individual committed to the commissioner's custody, placement must be in the "least restrictive environment consistent with the respondent's need for custody, care and habilitation for an indefinite or a limited period." However, when states are forced to make such determinations, to what extent is the focus on care and habilitation versus custody and detention? For how long should Mr. A. be committed? The Commissioner of DAIL presumably faced several challenging decisions regarding the level of restriction to place on Mr. A. These decisions are complex and involve weighing the interests of society (i.e., public safety) against the interests of the defendant (i.e., treatment and rehabilitation). This case highlights the complexity of determining dispositions for defendants who are not easily restored to competence or are deemed unrestorable, especially when politically charged crimes are involved. It underscores the need for better research in predicting restorability and identifying how best to approach the care and custody of such individuals (Parker GF: The quandary of unrestorability. *J Am Acad Psychiatry Law* 40:141–6, 2012).

Disclosures of financial or other potential conflicts of interest: None.

Missouri Supreme Court Reverses Judgment on a Wrongful-Death Claim Following a Suicide

Dor Marie Arroyo-Carrero, MD
Fellow in Forensic Psychiatry

Charles Dike, MD, MPH, MRCPsych
Assistant Professor of Psychiatry

Law and Psychiatry Division
Yale University School of Medicine
New Haven, CT

Plaintiff's Suicide in a Personal Injury Case: Controversy Surrounding the Causation and Implications of Suicide

In *Kivland v. Columbia Orthopaedic Group*, 331 S.W.3d 299 (Mo. 2011), the Missouri Supreme Court clarified the role of suicide in a claim of wrongful death from alleged medical negligence. Specifically, the court set out to answer the question of whether voluntary suicide is considered a new and independent intervening act that breaks the causal connection between the alleged act of medical negligence and the death.

Facts of the Case

In January 2005, Gerald Kivland underwent surgery to correct a spinal curvature. Dr. Robert Gaines performed the operation. Afterward, Mr. Kivland was paralyzed from the waist down and experienced constant pain in the affected anatomic area.

He received increasingly powerful painkillers, without relief. Ultimately, a combination of a surgically implanted morphine pump, an antidepressant, and two antianxiety medications also proved ineffective at controlling his pain. In July 2005, Mr. Kivland filed a suit for medical negligence against Dr. Gaines and his employer, Columbia Orthopaedic Group, seeking damages for injury, disability, and suffering. His wife, Jana Kivland, sued for damages due to loss of consortium. Eight months after filing the medical negligence suit, Mr. Kivland committed suicide with a gun.

After his suicide, the lawsuit was amended by adding a wrongful-death claim on behalf of Ms. Kivland and Kristin Bold, Mr. Kivland's daughter. If the wrongful-death claim were deemed not viable, the Kivlands would proceed with the claims of medical negligence and loss of consortium.

The plaintiffs' expert witness, Dr. Michael Jarvis, chief medical director of inpatient psychiatry at Barnes-Jewish Hospital in St. Louis, testified at deposition that Mr. Kivland's suicide was a direct result of the pain from the surgery, that it was not based on a rational choice, and that it therefore was not voluntary.

The trial court granted Dr. Gaines' motion to strike Dr. Jarvis as an expert witness and ruled that the expert would be precluded from testifying at trial as to the cause of Mr. Kivland's suicide. The trial court observed that Dr. Jarvis' opinions were "personal, and not expert, opinions" (*Kivland*, p 312), because Dr. Jarvis did not offer any diagnosis that explained Mr. Kivland's behavior or described his becoming "insane and bereft of reason" (*Kivland*, p 307), which would have consequently caused his suicide to be involuntary. According to the court, the lack of medical diagnosis meant that there was no basis, "factually or scientifically," for Dr. Jarvis' opinions. The court noted that "for Dr. Jarvis to be qualified as an expert, he needed to rely on facts and data that were reasonably relied on by experts in the field

and the facts and data needed to be otherwise reasonably reliable" (*Kivland*, p 312).

The trial court subsequently granted Dr. Gaines' motion for partial summary judgment on the wrongful-death claim and designated it as final for the purposes of appeal. Ms. Kivland and Ms. Bold appealed the ruling, but the Missouri Appeals Court affirmed the trial court's judgment. The plaintiffs then appealed to the Missouri Supreme Court.

Ruling and Reasoning

The Missouri Supreme Court reversed the trial court's partial summary judgment on the wrongful-death claim and the admissibility of the plaintiffs' expert witness and remanded the case to the trial court. The supreme court addressed an important question: whether the act of suicide makes irrelevant a wrongful-death claim in medical negligence cases.

The court began by reviewing decisions that showed how it had viewed suicide in personal injury cases. It observed that the decision of the trial court had mirrored the supreme court's ruling in *Wallace v. Bounds*, 369 S.W.2d 138 (Mo. 1963). The plaintiffs had to show that the decedent's suicide was the direct and proximate result of injuries caused by the defendant's negligence. As noted earlier, for the claim to be successful, the injury must have caused the decedent to become "insane and bereft of reason," such that his suicidal act was "involuntary" or due to an "irresistible impulse." If, on the other hand, the injury produced "mental torture" but the suicidal act is deemed "voluntary," such an act is not compensable. The court revisited subsequent cases that referenced *Wallace* when determining if a negligent defendant can be held liable for a decedent's suicide and found that no clear standard had yet been established for resolving this question.

The court then proceeded to discuss the implications of its rulings in the light of recent contrary opinions in other courts, as well as recent findings in the scientific literature. It cited the comments made *in dictum* in *Fuller v. Preis*, 322 N.E.2d 263 (N.Y. 1974): "[R]ecovery for negligence leading to the victim's death by suicide should perhaps, in some circumstances, be had even absent proof of a specific mental disease or even an irresistible impulse provided there is significant causal connection between the injury and the suicide" (*Kivland*, p 308). The court observed that the recent trend in other courts was to place less emphasis on the mental state of the decedent who committed suicide and more on the causal connections between the injury and the suicide. In addition, the court noted that "modern psychiatry supports the idea that suicide is sometimes a foreseeable result of traumatic injuries" (*Kivland*, p 308). It quoted literature that shows suicide to be more common in trauma patients than in the general population, and in fact, for spinal cord injuries, suicide is two to six times more prevalent than in the general population (Charlifue SW, Gerhart MS: Behavioral and demographic predictors. . . . *Arch Phys Med Rehab* 72:488–92, 1991).

The court subsequently concluded that requiring the plaintiffs to show that the decedent was insane or acting as a result of irresistible impulse at the time of the suicide would be problematic. It concluded that the best course would be to allow the jury to determine the causal connection between the suicide and the defendant's negligence.

The court also addressed the trial court's decision to strike Dr. Jarvis as an expert witness, essentially because Dr. Jarvis presented an expert opinion without a psychiatric diagnosis; in the trial court's view, this was tantamount to presenting a personal (rather than an expert) opinion, admission of which would be an abuse of discretion. The supreme court disagreed, citing the Missouri statute concerning expert witnesses, which requires experts to be qualified, to provide testimony that will assist the trier of fact and that is based on facts or data that are "reasonably relied on by experts in the field," and to demonstrate that the facts or data on which the expert predicated his opinion are "otherwise reasonably reliable" (Mo. Rev. Stat. § 490.065 (2009)). The court opined that Dr. Jarvis, a board-certified psychiatrist, had experience in diagnosing and treating patients similar to Mr. Kivland and was qualified to render testimony that would meet the standards for admissibility of expert witness testimony. It further opined that it is the duty of the jury, not the court, to evaluate the strengths and weaknesses of the expert's testimony. Therefore, the presence or absence of a diagnosis in Dr. Jarvis' testimony was a matter for the jury, not for the court.

Discussion

This case highlights an important point that most experienced psychiatrists have struggled with in their practice—namely, that abnormal behavior does not necessarily have to fit neatly under a category in the

Diagnostic and Statistical Manual of Mental Diseases (DSM) for it to be problematic or to warrant treatment. Although Gerald Kivland did not have a DSM diagnosis of note, he was in marked mental and physical anguish associated with hopelessness, resulting from (or worsened by) his surgery, which ultimately caused him to commit suicide. To suggest that there is no connection between Mr. Kivland's suicide and the life-changing consequences of his surgery just because there was no diagnosable mental illness responsible for his suicide is unfortunate. It is heartening, however, that the Missouri Supreme Court opened the door for expert witness testimony in cases (hopefully rare), for which there is no clear DSM diagnosis, despite obvious severe psychological distress.

In this case, we encounter the vexing question of what factors ultimately cause an individual to commit suicide. Suicide has traditionally been considered (nearly always) a consequence of mental illness. However, the scientific literature has identified other suicide risk factors, including demographic data and medical conditions. For example, in the *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors* (American Psychiatric Publishing, 2003), physical illness is a risk factor for future suicidal behavior. Likewise, recent literature shows that physical illness is a significant risk factor for suicide, independent of psychiatric diagnosis. An important point is that, even with identified risk factors, can we say with confidence what ultimately causes an individual to commit suicide?

The court also highlighted the importance of the jury in inconclusive situations "when the legal rules have been exhausted and have yielded no answer" (Scalia A: The rule of law. . . . *U Chi L Rev* 56:1175–81, 1989). In such cases, the jury should use their life experiences to arrive at an answer. In a case involving suicide, it is difficult to determine what life experiences the jury would use to make a final decision.

Disclosures of financial or other potential conflicts of interest: None.

Sexually Violent Predators Have a Right to Competent Counsel

David D. Vachon, MS
Predoctoral Psychology Fellow in Forensic Psychiatry

Reena Kapoor, MD
Assistant Professor of Psychiatry

Law and Psychiatry Division
Department of Psychiatry
Yale University School of Medicine
New Haven, CT

Inaction of Court-Appointed Counsel Is a Due Process Violation

In *In re Ontiberos*, 287 P.3d 855 (Kan. 2012), the Supreme Court of Kansas reviewed the case of Robert Ontiberos, who appealed his commitment under the Kansas Sexually Violent Predator Act (KSVPA). The court considered whether individuals facing sexually violent predator (SVP) commitment proceedings have a right to effective and competent representation by counsel, whether the KSVPA provides an adequate mechanism to contest the competence of counsel, and whether prosecutorial misconduct and the incompetence of Mr. Ontiberos' counsel resulted in an unfair trial.

Facts of the Case

In 1983, Mr. Ontiberos was convicted of the attempted rape of a casual acquaintance, and in 2001, he was convicted of the aggravated sexual battery of his mother-in-law. He received sex offender treatment in prison after both of these offenses. In 2007, just before his scheduled release on parole, the state filed a petition for civil commitment for treatment under the Kansas Sexually Violent Predator Act (KSVPA) (Kan. Stat. Ann. § 59-29a01 (2007)).

At the civil commitment trial, a jury heard evidence from two experts: Dr. Deborah McCoy for the state and Dr. Robert Barnett for the defense. Dr. McCoy was a clinical psychologist who evaluated Mr. Ontiberos by reviewing his prison records and prior psychological evaluations, conducting a personal interview, and administering two actuarial risk assessments: the Static-99 and the MnSOST. Dr. McCoy diagnosed Mr. Ontiberos with "paraphilia not otherwise specified, with themes of exhibitionism and non-consent" (*Ontiberos*, p 859), as well as a personality disorder not otherwise specified and polysubstance dependence. Dr. McCoy testified that, based in part on his Static-99 result, Mr. Ontiberos had a high risk of recidivism and could be deemed an SVP. In contrast, Dr. Barnett, also a clinical psychologist, stated that Mr. Ontiberos was at high risk only when intoxicated. He based this con-