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Serious Incident Inquiries: a survival kit for psychiatrists

Since 1999, a formal external inquiry into every homicide committed by a person with a mental disorder has been mandatory in the UK (Department of Health, 1994). Common opinion among psychiatrists is that Serious Incident Inquiries are unhelpful as they all reach similar conclusions, add nothing to our current knowledge and do more harm than good in terms of adverse publicity for mental health services (Buchanan, 1999). Despite this, there is presently little sign of a change in public policy. Psychiatrists continue to face the fact that the next incident could be 'the one that's coming here'. Although the many flaws of the inquiry process have been well described (Szmukler, 2000), few have interpreted this knowledge in a way that is of practical help to a psychiatrist facing an inquiry.

In 1997, one of my patients committed homicide. Since that time, I have studied serious incident culture. Here, I present my findings in a form that may be helpful to clinicians facing this distressing event.

Know the history of serious incident culture

Most societies have dealt with mental illness by marginalisation. Our own culture still regards containment as the mainstay of treatment. The asylums sustained a belief that it is part of the role of psychiatric services to shield society from the consequences of 'madness' as much as it is to help sick people. This expectation persists in our present and proposed mental health law and our risk-oriented working practices. The fact that it cannot be met in a non-place called 'the community' is something that professionals, politicians and the public are slow to grasp.

Between 1960 and 1989, five white papers recommended improved resources for community services with little result (Ministry of Health, 1962; Department of Health & Social Security, 1972, 1975; Department of Health, 1989a, 1989b). For much of this period, psychiatry was viewed from within the medical profession as a stagnant, inferior speciality. Society, however, changed greatly. Customs of deference and personal responsibility yielded to ideas of protest, consumer rights, risk avoidance and a demand for greater accountability from the medical profession. The public is also increasingly informed about mental illness, although its primary source of information on the subject remains grossly biased towards negative representations (Philo *et al*, 1994).

Viewing a serious incident within this context can help the clinician facing an inquiry. Knowledge of the salient events of the past 40 years (Stewart, 2001) provides a framework within which to compose one's responses to the event. By their very nature, inquiries focus on recent, local issues and so obscure the way that broader issues play a direct causal role in the event. A clinician can use history to guide the inquiry towards a wider, more balanced perspective.

Become familiar with the core irrationalities of the inquiry process

Whatever their 'terms of reference', inquiries serve many roles beyond the need to explain how something happened (Peay, 1996). They attempt to answer questions about meaning, morality and responsibility – areas where rational enquiry has a poor record of satisfactory results. A clinician facing an inquiry panel is, in effect, dealing with a highly irrational, quasi-legal form of local audit, invested with powers to drive change that are far in excess of what can rationally be expected from a single case study. Two fundamental irrationalities of Serious Incident Inquiries may be discerned. The first relates to the issue of complexity and the second relates to the confusion surrounding the idea of responsibility.

The sheer complexity of events

The complexity of necessary and sufficient factors leading up to any event, untoward or not, is so great as to be unknowable. Psychiatrists acknowledge the complexity of human nature in a way that inquiries cannot. Instead, inquiries resort to the study of ever greater detail in pursuit of a meaningful result. The folly of this approach is evident in the often ludicrous discrepancy between the length and expense of many published reports and the usefulness of their findings (Scotland *et al*, 1998).

Each Serious Incident Inquiry report presents a finite sequence of events drawn from this infinity of possible antecedents, published in the form of a narrative leading to the index event. Our brains have evolved to discriminate between events and arrange them in

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meaningful ways; the narrative is, therefore, a particularly powerful arrangement. Much evidence supports the idea that knowledge of an outcome exerts an irrevocable influence on the way in which antecedent events are chosen and arranged (Hawkins & Hastie, 1990; Sutherland, 1992). This even applies to imagined, counterfactual events of a 'what if?' nature. The very process of considering what might have happened can lead to conclusions that, although carrying a pleasing ring of truth, may be meaningless (Reiss, 2001).

Abnormal perceptions of responsibility

Danger and unpredictability are commonly associated with mental illness. Serious Incident Inquiries draw undue attention to the frightening but remote chance that a fellow human being might harm us for no reason. Our response to this age-old fear is all the more irrational within a risk-oriented culture that has undergone what Fitzpatrick (2001) terms a 'relocation of reassurance'. Nowadays, responsibility is construed in binary terms; a mentally-ill person's responsibility for their behaviour is perceived as non-existent. Oyebode (1999) notes where this relocated responsibility now lies; serious incidents are usually taken as prima facie evidence of a failure of care. This unfairly raises the threshold at which a psychiatrist may be forgiven for having 'tried their best'.

Knowledge of these irrationalities enables preparation. Expect to be involved in a process that has more to do with drama than with common sense and expect your efforts to be judged by a standard far higher than that expected of most other professions (with the exception of social work). Anticipate the finding of files, records and opinions unknown to your team and expect their content to be explored in Proustian detail. Collaboration with this process allows you to present some of the countless other contexts and events in the narrative that, without prior knowledge of the outcome, *might* have proved equally significant or led to a different outcome. In any rational inquiry, such information can only lead to a more authentic conclusion.

Watch your own mental state

A Serious Incident Inquiry provokes anxiety and self-doubt in any clinician. The fact that one's own practice *might* have contributed to the event is only the most explicit source of discomfort. It also arises from the disruption of one's normal routine. Surprisingly, this includes coping with the reactions of others. Each Serious Incident Inquiry releases thoughts of 'there but for the grace of God go I' among colleagues that may manifest in the form of phone calls, cards, letters and open expressions of sympathy. Such well-intentioned support can nourish a growing sense of isolation. Be wary of colleagues who offer formulations on your mental state, particularly those who tell you that you are becoming paranoid. People really are out to judge you. Within this atmosphere of suspended normality, it is easy to make mistakes. Resist the urge to modify your case notes in the false light of retrospect, as well as the urge to make early statements of defiance or culpability. Observe the involuntary lowering of your threshold for risk, and be wary of clinical vacillation in any case that reminds you of the event.

Systematic introspection balances the inevitable influence of feelings against one's judgement and behaviour in relation to both the incident and ongoing clinical work. A thoughtful colleague and a diary help to keep this balance. In spite of both training and common sense, many doctors still resist the ideas of mentoring and support. It need not be a formal arrangement, but choose one colleague rather than several. Meet regularly and tell them everything. A diary of the time and content of all your actions and interactions is a useful way to keep track of the many meetings and briefings that arise from the event. Both will help you to clarify your thoughts about the matter, and organise your written and oral presentation to the panel, the media, or any other agency that demands a response.

Emotional detachment avoids energy wasted trying to write the perfect report. A good report should cover all of the basic facts of the matter and make little use of adjectives and adverbs. Avoid any expression or connotation of guilt or blame, but do not avoid opinion altogether. Much of the information that the inquiry may later come to view as crucial might not even be seen as 'fact' at the outset. Moods, contexts, key worker case-loads, departmental restructurings and so on will not appear in any of the case notes relating to the incident.

Don't turn the inquiry into a court

In spite of its obvious formality, an inquiry is not a court of law. The crucial difference between one's status as an informant rather than the accused is hard to maintain when seated before a stern-faced panel and a stenographer, but the distinction reduces the discomfort of the experience. Eastman (1996) clarifies the difference (see Box 1). Inquiries ignore strict legal process; they do not allow cross-examination, even though this might identify issues that could determine outcome.

Although legal members sit on many panels, few have the experience of a judge, and so set thresholds for culpability well below those used in law (Bolam v. Friern Hospital, 1957). Clinicians are currently well protected by law (Howlett, 2001). Indeed, judges have even found that trusts do not owe a duty of care to a patient in common law (Clunis v. Camden and Islington Health Authority, 1998).

Box 1.

Unlike courts, inquiries:
Make no presumption of innocence
Do not allow cross-examination
Do not deliberate in public
Allow no right of appeal against their findings
Do not use established methods to set thresholds for culpability

(After Eastman, 1996)

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Do not appear before the panel alone, but choose your escort carefully. A formal, legal representative is more likely to feed a sense of legalism than a supportive colleague. Remember that you are entitled to question the panel. Given your knowledge of the inquiry process, it is quite reasonable to ask how they intend to control for history, hindsight and counterfactual bias. Remember also that unlike a court, your submission need not be confined to your 'time in the box'. If you later wish to elaborate, submit this in writing. A panel has no right to exclude this submission.

Build storm-proof bridges with your managers

In some ways, managers face greater challenges than clinicians during a Serious Incident Inquiry. Clinicians may confine themselves to essentially clinical aspects of the event, but managers must deal with its impact both on systems and individuals. A Serious Incident Inquiry is a testing time for the clinician–manager relationship, and a split must be avoided at all costs. Retreat into rival camps compounds the distress of the event and may mislead the panel to conclude that systems were running less effectively than was in fact the case. Few of us can expect a front-line visit from the Chief Executive within 24 hours of the news, but we do have a right to clear managerial support. Cultivate this pre-emptively. Re-read your trust's serious incident protocol and its policy on external relations. Make sure that you are on good terms with those responsible for their implementation. Clarifying who is going to say what to whom and how is greatly helped by this arrangement. Consider also the worries of the junior staff involved in the case, clinical and clerical, not just after the event, but throughout the process.

Work to extract something positive from the event

It may not appear so at the time, but each Serious Incident Inquiry represents a chance to employ one of the least-used skills in the psychiatrist's repertoire: public education. Use the attention generated by the event to repeat the key lessons of serious incident culture: We cannot read the future. Human nature is impossibly complex. Risk assessment is highly inexact. Risk management does not equal risk elimination. Responsibility is not a binary issue. Each incident provides a chance to help us explain the uncertainty and discomfort that mental illness provokes. Those who perceive their involvement in a Serious Incident Inquiry as in some way positive are less likely to emerge feeling embittered and closer to the 'burn-out' faced by all mental health workers. Serious incident culture is full of paradoxes. It is a comforting paradox that the confusion aroused by these events may yet prove helpful in both our professional survival of the event and our progress towards a more tolerant culture.

Declaration of interest

None.

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