Inquiry into homicides by psychiatric patients: systematic audit should replace mandatory inquiries

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Inquiries into homicides committed by psychiatric patients are currently mandatory under Department of Health guidance. They are often broadly defined in their terms of reference and almost always address not only the cause of the incident but also professional skill, practice, and culpability. Concurrent pursuit of both purposes is unlikely to maximise "learning from experience." Also, since inquiries can set their own thresholds for culpability, doctors can potentially be judged to a higher standard than would be required by the General Medical Council or negligence law. Lack of strict legal process increases the inherent potential unfairness to doctors. Investigation of cause and culpability should be separated and inquiries restricted to the former. There should also be a standing secretariat for inquiries to set terms of reference and to collate and distribute findings of inquiries. Widespread mandatory systematic audit of professional practice and service efficiency concerning risk assessment and management should largely replace costly ad hoc mandatory inquiries after homicides.

The Royal College of Psychiatrists' recent confidential inquiry into homicides and suicides by mentally disordered offenders identified 39 homicides committed over two periods totalling 26 months by patients who had had contact with psychiatric services in the preceding 12 months¹; currently, there are in train in England and Wales 30 or so inquiries into homicides by mentally disordered people.² What are the purposes of such inquiries? Are all the purposes best served by inquiries? Are inquiries fair to professionals?

An independent inquiry is currently mandatory³ (usually ordered and funded by the regional health authority, now the NHS Executive regional office) after any homicide by a mentally disordered person who has had recent psychiatric or social care. Unlike inquiries in the late 1960s into the mistreatment of (mainly) mentally handicapped or geriatric patients, but like inquiries in the 1970s and 1980s into child abuse, homicide inquiries are usually non-statutory (although inquiries can also, in some circumstances, be ordered under Section 125 of the Mental Health Act 1983). Non-statutory inquiries offer no procedural or prescriptive legal rights. They have therefore been criticised as inherently unfair because they make no presumption of professional innocence; the panel can (and usually does) deliberate in private; and such inquiries have no prescribed and known rules of procedure.⁴ There is also no entitlement to cross examination or any right of appeal to any court to challenge the inquiry's findings. Non-statutory inquiries also depend, inconveniently, on the patient's consent for access to medical records.⁵ It can be argued that lack of legal procedure combined with privacy optimises the pursuit of truth,⁶ but such aspects inherently offer less protection to witnesses, who are professionally at risk and yet are required to attend.

Report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People

Key problems

- Failures of communication between professionals
- Lack of clarity about care plans
- Lack of time for face to face contact with patients
- Need for additional staff training
- Poor compliance with treatment by patients
- Insufficient use of legal powers to supervise patients at risk

Key recommendations

- Strengthening risk assessment skills in clinical teams
- Increasing face to face contact time with patients
- Supporting the development of genuine multi-disciplinary teams
- Developing better systems for communication between professionals and between professionals and families
- Raising awareness about appropriate uses of legal powers under the Mental Health Act 1983 through further training
- Ensuring that treatment environments are acceptable for patients

A recent collation of the findings of all major psychiatric inquiries between 1985 and 1994⁷ shows a recent shift of focus from hospitals⁸ to the community. Recommendations of these inquiries are often similar. Typified by the Ritchie inquiry into the care and treatment of Christopher Clunis,⁹ they usually involve recommendations about the roles of many agencies and are often much concerned with communication between agencies and between staff within agencies. They also commonly recommend increased availability of medium security, low security, and open ward acute beds in inner city areas; increased staff training in risk assessment; and measures to increase collaboration of agencies in the care of psychiatric patients. The Ritchie inquiry also recommended registration of patients "at risk" and called for new legislative powers over patients in the community.

Purposes of inquiries

Sir Louis Blom-Cooper QC, a past chairman of the Mental Health Act Commission and distinguished chairman of two homicide inquiries, has described the purpose of any inquiry as "the truth ... what happened; how did it happen; and who, if anyone, was responsible, culpably or otherwise, for it having happened."¹⁰ To these purposes of learning and discipline Reder and Duncan have, on the basis of the experience of child care inquiries, added those of public catharsis and reassurance about the accountability of public servants.¹¹

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Are the purposes best served by inquiries?

The best method for achieving one purpose is often inherently not the best for achieving another. If an inquiry can amount to a basis for disciplining a professional, he or she is likely to be highly guarded and defensive in his or her responses, and this will militate against understanding fully and correctly what happened—and thus against learning and being able to modify service delivery. Essentially, “blame limits understanding.”¹¹ Alternatively, profound injustice may accrue to a professional witness, who often is not legally represented and may be seduced into openness by an inquiry panel which states cosily, “We merely want to improve services.”¹²

The main purposes of inquiries should be pursued separately. This implies that inquiries should investigate only causal explanation and should always be explicitly

“Inquiries should investigate only causal explanation [not] professional culpability.”

excluded from expressing a judgment about professional culpability. The proper bodies to address such culpability are the relevant professional governing bodies—in the case of doctors the General Medical Council (GMC)—and the civil courts. What justification is there for placing this function additionally in the hands of an ad hoc body, which can set aspects of its own terms of reference and which can apply its own standards of professional culpability? Medical culpability should be determined according to a professional peer standard, as applied either by the GMC or through the “Bolam test” within negligence law of whether the doctor acted in accordance with the practice of a responsible body of medical practitioners.¹² By contrast, inquiries are inherently at risk of inferring culpability by dint of describing causal responsibility, and of doing so potentially to a lower threshold than the accepted professional standard. As one commentator recently put it, “At an inquiry the relevant professional expertise is often to be found imbued in the various members of the inquiry [and] their views will inevitably [suffuse] the judgments they reach ... each professional member may be tempted to judge not only (generally) according to his or her own professional (individual) standards but also on the basis of his or her own experience.”¹²

Inquiry panels commonly include a legal chairman, a psychiatrist, and another clinical professional. It is unusual to include a manager as one of the experts. However, a clinician should properly be adjudicated on his or her practice given the resources and service organisation provided by the service managers. One legal academic has even argued that a homicide should result not in an inquiry into the event itself but in a general audit of the provider service that was responsible for the perpetrator.¹³

Repeated ad hoc inquiries are not the best means by which to improve health care. Aside from the inefficiency of concurrent pursuit of several purposes, an inquiry becomes part of the event represented by the homicide itself and its aftermath. Although single inquiries may sometimes result in a ubiquitous “sudden shift” of services for the better, as did the Maria Colwell inquiry¹⁴ and perhaps the Ritchie inquiry,⁹ generally the essence of learning is (like the services themselves) that it must be ongoing, using a service audit cycle. There is no evidence that homicide inquiry panels have commonly (or perhaps ever) revisited services even to check that their recommendations have been implemented. Neither are inquiry results collated centrally and disseminated as a growing body of knowledge available to all services and to be used towards continually refining practice. Also, an essence of audit is that it is mul-

tivariate in its scope. Several goals, sometimes inconsistent with one another, are set and weighted towards an aggregate measure of performance. By contrast, inquiries have a natural tendency to concentrate specifically on public safety, with no natural tendency to balance public safety against, say, excessive securing of patients by a service or underachievement of rehabilitation goals.

Reforming and limiting inquiries

Reform should include the establishment of a standing secretariat for all homicide inquiries. This would collate and distribute inquiry findings as a growing body of knowledge and give new inquiry panels not only such a backcloth but also clear and restricted terms of reference. Wherever possible, inquiries should sit after any managerial or professional disciplinary proceedings have been determined (though lengthy litigation timetables would not allow possible negligence to be adjudicated before an inquiry sat).

There should also be substantial further development of the confidential inquiry into homicides and suicides sponsored by the Department of Health.¹ This has been open to some criticism¹⁵ because it has been based largely on asking relevant clinicians whether anything went wrong with their cases. Through its aggregate approach, the confidential inquiry could, if better refined, be of great benefit to doctors, patients, and services.

Replacing inquiries with service audit

Audit of local mental health services should include assessment of the risk assessment skills of clinicians and a managerial requirement that clinicians show that they have had relevant postgraduate training within “continuing professional development.” Risk assessment and management of violence must be rid of their mystique.¹⁶

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There should also be agreed local criteria (perhaps based on national standards—for example, as implied in the Department of Health’s guidance on discharge of mentally disordered people¹⁷) for admission of patients into the “severe violent risk” category and agreed protocols for risk assessment and management which would include description of the types of information and process required. Even though it will usually be impossible to measure performance in terms of “avoided violent outcome,” it is at least possible to measure quality of process.

There is little justification for singling out psychiatric homicides for special treatment by way of mandatory inquiries. As regards possible failures of mental health care, there is little distinction between homicides and suicides—but there is no mandatory inquiry for suicides though they are much more common,¹ nor are other (non-psychiatric) serious medical mishaps singled out for such special attention. Public fear of mad people, combined with their greater visibility on the streets through community care, may explain (and perhaps even justify politically or democratically) the use of such inquiries. Reason demands, however, that they are modified and used less and also that concern about psychiatric violence be directed towards professional education, training, and audit, as well as towards service audit. Much more would be achieved by mandatory local audit of process than by the chance distribution of mandatory homicide inquiries across the country.¹⁷ Psychiatric violence is too important to be the subject of an inefficient, costly, and potentially unjust system of inquiry.

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Lesson of the Week

Katayama fever: an acute manifestation of schistosomiasis

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Katayama fever often mimics the symptoms of malaria in feverish travellers

Schistosomiasis is prevalent throughout sub-Saharan Africa and parts of south east Asia. It is contracted through contact with any fresh (but not salt) water that harbours the intermediate snail host. Katayama fever is a manifestation of acute schistosomiasis. Typical features include fever, an urticarial rash, enlarged liver and spleen, and bronchospasm. The precise pathogenesis of Katayama fever is unknown, but it is thought to be an immune complex phenomenon, initiated by eggs laid by maturing schistosomes. Typically, symptoms occur four to six weeks after infection. Diagnosis is on clinical grounds as there is no definitive serological or immunological test. Conventional antibody titres may take three months or more to become positive.¹ As a result, the diagnosis is often missed, occasionally with disastrous results, such as schistosomal myelopathy, which may result in permanent neurological damage.²

Case reports

Sixteen patients were admitted to the Hospital for Tropical Diseases in London between August 1994 and December 1995 with suspected acute schistosomiasis. All had travelled to sub-Saharan Africa. Fourteen had been exposed to fresh water only in Lake Malawi; the other two, travelling together, had swum in a river in a rural area of Mozambique. Symptoms at presentation were non-specific: apart from a history of fever, the dominant symptom was profound lethargy. Only two patients recalled having "swimmers' itch," a transient pruritic rash occurring within 12 hours of cercarial penetration. Symptoms began, on average, 36 days after exposure. Nine patients were febrile on admission and two more developed a fever during their hospital stay. Fourteen had eosinophilia; total eosinophil counts on admission ranged from 0.2 to 12.9 x 10⁹/l. Stool microscopy gave negative results in 12 patients—one had ova of *Ascaris lumbricoides*. Ova of *Schistosoma haematobium* were visible in the urine of another. Snips of rectal mucosa were examined for eggs in two cases; both were negative. An enzyme linked immunosorbent assay (ELISA) against soluble egg antigen of *S. mansoni* was performed in each case.³ Two cases had positive serology, and two others were weakly positive.

In most cases the diagnosis of acute schistosomiasis was made on clinical grounds—a history of recent exposure to potentially infected water, physical findings, a negative blood film for malaria, and the presence of

Table 1—Symptoms, physical findings, and laboratory investigations in 16 patients with acute schistosomiasis

	Proportion of patients
Symptom	
Fever	15/16
Lethargy	14/16
Myalgia	11/16
Cough	7/16
Headache	5/16
Anorexia	4/16
Rash	3/16
Swelling	3/16
Physical finding	
Hepatomegaly	4/16
Splenomegaly	4/16
Wheeze	2/16
Urticaria	2/16
Rash	2/16
None	9/16
Laboratory results	
Eosinophilia (> 0.4 x 10 ⁹ /l)	14/16
Raised bilirubin (> 18 IU/l)	3/15
Raised aspartate transaminase (> 55 IU/l)	6/15
Raised alkaline phosphatase (> 280 IU/l)	7/15
Parasitology:	
Urine positive for <i>Schistosoma haematobium</i>	1/15
Stool positive for <i>S. haematobium</i> or <i>S. mansoni</i>	0/16*
Rectal snips	0/2
Positive for soluble egg antigen of <i>S. mansoni</i> (ELISA)	4/16

*One sample positive for *Ascaris lumbricoides*.

eosinophilia in a peripheral blood sample (table 1). Only two cases had unequivocal results. All 16 cases were treated with praziquantel 20 mg/kg body weight, twice daily for three days. Eight also received prednisolone 20 mg/day for three days. All patients subsequently developed evidence to support the diagnosis—15 developed antibodies to soluble egg antigen and one was found to have non-viable ova of *S. haematobium* in the urine. The time taken to seroconversion averaged 1.6 months (range 0-6). Seven patients required further courses of praziquantel because of continuing symptoms, persisting eosinophilia, a subsequent rise in the antibody titre, or more than one of these. In several patients symptoms persisted many months after initial treatment (maximum one year).

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