standard of care. Respondents argue that "Petitioner has produced absolutely no evidence that Decedent was not properly assessed but offers only allegations and conjecture" (Resps'. Br. at p. 12). The record below, however, demonstrates that Petitioner is prepared to adduce ample evidence from highly qualified expert witnesses in the field of addiction medicine to the effect that the Respondents failed to meet the requisite standard of care in conducting both Austin's pre-admission initial assessment (JA 425-434, Vol 1) and the assessment of Austin's suicidality (JA 463-476, Vol. 1). Petitioner's expert opinion evidence to the effect that the Respondents breached their duty to adhere to the applicable standards of care is backed up by additional testimony tying such breach to Austin's ultimate death by drug overdose with such witnesses offering expert opinions that but for the Respondents' failure to meet their duty to provide healthcare services in accordance with the applicable standards of care it is more probable than not that Austin's death by drug overdose would not have occurred (JA 425-434, 463-476, Vol. 1).

Petitioner's actual theories of liability and points of error raised by this appeal must be distinguished from the Respondents constant assertion that Petitioner's action attempts to impose upon the Respondents anything other than a duty to provide the healthcare services received by Austin in a manner consistent with the acceptable standard of care under the MPLA. The duty sought to be imposed upon the Respondents in this case is not "an unprecedented expansion of liability for healthcare providers" in West Virginia, and has nothing to do with the Emergency Medical Treatment and Labor Act (EMTALA), an Act which Respondents injected into their initial defensive briefings, but now acknowledge has nothing to do with the instant action (Resps' Br. at p. 11).

Respondents' also argue that their "no duty" defense should be upheld on "public policy" grounds because, in their view, being held to the duty of care provided for under the MPLA would be such as to expose them to liability "with no manageable limits" (Resps'. Br. at p. 12). So long as Petitioner's medical negligence action is handled in accordance with the MPLA, however, there is little risk that the Respondents will be subjected to liability without "finite boundaries." Respondents cite to *City of Charleston v. Joint Comm'n.*, 473 F.Supp.3d 596 (S.D.W.Va. 2020) which was a class action brought by multiple cities on behalf themselves and similarly situated municipalities across the entire United States against the Joint Commission on Accreditation of Healthcare Organizations. The case was not an action brought under the MPLA and the Federal Court's determination that the duty sought to be imposed by the Plaintiffs would expose Defendants "to a liability to the public at large with no manageable limits" was clearly based upon the fact that the action was brought on behalf of a class composed of virtually every municipality in the country (i.e. the public at large).

The instant action is brought by a father on behalf of his deceased son. The duty sought to be imposed in this case is statutory; and any liability to which the Respondents' may be exposed is recoverable only by the statutory beneficiaries under the Wrongful Death Statute subject to the stringent limitations contained in the MPLA. Petitioner does not seek to expose Respondents to any liability to "the public at large"; and under the MPLA and Wrongful Death Statute pursuant to which this action was brought there is no danger that the Respondents' exposure to liability presents unmanageable limits.

Respondents also argue that "there is no evidence that Respondents ever made an actual diagnosis of the decedent as having or not having a drug addiction"; instead, Respondents contend that the "only determination made regarding the decedent by these Respondents was that he was not being accepted into Respondents' MAT Program for opiate addiction" (Resps'. Br. at

p. 12). This assertion is contradicted by Respondents' own policies and procedures which expressly required the respondents to conduct the pre-admission initial assessment at issue for purposes of determining whether he met the criteria for admission to the MAT Program and the Regulations governing such assessment requiring Respondents to determine whether Austin met the diagnosis for opioid use disorder, met the diagnosis as "high risk," or was otherwise diagnosed as meeting the criteria for admission to the MAT Program (C.S.R. 69-11-21.8). Respondents' audacious representation that they never diagnosed Austin as having or not having a drug addiction (Resps' Br. at p. 12) also flies in the face of the Clinical Director's testimony acknowledging that WTC's policies required every person presenting for treatment services to be initially assessed for appropriateness of admission; and that in conducting Austin's assessment, counselor Coen-Pickens was required to adhere to the required screening policy (JA 849-50, Vol. 2; JA 436, Vol. 1).

The evidence below shows that Austin admitted to a drug use problem and asked his father for help; Dr. Ghaphery immediately set-up an appointment with WTC so that his son could be evaluated by medical professionals practicing in the field of addiction medicine (JA 21-11, Vol. 1). Petitioner was concerned about his son's health and safety and brought Austin to WTC so that he could obtain the medical diagnosis and appropriate treatment. This was not a casual "stop and chat" (JA 212, Vol. 1). Austin had an appointment at WTC, appeared at the facility at the appointed time, and while at the facility underwent evaluations and assessments which clearly fall within the rubric of "healthcare" under the MPLA. Indeed, WTC's Clinical Supervisor admitted that in conducting Austin's pre-admission initial assessment the counselor was required to conduct such assessment in accordance with the requirement that the admission eligibility decision be made "using accepted medical criteria such as those listed in the approved version of the Diagnostic and Statistical Manual for Mental Disorders" (JA 853, Vol. 2; 69

C.S.R. 11, §69-11-21.2). WTC's own policy and the state regulations both required WTC and Dr. Schultz to also make a determination of whether Austin met the criterial for admission to the MAT Program. Austin's pre-admission initial assessment was essentially a diagnostic work-up to determine whether he met the criteria for admission to the MAT Program.

Respondents argue further that absent "a continuing physician-patient relationship" Respondents owed no duty to comply with the standard of care during the time that healthcare services were provided to Austin (Resps'. Br. at p. 13). Here they again misstate Petitioner's claim as being premised upon an allegation that Austin "should have" received healthcare from Respondents. As discussed in some detail above, the evidence adduced in this case establishes that Austin, did, in fact, receive healthcare services from the Respondents in the form of both an assessment as to whether he met the criteria for admission to the MAT Program and a suicide risk assessment. These healthcare services are not mere allegations, but rather are assessments which have been admitted to being conducted by WTC Staff and Dr. Schultz (JA 858-862; 843, Vol. 2). Additional evidence rebutting Respondents' claim that the purpose of their assessments were not diagnostic in nature is the fact that the counselor based her decision that Austin did not meet "criteria for treatment" in part upon a negative urine drug test result (a diagnostic drug test which Respondents have since admitted did not test for the presence of fentanyl) (JA 843, 845, Vol. 2).

Respondents also attempt to cast the healthcare services provided to Austin outside the healthcare provider-patient relationship by arguing that the parties never reached an express or implied agreement that the healthcare services at issue would be provided (Resps'. Br. at p. 14). Here, they argue that because they ultimately decided not to provide Austin with additional medical services, such decision insulates them from any liability for conducting the healthcare services which were performed. This argument is entirely without merit as Petitioner is making

no claim against the Respondents for any conduct arising out of healthcare services provided to Austin other than the assessments which the Respondents agreed to provide, and did provide, during his visit to the facility.

Finally, Respondents' attempt to parse the statutory of definition of healthcare in a way which excludes "medical diagnosis" and instead requires the services to be rendered in the furtherance of a "plan of care" is less than compelling. Obviously, W.Va. Code §55-7B-2(e)(1) must be read in its entirety, and the fact that no "plan of care or medical treatment" was offered to Austin beyond the assessments which were provided on September 28, 2017, does not take the diagnostic assessments conducted which were conducted while he was at the facility outside the definition of "healthcare."

**B. Respondents misconstrue their legal duty under the MPLA regarding their suicide risk assessment.**

Respondents' claim to have performed a suicide risk assessment of Austin during his visit to the facility. Because a suicide risk assessment falls within the purview of "healthcare services" under the MPLA, at the time such assessment was received by Austin he must be considered to be a "patient" under the Act for purposes of the Act, whether the suicide risk assessment was conducted as part of WTC's initial screening, or not. Accordingly, Respondents were required to provide such assessment in accordance with the applicable standard of care. The questions, however, as to whether the Respondents failed to comply with such duty and, if so, whether such failure was a proximate result of Austin's death are questions of fact for a jury.

Respondents requested the court below and now argue that this Court may determine that Austin was not "actively" suicidal on the day of his visit to the treatment center and that they were therefore under no duty to seek "involuntary commitment". This argument is flawed because questions relating to the extent and nature of Austin's suicidality, and what, if anything, was done by the Respondents for purposes of assessing such suicidality are contested such as to

present genuine issues of material fact. Moreover, although Austin's patient record is completely devoid of any documentation supporting the conclusion that any suicide risk assessment was conducted during his visit to WTC, both the counselor and Dr. Schultz have testified that they performed some assessment of Austin's suicidality (JA 418; JA 479, Vol. 1). Based on this testimony it is clear that to the extent any suicide risk assessment may have been undertaken, the Respondents were under a duty to conduct such assessment in accordance with the applicable standard of care.

The evidence adduced below relating to Austin's suicidality includes the Case Note written by WTC Staff after Austin left the facility stating that "concern was noted that Pt was having suicidal ideations and had a plan to follow through with utilizing a gun"; that "Pt reported being depressed", that a discussion was had with the Clinical Director and Medical Director about the patient being "in need of further assessment elsewhere"; and that calls were made to the Pt's emergency contact "to inform the clinic was requesting further evaluation"; but no one was able to be contacted (JA 160, Vol. 1). The evidence shows further that during his visit to WTC Austin placed a telephone call to his father stating "Dad, they want to admit me to Northwood. I saw the counselor, but I have to go see the doctor next" (JA 234, Vol. 1).

Petitioner was also prepared to adduce expert opinion testimony at trial to the effect that once the counselor reported her concern about Austin's suicidality to Dr. Schultz, the standard of care in the field of addiction medicine required Dr. Schultz to conduct a suicide risk assessment; and that when a suicide risk assessment supports the conclusion that a person who presents for treatment at a drug clinic is at an elevated risk for harm, the standard of care requires the physician to make a referral to a psychiatric facility for further assessment (JA 465, Vol. 1). The record below contains further evidence that had an appropriate suicide risk assessment been conducted, it would have demonstrated various factors placing Austin at an elevated risk for

harm on the day of his visit to WTC. Such risk factors include that Austin admitted he was having suicidal ideations (irrespective of whether those ideations were "active" or in the recent past); Austin admitted to having a lethal plan to use a gun; Austin appeared at WTC for help with a drug use problem; Austin had been diagnosed with a psychiatric disorder; and the presence of multiple risk factors combined in a single person placed Austin at an enhanced risk for harm (JA 465-466, Vol. 1).

While Respondents ask this Court to find that the standard of care did not require them to arrange for Austin's admission to a psychiatric facility, the expert opinion testimony adduced below was that: "given the risk factors present at the time of Austin's visit to the treatment center" an appropriate assessment of Austin's suicidality would have resulted in the determination that Austin was at an elevated risk for harm such that the standard of care required a referral to a psychiatric facility where his suicidal ideation with a plan, substance use disorder, and depression could have been appropriately evaluated and treated (JA 468-469, Vol. 1). Respondents mischaracterize this aspect of Petitioner's evidence as a standard of care which mandated involuntary commitment. The evidence below, however, suggests that neither Austin nor his father resisted the idea of Austin being evaluated at a psychiatric facility after WTC Staff told Austin that he needed to be evaluated and treated a Northwood (JA 234-235, Vol. 1).

While Respondents are certainly free to attempt to rebut Petitioner's expert evidence on the issue of whether Austin presented with risk factors were such that the standard of care required arrangements be made for a referral to a psychiatric facility where his suicidal ideation with a plan, substance use disorder, and depression could be appropriately evaluated and treated, that issue is ultimately a question of fact and a fundamentally different inquiry than the basic question of whether Respondents owed a duty of care to conduct any suicide risk assessment in accordance with the standard of care provided for under the MPLA.

### C. Petitioner has produced sufficient evidence on the question of whether Respondents failed to meet the applicable standard of care in conducting the assessments which are the subject of this action to overcome a motion under Rule 56.

Despite the presence of a record below making it imminently clear that genuine issues of fact are presented for jury determination on the issue of whether Respondents failed to meet the standard of care required in conducting his assessment for admission eligibility to the MAT Program or his suicidality; and the fact that the Circuit Court's Order granting summary judgment on the basis of Respondents' "no duty" defense does not contain any finding relating to the absence of genuine issues of material fact; and finally, the fact that Respondents filed no cross-appeal to raise the "lack" of such findings as error on the part of the trial court; Respondents nonetheless assert that even if they are found to be under a duty to comply with the applicable standard of care relating to the assessments which they admit to having performed, the Court should find that there is no genuine issue of fact to be tried and that they should be found to have met such standards as a matter of law (Resps'. Br. at p. 20). Accordingly, Petitioner is compelled to reply that the record below demonstrates the presence of ample evidence tending to prove that Respondents failed to comply with the applicable standards of care with respect to both their pre-admission initial assessment and suicide risk assessment. Such evidence includes not only expert testimony (JA 426-430, Vol. 1), but also evidence establishing that in conducting Austin's assessment WTC Staff and Dr. Schultz both failed to comply with WTC's own patient screening policy (JA 436, Vol. 1), failed to complete the required patient screening form (JA 438, Vol. 1), and failed to comply with State Regulations requiring that the performance of a pre-admission initial assessment to determine admission eligibility include the use of accepted medical criteria (JA 441, Vol. 1). The evidence below also establishes that Respondents failed to make any determination of Austin's use of substances of abuse, current substance use disorder, length of substance use disorder, and readiness to participate in treatment as required by

West Virginia Regulations pertaining to the assessment of a person's eligibility for admission to an MAT Program (JA 443, Vol. 1). Such evidence includes the testimony of WTC Staff (JA 447-50, Vol 1) and Respondents' own expert (JA 453-58, Vol. 1).

Likewise, Respondents ask this Court to disregard Petitioner's expert testimony to the effect that WTC Staff and Dr. Schultz breached the required standard of care in conducting Austin's suicide risk assessment (JA 464-476, Vol. 1). This expert opinion together with the facts showing that Austin presented with multiple risk factors placing him at an enhanced risk for self-harm (*Id.*) is certainly such as to present a genuine issue of material fact on the question of whether Respondents failed to meet the standard of care to which they were required to comply under the MPLA when they conducted the suicide risk assessment upon Austin they claim to have performed.

Although Respondents assert before this Court that "there is simply no evidence that the Decedent was in acute suicide crisis" or that he would have qualified for admission to a psychiatric facility at the time he was assessed at WTC (Resps'. Br. At p. 24), the Case Notes from Austin's visit make it clear that WTC Staff was much more concerned about Austin's suicidal ideations than they admit in their Brief, and that there was even a discussion about Austin being in need of further assessment elsewhere (JA 461, Vol. 1). Notwithstanding Respondents' argument to the contrary, the Case Notes must be seen as evidence supporting the opinions of Petitioner's expert to the effect that the standard of care required Dr. Schultz to conduct a suicide risk assessment and that if properly conducted such assessment would have shown that Austin was at an elevated risk for harm such as to require the physician to make a referral to a psychiatric facility for further assessment (JA 465-70, Vol. 1).

### D. A jury may find that Respondents' failure to meet the requisite standards of care in providing healthcare services to Austin was a proximate cause of his death.

As with respect to the question of negligence, neither did the trial court base its summary judgment ruling on a finding of no genuine issues of material fact as to causation, although that has not prevented Respondents from arguing such in this appeal. In any event, sufficient evidence exists from which a reasonable finder of fact may determine that Respondents' failure to meet the applicable standard of care was a proximate cause of Austin's death.

Petitioner's evidence is that Respondents' failure to meet the standard of care in conducting Austin's pre-admission initial assessment resulted in the erroneous conclusion that he did not meet the criteria for treatment (JA 432-33, Vol. 1). Petitioner will also show that but for the failure to properly conduct Austin's pre-admission initial assessment it was more probable than not that he would have been admitted to the MAT Program, and that upon admission, state and federal regulations would have required WTC to provide medical, counseling, vocational, educational, recovery, random drug testing, and substance use disorder counseling/monitoring in addition to referral to off-site facilities (C.S.R. 69-11-26). Expert testimony will further establish that the very reason why the standard of care requires MAT Programs to properly conduct pre-admission initial assessments is because the failure to do so carries with it the likelihood of the exact type of harm suffered in this case (i.e. death by drug overdose) (JA 434, Vol. 1).

Likewise, Petitioner is able to offer proof that Respondents' failure to appropriately assess Austin's suicidality was a proximate cause of his death. Here the Petitioner has presented expert testimony that given the risk factors present at the time of Austin's visit to WTC, the standard of care required Austin to be referred to a psychiatric facility where he could have been properly evaluated and treated (JA 468-69, Vol. 1). Petitioner's expert has also opined that it is the fact that patients like Austin are known to be at an elevated risk for injury or death by drug

overdose if they are not placed in a supervised psychiatric setting which gives rise to the standard of care requiring healthcare providers to arrange for their admission to a psychiatric facility where they may obtain evaluation and treatment (JA 470, Vol. 1).

Petitioner's expert testified below that "the foreseeability of a patient being injured or dying from a drug overdose by not adhering to the standard of care is the reason why there exists a duty for physicians to follow the standard of care when conducting a suicide risk assessment of a person with as many risk factors as those present in Austin's case" (JA 470-471, Vol. 1). Thus, rather than being the result of some intervening, superseding, or remote cause, Austin's death can be found to be the direct and entirely foreseeable result of the Respondents' failure to adhere to the applicable standard of care.

Further evidence of proximate causation (i.e. tying Respondents' failure to meet the standard of care to Austin's death) is the expert opinion showing that in the event Austin's suicidality had been appropriately assessed, and arrangements made for his admission to the psychiatric facility it is more probable than not that his drug problem would have been properly evaluated, including information about the type of drugs used, the routes that drugs were used, and the time that drugs were used (JA 472, Vol. 1). The record below also contains proof that but for the Respondents' failure to appropriately assess Austin's suicidality and arrange for his admission to a psychiatric facility, Austin would have been evaluated as an inpatient for a period of time during which he would have received intense counseling for drug abuse, depression and other issues (JA 472, Vol. 1); he also would have undergone a thorough treatment regimen which would have included programs designed to prevent him from continuing his drug use, and intervention to assist his depressive illness for purposes of decreasing the risk of injury or death resulting from drug use (JA 474, Vol. 1). Thus, if an appropriate suicide risk assessment had been conducted and arrangements made for Austin to be admitted to a psychiatric facility, there

is evidence from which a reasonable finder of fact may conclude that Austin would have received inpatient and outpatient treatment "such that he would not have died by drug overdose some 36 days after seeking entry to Wheeling Treatment Center for help with his drug problem" (JA 474-75, Vol. 1). It is clear that evidence of proximate cause as adduced via expert testimony is sufficient to carry a case to the jury. *Sexton v. Greico*, 216 W.Va. 714, 613 S.E.2d 81 (2005). Despite Petitioner's evidence tying the Respondent's negligence to Austin's death, Respondents argue that Austin's own conduct constituted a subsequent intervening independent act which was the sole proximate cause of his death. In West Virginia:

> "[A]n intervening cause, in order to relieve a person charged with negligence in connection with an injury, must be a negligent act, or omission, which constitutes a new effective cause and operates independently of any other act, making it and it only, the proximate cause of injury."

*Estate of Postlewait ex rel, Postlewait v. Ohio Valley Med. Ctr., Inc.*, 591 S.E.2d 226 (2003).

More recently in *J.F. Allen Corporation v. The Sanitary Board of the City of Charleston*, 785 S.E.2d 627, 237 W.Va. 77 (2016), the Court noted by Memorandum Decision that the defense of intervening/superseding cause is applicable where a "third party's acts" are alleged to extinguish the causal chain. *Id.* citing Restatement (Second) of Torts §440. The *Allen* Court further found that a superseding cause does not include the alleged acts of the plaintiff, and observed that distinction between the comparative fault of a plaintiff and a third party in cases where a defendant alleges plaintiff's negligence proximately caused his injury. Finally, the West Virginia Supreme Court's relatively recent decision in *Morris v. Corder, et al.*, 866 S.E.2d 66 (WV 2021) discusses why Respondents' reliance upon the intervening cause defense is misplaced. In *Morris*, the Court cited with approval to the duty-based "failure to prevent" suicide scenarios discussed in *McLaughlin v. Sullivan*, 461 A.2d 123, at 125 (NH 1983) relating to medical professionals with whom a duty to prevent suicide may lie; holding that the duty to prevent suicide may be imposed upon such 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 for control necessary to prevent that suicide." *Id.* The *Morris* court further observed that the recognition of a duty-based failure to prevent suicide claim is entirely consistent with law in West Virginia and elsewhere. Of significance to the instant appeal, the *Morris* court made it clear that because the plaintiff below had alleged that healthcare providers deviated from the applicable standard of care by, among other things, failing to admit the decedent to a crisis stabilization facility or an inpatient psychiatric facility "[i]t would defy logic to permit a healthcare provider to evade liability for failing to properly admit a patient on the basis that the patient was *not admitted*." *Id.* at p. 71 emphasis in original citing to *Compare Bexiga v. Havir Mfg. Corp.*, 290 A.2d 281, 286 (NJ 1972)(concluding it would be "anomalous to hold that a defendant has a duty…but a breach of that duty results in no liability for the very injury the duty was meant to protect against." )

The Respondents' argument that this Court should find that because Austin died of a drug overdose this Court should find in Respondents' favor as a matter of law is also in disaccord with *Rowe v. Sisters of Pallotine Missionary Soc.'y*, 560 S.E.2d 491 (W.Va. 2001) where the court held that "in a medical malpractice claim, the healthcare provider is not entitled to a negligence instruction requiring the jury to consider the plaintiff's negligent conduct that triggered the plaintiff's need for medical treatment" (*Id*. at 479). In this case, where the duty owed by Respondents includes the duty to determine whether the patient is suffering from a drug use disorder, the defense of comparative negligence is not available when the patient ultimately suffers harm from the drug use disorder for which he sought care and treatment, as such defense would excuse the Respondents' own failure to exercise reasonable care.

The Respondents' argument that this Court may find as a matter of law in their favor based on an intervening/superseding cause defense is entirely without merit, most importantly,

because the use of an intervening/superseding cause argument is improper in this case given that Austin's death by drug overdose was an entirely foreseeable consequence of the failure to meet the standards of care at issue in this case.

In this case, Petitioner alleges that Respondents deviated from the applicable standard of care by failing to admit Austin to their MAT Program or arrange for his admission to a psychiatric facility so that his drug problem, depression and suicidal ideation could have been properly evaluated and treated. Just as it would "defy logic" to permit a healthcare provider to evade liability for failing to admit a suicidal patient on the basis that the patient was not admitted as noted by the *Morris* court, it would certainly defy logic in this case to permit Respondents to evade liability for Austin's death by drug overdose on the basis that they were under no duty to appropriately assess his drug problem because he was not admitted to Respondents' program.

Just as the healthcare providers in *Morris* argued that decedent's suicide constituted an intentional intervening act such as to preclude liability, Respondents in this case argue that Austin's death by overdose was such as to constitute an intentional intervening act sufficient to insulate them from a finding of liability. Because however, the very reason that Austin came under the Respondents' care was to help prevent his drug problem from escalating to the harm that ultimately resulted in his death, such argument must fail. The *Morris* court's discussion regarding the duty to protect against suicide is equally applicable to the Respondents' duty to meet the standard of care in assessing Austin's drug problem; and it would be equally "anomalous" to hold that the Respondent's in this case have a duty to comply with the applicable standards of care in assessing Austin's condition, but the breach of that duty results in no liability for the very injury that duty was meant to protect against. See *Compare Bexiga v. Havir Mfg. Corp.*, at 286 cited with approval in *Morris*.

## III. CONCLUSION

Based on the foregoing, Petitioner respectfully requests that this Court reverse the Revised Order of the Circuit Court dated September 21, 2022 and remand this case back to the Circuit Court of Ohio County to allow Nicholas A. Ghaphery, D.O. as representative of the Estate of Austin Ghaphery (his son) to have his day in court, and exercise his right to have a jury determine all genuine and material facts at issue.

Respectfully submitted,

NICHOLAS A. GHAPHERY, D.O.
as Personal Representative of the Estate
of Austin Ghaphery, Plaintiff Below, Petitioner

By: /s/ Patrick S. Cassidy
Of Counsel

Patrick S. Cassidy, Esq.
West Virginia State Bar No. 671
CASSIDY LAW, P.L.L.C.
The First State Capitol
1413 Eoff Street
Wheeling, WV 26003-3582
Phone: (304) 232-8100
Fax: (304) 232-8200
pcassidy@walslaw.com

## CERTIFICATE OF SERVICE

Service of the foregoing REPLY BRIEF OF PETITIONER, was had upon the following by mailing a true and complete copy thereto to their last known address, by regular United States mail, postage prepaid, this 29th day of March, 2023, as follows:

RITA MASSIE BISER ESQ
LYNNETTE SIMON MARSHALL ESQ
MOORE & BISER PLLC
317 FIFTH AVENUE
SOUTH CHARLESTON WV 25303
rbiser@moorebiserlaw.com
lmarshall@moorebiserlaw.com

/s/ Patrick S. Cassidy
Of Counsel

Patrick S. Cassidy, Esq.
West Virginia State Bar No. 671
CASSIDY LAW, P.L.L.C.
The First State Capitol
1413 Eoff Street
Wheeling, WV 26003-3582
Phone: (304) 232-8100
Fax: (304) 232-8200
pcassidy@walslaw.com