

Mental Health Inquiries – Views from the Chair

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The data to be presented in this contribution form part of a more detailed account which will appear as a Chapter in a book entitled ‘The Age of the Inquiry’ edited by Nicky Stanley and Jill Manthorpe of Hull University, for Routledge (April 2004). The material is produced here with their kind permission. My brief from the editors was to write about my experiences of chairing mental health inquiries since hardly anything seemed to have been written about how those who chair inquiries and their colleagues viewed the problems they encountered. Although I had chaired three mental health inquiries I considered that my own responses might be seen as somewhat idiosyncratic and partial. I therefore decided to solicit the views of a small number of those who had also chaired such inquiries in the mental health field, including, in the main, homicide inquiries.¹

The three inquiries were all somewhat different. The *first* was into the sudden death of an African-Caribbean offender-patient following seclusion; the *second* was an inquiry into the circumstances in which a detained sex offender-patient had absconded from escorted day leave to a Zoo and theme park. Both these cases attracted a good deal of media publicity and a number of sensitive issues were involved. The *third* was a ‘homicide inquiry’ into the circumstances in which a former patient of the mental health and allied services had killed a vagrant in the centre of Leicester. This inquiry also had some unusual aspects, since several agencies were involved in addition to the mental health service (probation, education, social services and the voluntary sector). One or two of these services considered that we were exceeding our remit in including them in the inquiry. However, for reasons that are contained in our report, we felt we were highly justified in doing so.

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1 The three inquiries I chaired were (i) the Committee of Inquiry into Orville Blackwood’s death at Broadmoor Hospital (Prins, H., Backer Holst, T., Francis, E. and Keitch, I., 1993). Report of the Committee of Inquiry into the Death in Broadmoor of Orville Blackwood and a Review of the Deaths of two other Afro-Caribbean Patients: Big, Black and Dangerous?

Special Hospitals Service Authority. (ii) Prins, H., Marshall, A. and Day, K. (1997). Report of the Independent Panel of Inquiry into the Circumstances Surrounding the Absconion of Mr. Holland From the Care of the Horizon NHS Trust on 19 August, 1996. Horizon NHS Trust. (iii) Prins, H., Ashman, M., Steele, G. and Swann, M. (1998). Report of the Independent Panel of Inquiry into the Care and Treatment of Sanjay Kumar Patel, Leicester Health Authority.

Much has been written in recent years about mental health and allied inquiries and most of them have common findings.² As already indicated, little appears to have been written about the view from the 'other side of the table'. Debate has continued about private or public inquiries, their cost, their purpose etc. My questions to the respondents bore these (and allied) considerations in mind.

It is worthwhile noting here that a number of homicide inquiries pre-dated the central government requirement to hold them from 1994 onwards,³ a significant inquiry being that into the homicides committed by Graham Young.⁴ Other important cases were those of Sharon Campbell, who stabbed to death her former social worker Isabel Schwarz,⁵ and Carol Barratt, a young woman who stabbed to death an 11-year-old girl in a shopping mall following detention under Section 2 of the Mental Health Act 1983. A Mental Health Review Tribunal had ruled firmly against discharge but the Responsible Medical Officer (RMO) discharged her following representations by the patient's mother.⁶ Kim Kirkman was a patient with a long history of psychiatric secure hospital care; he killed a neighbour, but committed suicide before he could come to trial. The Inquiry held into his case concluded that there was no way in which Kirkman's homicidal behaviour could have been predicted, but the team did recommend that in future more use might be made by practitioners of actuarial devices and research findings.⁷ Michael Buchanan beat to death a complete stranger (a retired police officer) in an underground car park. Buchanan had a long history of both residential childcare and psychiatric treatment.⁸ Andrew Robinson's and Jason Mitchell's cases were the subject of *public inquiries* and, amongst other matters, both revealed serious deficiencies in risk

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- 2 For discussions of inquiries more generally see G. Drewry and C. Blake (eds) (1999) *Law and the Spirit of Inquiry: Essays in Honour of Sir Louis Blom Cooper*, Kluwer. Clothier, Sir Cecil, Q.C. 'Ruminations on Inquiries', in J. Peay (ed) *Inquiries After Homicide*, Duckworth. On the public versus private debate see: Blom-Cooper, L. Q.C. (1999) 'Public Inquiries in Mental Health (With Particular Reference to the Blackwood Case at Broadmoor and the Patients Complaints of Ashworth Hospital)'. In D. Webb and R. Harris (eds) *Mentally Disordered Offenders: Managing People Nobody Owns*, Routledge. Prins, H. (1999) *Will They Do it Again? Risk Assessment in Criminal Justice and Psychiatry*, Routledge (Chapter 4). More generally see: Prins, H. (1998) 'Inquiries After Homicide in England and Wales', *Medicine, Science and the Law*, 38, 211–220. See also Eldergill, A. (1999) 'Reforming Inquiries Following Homicides', *Journal of Mental Health Law*, 2, 111–136; also Morris, F. (2003) 'Confidentiality and the Sharing of Information', *Journal of Mental Health Law*, 9, 38–50. McGrath, M. and Oyeboode, F. (2002) 'Qualitative Analysis of Recommendations in 79 Inquiries After Homicide Committed by Persons With Mental Illness', *Journal of Mental Health Law*, 8, 262–282. Concerning the lessons to be learned see Petch, E. and Bradley, C. (1997), 'Learning the Lessons From Homicide Inquiries: Adding Insult to Injury', *Journal of Forensic Psychiatry*, 8, 161–184; Reith, M. (1998) *Community Care Tragedies: A Practice Guide to Mental Health Inquiries*, Venture Press. Walshe, K. (2002) *Inquiries: Learning From Failure in the NHS*, Manchester Centre For Health Care Management, University of Manchester.
- 3 Department of Health, NHS Executive (1994) *Guidelines on the Discharge of Mentally Disordered People and their Care in the Community*, HSG/94/27, London.
- 4 Aarvold, Sir Carl, Hill, Sir Dennis and Newton, G. (1973) *Report of the Review of Procedures into the Discharge of Psychiatric Patients Subject to Special Restrictions*, Cmnd 5191, HMSO.
- 5 Spokes, J.C., Pare, M. and Royle, D. (1985) *Report of the Committee of Inquiry into the After-Care of Miss Sharon Campbell*, Cmnd 440, HMSO.
- 6 Unwin, C., Morgan, D.H. and Smith, B.D.M. (1991) *Regional Fact Finding Committee of Inquiry into the Administration, Care, Treatment and Discharge of Carol Barratt*, Trent Regional Health Authority.
- 7 Dick, D., Shuttleworth, B. and Charlton, J. (1991) *Report of the Panel of Inquiry Appointed by the West Midlands Regional Health Authority, South Birmingham Health Authority and the Special Hospitals Services Authority to Investigate the Case of Kim Kirkman*, West Midlands Health Authority.
- 8 Heginbotham, C., Carr, J., Hale, R., Walsh, T. and Warrant, C. (1994) *Report of the Independent Panel of Inquiry Examining the Care of Michael Buchanan*, North-West London Mental Health Trust.

assessment and management.⁹ Finally, the case of Christopher Clunis, probably the best known of all homicide inquiries, has served very much as a pattern to be followed in all the subsequent homicide inquiries mandated by the government instruction of 1994.¹⁰ With a succession of such high profile cases (though minute in relation to the numbers of homicides committed annually overall) and the activities of intruders such as Michael Fagin in Royal Palaces, and Ben Silcock's intrusion into the lion's enclosure at London Zoo, it not altogether surprising that the politicians of the day decided that rather more formal procedures should be established for inquiring into such cases. However, it is also important to add that this need for central government direction was doubtless fuelled by media 'hype'.

It is also of interest to note that governmental preoccupation is with those having a history of involvement with *mental health services*. Although homicides and other serious instances of violence against the person will be the subject of internal inquiries where the perpetrator is known to other services (such as probation or social services), there appears to be no mandate for an *independent external* inquiry in such cases. However, it is also noteworthy that there is nothing to prevent a health authority setting up an independent inquiry into a *non-fatal* case concerning a patient known to the psychiatric services. This occurred in the case of Benjamin Rathbone who pleaded guilty to the attempted murder of a passenger at Loughborough station by pushing him on to the railway track. Mr. Rathbone was subsequently made the subject of a Hospital Order with Restrictions under Sections 37/41 of the Mental Health Act, 1983.¹¹

After much debate a new procedure appears to have now been agreed. In future independent inquiries into homicides are likely to come under the umbrella of a recently established *National Patient Safety Agency*. This agency is intended to serve as a body to collect information about clinical errors by health service staff and is expected to become operational in 2004.¹²

THE RESPONDENTS AND THE RESPONSES

I hope that the foregoing observations will have revealed a number of matters that are of particular concern to those who chair mental health inquiries of one kind or another, but, in particular, homicide inquiries. As stated earlier, I considered that a purely personal view might well be somewhat idiosyncratic. For this reason I addressed a series of questions to 13 respondents, nine of whom replied. No censure is due to the small number who, despite reminders, did not reply, since my two letters of inquiry might not have reached their destinations. To those who did reply (and most at very considerable length) I must express my sincere thanks for the trouble they took.¹³ Almost all of them had undertaken more than one inquiry into mental health or other matters such as childcare. One of my respondents had undertaken four into mental health and two into child abuse. Two had undertaken three and, in addition, one had also been a *member* of mental

9 Blom-Cooper, Sir L. Q.C., Hally, H. and Murphy, E. (1995) *The Falling Shadow: One Patient's Mental Health Care 1978–1993*, Duckworth. Blom-Cooper, Sir L. Q.C., Grounds, A., Guinan, P., Parker, A. and Taylor, M. (1996) *The Case of Jason Mitchell, Report of the Independent Inquiry*, Duckworth.

10 Ritchie, J. Q.C., Dick, D. and Lingham, R. (1994) *Report of the Inquiry into the Care and Treatment of Christopher Clunis*, HMSO.

11 Mackay, R., Badger, G., Damle, A., and Long, R. (2001) *Report of the Independent Inquiry into the Care and Treatment of Benjamin Rathbone*, Leicestershire Health Authority.

12 NHS Federation (2001) *Briefing Note, Issue 49, May*.

13 One of my respondents opted to talk around their answers, so my questions formed the basis of an extended interview during which I made notes of their responses.

health inquiry teams on several other occasions, including internal panels of inquiry. Thus, all of my respondents can be said to be persons of considerable experience and reputation. To the best of my knowledge (professional status was not asked for) all, save one, had legal backgrounds and two were Queen's Counsel. The replies of my respondents have been compressed to present composite answers. This is because of a promise of anonymity and non-attribution.

The questions I put to my respondents are summarised under the following headings. (They are produced in detail in my letter of inquiry – see Appendix).

1. Manner of appointment to chair the inquiry.
2. Extent to which chairman/woman had any 'say' in the selection of team colleagues.
3. Provision of support services.
4. Degree of 'lobbying' by interested parties.
5. Public or private debate.
6. Problems relating to possible conflict of interest between parties.
7. Management of 'hearings'.
8. Access to documentation.
9. Problems in drafting final report.
10. Arrangements for promulgation, publication and dissemination of findings. Feedback from appointing authority and any requests for return to undertake 'follow-up'.

I Manner of appointment to chair the inquiry

For the majority of my respondents the request to chair the inquiry came 'out of the blue'. One respondent had extensive experience of clinical negligence cases; another was already 'known' to the Department of Health; one or two had experience in chairing 'internal' inquiries so their competence was already 'tested'. In one instance, the respondent had agreed to take on the task on the recommendation of a colleague who had been approached first, but was unable to undertake it. The 'out of the blue' approach was usually by an initial telephone call. One of my respondents had chaired two previous homicide inquiries and turned down a request to undertake a third, not wishing to be 'type-cast'. Only rarely did the request seem to come through the recommendation of a body such as the Mental Health Act Commission.¹⁴

2 Extent to which chairman/chairwoman had any 'say' in the appointment of panel colleagues.

In general, chairmen/women did not have any direct 'say' in the appointment of panel colleagues, though in one or two instances names 'were run past' them and if, for any valid reason, they were not deemed suitable their views would have been taken into account. One or two of my respondents thought that chairman/women should be consulted and have a right to veto appointments. In general, chairmen/woman were very satisfied indeed with the contributions made by their fellow panel members.

¹⁴ *In my own case, in the Blackwood inquiry, I was not the first choice for chairman; the nominee of the SHSA was not considered by the Central Government Authority to have sufficient independence. Nominations would seem to be somewhat serendipitous, as the answers to Question 1 indicate.*

3 Support services

Generally speaking support services were considered to be very good. In one or two instances they were regarded as 'exceptional' and greatly facilitated the work of the inquiry.

4 Degree of lobbying by interested parties

Occasional lobbying did occur. For example, requests to hold the inquiry in public rather than in private. In one or two instances, attempts were made to proffer witnesses of an authority's choosing rather than those identified by the inquiry panel. One respondent considered that there had been less lobbying than they had expected. One's overall impression is that lobbying was not a problem. When it arose, it was dealt with effectively (and judiciously) by the inquiry panel.

5 Public or private inquiries

A small minority of my respondents favoured public inquiries (but did recognize the problems of expensive and more lengthy hearings). One or two favoured them if the matters being investigated raised issues of serious national concern or notoriety. The majority of my respondents favoured inquiries in private, largely on the grounds of them being less intimidatory, litigious and better able to deal with sensitive clinical issues. However, a number of them stressed the need for the *findings* of inquiries held in private to be made public. Two respondents thought that there might be a trend for more inquiries to be held in public as a result of the coming into force of the Human Rights Act 1998.¹⁵

6 Problems relating to possible conflicts of interests and the achievement of 'fairness' to all parties

The stresses involved for witnesses in inquiries, whether in private or in public, were noted sympathetically by my respondents. One or two of my respondents noted the problems involved in reconciling relatives' understandable desire to apportion 'blame' and the need to be fair to professional witnesses. There was a reported need to ensure that there was a proper factual basis for any criticisms that might be made. Occasionally, there was a need to 'rein in' a colleague adopting either too hard or too sympathetic an approach to a professional witness. Chairmen and women had to operate a delicate balancing act.

7 Management of hearings

No major problems were identified. Occasionally, witnesses needed to be given a sense of direction to lessen any tendency to ramble or be inconsistent, or to stop the grinding of 'axes'. Emphasis was placed upon the need for the chair of the panel to put all witnesses at their ease and to facilitate the proceedings generally. Some respondents adopted the practice of asking the relevant panel member to begin the questioning of a witness from their own discipline.

¹⁵ This would seem to be the case as is shown by the appeal of Paul and Audrey Edwards to the European Court of Human Rights in respect of the killing of their mentally ill son whilst on remand in prison. (*Edwards v. The United Kingdom*. application No. 46477/99, 14, March 2002). The reference was in respect of the decision not to hold the inquiry into his death in public. Coonan, K. Q.C., Bluglass, R., Halliday, G., Jenkins, M. and Kelly, O. (1998) *Report into the Care and Treatment of Christopher Edwards and Richard Linford*, North-East Essex Health Authority, Essex County Council, H.M. Prison Service and Essex Police.

8 Access to documentation

Several of my respondents would have welcomed clearer central government guidance on the need for compulsory disclosure of documents. Problems had arisen on several occasions when patients or their medical advisers refused access to their medical records. A clearer statement concerning what might constitute public interest 'over-ride' would have been welcomed. In one or two instances problems involved in accessing patients' medical records led to serious delays in the panel's work. This apart, the respondents did not seem to have had difficulty in accessing other medical and allied records. However, comment was made on the poor quality of record-keeping in some cases and an over-abundance of records in others, which took many hours to assimilate and put into comprehensible order!

9 Problems in drafting the final report

There seemed to be a broad consensus of opinion that drafting the final report could present considerable logistical problems. The difficulties of drafting 'by Committee' was alluded to by more than one respondent; it was considered more helpful if the chairman/woman took the initiative in constructing a first draft to be subsequently worked over and amended by the rest of the panel. Occasionally, the sponsoring authority requested changes at the drafting stage. In some cases panels had agreed to these if such changes were considered justified. In others, requests for change were resisted by the panel. One respondent referred to the dangers of individual panel members wishing to ride personal 'hobby-horses' – a tendency which needed to be resisted firmly. An essential requisite seemed to be that parties likely to be criticised should be informed of any potential criticisms in advance and given the opportunity to comment on them. Sometimes, modifications were made if these concerned matters of fact, but matters of opinion would remain unchanged if the panel considered these had been substantiated by their investigators.

10 Promulgation, publication and dissemination of findings. Feedback and requests for follow-up by panel

Respondents identified some problems concerning the 'launch' of their report. For example, insufficient publicity being given to the 'launch'; in some cases the panel members were not invited to attend such events. One is drawn to the conclusion from some of the replies that in a few instances the sponsoring authority did not wish for too much publicity. Hardly ever was there any feedback to panels from sponsoring authorities. Requests to return to see to what extent the panel's recommendations had been acted upon were very rare indeed. Only two of my respondents had been asked to revisit in this way. In one instance the offer was accepted, in the other it was declined on the basis that an independent assessor would be a more appropriate choice. This was acted upon by the sponsoring authority and the panel subsequently informed of the findings. One respondent considered that re-visiting was not appropriate and that the relevant authorities should be trusted to implement any recommendations. Two respondents referred to undue delay in the promulgation of their reports.

Other Observations

Respondents were asked to make any additional observations on matters not covered in my questions. One respondent referred to what could best be described as the serendipitous nature of panel membership. Normally, panel members seemed to work well, but where this might not be the case, serious problems could arise. The need to make proper allowance for the time required for an adequate inquiry was stressed. One or two respondents had reservations as to the impact their reports and recommendations would have on future practice. Another respondent considered that there needed to be some degree of control exercised over the number of inquiries taking place. My attention was also drawn to an omission in my questions to respondents. This concerned the very important question of venue. I had assumed (erroneously as it turned out) that this might be raised under the question of appropriateness of accommodation (Question 3). In most instances, accommodation does not seem to have been a problem. *Venue* is, of course, a rather different matter. In most inquiries it is usual to hold the formal panel hearings in, say, an hotel and arrange for 'site' visits as appropriate. For example, in our inquiry into Orville Blackwood's death, we held most of our 'hearings' at a London hotel. However, we paid several site visits to the unit at which Orville had been detained and also interviewed a number of patients there. We also, at my insistence, visited the local general hospital to which Orville's body had been taken. This was in order to inspect the 'viewing' arrangements for relatives. For various reasons these had been very unsatisfactory and caused Orville's relatives considerable distress. Had we not visited for ourselves, we would not have been able to assess the level of trauma caused to the family. Choice of venue can be a complex matter as, for example, in the on-going Saville inquiry into the events of 'Bloody Sunday' in Northern Ireland. In this instance the issue of whether soldiers/witnesses should travel to the province to give their evidence has proved problematic.

OVERALL IMPRESSIONS

My overall impression from my respondents' answers is that they recognised the inherent tensions involved in balancing the victims' relatives' views and feelings on the one hand, against those of the professionals involved in the case on the other. Most seemed satisfied with the arrangements for support services and accommodation. Lobbying by interested parties did not seem particularly problematic, and possible conflicts of interest seemed capable of resolution. Most respondents favoured inquiries being held in private, but acknowledged the need for public hearings in certain cases where the public interest or notoriety were of paramount importance. They seemed keenly aware of their role in seeing 'fair play' in the conduct of hearings and managing them with an appropriate mixture of informality and 'judicial' restraint. Problems were encountered concerning access to documentation; more specific guidance from central government would have been welcomed on this matter. Drafting the final report was occasionally problematic if sponsoring authorities wished for deletions or amendments. Allowing witnesses to suggest modifications to their factual evidence seemed a helpful device in this respect and panel chairmen and women seemed able to separate this from opinion. It was very rare for panels to be asked to return to the authority to examine to what extent their recommendations had been acted upon; and it was also rare to find the provision of feedback to panels. A final word of caution is necessary concerning the responses I obtained. The sample is a very small one; for this reason it would be unwise to over-generalise any conclusions. Had I chosen to survey a larger number of those who had chaired mental health inquiries the results *might* have been different.

APPENDIX

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CONFIDENTIAL

Dear

I am writing to solicit your assistance in the hope that you will feel able to help me. I have been commissioned by Taylor and Francis (Routledge) to contribute a chapter in a book (edited by Nicky Stanley and Jill Manthorpe of Hull University) and provisionally entitled 'The Age of Inquiry'. The remit given me by the Editors is to discuss some of the problems facing the chairmen/women of Inquiries (and, in particular, those into homicides committed by those known to the mental health services and agencies).

Having chaired three somewhat different mental health inquiries myself (Orville Blackwood's death at Broadmoor, Trevor Holland's absconsion from escorted day-leave to Chessington Zoo (Theme Park) and Sanjay Patel's killing of a vagrant in the City of Leicester) I have naturally formed some views about the problems confronting those who chair such investigations. However, I am very aware that my own views could well be somewhat idiosyncratic. For this reason, I am keen to solicit the views of a small number of colleagues who have chaired mental health inquiries. None of my hoped for respondents will be identified individually; I intend, if possible, to present a 'composite' picture of your views. I do not wish to constrain you in any reply you may wish to furnish me with, but comment on the following matters in particular would be very helpful.

1. The manner in which your appointment was made. For example, were you nominated by a particular agency or organisation or did the request come 'out of the blue' so to speak? The manner in which you were 'sounded out' by the body setting up the inquiry would be of interest.
2. Did you have any say in the appointment of your team colleagues, or were you presented with a 'fait accompli'?
3. Were the support services provided adequate (for example, secretarial/administrative help, accommodation)?
4. Were you exposed to any degree of 'lobbying' by interested parties? (For example, in our 'Blackwood' Inquiry, there was some pressure on the part of some of the parties for us to conduct the inquiry in public. There was also an initial reluctance on the part of the National P.O.A. (but not the local membership) to co-operate).
5. Have you any views on whether such inquiries should be in 'public' or 'private'?
6. Is it possible for you to describe any conflict you may have felt personally in attempting to be 'fair' to all parties and to avoid subjecting them to undue stress?

7. Did you experience any difficulties in ‘managing’ the actual hearings? (For example, was it necessary to exercise more than a ‘light’ degree of control over witnesses or, for that matter, your colleagues)?
8. Did you experience any problems in gaining access to relevant documentation (for example patient’s and other records)? Would clearer central government guidance on this matter have been of assistance?
9. Did you experience any major problems in drafting the various stages of the final report? Were there significant pressures placed upon you to modify your version of events, the conclusions you drew from these and your final recommendations?
10. Were you satisfied with the arrangements made for the promulgation, publication and dissemination of your findings? Were you asked to revisit to see if your recommendations had been implemented?

The above questions are, of course, highly selective and you may well have identified from your experiences other areas of concern that I have not indicated. Please feel free to add any additional comments.

Finally, may I thank you in anticipation for any help you may feel able to offer me. I enclose a stamped and addressed envelope for your reply.

With best wishes.

Yours sincerely,