torney" (*Plante*, p 893). It agreed with the trial court that the "lack of diligence in selecting an appropriate person or persons to review the case for malpractice can only be characterized as blatant and egregious conduct which was never intended to be condoned and sanctioned" (*Plante*, p 899). It ruled that since the disregard for selecting an appropriate expert was an egregious error, the statute of limitations on bringing suit still applies. This case was decided in 2011, more than four years after the cases were initiated.

*Discussion*

This Connecticut Supreme Court ruling illustrates legal and legislative attempts to balance the protection of meritorious claims of malpractice with procedural requirements established to inhibit frivolous law suits. In medicine, the specter of malpractice claims is the source of professional stress, prohibitive insurance costs, and the shrinking number of physicians in certain specialties. The requirements of a good-faith investigation and certificate of the negligence claim and an opinion letter from a similar health care provider were part of the Connecticut legislature's efforts to achieve the goal of inhibiting nonmeritorious malpractice actions. However, as demonstrated in this case, the praxis of this attempted balancing can still raise convoluted legal claims, requiring expensive and time-consuming efforts at resolution.

The facts surrounding the admission, discharge, and death of Ms. Plante are not available; the case is still open on further appeal on different claims. The merits of the case have thus not yet been determined.

What caused the case to fail was the preparation and support for the plaintiffs' claim. The choice of expert dramatically weakened whatever case there was. A forensic psychiatrist with expertise in suicide assessment and standards of care would have met criteria for a similar health care provider on either side of this case, but the role of the forensic psychiatrist goes beyond serving as an expert. Forensic psychiatrists familiar with reading statutes and understanding their application can serve as consultants for attorneys in matters related to experts in malpractice (regardless of medical specialty). Even more important, forensic psychiatrists can consult with other medical experts who are involved in such cases.

Finally, as malpractice tort reform continues, there will be increasing opportunities for forensic psychiatrists to consult with legislatures around the complex questions involved on both sides in these cases.

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# Too Dangerous to Be NGRI?

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## Future Risk of Violence and Lack of Confidence in the State's Mental Health System Should Not Be Bases for Rejecting an Insanity Defense

In *Galloway v. State*, 938 N.E.2d 699 (Ind. 2010) (hereafter *Galloway*), the Indiana Supreme Court reviewed the trial court's verdict of guilty but mentally ill despite the unanimous opinion of experts who testified that the defendant met the *Indiana* criteria for the insanity defense for the murder of his grandmother. The opinion was rendered on the basis of demeanor evidence and on the grounds that Mr. Galloway was too dangerous and that the state's mental health system would not be able to provide the necessary supervision and treatment.

*Facts of the Case*

Mr. Galloway had a well-documented history of bipolar disorder since 1989, with accompanying problems of medication noncompliance and substance abuse. He had been voluntarily or involuntarily detained or committed for treatment more than 15 times for psychotic and manic symptoms, particularly after 2001, when the episodes became more frequent. In the year before the crime, he had had at least 12 contacts with the mental health system, including psychiatric admissions where he was released, each time, within a few days.

In the days before the murder, Mr. Galloway was troubled by hallucinations and delusional thoughts. The night preceding the murder, he did not sleep and drank a pint of whiskey. By the morning of the murder, October 26, 2007, he reported feeling strange. His father was concerned that he was not acting normal. Mr. Galloway later told the police that he believed his father was sending coded messages telling him to kill his grandmother.

That morning, he went shopping and had lunch with his grandmother and his aunt without any apparent unusual occurrences, even though he was experiencing thoughts that his grandmother was the

devil and that she was out to get him. They returned to his grandmother's home, where Mr. Galloway lived. He believed "he needed to kill her to restore his powers" (*Galloway*, p 705). Later, believing that he was acting on his father's telepathic communications and that he needed to kill his grandmother in order to restore his powers, he suddenly ran into the living room and stabbed his grandmother in the chest in the presence of his father, son, and aunt. As he stabbed her, he yelled, "You're going to die . . . you're the devil," and said to his father, "[S]he was going to kill me" (*Galloway*, p 706). When he realized that he did not feel better as he thought he would, he expressed remorse, and told his grandmother that he loved her and had not meant to do it.

Mr. Galloway's bench trial for murder was held in October 2008. Three experts testified that he had a mental illness, with paranoid delusions. Dr. George Parker (a psychiatrist for the defense) and Dr. Philip Coons (a court-appointed psychiatrist) both testified that Mr. Galloway was, at the time of the murder, legally insane. Dr. Glenn Davidson, (a court-appointed psychologist) submitted a preliminary opinion that Mr. Galloway was not legally insane at the time of the murder. During cross-examination, in the light of additional facts of which he was unaware when he submitted his preliminary opinion, Dr. Davidson recanted his finding, ultimately testifying that he could not render an opinion.

On May 4, 2009, the judge found Mr. Galloway guilty but mentally ill (GBMI) for the murder of his grandmother and sentenced him to 50 years in prison. The court rejected the testimony of the experts and instead relied on demeanor evidence, noting that he had behaved appropriately with his grandmother while out shopping, made no attempt to conceal the killing, and was deemed competent during the trial. The insanity defense testimony was rejected despite the court's acknowledging that there was "absolutely no evidence that this mental illness is [feigned], or malingered, or not accurate and there is no dispute as to that " (*Galloway*, p 707). Given its concerns about Mr. Galloway's history of lack of compliance with medication, the court regretted that it could not order his commitment for life to a mental health facility, decrying the fact that he had been repeatedly released from hospitals and implying that a lack of funds for mental health care in the state was the root of the problem. The trial court admitted, during sentencing, that the case was as much "a trial of our mental health system as it is of a man" (*Galloway*, p 707). The decision was affirmed by the Indiana Court of Appeals' holding (in *Galloway v. State*, 920 N.E.2d 711 (Ind. Ct. App. 2010), which cited *Thompson v. State*, 804 N.E. 1146 (Ind. 2004)), that if there was "any evidence whatsoever supporting the verdict," the conviction by the trial court should be affirmed.

### *Ruling and Reasoning*

On December 22, 2010, the Supreme Court of Indiana reversed the conviction. It determined that the facts that Mr. Galloway shopped, ate lunch, and pumped gasoline without difficulty; cooperated with the police; had no motive for murder; was alert and oriented during the two-day trial; and became incompetent during the trial proceedings (which were delayed while he was committed to the state hospital for treatment) were not probative of his sanity at the time of the offense, as the trial court had ruled. In addition, the supreme court observed that the expert testimony, that Mr. Galloway was insane at the time of the offense, was without conflict and that the family members' eye witness testimony was more probative of his insanity than demeanor evidence of his behavior before and after the event or during the trial (which occurred almost a year later).

The supreme court further held that the trial court's concern about the limitations of the state's mental health system and Mr. Galloway's need for structure and constant supervision was "not relevant or appropriate in determining whether the defendant was legally insane at the time of the offense" (*Galloway*, p 718).

### *Dissent*

Chief Justice Shepard dissented and was joined by Justice Dickson in pointing out that Mr. Galloway's normal appearance before and after the offense and his immediate regret minutes after suggested that he knew at the time that killing his grandmother was wrong. They expressed distrust in the civil commitment process, since from past experience this could lead "sooner or later" to Mr. Galloway's being back in society. Asserting their opinion, they stated that setting aside the GBMI verdict could place at risk "some innocent future victim" (*Galloway*, p 719).

### *Discussion*

The first GBMI statute was enacted in Michigan, in 1975 in response to *People v. McQuillan*, 221

N.W.2d 569 (Mich. 1974), which resulted in the release of insanity acquittees who did not meet civil commitment criteria. Of the 214 acquittees released, two went on to commit outrageous crimes (Sloat LM, Frierson RL: Juror knowledge and attitudes. . . . *J Am Acad Psychiatry Law* 33:208–13, June 2005). According to the Michigan statute, a defendant could be found GBMI if the trier of fact finds that the person was guilty of the offense, was mentally ill at the time of crime, but failed to meet the jurisdiction's insanity standards. Indiana was the second state to adopt the GBMI verdict, in 1981, in response to the insanity verdict in the murder trial of Leonard Smith, who had killed Lyman Bostock, a star outfielder for the California Angels [Parker G, defense psychiatrist, personal communication, January 2013]. The public outcry following the *Hinckley* acquittal in 1982 led to an accelerated adoption of the GBMI statute by 14 more states (Sloat and Frierson, *ibid*.)

In Indiana, the statute related to the insanity defense (Ind. Code Ann. § 35-36-2-3 (LexisNexis 2007)) mandates that four verdicts—guilty, not guilty, NGRI, and GBMI—be considered whenever the defense is interposed. This requirement has raised concerns amid forensic experts, defense attorneys, and mental health advocates, as the option of GBMI undercuts the insanity defense, particularly where juries may be unclear about the nuanced difference between the two (Uliana S, attorney for Mr. Galloway, personal communication, August 2012).

Unlike the NGRI, the GBMI defense is not an affirmative one. The defendants remain responsible for their actions and Indiana statute mandates a defendant found GBMI must be sentenced as if he were found guilty. There is no provision in Indiana statute or in Indiana DOC procedures for any special treatment of a defendant found GBMI. Perhaps because of the availability of the GBMI verdict, NGRI verdicts are rare in Indiana; there were 14 from 2009–2012 [Parker G, personal communication, January 2013].

In Indiana, once a defendant is found NGRI, the prosecutor files a petition for civil commitment. Following a finding of mental illness and either dangerousness or grave disability (Ind. Code § 12-26-7 and Ind. Code § 12-26-6 (LexisNexis 2007), respectively), the person is confined to a state psychiatric facility, at which point the criminal court forfeits its authority over the defendant. For individuals found NGRI, under Indiana's annual civil commitment review statute (Ind. Code § 12-26-15-1 (LexisNexis 2007)), the hospital is required to file a report to the court regarding the individual's care and treatment, mental condition, and level of dangerousness. There is also a provision that the prosecutor and "other designated parties" be informed, at least every six months, of the individual's clinical status or of any privileges gained, transfers, or releases. This notification does not give the prosecutor or others legal standing regarding the civil commitment, and the decision to discharge an NGRI acquittee is at the discretion of the individual's treatment team, in conjunction with the local community mental health center, as Indiana does not have conditional release for insanity acquittees [Parker G, personal communication, January 2013].

The growing popularity of GBMI verdicts may reflect a culture that requires that those who commit offenses always be held responsible for their actions, even those who were mentally ill at the time of the offense. This attitude was voiced in the dissent, which considered whether certain kinds of violent conduct have the potential to threaten the very moral foundations of society, such that a punitive response must remain available to restore public confidence and safety.

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