

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

Dawn Davison,	:	
	:	No. 25AP-150
Plaintiff-Appellee,	:	(Ct. of Cl. No. 2018-00127JD)
v.	:	
	:	(REGULAR CALENDAR)
The Ohio State University	:	
Wexner Medical Center,	:	
	:	
Defendant-Appellant.	:	

D E C I S I O N

Rendered on October 1, 2026

On brief: *The Becker Law Firm*, and *Romney B. Cullers*; *Francis E. Sweeney, Jr. Esq. LLC*, and *Francis E. Sweeney, Jr.* for appellee. **Argued:** *Paul W. Flowers*.

On brief: [*D. Andrew Wilson*], Attorney General, *Brian M. Kneafsey*, and *Jeanna V. Jacobus* for appellant. **Argued:** *Brian M. Kneafsey*.

APPEAL from the Court of Claims of Ohio

MENTEL, J.

{¶ 1} Defendant-appellant, the Ohio State University Wexner Medical Center (“OSUWMC”), appeals judgments of the Court of Claims of Ohio (1) finding OSUWMC liable for the wrongful death of Brooks H. Davison, (2) awarding damages to plaintiff-appellee, Dawn Davison, the administrator of Brooks’s estate, and (3) denying OSUWMC’s motion for a new trial. For the following reasons, we affirm the judgments.

I. FACTUAL AND PROCEDURAL HISTORY

{¶ 2} Dawn and Brooks Davison were married and had three children. When Brooks was in his twenties, he began experiencing lower back pain. Brooks’s physicians

prescribed opioids to treat his back pain, and Brooks eventually became addicted to his pain medication. With his family's help, Brooks sought treatment for his addiction.

{¶ 3} Part of Brooks's treatment required him to take Suboxone, prescribed by his primary care physician, Dr. Beth T. Tranen. Suboxone consists of buprenorphine, an opioid partial agonist, and naloxone, an opioid antagonist. Buprenorphine is an opioid, and, like oxycodone, heroin, and other opioids, it binds to mu receptors in the brain. Activation of mu receptors causes pain relief and euphoria but also slows breathing.

{¶ 4} Buprenorphine is unlike conventional opioids in two important ways. First, unlike other opioids, which fully bind—and thus fully turn on—mu receptors, buprenorphine only partially binds—and thus partially turns on—mu receptors. In operation, buprenorphine activates the receptors enough to prevent cravings and withdrawal but has a “ceiling effect,” meaning buprenorphine cannot produce the high other opioids do. Also, buprenorphine binds tighter to mu receptors than most other opioids, so it blocks other opioids from attaching to the receptors.

{¶ 5} On February 1, 2016, Brooks underwent a spinal fusion surgery at OSUWMC. For the six years prior to the surgery, Brooks had successfully maintained his sobriety under Dr. Tranen's care. He took Suboxone daily, and he never failed a drug screen. Originally, Brooks resisted spine surgery. According to Dawn, Brooks delayed the surgery because “[h]e didn't want to be on pain medicine. He was concerned about relapsing. He was concerned about his sobriety.” (Tr. Vol. IV at 919.) But Dr. William J. Thoman, the neurological surgeon treating Brooks, alleviated Brooks's concerns. Dawn understood “the plan was that [Brooks] was supposed to go off of the Suboxone, have the surgery, be on pain medicine, wean off [of the pain medicine] within 30 days, and go back on the Suboxone.” *Id.* at 923.

{¶ 6} The morning before his surgery, Brooks did not take Suboxone. However, OSUWMC administered a dose of Suboxone to Brooks after his surgery, at 10:08 p.m. (Joint Ex. T at 364.)

{¶ 7} Approximately two hours later, the neurosurgical service asked for a consult from the acute pain management (“APM”) service due to the concern that inadequately controlled pain was causing Brooks to suffer tachycardia, a faster than normal heart rate. The neurosurgical service was treating Brooks's pain with 5 to 10 milligrams (“mg”) of

oxycodone every four hours and a patient-controlled morphine pump but had discontinued the morphine pump because of “concern for interaction with [S]uboxone.” (Joint Ex. P at 216.) After an initial consult with the APM service, the neurosurgical service reinstituted the morphine pump, which permitted a 1.4 mg dose of morphine every ten minutes.

{¶ 8} Despite the morphine, Brooks’s tachycardia increased through the early morning of February 2. Thus, in the late morning, a full evaluation of Brooks resulted in the APM service prescribing for Brooks (1) 8-2 mg Suboxone once a day, (2) 800 mg gabapentin three times a day, (3) the morphine pump (at the current settings), and (4) 10 to 20 mg of oxycodone every three hours. (Joint Ex. O at 212.) However, beginning on February 2, Brooks refused to take Suboxone. Brooks explained to Dr. Thomas J. Smith, an attending anesthesiologist with the APM service, that he and Dr. Tranen “had a preset plan [that he would] not take [S]uboxone while hospitalized.” (Joint Ex. P at 221.) Dr. Smith had “an in-depth discussion” with Brooks about the risk of relapse if he stopped Suboxone while taking opioids, and Brooks said he would “contact his [S]uboxone [pre]scriber when discharged for further management.” *Id.*

{¶ 9} On February 3, the APM service adjusted Brooks’s medications. While the service continued prescribing the same dosages of Suboxone and gabapentin, it discontinued the morphine pump. To compensate for the loss of the morphine pump, the APM service increased Brooks’s oxycodone dose to 30 to 45 mg every three hours, and it ordered 2 to 6 mg of morphine by IV every four hours as needed for breakthrough pain. (Joint Ex. P at 222; Joint Ex. Q at 323.)

{¶ 10} On February 4, the APM service discontinued Suboxone because Brooks had not been taking it. Otherwise, the service did not alter the medications it had previously ordered. The APM service then stated it would “sign off on this patient at this time.” (Joint Ex. P at 235.)

{¶ 11} OSUWMC discharged Brooks the evening of February 5. At 6:25 a.m. on the morning before his discharge, Brooks’s oxygen saturation level dropped to 80 percent, well below the normal level of 95 to 100 percent. (Joint Ex. U at 253.) At the same time, Brooks complained about shortness of breath and chest pain. *Id.* Nevertheless, OSUWMC chose to move forward with discharge.

{¶ 12} Before discharge, the neurosurgical service provided Brooks with prescriptions for (1) 5 mg tablets of diazepam, with instructions to take one tablet every eight hours as needed for muscle spasms, and (2) 30 mg tablets of oxycodone, with instructions to take one to one and a half tablets (30 to 45 mg) every three hours as needed for moderate pain. (Joint Ex. V.) Diazepam is a benzodiazepine and, when combined with an opioid such as oxycodone, can severely depress breathing. Brooks was instructed to resume Suboxone and follow up with Dr. Tranen at his scheduled appointment on February 17.

{¶ 13} On the way home from the hospital, Dawn and Brooks stopped at a pharmacy to fill the diazepam and oxycodone prescriptions. Once home, Brooks cut some of the oxycodone tablets in half and placed them in a smaller container to make taking the medication easier. At Brooks's request, Dawn assisted Brooks in keeping track of the timing for taking his pain medications and witnessed him take the medications. Dawn explained that Brooks "wanted to be accountable" in light of his previous addiction. (Tr. Vol. IV at 934.)

{¶ 14} On February 6, Brooks took one and a half pills of oxycodone (45 mg) at 11:00 or 11:30 p.m. and went to sleep. At about 2:00 or 2:30 a.m., Brooks awoke Dawn. She discovered the sheets on their bed were wet, and she and Brooks changed the bed. They then returned to bed and fell asleep. Dawn next awoke around 6 a.m. on February 7. When she checked on Brooks, she found he had stopped breathing and died.

{¶ 15} Dr. Susan L. Allen, a forensic pathologist and a deputy coroner with the Montgomery County Coroner, autopsied Brooks's body. Dr. Allen opined that Brooks's cause of death was "[m]ultiple drug intoxication (oxycodone and others)." (Joint Ex. X.) Dr. John A. Gabis, the Ross County Coroner when Brooks died, issued a coroner's verdict that listed Brooks's cause of death as "multiple drug overdose including oxycodone and benzodiazepines." (Capitalization omitted.) (Joint Ex. AA.)

{¶ 16} On January 31, 2018, Dawn filed an action against OSUWMC, alleging claims for medical negligence and wrongful death. The trial court dismissed Dawn's claim for medical negligence, finding that Dawn did not assert that claim within the statute of limitations. After bifurcating the issues of liability and damages, the trial court held a six-

day bench trial regarding whether Dawn proved her claim for wrongful death by a preponderance of the evidence.

{¶ 17} Although the parties contested both standard of care and proximate cause at trial, only proximate cause is at issue in this appeal. OSUWMC does not challenge the trial court’s finding that OSUWMC medical professionals breached the standard of care by “discharging Brooks with oxycodone at a high dose, as well as providing Brooks with a prescription for diazepam, while failing to contact Dr. Tranen before discharge to arrange follow-up care sooner than February 17, 2016.” (Apr. 5, 2023 Decision at 14.) We, therefore, focus in this decision on the evidence relevant to each party’s causation theory.

{¶ 18} According to Dawn, Brooks died because he followed the drug regimen negligently prescribed by OSUWMC’s medical professionals. To support this assertion, Dawn called to the stand two expert witnesses: Dr. Timothy R. Deer, a physician specializing in anesthesiology and pain medicine, and Dr. Gregory B. Collins, an addiction psychiatrist. Dawn also relied on the testimony of Dr. Gabis, the former Ross County Coroner.

{¶ 19} Dr. Deer explained that someone taking Suboxone initially needs more pain medication than someone who is opiate naïve to overcome buprenorphine’s tight bind to the mu receptors. However, once a person stops taking Suboxone and the buprenorphine disassociates from the receptors, that person needs much less pain medication to overcome the block caused by the buprenorphine. Dr. Deer explained:

[E]very time [the OSUWMC physicians] went up on the dose [of opioids], they were activating the receptors and making [Brooks] more prone to overdose later when the Suboxone was out of his system.

So he was resistant to the opioid to some degree; but as the Suboxone level went down in his system, the sensitivity will go up to the opioid. So . . . every time they go up in his dose, it’s leading to his eventual death, in my opinion.

(Tr. Vol. II at 364.)

{¶ 20} Brooks last took a dose of Suboxone on the night of February 1. According to Dr. Deer, Brooks would have started to become more sensitive to conventional opioids “somewhere between 24 to 48 hours” after his last dose of Suboxone, which was around the time the APM service increased his oxycodone dose to 30 to 45 mg every 3 hours. *Id.* at

367. Dr. Deer characterized this as a “very, very large dose” of oxycodone, “[w]ell above any limit [he had] ever really seen postoperatively.” *Id.* at 384. OSUWMC never decreased this high dose; rather, it discharged Brooks with a prescription for the same amount of oxycodone. Dr. Deer opined to a reasonable degree of medical certainty that “the whole complexity of the opioid dosing and the eventual discharge with the same opioid regimen led to [Brooks’s] death.” *Id.* at 368.

{¶ 21} Dr. Deer also explained that combining an opioid and benzodiazepine carries life-threatening risk because both drugs cause neurological dysfunction and respiratory depression. Consequently, to Dr. Deer, the prescription OSUWMC gave Brooks at discharge “was a very dangerous prescription.” *Id.* at 384. Dr. Deer testified that “[t]he opioid dose alone was very dangerous, but adding benzodiazepine to it was certainly overwhelming.” *Id.* at 384-385. Dr. Deer stated:

[I]f [Brooks] took [the oxycodone] the way it was prescribed at 30 to 45 milligrams every 3 hours and someone with his opioid exposure before coming in for the [spine surgery], it would have most likely killed him by itself without any need for anything else.

But then you add the benzodiazepine to that, certainly the risk of death goes way up.

Id. at 394.

{¶ 22} Dawn’s second expert witness, Dr. Collins, testified that an addiction psychiatrist would have advised against OSUWMC’s use of such a high dose of oxycodone to manage Brooks’s pain. As Dr. Collins explained, “The whole strategy in managing chemically dependent people through surgery is [to] get them through surgery with a minimum amount of opiate medication possible[.]” *Id.* at 502.

{¶ 23} “[A] serious sort of marker of how things [were] going” or “red flag” was the respiratory emergency that Brooks suffered during the early morning of February 5, which Dr. Collins stated was caused by the large amount of oxycodone Brooks was taking. *Id.* at 498, 516. During the respiratory emergency, Brooks’s blood oxygen level “dropped precipitously” to 80 percent, a “very low” level. *Id.* at 498. Despite this respiratory emergency, OSUWMC discharged Brooks later in the day with the prescriptions for oxycodone and diazepam. Dr. Collins opined that by prescribing Brooks an “extremely high

dosage” of oxycodone, in addition to a “powerful benzodiazepine,” OSUWMC proximately caused Brooks’s death. *Id.* at 512.

{¶ 24} Dr. Gabis, a physician and the coroner in the county where Brooks died, testified that he investigated Brooks’s death. According to Dr. Gabis, 26 of the 45 tablets of oxycodone tablets dispensed to Brooks on February 5 were remaining when Brooks died. (Joint Ex. BB.) Based on this pill count, Dr. Gabis concluded that Brooks did not take more oxycodone than prescribed.

{¶ 25} Dr. Gabis testified that the amount of oxycodone prescribed for Brooks was the highest amount he had ever seen in cases of overdose from prescription opioids. Dr. Gabis opined the amount of oxycodone prescribed was sufficient to cause Brooks’s death, and the amount of oxycodone prescribed did, in fact, cause his death. Dr. Gabis concluded benzodiazepine was implicated in Brooks’s death because the post-mortem toxicology screen detected diazepam in Brooks’s blood and, when combined, oxycodone and diazepam create a higher risk of death than oxycodone alone.

{¶ 26} OSUWMC agreed with Dawn that Brooks died as a result of an overdose of multiple drugs. But OSUWMC asserted Brooks died due to his own actions: he misused the drugs prescribed for him. To support this assertion, OSUWMC relied on the testimony of two expert witnesses: Dr. Timothy P. Rohrig, a toxicologist, and Dr. Cody J. Wenthur, a pharmacologist and pharmacist.

{¶ 27} Although Dawn retained Dr. Rohrig as an expert, she decided not to call him as a witness at trial. OSUWMC read parts of Dr. Rohrig’s deposition into the record in its case-in-chief. In his testimony, Dr. Rohrig stated that Brooks’s post-mortem toxicology report listed the concentration of oxycodone in Brooks’s blood as 545 nanograms per milliliter (“ng/mL”). According to Dr. Rohrig, the 45 mg dose of oxycodone that Dawn saw Brooks take around 11:30 p.m. on February 6 could not account for the 545 ng/mL post-mortem blood concentration. Dr. Rohrig testified, “[I]f it was just one and a half tabs of the 30 [mg], and . . . understanding this is a postmortem sample, getting up to 545 [ng/mL] is -- I just don’t see how that happened.” (Tr. Vol. V at 1242-1243.) Therefore, Dr. Rohrig concluded it was a “fair statement” that Brooks took more oxycodone than prescribed to him. *Id.* at 1243.

{¶ 28} Dr. Wenthur expanded on Dr. Rohrig's conclusion. Dr. Wenthur explained that when a patient takes oxycodone repeatedly at regular intervals, it accumulates in the bloodstream until it reaches an equilibrium point where the amount of oxycodone eliminated from the bloodstream equals the amount entering the bloodstream. That equilibrium point is known as steady-state concentration. Once steady-state concentration is reached, oxycodone does not accumulate further if taken in the same amount at the same interval.

{¶ 29} The amount of time it takes to reach a steady-state concentration and the blood concentration of a person once that person reaches a steady state depends on numerous individual factors, including the perfusion of the liver, the genotype of a person's enzymes, age, and sex. Using data from pharmacokinetic studies, Dr. Wenthur determined that the half-life of oxycodone, i.e., the time required for a 50 percent reduction of the drug in the blood, is 3.5 and to 5 hours. With this half-life, Dr. Wenthur calculated that if a person takes 45 mg of oxycodone every 3 hours, then oxycodone generally reaches a steady-state concentration in the person's bloodstream in 18 to 24 hours. Because Brooks began taking 45 mg of oxycodone on February 3, the oxycodone in his blood was in a steady-state concentration when he left the hospital on February 5.

{¶ 30} Dr. Wenthur further testified that the steady-state concentration of a person taking 45 mg of oxycodone every three hours falls between 128 and 314 ng/mL. At 545 ng/mL, Brooks's post-mortem blood concentration was higher than expected. Dr. Wenthur stated that he did not believe it was probable Brooks's blood concentration could reach 545 ng/mL if he had taken his oxycodone as prescribed. Rather, a higher blood concentration results from "tak[ing] more compound, more of the oxycodone all at once or in a much shorter interval . . . after . . . reach[ing] steady state." (Tr. Vol. VI at 1394.)

{¶ 31} In addition to presenting the testimony of Drs. Rohrig and Wenthur, OSUWMC attacked Dr. Gabis's testimony that the number of oxycodone tablets remaining upon Brooks's death, i.e., 26 of 45 tablets, was consistent with Brooks taking his medication as prescribed. Pursuant to Brooks's hospital records, Brooks last received a dose of oxycodone at the hospital at 4:01 p.m. on February 5. (Joint Ex. T at 380.) After leaving the hospital, Brooks obtained 45 tablets of 30 mg oxycodone pursuant to the prescription he received from OSUWMC. Presuming Brooks took a 45 mg dose of oxycodone

approximately every three hours after 4:01 p.m. on February 5, by 11:30 p.m. on February 6, he would have consumed 15 of the 45 tablets. Because 19 tablets ($45 - 26 = 19$) were missing upon Brooks's death, OSUWMC contends that Brooks disregarded the dosing instructions and consumed 4 oxycodone tablets sometime between 2:00 to 2:30 a.m. and his death on the morning of February 7.

{¶ 32} Dawn challenged OSUWMC's proximate cause evidence in two ways. First, to rebut Dr. Rohrig's testimony, she had Dr. Collins testify regarding post-mortem redistribution. In post-mortem redistribution, drug concentrations in the bloodstream rise after death as organs and tissues break down and the drugs stored in the organs and tissues move into the bloodstream. OSUWMC objected to this testimony for multiple reasons, including that Dr. Collins did not raise post-mortem redistribution in his expert report. The trial court, however, allowed Dr. Collins to provide the rebuttal testimony provisionally, stating:

[T]his is not a jury trial; and . . . if I find that this testimony should not have been given, believe me, I have absolutely no trouble in excluding it, because that's -- that's not a problem as far as it goes.

So, at this point [neither OSUWMC attorney] will have to make a motion to strike; although I -- you know, that's fine to put it on the record if you do. But I will just tell you flat out that if I do not think that this is appropriate, I am totally and completely going to disregard it. That is not -- because it's scientific and it's not anything else, I can absolutely set that aside.

So at this point, my feeling is I will allow Dr. Collins to give his opinions; but whether I pay any attention to them at all is going to depend upon how this case ultimately develops.

(Tr. Vol. III at 577.)

{¶ 33} Dawn also sought to discredit Dr. Wenthur's testimony through cross-examination. During his cross-examination, Dr. Wenthur acknowledged that to calculate the steady-state blood concentration of a person taking a 45 mg dose of oxycodone every three hours, he had to rely on studies performed by other experts for certain pharmacokinetic inputs for his calculations. Those studies used living people as test subjects, and the blood tested was drawn from a peripheral site, such as a wrist. In Brooks's

case, his blood was not tested until he was dead, and his blood was drawn from his femoral artery. Dr. Wenthur conceded that these “factors . . . [were] certainly relevant to the distinction between the [studies he relied on] and this case.” (Tr. Vol. VI at 1412.) Dr. Wenthur also recognized that, after death, substances in the blood, such as oxycodone, may redistribute, resulting in higher concentrations in femoral blood.

{¶ 34} In its April 5, 2023 liability decision, the trial court found Dawn proved all elements of her claim for wrongful death by a preponderance of the evidence. As we stated above, the trial court determined OSUWMC breached the standard of care by “discharging Brooks with oxycodone at a high dose, as well as providing Brooks with a prescription for diazepam, while failing to contact Dr. Tranen before discharge to arrange follow-up care sooner than February 17, 2016.” (Apr. 5, 2023 Decision at 14.) The trial court then turned to the proximate cause question.

{¶ 35} The trial court began its analysis with the premise that Dawn’s evidence proved that OSUWMC’s medical providers’ negligence proximately caused Brooks’s death. The trial court then summarized OSUWMC’s evidence in support of its theory of proximate cause and rejected it, finding:

Importantly, upon questioning at trial, Dr. Wenthur acknowledged that his opinion in this case was based, in part, on published studies of living patients—not human corpses. Dr. Wenthur further acknowledged that post-mortem lividity could have an effect on his conclusions and the location where blood was drawn from Brooks’[s] body also could affect his conclusions. Defendant’s claim that scientific evidence conclusively disproves Plaintiff’s theory of causation is not persuasive.

Id. at 16.

{¶ 36} Finally, the trial court concluded that, notwithstanding any discrepancy between the amount of medication remaining after Brooks’s death and the amount that should have been remaining, the evidence showed that OSUWMC prescribed to Brooks the instrumentality that caused his death. “Given Brooks’[s] susceptibility to misuse opioid medications,” the trial court found “Brooks’[s] death was foreseeable and [OSUWMC’s] actions, through its medical professionals, constituted the proximate cause of Brooks Davison’s death.” *Id.* at 17.

{¶ 37} In sum, the trial court found Dawn established OSUWMC's liability for Brooks's wrongful death. The trial court, therefore, entered judgment in Dawn's favor.

{¶ 38} The trial court subsequently held a damages trial. In a judgment dated December 23, 2024, the trial court awarded Dawn damages in the amount of \$4,531,700.50, plus post-judgment interest.

{¶ 39} OSUWMC moved for a new trial pursuant to Civ.R. 59(A)(1), arguing it was denied a fair trial due to judicial bias against it. The trial court denied this motion in a judgment dated May 2, 2025.

II. ASSIGNMENTS OF ERROR

{¶ 40} OSUWMC now appeals the trial court's judgments, and it assigns the following errors:

[1]. For three reasons, the trial court abused its discretion in allowing Plaintiff-Appellee's psychiatric expert, Dr. Collins, to testify regarding his new causation theory:

A. he offered new opinions not previously disclosed in violation of Civ.R. 26(E)(1)(b), Civ.R. 26(B)(7)(c), and L.C.C.R. 8(E);

B. he gave opinions based not on personal knowledge, but based on hearsay from unreliable medical literature that is inadmissible hearsay from Evidence Rule 803(18);

C. he was unqualified under Evidence Rule 702 to testify about toxicology results.

[2]. The trial court abused its discretion by ignoring undisputed scientific and mathematical evidence that demonstrates Mr. Davison did not follow doctors' directions and took more medication than prescribed.

III. DISCUSSION

A. First Assignment of Error—Admission of Rebuttal Testimony

{¶ 41} By its first assignment of error, OSUWMC argues the trial court erred in allowing Dr. Collins to testify regarding post-mortem redistribution in rebuttal to Dr. Rohrig's testimony. Assuming the trial court permitted the introduction of inadmissible evidence, no reversible error resulted because OSUWMC failed to show the trial court considered that evidence in arriving at its judgment.

{¶ 42} Appellate courts presume trial judges know the applicable law and apply it accordingly. *Sargsyan v. Martirosyan*, 2021-Ohio-4576, ¶ 31 (10th Dist.). Consequently, when reviewing a bench trial, an appellate court presumes the trial court considered nothing but relevant, material, competent, and admissible evidence in arriving at its judgment. *State v. Wiles*, 59 Ohio St.3d 71, 86 (1991); *In re P.C.*, 2021-Ohio-1238, ¶ 85 (3d Dist.); *Levine v. Kellogg*, 2020-Ohio-1246, ¶ 67 (10th Dist.); *White v. White*, 2014-Ohio-1288, ¶ 11 (2d Dist.); *accord Simmers v. Dennison*, 2025-Ohio-4935, ¶ 40 (4th Dist.) (presuming the trial court “was able to weed out” inadmissible evidence “and decide the matter based solely on admissible evidence”). An appellant may overcome this presumption only by an affirmative showing to the contrary. *Wiles* at 71; *Levine* at ¶ 67, *White* at ¶ 11.

{¶ 43} Civ.R. 26(B)(7) requires parties to disclose the identity of and provide a report from any expert the party expects to call as a witness at trial. Civ.R. 26(B)(7)(a) and (b). Generally, “a party may not call an expert witness to testify unless a written report has been procured from the witness and provided to opposing counsel.” Civ.R. 26(B)(7)(c) (recognizing an exception for certain healthcare providers testifying about matters within the provider’s records). “An expert will not be permitted to testify or provide opinions on matters not disclosed in his or her report.” *Id.* See also L.C.C.R. 8(E) (“An expert will not be permitted to testify or provide opinions on issues not raised in the expert’s report.”).

{¶ 44} Dawn’s counsel began eliciting the objectionable rebuttal testimony from Dr. Collins during his redirect examination of Dr. Collins. At that point, OSUWMC had not yet introduced into the record Dr. Rohrig’s deposition testimony, which contained the opinions Dr. Collins’s testimony would rebut. As a time-saving measure, the trial court decided to allow Dr. Collins to proceed with his rebuttal testimony, subject to OSUWMC’s objections and any later-filed motion to strike.

{¶ 45} While testifying, Dr. Collins admitted that he did not form the opinions he stated in rebuttal until a couple of days prior to the trial. Those opinions, therefore, could not have appeared in Dr. Collins’s expert report. Not surprisingly, then, Dawn does not contest on appeal OSUWMC’s contention that Dr. Collins’s rebuttal testimony was

inadmissible.¹ Dawn instead argues that OSUWMC cannot overcome the presumption the trial court did not consider Dr. Collins’s rebuttal testimony in reaching its judgment.

{¶ 46} Dawn first points out that the trial court only allowed Dr. Collins to testify conditionally, subject to OSUWMC’s objections and potential motion to strike.² The trial court told the parties it would “totally and completely” disregard Dr. Collins’s rebuttal testimony if it proved inadmissible. (Tr. Vol. III at 577.) OSUWMC asserts that the trial court was unable to fulfill this commitment, as shown in its decision. According to OSUWMC, the trial court relied on Dr. Collins’s testimony regarding post-mortem redistribution to reject Dr. Wenthur’s expert opinion regarding causation.

{¶ 47} OSUWMC misreads the trial court’s decision. The trial court found Dr. Wenthur’s opinion unpersuasive due to acknowledgments Dr. Wenthur made under cross-examination. Specifically, with regard to post-mortem redistribution, the trial court stated, “Dr. Wenthur further acknowledged that post-mortem lividity could have an effect on his conclusions[.]” (Apr. 5, 2023 Decision at 16.) This finding reflects Dr. Wenthur’s concession, made during cross-examination, that post-mortem redistribution can raise drug concentration levels in the blood. Therefore, cross-examination, not Dr. Collins’s rebuttal testimony, undercut Dr. Wenthur’s testimony.

{¶ 48} OSUWMC next contends the trial court’s questioning of Dr. Wenthur shows the trial court relied on Dr. Collins’s rebuttal testimony to disregard Dr. Wenthur’s opinions. During the direct examination of Dr. Wenthur, the trial court inquired, “[M]y understanding is that . . . lividity can lead to a higher concentration of the drug than actually would normally be in the system of a person while they were alive. Would you agree with that, or do you know about that?” (Tr. Vol. VI at 1369-1370.) Dr. Wenthur answered, “Yes, I know about this. Generally, I believe the theory you’re talking about is postmortem

¹ Because Dawn does not argue that she had the right to present Dr. Collins’s rebuttal testimony pursuant to *Phung v. Waste Mgt., Inc.*, 1994-Ohio-389, we do not address that issue. See generally *Lips v. Univ. of Cincinnati College of Med.*, 2013-Ohio-1205, ¶ 48 (10th Dist.) (questioning whether the right to present rebuttal testimony recognized in *Phung* “establish[ed] an absolute rule that a plaintiff in a civil case may completely disregard” procedural rules governing the presentation of expert testimony). We will assume, as Dawn does, that the rebuttal testimony at issue was inadmissible.

² After Dr. Collins’s rebuttal testimony, OSUWMC never sought a ruling on its objections, nor did it move to strike Dr. Collins’s rebuttal testimony. In closing argument, rather than arguing Dr. Collins’s rebuttal testimony was inadmissible, OSUWMC argued it was “entirely unbelievable” and “not credible.” (Tr. Vol. VI at 1532, 1541.) The trial court, therefore, never actually ruled on the admissibility of Dr. Collins’s testimony.

redistribution.” *Id.* at 1370. OSUWMC’s attorney interrupted the questioning to remind the trial court that Dr. Collins’s rebuttal testimony regarding post-mortem redistribution exceeded the bounds of his expert report. The trial court did not question Dr. Wenthur any further regarding post-mortem redistribution. This aborted inquiry does not demonstrate the trial court considered Dr. Collins’s rebuttal testimony when reaching its factual findings.

{¶ 49} In short, the decision finding OSUWMC liable for wrongful death does not mention Dr. Collins’s rebuttal testimony at all. Cross-examination, and not rebuttal testimony, led the trial court to discount testimony that Brooks took more oxycodone than prescribed based on his post-mortem blood concentration level. Therefore, OSUWMC has not made an affirmative showing the trial court considered any inadmissible testimony. Because we must presume the trial court did not err as OSUWMC alleges, we overrule the first assignment of error.

B. Second Assignment of Error—Manifest Weight of the Evidence

{¶ 50} By the second assignment of error, OSUWMC argues the trial court abused its discretion by ignoring evidence that Brooks took more oxycodone than prescribed. OSUWMC contends it established through undisputed mathematical and scientific evidence that Brooks died because he failed to follow his doctors’ instructions and, as a result, overdosed on oxycodone. According to OSUWMC, it provided the more credible and persuasive evidence on the issue of proximate cause, so the trial court erred in deciding that issue in Dawn’s favor.

{¶ 51} Although OSUWMC asserts in its assignment of error the trial court abused its discretion by ignoring certain evidence, OSUWMC actually argues the trial court erred in assessing the weight of the evidence bearing on proximate cause. “ ‘Weight of the evidence concerns “the inclination of the greater amount of credible evidence, offered in a trial, to support one side of the issue rather than the other. . . . Weight is not a question of mathematics, but depends on [the evidence’s] effect in inducing belief.” ’ ” (Emphasis omitted.) *Eastley v. Volkman*, 2012-Ohio-2179, ¶ 12, quoting *State v. Thompkins*, 1997-Ohio-52, ¶ 24, quoting *Black’s Law Dictionary* (6th Ed. 1990). OSUWMC contends the trial court should have found the greater amount of credible evidence supported it, not Dawn, on the issue of proximate cause. We, consequently, apply the manifest-weight standard to determine this assignment of error.

{¶ 52} In reviewing a judgment under the manifest-weight standard, an appellate court weighs the evidence and all reasonable inferences, considers the credibility of witnesses, and determines whether in resolving the conflicts in the evidence, the trier of fact clearly lost its way and created such a manifest miscarriage of justice that the judgment must be reversed. *Id.* at ¶ 20. Under the manifest-weight standard, a court of appeals sits as a “ ‘thirteenth juror’ ” who may disagree with the factfinder’s resolution of the conflicting evidence.” *State v. Martin*, 2022-Ohio-4175, ¶ 26, quoting *Thompkins* at ¶ 25, quoting *Tibbs v. Florida*, 457 U.S. 31, 42 (1982). However, “[i]n weighing the evidence, the court of appeals must always be mindful of the presumption in favor of the finder of fact.” *Eastley* at ¶ 21. “ ‘If the evidence is susceptible of more than one construction, the reviewing court is bound to give it that interpretation which is consistent with the verdict and judgment, most favorable to sustaining the verdict and judgment.’ ” *In re Z.C.*, 2023-Ohio-4703, ¶ 14, quoting *Seasons Coal Co. v. Cleveland*, 10 Ohio St.3d 77, 80, fn. 3 (1984), quoting 5 Ohio Jur.3d, Appellate Review, § 603, at 191-192 (1978). “[T]he fact-finder, ‘as the trier of fact, is in the best position to determine the weight and credibility of the evidence, including inconsistencies, along with witness manner and demeanor, and is in the sole position to believe or disbelieve all or any of the testimony presented at trial.’ ” *State v. Reillo*, 2026-Ohio-2701, ¶ 32, quoting *State v. Johnson*, 2023-Ohio-2424, ¶ 23 (6th Dist.). Thus, it is the fact-finder’s role to assess an expert’s credibility and to assign weight to the expert’s testimony and opinions. *In re N.Q.*, 2013-Ohio-3176, ¶ 59 (2d Dist.).

{¶ 53} To recover for wrongful death under a theory of negligence, a plaintiff must prove (1) the existence of a duty owed to the plaintiff’s decedent, (2) a breach of that duty, and (3) proximate causation between the breach of duty and the death. *Estate of Ridley v. Hamilton Cty. Bd. of Mental Retardation & Dev. Disabilities*, 2004-Ohio-2629, ¶ 14. The dispute at issue centers on the last element: proximate cause. “The rule of proximate cause ‘requires that the injury sustained shall be the natural and probable consequence of the negligence alleged; that is, such consequence as under the surrounding circumstances of the particular case might, and should have been foreseen or anticipated by the wrongdoer as likely to follow his negligent act.’ ” *Jeffers v. Olexo*, 43 Ohio St.3d 140, 143 (1989), quoting *Ross v. Nutt*, 177 Ohio St. 113, 114 (1964), quoting *Miller v. Baltimore & Ohio Southwestern RR. Co.*, 78 Ohio St. 309, 325 (1908).

{¶ 54} During trial, the parties presented evidence to support their conflicting theories regarding the cause of Brooks’s death. Dawn’s evidence showed Brooks died as a result of following the drug regimen prescribed by OSUWMC’s medical professionals. OSUWMC’s evidence indicated Brooks died because he took more oxycodone than prescribed.

{¶ 55} The trial court concluded Dawn proved all elements of her claim for wrongful death by a preponderance of the evidence. Therefore, the trial court determined Dawn established Brooks’s death was the natural and probable consequence of discharging Brooks from the hospital with prescriptions for diazepam and high-dose oxycodone without arranging appropriate follow-up care for him. In addressing the proximate cause element, the trial court considered OSUWMC’s evidence that Brooks took more oxycodone than prescribed but found OSUWMC’s “claim that scientific evidence conclusively disproves [Dawn]’s theory of causation . . . not persuasive.” (Apr. 5, 2023 Decision at 16.) The trial court thus weighed the conflicting evidence on causation and found Dawn’s theory of causation supported by the greater weight of the credible evidence.

{¶ 56} OSUWMC contends the trial court never adopted Dawn’s theory of causation. We disagree. The trial court explicitly rejected OSUWMC’s evidence that Brooks took more oxycodone than prescribed. Therefore, the trial court found Dawn’s theory of causation—that Brooks died as a result of following the prescribed drug regimen—more persuasive. We thus turn to determining whether that finding was against the manifest weight of the evidence.

{¶ 57} First, OSUWMC contends the trial court erroneously gave Dr. Collins’s inadmissible rebuttal testimony more weight than Dr. Wenthur’s testimony that he did not believe it was probable Brooks’s blood concentration could reach 545 ng/mL if he had taken his oxycodone as prescribed. However, as we explained above, the trial court’s decision does not reflect that the trial court gave any consideration to Dr. Collins’s rebuttal testimony. The trial court rejected Dr. Wenthur’s opinion based on his answers in cross-examination. As Drs. Rohrig and Wenthur reached the same conclusion, by rejecting Dr. Wenthur’s opinion, the trial court implicitly found Dr. Rohrig’s opinion also unconvincing.

{¶ 58} Second, OSUWMC asserts the trial court erred in throwing out Drs. Rohrig’s and Wenthur’s opinions based on factors, such as lividity after death, that *could* affect the

toxicology results, and thus, the experts' opinions. OSUWMC contends the trial court could not reject Drs. Rohrig's and Wenthur's conclusions because there is no evidence that the factors at issue *probably or likely* affected the experts' conclusions. We disagree. "While expert testimony on causation must be in terms of probability, on cross-examination reasonable possibility may be used to impeach or challenge the expert's theory when supported by evidence or facts in the case." *Staley v. Allstate Property Cas. Ins. Co.*, 2013-Ohio-3424, ¶ 33 (10th Dist.); *accord Bruce v. Junghun*, 2009-Ohio-2151, ¶ 18 (10th Dist.) ("[C]ross-examination may use 'possibility' evidence to 'chip away' the [opposing party's] case."). The trial court, therefore, did not err in disregarding Drs. Rohrig's and Wenthur's opinions.

{¶ 59} Third, OSUWMC argues the number of tablets remaining after Brooks's death supports its contention that Brooks took more tablets than prescribed between 2:00 to 2:30 a.m. and 6:00 a.m. on February 7. We agree with OSUWMC that, given that 26 tablets were remaining upon Brooks's death, Brooks had 4 tablets to consume between 2:00 to 2:30 a.m. and 6:00 a.m., when Brooks was found deceased. However, OSUWMC has no direct evidence as to when—or even whether—Brooks ingested those four tablets. Consistent with his drug regimen, Brooks could have taken one and a half tablets of oxycodone between 2:00 to 2:30 a.m. and another one and a half tablets between 5:00 to 5:30 a.m., for a total of three tablets. There is no evidence as to what happened to the remaining tablet. The trial court refused to engage in speculation regarding this tablet, and so do we.

{¶ 60} OSUWMC also argues Brooks must have taken more oxycodone than prescribed because he kept his medications in a basket, instead of using a pill organizer. Additionally, OSUWMC finds it suspicious that (1) Dawn did not retain the paper on which she tracked the timing of Brooks's doses of oxycodone, (2) tablets from medications (other than oxycodone) were unaccounted for when Dr. Gabis performed a pill count after Brooks's death, and (3) Dawn told the coroner she was concerned Brooks took medication while she was asleep. As the fact-finder, the trial court gave this evidence little weight, and we presume that assessment is accurate.

{¶ 61} Finally, OSUWMC asserts the trial court erred in not considering gabapentin or Suboxone as contributing factors in Brooks's death. However, Dr. Gabis testified that

neither gabapentin nor Suboxone were detected in the post-mortem toxicology screen of Brooks's blood.³ Given this testimony, we will not second-guess the trial court's weighing of this evidence.

{¶ 62} OSUWMC next contends the trial court erred by not addressing whether Brooks was comparatively negligent. According to OSUWMC, the trial court had to reduce Dawn's recovery under contributory negligence principles because Brooks negligently took too much oxycodone, and that negligence concurred with OSUWMC's negligence in contributing to his death.

{¶ 63} In arguing that the trial court erred in not addressing comparative negligence, OSUWMC relies on Dawn's contention that "the trial court's proximate cause findings were not dependent on whether Brooks Davison took his medication precisely as prescribed." (Appellee's Brief at 20.) OSUWMC agrees with this contention, asserting that the trial court did not decide whether Brooks followed his drug regimen. OSUWMC argues the trial court must decide this issue because if Brooks did not take his oxycodone as prescribed, he is comparatively negligent.

{¶ 64} The trial court did not need to consider contributory negligence principles because it rejected OSUWMC's evidence that Brooks misused oxycodone. The trial court concluded the proximate cause of Brooks's death was his consumption of the high amount of oxycodone, along with diazepam, negligently prescribed by OSUWMC's medical professionals without securing appropriate follow-up care. Thus, the trial court determined Dawn proved her wrongful death claim because it found the evidence that Brooks followed his drug regimen had greater weight than the evidence that Brooks took oxycodone in excess or more frequently than prescribed.

{¶ 65} After rejecting OSUWMC's causation theory, the trial court addressed whether OSUWMC's actions constituted a proximate cause of Brooks's death *even if* Brooks took too much oxycodone. Dawn's contention that the trial court's proximate cause determination did not depend on Brooks's adherence to his drug regimen arises from this part of the trial court's decision. The trial court found that, notwithstanding the discrepancies in the amount of medication remaining at Brooks's death and the amount

³ Initially, Dr. Gabis testified the post-mortem toxicology testing did not include gabapentin or Suboxone. After reviewing the toxicology report, he corrected himself and stated both drugs were included in the testing, and neither were detected.

that should have been remaining, the evidence showed that OSUWMC prescribed to Brooks the instrumentality that caused his death. The trial court then held, “Given Brooks’s susceptibility to misuse opioid medications,” Brooks’s death was foreseeable and OSUWMC’s actions were the proximate cause of Brooks’s death. (Apr. 5, 2023 Decision at 17.)

{¶ 66} In this analysis, the trial court was considering whether Brook’s alleged overconsumption of oxycodone could constitute an intervening act that broke the chain of causation. Under the law of intervening cause, an intervening act can break the causal connection between a defendant’s negligent act and the resulting damage. *Leibreich v. A.J. Refrigeration, Inc.*, 1993-Ohio-12, ¶ 12-13; *Knisley v. Bray*, 2004-Ohio-4553, ¶ 11 (10th Dist.). But this intervening act will only sever the casual connection, and thus relieve the defendant from liability, if it is not reasonably foreseeable to the defendant. *Leibreich* at ¶ 13; *Knisley* at ¶ 11.

{¶ 67} The trial court concluded that, even if Brooks exceeded the prescribed dosage, this intervening act of negligence would not break the causal connection between OSUWMC’s negligent act (prescribing a high dose of oxycodone) and Brooks’s death. Because OSUWMC could reasonably foresee that Brooks’s susceptibility to misuse might cause him to take more oxycodone, Brooks’s alleged negligent act could not absolve OSUWMC of liability, as it argued at trial. The casual connection remained intact, so OSUWMC’s actions constituted the proximate cause of Brooks’s death, even in the event Brooks had, as OSUWMC argued, misused oxycodone.

{¶ 68} Nevertheless, before engaging in this alternative analysis, the trial court had already determined that Dawn proved proximate cause with her evidence that Brooks died after consuming the pain medications prescribed to him. Given that the trial court had rejected OSUWMC’s evidence that Brooks misused oxycodone, the trial court did not err in foregoing a contributory negligence analysis.

{¶ 69} As a final matter, OSUWMC contends the trial court erred in denying its motion for a new trial. In support of this contention, OSUWMC advances no argument, but rather, incorporates by reference arguments it made in its motion. The Rules of Appellate Procedure do not allow parties to incorporate by reference arguments from other sources. *Mancz v. McHenry*, 2021-Ohio-82, ¶ 88 (2d Dist.); *McNeilan v. Ohio State Univ. Med. Ctr.*,

2011-Ohio-678, ¶ 7 (10th Dist.). To the contrary, an appellant must affirmatively demonstrate error and cite applicable legal authority in its brief. *Free State of Bavaria v. Ohio State Univ.*, 2026-Ohio-2493, ¶ 44 (10th Dist.); accord App.R. 16(A)(7) (requiring an appellant’s brief to include “[a]n argument containing the contentions of the appellant with respect to each assignment of error presented for review and the reasons in support of the contentions, with citations to the authorities, statutes, and parts of the record on which the appellant relies”). Because OSUWMC has failed to set forth an argument in its brief supporting its contention that the trial court erred in denying its motion for a new trial, we decline to review that contention.

{¶ 70} In conclusion, we determine the judgment in Dawn’s favor on her claim for wrongful death is supported by the manifest weight of the evidence. Accordingly, we overrule OSUWMC’s second assignment of error.

IV. CONCLUSION

{¶ 71} For the foregoing reasons, we overrule OSUWMC’s first and second assignments of error. We affirm the judgments of the Court of Claims of Ohio.

Judgments affirmed.

DORRIAN and LELAND, JJ., concur.
