Illinois Supreme Court Finds No Duty to Warn

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An Outpatient Mental Health Treatment Facility and Its Staff Do Not Have a Duty to Warn a Patient's Wife About his Dangerousness Since the Provider's Duty of Care Extends Only to the Patient

In *Tedrick v. Community Resource Center, Inc.*, 920 N.E.2d 220 (Ill. 2009), the Illinois Supreme Court, relying on Illinois case law, found that an outpatient mental health facility and its care providers did not have an obligation to warn a patient's wife of his threats and potential to commit violent acts.

Facts of the Case

Richard Street was hospitalized at Doctors Hospital in Springfield, Illinois, from May 13 to 16, 2003, with symptoms of paranoia, suicidality, and homicidality. He was discharged with a diagnosis of "major depression with mild psychotic features" and instructed to follow up with the Community Resource Center (CRC). A counselor at the CRC conducted an initial evaluation of Mr. Street on May 20, 2003, and a comprehensive assessment two weeks later.

On June 6, 2003, Mr. Street was accompanied to the CRC by his mother. He was in crisis and was evaluated by a licensed clinical social worker. He stated that he was going to kill his wife. He initially agreed to voluntary hospitalization; however, during the process of arranging for the hospital admission, he changed his mind and rejected voluntary hospitalization. The social worker secured an appointment for later that day with Mr. Street's family physician. Mr. Street left the clinic with his mother. After he left, his wife arrived at the clinic and met with the social worker who provided her with the crisis line telephone number. Mrs. Street agreed to call the crisis line or police in case of an emergency. Later that day Mr. Street, his mother, and his wife met with the family physician, who evaluated Mr. Street and noted that he was paranoid. Mr. Street denied suicidal ideation and any intent to hurt his wife. (Mrs. Street expressed her concern that Mr. Street might hurt her because he believed she was having an affair.) The family physician prescribed alprazolam and olanzapine and recommended psychiatric care.

On June 9, 2003, three days after meeting with the family physician, Mr. Street, having overdosed on medication, was found lying over the lifeless body of his wife, who had been strangled. He pleaded guilty to second-degree murder in her death and was sentenced to 18 years in prison.

The plaintiffs (the estates of Mrs. Street and her children), filed a wrongful death and survival action in the circuit court of Marion County against the CRC, the mental health providers, and the family physician, alleging that they had breached their duties to warn and protect Mrs. Street from foreseeable violent acts of her husband. The circuit court ruled that the plaintiffs failed to allege a recognized duty of care owed by any named defendant to Mrs. Street or grounds to allow transfer of duty to care to her. The appellate court held that the third amended complaint set forth sufficient factual allegations to establish a cause of action based on the theories of voluntary undertaking and transferred negligence, and reversed the circuit court's findings.

Ruling and Reasoning

The Illinois Supreme Court decided the case on the legal sufficiency of the third amended complaint by plaintiffs which alleged that the CRC and mental health providers afforded substandard care by failing to diagnose, treat, and monitor the condition of Mr. Street properly; failed to warn Mrs. Street and the police; and failed to hospitalize or otherwise control Mr. Street. The plaintiffs argued that the voluntary undertaking of the treatment of Mr. Street by CRC and mental health providers created a duty to warn and to protect Mrs. Street, although there was no patient-physician relationship or a special relationship between the patient and a third party, pursuant to the Restatement (Second) of Torts § 324A (1965). The appellate court agreed and relied on *Siklas v. Ecker Center for Mental Health, Inc.*, 617 N.E.2d 507 (Ill. App. Ct. 1993) to support its reasoning. The Illinois Supreme Court noted that *Siklas* was decided, in fact, under a different section of the Restatement (Second) of Torts § 323, which speaks to the liability of an actor to the one whom he has under-

taken to treat, and that it does not extend liability of the actor to third parties.

The Illinois Supreme Court cited two cases: *Kirk v. Michael Reese Hospital and Medical Center*, 513 N.E.2d 387 (Ill. 1987), and *Doe v. McKay*, 700 N.E.2d 1018 (Ill. 1998). In *Kirk*, the court held that a plaintiff cannot claim medical malpractice unless there is a direct doctor/patient relationship. In *Doe v. McKay*, the court ruled that providers have a duty of care only to the patient. The court wrote that the well-established principles found in *Kirk* and *Doe v. McKay* made it clear that the defendants did not have a duty to a third party, including the duty to warn.

The plaintiffs also made the claim of transferred negligence, citing *Renslow v. Mennonite Hospital*, 367 N.E.2d 1250 (Ill. 1977). In *Renslow*, the court determined that the defendant's duty of care to a patient extended to her infant daughter because of a special relationship and because the injury to the infant was a direct result of the negligent treatment of her mother. The Illinois Supreme Court wrote that the crux of the *Renslow* case was the relationship between mother and fetus which is "perhaps singular and unique." The marital relationship did not equate to the relationship between a mother and a fetus; therefore, the marriage did not qualify to allow third parties to extend a doctor's duty of care beyond a direct patient-physician relationship.

Discussion

In *Tedrick*, the Illinois Supreme Court did not cite either of the two Illinois statutes describing mental health professionals' duty to warn third parties. One appears to create an affirmative duty, and the other allows clinicians to use their judgment. The first, the Miscellaneous Provisions Chapter of the Mental Health and Developmental Disabilities Code (405 Ill. Comp. Stat. 5/6-103 (1979)), states that there shall be no liability on the part of the provider for failure to warn and protect, except when an individual has communicated to the provider a serious threat of physical violence against a reasonably identifiable victim or victims. The duty is discharged by making a reasonable effort to communicate the threat to the victim and to a law enforcement agency or by a reasonable effort to hospitalize the potentially violent individual. The statute was written in the wake of *Tarasoff* (*Tarasoff v. Regents of the University of California*, 551 P.2d 334 (Cal. 1976)), with the assumption that Illinois courts would establish a duty to warn, and was intended to limit rather than broaden the duty to warn required of providers. The second statute, the Mental Health and Developmental Disabilities Confidentiality Act (740 Ill. Comp. Stat. 110/11 (1979)), allows clinicians to use their judgment to determine appropriate disclosure when working with a potentially violent patient. This statute was enacted to protect mental health providers when disclosing information if a duty to warn exists.

Kachigian and Felthous (*J Am Acad Psychiatry Law* 32:263–73, 2004) reviewed how different states have codified the duty to warn. They found 23 states with duty-to-warn laws, and they divided them into four categories: 5 states have explicitly established a duty, 12 states prohibit liability except under specified circumstances, 2 states seem to be permissive, and 4 states fall into an "other" category.

While awareness of duty-to-warn state statutes is useful, Kachigian and Felthous found that courts rarely respect the legislative standard. In *Tedrick*, the Illinois Supreme Court did not reference either of Illinois' statutes relating to duty to warn, but relied on case law. The court's apparent disregard of the duty-to-warn statutes may result from an effort to demonstrate control over the establishment of this type of duty despite legislative action, the failure of lawyers to reference the statute in their arguments, or a lack of awareness of the existence of the statutes.

Soulier *et al.* (*J Am Acad Psychiatry Law* 38:457–73, 2010) examined duty-to-warn statutes and *Tarasoff*-related cases from 1985 to 2006, to determine to what extent courts found defendant psychiatrists and others liable for breach of duty to protect. They found that 28 states had affirmative duty-to-warn statutes, 10 jurisdictions (including the District of Columbia) had permissive duty-to-warn statutes, and 13 states had no statutes addressing the duty to warn. Their analysis of cases found that defendants were rarely found negligent on the grounds of not fulfilling a duty to warn or protect. Their findings suggest that statutes that mandate warning a third party may be the most protective of clinicians. It appears that permissive statutes may increase the liability for clinicians more than a mandatory statute or no statute relating to a duty to warn. The authors conclude that there is little basis for concern of being successfully sued for a bad outcome if reasonable clinical practice has been exercised.

The legal standard of the practitioner's duty to warn is a moving target and often lacks clarity. Cli-

nicians would be well served by coupling good clinical judgment with awareness of the statutes and case law relevant in the jurisdiction in which they practice.

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Duties to Protect and Control

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An Outpatient Mental Health Treatment Facility Does Not Take Charge of a Person Subject to an Outpatient Treatment Order in a Manner That Gives Rise to a Duty to Protect Others From or Control the Person's Conduct

In the matter of *Adams v. Board of Sedgwick County Commissioners*, 214 P.3d 1173 (Kan. 2009), the Supreme Court of Kansas held that an outpatient mental health center and its employees did not owe a duty to those injured by a psychiatric outpatient who became violent nine months after an outpatient treatment order was allowed to expire. Even though there was a basis to continue the outpatient commitment order, it did not equate to a duty to commit; and even if the order had been continued, it would not have given the defendants sufficient control over the patient to prevent the attack.

Facts of the Case

Adam Cummins made violent threats against family members and was admitted to a state hospital in Kansas in 1997, where his diagnosis was bipolar disorder and later was schizophrenia. Between 1997 and 1999, he was hospitalized two more times at another state hospital. Each time he was released, he began a cycle of treatment noncompliance that led to gradual deterioration in his mental status and culminated in his becoming hostile and threatening once more.

From May to July 1999, Mr. Cummins was involuntarily admitted to a state hospital after making violent threats toward his mother and other family members. Shortly after his release, the district court entered an outpatient treatment order directing him to take his medications as prescribed and keep scheduled mental health appointments. The order also required that the outpatient mental health clinic immediately report any noncompliance by him to the district court.

Soon after Mr. Cummins' release, his psychiatrist noted that he was not taking all his prescribed medications, but the noncompliance was never reported to the court. In August 1999, the outpatient treatment order was allowed to expire based on the recommendation of a nurse practitioner under the psychiatrist's supervision. Despite the expiration of the order, Mr. Cummins kept an appointment with the psychiatrist in September 1999. At that time the psychiatrist did not believe he was dangerous. In October 1999, Mr. Cummins' case manager recommended that his case be closed due to noncompliance.

Mr. Cummins' condition deteriorated after he was discharged from outpatient treatment. On May 15, 2000, he kicked down his mother's door and beat her in the head with a hammer. To save her grandmother's life, his daughter fatally shot him. His mother was permanently disabled by her injuries.

Mr. Cummins' mother and daughter named several defendants in separate suits that were eventually combined in this appeal. They alleged that under the Restatement (Second) of Torts § 315 (1965), the defendants had a "special relationship" with Mr. Cummins that gave rise to duties to control his conduct and protect the plaintiffs. The plaintiffs further alleged that the defendants had a statutory duty to report Mr. Cummins' noncompliance to the court and to file an accurate report summarizing his treatment under the Kansas Care and Treatment Act for Mentally Ill Persons, Kan. Stat. Ann. § 59-2945 et seq. (1996).

The district court did not address the question of whether a duty existed, but instead granted summary judgment to the defendants based on their claim that they were immune to liability as a government entity under the "discretionary function" exception of the Kansas Tort Claims Act, Kan. Stat. Ann. § 75-6104(e) (2008 Supp. 2000). The plaintiffs appealed, alleging that the defendants could not claim governmental immunity because they violated