Discussion

Although this case establishes a right to competent counsel in SVP commitment hearings, a more interesting aspect to forensic mental health professionals is the court's handling of discrepant risk assessment results and the expectation that counsel will competently interpret this divergence. In this case, for example, the court held that counsel was incompetent for failing to introduce discrepant Static-99 results: a 2006 assessment yielding a 9 percent chance of reconviction in 16 years, and a 2007 assessment yielding a 52 percent chance in 15 years. This difference is obviously sufficiently large to undermine the reliability of the Static-99 and justify the court's finding of incompetence. However, there are several factors that affect the reliability of test results, and it is important to consider their role when evaluating whether the attorney should have brought the problem to the court's attention.

Any two measures yield less consistent results as the method and measurement differences between them grow. The same examiner administering the same measure to the same examinee on the same day will, practice effects aside, get two different results because of the eccentricities of administration, the mental state of the examinee, and random factors. This difference between scores will be larger with greater time between administrations, different examiners, different measures (e.g., two different actuarial measures), and different methods (e.g., actuarial versus physiological). If it is reasonable to get different results between two identical administrations on the same day because of the standard error of measurement, then it is also reasonable to get larger divergences over longer periods and with different raters and methods.

Although, by any standard, a 43 percent difference in Static-99 risk results that were obtained one year apart is probably too large to be ignored by competent counsel, one might ask whether counsel would still be incompetent for not arguing that a smaller difference—say, 30 or 20 percent—undermines the reliability of the measure. In other words, is there a threshold difference between risk results that can be used to evaluate the competence of counsel's use of those results? When is the difference between test results sufficient that the attorney is obligated to highlight it, perhaps at the expense of other trial strategies?

Realistically, most attorneys know very little about psychological testing or actuarial instruments, and they rely on experts to guide them in this area. As this case illustrates, detailed knowledge of risk assessment tools—their indications, proper administration, and limitations—is an essential part of forensic psychological and psychiatric practice. Courts routinely ask experts to explain discrepant results, and counsel can be held accountable for not bringing these results to the attention of the fact finder. Lack of preparation or familiarity with the tools, by either the attorney or the expert, is unacceptable.

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Tort Reform Legislation: Connecticut Supreme Court Clarifies Standard for Negligence Action Against a Health Care Provider

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In a Case of First Impression, the Connecticut Supreme Court Held That, When a Medical Malpractice Action Has Been Dismissed for Failure to Meet a Statutory Suit Requirement, a Plaintiff May Bring an Otherwise Time-barred New Action Only if the Failure Was Caused by a Simple Mistake or Omission, Rather Than Egregious Conduct or Gross Negligence

In *Plante v. Charlotte Hungerford Hospital* 12 A.3d 885 (Conn. 2011), the Connecticut Supreme Court affirmed the dismissal of a medical malpractice complaint because of failure to attach a letter of opinion by a similar health care provider.

Facts of the Case

The estate of Joanne Plante sued a psychiatrist and clinical social worker employed by Charlotte Hungerford Hospital and two emergency room physicians practicing at the hospital on the grounds that Ms. Plan-

te's suicide, after discharge from the emergency room, was the result of professional malpractice. The suit claimed that she was experiencing a severe mental health crisis and had been discharged prematurely.

The plaintiffs filed two medical malpractice actions: one against the hospital, naming the psychiatrist and the social worker as hospital defendants, and the second against the two emergency room physicians. The hospital defendants entered a motion for dismissal, claiming that the plaintiffs had failed to attach to the complaint an opinion letter from a similar health care provider, as required by Connecticut statute, to show a good-faith belief that there are grounds for a negligence claim. The plaintiffs objected, arguing that the omission of the letter was a simple error and occurred because the letter had been inadvertently left out of the paperwork at filing. They attached a letter from a registered nurse along with a good-faith certificate with their motion. The date of the letter, however, was after that of the initial filing. The court granted the defendants' motion to dismiss but did not provide an oral or written explanation of its reasoning.

The plaintiffs then amended their complaint in the second suit against the emergency room physicians to include the required good-faith certificate and opinion letter from a health care provider. On the letter, the name of the provider and the qualifications were redacted. The plaintiffs also included an affidavit from the nurse, who cited computer error for the incorrect date. The defendants in that case moved to dismiss on the grounds that a letter from a similar provider had not been submitted. The court denied the motion.

The plaintiffs moved to reopen the case against the hospital defendants on the grounds that their case had been dismissed without opinion. They also attached a certificate of good faith and a letter from a board-certified psychiatrist. The defendants moved to dismiss based on the statute of limitations for filing malpractice claims. The court denied the motion to dismiss, but granted the defendants' motion to hear separately their challenge that the plaintiffs' case did not meet criteria for "accidental failure of suit" (*Plante*, p 889) that would save the suit despite the statute of limitations. The court also allowed the defendants to depose the plaintiffs' attorney and compel him to testify.

The supreme court held that, after the court trial, the plaintiffs had failed to meet their obligation of demonstrating a good-faith claim that there had been a breach of the standard of care, because they had failed to provide an opinion letter from a similar health care provider, defined as a practitioner who has the same license and training and experience in the same discipline as the defendant in a case. Under the statute, an acceptable expert should have sufficient training, experience, and knowledge as a result of practice or teaching in a related field of medicine, be certified by the appropriate American board as being a specialist, be licensed by the appropriate regulatory agency, or be trained and experienced in the same discipline or school of practice within the five-year period before the incident giving rise to the claim. The court held that the plaintiffs' letter from a nurse who was retired from practice and who had never worked in an emergency room did not come close to meeting the definition of a similar health care provider for either the psychiatrist or the social worker involved in the case against the hospital. After the court ruled in favor of the hospital defendants, the defendants in the second case (the emergency room physicians) moved to dismiss the claim against them on the grounds that the plaintiffs' opinion letter had not come from a similar health care provider. The court ruled in favor of the emergency room doctors.

The plaintiffs appealed to the Connecticut Supreme Court, offering the argument that the court that dismissed the suits had erred in its analysis when it ruled on the basis of an inadequate opinion letter, which was a "curable defect" (*Plante*, p 892). They further argued that a court's reasons for dismissal are relevant only when there is a lack of due diligence during the trial phase and not in response to deficiencies in a prelitigation investigation. The plaintiffs argued that the cases could be reopened under the accidental-failure-of-suit statute.

Ruling and Reasoning

The Connecticut Supreme Court affirmed the trial court's dismissals of the cases and held that an executor or administrator cannot commence a new action because of the time-barred action and that the plaintiffs did not merit relief because they had not met criteria for a "good-faith mistake, inadvertence or excusable neglect" (*Plante*, p 895) that might have preserved their ability to bring the suit beyond the time barrier. The court noted that the statute was designed to protect the "diligent suitor" (*Plante*, p 892). It held that the law was not intended to offer relief to "egregious conduct or gross negligence attributable to the plaintiff or the at-

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