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No. 91387-1

**SUPREME COURT OF
THE STATE OF WASHINGTON**

**IN THE COURT OF APPEALS, DIVISION III
OF THE STATE OF WASHINGTON**

NO. 318141

**BEVERLY VOLK, et al.,
*Respondents/Cross-Petitioners,***

v.

**JAMES B. DERMEERLEER, et al.,
*Petitioners/Cross-Respondents***

**PETITIONER/CROSS-RESPONDENT ASHBY'S
SUPPLEMENTAL BRIEF ON DISCRETIONARY REVIEW**

EVANS, CRAVEN & LACKIE, P.S.
Robert F. Sestero, Jr., WSBA #23274
Michael E. McFarland, Jr., #23000
Christopher J. Kerley, #16489
818 W. Riverside, Suite 250
Spokane, WA 99201-0919
(509) 455-5200
Attorneys for Respondent/Petitioner
Dr. Howard Ashby



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A. INTRODUCTION

On July 18, 2010, Mr. Jan DeMeerleer (“DeMeerleer”) assaulted Jack Schiering, Philip Schiering, Rebecca Schiering and Brian Winkler (“Respondents”). Rebecca and Philip Schiering died as a result of the assaults. After assaulting Respondents, DeMeerleer committed suicide.

For nine years preceding the assaults, DeMeerleer received private, voluntary and periodic psychiatric treatment from Dr. Howard Ashby. Although DeMeerleer never once voiced to Dr. Ashby any violent intentions directed at Respondents, Respondents have sued Dr. Ashby premised upon the theory that Dr. Ashby had a duty to protect them from DeMeerleer’s assaults. Given the fact that DeMeerleer never voiced to Dr. Ashby any intention, plan or even thoughts of harming Respondents, Respondents seek to impose liability on Dr. Ashby through application of an ambiguous, generalized duty to protect anyone who might foreseeably be harmed by the actions of DeMeerleer. Then, in an effort to establish that DeMeerleer’s homicidal actions were generally foreseeable, Respondents focus upon sexual issues and suicidal ideation disclosed by DeMeerleer to Dr. Ashby years prior to the assaults. Respondents’ misplaced reliance upon such evidence is necessitated by the fact that DeMeerleer never expressed to Dr. Ashby the vaguest intent to harm Respondents. As set forth herein, Respondents’ argument that Dr. Ashby had a general duty to protect anyone

who might be harmed by DeMeerleer, regardless of the absence of any specific threats of harm made by DeMeerleer, jeopardizes the fundamental principles and goals of psychotherapy and the foundation to the establishment of a mental health provider-patient relationship.

A patient's open disclosure of thoughts and feelings is the bedrock of modern psychotherapy and mental health treatment. A risk assessment, like that performed by Dr. Ashby on April 16, 2010, is based on questions answered honestly and accurately by the patient. The intended by-product of those confidential and truthful disclosures includes appropriate treatment management with the goal of resolving any harmful thoughts prior to the patient resorting to harmful behavior. In order to allow psychotherapists to build the foundation of trust that precedes complete and honest patient disclosures, patients and psychotherapists both need to know that their private communications, absent a patient's specific threat of harm against a reasonably identifiable victim, will remain confidential.

The Court of Appeals' decision admits to imposing on private-practice mental health providers a broad, ambiguous duty to protect third persons "from the violent behavior of the professional's outpatient client" because "the state legislature has not addressed the duty owed in the context of an outpatient client." *Volk*, 184 Wash. App. 389, 394 (2014). However, this broad duty originating in *Tarasoff* has been rejected in virtually all

jurisdictions. Further, the state legislature has in fact addressed this duty in both RCW 71.05 and RCW 70.02. Finally, the sweeping duty associated with those “foreseeably endangered” has largely been applied only in “in-custody” or “take charge” cases where governmental agencies had the authority to control the patient/parolees, a circumstance entirely different from a private practice relationship between a provider and patient. This Court should bring Washington in line with the overwhelming number of states that impose a duty on psychotherapists only when the patient expresses a specific threat against a readily identifiable person.

B. ASSIGNMENTS OF ERROR

1. In *Volk v. DeMeerleer*, 184 Wash. App. 389, 337 P.3rd 372 (2014), the Court of Appeals improperly imposes upon private psychotherapists an ambiguous and sweeping duty to protect third parties, despite a Washington statute requiring patient confidentiality, a Washington statute requiring “an actual threat” against “a reasonably identifiable” person before a duty arises, and the vast majority of other jurisdictions that have rejected such a duty because of the deleterious effect it has on mental health care. Recognizing the need to protect confidences shared with mental health providers, the Washington legislature and most jurisdictions have required the imposition of a duty to protect a third party only when a patient expresses an actual threat against a reasonably identifiable person.

2. The Court of Appeals erred in finding an issue of fact based upon a declaration (Dr. James Knoll) that the Court of Appeals actually concedes is speculative. Notwithstanding the admitted speculative nature of Dr. Knoll's declaration, and notwithstanding the acknowledgement that summary judgment jurisprudence directs courts to reject speculative evidence, the Court of Appeals erroneously held that the "law likely recognizes two levels of speculation," one for summary judgment and one for evidentiary hearings/trial. This is a distinction never before recognized by Washington and a distinction that is actually contrary to Washington law.

C. STATEMENT OF THE CASE

Respondents allege that Dr. Ashby did not follow the accepted psychiatric standard of care while attending to DeMeerleer and that the alleged violation proximately caused or allowed DeMeerleer's homicidal actions against non-client/third parties. In support of that theory, Respondents rely upon the opinion of Dr. Knoll, who opines that if Dr. Ashby had not allegedly breached the applicable standard of care, DeMeerleer (1) may have attended more therapy sessions with Dr. Ashby; (2) may have exhibited mental distress or digression of his mental health, (3) may have disclosed homicidal thoughts and feelings to Dr. Ashby (that Dr. Knoll speculates that DeMeerleer must have had); (4) may have been amenable to interventions; and then (5) may have avoided the tragedy.

According to Respondents, the array of retrospective assumptions culminating in a causation opinion are cleansed by Dr. Knoll uttering the phrases “more likely” or “more probable than not.” Not only is Dr. Knoll’s opinions purely speculative, but they demonstrate the problems of imposing a generalized duty to protect third parties in the absence of specific threats of harm against a reasonably identifiable person.

DeMeerleer became a patient of Dr. Ashby in September 2001. His history included bipolar disorder and a prior suicide attempt. DeMeerleer continued to be a patient of Dr. Ashby between 2001 and 2010, with the frequency of office visits largely driven by DeMeerleer’s life circumstances and the waxing and waning of his disorder. During manic and hypomanic stages of the disorder, DeMeerleer sometimes expressed anger, sexual fantasies and an inflated view of himself. Between 2001 and July 18, 2010, DeMeerleer did not assault anyone or attempt suicide. Over the years, Dr. Ashby and DeMeerleer developed a close, professional relationship.

In late 2003, DeMeerleer’s wife left him for another man, a divorce ensued, and DeMeerleer expressed his anger, emotions and depressed thoughts during sessions with Dr. Ashby. On January 23, 2004, DeMeerleer admitted to homicidal/suicidal thoughts, but he performed a reality check, felt embarrassed by the thoughts, and said that he “knows that he would never go there.” DeMeerleer repeatedly said he would never act on his “dark

thoughts.” DeMeerleer never expressed an intent or plan to kill or injure his ex-wife or her boyfriend.

DeMeerleer’s truck was vandalized around September 2005, after which he expressed a plan to lay in wait with guns where his truck had been vandalized. DeMeerleer’s family reported their concerns to Dr. Ashby, the guns were removed from DeMeerleer’s house, and no assaultive action occurred. On September 29, 2005, consistent with the objectives of psychotherapy, DeMeerleer voiced recognition of the link between his mood disorder and his conduct, stating he would not have staged any revenge had he not been “in a negative mode.” Dr. Ashby specifically assessed that DeMeerleer was less intense, showed no sign of mania, and that his judgment was intact

In late 2009, DeMeerleer temporarily lost his employment. At the time, DeMeerleer, Ms. Schiering and her children were living together in DeMeerleer’s house. Ms. Schiering’s son (Jack) has profound autism and his conduct tended to be a point of conflict in the relationship. In November or December 2009, Ms. Schiering broke off her romantic relationship with DeMeerleer because DeMeerleer struck Jack after becoming frustrated because Jack had struck DeMeerleer during an argument. CPS was called. Ms. Schiering moved out of DeMeerleer’s house, and DeMeerleer enrolled in a parenting course. At this difficult time in life, DeMeerleer never

threatened Ms. Schiering or her children, and there is no record of him making threatening comments about Ms. Schiering to others.

In January 2010, DeMeerleer got his job back and he and Ms. Schiering began attending counseling together. DeMeerleer attended individual counseling as well. Emails and notes in the first half of 2010 confirm that DeMeerleer and Ms. Schiering were working on their relationship while living apart. DeMeerleer took one of Ms. Schiering's twin sons to a DeMeerleer family reunion in June 2010. Emails in the summer of 2010 reveal that DeMeerleer sought to re-engage his romantic relationship with Ms. Schiering, and that Ms. Schiering was considering renewing the relationship, although she would not commit it.

On April 16, 2010, DeMeerleer had his last appointment with Dr. Ashby. At the time, DeMeerleer was taking Risperdal, Depakote and Bupropion. The assessment performed by Dr. Ashby revealed DeMeerleer as being logical, goal oriented, insightful and having intact judgment. Although he had some intrusive suicidal ideation when depressed, DeMeerleer reported to Dr. Ashby that he would not act on those thoughts.

On April 16, 2010, DeMeerleer did not express any intent, plan or desire to harm Ms. Schiering or her sons. Nor did DeMeerleer ever previously express the same to Dr. Ashby. By this last appointment on April 16, 2010, any documented, aggressive or assaultive thoughts were

about 4.5 to 6.0 years old and were unrelated to Ms. Schiering or her family.

It is uncontroverted that DeMeerleer never expressed the slightest suggestion to Dr. Ashby (or anyone) that he could or would harm Ms. Schiering or her children. Uniformly, Ms. Schiering's family, DeMeerleer's family, DeMeerleer's co-worker and DeMeerleer's friends never thought DeMeerleer would harm Ms. Schiering or her children. *See, Appendix C to Petition for Discretionary Review.* DeMeerleer's conduct and demeanor leading up to July 18, 2010 – as stated by friends, his ex-wife, family members, and his parents – all demonstrated that DeMeerleer gave no indication that he was in distress, was despondent or depressed, or that he had either thought of or intended to do any harm to Ms. Schiering, her family, others or himself. *Volk*, 184 Wn. App. at 405-07.

D. ARGUMENT

1. Public Policy Requires Imposition Of A Duty To Warn Third Persons Only After A Patient Voices An Actual Threat Of Harm To A Reasonably Identifiable Person.

This case presents the “humbling and daunting task of demarcating the duty a mental health professional owe[s] to third parties to protect them from the violent behavior of the professional’s outpatient client.” *Volk*, 337 P.3d at 327. This task necessarily seeks to balance a societal objective of protecting third persons against maintaining the protections and confidences inherent to and required by effective mental health care. In striking this

balance, Washington is one of but a few states that has not specifically and directly defined the duty as Dr. Ashby requests herein.

The ambiguity of a duty arising when a private patient's future conduct may "foreseeably endanger" an unidentified third party can only lead to a tendency to disclose client confidences and thus undermine the trust relationship necessary for effective psychotherapy. The *Petersen v. State* view standard ignores the mandatory obligation upon providers to keep patient confidentiality, and it is inapposite to a Washington statute that specifically addresses the duty at issue in this matter.

a. Confidentiality and Waiver Due to Imminent Harm To An Individual.

Confidentiality is a bedrock of mental health care and is statutorily required pursuant to RCW 70.02.050. The purpose of the physician-patient privilege is to enable the patient to secure appropriate treatment through candid communication with the health care provider, free of the fear of possible embarrassment and invasion of privacy via an unauthorized disclosure of information. *See, e.g.,* Louisell & Sinclair, *Reflections on the Law of Privileged Communications—The Psychotherapist-Patient Privilege in Perspective*, 59 Calif. L. Rev. 30, 52 (1971)(psychotherapy requires exploration of patient's innermost fears and fantasies, and effective treatment is dependent upon patient's trust in therapist).

The mandatory language of RCW 70.02.050 precludes a health care

provider from disclosing "health care information about a patient to any other person without the patient's written authorization." Disclosure is allowed when the health care provider reasonably believes that the patient poses an "imminent danger" to the health and safety of an "individual." RCW 70.02.050(d). Like the majority of states that have addressed the duty to non-client/third parties, this statute protects patient privacy while still allowing for disclosure of patient confidences when the patient's threat of danger is imminent and there is a discernable victim. The Washington legislature has already recognized that patient privacy rights cannot be trampled until imminent harm to an identifiable victim is known to the provider. This statute cannot be reconciled with a duty announced by the Court of Appeals to disclose non-specific and generalized confidences because they represent the potential of harm to unidentified third persons.

Fleeting thoughts, angry emotions, or hostile comments lacking direction or focus upon a specific person are the topics and disclosures that are common and fundamental to mental health care. Giving clear definition to the provider's duty, as opposed to a nebulous duty arising when harm can be retrospectively called "foreseeable," will give mental health patients the security in and privacy of their confidences as long as there is no actual and imminent threat of harm to an identifiable person. This balance furthers the public interest of encouraging persons in need of mental health care to in

fact seek out that care and share the necessary information, thoughts and feelings freely with their mental health professional.

Of equal importance, the provider is given clarity on when breaching the patient privacy and confidences under RCW 70.02.050 are allowed or required. The provider can perform services without needing to resort to defensive practices that undermine the objectives of therapy while properly insulating the provider from retrospective and speculative claims of foreseeability should a patient subsequently harm unknown victims.

b. Other Jurisdictions Reject *Tarasoff* and *Petersen*.

The vast majority of states have specifically defined, whether by legislative enactment or case law, the precise scope of the duty owed by mental health professionals to protect third persons from the risk of harm posed by the mental health professional's patients. As set forth in Dr. Ashby's Petition for Review, the broad scope of the duty first articulated in *Tarasoff v. Regents of University of California*, 17 Cal.3d 425, 551 P.2d 334 (1976), has been virtually abandoned in favor of a more clearly defined circumstance when the duty to protect a third person arises.

Here, the Court of Appeals reversed the trial court based upon *Petersen v. State*, 100 Wash.2d 421, 671 P.2d 230 (1983), which involved a state psychiatrist, who unlike a private practitioner like Dr. Ashby, was in a "take charge" relationship with his client. See, *Binschus v. State, Dept. of*

Corrections, 186 Wn. App. 77, 93, 345 P.3d 818 (2015). *Petersen* involved a known-to-be-dangerous patient held at a state mental hospital with a known propensity to use drugs and to act dangerously thereafter. The state psychiatrist was aware before discharging of the patient's reluctance to take the prescribed antipsychotic medication and that the patient would likely revert to using Angel Dust. Unlike Dr. Ashby, the provider in *Petersen* had the authority to detain the patient, and unlike Dr. Ashby, the provider in *Petersen* had prior, confirmed knowledge of the patient's expected dangerous conduct if released. *Petersen* does not control.

Dr. Ashby's Petition for Discretionary Review and its Appendices highlight the overwhelming majority of jurisdictions that have rejected the sweeping duty first identified in *Tarasoff*. Particularly noteworthy is *Lipari v. Sears Roebuck & Co.*, 497 F. Supp. 185 (D.Neb. 1980), a case substantially relied upon in *Petersen*, which was legislatively modified in 1994 to require patient communication of "a serious threat of physical violence against a reasonably identifiable victim or victims" before any duty of protection arises. This Court should bring Washington in line with the overwhelming majority of jurisdictions and require a disclosure of client confidences only when those confidences contain an actual threat of imminent harm to a reasonably identifiable third person.

c. RCW 71.05.120 Addresses The Duty To Warn.

The Court of Appeals erroneously concluded that the state legislature had not addressed the duty owed by psychotherapists in the context of an outpatient clinic. In 1987 the Washington Legislature in fact addressed the duty owed to a non-client/third party when it adopted RCW 71.05.120. This statute had the practical effect of abrogating *Petersen*. See, *Hertog v. City of Seattle*, 138 Wn.2d 265, 293 n. 7, 979 P.2d 400 (1999) (“the Legislature statutorily abrogated our holding in *Petersen* in Laws of 1987, ch. 212, §301(1) (codified at RCW 71.05.120(1)), with respect to liability of the State.”). In the present case, the Court of Appeals disagreed, pointing out that *Hertog* involved a parole officer rather than a private mental health professional. The Court of Appeals therefore refused to use the language of the statute “by analogy” to the private/outpatient setting in this case. *Volk*, 184 Wn. App. at 426. RCW 71.05.120(2) explicitly provides that a health care provider is not insulated from a duty to “warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims.” The legislature’s clear statement of when a duty may arise provides the clarity needed by psychotherapists as to when they can and should disclose client confidences without undermining the public safety interest. The Court of Appeals noted: “For the purpose of

demarcating to whom a duty is owed we discern no reason to differentiate between treating a mental health patient in the context of involuntary commitment and treating a patient outside that context.” *Volk*, 184 Wn. App. at 426. There is no rational reason to provide a narrowly defined duty and immunity to a provider who pursues patient confinement while the private health care provider, seeing a patient in a private office without the powers of custody and control, should be held to a more sweeping duty owed to all members of the public when no threatening expressions are made and no victim or target is identified. Public safety will be effectuated if a provider is required to disclose actual threats of harm against reasonably identifiable victims. Conversely, patient privacy rights and the foundational need for open patient disclosures suffer under the *Petersen* foreseeability approach.

2. Causation Cannot Be Established With Inadmissible Speculation and Conjecture.

In opposing summary judgment, Respondents offered a declaration from Dr. Knoll containing a causation conclusion that ignored the facts and sworn testimony and was instead premised upon a foundation of speculation and a pyramid of assumptions. With the benefit of hindsight, Dr. Knoll speculated that DeMeerleer was mentally distressed and digressing between April 16, 2010 and July 18, 2010. While nothing in DeMeerleer’s last appointment with Dr. Ashby suggests future distress, digression or

homicidal ideation, Dr. Knoll nonetheless opines that if DeMeerleer had been more “thoroughly assessed” on April 16, 2010, then DeMeerleer may have been seen and monitored more frequently thereafter and DeMeerleer’s purported distress or digression could have been found and treated. Contrary to this supposition, the record on summary judgment revealed no evidence of a “worsening condition” or “apparent psychological distress leading up to July 18, 2010.” Respondents’ argument that DeMeerleer was “unstable” during 2010 is unsupported speculation devoid of supporting evidence. In fact, given the absence of evidence that DeMeerleer presented as a risk to harm Respondents in 2010, Dr. Knoll is forced to rely upon DeMeerleer’s conduct many years prior (i.e., the vandalism incident) to conclude that DeMeerleer may have had homicidal ideation in April 2010.

This speculation was recognized by the Court of Appeals, but excused based upon a distinction never before recognized in Washington (“the law likely recognizes two levels of speculation”). While the Court of Appeals specifically acknowledged that courts are required to “reject” speculation “when reviewing summary judgment motions,” the Court inexplicably accepted Dr. Knoll’s speculation “for purposes of defending a summary judgment motion.” *Volk*, 184 Wn. App. at 432.

Essentially, the Court of Appeals authorizes speculative opinions from an expert opposing summary judgment even if the expert’s

conclusions are merely based in his/her "explanation," rather than on facts, documents or testimony so long as the expert blesses his or her explanation with the magical words of "reasonable probability." There is no shortage of case law clearly and unambiguously holding that evidence establishing proximate cause must rise above speculation, conjecture or mere possibility. *See, e.g., Reese v. Stroh*, 128 Wn.2d 300, 309, 907 P.2d 282 (1995); *Walker v. State*, 121 Wn.2d 214, 218, 848 P.2d 721 (1993)(expert opinions lacking an adequate foundation should be excluded).

Melville v. State, 115 Wash.2d 34, 793 P.2d 952 (1990) is on point. In *Melville*, a former inmate, shortly after being released from prison, murdered his ex-wife, their young daughter and his ex-wife's unborn child. The surviving spouse of the ex-wife brought suit against the State of Washington alleging that the Department of Corrections had a duty to provide mental health care to the ex-inmate, even though participation in the care would have been voluntary. "From there plaintiff constructs a theory of liability that had treatment been offered, the inmate would have accepted it voluntarily, that treatment would have been successful and that the inmate would not have killed the victims." *Melville*, 115 Wash. 2d at 35. To overcome the "initial obstacle that participation in any mental health treatment was voluntary," the plaintiff submitted affidavits from two psychologists, neither of whom had any personal contact with the ex-

inmate. *Id.* at 40. The psychologists opined “that if anger management treatment had been offered to the inmate while in custody, ‘he probably would have accepted the offer,” and that he “was a reasonably good candidate for a domestic violence anger management program.” *Id.* This Court noted that “[t]hese speculations are insufficient to raise an issue of fact.” *Id.* at 41. “The opinion of an expert must be based on facts. An opinion of an expert which is simply a conclusion or is based on an assumption is not evidence which will take a case to the jury.” *Id.* (citations omitted). Dr. Knoll’s speculative opinions cannot be distinguished from the speculative opinions this Court found insufficient to create an issue of fact in *Melville*.

Predication opinions based on events that had not happened, facts that never occurred, and a collection of possibilities that may have played out over an alternative past are not admissible expert opinions. Dr. Knoll offered no science, no clinical studies, no corroborating witness testimony, and no documents to support the series of assumptions culminating in his opinion that the homicides might have been avoided with more assessment, monitoring and treatment. This retrospective analysis can be given in all tort claims after an otherwise unpredicted event comes to pass.

The factual, informational, or scientific basis of an expert opinion, including the principles or procedures through which the expert’s

conclusions are reached, must be sufficiently trustworthy and reliable to remove the danger of speculation and conjecture and give at least minimal assurance that the opinion can assist the trier of fact. *Sanchez v. Haddix*, 95 Wn.2d 593, 627 P.2d 1312 (1981). Further, expert opinions based on unsubstantiated assumptions must be excluded. *Bellevue Plaza, Inc. v. City of Bellevue*, 121 Wn.2d 397, 418, 851 P.2d 662 (1993).

Dr. Knoll asserts that a risk assessment, more monitoring and undefined treatment would have changed the outcome because it would have averted the mental distress and digression that Dr. Knoll's concludes must have happened. *Volk*, 184 Wn. App. at 432-33. What Dr. Knoll does not and cannot do is link the alleged standard of care violations in April 2010 to the prevention of the homicides in July 2010 without engaging in a pyramid of speculation, and without making assumptions that contradict the evidence in the record.

Contrary to the observations and sworn testimony of DeMeerleer's friends, family, co-workers, and even the family of the victims, DeMeerleer was, according to Dr. Knoll, "unstable" in the summer of 2010. Dr. Knoll offers nothing but the acts of July 18, 2010 to retrospectively support his supposition about DeMeerleer's mental status in the preceding months. Retrospectively, and in contradiction to the evidence, Dr. Knoll *assumes* there was mental distress and some digression in DeMeerleer's mental

health between the last office visit of April 16, 2010 and the acts on the night of July 18, 2010. Dr. Knoll then concludes that if, and only if, all of his assumptions had come to pass, “the risk and occurrence of the Incident would have been mitigated, and probably would not have occurred, as DeMeerleer’s mental distress probably would not have digressed to the level of allowing for an act of suicide and/or homicide.” This conclusion is built on the quicksand of assumptions that contradict the evidence, is based entirely on retrospect and is devoid of scientific rigor or foundation.

There is no evidence DeMeerleer ever expressed or even held homicidal thoughts regarding Respondents before arriving at their house the evening of July 18, 2010, or that more therapy sessions and assessment would have revealed the thoughts that Dr. Knoll presumes to have existed. Simply because Dr. Knoll has proper credentials does not mean he can create a factual foundation for a causation opinion out of his qualified imagination.

E. CONCLUSION

As a result of the functional practicalities of private practice, the underpinnings of psychotherapy, and the legislative conflicts, the mental health community needs a clear and narrowly defined statement of duty. A decision bringing Washington law into conformity with the Washington legislature and the vast majority of jurisdictions would curb the “extreme version of duty” reflected in *Petersen* and recognized by the Court of

Appeals herein. The Court of Appeals imposed an impossible burden upon mental health providers of foreseeing harm when the patient expresses no threat of specific harm and never identifies the person who should be warned. The expansive duty imposed by the Court of Appeals undermines the goals of psychotherapy, violates patient confidentiality, and create a distinction in duties owed by mental health providers involved in involuntary commitment proceedings versus private practitioners.

While a superficial analysis of *Petersen* and the Court of Appeals' decision can result in a conclusion that the public as a whole benefits from imposing a duty on psychotherapists to warn persons who may be foreseeably endangered by a patient, the opposite is in fact true. Imposition of such an ambiguous duty damages the mental health care system as a whole, having a corresponding negative effect on the public as a whole.

Separate from the larger issue of duty, plaintiffs did not carry their burden of providing factually admissible evidence to create a genuine issue of fact on the causation element. Summary judgment in this case should be affirmed based on the speculative conjecture offered by plaintiffs' expert.

DATED this 26 day of August, 2015.

EVANS, CRAVEN & LACKIE, P.S.

A handwritten signature in black ink, appearing to read 'R. Sestero, Jr.', written over a horizontal line.

ROBERT F. SESTERO, JR., #23274

MICHAEL E. MCFARLAND, JR. #23000

CHRISTOPHER J. KERLEY, #16489

Attorneys for Respondent/Petitioner

Dr. Howard Ashby

CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the State of Washington, that on August 26, 2015, I caused to be delivered to the address below a true and correct copy of Petitioner/Cross-Respondent Ashby's Supplemental Brief on Discretionary Review:

Michael J. Riccelli
Attorney for Appellants
400 South Jefferson St., Suite 112
Spokane, WA 99204

James McPhee
Workland-Witherspoon
601 West Main Ave., Suite 714
Spokane, WA 99201

David Kulisch
Randall-Danskin
601 West Riverside Ave., Suite 1500
Spokane, WA 99201

DATED this 26 day of August, 2015.

Shauna & Wade

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Please see attached for filing, Petitioner/Cross-Respondent Ashby's Supplemental Brief on Discretionary Review.

Please file in Volk, et al v. Dermeerleer, et al, #91387-1

Please contact me with questions or concerns.

Thank you.

Shawna L. Wade
Legal Assistant to Robert F. Sestero, Jr.
and Markus W. Louvier
Evans, Craven & Lackie, P.S.
818 W. Riverside Ave.
Suite 250
Spokane, WA 99201
Ph: (509)455-5200
Fax: (509)455-3632

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