

STILL WAITING: THE SLOW EVOLUTION OF THE LAW IN LIGHT OF THE ONGOING STUDENT SUICIDE CRISIS

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INTRODUCTION

College and university student mental health issues—especially student suicide—have emerged as matters of national concern. Modern college and university students face an array of mental health challenges. The risks associated with suicide, which in some situations may include an attendant risk of homicide, have become signature risks in an ongoing college and university student mental health crisis. Suicide is neither the only, nor the most prevalent, mental health issue for students, but it has become salient. Just a few years ago, there was much less public discussion of the mental health challenges of the modern student and very little by way of systemic and proactive suicide prevention for a college and university community as a whole. The times have changed. Dealing with suicide risk in college and university populations is now a top concern for administrators.

In 2002, Nancy Tribbensee and I wrote of the emerging crisis of college and university student suicide.¹ We addressed the wave of mental health issues menacing institutions of higher education and sounded an alarm that the delivery of higher education and litigation patterns would change. We acknowledged that, at the time, alcohol and drug use dominated the agendas of many college and university administrators.² Events at Virginia Tech in April of 2007,³ however, put

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1. Peter Lake & Nancy Tribbensee, *The Emerging Crisis of College Student Suicide: Law and Policy Responses to Serious Forms of Self-Inflicted Injury*, 32 STETSON L. REV. 125 (2002).

2. *Id.* at 125.

greater priority upon issues of self-inflicted injury and attendant violence. While college and university mental health issues had continued to garner interest prior to 2007, the Virginia Tech tragedy served as a catalyst for greater intervention by colleges and universities with respect to mental health issues. In 2002, we anticipated “that in the near term, however, attention paid to suicide and other serious forms of self-inflicted injury will continue to increase and that these concerns may begin to gain prominence.”⁴ The April, 2007, tragedy has made our prediction regarding issues of suicide and related violence come true faster than we imagined. Unfortunately, although suicide and related risks have jumped in priority, the law has evolved at a frustratingly slow pace.

This article is an update to my earlier article with Nancy Tribbensee and a call to action: colleges and universities desperately need more legal guidance on the parameters of managing student suicide danger.⁵ The first wave of litigation has served to bring student suicide and student wellness issues out of the closet, but we need more than a smattering of cases with inconsistent results. Everywhere in America, in every type of institution of higher education, administrators make life and death decisions with imprecise and incomplete guidance from the law. While it is odd to call for *more* law in an era of such legal complexity, many colleges and universities simply need *some* law to govern their affairs. In an era where judicial activism is frowned upon, it is odd that legal inactivism—either in the form of legislative inertia or courts showing an unwillingness to apply existing doctrines, principles, or legislation—can be its own form of legal evil. Legal inactivism in the context of college and university student suicide is dangerous, and played a role, along with misperceptions of law, in events at Virginia Tech. There is a cost when neither courts nor legislatures articulate the ways in which general legal principles apply in the college and university context and fail to consider the impact upon administrators of partial, incomplete, or inconsistent legal commands. At this time, the law is failing colleges and universities with respect to the mental health crisis.

The college and university student suicide crisis is now in full swing. Suicide and self-inflicted violence remain major issues for the traditional college and university-aged population, and, in some ways, the dangers may have even increased. According to the Center for Disease Control and Prevention (CDC), suicide is the “second leading cause of death among 25–34 year olds and the third leading cause of death among 15– and 24–year olds.”⁶ Thus, suicide prevention is not simply a focus for traditional college- and university-aged populations, but must also be a focus for graduate and professional schools. The 25–34 year-old demographic factors prominently in most graduate and professional school programs and applies to the many college and university students who extend their

3. Shaila Dewan, *Drumbeat of Shots, Broken by Pauses to Reload*, N.Y. TIMES, Apr. 17, 2007, at A1.

4. Lake & Tribbensee, *supra* note 1, at 125.

5. As this article is an update, I recommend reviewing the prior article in conjunction with this article. *See id.*

6. CTRS. FOR DISEASE CONTROL AND PREVENTION (CDC), SUICIDE FACTS AT A GLANCE (2007), <http://www.cdc.gov/ncipc/dvp/Suicide/SuicideDataSheet.pdf>.

education.⁷ Newly published research also indicates that for some groups suicide rates have increased significantly.⁸

Males still successfully complete suicide at a much higher rate than females and constitute nearly 80% of all suicides in the United States.⁹ The fact that “[f]irearms are the most commonly used method of suicide among males”¹⁰ means that a very large percentage of total suicides involve firearm violence—which, as we have seen, can be directed at others as well. Moreover, data from the National Violent Death Reporting System (NVDRS) suggests the vast majority of murder-suicide perpetrators are male, and that most male murder-suicide violence is directed at females with whom they have shared or sought an intimate relationship.¹¹ The typical murder-suicide occurs in the twenties to early thirties, which of course overlaps with college and graduate school for many individuals.¹² We now see more clearly the connections between murder and suicide, and the dangers presented to all members of a college or university community by what was once seen as a self-regarding harm or risk.

The crisis has forced colleges and universities to accept a greater role in the mental health of the educational community as a whole. Yet, higher education is still waiting for the legal system to catch up to the crisis. As Tribbensee and I pointed out in 2002, “[t]he American legal system has been reluctant to hold institutions liable for suicide or self-inflicted injury.”¹³ This remains true; however, it is now evident that the legal system itself is reluctant to even approach issues regarding college and university student suicide and self-inflicted injury at all. What is remarkable, perhaps, is how little has happened in college and university law since 2002. In many states, and with respect to many issues, colleges and universities, students, parents, and others must still wait to receive necessary, basic governing rules. Higher education desperately needs such governing legal rules to manage its affairs effectively. Legal uncertainty is good in

7. See LUTZ BERKNER ET AL., U.S. DEP’T OF EDUC., NATIONAL CENTER FOR EDUCATION STATISTICS, NCES 2003–151, DESCRIPTIVE SUMMARY OF 1995–96 BEGINNING POSTSECONDARY STUDENTS: SIX YEARS LATER 16 (2002) (finding that only 50.7% of students beginning at a four-year institution completed a bachelor’s degree at that institution within 6 years and 58.2% of students completed a bachelor’s degree at any institution within 6 years).

8. See KM Lubell et al., *Suicide Trends Among Youths and Young Adults Aged 10–24 Years—United States, 1990–2004*, MORBIDITY AND MORTALITY WEEKLY REPORT, Sept. 7, 2007, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5635a2.htm>. It is also noteworthy that adult males age 75 years and older have the highest rate of suicide. Thus, as colleges and universities increasingly offer services to older Americans, they should expect to be working with groups that have the highest suicide rates in the United States. CDC, *supra* note 6.

9. CDC, *supra* note 6.

10. *Id.*

11. See Katherine van Wormer, Family Safety Current Trends—About Domestic Homicide and Murder-Suicide, <http://www.helpstartshere.org/Default.aspx?PageID=1248> (last visited Feb. 27, 2008). The National Violent Death Report System provides data from several states regarding murder-suicide.

12. See *id.* Thus, it is likely that law enforcement will respond to a murder-suicide as an event between domestic partners or between an individual who is obsessed and the target of that obsession.

13. Lake & Tribbensee, *supra* note 1, at 126.

some areas, but not here. This article serves as a call to action for courts and legislatures to move quickly in assisting higher education. To some extent, the three major reports regarding events at Virginia Tech in April of 2007 give higher education some guidance,¹⁴ but reports are not statutes or case decisions from courts of final jurisdiction. Indeed, it is eminently likely that courts and legislatures will ultimately reject some features of these reports.

What follows is a description of key cases and events since my 2002 article with Nancy Tribbensee. However, reporting the outcomes of a handful of battles and skirmishes hardly amounts to making predictions about the outcome of the war. The law is drifting, and seems to have no particular course. Most disturbing is the fact that lawmakers have shown no sense of urgency in, at least, offering basic governing principles to most or all institutions. This does not mean courts should all hold that colleges and universities have legal duties to prevent suicide, but, if there is no legal duty owed, courts should make that known. Thus, other actors, like parents, will understand what they must do.

Nonetheless, despite a general climate of little progress, some ideas have emerged in both the law and policy dimensions that will help colleges and universities manage the student mental health crises. First, law and policy makers now realize suicide is not primarily an individual event. Suicide affects an entire community whether or not violence is directed at others. However, as events at Virginia Tech demonstrated, when suicide combines with outward violence, it creates particularly grave danger for a campus community. Second, there is a renewed recognition that violence and suicide go hand in hand. All too often, we imagine suicidal individuals engaging in behaviors that are injurious but not particularly violent: for example, females typically use poisons to commit suicide.¹⁵ But the facts of suicide belie such an image, given that so many suicides are gruesome, violent, and dangerous to others. Thus, violence prevention is suicide prevention, and vice versa. Third, suicide and self-inflicted injury problems do not exist in isolation. Instead, suicide and self-inflicted injuries are phenomena that exist in an educational environment. Now, we recognize that suicide and self-inflicted injury are connected to general environmental wellness issues and intimately connect to both the safety and academic wellness of the community. Fourth, particularly in light of events at Virginia Tech in April 2007, weaknesses in higher education's business model have become evident. Higher education too often promotes or tolerates balkanization, information siloing, and self-help over collaboration. Our institutions were designed in another era to protect and preserve truth and information for subsequent generations. The very

14. See VA. TECH REVIEW PANEL, MASS SHOOTINGS AT VIRGINIA TECH 21 (2007), available at <http://www.vtreviewpanel.org/report/index.html> [hereinafter GOVERNOR'S REPORT]; See also DEP'T OF JUSTICE ET AL., REPORT TO THE PRESIDENT ON ISSUES RAISED BY THE VIRGINIA TECH TRAGEDY (2007), available at <http://www.hhs.gov/vtreport.pdf> [hereinafter PRESIDENT'S REPORT]; OFFICE OF THE INSPECTOR GENERAL FOR MENTAL HEALTH, MENTAL RETARDATION, AND SUBSTANCE ABUSE SERVICES, INVESTIGATION OF APRIL 16, 2007 CRITICAL INCIDENT AT VIRGINIA TECH, (2007), available at <http://www.oig.virginia.gov/documents/VATechRpt-140.pdf> [hereinafter INSPECTOR GENERAL REPORT].

15. CDC, *supra* note 6.

virtues that brought American higher education into the 21st century—such as careful deliberation and curriculum division—now appear in some situations to be weaknesses. Suicide and self-inflicted injury issues have illuminated the need to rapidly improve American higher education's ability to adapt to crises and generate environmental and coordinated responses. While American higher education has made important strides in violence prevention and student wellness, the changes and improvements have been incomplete.

KEY RECENT CASES AND EVENTS INVOLVING STUDENT SUICIDE AND/OR SERIOUS
SELF-INFLICTED INJURY

Since 2002, there have been several reported decisions relating to college and university student suicide or serious self-inflicted injury. There also have been a number of cases filed.¹⁶ However, there has not been a landslide of reported decisions, nor have all the decisions that have been reported come from courts of final resort. As the description of the cases and events that follow indicates, we have learned a number of things since 2002, but there is far more to come.

A. *Schieszler v. Ferrum College*¹⁷

In our 2002 article, Nancy Tribbensee and I referred to the *Ferrum College* case as a case “worth noting” and described the sad facts leading to the death of Michael Frentzel, who, at the time of his death, was a student at Ferrum College.¹⁸ In *Ferrum College*, Frentzel committed suicide in his dormitory room.¹⁹ Ferrum College knew he was a danger to himself. Indeed, it had gone as far as requiring him to attend anger management classes and had required him to sign a statement promising not to injure himself.²⁰ Ferrum College officials also knew Frentzel told his girlfriend and another friend of his intentions to kill himself.²¹ The representative of his estate claimed Ferrum College had a duty to prevent Frentzel's suicide.²² When Ferrum College attempted to dismiss the case by arguing no duty to prevent suicide was owed, the court refused to grant the motion to dismiss.²³ Subsequently, the case settled.²⁴

In settling the lawsuit, Ferrum College admitted “shared responsibility” for the

16. See, e.g., *Jordon Nott v. George Washington University*, Civil Case No. 05-8503 (D.C. Super. Ct.). The *Nott* case was settled under undisclosed terms. Daniel de Vise, *GWU Settles Lawsuit Brought by Student Barred for Depression*, WASH. POST, Nov. 1, 2006, at B05; Eric Hoover, *George Washington U. Settles Lawsuit With Ex-Student It Suspended After He Sought Help For Depression*, CHRON. HIGHER EDUC. (Wash., D.C.), Nov. 10, 2006, at A39.

17. 236 F. Supp. 2d 602 (W.D. Va. 2002).

18. Lake & Tribbensee, *supra* note 1, at 135.

19. *Ferrum Coll.*, 236 F. Supp. 2d at 605.

20. *Id.* at 609.

21. *Id.*

22. *Id.* at 605.

23. *Id.* at 614.

24. Eric Hoover, *Ferrum College Concedes ‘Shared Responsibility’ in a Student’s Suicide*, CHRON. HIGHER EDUC. (Wash., D.C.), Aug. 8, 2003, at A31.

freshman's suicide and acknowledged "errors in judgment and communication."²⁵ Although such an admission of shared responsibility was path-breaking,²⁶ the fact that only preliminary legal decisions were reached in the *Ferrum College* case leaves the case with limited precedential value. After all, refusing to grant Ferrum's motion to dismiss on no-duty grounds is not equal to granting summary judgment on duty grounds in favor of the plaintiff, nor is it equivalent to a jury determination that Ferrum failed to operate with reasonable care.

The *Ferrum College* matter is a clear example of how settlements reached in the private law system deprive colleges and universities of helpful precedent. Nonetheless, the fact that a federal trial court refused to grant a motion to dismiss on no-duty grounds and the case was settled on such broad terms will have, and has had, an effect on college and university administrators and attorneys. Although some may believe Ferrum College settled too quickly and broadly, many administrators think situations at their institutions are indistinguishable (partly because so many questions of liability remain unanswered) from the *Ferrum College* case and may be moved to revise practices or accept responsibility for student self-harmings.

B. *Mahoney v. Allegheny College*²⁷

Mahoney arose from the suicide of Charles Mahoney IV, an Allegheny College ("Allegheny") junior, in February of 2002 at an off-campus fraternity house.²⁸ Charles Mahoney had received counseling with the Allegheny College Counseling Center over the course of his two and a half years at Allegheny.²⁹ During football camp his freshman year, Mahoney visited the counseling center and was diagnosed with depression.³⁰ He received regular counseling throughout his freshman year in addition to medical treatment by his doctor.³¹ At the beginning of his sophomore year, he was hospitalized after an evaluation by the counseling center determined he was suicidal.³² Subsequently, he had continued and regular counseling throughout his sophomore year.³³ Upon returning for his junior year, he quit the football team and became increasingly distant from his few friends.³⁴ He continued receiving counseling from counseling services, and his counselor was aware of his suicidal thoughts.³⁵

In early February, 2002, Mahoney's counselor spoke with the Associate Dean

25. *Id.*

26. *See id.*

27. No. AD 892-2003 (Pa. Ct. Com. Pl. Dec. 22, 2005) (memorandum and order granting defendant's motion for summary judgment).

28. *Id.* at 1–2.

29. *Id.* at 3–4.

30. *Id.* at 3.

31. *Id.*

32. *Id.* at 3–4.

33. *Id.* at 4.

34. *Id.*

35. *Id.* at 3–11.

of Students.³⁶ Prior to this meeting, the Dean was unaware of Mahoney. Mahoney had been in disciplinary trouble and the counselor wanted to consider an involuntary leave of absence for health (due to the suicidal thoughts) and disciplinary problems.³⁷ While the counselor was restricted from contacting Mahoney's parents, the Dean was able to do so. Nonetheless, the dean refrained because the counselor thought it would do more harm than good.³⁸ At the meeting, the counselor informed the Dean of a troubling email in which Mahoney stated he "hate[d] living."³⁹ On February 11 of his junior year, Mahoney hung himself in his fraternity room.⁴⁰

His parents alleged that Allegheny breached its duty of care to prevent their son's suicide and had a duty to notify them regarding his mental health issues.⁴¹ The parents also made claims regarding Allegheny's failure to take appropriate actions under Pennsylvania medical health law regarding leave of absence procedures.⁴² Finally, Mahoney's parents argued breach of contract.⁴³ Prior to these claims, specific claims against the fraternity had been dismissed.⁴⁴

In response to these claims, Allegheny and affiliated defendants filed motions for summary judgment.⁴⁵ On December 22, 2005, a state trial court in Pennsylvania granted Allegheny's motion for summary judgment with respect to the counts alleging negligence and granted motions for summary judgment in favor of Allegheny with respect to the contract and misrepresentation claims.⁴⁶ Claims for punitive damages were also dismissed.⁴⁷

The court analyzed the determination of duty by balancing various factors.⁴⁸ Pennsylvania law recognized that duty is a result of the balancing of various considerations or factors.⁴⁹ The court, however, stated that the matter was a "case of first impression" and that there were no previous cases "imposing a duty to prevent suicide on a college or its employees."⁵⁰ Regardless, it performed the

36. *Id.* at 11–12.

37. *Id.* at 13.

38. *Id.*

39. *Id.* at 8.

40. *Id.* at 2.

41. *Id.*

42. *Id.*

43. *Id.*

44. *Id.*

45. *Id.*

46. *Id.* at 27.

47. *Id.*

48. *See id.* at 14–15. The factors are: "1. The relationship between the parties, 2. The social utility of defendant's conduct, 3. The nature of risk imposed and foreseeability of harm incurred, 4. The consequences of imposing a duty upon the defendant, and 5. The overall public interest in a proposed solution." *Id.* These factors derive from the earlier Pennsylvania case of *Sinn v. Burd*, 404 A.2d 672, 681 (Pa. 1979).

49. *Phillips v. Cricket Lighters*, 841 A.2d 1000, 1008 (Pa. 2003) (quoting *Althaus v. Cohen*, 756 A.2d 1166, 1169 (Pa. 2000)).

50. *Mahoney*, No. AD 892-2003, at 15. The issue was not entirely novel. There had been a previous case regarding responsibility to prevent suicide. *See McPeake v. William T. Cannon*,

required factor balancing.⁵¹

The court noted that American law is “reluctant to find civil liability arising out of a failure to prevent suicide.”⁵² However, it went on to point out that the old proximate cause rule⁵³ no longer dominates and “rather than relying on the rules of proximate causation to resolve cases involving students’ suicides, courts are increasingly looking at duty within the ambit of the existence of a ‘special relationship’ and whether an event is ‘reasonably foreseeable’ or ‘imminently probable.’”⁵⁴ After reviewing several recent decisions the court made extensive findings.

Several of the court’s findings are pertinent. First, it decided there was no law “imposing a personal duty on lay non-mental health professional college employees to prevent suicide.”⁵⁵ Second, it found “there was no ‘special relationship’ nor ‘reasonably foreseeable’ events that would justify creating a duty to prevent suicide or notify Mahoney’s parents of any impending danger.”⁵⁶ Third, it found that *Shin v. MIT* and *Schieszler v. Ferrum College* were unpersuasive and not precedential, because, in this instance, the student had not previously injured himself.⁵⁷ Fourth, the court held that finding a duty based on a special relationship would be “reactive” and not the “careful and precise legal analysis required in a duty of due care.”⁵⁸ In this finding, the court implied that such a duty may exist in a custodial context, but not in the present college/university–student relationship.⁵⁹ Fifth, if nonprofessionally trained lay persons were required to notify of impending dangers, many issues would arise, including foreseeability, “the disruption of a professional confidential clinical relationship,” and “a student’s right to privacy and expressed wishes involving notification.”⁶⁰

The court seemed focused upon the fact that the relationship between the Dean and Mahoney existed only for a matter of a few days and was not extensive in scope.⁶¹ The court, of course, recognized that Mahoney had an ongoing relationship with a mental health counselor, although the liability of any mental health care provider was not before the court in the pendant motions.⁶² The court did not impute any knowledge from the counselor to the College or the Dean. Presumably, mental health care professionals are like independent contractors and thus do not typically subject their principal employers to rules of imputation of

Esquire, P.C., 553 A.2d 439 (Pa. Super. Ct. 1989).

51. *Mahoney*, No. AD 892-2003, at 15.

52. *Id.* at 19.

53. See *Lake & Tribbensee*, *supra* note 1, at 126.

54. *Mahoney*, No. AD 892-2003, at 20.

55. *Id.* at 22.

56. *Id.*

57. *Id.* at 23. See *infra* Part II.D. for a discussion of *Shin v. Mass. Inst. of Tech.*, No. 02 0403, 2005 WL 1869101 (Mass. Super. Ct. June 27, 2005).

58. *Mahoney*, No. AD 892-2003, at 23.

59. *Id.* at 22.

60. *Id.* at 23.

61. *Id.* at 22.

62. *Id.*

knowledge under the law of agency (although the court engaged in no such discussion).⁶³ Moreover, the court also failed to address any issues regarding vicarious liability of Allegheny for potential counseling errors; presumably, the answer would be the same under rules of agency law.

Finally, and critically, the court also focused upon the fact that although there was evidence of Mahoney diving into a progressively deeper state of depression, there had been no specific acts or threats of self-harm.⁶⁴ In terms of foreseeability, the parents' claim was lacking. The court was unwilling to impose a duty to anticipate suicide by extrapolating from limited connections with a student and the mere fact that a student has some mental health issues. Moreover, there is a hint that the court thought the fact that a mental health counselor had an ongoing relationship with a patient should weigh in favor of the institution. To the extent that someone should be notified, or an intervention should take place, the person to initiate such action should be the mental health professional. Again, *Mahoney* did not so hold, but it does suggest that mental health professional responsibility may alter the responsibility of other individuals connected to a suicidal student. Speculating further, *Mahoney* may signal that some courts will think that a student suicide is typically a matter involving questions of medical professional responsibility, and litigation risk should be allocated first to professional malpractice carriers, not host institutions or non-medical staff. If that is so, *Mahoney* may imply that potential liability differs significantly for different classes of college and university employees, and that utilizing mental health care professionals on staff does not create an assumption of larger legal responsibilities for student wellness. That would certainly be a better way to interpret *Mahoney* than interpreting it to mean that the presence of treating mental health care professionals in the management of students with wellness issues absolves non-medical staff from engaging in reasonable interventions. *Mahoney* may simply be signaling that a college or university is not a hospital simply because it has medical staff.

As to the issue of the existence of a special relationship between the suicidal student and the institution, the court was unimpressed with authority expanding the meaning of special relationship and even the use of special relationship terminology "outside the context of custody and/or control."⁶⁵ The court went on

63. *See generally id.*

64. *Id.* at 23.

65. *Id.* The court's findings under heading VI are its least articulate and accurate. Special relationships have been found commonly in situations other than custody and/or control. When the question presented is one regarding protecting third parties from dangerous individuals—and in duty to prevent suicide cases—courts so limit special relationships, but do not always do so in other contexts. *See, e.g., Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334 (Cal. 1976). Indeed, the Pennsylvania Supreme Court specifically adopted the very balancing test that Dean Prosser advocated which has formed the basis of many courts holding that custodial relationships are not necessary for relationships to be special. *See, e.g., Peter F. Lake, Revisiting Tarasoff*, 58 ALB. L. REV. 97 (1994). Moreover, the court's concern over special relationship analysis shows a certain level of disagreement with its own high court's pronouncements—it is as if the *Mahoney* court was unwilling to follow the "balancing" directions of the Pennsylvania Supreme Court in prior cases. And, suggesting that acknowledging special relationships is tantamount to adopting in

to rule in favor of Allegheny with respect to the contract and misrepresentation counts of the complaint as well.⁶⁶

Despite exonerating the institution, the court expressed its concern and issued a call to action:

Clearly the increasing incidents of suicide on campuses throughout the United States is [sic] cause for grave concern. In the view of some commentators, suicide is a confession, actually multiple confessions of failure, and like most failures, it is shrouded in blame and rationalizations. However, incurring or creating a new duty of care in such cases is not the answer. Nevertheless, "failure" to create a duty is not an invitation to avoid action. We believe the "University" has a responsibility to adopt prevention programs and protocols regarding students [sic] self-inflicted injury and suicide that address risk management from a humanistic and therapeutic as compared to just a liability or risk avoiding perspective. In our view, the likelihood of a liability determination (even where a duty is established) is remote, when the issue of proximate causation (to be liable the university's act/omissions would have to be shown to be substantial) is considered. By way of illustration, even as to the issues of the lesser duty of notification of parents/others, there is always the possibility that such may make matters worse and increase the pressure on the student to commit the act. Rather than create an ill-defined duty of due care the University and mental health community have a more realistic duty to make strides towards prevention. In that regard, the University must not do less than it ought, unless it does all that it can.⁶⁷

Many colleges and universities would have trouble understanding the precise message of this important paragraph in the *Mahoney* decision. Certainly, the court was aware of the fact that institutional protocols regarding student suicide should be considered in light of the fact that they might make situations worse for students. Perhaps some colleges and universities will take comfort in the court's

loco parentis is misguided and incoherent. In higher education law, the doctrine of *in loco parentis* never created responsibility; it was merely a form of immunity. See ROBERT D. BICKEL & PETER F. LAKE, *THE RIGHTS AND RESPONSIBILITIES OF THE MODERN UNIVERSITY* 17-34 (1999). The *Mahoney* court follows an unfortunate tendency among American courts and legal commentary to assume in dicta that *in loco parentis* somehow existed in higher education to create duty or responsibility. Such a conclusion is fallacious, completely unsupported by any evidence, and illogical because *in loco parentis* existed as an immunity in higher education, not a responsibility-creating norm. Unfortunately, such misleading statements of law are common in lower court and unreported decisions. This further supports this article's thesis that the law regarding college and university student suicide remains in transition. It is not always well formulated.

66. See *Mahoney*, No. AD 892-2003, at 27. Moreover, the court pointed out that under Pennsylvania law the authority to involuntarily hospitalize a student lies only with "physicians, peace officers or others authorized by the County Administrator." Thus, the college and its employees could not be implicated under the Pennsylvania Mental Health Procedures Act, 50 P.S. § 7302. *Id.* at 23.

67. *Id.* at 25.

statement that legal duty is not “the answer” in student suicide litigation, or, perhaps, some institutions will heed the call to action and shun avoidance behavior as they “adopt prevention programs and protocols” that are both “humanistic and therapeutic.”⁶⁸ This important paragraph in the *Mahoney* decision is reminiscent of crucial paragraphs in decisions by Judge Cardozo, which as Judge Posner has pointed out, have meta-significance. The final quoted sentence is particularly mysterious and open to different interpretations.⁶⁹

Mahoney leaves as much open as it closes. For example, would *Mahoney* come out differently if facts indicating greater levels of foreseeability on the part of non-medical staff were involved? Would *Mahoney* be decided differently if the student had failed to engage, on an ongoing basis, with a medical health professional to assist with depression or other mental health issues? Would it be different if administrators had a longer and wider opportunity to observe and evaluate a student across multiple dimensions? Would *Mahoney* have come out differently had it considered precedents not discussed in the case such as *Eisel v. Board of Education*,⁷⁰ which reached a different result in a similar case involving a high school student? And, finally, would it have been decided differently had the suicide been a murder-suicide or a suicide that negligently or even innocently caused injury to third parties? Does *Mahoney* stand for the proposition that a student must cross a bright line, such as engaging in self-harm or make specific threats of self-harm, to trigger a duty? All of these questions remain open after *Mahoney*.

68. *Id.*

69. See RICHARD A. POSNER, *CARDOZO: A STUDY IN REPUTATION* 41–42, 92–124 (1990).

70. *Eisel v. Bd. of Educ.*, 597 A.2d 447 (Md. 1991). In *Eisel*, Nicole Eisel, a thirteen year old student, consummated a murder-suicide pact with another student. *Id.* at 448. Prior to her death, Nicole’s friends informed a school counselor of Nicole’s stated intention to kill herself. *Id.* at 449. The counselor questioned Nicole, she denied making the statements, and the counselor took no further action. *Id.* The court focused on the special relationship that results between the suicidal person and one with knowledge of the suicidal intent. *Id.* at 450. While the court noted that most cases declined to extend such a duty, it found Nicole’s adolescence and the therapeutic role of the school counselor made such a duty applicable in this instance. *Id.* at 452. The court then considered several factors: (1) the “Foreseeability and Certainty of [the] Harm,” (2) the “Policy of Preventing Future Harm,” (3) the closeness of the connection between the school’s conduct and the injury, (4) the general reaction to the event (moral blame), (5) the burden imposing a duty would have on the defendant, (6) the community consequences of finding liability, and (7) the insurability of the proposed duty. *Id.* at 452–56. Using these factors, the court held “school counselors have a duty to use reasonable means to attempt to prevent a suicide when they are on notice of a child or adolescent student’s suicidal intent.” *Id.* at 456.

C. *Bash v. Clark University*⁷¹

Perhaps, as the *Mahoney* court indicated, foreseeability is the crux of judicial concern and interest regarding duties to prevent self-inflicted injury. The Massachusetts Superior Court case of *Bash v. Clark University*⁷² is illustrative. *Bash* did not involve a suicide, but a student who died on campus after overdosing on heroin.⁷³ Following the student's death, the family brought a wrongful death action against Clark University ("Clark") and several administrators.⁷⁴ Clark administrators moved to dismiss the claims brought against them. Ultimately, the court granted the defendants' motions to dismiss after assuming the facts as alleged in the complaint to be true.

Michele Bash, the decedent, entered Clark in August of 2003.⁷⁵ She was housed in an on-campus residence hall, as was required for all first-year students.⁷⁶ Clark prohibited drug and alcohol use by underage students on school property.⁷⁷ While Clark prohibited drug use, the City of Worcester, where Clark is located, had a notable drug problem, possessing one of the three highest rates of heroin overdoses in Massachusetts.⁷⁸ During her first year, Michele had typical issues regarding alcohol use, resulting in police and RA intervention.⁷⁹ At one point, her parents became concerned with her illegal drug use and reported her to the campus counseling center.⁸⁰ Despite meeting with campus mental health administrators, Michele denied using drugs.⁸¹ She was eventually placed on academic probation and was given an academic advisor.⁸² The advisor met with Michele on several occasions and saw that she "did not look well, was not sleeping, and was homesick."⁸³ The advisor also "recommended that Ms. Bash go to the Counseling Center and Clark's Health Center."⁸⁴ Just about a month prior to her death in February 2004, Michele again ran into trouble regarding potential drug use on campus.⁸⁵ At this point, Michele finally admitted having used heroin but promised not to do it again.⁸⁶ Michele's mother was informed that Clark administrators had met with her.⁸⁷ The day before her death, Michele's residential advisor recognized

71. No. 06745A, 2006 WL 4114297 (Mass. Super. Ct. Nov. 20, 2006).

72. *Id.*

73. *Id.* at *1.

74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.* at *2.

78. *Id.*

79. *Id.*

80. *Id.*

81. *Id.*

82. *Id.*

83. *Id.*

84. *Id.*

85. *Id.*

86. *Id.*

87. *Id.*

problems, although he did not attribute them to heroin use.⁸⁸ Subsequently, Michele overdosed on heroin and died.⁸⁹

The court concluded that Clark owed Michele no duty to protect her from her own self-inflicted injury:

After carefully reviewing the circumstances involved in this case and the challenges faced by university officials and staff in attempting to eradicate drug use on college campuses, recognizing a special relationship in this instance would impose on university officials and staff an unreasonable burden that would be at odds with contemporary social values and customs.⁹⁰

The court began by recognizing that, typically, “[people] do not owe . . . a duty to take action to rescue or protect [someone] from conditions [they] have not created.”⁹¹ Quoting from Section 314(a) of RESTATEMENT (SECOND) OF TORTS, the court pointed out that the ordinary no-duty rule can be trumped if an appropriate special relationship exists.⁹² The court went on to point out that under Massachusetts law special relationships often turn principally on the existence of foreseeability.⁹³ The court stated:

The Supreme Judicial Court explained the basis for imposing a duty where a “special relationship” exists in *Irwin v. Town of Ware*, 392 Mass. 745, 467 N.E.2d 1292 (1984). It stated that special relationships are “based to a large extent on a uniform set of considerations. Foremost among these is whether a defendant reasonably could foresee that he would be expected to take affirmative action to protect the plaintiff and could anticipate harm to the plaintiff for failure to do so.”⁹⁴

Recognizing that Massachusetts to date had no case specifically dealing with duties to protect students from self-imposed harm arising from the voluntary use of drugs or alcohol, the court turned to other jurisdictions to help it determine foreseeability. Reviewing the cases, the court saw three principal themes all pointing to no-duty in the case at hand.

First, *Bash* interpreted prior precedent to the effect that foreseeability—leading to a determination of special relationship and a duty—turns on a “balancing approach.”⁹⁵ The court believed the appropriate balancing approach is balancing the risk of harm against the efforts needed to protect against the harm.⁹⁶ Performing this balancing, the court stated:

The evidence before the court, viewed in the light most favorable to the plaintiffs, does not support the conclusion that the tragic death of

88. *Id.*

89. *Id.*

90. *Id.* at *4.

91. *Id.* at *3 (quoting *Cremins v. Clancey*, 612 N.E.2d 1183, 1187 (Mass. 1993)).

92. *Id.*

93. *Id.*

94. *Id.* at *4 (quoting *Irwin v. Town of Ware*, 467 N.E.2d 1292, 1300 (Mass. 1984)).

95. *Id.*

96. *Id.*

Michele Claudia Bash from a heroin overdose was reasonably foreseeable to the defendants. The complaint states that Ms. Bash admitted to trying heroin once, several months before her death. It also states that it made her sick and she had not done any illegal drugs since. Furthermore, nowhere in the complaint does it state that Ms. Bash was suicidal or made any reference to wanting to end her life. This court believes that although there is ample evidence to suggest that Ms. Bash was homesick, or looked mad and upset without additional facts, the risk of death or serious injury resulting from a drug overdose was not so plainly foreseeable that a special relationship existed between the student and the university. In addition, as discussed below, this court has grave reservations about the capacity of any university to undertake measures to guard against the risk of a death or serious injury due to the voluntary consumption of drugs other than those provided by or with the approval of the university.⁹⁷

In analyzing relevant case law, the court put significant emphasis on the famous bystander era cases⁹⁸ of *Bradshaw v. Rawlings*⁹⁹ and *Baldwin v. Zoradi*.¹⁰⁰ *Bash* relied upon these cases to make the point that college and university students are fundamentally different from students who are in “elementary, middle and secondary levels.”¹⁰¹

Second, the *Bash* court also thought it is inappropriate to impose legal duties on colleges and universities to protect students from dangers associated with voluntary usage of alcohol or drugs. As *Bash* stated, “it is not appropriate to ground the existence of a legal duty on the part of university officials and staff on the basis of unrealistic expectations about their ability to protect their students from the dangers associated with the voluntary use of illegal drugs.”¹⁰² The court distinguished cases imposing a duty in situations where third parties created the danger as opposed to danger created on a first party basis:¹⁰³

It is not possible for the most vigilant university to police all drug use and protect every student from the tragic consequences of voluntary drug use. In *Crow v. State of California*, the court held imposing a duty of care on a university to protect its students from the risks of harm flowing from the use of alcoholic beverages would be “unwarranted and

97. *Id.* (internal citation omitted).

98. BICKEL & LAKE, *supra* note 65, at 49–103 (defining and examining “bystander era” cases).

99. *Bradshaw v. Rawlings*, 612 F.2d 135, 139 (3d Cir. 1979). In *Bradshaw*, a student was injured in a drunk driving accident and sued Delaware Valley College. The drunk driver was underage and had been supplied alcohol by Delaware Valley College. *Id.* at 137. Following a jury verdict for the plaintiff, the Third Circuit reversed. *Id.* at 141. Following the demise of *in loco parentis* and the campus revolutions of the 1960s and 1970s, colleges and universities owed no duty to their students to prevent foreseeable harm. *Id.* at 139.

100. 176 Cal. Rptr. 809. The *Baldwin* court largely relied on *Bradshaw*’s reasoning. *Id.* at 816.

101. *Bash*, 2006 WL 4114297, at *4.

102. *Id.* at *5 (internal citations omitted).

103. *Id.* at *5–6.

impracticable.” To impose liability on the part of university officials and staff in this case would be tantamount to imposing on them the duty of an insurer against the type of tragedy that happened to Ms. Bash. The inherent nature of drugs is that they are small, easily transportable, easily obtainable, and can be easily concealed. As such, this court is not of the view that the tragic consequences of the voluntary use of drugs by Ms. Bash was reasonably foreseeable. As the defendants have pointed out, a university cannot prevent these incidents from occurring “except *possibly* by posting guards in each dorm room on a 24-hour, 365-day per year basis” This is not the type of burden that one may expect a party or a social institution such as a university to assume as the basis of a special relationship.¹⁰⁴

The *Bash* court lumped voluntary alcohol usage, voluntary drug usage, and voluntarily overdosing into the same category with respect to special relationship analysis. While it may be true that stopping an individual student from overdosing would be practically impossible given the same facts as *Bash*, this is not the case in all situations. Surely, *Bash* does not purport to hold that an institution, knowing a student is about to overdose, can watch and stand idle. Furthermore, modern science does not support the broad statement that alcohol and drug use are not preventable.¹⁰⁵ Although preventing an individual student from using alcohol or drugs may be difficult in a given situation, there are interventions that, in the aggregate, can help to reduce high risk alcohol and drug usage.¹⁰⁶ The *Bash* court, like many courts, falls into the trap of conflating particular intervention strategies directed at one student with general intervention strategies designed to make the entire academic environment safer and more reasonable. Moreover, the *Bash* court also failed to consider the possibility that, in some situations, institutions may engender or facilitate alcohol or drug risk by decisions such as permitting the usage of certain facilities, permitting certain kinds of advertising, or through choice of architecture (for example, high density residence halls—especially those using triples—can intensify alcohol and drug problems) and staffing. In short, *Bash* utilized language that was overbroad for the issue presented; there are many further issues to be decided on a case-by-case basis in Massachusetts.

Third, the *Bash* court believed that a duty to intervene in a case like *Bash* would conflict with student privacy rights.¹⁰⁷ As the court stated:

[R]ecognition of the existence of a legal duty on the part of university officials and staff in this case would conflict with the expanded right of privacy that society has come to regard as the norm in connection with the activities of college students. The incursion upon a student’s

104. *Id.* at *5.

105. See generally REDUCING UNDERAGE DRINKING: A COLLECTIVE RESPONSIBILITY 87–249 (Richard J. Bonnie & Mary Ellen O’Connell eds., 2004), available at http://books.nap.edu/openbook.php?record_id=10729&page=87. See also College Drinking, 4 Tiers, <http://www.collegedrinkinglearning.gov/StatsSummaries/4tier.aspx> (last visited Feb. 27, 2008).

106. See generally REDUCING UNDERAGE DRINKING, *supra* note 105, at 87–249.

107. *Bash*, 2006 WL 4114297, at *5.

privacy and freedom that would be necessary to enable a university to monitor students during virtually every moment of their day and night to guard against the risks of harm from the voluntary ingestion of drugs is unacceptable and would not be tolerated.¹⁰⁸

Undoubtedly, no court would require general twenty-four hour monitoring of college students in all spaces—students remain tenants with legal rights and do not lose their tenancy rights simply by matriculating to a college or university.¹⁰⁹ However, the court's broad statements of student privacy rights are interesting when juxtaposed with concerns regarding misunderstandings of student privacy law expressed in reports relating to events at Virginia Tech.¹¹⁰

Bash may be the case that turns a no-negligence determination into a no-duty determination. Clark University officials did intervene on behalf of Ms. Bash and involved her family.¹¹¹ However, according to the record in *Bash*, Michele deliberately hid and lied about her heroin usage.¹¹² Unless a person could detect with reasonable care that statements are false, or that hidden information is readily discoverable, there should be no reason to impose responsibility. Sometimes, courts refuse to recognize students' claims, or claims that arise on behalf of the student, when the injured student voluntarily participated in dangerous behavior and lied about or misrepresented the nature of the behaviors or the risks associated with them.¹¹³

Bash, however, is the wrong case to set precedent suggesting colleges and universities should have no duty whatsoever to protect students from any form of voluntary intoxication or illegal drug use. For one thing, in some environments, a duty will obviously arise because of a landowner relationship, which is considered a legally special relationship such that it imposes duties on the landowner.¹¹⁴ As a matter of law, broad statements of no responsibility are inconsistent with existing special relationship law. Moreover, courts should be careful to extrapolate from individual prevention intervention situations to general environmental intervention situations. Courts frequently distinguish a duty to provide a generally safe environment from a duty to prevent a foreseeably dangerous individual's attacks.¹¹⁵ In the matter of self-inflicted injury, courts should do the same. Although Michele's individual heroin overdose was not foreseeable, self-inflicted injury by drugs, alcohol, or otherwise can be foreseen. Reasonable measures should be commensurate with what is reasonably within the college or university's control. Thus, it would be a mistake to consider *Bash* as a case that suggests

108. *Id.*

109. *See Nero v. Kan. State Univ.*, 861 P.2d 768, 780 (Kan. 1993) ("A university owes student tenants the same duty to exercise due care for their protection as a private landowner owes its tenants.").

110. *See* discussion *infra* Part II.E.

111. *Bash*, 2006 WL 4114297, at *2.

112. *Id.*

113. *See, e.g., Lloyd v. Alpha Phi Alpha Fraternity*, No. 96-CV-348, 1999 WL 47153, at *4 (N.D.N.Y. Jan. 26, 1999).

114. *Bash*, 2006 WL 4114297, at *4.

115. JOHN L. DIAMOND, *CASES AND MATERIALS ON TORTS* 244–45 (2001).

institutions should not engage in more proactive environmental strategy to generally reduce risks of alcohol, drug, or self-inflicted injury.

Finally, in light of events at Virginia Tech, it has become painfully apparent that individuals who inflict self-harm often present a serious danger to others. While the *Bash* scenario is not such a case, other cases of voluntary drug overdose could present such a scenario. For example, a student overdosing on certain types of drugs could have hallucinations, leading him or her to commit violence on others. Again, the law is quite clear that if a college or university has a foreseeably dangerous individual on its premises it must take action to protect other invitees on its premises.¹¹⁶

D. *Shin v. Massachusetts Institute of Technology*¹¹⁷

It is instructive that the Massachusetts lower courts have already split, at least in terms of result, in student self-inflicted injury scenarios. In *Shin v. Massachusetts Institute of Technology*, a Massachusetts Superior Court held that certain administrators at the Massachusetts Institute of Technology (“MIT”) could be responsible for the burning death of a student.¹¹⁸ The case is hard to reconcile with either *Bash* or the decision in *Mahoney*.¹¹⁹

The facts of *Shin* arose out of the death of Elizabeth Shin,¹²⁰ a student enrolled at MIT in September 1998.¹²¹ Elizabeth was hospitalized in the spring of 1999 after an overdose of codeine Tylenol.¹²² As a result of this episode, she was taken to a non-university hospital where she was treated for a week.¹²³ During her treatment, Elizabeth acknowledged that she suffered from mental illness and engaged in cutting prior to college.¹²⁴ An MIT administrator notified the Shin family that Elizabeth had been admitted to the hospital.¹²⁵ The family visited and, following a recommendation from clinicians at the hospital, Shin’s father brought her to a psychiatrist at the MIT mental health services department.¹²⁶

The initial trip to the hospital and subsequent meeting with MIT staff initiated a long, complicated, and painful series of interactions with Elizabeth. During her time at MIT, she suffered academic difficulty, relationship difficulty, dormitory

116. See, e.g., *Mullins v. Pine Manor Coll.*, 449 N.E.2d 331 (Mass. 1983).

117. No. 02 0403, 2005 WL 1869101 (Mass. Super. Ct. June 27, 2005) (memorandum and order on defendants’ motion for summary judgment).

118. *Id.* at *12–14.

119. *Mahoney v. Allegheny Coll.*, No. AD 892-2003 (Pa. Ct. Com. Pl. Dec. 22, 2005).

120. Initially, the Shin family argued that the death of their daughter was a suicide. See *Shin*, 2005 WL 1869101, at *1. However, when the case ultimately settled, the Shins asserted that Elizabeth’s death was accidental. See Eric Hoover, *In a Surprise Move, MIT Settles Closely Watched Student-Suicide Case*, CHRON. HIGHER EDUC. (Wash., D.C.), Apr. 14, 2006, at A41.

121. *Shin*, 2005 WL 1869101, at * 1.

122. *Id.*

123. *Id.*

124. *Id.* “Cutting” is the practice of deliberately cutting one’s own skin with a sharp object.

125. *Id.*

126. *Id.*

issues, and had multiple interactions with administrators and clinical staff.¹²⁷ Her suicidal propensities became known to a number of MIT personnel, and, at certain points, effort was expended to determine whether she was acutely suicidal.¹²⁸

Early in the morning on April 10, 2000, students in Elizabeth's residence hall notified an administrator that Elizabeth indicated to them that she "planned to kill herself that day."¹²⁹ The administrator contacted the MIT mental health center and spoke with a psychiatrist that had worked with Elizabeth.¹³⁰ The psychiatrist was not as alarmed as the administrator and directed the administrator to "check on" Elizabeth but not to bring her to the medical center because the psychiatrist had received assurances from Elizabeth that she was fine and that "her friends had overreacted."¹³¹ The administrator found Elizabeth sleeping at approximately 6:30 AM, and, later, had a conversation with her just before 10:00 AM.¹³² The conversation was accusatory and disturbing, prompting the administrator to contact another psychiatrist regarding Elizabeth.¹³³

A previously scheduled meeting between the deans and mental health professionals occurred on the morning of April 10 with several deans and mental health professionals attending.¹³⁴ The meeting attendees reviewed Elizabeth's situation.¹³⁵ There was some dispute as to what exactly occurred at the meeting and what information individual attendees possessed,¹³⁶ but, at the conclusion of the meeting, an appointment was made for Elizabeth to receive further treatment.¹³⁷ Elizabeth was informed of this new appointment by a message left on her answering machine.¹³⁸ Apparently, no one made direct contact with her later that day.¹³⁹ Just before 9:00 PM, students in Elizabeth's residence hall heard the "smoke alarm sounding in Elizabeth's room."¹⁴⁰ Campus police and the local fire department quickly responded and broke open her dormitory door, only to find her in flames.¹⁴¹ Emergency response and subsequent hospitalization failed and Elizabeth Shin died in the early morning of April 14.¹⁴² A medical examiner later determined her cause of death was "self-inflicted thermal burns."¹⁴³

127. *See id.* at *2–5.

128. *See id.*

129. *Id.* at *5.

130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.*

134. *Id.* This meeting was commonly referred to as the "deans and psychs" meeting. *Id.*

135. *Id.*

136. *Id.*

137. *Id.*

138. *Id.*

139. *Id.*

140. *Id.*

141. *Id.*

142. *Id.* at *6.

143. *Id.* Others concurred that Elizabeth's death was a suicide as well. *See id.* When the Shin family settled with MIT for an undisclosed sum, Elizabeth's father stated in a written statement that her death was "likely a tragic accident." *See* Eric Hoover, *supra* note 120.

Ruling on MIT's motion for summary judgment, the *Shin* court rendered a complex and somewhat surprising decision. The court granted MIT's motion for summary judgment to the Shins' claim for breach of contract.¹⁴⁴ The court also granted summary judgment to MIT for the Shins' claim under a Massachusetts statute relating to trade and commerce.¹⁴⁵ With respect to MIT's medical professionals, the decision granted summary judgment to MIT for the Shins' claim under Massachusetts' consumer protection statute for negligent delivery of medical care.¹⁴⁶ It also granted summary judgment with respect to the Shin family's claim for negligent infliction of emotional distress.¹⁴⁷

However, the court was unwilling to grant summary judgment with respect to gross negligence claims.¹⁴⁸ As the court stated:

The Plaintiffs argue that the MIT medical professionals individually and collectively failed to coordinate Elizabeth's care. As a "treatment team," the professionals failed to secure Elizabeth's short-term safety in response to Elizabeth's suicide plan in the morning hours of April 10. During the "deans and psychs" meeting on the morning of April 10, plans to assist Elizabeth were discussed, however, an immediate response to Elizabeth's escalating threats to commit suicide was not formulated. By not formulating and enacting an immediate plan to respond to Elizabeth's escalating threats to commit suicide, the Plaintiffs have put forth sufficient evidence of a genuine issue of material fact as to whether the MIT Medical Professionals were grossly negligent in their treatment of Elizabeth.¹⁴⁹

The court focused heavily upon intervention responses; Shin may have needed more urgent care.¹⁵⁰

Of course, simply because the matter created a triable issue of fact in the eyes of the court does not mean MIT medical professionals committed some form of "gross negligence." Nonetheless, because many administrators would prefer avoiding trial on issues involving care, denying summary judgment in a situation like this is *almost* like losing the case. Lawyers, of course, recognize the case is far from over, but, for clients, being forced to try issues of fact is often viewed as a loss. Lost time, increased cost, elevated stress, and the high scrutiny occurring in trial litigation all are significant.

Thus, although there was no determination of liability in the case, administrators will likely look for guidance from this particular "procedural" determination. Clients will naturally seek to behave in ways that allow them to *win* summary judgment, even if they are not able to articulate this desire the way trained lawyers would. What administrators might glean from the *Shin* court's

144. *Shin*, 2005 WL 1869101, at *8.

145. *Id.*

146. *Id.* at *9.

147. *Id.* at *9–11.

148. *Id.* at *8–9.

149. *Id.* at *9.

150. *See id.*

unwillingness to grant summary judgment at this stage in the proceedings is that the court may have been concerned that mental health professionals and others allowed regularly scheduled meetings to drive response coordination, as opposed to the specific needs of an individual student. For example, it may have been necessary for “deans and psychs” or others to meet again as a group either in person or by phone later in the day. Moreover, the court’s summary judgment ruling may also signal to administrators and others around the country that closer contact with a student in peril may be appropriate. For example, merely leaving a telephone message for a suicidal student may not be enough even if there is disagreement among treatment professionals regarding the acuteness of the suicide risk. Again, much of this is left to speculation. The case would have been much more helpful in guiding administrators had it been a decision after trial in post-trial motions on determined facts.

One medical health professional independently moved for summary judgment essentially arguing that no sufficient physician/patient relationship had formed to create a duty.¹⁵¹ However, the court was unwilling to grant this health professional summary judgment because the mental health professional was “part of the ‘treatment team.’”¹⁵² The court concluded there was sufficient evidence to raise an issue “as to whether [the health professional] was part of the ‘treatment team’ treating Elizabeth at the time of the suicide; thereby establishing a physician-patient relationship at the time of Elizabeth’s suicide.”¹⁵³ Thus, a mental health professional who is not a primary care deliverer, and even one who has never met a patient face to face, may be asked to explain his or her conduct at trial. Understanding that many colleges and universities around the country now have risk-management or other assessment teams means that membership on this team itself potentially implicates health care professionals.

In a sense, *Shin* seems to treat Elizabeth’s suicide as an issue of mental health care responsibility, as if arising under medical malpractice law. In a surprising move, however, the court indicated that individual administrators at MIT might themselves be liable for the wrongful death of Shin.¹⁵⁴

Certain administrators argued they had no duty to Elizabeth.¹⁵⁵ As non-treating non-clinicians they argued “persons who are not treating clinicians have a duty to prevent suicide only if (1) they caused the decedent’s uncontrollable suicidal condition, or (2) they had the decedent in their physical custody, such as a mental hospital or prison, and had knowledge of the decedent’s risk of suicide.”¹⁵⁶ The court quickly pointed out that neither of these situations occurred, and, therefore, no duty arose under those conditions.¹⁵⁷ The court went on to note that Section 314(a) of the RESTATEMENT (SECOND) OF TORTS recognizes special relationships can exist in certain circumstances beyond the two situations presented by MIT

151. *Id.* at *11.

152. *Id.*

153. *Id.*

154. *Id.* at *14.

155. *Id.* at *11.

156. *Id.*

157. *Id.*

administrators.¹⁵⁸ Quoting from Section 314A the court stated:

This Section states exceptions to the general rule, stated in § 314[,] that the fact that the actor realizes or should realize that this action is necessary for the aid and protection of another does not in itself impose upon him any duty to act. The duties stated in this Section arise out of special relationships between the parties, which create a special responsibility, and take the case out of the general rule. The relations [common carrier, innkeeper, land owner, one who is required by law or voluntarily takes custody of another] are not intended to be exclusive, and are not necessarily the only ones in which a duty of affirmative action for the aid and protection of another may be found . . . The law appears, however, to be working slowly toward a recognition of the duty to aid or protect in any relation of dependence.¹⁵⁹

Thus, the court correctly pointed out that special relationship analysis under Section 314 was intended to have an open-ended and evolving quality.¹⁶⁰

In considering several precedents imposing an affirmative duty, the court pointed to numerous instances in which administrators were made aware of Elizabeth's "self-destructive behavior."¹⁶¹ The court went on to state that there was sufficient evidence to show that certain administrators "could reasonably foresee that [Elizabeth] would hurt herself without proper supervision. Accordingly, there was a 'special relationship' between [certain MIT administrators] and [Elizabeth] imposing a duty on [those administrators] to exercise reasonable care to protect [Elizabeth] from harm."¹⁶² Moreover, the court refused to grant summary judgment in favor of certain MIT administrators because they became "actively a part of [Elizabeth's] 'treatment team.'"¹⁶³ The court stated:

[T]he . . . administrators failed to secure [Elizabeth's] short-term safety in response to [her] suicide plan in the morning hours of April 10. By not formulating and enacting an immediate plan to respond to

158. *Id.* at *12.

159. *Id.* (alterations in original).

160. Some courts seem to overlook and neglect this feature of special relationship analysis. In the recent case of *Iseberg v. Gross*, 879 N.E.2d 278 (Ill. 2007), the Illinois Supreme Court refused to find a special relationship when a victim of a shooting sued former business partners of an attacker who allegedly failed to warn him that a former investor had made threats against the victim's life. *Id.* at 292. In refusing to recognize a duty to prevent or warn of such an attack, the court analyzed Section 314 but mistakenly limited special relationships to the four specifically named special relationships contained within. *See id.* at 284–85. Somehow, the court completely ignored the language in Section 314 that points to the adoption of special relationships beyond those enumerated. The court relied heavily on the doctrine of *stare decisis*, but the flaw in the court's reasoning is apparent: by previously relying upon Section 314 and special relationship analysis, the court had already opened the door to the possibility it would expand special relationships beyond those enumerated. Although the result of the case may be correct, the reasoning is somewhat suspect.

161. *Shin*, 2005 WL 1869101, at *13.

162. *Id.*

163. *Id.* at *14.

[Elizabeth's] escalating threats to commit suicide, the Plaintiffs have put forward sufficient evidence of a genuine issue of a material fact as to whether the MIT administrators were grossly negligent in their treatment of [Elizabeth].¹⁶⁴

However, following its own path with respect to MIT and the health care providers, the court refused to recognize negligent infliction of distress or negligent misrepresentation claims against these administrator defendants.¹⁶⁵

The decision is, to say the least, somewhat confusing. There is nothing remarkable about the *Shin* summary judgment ruling to the extent that it holds medical health care providers have a duty when participating in treatment planning or providing direct treatment service. The remarkable feature of *Shin* is that non-health care administrators can be brought to trial for their participation in a treatment plan process as well. Although this was not explicitly contained in the decision, and may not be true, *Shin* leaves the distinct impression that by participating in an intervention planning process involving mental health care, administrators may be brought into some form of hybrid malpractice responsibility. Indeed, it is hard to avoid the comparison to hospital administrators in cases involving medical negligence. But, even if administrators do not actively participate in intervention planning, the *Shin* court held that an affirmative duty to act on behalf of a student may still exist. The *Shin* court seemed to rely heavily upon the indicia of foreseeability. This analysis of why certain administrators should become individually responsible is particularly interesting because Section 314 of the RESTATEMENT (SECOND) OF TORTS specifically states that foreseeability alone does not create an affirmative duty. However, Section 314 does indicate that relations of dependence may change the result. Nonetheless, the court seemed to focus more upon foreseeability than dependence in the facts giving rise to denying the administrators' motions for summary judgment. Thus, *Shin* may represent a significant extension of affirmative responsibility, one that other courts may be chary to follow.¹⁶⁶

To the extent *Shin* holds that foreseeability alone can create a duty to prevent a student suicide, it would be a novel and very broad departure from existing law. It is also interesting that the court did not engage in an analysis of whether or not MIT administrators had assumed a duty to Elizabeth by their involvement with her.

164. *Id.* Similarly, the court refused to grant summary judgment in favor of the administrators with respect to the negligence/wrongful death and conscious pain and suffering counts. *Id.*

165. *Id.* at *14–15.

166. See, e.g., *Mahoney v. Allegheny Coll.*, No. AD 892-2003 (Pa. Ct. Com. Pl. Dec. 22, 2005), where the court stated:

The *MIT* and *Ferrum* cases are factually distinctive in their neither precedential, nor non-persuasive finding of a “special relationship” and “imminent probability” of self-harm in consideration of the student’s [sic] assertions that they were going to kill themselves as well as their past and contemporaneous attempts to do so; such was within the knowledge of said college employees, as compared to Mahoney who despite a progressively deepening depression, had neither engaged in nor threatened any specific acts of self-harm.

Id. at 23.

The court never considered if the administrators had somehow increased the hazard to her with partial or incomplete interventions. Moreover, even though the court cited *Mullins v. Pine Manor College*,¹⁶⁷ it did not focus upon the land-owner relationship with respect to either MIT or its administrators. Instead, referencing *Irwin v. Town of Ware*,¹⁶⁸ the court placed heavy emphasis upon foreseeability as creating a duty.¹⁶⁹ Again, generally speaking, the law does not impose a duty simply from foreseeability alone, although foreseeability may be a prime determinant in whether a duty exists.¹⁷⁰

Shin's broad ruling suggests three possible, if inconsistent, hypotheses for why the court reached so broadly. First, perhaps *Shin* is nothing more than a trial court's decision in a case it believed would ultimately be decided in a court of last resort. Few observers believed that the case would settle at all, let alone as early in the proceedings as it did. If the court anticipated creating a record for appeal, it arguably makes judicial sense to allow a case to be tried and resolved in post judgment motions. Indeed, one principal contention in the case, that Elizabeth's death was not suicide, might have been better developed upon a full trial.

Second, possibly, *Shin* is reaching for the stars. In some quarters, there may be judicial intuition that, at least in some cases, foreseeability should be a prime determinant in deciding whether or not a duty exists. But, certainly, at least with respect to cases involving suicide, a rule establishing responsibility to prevent suicide based on mere foreseeability would be a very significant expansion in existing case law. (In suicide cases, furthermore, over-use of foreseeability might breed strange arguments of comparative fault to the effect that parent plaintiffs knowing of their son's or daughter's propensities for suicide might be partially to blame for the very injuries with respect to which they are suing.)

Third, *Shin* might also be expressing, intuitively, the idea that as foreseeability becomes more important, and countervailing policy considerations wane, a duty of care to intervene and protect may be more appropriate. For example, in the *Shin* matter, privacy arguments were weak, especially by April 10. Elizabeth had already consented to share certain information and had engaged in a variety of public behaviors, making her issues far from private. Moreover, to the extent that Elizabeth asserted some concern about others interfering with her, these statements were themselves evidence of her very problem: suicidal people often resist intervention even at the time of imminent crisis.¹⁷¹ Any assertions of privacy at this point trail into admissions of danger. The law has always had an instinct to consider the responsibility of parties or individuals who had the last, best chance to stop serious injury or damage from occurring.¹⁷²

167. 449 N.E.2d 331 (Mass. 1983).

168. 467 N.E.2d 1292 (Mass. 1984).

169. *Shin*, 2005 WL 1869101, at *12.

170. See, e.g., *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 342-43 (Cal. 1976).

171. Mayo Clinic Staff, *Suicide: Understand Causes, Signs, and Prevention*, Apr. 14, 2006, <http://mayoclinic.com/health/suicide/MH00053>.

172. This is sometimes referred to as the last clear chance doctrine. See *DIAMOND*, *supra* note 115, at 408-11, 590. Although not a bright line rule by any means, the fact that individuals had become situated to be in the best position to take care and avoid injury or danger is a factor to

Foreseeability becomes particularly salient in situations where a particular individual becomes a high risk. The vast majority of students glide through college with few problems, if any. But, a small percentage of students occupy a great deal of administrative time and cause administrators and others a great deal of concern. These individuals are often involved in repeated interventions (or should be) and, essentially, elect themselves to a class of individuals for whom administrators may be required to take extra care. Compare *Mullins v. Pine Manor College*, in which a student was a victim of background crime,¹⁷³ to a situation like *Shin*, where Elizabeth was not the victim of general background conditions, but was herself a particularized and known risk. This was also the case with Seung Hui Cho, the attacker at Virginia Tech in April 2007.¹⁷⁴ Cho exhibited a number of negative behaviors and issues before becoming a shooter.¹⁷⁵ Although it may not have been foreseeable that Cho would become a murderer, it was arguably foreseeable that he would be problematic and possibly dangerous.

It is an odd situation indeed when an actor or institution takes many steps to protect or assist an individual, and later asserts those efforts did not, as a matter of law, require reasonable care. This is especially true in situations where highly foreseeable dangers arise. These situations are very different from those where a defendant must exert unusual effort to assist others, or where a claim was made that an actor should engage in efforts to determine whether someone requires assistance in the first place. The duty determination is not black and white—there is a small gray area between a situation where an actor assumes a duty (or an actor increases the risk of harm through behavior), and a situation where an actor merely engages in beneficial conduct towards a dangerous or endangered individual. *Shin* is exactly that case. The *Shin* court did not consider issues of assuming a duty or creating a hazard and there are solid arguments to be made that neither situation occurred. Nonetheless, the magic combination of gratuitous undertakings, a very high degree of foreseeability, and the absence of strong countervailing policy reasons for not imposing a duty, suggest the possibility that *Shin*'s result is not so unusual.

In the end, however we interpret the *Shin* decision, the settlement of the matter deprived higher education of the possibility of a very clear directive in an all too common scenario. The *Shin* decision is, after all, an intermediate appellate court decision and has limited precedential value. In other jurisdictions that do not have a clear directive, it is likely administrators will behave as if such rulings are possible and operate with reasonable care when a student foreseeably endangers self or others. Moreover, the *Shin* decision does, at least, offer a nugget of wisdom to the effect that intervention processes should be tailored to present needs and

consider. It is perhaps for this reason that the newest Restatement of Torts has acknowledged the possibility that the law may evolve to recognize a duty when a victim is in a remote location and the individual or small group of individuals is situated to effect a rescue. See RESTATEMENT (THIRD) OF TORTS: PHYSICAL HARM § 44, Reporters' Note cmt. d (Proposed Final Draft No. 1, 2005).

173. *Mullins v. Pine Manor Coll.*, 449 N.E.2d 331, 333 (Mass. 1983).

174. See GOVERNOR'S REPORT, *supra* note 14, at 5.

175. *Id.* at 52.

dangers. Higher education sometimes has a preference for routine meetings when danger is anything but routine. Even if there is a regular meeting such as the “deans and psychs” meeting at MIT, that meeting should not be the one and only opportunity for team members to collaborate, especially during crisis situations.

E. Virginia Tech

On April 16, 2007, David Cho killed thirty-two students and faculty members, and injured two dozen more before killing himself.¹⁷⁶ Cho had a long history of mental illness and had displayed “suicidal and homicidal ideations” as early as 1999 when he was in eighth grade.¹⁷⁷ Various individuals in different capacities had a great deal of information regarding Cho prior to the shootings, but that information was never collected, synthesized, and analyzed by individuals who might have been in a position to prevent the tragedy.¹⁷⁸ The events at Virginia Tech may not illustrate a failure of an academic environment so much as opportunities for one. Virginia Tech illustrates, among other things, the need and opportunity for better information collection, transmission, collation, synthesis, and analysis.

The events at Virginia Tech and subsequent reports are important to suicide prevention and suicide prevention law.¹⁷⁹ As of February of 2008, there have been three major reports on the Virginia Tech incident: (1) INVESTIGATION OF APRIL 16, 2007, CRITICAL INCIDENT AT VIRGINIA TECH, (“INSPECTOR GENERAL REPORT”);¹⁸⁰ (2) REPORT TO THE PRESIDENT ON ISSUES RAISED BY THE VIRGINIA TECH TRAGEDY (“PRESIDENT’S REPORT”);¹⁸¹ and (3) MASS SHOOTINGS AT VIRGINIA TECH (“GOVERNOR’S REPORT”).¹⁸²

The reports on Virginia Tech are not court cases, nor are they legislation or official regulation. For example, the GOVERNOR’S REPORT contains critical statements that may suggest campus police were negligent in their response to the initial reports of a shooter on campus.¹⁸³ However, should the victims or any of their families sue, a jury might disagree with the GOVERNOR’S REPORT. Thus, the various reports do not have force of law in the usual sense. Nonetheless, they are very helpful in illustrating potential areas for future development of the law.

Collectively, the reports repeatedly return to a common theme. Over and over again, both in terms of particular recommendation and general observation, the reports point to opportunities to improve communication on campus and among various actors in the campus community. For example, the INSPECTOR GENERAL REPORT recommends reviewing procedures to insure notification occurs very quickly after an emergency custody period has been initiated for a student

176. INSPECTOR GENERAL REPORT, *supra* note 14, at 3.

177. See GOVERNOR’S REPORT, *supra* note 14, at 21.

178. *Id.* at 21–24.

179. Many of these implications are beyond the scope of this article.

180. INSPECTOR GENERAL REPORT, *supra* note 14.

181. PRESIDENT’S REPORT, *supra* note 14.

182. GOVERNOR’S REPORT, *supra* note 14.

183. *Id.* at 25.

suffering a psychiatric emergency.¹⁸⁴ The PRESIDENT'S REPORT focuses upon five "recurring and interconnected themes,"¹⁸⁵ two of which are "Critical Information Sharing Faces Substantial Obstacles" and "Improved Awareness and Communication are Key to Prevention."¹⁸⁶ With respect to critical information sharing, the PRESIDENT'S REPORT emphasizes frequent reports of "information silos" and expresses concern regarding the ways in which the interpretations of federal and state privacy laws may block the flow of critical information.¹⁸⁷ The PRESIDENT'S REPORT also focuses on improved communication and awareness. It states:

Recognizing that there were warning signs that preceded many school violence incidents, participants in our meetings discussed ways to address school cultures, including tacit "codes of silence," that may impede identifying and responding to those in crisis. Students may know of someone in need or someone who has made a threat, but frequently they do not share that information with individuals who can take appropriate action. Participants stressed the need to promote cultures of trust, respect, and open communication, to reduce student isolation, to normalize the act of seeking help by and for those who pose a threat to self or others, and to de-stigmatize mental illness. Underscoring the theme that information sharing is key, participants repeatedly identified the need for communication strategies that build bridges between education and mental health systems.

Participants in our meeting also focused on promoting prevention and early intervention.¹⁸⁸

Based on the information gathered the PRESIDENT'S REPORT develops specific

184. INSPECTOR GENERAL REPORT, *supra* note 14, at 15.

185. PRESIDENT'S REPORT, *supra* note 14, at 6.

186. *Id.*

187. *Id.* at 7. As the report stated:

We repeatedly heard reports of "information silos" within educational institutions and among educational staff, mental health providers, and public safety officials that impede appropriate information sharing. These concerns are heightened by confusion about the laws that govern the sharing of information. Throughout our meetings and in every breakout session, we heard differing interpretations and confusion about legal restrictions on the ability to share information about a person who may be a threat to self or to others. In addition to federal laws that may affect information sharing practices, such as the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and the Family Educational Rights and Privacy Act (FERPA), a broad patchwork of state laws and regulations also impact how information is shared on the state level. In some situations, these state laws and regulations are more restrictive than federal laws.

A consistent theme and broad perception in our meetings was that this confusion and differing interpretations about state and federal privacy laws and regulations impede appropriate information sharing.

Id. Similar observations occurred in the GOVERNOR'S REPORT. See GOVERNOR'S REPORT, *supra* note 14, at 63. Analysis of complex state and federal privacy laws and their impact upon college suicide law are beyond the scope of this article.

188. PRESIDENT'S REPORT, *supra* note 14, at 12.

recommendations for colleges and universities. Among its most important recommendations was that colleges and universities should:

Develop cultures within schools and institutions of higher education that promote safety, trust, respect, and open communication. Create environments conducive to seeking help and develop culturally appropriate messages to de-stigmatize mental illness and mental health treatment.

Educate and train parents, teachers, and students to recognize warning signs and other known indicators of violence and mental illness and to alert those who can provide for safety and treatment.

Establish and publicize widely a mechanism to report and to respond to reported threats of violence.¹⁸⁹

Coupling these observations and recommendations with the federal report's emphasis on information siloing, that report obviously points to a needed administrative culture shift in higher education towards better information sharing, transfer, collation, and information-based action.

The GOVERNOR'S REPORT makes similar statements. For example, it states that Virginia Tech officials misperceived information sharing law and wide-spread confusion about privacy law is common among colleges and universities.¹⁹⁰ In a notable section of the report entitled "Missing the Red Flags," the GOVERNOR'S REPORT states:

The Care Team at Virginia Tech was established as a means of identifying and working with students who had problems. That resource, however, was ineffective at connecting the dots or heeding the red flags that were so apparent with Cho. They failed for various reasons, both as a team and in some cases in the individual offices that make up the core of the team.

Key agencies that should be regular members of such a team are instead second tier, non-permanent members. One of these, the VTPD, knew Cho had been cautioned against stalking—twice, that he had threatened suicide, that a magistrate had ordered a temporary detention order, and that Cho spent a night at St. Albans as a result of such detention order. The Care Team did not know the details of all these occurrences.

Residence Life knew through their staff (two resident advisors and their supervisor) that there were multiple reports and concerns expressed over Cho's behavior in the dorm, but this was not brought before the Care Team. The academic component of the university spoke up loudly about a sullen, foreboding male student who refused to talk, frightened classmates and faculty with macabre writings, and refused faculty exhortations to get counseling. However, after Judicial

189. *Id.*

190. GOVERNOR'S REPORT, *supra* note 14, at 2.

Affairs and the Cook Counseling Center opined that Cho's writings were not actionable threats, the Care Team's one review of Cho resulted in their being satisfied that private tutoring would resolve the problem. No one sought to revisit Cho's progress the following semester or inquire into whether he had come to the attention of other stakeholders on campus.

The Care Team was hampered by overly strict interpretations of federal and state privacy laws (acknowledged as being overly complex), a *decentralized corporate university structure*, and the absence of someone on the team who was experienced in threat assessment and knew how to investigate the situation more broadly, checking for collateral information that would help determine if this individual truly posed a risk or not.¹⁹¹

The statements are striking in their critical tone (keeping in mind that the report is not a jury verdict or legal determination of negligence or fault). They are especially important in the themes they develop. The GOVERNOR'S REPORT, like the PRESIDENT'S REPORT, points to falsely perceived information barriers, a culture of information non-sharing, and administrative governance structures not designed to promote information sharing.

Although the reports raise many different issues, one issue for suicide prevention law that clearly emerges is the need to improve information sharing, transfer, collation, synthesis and information-based action. As the GOVERNOR'S REPORT hints, some of the problem in higher education lies with the very administrative structures in which it operates. Higher education is not designed to be a rapid response institution—quite the contrary. As a result, higher education's organizational models tend to work against the very needs that arise in critical incident response and prevention. Moreover, higher education institutions remain highly political in internal operation. Competition among departments, fear of responsibility, a desire to blame others, and often false hopes that ignoring a problem will make it go away while in a specific department—all contribute to an overall environment in which rapid response to critical incidents is not encouraged. As a result of the Virginia Tech incident, and perhaps despite the inconclusive nature of court decisions to date regarding the issue of student suicide and self-inflicted injury, colleges and universities around the country should critically examine their organizational structures.

These points could be lost in the rapid effort to improve critical incident response. Simply forming critical incident response teams may not be enough. In other words, creating an autonomous team within higher education charged with the mission of critical incident response may not itself generate the culture necessary for the team to function effectively. For example, if students, faculty, and others do not share information with team members, the team will not be in possession of the information critical for effective action. The events at Virginia Tech illustrate the fact that every individual in the higher education environment plays a role in gathering and recognizing information that should be shared with

191. *Id.* at 52 (emphasis added).

others. Unfortunately, a culture promoting a “protect your turf” mentality could result in vast over-sharing of information by individuals who are attempting only to move a problem out of their area. To the extent this happens on a campus, it illustrates that the Virginia Tech reports’ recommendations have not yet been implemented.

An appropriate culture is neither a tattletale culture nor an informant culture. Instead, it is one where individuals share information when that information would cause a reasonable person to share information or otherwise trigger an intuition or instinct that something is awry or dangerous. The particular facts regarding Seung Hui Cho show it may not be essential for each and every person who had a contact with him to share information for the big picture to emerge. Occasionally, it will be one puzzle piece among a thousand others that is the exact piece of information putting the puzzle together. However, most homicidal, suicidal, or otherwise dangerous students are train-wrecks, demonstrating numerous problems evidenced in a variety of situations, such as in the classroom or with roommates. In other words, there is ample over-determining information of a problem available through multiple sources. For example, Cho’s complete residential hall profile was needed before rational observers could see some of his behavior raised red flags.

Events at Virginia Tech also illustrate another issue beyond the issue of critical information sharing, collation, synthesis, and action. Homicide and suicide all too often occur together.¹⁹² Although recent decisional law in the college and university environment does not illustrate this directly, colleges and universities must acknowledge the risk that self-harming individuals will harm others. Such a risk presents itself in at least two forms. First, an individual might negligently or otherwise cause injury to others while attempting self-harm. For example, in *Jain v. Iowa*¹⁹³ and *Shin*¹⁹⁴, it is somewhat miraculous that other students were not harmed: Jain succeeded in killing himself through carbon monoxide poisoning in his room¹⁹⁵ and Shin died by fire, also in her room.¹⁹⁶ Carbon monoxide and fire have traditionally been enormous risks to residential facilities, including college and university facilities. In both situations, wrongful death or serious injury lawsuits were averted simply because emergency response, or other factors, prevented injury to third parties. Second, as illustrated by events at Virginia Tech, an individual may be both homicidal and suicidal. In this situation, a college or university faces a risk of responsibility not simply for preventing suicide, but also for preventing deadly violence.

It has been well established since *Mullins v. Pine Manor* that colleges and universities owe a duty of care to protect students on campus from foreseeable violent attack.¹⁹⁷ Often, cases involving criminal attacks on campus arise from a

192. VIOLENCE POLICY CENTER, AMERICAN ROULETTE: MURDER-SUICIDE IN THE UNITED STATES 11, available at <http://www.vpc.org/studies/amroul2006.pdf>.

193. 617 N.W.2d 293 (Iowa 2000).

194. *Shin v. Mass. Inst. of Tech.*, No. 02 0403, 2005 WL 1869101 (Mass. Super. Ct. June 27, 2005).

195. *Jain*, 617 N.W.2d at 296.

196. *Shin*, 2005 WL 1869101 at *5–6.

197. *Mullins v. Pine Manor Coll.*, 449 N.E.2d 331 (Mass. 1983); Peter F. Lake, *The Rise of*

general risk of criminal behavior in the area.¹⁹⁸ After Virginia Tech, campuses may now recognize that a background responsibility to use reasonable care to protect against foreseeable criminal violence is not identical to a responsibility to use reasonable care to protect against violence arising from an individual known or expected to be dangerous. In other words, a college or university must use reasonable care to protect against foreseeable non-specific risks, such as the general risk of a type of crime that has occurred in the area in the past, and/or must use reasonable care to protect against risks arising from a foreseeably dangerous individual. Such a responsibility can arise in one of two ways. On one hand, to the extent an institution has charge or control over a dangerous individual, the relationship with the dangerous individual alone may create a duty to protect others from foreseeable danger.¹⁹⁹ College and university students, however, are rarely under such charge and control, and courts are loath to expand this type of special relationship to broader circumstances.²⁰⁰ Nonetheless, such a duty is not simply an incident arising from a relationship *vel non* with a dangerous person. Instead, the responsibility to prevent foreseeable danger from a particular individual can arise from relationships with potential *victims* because of a special relationship with them. Thus, for example, students in residential facilities and students on campus often stand in a commercial or business invitor/invitee, landlord/tenant relationship with institutions sufficient to create a duty to protect them from foreseeable violence in a general and particular sense. Colleges and universities must contend with the fact that attempted or successful suicides are not simply self-harming acts, and liability may exist for the negligent or intentional injuries caused to others. Duty in these situations arises largely from foreseeability and the standard of reasonable care. To the extent that a jury conforms its determinations to statements made in sections of the GOVERNOR'S REPORT, for example, liability might be hard to avoid.²⁰¹

Thus, the events at Virginia Tech and the reports that followed, suggest a need for American higher education to re-conceive its organizational approach to information gathering, sharing, collation, synthesis, and action. Moreover, the need for this shift occurs precisely because of the potential for responsibility for self-inflicted injury, but more precisely because self-harming behavior does not occur in a vacuum and often results in serious injury or death to others. Until the events at Virginia Tech unfolded, it was common to discuss self-inflicted injury situations from the troubled student's point of view. Suicide and self-harming

Duty and the Fall of In Loco Parentis and Other Protective Tort Doctrines in Higher Education Law, 64 MO. L. REV. 1 (1999); Michael Clay Smith, *Institutional Liability Resulting From Campus Crime: An Analysis of Theories of Recovery*, 55 EDUC. L. REP. 361 (1989).

198. See, e.g., *Mullins*, 449 N.E.2d 331.

199. *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334 (Cal. 1976); see also *Mahoney v. Allegheny Coll.*, No. AD 892-2003 (Pa. Ct. Com. Pl. Dec. 22, 2005).

200. See *Iseberg v. Gross*, 879 N.E.2d 278, 292 (Ill. 2007) (finding no special relationship between dangerous person and former business associates sufficient to impose duty to warn third party of dangerous person).

201. Recall these statements were not statements regarding fault under a negligence standard nor were they determinations by a court or a special verdict by a jury. As such, they are not binding, and most likely not even admissible or probative in a court case.

issues were lumped into self-harm categories and were often dealt with under the rubric of preventing harm to the individual. After Virginia Tech, the luxury of compartmentalizing self-harming situations is no longer available.

CONCLUSION

Much has happened, and much more has not happened, regarding the law of responsibility for college student suicide in the past six years. A dearth of judicial precedent, coupled with the fact that much of the decisional law comes from lower courts and incomplete litigations, means that specific legal guidance regarding the duty to prevent college and university student suicide is very sparse. There is something for everyone under the current judicial precedent. Those who wish to avoid legal responsibility for student suicide have precedent to support their position. Those who believe such a duty exists also have precedent to back their position. No clear line of authority has developed for most colleges and universities, and only a few states have directly relevant precedent. In the field of tort law generally, there has been a slow evolution towards rules requiring more responsibility to prevent suicide, but many matters presented to courts regarding college and university student suicide ask courts to develop suicide law in ways that heretofore they have not.

Perhaps we should be content with small lessons. For example, *Mahoney* teaches that colleges and universities may not be required to discover undiscoverable facts regarding students who lie or conceal information about their mental health status, intentions, etc. *Bash* underscores the reality that much self-inflicted harm from serious drug usage is unpreventable, especially at point of use. *Shin* teaches that risk management teams should be adaptable to the needs of an individual student and not simply rely upon routine meetings to solve issues.

On the other hand, perhaps we should not be so comfortable with small messages. The events at Virginia Tech in April of 2007 stand in strange juxtaposition with the dearth and inconsistency of recent decisional law on college and university student suicide. Particularly, the GOVERNOR'S REPORT is critical and action-oriented in ways that many cases are not. Moreover, those events send a strong message that dramatic shifts in organizational strategies and attitudes towards responsibility for so-called "individual" self-harm must occur.

In the end, however, I detect three themes that have emerged from the case law and reports.

First, some of the facts of the cases suggest, and the events at Virginia Tech prove, that suicidal behavior puts others at risk and harms the academic environment. Suicide is no longer an individual problem.

Second, violence and suicide often go hand in hand, and violence can negligently or intentionally cause harm to others.

Third, the response to suicide risk must be holistic and environmental.

It is noteworthy that all three reports on Virginia Tech, especially the PRESIDENT'S REPORT and GOVERNOR'S REPORT, emphasize the need for multi-level action by actors from students to Congress. The reports illustrate the need for environmental action, collective response, and holistic solutions. More than ever,

preventing self-harm, and harm to others, requires rapid collection of, transmission of, synthesizing of, and acting upon information. There has been no point in American higher education history in which individual students, administrators, faculty, and others have carried so much responsibility and have had such an opportunity to prevent harm by sharing what they hear, see, and think. This is also a time, paradoxically, when there is a need not to over-share information and overreact. In a moment, students, faculty, administrators, and others, have become radically empowered as agents of safety on all American campuses. In the same moment, the exercise of judgment in not becoming a tattletale or snooper has never been more important. Administrators now walk the razor's edge, unsure of the legal consequences of falling.

To conclude, a word of caution. Critical incident prevention and response is certainly an important mission of the modern higher education environment. However, critical incidents, such as the one that occurred at Virginia Tech, are not as common as the ongoing risks on a day-to-day basis of college and university life.²⁰² Active shooters are rare; yet, everyday, high-risk alcohol use threatens academic communities. It would be wise to remember a simple formula first espoused by Justice Learned Hand in the *Carroll Towing* case: the B times P and L formula.²⁰³ This formula, restated for higher education, essentially encourages actors, including colleges and universities, to weigh the risks against the efforts they expend.²⁰⁴ We can assess risk by considering the fact that we should incorporate both the probability and the magnitude of potential harm and then weight the risk appropriately. From here we should be able to balance the burden to take precautions against the risk. Thus, a very low probability event, such as that which occurred at Virginia Tech, should be weighed against the unthinkable magnitude of the tragedy. This, in turn, would counsel that very significant effort should be directed to preventing such an incident and dealing with one in progress, though not all possible efforts, because there are many common risks of day-to-day college and university life that result in serious injury or academic risk. Persistent rates of high risk alcohol use, sexual assault, etc., undermine our educational communities on a daily basis. Virginia Tech is a call to action but should not be regarded as a complete re-prioritization of all of higher education's needs and goals. We may find that, in a balanced and measured approach to the entire academic environment, solutions are not as expensive, time-consuming, nor costly as we might think. Suicide and suicide/harming of others remain top issues for colleges and universities, but are not the only issues we face.

202. See GOVERNOR'S REPORT, *supra* note 14, at 14.

203. United States v. Carroll Towing Co., 159 F.2d 169, 173 (2d Cir. 1947).

204. The actual meaning of the terms is as follows: "[I]f the probability be called P; the injury, L; and the burden, B; liability depends on whether B is less than L multiplied by P: i.e., whether B [is] less than PL." *Id.* In other words, if the burden on the defendant is less than the cost of the injury to the plaintiff multiplied by the probability of that injury, then the defendant should, in principle, be liable to the plaintiff.