

# THE ACADEMY AND THE PUBLIC PERIL: MENTAL ILLNESS, STUDENT RAMPAGE, AND INSTITUTIONAL DUTY

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## INTRODUCTION: THE ACADEMY AND THE PUBLIC PERIL

### A. Surveying the Work: A View from the Top

This is the author's second article on rampage shootings in higher education.<sup>1</sup> As promised in the first, it points the way toward a model of duty to which academic institutions may be held accountable if they fail to prevent acts of extreme violence by students. It is framed in terms of the mental health aspects of the rampage phenomenon. The structure was suggested by a question raised at a meeting of the Board of Directors of a law school where the author presented her research in 2008, less than a year after the shooting at Virginia Tech: "A certain number of people are crazy enough to commit mass murder, and some of them end up in universities and professional schools. How can we be expected to do anything about that?"

The same question is asked, one way or another, in the corporate boardrooms of the academy whenever campus violence by students becomes an issue.<sup>2</sup> This article is a considered response. It shows why institutions of higher education can indeed be expected to do something

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1. See Helen de Haven, *The Elephant in the Ivory Tower: Rampage Shootings in Higher Education and the Case for Institutional Liability*, 35 J.C. & U.L. 503, 607-12 (2009).

2. In 1905, the President of the Massachusetts Institute of Technology wrote: The American university, whether supported by private gift or by the state, is conducted under an administrative system which approximates closer and closer as time goes on that of a business corporation. The administrative power is lodged in a small body of trustees or regents, who are not members of the university community. Henry S. Pritchett, *Shall the University Become a Business Corporation?*, THE ATLANTIC MONTHLY, Vol. 96: 289, 293 (Sept. 1905). It is with that historic trend in mind and to address those particular holders of administrative power that the adjective "corporate" is used in this article.

about specific manifestations of mental illness in the student body and why, if we do not take reasonable preventive measures, we should be held responsible for the violence that may result.

This article tells a number of true stories. In each, the facts are either adjudicated or otherwise officially reported. The strong narrative component is deliberate. Facts, as the common law process understands very well, are the essential organic soil of the growing and changing law. Moreover, detailed case studies are the best way of examining and drawing conclusions about rare events such as campus killings, about which there is insufficient empirical data.<sup>3</sup> Examining actual cases allows us to understand the subtle and intricate dynamics of campus organization and academic relationships that should determine the boundaries and the content of an institutional duty of care. Not knowing the relevant stories keeps us from seeing where our duty lies, because it permits continuing denial of the way things really are.

Each of the next three sections of this article is organized around one primary story. The first is the famous *Tarasoff* case<sup>4</sup> arising from the 1969 murder of an undergraduate student at Berkeley by a graduate student; the student killer had threatened to “get even with her” during a session with his university-employed psychiatrist several weeks earlier. The second story is the 1995 shooting spree at Chapel Hill by a law student who, as a condition of remaining enrolled, was taken for treatment to the university psychiatric clinic by a law school dean; his condition was misdiagnosed at the clinic, and the progression of his illness was not adequately monitored. The third story is the 2007 rampage at Virginia Tech by an undergraduate student whose teachers repeatedly voiced concerns to university administrators and mental health professionals about his obsession with violence and his extraordinary social behavior; yet, he was sent away without treatment or follow-up each time he presented himself at the university clinic. Other cases are examined briefly—in particular, four recent cases of campus suicide discussed in Section IV.C.

The Berkeley, Chapel Hill, and Virginia Tech killings present useful commonalities of fact: student murderers, mental health professionals, campus police actors, university health care services, and civil court actions. Each story forms the basis for exploring an aspect of tort duty—foreseeability, preventability, special relationships, voluntary undertakings—and for illustrating the weaknesses of the traditional tort model when applied to academic settings. The three cases are also logically related stepping stones from the past into the present. Educational institutions are not static entities, and the path to the duty charted here moves from the 1960s to arrive on today’s campus. Section IV of the

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3. See de Haven, *supra* note 1, at 516 n.27.

4. *Tarasoff v. Regents of Univ. of Cal.*, 108 Cal. Rptr. 878 (Cal. Ct. App. 1973) [*hereinafter Tarasoff*].

article provides an overview of change, as student rampages are becoming an increasingly foreseeable peril of academic life and as new resources are being developed for assessing and treating disturbed and disturbing students. Section IV ends by pointing toward a model of legal responsibility that supports the creation of safer academic spaces. The model emphasizes the prevention as well as the foreseeability of violent student behavior. It acknowledges the administrative relationships of campus organization. It reinforces the institution's capacity to communicate relevant information about disturbed students and to coordinate delivery of mental health services. The model respects the educational goals of inclusiveness and diversity in the student body, supports better training of faculty and staff in identifying and managing troubled and troubling students, and encourages college and university administrators to heed the warning signs of mental disturbance and to manage the situation promptly and effectively in ways that reduce the potential for violent outcomes.

In examining these narratives of violence and the lawsuits that resulted, the author's hope is that all of us, including our corporate directors, may come to understand why the academy should accept its inextricably intertwined, collectively-held legal duties: to provide effective treatment for mentally-ill students and to safeguard educational spaces against public displays of anti-institutional violence.

#### B. Choosing the Period: College in the 1960s

Between 1965 and 1972, when many of the current elders of the academic and legal professions were in college or post-graduate school, the United States experienced the worst period of turmoil, confrontation, and violence between students and institutions of higher learning since before the Civil War.<sup>5</sup> Many events of the late 1960s still darken the collective memory and influence current views of campus violence, but two of these events serve as points of departure because they engage the triple themes of madness, murder, and institutional mental health services. They are useful referents for the question that has been posed: what is the academy's duty, these days, if any, when it comes to extreme violence by students who are mentally ill?

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5. See, e.g., *The Report of the President's Commission on Campus Unrest* (1970) [hereinafter *The Scranton Report*], available at <http://www.eric.ed.gov/PDFS/ED083899.pdf> (last visited May 3, 2010); Alan E. Bayer & Alexander W. Astin, *Violence and Disruption on the U.S. Campus, 1968-1969*, 4 EDUC. REC. 337 (1969) (American Council on Education); CHRISTOPHER J. LUCAS, *AMERICAN HIGHER EDUCATION: A HISTORY* 275-283 (2d ed. 2006); MARK EDELMAN BOREN, *STUDENT RESISTANCE: A HISTORY OF THE UNRULY SUBJECT* 138-146, 171-183, 186-192 (2001).

### 1. Austin, Texas: The Sniper in the University Tower

In the first event, on August 1, 1966, Charles Whitman, an undergraduate student at the University of Texas, shot forty-two people from the observation deck of the University Tower at Austin.<sup>6</sup> Four months before the shooting, Whitman, a twenty-five year old former Marine sharpshooter, made a single, voluntary appointment with University of Texas Health Center staff psychiatrist M. D. Heatly.<sup>7</sup> At the time, Dr. Heatly noted his patient “had fantasized about ‘going up on the Tower with a deer rifle and shooting people.’”<sup>8</sup> He also observed that Whitman “seemed to be oozing with hostility.”<sup>9</sup> The psychiatrist made no formal threat assessment, prescribed no medication, and alerted no authorities.<sup>10</sup> He simply advised Whitman to schedule another appointment in a week and to call him in the meantime if he needed to talk.<sup>11</sup> Whitman never called and did not return.<sup>12</sup> Neither Dr. Heatly nor the University clinic ever attempted to follow up with him; nor did anyone at the clinic think to warn city or University officials that Whitman might pose a threat to community safety.<sup>13</sup>

Whitman’s sniper attack was the first and, for many years, the worst school shooting in United States history. Not until the Virginia Tech rampage in 2007 would another such act of mass violence result in so many casualties. The Texas Tower shooting realized a previously unthinkable assault on the safety and integrity of academic space. It shook the entire

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6. Marlee Mcleod, *Charles Whitman: The Texas Tower Sniper, Back in Austin*, [http://www.trutv.com/library/crime/notorious\\_murders/mass/whitman/austin\\_3.html](http://www.trutv.com/library/crime/notorious_murders/mass/whitman/austin_3.html). (last visited Jul. 21, 2009).

7. *Id.*

8. *Id.*

9. *Id.*

10. Whitman was prescribed Valium by another doctor and self-medicated with the amphetamine Dexedrine. *Id.*

11. *Id.*

12. *Id.*

13. The morning of the shooting, having killed his wife and mother, Whitman wrote:

[L]ately . . . I have been a victim of many unusual and irrational thoughts. These thoughts constantly recur, and it requires a tremendous mental effort to concentrate on useful and productive tasks. In March . . . I noticed a great deal of stress. I consulted a Dr. Cochran at the University Health Center and asked him to recommend someone that I could consult with about some psychiatric disorders I felt I had. I talked to a Doctor [Heatly] once for about two hours and tried to convey to him my fears that I felt come [sic] overwhelming violent impulses. After one session I never saw the Doctor again, and since then I have been fighting my mental turmoil alone, and seemingly to no avail.

Whitman’s letter dated July 31, 1966, is in the collection of the Austin History Center and can be accessed through [http://www.popsubculture.com/pop/bio\\_project/sub/whitman\\_letter.pdf](http://www.popsubculture.com/pop/bio_project/sub/whitman_letter.pdf) (last visited Jul. 21, 2009).

country at the time. It prompted the University of Texas to transform its campus security guards into a professional campus police force.<sup>14</sup> For many years it remained a singular trail marker on the long path of student violence through the groves of the academy. But it did not have a direct impact on legal relationships between a college or university and its students, or therapists and their patients. Whitman was thought to have chosen the tower for its height, not for its academic associations, and there was not the slightest suggestion in the public commentary that the psychiatrist had been in any way negligent.<sup>15</sup>

## 2. Berkeley, California: The Murder of Tatiana Tarasoff

It was a different matter three years later when a graduate student at the University of California at Berkeley, Prosenjit Poddar, murdered Tatiana (Tanya) Tarasoff, an entering undergraduate who had rejected his offer of marriage.<sup>16</sup> Like Whitman, several months before the murder, Poddar voluntarily sought psychiatric help at Berkeley's university clinic.<sup>17</sup> Like Whitman, Poddar confided to a psychiatrist, Dr. Warren Moore, that he was thinking of committing a specific violent act—"getting even with" Tanya Tarasoff.<sup>18</sup> Like Dr. Heatly at Texas, Dr. Moore at Berkeley recommended that his patient continue therapy.<sup>19</sup> Like Dr. Heatly, Dr. Moore did not

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14. University of Texas Science Center San Antonio, *UT Police History*, [http://utpolice.uthscsa.edu/aboutus\\_2.asp](http://utpolice.uthscsa.edu/aboutus_2.asp) (last visited Jun. 19, 2010). Until the 1960s the campus police at most colleges and universities, even public ones, acted as unarmed security guards with no actual police authority conferred by the state. DIANE C. BORDNER & DAVID M. PEARSEN, *CAMPUS POLICING: THE NATURE OF UNIVERSITY POLICE WORK* ix–xi (1983).

With the advent of student dissent, campus protest demonstrations, disruptive student activities, violence and increases in reported crime and fear of crime, an increasing number of educational institutions began replacing their line security officers with more educated and better trained police officers with police powers of arrest and duties to enforce state statutes on campus. The decision to professionalize the campus police was, in part, a direct result of the negative experiences with intervention of local police and national guardsmen on campus. During the era of student dissent, Kent State offers a vivid example. It was also recognized that if the university did not govern itself it would be governed by others who might be less responsive to the campus community. Thus, professional police departments began to emerge on college campuses during the 1960s and early 1970s . . .

*Id.* at xi. See also *infra* notes 109–10 and accompanying text; *infra* note 61.

15. Other than the inquest, no legal proceedings followed the shooting at the University Tower. The killer was dead, shot by the police, and no tort suits appear to have been filed against his estate, the University, or his psychiatrist.

16. *Tarasoff v. Regents of Univ. of Cal.*, 108 Cal. Rptr. 878, 880 (Cal. Ct. App. 1973).

17. Fillmore Buckner & Marvin Firestone, "Where the Public Peril Begins": 25 Years After Tarasoff, 21 J. LEGAL MED. 187, 193 (2000).

18. *Id.*

19. *Tarasoff*, 108 Cal. Rptr. at 880.

attempt to follow up when Poddar terminated the therapeutic relationship—indeed, he was prevented from doing so by his superior at the university clinic.<sup>20</sup> Nor did anyone associated with the clinic or the University warn Tanya Tarasoff that Poddar was talking about killing her—which he did, about two months after his last counseling session.<sup>21</sup>

The Berkeley murder on October 26, 1969, did not seize the public imagination to the same extent as the Texas University shooting, at least in part because it did not happen on campus. Nevertheless, when Tanya Tarasoff's parents successfully sued the therapists at Berkeley's hospital for neglecting to protect their daughter from harm, the killing resulted in a decision of major significance to institution-student relationships and the role of college and university mental health clinics in academic life.<sup>22</sup>

### C. Testing the Foundations: Violence, Madness, and the University

Two generations of students have occupied campuses since the Texas Tower shooting and the murder of Tatiana Tarasoff. Cultivating less in the way of collective protest or defiance, the groves of the academy now produce the strange fruit of the rampage shooting. Targeted school violence has been an alarming aspect of higher education since 1990, with the alarm sounding more and more often.<sup>23</sup> Even though the risk that a shooting will happen on any given campus at any particular time is remote, the academy is right to be alarmed. However infrequently it occurs, the rampager's assault is shocking and deeply destructive to the whole educational body. The merciless gunner, aiming to kill defenseless faculty and students, strikes terror both in the heart of the educational enterprise and at its higher centers. Though the horrific event typically produces an immediate surge of cohesive and restorative spirit, a campus shooting also leaves deep and lasting scars of dread, anxiety, and distrust among the members of the community.<sup>24</sup> Ensuring that campuses are safe from murderous insiders as best we can is appropriately the concern of the whole

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20. See *infra* text accompanying note 54.

21. *Tarasoff*, 108 Cal. Rprt. at 881.

22. *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334 (Cal. 1976) [*hereinafter Tarasoff II*]. The *Tarasoff* facts and decisions are discussed at greater length in Section I *infra*.

23. As used in this article, “targeted school violence” comprises “school shootings and other school-based attacks where the school was deliberately selected as the location for the attack and was not simply a random site of opportunity . . . . In the case of targeted school violence, the target may be a specific individual, such as a particular classmate or teacher, or a group or category of individuals, such as ‘jocks’ or ‘geeks.’ The target may even be the school itself.” Brian Vossekuil et. al., *The Final Report and Findings of the Safe School Initiative: Implications for the Prevention of School Attacks in the United States* (May 2002), available at [http://www.secretservice.gov/ntac/ssi\\_final\\_report.pdf](http://www.secretservice.gov/ntac/ssi_final_report.pdf). See *infra* notes 425–33 (definition of “school rampage”).

24. See de Haven, *supra* note 1, at 607–12.

academy.

Much work is already being done to shift tort law toward a model of shared responsibility that better serves the fundamental purposes of higher education than the present arm's length relationship between colleges or universities and their students.<sup>25</sup> Professors Bickel, Dickerson, Lake, and others have discussed an institutional duty to create and maintain reasonably safe learning and living conditions on the modern campus.<sup>26</sup> Addressing the overall physical and psychological safety and well-being of the student body is certainly integral to achieving safe conditions.

The duty this article considers is fully congruent with a general duty to provide reasonably safe learning conditions. This duty, however, is narrower and more specific: it focuses not on the educational environment as a whole, but on the singular student who may endanger it as a result of mental illness.<sup>27</sup> Like lights on an airstrip, the Texas Tower shooting and the Berkeley murder mark the ground from which this search for duty departs. We begin knowing that, first, in the new age of advanced and accessible weaponry, the ivory tower can be attacked from within, with devastating consequences, by a lone gunman who knows his way around. Second, if a mentally-ill student becomes violent following treatment at a college or university mental health facility, the common law may hold his treating therapist responsible, and possibly others as well. There is much more to be understood from the academy's legacy of violence than the easy lessons. We shall return to Texas at the end of this article. Next, we shall continue examining the *Tarasoff* case in greater detail.

#### I. BALANCING UNFORESEEABILITY: THE 1969 MURDER IN BERKELEY, CALIFORNIA

*"He is at this point a danger to the welfare of other people and himself."*<sup>28</sup>

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25. See generally de Haven, *supra* note 1.

26. See, e.g., ROBERT D. BICKEL & PETER F. LAKE, *THE RIGHTS AND RESPONSIBILITIES OF THE MODERN UNIVERSITY: WHO ASSUMES THE RISKS OF COLLEGE LIFE?* (1999); Darby Dickerson, *Background Checks in the University Admissions Process: An Overview of Legal and Policy Considerations*, 34 J.C. & U.L. 419 (2008).

27. As Professor Lake recently reminded us, "Courts frequently distinguish a duty to provide a generally safe learning environment from a duty to prevent a foreseeably dangerous individual's attacks." Peter F. Lake, *Still Waiting: The Slow Evolution of the Law in Light of the Ongoing Student Suicide Crisis*, 34 J.C. & U.L. 253, 268 (2008). See also Ann M. Massie, *Suicide on Campus: The Appropriate Legal Responsibility of College Personnel*, 91 MARQUETTE L. REV. 625 (2008). The duty discussed here is the second, though the author also foresees circumstances in which the two may converge. See *infra* note 542.

28. DEBORAH BLUM, *BAD KARMA: A TRUE STORY OF OBSESSION AND MURDER* 249 (1986) (treating psychiatrist Dr. Moore's letter to campus police concerning patient Prosenjit Poddar).



### A. The Facts

*Tarasoff v. Regents of the University of California* is among the most famous tort cases of the last century, but its facts were somewhat obscurely stated in the original California Supreme Court decision.<sup>29</sup> What follows are the basic facts of *Tarasoff* as they relate to the negligence issues decided by the Court.

Twenty-two year old Prosenjit Poddar arrived at Berkeley from Bengal in 1967 to take a graduate degree in shipbuilding.<sup>30</sup> About a year later, Poddar became romantically obsessed with nineteen-year old Tanya Tarasoff, whom he met at a campus dance.<sup>31</sup> Tarasoff did not reciprocate Poddar's affections, and he was disturbed and enraged by her rejection.<sup>32</sup> The intensity of his obsession alarmed his acquaintances.<sup>33</sup> In early June 1969, Poddar's best friend took him to the psychiatric clinic at Berkeley's Crowell Hospital.<sup>34</sup>

The Berkeley clinic was an internationally recognized treatment center, specializing in short-term but effective psychotherapy for young adults.<sup>35</sup> It had a staff of over forty psychiatrists, psychologists, and psychiatric social workers.<sup>36</sup> The clinic had experienced a 600% rise in student use between 1965 and 1968.<sup>37</sup> When Poddar first sought clinical services in June 1969, the Berkeley administration and a large group of students were embroiled in the People's Park controversy: the National Guard was on campus in force, a curfew was imposed, and students were flooding into the clinic for counseling.<sup>38</sup> Nevertheless, Poddar was immediately seen by psychiatrist Stuart Gold on an emergency basis, received medication, and within a few days began outpatient therapy with Dr. Warren Moore, a clinical psychologist.<sup>39</sup>

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29. The facts have been admirably clarified in several works. See Peter H. Shuck & Daniel J. Givelber, *Tarasoff v. Regents of the University of California: The Therapist's Dilemma*, in TORTS STORIES 100 (Robert Rabin & Stephen D. Sugarman, Eds.) (2003); Buckner & Firestone, *supra* note 17; CHARLES PATRICK EQING & JOSEPH T. MCCANN, MINDS ON TRIAL: GREAT CASES IN LAW AND PSYCHOLOGY 57–67 (2006); BLUM, *supra* note 28.

30. Buckner & Firestone, *supra* note 17, at 192.

31. Shuck & Givelber, *supra* note 29, at 102.

32. *Id.*

33. His studies and his work suffered. He stopped eating, bathing, and sleeping. He isolated himself and often wept uncontrollably. He taped conversations with her and replayed them over and over. He told a friend that he could not help himself. He said that he intended to kill Tarasoff by blowing up her room. His condition worsened over the spring semester. He lost his job and was in danger of losing his graduate career. Buckner & Firestone, *supra* note 17, at 4.

34. BLUM, *supra* note 28, at 198.

35. *Id.* at 198–99.

36. *Id.*

37. *Id.*

38. *Id.*

39. *Id.* at 204–05. Gold diagnosed paranoid schizophrenia and prescribed

Moore had eight or nine sessions with Poddar over a period of two and a half months.<sup>40</sup> He became increasingly alarmed at the persistence of Poddar's obsession with Tarasoff, especially after he learned that his patient was trying to acquire a firearm.<sup>41</sup> On August 18, Moore challenged Poddar about his hostility towards Tarasoff, and Poddar angrily discontinued his therapy session.<sup>42</sup> On August 20, Dr. Moore called the campus police and reported that Poddar was dangerous to himself and others.<sup>43</sup> He proposed to sign a 72-hour emergency detention order if the police would pick Poddar up and take him to the hospital.<sup>44</sup> Dr. Moore provided the Campus Police Chief with a letter diagnosing Poddar, in which Dr. Gold concurred, as did the acting director of the psychiatry department.<sup>45</sup> Diagnosing Poddar as having "paranoid schizophrenic reaction, acute and severe," Dr. Moore wrote, "He is at this point a danger to the welfare of other people and himself."<sup>46</sup> He requested the assistance of the campus police in committing Poddar to a mental hospital for observation.<sup>47</sup> The letter warned, "At times [Poddar] appears to be quite rational."<sup>48</sup>

Acting on Dr. Moore's report, three campus police officers interviewed Poddar, who agreed that he would "try" to leave Tanya Tarasoff alone.<sup>49</sup> Based on that conversation, the officers decided that Poddar was not dangerous and therefore did not detain him or attempt to initiate committal proceedings.<sup>50</sup> Poddar never returned to therapy.<sup>51</sup> Neither Dr. Moore nor the clinic attempted to get in touch with him.<sup>52</sup>

Well before the murder occurred, Dr. Harvey Powelson, the Clinic's Director, condemned Dr. Moore's actions as a breach of patient

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Thorazine, Compazine, and Cogentin. *Id.* It is not clear that they were effective to treat his condition or that he kept taking them. The antipsychotic drugs Navane and Haldol prescribed for Wendell Williamson in the 1990s were not yet available in the 1960s, and such drugs play a larger part in that story. *See infra* Section II.A.

40. Buckner & Firestone, *supra* note 17, at 193.

41. BLUM, *supra* note 28, at 237.

42. *Id.* at 243–44; Shuck & Givelber, *supra* note 29, at 102; Buckner & Firestone, *supra* note 17, at 5.

43. BLUM, *supra* note 28, at 244.

44. Herrick Hospital, unlike Crowell, was a state-authorized evaluation and detention facility. *Tarasoff v. Regents of Univ. of Cal.*, 108 Cal. Rptr. 878, 882 (Cal. Ct. App. 1973).

45. BLUM, *supra* note 28, at 201, 245.

46. *Id.* at 249.

47. *Id.*

48. *Id.*

49. Buckner & Firestone, *supra* note 17, at 5.

50. The three officers and the Campus Police Chief were later named as individual defendants in the Tarasoffs' wrongful death lawsuit. *See infra* note 61.

51. Buckner & Firestone, *supra* note 17, at 194.

52. *Id.* at 193–94.

confidentiality.<sup>53</sup> He requested that Moore's letter to the campus police be returned, insisted that Moore destroy all copies, and directed that no further action be taken.<sup>54</sup> Thus, Dr. Moore, who believed Poddar might well try to kill Tarasoff, did not warn her of the danger.<sup>55</sup> Nor did the campus police let Tarasoff or her parents know that they had extracted a promise from Poddar to leave her alone.<sup>56</sup>

Tanya Tarasoff came back to Berkeley from a summer abroad in September 1969 and enrolled as an undergraduate student at the University.<sup>57</sup> Poddar stalked her for several weeks.<sup>58</sup> Finding her alone at her parents' house on October 27, he shot her with a pellet gun, chased her into the front yard, and stabbed her to death with a kitchen knife.<sup>59</sup> He then called the police and turned himself in.<sup>60</sup>

## B. The Civil Litigation

### 1. *Tarasoff I*

Tanya Tarasoff's parents brought a wrongful death claim against the University in September 1970, within a month of Poddar's criminal trial, at which Dr. Gold and Dr. Moore testified that their daughter's murderer was insane and not responsible for his actions.<sup>61</sup> The trial court dismissed the civil lawsuit, and the California Court of Appeals affirmed.<sup>62</sup> With respect

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53. *Id.* at 193.

54. *Tarasoff v. Regents of Univ. of Cal.*, 108 Cal. Rptr. 878, 880 (Cal. Ct. App. 1973); Buckner & Firestone, *supra* note 17, at 5.

55. *See Tarasoff*, 108 Cal. Rptr. at 881.

56. *Id.*

57. BLUM, *supra* note 28, at 261, 281.

58. Buckner & Firestone, *supra* note 17, at 194.

59. *Id.*

60. *Id.*

61. *Tarasoff v. Regents of Univ. of Cal.*, 108 Cal. Rptr. 878, 880 (Cal. Ct. App. 1973). In addition to the Regents of the University, plaintiffs Vitaly and Lydia Tarasoff named as defendants Dr. Moore, Dr. Gold, Dr. Yandell, and Dr. Powelson, Campus Police Chief Beall, and campus police officers Atkinson, Teel, Brownrigg, and Halleran.

The complaint alleged, *inter alia*, that defendants did not place Poddar in a 72-hour evaluation facility or otherwise detain him. It also alleged that, knowing he was mentally disturbed, they released him from the custody of the campus police and did not warn the Tarasoffs of the danger he posed. *Id.* at 881.

62. *Id.* at 879. The appellate court held that neither the individual psychiatrists nor the individual police officers had a duty to detain Poddar for evaluation even if they considered him dangerous to himself or others. The California Code sections governing involuntary commitment procedures did not empower either the campus police or the attending staff at Crowell to take custody of a dangerous person and place him in an evaluation facility. The campus police were not "peace officers" under the statute, and the therapists were not on the attending staff of a designated and approved evaluation facility. *Id.* at 882–83. Furthermore, the court held, even if defendants had a duty to detain and evaluate Poddar, their failure to do so was so clearly not the

to the defendants' failure to warn the Tarasoffs, the court held, neither the police nor the therapists had a special relationship with either Tanya Tarasoff or her parents that created a duty to keep Poddar from harming them.<sup>63</sup> Nor had any of them voluntarily undertaken such a duty.<sup>64</sup>

Dissenting, Judge Sims argued, more persuasively, that the facts compelled different reasoning.<sup>65</sup> Defendant University, through its staff at Crowell, accepted Poddar for treatment as a voluntary outpatient, and, as a result, he was "diagnosed as a danger."<sup>66</sup> The diagnosis included a recommendation for further treatment: that he "should be committed for observation in a mental hospital."<sup>67</sup> The diagnosis and recommendation created a duty to go forward with treatment.<sup>68</sup> Negligent failure to do so would be actionable.<sup>69</sup> Since Poddar was being uncooperative and since Dr. Moore and his colleagues did not work at a designated evaluation facility, their only alternatives under the state statute were to have Poddar taken into custody by a peace officer or to refer his case to the county social service agency empowered to secure a court order of committal.<sup>70</sup> Dr. Moore chose the first alternative and notified the campus police.<sup>71</sup> The dissent considered the police negligent in releasing Poddar, but argued that their intervening, untrained "diagnosis" did not relieve the therapists of their duty.<sup>72</sup> Once the therapists learned that their patient was still at large, they had a duty to warn his prospective victim.<sup>73</sup>

In the dissent's view, Dr. Moore exercised reasonable care, and the police, though negligent, were immunized from liability by statute.<sup>74</sup> Therefore, Dr. Powelson's decision to overrule Dr. Moore without reevaluating Poddar was the actionable event.<sup>75</sup> When Dr. Powelson

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proximate cause of Tanya Tarasoff's injury that the court could resolve the issue against the plaintiffs as a matter of law. *Id.* at 883–84.

63. *Id.* at 886.

64. *Id.*

65. *Id.* at 889 (Sims, A.J., dissenting).

66. *Id.*

67. *Id.* at 891.

68. *Id.*

69. *Id.*

70. *Id.*

71. The dissent pointed out that "[t]he law in effect prior to July 1, 1969 did not purport to define the type of "peace officer" who could effect an emergency apprehension." *Id.* at 892 n.4 (Sims, A.J., dissenting).

72. *Id.* at 893.

73. *Id.*

74. *Id.*

75. *Id.* at 893–94. Judge Sims elaborated:

Dr. Powelson did not undertake to furnish the diagnosis or treatment which the patient was entitled to expect from the clinic from which he had sought medical psychiatric assistance. . . . Dr. Powelson never examined the patient . . . . Dr. Powelson requested the chief of the campus police to return Dr. Moore's letter; . . . he ordered that all copies of that letter, and all copies of

“arbitrarily terminated the relationship with the patient,” he failed in his statutory duty to provide treatment.<sup>76</sup>

Moreover, the dissent explicitly relieved the individual therapists of responsibility for discharging the duty and placed it instead directly on the institution, thus avoiding the aggravating question of conflicting duties, loyalties, interests, and relationships within the clinical hierarchy: “*The responsibility for carrying out the prescribed treatment was that of the clinic[,] not the individual doctors who were subject to Powelson’s directives.*”<sup>77</sup>

With respect to the duty to warn Tarasoff or her parents, the dissent wrote:

[B]alancing . . . the potentiality of the foreseeable risk and the fact that the injury, if resulting, would be fatal, with the preventative action involved in ‘the simple act of reaching for a telephone or of dispatching a messenger’. . . authorizes the imposition of a legal duty to one who would be directly endangered by the threatened action.<sup>78</sup>

Lastly, the dissent argued that the court could not reasonably conclude as a matter of law that defendants’ alleged negligence was not the proximate cause of Tanya Tarasoff’s wrongful death.<sup>79</sup> Her parents were entitled to prove that under reasonable psychiatric standards, but for the clinic’s negligence, Poddar would have been committed or successfully treated so that he was no longer a danger to their daughter.<sup>80</sup> In other words, the plaintiffs were entitled to prove that Poddar’s violence was preventable.

Judge Sims’ dissent in the court of appeals mapped a clearly confined theoretical terrain of institutional liability. First, it respected the immunity conferred on the campus police by the legislature, but it did not exonerate as a matter of the common law their inexpert and ill-considered decision not to hospitalize Poddar once they had undertaken to act as authorized

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Dr. Moore’s notes on the patient be destroyed; and . . . he ordered that no action be taken to place the patient in a 72-hour treatment and evaluation facility . . . . These allegations, strictly construed in favor of the pleader, do not permit the inference that Dr. Powelson’s actions were an exercise of discretion or part of a course of diagnosis or treatment . . . .

76. *Id.* at 894. The dissent characterized Powelson’s behavior as malfeasance, not nonfeasance, though it is arguably either. So viewed, Powelson’s action amounted to an “omission with respect to administering treatment prescribed for mental illness” for which the California Code specifically withheld immunity. *Id.* at 889.

77. *Tarasoff*, 108 Cal. Rptr. at 895 (emphasis added).

78. *Id.* at 897. With respect to the determinative element of foreseeability, the dissent concluded, “If the officers sought his promise to keep away from her, it cannot be considered remote or unexpected if she, unwarned, later was exposed to the fulfillment of [Poddar’s] demented purpose. *Id.* at 898.

79. *Id.* at 900.

80. *Id.* at 900–01.

peace officers under the committal statute.<sup>81</sup> Second, it respected all of the special relationships involved: not only the patient-therapist relationship between Poddar and the clinicians who diagnosed and treated him, but also the relationship between those clinicians and the university at which they worked, which imposed significant limitations upon their individual professional autonomy.<sup>82</sup> Third, it clearly located at the institutional level—not merely (and perhaps not at all) at the level of the individual therapist—the duty to treat the University clinic’s patients with a reasonable degree of care both for themselves and for their potential victims.<sup>83</sup> Last, in allocating liability for failure to act in circumstances of foreseeable danger, it articulated a balancing test that took into account both the nature of the risk and the relative ease of the protective measure called for.<sup>84</sup> Even if none of the defendants could reasonably have been expected to confine or treat Poddar after he evaded committal in August, and even if the risk that he would carry out his murderous fantasy became less foreseeable (and less preventable) by the defendants after their relationship with him ended, a telephone call to the Tarasoff home would have cost very little in time or energy, and, as it turned out, it might well have saved a life.<sup>85</sup>

The California Supreme Court issued its first opinion in the case (*Tarasoff I*) in 1974, sustaining a cause of action against all the therapists and the campus police for failing to warn Tarasoff’s parents.<sup>86</sup> Writing for the majority, Justice Tobriner affirmed the common law rule that there is no duty to control the conduct of another or to warn the potential victims of another’s conduct unless one of two circumstances is present: either the defendant has a special relationship to the actor or the victim that justifies imposition of a duty, or the defendant has voluntarily assumed an obligation to control the actor’s conduct or to protect the victim.<sup>87</sup> Under the first formulation, the therapist-patient relationship between Prosenjit

81. *Id.* at 894.

82. That Dr. Moore’s individual diagnosis and recommended treatment plan should bind the clinic until it was changed by another equally professional diagnosis made both medical and legal sense. To suggest, as the California Supreme Court did, that Dr. Moore was bound to a course of action that the clinic for which he worked was free to ignore, or contradict, was neither fair nor productive.

83. *Tarasoff*, 108 Cal. Rptr. at 895.

84. *Id.* at 897.

85. For example, Poddar moved in with Tanya’s brother in August, only a few blocks from Tarasoff’s house, which made his stalking of her much easier. Tanya had also enrolled at Berkeley and began attending classes in early October, which increased Poddar’s opportunities of stalking her on campus as well. See BLUM, *supra* note 28, at 262, 281.

86. *Tarasoff v. Regents of Univ. of Cal.*, 529 P.2d 553, 565 (Cal. 1974) [*hereinafter Tarasoff I*].

87. *Id.* at 557, 559 (“[A] duty . . . may also arise from a voluntary act or undertaking by a defendant. Once the defendant has commenced to render service, he must employ reasonable care . . .”).

Poddar and his treating therapists was sufficiently special to create a duty to warn Tanya Tarasoff, even though none of the therapists had any professional relationship with her.<sup>88</sup> “We conclude,” wrote the Court, “that a doctor or psychotherapist treating a mentally ill patient . . . bears a duty . . . to give threatened persons such warnings as are essential to avert foreseeable danger arising from his patient’s condition or treatment.”<sup>89</sup>

Imposing upon the defendants a duty to take Tarasoff’s safety into account was also justified, because the defendants had “voluntarily commenced to render services” and were therefore under an obligation not to “bungle” matters without warning those likely to be endangered as a result.<sup>90</sup> The facts alleged would sustain the inference that defendants’ actions caused Poddar to discontinue treatment that might otherwise have been effective to curb his violence.<sup>91</sup> In other words, plaintiffs were entitled to prove that defendants had made matters worse.

*Tarasoff* was the relatively rare case in which a psychiatrist and two clinical psychologists concurred in predicting that, unless confined, a patient was likely to harm a readily-identifiable victim.<sup>92</sup> The court remarked that discerning the difference between threats of violence that pose a serious danger and those that do not requires “a high order of expertise and judgment.”<sup>93</sup> The decision promised considerable deference to the therapist’s determination, but offered little else in the way of guidance. The lack of definition and guidance ignited fears that “playing it safe” would cause therapists to decline treatment of problematic individuals, would cause unnecessary hospital committals and breaches of confidentiality, and would result in loss of trust in the therapist-patient relationship.<sup>94</sup>

The decision was unsatisfactory in other respects as well. It raised and then ducked the question whether the duty to warn required Dr. Moore to disobey Dr. Powelson’s directives.<sup>95</sup> It also provided no limits on the duty of the police once they assumed responsibility for confining an

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88. *Id.* at 557.

89. *Id.* at 559. The second decision dropped this language. *See infra* text accompanying note 97.

90. *Tarasoff I*, 529 P.2d at 555.

91. *See id.* at 555, 559.

92. The defendant therapists argued that patients in psychotherapy often express violent thoughts—indeed, are encouraged to do so by their therapists—but act on them only rarely. Moreover, imposing a duty to warn others would disable the confidentiality essential to the therapeutic relationship, could interfere with therapy, and would be of little social benefit. *Id.* at 560.

93. *Id.* The assumption may not have been correct. *See Monahan, infra* note 458.

94. *See, e.g., Alan Stone, The Tarasoff Decisions: Suing Psychiatrists to Safeguard Society*, 90 HARV. L. REV. 358 (1976). *See also infra* text accompanying note 104.

95. “We lack sufficient factual background to adjudicate this conflict.” *Tarasoff I*, 529 P.2d. at 561 n.12.

individual.<sup>96</sup> Moreover, in contrast to the dissent, the decision did not impose a direct institutional obligation on the clinic (in the person of Dr. Powelson) to act with reasonable care.<sup>97</sup>

## 2. *Tarasoff II* and its Impact on the Academy

The outcry from the psychotherapeutic community persuaded the California Supreme Court to rehear the case in 1976.<sup>98</sup> The second decision did not, as a practical matter, improve matters much for the therapists. *Tarasoff II* no longer limited the duty to circumstances arising from the patient's treatment, nor limited the obligation to a warning.<sup>99</sup> "[O]nce a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger."<sup>100</sup>

Though it did not greatly help the therapists, *Tarasoff II* improved matters considerably for the University defendants. The Court reversed its initial ruling that the University could be liable for acting in a way that increased the risk of violence.<sup>101</sup> *Tarasoff I* had been clear that a voluntary undertaking can create a duty not to make matters worse even when there is no prior special relationship between the parties.<sup>102</sup> *Tarasoff II* abandoned that position altogether, and without explanation.<sup>103</sup>

96. Dissenting, Justice Clark would have preserved confidentiality at the expense of warning the potential victim of patient violence unless it could be shown that the psychiatrist's termination of treatment increased the risk of violence. He would not have imposed a duty upon the police using essentially the same formula, however, because the majority had explained neither the circumstances that triggered the duty nor the policy upon which it was said to depend. *See id.* at 569 (Clark, J., dissenting).

97. It simply concluded that:

[P]laintiffs' complaints can be amended to state a cause of action against [the individual treating and supervising therapists] and against the Regents as their employer, for breach of a duty to warn Tatiana arising from the relationship of these defendants to Poddar. The complaints can also be amended to assert causes of action against the police defendants for failure to warn on the theory that the officers' conduct increased the risk of violence.

*Id.* at 561 (footnote omitted).

98. *Tarasoff II*, 551 P.2d at 334.

99. *See supra* text accompanying note 89.

100. *Tarasoff II*, 551 P.2d at 345.

101. *Id.* at 343.

102. *Tarasoff I*, 529 P.2d at 555.

103. The court wrote:

Turning now to the police defendants, we conclude that they do not have any . . . special relationship to either Tatiana or to Poddar sufficient to impose upon such defendants a duty to warn respecting Poddar's violent intentions. . . . Plaintiffs suggest no theory, and plead no facts that give rise to any duty to warn on the part of the police defendants absent such a special relationship.

*Tarasoff II*, 551 P.2d. at 349. Judge Sims's dissent had discussed such facts, and *Tarasoff I* had taken such facts as sufficiently alleged.



*Tarasoff* is best known for its impact on the mental health profession, where it is generally conceded to have done no significant harm and may have operated to the public benefit.<sup>104</sup> Some states have enacted “anti-*Tarasoff*” legislation, relieving individual therapists of liability for failing to warn except in very limited circumstances.<sup>105</sup> Few jurisdictions have specifically rejected the duty.<sup>106</sup> Some have expanded it either in scope or

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104. See, e.g., Christopher Slobogin, *Tarasoff as a Duty to Treat: Insights from Criminal Law*, 75 UNIV. CINN. L. REV. 645, 645–46 (2006). Professor Slobogin adds, however:

That conclusion does not mean that *Tarasoff* is without flaws, of course. At the margins, the *Tarasoff* rule undoubtedly leads to unnecessary breaches of confidentiality and hospital commitments, reticence about taking on problem patients, more tension between doctor and patient because of an increased focus on dangerousness, and more stress among therapists who know they are not particularly good at assessing risk.

*Id.* at 646.

105. In 1987, in response to expansive judicial decisions, the American Psychiatric Association proposed a model statute on the duty of physicians to take precautions against patient violence. The model statute imposes a duty to prevent harm by a patient only when the patient has communicated to the therapist an explicit threat to kill or seriously injure a known or reasonably identifiable victim and has the apparent intent and ability to carry out the threat. See AMERICAN PSYCHOLOGICAL ASSOCIATION, MODEL ACT FOR STATE LICENSURE (1987), available at <http://forms.apa.org/practice/modelactlicensure/mla-review-2009.pdf>. Virginia has adopted a version of this model. See *infra* note 313.

106. Since 2002, the following states have affirmed the imposition of an actual duty to warn: Arizona, see, e.g., *Graham v. Valueoptions, Inc.*, 2010 WL 5054442 (Ariz. Ct. App. 2010); California, see, e.g., *Ewing v. Northridge Hospital Medical Center*, 16 Cal. Rptr. 3d 591 (Cal. Ct. App. 2004); Colorado, see, e.g., 609 F.3d 1096 (10th Cir. 2010); Delaware, see, e.g., *Riedel v. ICI Americas, Inc.*, 968 A.2d 17, 24 (Del. 2009); Indiana, see, e.g., 910 N.E.2d 868 (Ind. Ct. App. 2009); Kentucky, see, e.g., *Devasier v. James*, 278 S.W.3d 625 (Ky. 2009); Louisiana, see, e.g., *United States v. Auster*, 517 F.3d 312, 316 (5th Cir. 2008); Maine, see, e.g., *Joy v. Eastern Med. Ctr.*, 529 A.2d 1364 (Me. 1987); Michigan; see, e.g., *Dawe v. Dr. Reuven Bar-Levav & Assoc., P.C.*, 780 N.W.2d 272 (Mich. 2010); Minnesota, see, e.g., *Molloy v. Meier*, 660 N.W.2d 444, 450 (Minn. Ct. App. 2003); Missouri, see, e.g., *American Home Assurance Co. v. Pope*, 487 F.3d 590 (8th Cir. 2007); Montana, see, e.g., *Gudmundsen v. State, ex. rel. Montana State Hosp. Warm Springs*, 203 P.3d 813 (Mont. 2009); Nebraska, see, e.g., *Munstermann v. Alegent Health-Immanuel Med. Ctr.*, 716 N.W.2d 73 (Neb. 2006); New Jersey, see, e.g., *Marshall v. Klevanov*, 902 A.2d 873 (N.J. 2006); New York, see, e.g., 864 N.Y.S.2d 264, 277 (N.Y. 2008); Ohio, see, e.g., *Douglass v. Salem Cmty. Hosp.*, 794 N.E.2d 107, 120 (Ohio Ct. App. 2003); Oklahoma, see, e.g., *J.S. v. Harris*, 227 P.3d 1089 (Okla. Civ. App. 2009); Pennsylvania, see, e.g., *DeJesus v. U.S. Dep’t. of Veterans Affairs*, 479 F.3d 271 (3d Cir. 2007); South Carolina, see, e.g., *Doe v. Marion*, 645 S.E.2d 245, 250 (S.C. 2007); Tennessee, see, e.g., *Stewart v. Fakhruddin*, 2010 WL 2134150 (Tenn. Ct. App. 2010); Vermont, see, e.g., *Barrett v. Prison Health Serv., Inc.*, 2010 WL 2837010 (D. Vt. 2010); Wisconsin, see, e.g., *Johnson v. Rogers Mem’l Hosp. Inc.*, 700 N.W.2d 27, 42 (Wis. 2005).

By statute, Alabama imposes a duty to warn in the context of marriage and family therapy. See Ala. Code § 34-17A-23 (2010).

The following jurisdictions allow but do not require warnings: District of Columbia; Alaska; Connecticut, see, e.g., *Weigold v. Patel*, 840 A.2d 19, 25 (Conn. App. Ct. 2004); Illinois, see, e.g., *Tedrick v. Cmty. Res. Ctr., Inc.*, 920 NE.2d 220, 229

applicability.<sup>107</sup> The few studies done since 1976 indicate that therapists

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(Ill. 2009); Iowa, *see, e.g.*, Long v. Broadlawns Med. Ctr., 656 N.W.2d 71, 79 (Iowa 2002), *but cf.* Iowa Code § 141A.5 (2010) (requiring warning to third party who is a sexual partner of HIV infected patient); Oregon, *see, e.g.*, U.S. v. Chase, 340 F.3d 978, 984 (Or. Ct. App. 2003); Rhode Island, *see, e.g.*, Santana v. Rainbow Cleaners, 969 A.2d 653; Texas; West Virginia.

The following states remain unclear as to whether warnings are allowed or required: Arkansas; Georgia, *see, e.g.*, Talton v. Arnall Golden Gregory, LLP, 622 S.E.2d 589 (Ga. Ct. App. 2005), *see also* Ga. Code Ann. § 19-7-5 (2009); Hawaii; Kansas, *see, e.g.*, Cunningham v. Braum's Ice Cream and Dairy Stores, 80 P.3d 35 (Kan. 2003); Maine; Nevada, *see, e.g.*, Sanchez v. Wal-Mart Stores, Inc., 221 P.3d 1276 (Nev. 2009); New Mexico; North Dakota; South Dakota; and Wyoming.

Virginia's Supreme Court has held that the relationship between a psychiatrist and a voluntarily committed mental patient is not sufficiently special to create a duty to protect or warn. Nasser v. Parker, 455 S.E.2d 502, 506 (Va. 1995). North Carolina has also expressly rejected *Tarasoff's* duty to warn. Gregory v. Kilbride, 565 S.E.2d 685, 692 (2002) *disc. rev. denied*, 580 S.E.2d 365 (2003). Texas, too, declined to impose a duty to warn. Thapar v. Zezulka, 994 S.W.2d 635, 638 (Tex. 1999). Florida has declined to impose a *Tarasoff* duty in case law, *see* Boynton v. Burglass, 590 So.2d 446, 447 (Fla. Dist. Ct. App. 1991), but allows warning by statute for communications between a patient and psychiatrist, *see* Fla. Stat. § 456.059 (2010). *See generally* RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL HARM § 41 cmt. g (Proposed Final Draft No. 1, 2005).

Although Washington imposed a duty to warn prior to 2002, *see* Paul B. Herbert, *The Duty to Warn: A Reconsideration and Critique*, 30 J. AM. ACAD. PSYCHIATRY & L. 417 (2002), the court in *Hahn* held that Washington's duty to warn statute, § 71.05.120, does not actually create a duty to warn under subsection (2), but simply provides that failure to warn will preclude immunity under subsection (1). *Hahn v. Chelan-Douglas Behavioral Health Clinic*, 2009 WL 3765993 (Wash. Ct. App. 2009).

For a list of whether each state imposes a duty to warn, whether it allows but does not require warnings, or whether it has no clear *Tarasoff* law as of 2002, *see* Paul B. Herbert, *The Duty to Warn: A Reconsideration and Critique*, 30 J. AM. ACAD. PSYCHIATRY & L. 417, 417 (2002), *available at* <http://www.jaapl.org/cgi/reprint/30/3/417.pdf>.

107. *Tarasoff's* progeny have extended the duty to warn beyond communications between therapist and patient. The scope and coverage of the post-*Tarasoff* duty extends to the physician-patient relationship, including the duty to warn of the danger of driving while medicated. *See, e.g.*, Myers v. Quesenberry, 192 Cal. Rptr. 583 (Cal. App. 1983), *republished*, 193 Cal. Rptr. 733 (Cal. App. 1983); Powell v. Catholic Med. Ctr., 749 A.2d 301 (N.H. 2000) (of the danger of stroke victim's behavior during treatment); Lipari v. Sears, Roebuck & Co., 497 F. Supp. 197 (D. Neb. 1980) (of pharmaceutical effects); DiMarco v. Lynch Homes-Chester County, 583 A.2d 422, 424 (Pa. 1990) (of infectious diseases), Hofmann v. Blackmon, 241 So.2d 752, 753 (Fla. Dist. Ct. App. 1970), C.W. v. Cooper Health Sys., 906 A.2d 440, 450 (N.J. Super. Ct. App. Div. 2006); Safer v. Estate of Pack, 677 A.2d 1188, 1192 (N.J. Super. Ct. App. Div. 1996) (of genetic conditions). For a comprehensive study of the physician-patient duty to warn, *see* W. Jonathan Cardi, *A Pluralistic Analysis of the Therapist/Physician Duty to Warn Third Parties*, 44 WAKE FOREST L. REV. 877 (2009).

States have also extended the duty to warn to cases of child abuse and neglect, some by statute. *See, e.g.*, Ga. Code Ann. § 19-7-5 (2009). *Tarasoff's* reasoning has additionally been extended to other types of special relationships including the owner of a movie theatre and its patrons, Mostert v. CBL & Assoc., 741 P.2d 1090 (Wyo. 1987), and the lawyer-client relationship, *see, e.g.*, Hawkins v. King Cnty. Dep't of Rehab. Servs., 602 P.2d 361 (Wash. Ct. App. 1979). For an examination of whether a

now routinely make a practice of warning the known potential targets of patients they consider dangerous.<sup>108</sup>

More to the point here is how *Tarasoff II* shaped the behavior of colleges and universities.<sup>109</sup> As a practical matter, the second decision handed the University a virtually clean win despite its reinstatement of the plaintiffs' negligence claims against the therapists. The result was timely and fortunate for University administrators. When the case began in 1969, the presence of police forces on campus was a national issue, and the *Tarasoffs* were by no means the only parents claiming that the police presence on campus provoked, exacerbated, and bungled confrontations with students in ways that increased the risk of violence.<sup>110</sup> Wrongful death actions in the Kent State killings were still active when the *Tarasoff* Court reversed itself and held that the Berkeley University police had no duty to take reasonable care in executing their commission.<sup>111</sup> *Tarasoff II* effectively privileged careless and indifferent police behavior towards students endangered by other students on college campuses, even when individual officers were aware of the danger. It declined to hold them (or their institution) accountable when they undertook to act, even if they made

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particular relationship could be deemed "special" for the purpose of determining whether a duty exists, see *Delgado v. Trax Bar & Grill*, 113 P.3d 1159 (Cal. 2005). See generally *Bruckner & Firestone*, *supra* note 17, at Section III; *Shuck & Givelber*, *supra* note 29, at 117–27.

108. See *Bruckner & Firestone*, *supra* note 17, at 21–23 (discussing studies). Law enforcement officers, on the other hand, who have no duty to warn, apparently do not warn the identifiable victims of specific threats even when it would cost them little to do so. See Michael Huber et al., *A Survey of Police Officers' Experience With Tarasoff Warnings in Two States*, 51 PSYCHIATRIC SERV. 807–09 (June 2000), available by subscription at <http://psychservices.psychiatryonline.org/cgi/reprint/51/6/807>.

109. *Tarasoff's* formulation of duty has been "frequently cited with little variation in most of the major university cases of the last twenty years. This may be the only undeniable point of consensus among all the disparate cases of the last few decades." BICKEL & LAKE, *supra* note 26, at 202. See also Peter F. Lake, *Revisiting Tarasoff*, 58 ALB. L. REV. 97 (1994).

110. For example, on May 15, 1969, allegedly the day Poddar first went to the Crowell Clinic for emergency treatment, the Berkeley campus police participated in the violent confrontation at People's Park that resulted in the shooting death of student James Rector by an officer of the Alameda County Sheriff's Department. See, e.g., BLUM, *supra* note 28, at 198–99; John Burks, John Grissim Jr., and Langdon Winner, *The Battle of People's Park*, ROLLING STONE MAG. (June 14, 1969), available at <http://www.beauty-reality.com/travel/sanFran/peoplespark3.html>. A year later, four unarmed student protesters were shot and killed on Kent State University's campus by National Guardsmen called in by the Ohio governor at the request of the University administration. See *The Scranton Report*, *supra* note 5, at 233–90.

111. In 1974, shortly before *Tarasoff I* upheld a cause of action against the campus police, the United States Supreme Court decided that state officials were not immune from wrongful death actions by the parents of the students killed by National Guardsmen at Kent State. See *Scheuer v. Rhodes*, 416 U.S. 232 (1974). On remand for trial on the merits, *Krause v. Rhodes* was still in active litigation and unsettled when *Tarasoff I* was issued. See Historical Note on *Krause v. Rhodes*, available at <http://speccoll.library.kent.edu/4may70/box113/113.html>.

matters worse.

Even more discouraging for long-term management of students suffering from mental illness, *Tarasoff*'s way of thinking does not promote effective communication between mental health providers and college and university administrators when the student-patient may pose a danger to others on campus. What if the identified target were everyone in sight of the University Tower, as in Whitman's case, or teachers in the College of Nursing, or fellow students in a creative writing class? To whom must the warning ultimately be delivered in such cases if not the college and university administration? But if that administration is free to ignore the warning, as appeared the case after *Tarasoff II*, what has been accomplished in the way of safety for the potential victims? On the other hand, what if the college or university administration has information about a disturbing student that the psychotherapist needs to know, and vice versa, in order for appropriate decisions to be made about the student's standing in the academic community? *Tarasoff*'s facts raised these issues only tangentially, but the decision did nothing to encourage such communication. The exception to the general rule of patient confidentiality was narrowly confined and generally applicable. It left for another day whether the special "public peril" posed by a disaffected student growing ever more violent on a college or university campus justifies a more situation-specific formulation of the duty to protect.

*Tarasoff II* also left for another day consideration of the intra-organizational realities of the college and university governance system, but it still revealed, and enabled, college and university dysfunction. It did not address the relationship between the clinical staff and the campus police with respect to diagnosis and detention. It deliberately avoided the issue raised by Dr. Powelson's administrative decision to overrule the treatment recommendations of his staff and forbid further contact with Poddar.<sup>112</sup> It ignored Judge Sims's opinion that the institution itself had a duty to prevent Poddar's reasonably foreseeable violence.<sup>113</sup> It confined the University's liability to *respondeat superior* and cloaked it with the statutory immunity provided to therapists and peace officers.<sup>114</sup> As nearly

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112. The opinion left for later decision whether duty required Dr. Moore to defy superior orders and risk termination by warning the Tarasoffs. See *Tarasoff II*, 551 P.2d. at 348 n.16. Since Powelson was not Poddar's treating therapist, the decision placed no duty on him. His "bungling," which he accomplished only by virtue of his position in the university hierarchy, was not actionable, and therefore not attributable to Berkeley under *respondeat superior*.

113. See *supra* text accompanying note 77.

114. *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 349 n.20 (Cal. 1976). In the end, the Tarasoffs negotiated a settlement with Dr. Moore's insurance company and the State of California. See Robert Reinhold, *Case of Two Brothers Accused of Killing Parents May Test Secrecy Limit in Patient-Therapist Tie*, N.Y. TIMES, Sept. 7, 1990, available at <http://www.nytimes.com/1990/09/07/us/law-case-two-brothers-accused-killing-parents-may-test-secrecy-limit-patient.html?pagewanted=all>.

as possible, it allowed college and university administration to disappear as a legal actor from the violent dramas of campus life, to cast itself as a bit player on its own stage. Even as it heralded a period of generally expanding tort liability, the case provided the basic script from which colleges and universities would successfully argue that their agents have no more duty than bystanders with respect to student violence on campus.<sup>115</sup> The position sanctioned by *Tarasoff* is that a college or university does not have a sufficiently special relationship with its students to create a legal duty to protect them.<sup>116</sup> This position has been considerably eroded by tort decisions in several states finding a duty by analogy to landlord-tenant and premises-liability law.<sup>117</sup> However, it is still the dominant view that institutions of higher education generally have no duty to protect the safety of their students, and, when on the defensive, institutions of higher education continue to maintain that position.<sup>118</sup> It is, in fact, the position taken by the Virginia Tech defendants in the wrongful death lawsuits that followed the 2007 rampage.<sup>119</sup>

### C. Reframing the Duty: On the Importance of Preventability

Violence is seldom predictable with any certainty; its precise timing and location are even less so.<sup>120</sup> Thus, when it comes to rare but catastrophic events such as campus rampages, preventing violence is more important than foreseeing it.<sup>121</sup> *Tarasoff's* focus on foreseeability as a virtually determinative factor doubtlessly operates to the benefit of the therapist most of the time. It is a way of confining individual professional liability to the most extreme cases. It is a much less satisfactory rubric, however, if it permits colleges and universities to wash their hands of a student solely because he has not made an overt threat of harm against a specific, identifiable victim.

Moreover, mental health professionals are not necessarily better equipped than others (such as teachers and student services administrators) to read the warning signs, particularly if they lack relevant information or if their judgment is clouded by other factors. And, to the extent that it is

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115. See BICKEL & LAKE, *supra* note 26, Chapter IV; de Haven, *supra* note 1, Section III.

116. *Tarasoff v. Regents of Univ. of Cal.*, 108 Cal. Rptr. 878, 886 (Cal. Ct. App. 1973).

117. See BICKEL & LAKE, *supra* note 26.

118. See de Haven, *supra* note 1, at 578–607.

119. See *infra* Section III.C.

120. Even the prescient Dr. Moore did not necessarily foresee that Poddar would wait another two months before acting on his violent fantasies.

121. “[T]he best practice of campus crisis management is evidenced by the violence that is averted or minimized.” Margaret Jablonski, George McClellan & Eugene Zdziarski, eds., *In Search of Safer Communities: Emerging Practices for Student Affairs in Addressing Campus Violence*, 9 (Nat’l Ass’n for Student Personnel Adm’rs 2008), available at <http://cra20.humansci.msstate.edu/fulltext.pdf>.

confined to therapists, the duty articulated by *Tarasoff II* may operate under-inclusively.

To illustrate this point, Professor Christopher Slobogin recently posed the question why mental health professionals have been “saddled with a duty to prevent violent harm while other groups—including medical doctors, lawyers, teachers and ordinary citizens—have not.”<sup>122</sup> He argued that only the capacity to treat threatening individuals with outpatient therapy or involuntary commitment usefully distinguishes therapists from others who may also recognize that the individual is dangerous.<sup>123</sup> We can recast Professor Slobogin’s argument without diminishing its logic. If it makes sense to impose a duty upon mental health professionals based on their capacity for therapeutic intervention, we should impose the same duty upon college and university officials who have the equivalent capacity to observe and monitor the behavior of disturbed students and exercise authoritative intervention, including the delivery of appropriate therapeutic measures. The operative factor then become less one of foreseeability and more one of the capacity to take reasonably effective preventive measures. When a law student in the criminal procedure class announces that he is telepathic and angrily demands that his classmates quit thinking about him, should the professor report it to the school administration? If he learns of the incident from the professor, should the dean of the law school insist that the student be given a clean bill of mental health before returning to class? What about the head of an English department, or a university-wide CARE team, who believe that a student, if untreated, may pose a threat to himself or the community?<sup>124</sup> What about a faculty member who is alarmed by the violence of a student’s written work or his threatening classroom behavior? Upon whose shoulders should the duty rest to rule out mental illness as a

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122. Slobogin, *supra* note 104, at 653. Professor Slobogin is not the only scholar to discern that the reasoning of *Tarasoff* is much less limited than its holding. See, e.g., Sara Buell & Martha Drew, *Do Ask and Do Tell: Rethinking the Lawyer’s Duty to Warn in Domestic Abuse Cases*, 75 U. CINN. L. REV. 447 (2006); Shuck & Givelber, *supra* note 29, at 118–20.

123. *Tarasoff’s* assumption, Professor Slobogin argued, is that because clinicians get to know their patients and are trained in prognostication and treatment, they can justly be required to prevent those patients from harming others. That assumption does usefully distinguish mental health professionals from others to the extent that the *Tarasoff* duty depends upon an ability to predict dangerousness and an ability to treat it. Although mental health professionals are not particularly good at foreseeing violence, those trained in modern risk assessment techniques are undoubtedly better than any other group at that task. And, compared to laypeople, psychiatrists and psychologists are clearly superior at treating aggressive individuals, and better equipped, both professionally and legally, to initiate civil commitment proceedings when appropriate.

Slobogin, *supra* note 104, at 654. See also Monahan, *infra* note 458.

124. “CARE team,” in this context, refers specifically to Virginia Tech’s case management team. See *infra* text accompanying note 314. Such student at-risk response teams are discussed further *infra* at text accompanying note 447.

safety concern? If we accept that *Tarasoff* is under-inclusive, all of these individuals might arguably have a legal duty to act with reasonable care for student safety, but at what point in the college or university hierarchy is it fair or useful or counterproductive to impose such a duty? Fully accepting Professor Slobogin's premise would mean imposing legal liability only upon those whose institutional authority extends to requiring outpatient therapy or inpatient treatment as a condition of continued enrollment.

The next section explores this issue further by examining the case of schizophrenic law student Wendell Williamson.

## II. UNDERTAKING THE SPECIAL RELATIONSHIP: THE 1995 SHOOTING AT CHAPEL HILL

*"Rule out schizophrenia."*<sup>125</sup>

### A. The Facts

It is seldom that a case like *Tarasoff* appears, with a comparable mix of student madness, student murder, therapeutic intervention, and administrative supervision. However, a shooting spree by a law student at Chapel Hill, North Carolina, in January 1995, raised many of the same factual issues, in a jurisdiction that, like California in 1969, did not impose upon mental health professionals a duty to protect or warn potential victims of violent patients.<sup>126</sup> Nor did North Carolina's courts impose upon colleges and universities a general duty to safeguard students.

The University of North Carolina (UNC) School of Law is among the oldest, most respected, and most selective in the country.<sup>127</sup> Located on the

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125. *Williamson v. Liptzin*, 539 S.E.2d 313, 315 (N.C. Ct. App. 2000); *see also infra* text accompanying note 148. Many of the facts reported here are from the depositions of Wendell Williamson, his mother Fonda Williamson, his father Dee Williamson, UNC Law Dean Judith Wegner, UNC Dean of Students Winston Crisp, and expert psychiatric witness John Warren, who testified on behalf of the defense at Williamson's trial for murder. The depositions of Dean Wegner (Oct. 7, 1996), Dean Crisp (Jul. 8, 1996), and Dr. Liptzin (Apr. 25, 1997), Dee Williamson (Jul. 16, 1996), and Fonda Freeman Williamson (Jul. 16, 1996) were all taken in connection with civil lawsuits filed after Williamson's rampage by the family of his victim Kevin Reichardt against Williamson's family, *Karl Reichardt v. Wendell Williamson*, 95-CVS-1707 (N.C. Superior Ct. 1996) and *State Farm & Casualty Co. v. Wendell J. Williamson et al.*, 96-CVS 132 (N.C. Super. Ct. 1996). The deposition of Dr. John Warren (May 20, 1998) was taken in connection with *Williamson v. Liptzin*. Copies of these documents, together with academic and medical records papers cited herein, were generously provided by the Reichardts' attorney Jona Poe, Durham, N.C., and are on file with the author.

126. *Gregory v. Kilbride*, 565 S.E.2d 685, 692 (N.C. 2002).

127. The Law School was established in 1845 and ranked 30th in the national rankings in 2010. It admits only 15.6% of applicants. The median LSAT score of admitted applicants is 162. Seventy-five percent of its applicants are from out-of-state. Seventy-five percent of its admitted applicants are from North Carolina. *University of North Carolina School of Law*, WIKIPEDIA, <http://en.wikipedia.org/wiki/>

main campus of UNC in Chapel Hill, the Law School has about 700 students, who have access to a full range of student services, including a mental health clinic.<sup>128</sup> In April 1992, Judith Wegner, the Dean of the Law School, hired its first Dean of Students, Winston Crisp.<sup>129</sup> Dean Crisp had primary responsibility for non-academic student issues, including tracking and “facilitating” students who needed counseling for various reasons.<sup>130</sup>

A 1991 graduate of UNC, Wendell Justin Williamson entered UNC Law School as a 1L in September 1992 after taking a year off to play bass and sing in a rock band.<sup>131</sup> A native of Western North Carolina, with a B.A. in English, and a score of 166 on the LSAT, Williamson was an attractive law school candidate, at least on paper.<sup>132</sup> He had no history of mental health issues or violence.<sup>133</sup> By the time he got to law school, however, he had been hearing voices for almost nine months without seriously pursuing treatment.<sup>134</sup> Williamson believed that people could read his thoughts.<sup>135</sup>

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University\_of\_North\_Carolina\_School\_of\_Law (last visited May 5, 2010).

The Law School’s administrators are bound by the policies and procedures of the larger UNC community relating to dangerous students and emergency situations. The Committee on Problem Admissions and Extraordinary Disciplinary Emergencies was established in part pursuant to NCGS §116-11(2) and “the university’s obligation to assure a safe campus.” Its membership consisted, *inter alia*, of the Vice Chancellor for Student Affairs, the Director of the Student Health Service, the Deans of the General College, the College of Arts and Sciences, the Graduate School, and the professional schools. Crisp Dep., *supra* note 125, at 17.

128. Liptzin Dep., *supra* note 125, at 24. Clinical services were paid for by \$150/year fee included in student tuition and fees. In 1995, the clinic had two psychiatrists on its payroll and 6–10 psychologists and social workers. It also provided clinical internships for medical students, though the clinic and the UNC Hospital were separate entities. The Student Services health clinics were under the direction of the Vice-Chancellor of Student Affairs; the UNC Hospital was under the direction of the Medical School. *Id.*

129. Wegner Dep., *supra* note 125, at 19; Crisp Dep., *supra* note 125, at 12. In 2006, Winston Crisp became Assistant Vice-Chancellor for Student Affairs at UNC, where he is now Vice-Chancellor for Student Affairs. He served as an on-campus consultant to Virginia Tech after the rampage there. *Crisp Supports and Learns from Virginia Tech Counterparts*, UNIV. GAZETTE ONLINE (Aug. 29, 2007), available at <http://gazette.unc.edu/archives/07aug29/file.4.html>.

130. Crisp Dep., *supra* note 125, at 13.

131. WENDELL JUSTIN WILLIAMSON, NIGHTMARE: A SCHIZOPHRENIA NARRATIVE 4 (2001).

132. In 1995, 166 represented the ninety-fifth percentile among LSAT takers. See <http://tars.rollins.edu/prelaw/percentiles.htm> (last visited Jan. 18, 2010).

133. As an undergraduate, Williamson sought and received counseling at Student Services once in May 1990 “for relationship issues and academic problems.” His problem was noted as “fairly normative” by the reviewing Student Services doctor. See *Williamson v. Liptzin*, 539 S.E.2d 313, 315 (N.C. Ct. App. 2000).

134. According to his personal account, published in 2001, Williamson first began hearing voices in January 1992, shortly before his twenty-fourth birthday, an event he associated with hitting too many high notes. WILLIAMSON, *supra* note 131, at 5. He tried to see a psychiatrist at the UNC Student Services facility in March 1992 but was turned away because he did not have an appointment. *Id.* at 19. He did not make an appointment and did not return to the clinic:



He had thought about killing himself and about harming others.<sup>136</sup> He was hearing voices telling him to get his gun and shoot people.<sup>137</sup> He had a loaded rifle in his apartment.<sup>138</sup>

Williamson had been in law school only a few weeks when he set off public alarm. It started at The Pit, an outdoor gathering place on campus near the Student Union building.<sup>139</sup> With no apparent provocation, Williamson began to scream and yell and slap himself in the face until someone called the campus police.<sup>140</sup> The police found him in the law school parking lot and took him to Student Services.<sup>141</sup> At Student Services, still under police escort, he was referred to UNC Hospital, where he was involuntarily committed for ten days.<sup>142</sup> At the hospital, he was argumentative and denied having any mental problem.<sup>143</sup> His treating

One day I went over to UNC Student Health to talk about what was happening to me. I wasn't really sure if it was a mental illness or not, but I believed someone in authority should be able to help me. When I got there, though, they told me I needed an appointment and that it would be at least a week before anyone could see me. While they were telling me this, I also heard them telepathically "telling" me that I was truly telepathic and not mentally ill, but that if I came back they were going to tell me I was going crazy and that they would lock me up. I didn't want that, so I didn't make the appointment. I decided I couldn't trust the professionals to tell me the truth any more than I could trust anyone else to do it.

*Id.* Cf. *supra* note 133, at 19 (Charles Whitman's last letter).

135. Williamson was tormented, among other hallucinations, by shame-inducing memories of having used a vibrating back massager to masturbate when he was a teenager. *Id.* at 12, 22–27. He was convinced that everyone around him could tell whenever he thought about the vibrator. *Id.* at 25–27. He therefore concentrated on imagining his M1 rifle instead, a practice he discontinued only when he began prescribed drug therapy in 1994. *Id.* at 25–27; *see also infra* note 192.

136. WILLIAMSON, *supra* note 131, at 19–23; Williamson Dep., *supra* note 125, at 29.

137. WILLIAMSON, *supra* note 131, at 37.

138. *Id.* *See also infra* note 142.

139. WILLIAMSON, *supra* note 131, at 41.

140. *Id.* at 41–42.

141. *Id.*

142. *Id.* at 43. According to some accounts, including his own, Williamson at this time kept an M1 rifle in his apartment. Shortly before the incident at The Pit in September 1992, he had loaded the weapon, put the barrel in his mouth, and thought about pulling the trigger, an event about which he told the intake interviewer at the hospital. The hospital staff arranged for his parents to confiscate it. Paul B. Herbert, *Williamson v. Liptzin Appeal: Issues of Liability for a Patient's Unexpected Act of Violence*, 26 AAPL NEWSLETTER 2 (Apr. 2001), available at [http://www.aapl.org/newsletter/N262\\_Williamson\\_v\\_Liptzin.htm](http://www.aapl.org/newsletter/N262_Williamson_v_Liptzin.htm); WILLIAMSON, *supra* note 131, at 41; Williamson v. Liptzin, 539 S.E.2d 313, 315 (N.C. Ct. App. 2000). The rifle in question, which was later used in the rampage, had belonged to Wendell's grandfather and was kept in the closet of Wendell's bedroom in the family home in western North Carolina. Fonda Williamson Dep., *supra* note 125, at 17, 49–51; Dee Williamson Dep., *supra* note 125, at 41–44.

143. Forensic Psychiatric History and Evaluation/Legal Assessment/Discharge Summary and Aftercare Plan at 8 (Apr. 21, 1995) (post-rampage assessment) (copy on

psychiatrist recommended that he remain at the hospital for another four weeks to determine whether the appropriate diagnosis was bi-polar or schizo-affective disorder and to establish an appropriate medication regimen.<sup>144</sup> She also recommended that he drop out of law school.<sup>145</sup>

Williamson refused to remain in the hospital voluntarily and refused all medication.<sup>146</sup> The hospital staff filed a committal petition.<sup>147</sup> Though agreeing that Williamson's thinking was "psychotic," the judge let him out of the hospital with the understanding that he would seek outpatient psychiatric care instead.<sup>148</sup> The diagnosis on his hospital discharge summary was "rule out schizophrenia."<sup>149</sup>

Williamson ignored the judge and pursued no further treatment. Instead, he resumed his studies at the Law School in mid-October, having missed 10 days of classes.<sup>150</sup> Dean Wegner and Dean Crisp knew only that Williamson had been taken to Student Services following an incident at The Pit.<sup>151</sup> They were not aware of the nature of his problem at the time and Williamson refused to discuss it with them.<sup>152</sup> Dean Crisp placed a call to Student Services to inquire whether there was any reason Williamson

file with author).

144. WILLIAMSON, *supra* note 131, at 43. Williamson's drug screen was negative at this point, and there was no evidence of marijuana use, though that later became an issue. *See infra* note 166.

145. WILLIAMSON, *supra* note 131, at 45.

146. *Id.* at 46.

147. As head of UNC's Student Services mental health clinic, Dr. Myron Liptzin was informed of the petition. Liptzin Dep., *supra* note 125, at 51. *See also infra* note 181. Williamson later reported "faking it" at the committal hearing. "I knew I had 'reconstituted' because I could act like there was nothing wrong any time I wanted to, which I believed I could do because I thought I wasn't really mentally ill. I was likewise faking it because I wanted out of that hospital . . ." WILLIAMSON, *supra* note 131, at 46.

148. The magistrate judge did not order outpatient treatment as a condition of his release. *Williamson v. Liptzin*, 539 S.E.2d 313, 315 (N.C. Ct. App. 2000).

149. *Id.* "[R]ule out/schizophrenia' means that either: (a) 'it's [schizophrenia] until proven otherwise, but we haven't had enough time to prove otherwise yet[.]" or (b) 'you should keep [schizophrenia] first and foremost in your mind until a less serious condition is shown to be causing the problem.'" *Id.*

150. Many would consider that a disabling number of absences for a first-semester 1L. UNC Law School did not have a practice of tracking student attendance, a matter that was left to the discretion of the individual professor. Crisp Dep., *supra* note 125, at 161. Students could also be dropped from the class if they did not show up for the first two or three class meetings so that other students could take their places. *Id.* at 194. When Williamson returned from his hospital confinement, Dean Crisp wrote to his professors that he should be readmitted and allowed to catch up on his work. Letter from Winston Crisp (Oct. 15, 1992) (on file with author).

151. Deans Crisp and Wegner both testified in depositions that they believed Williamson had some kind of seizure in the parking lot and might be suffering from epilepsy. Crisp testified that Williamson did not confide that he was hearing voices and suffering other forms of hallucination at that time. Crisp Dep., *supra* note 125, at 32-33; Wegner Dep., *supra* note 125, at 28.

152. Letter from Winston Crisp (Oct. 12, 1992) (on file with author).

should not be allowed to resume his studies and was told that there was not.<sup>153</sup> Crisp so notified Williamson's professors and Williamson resumed classes.<sup>154</sup> It was around this time, Williamson later said, that he first contemplated mass violence, but he was "still opposed to killing."<sup>155</sup> He was to have his mind changed on that score as his career in law school continued.

Here, then, is one of those junctures at which, in hindsight, subsequent events might have been prevented had there been better communication between the Law School and the student's mental health provider. Had Dean Crisp been forewarned that Williamson was resisting evaluation for possible schizophrenia and that he had been advised to discontinue his legal studies, he might have viewed the situation rather differently. As it was, the Dean had little to go on. Williamson was high-functioning and adept at disguising his symptoms.<sup>156</sup> Indeed, for over a year after his hospitalization, he was able to keep functioning in spite of his delusions of grandeur and persecution.<sup>157</sup>

That is not to say that there were no signs of trouble. In November 1992, soon after his release from the hospital, a woman student complained that Williamson was staring inappropriately at her in the library and had removed his shirt.<sup>158</sup> Associate Dean Powell cautioned him about his behavior.<sup>159</sup> That time, Williamson was able to persuade the Law School administration that he was suffering from "gross immaturity" rather than mental illness.<sup>160</sup> As time went on, however, it appears that one or more professors became fearful of him. At least one later reported being afraid to not give Williamson a passing grade.<sup>161</sup>

Williamson's fall semester grades—mostly D's—surely gave the Law School cause for concern, and might, at some schools, have been grounds for intervention on purely academic grounds.<sup>162</sup> His grades improved

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153. Crisp Dep., *supra* note 125, at 36.

154. *Id.* at 120.

155. WILLIAMSON, *supra* note 131, at 37; Forensic Psychiatric History, *supra* note 143, at 8.

156. Williamson's handwritten note dated October 15, 1992, to the Associate Dean read: "This is to confirm that today we discussed the causes of my disruptive behavior on Tuesday, September 29, 1992. Again I reiterate: I have no prior history of such outbursts. Nor is there any foreseeable risk of a repeat performance. I regret the incident, and apologize for any embarrassment it may have caused. Sincerely. . . ." Letter from Wendell Williamson (Oct. 15, 1992) (note on file with author).

157. It was at this time that he met and started dating Annette, who left him a year later when his symptoms worsened and he refused to get treatment. WILLIAMSON, *supra* note 131, at 55; *see infra* note 168.

158. Crisp Dep., *supra* note 125, at 38, 49.

159. *Id.* at 50.

160. WILLIAMSON, *supra* note 131, at 49.

161. Warren Dep., *supra* note 125, at 162.

162. WILLIAMSON, *supra* note 131, at 52–53. Williamson was a scholarship student. His fall grades were D- (civil procedure), D+ (property), D+ (torts), C-

dramatically in the spring, however, and he finished the year with a C average.<sup>163</sup> He improved his academic standing even further by attending summer school, where he made two B's.<sup>164</sup>

Williamson's delusions continued into his second year of law school. He kept hearing voices, smelling foul odors, and believing that he could hear what other people thought of him—most of it derogatory.<sup>165</sup> He dealt with his symptoms by drinking a six-pack of beer and smoking marijuana daily.<sup>166</sup> In January 1994, in order to prove that he was telepathic, he bought a camcorder and began to record the conversations of people around him at bars he frequented.<sup>167</sup> By then, his psychosis was becoming apparent.<sup>168</sup> The situation came to a head in March 1994 when Williamson's best friend, classmate Bill Brown, burst into Dean Crisp's office and said, "Come quick. Wendell's going crazy!"<sup>169</sup> In the criminal procedure classroom, where class was about to begin, Dean Crisp found that Williamson had angrily announced that he was telepathic, could tell what everyone thought of him, and was tired of being "jerked around" by his classmates.<sup>170</sup> Williamson insisted on remaining for class (to which the professor agreed), but he came to Crisp's office afterwards.<sup>171</sup> Several

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(contracts), and C+ (criminal law); and he passed legal writing. Williamson's UNC Law School Transcript (Mar. 27, 1995) (on file with author). Some law schools might, for example, have given him the option to withdraw, since his GPA was below 1.6 at the end of the first semester, and restart with a clean slate the next year, if circumstances had changed.

163. *Id.* at 56–57. In spring semester 1993, he made a B- in civil procedure, a B in contracts, a C+ in property, a C in torts, and a B in legal research and writing. Transcript, *supra* note 162.

164. *Id.* at 57.

165. *Id.* at 58.

166. *Williamson v. Liptzin*, 539 S.E.2d 313, 315 (N.C. Ct. App. 2000). The decision finds that Williamson engaged in "occasional" marijuana use, but his case records, including Dr. Liptzin's notes, indicate the use was daily. His post-shooting psychological evaluation states that "chronic marijuana use of one to two joints per day may have contributed to even more impaired judgment" on the day of the shooting. Forensic Psychiatric History, *supra* note 143, at 11.

167. He intended to submit the tape to a parapsychology laboratory as proof of his telepathic powers. The lab refused to accept the tapes. WILLIAMSON, *supra* note 131, at 69.

168. At that point, his girlfriend left him because he would not seek psychiatric help. *Id.* at 65. At the parapsychology lab where he tried (unsuccessfully) to have his videotapes analyzed, the operator told him that he was mentally ill. *Id.* at 69.

169. Crisp Dep., *supra* note 125, at 75.

170. WILLIAMSON, *supra* note 131, at 69; *Williamson*, 539 S.E.2d at 315.

171. WILLIAMSON, *supra* note 131, at 69–70; Crisp Dep., *supra* note 125, at 77, 83–84, 99–100. Dean Crisp also spoke more than once in early March 1994 with Williamson's mother, who was anxious about her son and wanted him to get treatment. "It's a little tricky," Crisp explained, "because he's an adult, I mean, and he's over twenty-one and so I sometimes feel constrained about how much of a student's personal information you can divulge to parents. But being concerned, we talked about a number of things." Crisp Dep., *supra* note 125, at 125. Mrs. Williamson and Dean Crisp even discussed involuntary committal proceedings. *Id.* at 126. She did not,

times during the next few days, the Dean urged Williamson to get psychiatric treatment.<sup>172</sup> Crisp also consulted the University's Dean of Students and the other Law School Deans about the situation, discussing the possibility of involuntary committal if Williamson would not agree to treatment.<sup>173</sup> He also discussed Williamson with Dr. Myron Liptzin, who directed the mental health clinic at UNC's Student Services.<sup>174</sup> Williamson continued to refuse treatment until, at Dr. Liptzin's suggestion, Dean Crisp warned him that he would not otherwise be recommended as a candidate for admission to the bar, whereupon he immediately agreed to comply.<sup>175</sup> The Dean escorted him to Student Services for an intake evaluation and told him that the Law School would check to make sure he was keeping his appointments.<sup>176</sup>

In fact, however, contact between the Law School and Student Services was virtually nonexistent.<sup>177</sup> Liptzin never initiated communication with any Law School official, and Crisp was able to get very little information from Student Services—after calling once to verify that Williamson was keeping his appointments, he did not try to communicate directly with the clinic.<sup>178</sup>

Williamson disliked the two women psychologists who evaluated him, so Liptzin took him on, even though he was planning to retire in May and

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however, confide in Crisp that Williamson had previously been hospitalized, nor did they at any time discuss firearms. *Id.* at 126–128.

172. *Id.* at 79–80. In an attempt to establish some rapport with Williamson, Crisp even watched the videotapes he had been taking at the local bar every night for months. *Id.* at 102.

173. *Id.* at 57–58, 79–80. “We felt that this was a student that we needed to have evaluated.” *Id.* at 58.

174. *Id.* at 95.

175. WILLIAMSON, *supra* note 131, at 70; *Williamson*, 539 S.E.2d at 315. The coercion (leverage) was Liptzin's suggestion. Crisp Dep., *supra* note 125, at 109; Liptzin Dep., *supra* note 125, at 64.

176. WILLIAMSON, *supra* note 131, at 70. The intake psychologist again diagnosed “rule/out schizophrenia” but did not recommend hospitalization because Williamson denied any suicidal thoughts or violent urges. *Williamson*, 539 S.E.2d at 315. Williamson made a further attempt to avoid follow-up treatment after the diagnostic session, but Dean Crisp “clarified behavioral expectations” and Williamson agreed to continue therapy. Forensic Psychiatric History, *supra* note 143, at 13.

177. Dean Crisp might have been well-advised to ask Williamson to sign a waiver permitting his therapist to share information with law school administrators. *See infra* note 456 and accompanying text.

178. Crisp Dep., *supra* note 125, at 141. Crisp recalled having a conversation with Liptzin at some point about the effects of the anti-psychotic medication Navane. *Id.* at 123–24. Liptzin did not recall having any conversation with Crisp after Williamson became his patient. Liptzin Dep., *supra* note 125, at 65. “Once a student goes off into Student Health Services there really isn't much information that comes back. . . . [T]he student is now in treatment and it's treated as a confidential situation and you don't get status reports. . . . When I first started, I would ask, [but] once I became aware that no, you don't get things, then I stopped.” Crisp Dep., *supra* note 125, at 139–41.

knew that his patient had another year and a half to go in law school.<sup>179</sup> His decision was more problematic because until then he had been communicating with the Law School administration about the best way to manage the troubled student, and the Law School abruptly lost the benefit of his counsel in that regard.<sup>180</sup> Liptzin counseled Williamson six times between March 8 and May 24, 1994, in sessions lasting between twenty minutes and one hour.<sup>181</sup> Liptzin certainly did not “rule out schizophrenia.” Instead, he recorded a “more generous” diagnosis—“delusional disorder grandiose”—so that his patient’s career in law would not be jeopardized.<sup>182</sup> He prescribed the anti-psychotic drug Navane.<sup>183</sup>

Williamson found the medication regimen frustrating and unpleasant.<sup>184</sup> His thinking remained incoherent for weeks, and he still claimed to be telepathic.<sup>185</sup> One of his professors reported to Dean Crisp that Williamson’s midterm paper was complete nonsense and that she was concerned about his mental state.<sup>186</sup> Crisp encouraged Williamson to persevere, and he kept an eye on the troubled student until the end of the semester.<sup>187</sup> In April, about six weeks after starting medication and therapy, Williamson told Crisp that the medication was working and that it felt “like waking up from a nightmare.”<sup>188</sup> He apologized, thanked the Dean, and said he was ashamed of his previous behavior.<sup>189</sup>

For the remaining few weeks of the semester, Williamson reduced his alcohol consumption somewhat.<sup>190</sup> He recognized that his delusions had “an organic cause” and that, at least for the time being, he needed the Navane in order to think normally.<sup>191</sup> He was able to concentrate on his studies.<sup>192</sup> He attended class, did well on his exams, entered a legal writing

179. Forensic Psychiatric History, *supra* note 143, at 4.

180. See *supra* text accompanying notes 176–78.

181. *Williamson v. Liptzin*, 539 S.E.2d 313, 315 (N.C. Ct. App. 2000). It is reported that he reviewed Williamson’s chart from Student Services but only the discharge summary, not the full hospital records, from Williamson’s 1992 temporary committal. See *supra* note 143.

182. *Williamson*, 539 S.E.2d at 315.

183. *Id.* at 316; WILLIAMSON, *supra* note 131, at 71.

184. WILLIAMSON, *supra* note 131, at 70–71.

185. *Id.*

186. Crisp Dep., *supra* note 125, at 120–21.

187. Crisp met with Williamson several times at the Law School and went out with him once for a beer. Crisp Dep., *supra* note 125, at 113–14, 117.

188. *Id.* at 119.

189. *Id.* at 118, 172.

190. Forensic Psychiatric History, *supra* note 143, at Liptzin’s record sheet of 4/19/94 session.

191. WILLIAMSON, *supra* note 131, at 71.

192. *Id.* Williamson was able to stop concentrating on his M1 rifle. He does not appear to have confided in Dr. Liptzin that he visualized a rifle in order to keep his mind off other disturbing thoughts.

competition, and became “more like his old self.”<sup>193</sup> He had no urge to commit violence.<sup>194</sup>

Nevertheless, Liptzin detected “a good bit of hostility just below the surface” in his new patient.<sup>195</sup> He was not the first to observe that Williamson was easily angered, but he apparently did not read the records made by Williamson’s psychiatrist at the hospital in 1992, which included information about his possession of a weapon and about his earlier suicidally violent thoughts.<sup>196</sup> Instead, Liptzin decided to treat Williamson’s symptoms “pragmatically.”<sup>197</sup> He apparently did not try to convince Williamson that he had a permanent psychiatric condition. Instead, Liptzin allowed Williamson to believe that his illness might be temporary.<sup>198</sup> He even told Williamson that he might be able to discontinue the medication at some point, so long as he told a trusted adult that he had done so.<sup>199</sup>

In late April, Liptzin suggested that Williamson should start seeing another Student Services therapist in June.<sup>200</sup> Williamson declined, saying that he expected to be away from Chapel Hill over the summer, as he would probably be staying with his family.<sup>201</sup> Liptzin did not insist upon the introduction, a departure from best practices for which he was later criticized. Nor did he inform the Law School administration that continuation of therapy was recommended but not yet guaranteed, though he could easily have done so.<sup>202</sup> Instead, despite Williamson’s past

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193. *Williamson v. Liptzin*, 539 S.E.2d 313, 316 (N.C. Ct. App. 2000); WILLIAMSON, *supra* note 131, at 71.

194. *Williamson*, 539 S.E.2d at 316.

195. Forensic Psychiatric History, *supra* note 143, at Liptzin record sheet of 3/8/94 session.

196. The omission is particularly striking since he was aware of Williamson’s hospitalization at the time he was hospitalized. Liptzin Dep., *supra* note 125, at 51. He also had easy access to Williamson’s records, which is not always the case when students arrive at college with a history of hospitalizations they do not wish to reveal.

197. “I address his concerns strictly pragmatically. He insists that I review his evidence of the video tape and I tell him it’s immaterial, that whether or not he’s experiencing these things he needs to make a decision about priorities, and if it’s important to him to finish law school and to sit [for] the bar exam he must try to suppress these other experiences . . . .” Forensic Psychiatric History, *supra* note 143, at Liptzin’s record sheet of 3/8/94 session.

198. “He told me that he didn’t believe I was really psychotic or really schizophrenic but that possibly my past drug use had give me some ‘sensitive nerve endings’ in my brain . . . which might go away over time.” WILLIAMSON, *supra* note 131, at 73.

199. By Williamson’s account, that turned out to be “extremely bad advice.” *Id.*

200. Forensic Psychiatric History, *supra* note 143, at Liptzin’s record sheet of 4/5/94 session. Liptzin raised the matter of his successor again in late May: “He does know that I am leaving the service here and he will be seeing my replacement.” *Id.* at Liptzin’s record sheet of 5/25/94 session.

201. *Williamson v. Liptzin*, 539 S.E.2d 313, 316 (N.C. Ct. App. 2000).

202. Disclosing these facts would not have violated any confidences of the patient.

resistance to therapy and medication, Liptzin trusted that Williamson's career ambitions would keep him on Navane through the summer, even though that meant he would have to find another doctor to prescribe it, and that he would resume therapy of his own accord at UNC Student Services in the fall.<sup>203</sup>

Dr. Liptzin was wrong, and later experts testified that he should have known better.<sup>204</sup> Williamson discontinued the Navane in June because it made him sunburn more easily, and he never took it again.<sup>205</sup> Although his voices were attacking him again in August, he did not return to Student Services when he came back to Chapel Hill in the fall, and there was no follow-up by clinicians at Student Services.<sup>206</sup> Nor was there further follow-up by the Law School administration, although Williamson was enrolled as a 3L and attending classes.<sup>207</sup>

In his fifth of six semesters Williamson was not disruptive in class, but he stopped studying.<sup>208</sup> He barely passed his courses.<sup>209</sup> He again began to contemplate committing mass murder.<sup>210</sup> By October 1, he had "decided to go through with it for sure."<sup>211</sup> He attended a gun show, bought ammunition, and chose his weapons.<sup>212</sup>

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Such disclosure was also reasonably to be expected from the circumstances of Williamson's agreement with the law school and behavioral expectations of him. Dr. Liptzin could have secured Williamson's express permission had he been in any doubt about the propriety of such communication. *See infra* text accompanying note 445.

203. *Williamson*, 539 S.E.2d at 316.

204. *See infra* text accompanying note 248.

205. Williamson told his mother when he stopped taking the medication. "I thought if the symptoms came back I would know them to be an illness and start taking navane again. How naive I was." WILLIAMSON, *supra* note 131, at 74.

206. *Id.* at 74, 97.

207. Crisp stated in his deposition that Williamson stopped by to see him toward the end of the fall semester and said he was thinking about discontinuing his medication, which he had in fact done months before. *See infra* text accompanying notes 212 et seq.

208. *Id.* at 75; *Williamson v. Liptzin*, 539 S.E.2d 313, 316 (N.C. Ct. App. 2000).

209. *Williamson*, 539 S.E.2d at 316. Williamson's transcript shows that he took twelve hours of elective courses in which he made a 1.5, a 1.6, a 1.2, and a 1.3—all grades in the D range. Transcript, *supra* note 162. He later told psychiatric evaluator Dr. John Warren that he "gave up on law school" in September because "[p]eople were so jealous of me being a telepath. They would lay me as low as possible." Forensic Psychiatric Evaluation and Report on Wendell Justin Williamson at 15 (Oct. 3, 1995) (on file with author).

210. WILLIAMSON, *supra* note 131, at 76. "I decided that the risk-averse, and therefore safe, and therefore moral, thing to do would be to kill in order to prove others were afraid to kill me in return, and thus by implication force them to admit that this was because I was telepathic and very important to their scheme of things." *Id.* at 80.

211. "I would have to be brutal, remorseless, cold-blooded, calculating, from that day forward. There could be no more doubt." *Id.* at 83.

212. Williamson alarmed his friend Bill Brown by bringing a Nazi uniform to a Halloween party. Forensic Psychiatric Evaluation Report, *supra* note 212. He also told people that he knew how to get away with murder by establishing insanity



Shortly before Thanksgiving, Williamson initiated a conversation with Dean Crisp—the only one that semester that Crisp later remembered. He told the Dean that he was thinking about discontinuing his medication because the side effects were “tough.”<sup>213</sup> He did not think he had a mental problem any longer, or that he needed the drugs.<sup>214</sup> Crisp told Williamson that it was a “big mistake” to stop the medication and asked if Williamson had talked to his doctor about it.<sup>215</sup> Williamson said that he had.<sup>216</sup> Crisp was not satisfied. “I remember making a deal with him that he would think about it,” he later testified, “and if he decided that he was going to stop taking his medication, that before he did that he would come back and talk to me.”<sup>217</sup> Crisp did not see or hear from Williamson again.<sup>218</sup> Crisp did not try to get any information from Student Services, which would likely have told him nothing.<sup>219</sup> Instead, he discussed the conversation with the Law School’s Associate Dean Lisa Broome, who agreed that the Law School administration would “keep a watch” on Williamson.<sup>220</sup>

When Williamson returned to Chapel Hill after Christmas break, he began living out of his car.<sup>221</sup> He enrolled in school, but he paid no attention to his legal studies.<sup>222</sup> In mid-January, one of his professors

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beforehand, which greatly alarmed his lawyers later. WILLIAMSON, *supra* note 131, at 140.

213. Crisp Dep., *supra* note 125, at 132–33.

214. *Id.*

215. *Id.* Crisp knew by then that Dr. Liptzin had retired. *Id.* at 139.

216. *Id.* at 133–34.

217. *Id.*

218. *Id.*

219. Crisp Dep., *supra* note 125, at 132–33.

220. *Id.* at 136. Williamson found it even more difficult to convince his mother that he was no longer mentally ill. When he went home for Thanksgiving, she suggested that he go back to the psychiatrist and back on the medications, but he ignored her. *Id.* at 136. He did not come home for Christmas, and by the time he saw his parents again in early January, he had become so uncommunicative that his mother was even more alarmed. He refused to speak and spent his days sleeping or “flipping through the encyclopedia.” Fonda Williamson Dep., *supra* note 125, at 43. He later testified that he was silently warning everyone what he was about to do. Williamson Dep., *supra* note 125, at 41.

221. Williamson v. Liptzin, 539 S.E.2d 313, 316 (N.C. Ct. App. 2000). Williamson was afraid that he would be apprehended and prevented from carrying out his plan if he stayed in his apartment. Williamson Dep., *supra* note 125, at 44.

222. Instead, Williamson planned and prepared his assault. He was again self-medicating with marijuana and alcohol. See *supra* note 166. He made a trip home to get his M1 rifle and practiced target shooting at his family’s farm in Tennessee. WILLIAMSON, *supra* note 131, at 101; Williamson, 539 S.E.2d at 316. He picked his route. He decided that he would start shooting on Henderson Street at mid-day, then “cut a deadly swath” across the UNC campus to the Botanical Gardens. WILLIAMSON, *supra* note 131, at 105–06. He walked the projected route, *id.* at 105, stashed a cache of ammunition at the spot where he expected to make his final stand, *id.* at 104, loaded a backpack with over 600 rounds of ammunition, *id.*, and stopped calling his mother, Fonda Williamson Dep., *supra* note 125, at 51.

reported to Dean Crisp that he was not attending class.<sup>223</sup> The registrar also reported that Williamson appeared to be “missing in action.”<sup>224</sup> Crisp spoke with Williamson’s other professors and learned that he was not in their classes, either.<sup>225</sup> He left a couple of notes in Williamson’s mail file asking him to communicate about his absences.<sup>226</sup> He did not call Student Services to find out if Williamson was still in treatment.<sup>227</sup>

Early in the week of January 23, 1995, Williamson’s mother called the Law School and spoke with Dean Crisp.<sup>228</sup> She was worried about her son.<sup>229</sup> He had been very withdrawn over the Christmas break, she told Crisp.<sup>230</sup> She could not find him and had not heard from him since January 13.<sup>231</sup> On Thursday, January 26, Dean Crisp and Associate Dean Broome went to lunch to discuss what to do about the situation.<sup>232</sup> By the time they returned to campus, Wendell Williamson’s rampage was over: he had shot and killed two people and was in police custody.<sup>233</sup>

Williamson carried out his plan eight months and two days after his last session with Dr. Liptzin. He walked along Henderson Street with his M1 rifle and a loaded backpack.<sup>234</sup> He shot at random, whomever he saw, and he was a good shot. He killed UNC undergraduate student Kevin Reichardt, who was bicycling toward campus.<sup>235</sup> He killed Chapel Hill resident Ralph W. Walker, who was sitting on his front porch.<sup>236</sup> Williamson also injured police officer Dimitra Stevenson before police subdued him by shooting him in the legs.<sup>237</sup> He was stopped before he reached the campus; otherwise he might have killed or injured many others.

Williamson was arrested on two charges of first degree murder and was immediately suspended from the University.<sup>238</sup> At his trial in October 1995,

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223. Crisp Dep., *supra* note 125, at 137.

224. *Id.*

225. *Id.*

226. *Id.* at 138.

227. *Id.* He would not likely have been answered. *See supra* note 178.

228. Fonda Williamson Dep., *supra* note 125, at 51–52; Crisp Dep., *supra* note 125, at 142.

229. Fonda Williamson Dep., *supra* note 125, at 51–52. She also called her son’s apartment manager and Student Services. *Id.* at 52.

230. *Id.*; Crisp Dep., *supra* note 125, at 142.

231. Fonda Williamson Dep., *supra* note 125, at 51–52; Crisp Dep., *supra* note 125, at 142.

232. Crisp Dep., *supra* note 125, at 30.

233. *Id.*; Gloria Lopez, *Wendell Williamson Back at Dorothea Dix Hospital Following Disappearance* (June 11, 2004), <http://www.wral.com/news/local/story/111584>.

234. WILLIAMSON, *supra* note 131, at 107–09; Lopez, *supra* note 233.

235. *Id.*

236. *Id.*

237. *Id.*

238. Letter Frederic W. Schroeder, Jr., UNC Dean of Students, to Wendell Justin Williamson (Jan. 26, 1995) (on file with author). Citing university procedures on

by which time he was again taking anti-psychotic medication and capable of non-delusional thinking, Williamson was found not guilty by reason of insanity.<sup>239</sup>

Williamson was committed to a state mental institution.<sup>240</sup> He applied for readmission to the University and permission to complete his law degree from the hospital.<sup>241</sup> Both applications were denied.<sup>242</sup>

### B. Williamson's Civil Litigation

A welter of lawsuits followed Williamson's acquittal. Suits were filed on behalf of all three victims against Williamson, his parents, and their homeowners' insurance carrier.<sup>243</sup> The parents of Kevin Reichardt also filed a tort claim against the University for wrongful death.<sup>244</sup> Williamson filed a negligence action against Dr. Liptzin and a tort claim of *respondet superior* against UNC.<sup>245</sup>

The only case that went to trial was Williamson's negligence action against Dr. Liptzin for failing to warn him of the serious nature of his mental illness and the almost certain return of his delusions if he

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admissions problems and extraordinary disciplinary emergencies, the University's Dean of Students suspended him "because of the seriousness of these [murder] charges and in consideration for the safety of the University community." *Id.*

239. *Williamson v. Liptzin*, 539 S.E.2d 313, 316 (N.C. Ct. App. 2000); WILLIAMSON, NIGHTMARE, *supra* note 131, at 156. Dr. Liptzin did not testify at the murder trial. Liptzin Dep., *supra* note 125, at 58.

240. *Williamson*, 539 S.E.2d at 316. Williamson has not yet been released and is unlikely to be. In that regard, he wrote, "As if it weren't bad enough that I had killed completely innocent people, it looked like my life was forever going to be ruined because of it." WILLIAMSON, *supra* note 131, at 132-33. In 2000, Williamson's forensic treatment team at Dorothea Dix Hospital recommended that he be allowed short periods of unsupervised time to engage in "off-ward" activities. *In re Williamson*, 151 N.C. App. 260 (N.C. Ct. App. 2002). The hospital grounds at Dorothea Dix Hospital are not fenced, and there have been escapes. *Id.* The Orange County Superior Court found that the public risk of allowing Williamson to be unsupervised outweighed the benefits and denied the recommendation. Williamson appealed on jurisdictional, equal protection, and due process grounds. Finding his arguments "unpersuasive," the Court of Appeals upheld the lower court. Two years later the trial judge did allow Williamson up to an hour of unsupervised time every day and in June, 2004 he created a local news sensation by disappearing for twelve hours. Lopez, *supra* note 233. He was found six miles away at a lakeside. *Id.*

241. WILLIAMSON, *supra* note 131, at 168.

242. *Id.*

243. All three suits settled after the Reichardts defeated a summary judgment motion by State Farm arguing that Wendell Williamson, as an adult child not living at home, was not covered by the policy. The court held that the circumstances created a genuine issue of material fact with respect to Wendell's capacity. Thereafter, State Farm settled with all three victims. Conversation with Jona Poe, Esq., attorney for the Reichardts (Jan. 4, 2010); WILLIAMSON, *supra* note 131, at 171.

244. *See Reichardt*, *infra* note 272.

245. *Williamson*, 539 S.E.2d at 313; Conversation with Nick Gordon, Esq., civil lawyer for Williamson (Oct. 15, 2009).

discontinued the anti-psychotic medication.<sup>246</sup> Experts who appeared on Williamson's behalf testified that Liptzin had violated the community standard of professional care by deciding not to diagnose Williamson's condition as schizophrenia (chronic, paranoid), by failing to perform a formal risk assessment, by failing to educate Williamson about his mental illness, and by failing to develop a plan for Williamson's continued treatment after Liptzin retired from Student Services.<sup>247</sup> Williamson had a history of recalcitrance and noncompliance with treatment and was an untreated substance abuser.<sup>248</sup> He had "no insight into his illness" when he began therapy and, it would appear, gained little from his sessions with Liptzin.<sup>249</sup> Under the circumstances, Liptzin's careless diagnosis and treatment, however generously intended, made it foreseeable that his patient's condition would worsen over time: that he would not comply with instructions; that his psychotic symptoms would increase; that his insight and judgment would remain poor or get worse; that he would continue to abuse substances; that he would again believe himself to be telepathic; that he would deteriorate and decompensate; that he would fall apart mentally; that he would become sicker.<sup>250</sup> About this much his experts could testify with confidence, and without significant contradiction.<sup>251</sup> Nor was there any significant dispute that paranoid schizophrenia is the mental illness most closely associated with violence. The probability of violence goes up when the schizophrenic is young and male and has easy access to firearms. Williamson fit all three categories.<sup>252</sup>

What was less clear, however, even to Williamson's own experts, was that his inevitable psychological disintegration would lead to violence of the sort he engaged in and result in the injuries of which he complained.<sup>253</sup> They were prepared to state that as his illness progressed it was foreseeable that he *might* retrieve his rifle from home and that he *might* become dangerous, but further than that none would hazard a prediction.<sup>254</sup>

Apparently, the jury was not troubled by such subtleties. Williamson's preventability argument was too strong: had Dr. Liptzin been reasonably thorough and discerning, had he taken his diagnostic obligations more seriously, had he not been lax in his therapeutic approach and soft on his

246. *Williamson*, 539 S.E.2d at 315.

247. *Id.* at 317; Warren Dep., *supra* note 125, at 44 (stating that Liptzin should have done a formal risk assessment).

248. The experts criticized Liptzin for failing to treat Williamson's substance abuse seriously, though Liptzin did encourage his patient to reduce his drinking and consider a 12-step program.

249. *Williamson*, 539 S.E.2d at 317.

250. *Id.*

251. *Id.*

252. *Id.*

253. Injuries included getting shot, being incarcerated indefinitely, and losing his legal career.

254. *Williamson*, 539 S.E.2d at 317.

manipulative patient, Williamson would not have discontinued treatment, his psychotic thought processes would not have returned or worsened, and his rampage never would have happened.<sup>255</sup> He would not have murdered two people, he would not have been shot in the legs, he would not have been dismissed from law school, and he would not be indefinitely incarcerated in a mental hospital.<sup>256</sup> On that reasoning, the jury awarded Williamson \$500,000.<sup>257</sup>

Like *Tarasoff*, the jury award made national headlines and created a furor in the psychiatric community, to say nothing of the moral outrage expressed by the victims' families and by members of the public.<sup>258</sup> On the sole ground that Dr. Liptzin could not reasonably have foreseen Williamson's rampage, the North Carolina Court of Appeals reversed.<sup>259</sup> It left intact, and did not address, the jury's findings that Liptzin's care of Williamson was negligent and harmful to his patient, and that Williamson's own negligence did not contribute to the violent outcome.<sup>260</sup> Instead, it denied him a remedy out of "convenience, . . . public policy, . . . [and] a sense of rough justice."<sup>261</sup>

The court of appeals candidly acknowledged that its reversal of the jury's verdict was an extraordinary, even arbitrary move.<sup>262</sup> The extent to which a plaintiff's injury was a foreseeable result of the defendant's

255. Herbert, *supra* note 142, at 8.

256. *Id.* The jury found no contributory negligence. *Id.* See also *Williamson*, 539 S.E.2d at 318.

257. *Williamson*, 539 S.E.2d at 318.

258. William Glaberson, *Killer Blames His Therapist, and Jury Agrees*, N.Y. TIMES, Oct. 10, 1998, at A1.

259. *Williamson*, 539 S.E.2d at 320.

260. Yale clinical psychologist (and law clerk to Justice Tobriner on the *Tarasoff* case) Paul Herbert wrote:

As legal precedent, there is considerably less to Williamson than meets the eye. . . . As clinical precedent, however, [it] is signal. Stripped bare, the facts are that defendant (apparently purposely) misdiagnosed schizophrenia as "delusional disorder," neglected to diagnose or target for specific treatment (such as AA meetings or partial hospital therapy) substance abuse in a six-pack-a-day (plus "occasional" marijuana) gun-owning schizophrenic, and made no specific follow-up arrangements at termination (occasioned by defendant's retirement).

Herbert, *supra* note 142, at 8.

261. *Williamson*, 539 S.E.2d at 324 (quoting *Palsgraf v. Long Island R.R. Co.*, 162 N.E. 99, 103 (N.Y. 1928) (Andrews, J., dissenting)).

262. The court wrote:

We recognize that our jurisprudence in the area of proximate cause is quite varied. . . . We further recognize that it is only in the rarest of cases that our appellate courts find proximate cause is lacking as a matter of law. . . . However, the law of proximate cause "cannot be reduced to absolute rules." . . . This is one of those rare cases where "because of convenience, of public policy, of a rough sense of justice, the law arbitrarily declines to trace a series of events beyond a certain point."

*Id.* at 324 (citations omitted).

negligence is an element of proximate cause in North Carolina, and causation is a question of fact for the jury.<sup>263</sup> A court of appeals is seldom justified in reversing the jury's finding.<sup>264</sup> The court's reliance on foreseeability was not particularly persuasive.<sup>265</sup>

Even less persuasive was the court's suggestion that university mental health care is inherently more short-term and stop-gap than other clinical care arrangements. To the contrary:

University students are a fairly stable catchment, often followed for several years. ([Williamson's] contacts with his campus mental health service spanned four years, from May 1990 to May 1994); it is not clear that community mental health center clientele or private outpatients, given the limitations of health insurance coverage, have characteristically lengthier or deeper courses of treatment nowadays.<sup>266</sup>

Moreover, a well-functioning university clinic should be able to enhance

263. Moreover, North Carolina's definition of proximate cause is loose enough to support the jury's award in *Williamson*:

The element of foreseeability is a requisite of proximate cause. To prove that an action is foreseeable, a plaintiff is required to prove that "in the exercise of reasonable care, the defendant might have foreseen that *some* injury would result from his act or omission, or that *consequences of a generally injurious nature* might have been expected."

*Id.* at 319 (quoting *Hart v. Curry*, 78 S.E.2d 170, 171 (N.C. 1953)) (emphasis added).

264. *Id.*

265. Shortly after the decision issued, Paul Herbert commented:

But for a quite striking confluence of serendipitous facts, the appellate court could not have saved the defendant (and surely would not have been inclined to do so): the plaintiff harmed others rather than himself (the court view[ed] self-harm in this case as significantly more foreseeable); the plaintiff was extraordinarily high-functioning (attenuating the nexus between defendant's actions and the plaintiff's decompensation); a full eight months went by; the plaintiff made no attempt to pursue follow-up (as distinct from a mentally disturbed patient who might try on his own to make an appointment not arranged for him but fail[]; there were no documented threats or past acts whatsoever of violence (quite peculiar in a case that eventuates in a shooting spree); and the clinical setting was a university health service (which the court implie[d] unconvincingly carries a lesser standard of care with respect to diagnosis and follow-up).

Herbert, *supra* note 142, at 8.

266. *Id.* at 4. Nor did the court have any factual basis for implying, if it meant to, that university psychiatrists are or should be exempted from professional standards of care when diagnosing student-patients or arranging for their follow-up treatment. *Id.* at 5. Benign motives do not excuse false diagnosis in any setting. Herbert observed, "A cardiologist would not deliberately overlook a basketball prospect's serious valve pathology and then expect to be exonerated in a wrongful death suit by asserting that he had not wanted to stand in the way of the player's athletic career." *Id.* at 9. He continued, "[W]here follow-up is clearly indicated (as with a young and noncompliant substance-abusing schizophrenic), more must be done (and documented) than urging the patient himself to make appropriate arrangements." *Id.*

effective follow-up arrangements for patient care after a therapist retires, since it is capable of providing administrative continuity, intra-organizational communication, and professional replacement therapists.<sup>267</sup>

The professional therapists who treat students at such clinics are university employees. Dr. Liptzin was on both the staff of the clinic and the faculty of the University's medical school. The court of appeals was surely aware that if it did not rescue him from the jury award, UNC would absorb at least a portion of the cost.<sup>268</sup> Once again, as in the original case, application of the *Tarasoff* formula diminished the institutional context in which the professional negligence arose and relieved the institution of liability it might otherwise have incurred. Indeed, it is one of the ironies of the case that the North Carolina court cited *Tarasoff* in support of finding that Liptzin had no duty to warn his patient of the nature of his illness, because Williamson's violence was unforeseeable.<sup>269</sup>

It is difficult not to concur with the result of the *Williamson* appeal, since the jury award appeared to compensate the plaintiff for premeditated murder.<sup>270</sup> Given the self-confessed weakness of the appellate decision, however, the outcome left troubling questions concerning the extent of the University's potential liability to a more deserving claimant. It is perhaps not surprising that UNC decided to settle rather than defend the wrongful death claim of student victim Kevin Reichardt.<sup>271</sup>

### C. The Reichardts' Wrongful Death Action

#### 1. The Lawsuit

Filed in January 1997, the Reichardts' suit specifically identified Dean

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267. Compare, for example, the court's account of the course of treatment of a suicidal student in *Shin v. Mass. Inst. of Tech. (MIT)*, No. 020403, 2005 WL 1869101 (Mass. Super. Jun. 27, 2005). See *infra* note 478 and accompanying text.

268. The North Carolina Tort Claims Act (N.C.T.C.A.) covers public universities and in 1997 capped damages at \$150,000. N.C. GEN. STAT. §143-299.2 (1995) (amended 2007, increasing damage limit to \$1,000,000). Cases under the N.C.T.C.A. are adjudicated by the North Carolina Industrial Commission and reviewed by the North Carolina Court of Appeals. *Id.* § 143-291. At the same time that he sued Liptzin, Williamson filed a claim against the University on a theory of *respondeat superior*. The claim was dismissed when he lost his appeal in the separate suit against Liptzin. Conversation with Nick Gordon, Esq., Williamson's civil lawyer (October 15, 2009).

269. *Williamson v. Liptzin*, 539 S.E.2d 313, 322 (N.C. Ct. App. 2000) ("We recognize the difficulty that a therapist encounters in attempting to forecast whether a patient presents a serious danger of violence." (quoting *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 345 (Cal. 1976)).

270. The court also recognized a public policy in favor of less restrictive treatment modalities. *Id.* at 323. It did not, however, disturb the jury's determination that, even so, Liptzin's diagnosis and treatment of Williamson was so lax as to amount to negligence. *Id.* at 324.

271. See *supra* note 243 and accompanying text.

Crisp, Dr. Liptzin, and UNC Dean of Students Frederic Schroeder as negligent actors.<sup>272</sup> First, the plaintiffs complained that Williamson was allowed to resume law school in 1992, after his involuntary ten-day committal, and that defendants did not make sure he received continuing psychiatric care—the condition upon which he was discharged from the hospital.<sup>273</sup> Second, after Liptzin retired in May 1994, defendants made no effort to monitor Williamson's psychiatric condition or require continuation of his treatment.<sup>274</sup> Third, defendants knew days before the shooting that Williamson was mentally ill, should be on medication, was missing classes, and was out of communication with his parents, but they did not call the UNC or Chapel Hill police or otherwise try to locate him.<sup>275</sup>

UNC's answer denied any liability, but a later case, decided by the court of appeals in early 2001, suggests that discreet resolution may have been the better part of valor.<sup>276</sup>

## 2. The Sources of Law

### a. Davidson v. University of North Carolina

In *Davidson v. University of North Carolina*, the plaintiff was an undergraduate at UNC who suffered permanent brain injury in 1985 when

272. Karl Reichardt et al. v. Univ. of N. Carolina at Chapel Hill, I.C. File No A-14669 (Jan. 24, 1997) (on file with author); conversation with Jona Poe, *supra* note 243.

273. *Reichardt*, *supra* note 272.

274. The complaint also alleged that Crisp knew that Williamson was off his medications. See *supra* text accompanying notes 212–16.

275. *Reichardt*, *supra* note 272. The complaint concluded:

UNC through its employees owed to Mr. Reichardt the duty to protect him from and warn him about students that it knew or should have know presented a danger to inflict harm to other students and to otherwise assure a safe campus for the University community. UNC breached this duty in that it failed to secure adequate psychiatric care for Mr. Williamson despite the fact that it had determined that he posed a danger to himself and the University community and that he was suffering extreme psychotic delusions as a result of his paranoid schizophrenia. In addition, UNC failed to protect the University community, including Mr. Reichardt, from a student (Wendell Williamson) that it knew or should have known posed a continuing threat to himself and to other members of the University community despite the fact that it had the ability and duty to remedy the situation through the express powers of its Committee on Problem Admissions and Extraordinary Disciplinary Emergencies. As a direct and proximate result of UNC's breach of duty, Kevin Reichardt was murdered by Wendell Williamson. Accordingly, claimants Karl and Carol Reichardt, as co-administrators of the estate of Kevin Reichardt [,] have brought the present wrongful death claim against UNC for all damages recoverable pursuant to N.C.G.S. § 28-A-18-2.

*Id.*

276. See *Davidson v. Univ. of N. Car.*, 543 S.E.2d 920 (N.C. Ct. App. 2001), *cert. denied*, 353 N.C. 724, 550 S.E.2d 771 (2001).



she fell from a human pyramid during cheerleading practice.<sup>277</sup> The North Carolina Industrial Commission denied the claim, but the North Carolina Court of Appeals reversed.<sup>278</sup> The court confirmed that the school-pupil relationship is not special by definition in North Carolina.<sup>279</sup> However, a student's dependence upon the university, the benefit the university derives from the situation, and the university's control over student conduct and activities may in some circumstances create a special relationship that in turn gives rise to an affirmative duty to protect. Moreover, the court held that a duty to exercise reasonable care may also arise from a voluntary undertaking by the university.<sup>280</sup>

*Davidson's* reasoning provides a theoretical basis for liability in the Reichardt's wrongful death claim, even if Williamson's rampage was not precisely predictable. The University's Student Services was a benefit to both UNC and its students, and it was not gratuitous. Requiring students to pay \$150 per year in fees to support the clinic, which then provided services at no additional cost, benefitted students as it encouraged them to depend upon the clinic for mental health services.<sup>281</sup> Student Services had its own paid staff and also offered clinical practice opportunities for medical students at UNC, which benefitted the University.<sup>282</sup> Another benefit was that Dr. Liptzin not only directed the mental health clinic and taught in the medical school, but also served as a consultant to university administrators on psychological issues and "extraordinary disciplinary emergencies" (such as that which Williamson created by his outburst at The Pit, of which Liptzin was aware).<sup>283</sup> This arrangement enhanced UNC's capacity to maintain coordination and consistency in its approach to mental health issues on its campus.

The *Davidson* court also considered the degree of control that UNC exercised over student life as it related to the negligence claimed.<sup>284</sup> In

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277. *Id.*

278. *Id.* at 921.

279. *Id.* at 929.

280. *Id.*

281. The benefit of such a clinic is statistically greatest for full-time graduate and professional students, like Williamson, who are likely excluded by age 23–25 from parental insurance and unlikely to have health insurance available through an employer. See, e.g., MD. HEALTH CARE COMM'N, *Health Insurance Coverage Among College Students*, at 2 (2009), available at [http://mhcc.maryland.gov/legislative/hlthins\\_college.pdf](http://mhcc.maryland.gov/legislative/hlthins_college.pdf) (nationally, thirty percent of 19–29 year olds were uninsured in 2006–2007). They are therefore least likely to get medical care unless they have access through their educational institution.

Post-graduate students as a group are also the most likely to commit murder on campus. de Haven, *supra* note 1, at 508 n.10. Seen as a protective and preventive measure, affordable mental health care is of mutual benefit to them and to the institution at which they are enrolled for this reason as well.

282. Liptzin Dep., *supra* note 125, at 14, 21, 24, 36, 40.

283. *Id.* at 32, 33.

284. *Davidson*, 543 S.E.2d at 927.

Williamson's case, UNC exercised considerable control over students with psychological problems that manifested in disorderly public conduct. First, it could immediately control disturbances on its campus. Campus police employed by UNC had authority to detain and arrest students on campus, and UNC's Hospital, unlike Berkeley's, could accept short-term involuntary committals.<sup>285</sup> In September 1992, when Williamson was hurting himself at the Pit and in need of restraint, the University took immediate control of the situation.<sup>286</sup> The campus police were summoned and took Williamson to the UNC hospital, where he was treated and diagnosed by UNC staff who then notified the UNC psychiatric consultant with their recommendation that his commitment be extended.<sup>287</sup>

The University had control over the situation, too, by virtue of its power to dismiss students who posed a danger to people or property, created a serious threat of disruption of the academic process, or were charged with a serious crime.<sup>288</sup> The Law Deans had the additional clout of being able to make it difficult, if not impossible, for Williamson to take the bar examination if he did not seek psychiatric help.<sup>289</sup> The threat of disqualification, suggested by Dr. Liptzin, prevented further disturbance of the learning environment and protected the academic community without dismissing a promising law student. Moreover, it was effective. Only fear of exclusion from the legal profession persuaded Williamson into treatment.<sup>290</sup> The pleas of his mother, the concern of his friends, and the loss of the woman he intended to marry had had no such effect, and actual dismissal from school would have removed the incentive.<sup>291</sup> Considering the difficulty of coercing a disturbed adult into seeking outpatient

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285. Williamson, 539 S.E.2d at 315; University of North Carolina Public Safety, available at <http://www.dps.unc.edu/Police/police.nav.cfm>; see *infra* note 288.

286. WILLIAMSON, *supra* note 131, at 41–43.

287. See *supra* text accompanying notes 142–48 (Williamson's first hospitalization). Taking Williamson to UNC's hospital for treatment further reinforced his dependence upon UNC's medical services and probably "caused him to forego other alternatives for protecting himself." See *infra* text accompanying note 466.

288. See UNC COMMITTEE ON PROBLEM ADMISSIONS AND EXTRAORDINARY DISCIPLINARY EMERGENCIES in effect in 1995 (on file with author).

289. Candidates for admission to the bar must undergo investigation to ensure they are of good character and otherwise fit to practice law. Law Deans or their designates have an opportunity to notify the candidate's state board of bar examiners if there is a question about a graduate's character or fitness based on law school performance, including mental or emotional instability. See, e.g., Nat'l Conference of Bar Examiners & ABA Section of Legal Educ. and Admissions to the Bar, Comprehensive Guide to Bar Admissions iii (2010), available at [http://www.ncbex.org/fileadmin/mediafiles/downloads/Comp\\_Guide/CompGuide\\_2010.pdf](http://www.ncbex.org/fileadmin/mediafiles/downloads/Comp_Guide/CompGuide_2010.pdf).

290. WILLIAMSON, *supra* note 131, at 70.

291. Had the more gentle coercive tactic not succeeded, the deans were considering having Williamson picked up and taken to the hospital again involuntarily. Dean Wegner testified in deposition that she generally preferred involuntary committal as the appropriate course of action. Wegner dep., *supra* note 125, at 43.

treatment, the school's capacity to insist that Williamson get help supports finding a special relationship.<sup>292</sup>

Moreover, UNC officials were clearly concerned about the danger Williamson might pose to the law school community and acted on that basis. In October 1992, Dean Crisp insisted on receiving official medical and psychological clearance before allowing Williamson's return to class.<sup>293</sup> When UNC dismissed Williamson summarily on the day of the rampage, it did so partly "in consideration for the safety of the University community."<sup>294</sup> These actions surely reflect the assumption of an ethical, if not a legal, duty on the part of college and university officials.

#### *b. Furek v. University of Delaware*

Even if dependence on UNC's clinical mental health services and UNC's control over dangerous and disturbing student behavior were not enough to establish a special relationship with Williamson, UNC might still have assumed a duty to keep him from injuring himself or others. To be sure, in terms of moral culpability, if not legal liability, there is a big difference between neglecting to prevent an accident during cheerleading practice and neglecting to prevent a suicide, an assault, or a rampage killing. Nevertheless, the *Davidson* court cited with approval *Furek v. University of Delaware*, a case holding a university liable to a student

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292. In 2004, in a report on incarceration of the mentally ill, the American Psychiatric Association cited scarce community resources and resistance to treatment as primary reasons why mentally-ill adult offenders do not receive appropriate outpatient mental health care:

In many jurisdictions in the United States, mental health treatment . . . resources are insufficient to serve the numbers of community members with mental illness. People with mental illness may be expected to get themselves to outpatient clinics, when the real need for a large proportion of them is for outreach services like assertive community treatment programs. Some service providers may lack the ability to provide the degree of structure often required by offenders who have mental illness. Since many of them have illnesses that are highly resistant to treatment, they may refuse to visit treatment providers, refuse or be unable to tolerate their medications, or may be unable to refrain from substance abuse.

THE AMERICAN PSYCHIATRIC ASS'N, *Mental Illness and the Criminal Justice System: Redirecting Resources Toward Treatment, Not Containment* 3 (2004), available at [http://archive.psych.org/edu/other\\_res/lib\\_archives/archives/200401.pdf](http://archive.psych.org/edu/other_res/lib_archives/archives/200401.pdf). Williamson appears clearly to have been in the category of individuals who are resistant to treatment, intolerant of medication, and engaged in substance abuse and therefore unlikely to receive mental health treatment unless coerced in some fashion.

293. Dean Crisp wrote to Williamson, "[A]s long as your situation is not one that can endanger either you or members of the law school community, we do not need to know any specifics." Letter from Crisp to Williamson (Oct. 12, 1992) (on file with author).

294. Letter from Schroeder to Williamson (Jan. 26, 1995) (on file with author). The sense of duty is surely strengthened by the independent obligation of law school administrators to certify the character and fitness of law graduates to their state boards of professional responsibility.

injured during a fraternity hazing.<sup>295</sup> The reference suggests that North Carolina, like several other jurisdictions, may be prepared to hold a college or university liable for deliberate student violence that it has undertaken to prevent.<sup>296</sup> Indeed, besides *Davidson*, the few cases that adopt an affirmative undertakings theory in the university context involve deliberate violence, not athletic injuries.<sup>297</sup>

In *Furek*, the University of Delaware had voluntarily undertaken to adopt, publish, and remind students of policies forbidding fraternity hazing.<sup>298</sup> However, it had neglected to communicate its policy to the campus police, and the policy had not been actively enforced.<sup>299</sup> On that basis the Delaware Supreme Court held that the school had breached its affirmative duty to protect an undergraduate fraternity pledge who was burned with oven cleaner during Sigma Chi's "Hell Night" hazing ritual.<sup>300</sup>

### c. Mullins v. Pine Manor College

*Furek*, in turn, cited with approval a 1983 decision by the Massachusetts Supreme Judicial Court, *Mullins v. Pine Manor College*, in which a woman student was kidnapped from her dorm room and raped by an off-campus intruder.<sup>301</sup> The Massachusetts court observed that, in general, colleges of "ordinary prudence" have imposed upon themselves, by consensus, a duty to protect the well-being of their resident students.<sup>302</sup> It also held, in particular, that Pine Manor College had voluntarily undertaken to protect the plaintiff, who had paid dormitory fees and had relied upon it for security.<sup>303</sup>

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295. *Davidson v. Univ. of N. Car.*, 543 S.E.2d 920, 929 (N.C. Ct. App. 2001) (citing *Furek v. Univ. of Del*, 594 A.2d 506 (Del. 1991)).

296. *Furek* was not cited in the appellate brief of either party. It was the only out-of-state authority cited by the court, and the only case involving a university defendant. *Id.*

297. In addition to *Furek*, see *Nero v. Kan. St. Univ.*, 861 P.2d 768 (Kan.1993); *Mullins v. Pine Manor Coll.*, 449 N.E.2d 331 (Mass. 1983); *Jesik v. Maricopa Co. Comm. Coll. Dist.*, 611 P. 2d 547 (Ariz. 1980); *Schieszler v. Ferrum Coll.*, 236 F. Supp.2d 602 (W.D. Va. 2002).

298. *Furek*, 594 A.2d at 511.

299. *Id.*

300. The *Furek* court based its analysis directly on RESTATEMENT (SECOND) OF TORTS § 323 (1965):

One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if (a) his failure to exercise such care increases the risk of such harm, or (b) the harm is suffered because of the other's reliance upon the undertaking.

301. 449 N.E.2d 331 (Mass. 1983).

302. *Id.* at 335.

303. *Id.* at 336-37. In an earlier case, *Jesik v. Maricopa Co. Comm. Col. Dist.*, 611

#### D. Reframing the Duty: On Situations that Require Special Attention

*Davidson's* reasoning, as illuminated by *Furek* and *Mullins*, might have been even more persuasive in a case involving extreme violence and death than in a case involving a cheerleading accident. The Reichardts could have argued that UNC became a legal actor when its Law School Dean of Students "committed" a student to outpatient treatment as a condition of continuing in law school, thereby necessarily undertaking to monitor his compliance.<sup>304</sup> In Williamson's case, UNC was providing non-gratuitous psychological services to its students upon which many relied, and that might itself be viewed as an affirmative undertaking by the same reasoning as *Pine Manor*. Moreover, Dean Crisp undertook to escort Williamson to Student Psychiatric Services and explicitly made his continuing therapy a condition of staying in school—the kind of particular control over a certain student's behavior that can support finding a duty based on special circumstances. That Dean Crisp also directly monitored and encouraged Williamson's compliance for the next eight months, whenever Williamson was enrolled in school, strengthens the argument that, knowing his mental condition was problematic, the Law School undertook to look out for his welfare and the welfare of the students among whom he was still being allowed to study.

Arguably, too, Dean Crisp and, through him, Dean Schroeder were in a better position than almost anyone else to know whether Williamson posed a danger to himself or the community in January 1995. Weeks before the rampage, Dean Crisp knew that Williamson might have stopped taking his medication, which Crisp considered a "big mistake" and a "bad idea."<sup>305</sup> He knew that Williamson was missing his classes.<sup>306</sup> He had Williamson on the "watch list."<sup>307</sup> He knew that Williamson's mother was very worried and that Williamson was not communicating with her or with the school.<sup>308</sup> He and Dean Schroeder might not have been trained to administer a formal risk assessment themselves, but they were empowered

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P.2d 547 (Ariz. 1980), one student shot another during class registration after the victim had sought assistance from a campus security guard. The Arizona Supreme Court held that defendant university had a statutory duty to protect students even from a third party's intentional crime based on premises liability theory if the school "realized or should have realized the likelihood that such a situation might be created, and that a third person might avail himself of the opportunity to commit such a . . . crime." *Id.* at 550 (citation omitted). The Court found it unnecessary to consider plaintiff's alternative argument based on affirmative undertaking. *Id.* at 551.

304. He also expressly undertook to keep tabs on the student, and conscientiously did so for the remainder of the semester. "*Furek* [is] about starting something and finishing it properly when people (mainly students) have come to rely on what you have started." BICKEL & LAKE, *supra* note 26, at 129.

305. Crisp Dep., *supra* note 125, at 132–34

306. *Id.* at 137.

307. *Id.* at 138.

308. *Id.* at 142.

to initiate a search for the missing student and to arrange immediate psychiatric evaluation, including a risk assessment, and longer-term treatment if necessary. As with the telephone call that was not made in *Tarasoff*, intervention of this kind would have been relatively easy to accomplish and might have averted much grief.

Based on *Davidson's* voluntary undertaking analysis, the North Carolina court might well have found that the University administrators had a duty, independent of Dr. Liptzin's, to pay closer attention to Williamson's mental state. If so, they also had a duty to take reasonable action when they learned within days of the rampage that Williamson was off his medications, missing, and incommunicado—that is, while the harm they had anticipated was still preventable and growing ever more imminently foreseeable. The primary question would have been whether they could reasonably have done more, under the circumstances, to prevent the tragedy that occurred. As in *Tarasoff*, where responsibility for the failure to prevent murder came to rest on Dr. Moore alone, it is difficult to justify imposing liability based on the alleged inaction of the conscientious Dean Crisp while exonerating Dr. Liptzin's adjudicated negligence. Whatever the outcome, however, resolution of the causation issues would almost certainly have required an evidentiary hearing before the Industrial Commission, painful for all concerned. Not long after the *Davidson* opinion issued, UNC settled quietly with the Reichardts for an undisclosed amount.<sup>309</sup>

### III. MAKING MATTERS WORSE: THE 2007 RAMPAGE AT VIRGINIA TECH

*"It could be hell trying to get help for a troubled student at Virginia Tech."*<sup>310</sup>

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309. The settlement was negotiated in late 2001 and executed in early 2002. The amount did not exceed the damage cap. See *supra* note 243; see also e-mail from Jona Poe (March 1, 2010) (on file with the author).

310. LUCINDA ROY, *NO RIGHT TO REMAIN SILENT: THE TRAGEDY AT VIRGINIA TECH* 30 (2009). Lucinda Roy was the Chair of the English Department at Virginia Tech during much of the relevant time frame, and she had numerous encounters with Seung Hui Cho before his rampage. Her personal account of the events, *No Right to Remain Silent*, is used here to supplement the primary source of information, the Virginia Governor's Report. See VIRGINIA TECH REVIEW PANEL, *MASS SHOOTINGS AT VIRGINIA TECH* (April 16, 2007) [*hereinafter* VT PANEL REPORT], available at [http://www.governor.virginia.gov/TempContent/techPanelReport-docs/Full\\_Report.pdf](http://www.governor.virginia.gov/TempContent/techPanelReport-docs/Full_Report.pdf). Other sources of information, including medical records of the shooter obtained during civil discovery, are noted *passim*.

The VT Panel Report is the most frequently cited resource for information about the events surrounding the rampage, but its findings are not undisputed. The families of some of the victims objected to certain aspects of the original report. The report was revised in 2010. Documents related to the controversy surrounding the report are accessible at David Cariens, *A Sense of Security: Our Children and Our Schools* (Jun. 6, 2010), [http://aquestionofaccountability.blogspot.com/2010\\_07\\_01\\_archive.html](http://aquestionofaccountability.blogspot.com/2010_07_01_archive.html).

Two other reports provide useful perspectives and information. Virginia's

Wendell Williamson is not the only student to have committed mass murder since the Texas Tower shooting—he is not even the only law student.<sup>311</sup> Attack by a solitary rampager, virtually unthinkable until the 1960's, has become an increasing risk of academic life.<sup>312</sup> The “Virginia Tech Massacre” committed by Seung Hui Cho is, so far, the worst of the university rampages, resulting in 50 casualties—even more than the Texas Tower shooting.

Like the murder in *Tarasoff* and the rampage at UNC, the shooting at Virginia Tech illuminates the dynamics of the university's administration, its mental health clinic, and a student exhibiting signs of mental illness—both in the classroom and in the university residence halls. The rampage at Virginia Tech also occurred in a jurisdiction that strictly limits a therapist's duty to protect third parties from violent behavior by a client.<sup>313</sup>

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Inspector General for Mental Health, Mental Retardation & Substance Abuse Services issued a report. OFFICE OF THE INSPECTOR GENERAL, INVESTIGATION OF APRIL 16, 2007 CRITICAL INCIDENT AT VIRGINIA TECH (2007) [*hereinafter* INSPECTOR GENERAL'S REPORT], available at <http://www.oig.virginia.gov/documents/VATechRpt-140.pdf>. The United States Department of Justice also authored a report to the President. U.S. DEPARTMENT OF JUSTICE, REPORT TO THE PRESIDENT ON ISSUES RAISED BY THE VIRGINIA TECH TRAGEDY (June 13, 2007), available at <http://www.hhs.gov/vtreport.pdf>.

311. See *infra* note 431 (Peter Odighizuwa, Appalachian School of Law, January 2002).

312. See de Haven, *supra* note 1; see also *infra* Section IV.A.

313. Virginia has limited the duty both by common law and by statute. See *supra* note 106. The Virginia Code Annotated provides in relevant part:

B. A mental health service provider has a duty to take precautions to protect third parties from violent behavior or other serious harm only when the client has . . . communicated to the provider a specific and immediate threat to cause serious bodily injury or death to an identified or readily identifiable person or persons, if the provider reasonably believes, or should believe according to the standards of his profession, that the client has the intent and ability to carry out that threat immediately or imminently. . . . The duty to protect does not attach unless the threat has been communicated to the provider by the threatening client while the provider is engaged in his professional duties.

C. The duty set forth in subsection B is discharged by a mental health service provider who takes one or more of the following actions:

1. Seeks involuntary admission of the client . . . .
2. Makes reasonable attempts to warn the potential victims . . . .
3. Makes reasonable efforts to notify a law-enforcement official having jurisdiction in the client's or potential victim's place of residence or place of work . . . .
4. Takes steps reasonably available to the provider to prevent the client from using physical violence or other means of harm to others until the appropriate law-enforcement agency can be summoned and takes custody of the client.
5. Provides therapy or counseling to the client or patient in the session in which the threat has been communicated until the mental health service provider reasonably believes that the client no longer has the intent or the

### A. The Facts

Like UNC and Berkeley, Virginia Tech is a large, public research university.<sup>314</sup> It has a fully-accredited police force with its own SWAT team.<sup>315</sup> In April 2007, it had an emergency response plan, including an emergency warning process that had been in place for two years.<sup>316</sup> It also had an interdisciplinary “Care Team” comprised of the Director of the Office for Student Life and Advocacy, the Director of Resident Life, the head of Judicial Affairs, representatives from Student Health, and legal counsel.<sup>317</sup> The Care Team met regularly to identify and discuss problem students and to make appropriate referrals and recommendations in specific cases of concern.<sup>318</sup>

Like UNC and Berkeley, Virginia Tech operated a mental health clinic, the Cook Counseling Center (CCC), supported by student fees. CCC provided therapeutic outpatient services to students free of charge.<sup>319</sup> Like Berkeley, however, CCC did not have the capacity to evaluate disturbed students for purposes of involuntary committal, even in an emergency.<sup>320</sup> Students whose need for professional intervention appeared acute were transported, often by way of the campus police, to the Carilion New River Valley Medical Center for evaluation; from there they could by magistrate’s order be admitted for overnight observation at St. Alban’s

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ability to carry out the threat.

D. A mental health service provider shall not be held civilly liable to any person for:

1. Breaching confidentiality with the limited purpose of protecting third parties by communicating the threats described in subsection B made by his clients to potential third party victims or law-enforcement agencies or by taking any of the actions specified in subsection C.
2. Failing to predict, in the absence of a threat described in subsection B, that the client would cause the third party serious physical harm.
3. Failing to take precautions other than those enumerated in subsection C to protect a potential third party victim from the client's violent behavior.

VA. CODE ANN. § 54.1-2400.1B-D (Sup. 2010). *See also infra* note 410.

314. WIKIPEDIA, *Virginia Polytechnic Institute and State University*, [http://en.wikipedia.org/wiki/Virginia\\_Tech](http://en.wikipedia.org/wiki/Virginia_Tech) (last visited May 24, 2010). It has, however, no medical school and no hospital.

315. JEANNE CLERY, *DISCLOSURE OF CAMPUS SECURITY POLICY AND CAMPUS CRIME ACT ANNUAL REPORT OF 2007* 4 (2007).

316. ROY, *supra* note 310, at 101.

317. The VT Panel Report criticized the composition of the Care Team as insufficiently inclusive. VT PANEL REPORT, *supra* note 310, at 52. In 2003, Virginia Tech abolished the Office of the Dean of Students (ODS) and decentralized its functions. The ODS was reinstated and a new dean appointed only after the shootings. ROY, *supra* note 310, at 130.

318. VT PANEL REPORT, *supra* note 310, at 52.

319. ROY, *supra* note 310, at 65.

320. *Id.*



Hospital.<sup>321</sup>

Seung Hui Cho enrolled as a freshman at Virginia Tech in August 2003 intending to major in Business Information Systems.<sup>322</sup> He completed his first year with a 3.0 average and without apparent difficulty, and his second year was equally uneventful.<sup>323</sup> In his junior year, however, hoping to become a creative writer, he switched his major to English, and his so-far unremarkable academic performance became both singular and disturbing.<sup>324</sup>

At the time, Virginia Tech's English Department employed about fifty professors and an equal number of instructors.<sup>325</sup> Cho was a junior in fall 2005, twenty months before his rampage, when he enrolled in Professor Nikki Giovanni's poetry writing class. In class he was silent and withdrawn, his face hidden behind mirrored sunglasses.<sup>326</sup> When required to speak, he was inaudible, until one day in mid-October when he unexpectedly found his voice and read aloud an angry piece directed at Giovanni and his classmates.<sup>327</sup> The performance alarmed Giovanni very much.<sup>328</sup> She also learned that Cho was photographing his classmates with his cell phone, which frightened several of them enough to stay away from class.<sup>329</sup> Giovanni reported her concerns to Professor Lucinda Roy, Ph.D., Chair of the English Department.<sup>330</sup> After Cho refused to switch

321. See VT PANEL REPORT, *supra* note 310, at 46–49. St. Alban's was not affiliated with the University.

322. ROY, *supra* note 310, at 33.

323. He was shy, silent, and isolated, as he had been in high school, but he was excited about college and appeared to be adjusting well. *Id.* at 37.

324. *Id.* at 40–41. At the same time, he also moved to a residential suite on campus with several suitemates. *Id.* at 41. His behavior in university housing would also prove a source both of concern and of information to the administration. See *infra* text accompanying note 363.

325. ROY, *supra* note 310, at 15.

326. VT PANEL REPORT, *supra* note 310, at 42. He came to Giovanni's class wearing dark glasses and a hat that obscured his face. Each time the class met, she had to insist that he take them off. Giovanni considered him disruptive and uncooperative. Later, he took to wearing a bedouin-style turban to class. She thought he was trying to bully her. He also refused to make changes in his writing. *Id.*

327. ROY, *supra* note 310, at 40.

328. The composition that alarmed Giovanni was delivered in a loud voice. ROY, *supra* note 310, at 40. It was entitled "So-Called Advanced Creative Writing-Poetry" and apparently took its subject from an earlier class discussion about eating animals. Addressing his classmates, Cho wrote:

You low-life barbarians make me sick to the stomach that I wanna barf over my new shoes. If you despicable human beings who are all disgraces to [the] human race keep this up, before you know it you will turn into cannibals—eating little babies, your friends. I hope y'all burn in hell for mass murdering and eating all those little animals.

VT PANEL REPORT, *supra* note 310, at 42. In a later e-mail to Roy, Cho compared his work to Jonathan Swift's "A Modest Proposal." ROY, *supra* note 310, at 42.

329. VT PANEL REPORT, *supra* note 310, at 42–43.

330. With respect to Giovanni's reaction to the student, Professor Roy later wrote:

voluntarily to another course, Giovanni insisted that he be removed from her class.<sup>331</sup>

Professor Roy appealed for advice and assistance to the division of Student Affairs, the Cook Counseling Center (CCC), the Dean of the College, and the Virginia Tech Police Department (VTPD).<sup>332</sup> She asked for both psychological and disciplinary review of Cho's behavior.<sup>333</sup> She was advised that University policies prohibited intervention unless a student had made an overt threat or seemed to be an "imminent danger" to him/herself or others.<sup>334</sup> When the University administration declined to intervene, Professor Roy tried to figure out for herself how troubled Cho was by conducting what she called "an initial interview."<sup>335</sup> The results

Creative writing and artistic license go hand in hand. What might seem provocative could simply be a testament to a student's vivid imagination. But experienced teachers tend to know when something just doesn't feel right. If there was also something troubling about a student's behavior, I felt that we needed to respond. And as soon as I read the poem that Seung-Hui Cho had written earlier for Nikki Giovanni's class, I realized why she had asked me to look at it. The tone was angry and accusatory, and it appeared to be directed at Nikki and her students.

ROY, *supra* note 310, at 30.

331. *Id.* at 43.

332. Roy wrote:

It is not uncommon at any large institution for there to be a lack of communication between one unit and another, so I had learned to send out material to several places at once, in hopes that we would then all be on the same page. It wasn't a strategy that was always well received at Virginia Tech where reporting lines can be as rigidly adhered to as papal edicts.

ROY, *supra* note 310, at 32. *Cf. infra* text accompanying note 441 (Delworth).

333. *Id.* at 30–31. Before informing University officials of the problem, Professor Roy "followed a series of protocols" she had devised as department chair:

I consulted with trusted colleagues in the department . . . [W]e agreed that Nikki had been absolutely right to be concerned. Seung . . . had read the poem aloud in class, and although his piece could perhaps be read as immature student venting, it could also be interpreted in a more threatening way. I wasn't at all surprised that Nikki's students had been alarmed by it.

*Id.* at 31.

334. *Id.* at 32. The VTPD and the OSLA advised her that there was no specific university policy about cell phones but that a general prohibition on disruptive behavior that interfered with orderly University processes would apply and be grounds for discipline if Cho did not stop taking photographs of his classmates during class. The Dean also reported that he had showed Cho's writing to a counselor and that she "did not pick up on a specific threat." VT PANEL REPORT, *supra* note 310, at 43. He advised Roy to refer Cho to the counseling center and warn him that further disruption would be referred to the office of Judicial Affairs. *Id.*

By Roy's account, she was initially concerned that Cho might become violent—that is, might pose an imminent danger to himself or others—and that was one of the reasons she initially contacted the VTPD. ROY, *supra* note 310, at 32. She was somewhat relieved of that concern when Cho agreed to leave Giovanni's class and finish the course as a tutorial. *Id.* However, for some time she remained afraid of what he might do and was reluctant to teach him one-on-one. *Id.* at 43.

335. ROY, *supra* note 310, at 35.

did not reassure her.<sup>336</sup> She was even more troubled when she received a two-page, single-spaced e-mail from him defending his writing and criticizing Professor Giovanni's teaching.<sup>337</sup>

The University administration had made it clear to Professor Roy that Cho could not be compelled to seek outpatient counseling as a condition of continued enrollment.<sup>338</sup> Feeling out of her depth after the initial interview

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[A]n initial interview [was] a procedure I had instituted in English soon after I became chair so I could find out more about students who appeared to be disruptive, at risk, troubled, or even deeply disturbed. I use the term *deeply disturbed* to characterize writing and behavior that seemed to me to merit immediate intervention. The term *troubled* refers to students who seem to be in distress for one reason or another. Many "troubled" students are depressed, anxious about something, or overwhelmed by the pressures of academe. They are not potentially violent students, though, in my experiences, a small minority could wish to harm themselves. *At risk* is a broad term that is applied at some institutions to struggling minority students and those with low grade-point averages. It was not unusual to have a faculty member report that a student was in distress or at risk, but often these alerts were about students who seemed despondent, overwhelmed, or depressed. Angry and disruptive students were less common, though I had been asked by other faculty members to deal with them in the past, so it was not an unprecedented request by any means.

*Id.* See also *Documents Concerning Seung-Hui Cho*, COLLEGIATE TIMES, Dec. 18, 2008, available at <http://www.collegiatetimes.com/stories/12708/documents-concerning-seung-hui-cho> (last visited Mar. 16, 2011) [*hereinafter Cho Documents*] (notes taken by Roy's assistant during the initial interview).

336. "He was," Roy wrote, "strangely detached from his surroundings." ROY, *supra* note 310, at 40. He spoke very slowly and softly and with obvious difficulty. He was unenthusiastic at her suggestion that he see a counselor. *Id.* at 38–40. Roy and her assistant, who sat in on the interview, agreed "that we had never experienced anything quite like the interview we had just had with . . . Cho. There was no doubt in our minds that he was in trouble." *Id.* at 40.

337. "It contrasted sharply with the silent person who had shown up for the initial interview. Again, the tone of the note worried me. I therefore forwarded it to the units I had first contacted." *Id.* at 42.

338. *Id.* at 43–44. This prohibition was apparently a matter of policy, not authority. In other cases, Virginia Tech has required psychiatric examination as a condition of continued enrollment. See *Cheng-chien Chang v. Virginia Polytechnic Inst.*, No. 85-2134, 1986 WL 16227 (4th Cir. Oct. 1, 1986).

The Inspector General's report found that the Cook Counseling Center (CCC) observed the following practices, which precluded involuntary referrals:

[T]he center does not accept involuntary or ordered referrals for treatment from any source including other departments of the university, outside agencies and the courts. CCC will not report to outside agencies (including the courts) because it disrupts the voluntary nature of the service and it takes too much time away from direct services to other students. . . . A student who is dangerous to self or others would only be treated at CCC willingly or voluntarily. . . . The CCC will not accept referrals as a part of disciplinary action by the university. Students who are disruptive to the university community are only treated if willing to be served. . . . The director of Judicial Affairs reported to the [Inspector General] that they do not use mandated counseling with students because CCC will not accept these referrals. They do not make mandated referrals to outside agencies or

with Cho but convinced that he needed immediate psychological help, Professor Roy made a personal appeal to Dr. Cathye Betzel, a CCC counselor, to come and meet Cho with her.<sup>339</sup> Dr. Betzel refused to see Cho unless he came voluntarily to the clinic.<sup>340</sup> Disappointed, Professor Roy consoled herself:

If [Cho] did show up at the CCC, they would certainly take him seriously because he had been flagged. Several people over there, including Bob Miller [EdD, Director of CCC]—someone who had been helpful in the past—were aware of his writing and his behavior. There had only been one other occasion when I had been as insistent as this about needing help with a particular student, so counseling services would know that this was important. If Seung-Hui Cho called over to the CCC or stopped by for an appointment, I assumed he would be seen at once. All I had to do was persuade him that he needed help.<sup>341</sup>

From October through the end of the semester, Professor Roy communicated with a wide network of University officials about Cho.<sup>342</sup> The Care Team considered Cho's case that fall, but decided that the situation was taken care of when Professor Roy removed him from Giovanni's class and taught him herself, one-on-one, for the rest of the semester.<sup>343</sup> Nevertheless, Professor Roy continued to broadcast her reports: all of Cho's writing was now "about shooting and harming people because he's angered by their authority or by their behavior."<sup>344</sup>

Professor Roy's attempts to persuade Cho to seek counseling eventually proved successful.<sup>345</sup> She was wrong, however, to have assumed that he

professionals because the cost is too high.

INSPECTOR GENERAL'S REPORT, *supra* note 310, at 12.

339. ROY, *supra* note 310, at 43.

I explained why the current policy placed students, faculty, and staff in jeopardy. I said it was ridiculous that Virginia Tech expected me and others to meet with students who had indicated through their work or their behavior that they had the potential to be violent. I wanted to require Seung to see a counselor. Weren't there times when students were unable to ask for help even though they might need it? I asked.

*Id.*

340. *Id.* at 43–44. Professor Roy protested that she lacked the training to work with Cho, but "[t]he argument did not sway [Dr. Betzel]." *Id.* at 44.

341. *Id.* at 44. Dr. Robert Miller, EdD, head of the CCC, had spoken at the English Department's annual staff retreat the previous year at Professor Roy's invitation about handling angry students. *Id.* at 41. He also served on the CARE team. INSPECTOR GENERAL'S REPORT, *supra* note 310, at 12.

342. VT PANEL REPORT, *supra* note 310, at 43.

343. *Id.*

344. *Id.* at 45. From that point on, violent and angry content was a consistently disturbing aspect of Cho's writing for professors in the English Department.

345. See VT PANEL REPORT, *supra* note 310, at 44. Cho's decision to seek counseling may also have been influenced by the events of November 27, when a

would be counseled immediately because of her discussions with clinic personnel. On November 30, 2005, Cho called CCC and asked for an appointment with Dr. Betzel.<sup>346</sup> He was given an appointment for an initial intake on December 12, almost two weeks later.<sup>347</sup> By then, Cho was having second thoughts. Instead of showing up in person for the appointment, he called at the scheduled time to speak with Dr. Betzel.<sup>348</sup> He told her that his difficulties were the same but that he did not want “to come in at this time.”<sup>349</sup> When she offered to reschedule the appointment, he declined.<sup>350</sup>

This is one of the junctures at which plaintiffs are likely to ask, “What if?” and defendants are likely to ask, “So what?” What if, like Dean Crisp at UNC, Professor Roy had been allowed to escort Cho to the mental health clinic and insist that he agree to treatment as a condition of continuing his studies? What if Dr. Betzel had agreed to interview him and assess the risk he posed to himself or others when Professor Roy requested it? What if Professor Roy’s informal assessment had been taken seriously? Do Professor Giovanni’s warnings and Professor Roy’s observations and concerns not establish that Cho’s violent tendencies were not only foreseeable but foreseen? Once safety concerns were raised, should the University not have had an obligation to assess Cho’s capacity to participate safely in the educational program? On the other hand, did the situation call for more special attention than it received? Was not the accommodation of the specific conduct-based classroom issue sufficient to satisfy any duty the University may have had? So what if Dr. Betzel did not see Cho the day he called for an appointment? What difference should it make, at this point in the story, that the therapist had been forewarned by his teachers, or that she knew others found him alarming? Did any action taken or not taken by the University’s administrators, or therapists make matters worse for Cho or push him towards violence? If we did not know the end of the story, would we conclude at this point that the University

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woman student complained to the campus police that Cho was annoying her. *Id.* A campus policeman came to Cho’s suite to warn him to leave her alone and to advise him that the complaint would be referred to Judicial Affairs. *Id.* After the officer left, in a rare burst of audible extemporaneous speech, Cho volunteered to his suitemates that he had been playing a game: he sent the girl several text messages signed “?” and then showed up in her dorm room in his habitual dark, mirrored glasses and face-obscuring hat. *Id.* “I’m question mark,” he told her. *Id.* She “freaked out” so that the resident advisor called the campus police. *Id.*

346. Cook Counseling Center (CCC) Triage report dated November 30 states: “Ref. to CCC by prof. He has been depressed & has difficulty in social situations. Would like to see Cathye since one prof. has talked to her about the student.” COOK COUNSELING CENTER TRIAGE, REPORT (November 30, 2005) [hereinafter TRIAGE REPORT], available at <http://static.mgnetwork.com/rtd/pdfs/2009-08-rmrecords.pdf>.

347. *Id.*

348. *Id.*

349. *Id.*

350. *Id.*

was failing in a duty of care to Cho or the rest of the educational community?<sup>351</sup>

More such junctures and more such questions were to come. Cho did not come to the particular attention of University authorities and CCC, only through Professor Roy's attempts to get him into counseling. His behavior towards women in the dorms got him into trouble with the campus police as well.<sup>352</sup> On December 12, only a day after he declined to continue at CCC, a student complained that his attentions were making her uncomfortable.<sup>353</sup> It was the second such complaint within a month, and the second visit from the campus police warning him that his behavior was unacceptable and would be referred to the Office of Judicial Affairs.<sup>354</sup> Cho sent an instant message to a suitemate that he might as well kill himself "because everybody just hates me."<sup>355</sup> The student called the campus police, which prompted a third visit.<sup>356</sup> This time the police took Cho for a psychological pre-committal screening by Kathy Godby, a licensed clinical social worker at Carilion.<sup>357</sup>

Cho claimed it was all a joke, just as he had claimed that his composition about his classmates was a satire.<sup>358</sup> He denied any suicidal intent and insisted that he was not upset at being confronted by the police.<sup>359</sup> Godby spoke with his roommate, however, who told her that Cho's behavior had been "bizarre" lately: he had posted a "?" instead of a picture in an online profile; he claimed to be named "Question Mark" and that Seung-Hui Cho was his twin brother; he had had another run-in with the police about his behavior towards women residents.<sup>360</sup> Godby found Cho mentally ill, imminently dangerous, and resistant to voluntary treatment.<sup>361</sup> She secured a temporary detention order from a county magistrate, and Cho spent the night at St. Alban's, the local mental hospital.<sup>362</sup> Dr. Miller, at the CCC, received a report of the detention

351. See *infra* Section IV.C.

352. VT PANEL REPORT, *supra* note 310, at 23.

353. *Id.*

354. *Id.*

355. *Id.* at 47; CARILION HEALTH SYSTEM DISCHARGE SUMMARY (Dec. 14, 2005) [*hereinafter* DISCHARGE SUMMARY], available at <http://static.mgnetwork.com/rtd/pdfs/2009-08-rmrecords.pdf>.

356. VT PANEL REPORT, *supra* note 310, at 47; DISCHARGE SUMMARY, *supra* note 355.

357. VT PANEL REPORT, *supra* note 310, at 47; DISCHARGE SUMMARY, *supra* note 355.

358. DISCHARGE SUMMARY, *supra* note 355.

359. *Id.*

360. *Id.*

361. VT PANEL REPORT, *supra* note 310, at 47–48; DISCHARGE SUMMARY, *supra* note 355.

362. VT PANEL REPORT, *supra* note 310, at 47–49. He was given a single dose of anti-depressant medication. DISCHARGE SUMMARY, *supra* note 355.

before noon the following day.<sup>363</sup>

The psychiatrist who interviewed Cho at St. Alban's after his overnight stay recommended that he be discharged with "some outpatient counseling to [ac]culturate to proper norms."<sup>364</sup> At the commitment hearing, the judge ruled that Cho presented an imminent danger to himself as a result of mental illness and ordered that he follow all recommended outpatient treatments.<sup>365</sup> Before Cho was released, he made an appointment at CCC for 3:00 that afternoon.<sup>366</sup> Carilion faxed his psychiatric discharge summary to CCC at 2:30.<sup>367</sup>

Cho showed up for his appointment at CCC. He met for thirty minutes with therapist Sherry Lynch Conrad.<sup>368</sup> Conrad did not know that he had been adjudged mentally ill and a danger to himself or that he was there to commence court-directed counseling.<sup>369</sup> She did not attempt an evaluation since he had talked to Cathye Betzel only two days earlier.<sup>370</sup> She knew nothing about Professor Roy's e-mails to Dr. Miller, her clinical director.<sup>371</sup> She allowed Cho to leave without scheduling another appointment.<sup>372</sup> There was no follow up by the CCC.<sup>373</sup> His detention and overnight committal were not reported to the Care Team.<sup>374</sup> His parents were not told; nor was Professor Roy.<sup>375</sup> He never again attempted to get mental health support from the University. He made no more overtures to women, and he sent no more messages to his roommates. For the next two semesters, the content of his writing was the primary indicator of his state of mind. He raised his voice again in public only once more that has been reported, when Professor Carl Bean dismissed him from the Technical

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363. An e-mail report of the detention was forwarded to Dr. Miller at CCC at 10:46 a.m. on December 14 from Virginia Tech's Resident Life group. Dr. Miller in turn forwarded the report ("in the event this student is seen here") to Dr. Betzel and Sherry Lynch Conrad at 4:26 p.m. that afternoon, about an hour after Cho had come and gone. Karin Kapsidelis, *Va. Tech Releases Seung-Hui Cho's Medical Records*, RICHMOND TIMES DISPATCH, Aug. 19, 2009, available at <http://www2.timesdispatch.com/news/2009/aug/19/techgat19120090819-135002-ar-33614/>.

364. VT PANEL REPORT, *supra* note 310, at 49; DISCHARGE SUMMARY, *supra* note 355.

365. VT PANEL REPORT, *supra* note 310, at 48.

366. *Id.* at 49.

367. CCC later claimed not to have received it. *Id.* at 49; DISCHARGE SUMMARY, *supra* note 355.

368. VT PANEL REPORT, *supra* note 310, at 49; TRIAGE REPORT, *supra* note 346.

369. VT PANEL REPORT, *supra* note 310, at 49; TRIAGE REPORT, *supra* note 346.

370. TRIAGE REPORT, *supra* note 346.

371. *Id.*

372. *Id.*

373. VT PANEL REPORT, *supra* note 310, at 49.

374. *Id.* at 52.

375. *Id.* at 49.

Writing Class.<sup>376</sup>

The incident occurred in spring semester 2006.<sup>377</sup> Professor Bean, who taught Cho Technical Writing in the spring semester, refused to allow him to write his term paper as “an objective real-time experience” of Macbeth as a serial killer.<sup>378</sup> In mid-April, he suggested that Cho withdraw from the course.<sup>379</sup> In one of his rare audible speeches, Cho argued angrily and loudly that he would not withdraw.<sup>380</sup> Professor Bean refused to talk further until Cho could control himself.<sup>381</sup> Cho left Bean’s office and withdrew from the course.<sup>382</sup> Professor Bean apparently never discussed Cho with anyone in the administration.<sup>383</sup> He was unaware that Cho had been removed from Professor Giovanni’s class.<sup>384</sup>

That same semester, Professor Robert Hicock taught Cho in a fiction workshop.<sup>385</sup> He was concerned enough about Cho’s lack of participation in class and the violent content of his writing to discuss him with Professor Roy but decided he would “just deal with him.”<sup>386</sup> Cho wrote a story for Hicock’s class in which the narrator was a student shooter struggling to overcome his reluctance to kill.<sup>387</sup> Hicock gave him a D+ and never saw him again.<sup>388</sup>

Lucinda Roy vacated the Chair of the English Department in spring semester 2006, and she was in Sierra Leone when Cho returned to Virginia Tech in the fall.<sup>389</sup> There was no repetition of the behavior that caused him trouble the previous year.<sup>390</sup> He did not speak to his roommates.<sup>391</sup> He

376. *Id.* at 50.

377. The VT Panel Report notes that the incident occurred exactly a year before the rampage. *Id.* at 50. Lucinda Roy speculates that the altercation may have a direct bearing on the rampage for this reason, especially since Cho wrote an angry letter about Bean that he included in the packet of materials he mailed on the day of the rampage. ROY, *supra* note 310, at 79–82.

378. VT PANEL REPORT, *supra* note 310, at 50.

379. *Id.*

380. *Id.*

381. *Id.* Cho later told Professor Bean by e-mail that he had dropped the course. A year later, on the day of his rampage, Cho mailed a letter to the English Department about his encounter with Professor Bean. The letter was delivered by the then-English department chair, Carolyn Rude, to University counsel. ROY, *supra* note 310, at 79–82. No one in the English department saw it until after it was released to the VT Review Panel. *Id.* at 85.

382. VT PANEL REPORT, *supra* note 310, at 50.

383. *Id.* at 51.

384. *Id.* at 50–51.

385. *Id.* at 50; ROY, *supra* note 310, at 66–67.

386. VT PANEL REPORT, *supra* note 310, at 49.

387. *Id.* at 49–50. He did not inform anyone that Cho had written a school-shooting story until after the rampage. *Id.*

388. *Id.* at 49.

389. ROY, *supra* note 310, at 15.

390. VT PANEL REPORT, *supra* note 310, at 51.

391. *Id.*



went to bed early, got up early, and kept entirely to himself.<sup>392</sup> His room was extremely neat; the only book in it was a Bible.<sup>393</sup> His resident dorm advisor, who was expecting trouble, did not have a single problem with him.<sup>394</sup> His teachers and classmates, however, continued to regard him with alarm. The two plays he wrote fall semester 2006 for Professor Falco's drama class were graphic, angry, and violent.<sup>395</sup> One involved killing a teacher.<sup>396</sup> His fiction-writing teacher, Lisa Norris, repeatedly suggested that he go to counseling and requested the assistance of her colleagues.<sup>397</sup> She also asked for help from Mary Ann Lewis, Associate Dean of Liberal Arts and Human Sciences.<sup>398</sup> Though Dean Lewis had been copied on Professor Roy's e-mails the previous year, her staff found "no mention of mental health issues or police reports" in Cho's file.<sup>399</sup> Moreover, even had Cho agreed to seek counseling again, even if he had gone to CCC, the clinicians would have had no record of his previous visits or his overnight commitment at St. Alban's: his CCC records went missing sometime in the spring of 2006, when, for reasons yet to be explained, CCC's outgoing Director, Dr. Robert Miller, took Cho's file home and never returned it to the clinic.<sup>400</sup>

At this point, six months before the rampage, Cho was about to slip completely under the University radar. The only place he was still causing alarm was the place where his teachers and classmates first learned to fear him: in the small creative writing workshops in which a student could not easily disappear.<sup>401</sup> In spring semester, he took no such courses, and his

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392. *Id.*

393. *Id.*

394. *Id.*

395. Student reaction to the plays was cautious. *See id.*

396. Scripts and video enactments of the two plays, "Richard McBeef" and "Mr. Brownstone" can be found on the internet. *See, e.g., Virginia Tech Gunman Cho Seung-Hui's Plays—Mr. Brownstone*, MAVERICK (Tuesday, April 17, 2007, 5:52 PM), [http://nightskymine.blogspot.com/2007/04/virginia-tech-gunman-cho-seung-huis\\_17.html](http://nightskymine.blogspot.com/2007/04/virginia-tech-gunman-cho-seung-huis_17.html). Professor Falco described them as "juvenile, with some pieces venting anger." He did not let his colleagues or the administration know about their content. VT PANEL REPORT, *supra* note 310, at 51. After the shooting, however, he was instrumental in creating guidelines for assessing violent student writing. *See* Elizabeth Redden, *When Student Writing Could Be a Red Flag*, INSIDE HIGHER ED. (Sept. 5, 2007), <http://www.insidehighered.com/news/2007/09/05/writing>.

397. Cho declined Norris' suggestion that she accompany him to counseling. VT PANEL REPORT, *supra* note 310, at 24.

398. *Id.*

399. *Id.*

400. *See, e.g.,* Brigid Schulte & Rosalind S. Helderman, *Va. Tech Shooter's Mental Files Turn Up*, WASH. POST, July 23, 2009, available at <http://www.washingtonpost.com/wp-dyn/content/article/2009/07/22>; Michael Sluss & Tonia Moxley, *Missing Va. Tech Shooter records found in former counseling center director's home*, THE ROANOKE TIMES (July 22, 2009, 4:57 PM), <http://www.roanoke.com/news/breaking/wb/212699>.

401. Norris wrote to her colleagues:

class attendance dropped off.<sup>402</sup> Professor Roy, just back from Africa, thought that he must have graduated.<sup>403</sup>

Now that he had written the script of rampage and murder, Cho began acquiring the props and rehearsing the action: he bought guns and ammunition, made videotapes of himself pointing pistols and shouting at his victims, and checked the stage at Norris Hall, an older building with doors that could be chained shut from the inside.<sup>404</sup> On April 16, a year to the day after his shouting match with Professor Bean, he killed thirty-two students and teachers and then himself during a twenty-minute rampage that left the academy reeling with horror.<sup>405</sup>

### B. The Civil Litigation

Intense public scrutiny followed the rampage, including the first government investigation of a school rampage in higher education.<sup>406</sup> Most of the victims at Virginia Tech and their families eventually settled with the University, but on April 15, 2009, the parents of two students killed during Cho's rampage filed wrongful death suits, still pending at the time of this writing.<sup>407</sup> According to the plaintiffs, by the time Cho was taken to St. Alban's, University officials and therapists at the CCC should have known that he was psychologically disturbed and posed a threat to himself and others, yet they did not make an individual threat assessment or otherwise diagnose or treat his condition.<sup>408</sup>

On January 17, 2010, the trial court denied the defendant university therapists' motion to dismiss. Specifically, the trial court held that CCC employees Robert Miller, Cathye Betzel, and Sherry Lynch Conrad were not entitled to absolute or sovereign immunity.<sup>409</sup> It reserved for later

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He was in my Contemporary Fiction class last semester, and didn't say a word, but it was a large class . . . and he was effectively invisible . . . This semester, however, he is in a class of 14 students, and the majority are quiet, shy people, and it is a workshop. He is extremely visible, and if you . . . have dealt with him, you know that he is not simply shy and quiet—there is something else going on.

See *Cho Documents*, *supra* note 335.

402. VT PANEL REPORT, *supra* note 310, at 51.

403. ROY, *supra* note 310, at 24–25.

404. VT PANEL REPORT, *supra* note 310, at 24, 52.

405. *Id.* at 77, 98.

406. See *supra* note 310.

407. Peterson & Pryde v. Thyden, Case No. CL09005525-00 (Montgomery Cir. Ct. VA Oct. 2009) [*hereinafter Thyden*] (ruling demurrer), available at [http://www.collegiatetimes.com/cms/resource/pdf/ruling\\_demurrers.pdf](http://www.collegiatetimes.com/cms/resource/pdf/ruling_demurrers.pdf).

408. *Id.* The suits also allege that on the day of the rampage, University officials, knowing that two students had been shot dead in a dormitory by an unknown assailant, negligently failed to lock down the campus or otherwise issue a timely warning to students and faculty that an active shooter might be loose on campus. These allegations are outside the scope of the present inquiry.

409. *Thyden*, *supra* note 407, at 7–8. The court also held that Dr. Miller was not

determination the therapists', perhaps somewhat disingenuous, claim that they should be cloaked with statutory immunity because they "provided medical services to Cho."<sup>410</sup>

More important to the present inquiry, the trial court held that the defendant therapists owed Cho and his student victims a legal duty to protect their safety through delivery of mental health services.<sup>411</sup> The court grounded the duty in the business invitee relationship between the university and its students and in a Virginia statute that charges the Virginia Tech Board of Visitors with "the protection and the safety of students . . . residing on the property. . . ."<sup>412</sup> Echoing Judge Sims's dissent in *Tarasoff*, the court also found that imposing a duty of care was justified under the circumstances, not because the harm to the rampage victims was foreseeable, but because the burden of preventing harm was "slight."<sup>413</sup>

### C. Reframing the Duty: On the Ease of Prevention

The Virginia Tech Massacre is widely and rightly viewed as a tipping

entitled to absolute immunity because he was not a high-ranking government official administering "any policy or regulation that affects the state as a whole." *Id.* at 7. Nor were the other university officials named as defendants, including the university president, entitled to such immunity. *Id.*

410. *Id.* at 10. Virginia Code Annotated § 54.1-2400.1A (West) defines "client" or "patient" as "any person who is voluntarily or involuntarily receiving mental health services or substance abuse services from any mental health service provider." The trial court wrote, "Defendants argue that Cho was a client and [the] triage assessments were 'counseling interventions designed to remediate Mr. Cho's mental, emotional and behavioral disorders.' It may be that triage does put Cho within the statutory definition of 'client' . . . . Since this is a factual determination, it may be a jury question." *Id.*

411. *Thyden, supra* note 407, at 11.

412. *Id.* at 11. Virginia Code Annotated § 23-122 applies by its terms only to the Board of Visitors of Virginia Tech. It provides as follows:

The board shall be charged with the care and preservation and improvement of the property belonging to the University, and with the protection and safety of students and other persons residing on the property, and in pursuance thereof shall be empowered to change roads or driveways on the property or entrances thereto, or to close temporarily or permanently the roads, driveways and entrances; to prohibit entrance to the property of undesirable and disorderly persons, or to eject such persons from the property, and to prosecute under the laws of the state trespassers and persons committing offenses on the property.

The board shall regulate the government and discipline of the students; and, generally, in respect to the government of the University, may make such regulations as they deem expedient, not contrary to law. Such reasonable expenses as the visitors may incur in the discharge of their duties shall be paid out of the funds of the University.

The trial court acknowledged that "[d]efendants contend this is not a safety statute and . . . call[] plaintiffs' position "absurd." *Thyden, supra* note 407, at 11.

413. *Thyden, supra* note 407, at 12. "These defendants simply needed to provide Cho the services [] he needed. The consequences of placing that burden on these defendants are simply that they would be required to perform the functions for which the office was created and the duties for which they were employed." *Id.*

point in the academy's attention to mental health issues as they relate to campus safety.<sup>414</sup> The Virginia Tech Review Panel commissioned by the Virginia Governor was critical of University administrators who missed the "red flags."<sup>415</sup> The Panel wrote:

The academic component of the university spoke up loudly about a sullen, foreboding male student who refused to talk, frightened classmate[s] and faculty with macabre writings, and refused faculty exhortations to get counseling. However, after Judicial 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.<sup>416</sup>

Elsewhere, the Report pointed out that not only the English department professors, but the Virginia Tech Police and the Resident Life staff received multiple reports and concerns about Cho's behavior in the dorms.<sup>417</sup> The Panel reported that "[t]he lack of information sharing among academic, administrative, and public safety entities at Virginia Tech and the students who had raised concerns about Cho contributed to the failure to see the big picture."<sup>418</sup>

What the Panel failed to identify as an impediment to effective intervention was the University's policy of refusing to engage in a psychological threat assessment unless a student made an overt threat of specific harm. This policy, which was invoked when Professor Roy first sought assistance from CCC, was central to the University's concept of its duty to act, and that concept reflected *Tarasoff's* rubric that foreseeability of harm is the primary element giving rise to a duty to protect either a potentially violent student or his potential victims.

Evaluating Cho at CCC when Professor Roy and her colleagues first identified him as a disturbed and disturbing student might have made a material difference in preventing his rampage for several reasons. First, if the University had insisted that Cho be evaluated by a trained therapist, much about his psychological history that was hidden until after the rampage might perhaps have been revealed: that his classmates in middle school mocked and teased him when he spoke in class because he was still not fully conversant in English; that he was diagnosed with "selective mutism" and provided with tutorial classes in high school (much the same

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414. Jablonski et al., *supra* note 121, at 6.

415. VT PANEL REPORT, *supra* note 310, at 52. "The Care Team at Virginia Tech was established as a means of identifying and working with students who have problems. That resource, however, was ineffective in connecting the dots or heeding the red flags that were so apparent with Cho." *Id.*

416. *Id.*

417. *Id.*

418. *Id.*

accommodation that Professor Roy devised); that he had an episode of depression in 1998 in which he said that he wanted to “repeat Columbine” and was placed on anti-depressant drugs for a year; that he had seen a therapist for several years; that his high school guidance counselor had recommended against his enrollment at Virginia Tech, advising instead that he attend a smaller school where he could get more individual attention.<sup>419</sup> Second, ongoing psychotherapy might well have helped him resolve his anger in more constructive ways than mass murder. Third, as in *Tarasoff*, his desire to “repeat Columbine” might have been expressed to his therapist in such a way that his capacity and intent to commit a rampage might have been clear enough to justify more extreme measures.

Moreover, and even more alarming, the University’s policy of limiting psychological threat assessment and therapeutic intervention to cases in which the threat of violence was overt may well have made matters worse—may, that is, have made Cho’s rampage more rather than less likely—for reasons having to do with the situational nature of rampages.<sup>420</sup> The disassociated rage that makes a rampage possible does not in most cases spring entirely from an individual’s innate pathology; it develops over time and as a result of environmental circumstances that shame and humiliate the perpetrator.<sup>421</sup> It is apparent that Cho reacted with anger and resentment to being “kicked out” of Giovanni’s and Bean’s classes.<sup>422</sup> His attempts to comply with his teachers’ recommendation that he seek counseling were failures. His encounters with the Virginia Tech Police and the mental health system in place at Virginia Tech frightened him and apparently left him even more deeply isolated and disaffected from University life. That none of these events resulted in appropriate long-term psychological treatment is extremely unfortunate: he was deprived of any benefit from the system, and his hatred of the institution in which he was enrolled may have grown increasingly murderous as a result.

#### IV. CORNERING OUR PRESENT DUTY

##### A. Describing the Campus Rampage

Since 1991, the academy has experienced mass shootings by current and former students in law, nursing, and business colleges, in graduate departments and undergraduate schools—accompanied by an equally disturbing rise in the number of mass shootings by high school students.<sup>423</sup>

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419. VT PANEL REPORT, *supra* note 310, at 35–37.

420. See *infra* text accompanying notes 426–32.

421. See Thomas J. Scheff, *Rampage Shooting: Emotions and Relationships as Causes* (Sept. 2, 2007), <http://www.soc.ucsb.edu/faculty/scheff/main.php?id=61.html>.

422. VT REVIEW PANEL, *supra* note 310, at 44; see *supra* text accompanying note 336 and text accompanying notes 376–78.

423. See de Haven, *supra* note 1, at 527 n.107.

An entire generation of students has now entered college with a cultural memory of Columbine.

In general, the crimes committed by students on campus are much the same as those committed off campus by the same-age population, except that campuses are, on the whole, less violent than the streets.<sup>424</sup> The facts upon which *Tarasoff* is based are, to that extent, typical of much campus crime: stalking and murder can happen anywhere.

However, school rampages are in a different category.<sup>425</sup> First, they involve extreme violence—that is, actual or attempted mass murder.<sup>426</sup> Second, unlike most other campus crimes, rampages do not happen “just anywhere.”<sup>427</sup> Anti-institutional motivation is characteristic of the school

424. *Id.* at 505 n.6.

425. “School rampage” (SR) is a term of art applied to secondary-school shooting sprees. *See, e.g.*, JONATHAN FAST, CEREMONIAL VIOLENCE: A PSYCHOLOGICAL EXPLANATION OF SCHOOL SHOOTINGS 9–14 (2008); *see also* KATHERINE S. NEWMAN, RAMPAGE: THE SOCIAL ROOTS OF SCHOOL SHOOTINGS (2004). Though there have as yet been no fully developed sociological or psychological case studies of rampages in institutions of higher education, the same term and definitions are used here. That definition excludes mass shootings on campus if the perpetrator is not a current or former student. For example, the shooting at Dawson College in Montreal, Canada on September 13, 2006 is excluded because the shooter, Kimveer Gill, was a stranger to the campus. *See infra* note 426.

426. “Extreme violence” is defined as “an act of retaliation completely disproportionate to its provocation.” FAST, *supra* note 425, at 12. Discussing mass murders, Professor Fast continues:

Most murders are unplanned, spontaneous, and occur when anger and fear produce violent behavior in response to an imminent threat. Such murders are often called “affective,” the human equivalent of the fight or flight response seen in animals. Mass murders, “the intentional killing of multiple victims by a single offender within a 24 hour period of time,” are rare events, accounting for less than one percent of all violent crimes. This latter style of aggression tends to be “predatory”: planned, purposeful, and without emotion. In the 1980s, Park Eliot Dietz, an eminent criminologist, proposed a typology of mass murderers with three categories: “family annihilators,” depressed men, highly invested in their families, who kill their wives and children along with themselves because they fear, or wish to believe, that no one else can care for them; “set and run” killers, those who set bombs and disappear, such as Ted Kaczynski, the Unabomber; and “pseudo-commandos,” those who are preoccupied with fire-arms and military garb, and plan and deliberate extensively before they act. School rampage shooters, obsessed with weapons and planning, often donning militaristic or terrorist costumes for their shootings and even playing theme music to “pump themselves up,” fall into the final category.

*Id.* at 12–13.

427. The prevailing definition makes this clear. “An institutional attack takes place on a public stage before an audience, is committed by a member or former member of the institution, and involves multiple victims, some chosen for their symbolic significance or at random. This final condition signifies that it is the organization, not the individuals, who are important.” NEWMAN, *supra* note 425, at 231. *See also* Glenn W. Muschert, *Research in School Shootings*, SOCIOLOGY COMPASS (July 2007) at 63–64.

rampage: the target is the school itself and what it has come to represent to the killer.<sup>428</sup> Thus, there is almost always a strong situational component to the event. Even Williamson, whose conscious motives were not vengeful, but messianic, intended to take his last stand on the campus where, he believed, his cohorts “would lay [him] as low as possible” to keep him from getting a law degree.<sup>429</sup> Almost always, rampage school shooters are acutely sensitive to the insults, indignities, and powerlessness of student life. They have unresolved grievances arising out of their academic experience, and some of their complaints may be justified, at least in part.<sup>430</sup> They often nurse grudges and pursue complaints against teachers,

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428. See de Haven, *supra* note 1, at 512–15. Professor Fast describes secondary school shootings as “acts of terrorism without an ideological core.” FAST, *supra* note 425, at 9. In their anti-institutional aspect, school rampages are akin to acts of domestic terrorism, such as the Oklahoma City bombing: the target is chosen for its symbolic significance; the violence is public; and the victims are harmed because of their relationship to the target, not because of their relationship to the killer. See generally, DOUGLAS KELLNER, *GUYS AND GUNS AMOK: DOMESTIC TERRORISM AND SCHOOL SHOOTINGS FROM THE OKLAHOMA CITY BOMBING TO THE VIRGINIA TECH MASSACRE* (2008).

Rampages in higher education also have many characteristics in common with workplace rampages. See NEWMAN, *supra* note 425, at 58. Like colleges and universities, workplaces are selective and intentional communities with a set of distinguishing relationships and distinctive behavioral norms. Like workplace rampages, rampages in institutions of higher education tend to be situational, in the sense that “a tendency toward violence is often bred by the workplace itself.” RICHARD V. DENNENBERG & MARK BRAVERMAN, *THE VIOLENCE-PRONE WORKPLACE: A NEW APPROACH TO DEALING WITH HOSTILE, THREATENING, AND UNCIVIL BEHAVIOR* ix (1999). Workplace rampages are also anti-institutional: “Violent incidents often appear to be random acts of slaughter but upon close examination reveal a calculated attempt to decapitate the command structure of the workplace. Such assaults might be labeled ‘organicides. . . .’” *Id.* at 5. See also NEWMAN, *supra* note 425, at 58.

429. See *supra* note 209 and accompanying text. Steven Kazmierczak, who rampaged at Northern Illinois University on Valentine’s Day 2008, also was not known to have expressed a grievance against NIU, where he had a successful career as an undergraduate, but he had recently left the graduate program at NIU under circumstances that are not entirely clear, and his studies and career hopes apparently began to derail at that point. See de Haven, *supra* note 1, at 574–76. Kazmierczak was also the only rampager besides Williamson known to have been “off his meds” when he rampaged. *Id.* at 576.

In other respects, however, especially in terms of the institutional duty under discussion here, the NIU rampage is unlike other campus rampages. See *infra* notes 430–33 and accompanying text. The perpetrator did not single himself out as having either conduct or mental health problems while he was an undergraduate or during the brief period he spent at NIU as a graduate student. Moreover, he moved to another city more than six months before his rampage, had very little contact with his former associates at NIU, made no threats, and apparently confided his intentions to no one. An attack like his would appear virtually impossible to prevent or to foresee at the institutional level.

430. See de Haven, *supra* note 1, at 512–15. The male pronoun is used advisedly throughout to refer to rampagers. Women only rarely engage in spree shootings or rampages. See Sam Tanenhaus, *The Amy Bishop Case—Violence that Art Didn’t See Coming*, N.Y. TIMES, Feb. 28, 2010, at AR1, available at

classmates, or members of the school administration.<sup>431</sup> Their hostility worsens over time: the author has discovered no college or university rampage whose perpetrator has been at the school for fewer than three semesters.<sup>432</sup> Almost always, the killer has experienced, or is about to

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[http://www.nytimes.com/2010/02/28/arts/28bishop.html?\\_r=2&pagewanted=1&hp](http://www.nytimes.com/2010/02/28/arts/28bishop.html?_r=2&pagewanted=1&hp). One exception is Brenda Ann Spencer, who, in 1979, at the age of sixteen, shooting from the door of her house, killed two adults and wounded a police officer and eight children on the playground of the elementary school across the street. See FAST, *supra* note 425, at 65–82. Another exception is forty-four-year-old Jennifer San Marco, who, in January 2006, shot and killed five employees at the postal service's processing and distribution center in Santa Barbara, California, from which she had been dismissed for mental health reasons two years previously; she also killed herself. See Dan Frosch, *Woman in California Postal Shootings Had History of Bizarre Behavior*, N.Y. TIMES, Feb. 3, 2006, at A19, available at <http://www.nytimes.com/2006/02/03/national/03postal.html>. The most recent case is Dr. Amy Bishop, who, on February 12, 2010, shot and killed three colleagues on the biology faculty at the University of Alabama at Huntsville and wounded three others. See Tanenhaus, *supra* note 430.

431. Gang Lu, a student at the University of Iowa, resented the fact that his professors had awarded a prestigious dissertation prize to another student, a decision that Lu appealed through University channels, and had not offered him a position at the University after he received his Ph.D. See de Haven, *supra* note 1, at 517. Among his victims were the academic rival who won the prize, his major professors, the head of the department, and the Associate Vice President for Academic Affairs who denied his appeal. *Id.* at 518–19. In the weeks before his December 1992 rampage at Simon's Rock, Wayne Lo was increasingly hostile toward college authorities, especially after one of his few friends was dismissed for stalking. FAST, *supra* note 425, at 90. He became confrontational with his adult dormitory advisors, claiming that he had “the power to bring the whole school down to its knees.” *Id.* at 92. He told a student acquaintance that he intended to kill the dorm advisor and her family. See *id.* at 95; see also de Haven, *supra* note 1, at 522. Peter Odighizuwa, the shooter at the Appalachian School of Law in 2002, filed complaints against employees in the student services department and against a professor whom he accused of treating him unfairly. *Id.* at 532. He was confrontational and abusive with other school personnel. *Id.* On the day before the shooting, he had a shouting match with an employee in Student Services. *Id.* at 533. On the day of the shooting, he had an acrimonious meeting with a professor. See *id.* at 527–34. Robert Flores, the shooter at the University of Arizona College of Nursing, left a lengthy suicide letter detailing numerous grievances against the nursing school and the faculty members who had given him failing grades in two of his clinical courses. *Id.* at 541–42. He wrote that he wanted his rampage to provoke lawsuits that would “change ‘the face of education.’” *Id.* at 545. Biswanath Halder, the rampler at Case Western Reserve University, sued an employee of the Weatherhead School's computer lab for allegedly hacking his website and destroying his computer files. *Id.* at 550. His rampage occurred a few days after his appeal had been dismissed. See *id.* at 552. Virginia Tech shooter Seung Hui Cho's student writing expressed alarming hostility towards classmates and teachers; he complained in writing to the head of the English Department about his professors; the videotapes he posted on the day of his rampage castigated his fellow students for their hedonistic lifestyles and their treatment of him. See *id.* at 556–66.

432. See generally de Haven, *supra* note 1. Gang Lu completed his entire Ph.D. program at the University of Iowa before he rampaged. *Id.* at 519. Wayne Lo rampaged during exam week of his third semester at Simon's Rock. *Id.* at 522. Peter Odighizuwa was enrolled at the Appalachian School of Law in fall semester 2000, then withdrew for a semester during which he was frequently on campus; he then returned for fall semester 2001. *Id.* at 530–31. He rampaged shortly after classes resumed for



experience, a severance of his relationship with the school.<sup>433</sup> For all these reasons, the rampage is best described not as a drive-by shooting, but as a parting shot at a hated place and a hated community.

Rampages also differ from other campus crimes because they invariably raise mental health issues. It almost defies belief that an act of such extreme and disproportionate violence could be conceived, planned, and carried out by someone of right mind.<sup>434</sup> Rampagers are “madmen,” whose rage against the institution has made them capable of shocking injustice and inhumanity. However, they also usually function within normal limits in most respects. They almost never make overt threats, and adult rampagers seldom feel the need to confide their intentions to others.<sup>435</sup> They are often not clearly insane in the legal sense, and they seldom meet the criteria for long-term psychiatric committal before they rampage.<sup>436</sup> Though insanity and diminished capacity have typically been raised in mitigation by the lawyers of rampagers, Wendell Williamson is the only student shooter to have been acquitted by reason of insanity.<sup>437</sup>

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spring semester 2002. *Id.* 533–34. Robert Flores, who rampaged in October 2002, had been at the University of Arizona College of Nursing as a transfer student since fall semester 2000. Biswanath Halder attended Case Western Reserve University for two years and received a master’s degree in 1999; at the time of his rampage in 2002, he had not been enrolled in courses at the University since August 2000. Seung Hui Cho had completed almost four years at Virginia Tech and was close to graduation when he rampaged. Steve Kazmierczak completed his undergraduate education and attended graduate school for a year at Northern Illinois University; he transferred to another graduate school a few months before he returned to his alma mater and opened fire on an undergraduate class. *Id.* at 574–75.

433. *See de Haven, supra* note 1. Gang Lu had recently completed his Ph.D. and was still working as a research assistant but had not been offered a position at the University of Iowa. *Id.* at 517. Wayne Lo told the Dean at Simon’s Rock on the day of his rampage that he intended to transfer. *Id.* at 523 n.80. Peter Odighizuwa was not in academic good standing at the Appalachian School of Law and had withdrawn the day before the shooting. *Id.* at 533. Robert Flores had been told that he was failing a course and was not allowed to take the exam; he believed that he would not be able to complete his degree at the University of Arizona College of Nursing. *Id.* at 544. Biswanath Halder had just lost his appeal in a lawsuit against Case Western Reserve University. *Id.* at 552. Seung Hui Cho was about to graduate from Virginia Tech. *Id.* at 556. Steve Kazmierczak had recently transferred from Northern Illinois University to the University of Illinois. *Id.* at 574–75.

434. Researchers believe that a rampage is always premeditated. Katherine S. Newman, *Opinion: Finding Causes of Rampage Shootings Is One Thing; Preventing Them Is Another*, CHRON. HIGHER EDUC., Apr. 19, 2007, available at <http://chronicle.com/article/Opinion-Finding-Causes-of/122449/>; FAST, *supra* note 425, at 12. Though the time between decision and action may be short, rampagers almost never “just snap.” Robert Fein et al., *Threat Assessment in Schools*, U.S. SECRET SERV. & U.S. DEP’T OF EDUC., at 18 (2002), available at [http://www.secretservice.gov/ntac/ssi\\_guide.pdf](http://www.secretservice.gov/ntac/ssi_guide.pdf).

435. FAST, *supra* note 425, at 13; *see also* Fein et al., *supra* note 434, at 20.

436. *See de Haven, supra* note 1.

437. Against their client’s wishes, Wayne Lo’s lawyers claimed he was insane, but the jury disagreed, and he was convicted. FAST, *supra* note 425, at 104–07.

Though most rampagers (again, Williamson is an exception) are not obviously insane, they are almost always obviously disturbed or disturbing in their campus conduct and interactions.<sup>438</sup> They are angry, depressed, and increasingly extreme in their reactions to their environment. More often than not—in the days, weeks, months, or even years before the shooting—the student killer alarmed faculty, staff, and other students by public displays of rage or other disruptive and extreme behaviors.<sup>439</sup> In

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Odighizuwa's trial was delayed for almost three years because he was considered psychologically incapable of assisting in his own defense; when he recovered enough to stand trial, he was offered a plea bargain. de Haven, *supra* note 1, at 539. The Commonwealth Attorney claimed to have developed doubts about his sanity at the time of the shooting. *Id.* at 539 n.163. He accepted life imprisonment without possibility of parole. *Id.* Biswanath Halder was convicted but apparently saved from the death penalty by his attorneys' arguments that he was mentally unbalanced. *Id.* at 553 n.272.

438. See de Haven, *supra* note 1.

Disturbing students are those whose conduct violates an institution's code of conduct but who do not have any evident mental health concerns . . . .

Disturbed students are those who may be experiencing mental health problems but whose conduct does not violate the college or university's code of conduct . . . . The disturbing/disturbed student is both disruptive and suffering from mental health problems.

John H. Dunkle, Zachary B. Silverstein, & Scott L. Warner, *Managing Violent and Other Troubling Students: The Role of Threat Assessment Teams on Campus*, 34 J.C. & U.L. 585, 596 (2008) (citations omitted).

439. See de Haven, *supra* note 1. During his final year as a graduate student, Gang Lu, the University of Iowa shooter, developed a grudge against his dissertation advisor, plasma physics theoretician Stan Goertz, whom he killed during his rampage. See EDWIN CHEN, *DEADLY SCHOLARSHIP: THE TRUE STORY OF LU GANG AND MASS MURDER IN AMERICA'S HEARTLAND* 95–96 (1995). At least twice in the weeks before the shooting, Lu, who was normally quiet and withdrawn, shouted and ranted at his advisor, accusing him of delaying a letter of recommendation, unfairly passing him over for an academic award, and discrediting his work. See *id.* at 117–18. He also had a loud and stormy confrontation with Dwight Nicholson, the head of the department, whom he also killed. See *id.* at 138–39. After an uneventful first year as an undergraduate freshman at Simon's Rock, Wayne Lo joined a trio of "perennially angry" and disaffected students, one of whom was dismissed for stalking. Openly racist and anti-Semitic, he became increasingly confrontational with his adult resident advisors, a bi-racial couple. Several hours before his rampage he told friends and acquaintances that he had a firearm and intended to use it, alarming them to such an extent that one of them called the college and reported the threat. See FAST, *supra* note 425, at 95; see also de Haven, *supra* note 1, at 521–24. Peter Odighizuwa, at the Appalachian School of Law, was openly threatening and hostile to fellow students in the classroom. de Haven, *supra* note 1, at 530–31. The victims claimed that he verbally assaulted and threatened women students and staff. Students nicknamed him "Shooter." *Id.* at 531. Several students and employees complained to the law school administration that he was abusive and that they were afraid of him. *Id.* In the twenty-four hour period before his rampage, he had a loud and angry confrontation with student services personnel about his student loan status and another loud and acrimonious meeting with a professor about his grades. *Id.* at 532–34. Robert Flores, at the University of Arizona College of Nursing, was frequently hostile to his teachers, all of whom were women. *Id.* at 542–43. He called them names in class and was so disruptive that the Associate Dean warned him that he could be expelled for inappropriate behavior. *Id.* at 542 n.186. He made it clear that he was capable of

several cases (including Williamson's), faculty, students, or staff reported such behavior to the campus police, the student mental health service, or other appropriate institutional authorities, specifically raising conduct-based concerns about the student's mental state.<sup>440</sup> After the rampage, questions are almost always raised about the adequacy of the institutional response.<sup>441</sup>

### B. Managing Troubled Students

Managing disruptive students is obviously not a new problem for college and university administrators. In 1989, proposing a threat assessment model for colleges and universities, Ursula Delworth wrote: "All campuses have or should have some system in place for handling the discipline or judicial problems and the psychological problems of students. *The issue often becomes one of insufficient coordination, inadequate information flow, and lack of a shared process . . .*"<sup>442</sup>

Delworth's last observation certainly applies in Williamson's case, when it comes to coordination and information flow between the University clinic and the Law School administration.<sup>443</sup> Its applicability is even more

"bash[ing] someone's head against a curb"; threatened one teacher that if she gave him a low grade she should "watch [her] back"; and once threatened to plant a bomb under the school. *Id.* at 542–44. Biswanath Halder, who filed a lawsuit against a computer lab employee at Case Western Reserve University for hacking and destroying his website, threatened to "fuck those fuckers up" if he lost his appeal. *Id.* at 551. *See also supra* Section III.A. (discussing Seung Hui Cho's rampage at Virginia Tech).

440. *See supra* note 439; *see also supra* Section III.A.

441. *See de Haven, supra* note 1.

442. URSULA DELWORTH, DEALING WITH THE BEHAVIORAL AND PSYCHOLOGICAL PROBLEMS OF STUDENTS, NEW DIRECTIONS FOR STUDENT SERVICES 9 (1989), *quoted in* Dunkle, Silverstein & Warner, *supra* note 438, at 590. Delworth was a professor of counseling psychology at the University of Iowa. Dunkle, Silverstein & Warner, *supra* note 438, at 589. According to Dunkle, Silverstein, & Warner, "the framework she articulated, the Assessment-Intervention of Student Problems (AISP) Model, remains as relevant and useful as it did when it first appeared almost twenty years ago." *Id.* at 590.

The standard components of Delworth's threat assessment model are the formation of a campus assessment team; a general assessment process for channeling students into the most appropriate on-campus and off-campus resources; and intervention with the student of concern. *Id.* The AISP is currently the model recommended by the National Association of Student Personnel Administrators (NASPA). *See Jablonski et al., supra* note 121, at 2, 6, 13. More sophisticated and comprehensive refinements to the basic model are being developed by experts in the field of education, law, and mental health, and these efforts have gained momentum since the Virginia Tech rampage. *See* The Jed Foundation, *Student Mental Health and the Law: A Resource for Institutions of Higher Education*, THE JED FOUNDATION (2008), *available at* [http://www.jedfoundation.org/assets/Programs/Programs\\_downloads/StudentMentalHealth\\_Law\\_2008.pdf](http://www.jedfoundation.org/assets/Programs/Programs_downloads/StudentMentalHealth_Law_2008.pdf).

443. Otherwise, however, the informal process in place for handling students such as Williamson appears to have worked reasonably well and to have complied with Delworth's model, which does not require formality so much as accountability. In the

obvious in the case of Virginia Tech.<sup>444</sup> Collective experience with school rampages between the UNC and Virginia Tech shootings has not only reinforced Delworth's critique, but also focused attention on the best ways of creating safer educational environments and managing troubled and troubling students.<sup>445</sup> Because rampagers plan their attacks and give other warning signs of their intentions, often long before they attack, the appropriate use of threat assessments may prevent many incidents of targeted school violence.<sup>446</sup> A number of threat assessment models have emerged—indeed, it is recommended that each school adopt a model best suited to its circumstances.<sup>447</sup> There appears to be an emerging consensus, however, that an institution of ordinary prudence should create and empower a collaborative, interdisciplinary group, supported at the highest institutional levels, through which information about students of concern can reach appropriate ears and result in appropriate intervention.<sup>448</sup> Such groups should include “mental health professional[s].”<sup>449</sup>

Along with the development of case management protocols, statutory protections not available to students in *Tarasoff's* day now inform and contain institutional treatment of disturbed and disturbing students.<sup>450</sup>

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wake of the Virginia Tech rampage, NASPA is now calling for a formalized approach to threat assessment and intervention. See Jablonski et al., *supra* note 121, at 14.

444. See *supra* text accompanying note 415.

445. In 2002, in response to the alarming rise of high school rampage shootings, the United States Department of Education, in collaboration with the United States Department of Homeland Security (formerly the Secret Service), published a guide to threat assessment in schools directed specifically at preventing incidents of targeted school violence. Fein et al., *supra* note 434.

446. *Id.* A cautionary note: there are apparently differences between adolescent rampagers, who are likely to have confided their plans and intentions to friends, and adult rampagers, who are not likely to have done so. FAST, *supra* note 425, at 13.

447. See Dunkle, Silverstein & Warner, *supra* note 438, at 589; see also Jablonski et al., *supra* note 121, at 6.

448. Jablonski et al., *supra* note 121, at 6. Such groups are variously known as “campus response and evaluation” (CARE) teams, “behavioral intervention teams” (BIT), or, currently preferred, “student at-risk response teams” (SARRT).

The goal in developing a threat assessment [team] is early intervention to help assure the health, safety, and success of the individual and other members of the campus community. As such, the development of a team is an act of caring, as are the activities of that team, including the team's decision to share information with appropriate members of the campus community on a need-to-know basis or with a student's family.

*Id.* at 15. See Vossekuil et al., *supra* note 23, at 37; see also Dunkle, Silverstein & Warner, *supra* note 438, at 587; The Jed Foundation, *supra* note 442, at 11.

449. Dunkle, Silverstein & Warner, *supra* note 438, at 594; see also Jablonski et al., *supra* note 121, at 14. The team should also include Student Affairs professionals, law enforcement representatives, and legal counsel, and it may include others, such as health services representatives, clergy, and teachers in particular cases. Jablonski et al., *supra* note 121, at 17; see also The Jed Foundation, *supra* note 442.

450. Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131–12134 (2006), prohibits discrimination against otherwise qualified individuals suffering from mental or psychological disability who are receiving educational services. Section 504

Colleges and universities are now well-advised to develop “individualized and objective” threat assessment capacities for determining whether students with mental disabilities pose a threat of harm to themselves or others.<sup>451</sup> At the same time, once appropriate guidelines are in place, an institution of higher education is not prevented from imposing conditions upon the continued enrollment of a disturbed or disturbing student to protect the safety of the student and the academic community.<sup>452</sup> Reasonable interventions may even include mandatory withdrawal or leave of absence.<sup>453</sup> There appears to be no question that requiring anger management classes, suicide counseling, or other therapeutic interventions as a condition of residence or enrollment is a legitimate exercise of institutional authority in appropriate cases.<sup>454</sup> Students’ statutory rights to privacy also ensure that care and discretion will be used in sharing information about students. At least since the Virginia Tech Massacre, it is clear that the Family Educational Rights and Privacy Act (FERPA) permits “well-informed professionals engaged in legitimate university business” to share “information related to protecting the health and safety of a student or member of the campus community.”<sup>455</sup>

Moreover, though institutions should always proceed with due respect for student rights and due care for confidential relationships, as a practical matter, the cases that justify threat assessment or other involuntary mental

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of the Rehabilitation Act applies to the same effect at educational institutions that receive federal funding. 29 U.S.C. § 794(b)(2)(A) (2006). The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 12329 (2006), protects student educational records from disclosure, and the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. §§ 1320d to d-8b (2006), protects student medical records from disclosure. Fuller discussions of the interface between these laws and the operation of effective student at-risk response teams can be found in Dunkle, Silverstein & Warner, *supra* note 438, and Massie, *supra* note 27.

451. Dunkle, Silverstein & Warner, *supra* note 438, at 612. According to the Office of Civil Rights (OCR) of the United States Department of Education, to which college and university administrators now look for guidance, students with mental disabilities lose the protection of federal law and may be removed or dismissed from the academy when there is a “high probability of substantial harm” to themselves or others, not merely “a slightly increased, speculative, or remote risk.” *Id.* The school should make removal decisions based on sound evidence and not on “unfounded fear, prejudice, or stereotypes.” *Id.* at 613. The touchstone is whether the student can safely participate in the institutions’ academic programs. The OCR advises institutions of higher education to consult with medically-trained professionals when making removal decisions. *See id.* at 612.

452. *See* Darby Dickerson, *Mandatory Withdrawal and Leave of Absence Revisited*, 28 NASPA LEADERSHIP EXCHANGE (2007).

453. *Id.*; *see* Dunkle, Silverstein & Warner, *supra* note 438, at 614–16.

454. *See supra* Section III.C.

455. Jablonski et al., *supra* note 121, at 15–16. So, too, does HIPAA. *Id.* FERPA also contains an exception for emergency situations that permits disclosure of educational records covered by the Act “if . . . such information is necessary to protect the health or safety of the student or other persons.” 20 U.S.C. § 1232g(b)(1)(I) (2006). *See* Dunkle, Silverstein & Warner, *supra* note 438, at 626–27.

health intervention seldom raise such issues.<sup>456</sup> There were no overriding confidentiality or privacy issues in the case of Wendell Williamson that justified the virtually impenetrable wall of silence around him and Dr. Liptzin once his treatment began. Nor should privacy concerns have hindered the Care Team from considering Seung Hui Cho's repeated alarming behaviors and encounters with University and mental health professionals.<sup>457</sup>

The mental health landscape has also been altered since *Tarasoff* in several ways that tend to enhance a college or university's capacity to prevent campus violence by students who are mentally disturbed. For one thing, the profession has developed better risk assessment practices for professionally-trained therapists than were available in 1969.<sup>458</sup> Risk assessment instruments and guidelines have also been developed that can be used as screening devices by non-clinicians such as Professor Roy, who may need to make an individualized and objective initial assessment of an alarming student.<sup>459</sup> Further, there is growing acceptance in the therapeutic community that outpatient commitment may be an effective means of

456. It is the experience of the authors that, when approached with thoughtful concern, most students who are at risk of self-harm will: agree to sign waivers that permit information sharing between caregivers and college or university administrators; voluntarily move to more appropriate housing; and even voluntarily withdraw from school on a temporary basis until they are able to obtain the treatment and care they need in order to diminish any risk of harm. Where the student has agreed to permit threat assessment teams to share information that would otherwise be confidential, or where a student agrees to withdraw voluntarily from a program in order to seek treatment, the risk of a legal claim against the institution is greatly reduced. Thus, it is important for threat assessment teams to engage students of concern consensually throughout the threat assessment process to the extent possible.

Dunkle, Silverstein & Warner, *supra* note 438, at 610–11.

457. “The Cook Counseling Center and the University’s Care Team failed to provide needed support and services to Cho during a period in late 2005 and early 2006. The system failed for lack of resources, incorrect interpretation of privacy laws, and passivity.” VT PANEL REPORT, *supra* note 310, at 2.

458. Since *Tarasoff*, “the field of violence risk assessment has burgeoned and is now a vast and vibrant area of interdisciplinary scholarship.” John Monahan, *Tarasoff at Thirty: How Developments in Science and Policy Shape the Common Law*, 75 U. CINN. L. REV. 497, 497 (2006). Professor Monahan observes that “no instruments for structuring violence risk assessments were available in 1976. Rather, Poddar’s clinicians assessed whatever risk factors they believed to be most relevant to his particular case, and combined those risk factors in a subjective manner to generate their clinical opinion about his violence risk.” *Id.* at 499–500. Professor Monahan cites four studies conducted since *Tarasoff* supporting the conclusion that using traditional, unstructured, subjective assessment methods, “clinicians are able to distinguish violent from nonviolent patients with a modest, better-than-chance level of accuracy.” *Id.* at 501 (citation omitted).

459. See, e.g., Carl J. Patrasso, *Questions in the Evaluation for Threat Assessment in Schools*, THE FORENSIC EXAMINER (Winter 2005), available at [http://findarticles.com/p/articles/mi\\_go1613/is\\_4\\_14/ai\\_n29221396](http://findarticles.com/p/articles/mi_go1613/is_4_14/ai_n29221396); Fein et al., *supra* note 434, at 43–59. See also Dunkle, Silverstein & Warner, *supra* note 438, at 598 n.68; *supra* note 336 and accompanying text.

reducing violence by mentally ill patients, which reinforces the value of requiring students to use mental health services as a condition of continued enrollment in appropriate cases.<sup>460</sup>

### C. Litigating Student Suicides

Student suicides and campus rampages are not unrelated phenomena. Both are acts of violence occurring at an educational institution.<sup>461</sup> Though some campus rampagers are simply murderous and far from suicidal, about half have killed themselves before they could be arrested.<sup>462</sup> Even when suicidal students do not pose a risk of direct harm to others, suicide on campus demoralizes the academic community. Student self-injury is a major and growing concern of colleges and universities in what is being described as a “suicide crisis” in higher education.<sup>463</sup>

Since 2000, courts have taken differing theoretical paths and have come out in different places regarding a college or university’s duty to prevent student suicide. Along the way, they have encountered complaints not only against college and university therapists but also against Deans of Students and other university administrators who were not directly involved in mental health treatment of the suicidal student. Indeed, the complaint may be that college and university administrators knew the student was psychologically disturbed, even suicidal, but did not arrange appropriate professional treatment or warn the student’s family of the situation. Thus, the student suicide cases raise many of the same issues as the student rampage cases. A brief review of the few suicide cases decided since 2000

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460. Monahan, *supra* note 458, at 515. In a study conducted using patients who had previously been committed as in-patients and then released, results indicated that, provided the patient actually used the out-patient services, extended outpatient commitment of more than six months reduced the probability of violence by fifty percent. While another study reached the conclusion that court-ordered outpatient commitment does not reach better outcomes than enhanced follow-up services, Professor Monahan suggests that in *Tarasoff*-type cases raising particular concerns about violence, therapists should consider “intensified voluntary treatment, *outpatient commitment*, inpatient commitment, or warning the potential victim.” *Id.* at 519 n.81 (emphasis in original).

461. *See* Lake, *supra* note 27.

462. The following rampages ended in suicide by the killer: Gang Lu at the University of Iowa; Robert Flores at the University of Arizona; Seung Hui Cho at Virginia Tech; Steven Kazmierczak at Northern Illinois University.

On the other hand, campus rampagers have not for the most part been substance abusers (Williamson, again, is exceptional). Cases involving university liability for student self-injury relating to recreational drug use are not considered here. *See, e.g.*, *Bash v. Clark Univ.*, 22 Mass. L. Rptr. 84 (Super. Ct. Mass. 2006) (finding no university liability for student’s accidental death by heroin overdose).

463. *See* Lake, *supra* note 27, at 254. Student suicides affect graduate and professional schools as well as undergraduate institutions, and they appear to be increasing among older members of the student population. *Id.* at 254–55. Like rampagers, most successful student suicides (about eighty percent) are men, and among men, firearms are the most commonly used means of death. *Id.*

is therefore instructive if only to underline the need for a formulation of duty better adapted to the realities of academic experience with mentally disturbed students.<sup>464</sup>

### 1. *Jain v. State of Iowa*

Decided in 2000, *Jain v. State of Iowa* was typical of the *Tarasoff*-era analysis in rejecting the plaintiff's argument that the University of Iowa was responsible for the suicide of his son, Sanjay Jain, a young undergraduate in his first semester at the University of Iowa in 1994.<sup>465</sup> Upholding the trial court's dismissal of the action, the Iowa Supreme Court held that the University had not affirmatively undertaken to warn Jain's family that their son had threatened suicide.<sup>466</sup> The University's knowledge of the student's mental condition was not enough to create a special relationship giving rise to an affirmative duty of care, because the University's performance did not make matters any worse for Sanjay Jain or "cause [him] to forego other alternatives [for] protecting [himself]."<sup>467</sup>

### 2. *Schieszler v. Ferrum College*

Decided only a few months before *Davidson v. UNC*, *Jain* supported an institutional hands-off approach to self-inflicted student injuries, even when the college or university offered mental health services to students and could insist that they use them.<sup>468</sup> A year later, in *Schieszler v. Ferrum*

464. "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 . . . . At this time, the law is failing colleges and universities with respect to the mental health crisis." *Id.* at 254.

465. *See* *Jain v. State*, 617 N.W.2d 293 (Iowa 2000). The hall coordinator at Sanjay's dorm learned a couple of days before Thanksgiving break in 1994 that he was threatening to gas himself and had a Moped in his room. *Id.* at 295. Jain later denied any suicidal intent, claimed that he was merely suffering from homesickness, and refused to let his parents be contacted. *Id.* The hall coordinator, whose qualifications and training are not reported, advised Sanjay to seek help at the University counseling center and gave him her home number. *Id.* at 295. Sanjay went home for Thanksgiving and did not mention his suicidal thoughts to his family. *Id.* He returned to school, where the hall coordinator checked on him. *Id.* He told her "things were going good." *Id.* His friends knew but did not share with the residence staff that Jain was still contemplating suicide and was still keeping the Moped in his room. *Id.* On December 4, when his roommate was out of town, Jain died in his room from inhaling exhaust fumes. *Id.*

466. *Id.* at 300. The University had an unwritten policy that the Dean of Students would notify the parents of any student who attempted suicide based upon "information gathered from a variety of sources." *Id.* at 296. The dormitory hall coordinator reported Jain's suicidal comments to the Resident Advisor, but the Dean of Students was not told about the situation. *Id.* at 295-96.

467. *Id.* at 299, citing RESTATEMENT (SECOND) OF TORTS § 323 (1977). Indeed, the Court noted, Jain failed to take advantage of the counseling services offered him. *Id.*

468. Early in his short undergraduate life, Jain was required to take substance abuse classes as a condition of remaining in the dormitory. *Id.* at 295.



*College*, a trial court in Virginia took a less tolerant view of the college or university's role when freshman Michael Frentzel hanged himself in his dorm room.<sup>469</sup> A federal court, sitting in diversity, found that a special relationship existed between Frentzel and the College under Virginia law because the facts alleged, if proved, constituted special circumstances that made the suicide foreseeable.<sup>470</sup> "[A] trier of fact could conclude that there was 'an imminent probability' that Frentzel would try to hurt himself and that the defendants had notice of this specific harm."<sup>471</sup> The college might therefore have had a duty to prevent the suicide. The court also appeared to find persuasive the reasoning of *Furek* and *Mullins*, both of which rested in part on the recognition that the defendants had voluntarily undertaken a duty to act. During oral argument on defendants' motion to dismiss, however, the plaintiff abandoned the claim of affirmative undertaking, and the court therefore did not address the obstacles raised by *Jain* to finding an affirmative undertaking in the context of student suicide.<sup>472</sup>

The two cases were not necessarily irreconcilable in theory or in outcome. In *Jain*, the student's first suicide threat (the only one about which the University learned) was investigated by his dormitory advisor, who determined that he did not intend to kill himself. She reported it and discussed it with her supervisor, and they decided not to report it to the Dean of Students for further action.<sup>473</sup> Moreover, Jain made a trip home after his alleged threat, and he reported to his dorm advisor that he was doing fine when he returned.<sup>474</sup> Under the circumstances it is hard to make a case that Jain's suicide, though perhaps preventable, was foreseeable. In contrast, the plaintiff in *Ferrum College* could state a case that Frentzel's

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469. 236 F. Supp. 2d 602, 605 (W.D. Va., 2002). In 2000, six years after Sanjay Jain's death, Michael Frentzel killed himself in his college dorm room. *Id.* The two cases had much in common. Like Jain, Frentzel was a young freshman living in student housing. *Id.* Like Jain, he had difficulty adjusting to college life and was required to enroll in "anger management counseling" as a condition of continuing his enrollment. *Id.* at 609. As in *Jain*, Ferrum College authorities knew that Frentzel had threatened suicide and that he had the means to carry out his threat. *Id.* Frentzel sent a note to his girlfriend threatening to hang himself with his belt. *Id.* She showed the note to the resident assistant at the dorm and the campus police, who intervened and found Frentzel in his dorm room with bruises on his head that he admitted were self-inflicted. *Id.* This information was communicated to the Dean of Student Affairs, and the Dean required Frentzel to sign a statement that he would not harm himself. *Id.* The Dean did not, however, place Frentzel on a suicide-watch or take any other action. *Id.* A day or so later (the facts are unclear), when Frentzel sent his girlfriend another alarming note, the Dean prevented her from seeing him. *Id.* Left all alone, Frentzel sent his girlfriend a third note. *Id.* This time she persuaded the administration to intervene, but the campus police arrived too late. Frentzel was dead by the time they opened the door. *Id.*

470. *Id.* at 609.

471. *Id.*

472. *Id.* at 608.

473. See *Jain*, 617 N.W.2d at 295–96.

474. *Id.* at 295.

suicide was both preventable and foreseeable even by a college or university administrator who was not trained in psychology. Indeed, because the matter was brought to the Dean, who then extracted a written promise from Frentzel not to injure himself, the jury might have inferred that the College actually did foresee the suicide.<sup>475</sup> Moreover, in contrast to *Jain*, the College's self-protective intervention probably made matters worse. The Dean not only left Frentzel alone and unattended; he affirmatively forbade Frentzel's friends to visit him in his dorm room, thereby depriving him of attention, companionship, and emotional resources and increasing his isolation at a critical juncture.<sup>476</sup> Under the circumstances it is perhaps not surprising that in settling the case, the College took the unusual step of publicly acknowledging "errors in judgment and communication" and "shared responsibility" for Frentzel's death.<sup>477</sup>

### 3. *Shin v. MIT*

In 2005, three years after the decision in *Ferrum College*, a trial court in Massachusetts upheld a wrongful death action against the Massachusetts Institute of Technology (MIT), where Elizabeth Shin apparently set herself on fire in her dormitory room in April 2000.<sup>478</sup> Shin was a sophomore who experienced recurrent states of suicidal depression related to the stress of academic life.<sup>479</sup> University mental health professionals and academic and residential administrators had been continuously involved in her care since she attempted suicide by drug overdose during the second semester of her freshman year.<sup>480</sup> After her death, her parents brought a wrongful death

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475. In *Tarasoff*, Judge Simms made much the same argument with respect to the campus police, who let Poddar go when he promised to stay away from the woman he later killed. *Tarasoff v. Regents of Univ. of Cal.*, 108 Cal. Rptr. 878, 898 (Cal. Ct. App. 1973)

476. *Schieszler*, 236 F. Supp. 2d at 610.

477. Eric Hoover, *Ferrum College Concedes 'Shared Responsibility' in a Student's Suicide*, CHRON. HIGHER EDUC., Aug. 8, 2003, at A31.

478. *Shin v. Mass. Inst. of Tech.*, 2005 WL 1869101 1, 5 (Mass. Super. Jun. 27, 2005).

479. *Id.* at 9.

480. *Id.* at 1–5. Elizabeth Shin had a history of depressive behavior and "cutting" in high school. *Id.* at 1. Her father took her to MIT's Mental Health Center after she attempted suicide during her second semester, and she remained in treatment by an MIT psychiatrist for the rest of her freshman year. *Id.* at 1–2. When Shin returned to MIT for her second year, she told the Dean of Counseling and Support Services (CSS) that she was again thinking of killing herself. *Id.* at 2. The Dean sent her to the Mental Health department for immediate assessment, and she again began treatment by MIT psychiatrists. *Id.* In the spring of her sophomore year, Shin's mental health continued to deteriorate. *Id.* at 3. Her teachers, tutors, classmates, and housemasters reported to CSS and the Mental Health department that Shin was continuing openly to contemplate suicide. *Id.* In mid-March 2000, she was hospitalized in the MIT infirmary because she was considered unsafe to leave alone. *Id.* Her father took her home from the infirmary, but she returned to school after spring break. *Id.* She began seeing another

and negligence action against the MIT psychiatrists who had treated her, the Dean of MIT's Counseling and Support Services (CSS), and the housemaster at her dormitory.<sup>481</sup>

Only one of the defendant MIT psychiatrists denied having a special doctor-patient relationship with Elizabeth Shin that gave rise to a duty of care.<sup>482</sup> Defendant Dr. Girard moved for dismissal because she had ceased treating Shin six months before her death.<sup>483</sup> However, the court found that the psychiatrist was a member of the "deans and psyches" group that considered Shin's case on the day of her death and therefore might be considered still part of Shin's "treatment team."<sup>484</sup>

That a duty once owed a patient might continue, or be revived, if the therapist later participates in decisions affecting the patient's treatment is not much of a stretch, though the ruling has been taken as a sign that any mental health professional's membership on a threat assessment team may be sufficient to impose a duty of reasonable care.<sup>485</sup> Even more expansive was the court's extension of the duty to both MIT's Dean of CSS and Shin's dormitory housemaster, neither of whom was a mental health professional.<sup>486</sup> The court relied in part upon *Mullins v. Pine Manor*, locating the administrators' duty of care in the consensus of "existing social values and customs" that inform the academic community as a whole.<sup>487</sup> It also discussed with approval the ruling in *Ferrum College*, that the Dean of

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MIT psychiatrist, who prescribed medications, but her condition did not improve, and her teachers continued to sound the alarm to CSS and the Mental Health Center clinicians. *Id.* at 3-4. On April 8, following another suicide threat, one of Shin's suite mates called the MIT Campus Police, who took her to the Mental Health Center, where she spoke by telephone to an on-call psychiatrist, Dr. Van Niel. *Id.* at 4. Van Niel determined within five minutes that she was not "acutely" suicidal and sent her back to the dorm with no restrictions or follow-up plan. *Id.* Less than 48 hours later, shortly after midnight on April 10, Shin announced that she planned to kill herself that day and asked another student to erase her computer files. *Id.* at 5. The housemaster called the Mental Health Center and spoke to Dr. Van Niel, who declined to see Shin at that time because he believed that she was fine and that her friends were overreacting. *Id.* Shin's mental state still alarmed the housemaster at 9:45 that morning. *Id.* The housemaster contacted the Dean of CSS, who discussed Shin at a meeting of "deans and psyches" that met later that day. *Id.* At 9:00 that night, the campus police responded to a smoke alarm in Shin's locked dorm room and found her engulfed in flames. *Id.* She died a few days later of injuries suffered in the fire. *Id.*

481. *Id.* at 11.

482. *Id.*

483. *See generally id.* The other defendant psychiatrists moved for summary judgment on the grounds that although they owed a duty of care to Elizabeth Shin, they had not committed gross negligence as alleged. The trial court found a genuine issue of fact in that regard based on plaintiff's allegations that the defendant psychiatrists had failed to formulate and enact an "immediate" treatment plan in response to Shin's escalating suicide threats. *Id.* at 9.

484. *Id.* at 11-14.

485. *See Lake, supra* note 27, at 272.

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

487. *Id.* at 33.

Students had a duty because he knew or should have known that the suicide was imminently foreseeable.<sup>488</sup> It noted that both administrators had participated in important ways in caring for Shin's mental health and concluded that they, too, could both be sued as members of Shin's "treatment team."<sup>489</sup>

The ruling appeared to rest the administrators' duty entirely upon the fact that the Dean and the housemaster knew Shin's situation and should have foreseen that her death by suicide was imminent.<sup>490</sup> As Professor Lake has pointed out, ruling that foreseeability of harm alone creates a duty to prevent that harm "would be a novel and very broad departure from existing law."<sup>491</sup> The facts suggest, however, that distinctions might usefully have been drawn between the two administrative defendants to arrive at a somewhat more precise formulation that relies not only upon foreseeability, but also upon the capacity to take effective preventive action. The record on summary judgment, incomplete though it doubtless was, reflected that the Dean of CSS and the housemaster each had ongoing and significant involvement in Shin's care, but that they operated at different levels of institutional authority. The housemaster, for example, obviously played a vital front-line role in MIT's collaborative and interdisciplinary model of student mental health management. She received communications about Shin's mental state from other students, from Shin's teachers, and from Shin herself.<sup>492</sup> She communicated all such information either to the Dean of CSS or, in an emergency, directly to MIT's mental health services.<sup>493</sup> At one point, Shin's psychiatrist requested, through the Dean of CSS, that the housemaster discourage Shin from moving out of the dorm, and the housemaster was able to do so.<sup>494</sup> However, though the housemaster's personal and institutional influence was important, she does not appear to have occupied a position of institutional authority. The Dean of CSS, on the other hand, wielded considerable institutional power to intervene in Shin's situational distress. For example, two successive Deans arranged for Shin to receive immediate assessment for suicide risk at the MIT Mental Health Clinic based on alarming personal conversations with her.<sup>495</sup> The Dean of CSS was on the "deans and psychs" assessment team, in which the housemaster did not participate.<sup>496</sup>

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488. *See id.* 35–37.

489. *Id.* at 14.

490. *Id.*

491. Lake, *supra* note 27, at 274.

492. *Shin*, 2005 WL 1869101 at 1, 3, 5.

493. *Id.*

494. *Id.* at 3.

495. *Id.* at 2.

496. *See generally id.* at 5. The opinion does not reflect whether the Dean of CSS could arrange academic leaves of absence but does indicate that the Dean arranged to

Recognizing that only those with institutional authority to intervene should have a duty to prevent student injury would have provided an important limiting principle to the *Shin* court's expansive foreseeability formula. As it turned out, the parents and MIT finally agreed that Elizabeth Shin's "imminently foreseeable" suicide was in fact an accident, which had been MIT's position all along.<sup>497</sup> The settlement cast further doubt on the value of foreseeability as a determinative element in imposing a duty of care in cases of student self-injury.

#### 4. *Mahoney v. Allegheny College*

Shortly after *Shin* was decided in Massachusetts, a trial court in Pennsylvania dismissed negligence claims against two college administrators who were not treating therapists of the student who had committed suicide.<sup>498</sup> Charles Mahoney went to Allegheny College as a freshman in 1999 expecting to play football.<sup>499</sup> Like Elizabeth Shin, he quickly experienced psychological difficulties at college, and his mother referred him to the College Counseling Center (CCC), where he continued to receive drug therapy and counseling for major depression until his suicide by hanging in February of his junior year.<sup>500</sup> After his death, his

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postpone at least one of Shin's exams shortly before her death. *Id.* at 3.

497. Marissa Vogt, *MIT Settles Case, Parents Agree Death Likely an Accident*, THE TECH (Apr. 4, 2006), <http://tech.mit.edu/V126/N15/15shin.html>.

498. *Mahoney v. Allegheny College*, No. AD892-2003 (Pa. Ct. Com. Pl. 2005).

499. *Id.*

500. *See generally id.* Mahoney had panic and anxiety attacks when he started football camp as a freshman in August 1999. *Id.* at 3. He was evaluated and diagnosed with major depression, single episode. *Id.* He participated in regular counseling with Jacquelyn Kondrot at CCC throughout his freshman year. *Id.* In fall 2000, he began to feel suicidal and was again assessed by a CCC psychiatrist. *Id.* This time hospitalization was recommended, and Mahoney's parents were notified. *Id.* at 4. Mahoney was hospitalized briefly and anti-depressant medication was prescribed. *Id.* He continued counseling with Kondrot for the rest of the school year and continued taking anti-depressants when he left college for the summer. *Id.* When he returned as a junior in fall semester 2001, his condition began to deteriorate. *Id.* He quit the football team and broke up with his girlfriend because he thought he was ruining her life. *Id.* He confessed to Kondrot that he had lied to her about his high levels of alcohol consumption. *Id.* He began to say that he wished he were dead. *Id.* at 5. In late January 2002, his fraternity friends and former girlfriend visited Kondrot and voiced concerns that Mahoney was isolating himself and drinking heavily. *Id.* He arranged for one of his friends to adopt his beloved dog "if anything happens to me." *Id.* On January 28, Kondrot discussed his case with the Dean of Students. On February 1 Kondrot again referred him to the CCC psychiatrist for evaluation and diagnosis, review of his medication therapy, and assessment for suicide risk. *Id.* at 6. On February 11, Kondrot received an alarming e-mail from Mahoney. She met with him that day and tried to persuade him to take a leave of absence. *Id.* at 9-10. He refused. *Id.* at 10. She told him that normally she would call his parents and the Dean of Students to discuss options for his continuing care. *Id.* Again, Mahoney refused to permit his parents to be called. *Id.* He also firmly refused to consider hospitalization. *Id.* He left for class after a counseling session of over an hour, promising to check in with the counselor the

parents brought claims of medical malpractice and negligence against the CCC counselor who treated him, the College as her employer, and the College's consulting psychiatrist who prescribed his anti-depressant medication.<sup>501</sup> These claims proceeded to trial based upon expert affidavits proffered by the plaintiff creating factual issues with respect to malpractice.<sup>502</sup> The plaintiffs, the College's Dean of Students and Associate Dean of Students, were also named as negligent actors.<sup>503</sup> They claimed that the deans had a duty to prevent their son's suicide by having him hospitalized, by placing him on involuntary leave of absence for health reasons, or by notifying them of his deteriorating mental condition.<sup>504</sup>

The evidence before the court on summary judgment was that the Deans of Students learned about two weeks before Mahoney's suicide that he was having conflicts with fraternity brothers and seeing a counselor for depression.<sup>505</sup> They determined that his misconduct at the fraternity did not warrant disciplinary action.<sup>506</sup> On February 11, the day of his suicide, Mahoney's worried counselor discussed with them whether to advise Mahoney's parents of his condition and/or to place him on an involuntary leave of absence for mental health reasons.<sup>507</sup> The counselor advised the deans that taking either action was likely to make matters worse for Mahoney.<sup>508</sup> The deans testified in depositions that they deferred to the counselor's judgment with respect to the best course of action (or inaction) in Mahoney's case.<sup>509</sup>

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next morning. *Id.* at 11. Later that afternoon he hanged himself with the dog's leash at his off-campus fraternity house. *Id.* at 2; Elizabeth Bernstein, *After a Suicide, Privacy on Trial*, WALL STREET JOURNAL, Mar. 24, 2007, at A1, available at <http://online.wsj.com/article/SB117470447130847751.html>.

501. Mahoney v. Allegheny College, No. AD892-2003 (Pa. Ct. Com. Pl. 2005).

502. The jury found that the mental health professionals were not negligent in treating Mahoney, nor was Allegheny College liable in *respondeat superior*. See Bernstein, *supra* note 500.

503. See *Mahoney*, No. AD892-2003, slip op. at 2. The depositions and affidavits showed that the Office of the Dean of Students had first become aware of Mahoney's situation (though not his name) by way of a discussion on January 28, 2002, with his counselor, Kondrot, who was concerned about his depressed state. *Id.* at 11. On February 8, the Dean heard that Mahoney had disturbed the SAE fraternity house where he lived, apparently because his former girlfriend was dating one of his fraternity brothers. *Id.* at 11-12. He also learned that Mahoney was the student about whom Kondrot had reported. *Id.* at 12. The Dean investigated the fraternity incident, received assurances from the students that there would be no fighting, and decided that no formal disciplinary action was warranted. *Id.* at 12. Three days later, on February 11, the Dean received an e-mail from a student at the fraternity house again expressing concerns about Mahoney's emotional health and potential for violence. *Id.*

504. *Id.* at 12.

505. *Id.*

506. *Id.*

507. *Id.*

508. *Id.* at 13.

509. *Id.*

Viewing the lawsuit as essentially a claim of malpractice against the therapist, the psychiatrist, and, by extension, the deans, the trial judge declined to extend the mental health professional's duty of care to lay administrators.<sup>510</sup> The decision acknowledged that "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,'" but it determined that the circumstances did not warrant finding a special non-therapeutic relationship between Mahoney and the deans.<sup>511</sup> Unlike Michael Frentzel and Elizabeth Shin, Mahoney had not previously attempted to kill himself or revealed suicidal intentions to the College deans.<sup>512</sup> Their only personal contact with him was in the context of a minor disciplinary matter. While Mahoney's therapist advised them of his mental health issues, she specifically requested that they not intervene on that basis.<sup>513</sup> They had no independent basis for placing him on leave of absence or calling his parents, although it is worth noting that they apparently had the institutional authority to take such actions in appropriate cases.<sup>514</sup> In addition, as the court noted, neither of the deans made matters worse.<sup>515</sup> They took no action that would have kept Mahoney from getting the professional help or parental support he needed.<sup>516</sup>

Moreover, the court was reluctant to extend the therapist's duty to college and university administrators because of the disruptive impact such an extension might have on other rights and relationships. "Concomitant to the evolving legal standards for a 'duty of care' to prevent suicide are the legal issues and risks associated with violations of the therapist-patient privilege, student right of privacy and the impact of 'mandatory medical withdrawal policies' regarding civil rights of students with mental disability."<sup>517</sup> Nevertheless, the court ended its decision with a note of caution to college and university administrations:

"[F]ailure to create a duty is not an invitation to avoid action. . . . Rather than . . . 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."<sup>518</sup>

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510. *Id.* at 20.

511. *Id.*

512. *Id.*

513. *Id.* at 13.

514. *Id.* at 12.

515. *Id.* at 25.

516. *Id.* at 25. *See also supra* Section III.B.

517. *Id.* at 20.

518. *Id.* at 25.

## D. Framing a Newer Model of Institutional Accountability

Writing in 1983 in *Pine Manor College*, the Supreme Judicial Court of Massachusetts observed “with confidence” that colleges and universities “of ordinary prudence” exercise care for the protection and well-being of their resident students and that recognition of their duty to do so is therefore “firmly embedded in a community consensus.”<sup>519</sup> In 2010, the same can be said with equal confidence when it comes to protecting and safeguarding the well-being of faculty, students, and staff in classrooms, libraries, laboratories, offices, and other academic spaces.<sup>520</sup> Safe space is integral to the educational enterprise, and there is surely no dispute that a responsible institution of higher education must value the physical and psychological safety of the learning community.<sup>521</sup> That so much time and energy are now being devoted to campus safety practices in the wake of Virginia Tech is hopeful evidence that the consensus continues.

In her first article, the author argued that a duty of reasonable care for student safety should rest with institutions of higher education as such—that is, not as a result of their landlord-tenant or business-invitee relationship with students, but because of the unique characteristics, circumstances, and relationships of academic life.<sup>522</sup> To go further, at least with respect to students identified as disturbed or disturbing, recognizing that colleges and universities have a responsibility to protect students from reasonably preventable peer violence or deliberate self-injury, including rampage violence, makes sense for the reasons that support imposing tort duty upon the more powerful and capable party in other special relationships, such as employer-employee or manufacturer-consumer.<sup>523</sup>

First, as the *Furek* court pointed out, institutions of higher education

519. *Mullins v. Pine Manor Coll.*, 449 N.E.2d 331, 335; *see also Schieszler v. Ferrum Coll.*, 236 F. Supp. 2d 602, 610 (W.D. Va. 2002).

520. In 1997, Professors Robert Bickel and Peter Lake wrote, “There is a growing sentiment that universities have done things, can do things, and should do things to prevent unreasonable student injury. Ostrichism is bad policy and increasingly legally suspect.” BICKEL & LAKE, *supra* note 26, at 135.

521. *See* Peter F. Lake, *Private Law Continues to Come to Campus: Rights and Responsibilities Revisited*, 31 J. C. & U.L. 621, 622–32 (2005).

522. de Haven, *supra* note 1.

523. Section 314A of the Restatement (Second) of Torts states, “The law appears . . . to be working slowly toward a recognition of the duty to aid or protect in any relation of dependence.” RESTATEMENT (SECOND) OF TORTS § 314A (1977). Commenting on the *Shin* decision, Professor Lake reminds us that “special relationship analysis under Section 314 was intended to have an open-ended and evolving quality.” Lake, *supra* note 27, at 273.

To confirm Professor Lake’s observation, Section 40 of the new Restatement (Third) of Torts specifically recognizes that there is a special relationship between a school and its students that imposes a duty of reasonable care under the circumstances. RESTATEMENT (THIRD) OF TORTS §§ 40(a), (b)(5), cmt. d. (1998). *See also* Massie, *supra* note 27, at 637–39.



have significant and unique power to make campuses more or less safe.<sup>524</sup> Professors Peter Lake and Robert Bickel wrote in 1997, “[A] college is not merely a passive educational repository for students, like parentheses in an equation, but is one of the most important variables and part of the functions.”<sup>525</sup> When exercised with care and competence, institutional control and coordination operate to the benefit of the institution in general and are the best way to make campuses safe enough for learning to flourish. As at workplaces, where the employer’s responsibility for worker safety is well-established, educational institutions establish rules and guidelines for the conduct of the community, engage in strategic planning, hire and empower trained personnel, communicate expectations, monitor performance, and impose sanctions and restrictions, including dismissal, for aberrant behavior. Colleges and universities are capable of authoritative intervention that balances individual against community interests in the educational setting. Their administrations are in the best position to establish appropriate assessment and intervention capacities, to adopt and coordinate policies and procedures, to determine and enforce sanctions and interventions, and to allocate resources and raise funds. Specifically, as the cases considered here demonstrate, colleges and universities can coordinate the delivery of mental health services. They can also require in appropriate circumstances that students accept such services as a condition of remaining enrolled.

Next, many institutions of higher education have undertaken to care for disturbed and/or disturbing students by enlisting the services of mental health professionals on their campuses. It makes a significant difference in results when they manage such care responsibly.<sup>526</sup> Indeed, colleges and universities are largely successful in protecting students from extremes of rage and self-destruction as they live through the challenges of academic life.<sup>527</sup> At the same time, as the rampage and suicide scenarios show, the

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524. *Furek v. Univ. of Delaware*, 594 A.2d 506, 519 (Del. 1991).

525. BICKEL & LAKE, *supra* note 27, at 129.

526. See Lake, *supra* note 27, at 276. “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.” *Id.* at 276.

527. The university’s capacity to affect outcomes is perhaps greatest when it owns the mental health services provider, as in the cases examined here. Then it can make sure, for example, that the director of the mental health clinic sits on the university threat assessment team and has a finger on the pulse of campus life. It can encourage its clinicians to use the assessment tools best suited to the academic environment and therapeutic methods best suited to the psychological problems of students. It can develop protocols and practices for communication between the mental health professionals at the clinic and other sectors of the university. The dean of the law school can then make sure that the student he sent to the clinic is keeping his appointments. The therapist or intake psychologist can learn more about the student’s alarming behaviors than the student himself may have revealed.

Colleges and universities that do not have the advantage of campus mental health

institution can make matters significantly worse by tolerating barriers to effective communication and intervention, by ignoring credible concerns, and by failing to act in situations of potential or actual violence. It can also make matters worse by adopting unreasonable protective measures that are not in the best interest of either the student or the community as a whole.<sup>528</sup> From a safety perspective, the complex dynamics of campus life are also worsened by hierarchical layers and disconnections among college and university constituencies—a problem that can be addressed only by recognizing the institution’s contribution to it and holding it accountable for its own disorder.

Another reason for making colleges and universities take some legal responsibility for student mental health is that students are a vulnerable population.<sup>529</sup> They depend on the college or university for their safety in two respects. First, as the cases discussed show, many students are psychologically vulnerable to the particular stresses of academic life, which

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services can accomplish effective assessment and treatment capacities for mentally disturbed students by developing relationships with independent service providers. *See* Dunkle, Silverstein & Warner et al., *supra* note 438, at 591 n.24.

Standard 209 of the American Bar Association Standards for Approval of Law Schools provides that “if a law school is not part of a university . . . [it] should seek to provide its students and faculty with the benefits that usually result from a university connection . . . .” AMERICAN BAR ASSOCIATION, 2010–2011 STANDARDS AND RULES OF PROCEDURE FOR APPROVAL OF LAW SCHOOLS (2010), *available at* [http://www.americanbar.org/content/dam/aba/migrated/legaled/standards/2010-2011\\_standards/2010-2011abastandards\\_pdf\\_files/chapter2.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/migrated/legaled/standards/2010-2011_standards/2010-2011abastandards_pdf_files/chapter2.authcheckdam.pdf). Presumably the benefits of a university connection include mental health services as well as library and other educational resources.

528. George Washington University, for example, was sued under the Americans with Disabilities Act when it suspended a student for “endangering behavior” in violation of the code of student conduct after he checked himself into GWU hospital in 2004 with depression and suicidal thoughts. Daniel de Vise, *GWU Settles Lawsuit Brought by Student Barred for Depression*, WASH. POST (Nov. 1, 2006), *available at* <http://www.washingtonpost.com/wp-dyn/content/article/2006/10/31/AR2006103101193.html>. *See also* Rob Capriccioso, *Counseling Crisis*, INSIDE HIGHER ED. (Mar. 13, 2006), <http://www.insidehighered.com/news/2006/03/13/counseling>. In contrast, the University of Illinois has an effective student prevention program that requires any student who has expressed suicidal intent to undergo four assessment sessions with a mental health professional. The program has resulted in a 40% relative reduction in suicide at the university between 1984 and 2002. *But see* Marlene Busko, *College Mental Health Issues and Suicide-Prevention Program Discussed*, MEDSCAPE MEDICAL NEWS (Oct. 3, 2007), <http://www.medscape.com/viewarticle/565545>. MIT, the University of Rochester, Harvard, Cornell, and Princeton are participating in a pilot project to adapt the United States Air Force’s suicide prevention program to college campuses. *Id.* The Jed Foundation also provides helpful guidance in establishing institutional suicide prevention programs. *See* THE JED FOUNDATION, *supra* note 442.

529. The *Furek* court determined that the university’s relationship with students is unique because of “situation[s] created by the concentration of young people on a college campus and the ability of the university to protect its students.” *Furek*, 594 A.2d at 519.

may precipitate or exacerbate mental health problems.<sup>530</sup> Students who suffer from psychological disturbance frequently must depend upon the services of the college or university mental health clinic, which may be the only care to which they have effective and affordable access, and responsible institutions encourage them to use such services. Second, students are vulnerable to attacks by other students. They are congregated in open spaces, such as classrooms and libraries. They are overwhelmingly unarmed.<sup>531</sup> They are encouraged to depend upon institutional safety measures—to rely, for example, on the campus police, or judicial affairs—when they feel endangered by other students. There is little support among college and university administrators for permitting students to carry firearms or engage in other self-help measures instead of using college and university processes in dangerous situations.<sup>532</sup>

Moreover, threat assessment methodologies and intervention practices specific to college and university campuses are sufficiently developed for a standard of reasonable care to be defined. An adaptable model of coordinated care makes it more likely that relevant information will be available to those who can best assume responsibility for managing disturbed and disturbing students so that they do not become dangerous to themselves or others.<sup>533</sup> Individual assessment methods for determining the risk of violence by a particular student are also improving.<sup>534</sup> Though not all mentally ill students are violent, and not all violent students are mentally ill, one effective way to reduce campus violence is to make sure

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530. See, e.g., Lawrence S. Krieger, *Institutional Denial About the Dark Side of Law School, and Fresh Empirical Guidance for Constructively Breaking the Silence*, 52 J. LEG. ED. 112 (Mar/Jun 2004); Helena Oliviero, *Anxiety, Stress plague college students*, ATLANTA JOURNAL-CONSTITUTION (Feb. 5, 2010), available at <http://www.ajc.com/health/anxiety-stress-plague-college-292174.html>; Ema Garcia, *A New Hope: Addressing the mental health problems of law students*, STUDENT LAWYER 33 (Mar. 2008).

531. It is estimated that nine percent of postsecondary students (eight percent of men, one percent of women) have working firearms on campus. Joetta L. Carr, AM. COLL. HEALTH ASS'N, *Campus Violence White Paper 2* (2005), available at [http://www.acha.org/info\\_resources/06\\_Campus\\_Violence.pdf](http://www.acha.org/info_resources/06_Campus_Violence.pdf). See de Haven, *supra* note 1, at 506 n.6.

532. In August 2008, the International Association of Campus Law Enforcement Administrators (IACLEA) issued a position statement opposing legislative initiatives that would allow students to carry concealed weapons on campuses. Lisa A. Sprague, INT'L ASS'N OF CAMPUS LAW ENFORCEMENT, *IACLEA Position Statement: Concealed Carrying of Firearms Proposals on College Campuses* (2008), available at [http://www.iaclea.org/Visitors/PDFs/ConcealedWeaponsStatement\\_Aug2008.pdf](http://www.iaclea.org/Visitors/PDFs/ConcealedWeaponsStatement_Aug2008.pdf).

The National Association of Student Personnel Administrators takes the position that there is no “legitimate educational purpose for the presence of firearms on campus with the exception of those being carried by law enforcement officers. If a college or university has a safety or sworn police force, the decision as to whether or not those officers are armed ought to include the opportunity across campus to comment on the question.” Jablonski et al, *supra* note 121, at 6.

533. See Jablonski et al., *supra* note 121, at 29–31.

534. *Id.*

that disturbed and disturbing students are receiving appropriate mental health services while enrolled in school.<sup>535</sup>

So how can the law of civil duty best be adapted to support safer campuses and more careful administration of essential student mental health services? As we remove the distorting lenses of *Tarasoff*, what lessons can we still learn from it? The law can recognize that an institution of higher education can and should take reasonable measures to prevent the violent disruption of academic spaces by students who are or ought to be treated as mentally ill. In applying this duty in any particular case, the following seven points, derived from the particular nature of the academic setting, should inform the analysis.

Point 1: When it comes to identifying where the public peril begins in the context of higher education, the existence of an overt or direct threat to an identifiable victim should not be required to trigger the institution's duty to engage in threat assessment as a means of preventing violence. Threat assessment involves the use of judgment, discretion, and expertise to which courts may properly defer, but an institutional policy that declines to engage in such assessment in the absence of an overt threat is unjustifiably simplistic given the sociology of targeted school violence. It also leaves it largely up to our killers whether or not we act to prevent the harm they intend to cause. When other warning signs are present and credibly reported, the school should at least be obligated to rule out intervention for reasons other than lack of overt and specific threat.<sup>536</sup>

Point 2: Even though not all college- and university-student relationships are special, special circumstances can make them so.<sup>537</sup> That the institution has undertaken to act in a situation of potential violence is material to determining whether such circumstances exist. Moreover, the situational nature of targeted school violence strongly suggests that when a student is psychologically disturbed and potentially violent, institutional carelessness, indifference, or overreaction is likely to make matters worse. Thus, where the administration knows or should know that a student has become singularly disturbed or disturbing, a special relationship is created that imposes a duty to act with reasonable care both for the student's psychological health and for the safety of the campus community.<sup>538</sup> The

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535. See *supra* note 527 (on successful suicide prevention programs).

536. See *supra* note 450 (briefly discussing threat assessment parameters under federal disability statutes).

537. Lake, *supra* note 27, at 276. 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 a class of individuals for whom administrators may be required to take extra care. *Id.*

538. Again, students get up to all kinds of activity, so precise formulation is not possible or desirable. However, as this inquiry shows, law students who slap themselves in the face and scream until the police are called are singular and

duty should continue at least as long as the student is permitted to remain enrolled or on campus.

Of particular concern here, too, are students whose leave-taking is angry and unresolved in some important way; those who feel that they have been unfairly treated by professors, classmates, or the administration; those who, like Cho at Virginia Tech, feel “kicked out.” Like domestic murders, rampages seem most likely to occur when the individual’s relationship with the institution is severing. Therefore, the duty of care should extend to the manner in which dismissals or separations are accomplished. The point is, first, that the special relationship, once created, is not necessarily extinguished when the student is no longer enrolled. The student may continue to interact with the institution in some fashion that keeps the relationship alive, for example, as did Biswaneth Halder at Case Western Reserve University, who sued the school after he graduated.<sup>539</sup> Or he may distinguish himself from other graduates in some disturbing manner, as did Gang Lu at the University of Iowa, who became increasingly angry and desperate when he was not offered employment in the physics department after completing his Ph.D.<sup>540</sup> Second, the special relationship may be created or strengthened at the point that the severance from the institution occurs. The student intending to withdraw from the program may become (even more) threatening when he discovers that he must immediately begin to pay back his student loans, as did Peter Odighizuwa at the Appalachian School of Law.<sup>541</sup> Under the circumstances, reasonably prudent institutions should proceed in a manner that does not make matters worse between the student and the institution but, rather, ensures objective and individualized treatment, respects the privacy of the affected student, and provides as much justice as the institution can reasonably afford under the circumstances.<sup>542</sup>

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disturbing. So are students who announce before Crim. Pro. that they are telepathic and know what their classmates are thinking. So are students the content of whose writing is unusually and consistently violent and whose interpersonal behavior is unusually and consistently inappropriate. *See supra* note 439.

539. *See* de Haven, *supra* note 1, at 546–54. *See also* Lake, *supra* note 27, at 281. (“[M]ost 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.”).

540. de Haven, *supra* note 1, at 517–20.

541. *Id.* at 527–39.

542. Particular challenges are faced by administrators at colleges and universities that must depend upon local law enforcement instead of campus police in the (rare, one hopes) event that a dangerous student needs to be removed from campus. Often that support may not be forthcoming, particularly when it comes to having a student involuntarily committed. In terms of the practicalities, not all institutions are as well-equipped with either security forces or mental health services as Berkeley, UNC, and Virginia Tech, and institutional authority and control is accordingly diminished in reality. The author is indebted to Dean Darby Dickerson for this observation.

Point 3: The duty of care rests primarily with those who have the institutional power to protect both the community and the individual students by implementing protective or therapeutic measures, such as immediate risk assessment, mandatory outpatient treatment, or temporary removal from campus. Administrators who manage student mental health clinics, heads of colleges, chiefs of campus police forces, deans of students, deans of law schools, and administrators of student evaluation and referral processes are among those likely to possess such institutional authority as individuals, members of student at-risk response teams, or both. They bear a correlative responsibility, on behalf of the institution, for careful identification, assessment, and management of disturbed and disturbing students. It does not advance the goal of campus safety to shield institutions from liability for the negligence of those in positions such as Dr. Powelson's at Berkeley, or Dr. Liptzin's at UNC, or Dr. Miller's at Virginia Tech. It does not support more careful campuses to privilege, as did *Tarasoff*, administrative disconnection between the college or university apparatus and the actual delivery of student services.

Point 4: Liability should be limited to those who have the authority to act. In the context of an academic community, treating therapists are not the only ones who can identify and protect the potential victims of mentally-ill students who become violent. As Professor Slobogin pointed out, experienced faculty and staff are often as good as mental health professionals at identifying disturbed and/or disturbing students who act out in various ways in college and university classrooms, labs, libraries, and offices. Their warnings should be given serious attention and respect, which does not always happen. The examples of Professor Giovanni, Professor Roy, and Dean Crisp show that they may feel an ethical obligation to act and that they may be faced with a practical need to do so. The institution should support them in the exercise of such judgments.<sup>543</sup>

An institutional culture that supports or even requires that professors identify and share concerns they have about potentially dangerous students, with due respect for student confidentiality and privacy, should make for a safer educational environment. Thus, the institution can and should set policies and guidelines with respect to encounters with disturbed and disturbing students, and it can and should expect its authorities to be informed about a student who creates a disturbance in Criminal Procedure,

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This may be one of those junctures foreseen at the beginning, where the duty to prevent violence by a particular student meets the more general institutional duty to provide a safe educational environment. See *supra* note 27. In the end, the range of effective intervention available to institutional agents may fairly reflect how much, or how little, the institution values the safety of its campus in general.

543. See Jablonski et al., *supra* note 121, at 24 (“[F]aculty members are often the first to identify students who are troubled or in distress.”). Specific information and resources should be provided to faculty concerning the identification of such students, who to contact, and how to make referrals.

as Williamson did, or frightens his classmates with menacing performances like Cho's. However, faculty and staff should not be legally responsible if they are without the institutional power to trigger effective intervention. One of the most troubling aspects of *Tarasoff* remains the inherent unfairness of saddling Dr. Moore with liability for not warning Tanya Tarasoff after Dr. Powelson ordered him to stop all activity. Another is the decision's immunization of Powelson's carelessness in giving that order. The unfairness should not be perpetuated by obliging the Professor Roys and Dean Crisps of the academic world (or the housemasters and dormitory advisors) to proceed without adequate institutional backing while at the same time they risk incurring liability on behalf of the institution for inattention to student disturbances.<sup>544</sup>

Point 5: The duty must be shared by those whose action is necessary for an effective response. When credible concerns are raised about a potentially dangerous student, as at Virginia Tech and UNC, whether by students or faculty, the institution should have an affirmative obligation to assess both the student and the situation. Poor responsiveness to such reports at the institutional level is a recurrent theme in rampage cases. The unnecessary roadblocks encountered when Lucinda Roy tried to get help for Cho are a good example of poor practice in action, almost guaranteed to make matters worse both for Cho and for his teachers in the English Department, who were left on their own to deal with him and did so with varying levels of success. Dean Crisp had better access to effective intervention advice and support from other "deans and psychs," but he, too, was hampered by lack of expert advice and by lack of communication with the clinic.

Point 6: An important factor to consider is whether the institutional action or inaction made matters worse for the student, for other members of the academic community, or for the educational enterprise itself. "First do no harm" is an important cautionary principal for therapists and anyone else associated with the management of disturbed or disturbing students. In *Mahoney*, for example, the counselor's conscientious judgment, communicated to the deans, that calling the student's parents would do more harm than good legitimates what might otherwise be seen as culpable nonfeasance. Thus, applying the principle, even if turns out to be a mistake, is in and of itself evidence of due care. Moreover, as institutions of higher education learn to play it safer, being careful not to make matters

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544. What makes sense is to impose the duty at the highest corporate level and permit the institution wide discretionary authority to delegate and manage the responsibilities that attend it. In the dynamic of relationships in the modern university, faculty play complex and sometimes ambiguous roles, and faculty governance structures within the university system may complicate matters further. The author's next article focuses on the faculty's role(s) in campus violence. Suffice it to say here that absent provocation or incitement to violence, faculty and staff should not be individually liable if students in their care become violent.

worse is a principle of general as well as situational applicability. It includes, for example, recognizing that if a faculty member reports being alarmed or threatened by a student, it may increase the potential for harm to the faculty member if the institution fails to respond appropriately. As we create more effective safety nets, we must develop guidelines and protections for students who may get caught in them unfairly or by mistake, and we must also carefully avoid placing faculty and staff at greater risk.<sup>545</sup>

Point 7: The duty to protect includes the obligation to communicate vital information among those with an educational or administrative need to know.<sup>546</sup> If Liptzin and the mental health clinic at UNC had told Dean Crisp only that Liptzin was retiring, that Williamson had not transferred to another therapist, and that Williamson should continue therapy in the fall—none of which raised privacy or confidentiality concerns—his attack might have been prevented.<sup>547</sup> The Virginia Tech Massacre might not have happened if Miller had reported to the Care Team what he knew, or should have known: that continuing concerns were being raised about Cho's mental health, that he had been taken to St. Alban's, that there had been a committal proceeding resulting in recommendations for further treatment, and that the student had been repeatedly triaged at CCC but never thoroughly assessed or formally treated. None of this information was

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545. See *supra* note 338. Embedded in these narratives of campus violence are many and varied faculty and staff responses to singular student disturbance, some less effective than others. Not reflected in these stories are the faculty who are intimidated, harassed, or seriously inconvenienced by ongoing students or former students with whom they have had academic or disciplinary confrontations. An illustrative account was recently published in *Huggins v. Boyd*, 697 S.E.2d 253, 256 (Ga. App. 2010). Respondent was associate dean at a university in South Carolina who decided a disciplinary action against the Petitioner when he was a student at the university in the mid-1990s. *Id.* at 256 (Barnes, J., concurring). When Respondent left the university, Petitioner sent her e-mail for 18 months. *Id.* When she complained to authorities at Petitioner's school, the e-mail "became adversarial." *Id.* In 2003 Respondent received a warning from police that Petitioner was threatening her and e-mail from Petitioner claiming to be watching her. *Id.* Since then, according to her complaint, she has been subjected to continuing harassment and threats, many in the form of lengthy (65-page) e-mail messages to her colleagues. *Id.* These and other occupational hazards of teaching should be recognized and taken into account when decisions are made with respect to specific students. Moreover, the institution should benefit from allowing the faculty a strong voice in formulating and adopting best practices, guidelines, standards, and training programs designed to encourage safe relations between faculty and their disturbed or disturbing students and in identifying the kinds of institutional support reasonably necessary to protect faculty and staff from harm.

546. Campuses should make it a matter of policy that staff and faculty members acting in good faith, and in an effort to comply with applicable law and policy, should err on the side of caution by sharing more information rather than less when it relates to a matter of campus safety. Further, it should be a matter of policy that staff and faculty members doing so will be supported by the institution in the event of legal action. Jablonski et al., *supra* note 121, at 6.

547. Students whose continued enrollment is conditioned upon mental health monitoring may be required to agree to such disclosures. See *supra* note 456.



confidential, and the Care Team could have acted upon it to ensure that Cho was assessed and managed more carefully.

Point 8: The relative ease of protective or preventive measures should be a factor in determining the care to be exercised in a particular case. Most of the time the discharge of the duty means no more than “compliance with self-imposed standards” already in place.<sup>548</sup> Proposing to balance the risk of harm against the ease of prevention in *Tarasoff*, Judge Sims asked how hard it would have been for Dr. Moore to pick up the telephone and call Tanya Tarasoff’s mother. So, too, may we ask how hard it would have been for Liptzin to let Dean Crisp know about his retirement and the situation in which he was leaving Williamson? Or for Dr. Betzel to meet Cho in the English Department as Professor Roy requested, instead of insisting that the morbidly shy student present himself at the clinic? Or to make sure that if Cho did turn up at the clinic, he would immediately get in to see her, or someone else, who could begin his treatment immediately? Or to keep his clinical records complete and accessible?

These points do not obviate the need for more precise guidance expressed by *Mahoney* in the context of student suicide. But at both UNC and Virginia Tech, the killer came to the attention of the institution in some particularly aberrant way—he singled himself out, that is, for special attention and treatment that was not confined to the mental health services voluntarily available. Therefore, the duty being described, though more broadly applicable than the *Tarasoff* duty, is still quite narrow. The university-student relationship must have become special in fact at some authoritative level to trigger liability for negligent inaction. Nor does greater attention to prevention mean that foreseeability is not still a critical factor. The special relationship is between colleges and universities and a category of students whose disturbing behavior places them at higher risk of violence to themselves, others, or both. Applying the principles and distinctions proposed here would probably not change the outcome in *Jain*, *Ferrum College*, or *Mahoney*, for example, and it would almost certainly reduce potential liability in *Shin* by dismissing the housemaster. But reframing the way duty is allocated in the ivory tower will help keep us safe. Students whose psychological disturbance is disrupting the academic program will be less likely to slip through the cracks of institutional dysfunction and spiral into madness for lack of easily available treatment.

#### V. CONCLUSION: LIVING WITH OPEN ENDS

This inquiry has centered upon violence at colleges and universities with mental health clinics, and it has moved through years of college and university history as well. We are a long way now from the ‘60’s — the days of the Texas Tower sniper, the Berkeley Clinic, and the power

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548. *Furek v. Univ. of Delaware*, 594 A.2d 506, 519 (Del. 1991).

struggle between students and college and university administrations over control of campuses. In many respects, the academic landscape has not greatly changed, but we now find the peace and safety of our campuses threatened less from organized groups of protesters or police than from singular students whose response to their academic experience becomes extremely violent. From this peril we can best protect ourselves by creating wider networks of communication and shared responsibility among the centers of institutional authority, even if the institution does not directly employ mental health professionals.

In recognizing that a therapist may have a legal duty to protect the victim of a dangerous patient, *Tarasoff* laid a common law duty upon an already existing structure of statutory obligations and immunities, ethical and confidentiality requirements, and community standards of practice. Recognizing that an institution of higher education should exercise reasonable care to prevent extreme violence by obviously deranged students does essentially the same thing. Like *Tarasoff's* formulation, what is suggested here are a few restructuring principles, a scaffolding for situations of unusual stress in the educational relationship.<sup>549</sup>

College and university administrators and faculty alike are now living with many unanswered questions about where our ethical and statutory duties may lie and by what standards we may be judged in any situation involving threatening or alarming students. We should not be trying to live at the same time with corporate assumptions that there is no institutional duty to protect common educational spaces from extreme violence by students who have exhibited clear signs of mental illness.<sup>550</sup> Acknowledging an institutional duty of reasonable care with respect to disturbing behavior by students, on the other hand, encourages the academy to develop its own best practices and governance principles, to which courts are likely to give substantial deference, just as they gave the decisions of therapists to warn (or not) after *Tarasoff*.<sup>551</sup>

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549. It does not and should not be taken to provide an argument for disregarding the civil rights or invading the privacy of students or denying them due process in the event of involuntary dismissal. At the same time, it certainly does not hinder and may even facilitate individualized and objective assessment of students whose capacity to participate in the academic program is questioned on psychological grounds. *See supra* note 449 and accompanying text.

550. Such assumptions, if nothing else, may impact the institutional resources devoted to student services, mental health services, the establishment of CARE teams, and other institutional best practices discussed herein. The author is indebted to Vice-Chancellor Crisp for pointing out that disturbed and disturbing students are more likely to fall through the cracks when such services are underfunded and understaffed.

551. Dean Darby Dickerson has written:

[I]t is important to remember that trained administrators must use their best judgment in issues of campus health and safety, and that courts are hesitant to second-guess decisions that are made in reasonable manner . . . . Accordingly, when balancing interests and options, student health and safety must remain paramount.

Publicly or privately, for profit or not, the academy owns the ivory tower. It is up to the academy to keep the Charles Whitmans, Wendell Williamsons, and Seung Hui Chos among us from climbing the tower with a rifle and a backpack full of ammunition. To that end, as the *Mahoney* court put it, we must not do less than we ought, unless we are doing all that we can.<sup>552</sup>

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Dickerson, *supra* note 452, at 29.

552. *Mahoney v. Allegheny College*, No. AD892-2003, slip op. at 25 (Pa. Ct. Com. Pl. 2005).