ity to make some rational decisions. For all these reasons, the court found that it was possible for the fact finder to assign less probative value to expert testimony.

Finally, the state supreme court acknowledged that the lack of a well-documented history of mental illness throughout Ms. Barcroft's life did not provide much support for her insanity defense. Her medical records never formally included a diagnosis of a psychotic disorder, although there was mention of "questionable schizophrenia." Although this does not preclude an individual from successfully being found legally insane, "the lack of such history is a circumstance that a fact finder may consider in evaluating an insanity defense" (*Barcroft*, p 1008, quoting *Lawson v. State*, 966 N.E.2d 1273 (Ind. Ct. App. 2012), p 1282).

### Discussion

This case raises a fundamental question regarding the use of the insanity defense, namely the ownership of both the definition and assignment of insanity. Insanity is not a formal psychiatric diagnosis but a legal construct that varies from state to state and can evolve with societal standards. This case invites a discussion about how society has attempted to define insanity, struggling to find a balance between emerging data and long used legal and mental health definitions. As highlighted in *Galloway*, "insanity is not limited to the stereotypical view of a 'raging lunatic' . . . a person experiencing a psychotic delusion may appear normal to passersby" (*Galloway*, p 713–14).

Mental health professionals are consulted to provide expert opinions, not to answer the ultimate legal question. The legal system depends on mental health experts to provide expertise about how a defendant's behavior, history, and psychiatric diagnoses are relevant to a defendant's state of mind. As a result, insanity defenses in which there is consensus of expert opinion generally are not controversial. This case is an exception. Despite the fact that the mental health experts took into consideration Ms. Barcroft's demeanor at the time of the crime and agreed on her state of mind, the Indiana Supreme Court upheld the trial judge's own interpretation of the evidence in determining Ms. Barcroft's sanity.

When weighing evidence and assessing complex legal questions about an individual's ability to appreciate wrongfulness, it is essential for the courts to have an accurate understanding of mental illness. "Thus, as a general rule, demeanor evidence must be considered as a whole, in relation to all the other evidence. To allow otherwise would give carte blanche to the trier of fact and make appellate review virtually impossible" (*Galloway*, p 714).

To best assist the courts, mental health experts need to fulfill their role as educators in the criminal justice system. Experts can "provid[e] factual information to help jury members grasp the reality, the gravity, and the behavioral implications of mental illness" even if "it often goes against the grain of many people to appreciate and acknowledge the unpredictability that can be caused by severe mental illness" (Targum SD and Ebert R: Educating the public through the courtroom: efforts of a forensic psychologist. Innov Clin Neurosci 9:48–50, 2012, p 49). As educators, in and out of the courtroom, forensic experts can illuminate the intricacies of psychiatric illness and can counter antiquated conceptions of insanity.

# Procedural Challenge in Competency to Stand Trial Proceedings

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## A Procedural Challenge Related to Competency Proceedings Cannot Be Raised if a Substantive Claim Is Not Also Raised

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In *State v. Roberts*, 435 P.3d 1149 (Kan. 2019), the Kansas Supreme Court determined that a procedural claim regarding competency to stand trial could not be brought forth when the defendant did not have a substantive competency claim (i.e., if the defendant was not incompetent). *Roberts* raises additional questions for mental health professionals to consider, including the level of competency needed to advance a substantive claim and the difficulties

with reporting nuanced findings in assessment reports.

### Facts of the Case

Leslie Hugh Roberts, Jr., was charged with 15 counts of rape and 15 counts of aggravated criminal sodomy when he was 26 and 27 years old against a child, who was aged 12 and 13. During his initial trial in 2010, Mr. Roberts' attorney expressed concerns about his competency, which was then evaluated by a psychologist. The psychologist recommended that Mr. Roberts be found competent to stand trial. He reported that Mr. Roberts understood the charges against him and could assist his attorney in his defense. The psychologist's report also noted that Mr. Roberts could not read and had low to borderline cognitive abilities. The psychologist suggested that the "court should take into consideration some 'special concerns' to maintain Roberts' competency throughout the proceedings" (*Roberts*, p 1150). The court acknowledged the recommendations of the competency evaluation in open court before proceeding to schedule a preliminary hearing. Mr. Roberts entered a no-contest plea and ultimately waived his right to a preliminary hearing.

Kan. Stat. Ann. § 22-3302 (2012) states that a competency hearing should be held if the judge or either party questions the defendant's competency to stand trial. In Mr. Roberts' case, a competency hearing was not scheduled because further concerns about competency were not raised. At his plea hearing, Mr. Roberts' attorney acknowledged Mr. Roberts' inability to read and stated that he had gone over each line of the plea agreement with him. The judge confirmed with the attorney that Mr. Roberts understood the consequences of the plea and that the plea was freely and willingly given.

Initially, Mr. Roberts did not mount a procedural challenge that a formal competency hearing had not been held. He did, however, challenge the sentence for different reasons on two occasions. First, in *State v. Roberts*, 272 P.3d 24 (Kan. 2012), he appealed the conviction, stating that the sentence was cruel and unusual punishment because of his lack of criminal history and poor education, and that the sentence was disproportionate to the alleged harm, severity, and time course of the offense. He also claimed that the district court had abused its discretion. The original decision was affirmed because Mr. Roberts had not raised concerns about cruel and unusual punishment in district court. Additionally, the appeals court noted that the district court had considered mitigating and aggravating circumstances in its decision. Second, in a subsequent *pro se* motion, Mr. Roberts said that he had never admitted he was over 18 or that the victim was under 14 at the time of the crime. The motion was dismissed because the ages of both Mr. Roberts and his victim had been established. After these challenges failed, Mr. Roberts claimed that his procedural due process had been violated because the judge had not held a competency hearing.

### Ruling and Reasoning

The Kansas Supreme Court affirmed the judgment and found that a violation of Kan. Stat. Ann. § 22-3302 (2012) did not occur. The competency evaluation had recommended that Mr. Roberts be found competent. This was acknowledged in the exchange between the judge and Mr. Roberts' lawyer in open court. Moreover, Mr. Roberts did not contest the recommendations of the competency evaluation. He did not claim that he was convicted while incompetent (i.e., he did not advance a substantive competency claim). Additionally, the judge noted that an illegal sentence can only be corrected under specific and narrow circumstances that did not apply in the present case.

### Discussion

This case raises several points of interest to forensic mental health professionals. One point raised by the court was that Mr. Roberts advanced a procedural claim (i.e., that no formal hearing was held) and not a substantive claim related to competency to stand trial. Moreover, the determination that he did not have an adequate substantive claim was made despite a note in the report that he had low to borderline cognitive ability and could not read. This raises the question of how intellectual disability should affect the evaluation of competency to stand trial, as well the level of impairment required for a substantive claim to have been advanced. There are several examples of successful substantive competency claims. In *Anderson v. Gipson*, 902 F.3d 1126 (9th Cir. 2018), a defendant was determined to have had his due process rights violated after not having received a competency hearing because he had acted erratically during the proceedings and attempted suicide prior to

the trial. In *McGregor v. Gibson*, 248 F.3d 946 (10th Cir. 2001), the defendant's procedural due process rights were determined to have been violated because a competency hearing was not performed when the defendant did not consistently receive medication during the trial despite a history of mental illness, had an unusual demeanor, and his attorney consistently expressed concerns. Generally, successful substantive competency claims raise significant doubt that the defendant was competent during the course of legal proceedings.

*Roberts* also highlights the challenges that emerge when evaluations of competency to stand trial note a complex history or offer nuanced recommendations. Psychological and psychiatric evaluation reports often note important complexities in competency recommendations and identify elements that are needed to maintain competence or, conversely, that may destabilize and undermine competence.

Forensic mental health evaluators do not know how courts will use their observations and recommendations. Evaluators who comment on factors that affect the maintenance of competence may also have a responsibility to create a more detailed description of a defendant's mental state and abilities so that the court can make fully informed decisions. The psychologist in *Roberts* suggested that the court take into account "special concerns" to support Mr. Roberts' continued competency but did not offer specific recommendations for how to do so. Forensic mental health evaluators should be as clear as possible in the recommendations they offer in such situations.

# Claim of Professional Negligence in Absence of Explicit Physician–Patient Relationship

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## Physician–Patient Relationship Is Not a Necessary Requirement for a Claim of Professional Negligence

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In *Warren v. Dinter*, 926 N.W.2d 370 (Minn. 2019), the Supreme Court of Minnesota held that a physician–patient relationship is not a necessary element for a professional negligence claim in all cases, and a professional duty may be created when it is reasonably foreseeable that the patient may rely on, and subsequently be harmed by, advice from the physician. Therefore, a malpractice claim cannot be dismissed as having no legal merit merely because there was no defined physician–patient relationship.

### Facts of the Case

On August 8, 2014, Susan Warren presented to the Essentia Health Hibbing Clinic (Essentia), reporting recent smoke exposure and complaining of several symptoms including abdominal pain, fever, and chills. Sherry Simon, one of Essentia's nurse practitioners, examined Ms. Warren and concluded that she required inpatient hospitalization for treatment of an underlying infection. Because Essentia did not have its own inpatient hospital, it was standard practice for Essentia staff to call the only local hospital, Fairview, to present the cases for potential hospitalization.

When Ms. Simon called Fairview, she was connected to one of the hospitalists, Dr. Richard Dinter, and they discussed Ms. Warren's case by telephone for about ten minutes. Ms. Simon and Dr. Dinter dispute the specifics about their phone call. Ms. Simon stated she presented all laboratory results to Dr. Dinter, who reasoned that Ms. Warren's symptoms could be secondary to uncontrolled diabetes, and advised that Ms. Warren did not require hospitalization. In contrast, Dr. Dinter reported that Ms. Simon did not convey a complete picture of the patient and that he did not provide conclusive advice on the question of hospitalization.

After that phone call, Ms. Simon remained concerned that Ms. Warren required hospitalization and consulted with Dr. Jan Baldwin, a colleague at Essentia. Ms. Simon was specifically concerned about Ms. Warren's high white blood cell count, which she claimed Dr. Dinter had attributed to diabetes. Dr. Baldwin concurred that Ms. Warren's high cell count could be due to the diabetes. Ms. Simon then sent Ms. Warren home with diabetes medication and a follow-up appointment. After three days, Ms. Warren was found dead; on autopsy, the cause of death was identified as sepsis.