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Murder Masquerading as Suicide: Postmortem Assessment of Suicide Risk Factors at the Time of Death

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ABSTRACT: Postmortem assessments of suicide risk factors present at the time of death were used to expose a murder masquerading as a suicide. Postmortem assessment of clinically based suicide risk factors in equivocal suicide cases should readily meet prevailing evidentiary criteria of ''reasonableness.'' Assessing the presence or absence of suicide risk factors can assist in clarifying the question of suicide intent at the time of death. However, discerning the motives for suicide is usually a more difficult task. Forensic opinions should avoid conclusory statements that invade the province of the fact finder in determining criminal responsibility.

KEYWORDS: forensic science, forensic psychiatry, suicide assessment, murder or suicide, Daubert

You only die once—but did you intend it? Or did someone else intend it? Was it natural or accidental? Forensic psychiatrists are asked to assist in answering these questions, particularly to help determine for insurance purposes whether an individual's death was a suicide or accidental (1–3).

In criminal cases, forensic psychiatric expertise can be useful in distinguishing suicide from homicide as the cause of death. On August 5, 1962, Marilyn Monroe was found lying nude, face down, with a sheet pulled over her body. No suicide note was found. No disturbance was heard by her neighbors the night before her death. On the morning following her death, an autopsy was conducted by Deputy Coroner Thomas Nogushi, M.D. Five days later, the Los Angeles Coroner rendered a preliminary judgment—Marilyn Monroe had died of possible barbiturate overdose. On August 17, the judgment was amended to probable suicide. Ten days later, the coroner issued his final judgment stating that Marilyn Monroe died of acute barbiturate poisoning following an overdose. Decades later, controversy still continues over the cause of her death. Was it a suicide? Was it an accidental overdose? Or was it, as some have hinted darkly, a murder staged as a suicide?

Robert Maxwell, the billionaire publishing magnate, suddenly and inexplicably ordered the captain of his yacht to sail for Madeira and Tenerife Island, off the northwestern coast of Africa. The captain reached Grand Canary Island and sailed around it, since Maxwell had decreed no particular course. On November 4, 1991, at approximately 5 a.m., Maxwell called the bridge to complain that his room was too cold. Then, unseen by anyone, he made his way up to the deck and either fell, jumped, or was pushed to his death. His naked body was found floating in the calm waters off Grand Canary Island. Was it suicide? An accident? Murder? The answer was of critical importance. A monumental scandal concerning the disappearance of corporate assets and monies from pension funds was brewing back in England. Personal disgrace and imprisonment were a distinct possibility. The family also stood to collect $36 million from his life insurance policy.

Various theories about the cause of his death abounded, including that he suffered from multiple personality and was killed by a murderous personality that emerged under the extreme stress of events. Maxwell also had enemies who would have wanted him dead. Personal humiliation and the destruction of his self-invented, larger-than-life image that he constructed of himself could have led to suicide. However, the explanation of his death could be a lot simpler: a Spanish pathologist took note of the fact that Maxwell's stomach contained a barely digested banana and surmised that he could have slipped on a banana peel and fallen to his death.

On Tuesday, July 20, 1993, White House Counsel Vincent W. Foster, Jr. walked out of his office in the West Wing of the White House. He told his secretary to help herself to some M&M's candy left on his lunch tray. Mr. Foster then drove his car to Virginia, taking the George Washington Parkway to a scenic and secluded spot in Fort Marcy Park, and shot and killed himself. Or did he? Conspiratorial theories of murder continue to swirl around Foster's death. Congressional hearings were held. Doubt that Foster committed suicide lingers still, despite the fact that his death was ruled a suicide by a Special Prosecutor (4).

The staging of a murder as a suicide is rare. It appears less likely to occur with a celebrity, where there is fear that close scrutiny may uncover the deception. The murder of an individual that masquerades as a suicide is more likely to go undetected or remain unsolved if there is a history of mental illness.

Case History[2]

Lisa, a 34-year-old married but separated woman, was found hanging naked in her bedroom closet by her landlord. Her knees were approximately 3 in. above the floor. Lisa had not reported to work for a week. Neighbors were complaining of a foul odor emanating from Lisa's apartment. The police found no signs of a struggle in the apartment or any suicide note. Lisa had told friends and coworkers that she was taking a few days off from work to complete her taxes. Partially completed tax forms were found on her desk. Lisa did not have any financial problems.

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[2] For heuristic purposes, a number of facts from the original case have been changed (People v. Darrell Younger, Sonoma County Superior Court Case Number SCR-24618; Sonoma County District Attorney Case Number DAR-330986).

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The body was cut down, preserving the knot made for the noose. Fingerprints were obtained but were found to be inconclusive. The forensic pathologist retained by the prosecution felt that the death was suspicious for a number of reasons. Suicide by hanging is relatively uncommon for women. A slip knot was used that contained clumps of the deceased's hair within the knot. The forensic pathologist asserted that individuals who hang themselves usually do so with a simple slip knot that is not intertwined with the victim's hair. The slip knot is tied first and the noose is then placed over the head without ensnarling the hair in the knot. The rope around Lisa's neck was in a horizontal plane, as if it were tightened first before any strain was added. The forensic pathologist noted that a diagonal misplacement is more pronounced in suicides. Nor was the rope's impression on the neck as pronounced as seen in hanging deaths. Furthermore, women who kill themselves do not usually do so in a naked state. Because of advanced bodily decay, it could not be determined if Lisa had sustained any trauma to her body. There did not appear to be any evidence of sexual assault. Blood analysis for drugs or alcohol was negative. On cross-examination, the prosecution's pathologist testified that she could not definitively rule out suicide.

The defense forensic pathologist testified that Lisa's death was a straightforward suicide. He stated that it is not unusual for hair to become entangled in a noose. Nor could any conclusions be drawn from the knots used. Moreover, women hang themselves in various states of undress. Also, the angle of the ligature was equivocal. On cross-examination by the prosecution, the pathologist testified that he could not definitively rule out homicide.

On further investigation by the police, it was learned that Lisa's husband, age 43, had a police record for physical spousal abuse. Lisa was moving forward with a divorce after ten years of marriage. A protective order was obtained by Lisa against her husband for stalking one year before her death. She was developing a romantic relationship at work. Neighbors and co-workers stated that Lisa expressed concern about being stalked again by her husband whom she greatly feared. Witnesses reported that her husband had once threatened to kill Lisa, while in a rage. Lisa had told friends that her husband said he would kill her rather than lose her to another man.

Hair samples found in Lisa's apartment matched those of her husband. Fingernail clippings from the body were unrevealing. He was questioned about his wife's death. The husband denied any knowledge concerning his wife's death. He said that he had not spoken to his wife in over a year. The husband revealed that Lisa had an extensive psychiatric history, having previously attempted suicide on a number of occasions. He stated that he was out of town attending a regatta during the time his wife died but he could not substantiate his alibi. Lisa's husband was a retired military officer and an ardent sailor.

Neighbors gave sworn statements that they heard loud voices and the sounds of furniture being moved, about the time of Lisa's death. At approximately the same time, one witness saw her husband's car in the parking lot and observed him entering the apartment building where Lisa lived.

Because of the suspicious circumstances surrounding the death of Lisa, the district attorney requested a postmortem psychiatric assessment to determine the presence or absence of suicide risk factors. Witness statements (friends, co-workers, family, neighbors) were reviewed. Prior medical and psychiatric records were obtained. The psychiatric records revealed that Lisa developed bulimia nervosa at age 15. The dissolution of a romantic relationship resulted in depression, superficial wrist cutting and a brief hospitalization at age 17. A diagnosis of adjustment disorder with depression was made at that time.

Lisa married at age 24, shortly after obtaining a master's degree in business administration. Because of the physical and psychological abuse by her husband, she sought outpatient treatment. The decision to seek treatment followed a particularly violent beating by her husband. She sustained three fractured ribs and the fracture of the right zygomatic process. Her husband was arrested, jailed briefly and ordered to attend a treatment program for batterers. Lisa's therapist made the diagnosis of dysthymic disorder (chronic depression). He noted that Lisa had brief flurries of suicidal thoughts following assaults by her husband but no suicidal intent or plan. The therapy lasted two years, ending one year prior to Lisa obtaining the protective order against her husband. The frequency of therapy sessions varied from once a week at the beginning to once a month during the last six months of treatment.

It was learned from Lisa's parents that she was about to receive a $300,000 inheritance from an aunt who had died recently. Both Lisa and her husband knew of this bequest. As long as the couple stayed legally married, Lisa's husband was a secondary beneficiary of the inheritance.

Assessing Suicidal Risk of the Deceased

Suicide risk factors can be divided into individual, clinical, interpersonal, situational and statistical categories. An example of a unique, highly individual suicide risk factor occurred in a patient who only became suicidal when he would stop stuttering. Careful attention should be paid to short-term risk factors statistically significant within one year of assessment (derived from prospective studies of completed suicides of patients with major affective disorders) and long-term, traditional suicide risk factors that are significantly associated with suicides completed two to ten years following assessment (derived from community based psychological autopsies and the retrospective studies of completed suicide by psychiatric patients) (5,6).

When performing a postmortem assessment of suicide risk, the forensic psychiatrist considers death scene evidence, witnesses' statements, the findings of the pathologist, medical-psychiatric records and any other sources of relevant information in determining the presence or absence of suicide risk factors at the time of death. For example, careful analysis of knots in a noose can yield important evidence whether a death was a suicide, homicide or accident (7). The forensic psychiatrist may have more data when assessing suicide risk factors of the deceased than in the clinical setting with an uncooperative, disorganized or a withholding suicidal patient. Table 1 describes one method of suicide risk assessment adapted from clinical practice (8). Other methods of suicide risk assessment are also available (9–11). The assessment of suicide risk factors can be applied to both the living and the dead (12). Regardless of the method used, the quality of suicide risk assessments significantly depends upon the training, knowledge, experience and clinical judgment of the evaluator.

Using Table 1 to assess suicide risk factors for Lisa at the time of her death indicates that no uniquely individual or short-term anxiety associated suicide risk factors could be discovered (13). There was no evidence of anxiety symptoms. Lisa had made reservations to go on a boat cruise with friends. She maintained a lively interest in her two nieces, ages 5 and 7. Lisa also pursued numerous interests at the time of her death such as horseback riding, quilting and a passion for the theater. Lisa worked as the office manager for a very large computer firm. Co-workers did not notice any

TABLE 1—*Assessment of suicide risk.*

Risk Factors	Facilitating Suicide	Inhibiting Suicide
Individual (unique to person)	O	. . .
Clinical		
Current attempt (lethality)	O	. . .
Suicidal ideation: syntonic or dystonic − current†	O	. . .
Suicide intent†	O	. . .
Suicide plan	O	. . .
Panic attacks*	O	. . .
Psychic anxiety*	O	. . .
Loss of pleasure and interest*	O	. . .
Alcohol abuse*	O	. . .
Depressive turmoil*	O	. . .
Diminished concentration*	O	. . .
Global insomnia*	O	. . .
Recent discharge from psychiatric hospital (within 3 months)*	O	. . .
Hopelessness†	. . .	M
Psychiatric diagnoses (Axes I and II)—Current	O	. . .
Prior attempts (lethality)†	L	. . .
Family history of suicide	O	. . .
Impulsivity (violence, driving, money)	L	. . .
Drug abuse	O	. . .
Physical illness	O	. . .
Mental competency	. . .	H
Interpersonal		
Therapeutic alliance with patient	O	O
Other relationships (work, partner or spousal, family)	O	H
Situational		
Specific situational factors	M	. . .
Living circumstances	. . .	M
Employment status	. . .	H
Financial status	O	. . .
Availability of lethal means (guns)	. . .	M
Statistical (age, sex, marital status, race)	L	. . .

Rating System: L = low factor; M = moderate factor; H = high factor; 0 = nonfactor.
NOTE: Clinically judge overall suicide risk as high, moderate, or low.
* Short-term indicators are risk factors found to be statistically significant within one year of assessment.
† Long-term indicators associated with suicide two to ten years following assessment.
Source: Adapted from Simon RI: *Clinical Psychiatry and the Law, Second Edition* (Washington, DC: American Psychiatric Press, 1992).

change in her usual high level of functioning. Her parents and sister, who saw Lisa frequently, heard no complaints of any sleep or appetite problems and saw no evidence of depression. Her family was out of town at the time of Lisa's death.

Long-term, depression associated suicide risk factors were minimal (8). Lisa's relationships with friends, family and a new boyfriend were important to her and mutually supportive. There was no evidence of depression or hopelessness. Lisa had personal plans and life goals that she was pursuing. For example, at the time of her death, Lisa was planning a 30-day trip through Europe for the following year. She was also planning to use her inheritance to make a major career change. She was applying to law school. The fact that she was future-oriented and avidly pursuing life goals was rated as moderately inhibiting of suicide in Table 1 under the risk factor, ''hopelessness.''

Suicide risk factors may be acute, chronic or both. In the patient context, acute suicide risk factors are the main focus of clinical attention. In the retrospective assessment of overall suicide risk, the presence of acute suicide risk factors should be given added weight. For example, a major depressive episode would be considered an acute suicide risk factor. A history of suicide in the family would be considered a chronic suicide risk factor. Recurrent depression can be both an acute and a chronic risk factor.

Lisa had a prior psychiatric history. As an adolescent, she was hospitalized after making an impulsive suicide gesture by superficially cutting her wrists. In her therapy as an adult, it was noted that she entertained suicidal thoughts following abusive episodes with her husband. However, she never acted on her thoughts. The therapist's record indicated that she had thoughts of overdosing on pain medications that she would occasionally take for a severe ''tennis elbow.'' At the time of Lisa's death, there was no evidence that she manifested symptoms of any psychiatric disorder or communicated suicidal intent to anyone. In fact, friends and relatives felt that Lisa was quite happy, particularly after she obtained the protective order against her husband.

Clark and Fawcett (14) found that direct communication of suicidal intent to significant others occurred in two-thirds of completed suicides in the weeks prior to death. Clark and Harden (15), in their study of suicide completers, found that twice as many males as females committed suicide, that the decedents almost always qualified for a psychiatric diagnosis and, more often than not, communicated their suicide intent. They also found that 93 to 95% of all cases of completed suicide met diagnostic criteria for one or more DSM-III-R diagnoses (16).

Lisa's living circumstances were comfortable. She was a highly competent, valued employee, earning a substantial salary. Lisa was highly respected by both her co-workers and boss. These items were rated as significantly inhibiting suicide in Table 1. The fact that she was separated and pursuing a divorce put Lisa in a class that was statistically at increased risk of suicide. However, she viewed divorce as a liberation from her abusive husband. Nonetheless, Lisa kept a gun hidden under her bed for protection. She had the means to obtain or accumulate a lethal supply of pain medications prescribed by her physician for chronic ''tennis elbow.'' The fact that Lisa had readily available lethal methods for suicide makes it unlikely that she would choose hanging as the method to kill herself. Thus, the presence of readily available lethal means of suicide that were not used was rated as a moderate *inhibiting* suicide risk factor in this case.

The therapist's notes clearly indicated that Lisa's suicidal thoughts were dystonic; that is, they were perceived by her as unbidden and unwanted. At the time of her death, there was no evidence of any suicidal ideation, plan or behavior. No conclusion could be drawn from the absence of a suicide note. Research indicates that only 10 to 35% of persons who commit suicide leave notes (17).

The absence of any family history of mental illness is rated in Table 1 as a low inhibiting factor. In spite of the fact that Lisa impulsively made a suicide gesture as an adolescent, at the time of her death she was considered by all who knew her to be a prudent, reasonable and careful person. Nevertheless, the adolescent history of impulsivity earned a rating of low facilitating suicide. There was no history of drug or alcohol abuse. She was in good physical health except for a chronic ''tennis elbow.'' Lisa was a very high functioning, competent person. If she were depressed and suicidal, it is highly likely that she would have

sought professional help. ''Mental competency'' in Table 1 is rated as highly inhibiting suicide.

The specific stressful situational factor in her life that she told her parents and friends about was the apprehension that her husband would start stalking again. Lisa feared that her husband might harm her because he had threatened to kill her if she had a relationship with another man. Living with the fear of being terrorized by a stalker can certainly cause despair and depression. However, there was no evidence that Lisa was despairing or depressed at the time of her death. The fear of being stalked was liberally rated as a moderate facilitating suicide risk factor under ''specific situational factors.'' Suicide risk factors that are unique to the individual are also rated under this category.

A postmortem overall assessment of Lisa's suicide risk factors reveals a low or minimal suicide risk at the time of death. The risk factors favoring suicide are far outweighed by the presence of factors that tend to exclude suicidal risk. Heavy weight is given to the absence of any overt symptoms of psychiatric disorder, no evidence of suicidal ideation, no alcohol or drug abuse, future orientation, and factors indicating good interpersonal and occupational functioning. This assessment method is qualitative and, as with the living patient, relies heavily upon the clinical judgment of the evaluating psychiatrist in determining the weight he or she gives to the various risk factors.

Obviously, the forensic psychiatrist retained by the prosecution could not testify with absolute certainty that the patient did not commit suicide by hanging or that she was murdered by her husband or, for that matter, by someone else. However, it was possible to credibly testify that the postmortem suicide risk assessment indicated that Lisa was at low risk for suicide at the time of her death. The defense psychiatrist testified that suicide could not be ruled out, given Lisa's psychiatric history of a prior impulsive suicide attempt, psychiatric hospitalization, chronic depression and recurrent suicidal thoughts triggered by marital distress. Nor could she definitively rule out murder. Did Lisa commit suicide? Was she murdered? And, if so, by whom? These were ultimate questions for the jury. Courts are wary of possible prejudicial psychiatric testimony that goes to the ultimate issue of how the individual died (18).

The prosecution argued that Lisa's husband strangled her out of intense jealousy and for her sizable inheritance, staging the murder as a suicide. The defense argued that Lisa had a long psychiatric history with a prior psychiatric hospitalization following a suicide attempt. She continued to experience suicidal thoughts following alleged physical abuse by the husband. The defense further argued that Lisa's fear that her husband would harm her, because of a new romantic relationship she had established, led to depression and suicide.

The husband was charged with first-degree murder and found guilty by the jury. He received a 25-years-to-life sentence. There were no eyewitnesses to the alleged crime. No single piece of evidence or testimony by itself was conclusive in determining how Lisa died. Nonetheless, after hearing over 100 witnesses, the jury determined that the prosecution had constructed a sufficiently compelling mosaic of facts to support a guilty verdict of guilty of first-degree murder beyond a reasonable doubt. The postmortem suicide risk assessment was an important piece of that mosaic.

Postmortem Suicide Risk Assessment and Daubert

Competently assessing suicide risk factors meets the standard of care in the clinical management of potentially suicidal patients (19). Postmortem assessment of clinically based suicide risk factors in equivocal suicide cases should also meet the evidentiary criteria for probative testimony (18). In Daubert v. Merrell Dow Pharmaceuticals, Inc. (20), the U.S. Supreme Court held that the ''general acceptance'' test established under Frye v. United States (21) had been superseded by the ''reasonableness'' standard of the Federal Rules of Evidence. Thus, Daubert shifts the focus from the general acceptance of the conclusion to the underlying soundness of the methodology (22). Daubert applies to federal courts but it has also been adopted by a majority of states. Dauberts criteria include testability, peer review and publication, factors affecting potential error rate as well as general acceptability by the relevant scientific community. Clinically based standard suicide risk assessments, though not considered to be ''hard science'' may meet some but not all process-driven Daubert criteria. For example, the error rate for suicide risk assessments is unknown. Assessment, even if a court were to find that postmortem suicide risk is not a ''science'' that would meet Daubert criteria, it would probably be admissable under other relevant factors. In Moore v. Ashland Chemical, Inc. (23), the U.S. Court of Appeals for the Fifth Circuit held that testimony based on clinical medicine is not ''hard science.'' Therefore, it is not subject to the factors governing the admissibility of scientific testimony as established by *Daubert*. In McKendall v. Crown Control Corp. (24), the U.S. Court of Appeals for the Ninth Circuit held that the admissibility of expert testimony need not be based solely on scientific knowledge and *Daubert* criteria. Instead, expert testimony may be based upon experience or training of the expert.

Appellate courts have been generally receptive to the use of psychological autopsy methods as providing helpful testimony. In United States v. St. Jean (25), the court admitted testimony of suicide profiles and psychological autopsies in a murder trial. The defendant was charged with the premeditated murder of his wife. The defense claimed that there was reasonable doubt of his guilt because the evidence was just as consistent with suicide. The prosecution's expert testified that the victim manifested none of the suicide risk factors associated with persons who commit suicide. The defense countered that testimony based upon psychological autopsies is inherently unreliable under Federal Rules of Evidence 702 (helpfulness of expert testimony) and 403 (prejudicial versus probative value of evidence) (26). The court ruled that the expert's testimony was helpful on the issue of the wife's suicidality. The expert testified that the assessment method was reliable and accepted by the psychiatric and psychological professions. Psychological autopsy evidence has also been accepted by courts in child abuse cases where the child has committed suicide (27,28). Standard suicide risk assessment methods are the stock-in-trade of psychiatric clinicians and have been beneficially utilized (''tested'') in clinical settings for many years.

The psychological autopsy has found acceptance among psychiatrists for its use in litigation (29). To address criticism that the psychological autopsy lacks psychometric properties such as reliability and validity, the Centers for Disease Control developed the 16-item Empirical Criteria for the Determination of Suicide (ECDS) that has been shown to be 92% accurate in differentiating between suicide and accident (30). The ECDS is an adjunctive tool to professional clinical judgment.

Attempting to reconstruct the mental state or *intention* of the deceased is usually more difficult than retrospectively assessing suicide risk factors alone. Oliver Wendell Holmes observed that ''even a dog knows the difference between being tripped over and being kicked'' (31). However, the legal concept of intent as applied

to equivocal suicide cases is complicated. Assessing the presence or absence of suicide risk factors may assist in clarifying the question of suicide intent. But retrospectively discerning the intent and motives for suicide can be a difficult task (2). A person's intentions or subjective mental state are often opaque, sometimes impossible, to discern, even by direct psychiatric examination.

The psychological autopsy was first proposed by Shniedman (32). He stated, ''the psychological autopsy is no less than a reconstruction of the motivations, philosophy, psychodynamics, and existential crises of the decedent'' (33). However, such expansive testimony given about the deceased's mental state or intention to commit suicide must satisfy the court following the Federal Rules of Evidence that the Daubert criteria required for the reliability of opinion testimony has been met. Although Rule 704 of the Federal Rules of Evidence allows an expert's opinion on an ultimate issue to be decided by the trier of fact, subsection (b) prohibits expert opinions concerning intent, guilt, or innocence in a criminal case (34).

Biffl (18) states that before psychological autopsy testimony is admissible, the court will require that the evidence is relevant under Federal Rule 401, that the expert is qualified in this area under Federal Rule 702, that the testimonial evidence will be helpful to the jury and is reliable under Federal Rules 702, 703, using either Frye or Daubert. The court must also consider whether prejudicial factors outweigh the probative value of the evidence under Federal Rule 403.

Conclusion

Forensic psychiatrists are increasingly retained in equivocal suicide cases in both civil and criminal litigation. Forensic psychiatrists can be of considerable assistance in these cases if their opinions are based upon careful postmortem suicide risk assessment based on the review of relevant collateral sources of information, including death scene analysis and autopsy findings. In some cases, the forensic psychiatrist's suicide risk assessment may prove inconclusive. Forensic opinions should avoid conclusory statements that invade the province of the fact finder in determining criminal responsibility. After careful evaluation of the case, probabilistic assessments of suicide risk such as low, moderate or high at the time of death have the most credibility.

The deaths of Marilyn Monroe and Robert Maxwell remain shrouded in mystery despite numerous attempts to elucidate their causes. The death of Vincent W. Foster, Jr., though officially ruled a suicide, has become the subject of political controversy and continuing conspiracy theories. Forensic psychiatrists who are retained in high-profile cases of celebrity deaths must maintain their usual ethical stance of striving for objectivity and honesty amidst great distractions and intense pressure for certainty (35). The same professionalism is required of the assessment in the equivocal death of the ordinary citizen.

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