

No. A08-1478

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STATE OF MINNESOTA

IN COURT OF APPEALS

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Regina C. Losen, trustee for the heirs and next-of-kin of Deborah Miller,  
deceased, Randolph C. Miller and Laurie A. Miller,

Appellants,

vs.

Allina Health System, d/b/a United Hospital, and Paul Goering,

Respondents,

Minnesota Epilepsy Group, P.A., a Minnesota Corporation,  
Deanna L. Dickens, M.D., and Patricia E. Penovich, M.D.,

Respondents.

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**BRIEF AND APPENDIX OF RESPONDENTS  
MINNESOTA EPILEPSY GROUP, DICKENS, AND PENOVICH**

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## LEGAL ISSUES

- I. Are Respondents Dickens, Penovich and the Minnesota Epilepsy Group entitled to the immunity accorded by Minn. Stat. § 253B.23, subd. 4?

The trial court held:

In the affirmative.

Apposite authority:

Minn. Stat. § 253B.23, subd. 4; Enberg v. Bonde, 331 N.W.2d 731, 735 (Minn. 1983); Mjolsness v. Riley, 524 N.W.2d 528, 531 (Minn. Ct. App. 1994).

- II. Do considerations of public policy support the application of immunity to Respondents Dickens, Penovich, and the Minnesota Epilepsy Group?

The trial court held:

In the affirmative.

Apposite authority:

In Re: Colbert, 464 N.W.2d 505, 507 (Minn. 1991); Enberg v. Bonde, 331 N.W.2d 731, 735 (Minn. 1983); In Re: Raboin, 704 N.W.2d 767 (Minn. Ct. App. 2005).

- III. Is there a separate common-law basis for holding the Respondents liable for claimed violations of the Minnesota Commitment and Treatment Act?

The trial court held:

The trial court did not specifically address this issue.

Apposite authority:

Minn. Stat. § 253B.23, subd. 4; Minn. Stat. § 645.17.

- IV. Does the trial court's interpretation of Minn. Stat. § 253B.23, subd. 4 violate the "certain remedy" provision of article 1, section 8 of the Minnesota Constitution?

The trial court held:

The trial court did not specifically address this issue.

Apposite authority:

Schweich v. Ziegler, Inc., 463 N.W.2d 722 (Minn. 1990); Snyder v. City of Minneapolis, 441 N.W.2d 781, 788 (Minn. 1989); Schmidt v. Modern Metals Foundry, Inc., 424 N.W.2d 538 (Minn. 1988).

## **STATEMENT OF THE CASE**

Appellants have brought this action arising out of an incident that occurred on August 12, 2003. On that day Ryan Miller shot and killed his mother Deborah Miller and shot and wounded his father, Randolph Miller, and his stepmother, Laurie Miller. Appellants have sued three physicians, a hospital, and a clinic that were involved in evaluating Ryan Miller during a July 28-29, 2003 hospital admission. During the admission, Ryan Miller was seen by Dr. Paul Goering, a psychiatrist employed by Allina Health Systems, and two neurologists employed by Minnesota Epilepsy Group, P.A., Dr. Deanna Dickens, and Dr. Patricia Penovich.

Appellants commenced their suit in July of 2006. All Respondents moved for summary judgment based on the immunity provisions of the Minnesota Treatment and Commitment Act, Minnesota Statutes chapter 253B. Respondents also moved for summary judgment based on the assertion that Appellants had failed to comply with the affidavit requirements of Minn. Stat. § 145.682.

By order dated April 28, 2008, the trial court granted summary judgment to Respondents United Hospital and Goering on all claims against them. The trial court also granted summary judgment to Respondents Dickens, Penovich, and the Minnesota Epilepsy Group based on the commitment immunity statute, Minn. Stat. § 253B.23, subd. 4. The trial court denied the motion with respect to other issues raised by Dickens, Penovich, and the Minnesota Epilepsy Group, but invited a renewed summary judgment motion with respect to these other issues.

Respondents Dickens, Penovich, and the Minnesota Epilepsy Group filed memoranda in support of a renewed motion for summary judgment. While this motion was pending, the trial court amended its earlier summary judgment order to permit an immediate appeal by inclusion of the language contained in Rule of Civil Procedure 54.02. The trial court's amended order of July 1, 2008 and its resulting judgment of July 10, 2008, omitted reference to Respondents Dickens, Penovich, and the Minnesota Epilepsy Group. By Order dated October 21, 2008, the Court ordered that this appeal would proceed and that the Court would reserve determination of the question of whether it would review claims against Dickens, Penovich, and the Minnesota Epilepsy Group as they related to application of the commitment immunity statute.

## **STATEMENT OF FACTS**

Ryan Miller had a long history of epilepsy. Past treatment included a lobectomy and he had taken various anti-seizure medications for many years. During July 2003, Ryan Miller, then 26 years of age, began exhibiting some peculiar behaviors. His parents observed that he was constantly writing stories, doing mathematical formulas and talking to non-existent people. RA-1<sup>1</sup>; R. Miller Depo., pp. 30-31. On July 26, 2003, Deborah Miller called Minnesota Epilepsy Group and reported these behaviors to Dr. Ritter, Ryan Miller's childhood treating neurologist who was on call. RA-24; Penovich Depo., p. 76. In addition, Deborah Miller reported that Ryan Miller had stopped taking his medications for two days because "God told him he didn't have epilepsy anymore." *Id.* Dr. Ritter returned Deborah Miller's call on July 27<sup>th</sup> and instructed her to have Ryan Miller take his medications, but if her concerns increased she was to bring him in for admission. RA-25; *id.* at 77.

### **July 28, 2003**

On July 28, 2003, Deborah Miller contacted Respondent Dr. Penovich, Ryan Miller's adult neurologist at Minnesota Epilepsy Group, and shared her concerns about Ryan Miller's continued "bizarre behavior." *Id.* Deborah Miller shared that Ryan Miller was typing stories about spirits talking with him, telling him he did not have epilepsy so that he had stopped taking his medications. *Id.*

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<sup>1</sup> References cited as "RA-\_\_\_" are to the appendix of this brief.

Dr. Penovich instructed Deborah Miller to bring Ryan Miller to the hospital for admission. RA-25; id. at 79.

Deborah Miller and Ryan Miller presented to United Hospital and met with Dr. Jason Doescher, who in 2003 was a fellow at the Minnesota Epilepsy Group and Respondent Dr. Dickens, who was the neurologist on call at Minnesota Epilepsy Group. Upon examination, Ryan Miller reported a history of hearing voices, but was not hearing voices at the time of this examination. RA-29-32; Minnesota Epilepsy Group Records. Exhibit G. He denied visual hallucinations. Id. He also denied suicidal and homicidal ideation. Id. Ryan Miller told Dr. Doescher he was not uncomfortable or made fearful by the voices he heard. Id. He denied that the voices were derogatory or encouraged him to hurt himself or others. Id. He said that approximately one week earlier he had heard from God that he did not have epilepsy and he had therefore, at some time within the past few days, stopped taking his anti-epilepsy medications. Id.

Dr. Doescher also interviewed Ryan Miller's mother Deborah Miller. Deborah Miller reported that he had never demonstrated these types of behaviors before, that he had not made any threatening gestures or statements toward them<sup>2</sup>, and that on this date he looked better than in days prior. Id. Dr. Doescher's note indicates he reviewed some of Ryan Miller's "manuscripts" and

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<sup>2</sup> Randy Miller also observed that Ryan Miller had never threatened to hurt him or anyone else. RA-6; R. Miller Depo., p. 51. Indeed, Randy Miller stated that "everybody knew that Ryan Miller as the gentle giant." Id. Laurie Miller testified that Ryan Miller was not threatening to her or anyone else. RA-33.

that these manuscripts demonstrated stream-of-consciousness writing without particular direction. Id. Dr. Doescher diagnosed Ryan Miller with an acute psychosis and admitted Ryan Miller on a voluntary basis for observation and follow-up, including EEG monitoring to determine whether he had experienced seizure activity. RA-46; Dickens Depo., pp. 146-147; and RA-29-32; Minnesota Epilepsy Group History and Physical Medical Records.

**July 29, 2003**

The next day, Dr. Dickens conducted a follow up consultation with Ryan Miller. Dr. Dickens determined, based in part on the EEG information obtained overnight, that Ryan Miller had not been experiencing seizures and that his symptoms were not the result of epilepsy exacerbation. RA-36-37; 41; Dickens Depo. pp. 88-89, 106. Dr. Dickens proceeded to request a psychiatric consultation. Id. This consultation was performed by a psychiatrist, Respondent Dr. Paul Goering. Prior to evaluating Ryan Miller, Dr. Goering reviewed all pertinent records, reviewed Ryan Miller's personal correspondence and letters, and discussed Ryan Miller's clinical presentation and past medical history with him. RA-49-53; Minnesota Epilepsy Group Psychiatric Records. He spent almost an hour interviewing Ryan Miller.

Ryan Miller's behavior during this admission had been appropriate in that there was no demonstration of threatening or hostile conduct. Id. No comments had been made that could have been interpreted as dangerous. Id. Dr. Goering reviewed the stories that Ryan Miller had written over the preceding few weeks,

many of which mentioned family members. Id. Most of these stories were stream-of-consciousness writings and some mentioned the military, guns, or death. Dr. Goering discussed these stories with Ryan Miller. Ryan Miller first told Dr. Goering that he did not write these stories. RA-58; Goering Depo., p. 82. Despite denying authoring these stories, Ryan Miller discussed the contents of these writings with Dr. Goering and denied having thoughts or feelings about death or killing people. RA-57; id. at 60. Although Ryan Miller also denied hallucinations, in discussing specific auditory hallucinations Ryan Miller stated that the voices he heard did not scare or distress him. RA-58; id. at 82. Ryan Miller was adamant he did not need to be seen by a psychiatrist and appeared “mad” that one was at his bedside. RA-57; id. at 57.

While Dr. Goering felt Ryan Miller would benefit from treatment, he refused additional treatment and also refused to allow Dr. Goering to speak to Deborah Miller. RA-55-56; id. at 44-45. Ryan Miller specifically requested that Dr. Goering not tell Deborah Miller that Dr. Goering wanted Ryan Miller to be admitted to the hospital. RA-56; id. at 47. Dr. Goering did not feel Ryan Miller was holdable, as he felt there was no risk of harm to Ryan Miller or others. RA-56. Dr. Goering diagnosed Ryan Miller with a psychotic disorder unrelated to his seizure disorder and recommended that he start on Risperdal to treat the psychosis. Id. His note indicates that while Ryan Miller demonstrated poor insight, he would only be holdable if he developed “more dangerous behavior.”

Sometime after his meeting with Dr. Goering, Ryan Miller attempted to leave the hospital, pulling out his IV line and the EEG wires off. Ryan Miller's attempt to flee warranted the staff's assistance. Dr. Dickens was not on floor when Ryan Miller ran out of the hospital. RA-34; Dickens Depo., p. 73. Dr. Dickens was informed that Ryan Miller wanted to leave the hospital and that he was resistant when security required him to return. RA-38. Upon return to the hospital, security decided to place Ryan Miller in restraints until further analysis could be conducted.

Dr. Dickens contacted Dr. Goering to inform him of Ryan Miller's conduct and they discussed the same. RA-39. Dr. Goering maintained his opinion that Ryan Miller was not a danger to himself or others and therefore was still not holdable as long as he agreed to take his medications. RA-39, RA-59. If Ryan Miller refused to take his medications, Drs. Dickens and Goering agreed they would need to discuss the situation further. RA-59.

Dr. Dickens also had an extensive consultation with Ryan Miller after he attempted to leave the hospital. RA-40. Dr. Dickens asked Ryan Miller why he chose to remove his wires and leave the hospital. RA-40. Ryan Miller replied that he "wanted to go outside" and that he had done everything the doctors had asked him to do except have another MRI and that he had had enough MRI's and did not want another one. RA-40. Ryan Miller stated he knew he was not having seizures and he had reported the same to both of his parents. Id. He also mentioned that his father agreed he should not have to come into the hospital,

but that his mother wanted him to get checked out and prove he was not having seizures. Id. Ryan Miller also expressed his frustrations with his medications, and stated that he did not believe that he needed his anti-seizure medications, and requested that he be put back on Carbatrol, his old anti-seizure medication which he had taken for years, because he did not like Trileptal, a new anti-seizure medication he had been prescribed within recent months. RA-40. Id. at 104. He refused to stay in the hospital, and stated that if he were asked to stay, the hospital would be keeping him against his will. Id.

Ryan Miller agreed to stay in the hospital long enough for his father to arrive so that Dr. Dickens could speak to him. Id. Ryan Miller agreed that if he were discharged he would continue to take his anti-seizure medications and would also take the antipsychotic medication, Risperdal, that Dr. Goering had prescribed earlier that day. Id. Dr. Dickens also asked Ryan Miller if he would be agreeable to meeting with a psychiatrist near his home as Dr. Goering recommended. Id. Ryan Miller replied that he would do so as long as he would be able to go home. Id. Ryan Miller commented that he was not sure that he needed to see a psychiatrist, but that he was willing to do so. RA-41. Id. at 105-06. Ryan Miller demonstrated a good understanding of his seizure history and medications, but denied hallucinations and hearing voices. RA-41.

Dr. Dickens consulted with Deborah Miller regarding what they had observed overnight and the anticipated treatment plan for Ryan Miller. RA-46. Dr. Dickens then also consulted with Randy Miller, who arrived at the hospital

shortly after being notified that Ryan Miller attempted to leave the facility. RA-2. Dr. Dickens explained to Randy Miller that the EEG findings indicated that Ryan Miller was not having seizures. RA-3, 47. Randy Miller told Dr. Dickens he was “very proud” of Ryan Miller for standing up for himself and speaking his mind about not wanting to stay in the hospital because he had been “agreeing with his mother his entire life.” RA-48, 4. Dr. Dickens explained that Ryan Miller was not thinking clearly and had impaired judgment. RA-42. Randy Miller was instructed to keep Ryan Miller’s regular appointment with Dr. Penovich and was also instructed to seek psychiatric treatment for Ryan Miller as an outpatient. RA-48. Randy Miller admits that while he does not specifically recall whether Dr. Dickens told him that Ryan Miller would need to follow up with a psychiatrist to manage his Risperdal, he recalled that he may have had a conversation on this topic with Deborah Miller. RA-22-23. While Randy Miller maintains that he was under the impression that Minnesota Epilepsy Group was going to make a psychiatric referral for Ryan Miller, Randy Miller does not recall speaking to any specific person at the Minnesota Epilepsy Group who said that they were going to give a referral to a psychiatrist for Ryan Miller’s care. RA-23.

Dr. Dickens explained to Randy Miller that Dr. Goering recommended Ryan Miller see a psychiatrist closer to home, and Ryan Miller and Deborah Miller were agreeable to this treatment plan. RA-43. Deborah Miller told Dr. Dickens that Dr. Goering had given her the telephone number of a local psychiatrist. RA-43. Randy Miller stated that Ryan Miller “would not see a quack

[in Mora] and if he needed to see a shrink he would see one in the Twin Cities.” RA-43. Dr. Dickens offered to contact Dr. Goering to see if he would be able to follow up with Ryan Miller. Id. Randy Miller declined the offer to speak with Dr. Goering, stating that “Deb could do it” (meaning speak to Dr. Goering about treatment or a referral) because she knew Dr. Goering through her employment at the Minnesota Epilepsy Group. Id.

After this consultation, Randy Miller returned to Ryan Miller’s room and Deborah Miller once again spoke with Dr. Dickens. RA-48. Dr. Dickens explained that she wanted Ryan Miller to have his blood levels checked in one week, and provided Deborah Miller with a lab kit, which included all of the necessary lab order forms to complete the work-up. RA-35. Deborah Miller was an employee of Minnesota Epilepsy Group and therefore familiar with their lab order processes. She told Dr. Dickens that she would rather use a different lab order form and indicated that she would obtain these forms the next day she was scheduled to work. RA-45. Dr. Dickens also spoke to Deborah Miller about the need to follow up with a psychiatrist, and suggested that she follow up with Dr. Goering given Randy Miller’s objection to seeing a psychiatrist in Mora. RA-48. See id. at 155. Deborah Miller told Dr. Dickens that she would either follow up with Dr. Goering while she was working or call him to see if she could get Ryan Miller a referral. Id. Deborah Miller never followed-up with Dr. Goering as promised. RA-54.

Ryan Miller was discharged on July 29, 2003 to the care of his father after extensive counseling with Ryan Miller, his mother, father and sister. Ryan Miller

agreed to take his antiepileptic meds along with the Risperdal and to have anticonvulsant levels checked in one week. The family members understood they were to call 911 should Ryan Miller demonstrate “unmanageable” behaviors. RA-6, 42. Specifically, Dr. Dickens advised that they should immediately return Ryan Miller to the nearest hospital if he refused to take his medications or displayed concerning behavior. RA-42. They were also instructed to maintain Ryan Miller’s medication regimen including the anti-seizure medications and the Risperdal. RA-6. Finally, Dr. Dickens’ note indicates the family also was instructed to remove all guns and potentially harmful objects/weapons from the home until Ryan Miller’s judgment got better. RA-5, 44.

**July 29–August 11, 2007**

Ryan Miller left the hospital and agreed to live with Randy Miller and Laurie Miller so they were better able to keep an eye on him. During this time, Randy Miller kept a journal to document Ryan Miller’s behavior. RA-7, 62-63. Randy Miller was responsible for providing the prescribed medications to Ryan Miller. RA-7. Randy Miller gave the medications to Ryan Miller, and claims to have observed him swallow the medications because “Ryan Miller did not want to take the Risperdal and often tried to avoid taking it.” RA-7. See id. Indeed, Randy Miller’s July 31 journal entry indicates that Ryan Miller lied about taking his medications. RA-8. Id. at p. 58. Randy Miller testified:

I was trying to see how much trust I could give him as far as taking his own medications and so I would look in his medication box and

see if he had when I would tell him to take his meds and I apparently saw that he didn't.

Id.

Throughout this time Ryan Miller continued to exhibit peculiar behavior, including writing mathematical formulas, carrying imaginary objects, and making nonsensical statements about a girlfriend he did not have. RA-9. Despite this behavior, Randy Miller did not contact the Minnesota Epilepsy Group or a psychiatrist as recommended by Dr. Dickens and Dr. Goering upon discharge. RA-10<sup>3</sup>.

On August 3, 2007 Randy Miller drove Ryan Miller to Deborah Miller's house for a visit. RA-11. Before dropping him off, Randy Miller told Ryan Miller to tell Deborah Miller to "cut [Ryan Miller] some slack and quit nagging constantly." Id. Randy Miller wanted Deborah Miller to try to have quality time with Ryan Miller and not worry about his medications and things and to "take a break." Id.

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<sup>3</sup> Again, Randy Miller cannot recall whether he contacted a physician during this time. It is undisputed that Randy Miller did not contact any treatment facility besides the Minnesota Epilepsy Group, and the call records from Minnesota Epilepsy Group do not reflect any communication reporting strange behavior from either Randy Miller or Deb Miller until August 5, 2003. The only contact with the clinic prior to August 5 occurred on July 31, 2003. A Minnesota Epilepsy Group Phone Contact Form indicates Deborah Miller Miller called for a prescription and was given a prescription for Neurontin 800 mg./four times a day, Tegretol 900 mg. three times a day and Risperdal 1 mg./at hour of sleep per Dr. Penovich. This note further indicates a one-month supply with three refills was given to Ryan Miller's mother – Deborah Miller. There is no indication of any reports of bizarre behaviors/thoughts on this date.

Ryan Miller continued to exhibit abnormal behavior in the days that followed. He commented that the family's rocking chair once belonged to a psychic woman on the Montel Williams Show, reported that he had a sore throat because the devil was inside it, and that Randy Miller and Ryan Miller "died in a nuclear blast one day." RA-12. Ryan Miller also resumed writing stories. Id. Despite Dr. Dickens's discharge instructions, neither Randy Miller nor Deborah Miller consulted with a psychiatrist or other physician during this time nor was this information mentioned to them.

On August 5, 2003 Deborah Miller requested a lab order from the Minnesota Epilepsy Group. RA-60. Deborah Miller requested an appointment for the labs to be drawn on August 6<sup>th</sup>. Id. Deborah Miller shared that it had been a rough weekend but that things got better on August 4, 2003. Id.

On August 6, 2003, Deborah Miller called the Minnesota Epilepsy Group to see if Ryan Miller could discontinue taking the Risperdal, as he complained of blurred vision and stomachache after taking this medication. RA-61. She reported that he was "doing good overall" and that labs were drawn on this date. Id. Dr. Penovich's nurse consulted with Dr. Penovich, who indicated that Ryan Miller could not discontinue Risperdal, and should consult with a psychiatrist regarding this medication. RA-26.

Later that day, Deborah Miller spoke with Randy Miller regarding her concerns related to Ryan Miller's behavior. Randy Miller documented in his journal that Deborah Miller was trying not to bug Ryan Miller or cry when he was

around, but also complained about “her hurt feelings” and being “disrespected.” RA-62. She told Randy Miller that if Ryan Miller did not get better soon, she would have to do something, and suggested that she may have to take him to the hospital. Id. Randy Miller told Deborah Miller to “back off” and to give Ryan Miller some time. RA-13. Between August 7 and August 10, Ryan Miller continued to exhibit unusual behaviors. RA-13-15. Again, no health care providers were contacted with this information.

On August 11, 2003, Randy Miller contacted the Minnesota Epilepsy Group and stated that he wanted Ryan Miller off the Risperdal due to noted drowsiness, fatigue, occasional slurred speech and intermittent numbness of the face, legs and arms. RA-15, 64. Randy Miller instructed the nurse to relay his request to Dr. Penovich and to “make sure” she knew that he “strongly” wanted Ryan Miller off the Risperdal. RA-15, 63. Beth, Dr. Penovich’s nurse, communicated this request to Dr. Penovich, and Dr. Penovich denied the request. RA-27. Dr. Penovich concluded it was not safe to change medications until Ryan Miller was evaluated by a psychiatrist. RA-28. Beth returned Randy Miller’s call and left a message instructing that only a psychiatrist could change Ryan Miller’s medications and that if Ryan Miller was hearing voices his medications should not be changed until a psychiatrist could evaluate Ryan Miller, and that it would not be safe to change the medications until then. Id.

Randy Miller was also told that either he or Deborah Miller needed to arrange an appointment with a psychiatrist before making any changes to Ryan

Miller's medications. Id. Randy Miller's journal, which was created contemporaneously with the phone call to the Minnesota Epilepsy Group states:

"Message from Beth - no changes. Arrange local psych to manage."

RA-63. It is undisputed that Randy Miller made no effort to contact the Minnesota Epilepsy Group after receiving Beth's message to obtain a referral to a local psychiatrist. RA-16. In fact, the very next line in Randy Miller's journal reads:

"Talk to Deborah - she agrees no shrink and bring him off Risperdal. Reduced to 1/2 tab (.5 mg) / evening dose."

RA-63. Randy Miller admits that he and Deborah Miller then discussed reducing Ryan Miller's Risperdal dosage by half. RA-16. Although Randy Miller alleges he called the Minnesota Epilepsy Group on "several occasions" he cannot describe any such contact except the August 11 telephone call in which he "strongly requested" that Ryan Miller be taken off Risperdal. RA-16-17. Indeed, his journal only reflects the August 11 contact, and otherwise contains various notes where he discourages Deborah Miller from making contact with the clinic. RA-62-63.

There is no indication within any of these records that Ryan Miller was telling health care providers he was going to harm or kill anyone. Rather, these records indicate he was hearing voices of dead people and God and these voices were telling him he did not have epilepsy. Randy Miller testified that there was no time prior to the incident on August 12, 2003 that he felt worried about his own safety. RA-21.

**August 12, 2003**

On August 12, 2003, Randy Miller took Ryan Miller over to Deborah Miller's house around noon. RA-17. The plan was that Ryan Miller was going to visit with Deborah Miller and that she would call Randy Miller to come pick up Ryan Miller when he was ready to leave, or that Deborah Miller would bring him home. Id. That afternoon, Randy Miller observed Ryan Miller in the yard near the driveway. RA-17. Randy Miller called Deborah Miller to see if Ryan Miller had just wandered off, but there was no answer. Id. Randy Miller then walked outside to see what Ryan Miller was doing. RA-18. As he approached, he noticed that Ryan Miller was pointing a rifle at him, and he jumped to attempt to get out of the way. Id. Ryan Miller shot Randy Miller in the neck. Id. Moments later, Laurie Miller pulled into the driveway and Ryan Miller began firing at her as well. Id. Ryan Miller continued to shoot at both of them until Randy Miller was able to make it inside Laurie Miller's car. RA-18. Id. at 98. Laurie Miller called 911 and they both drove away from the home. Both Randy Miller and Laurie Miller were found on the roadway by local law enforcement and transported to the hospital by ambulance. Deborah Miller was later found dead.

Ryan Miller was charged with murder and attempted murder. RA-18. His trial was ultimately bifurcated and during the first phase he was found guilty of the crimes charged. RA-19. Id. at 101. During the second phase of the trial, testimony was given to determine whether Ryan Miller's defense of insanity would be accepted. Id. As a result of these proceedings, Ryan Miller was

indeterminately committed to St. Peter's Security Hospital. While in jail, and also while at St. Peter's Security Hospital, Ryan Miller refused to take his anti-psychotic medication. RA-20. Indeed, while he was at St. Peter's, a medical emergency had to be declared and a Jarvis hearing was sought in order to force Ryan Miller to take his anti-psychotic medications. Id.

Ryan Miller reported to health care providers at St. Peter Security Hospital that he was not taking any medications prior to the shootings and that he purposefully stopped taking the medications. RA-65-66.

**Expert Allegations:**

Plaintiffs have disclosed two experts, Dr. Menahem Krakowski and Dr. Jordan Holtzman to offer opinions related to the standard of care and causation in this case. A-129-145. Specifically, Plaintiffs allege that the Minnesota Epilepsy Group, Dr. Dickens and Dr. Penovich departed from generally accepted medical practice by failing to retain Ryan Miller on a 72-hour hold and by discharging Ryan Miller to the care of his father without a proper treatment plan or follow-up recommendations or referrals. Id.

**ARGUMENT**

**I. THE STANDARD OF REVIEW**

On an appeal from summary judgment, the Court is presented with two questions: (1) whether there are any genuine issues of material fact and (2) whether the district court erred in its application of the law. State by Cooper v. French, 460 N.W.2d 2, 4 (Minn. 1990).

A trial court is required to grant a motion for summary judgment if “the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of material fact and that either party is entitled to a judgment as a matter of law. On appeal, the reviewing court must view the evidence in the light most favorable to the party against whom judgment was granted.” Fabio v. Bellomo, 504 N.W.2d 758, 761 (Minn. 1993). No genuine issue of material fact exists “[w]here the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party.” DLH, Inc. v. Russ, 566 N.W.2d 60, 69 (Minn. 1997) (alteration in original) (quoting Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 587 (1986)). “[T]he party resisting summary judgment must do more than rest on mere averments.” Id. at 71. Here the trial court properly determined that there were no genuine issues of material fact and properly applied the immunity provision of Minn. Stat. § 253B.23, subd. 4 (2002). Accordingly, its decision should be affirmed.

**II. PHYSICIANS WHO EVALUATE PATIENTS PURSUANT TO THE COMMITMENT AND TREATMENT ACT TO DETERMINE WHETHER THEY SHOULD BE HELD OR COMMITTED ARE PROTECTED BY THE IMMUNITY PROVIDED BY THE ACT.**

Appellants assert that immunity must be denied because Ryan Miller was never actually committed. In making this argument the Appellants misconstrue the nature of the immunity afforded by Minnesota’s Commitment and Treatment Act. The trial court got it right when it extended immunity to the present case.

The immunity provided by the Act is broad and the trial court's decision properly recognized this.

**A. The Act Contemplates Both Voluntary and Involuntary Admissions for the Purpose of Evaluation of the Need for Commitment.**

Issues related to the commitment and treatment of citizens with mental health problems have long been the subject of public debate. In 1982 the Minnesota legislature revisited the manner in which civil commitments occur and recodified the Minnesota Commitment and Treatment Act, Minnesota Statutes chapter 253B. The Act represented a comprehensive reworking of the law relating to commitment and created a detailed scheme for the examination, treatment, evaluation, and commitment of persons, including those with mental health illnesses. The Act touches on competing policy interests. On the one hand it seeks to protect individuals by establishing rights that individuals have as they proceed through the commitment process. On the other hand, the Act seeks to provide a method of dealing with persons who are dangers to themselves or others. The Act thus attempts to harmonize public and private interests and defines various roles for patients, law enforcement officers, courts, physicians, and other professionals. Because the scope of the immunity at issue here depends upon the scope of the Act itself, a brief overview of the Act is necessary.

The Act represents a comprehensive collection of the procedures relating to commitment from first contact with individuals who might be committed

through the commitment hearing process, and on to post-commitment issues such as treatment and release.

There is more than one way that an individual can come to be examined for commitment under the Act. One common way that commitment occurs is through an emergency admission, which results in a 72-hour hold. Minn. Stat. § 253B.05 (2002). Emergency admission can arise either through the action of a referring peace or health officer, under subdivision 2 of the statute, or through the decision of the head of a treatment facility, under subdivision 1. Minn. Stat. § 253B.05, subd. 1, 2 (2002).

In addition to the involuntary hold provisions of the Act, the Act also provides for voluntary admission for examination:

Any person 16 years of age or older may request to be admitted to a treatment facility as a voluntary patient for observation. . . . The head of the treatment facility shall not arbitrarily refuse any person seeking admission as a voluntary patient. . . .

Minn. Stat. § 253B.04, subd. 1 (2002). The Act also contains a provision allowing persons with mental illness to voluntarily admit themselves: “A person with mental illness may seek or voluntarily agree to accept treatment or admission to a facility.” Minn. Stat. § 253B.04, subd. 1a (2002). The legislature did not intend the voluntary admission provisions of the Act to be some kind of odd exception or curiosity. In fact, it intended voluntary admission to be the primary manner by which individuals would come to be examined for commitment:

“voluntary admission is preferred over involuntary commitment and treatment.”  
Minn. Stat. § 253B.04, subd. 1 (2002). The preference for voluntary admission over involuntary admission is so strong that the Act even provides that involuntary admitted persons may be transferred to voluntary status with the permission of the head of the facility. Minn. Stat. § 253B.05, subd. 4 (2002).

Beyond there being these two different points of admission to the commitment process, voluntary and involuntary, the Act makes it clear that its provisions relating to the evaluation of individuals with mental illness apply equally to situations involving either voluntary admission or involuntary admission. Whether the admission is voluntary, under 253B.04, or involuntary, under 253B.05, an examination must be conducted with 48 hours of the admission:

Every patient hospitalized as mentally ill or mentally retarded pursuant to section 253B.04 or 253B.05 must be examined by a physician as soon as possible but no more than 48 hours following admission.

Minn. Stat. § 253B.06, subd. 1 (2002).

**B. By Its Terms the Immunity Provision of the Act Applies to Both Voluntary and Involuntary Admissions.**

The immunity provision here at issue applies to all admissions under the Act, whether voluntary or involuntary:

Subd. 4. **Immunity.** All persons acting in good faith, upon either actual knowledge or information thought by them to be reliable, who act pursuant to any provision of this chapter or who procedurally or physically assist in the commitment of any individual, pursuant to

this chapter, are not subject to any civil or criminal liability under this chapter.

Minn. Stat. § 253B.23, subd. 4 (2002) (emphasis added).

The immunity applies whenever someone “acts pursuant to any provision of [the Act].” Minn. Stat. § 253B.23, subd. 4. The statute's grant of immunity is designed to protect all persons who participate in the commitment process in good faith. Mjolsness v. Riley, 524 N.W.2d 528, 531 (Minn. Ct. App. 1994) citing Enberg v. Bonde, 331 N.W.2d 731, 735 (Minn.1983) (doctors who acted in good faith and complied with provisions for emergency commitment were immune from liability even though subject of emergency commitment never was committed); see also Reuter v. City of New Hope, 449 N.W.2d 745, 750 (Minn. Ct. App. 1990) (police officers entitled to qualified immunity under 42 U.S.C. § 1983 for their role in emergency involuntary commitment despite fact that subject of commitment was released from hospital within a short time after her arrival). To hold a party liable simply because the subject of possible commitment was not ultimately committed would be contrary to the statute's broad grant of immunity. Id. The statute's plain language unambiguously applies to all persons acting in good faith and its grant of immunity is not limited to persons who are successful in their efforts to commit someone. Id. citing Minn.Stat. § 253B.23, subd. 4 (“All persons acting in good faith . . . are not subject to any civil or criminal liability.”) (emphasis in original).

Physicians who act pursuant to the voluntary commitment provisions of section 253B.04 are acting pursuant to chapter 253B and such actions are therefore entitled to the same immunity as the actions taken pursuant to 253B.05. Ryan Miller was evaluated by Dr. Goering, a psychiatrist, with input from Dr. Dickens, for purposes of determining whether he should have been held under the commitment statute. Dr. Goering initially determined that Ryan Miller did not meet the criteria that would permit him to be held against his will. A-115-16. This decision was reaffirmed after Dr. Dickens called Dr. Goering and advised that Miller had pulled out his EEG wires and had been placed in restraints. A-127. Appellants concede that the Respondents “each made affirmative decisions not to initiate a commitment.” Appellants’ Brief, p. 14. Because Respondents’ determination of whether to commit Ryan Miller was made pursuant to chapter 253B, it cannot give rise to civil liability.

**C. Appellants’ Arguments Urging the Court to Deny Respondents Immunity Are Unsound.**

Appellants offer a string of flawed arguments in support of their position that immunity does not apply. First they suggest that because the reported cases involve individuals who have actually been committed this somehow counters the statute’s direct grant of immunity. In this regard Appellants rely on dicta from Engle v. County of Hennepin, 412 N.W.2d 364 (Minn. Ct. App. 1987). While the Engle court did state that it was not going to consider the applicability of the commitment immunity statute where no commitment took place, its statement

was a classic example of dicta, since this offhand statement was not necessary to the result in the case. The Engle court decided that statutory discretionary immunity barred the claims and therefore its decision was not important to the outcome of the case. Id. at 367. Importantly, the Court had no occasion to address the scope of the language of the 253B.23, subd. 4, which plainly provides coverage beyond cases where commitment actually occurs. It is fundamental that the Court is not free to disregard the plain language of a statute.

Here the statute provides immunity if the Respondents acted pursuant to chapter 253B. The Respondents collectively interviewed, examined, monitored, and evaluated Ryan Miller for purpose of determining whether they should initiate the commitment process by placing a hold on him. They made a decision not to initiate an involuntary commitment. Any dicta in Engle notwithstanding, the collective actions of the Respondents were taken to evaluate a patient who had been voluntarily admitted because of reported mental disturbances for purposes of determining whether or not he should be held. These decisions were protected by the immunity the statute confers.

Appellants also argue that there is some significance to the fact that the Act's provisions governing involuntary 72-hour holds was not followed. But of course, since Ryan Miller was voluntarily admitted and examined by a psychiatrist for the same purposes that an involuntarily held patient would be, it is illogical to argue that this is of any significance. If there are two doorways into the commitment process, one voluntary and one involuntary, the fact that one did

not enter by means of the involuntary entrance does not mean that one has not entered the commitment process.

Appellants also spend time discussing the distinction between “quasi-judicial powers” and the duties of physicians as physicians. Appellants’ Brief, p. 14 to 15. But this discussion misses the basic point. The real issue is whether the actions taken were taken pursuant to chapter 253B. If they were, immunity applies. If they were not, the immunity conferred by chapter 253B would not apply. Because the physicians evaluated Ryan Miller for purposes of determining whether he should be held under the involuntary hold provisions of the act, they have acted pursuant to the statute and are entitled to immunity.

### **III. COMPELLING CONSIDERATIONS OF PUBLIC POLICY SUPPORT THE ACT’S EXTENSION OF IMMUNITY TO THOSE WHO MAKE DECISIONS REGARDING THE HOLDING AND COMMITMENT OF INDIVIDUALS WITH MENTAL HEALTH ISSUES.**

The decision of the trial court is in harmony with considerations of public policy. Appellants suggest that failing to impose liability for a decision not to involuntarily hold a patient would be contrary to the public interest. But the policy considerations articulated by both the legislature and Minnesota’s courts support the trial court’s decision.

The legislature has expressly stated its chief policy concerns related to the commitment of those with mental health problems. First, the legislature has expressly stated that it prefers that physicians attempt to begin the steps towards detention and commitment with voluntary admission: “voluntary admission is

preferred over involuntary commitment and treatment.” Minn. Stat. § 253B.04, subd. 1 (2002). Further, the legislature’s preference for erring on the side of liberty—perhaps sometimes at the expense of public safety—is reflected in many provisions of the Act. See, e.g., Minn. Stat. § 253B.045, subd. 1 (2002) (limiting temporary confinement to those cases necessary to protect the life of the patients or others); Minn. Stat. § 253B.045, subd. 6(a) (2002) (mandating coverage for plans that identify the least restrictive means of treatment); Minn. Stat. § 253B.05, subd. 1 (2002) (limiting ability to place emergency hold unless patient is in danger of harming self or others); Minn. Stat. § 253B.065, subd. 5 (2002) (limiting treatment programs to least restrictive programs); Minn. Stat. § 253B.045, subd. 6(a) (2002) (limiting judicial standard for commitment to least restrictive treatment program or alternative). The legislature has also made it clear that those involved in the commitment process, whether physicians, social workers or courts must err on the side of the patient’s liberty.

Minnesota courts have similarly stated that it is important to err on the side of liberty when considering the interpretation of provisions of the Act. Ambiguities in the Act must be construed against the State and in favor of interests of individual liberty. In Re: Colbert, 464 N.W.2d 505, 507 (Minn. 1991); In Re: Raboin, 704 N.W.2d 767 (Minn. Ct. App. 2005).

Appellant’s discussion of public policy fails to give appropriate weight to the fact that decisions relating to the detention of individuals should be used sparingly and that the Courts are loathe to interfere with individuals’ civil

liberties merely because they demonstrate some form of mental illness. In addressing this issue, the Minnesota Supreme Court cautions that civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection. Enberg, 331 N.W.2d at 737 (citing Addington v. Texas 441 U.S. 418 (1979); Jackson v. Indiana, 406 U.S. 715 (1972); Humphrey v. Cady, 405 U.S. 504 (1972); In re Gault, 387 U.S. 1 (1967); and Specht v. Patterson, 386 U.S. 605 (1976)). The Enberg court also noted the importance of the interests at stake by citing the following passage from Addington:

It is indisputable that involuntary commitment to a mental hospital after a finding of probable dangerousness to self or others can engender adverse social consequences to the individual. Whether we label this phenomena "stigma" or choose to call it something else is less important than that we recognize that it can occur and that it can have a very significant impact on the individual.

Enberg, 331 N.W.2d at 736 (citing Addington, 441 U.S. at 425-26). The desire of the legislature and the courts to err on the side of liberty creates a problem, particularly when this consideration of liberty is placed alongside the realities of the imperfect science of predicting future human behavior.

Minnesota courts have long recognized the difficulty of predicting the course of mental illnesses and attempting to predict the behavior of mentally ill persons. In Enberg v. Bonde, 331 N.W.2d 731, 737 (Minn. 1983), the Minnesota Supreme Court recognized the problems involved in predicting dangerousness, noting that

many psychiatrists themselves admit that their ability to predict future dangerousness is not reliable; to date, no valid clinical experience or

statistical evidence reliably describes psychological or physical signs or symptoms that can be reliably used to discriminate between the harmless and the potentially dangerous individual.

Id. (citing Johnson v. Noot, 323 N.W.2d 724, 728 (Minn. 1982)).

In the context of interpreting the statutes then applicable to commitment, the Enberg Court held that their determination of the issue of whether an overt act, attempt or threat of harm to self or others is required by due process was moot because the Minnesota Legislature had, in fact, adopted this requirement.

Id. The Court noted Minn. Stat. § 253A.04 (1), the statutory provision then providing the definition of “mental illness,” required a threat of physical harm to one’s self or others to be demonstrated by either (i) a recent attempt or threat to physically harm himself or others, or (ii) a failure to provide necessary food, clothing, shelter or medical care of himself, as a result of the impairment. Minn. Stat. § 253A.04 (1) (2002).

The current definition of mental illness likewise contains similar requirements for a finding of an “overt act, attempt or threat” before an examiner may conclude that a patient presents a danger of injury to herself or others and place a patient on emergency hold. Minnesota Statute § 253B.02(13) provides:

A person who is mentally ill is any person who. . . poses a substantial likelihood of physical harm to self or others as demonstrated by (1) a failure to obtain necessary food, clothing, shelter, or medical care as a result of the impairment; (2) an inability for reasons other than indigence to obtain necessary food, clothing, shelter, or medical care as a result of the impairment and it is more probable than not that the person will suffer substantial harm, significant deterioration or debilitation, or serious illness unless appropriate treatment and services are provided; (3) a recent attempt or threat to physically

harm self or others; or (4) recent and volitional conduct involving significant damage to substantial property.

Minn. Stat. §253B.02 (13) (2002). The plain language of this statute dictates a patient's propensity for injury to self or others must be demonstrated by a set of objective facts described above. Other courts have also noted the difficulties of predicting the outcome of cases involving mental illness. See, e.g., Soutear v. U.S., 646 F.Supp. 524, 536 (E.D. Mich. 1986) (noting the uncertainty of mental health treatment). Yet Appellant advances an interpretation of the Act's immunity provision that would encourage physicians to commit individuals to protect themselves from lawsuits like the present one.

The interests at stake here are profound and the imposition of liability in this case would force physicians to err on the side of commitment, something not countenanced by Minnesota's policy of erring on the side of liberty.

**IV. APPELLANTS' INTERPRETATION OF THE IMMUNITY WOULD RENDER IT MEANINGLESS AND WOULD BE CONTRARY TO THE ACT'S EXPRESS LANGUAGE.**

At one point during their argument Appellants suggest that they are simply advancing ordinary medical negligence claims that "overlap" with the statutory duties of the Act. Appellants' Brief, pp. 15-17. This view, of course, would render the Act's immunity provision meaningless. Appellants are arguing that liability should be imposed on Respondents for failing to involuntarily detain Ryan Miller pursuant to the provisions of chapter 253B. While it may be true that physicians

can have duties beyond the scope of the Act, this is a case where the issues addressed by the trial court were wholly within the scope of the Act.

The Act represents the legislature's comprehensive attempt to define the rights and duties of all the players in the commitment process. It leaves no room for a separate common law of commitments. Instead, the process is to be governed by the terms of the legislature's comprehensive enactment. Nothing about the Act necessarily springs from the font of the common law: neither the numerous different time limits imposed; the types of proceedings; the detailed rules related to commitment standards; the categorization of different types of mentally ill persons; or the hundreds of other unique provisions contained in the Act.

Appellants' argument on this point is fundamentally wrong. There are no independent, occult legal requirements relating to making decisions about holding those with mental illness. The manner in which these decisions are made must be done pursuant to the Act, not according to some hidden body of common law. Accordingly, what Appellants really ask is that this Court find that issues related to the admission, observation, and evaluation of patients under the Act are immunized to the extent that a party points to the Act as a basis for liability, but that they are not immunized to the extent that they are performed by physicians with a duty to follow the Act. To read the Act's immunity provision in this manner would render it meaningless, because whenever a physician or provider attempted to invoke it, the plaintiff would just claim that their lawsuit

was based on a duty to follow the Act's provisions. The result that Appellants advocate would render the immunity provision meaningless and ineffective, something that the legislature never intends. See Minn. Stat. 645.17 (2008) (stating that the legislature does not intend absurd results, intends all of its enactments to have meaning, and intends to serve the public interest over the private).

The argument that there is some co-extensive common law duty relating to the detention and commitment of persons who are mentally ill is to no avail. The Act's immunity expressly applies to any action taken pursuant to chapter 253B and there is no other governing basis for liability with respect to decisions related to the determination of whether or not a person with mental illness should be held or released.

**V. THERE IS NO BASIS FOR REVERSING THE TRIAL COURT BASED ON A CLAIM THAT THE RESPONDENTS ACTED IN BAD FAITH.**

Amicus curiae Minnesota Association for Justice, though not Appellants, argues that the trial court should also be reversed on the issues that have been appealed because the Act's immunity provision does not apply in cases involving bad faith. Brief of Amicus Curiae Minnesota Association for Justice, p. 9. This assertion should be rejected for several reasons. First, Appellants never raise the issue of "good faith" in their statement of issues. Appellants' Brief, p. 1-2. Appellants also never raise the issue of "good faith" in the argument section of their brief. Appellants' Brief, p. 13-26. Finally, a party advancing a claim of lack of

good faith must come forward with at least some evidence supporting the claim and there is simply no basis for concluding that Respondents acted in bad faith. The absence of evidence supporting such a claim requires that it be rejected.

Mjolsness v. Riley, 524 N.W.2d 528, 531 (Minn. Ct. App. 1994).

**VI. THE STATUTE LIMITING THE LIABILITY OF THOSE PARTICIPATING IN THE EVALUATION AND DETENTION OF MENTALLY ILL PERSONS DOES NOT VIOLATE THE MINNESOTA CONSTITUTION.**

Appellants also contend that the trial court's ruling runs afoul of the "certain remedy" clause of the Minnesota Constitution, article 1, section 8. This provision provides:

Every person is entitled to a certain remedy in the laws for all injuries or wrongs which he may receive to his person, property or character, and to obtain justice freely and without purchase, completely and without denial, promptly and without delay, conformable to the laws.

Minn. Const. art. 1, § 8. Early cases interpreted the case broadly, but later decisions read the clause more narrowly. Schweich v. Ziegler, Inc., 463 N.W.2d 722 (Minn. 1990). Contemporary decisions of the Minnesota Supreme Court uphold the abolition of common-law rights when the rights are replaced by a reasonable substitute or where the legislature pursues a permissible legislative objective. Id.

The Act's statutory immunity passes muster under the "certain remedy" clause because it was enacted in furtherance of a legitimate governmental objective: assuring that those involved in the process of admitting, evaluating,

and committing mental health patients will not be subject to liability and have their judgment chilled or affected by the specter of liability. In this respect the immunity accorded by Minn. Stat. § 253B.23, subd. 4 is no different than numerous other statutes that limit civil liability. See Schweich, 463 N.W.2d at 734 (holding statute limiting recovery of intangible losses does not violate the “certain remedy” clause); Snyder v. City of Minneapolis, 441 N.W.2d 781, 788 (Minn. 1989) (holding statutory caps on government liability constitutional because they were related to a legitimate legislative goal); Schmidt v. Modern Metals Foundry, Inc., 424 N.W.2d 538, 541-42 (Minn. 1988) (upholding amendments to workers’ compensation statutes); Allen v. Pioneer-Press Co., 41 N.W. 117, 123 (Minn. 1889) (upholding statute eliminating general damages recovery where newspaper printed retraction). A statute limiting recovery passes constitutional muster as long as the legislature has a legitimate public purpose in mind when enacting it. The immunity provision’s obvious purpose is to allow professionals to act freely with respect to the admittance, evaluation and commitment of patients without being dogged by the fear of civil liability. This is a proper purpose and defeats Appellants’ argument based on the “certain remedy” clause of the Minnesota Constitution.

### **CONCLUSION**

The trial court’s well-reasoned decision affording Respondents the protection of Minn. Stat. § 253B.23, subd. 4 should not be disturbed. The Court should affirm the decision in all respects.

QUINLIVAN & HUGHES, P.A.

Dated: 12-2-08

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