

Chapter IV

SUICIDE

OVERVIEW

Suicide is the third leading cause of death for individuals age 15-24 and the second leading cause of death for college-age individuals. The U.S. Department of Health reported that in 2000, over three million individuals seriously considered suicide and over one million actually attempted suicide.

The risk of suicide is highest among white males, although the suicide rate among African-American males is increasing more rapidly than any other group. Males account for 75 to 80 percent of all suicide deaths; but more females attempt suicide. There are approximately 3 female suicide attempts for every male attempt.

Gay and lesbian youths are two to three times more likely to commit suicide. In fact some researchers report that up to 30 percent of all attempted and completed suicides among young people are related to sexual identity issues.

| 2002 Suicides by Race | |
|-------------------------|--------------------|
| Group | Number of Suicides |
| White Male | 23,049 |
| White Female | 5,682 |
| Nonwhite Male | 2,360 |
| Nonwhite Female | 564 |
| Black Male | 1,633 |
| Black Female | 306 |
| Hispanic | 1,954 |
| Native Americans | 324 |
| Asian/Pacific Islanders | 661 |

American Association of Suicidology, 2002

Suicide rates have increased dramatically in recent years. They have tripled in the past 40 years. In 1998, suicide took more young lives than cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined.

Research has shown a relationship between depression and suicide. The risk of suicide increases more than 50 percent in depressed students. The risk of suicide increases even more for depressed students abusing alcohol and drugs. Other risk factors include adverse life events, such as family instability, significant family conflict, and physical and sexual abuse; social isolation; and stressors, such as getting in trouble or experiencing recent disappointment or rejection.

The statistics are clear--suicide is an issue for young college students. Administrators must focus on suicide and develop prevention policies that address how warning signs of suicidal behavior should be handled, when parents should be contacted, and where students can find help on campus.

While a decision to commit suicide is an individual choice, in certain instances courts have found institutions liable when administrators knew or should have known a student suicide was foreseeable. While it may seem impossible for a college to predict when a student may commit suicide, research suggests that at least four out of five people who have attempted suicide have given clear warnings. Often these warning signs make their way to student administrators through faculty, resident assistants, and concerned friends. How these responders react to these warning signs is of extreme importance. It could be a life or death situation.

This chapter will address the issue of institutional liability for student suicide and provide preventive strategies that can be utilized to reduce liability and reduce the risk of students harming themselves.

APPLICATION

How Courts Find Liability

Commentators predict that more courts will be considering the question of whether a college may be held responsible when one of its students commits suicide. Typically, if a person commits suicide, an outside party cannot be held responsible. The reason is obvious—people who commit suicide are the sole cause of their injury or death. However, if a special relationship exists, a duty to protect a person from self-inflicted harm may be present, particularly if the risk of suicide is foreseeable. This exception traditionally occurs in custodial relationships, such as in prisons or hospitals, where individuals have special training enabling them to detect the potential for suicide, have the control necessary to prevent the suicide, but fail to take appropriate actions.

Courts have identified two exceptions where a college or university may be held responsible for a student suicide on campus. The first exception occurs when the conduct of the college or university contributed to the suicide or increased the risk of suicide. The second exception occurs when a special relationship exists and the institution knows about the potential suicide, but fails to take measures to prevent it from occurring. The second exception is the most commonly argued.

Contributing to the Risk of Suicide

In *Wallace v. Broyles* (1998), the Arkansas Supreme Court concluded the University of Arkansas may have contributed to the suicide of Shannon Wright, a varsity football player, by dispensing Darvocet, a strong painkiller, from an athletic complex without proper registration or any warnings of the side effects.

Wright was injured during a football game, and required treatment with a drug called Darvocet, a strong painkiller that may have mind-altering properties. The university supplied Darvocet without

any advice or warnings of its side effects or the interaction it may have if combined with alcohol or other drugs. When dispersed properly, Darvocet comes with warnings of drug-related deaths, addictive and depressive effects, emotional disturbances, and suicidal ideation. The liberal method used by the athletic department to distribute Darvocet and other pain medications violated

| Methods of Committing Suicide 2002 | | |
|---|-------------------------|-------------------|
| Suicide Method | Number of Deaths | % of Total |
| Firearm | 17,108 | 54 |
| Suffocation/Hanging | 6,462 | 20.4 |
| Poisoning | 5,486 | 17.3 |
| Falls | 740 | 2.3 |
| Cut/Pierce | 566 | 1.8 |
| Drowning | 368 | 1.2 |
| Fire/Flame | 150 | 0.5 |
| American Association of Suicidology, 2002 | | |

the Federal Drug Enforcement Agency and NCAA standards.

Prior to his death, Wright used Darvocet and had apparently been drinking large amounts of alcohol. Shortly thereafter, Wright died of a self-inflicted gunshot wound. The court ruled that the illegally dispensed Darvocet by the university athletic department may have contributed to or caused Wright's death.

Institution Owes Student Duty of Care

A court may impose liability for a student suicide on the grounds that the institution owes a duty of care to the student. The law recognizes that certain situations exist that may give rise to a duty of care between parties that normally does not exist. Courts will look at each case on an individual basis and determine if there were particular circumstances which gave rise to a duty of care. Once the court has found that a duty existed, the next inquiry will be whether the college or university has breached that duty to the student.

IV. Suicide

The leading case imposing a duty on colleges and universities to protect students from known suicidal attempts is *Schieszler ex. Rel. Estate of Frentzel v. Ferrum College* (2002), where the court found that a breach of duty may have occurred based on the college's failure to provide adequate supervision and intervention.

In this case, the personal representative, aunt, and guardian of Michael Frentzel, a student who committed suicide in his dorm room, brought a wrongful death suit against Ferrum College, a college official, and the dormitory resident assistant. The wrongful death claim asserted that Ferrum College "knew or should have known that Frentzel was likely to attempt to hurt himself if not properly supervised," and that the college was "negligent by failing to take adequate precautions to ensure that Frentzel did not hurt himself."

The claim asserts that Frentzel's death was a result of negligence by failing to take adequate steps to prevent his suicide. In response, Ferrum College asserted that the Frentzel's claim should be dismissed because Ferrum College did not have a legal duty to prevent Frentzel from committing suicide, and that Ferrum College's actions were not the cause of Frentzel's death. The U.S. Federal District Court for the Western District of Virginia held that the college had a duty to protect Frentzel from danger of harming himself based on a special relationship that the college had established with Frentzel.

Frentzel was a freshman at Ferrum College when he committed suicide. During his freshman year, as a result of disciplinary issues, Ferrum College required Frentzel to enroll in anger management counseling before returning for his spring semester. During spring semester, campus police and Frentzel's resident assistant intervened in a fight between Frentzel and his girlfriend Crystal. Around this time, Frentzel sent his girlfriend a note stating that he intended to hang himself with a belt. When campus security and the dormitory resident assistant arrived, Frentzel had bruises on his head, and he informed security that they were self-inflicted. Campus security then contacted the dean of student affairs, who responded

by requiring Frentzel to sign a statement that he would not hurt himself.

Within a few days, Frentzel wrote another note to a friend stating, “tell Crystal I will always love her.” The friend told Crystal, who told college officials. The college refused to allow Frentzel’s girlfriend to return to his dorm room and took no other action. Frentzel wrote one last note, which stated “only God can help me now.” Frentzel’s girlfriend also gave this note to campus officials. Frentzel had hanged himself with a belt by the time campus security arrived at his room.

The court found that Ferrum College’s awareness of Frentzel’s emotional problems and his intent to commit suicide were sufficient to impose a duty to protect Frentzel from the danger that he would hurt himself.

The court was particularly persuaded by Frentzel’s signed statement that he would not hurt himself, and that this could have lead Ferrum College to “conclude that there was ‘an imminent probability’ that Frentzel would try to hurt himself.”

The college breached its duty by leaving Frentzel alone in his dorm room after finding him with self-inflicted bruises and receiving information that he intended to hurt himself. The college and its officials failed to ensure that Frentzel was supervised, to contact his parents or to make him seek counseling. For these reasons, the court found that Ferrum College may have breached its duty and denied Ferrum College’s motion to dismiss the plaintiff’s negligence claim. The court also held that the resident assistant was not negligent because she was unable to take additional steps without guidance from college officials.

Although the parties have since settled the lawsuit, the holding of the Virginia court is important and has a number of implications. The court discusses that the college failed to supervise Frentzel and failed to notify his parents and, in turn, breached its duty to him. The central theme arising from this case is the emphasis is on the institution’s knowledge of imminent harm. This may leave the door open for negligent behavior in both failing to notify parents or

IV. Suicide

guardians and a duty to provide supervision and take affirmative steps to prevent the suicide.

It is also important to note that this case is an exception to the rule that a self-inflicted injury is the proximate cause of death in the event of suicide. In order to have an actionable negligent breach of duty, as may have been found on the part of Ferrum College had the case not been settled, the breach must constitute the proximate cause of the injury. The court noted that the issue of whether the institution's actions or failure to act was the proximate cause of the student's death cannot be resolved at the motion to dismiss phase of the proceedings because it is a factual dispute. This means that under Virginia law, the question of whether the college or university's negligence was sufficient to constitute the proximate cause of the suicide should go to a jury and will not be resolved in earlier proceedings to dismiss the case.

As part of the settlement, Ferrum College has made a commitment to change its crisis intervention procedures, improve its student counseling and support procedures, and established a scholarship in Frentzel's name. According to a college official, "We will also be clarifying to students' families the role of a college. A college cannot act as a treatment center, and it's important that we clarify that role."

The Massachusetts Institute of Technology (MIT) has had to face potential liability arising from two student suicides committed on its campus. Since 2002, MIT has had to defend against two lawsuits filed by the deceased students' parents.

The first lawsuit was filed by the parents of Elizabeth Shin, a sophomore at MIT that committed suicide by setting herself on fire on April 10, 2000. In 2002, Shin's parents brought a \$27 million wrongful-death suit against MIT, its administrators, and its medical department doctors, psychiatrists, and counselors (*Shin v. Massachusetts Institute of Technology*).

Prior to committing suicide, Shin had been receiving psychotherapy and counseling through the MIT Mental Health Services Department for over a year. She was referred to the school's

mental health department after spending a week in inpatient psychiatric services following a Tylenol codeine overdose her freshman year. Shin received counseling and psychotherapy through the campus mental health department about every two or three weeks.

The day Shin committed suicide, two students in her dormitory contacted the housemaster at 12:30 AM and explained that Shin had told them she planned to kill herself that day. The housemaster called the MIT Mental Health Department to contact the on-call psychiatrist. The on call psychiatrist did not believe it would be necessary to bring Shin into MIT Medical, but said he would call back to check on her at 6:30 AM.

When the on-call psychiatrist called back later that morning, the housemaster advised that Shin was sleeping and she decided not to wake her up. The psychiatrist asked the housemaster to convey the events of the evening to one of the deans who was providing counseling to Shin because a “deans and psychs” meeting was scheduled later that morning.

The housemaster contacted the dean and sent an email to Shin asking her to call when she awoke. At 9:45 AM, Shin called the housemaster and accused her of wanting to send her home and told her, “You won’t have to worry about me anymore.” Following the phone call, the housemaster immediately contacted the dean. The dean assured her that he would convey her concerns to everyone attending the deans and psychs meeting.

The deans and psychs meeting convened at 11:00 AM. In attendance were several of the psychiatrists that treated Shin. Shin’s case was discussed at the meeting, including the statement

| Factors Reported to Cause Suicidal Ideations |
|---|
| Stress related to college |
| Trouble with relationships |
| Family problems |
| Depression |
| Hopelessness |
| Financial Stress |
| Feelings of social isolation |
| Exposure to trauma |
| Involvement with drugs or alcohol |
| Inside HigherEd, 2005 |

IV. Suicide

that she intended to kill herself that day. At the conclusion of the meeting, one of her treating psychiatrists made an appointment for Shin the next day at Two Brattle Center, an outpatient treatment facility in Cambridge. No other actions were taken by anyone in the MIT Mental Health Services department that day.

That night, around 9:00 PM, students in Shin's dormitory heard the smoke alarm in Shin's room. The MIT Campus Police and Cambridge Fire Department responded in minutes. The Campus Police broke open Shin's door and found her engulfed in flames. As a result, Shin suffered third degree burns over 65 percent of her body and irreversible neurological brain damage. She died four days later.

The central premise of the Shin's argument is that a number of parties at MIT—administrators, medical professional, and fellow students—were aware that Shin threatened to commit suicide, and given her prior mental health history, MIT had a duty of care to intervene before she did. The Shin's also alleged that they had an expressed and/or implied contract with MIT, supported by their daughter's tuition, that MIT would provide necessary and reasonable medical services for the benefit of Elizabeth.

On a motion for summary judgment filed by the defendants, the court ruled that the Shin's could pursue their claims against the MIT Medical Professionals for negligence. The court agreed with the Shin's that the MIT medical professionals "individually and collectively failed to coordinate Elizabeth's care" when they failed to formulate an immediate plan to respond to Elizabeth's escalating threats to commit suicide at the deans and psychs meeting. According to the court, a genuine issue of fact exists as to whether the MIT medical professionals were grossly negligent in their treatment of Elizabeth.

The court also allowed the Shin's to proceed on their claims against MIT administrators. The primary argument of the administrators was that they had not duty to prevent Shin's suicide based on Massachusetts law which states that "persons who are not treating clinicians have a duty to prevent suicide only if (1) they

caused the decedent's uncontrollable suicidal condition, or (2) they had the decedent in their physical custody . . . and had knowledge of the decedent's risk of suicide," citing *Nelson v. Massachusetts Port Authority*, 2002. The court however rejected this argument, pointing to the exception to the basic tort principle, which imposes a duty to act or protect when a special relationship exists. When a special relationship exists, liability may be imposed when a defendant could reasonably foresee or anticipate harm to the plaintiff if no affirmative action was taken.

Relying on the analysis of the *Ferrum* decision, the court concluded that based on the circumstances of this case, the administrators had a special relationship with Shin. Moreover, Shin's suicide was reasonably foreseeable based on the specific notice of her intentions reported by two students.

The court, however, dismissed the breach of contract claims against MIT. The Shin's alleged they had a contract with MIT based on representations made in the institution's Medical Department brochure to incoming students and its Medical Department Bylaws. The brochure and the by-laws included statements such as:

- "This gives you access to a full range of physicians and other health care professionals who can care for your physical and psychological needs. These care givers also will help you maintain good health."
- "We want to help you maintain your physical, psychological, and emotional well-being, and hope that you will take advantage of our wide range of services."
- "The Medical Department . . . has the responsibility to provide high quality, low barrier comprehensive health services to the MIT community . . ."

The court acknowledged that the relationship between a university and a student is contractual in nature and that under Massachusetts law, statements in "handbooks, policy manuals,

IV. Suicide

brochures, catalogs, advertisements, and other promotional materials can form the basis of a valid contract.” However, the court rejected the argument that the Medical Department brochure and By-laws created a binding contract because the statements were “generalized representations” and did not rise to the level of a “specific promise.”

The final outcome of this case is still pending, but the ruling has national implications. When administrators know of a student’s suicidal intimation, immediate steps should be taken to prevent the students from harming themselves. Courts are sending the message that administrators should error on the side of caution when dealing with reports of suicidal warning signs.

Only a year after Elizabeth Shin committed suicide, another MIT student, Julie Carpenter, committed suicide by ingesting cyanide in her dorm room. At the time of Carpenter’s suicide, she was the sixth MIT student to commit suicide in four years. Carpenter’s parents have filed a \$20 million lawsuit against MIT alleging that their daughter’s death was caused by university’s failure to stop the harassment of a fellow student.

The suit also alleges that MIT breached its contract by failing to meet its obligation to shield Carpenter from harassment. The alleged harasser, Charvak Karpe, was a fellow student in Carpenter’s dormitory. Karpe was accused of stalking, harassing, and invading Carpenter’s privacy. On another occasion, Karpe broke into Carpenter’s room, installed software on her computer which allowed him to track all of her computer activity, and copied a video of Carpenter and her boyfriend during sexual activity, which he then showed other students.

Julie Carpenter filed a complaint with the dorm Judiciary Committee in February 2001, charging Karpe with harassment, invasion of privacy, and improper conduct. The Judiciary Committee ruled that Karpe was permitted to stay in the dorm as long as he stopped drinking, gave away his computer, gave up his job working in the dormitory, went to counseling, and stayed away from Carpenter.

The same day that Carpenter was informed of this decision, she called her boyfriend and told him she wanted to slash her wrists. Her boyfriend called friends at MIT who then talked to Carpenter about her problems and obtained her permission to contact MIT administrators.

The senior associate dean of students was then contacted, and he met with Carpenter. Carpenter asked the dean to remove Karpe from the dorm, which was done ten days later. The dean also referred Carpenter to a substance abuse counselor, whom she contacted about a month later.

On April 20, Carpenter filed another complaint against Karpe with the student discipline office, which apparently resulted in the Dorm Judiciary Committee issuing a written decision that allowed Karpe to return to Carpenter's dorm in the fall. MIT denies that the committee allowed Karpe to return; however, the college's intentions were never discussed with Carpenter.

On the same day as she picked up the Dorm Judiciary Committee's decision, Carpenter visited a Web site and tried to obtain sodium cyanide. She received the cyanide three days later and was found dead in her dorm room of cyanide poisoning.

Unlike Elizabeth Shin's suicide, MIT did not have specific knowledge that Carpenter had suicidal ideations. In fact, her death was a mystery until the medical examiner ruled her death a suicide by cyanide almost two months later.

Carpenter's parents contend that their daughter's suicide was caused by MIT's failure to appropriately address complaints of harassment. While MIT had knowledge of Carpenter's harassment, determining whether MIT's response caused her suicide is a question the courts will need to answer. The result of this case is also pending, and MIT maintains that it acted appropriately.

Students and Mental Disabilities

In most cases, individuals give clear warning signs before they commit suicide. The most common signs include depression,