Looking Through the Reeds: System-Theorising the Independent Homicide Inquiry

A thesis submitted to the University of Manchester for the degree of Doctor of Philosophy in
the Faculty of Humanities

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<td>AO</td>
<td>Assertive Outreach</td>
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<td>CPA</td>
<td>Care Programme Approach</td>
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<td>CPN</td>
<td>Community Practice Nurse</td>
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<td>CRHT</td>
<td>Crisis Resolution and Home Treatment Team</td>
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<td>DSPD</td>
<td>Dangerous and Severe Personality Disorder</td>
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<td>Driving and Vehicle Licensing Agency</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HO</td>
<td>Home Office</td>
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<td>IHI</td>
<td>Independent Homicide Inquiry</td>
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<td>IIT</td>
<td>Independent Investigation Team</td>
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<td>MHSU</td>
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<td>SUI</td>
<td>Serious Untoward Incident</td>
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<td>SHA</td>
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Abstract
Submitted by David P. Horton for the degree of PhD entitled *Looking Through The Reeds: System-Theorising the Independent Homicide Inquiry*, School of Law, Faculty of Humanities, University of Manchester, August 2013.

Independent Homicide Inquiries (IHIs) investigate homicides committed by persons in receipt of mental health services. They explore the potential causes of these events in order to learn lessons and improve the future provision of mental health services. IHIs decipher complex mental health care histories that, on further inspection, appear resistant to linear causal theories about what actually happened. IHIs are thus constantly open to indeterminacy in their findings regarding what caused the homicide, whether it was predictable and whether it could have been prevented. This is important because IHIs use these findings as a platform for changing the way mental health services are provided.

The present thesis implements a theoretical framework, based on Niklas Luhmann’s systems theory, which explains why this problem occurs. Luhmann argued that reality is constructed by distinctly meaningful social systems of communication based around specific social codes. He furthermore posits that decisions are open to continual objection, disagreement and regret. Not only can decisions be decided otherwise by virtue of being decisions, but that social systems will observe decisions in different ways. Decisions can always be observed to be objectionable, incorrect and regrettable after they have been taken.

Using this framework, this thesis asks how IHIs retrospectively understand the provision of mental health services in the cases that appear before them. It argues that IHIs construct their investigation and findings using specific social communications that give their observations specific meaning. In light of an expanding, interconnected decision making edifice that comprises mental health services however, the link between identifiable decisions and acts of homicide is obfuscated by ‘systems and processes’. This, in turn, obfuscates individual agency. The thesis consequently calls for a revision of what it means to hold mental health professionals to account in the aftermath of homicide.
Declaration

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Dedication

This work is dedicated to Rose ‘Nanna’ Horton (1922 – 2010).

David. P Horton, August 2013, Manchester
Acknowledgment

I have been incredibly fortunate to spend the last few years engaged in doctoral research. This experience has exposed me to a wealth of knowledge, ideas and opportunities for personal development. I am truly grateful for this. It all would not be possible however without the love and support of my family. I thank them from the bottom of my heart.

I owe an incredible thanks to my supervisor, Kirsty Keywood. Kirsty has held an unwavering belief in my abilities ever since she supervised my Masters’ dissertation in 2004. She also first introduced me to systems theory in 2009. It has been a pleasure to be her student, despite being pushed to the limit on many occasions. I would also like to thank my second supervisor, Professor Toby Seddon. His intellectual guidance has proved invaluable from start to finish. We have shared numerous discussions that proved absolutely crucial in helping this thesis come to life. I must also thank Gary Lynch-Wood and Dave Williamson for being willing to engage in discussion with me about the merits of systems theory.

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A final thank you goes to Karen, for her presence.
Chapter 1

Introduction

1.1 Research Background

Homicide – known in law as the unlawful killing of a human being, is a criminal offence. Two forms of homicide exist. The first is murder (which requires an intention to kill or commit grievous bodily harm). The second is manslaughter (which does not require an intention to kill or commit grievous bodily harm). When committed, these offences activate a series of measures. The perpetrator is arrested, charged, sent to trial and, if found guilty, is usually given a custodial sentence. A coroner’s inquest will undoubtedly be held. A death certificate is signed. The family of the deceased may initiate a claim in the civil courts. An additional legal and policy response is invoked however if the perpetrator was receiving care and treatment from mental health services for a mental disorder at the time of the offence.

One key response - the Independent Homicide Inquiry (IHI) - is an investigatory measure mandated by law and set up by policy makers in order to examine the care and treatment received by the perpetrator before the homicide was committed.

Buchanan claims that when mental health homicides occur, there is a prima facie case for arguing that inadequate mental health care was provided.¹ Care and treatment provided to a homicidal patient is therefore placed under intense scrutiny with a view to confirming whether or not the care and treatment provided was de facto inadequate. The IHI is the central vehicle through which this is achieved. What is more, IHIs necessitate a shift in focus away from the perpetrator of the homicide towards the actions and decisions of those previously responsible for the perpetrator’s care and treatment.² Mental health services, therefore, carry a huge responsibility. Not only must they provide effective care and treatment, they must also be attentive to those patients who may be at risk of harming others. They are also expected to account for their actions and decisions when adverse events occur.

The IHIs investigatory responsibility is sometimes compounded by difficult-to-treat patients. This may be for reasons related to the complexity of the patient’s condition (for instance, a patient may have more than one mental disorder). Other reasons include the

¹ A. Buchanan ‘Independent inquiries into homicide: Should share common methods and be integrated into new quality systems’ 318 (1999) BMJ 1089 at 1089.
patient’s aggravating circumstances (such as drug use), multi-professional involvement (for example, patients with complex presentations often require care and treatment from different professionals, such as psychiatrists, social workers and housing officials), nomadic lifestyles (it is not uncommon for patients treated in the community to move location without informing mental health services) and so on. When a mental health homicide does occur, the initial response is to scrutinise the care and treatment provided. Was there a weak link in the previous chain of decision making which made the homicide inevitable? Did a mental health professional do something that he or she should not have done?

These questions are often asked by IHIs, despite there being a thick density of past decision making in the case that is notoriously difficult to unravel. They make for very complex, question-begging investigations. ‘Seeing the wood for the trees’ is often an issue in cases. As one notable IHI report commented, “[w]e have given this report the title of ‘Looking Through the Reeds’ as this phrase was used to us by a sister of John West to describe the inherent difficulty of reconstructing events prior to the homicide”.3 The present thesis adopts this title also in order to encapsulate its argument. A claim advanced in Chapter 4 and 6 particularly is that IHI investigators are faced with a raft of historical interconnected decisions that cannot be meaningfully excised from the corpus of decisions made about a patient.

This thesis identifies the IHI as providing a vital context through which a small series of interrelated theoretical questions can be asked. This is because the IHI raises issues relating to the concept of risk (mental health homicide risks and their reduction), the issue of time (IHIs are prominently retrospective investigations) and accountability (IHIs must elicit information from mental health professionals about their past decisions and create conditions for those professionals to make better decisions going into the future). More specifically, this thesis is concerned with how systems theory – with its emphasis on the concept of communication - and the concepts of risk and accountability can shed further light on the nexus between mental health care services and the law. The IHI is the most appropriate context through which this nexus can be illuminated. This is because the thesis recognises that the IHI is a unique brand of administrative mechanism that has emerged in recent years. It is able to explore complex areas of decision making that traditional mechanisms (such as law) are seemingly ill-equipped to cope with. Nevertheless, the IHI relies on the existence of law

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and policy to exist and formulate its aims. As a quasi-legal mechanism, IHIs thus straddle the boundary between law and policy on the one hand and mental health services on the other. They provide a conduit through which the former can investigate and change the way the latter is provided. To reiterate, this thesis is not simply about exploring a defined series of theoretical questions through the conduit of the IHI. It is also about providing a fresh look at how the connection between law, policy and mental health services is constructed.

This, in turn, requires identifying a set of research objectives. The central question of this thesis is to examine the extent to which the legal and policy objectives anticipated by IHIs, namely, the learning of lessons from homicide events, the investigation of their causes and the subsequent improvement of mental health services can be achieved. This is important because the use of IHIs has continually been a source of controversy. It has been reported that mental health professionals regard the involvement of IHIs as invasive and humiliating. They are said to have little use value because they are expensive, time consuming, biased and fail to produce answers to some basic questions about what happened in a particular case. These questions typically relate to why the fatal event happened and what can be done to prevent a future homicide happening again. This thesis acknowledges that IHIs are stifled in their efforts to fulfil their stated legal and policy objectives. The construction of a theoretical framework based on systems theory, risk theory and accountability theory can assist with exploring these issues.

1.2 The Theoretical Framework: In Brief

Systems theory is concerned with how reality is constructed using certain types of social communications. For instance, systems of communication like law will create distinct legal realities. Scientific systems of communications will construct distinct scientific realities. The same applies to the system of psychiatry; a psychiatrist will ordinarily construct reality in terms of what kind of mental disorder a patient is suffering from, what treatment they should receive and so on. These points appear trite, but they are stitched together by a unique theoretical perspective regarding how meaning about social reality is produced in order to ‘control’, ‘monitor’ and ‘steer’ society.

IHIs are concerned with constructing mental health homicide cases using certain types of communications also. What these communications are will become apparent in due

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5 Ibid., at 7 and 8.
Generally speaking however, they are systems of communication that have specific meaning in specific contexts. What is more, IHIs construct a particular reality about mental health homicide cases that may not be meaningful or even recognisable in other contexts that do not utilise the same communications. Systems theory resonates convincingly with this trait. Its concepts prompt the question as to whether systems of communication, particularly those that make up the IHI process, construct the reality of mental health homicide in a way that is accessible and meaningful in other contexts removed from the IHI process. By way of example, the findings and conclusions of an IHI might well have a wholly different significance and meaning in other contexts of meaning, for instance in the managerial or administrative departments of an NHS Trust or the media. This point is important because it begins to question how the mental health profession is understood by those outside of it and what role, if any, the IHI has in mediating a relationship between law, policy and the provision of care to homicidal individuals.

IHIs seek to learn lessons for the future. In order to do this however, they must investigate what happened prior to the homicide and use their findings to propose changes to the future provision of mental health services. It is for this reason that issues of time are hugely important to the study of IHIs. What is more, this can act as a gateway for the further recruitment of systems theory because time is important to the latter also, in two ways. On the one hand, systems theory posits that certain types of communications must refer back to previous communications of the same type in order to have meaning. For example, communicating a medical diagnosis or a legal argument is meaningful because previous communications (medical research and case law respectively) provide a vital point of reference for those communications. On the other hand, systems of communication take time to be triggered. An adverse event may occur, prompting reactions from the medical and legal professions. And yet these professions, supported by systems of communication that comprise their identity, respond at different speeds. Medical communications to a homicide will often be triggered immediately (the administration of medication, for example), whereas legal communications are produced much later, for example in court proceedings.

In the same way that time is important, so is risk. Risk refers to the future and the probability that an adverse event is likely to happen but has not yet occurred. When reaching

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6 See R. Nobles and D. Schiff ‘A Story of Miscarriage: Law in the Media’ 31(2) (2004) Journal of Law and Society 221 at 222. Nobles and Schiff explore the relationship between law and the media in the context of miscarriages of justice, arguing that “the media misreads law for its own purposes”.

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In their findings, IHIs must instigate a raft of decision making. They do this in order to address perceived flaws, problems and concerns identified by the investigation. This is often done through making recommendations. This involves calling on decision makers within the NHS Trust to implement measures that change the way mental health services are provided. These decisions have future consequences and are taken so as to minimise their negative effects. They are taken to minimise or eradicate risks, namely the reoccurrence of homicide events. In the same way that time is a relevant concept to IHIs and systems theory, so is risk. As Chapter 4 will demonstrate, systems theory posits that communicating is inherently risky because it is never certain that decisions, supported by social systems of communication, will achieve their desired effect. Everything happens at once. The environment in which a decision is made is constantly in flux with communication, meaning that decisions will be constantly prone to error, objection and regret by virtue of being made in a world of contingency. The IHI provides a unique context with which to appreciate how mediating the link between law and psychiatry is fraught with risk and uncertainty.

Lastly, accountability theory is important because IHIs must interact with members of the mental health profession (and others too, such as the perpetrator and relatives of the deceased) in order to discover what happened and why. Again, this involves the concept of time (because mental health professionals must account for their past decisions) and risk (because the IHI want to make a set of future-oriented recommendations based on the accounts rendered before it). The IHI therefore provides a fruitful space with which to connect these interlocking concepts and thus facilitate the construction of a theoretical framework. Again, this framework can ultimately shed some new light on what it means to mediate the complex nexus between law and psychiatry when adverse events occur.

In order to do this, it is important to consider the extent to which the concept of accountability is used to advance the aims of law and policy-makers when it comes to investigating mental health homicide cases. The concept of accountability has been said to perform a variety of analytical and rhetorical tasks, but it is said to be generally concerned with the situation where persons are called to provide an account for their previous actions and decisions before an authority. This is reflective of what happens during IHIs. Persons, particularly mental health professionals, render accounts before an IHI so that the latter can

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build up a picture (rendered meaningful through the lenses of communication it uses) of what happened, what caused the homicide and what lessons for the future can be learned from it.

1.3 The Methodology
The research conducted for the present thesis imports a qualitative, literature-based approach. This is complemented by some use of legal resources (both primary and secondary). This approach is two-fold. Firstly, the thesis reviews the relevant law and policy literature relating to IHIs. The theoretical framework of the thesis is rooted in systems theory however, which prompts an interdisciplinary perspective. It therefore cultivates areas from legal and sociological research. Secondly, a qualitative analysis of a sample of IHI Reports\(^8\) (Chapter 6) is used in order to achieve the thesis objectives and corroborate the theoretical framework. More specifically, this method is a tool which, like a case study (although broader and more in-depth than a case study approach) allows “researchers to study complex phenomena within their contexts”\(^9\). The merits of this sample-based approach lie in its ability to introduce a broad, representative context into what would otherwise be a highly abstract piece of work. This is useful for a study of the present type. Systems theory is known for its abstract concepts. A close reading of IHI reports can help strike an appropriate balance between abstraction and context. As will be discussed later in this work, employing research methods of this kind is somewhat of a paradox in the context of systems theory. The latter promulgates the view that all meaning derives from communications and thus cannot be relied upon as a guide to objective ‘truth’, which is what researchers often try to achieve as much as they can.

Analyses like the one described above must however be selective. The analysis introduced in Chapter 6 involved a review of 30 IHI Reports\(^10\). The wealth of themes and information extracted from these Reports is stunning. The sample of Reports chosen was limited and only those themes that resonated with the theoretical issues raised in Chapter 2, 3, 4 and 5 are explored. The work makes an attempt to be as comprehensive and informative as possible. It is for this reason that aspects of the wider law and policy literature are considered from time-to-time.

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\(^8\) Capitalisation is used when referring to IHI reports used specifically for the analysis conducted in Chapter 6.
\(^10\) Chapter 6 of the thesis is the culmination of a review of 30 IHI Reports by six Strategic Health Authorities (SHAs) in England.
1.4 Thesis Outline

This work is comprised of seven chapters and is divided into three parts. Part I (Chapter 2) introduces the context of the IHI, what it is, its rationale, its foundation in law and policy and its relevance to systems theory. Part II (Chapter 3, 4 and 5) establishes the theoretical spine of the thesis. Chapter 3 introduces the central concepts of Luhmann’s systems theory and develops themes introduced at the end of Chapter 2 by locating the relevance of these concepts to the IHI. These concepts are used in order to understand what the IHI is from the perspective of systems theory. Chapter 4 introduces the concept of time and its connection to systems theory. The concept of risk is also introduced, specifically Luhmann’s version of it. The purpose of this chapter is to develop further the theoretical linkages between risk and time, whilst at the same time informing an original understanding of IHIs and how they work.

Chapter 5 develops the theme of risk by introducing a systems theory-based reading of the concept of accountability. This is done in order to explore the way in which IHIs form multiple relationships with professionals in order to elicit accounts about mental health homicide. This is connected to Luhmann’s theory of social systems and risk. More specifically, this chapter is concerned with the specific view that past decisions are inherently regrettable and comprise a network of possibilities that render making decisions in the present uncertain. Accountability, it is argued, is the communicative vehicle through which this network of possibilities becomes meaningful to an IHI Panel.

Part III (Chapter 6) sets out the contextual analysis. Thirty IHI Reports published by 5 Strategic Health Authorities (SHA) in England are reviewed. Important themes are extracted from these IHI Reports with a view to providing the contextual corroboration necessary to vindicate (or question) the theoretical framework laid out in Part II. Some common, taken-for-granted assumptions (both past and present) regarding the extent to which IHIs can adequately address the cases that come before them are questioned. Ultimately, Chapter 6 connects the abstraction of systems theory and the theoretical framework in general to the practical nuances of IHIs, which have yet to be explored using a theoretical framework based in systems theory.

Chapter 7 concludes by addressing the issue of utilising systems theory with a view to advancing the possible ways in which it can support normative claims for change. This thesis claims that there is nothing to prevent systems theory being used to posit suggestions regarding whether or not IHIs should be modified or replaced by a system that avoids
contingency, indeterminacy and professional anxiety. It nevertheless faces the realisation that contingency and indeterminacy are an inevitable part of homicide investigations, regardless of the approach used.
Chapter 2

The Independent Homicide Inquiry

2.1 The Independent Homicide Inquiry: A Brief Outline

Walshe and Higgins define an NHS inquiry generally “as a retrospective examination of events or circumstances surrounding a service failure or problem, specially established to find out what happened, understand why and learn from the experiences of those involved”.\(^1\) IHIs reflect this description, except that they are concerned with homicides specifically. They appear to vindicate the view that “we gain our knowledge of life in catastrophic form”.\(^2\) To reiterate, a mantra repeated by law and policy-makers over the years is that IHIs facilitate the ‘learning of lessons’.\(^3\) This learning however is only made possible through the commission of a horrific act of violence. IHIs clearly gain their knowledge in the most catastrophic circumstances possible.

IHIs can also be said to gain knowledge for future improvements, namely, the compiling of recommendations that change the way mental health care services are provided. At many times during this thesis, reference will be made to the recommendations that IHIs make. These recommendations normally seek to alter the way mental health services are provided so as to improve the latter. For instance, an IHI may recommend that an NHS Trust provide more rigorous training for staff or it may suggest the recruitment of further staff. Whilst recommendations are based upon the acquisition of knowledge during an investigation, this is hedged with expertise specific to an IHI Panel. Expert and professional knowledge generally is asymmetrical.\(^4\) IHI Panels share commonalities with many of those who are the target of their investigations, namely, mental health professionals. And yet, by virtue of sitting on an IHI Panel, there will be inevitable differences in the way an IHI Panel will approach the

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\(^1\) K. Walshe and J. Higgins, ‘The use and impact of inquiries in the NHS’ 325 (2002) BMJ 895 at 895. See also Buchanan op.cit., at 1089. He writes that “[t]he question they [IHIs] should attempt to answer is: Was there anything that should have been done, but was not done, which would have reduced the chances of the homicide occurring?”


\(^4\) See J. Black, ‘Decentering Regulation: Understanding the Role of Regulation and Self-Regulation in a Post-Regulatory World’ 54 (2002) Current Legal Problems 103 at 107. Black raises the issue of knowledge asymmetry in the context of regulation, but it resonates with the issue of how asymmetrical relations between different actors in complex industries and professions are inevitable also.
issues in each case and the professionals whom it is investigating. After all, those individuals called to account before IHI Panels will have first-hand experience of making decisions about a particular patient in highly-pressurised circumstances. Mental health professionals called to account before IHI Panels are furthermore called to account for what they did in a past mental health care context. There is a reliance on memory and hindsight in this respect, which are not always reliable.

IHI Panels are composed of a range of professionals and are specifically skilled in the task of investigation in the present. Those called to render accounts before an IHI Panel therefore often do not have the breadth of knowledge, skills and expertise possessed by the IHI Panel itself. Investigations require a different set of skills and techniques. What is more, the experiences of mental health professionals called on to give accounts before the IHI Panel are just that. They are experiences that cannot be re-lived through by members of an IHI Panel. Those experiences are unique and may not be completely understood except by the person whose experience it was. Can the skills and techniques of an IHI Panel, despite their perceived reliability, really help an IHI Panel reach objective conclusions about the adequacy of mental health services provided to a homicidal patient? Can IHI Panels base accurate recommendations for the improvement of services, based on their findings? Using systems theory, there is reason to doubt that it can. This thesis indicates that IHIs are fraught with problems that centre on the distilling of complex case histories. These histories involve many decisions, decision makers and a galaxy of possible causal theories about what could (or should not) have been done in relation to the patient. As this thesis will show, the complexities of IHI cases pose considerable challenges for an IHI Panel. Answering what appear to be the most basic questions, such as why the homicide happened, whether it could have been prevented and whether future events can be prevented is often not straightforward.

2.2 Independent Homicide Inquiries: A Brief Law and Policy History

IHIs were originally mandated in government guidance document HSG(94)27. Issued in 1994, HSG(94)27 set out the circumstances in which an IHI should be held. Paragraph 34 of

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5 See Department of Health, Local Authority Social Services Letter (LASSL)(94)4/HSG(94)27, Guidance on the discharge of mentally disordered people and their continuing care in the community (London: Department of Health, 1994) as amended by Independent investigation of adverse events in mental health services, (London: Department of Health, 2005). The 2005 amendments to HSG(94)27 stipulate that the skills and expertise of the investigation team include “relevant clinical, social care and managerial expertise; other expertise where appropriate eg housing or probation; investigation skills such as root cause analysis or similar; report writing skills; interviewing and communication skills”.

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HSG(94)27 specifically stated that “in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved”.6 Paragraph 36 sets out the remit of an independent inquiry. It stipulated that they should encompass “the care the patient was receiving at the time of the incident”, “the suitability of that care in view of the patient’s history and assessed health and social care needs”, the extent to which that care “corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies”, “the exercise of professional judgement” and “the adequacy of the care plan and its monitoring by the key worker”.7

Paragraph 33-36 of HSG(94)27 was amended in 2005 however to reflect shifting medical, social and legal conditions.8 On the one hand, the amending guidance posits that independent inquiries must be set up in response to a homicide committed by a person who was receiving care from specialist mental health services in the six months prior to the event. On the other hand, independent inquiries must be set up to comply with the State’s obligation to conduct an effective investigation into the circumstances surrounding the death of an individual potentially caused by the State, as required by Article 2 of the European Convention on Human Rights (ECHR). An independent inquiry must furthermore be set up if the SHA is concerned that an adverse event represents a serious systemic service failure. IHIs largely fall into the first two categories. They often emerge suddenly under the umbrella of mental health care provision as shocking and isolated events, triggering the State’s Article 2 obligation to carry out an effective investigation.

2.2.1 Independent Homicide Inquiries as a Quasi-Legal Species

Legal proceedings, in common law countries at least, are known to be adversarial. Litigants argue their case and the court decides if a case has been proved or not. There is no ‘investigation’ by the court. IHIs however are not courts of law. There are no litigants and there is no case to promote by any party.9 They are investigative. What is more, IHIs do not produce case law, nor do they rely on it. IHIs are not hedged with the strictures of legal rules and procedure typical of the courts. References to the law in IHIs sit in tandem with a host of

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6 Department of Health, Guidance on the discharge of mentally disordered people and their continuing care in the community, NHS Executive, HSG(94)27, p 11, para. 34. The exception to this however is where the victim is a child. The unlawful killing of children is investigated by an “Area Child Protection Committee”.
7 Ibid., para. 36.
8 Department of Health, Independent investigation into adverse events in mental health services, op.cit., n. 5.
other factors that a court of law would not consider relevant or even meaningful. NHS policy and psychiatric expertise are but some of the relevant considerations IHIs embody in a bid to investigate the possible causes of the fatal event and what lessons can be learned going forward. IHIs create space for law to be communicated about with other non-legal factors, as opposed to creating law through its processes. As will be discussed later, IHIs represent part of a recent explosion of administrative measures that enable law and policy-makers to investigate complex areas of life that ordinarily would be impervious to investigation using traditional methods, such as the courts.

Using systems theory, Chapter 3 considers the extent to which the IHI is a system of communication that is separate from the law. This is a complex question from the point of view of systems theory. If law is a ‘system’ under systems theory, an IHI surely is a host for many different ‘systems’. As will become clear in the thesis to follow, IHIs are an eclectic soup of legal and non-legal expertise. To reiterate, they can perhaps be associated with an explosion of administrative/regulatory mechanisms - agencies, commissions and authorities - designed to oversee complex areas of life that traditional forms of law are ill-equipped to cope with.\(^\text{10}\) This explosion has been considered to be a response to the failings of cumbersome legal processes and a distrust of government generally.\(^\text{11}\) This has stimulated concern regarding the tackling of pressing social problems with effectiveness and impartiality. The introduction of sentencing commissions\(^\text{12}\) and prosecution services, for example, were seen to overcome this problem; their *ad hoc* rule-making function was considered more flexible and responsive than the slow, cumbersome legal procedures typical of the legislature and the courts.\(^\text{13}\) These administrative bodies have recently been referred to as “fourth branch of government”, due to their rising prominence.\(^\text{14}\)

Whilst not strictly ‘rule making’, IHIs can be similarly regarded. They are a flexible means of investigating the complexities of mental health care that traditional arenas of law are considered incapable of addressing effectively and precisely. IHIs furthermore promulgate changes in the delivery of mental health services that traditional legal methods would not be

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\(^\text{11}\) Ibid.

\(^\text{12}\) Sentencing commissions are agencies that form part of the judicial branch of the United States government. They are independent and, amongst other things, are set up to establish sentencing policies and practices for the federal courts (see United States Sentencing Commission, ‘An Overview of the United States Sentencing Commission, http://www.ussc.gov/About_the_Commission/Overview_of_the_USSC/USSC_Overview.pdf, accessed 21 August 2013)

\(^\text{13}\) A.J. Wistrich, op.cit., at 785.

\(^\text{14}\) Ibid., at 784.
able to conjure with any specification or precision. IHIs therefore act as a nuanced conduit of localised change in mental health services that would ordinarily be impossible to consider using other means, such as law. Combined with the ambiguous nature of IHIs under systems theory, it can be said that IHIs form part of a new genre of ‘government’ that is distinctly different from traditional legal methods.

2.2.2 Independent Homicide Inquiry Panels

HSG(24)94 originally required that a legal member (a judge or senior lawyer) chair an IHI Panel. He or she was thought to bring a special skill-set into the process, although the extent to which this was beneficial has been disputed. The 2005 amendment to HSG(27)94 however has since changed this. The purpose of this amendment was to bring IHI Panels closer to the issues of expertise raised in cases and help accurately identify lessons that could be learned for future practice. The technical idiosyncrasies raised in cases were considered alien to the backgrounds of lawyers. An IHI Panel composed without lawyer would arguably minimise misunderstanding of the technical issues raised.

For example, if the case requires extensive scrutiny of social services, then the IHI Panel should be tailored to this end. A problem noted with having a legal member on an IHI Panel was that they are good at establishing cause and effect through persuasive argument but “are poor at checking the reliability of their inferences”. The technical issues of mental health practice were increasingly seen as being somewhat removed from the background and expertise of the judge and lawyer. The latter were eventually considered to be overly inflexible and unsuitable for dealing with cases that did not require rigorous legal scrutiny. This concern is understandable. Courts in England and Wales operate on the basis that “each

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16 G. Szmukler, ‘Homicide inquiries: what sense do they make? 24 (2000) Psychiatric Bulletin 6 at 9. Szmukler illustrates the double-standard thus: “[w]hat if a psychiatrist chairman of the inquiry panel were giving an account at a press conference of a report, years in the preparation, to be presented to the Bar Council of, for example, evidence not adequately uncovered, poor communication between members of the prosecution team, arguments poorly presented, and so on, all in the presence of the victim’s family and the sensationalist-seeking gaze of the media? Would this be reasonable?”
17 Supra., n. 5.
18 D. Carson, op.cit., p 143.
side has a case to be placed before the court for the court’s consideration”. 19 This appeared ill-suited to the more inquisitorial approach championed by the 2005 guidance. 20

Although post-2005 IHIs aim for more objectivity in their investigations, scholars remain reticent about the extent to which the technical skill-set they inhere can achieve this aim. 21 IHIs involve an open and flexible process. Unpredictable consequences can emerge from them. They are always willing to hear evidence from contributors unbound by rules of evidence typical of the courts. IHIs field evidence from many different sources too. These sources include psychiatrists, social workers, probation officers, General Practitioners, psychiatric nurses, housing officers, family members and patients. IHIs are a social process in this respect, involving considerable interaction. 22 This can exact heavy workloads on IHI Panels and stimulate a galaxy of issues that may seem relevant at the start of the investigation but fade into irrelevance as the investigation progresses. This style of investigation would arguably prove challenging for lawyers who would not ordinarily encounter such difficulties in their usual line of work. 23 Compiling a theoretical framework that takes into account how the relationship between mental health homicide events and mental health care is observed and understood must therefore consider the unique role the IHI Panel has to play. After all, IHI Panels must marshal this relationship by holding persons to account, allowing witnesses to give evidence and reviewing swathes of documentation relating to the patient’s care. What is more, all this must be done using a particular set of skills and expertise.

2.3 Independent Homicide Inquiries: What The Current Research Shows

From the 1990s onwards, IHIs have attracted attention from scholars interested in how they work, what they achieve and whether they can realistically achieve their goals. This scholarly interest has ignited debates that are, to some extent, employed in the present thesis in order to support the theoretical framework. It is apposite at this early stage to briefly signpost these debates.

19 R. Scott, op.cit., at 596.
21 J. Peay, Themes and Questions: The Inquiry in Context’ in J. Peay (ed.) Inquiries After Homicide, op.cit., p 27. Writing about the IHI Panel, Peay notes that “[t]he questions it asks, the problems it perceives or fails to perceive, the resolution of which participants are to be seen as having fallen from grace, will be a reflection of the make-up of the panel, no matter how skilled they are at remaining objective”.
The Ritchie Report\textsuperscript{24} and \textit{The Falling Shadow}\textsuperscript{25} are perhaps two of the most high-profile examples that have stimulated debate and research into IHIs in recent years. Other examples may be cited too, such as the Michael Stone case.\textsuperscript{26} It is the Ritchie Report and \textit{The Falling Shadow} however that are notable for their unique style, impact and ability (or inability, depending on one’s point of view) to procure the ‘learning of lessons’. Authored by Blom-Cooper, \textit{The Falling Shadow} was however considered to be too idiosyncratic, unhelpful and gave the impression that the IHI Panel ghoulishly enjoyed their experience working on the case.\textsuperscript{27} The tone set by \textit{The Falling Shadow} sat uncomfortably with lawyers and psychiatrists.\textsuperscript{28}

The Ritchie Report, on the other hand, was hailed in Parliament as the archetype in IHI reporting.\textsuperscript{29} Not only was it known for its ability to vividly expose the fragmented provision of mental health services in East London at the time, but it also became known for the personalities involved in the case. For instance, the wife of the deceased was very prominent in proceedings. She gave evidence to the IHI Panel and was praised for her participation. She later went on to found the Zito Trust, an organisation instrumental in bringing about legal reform of mental health legislation.\textsuperscript{30}

During the 1990s, the Zito Trust commissioned the publication of the seminal \textit{Learning the Lessons}, authored by Dave Sheppard.\textsuperscript{31} This work is a compilation of over 700 recommendations advanced by IHIs between 1969 and 1996. The premise supporting this effort was to provide an accessible and concise summary of those lessons learned in each case. A common criticism of IHIs is that despite their good intentions, learning lessons from them

\textsuperscript{29} HL Deb, vol. 262, col. 159, 20 June 1995: “We have in particular taken very full account of the recommendations of the inquiry into the treatment and care of Christopher Clunis”.
\textsuperscript{30} See O. Bowcott, ‘Jayne Zito: why it’s time to end the campaign’ \textit{The Guardian} (London 17 May 2009) http://www.theguardian.com/society/2009/may/17/jayne-zito-trust-charity-schizophrenia-clunis. In this piece, Jayne Zito specifically cites the passing of the Mental Health Act 2007 as a reason for dissolving the Zito Trust. She regarded the Trust’s work as ‘done’, accepting that it had successfully campaigned for what it regarded as an acceptable change to the law.
\textsuperscript{31} D. Sheppard, op.cit.
is quite difficult. On the one hand, there is no central repository containing all published IHI Reports, with some reports being difficult to obtain. Although these are factors which *Learning the Lessons* attempted to address, the latter has since been criticised on the basis that it failed to place the recommendations it cites into sufficient context. Without providing adequate context and meaningful links between recommendations, *Learning the Lessons* ironically inhibits the learning of lessons.

At about the same time as *Learning the Lessons*, a one-day seminar was held at which a range of academics, professionals and lawyers exchanged views about what IHIs do, the benefits they bring and, crucially, the lessons learned from them. The outcome of this exchange was an edited collection importing a range of themes and perspectives about inquiries after homicide. Generally speaking, it can be said that the current status of research in this area is a variation on one theme, namely, the extent to which IHIs facilitate the learning of lessons. Research conducted since 1996 has been sporadic, but it nonetheless makes a range of observations about the benefits and pitfalls of IHIs. If IHIs are considered to assist in the learning of lessons, as law and policy-makers believe, how do these beliefs correlate with the problems scholars have identified? These problems are indeed varied. They include the difficulty of conducting retrospective investigation, the engagement in counterfactual reasoning, the accessibility of IHI findings, an IHI Panel’s awareness of evidence, the examination of individual conduct vis-à-vis structural factors and the effects investigations have had on professional’s confidence.

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33 J Peay (ed.), *Inquiries After Homicide*, op.cit.
35 D. Reiss, op.cit., at 177. Reiss argues that IHIs “mutate” those past actions of mental health professionals that could have easily been done differently. This arguably prompts a dysfunctional causal analysis to occur which does not reflect reality; a cause may be imputed to a homicide on the basis that an event simply could have been done differently, as opposed to it being judged as a fundamentally causative.
37 R. Scott, op.cit., at 602. Scott points out that “witnesses of whose existence and of whose evidence the Inquiry has no knowledge cannot be asked to give evidence”.
38 D. Carson, op.cit., p 120.
39 G. Szmukler, op.cit., at 8.
Chapter 2 – The Independent Homicide Inquiry

Other complaints revolve around the view that IHIs foster clinical blaming cultures and encourage defensive medical practices. Experience has proved that learning lessons from mental health homicides is less than straightforward. It is sometimes fraught with emotion. Scholars have acknowledged the government’s concern that homicide inquiries engender ‘blaming cultures’ because they are so case-specific. Attempts have been made to distil an explanation for this by turning attention to the way in which the findings of IHIs are reported in the media.

Rather than contributing to this field of research by simply exposing the practical issues relating to IHIs, this thesis conducts a theoretical examination of these practical issues. More specifically, the thesis advances a theoretical explanation for the claim that IHIs do not facilitate the learning of lessons in the way that law and policy-makers hope. The various practical explanations surrounding that claim are drawn together under a theoretical framework inspired by Luhmann’s systems theory, but drawing upon other influences from accountability and risk theory. The thesis acknowledges that it is worthwhile deploying systems theory for its resonance to the issues at stake, but that it is also apposite to deviate from systems theory at various junctures. This work has therefore attempted to remain flexible. The overall rigidity of Luhmann’s theory of social systems can make it appear uncompromising, particularly when it comes to Luhmann’s general pessimism regarding the ability of social systems to ‘steer’ society in a particular direction. What is more, the high-level of abstraction often makes it difficult to give systems theory adequate context, especially when it comes to making sense of the idiosyncrasies of IHIs. The latter are peculiar because they represent one of many new ways in which adverse events are being addressed by law and policy-makers.

42 G. Szmukler, op.cit., at 8.
2.4 Systems Theory and Independent Homicide Inquiries

Systems theory is an ideal theoretical framework for the present thesis because it is concerned with the way complex interconnections between events, objects and concepts are understood through meaningful observation. To reiterate, the IHI provides a perfect context for such a framework because it harbours salient interconnections between time, accountability and risk. These are notable pieces of the IHI puzzle which have significance within systems theory.

If it is accepted that IHIs, using their expertise, retrospectively observe an environment of complex mental health care provision composed of objects and concepts, it is not tenuous to assert that systems theory is a suitable candidate for application in this respect. This thesis is particularly concerned with Luhmann’s systems theory. But before introducing some of the main themes contained in it, it is prescient to develop a fuller profile of systems theory initiated above.44

The issue of what a system ‘is’ will become clear shortly. It is apposite however, briefly, to cite Baecker’s summary of this issue. He writes that “the concept of systems and the idea of systems theory are certainly entangled with modern society's attempt to monitor and control itself”.45 This is relevant because it helps reflect on how the IHI monitors and controls the relationship between mental health care and homicide. IHIs clearly monitor past mental health care provision and exert control over the future provision of mental health care services. Control in IHIs is arguably achieved by establishing what happened in the case,46 calling persons to account for their actions,47 assigning responsibility for previous decisions,48 pursuing truth49 and determining how future mental health care services can be improved through recommendations.50 The correlation between IHIs and the ‘control-and-monitor’ essence of systems theory is therefore quite prominent.

44 Supra., 1.1.2.
48 Ibid.
49 L. Blom-Cooper, op.cit., p 59.
2.4.1 Luhmann’s Systems Theory

Firstly, Luhmann’s thesis is “that there are systems”.\(^{51}\) This appears as mere assumption but Luhmann comes to this conclusion on the basis that an event is meaningful insofar as there is something else to distinguish it from. In short, “[a]ll identity is constituted by way of negation”.\(^{52}\) In other words, if an aspect of the world is to make sense, then it must be given an identity \textit{vis-à-vis} what constitutes what it is not.\(^{53}\) Without a distinguishing form against which to identify an object from other objects, it is simply meaningless. It cannot exist. Systems are meaning. Luhmann uses this argument to advance the claim that open systems theory precludes the possibility of a system existing in the first place.\(^{54}\)

Luhmann derived this view from the mathematical work of George Spencer Brown. Spencer Brown presents an explanation for managing complexity. It provides a crucial backdrop to Luhmann’s thesis that reality is rendered meaningful through a form, or a \textit{distinction}. This distinction marks a boundary which renders an object of focus meaningful from what is meaningless.\(^{55}\) There is only a void before the distinction is made.\(^{56}\) “[I]t [the world] must cut itself up into at least one state which sees, and at least one other state which is seen”.\(^{57}\) Spencer Brown argued that this casting of a distinction \textit{forms} the basis of what reality is and the various relationships that may arise with it.\(^{58}\)

Luhmann realises that it is possible to understand the reality of modern social theory and institutions in this way. His position is that the ‘form’, or ‘distinction’, can be used to posit the fundamental distinction between system and environment.\(^{59}\) A system represents a marked state that is meaningful because it is distinguishable from an unmarked state (its environment). Rather than taking human beings as a unit of analysis (which many social theories do), Luhmann adopts systems and meaning as his unit of analysis.\(^{60}\) Meaning, according to Luhmann, is what makes systems and society possible.\(^{61}\) Luhmann is asking his

\(^{52}\) Ibid., p 36.
\(^{54}\) M. Schiltz, ‘Space is the Place: The Laws of Form and Social Systems’ 88(8) (2007) \textit{Thesis Eleven} 8 at 8.
\(^{55}\) J. Arnoldi, ‘Niklas Luhmann: An Introduction’ 18(1) \textit{Theory, Culture & Society} 1 at 4. At 5, Arnoldi comments that “the distinction is meaning-constituting because it contains its own (self-reference) outside”.
readers “to become observers of observations – observers of all those theories, concepts and beliefs which people use to understand events, attribute causes, make predictions and so on.”

The distinction between system and environment in systems theory enables a more specific look at what the mental health care system actually ‘is’. After all, mental health care is what forms the central focus of an IHI investigation. Scholars sometimes refer to mental health care services as a ‘system’. Caution must however be expressed at this, for mental health care is delivered through a range of different professionals and disciplines. If a system, under Luhmann’s cosmology, embodies a single meaning and that meaning is identifiable on the basis of what it is not, then questions begin to surface about the extent to which a uniform system of meaning across the mental health profession is possible. It will become apparent throughout this thesis that many different protagonists play a part in the care and treatment of a patient. Psychiatrists, nurses, social workers and probation officers all utilise a range of different knowledge, skills, techniques and meanings in order to carry out their functions. They are clearly not the same, in the same way that psychiatry cannot be law and law cannot be psychiatry. What it means to ‘do’ psychiatry or ‘do’ law cannot be the same. They are distinct because they engender different meanings about reality.

This resonates with themes advanced elsewhere that the mental health system is a collection of fragmented, polycentric and ambiguous disciplines that often conflict with each other. The plurality of perspectives within mental health care therefore rallies against the notion that there is one monolithic mental health care ‘system’ with a uniform meaning. On the contrary, there is ample scope to consider the view that the mental health care ‘system’ is a collection of many ‘subsystems’. Scholars have already pointed out that risk-based mental health care practices stir up new ethical and legal controversies, providing further weight to the view that within mental health care nests a tapestry of different social systems of

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62 M. King and C Thornhill, op.cit., p 2.
64 See A. Perron T. Rudge and D. Holmes, ‘Citizen minds, citizen bodies: the citizenship experience and the government of mentally ill persons’ 11(2) (2010) Nursing Philosophy at 107. Perron, Rudge and Holmes claim that psychiatric risk assessment techniques arose out of the increasing need to assess mental disorders using jargon gleaned from other disciplines from the eighteenth century onwards.
communication. This has undoubtedly contributed to the dynamism of the genre and increased its complexity.

What is more, questions relating to how these different meanings are understood in different disciplines surface. The potential complexity of meaning inherent in mental health care is stunning, given that the latter make up the complex lives, views, feelings, thoughts and utterances of patients, staff and the relationships they form. Systems theory gives this a distinct, yet radical theoretical complexion. The realms of meaning in social systems like law and psychiatry cannot overlap, under systems theory. It is inconceivable, from the point of view of systems theory, for the law to ‘think’ that it can produce meanings that form a reality about what kind of treatment mental health patients must receive to improve their health, for instance. Only mental health professionals, particularly psychiatrists, can do this.

The implications of this argument are far-reaching for mental health law and policy in particular. Mirroring research that claims that medicine generally is actually harmful to patients, systems theory has been utilised in order to claim that legal communications exclude mental health patients from being involved in the decisions that affect their lives. Munro argues that even where law and psychiatry purport to offer help, support and assistance to patients, this leads to more exclusion; the meanings these social systems of meaning are inhered with are simply insensitive to the complex needs of patients. This is supported by other enquiries that reveal mental health professionals construe the needs of patients more narrowly than patients themselves. On the other hand, the meaning of what constitutes a ‘risk of harm’ in mental health law and policy may invite diverse interpretations

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66 See N. Eastman and J. Peay., op.cit., p 21; T. Ward, ‘The Sad Subject of Infanticide: Law, Medicine and Child Murder, 1860-1938 8(2) (1999) Social & Legal Studies 163 at 174. This is particularly obvious in the context of criminal law and the defence of insanity. The latter is a legal concept. It requires a ‘disease of the mind’. Insanity and a ‘disease of the mind’ are concepts completely foreign to the world of psychiatry. The latter is more concerned with producing empirical statements, based on procedures validated by its previous communications (see M. King and C. Piper, How the Law Thinks About Children, op.cit., p 49).


69 Ibid., p 81.

70 E.J Novella, ‘Mental health care and the politics of inclusion: A social systems account of psychiatric deinstitutionalization’ 31 (2010) Theoretical Medicine and Bioethics 411 at 421-422. Inversely, and as a testament to the malleability of systems theory, Novella argues that psychiatric communications facilitate the inclusion of patients in society’s social subsystems. She argues that the shift from asylum-based psychiatry to community-based psychiatry necessitates the inclusion of patients in many of society’s functionally differentiated social systems. For example, she points out that as part of community care-based initiatives, patients are encouraged to participate in social activities as a way of improving their mental health.

from mental health professionals. This has been said to create a gulf between lawyers and practitioners. Psychiatrists, nurses, social workers, General Practitioners, carers, family members, counsellors and lawyers have different professional backgrounds and are held to different standards. The individuals occupying these different roles embody different meanings about the reality they communicate about on a daily basis. According to systems theory, these roles occupy different systems of reality that cannot interfere with each other. They do not meaningfully overlap.

Although it may seem like it, Luhmann does not license the view that there are barriers between social systems. The work of those involved in mental health care is clearly informed by laws, policies, codes of practices, protocols and so on. These instruments are often created outside of the mental health profession itself. They originate in law, policy and public administrative circles. This is patently obvious in the area of IHIs. IHIs are founded on a small crop of laws and policies that intend to ‘communicate’ with the mental health care profession and observe the latter with a view to accurately steering its direction in the aftermath of a homicide. Despite being rather distinct in their generation of meaning, the different subsystems of the mental health profession do form diverse, yet interconnecting sites of bureaucracy, administration and rationality. This nevertheless remains consistent with Luhmann’s theory because the latter allowed for social subsystems to exist within wider social systems. According to Luhmann, these subsystems ‘irritate’ each other; there is an indirect stimulation of activity between social systems.

Whilst social systems cannot overlap, they produce meanings about their environment (other social subsystems) through communications that happen because other communications happen also. They are contingent. The communications produced by these social systems will trigger communications in another social system, but that social system will construe those communications in accordance with its own version of reality. There is a mutual irritation of social systems, as opposed to there being direct contact and understanding between each.

74 R. Nobles and D. Schiff, Observing Law Through Systems Theory (London: Hart Publishing, 2012), p 132: “The separation is simply the negation of total and instantaneous reactions between the thing and the surrounding medium, and the substitution of internal reactions to that environment”.
Chapter 2 – The Independent Homicide Inquiry

For example, a murder is an environmental trigger for the subsystem of medicine to conduct a post-mortem, whereas the same event will trigger a series of ‘due process’ measures (arrest, trial, verdict and so on) in law. Ascertaining a biological cause of death through medical techniques is legally meaningful insofar as that process is lawful and consistent with the need to maintain society’s expectations regarding how cadavers should be handled. The medical professional, on the other hand, embodies meaning about reality medically in order to determine a cause of death according to medically-established standards. Medicine as a discipline is not concerned with what is lawfully required. A medical professional that is concerned about what is lawfully required in any particular situation will nonetheless produce legal meaning to that end. As will later be discussed, Luhmann’s theory of social systems is not a theory about what individuals do. It is about individuals ‘stepping into’ meanings, or more accurately, communications, whenever a situation requires it.

2.4.2 The Importance of Communication

The concept of communication is hugely important to Luhmann’s brand of systems theory. It also constitutes the main gateway through which the meaningful relationship between mental health homicide events and mental health care is commandeered by IHIs. It was mentioned at the beginning of this chapter that Luhmann’s work represents a paradigmatic shift of thought in the area of systems theory. Before Luhmann, the broad spectrum of systems theory was ontological. Objects, actions and organisms provided the conceptual foundation of its theories. Luhmann however eschewed constructing an ontologically-based theory of social systems. Ontological approaches in social science, argues Luhmann, require meaning in the first instance. For objects or actions or events to be relevant, they must first of all acquire meaning. Luhmann asks how this meaning is made possible. His answer is communication.

Luhmann argues that communication consists of a synthesis of information, utterance and understanding. He posits that communication is the building block of society, consisting of an instantaneous event between two or more social subsystems. Information is uttered, picked up and understood in one single event between alter and ego, which

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77 Ibid., p 140.
78 Ibid., p 139. See also C. Baraldi, ‘Structural Coupling: Simultaneity and Difference Between Communication and Thought’ 3(2) (1993) *Communication Theory* 112 at 117. Communication is a social dimension because it “implies a double perspective (Ego and Alter)”. Communications are the only observable phenomenon in Luhmann’s schema, on the basis that they are meaningful. Consciousness is accessible only to ‘psychic’ systems inside the minds of living human beings. Living things are meaningful as ‘living beings’ insofar as there is a
produces communication. Luhmann also explains that it is misleading to say that communication can be transmitted.\(^{79}\) The ‘transmission’ metaphor implies that communication is a “two-part process”,\(^{80}\) it being transmitted from sender to receiver without undergoing change.\(^{81}\) Luhmann’s theory denies this possibility. Instead, social systems of communications such as law and medicine produce meanings that cannot be replicated within each other’s contexts. Law is meaningful on a social level because it embodies concepts (\textit{stare decisis}, negligence and so on) and roles (judge, lawyer, defendant, litigant and so on) for all human beings (human beings being defined by Luhmann as independent biological systems) to utilise and ‘slot’ in and out of.

Luhmann argues that communication becomes increasingly improbable and suspicious as newer challenges to its creation emerge over time.\(^{82}\) These challenges - changing contexts, demands on memory, and the distance between recipients - all hinder attempts at communicating.\(^{83}\) He was particularly concerned with the way in which social awareness of risk comes about:

> Practical experience tends to teach us the opposite: the more we know, the better we know what we do not know, and the more elaborate our risk awareness becomes. The more rationality we calculate and the more complex the calculations become, the more aspects come into view involving uncertainty about the future and thus risk.\(^{84}\)

The invention of language and printing, according to Luhmann, overcame many of the early obstacles to communicating.\(^{85}\) Language and printing however presented newer challenges in the form of disagreement and confusion.\(^{86}\) The invention of printing “revealed

\(^{79}\) N. Luhmann, \textit{Social Systems}, op.cit., p 148
\(^{80}\) Ibid., p 140.
\(^{81}\) Ibid., p 139.
\(^{82}\) N. Luhmann, \textit{Social Systems}, op.cit., p 150.
\(^{85}\) Ibid., pp 38 and 302. Luhmann subscribes to the prevalent view that before the invention of language, signs were used to communicate information. The performance of a sign in primitive times, under Luhmann's analysis, could only be successful within close physical proximity. The subsequent evolution of language, coupled with voice projection and volume, could afford greater distance between ego and alter and improve the chances of successful communication with a wider audience
how much knowledge already existed simultaneously, so that new selection and classification requirements arose”.

Reaching out to recipients using printed language sources, for example, removes the element of physical presence. This encourages misunderstanding, for there is not an immediate vehicle of clarification.

2.5 Conclusion

In light of Luhmann’s approach, communicating about homicide cases is perhaps more complex than is normally assumed. If it is accepted that communicating is improbable, containing an ‘in-built’ tendency to invoke disagreement, confusion and objection, it is open to argue that communicating about mental health homicide cases is similarly presented with these challenges. The present thesis is specifically concerned with these challenges. Is the IHI a linear process of communication, whereby only one form of communication is used to understand mental health homicide? In short, is the IHI a system of communication? Or does it contain a plurality of communications, thereby precluding the possibility that it is a system of communication?

The following chapter looks to answer these questions. These questions are important because answers to them will help distil a particular viewpoint of the challenges facing IHIs when communicating about homicides, whilst at the same time illuminating how the link between law, policy and psychiatry is constructed through the vehicle of the IHI. After all, if there are a number of different types of communication being used within the IHI to make sense of events and that these communications germinate in their own unique meaningful universes, it is open to argue that the conclusions reached by an IHI Panel in a given case will be contradictory or meaningless. This thesis is dedicated to confirming whether or not this is the case.

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Chapter 3

Independent Homicide Inquiries: A Systems Theory Perspective

3.1 Introduction

Retrospectively examining the provision of mental health care and treatment is complex. Cases histories are often dense, involving many decisions being made about a patient by many different people across many different professions. IHIs inevitably have to rely on hindsight when investigating these case histories also, which scholars argue leads to biased reasoning. The challenges facing IHIs are therefore considerable. Can they overcome these challenges and achieve their law and policy goals? What is more, how are these challenges understood under the auspices of systems theory?¹

IHIs rely on special analytical tools originally developed in other industries in order to draw logical relationships between past decisions and events. This forms the focus of an investigation. Despite the ‘scientific’ nature of these tools, can using them promote an accurate understanding of complex mental health care and treatment scenarios in particular? Can lessons for the future really be learned? Can mental health services be made safer? Arguably not, for is it possible that a mechanism designed for the business industry² can have similar application in the investigation of mental health services?

Systems theory can help answer these questions. There are many variations of systems theory. It can be regarded as a “catchall concept for very different denotations and very different levels of analysis”.³ What is more, it serves “as a collective designation for quite different kinds of research efforts, which are general to the extent that they do not specify their domain of

¹ Theoretical questions have already been raised however about an IHIs ability to meaningfully conduct this examination. Theoretical understandings of this type, nonetheless, typify a very slender aspect of the current literature (see J. Rumgay and E. Munro, ‘The lion’s den: professional defences in the treatment of dangerous patients’ 12(2) (2001) The Journal of Forensic Psychiatry 357 at 357).
³ N. Luhmann, Social Systems (Stanford: Stanford University Press, 1984/1995), p 1. At p xi, Knodt’s forward describes Luhmann’s theory as a “counter-genealogy that includes, among others, a cybernetician (Heinz von Foerster), two evolutionary biologists (Humberto R. Maturana and Francisco Varela), an obscure mathematician (George Spencer Brown), not to speak of the Devil Himself”.
application and its boundaries”.

In general however, systems theory attempts to delineate the relationship between the components of systems and the dynamics in and between them.

IHIs have been regarded as instrumental in prompting organisations to assimilate and learn from different messages. Can IHIs learn? Systems theory does not deny the ability of ‘systems’ and organisations to learn. It does however grant a licence to question whether this ‘learning’ is objective and open to shared meaningful understandings about the world. It is therefore prescient for the present chapter to consider the extent to which systems theory, particularly the form advanced by Luhmann, establishes a new understanding of what IHIs are and how they communicate about homicide. The examination will be supplemented with reference to how systems theory has been used to explore other law and policy areas also.

This will provide a further opportunity to develop systems theory, examine whether its conceptual apparatus is sensitive to the nuanced issues thrown up by IHIs and ultimately to forge a new look at the nexus between law, policy and mental health services.

3.2 Social Systems of Communication

Luhmann’s argument is that there are three distinct systemic realms that appropriately explain how society works. These are biological systems (Nature), psychic systems (thoughts) and social systems (communication). Moeller succinctly sums up this triad of systems:

Brains are biological systems, and minds are psychic systems. Brainwaves are continued with further brainwaves, not with thoughts. Similarly, thoughts have to be continued with more thoughts, not with brainwaves. The brain and the mind are systemically separated. They cannot mutually interfere with one another’s operations: they are environments for one another. Similarly, communication cannot be continued with either thoughts or brainwaves. Neither minds nor brains can speak. We have developed the linguistic habit of confusing these three empirically distinct systemic realms.

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4 Ibid., p 16
6 After all, the conceptual constellation of systems theory has already proved useful in a variety of disciplines (see J. Mingers, Self-Producing Systems: Implications and Applications of Autopoiesis (London: Plenum, 1994), p 2).
Social communication is something that individuals engage in under systems theory. It is not a manifestation of them as individuals. Human beings are communicated about politically (as ‘politicians’ and the ‘electorate’), legally (as ‘litigants’, ‘lawyers’ and ‘judges’), medically (as ‘clinicians’ and ‘patients’), psychiatrically (as ‘psychiatrists’ and ‘service users/patients’) and so on because previous communications of the same type inform the meaning of those terms. Social systems are not composed of individuals. Individuals are concepts. They are “semantic artefacts” under this view and have no separate a priori existence beyond the boundaries of social systems of communication:

the principle of the inclusion of all individuals in all functions systems is regarded as a postulate, and has increasingly become a matter of fact...accordingly, access to all functional spheres must be granted to every single person depending on his necessities, particular situation, relevant skills and other factors.

Individuals, according to this view, are constructed “ex negativo on the background of an aggregate of roles deriving from all the partial inclusions of the individual in the different function systems”. Although individuals are absolutely necessary for communication to happen, individuals are nevertheless re-fillable vessels under systems theory. Individuals are constantly filled and re-filled with roles and statuses determined by meaningful social communication. Conventional theories of the subject, on the other hand, posit that the individual is empowered by sources such as God or human rights. Under these approaches, human beings occupy an inalienable status. They are capable of controlling social and political affairs.

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9 Ibid., p 267.
It is for this reason that some commentators describe Luhmann’s theory as “frightening”. His statement that only communication can communicate and not individuals (as evidenced in the distinction between social and psychic systems) has been considered to “thoroughly trample the human subject”. Similar to Foucault, Luhmann appears to be arguing that the destiny of individuals cannot be reduced to “an identifiable individual or group of individuals who decide to implement it so as to further their interests or facilitate their utilisation of the social body”. Does a social system such as the legal system work “above the heads, or behind the backs, of legislators and jurists”? Do markets work above the head of economists? Do investigations into mental health homicide work above the heads of IHI Panel members?

Despite Luhmann’s radicalism, it is rather easy to see that individuals (especially mental health professionals) are connected by a host of routines, procedures and relationships that arguably diminish the influence individuals can have over the way mental health care is delivered. The parties involved “have a number of formal and informal roles, some conflicting. Moreover, not all will necessarily be anticipated”. The killing of an individual is, furthermore, a meaningful event for the legal system in a vastly different way to how that event is meaningful in the system of medicine. The law will construct the killing of an individual by another as an illegal act (depending on whether the killing was in self-defence, for instance) using legal communications relating to arrest, charge, trial, evidence, causation, guilt and so on. The medical system however will construct the event as having a series of medical implications about the severity of the wound inflicted, the anatomical location of the injury and the treatment applied to it. Rather than producing facts that confirm the health status of the victim, law simply uses these medical confirmations as a value which can help it stipulate what types of violent conduct will be considered lawful or unlawful. Law has previously communicated about homicide in this way,

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16 Ibid., at 1742. But see G. Teubner, Law as an Autopoietic System, op.cit., p 45. Teubner claims that systems theory reinstates the individual, on the basis that the former “breaks up the unity of the individual and society, and makes us view human thought and social communication as autonomous processes which reproduce themselves according to a logic of their own”.
with these previous communications inevitably informing further communications about the topic, as and when it arises.

Luhmann also distinguishes between social communications and small-scale interactions. The latter he posits as occurring between living beings and involving conversations that have no meaningful social significance. They only have social meaning if they are relevant for society’s social systems. An interaction about the weather might be irrelevant to society’s social subsystems, unless that interaction was made relevant by the internal logic of a receptive social system. Such an interaction could be made legally relevant as evidence in a court case or economically relevant if used as a basis to relocate an umbrella business to a wetter climate so as to increase profitability. By itself however, such an interaction has no meaningful social relevance.

3.3 Independent Homicide Inquiries as a System of Communication?

When it comes to communicating about the circumstances surrounding a mental health homicide, IHIs use a ‘bundle’ of different communications. On the one hand, they use an analytical tool called Root Cause Analysis (RCA). RCA is a ‘flagship’ development in the context of IHIs and its origins lie in the area of business management. It has since been adapted to draw “logical relationships” between events when investigating mental health homicides. In this sense, RCA is a scientific communication. It assists in the establishment of causes and their effects according to ‘objectively’ determined standards.

Within the IHI process however, the application of RCA co-exists with other forms of communication. For instance, an IHI Panel is usually (although not always) made up of mental health professionals, usually a psychiatrist, social worker and senior nurse. These experts are versed in the communications specific to their discipline. In broad terms, an IHI Panel will identify events relevant to the provision of care and treatment received by the patient. It will become apparent throughout this chapter and thesis as a whole that IHI investigations are selective in what they investigate. Certain events, such as occasions where the patient made

21 See L.A Neal, D. Watson, T. Hicks, M. Porter and D. Hill, op.cit., at 75.
contact with mental health services, are selected because they are crucial to the patient’s mental health and the potential threats he poses to others. This in turn requires the utilisation of meaningful communications specific to the mental health profession and understandable on the level of psychiatric, nursing, and social work communications. A nursing decision to administer medication, for instance, will be evaluated according to whether the patient’s health was benefited in the circumstances. The IHI Panel will therefore endeavour to establish an understanding about how the events identified impacted on the patient’s mental state, or at least to reveal something about it. The intention of the IHI Panel is to uncover meaningful clues relating to how and why the patient did what he or she did.

In marshalling the relationship between mental health homicides and the provision of past mental health care, IHIs are faced with the challenge of ‘making sense’ of the various locales of decision making where past decisions about the patient germinated. Concerns throughout the 1990s gravitated around the view that IHIs subjected the clinician’s role to a degree of scrutiny which many regarded as too blame-orientated and accusatory. This could be interpreted as a form of moral communication, where an individual’s actions or decisions are judged as ‘right’ or ‘wrong’. An official shift away from this approach has been identified by scholars as dating from 2001, with the 2005 amendments to HSG(27)94 signalling a nadir in blame-oriented IHI investigations. Structural concerns or ‘system’ factors have come to the fore in modern IHIs. This is not to say that blame does not potentially play a role in such contexts. For instance, the perpetrators at the centre of those IHI Reports reviewed for Chapter 6 were either convicted of murder or diminished responsibility manslaughter. It is therefore clear that the IHI operate within

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23 IHIs may feasibly be seen as an attempt by the mental health care profession to observe and communicate about itself. For instance, they may be regarded as “a self-critique that parallels the self-analysis that has become evident in 21st century medicine. This self-analysis is a culmination of processes that, in the course of the last century and particularly over the last 40 years or so, turned the medical gaze increasingly in on itself” (R.A.M. Iedema, C. Jorm, D. Long, J. Braithwaite, J. Travaglia, and M. Westbrook, ‘Turning the medical gaze in upon itself: Root cause analysis and the investigation of error’ 62(7) (2006) Social Science & Medicine 1605 at 1613). It is perhaps too simplistic however to assume that IHIs are part of the mental health profession because IHI Panels are sometimes constituted by mental health professionals. IHI Panels are assigned the task of investigation and have to utilise a particular skill-set as investigators, and not simply as mental health care professionals.


a framework of blame established by the legal system. The purpose of this thesis, however, is to distil how the landscape of blame has shifted with the onset of ‘systemic’ reasoning in IHIs.

IHIs communicate legally also. Although IHIs do not make legal decisions in the way that courts do, they do ‘communicate’ legally in the sense that they will sometimes allude to the requirements of law, namely the Mental Health Act 1983, Article 2 of the ECHR, comments made by the trial judge about the patient (such as the extent to which alcohol or drugs played a part in their behaviour) and what the patient was found guilty of. For example, Independent Investigation into SUI 2006/811926 suggested that the court ruling in R (on the application of CS) v Mental Health Review Tribunal; Managers of Homerton Hospital (East London and City Mental Health NHS Trust (Interested Party)27 should have been followed by the Assertive Outreach Team. More specifically, an IHI Panel will make judgements about whether or not mental health professionals connected with the case met the requirements of the law. It is clear therefore that IHIs will refer to communications meaningful to the legal system only. What is more, economic communications may be relevant. It is not completely uncommon for IHIs to comment on the lack of funding given to mental health services when putting mental health care into context.

IHIs therefore appear to resemble a “hybrid discourse”.28 Hybrid discourses are discussed by King in the context of child welfare and they provide a useful illustration which resonates with what IHIs aim to achieve. Child welfare knowledge, according to King, is acquired through scientific testing and empirical observation of children in controlled conditions. Whilst this kind of testing may not mirror testing found in the physical sciences (because a child’s psychology is understood using interview and observational techniques, as opposed to laboratory testing), it is carried out using validated procedures and empirical observation techniques in order to produce ‘objective facts’ about children’s welfare.29 Social workers particularly have been said to bundle this kind of scientific knowledge together with other forms of communication (legal, medical and political communications in particular) with a view to

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27 2004 EWHC (Admin) 2958. The judge ruled that a patient could be recalled to hospital for treatment if she refused or failed to take her medication in the community.
identifying child abuse and what is best for children in custody battles. In this sense, social workers are “a repository of legal and procedural knowledge and the representative of the link with other areas of social services and local authority provision”.

IHIs, particularly when it comes to delivering their findings in their Final Report, can be regarded as ‘cobbling’ together different discourses in a similar fashion. After all, they have been considered to go “beyond analysis of the medical consultation, and involve various health care professionals in scrutinizing medical–clinical practice as a whole”. This is unlike the systems-theoretical concept of ‘enslavement’ however, which refers to the reconstruction of knowledge created in one social system within another. In mental health law at least, enslavement occurs when controversial psychiatric meanings attached to mental disorders are arguably reconstructed anew in the legal system. For instance, the need for a court to establish whether or not legal or illegal acts have been committed in a particular case does not concern itself with the niceties of scientifically controversial scientific research (for instance, in terms of the scientific method used or what different theories might say). This has been said to apply to the way law and psychiatry produce different meanings about people, with law demanding very firm answers which medical science cannot give.

If IHIs are not a social system of communication under systems theory, then what are they? As a procedure, IHIs are mandated by HSG(24)94 and Article 2 of the ECHR. These set out aims and objectives which IHIs are designed to fulfil. What is legal under Article 2, for

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30 Ibid., p 49.
33 M. King, ‘An autopoietic approach to ‘Parental Alienation Syndrome’ 13(3) (2002) *The Journal of Forensic Psychiatry* 609 at 620. Experts are recruited and their statements about a child’s future welfare, for example, are assessed for their ability to support judgements about what kind of behaviour is legal and illegal.
34 K. Keywood, ‘Rethinking the anorexic body: How English law and psychiatry ‘think’ 26 (2003) *International Journal of Law and Psychiatry* 599 at 603. “[I]f the English legal system were to acknowledge the lack of certainty as to what anorexia nervosa ‘is’, the law’s credibility would be severely compromised for the law would lose its authority to determine the appropriateness of treatment and detention of patients diagnosed with anorexia nervosa”.
instance, is the provision of a fair and independent investigation of deaths potentially caused by the State. To not provide this investigation is illegal. The IHI can therefore be regarded as a mediating conduit through which these law and policy objectives are achieved. This is not to say that the IHI is the one and only way these objectives can be reached. Scholars have long insisted on the replacement of IHIs with systems of auditing.\textsuperscript{38} IHIs can therefore be considered as one of a variety of means through which law and policy can ‘make contact’ with events that occurred in its environment in order to establish legality. They have the appearance of a ‘tool’ which law and policy have co-opted into fulfilling certain aims and objectives. Luhmann’s concept of coding and programming offers a useful way of fleshing out this argument.

### 3.4 Coding and Programming

According to Luhmann, a social system’s binary code\textsuperscript{39} allows it to meaningfully select information from its environment. Codes allow for the establishment of expectations “as things, human beings, events, symbols, values, concepts, norms”\textsuperscript{40} and so on. What is more, this selection gives the social system its identity and character.\textsuperscript{41} This identity is unique to the social system. It cannot be removed or transplanted into other social systems. To do so would spell the cessation of the social system’s identity as we know it. For example, the legal system’s binary code determines what is legal and what is illegal (legal/illegal). The code is visible only to the social system that produces meaning through it. It clearly distinguishes law from other social systems that are not law.\textsuperscript{42} Systems theorists have developed these themes further in a variety of other contexts also.\textsuperscript{43} As mentioned earlier, law cannot at the same time be medicine. The latter

\textsuperscript{38} N. Eastman, ‘Inquiries into homicides by psychiatric patients: systematic audit should replace by mandatory inquiries’ 313(7064) (1996) \textit{British Medical Journal} 1069.
\textsuperscript{39} N. Luhmann, \textit{Social Systems}, op.cit., p 142.
\textsuperscript{41} Ibid. “Coded events operate as information in the communication process, uncoded ones as disturbance (noise)”. Luhmann elsewhere writes that binary codes allow for the establishment of expectations “as things, human beings, events, symbols, values, concepts, norms” (see Luhmann, N, \textit{A Sociological Theory of Law} (Taylor & Francis, 1985), p 25.
\textsuperscript{43} See D. Michailkis, ‘A Systems Theory Concept of Disability: one is not born disabled, one is observed to be one’ 18(2) (2003) \textit{Disability & Society} 209. For example, the medical system communicates about disability in terms of its bodily manifestations (blindness, brain damage and so on). In the education system, it is communicated about in terms of its effects on the capability of a person to learn and have special needs. In the legal system, disability is communicated about in terms of what rights and duties disabled persons are capable of enjoying (employment rights, access to health care and so on).
utilises the code *health/illness* when making sense of reality. The notion of law being able to communicate in this way would be to say that legal communications can at the same time be medical communications. This is a logical impossibility under Luhmann’s theory. The binary coding gives social systems a fixed identity that cannot be removed or replaced.

Social systems are said to observe communications in their environment (other social systems of communication) through their binary code. The uniqueness of this code determines a reconstruction of social reality that the system creates for itself. Communications that happen in a system’s environment (homicides, for example) are selected and given meaning according to the logic of an internal code and no other code. The internality of this code, according to systems theory, means that there is no higher code to refer to. There is “no privileged metaphysical distinction”.\(^44\) Paradoxically therefore, law can only be legal.\(^45\) Legal findings are reached because the processes used to reach them are similarly subject to the code *legal/illegal*.\(^46\) This necessitates the further paradox that what is illegal is legal, because the law proclaims what constitutes illegality under its code.\(^47\)

The argument advanced earlier - that IHIs inhere a ‘bundle’ of distinct social communications about mental health homicide cases - leads to the conclusion that they utilise a range of binary codes also. If communicating legally, for example, by considering whether section 17 of the Mental Health Act 1983 was fully complied with and that the patient’s leave of absence from hospital was lawful, the code *legal/illegal* will undoubtedly be used by an IHI Panel. If considering whether the administration of medication to the patient benefited the patient’s mental health and bodily integrity on a particular occasion, then the code *health/illness* and *sane/insane* will be utilised; the IHI Panel in this instance is communicating medically.

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\(^{44}\) N. Luhmann, *Social Systems*, op.cit., p 178.

\(^{45}\) N. Luhmann, *Law as a Social System*, op.cit., p 175. At p 197: “the thesis that the distinction between legal and illegal is obviously legal, because otherwise there could be no orderly administration of justice”. Similarly, it would be inconceivable for the psychiatric profession to decide whether the distinction between sanity and insanity was sane or not. Luhmann describes this paradox as a ‘blind-spot’ of social subsystems.

\(^{46}\) See G. Teubner, *Law as an Autopoietic System* (Oxford: Blackwell Publishers, 1993), p 2. “Legal validity cannot be brought in from the outside; it can only be produced within the law”.

(whether the administration of the drug benefited the patient’s physical health) and psychiatrically (whether the administration of the drug beneficial for the patient’s mental health).

This does not however reveal much about what the IHI is. If the IHI utilised one specific code, it could perhaps be argued that they do constitute one social system of communication. The hybridisation of communication within the IHI however demands a more sophisticated explanation. Clues may be found in Luhmann’s concept of *programming*. It was mentioned above that binary codes are paradoxical because they cannot logically apply to themselves. For the legal system to ask whether it is legal or not to utilise the code *legal/illega* would be absurd. This paradox is only visible at the level of systems theory and not the social system of law. Luhmann posits an explanation for why law is unable to do this. He argues that legal communications, like all other social systems, create “programmes of internal regulation” that ‘deflect’ the system away from its own paradox. This ‘deflection’ creates the appearance of rationality. The paradox is concealed by programmes.

All social systems have programmes (norms, rules and principles), according to Luhmann. These change from time-to-time. They are never fixed. New social circumstances demand that new decisions, rules and laws be revised, replaced or simply left untouched. What remains intact is the social system’s code. In the context of law, programmes fill the fixed legal code with content. The legal code, if you will, is like a glass container. It remains solid and constant. A programme however is the liquid solution moulding itself around the contours of the container and providing it with replaceable content. It may be goal-oriented, stipulating the future conditions in which a binary code should apply. Or programmes may be conditional because they rely on the occurrence of a past event in order for the code to then apply in present circumstances. IHIs are similarly flexible because they can easily be replaced with some other measure that can similarly fill the legal code with content. It could be said that IHIs, as replaceable content, are programmes for the purposes of systems theory.

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51 Ibid., p 199. An example of a future-oriented programme would be risk management in economics; hedging capital is an economic programme designed to avoid the loss of profit by being continually calibrated as time goes by. See also M. King, ‘Future Uncertainty as a Challenge to Law’s Programmes: the Dilemma of Parental Disputes’ 63(4) (2000) *Modern Law Review* 523 at 534.
Chapter 3 – Independent Homicide Inquiries: A Systems Theory Perspective

A programme might lay down the particular circumstances in which the binary code is correctly applied or kept stable. The value of truth produced in forensic science for example, is a legal programme that determines whether or not it is appropriate to codify behaviour as legal or illegal. On the other hand, the legal system might refer to the moral principle that no one shall be permitted to profit from his own wrong in order to give effect to the legal code in probate cases. For lawyers, the issue is concluded with a legal finding and not a scientific or moral one. The law is not questioned further. Identifying codes within programmes is also not easy or obvious either.

Concepts of ‘justice’ in law are programmes under this argument too. They have arguably “been produced in conjunction with self-descriptions of the legal system”. Laws are justified on the basis that they are ‘just’. Justice however, according to Luhmann, is a programme that only the legal system can produce. Whatever the law decides one way or another, it will be ‘just’ to do so and thus conceal the original paradox referred to earlier. This is the paradox of whether law is legal or not and can be considered as an aporia of justice. Luhmann argued that “the code is a tautology and is, if applied to itself, a paradox.” The legal system, under this view, cannot apply the legal/illegal code to itself without the meaning and function of law becoming paralysed. Programmes conceal this paradox by stimulating “further points of view” thus creating “the semblance of certainty” in a shifting world of communication and decision making.

52 G. Teubner, Law as an Autopoietic System, op.cit., p 105. Whether the law or policy is a success is immaterial. Under systems theory, the codes and programmes are neutral.
55 See R. Nobles and D. Schiff, op.cit., p 11.
56 Ibid., p 101. Nobles and Schiff write that “one does not take a single communication, whatever distinction that communication might include, and allocate it to a system; one has to observe which system a communication belongs to by examining its trajectory within systems: what communication is it linked to in the past, and in the future, and what code is being applied by the system of which it forms a part?”.
57 N. Luhmann, Law as a Social System., op.cit., p 50 and 54. See also Luhmann, N, A Sociological Theory of Law (London: Routledge & Kegan Paul, 1978), p 19. Luhmann contends that legal theories assume law to be “understood as an interrelation which...can be examined empirically like the relationship of cause and effect”.
60 Ibid.
Rather than social systems making sense of reality using simple binary distinctions, programmes enhance the selectivity and stability of social systems through the employment of patterns. These patterns are the standardised routines and procedures which can transform what would otherwise be a chaotic environment into something meaningful for the social system. Codes, by themselves, would not be flexible enough to acknowledge the complexity of the system’s environment. Programmes allow codes to be applied by utilising a range of values that are not typically ‘legal’ on the surface. For instance, norms and rules in the Mental Health Act 1983 are concerned with a host of mental health issues, such as the definition of mental disorder, without openly referring to the code legal/illegal. But those rules and norms are not communicating psychiatrically. They set out how mental health professionals legally conduct themselves. Those rules and norms are patterns which the legal system has created in order to establish ‘contact’ with the mental health profession. They are legal programmes. Other examples could include how the courts have shown a willingness to increasingly consider the importance of clinicians’ day-to-day experience regarding the nature and extent of any relevant medical dispute.

The IHI bears a resemblance to a programme of the legal system. The law, in mandating the upholding of the right for the deceased to have a full and fair investigation into their death under Article 2, requires a ‘pattern’ in order to identify and react to the stimulus produced in law’s environment. This stimulus, namely, the homicide and a patient’s deteriorating mental state, cannot be acknowledged by simply holding that it is illegal not to stage a full and fair investigation. Legality requires an investigation to be carried out. Providing this level of close investigation would be impossible for the law to do beyond the confines of existing mechanisms (criminal law, civil law, coroner inquests and so on). The IHI however provides this. It could be said, therefore, that the IHI fills the legal code with content. What is more, the IHI could be

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62 See M. King and C. Thornhill, op.cit., p 24. Legislation, case law and government policy documents do not explicitly allude to the legal and political codes, for example. These instruments, under systems theory, are flexible programmes that enable fixed binary codes to be continually applied in different contexts. These instruments can be amended, revised, discarded, replaced or overruled without compromising the fixed binary codes that they support.


64 See R (on the application of B) v S (Responsible Medical Officer, Broadmoor Hospital) [2005] EWHC 1936 (Admin).
regarded as a political programme also by being mandated through government guidance HSG(27). In this respect, this is arguably the political system’s way of filling its binary code (power/no power) with content; the political system delegates the powers of investigation to the IHI, through the NHS Trust.

Needless to say, it is difficult to imagine how the IHI can be a programme of both the legal and political systems at the same time. According to Luhmann’s thesis, codes and programmes are complimentary. They are elements of a system and not multiple systems. If IHIs are programmes of the legal and political systems, it would licence the view that what happens in law mirrors what happens in politics. This is not possible under Luhmann’s systems theory. The legal and political codes create distinct programmes that help them carry out their operations. More importantly, the IHI is a complex process. They harbour a range of techniques, concepts and points of view. It is arguably too simplistic to regard it as a monolithic entity that can be slotted into one of Luhmann’s concepts. A better and more compromising view therefore is that IHIs contain features that may appropriately be attributed to the legal and political systems. This may also include the psychiatric and scientific systems. This is consistent with the argument advanced earlier, namely, that IHIs are a repository of different communications. This can be developed further by advancing the claim that IHIs may be a social system ‘in the making’.

### 3.4.1 Independent Homicide Inquiries as ‘Partial’ Social Systems?

If it is accepted that IHIs exhibit features of law, politics, science and psychiatry but cannot be described as being firmly part of just one of these systems, is it possible that IHIs are a social system ‘in the making’? Under systems theory, meaningful communication cannot be considered “in the same way in which one grabs one thing or another off the rack”. Luhmann writes that

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65 It is beyond the confines of the present thesis to consider whether HSG(27)94 is a political programme under Luhmann’s theory. It is nevertheless worth mentioning that it arguably does constitute such a programme. It is created by the political system and is used to fill the political code (power/no power) with content. This content can be said to be the delegation of investigatory power in mental health homicide cases to NHS Trusts. What the document is arguably doing is using the values produced by other systems (‘mental health’, ‘homicide’ and ‘human rights’) as a way of moulding what would otherwise be an inflexible political code around complex issues. In short, the values of other social systems are being enslaved by politics through the programme of government guidance.


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“[m]eaning always refers to meaning and never reaches out of itself for something else”.67 He describes this as “self-contact”; social systems of communication produce meaning, not from other social systems, but from itself.68 Luhmann’s utilises the concept of autopoiesis to advance this argument.

The concept of autopoiesis “presupposes that systems seek the fixed points of their mode of operation in themselves.”69 ‘Autopoiesis’ is used by Luhmann to maintain that social systems ‘self-make’ their own communications by referring to previous communications of the same type.70 Social systems arguably “create everything that they use as an element and thereby use recursively the elements that are already constituted in the system”.71 There is no higher law or referent point which social systems refer to when communications are produced. Social systems however remain cognitively open to their environment. What is more, Luhmann contends that it is not contradictory for a social system to be open and closed at the same time.72 Social systems pick up stimulus from the environment, but on their own meaningful terms. Whereas operational closure can be regarded as the need for social systems to constantly refer back to themselves with a view to validating the meaningfulness of its communications,73 cognitive openness is regarded by systems theory as not “communicat[ing] with the environment, but necessarily communicat[ing] about (my emphasis) the environment”.74

A social system may therefore be compared to an individual dreaming about cooking dinner for his girlfriend.75 The individual dreams all the elements of this event in a sequence –

68 This can be appreciated by looking at the way scientific knowledge is validated. Scientific truth is true because the means used to establish it (scientific methods) are deemed true, according to science (see Y. Fujigaki, ‘Filling the gap between discussions on science and scientists’ everyday activities: applying the autopoiesis system theory to scientific knowledge’ 37(1) (1998) Social Science Information 5).
70 N. Luhmann, Social Systems, op.cit., p 144. See also J. Paterson, Behind the Mask: regulating health and safety in Britain’s offshore oil and gas industry (Dartmouth: Ashgate, 2000), p 55.
71 N. Luhmann, Social Systems, op.cit., p 444.
72 Ibid., p 37.
preparing the food, preparing the table and lighting the candles. His alarm clock suddenly sounds, but instead of waking him from the dream, the noise is incorporated into the dream as the ringing of the doorbell by his girlfriend. Under Luhmann’s thesis, social systems work in the same way. Their internal code reconstructs noise produced by other social systems in their environment but in accordance with a unique function dictated by the code.

But if IHIs are not part of any one system, but resemble features of existing social systems, utilise their different codes and are quite ‘open’ to the values generated by those other social systems, they cannot be a ‘system’. Are they partial systems, reflecting a greater degree of openness that might be indicative of an evolving social system? The thesis that there are partial systems is prohibited by Luhmann. According to Luhmann, systems are either autopoietic or they are not. Either there are systems or there are not. Teubner’s articulation of systems theory nevertheless allows for the view that social systems can evolve into systems. They are not ‘born’ into existence, as Luhmann’s theory argues.

Teubner’s position is that social systems become autopoietic only when they have built up enough internal complexity by fully referring to their own operations in order to produce their own communications. They thus go through stages of partial autopoiesis to full autopoiesis. The latter is what Teubner calls a ‘hypercycle’. An autopoietic hypercycle is established when a system acquires its own self-producing life and refers to its own values for its continued existence. Teubner’s principle example of a fully autopoietic social system is law, which he argues has evolved to the extent that it is completely free of other social values. Law’s existence is quintessentially ‘legal’, with its elements referring to each other for meaning and validity. For example, the law relies on the concept of justice for self-validity, yet the law itself defines what justice requires in any given case. IHIs clearly refer to the values of more than one existing social system and thus cannot be considered to engage in a self-producing hypercycle. It can be concluded that an IHI is not a social system that is fully autopoietic, in the Teuberian sense.

The problem with Teubner’s argument however is the status of communications before they become autopoietic. Can social systems originate in other social systems? To accept that a social system has a ‘pre-birth’ history is surely to accept that it formed out of other social systems.

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76 G. Teubner, Law as an Autopoietic System, op.cit., p 26
77 Ibid., p 35
78 Ibid., p 189.
Systems theory is unequivocal in its view that communications do not exist in a vacuum. One matter that Luhmann and Teubner appear to agree on is that communications do not constitute the environment. Communications can only be made about the environment from within social systems. It is therefore more feasible to accept that social systems evolve from within pre-existing social systems. This chimes with the view that IHIs, at the very least, are at a stage where they are reliant on the social communications of other systems in order to function. They are not fully matured social systems, but the analysis above allows for the possibility that they are evolving into a social system.

By way of illustration, Philippopoulos-Mihalopoulos argues that there is a credible distinction between “incipient and established autopoietic systems”. He provides the example of environmental law, which he claims “has not crystallised its elements self-referentially, but relies to a great extent on seemingly external contributions, such as scientific findings, ethical impedimenta and political issues of participation and democracy”. Philippopoulos-Mihalopoulos furthermore posits that the difference between incipient systems, like environmental law, and fully autopoietic systems, is a quantitative one. It is simply the “cognitive capacity” of a system which determines whether it is fully autopoietic or not. This reflects the extent to which the ‘cognitive domain’ of the system is open to external references in other systems.

IHIs can be said to be quite cognitively ‘open’ to the external references contained in other social systems, like law, psychiatry and science. There are grounds therefore for arguing that IHIs are a ‘system in the making’. IHIs may well evolve into a social system, although it is difficult to predict what this could be. Needless to say, they have become more technocratic in recent years. They have been prepared to eschew reliance on legal professionals by being willing to dispense with having a legal member on the IHI Panel (although IHIs continue to be advised by a solicitor). What is more, investigations are now carried out by private companies. These companies are systematic investigators that consult, review and investigate on behalf of an NHS Trust. Their services can cover a range of events, incidents and circumstances ranging from the

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80 Ibid., p 191.
81 Ibid., p 190
82 Ibid.

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analysis of internal governance mechanisms to adverse incidents such as mental health homicide and suicide.\textsuperscript{83} IHIs are clearly becoming more of a self-sufficient ‘industry’ in this respect. But like environmental law, they can be regarded as an incipient social system that is open to further evolution.

3.5 Eliciting Change in Mental Health Care Services: The Implications of Autopoiesis

Despite the questionable links commentators have accused Luhmann of making between biological autopoiesis and social autopoiesis,\textsuperscript{84} the implications the concept has for the study of IHIs are significant. IHIs, like any communicative process which seeks to explore a technical area of activity and address problems within it, can be said to be confronted by the problem of incongruence between itself and the area targeted under scrutiny.\textsuperscript{85} For instance, the tools IHIs use to investigate homicide cases are inhered with a particular rationality. These tools are used to reach a set of findings and perhaps facilitate a solution to a perceived problem. The trajectory of perceiving such problems, working on them, producing a finding and eventually advancing a solution in this way is in danger of underplaying, misinterpreting or ignoring features of the target area that are inhered with a different rationality. After all, the whole premise of system theory is based on the notion that different meanings, produced at the level of social systems of communication, are fundamentally different and non-transferable.

To reiterate, IHIs can be regarded as an emerging vehicle through which different bundles of autopoietic communications (psychiatric, legal and scientific) are channelled in order to meaningfully investigate mental health homicides. Any attempt to reach beyond the internally-produced meanings of IHIs and ‘fix’ problems in other operationally-closed spheres of meaningful

\textsuperscript{83} The companies commissioned for the IHI Reports reviewed for this thesis are Verita, Niche Health & Social Care Consulting, Consequence UK, Caring Solutions UK, Health and Social Care Advisory Service, Associate Caring Solutions (UK). There were three exceptions however. J. Smith, M. Clifton, C. Dale and M. Rosenberg, \textit{Independent Investigation into the Homicide of Mr A by Mr B}, South West Strategic Health Authority, Caring Solutions UK (October 2011) and B. Hanson, T. Barre, D. Beer and D. Bull, \textit{The Report of the Independent Investigation into the Care and Treatment of JW}, NHS East of England SHA (January 2009). The cases were authored by individuals commissioned by the NHS Trust.

\textsuperscript{84} K.D. Bailey, ‘Towards Unifying Science: Applying Concepts Across Disciplinary Boundaries 18(1) (2001) Systems Research and Behavioural Science 52 at 52. Bailey complains that social autopoiesis and cellular autopoiesis are not the same thing. Any comparison between them is, accordingly, impoverished.

reality will be unsuccessful and confusing. The logic produced by IHIs in order to understand the link between homicide and mental health care provision simply does not mirror the kind of logic produced outside of the IHI, for instance, in day-to-day mental health care practice where causative theories about past decisions do not play a role in treating patients, except in terms of individual decisions being taken with a view to having a particular isolating effect.

Autopoietic communications produced within different social systems are only ever able to produce communications by referring to previous communications constituted by the same code. IHIs may refer to policy or guidance. These instruments however germinate in an entirely different context and are not necessarily concerned with the cause-and-effect way of thinking indicative of IHIs. These documents are more concerned with what constitutes ‘best practice’ and who should make certain decisions. This may imply causal rationality, in the sense that ‘best practice’ ultimately is designed to have positive effects through good decision making. This is far removed from the proclivities of RCA in IHI processes however. RCA instigates a different form of causal rationality that is dependent on established rules and principles created pursuant to scientific testing. It also requires a distinct memory of the past that is meaningful according to established social communications.

Advancing recommendations may therefore prove risky for IHIs, in the sense that they may not resonate meaningfully with the mental health care profession. As Chapter 4 will demonstrate, the latter is complex and hosts a variety of unique local arrangements (working patterns, personal conflicts and defensive practices) that are invisible to the aims and objectives of IHIs. This is not to say that certain IHI recommendations will not prove helpful. Issues relating to the success and failure of IHI recommendations are nonetheless immaterial from the point of view of systems theory. Under Luhmann’s thesis at least, any perceived success of an interventionist measure is purely coincidental. The crucial point here is that an attempt to manipulate, change or steer a complex sphere of industrial life through advancing IHI

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86 G. Teubner, ‘Introduction to Autopoietic Law’, op.cit., p 19. Generally speaking, the “regulatory trilemma” refers to attempts by law to reach beyond its autopoietic boundaries and interfere with its target area at the risk of being irrelevant and damaging to the regulated area.

87 For example, it was common throughout the IHI Reports reviewed for Chapter 6 to consult the provisions of the Mental Health Act 1983 and other arms-length developments such as the National Patient Safety Agency Decision Tree, http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59900 and L. Appleby, J. Shaw, T. Amos, Safer Services: Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (London: Department of Health, 1999).
recommendations will have effects that neither the IHI or target system can control. According to the theoretical framework of this thesis, IHIs have control over how it produces meaning about its environment but lacks control over how the effects of its communications are constructed by other social systems that are guided by a wholly different binary logic. Whether these effects instigate ‘successful’ or ‘unsuccessful’ effects is irrelevant, from the perspective of systems theory. Systems theory is concerned rather with function.

3.6 Structural Coupling and the Independent Homicide Inquiry

It may furthermore be argued that the relationship between homicides and mental health care provides the opportunity for legal, political, scientific and psychiatric systems of communication to reinforce their meaningful identity. IHIs could be said to be the ‘vehicle’ through which this opportunity is taken up. Just like the way language can be considered as a necessary vehicle through which human thoughts and society converge, IHIs ‘hold’ different communications together. It was discussed earlier that the IHI may be considered as an evolving system of communication. Instead of being fully autopoietic in the way that law or the economy is, for instance, IHIs are an incipient branch of evolving social communication that borrows communications from other social systems. It is nevertheless obvious that IHIs do not just merely utter different communications without any meaningful connections between these communications. IHIs appear to establish a seamless flow in how they can move from issue-to-issue in homicide cases using different communications.

For instance, the very meaning of the concept of homicide or manslaughter will have legal relevance because it signals to the law that somebody’s actions might well be inconsistent with what previous legal communications stipulate about how individuals ought to behave. IHIs fully recognise this and usually acknowledge what the patient was convicted of at the beginning of their Final Report. IHIs thus utilise legal communications to that end. But a homicide or manslaughter from a psychiatric point of view will have a different meaning, namely, that the patient’s mental disorder may not have been managed properly. It signals to an IHI Panel that

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questions need to be asked about the standard of care and treatment the patient received and how the latter might have impacted on the patient’s homicidal conduct.

It can be said therefore that the different communications that IHIs utilise in order to conduct their investigations gravitate around certain issues and ideas, but with divergent meanings attached to them. In the case of law and psychiatry therefore, there is a reaction of each to the other. This reaction however is produced by internally-created meanings inside these social systems that are invisible to each other. There is no relationship of causality between systems, whereby one system instigates a precise reaction in the other. Luhmann argues that there is “reciprocal irritation of these systems and influence”. 89 They project internally-derived “expectations on perturbing events”. 90 As discussed towards the beginning of the present chapter, communications under Luhmann’s theory cannot be directly transferred or telegraphed unchanged from their original site of meaning to a different site of meaning. Systems theory posits that when certain communications gravitate around concepts or ideas in this way, these systems are **structurally coupling** with one another. 91

Structural coupling is advanced by Luhmann in order to clarify how the relations between social systems are shaped. 92 Luhmann defines structural coupling as “simply the specific form in which the system presupposes specific states or changes in its environment and relies on them”. 93 Structural couplings are simultaneous, non-causal relationships between social systems. 94 Systems that structurally couple:

- may irritate another by observing a part of its activity and strategically interfering with its operations.
- Structural couplings emerge as a system struggles to find a way to cope with a recurring source of environmental irritation. 95

91 N. Luhmann, ‘Operational Closure and Structural Coupling: The Differentiation of the Legal System’ op.cit., at 1432. But see R. Münch, op.cit., at 1468, who argues that Luhmann devised this concept as a reaction to mounting criticism.
94 Ibid.
Structural coupling is about meaning. It arguably occurs *within* social subsystems about certain issues and concepts. This would be consistent with Teubner’s view that cognitive openness is not openness in any real sense. Structural couplings seem to appear as internally-constructed realities that converge around a meaningful event on an on-going basis. At first blush however, the concept of structural coupling appears inconsistent with the view that IHIs are a social system ‘in the making’; can a social system in the making structurally couple with other social systems? Only fully-fledged social systems can structurally couple, under Luhmann’s thesis. In order to answer this question, it must be remembered that incipient social systems must still rely on existing social systems of communication to evolve. In the case of IHIs, different social systems of communications are utilised, but with a view to establishing a set of causal theories and judgements about the quality of care provided to the patient. In order to do this, different concepts are drawn from existing social systems. These concepts, according to systems theory, can irritate the communications of other social systems and ‘stir up’ different meanings about what those concepts refer to. For example, a ‘homicide’ in law is where there is both a guilty act and a guilty mind, as defined by previous legal communications. In medicine however, a homicide involves the cessation of biological life through the application of trauma to the human body, the meanings of which are defined by previous medical communications. The concept of homicide is therefore a ‘structural coupling’ between law and medicine. The IHI refers to the concept of homicide as a way of triggering and navigating the IHI process for purposes peculiar to its Terms of Reference.

Critics have argued that the concept of structural coupling is simply metaphorical or, further still, does not achieve anything. An example is a lawyer who refers to policy documents
or Parliamentary debates when constructing a legal argument. An open systems theoretical account would describe this as the law communicating with the political systems, whereas autopoietic theory would claim that it is a matter of a system filtering an event through its own realm of meaning.\textsuperscript{99} According to Sinclair, the concept of structural coupling does not make for a novel conclusion, for this reason.\textsuperscript{100} The impact Luhmann’s thesis has had on wider regulatory and organisational research is undeniable however.\textsuperscript{101}

If the concept of structural coupling is considered alongside the issue of how mechanisms like IHIs are able to utilise communications with fundamentally different meanings in a relatively unproblematic way, it does have significance. Concepts and events relevant to the purview of the IHI (‘homicide’, ‘manslaughter’, ‘negligence’, ‘best practice’, ‘risk’ and so on) automatically trigger different communications that produce a meaningful reality for the IHI. A mental health homicide will trigger legal communications about the lawfulness or unlawfulness of the act. Psychiatric communications however will be made about the act in terms of the state the patient’s mental health was in at the time of the homicide. The media might report about the homicide in terms of its value in being newsworthy as opposed to not being newsworthy.\textsuperscript{102}

Social systems may therefore be loosely likened to a dance between two people, with each system attempting to perform steps (the system’s operations) to different rhythmic perceptions (autopoiesis). A similar example would be the ‘alarm clock’ analogy cited earlier.\textsuperscript{103} The concept of structural coupling appears to imply \textit{co-ordination} in dealings between social systems, but not synchronicity.\textsuperscript{104} There is adaptation and adjustment. These adaptations and adjustments are not, according to autopoietic theory, causally procured from one system to another.\textsuperscript{105} If it is accepted that IHIs are an incipient social system ‘in the making’, then within

\begin{itemize}
\item \textsuperscript{99} M.B.W. Sinclair, op.cit., p 89 – 90.
\item \textsuperscript{100} Ibid., at 83 and 87. See also R. Münch, op.cit., at 1464 and K.D Bailey, op.cit., at 52 who respectively argue that structural coupling is “stipulative definition” and has “explanatory value”.
\item \textsuperscript{101} See H-G. Moeller, op.cit. p 136.
\item \textsuperscript{102} See generally R. Nobles and D. Schiff, ‘A Story of Miscarriage: Law in the Media’ 31(2) (2004) \textit{Journal of Law and Society} 221.
\item \textsuperscript{103} Supra, 2.3.1.
\item \textsuperscript{104} N. Luhmann, \textit{Law as a Social System}, op.cit., p 42
\item \textsuperscript{105} J. Mingers, \textit{Self-Producing Systems: Implications and Applications of Autopoiesis}, op.cit., p 35.
\end{itemize}
their investigations nests an arrangement of concepts and issues that stimulate communications in different social systems.

To reiterate, law communicates about some non-legal communications in its environment and attributes legal meaning to them. The same can be said for the relationship between law and the economy. The conclusion of a contract for goods has economic (the transfer of money for goods and the acquisition of profit) and legal (who is entitled to have possession of those goods and when possession begins) implications. Economic communications relating to prices, the amount of taxation and profit are legally irrelevant but nevertheless require legal ownership to make economic sense. Similarly, constitutions and legislation structurally couple politics and law, the former constructing them as embodiments of democracy and the latter constructing them as embodying rights and obligations. Even works of art have been offered up as examples of structural coupling.

What is more, these forms of structural coupling enable social systems to exist separately, but remain locked into a relationship which is essential for their survival. Forms – ‘contracts’, ‘constitutions’, ‘homicide’, ‘best interests’ - arguably serve “the dual function of including and excluding reciprocal perturbations”. Legal meanings about property ownership rely on economic transactions to exist. Conversely, the exchange of money for goods would be rendered meaningless if the law could not stipulate rules relating to the legal ownership of those goods. Legislation can be regarded in a similar light; politics is essential for the enactment of legislation and for the continuation of judicial law making through statutory interpretation. Conversely, politicians are only able to pass laws if they are legally mandated to do.

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109 Even where the legal system does acknowledge that value exchange did take place (as required by the doctrine of consideration), this will simply be recognised by the legal system as something signalling a claim to legal ownership.
111 N. Sevanen, op.cit., at 95. Here, Sevanen depicts the art trade as an example of structural coupling in that it commonly designates works of art as capital investments or expensive commodities. This is insightful but arguably fails to tackle the fundamental issue as to how the structural coupling process is instigated and played out.
112 Ibid.

The concepts and issues that fill the container of an IHI similarly found the very meaningful basis of those social systems which depend on those concepts and issues for continued survival. For instance, the concept of homicide triggers legal communications which cannot make sense without an accompanying psychiatric communication about the mental health of the patient. The vast majority of those IHI Reports reviewed for the thematic analysis in Chapter 6 involved the patient being found guilty of manslaughter. This legal finding requires insight into the patient’s mental health at the time of the killing. Nevertheless, manslaughter is a distinctly legal concept that has no place in the vocabulary of psychiatry. And yet, the legal finding of manslaughter is similarly required by the system of psychiatry in order to discover whether the provision of care and treatment debilitated the patient’s mental health and led to the manslaughter taking place. The production of respective meaning in each system about the event is arguably dependent on each social system’s environment. Structural coupling explains how social systems, including the ones just mentioned, are operationally closed and cognitively open.\textsuperscript{114}

3.6.1 \textbf{Structural Coupling and Irritation in the Delivery of Mental Health Care}

Peay acknowledges that structural coupling may be able to explain why mental health care can be deliverable in certain circumstances, despite the presence of different disciplines (law, psychiatry and social work) when it comes to making multi or duo-disciplinary decision making.\textsuperscript{115} Research has shown that mental health professionals (lawyers included) place the concept of ‘best interests’ centre-stage when communicating about patients.\textsuperscript{116} Peay cites the concept of ‘best interests’ as a possible form of structural coupling. The basis for this claim is that ‘best interests’ is a concept which is reconstructed anew in medical terms (with ‘best interests’ relating to how decisions about patients can enhance their health and alleviate their illness) and legal terms (with ‘best interests’ relating to what rights a patient is entitled to).

\textsuperscript{114} N. Luhmann, \textit{Social Systems}, op.cit., pp 9 and 444.
\textsuperscript{116} Ibid., at 56.
Similar arguments have taken shape in the context of how law ‘makes sense’ of suicide risks in psychiatric hospitals, with some accounts being rather pessimistic about the incongruence between law and psychiatry. Contrary to the apparent creative disharmony depicted by Peay in her analysis of the ‘best interests’ concept, the concept of ‘risk’ appears to present many challenges for both legal and mental health professionals. Risk is arguably constructed ‘autopoietically’ in the social systems of law and psychiatry. Judges refer to previous legal communications which proclaim that risk is an ‘objectively verifiable’ concept. Psychiatrists have been known to adopt their own distinct approaches towards risk, eschewing sluggish, bureaucratic procedures contained in NHS policies that have a detrimental effect on the health of patients. Whereas Peay allows for creativity and flexibility in her depiction of the concept of best interests as a structural coupling, the concept of risk arguably tells a different tale. Different understandings of risk may result in litigation, recrimination, over-cautious mental health decision making and even fear.

The thesis that IHIs contain structural couplings between different social communications does not necessarily mean that IHIs can directly induce changes in the provision of mental health services through advancing recommendations. It can be argued however that whatever lessons are learned in any given case, these lessons are not necessarily carried forward in a uniform way. If systems theory is taken as a starting point, the possible lessons that IHIs seek to teach may well be psychiatric, legal, scientific and so on. Structural couplings might well be ‘successful’, in that certain concepts might facilitate the making of certain communications. But this does not necessarily mean that real lessons are being learnt in IHI cases. After all, Luhmann’s theory of social systems is anormative. Making ‘successful’ interventions into

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119 D.P. Horton, op.cit., at 579 to 580. The trial judge in Anna Savage v South Essex Partnership NHS Foundation Trust [2010] EWHC 865 (QB); 2010 WL 1608604 referred to previous law in a bid to acquire an understanding of how suicide risks should be conceptualised. He referred to the case of Re W’s Application [2004] NIQB 67 at [17], in which Lord Carswell made it clear that ‘a real risk is one that is objectively verified (my emphasis) and an immediate risk is one that is present and continuing’.
120 Ibid., at 584.
121 Ibid.
122 J. Peay, ‘Decision Making in Mental Health Law: Can Past Experience Predict Future Practice’, op.cit., p 44. Combined with the pressure of mental health professionals interacting with one another and the obligation to protect others, this arguably made them approach decisions in a way that produced “a situation that was potentially full of dread”.

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complex areas of life is coincidental. Social systems of communication have no direct control over the way their communications are constructed in other social systems. All communications and decisions are contingent.

3.7 Conclusion

This chapter has sought to initiate a theoretical framework for exploring the relationship between mental health homicides and mental health care. At the heart of this relationship is the IHI, which constructs this relationship using operationally-closed communications drawn from psychiatry, law and science. Under systems theory, operationally-closed communications are inhered with unique meanings that cannot be accessed or mutually understood by communications of a different form. This, firstly, raises issues regarding to what extent IHIs can be referred to as a social system of communication. Secondly, it raises implications for how IHIs can facilitate understandings about mental health homicide events.

On the first issue, the chapter concludes that the IHI is a rather ambiguous species. Using systems theory, IHIs can be said to be an incipient form of communication – a social system ‘in the making’ - that utilises communicative meanings in the systems of law, psychiatry and science. Whilst the IHI could be touted as a form for the structural coupling of different communications within the process, it is more convincing to regard the IHI process as a harbour of many structural couplings. The concepts of ‘risk’, ‘homicide’, ‘mental disorder’ and so on may amount to structural couplings around which the systems of psychiatry, medicine and law coalesce in order to produce self-referential meanings about. The claim that merely the IHI is a structural coupling appears too ‘clunky’ to have traction in this respect.

On the second issue, the communicative composition of an IHI allows it to consider a broad spectrum of factors in mental health homicide cases that would not ordinarily be recognised in rigid systems of communication, such as law. By the same token, this broad spectrum of factors might well lack the sharp refinement or simplicity typical of fully established social systems of communication. When it comes to fulfilling their basic law and policy goals (examining deaths caused by the State, restoring confidence in the mental health care profession and laying the ground for a safer mental health care service) it can be argued that the hybridised constitution of the IHI prevents it from achieving these particular goals. The law and policy
measures supporting IHIs are embedded with meanings that are not necessarily shared by those social systems of communication which IHIs utilise in their investigations. What is more, IHIs aim to publish findings and make recommendations that are designed to have future effects for the mental health services. Under systems theory, it is difficult to envisage a situation where these law and policy objectives can be achieved using the hybridised approach of an IHI, despite the apparent flexibility this affords the investigatory process.

The potential difficulties associated with communicating about mental health homicides present significant challenges for IHIs. Not only is this related to the way communication is conceptually conceived under systems theory (through the concept of operational closure), it is also related to what those communications are focused on. The present chapter discussed the controversial claim by Luhmann that individuals can only be communicated about. They are ‘artefacts’. Individuals ‘step into’ communications whenever there is an attempt to produce social meaning about events. The specificity of meanings inherent in social communication vastly reduces the complexity of a social system’s environment, according to systems theory. This condenses social reality into a unique frame of meaning for the purpose of making decisions, which according to systems theory leads to inevitable conflicts in meaning between social systems. Conversely, this condensing of meaning through communication may produce ignorance about the realities produced by other social systems of communication; what one social system finds meaningful another may simply not recognise.

In the context of IHIs, individuals are but one point of focus for its communications. It was alluded to earlier that IHIs are retrospective investigations. Not only do they communicate about individuals, they communicate about the past. What is more, IHIs communicate about the past in order to make recommendations about the future provision of mental health services. Communications about time are therefore equally important to the functions of the IHI. It is prescient therefore to consider the significance of the concept of time in the context of IHIs and its relationship with systems theory. Moreover, it is prescient to consider how a concept of time can help answer the question as to whether the IHI can help achieve the stated intentions of law and policy-makers.
4.1 Introduction

Systems theory can be considered as a novel tool for examining how IHIs orchestrate a meaningful relationship between mental health homicides and the provision of mental health care services. It is also useful for framing a particular set of questions regarding how the interface between law and psychiatry is constructed. According to Chapter 3, IHIs ‘bundle’ various meaningful communications together into a hybridised discourse. It is nevertheless the case that in order for IHIs to orchestrate a meaningful relationship between homicide and care, they must examine the past decisions of mental health professionals. In fact, IHIs appear to look back into the past, produce findings that support decisions made in the present, with those decisions having future consequences. Not only do IHIs facilitate communications about events and individuals (as evidenced in Chapter 3), they facilitate communications about time.

The first part of this chapter is dedicated to exposing a concept of time that will assist an understanding of how IHIs position individuals and their decisions in meaningful alignment with the communications they use to investigate homicides. Luhmann however makes important claims about time in the context of risk that import relevance for this thesis. According to Luhmann, risk is a mechanism through which social systems like law or medicine communicate about the possibility of future loss. Reducing homicide risks is a primary goal of IHIs and mental health services.¹ They seek to avoid a repeat of a homicide event and thus set future-oriented goals through decisions. As the present chapter will illustrate, decision making is always open to error, disagreement and objection in a society functionally differentiated into social systems of communication.²

² For instance, a psychiatrist may enter into an agreement about the level of risk a patient presents on different grounds to that of a social worker.
Time and risk are therefore connected. The present chapter acts as a vehicle through which this connection can be made. It furthermore questions the assumption that IHIs can facilitate the learning of universal lessons about homicides which mental health professionals are assumed to assimilate and understand. Systems theory holds that this is not possible.

4.2 The Concept of Time

Tabboni puts it best when she writes that “intuitively, everyone knows very well what time is, but its mystery becomes impenetrable when we try to explain it”. The concept of time is elusive. It is fragmented, varying historically, culturally, socially and theoretically. Time is said to refer to “a specific human ability to work on the experience of change, to react, to organise and confer meaning (my emphasis) on the experience”. If it is accepted that the forming of a relationship between mental health homicide events and mental health care services is a process of meaningful communication at the centre of which is an IHI, can time be similarly conceived in this way? This is a pertinent question because, as will be discussed, IHIs are adept at communicating about the past, the present and future provision of mental health services using communications that are operationally-closed.

The challenge of pinpointing a reliable concept of time can be met by first acknowledging the view that time derives from social activities inhered with a distinct ‘rhythm’.

This view can be traced as far back as Durkheim and his view that reality is germinated in the

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5 S. Tabboni, op.cit., at 6; N. Elias, *Time: An Essay* (Oxford, Blackwell, 1992) p 46: “[T]he word “time” is a symbol of a relationship that a human group of beings biologically endowed with the capacity for memory and synthesis establishes between two or more continua of changes, one of which is used by it as a frame of reference or standard of measurement for the other or others”.
6 H. Nowotny, op.cit., at 422; José. M. Domingues, ‘Sociological Theory and the Space-Time Dimension of Social Systems’ 4 (1995) *Time & Society* 233 at 236. Holidays, working days and Parliamentary elections punctuated social life with intervals. For an insight into the particular rhythms of law in mental health suicide cases, see D.P Horton, ‘Making Sense’ of Risk in a Mental Health Facility 18(4) (2010) *Medical Law Review* 578 at 584. For law, verifying risk as future is arguably “steered by the practicalities of upholding the human right of the claimant, the credibility of the witness testimony, the timetable for trial, and so on”.

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beliefs and practices of their subscribers. Past social activities provide the conditions under which the present and the future are meaningfully visible. Systems theory is relevant to time because social systems need time to produce meaning and “every event…appears with a minimal feature of surprise, namely as different from what preceded it”. The notion of time having a distinct rhythm is understandable if it is accepted that communications take time to make. For example, when a mental health homicide occurs, the legal system needs a period of time to conduct an inquest, hold a trial and reach a verdict. This can take days, weeks or months. What is more, these communications are meaningful at the level of social systems if they refer to past communications of the same type. An example would be the legal system’s previous communications about homicide through the legal concepts of actus reus, mens rea and causation. These concepts provide the meaningful backdrop to the law’s communications about homicide in the present.

The future is also important because communications that take place in the present form the basis of programmes, such as decisions, that have future consequences. Programmes are not made in a vacuum. They are made in order to initiate effects. In general, the code legal/illegal is sometimes deployed in order to form the basis of decisions that serve to avoid future injustice for the legal system. This may entail not letting the guilty go free or upholding an individual’s right to free speech. For the system of psychiatry, the code sanity/insanity or madness/sanity is sometimes deployed in order to reduce the future onset of mental illness through care and treatment decisions. Under Luhmann’s theory at least, social systems face the future by producing communications the meaning of which are informed by previous communications of the same type.

What is more, IHIs must make sense of past events that are meaningful socially. If it is the case that “we have an almost infinite historical past, structured and limited only by our actual

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7 E. Durkheim, *The Division of Labour in Society* (New York: The Free Press, 1964/1933), pp 79 – 80: “The totality of beliefs and sentiments common to average citizens of the same society forms a determinate system which has its own life…Nevertheless, it has specific characteristics which make it a distinct reality”.
9 Supra., 3.4.
interest”, what does time look like if that interest is circumscribed by communications used in IHI processes? If IHIs are guided by a bundle of legal, psychiatric and scientific communications, will the past, present and future reflect the meanings produced by these communications? If social systems of communication construct reality using their own internal logic, they must also apply that logic to their sense of time. And if IHIs are accepted as using social communications in order to render meaningful the relationship between mental health homicides and mental health care, then it may be further argued that the logic contained in these communications ‘packages’ time into a meaningful agenda.

4.3 Time and Meaning in Independent Homicide Inquiries

IHIs utilise chronologies of care when identifying meaningful events and identifying causal pathways between different events. For instance, chronologies of time facilitate knowledge about when a particular decision was made. This is important because if a mental health care decision about the homicidal patient was made before an adverse event, that decision is placed in a potential relationship of causality with the fatal event. Chronologies of time are a way of organising past events according to a series of dates. All IHIs utilise chronologies of time in their reports. As a linear way of organising a sequence of events relating to the patient, chronologies in IHIs provide a basic vehicle through which all aspects of a patient’s past care are observed and communicated about. Luhmann insists however that chronology and time should not be confused. He writes that a chronology “combines very simple rules for its use with highly complex functions – like money”. In other words, chronologies must be meaningful to make sense.

A typical IHI chronology of care begins on the very first encounter the patient had with mental health services. Throughout the timeline of care, all contacts between the patient and

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12 The medical law literature generally is beginning to appreciate that law’s relationship with time is a unique one when compared to the relationship between time and the medical profession (see J. Harrington, op.cit., at 496).
13 H. Nowotny, op.cit., at 433: “[C]alculations for actions which can only be achieved in the present. Time becomes scarce, insofar as it is used for social coordination; it predisposes some kind of ‘packaging’, or ‘splitting’, it necessitates limitations and terminations, as well as agenda setting. Action in the end is always a ‘time-binding’ disposition which fills the memory beyond the moment and creates premises for future action”.
15 Ibid.
mental health care services are included in the chronology. These events inevitably have meaning in the present psychiatrically because they are instances which raise the issue of why the homicide happened, namely, the patient’s deteriorating mental health. Contacts between the patient and mental health services go to the heart of this issue and make it meaningful.

It is possible to extend this argument to the way in which the crystallisation of meanings in an event appears inseparable from when that event begins and ends. In short, communicative meaning renders the past meaningful to an observer. Where there is no communication, there is no meaning and thus no time. Psychiatric (pursuant to the code *ill/healthy*), legal (pursuant to the code *legal/illegal*), political (pursuant to the code *power/no power*) and root cause analyses (pursuant to the code *cause/no cause*) are utilised to mandate the IHI, achieve particular future objectives through it (such as fulfilling human rights under Article 2 of the ECHR and learning lessons for the future) and identify past events of interest through the investigation itself. Making decisions to select certain recommendations certainly have the ability to fill the aforementioned communicative codes with content, but they all necessitate future consequences and fill time with meaningful content also. Decisions to administer medication to the patient, the holding of meetings between professionals, the filling out of forms and so on are identified as ‘artefacts’ meaningful to one or more of the subsystems and thus give time the content required for it to be meaningful.

Scholars have already reasoned that systems theory licences the view that the fundamental differences in meaning produced by social systems produce inclusionary and exclusionary effects. After all, psychiatric communications and RCA have been known to be rather ignorant of factors crucial to the delivery of mental health care. This can be

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16 Ibid., at 133. According to Luhmann, the past and future are integrated into a present. The past and future are horizons of relevance for the present. “[T]he present becomes the turning point which switches the process of time from past into future”. At 137, Luhmann furthermore posits that “the relevance of time (in fact, I would maintain relevance as such) depends upon the capacity to mediate relations between past and future in a present”.
17 R. Nobles and D. Schiff, op.cit., p 134 and 135. The authors illustrate this point with the example of a surgical operation. The surgical event can be understood to be a series of movements learnt by surgeons during their time at medical school. The event begins when the surgeon picks up the scalpel and end when he leaves the theatre. The law however may impose liability on a person for all damage arising out of the surgical procedure, which may well necessitate a wider chronology of relevant events. These events may include after-care procedures or administrative errors committed before or after the procedure.
18 See P. Munro, op.cit., p 84.
19 Supra., at 1.4.1.
supplemented with the argument that this occurs because these forms of communication produce different meaningful orientations of time. Similarly, RCA has been said to be insensitive to the different ways a “logical relationship” between different ideas, issues and events in mental health care look like. Adshead points out that the logical manner in which IHIs draw relationships ignores: the application and understanding of strong feelings. We sometimes make decisions (which in retrospect seem illogical) because we are moved by powerful feelings, usually negative ones of fear, anxiety and hostility. Post incidents inquiries frequently meet and are moved by similar feelings, and those feelings affect the way that they perceive logical relationships and analyse them.

These sentiments are important because the various communicative tools deployed by IHIs allow a narrow band of events to be filtered through to their investigations, making the IHI ignorant of what would normally be considered to be the ‘human factor’ (personal needs, thoughts and feelings) in mental health homicide cases. According to the present chapter, this narrow band of events will orient the IHI towards a simplistic experience of time.

In addition to reproducing a communicative reality, social systems have been said to deploy the binary distinction before/after in order to identify new events. It is without the scheme of before/after that new events cannot be distinguished from events that have already happened. Meaningful events, such as a mental health homicide, must begin and end. That beginning and end is inextricably linked to whether that event is relevant to a social system’s internal logic. For instance, a decision to forego administering the patient with his usual medication before a mental health homicide took place will inevitably be relevant pursuant to the code sanity/insanity. Such treatment decisions are inevitably seen as having possible negative implications for the patient’s mental health and thus present as meaningful aspects of the psychiatric past with potential links to the fatal event.

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21 Ibid.
22 Ibid.
23 At the risk of tautology, ‘new’ events are events which did not exist before they happened. See also H. Nowotny, ‘Time Structuring and Time Measurement: On the Interrelation Between Timekeepers and Social Time in J.T. Fraser and N. Lawrence (eds.) The Study of Time II (Berlin/New York, Springer, 1975), p 326.
24 Luhmann, Social Systems, op.cit., p 288.
4.3.1 Time as a Communicative Construct

Time is an aspect of the social construction of reality. If society is regarded as being functionally differentiated into spheres of different communications, it can be argued that there are “several times, a plurality of Temporalgestalten or of social times.”

The past (in terms of exploring past decisions) and the future (in terms of making recommendations) have a unique significance and, under the present thesis, communications facilitate this significance. Systems theory posits however that social systems react to an external environment in ways that are not mimicked in other social systems of meaning. As a consequence, functionally differentiated social systems can be said to be inhered with their own unique orientations of meaningful time.

For instance, the time it takes for the legal system to respond to an industrial accident is far greater than the time it takes for the system of employment or the economy to respond to it. Attempts by social systems to reduce the complexity of their environment through meaningful communication that expressly accord with the internal logic of that system only, under this view, may lead to misunderstanding, delay, conflict, or complete exclusion by one system of another. What is more, what the law might consider as relevant in the past and what the future requires may not be shared by other social systems.

This is important to the present thesis for two reasons. Firstly, if IHIs are seen to bundle social systems of communication together in order to render the past and future meaningful in the present, these meanings will ultimately not be shared in other systems of communication. If time

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27 R. Nobles and D. Schiff, Observing Law Through Systems Theory, op.cit., p 133. At p 132, the authors write that “[t]ime is an inevitable part of this separation” because “the fundamental separation between social systems and their environment (other social systems) require various reactions to take place”. In other words, the reactions of social systems take place at different speeds and take time.
28 Legally claiming damages through the courts is a lengthy process, whereas conducting disciplinary proceedings or compiling reports about costs after an accident are much shorter.
29 P. Munro, op.cit., p 107; M. King, and C. Piper, How the Law Thinks About Children, 2nd edition (Aldershot: Arena/Ashgate Publishing, 1995), p 32; N. Luhmann, Risk: A Sociological Theory, op.cit., p 106. From the point of view of other social subsystems, law may indeed be failing in its task to appreciate the realities of conflicts, for example. This is perhaps inevitable, because these systems look through an entirely different communicative lens to that of the law and are unable to share common ground with legal decisions. Oddly enough, law simplifies social communications through its normative framework because otherwise it would simply mirror its environment, thereby ceasing to be law entirely.
is accepted to be inextricably linked to meaningful communication, IHI Panels will be clearly sensitive to past events (and possible future events) that import meaningful relevance to the questions they wish to answer. In short, time is meaningful because it is constructed by meaningful communications utilised by the IHI Panel.

On the one hand, the relevant questions for an IHI Panel in this respect – whether any failings in care and treatment took place, whether the decisions taken should have been taken differently and so on – can be regarded as answerable on the basis of whether or not they were pursuant to a communicative code. The case chronology for the high-profile Ritchie Report cited earlier was provided by Clunis’ solicitor.30 Similarly, the “able and astute eyes” of Oliver Thorold and Michelle Strange were highly valued in The Falling Shadow,31 in the context of its investigation. It is possible, therefore, for an IHI care chronology to acquire a particular emphasis on legal communications in the course of its creation, in this respect. This was one of the criticisms aimed at The Falling Shadow. The implication of this is that the prevalence of one form of communication over another may lead to a particular case being defined by its legal past as opposed to other forms of past, such as the psychiatric past. After all, Thorold and Strange were legally trained investigators who, in the course of their investigation of the documentary material, composed a set of findings that was subsequently criticised as being overly-focused on legal issues.

IHI Panels are mostly composed of mental health professionals. Whilst remaining capable of communicating legally,32 they are particularly concerned with what constitutes ‘best practice’ psychiatrically. Combined with a ‘scientific’ emphasis through the use of RCA, IHIs nowadays are less legalistic than has previously been witnessed. Some commentators have argued that the technocratic emphasis advanced by IHIs reduces scope for ambiguity, uncertainty

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31 This is not to say that these experts were only able to communicate legally about mental health care. Chapter 3 discussed how systems theory re-conceptualises individuals as operationally-closed psychic systems that structurally couple with a range of communications about social events. Individuals ‘step into’ communications when they communicate about whether a statutory provision was complied with (a legal communication), whether enough resources were available to provide a patient with accommodation (an economic communication) or whether the incorrect amount of medication was administered (a medical communication).
32 Chapter 6 gives examples of IHI Panels communicating legally, for example, by referring to the remarks of the trial judge in the patient’s prosecution in a bid to differentiate between legal culpability for manslaughter and the aims of the IHI.
or contradiction. This is understandable in the present context because the expertise IHIs embody is accredited and capable of establishing authoritative statements about the past, present and future. It is nevertheless the argument of the present thesis that despite the appearance of certainty provided by the expertise of IHI Panels, the social concept of time leaves open the argument that what IHIs are engaging in can never be authoritative and representative of objective time. This is related to the ‘one world’ vision of social systems, whereby the internal logic infused in its communications cannot take into account the basis upon which decisions made at the level of other social systems are made.

4.4 Looking Into the Past and the Future

Systems theory not only provides an opportunity to explore how social systems of communication make the past meaningful in the present. It also prompts consideration of how social systems of communication are used to make the future meaningful. The future poses particular challenges to social systems because, as Luhmann points out, “the future can never begin”.

The future for social systems, like the past, is a horizon for the present:

The essential characteristic of a horizon is that we can never touch it, never get at it, never surpass it, but that in spite of that, it contributes to the definition of the situation. Any movement and any operation of thought only shifts the guiding horizon but never attains it.

The basis of Luhmann’s view of the future is that it acts as a projection screen for present hopes and fears. These hopes and fears are ultimately a permanent feature of a functionally differentiated society; the structural conditions (social communication) of the present have only an internal logic to rely on for making communications that serve the values of the system in which those communications are being made. For an IHI, these hopes and fears flow from making attempts to prevent the unthinkable, namely, future mental health homicides. This is one of the central reasons why an IHI is triggered. Their ultimate goal is to reach findings and more

35 Ibid., at 140.
36 Ibid., at 145.
37 Ibid.
often than not make recommendations that alter the way mental health services are configured for the future. The aim is to make improvements and make the future provision of services safer.

IHIs however are met with the challenge of having to change (or leave untouched) a mental health care ‘system’ that is constantly shifting. Communications must occur against a background of *time passing*. Communications occur all the time and do not stop. They make for an unpredictable and uncoordinated constellation of communications with various unpredictable effects. The time it takes for an IHI investigation to be conducted and recommendations implemented inevitably occurs against a background of shifting communications in the mental health care profession. This requires on-going monitoring. As one IHI Report noted:

> Any plan agreed must be shared with the SHA and the commissioners and have measurable objectives so that the impact of the agreed action implementation plan can be monitored in the short, medium and long term.\(^{38}\)

Advancing recommendations in IHIs therefore is akin to aiming for a target that is obscured in camouflage and is constantly on the move. Policy guidance, psychiatric communications and RCA all help to inhere a distinct meaning of the past. But these understandings about the past, particularly in terms of how events and decisions connect to each other, also fuel decisions in the present that aim to control the future by making it safer. The findings and recommendations advanced by IHIs that hallmark the latter’s attempt to influence the future may ultimately prove to be irrelevant, given that the time it takes for them to be made is long enough for the mental health profession to identify fresh problems relating to service provision.

### 4.4.1 Making Recommendations and Creating Divergent Futures

The argument that time is contingent upon the communications used to make sense of it clearly has implications for the way IHI recommendations are received and understood. If there is “temporalized complexity”,\(^{39}\) where different universes of time co-exist in society and are unable

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\(^{39}\) H. Nowotny, *op.cit.*, at 429.
to access each other due to operational closure, making the interface between homicide and care ‘make sense’ to observers beyond the boundaries of the IHI poses a particular problem. Delivering recommendations to those observers (NHS Trust officials, policy makers and mental health professionals) will be potentially fraught with difficulty because different meanings about the future cut across the mental health edifice. From psychiatrists to social workers, all have different expectations, opinions, fears and concerns that are not necessarily shared by an IHI Panel. And not only is it a case of there being a clash of meanings about what events in time are relevant to a construction of the past and what to do about the future, but IHIs also take time to investigate, reach their findings and deliver recommendations.

IHIs are known for their association with a “complex, real world that is in a continuous and dynamic flow”.  

40 This flow contributes to the difficulty of having to investigate a functionally differentiated mental health profession with many different forms of communication being made about the same patient. The present chapter seeks to link this “dynamic flow” to a concept of time as meaningful communication on the basis that time is meaningful insofar as there is a social system of communication in existence that can make sense of it.41

IHIs are known to instigate defensive medical practices.42 Defensive practices are hedged with the fear of liability, legal or professional blame.43 These fears are inherently connected with making decisions that limit exposure to liability and blame in the future. IHIs are sometimes acknowledging of these issues in their reports. The following is but one example of IHIs acknowledging the fears of the mental health profession:

An external review into alleged bullying and harassment was being undertaken and this revealed that there had been deficiencies in human resource management, a lack of clinical engagement and a culture of fear.44

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41 R. Nobles and D. Schiff, op.cit., p 133.
42 J. Warner, ‘Inquiry reports as active texts and their function in relation to professional practice in mental health’ op.cit., at 233.
44 H. Waldock, L. Chenery and A. Irons, Independent Investigation into the Care and Treatment provided to Mr AT, NHS South West SHA, Health and Social Care Advisory Service, (November 2009)), p 42.
Mental health professionals will nevertheless form fears of the future the basis of which IHIs have no meaningful view of. These fears can emerge as localised constructions in working practices that have no meaningful reality outside of their contexts.

Since the introduction of the 2005 amendments to HSG(27)94, less emphasis has been placed on the need to locate blame in IHIs. This does not however abate concerns about the future in the eyes of mental health professionals. Issues of time, and particularly the future, can ultimately have resonance in mental health service localities, but in communicative terms not shared by an IHI Panel. IHIs locate an entirely different meaning in their concerns about the future. This may involve addressing decision making systems and processes in a bid to make services safer, as opposed to limiting exposure to blame and liability. Their recommendations will be delivered in a bid to improve mental health services, but these will occur against a background of meaningful experience of past and future, integrated in the present. Consequently, recommendations are likely to not address issues arising out of homicide cases that have negative implications for the delivery of care and treatment. Blame is not an issue. Systems and processes are. A central aim of this thesis is to provide an explanation for this discrepancy.

Consistent with this theme, the hybridised bundles of communications IHIs use to construct time create a map of interlinked decisions, largely due to the use of the code *cause/no cause*. As a result, some decisions do not even appear under the IHIs gaze, such as the decisions of politicians to cut or modify hospital budgets, for example. These decisions do not form part of the relevant past for the purposes of the investigation. The bundles of communications IHIs use to understand time therefore appear to cohere into a distinct understanding of past mental health care decisions as connected to each other. Multiple causal relationships with adverse events are posited and the need to continue this causal link with decisions in the present about the future safety of mental health care services is a main priority.

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45 IHIs held throughout the 1990s were more inclined to assign blame rather than focus on systemic factors. With the advent of RCA however and a more complex provision of mental health care services, the assignation of individual blame is increasingly becoming less useful.
46 J. Warner, ‘Inquiry reports as active texts and their function in relation to professional practice in mental health’ op.cit., at 234. Mental health professionals may erroneously redefine potentially harmful defensive practice as ‘good practice’ or ‘doing the job better’. This is very much about professionals making decisions with an eye on their future consequences, displaying over-caution at the expense of ‘best practice’.
4.4.2 Making the Future Safe in a Shifting Climate of Communication

The notion of social systems playing ‘catch up’ is visible in Luhmann’s work. If social systems react to an external environment at different speeds and in a shifting sand of communication, this can make controlling the future in the present difficult:

the environment of a system always exists simultaneously with the system – neither prior to nor subsequent to it. Thus it can never happen that the environment gets stuck, as it were, in the past, while the system becomes the future of the environment (or vice versa).\(^{47}\)

Consistent with this, new scientific discoveries may render existing laws relying on previous science obsolete, particularly in the area of health and safety where regulations previously considered ‘safe’ by the scientific community may be proved to be flawed through testing.\(^ {48}\) This is perhaps further demonstrable in the way IHIs make their recommendations. They are not known for making radical changes to the way mental health services are provided. Their recommendations are often piecemeal and usually encourage more of the same of what was being provided before. More training of staff, stricter adherence to risk assessments and more regular meetings between staff and teams are common recommendations IHIs make. They are not far-reaching and rarely advocate sweeping changes to mental health care services. When it comes to making the future of mental health care services safer, conservatism as opposed to radicalism appears to be the preferred approach.\(^ {49}\)


\(^{48}\) J. Paterson, ‘Trans.Science, Trans-Law and Proceduralization’ 12(4) (2003) *Social & Legal Studies* 525 at 534. Writing on the legal regulation of risks, Paterson claims that “[i]t is true that when tasked with the regulation of risks law does face a significant challenge and that the apparent absoluteness of the norm in such circumstances can rapidly dissolve into the provisional in the light of the ongoing evolution of scientific knowledge”.

4.5 The Risk-Time Connection

Time is intrinsically connected with risk.50

Social systems, such as the mental health care system,51 operate in the present and are guided by their past.52 Communicating requires referring to the past in the form of previous communications.53 IHIs accomplish this by referring to previous psychiatric, legal, scientific and political communications. In addition to referring to past communications however, IHIs also expressly reconstruct the relationship between homicide and mental health care by selecting past events that make up the meaningful past. Events meaningful to the social system of psychiatry, namely, the care and treatment that the patient received since his or her first contact with mental health services, will undoubtedly be made relevant.

IHIs do not engage in academic exercises however. IHIs reconstruct the past in order to instigate a particular set of arrangements in the present that have future implications for the way mental health care services are delivered. Time, in terms of the connection IHIs make between past and future, is thus important to an understanding of the relationship between homicide and mental health care provision. But the future is elusive. Decisions are made in the present but “we cannot gain sufficient knowledge of the future; indeed, not even of the future we generate by means of our own decisions”.54 More than that, the future cannot exist in the present. Social systems (law, medicine, psychiatry) are only “guided by their (immediate) past. They can gain no access to their future. Hence, they move backwards into the future”.55 Social systems therefore rely on meaningful memory in the present only.

51 See N. Rose, ‘Psychiatry as a political science’ 9(2) (1996) History of the Human Sciences 1 at 3 - 4. The terms ‘psychiatry’ or ‘mental health care system’ are misleading. Rose explains this well by pointing to the “heterogeneous complex of contested relations among different professionals who claim to be able to identify difficulties of conduct in terms of a theoretical and practical knowledge of the vicissitudes of the psyche, and to act upon persons in light of that knowledge”. For the purposes of this chapter and thesis as a whole, the aforementioned terms are to be deployed merely as shorthand to refer to the multitude of different subsystems relevant to the legal and policy framework erected to facilitate decision making on mental health issues.
53 Ibid. “Recursively operating (operatively closed) systems proceed on the basis of the state they have attained” which in turn produces a “complex memory…in the form of the twin horizons of the past and future”.
55 Ibid., p 35.
The future is nonetheless realisable as a concept from the point of view of IHIs. IHIs perform their investigations in order to make the future provision of mental health care safer. If the future cannot exist in the present, how do IHIs go about meeting the challenge of making the ‘unreal’ future ‘safer’? The answer is through decision making. Connecting the past and future in the present does not occur in a vacuum. It requires decisions.\(^5\) A mental health homicide creates a wealth of suspicion that if mental health services continue to be provided in the wake of the fatal event without investigation and possible change, a homicide is likely to occur again. IHIs must therefore reduce this likelihood. They must reduce the risk. But risk is a challenging concept because a clear and commonly agreed definition of it is extremely hard to come by.\(^5\) Risk seems to embody the “limits of ignorance”\(^5\) because if a risk was knowable, it would cease to be a risk because what is ‘knowable’ has already passed through the present and has been converted into the past.\(^5\)

The concept of risk will be discussed further below, but for now it is simply apposite to bear in mind that risk relates to the possibility of future loss occurring. A possible future loss in the present context is a homicide. According to systems theory at least, the concept of risk is a description society applies to its future.\(^5\) But in order to describe the future, communication is required and thus past communications are essential for this. Decisions must “always revert[s] to the past ‘stock of knowledge’ in order to acquire and organise the measurements of the future risk”.\(^5\)

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\(^5\) A. Philippopoulos-Mihalopopoulos, op.cit., p 120.

\(^5\) Ibid., p 119. Philippopoulos-Mihalopopoulos writes that “[a]ny definition of risk simultaneously tries to negate the subject matter of definition: the fear of risk renders obsolete the need for a definition of risk per se” because “we define risk by defining the initial steps of any method of prevention, which are the calculation of probability and of consequences”. See also N. Luhmann, Risk: A Sociological Theory, op.cit., p 7. Attempts to define risk have been said to “delimit, [and] not adequately describe (let alone explain) the object under investigation


\(^5\) A. Philippopoulos-Mihalopopoulos, op.cit., p 122.
4.6 Risk and Decision Making

Mental health care decisions have increasingly become more future-oriented and thus more descriptive of time, with risk science being relied on as a way of controlling the future consequences of mental health care decisions. As will be illustrated further on, this connection between risk and time is useful for understanding how IHIs render the relationship between mental health homicides and mental health care meaningful.

The descriptions society applies to its future may come in many forms however. Most notably, these forms include sterile forms of risk management and control, such as statistical calculation. The latter does not apply to IHIs however. They do not apply actuarial science in order to reduce mental health homicide risks. IHIs do however make decisions. Decisions generally are the one universal conduit through which descriptions of the future are always made:

Irrespective of any eventual resolution, what both sides agree on, explicitly or implicitly, is the importance of decisions in the emergence and treatment of risks. Whether one perceives a paradigmatic shift or a more complex picture composed of known and ongoing phenomena familiar to observers of regulation, it remains the case that risks do not just happen, do not just arise out of the background or the environment unmediated by human influence. They are the product of decisions.

How is risk the product of decisions and how is this related to time in the context of IHIs? Firstly, essential to decisions are the future consequences of them. Without future consequences, decisions would not be recognisable as decisions. And in order to make decisions, the past must be realisable in a particular communicative framework. This corresponds

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64 Scholars have argued that IHIs should be replaced with similar techniques however (see N. Eastman, ‘Inquiry into homicides by psychiatric patients: systematic audit should replace mandatory inquiries’ 313 (7064) (1996) British Medical Journal 1069).

65 J. Paterson, op.cit., at 526.

to a meaningful basis upon which arrangements can be made in the present in order to make the future of mental health services safer. This basis is provided by the policy goals of the IHI. These are the location of the causes of mental health homicides, learning lessons, holding certain individuals to account and implementing certain recommendations over others that procure a ‘safer’ mental health care service for the future. But all this necessitates the making of meaningful decisions. Holding certain individuals to account, what past events are relevant to an investigation and the advancement of certain recommendations over others require decisions to be made.

Such decisions are risky however because other decisions could have been taken, with different consequences. What is more, decisions have unknown future consequences. For instance, the success related to the implementation of recommendations may well be dependent on other factors beyond the control of an IHI or NHS Trust, such as decisions to allocate resources and the decisions of professionals to leave their jobs as a result of stress (high staff attrition rates are typical in high-security facilities). It can be argued therefore that IHIs embody a firm connection between the concepts of time and risk by making decisions about the future safety of mental health services.

4.6.1 Law, Policy and the Risk-Time Connection

The connection between risk and time to specific contexts, like law and policy, is clearly a concern. This is because law and policy is increasingly being looked upon to provide answers to pressing social concerns about the unknown future. For instance, issues of health, safety and environmental regulation are taxing the area of science with difficult, unanswerable questions.67 Popper exemplifies this point in his famous ‘swamp’ analogy of scientific discovery.68 Ensuring effective future safety for society and patients especially is becoming more and more up for dispute. After all, research shows that different mental health professionals construe the needs of

68 K. Popper, The Logic of Scientific Discovery (London, Hutchison, 1972) p 111: “The empirical basis of objective science has nothing ‘absolute’ about it. Science does not rest upon a solid bedrock. The bold structures of its theories rises, as it were, above a swamp. It is like a building erected on piles. The piles are driven down above into the swamp, but not down to any natural or ‘given’ base; and if we stop driving the piles deeper, it is not because we have reached firm ground. We simply stop when we are satisfied that the piles are firm enough to carry the structure, at least for the time being”.

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patients more narrowly than patients themselves,\(^6\) with law and policy being given a more commanding role in a possible resolution to these questions.\(^7\) This is reflected in the mandate given by law and policy for the holding of IHIs in order to procure a safer future for mental health services.\(^8\) Why does law and policy have more of a say in this respect? This question is important because an answer to it can give further complexion to how the unknown future is rendered meaningful in IHI cases. It can be answered in two parts.

### 4.6.2 Conducting Independent Homicide Inquiries in the ‘Risk Society’

The first part relates to Beck’s ‘risk society’ thesis. The risk society unleashes its logic of risk in its pursuit of wealth. Pursuing wealth in such a society exposes the latter to an explosion of hazards that culminate from that pursuit. This involves “discovering, administering, acknowledging, avoiding or concealing such hazards with respect to specially defined horizons of relevance”.\(^9\) The unintended ‘side effects’ of technological progress (genetic mutations from the use of pesticides, accidents on oil platforms and so on) have, according to Beck, slipped through the net of rigorous scientific expertise. The latter is consequently exposed as being unable to provide answers to fundamental questions raised by the onset of modern technology and disaster.\(^10\) Other, non-scientific, voices are thus seen as carrying equal, if not more, weight, to the issue of how hazards should be controlled, monitored and addressed. Promises by science to secure safety simply bring with them more doubt about reducing risks:

> [t]he promise of security grows with the risks and destruction and must be reaffirmed over and over again to an alert and critical public through cosmetic or real interventions in the techno-economic development.\(^11\)

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\(^8\) In the form of HSG(27)94 and Article 2 of the ECHR.


\(^10\) Ibid., p 28. “Modern risk-orientated society is a product not only of the perception of the consequences of technological achievement. Its seed is contained in the expansion of research possibilities and of knowledge itself.”

\(^11\) Ibid., pp 19 – 20
According to Weinberg, law and policy have become notable voices on the debating stage, in this respect.\textsuperscript{75} A mental health homicide, whilst not strictly a technological hazard, is nevertheless an event law and policy-makers have shown a great willingness to avoid. HSG(27)94 and its 2005 update clearly demonstrate the willingness of the government to tackle the spectre of mental health homicide. The IHI is the vehicle through which this is achieved. They are engineered to uncover the causes of mental health homicides and instigate changes to mental health care services in order to reduce their likelihood. But this does not necessarily mean that IHIs can provide firm answers to questions about mental health homicide risks. In fact, IHIs can raise more questions about how mental health care can be made safer for the future. IHIs can therefore be seen as being an extension of Beck’s risk society. They are not simply observers of the past but are increasingly consistent with wider law and policy trends that place the unknown future centre-stage.\textsuperscript{76}

\subsection{Law and Policy: Immunising Mental Health Services Against the Unknown Future}

The recruitment of law and policy to tackle future uncertainty raised by mental health homicides could be said to be significant for the following reason; IHIs could, in principle, be regarded as a “fourth branch of government”\textsuperscript{77} which (from the point of view of the present thesis) law has recruited to ‘access’ and ‘control’ the future of the mental health profession more effectively.\textsuperscript{78} Although law and policy are sometimes seen as beacons of alarm, panic\textsuperscript{79} or what Beck might describe as part of a “commonality of anxiety”\textsuperscript{80} about making the future safer in the wake of crisis, Luhmann describes how the law often guarantees the elimination of risk. Law is “risk-free” because being guided by law in one’s conduct is considered free of recrimination, blame or

\begin{footnotesize}
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\item \textsuperscript{75} A.M. Weinberg, ‘Science and Trans-Science’ 10(2) (1972) \textit{Minerva} 209 at 215. At 209, Weinberg writes science is particularly burdened when it “attempts to deal with social problems”.
\item \textsuperscript{76} A.J. Wistrich, ‘The Evolving Temporality of Lawmaking’ 44(3) (2012) \textit{Connecticut Law Review} 737. At 783, Wistrich claims that this shift has been facilitated by the creation of regulatory law administered by quasi-legal agencies.
\item \textsuperscript{77} Ibid., at 783.
\item \textsuperscript{78} Supra., 3.4.
\item \textsuperscript{79} S.P. Hier, ‘Risk and panic in late modernity: implications of the converging sites of social anxiety’ 54(1) (2003) \textit{British Journal of Sociology} 3.
\item \textsuperscript{80} U. Beck, op.cit., p 49.
\end{itemize}
\end{footnotesize}
even fear.\textsuperscript{81} Even if the law is proved ‘wrong’ or obsolete in the future because new advances in science require a different regulatory approach to be taken, for instance, law remains valid as long as it is valid. Even if repealed or replaced, law requires new law to change it.\textsuperscript{82} No matter what developments happen outside of law, legal norms will always provide a truth in order to immunise society against the anxiety of the unknown future. Law and policy, it seems, render the unknown future less risky.

It can be argued therefore that the law and policy basis of an IHI gives it the communicative ability to make decisions without instigating excessive uncertainty about whether those decisions really are the best ones to take. IHIs contain features of law, particularly when it comes to their law and policy foundation and the way they refer to legal communications in their reports. After all, an IHI has no real ‘teeth’ if it has no law and policy basis supporting it. It would have no ability to make communications that influence the future for there would be no risk for NHS Trusts in not being guided by its findings. This is not to say that risk is truly negated however. As will later be discussed, IHIs embody considerable risk and uncertainty, despite their accredited foundation in law, policy and technical scientific and psychiatric expertise.

To reiterate, Beck’s risk society thesis places weighty emphasis on technological risks. This thesis however has been particularly concerned with how the connection between time and risk characterises the meaningful relationship between homicide and mental health care, using communications. Whilst risk is relevant to IHIs, Beck’s thesis appears to lack the sophistication required to account for the IHIs idiosyncrasies.\textsuperscript{83} Beck presents an epochal portrait of risk and limits its conceptual remit to physical hazards. The trajectory of the present thesis prefers to locate risk in communication, meaning and decisions. Risk logic, according to this trajectory, is not definable by distinguishing it from a previous era which lacked risk logic (such as the wealth

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\begin{enumerate}
\item N. Luhmann, \textit{Risk: A Sociological Theory}, op.cit., p 54; N. Luhmann, \textit{Law as a Social System}, op.cit., p 469. “Norms, and the validity that supports them, are no longer based on the constants of religion or nature or an unchallenged social structure, but are now experienced and dealt with as time projection. They are valid until further notice”. See also J. Paterson, ‘Trans-Science, Trans-Law and Proceduralization’, op.cit., at 533.
\end{enumerate}
\end{footnotesize}
logic of industrial society).\textsuperscript{84} It is rather concerned with how risk is made realisable through establishing meanings about time by linking the past with the future in the present through decisions.

Rather than fencing-in the concept of risk ontologically, such a concept should be capable of application “to every instance of decision making and therefore does not restrict the concept of risk to the realm of technology or health or to aspects of globalization”.\textsuperscript{85} This makes for a comprehensive basis upon which a concept of risk can be elucidated further, whilst at the same time understanding how the IHI mediates the link between law, policy and the mental health profession when addressing homicides.

4.7 Contingency and the Pursuit of Safety

One aspect of risk has already been covered. This is the view that IHIs make decisions and recommendations that are inextricably linked to having unknown future consequences and possible future losses. In short, IHIs embody a connection between time and risk. There is a second aspect to this concept of risk however and that is the view that decisions are inherently contingent. This second aspect is crucial because it relates to how IHIs make sense of the past in order to make decisions about the future.

For Luhmann, contingency occurs when social systems of communication are situated in a context of other possibilities.\textsuperscript{86} In other words, decision makers who utilise social communications must select from a horizon of other, potentially more advantageous possibilities, in order to avoid possible future losses. That only one decision can be taken from a possibility of many (such as whether to make certain forms of conduct legal or not, whether to elect for certain forms of medical treatment over others and so on) appears to create an “excess of options”.\textsuperscript{87} After all, psychiatrists base their decisions on their skills, not on non-human factors such as laboratory conditions or equipment.\textsuperscript{88} Psychiatrists, like any other decision maker, select decisions based on their skills which may act as a potential source of regret after the decision has

\textsuperscript{86} N. Luhmann, \textit{Social Systems}, op.cit., p 56.
\textsuperscript{87} K.P. Japp and I. Kusche, op.cit., p 81.
been made. Even choosing not to make a decision to do anything is a decision.\textsuperscript{89} Omissions are essentially decisions also, with “zero values gain[ing] causality”.\textsuperscript{90} This is a fundamental aspect of Luhmann’s concept of risk:

Risk can be defined as the possibility of future damage, exceeding all reasonable costs, that is attributed to a decision. Risk is the hopefully avoidable causal link between decision and damage. In other words, it is the prospect of post-decisional regret.\textsuperscript{91}

Luhmann fleshes this theme out accordingly:

At the present moment we cannot know how they [decisions] will turn out. But we can know that we ourselves and other observers will in a future present know what the situation is, and will then judge differently from the way we do now – although differences of judgement among us might arise.\textsuperscript{92}

At first blush, it is difficult to appreciate that decisions are always regretful. On the surface, certain decisions can facilitate a slew of positive consequences. ‘Making the right call’ does sometimes occur, with regrets being non-existent. It must be stressed however that Luhmann’s theory of social systems is not a normative theory.\textsuperscript{93} It is not concerned with questions about whether communications, decisions, laws and so on are good or bad for society. For Luhmann, the notion of good and bad is a communicative construct. What Luhmann’s theory does is observe observers. How observers observe, make their decisions and produce discourse about a risky future is what is important for his theoretical outlook. His theory is not conceptually positioned to enter debates about the existence of risks and whether certain ways of addressing them are adequate or not.

This technique leads Luhmann to question some basic assumptions about ‘safety’. If it is accepted that social systems of communication create operationally-closed realities that cannot be

\textsuperscript{89} Ibib., p 20.
\textsuperscript{90} Ibid.
\textsuperscript{91} N. Luhmann, ‘Technology, environment and social risk: a systems perspective’ 4(3) (1990) \textit{Industrial Crisis Quarterly} 223 at 225. See also ibid., p 21. The closest Luhmann comes to postulating a concept for this is through the phrase “postdecision surprise”, although he mentions this only once and even that is in a footnote (see N. Luhmann, \textit{Risk: A Sociological Theory}, op.cit., p 21).
\textsuperscript{93} N. Luhmann, \textit{Social Systems}, op.cit., pp 123 and 325.
shared, judgements about what is safe will inevitably differ. More importantly, Luhmann argues that decisions made at the level of social systems can never be ‘safe’. Any decision, if taken, must necessarily forego other possible decisions which are inhered with their own unique advantages. These advantages are only enjoyable if those decisional possibilities had been taken up:

[the apparently ‘safe’ alternative then implies the double certainty that no loss will occur and that the opportunity will be lost that one would possible [sic] have been able to take via the risky variant. But this argument is deceptive, for the lost opportunity was in itself no certainty. It thus remains uncertain whether by forgoing the opportunity one has lost out on something or not; and what remains is an open question of whether one ought to regret preferring the ‘safe’ variant or not.  

Causation in accidents ranging from nuclear power to mental health homicide have been said to be united by the view that something could have always been done to prevent the fatal event. The pursuit of safety in the present will arguably always incur criticism or comment from others that not enough information was obtained about the risk in question or that another decisional possibility should have been taken but was not. This view is not surprising, for “there are so many causes for things going wrong in improbable ways that they cannot all be allowed for by rational calculation."

IHIs are nevertheless considered to strengthen the ‘safety culture’ of mental health services. Homicides, however, can be said to expunge the regret of mental health care decisions to the surface of an IHI investigation. The diversity of voices deemed relevant to the investigation enable the gathering of different questions and viewpoints about what happened and whether certain decisions should or should not have been taken. For example, in one IHI Report, the patient’s mother was granted a forum by the IHI Panel to request information that she specifically wanted to know:

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94 Ibid., p 20
The Service User’s mother wanted to know...whether there were any aspects of his mental health care and treatment that could and should have been better.⁹⁸

These requests, met by the IHI Panel, shaped the investigation somewhat and did lead to the conclusion that the care provided could have been better (despite the homicide not being preventable).⁹⁹

Some past decisional possibilities explored by the IHI not chosen by those professionals count as ‘missed opportunities’ perceived as having ‘safer’ advantages that could have been enjoyed if they had been taken up. There is always, therefore, future loss and thus risk regardless of what decision has been taken:

The potential loss is either regarded as a consequence of the decision, that is to say, it is attributed to the decision. We then speak of risk – to be more exact of the risk of decision. Or the possible loss is considered to have been caused externally, that is to say, it is attributed to the environment. In this case we see speak of danger.¹⁰⁰

In giving “attention to the ways in which risks are communicated (my emphasis)”¹⁰¹ a fresh complexion can be put on the different ways time is constructed by social systems of communication. Decisions are the main vehicle through which this is done, whilst filling the social system’s communicative code with content as a programme. This may cover “new techniques, institutions, regimes and management systems promoted in the promise of extending supervisory capacity or perfecting security”.¹⁰² On the other hand, it may cover Luhmann’s programmes of altered rule-making, decisions and so on. The range of content is therefore quite wide.

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⁹⁹ Ibid., pp 7, 8, 30, 79, 82.
¹⁰⁰ N. Luhmann, *Risk: A Sociological Theory*, op.cit., pp 21 – 22. But see A. Phillipopoulos-Mihalopoulos, op.cit., p 136 Under systems theory, everything that is acknowledged by a system in its environment must be exposed to the contingency of decision making and thus stimulate an endless pursuit of “cognitive explorations”. ‘Dangers’ beyond the system’s boundaries cannot be comprehended as such because they would have to be within the system’s boundaries to make sense. And only at that point do they become a risk because dealing with dangers involves having to make a decision, which is risky. An all-encompassing concept of risk, as opposed to a conceptual distinction between risk and danger appears to be “more malleable and conceptually faithful to autopoiesis to accept that all risks are risks”.
¹⁰¹ Ibid, p 132.
¹⁰² Ibid., p 139.
Rather than invest faith in a distinction between risk and safety, therefore, Luhmann utilises a distinction between risk and danger. This “presupposes (thus differing from other distinctions) that uncertainty exists in relation to future loss”.\footnote{N. Luhmann, \textit{Risk: A Sociological Theory}, op.cit., p 21.} In typical Luhmannian fashion, even if a decision made yielded exceptional benefits (the decision to purchase a winning lottery ticket, for example), the fact that another, far less beneficial decision could have been taken (the decision \textit{not} to purchase the lottery ticket) is a missed opportunity for a decision maker. The decision to not purchase what would have been the winning lottery ticket would save the prospective lottery ticket purchaser the cost of the ticket, the time spent in the store to purchase the ticket and so on. Whatever decision is made, there is a risk of future loss.

Likewise, mental health professionals make decisions over other decisional possibilities in the same way that IHIs must make decisions about whether to make certain recommendations based on their findings. These decisions however necessitate consequences that are meaningful to the operations of those social systems of communication (namely, psychiatric, legal, scientific and political communications). Decisions in functionally differentiated societies are functionally specified. They produce variance between each other; no longer is there unity in how time is seen to progress into the future.\footnote{This unity refers to how in pre-functionally differentiated societies, religion provided the basis for all social activity. Rather than individuals (through social systems of communication) being the ultimate arbiter of their future, God was instead to provide this. Decisions, in the way they have been conceptualised by Luhmann, did not exist. K.P. Japp and I. Kusche, op.cit., pp 83 – 84.} Instead there are fundamental differences in how time is constructed. This makes for an uncertain, open future. Open futures are circumscribed by meaningful communications but they also necessitate further decision making in the face of uncertainty.\footnote{See P. Munro, op.cit., pp 97 and 99. See also M. Foucault, \textit{Madness and Civilisation} (London: Routledge, 1971/2008); R. Porter, \textit{A Social History of Madness} (London: Weidenfeld and Nicholson, 1987); A. Scull, ‘The domestication of madness’ 27(3) (1983) \textit{Medical History} 233; I. Hacking, \textit{Mad travelers: reflections on transient mental illness} (Richmond, Virginia: University of Virginia Press, 1998). See also P. Munro, op.cit., pp 97 and 99.} Time, paradoxically, cannot move forward without decisions.

This theme of decisions being contingent shares parallels with those arguments that posit psychiatry as a fragile system of thought.\footnote{See P. Munro, op.cit., pp 97 and 99. See also M. Foucault, \textit{Madness and Civilisation} (London: Routledge, 1971/2008); R. Porter, \textit{A Social History of Madness} (London: Weidenfeld and Nicholson, 1987); A. Scull, ‘The domestication of madness’ 27(3) (1983) \textit{Medical History} 233; I. Hacking, \textit{Mad travelers: reflections on transient mental illness} (Richmond, Virginia: University of Virginia Press, 1998). See also P. Munro, op.cit., pp 97 and 99.} The future, unknown by social systems until the future becomes past, is a source of uncertainty. Social systems of communication arguably do ‘think’ and have knowledge but the ‘thinking’ and ‘knowledge’ produced is constantly exposed to the contingency of decision making. And in a functionally differentiated society made up of
operationally closed social systems that are constantly shifting, a clash of understandings about what we desire to know more about when making decisions is inevitable.\footnote{107} Decisions, according to Luhmann, can never be conceived as opportunities to introduce safe conditions because decisions are inherently contingent. Decisions and their effects coexist alongside each other. These effects often converge, collide and demand the making of further decisions. These new decisions serve to readjust or reappraise previous decisions in light of the unpredictable convergence of their different effects have between each other.

Decisions clearly self-perpetuate themselves and thus enhance contingency, under the theoretical arguments advanced thus far. Actively dealing with risks at the level of social systems require the making of decisions that lead to further risks.\footnote{108} General psychiatric decisions to tackle homicide and suicide risks using a certain method, such as risk assessment, amounts to a selected way of dealing with future loss that is, once again, selected from a range of possibilities that are inhered with advantages that are enjoyable only if taken.\footnote{109} Luhmann describes these instances of making decisions in order to make a decision as “alibi risks”, which refer to the risks associated with preventing primary risks.\footnote{110} Decisions are omnipresent and harbour risks, even if those decisions are made to escape risk.

### 4.8 Contingency and Time in Independent Homicide Inquiries

A common criticism of IHIs is that they engage in hindsight bias and counterfactual reasoning.\footnote{111} Counterfactual reasoning occurs when the past is retroactively examined,\footnote{112} leading to the advancement of a hypothesis of an alternative, possible past that never actually materialised.\footnote{113}
Whilst social systems such as law are inherently backward-looking also,\textsuperscript{114} they are nonetheless concerned with facts. Courts, for instance, do not consider what other alternatives could have been decided in the past. Rather, courts establish what actually occurred in the past and create expectations in the present about the type of behaviour deemed acceptable going into the future.

Counterfactual examinations appear as a series of ‘what if’ questions.\textsuperscript{115} They also appear through the commission of bias\textsuperscript{116} and the mutation of foreground events.\textsuperscript{117} IHIs have often subjected the clinician’s role to a degree of scrutiny which many regard as blame-orientated and accusatory.\textsuperscript{118} That such an awful event happened has been reported to automatically produce the expectation that an IHI will uncover wrongdoing and that the investigation is conducted in accordance with this bias.\textsuperscript{119} This outlook has undoubtedly waned since the introduction of the 2005 amendments to HSG(27)94 and the official acknowledgement of RCA as an important investigatory tool. As will soon be discussed however, this does not mean that observers of the IHI, namely, mental health professionals, will regard the past and the future in the same terms.

Systems theory places a focus on decisions and their consequences, with these being the fundamental basis of a concept of risk initially explored by Luhmann. IHIs are preoccupied with constructing a particular version of the past by observing the decisions of mental health care professionals and making new decisions that aim to facilitate better ones for the future. This is done self-referentially however, for decisions “depend on the operationally constituted past and projections of the future one can link to this past”.\textsuperscript{120}

The contingency of decision making however, combined with the competing variations of meaningful time that are constructed beyond the communicative frame of the IHI, can lead to considerable regret, resentment or objection relating to the decisions made. After all, it has been

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\textsuperscript{114} See J. Paterson, op.cit., at 532 – 533: In order to stipulate how individuals should behave “it is necessary to know how they should behave in the future”.

\textsuperscript{115} Ibid.


\textsuperscript{118} G. Szmukler, op.cit., at 9.

\textsuperscript{119} D. Carson, op.cit., p 124.

\textsuperscript{120} K.P. Japp and I. Kusche, op.cit., p 85.
said that decisions invite speculation about what the possible consequences of them might be.\footnote{121} The contingency of decisions can prompt decision makers, such as IHIs, to express regret at not taking another decision. As stated above, an IHI might select a set of recommendations over others that may prove to be ill-suited to the changing dynamics of mental health care services.

In the context of systems theory, it is inevitable that the reconstruction of events using operationally-closed communications will offer different observers differing perspectives.\footnote{122} In mental health law and policy especially, matters of mental illness and the risk of future violence require management from a varied collective of decision makers with different opinions and agendas.\footnote{123} The mental health profession is frequently “caught up within a culture of blame, in which almost any unfortunate event becomes a ‘tragedy’ which could have been avoided and for which some authority is held culpable”.\footnote{124} Objection and conflict in these matters is inevitable.\footnote{125} On the other hand, decisions can be regretted or objected to by those who did not make the decision on the basis that they viewed the decisions on completely separate, operationally-closed terms. For instance, the mental health profession might disagree with the IHIs findings on terms which the latter would find irrelevant or meaningless. What is more, the mental health profession has been reported to develop distinct ‘blaming cultures’ that do not remotely reflect what IHIs normally conclude. This is relevant to the present discussion because IHIs have been accused of inadvertently stimulating blaming cultures and associated defensive medical practices within the mental health profession.\footnote{126} The latter are inherently future-focused, with mental health

\footnote{121} A. Philippopoulos-Mihalopoulos, op.cit., p 123. Philippopoulos-Mihalopoulos distinguishes between different versions of the present a system may tailor itself to, namely \textit{a} present and \textit{the} present. This prompts the projection into the future of one of many presents to experience. The other option is to not visibly make a decision, thereby concluding that decisions are ‘not needed’.

\footnote{122} N. Luhmann, \textit{Risk: A Sociological Theory}, op.cit., p 16.\footnote{123} N. Wolff, ‘Risk, Response and Mental Health Policy: Learning from the Experience of the United Kingdom’ 27(5) (2002) \textit{Journal of Health Politics, Policy and Law} 801 at 802 See generally J. Peay, \textit{Decisions and Dilemmas: Working With Mental Health Law} (Oxford: Oxford University Press, 2003).\footnote{124} N. Wolff, op.cit., at 802. Hence this chapter’s concern as to whether the complexity of modern decision making prevents genuine accountability to crystallise. The culpability factor, highlighted by Rose, is theoretically explored later in the context of extra-legal accountability findings. Briefly, the latter impose a strict binary (\textit{blame}blameless and \textit{accountable}not accountable) on how a disappointing event was ‘caused’ by a decision(s), allowing the law to convert this ‘culpability’ finding into a legal communication for reform.\footnote{125} See D. Carson, op.cit., p 139. See also A. Buchanan, ‘Independent inquiries into homicide: Should share common methods and be integrated into new quality systems’ 318 (1999) \textit{BMJ} 1089 at 1089, who writes “[t]he question they should attempt to answer is: Was there anything that should have been done, but was not done, which would have reduced the chances of the homicide occurring?”.\footnote{126} Supra., 2.3.
professionals conducting their work over-cautiously in order to avoid blame in the future for any possible homicides that may happen.

For instance, IHIs have been known to instigate closer adherence to risk assessment policies in order to protect against the possibility of blame.\textsuperscript{127} Whether this has been successful is a moot point, for IHIs continue to be a source of anxiety in the mental health profession itself. Critical media reports of high profile mental health homicides are a testament to this point. It is understandable that IHIs have been considered to embody the precautionary principle “in action”, in this respect.\textsuperscript{128} In addition to working out how to make the future safer, the concern to hedge day-to-day mental health care decisions with precaution in order to avoid possible blame for negative future consequences of actions that have not happened yet is something IHIs inadvertently cultivate.

IHIs have therefore played a demonstrable role in creating an attitude of caution about the future, both within and without. This is important because further complexion can be given to how IHIs meaningfully create a relationship between a mental health homicide and mental health care that is distinct from other functional contexts, such as mental health care in-action. More specifically, this relationship is clearly hallmarked by a meaningful link IHIs make between the meaningful past and the meaningful future. Thus far, it is possible to conclude that one of the main aims of the IHI – to make mental health care services safer – is problematic because the future is unknowable, particularly in a shifting and contingent mental health care environment.

The claim that IHIs engage in hindsight bias is trite if questions are asked regarding how that hindsight is made possible. This chapter argues that hindsight can only be carried out using meaningful communications, whether those communications are psychiatrically, legally, medically informed and so on. What follows is that variations in how the past is constructed is attributed to different decisions that could have always been decided differently, particularly if observers of those decisions utilise communications that do not share the same internal logic as the decisions themselves. There are several aspects to the contingency of decision making which impinge on how the past is constructed. This is highly resonant in the case of IHIs, where friction

\textsuperscript{127} J. Warner, ‘Inquiry reports as active texts and their function in relation to professional practice in mental health’ op.cit., at 231.
\textsuperscript{128} Ibid.
about what decisions were causative of the homicide, those responsible for them and what should be done to prevent further homicides all come under hot dispute.

4.8.1 Contingency and the Flow of Meaningful Time in Independent Inquiries

Enhancing the contingency of decision making in IHI processes, according to the present thesis, is the flow of meaningful time within different social systems of communication. This was discussed earlier in the context of how IHIs are future-oriented in the way they seek to secure a safer future for mental health services in a shifting climate of on-going communications and decision making. These arguments will not be repeated here. It is important to point out however the central implication of this argument; that making future-oriented recommendations to improve the safety of mental health care is open to error for the reason that the target system is in a state of constant communicative flux. This mirrors themes in the governance literature, which acknowledges that in order to manage the course of events in a social system, collectivities must identify ‘static’ outcomes. In other words, “the identification of ‘outcomes’ must stop time; outcomes are conceived as cross-sectionally, as static, when in fact they exist dynamically in time”.129 New events emerge all the time as a result of communications and decisions being made. Decisions must be made repeatedly because other decisions are being made.130 The future is uncertain and increasingly contingent because the dynamic flow of decisions and communication never cease.

If it is accepted that time is a meaningful construct of communication, it is inevitable that the meanings available to social systems of communication within and without the mental health profession at a later point in time will procure a different understanding about those decisions originally made. The flow of change due to contingency requires that what seemed correct yesterday may seem erroneous tomorrow. Rather than social systems being static, they are constantly changing by making decisions in response to events that occur in their environment. With ever-increasing legions of decision-makers populating the mental health care edifice and with an ever-increasing differentiation of expertise (psychiatry, nursing, social work, probation services and so on), competing orientations of time arguably proliferate, especially if systems

130 N. Luhmann, Risk: A Sociological Theory, op.cit., p 189. Luhmann posits that “[t]o be a decision, a decision requires other decisions”.

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theory is taken as the lens of enquiry. It has been rightly argued elsewhere that mental health care
decision making preceding homicides are made within nests of “local rationality”.

In other
words, the conditions prevailing at the time those decisions were made cannot be replicated by an
investigating IHI. These conditions may involve a range of transient factors, such as personal
workloads, stress and so on. These factors constitute a shifting sand of conditions that only the
decision makers experiencing them can really appreciate. IHIs make their observations neutrally,
in their own form of local rationality, involving strictly defined investigative techniques that may
not have any resonance with what mental health professionals experience in a given case.

What is more, decisions under systems theory require their selection from other
decisional possibilities using self-referential communications. The latter, under systems theory,
are a source of internally-produced meanings that provide ‘authority’ for how the future should
be communicated about in the present using decision making. Fate, or the future, is ‘made sense’
of in this way as opposed to leaving it to God. If it is accepted that social systems consist of
operationally-closed communications and are miscorrelated temporally, IHIs will inevitably
procure regret and objection about mental health homicide in their unique communicative
outlook of the homicide event. The present thesis argues that this comes about because the
meanings IHI Panels produce about homicide cases do not reflect the meanings produced by
those who will be directly affected by recommendations, namely mental health professionals. The
decisions of mental health professionals, just like the decisions of an IHI Panel, will be made
pursuant to the communicative codes available at the time the decision was taken. Decisions will
unavoidably foment distrust because conditions change as a matter of course:

One demands more information, better information, complains about the information being withheld
by those who wish to prevent others from projecting other interpretations or making greater demands
on an objectively given universe of facts – as though there were ‘information’ available that one could
have or not have as the case may be.

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Psychiatry & Psychology 475 at 479.
133 Ibid., p 21.
Luhmann describes a vicious circle of mistrusting decisions where “we feel it increasingly appropriate to complain about and to attack decision makers, in particular those responsible (and therefore attracting attribution) at high levels”.\footnote{Ibid., at 226.} It is not surprising therefore to see those on the periphery of an IHI disagree and object to its findings or even the fact that an investigation is necessary at all. The distrust of IHIs by psychiatrists is well-documented, together with reports of defensive medicine in response to their findings.

4.9 Risk, Causation and Decision Making

This thesis has argued that in establishing a relationship between mental health homicide and mental health care, IHIs connect the past and the future in the present through decision making. Decisions are nonetheless uncertain and contingent, from a systems theoretical perspective. They embody risk. Systems theory posits that decisions embody risk because other advantageous decisions are always possible to make. There is always a missed opportunity, regardless of the extent to which a decision can yield benefits.

It can be claimed that in communicating about past decisions and engaging in counterfactual reasoning, IHIs expunge the contingency of decisions to the surface of their investigations. IHIs must furthermore make decisions of their own. For instance, retrospective investigations ultimately ‘feed’ into decisions to adopt certain lines of questioning for accountability purposes, what findings are most significant when compiling the Final Report, what recommendations can best put mental health services ‘back on track’ and so on. These factors require the selection of certain decisions over other, possibly more advantageous, decisions. Contingency not only exists during the provision of the patient’s mental health care. It also exists at every level of an IHI investigation.

More importantly for the current section of this chapter, the contingency of decisions is a source for further decision making. The unknown consequences of decisions occur against a shifting environment of communications. The future being uncertain in this way, the more we know, the more we do not know.\footnote{Ibid., p 28. “[T]he more we know, the better we know what we do not know, and the more elaborate our risk awareness becomes. The more rationally we calculate and the more complex the calculations become, the more aspects come into view involving uncertainty about the future and thus risk.”}

The future is simply too unpredictable for attempts to gain
more knowledge through decision making to be capable of establishing absolute certainty or safety. The further social systems communicate about their environment, the more they diverge in their construction of meaningful social reality. Events happen and conditions change, with different social systems of communications being recruited to generate meaning and constantly reappraise situations. The future consequences of decisions are therefore deeply uncertain and prone to error and disappointment, which in turn calls for more decisions to be taken as a form of readjustment.

4.9.1 Risk, Decisions and the Chain of Causality
The will to constantly readjust meaningful reality through decision making can be said to create ‘chains’ of decisions, the effects of which become untraceable. These ‘chains’ of decision making are arguably rendered meaningful using communications that construct the past of each case. Decisions appear as if they are consequent on the making of previous decisions. Increased decision making makes for increased communication also and hence more uncertainty about what is known about within cases. The argument that the contingency of decisions necessitates further ‘chains’ of decision making is abundantly clear, not only in Luhmann’s work, but in the work of Beck also. This centres on the argument that identifying risks and addressing them is an intractable exercise because “one can relate everything to everything else”.

Everyone is cause and effect, and thus non-cause. The causes dribble away into a general amalgam of agents and conditions, reactions and counter-reactions, which brings social certainty and popularity to the concept of system.

Luhmann expresses a similar view of causality when he describes “causality problems [as] involving long-term remote effects and an incalculably high number of contributing causes”. He explains this further:

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136 Ibid., p 23.
138 Ibid., pp 32 – 33.
in the accumulation of the effects of decision making, in long-term consequences of decisions no longer identifiable, in over-complex and no longer traceable causal relations, there are conditions that can actuate considerable losses or damage without being attributable to decisions – although it is clear that without decisions having been made such detrimental effects would never have occurred.\footnote{Ibid., p 26.}

These theoretical insights are useful for the study of IHIs because the latter are similarly faced with a raft of evidence relating to past decisions and their effects:

When investigating a homicide after the fact, we are tracing a chain of events back in time to understand how it happened. We are not, however, dealing with a closed system with linear causality (where it can be relatively simple to identify the causes of an outcome) but with the complex, real world that is in a continuous and dynamic flow.\footnote{E. Munro, op.cit., at 479.}

IHIs arguably represent a microcosm of risk. They reveal how difficult it is to address present uncertainty about mental health homicides in a myriad of potential causes that obfuscate linear lines of causality. Causes arguably ‘build up’ into a constellation of ‘missed opportunities’, with possibilities for acting in the present being more difficult, not less.\footnote{See A. Philippopoulos-Mihalopoulos, op.cit., p 120: “the more risks technology tries to prevent, the more risks it brings along. The theoretical consequence is of course that the usual binarism between risk/security no longer stands”.} This is expected if it is accepted that different courses of possible action emerge in “an accelerated dynamic of information and knowledge”.\footnote{Japp, K.P and Kusche, op.cit., p 81.}

Aspects of the mental health law literature demonstrate Luhmann’s theme, particularly in Eastman and Peay’s argument that “as knowledge expands so does manufactured uncertainty. Hence, our attempt to understand why risks materialise contributes to, rather than deflates, our perceptions of risk”.\footnote{N. Eastman and J. Peay (eds.) \textit{Law without Enforcement: Integrating Mental Health and Justice} (Oxford: Hart Publishing, 1999), p 4.} Comparisons may be made with aspects of the governance literature, which posit that “[t]he fact that everything is an outcome of what has come before, that processes continue over time, and that our attempts to disaggregate chains of causation must inevitably be biased means that we will inevitably get it ‘wrong’ to some extent”.\footnote{S. Burris, P. Drahos and C. Shearing, op.cit., at 35.} A risky chain of decision

\footnote{\textsuperscript{140} Ibid., p 26.} \footnote{\textsuperscript{141} E. Munro, op.cit., at 479.} \footnote{\textsuperscript{142} See A. Philippopoulos-Mihalopoulos, op.cit., p 120: “the more risks technology tries to prevent, the more risks it brings along. The theoretical consequence is of course that the usual binarism between risk/security no longer stands”.} \footnote{\textsuperscript{143} Japp, K.P and Kusche, op.cit., p 81.} \footnote{\textsuperscript{144} N. Eastman and J. Peay (eds.) \textit{Law without Enforcement: Integrating Mental Health and Justice} (Oxford: Hart Publishing, 1999), p 4.} \footnote{\textsuperscript{145} S. Burris, P. Drahos and C. Shearing, op.cit., at 35.}
making obscurates progress and may actually inhibit the pursuit of future safety when adverse events happen. More, not less, contingency is invited into the present by requiring the making of further decisions in such instances. The sheer complexity of these decision chains furthermore makes it unclear as to what consequences belong to a particular decision.\textsuperscript{146} To reiterate, further contingency arises and not less.

It has long been acknowledged that IHIs raise complex and intractable issues about responsibility and accountability in their quest to delineate causal pathways surrounding a homicide event. As the previous point briefly illustrated, IHIs employ specific techniques in order to answer the most basic questions that emerge during an investigation. As the present thesis will show, these techniques are not amenable to simple answers. Peay succinctly provides an account of this:

They [IHIs] examine not a single decision and its wisdom or lack of it, but the interaction of a series of decisions and omissions and their consequences, and yet further courses of action, adopted or neglected, taken by a range of people whose responsibilities overlap, occur sequentially or merely run parallel to, possibly in ignorance of, one another.\textsuperscript{147}

This apparent inability to provide what are, to some concerned individuals connected to the IHI at least, straightforward answers is interesting. In one particular case reviewed in Chapter 6, the IHI Panel expressed their willingness to entertain comment on the predictability and preventability of the incident in the following terms:

the IIT agreed with the Strategic Health Authority that it would comment on the predictability and potential preventability of the incident. This was an issue of importance to the families of V1 and V2.\textsuperscript{148}

\textsuperscript{146} See N. Luhmann, \textit{Risk: A Sociological Theory}, op.cit., pp 26 and 41. For example, disastrous events are often precipitated by a conglomerate of decisions that cannot be linked to such an event. And yet, without these decisions being made, the disastrous event would not have occurred. Luhmann writes that “[o]bservers may well continue to fight about shares, for example in the question of whether and to what extent automobile exhaust fumes are responsible for the death of forests; but even then, it would not be possible to classify starting up a car engine as a risky decision”.


The most basic and pressing questions make IHIs a unique area of concern. They arguably represent a clash between competing interests. How do IHI Panels deal with this competition? The high emotional tide produced by families, relatives, the media, combined with the complexity of mental health care settings and the rationality used to understand them render a complex investigation even more complex. Even the mere passing of time can cause investigatory problems, as one Report reviewed for Chapter 6 noted:

Inevitably, an investigation commencing four years after the incident has resulted in a number of challenges. There have been significant positive changes in policy, standards, systems and processes, a number of key witnesses have moved on, there is imperfect recall and we appreciate that the reopening of painful memories has caused anxiety and distress to both families and some staff members.\textsuperscript{149}

It is clear then that IHIs host real investigatory problems when it comes to ascertaining causality, a notable one being the sheer scale of decisions made about a patient:

Actions of care providers which, alongside hundreds and thousands of similar decisions each day and week, were taken rapidly and as part of systems or processes, are individually abstracted, described, mulled over and commented upon in detail.\textsuperscript{150}

As Chapter 6 will show, IHIs often encounter the problem as to what led to a fatal homicide occurring. The answer is rarely forthcoming for IHI Panels because there are so many past decisions open to scrutiny in each case. The possibilities of assigning causality to one decision and not another are endless, further intensifying the pursuit of safety in mental health services.\textsuperscript{151} Despite previous assertions to the contrary,\textsuperscript{152} IHIs do search for causes of mental

\textsuperscript{149} M. Rae, C. Robinson and N. Georgiou, Report of the independent investigation into the circumstances surrounding the care and treatment of Mr A, NHS London Strategic Health Authority, Caring Solutions UK (February 2012), p 8.
\textsuperscript{150} D. Carson, op. cit., p 124.
\textsuperscript{151} Instead of focusing on what makes mental health care safe and effective, IHIs are focused squarely on those factors that, in its view, precipitate homicide events. This approach has been criticised for being too narrow and self-defeating on the basis that improvements to mental health services can only come about if the lessons learnt reveal the successes of mental health care as opposed to the failure. Learning from failure can only instigate further failure, according to this view.
health homicide. IHIs can logically investigate all manner of causal possibilities that impact on other causal factors in homicide cases.\textsuperscript{153} There is potentially no end to what an IHI can explore:

A thorough examination of a patient’s history could include a study of society in general and how public attitudes to mental illness or racial, social, and economic factors affect someone’s mental well-being and how these, in turn, limit the beneficial effects of psychiatric treatment.\textsuperscript{154}

For practical reasons however, IHIs must stop asking questions at some point. Munro points out that IHIs apply ‘stop rules’ in order to ‘rein in’ its investigation. These rules circumscribe the IHIs line of questioning by evaluating patient care against accepted policies on ‘best practice’.\textsuperscript{155} This ultimately is constructed in ways that are medically and psychiatrically meaningful, thus condensing historical time to a series of relevant events. Despite IHIs recognising the contingency of decisions in this way, the different meanings produced by social systems of communication will inevitably procure misunderstandings about how successful changes to the mental health care system can be made. What is more, social systems communicating at the same time in different ways simply create a confusing accumulation of decisions which have untraceable effects. Unlike highly evolved communications, such as law, which are able to attribute individuals to a relatively simply relationship of causality with an adverse event,\textsuperscript{156} IHIs seemingly utilise a range of communications that recognise groups of decisions more so than individual decisions.

IHIs have been said to confirm what we already know about issues important to mental health care, such as patient behaviours with personality disorder for instance.\textsuperscript{157} This may well be true, but the thrust of this thesis is that IHIs encounter more complexity in their investigations than they do certainty. In fact, IHI investigations promulgate uncertainty. This is despite the efforts of IHIs to reduce complexity by imposing ‘stop rules’ and utilising ‘accredited’ social

\textsuperscript{152} C. Parker and A. McCulloch, \textit{Key Issues in Homicide Inquiries} (London: MIND, 1999), p 2. The authors claim that IHI are not in the business of establishing the causes of mental health homicides. With the introduction of RCA however, experience has shown that this is no longer applicable.
\textsuperscript{153} E. Munro, \textit{op.cit.}, at 479. “[I]t is logically possible to ask why it [the factor deemed to have a causal effect] itself occurred and so continue tracing events further and further back in time”.
\textsuperscript{154} Ibid., at 480.
\textsuperscript{155} Ibid.
\textsuperscript{156} Supra., 3.8.2.
\textsuperscript{157} M. Reith, ‘Can we learn anything about personality disorder from Mental Health Inquiries’ 37(1) (1999) \textit{Criminal Justice Matters} 55 at 55.
communications, such as legal and psychiatric communications. In addition to having to select an avenue of change to how future mental health care services ought to be provided, IHIs are clearly faced with the challenge of ‘feeding’ the complexity of past mental health care decisions, their diffuse effects and their relationship with the fatal event into their agenda-setting.

### 4.9.2 Time, Humans and Causality

The analysis above in relation to risk and causality places into doubt the ability of individuals to be visible in the network of mental health care decisions that IHIs investigate. This has already been subtly appreciated by psychiatrists themselves, who claim that IHIs eradicate the prospect of appreciating that individuals, patients especially, lack human agency.\(^\text{158}\) If mental health care decisions are inextricably linked to each other in an amorphous mass of decisions with no linear path of causality, individuals come dangerously close to being meaningless artefacts when the IHI reaches its conclusions. What is more, this analysis casts doubt on the ability of individuals to directly manipulate their environment. If they are inextricably linked to making decisions the effects of which prompt further decisions which equally have effects, individuals appear to lack any real control over their environment.

Chapter 2 explored the systems-theoretical argument that individuals are “semantic artefacts”.\(^\text{159}\) Individuals can only be communicated about through communication. Communication exists independently of living human beings, it being produced in operationally-closed spheres of meaning that rely on a binary code through which reality is constructed and roles for people to ‘step into’ produced. If time is regarded not only as a social relation but a communicative one that is constituted by meanings that deny a ‘steering’ role for individuals (‘individuals’ as conceived in the classic Western philosophical tradition), this is confirmed by the argument that the contingency of decisions obfuscates direct causal pathways between individual decisions, their effects and ultimately mental health homicides. The obfuscation of causality is nevertheless a factor not experienced in all social systems. The legal system is known

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\(^{158}\) G. Szmukler, op.cit., at 7. Szmukler contends that the retrospective gaze applied to previous care decisions by IHI’s tends to omit acknowledgement of the patient’s capacity for agency and his or her abilities to respond to their environment.

\(^{159}\) Supra., 2.1.
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for its individualistic approach. Narrow theories of causation in negligence, for example, are a testament to the way in which law makes liability dependent upon a relatively simple causative link between defendant and damage. Law is considered to be highly evolved and adept at reducing the complexity of its environment, in this respect. With the advent of new industrial dangers however, such as asbestos, the simplicity of legal causation is being challenged. This is due to the nomadic working lives of some asbestos workers who have later contracted mesothelioma.

It is relatively easy to see therefore why systems theory has been used to argue that mental health law is simply incapable of giving effect to the rights of patients. Law requires relatively quick and straightforward answers to its questions in order to orient expectations about what conduct is legally acceptable and unacceptable in society. Ironically, it could be argued that this is part of the reason why the onset of a risk society – or at least a vast increase in the complexity of life, the rate of change and the inequality between resources, institutional structures and the demands placed upon them – has left the law communicatively incapable of addressing adverse events with precision. Law is often criticised for being too rigid and ham-fisted to attend to the complex nuances of a post-industrial risk society. Traditional law is demanding something in its place to reach those complex areas of social life that defy typical legal intervention. What this has arguably led to is an explosion of future-oriented administrative regulatory mechanisms that constitute an extension to traditional legal mechanisms. IHIs can be considered to be part of this explosion. They are able to investigate networks of decisions,

160 For instance, litigation often involves a select few parties. Law has furthermore gone to great lengths to create ‘fictional’ legal personalities in order to solve the problem of assigning liability for wrongdoing in corporate matters. Negligence claims often hinge on narrow theories of causation, such as the ‘but for’ test. Law is not in the business of exploring whole systems and processes. It aims to simplify. Where it is obvious that the actions, decisions or omissions cannot be separated from other intervening events, the law is often unable to impose liability. Law, it seems, requires individuals for the purposes of liability and blame.
161 Legal scholars however have sought to draw attention to the apparent shift in law from a philosophy of individual responsibility to group responsibility. Barach Bush maps this gradual shift by exploring the implications of vicarious liability, which allows the imposition of legal liability on a group for the actions of its members (see R.A. Baruch Bush, ‘Between Two Worlds: The Shift From Individual to Group Responsibility in the Law of Causation of Injury’ 33 (1986) UCLA Law Review 1473 at 1477).
162 Fairchild v Glenhaven Funeral Services Ltd and Others [2003] 1 AC 32 at 43, per Lord Bingham: “There is no way of identifying, even on the balance of probabilities, the source of the fibre or fibres which initiated the genetic process which culminated in the malignant tumour”.
163 P. Munro, op.cit., p 197.
164 A.J. Wistrich, op.cit., at 783.
165 Ibid., at 785 – 786.
diagnose possible failings and condense observations of cases into meaningful findings that traditional legal methods cannot accomplish. The latter is only possible because IHIs enlist certain communications, namely psychiatric communications and RCA. Law, under this analysis, is ill-equipped to produce meanings about whether mental health care services are causally linked to a homicide.

As Chapter 6 will show, IHIs are adept at communicating about the relationship between mental health services and homicide events, albeit in the context of various systems and processes that facilitate the decisions of mental health professionals. Different grades of causation are identified, ranging from root causes to contributory causes. Is traditional substantive law becoming incapable of locating causality in the risk society? Do IHIs signal a further shift towards administrative regulation of a risky, contingent society? In this sense, IHIs employ communications that do not target the specific effects of the decisions of individual professionals, for the purposes of establishing causes. Although IHIs do utilise ‘bundles’ of communications that expose ‘individuals’, such as psychiatrists and social workers, they only do so insofar as these individuals occupy a meaningful ‘role’ within the social systems of communication being used to make sense of them. Nevertheless, the decisions these roles require inevitably occur because other decisions and events happen. Decisions about patients cannot be isolated from the corpus of care. They are all inherently connected through their effects, with those effects promulgating further decisions to be made.

In terms of generating findings of causation, IHIs appear to not have the ‘sophistication’ of legal communications. Conversely, it could be argued that the sophistication of legal communications prohibits subtle responses to the questions left open by mental health homicides. With a burgeoning mental health profession and an increasing amount of professional input into the care and treatment of patients, IHIs have emerged to be the most effective way of meaningfully responding to the questions left open by homicides in their aftermath. It just so happens that the meanings produced by IHIs cannot be located in causal understandings about whether or not individual professionals are responsible for the homicide. IHIs are rather more adept at producing meanings about the relationship between care and homicide through systems and processes. This appears to be a new form of logic which IHIs have recruited to make sense of a post-industrial mental health care service.
4.10 Conclusion

On the surface, IHIs do not seem susceptible to a connection with popular concepts of risk. Popular concepts of risk, like that articulated by Beck, appear to over-emphasise the importance of measurement, statistical calculation and technological hazards. Whilst these concepts of risk may remain important to the issue of how professions such as psychiatry attempt to exert control over the future using measurement, they appear overly atomistic in their outlook. IHIs however provide narratives about the connection between events and decisions, as opposed to numerical and statistical methods of risk. They communicate about the past and the future. These narratives are personalised (‘community care has failed’, for example) and underwrite the promises of the mental health profession to learn lessons, establish safety and deliver adequate care and treatment to patients. IHIs are also faced with the uncertainty of the latter and yet popular concepts of risk appear ill-equipped to delineate the challenges they face.

Systems theory provides a possible escape from this impasse because it provides a far more explicit and comprehensive link between the concepts risk and time. Weather forecasting, risk assessments of homicidal patients and what recommendations IHIs should advance in order to improve mental health services can all be viewed as communications about risk, namely, the future consequences of decisions. This accordingly meets a more general need to conceive of risk as residing in those mundane locales of procedural and managerial reappraisal that so often occur after the initial visibility of adverse events has passed.

Systems theory also adds that communicative meanings about time are inhered with a range of causal attributions to decisions for events that happen, particularly adverse events. Whilst causal attribution may have, at one time, been a relatively simple matter, this thesis argues that the explosion of complexity in the mental health care profession has brought with it a concomitant need to transcend risk by eschewing traditional forms of law. The latter produce rigid meanings about reality that often fail to grasp the complexity of what Beck would call the ‘risk society’. IHIs are a prime example of this transcendence. They are a tool through which the

168 Ibid., p 129.
meaninglessness of homicide cases, in terms of the chains of decisions that permeate cases, can be converted into meaningful findings for the purposes of decision making.

But Luhmann’s concept of risk emphasises the contingency of decision making. Decisions are in themselves risky because they could always be decided differently and more advantageously. They are open to constant readjustment because the dynamic flow of time in social systems, such as law and psychiatry, is unpredictable. Social systems of communication cannot ‘see’ each other except within their own self-created reality and so must respond quite spontaneously to events that occur in their environment. IHIs are fundamentally concerned with decisions (both the decisions of mental health professionals and their own) and appear to mould meanings around those decisions by using a hybridised discourse of communication that identifies past events as having a beginning and an end. What is more, these understandings provide the IHI with a basis for new decisions in the present about making the future ‘safer’. Under this analysis, IHIs can be said to be equally contingent because they too use decisions that are potentially regrettable in the future. Whereas IHIs might express confidence in their ability to ‘learn lessons’ for the future and boost confidence in mental health services, the present chapter militates against this assumption. IHIs explore decisions and make decisions based on past understandings of causality. But these explorations depend on a wide range of causal attributions that obfuscate a clear lesson to be learned. Even the most routine of mental health homicide cases involves many decisions, inviting a voluminous and wide-ranging set of causal attributions to be made between decisions, their effects and the fatal event. That a linear pattern of causality is notoriously cited to be a problem in the literature can be theoretically explained using a concept of time and risk rooted in systems theory.

It is prescient at this stage to consider how, despite the inherent complexities associated with investigating mental health homicides, IHIs nevertheless retain an ability to investigate and reach a conclusion. This thesis thus far has argued that IHIs are faced with an insurmountable obstacle to achieving certainty. Investigations are simply too complex and decisions too contingent. Reaching firm conclusions about what caused a homicide to happen is not possible. Families and mental health services require closure and catharsis. Mental health services cannot be expected to languish in the aftermath and do virtually nothing. The pressure to come up with findings and advance an agenda upon which the NHS Trust can ‘move forward’ appears
inconsistent with the central anomaly pertinent to this chapter, namely, that individual decisional causes to homicides are impossible to locate.

IHIs are always able to assemble a picture regarding what care the patient received, when this care was provided, its quality and the extent to which it caused the fatal event. IHIs do not simply cease their investigations because the challenges presented by the latter are too onerous. How do IHIs surmount the insurmountable? Chapter 5 turns to the concept of accountability for assistance in this respect. This is because in order for IHIs to assemble their investigations and reach conclusions based on it, they must hold individuals to account. This is their source of information. Accountability theory has the ability to provide clues concerning how IHIs produce order out of the noise of contingency.
Chapter 5

Holding the System to Account

5.1 Introduction

Chapter 3 and 4 forged a theoretical framework based in systems theory on how IHIs render the relationship between mental health care and homicide meaningful. IHIs rely on hybridised bundles of distinct communications to do this and generate unique understandings about past mental health care decisions and their connection with a homicide. Under systems theory however, the effects of decisions converge, clash and require new decisions to be made. This thesis has argued that due to the contingency of decisions IHIs generate indeterminate findings about what could or could not have been done differently in the circumstances of each case.\(^1\) Despite this indeterminacy, IHIs are able to meaningfully connect the past, present and future through their investigation and recommendations. How is this achieved? The answer is through holding individuals to account. Briefly, the concept of accountability is used to analyse the way in which the IHI elicits answers to its questions from professionals regarding their previous actions and decisions.\(^2\) Without eliciting answers this way, IHIs would not be able to compile the puzzle of care together, articulate regret about certain decisions and posit causal theories about what happened.

The level of abstraction at which Luhmann pitches his systems theory however prevents it from providing a nuanced account of social processes.\(^3\) It is prescient at this stage to simply begin providing this nuance through the concept of accountability, arguing that existing concepts

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\(^1\) This forms the basis of arrangements (namely, recommendations) to make the future provision of mental health services safer. These arrangements will not necessarily have their desired effect however because they originate in operationally-closed contexts.


\(^3\) Luhmann’s theory is all-encompassing, appearing “within the real world as one of its own objects” (see N. Luhmann, Social Systems, op.cit., p 11). The theory, like all other theories it examines, is self-referential. It cannot provide a privileged view of society. Empirical research is similarly ‘afflicted’ by this problem, rendering an attempt to join up Luhmann’s theory with an empirical approach difficult to do (see L. Leydesdorff, ‘Luhmann Reconsidered: Steps Towards an Empirical Research Programme in the Sociology of Communication’, Cornell University Library, http://arxiv.org/abs/0911.1041 (accessed 27th August 2013), at 20 – 21. Leydesdorff argues that Luhmann’s theory never accepted that a bridge between systems theory and empirical research was possible, although Leydesdorff is of the view that the latter is best suited to identifying uncertainties in social processes that systems theory might not be able to designate, due it being self-applicable. This point is explored further in Chapter 6.
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are insensitive to some of the challenges IHIs face, namely the obfuscation of an individual’s connection with a mental health homicide. A systems-theoretical concept of accountability can however help address this issue. This is because for accountability to be established there must be communication. Holding individuals to account in IHIs is a communicative process that constructs the past and connects it with the future in the present. If it is accepted that IHIs orient a unique communicative discourse in an attempt to create the reality of the past, the present chapter examines how this is achieved through entering into interactions and exchanges within the IHI process itself.

5.2 The Concept of Accountability

The concept of accountability places a general emphasis on individuals providing justifications for their actions to an authority. The ‘core’ definition of accountability is a:

relationship between an actor and a forum, in which the actor has an obligation to explain and justify his or her conduct, the forum can pose questions and pass judgement, and the actor may face consequences.

4 As the present chapter will explore, existing concepts of accountability are very individualistic. They place heavy emphasis upon the ‘answerability’ of subjects. But if those answers collectively produce an interconnected picture that obfuscates a single identifiable cause, how is it that an authority (such as an IHI) can act on that interconnected picture and continue the process of accountability? The purpose of this chapter is to formulate a revised concept of accountability, using systems theory, to answer this question.

5 Supra., Chapter 3.

6 See, for example, the definition by E.L. Normanton, ‘Public Accountability and Audit: A Reconnaissance’ in B. Smith and D.C Hague (eds.) The Dilemma of Accountability in Modern Government: Independence Versus Control (London: MacMillan, 1971), p 311: “A liability to reveal, to explain, and to justify what one does; how one discharges responsibilities, financial or other whose several origins may be political, constitutional, hierarchical or contractual”. See also E.J. Emanuel and L.L. Emanuel, ‘What is Accountability in Health Care?’ 124(2) (1996) Annals of Internal Medicine 229 at 229 who define accountability in healthcare specifically as entailing “the procedures and processes by which one party justifies and takes responsibility for its activities”. They write that accountability in health care comprises three essential components. Firstly, there is “the loci of accountability”, in which “health care consists of at least 11 different parties that can be held accountable or hold others accountable”. Secondly, “the domains of accountability”, in which “parties can be held accountable for as many as six activities: professional competence, legal and ethical conduct, financial performance, adequacy of access, public health promotion, and community benefit. Thirdly, “the procedures of accountability”, which include “formal and informal procedures for evaluating compliance with domains and for disseminating the evaluation and responses by the accountable parties”.

It is not conceptually tenuous to assert that this applies to mental health professionals who, on behalf of the State (in the form of the NHS), are accountable for their actions. IHIs have been specifically identified as providing public reassurance and control in this respect. Although core accountability provides for the ‘facing of consequences’, this is not necessarily mirrored in IHI processes. IHI Panels are not empowered to punish or impose sanctions on individuals for any errors they discover. IHIs only have the power to deliver persuasive recommendations.

Chapter 4 nevertheless showed that IHIs instigate a range of negative and unintended consequences for mental health professionals. These unintended consequences therefore can be reformulated as an unintended sanction. The possibility of shame or humiliation being poured upon an account-rendering individual is arguably a veiled form of sanction, albeit a potentially unjustifiable one given that the individual might be wholly unconnected to the fatal event.

5.2.1 Independent Homicide Inquiries: Revisiting the Concept of Accountability

The IHI is a relative ‘newcomer’ to the world of law, policy and public administration. Its compatibility with existing concepts of accountability cannot be taken for granted however. IHIs involve the detailed review of complex scenarios involving a range of different interactions

10 That is, to make recommendations that the NHS Trust are free to ignore when it comes to implementation. The issue of implementation of recommendations is a thorny one, for the reason that there is a lack of basic data about the number of countless recommendations that have been implemented, the lack of standards on implementation and a lack of guidance on how recommendations are implemented (see G. Downham and R. Lingham, ‘Learning Lessons: Using Inquiries for Change’ 57(1) (2009) Journal of Mental Health Law 57 at 68 – 69). As a consequence, scholars have showed hesitation in their judgement about the extent to which IHI recommendations are implemented. Generally speaking, IHIs differ from a court in that they have only persuasive power to achieve change. More specifically, inquiries have persuasive power to instigate change on the basis of their credibility (see K. Walshe and J. Higgins, ‘The use and impact of inquiries in the NHS’ 325 BMJ (2002) 895 at 899).
11 P. Hobbs, ‘Inquiries – high costs, unacceptable side effects and low effectiveness: time for revision’, 9(2) (2001) Australasian Psychiatry 156 at 159. Szmukler, for instance, reports that the professionals who provide mental health services are often humiliated by IHIs (G. Szmukler, ‘Homicide Inquiries: what sense do they make?’ 24 (2000) Psychiatric Bulletin 6 at 9). Members of staff have been known to hand in resignations, suffer drops in confidence and deteriorating morale. IHIs have proved to be very unpopular amongst professionals for this reason, with their repetitive findings militating against the aim of learning lessons (see A. Maden, Treating Violence: A guide to risk management in mental health (Oxford: OUP, 2008), pp 39 and 40 and R. Sulitzeanu-Kenan, ‘Mental State of Inquiry: Tragedy, Policy and Accountability in the Case of the Ritchie Inquiry’, http://public-policy.huji.ac.il/upload/Clunis%20WP%20%5B17.10.07%5D.pdf (accessed 6 March 2013), p 28. If IHI findings are not revealing new insights about mental health homicides, it is difficult to imagine how services can genuinely be improved.
between mental health professionals. The contents of accountability relationships are furthermore filled with different contributions of expertise on both sides, from psychiatrists to social workers. Formal lines of accountability might well be relatively simple to discern, but using the information gleaned from multiple accountability relationships in order to ascertain causes for adverse events in the context of individual, multi-party and multi-team decision making is notoriously elusive. Is it reasonable to expect that the individual decisions of a psychiatrist, for example, can be dismembered from the mental health care web of decisions of which they form a part? Can IHIs question mental health professionals, elicit answers and then draw precise conclusions about the extent to which those decisions were causative of the homicide? How does this reconcile with the widely-reported difficulty of establishing causes in mental health homicide cases? And can IHIs coherently connect the past and the future together in their findings on this basis?

5.2.2 Accountability as an Elusive Concept in Independent Inquiries

Concepts of ‘responsibility’, ‘responsiveness’ and ‘control’ have been used interchangeably in order to describe what accountability is. The concept is not straightforward, it being compared to a chameleon. In an increasingly complex society, scholars conclude that accountability can be ‘upwards’, ‘downwards’, ‘horizontal’, and hierarchical. What is more, accountability

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12 The accountability of a Ward Manager to the IHI for what occurred on a hospital ward at a particular time during the care of the patient is a case in point.
14 R. Mulgan, ‘Accountability’: An Ever-Expanding Concept?’, op.cit., at 555. “The concept of ‘accountability’ has lost some of its former straightforwardness and has come to require constant clarification and increasingly complex categorization”.
16 C. Scott, ‘Accountability in the Regulatory State’ 27(1) (2000) Journal of Law and Society 38 at 42. ‘Upwards’ accountability is rendered to a higher authority (such as a Junior Minister accounting to a Cabinet Minister).
17 Ibid. ‘Downwards’ accountability involves rendering an account “to lower level institutions and groups (such as consumers).
18 Ibid. ‘Horizontal’ accountability involves rendering an account to a parallel institution, for instance between contracting agencies.
19 M. Bovens, op.cit., at 458. Bovens describes hierarchical accountability as being underlines by a “pyramidal image of organisations”. He goes on to write that accountability starts “at the top, with the highest official”, with the “rank and file” hiding “behind the broad shoulders” of whoever is in charge. See also J. Roberts, ‘The Possibilities of Accountability’ 16(4) (1991) Accounting, Organizations and Society 355 at 356.
relationships in one context (for example, the accountability relationship between Mental Health Tribunals (MHTs) and mental health professionals) may not completely match accountability relationships in another context (for instance, an accountability relationship between an IHI Panel and a mental health professional). The State is no longer the sole orchestrator of accountability.\textsuperscript{20} The latter has furthermore been developed as a “clarifying focus into the lived reality of everyday life”,\textsuperscript{21} a ‘self-disciplining’ device that socializes the individual into a “fictitious atom of an ‘ideological’ representation of society”.\textsuperscript{22} Accountability relationships therefore develop “more fully than functional utility demands or officially requires”.\textsuperscript{23} Different contexts (whether that is an IHI, MHT or some other forum of accountability) will consist of resources, technology, norms and values that coalesce to produce a variety of outcomes that warrant different conceptual explanations.

For example, an IHI and an MHT are both supported by different rules, principles, procedures, and more importantly, communications.\textsuperscript{24} They similarly involve calling an actor (a mental health professional) to account through questioning in order for information to be elicited.\textsuperscript{25} MHTs are far more legalistic in tone however, utilising different resources, rules and technologies in order to answer the questions that they wish to answer. IHIs, on the other hand, are more flexible, unhampered by strict procedures relating to evidence. They utilise different rules and resources and are willing to entertain a wide spectrum of information and evidence relating to the case.

\textsuperscript{20} N. Rose, \textit{Governing the Soul} (Free Association Books, London 1989/1999), p 10. Rose posits the view that although the State might formally delegate power and responsibility through the psychiatric edifice and thus expand accountability relationships between individuals, a host of informal, unobserved interactions can be said to take place beneath the veil of ‘the State’. The concept of accountability as an ‘interactional process’ therefore carries weight.
\textsuperscript{21} J. Roberts, op.cit., at 357.
\textsuperscript{23} J. Roberts, op.cit., at 363.
\textsuperscript{24} cf E.J. Emanuel and L.L. Emanuel, op.cit., at 232 – 233. The authors posit that there is no one concept of accountability and that three models of it can be advanced. These are professional accountability (the clinician is accountable directly to the patient), economic accountability (providers of health care - clinicians, hospitals and managed care plans - are held accountable to consumers) and political accountability (a board of representatives are held accountable to patients as citizens). According to the authors, elements of these models of accountability cut across the entire provision of health care in many different contexts and are used simultaneously.
\textsuperscript{25} M. Bovens, ‘Analysing and Assessing Accountability: A Conceptual Framework’, op.cit., at 456. A core concept of accountability includes the exploration by a committee or a body of specific professional practices.
It is therefore possible to argue that accountability in IHIs is embedded in a nest of complex *interactions.*\(^{26}\) Creating a concept of accountability that recognises its interactional qualities certainly enhances the resonance such a concept can have with systems theory. The latter is anchored in the concept of communication and it might be reasonable to suggest that accountability is a communicative process also. Like a regulatory ‘conversation’,\(^{27}\) accountability can be regarded as a social conversation between the IHI and those providing an account before it. Under systems theory, this conversation is ‘constructed’ inside distinct communicative universes of meaning. A synthesis of the concept of communication and accountability may well better appreciate the complex interactional qualities of accountability relationships between IHIs and mental health professionals, particularly the cross-disciplinary manner in which they form and the attempts to ‘understand’ the questions and answers that emerge from it.

### 5.3 Accountability and Blame in Independent Inquiries

IHIs were once considered to be beacons of accountability, truth-seeking and blame assignment.\(^{28}\) In political contexts at least, the occurrence of a mental health homicide has historically evoked a discourse of blame, confusion and distrust which has been known at times to penetrate debates about public safety in Parliament.\(^ {29}\) The introduction of the 2005 amendments to HSG(27)94 signalled a shift in the way mental health homicides were being

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\(^{26}\) See generally J. Black, ‘Decentering Regulation: Understanding the Role of Regulation and Self-Regulation in a ‘Post-Regulatory World’ 54 (2002) *Current Legal Problems* 103 at 106 – 107. Regulatory conversations, according to Black, are “forms of interpersonal communications, extending beyond standards, policy documents, and guidance notes to include all micro-level conversations that may occur in formal or informal setting”. See also J. Paterson, *Behind the Mask: Regulating the Health and Safety Industry in Britain’s Offshore Oil and Gas Industry* (Aldershot, Ashgate, 2000), p 57. Paterson interestingly encapsulates the view of social systems “interacting with their own internal constructions”, which the present chapter seeks to take further in the context of accountability.


\(^{29}\) For example, the high profile homicide of Jonathan Zito by Christopher Clunis stimulated intense calls for senior politicians to be held accountable and for remedial action to be taken. In the aftermath of the 1992 killing, the Prime Minister was directly challenged in this way: “[i]n view of the revelations at the trial of Christopher Clunis, who stabbed and killed Jonathan Zito, will the Prime Minister accept that although most people suffering from schizophrenia are not dangerous, the failure of the Government's care in the community policy means that dangerous mentally ill people are walking the streets? What does he intend to do about that, and will he now order a public inquiry into the case and its implications for community care, as requested by Mr. Zito's widow?” (HC Deb. vol. 227, col. 822, 29 June 1993).
communicated about. The thrust of these measures was to facilitate a more objective IHI process, with RCA being an important vehicle to this end.\footnote{In tandem with this move, there has been an urgent need of late to re-confirm that holding persons to account should not be conflated with an individualistic blaming approach. Although not an IHI, the recent high profile inquiry into substandard care practices at Stafford Hospital exemplifies this approach: It must be remembered that the inquiry mechanism is not equipped to determine individual responsibility by way of anything akin to a “trial”. Individuals and organisations may be called to provide evidence, may have legal representation and may have the opportunity to respond in accordance with the Inquiry Rules 2006 and procedure to potential criticisms, but they cannot defend themselves as they could in adversarial proceedings – by cross-examination of critical witnesses, or presentation of evidence they choose to call in their defence – and they only have a limited right to make representations to the Inquiry. An Inquiry does not and cannot determine civil or criminal liability (see R. Francis, \textit{Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry} (London: TSO, 2013), p 36.} As discussed in Chapter 2 and 3, RCA seeks to go beyond individual blame and recognise the ‘root causes’ of problems that might appear as ‘blameworthy’ incidents on the surface. There is still a realisation that inquiries generally are not capable of fulfilling the purpose of individual blame, “except in the limited sense of being able to require individuals and organisations to give an explanation for their actions or inaction”.\footnote{Ibid., p 35.} Human error is increasingly being understood to be part of a wider organisational influence and not a cause in itself.\footnote{E. Munro and A. Hubbard, ‘A Systems Approach to Evaluating Organisational Change in Children’s Social Care’ 41 (2011) \textit{British Journal of Social Work} 726 at 727.}

The shift in tone more generally at the way in which the relationship between the individual and his or her complex environment has become more opaque in the aftermath of disasters is a relevant case in point. The more sympathetic stance towards an individualistic blaming approach in IHIs throughout the 1990s was reflected in many different industries where inquiries were set up in response to adverse events. It cut across many areas of expertise, such as mental health care, child protection, aviation and nuclear power.\footnote{E. Munro, ‘Mental health tragedies: investigating beyond human error’, op.cit., at 477 – 478.} The aim of inquiries in these areas was to locate individual blame and to then take measures to control erroneous individuals.\footnote{Ibid., at 478.}

The shift from a blaming approach to one which highlighted the role of wider systems and processes ultimately requires a reappraisal of what it means to hold individuals to account in IHIs. After all, existing concepts of accountability place considerable focus on the individual being answerable, at the expense of how accountability is formed and what it means for the parties involved. Repositioning the concept of accountability in alignment with the contemporary need to go beyond blame is what the present chapter seeks to do. Accountability also may have a
political (perhaps in terms of a forum exerting power over others pursuant to the code power/no power) or moral context (perhaps in terms of witnesses volunteering to account for their actions because it is the ‘right’ and ‘honourable’ thing to do, pursuant to the code moral/immoral). This is typical of vertical forms of accountability that serve the purpose of restoring a lack of public confidence in mental health services; a process of accountability may well rely on the good nature of individuals to come forward and expose their practices so that broader lessons can be learned. In combination with this, accountability as a social relation will undoubtedly have professional and administrative nuances also. After all, IHI Panels consist of mental health professionals who judge the practices of their peers in accordance with accepted policies and issue recommendations that sometimes are followed up and reviewed over time.

To recall a theme from Chapter 4, time can be conceived of as a social relation. The same can apply to the concept of accountability. The latter is far more than just a formulaic exercise of actors appearing before a forum to answer questions. Although accountability as a social relation still encompasses the core features of accountability, namely, the obligation on an actor to render an account before a forum, a series of judgments are made and communicated by the forum about the actor’s conduct.

It is therefore overly simplistic to place accountability in IHIs within a vacuum, which narrow concepts of accountability appear to do. There is arguably an inherently fluid dynamic of interaction and exchange, typical of social relations, between IHI Panels and witnesses, clinical or otherwise. There is a trade-off of views. There is a formation of opinions and a ‘building-up’ of facts, information, meaning and feelings. It is arguably “discipline-specific” and “shaped by social norms or aspirations”. If systems theory is taken as the starting point, this theme is open to further development; accountability can only occur through producing communications in one or more social systems. The view that accountability is an expansive concept is therefore preferable because the shifting contexts of accountability relationships demand a flexible concept of accountability that can adequately comprehend its changeable features. Similarly, the present

35 Ibid., at 460.
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...chapter adds complexion to the concept of accountability by claiming that it is a communicative construct.

### 5.3.1 Accountability and Communication

If systems theory is taken as a starting point, the concept of accountability can be regarded as a communicative vehicle through which society can accommodate changes wrought on by a functionally differentiating society. In other words, accountability is a vehicle through which IHIs can communicatively connect individuals (as ‘professionals’, ‘patients’ and so on) and events (mental health care decisions) of the past with decisions in the present (recommendations, for instance) that have future consequences.

The accountability relationship between an IHI and an account-rendering subject, namely, a mental health professional, and a patient (family members sometimes feature also), are guided by communications. Depending on the context, these communications are mainly communications of the psychiatric, legal and scientific type. For example, psychiatric communications support meaningful references to the relationship mental health professionals have with patients. This is necessary for IHI processes to have meaning and significance. It justifies the calling to account of mental health professionals and not others who would not normally be related to the provision of care and treatment. The same can be said of communications between an IHI Panel and a member of the patient’s family. These may well be guided by psychiatric communications but also communications about love and the family.

Such communications must underpin the line of questioning adopted by IHIs. That questioning will ultimately be oriented towards confirming whether the past decisions of the individual called to account were consistent with the health of the patient and others around him or her. In other respects, questions might be oriented around the degree to which the patient was loved by his family. In this sense, accountability relationships can be said to be authored by the very communications that IHIs use to render the relationship between care and homicide.

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39 C. Scott, op. cit., at 48. “[E]xtending accountability (of various forms) to actors previously immune, extending the range of values accounted for, and introducing new and more formal bodies for calling to account are central features of regulatory governance”; R. Mulgan, ‘Accountability’: An Ever-expanding Concept’, op. cit., at 558. Mulgan discusses how accountability has been widened to include the area of administrative discretion.

40 N. Luhmann, Love as Passion: The Codification of Intimacy (Cambridge: Harvard University Press, 1986). Luhmann explores the “semantics of love”. In this work, he explains that love is not a feeling but a form of communication, used pursuant to a symbolic code of love/hate, which encourages individuals to have feelings.
meaningful. The implication of this argument however is that accountability is not an objective process. It is highly subjective, its meaning and significance being made dependent on the form of social communication used to understand it. For instance, the creation of an accountability relationship for an IHI Panel may be to discover whether a certain decision had specific consequences for the mental health of the patient. For a witness however, it may be portrayed as an attempt by the Panel to attribute blame or moral responsibility for the homicide. A systems-theoretical concept of accountability therefore links up how the IHI produces a rich tapestry of labels that mean different things to different people.\(^{41}\) The quest for accountability therefore involves a variety of opinions and assumptions that are not immediately obvious on the surface.\(^{42}\)

Accountability is therefore not simply a sterile process of asking questions of individuals and eliciting answers.\(^{43}\) ‘Core’ accountability places too much focus on the individual and presents an atomistic vision of accountability. This is avoided through the employment of systems theory because the latter does not place individuals at the seat of its theory. The comprehensive remit of Luhmann’s concept of communication allows accountability to be re-conceptualised as a relationship created by the communications used by the parties involved. And because the communications IHIs utilise are about the past, the relationship of accountability allows this past to be meaningfully ‘packaged’ in the present so that the future provision of mental health services can be governed more effectively. Holding individuals to account therefore simply creates a meaningful lens through which these communications can make sense of the patient’s care and treatment. It is impossible to separate an individual’s contribution to the patient’s care from others’ contributions. So rather than relying on existing concepts of accountability that appear individualistic, IHIs signify that accountability in an expanding administrative/regulatory state needs to be conceived of differently. The present chapter argues that the significance of accountability, in IHIs at least, relates to how it encourages a meaningful appreciation of the link between past mental health care decisions, homicides and decisions in the present about how future mental health care services are provided. In short, accountability should

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41 J. Peay, ‘Introduction’ in J. Peay (ed.) Inquiries After Homicide op.cit., p 25. “There can be little doubt that the Inquiry is a powerful means of labelling behaviour as good or evil and creating a forum for shaming”.

42 Ibid. Peay recites the argument that despite IHIs engendering an appearance of accountability, it nonetheless falls short of achieving it. She comments that inquiries “reflect a compulsion in society to attribute blame”, this being evidenced by private proceedings and lack of an appeal mechanism.

be conceived of as a process of meaningful communication about time. After all, IHIs are concerned with analysing problems and identifying ways of reducing any future risk to the public in general through communication.

5.3.2 Accountability, Knowledge and Expertise

As part of being a social relation, accountability can furthermore be conceived of as a relation between knowledge and expertise. This relation is arguably based upon the recognition of a problem to be acted upon, namely, the governing of the future. IHIs appear loosely orchestrated through an “asymmetric authority relationship” between two parties. It may be contended that both sides of this relationship are positioned asymmetrically in terms of their knowledge and perspectives also. Asymmetry in knowledge and perspectives certainly brings about different experiences and responses to problems. This arguably enables discourses of power and knowledge to flourish. In the present context, professionals can be seen as being turned into account-rendering subjects so that problems in service delivery are identified and ways of acting on those problems are enabled. The core concept of accountability is simply incapable of taking these issues into account. But a systems-theoretical concept of accountability can. This is because knowledge and expertise used to identify and respond to account-rendering subjects requires an underbelly of social communication upon which that knowledge and expertise can be built.

More specifically, problems about the future are meaningful insofar as communications refer to previous communications in order to make sense of the future. As Chapter 4 claimed, this is done specifically through decisions. IHIs utilise many different forms of communications in this respect, with decisions being the conduit through which the future is converted into the past in the present. As will later be discussed, accountability is important to this process because it

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44 E. Munro, ‘Mental health tragedies: investigating beyond human error’, op.cit., at 477.
45 See R. Castel, ‘From Risk to Dangerousness’ in Risk’ op.cit. For instance, psychiatric risk technologies resolved problems of subjectivity and unpredictability associated with single case diagnoses.
47 J. Black, ‘Decentering Regulation: Understanding the Role of Regulation and Self-Regulation in a Post-Regulatory World’, op.cit., at 107. Although Black discusses knowledge asymmetry in the context of regulation, it raises the pertinent issue of asymmetrical relations between actors who make decisions and for others who are affected by them to understand them.
48 M. Foucault, ‘Subject and Power’ 8(4) (1982) Critical Inquiry 777 at 778. “I would like to suggest…a way which is more empirical, more directly related to our present situation, and which implies more relations between theory and practice”. Further on, Foucault seeks to “bring to light power relations, locate their position, and find out their point of application and the methods used”.
provides the very lens through which the past is observed and converted into present arrangements that seek to control the future.

5.3.3 Establishing Accountability in the Mental Health Care System

If it is accepted that a systems-theoretical concept of accountability can recognise the importance of social systems in the construction of accountability relationships, opportunities emerge for casting further light on how IHIs render the relationship between mental health care and a homicide event meaningful. A changing landscape of mental health law and policy has clearly brought with it changes and additions to an increasing range of disciplines, professions, decision-makers, conflicts, constructs and social relations that make up the mental health care system.49 Times have changed. The psychiatrist is no longer the sole voice of authority inside the edifice of mental health care.50 This is despite the popular belief that psychiatrists should continue to act as leaders.51 As Hobbs correctly remarks, “[t]reatment decisions do not take place independently of the system”.52 An expansive concept of accountability oriented in systems theory can certainly take stock of this. Furthermore, if the relationship between individuals and the wider systemic environment can be framed in terms of the meanings given to it through communication by the parties involved, to what extent can those communications help an IHI achieve its law and policy objectives?

It is clear from previous chapters that IHIs are prone to making findings of causal indeterminacy,53 thus obfuscating the achievement of their goals. The wide-ranging involvement of professionals in cases is a particular problem. This is because each professional makes decisions the effects of which become untraceable throughout the decision making lifecycle of a patient’s care. In short, professional involvement is difficult to measure. Creating a coherent link between individual decisions and the fatal event becomes problematic, thus diluting the certainty

49 N. Eastman and J. Peay (eds.) Law without Enforcement: Integrating Mental Health and Justice (Hart Publishing, 1999), pp 9 and 21. “Indeed, the manifest forms and ways in which the domination and subjugation are exercised within social relations probably best capture the realities of day-to-day mental health practice”.
51 P. Hobbs, op.cit., at 158.
52 Ibid.
about what happened and what could have been done to prevent the homicide. Systems theory can however be recruited to highlight the functional aspects of accountability, in terms of enabling an IHI to connect the past and future together in a meaningful causal chain of decisions. To regard accountability as an end in itself, designed to hold individuals to account for their previous actions (as the more traditional concepts of accountability) ceases to have significance if it is accepted that the effects of mental health care decisions are obfuscated by the wider system of decisions built up over time about a patient.

5.4 Making Sense of a Burgeoning Mental Health Profession

The problem of holding individual mental health professionals to account is in their contribution to care and treatment. The various locales of input into a patient’s care are diverse and connected, rendering each individual contribution inseparable from the next. The degree to which a certain contribution facilitated the fatal event or led to a decrease in the adequacy of care is difficult to ascertain because there are so many contributions made. If it is accepted that decisions (particularly mental health care decisions) are contingent and happen because other decisions happen, divorcing these decisions from a wider corpus of activity is not straightforward. This reflects the complexity of mental health care generally.54

If it is accepted that the mental health profession is operationally closed into subsystems of communication (such as psychiatry, social work, probation services and so on), it is possible that some perceived deficiencies will arise out of mutual misunderstandings between these subsystems. These deficiencies could amount to the failure to achieve legal and policy intentions. What is more, these deficiencies will:

[b]ecome the subject of extensive criticism, but it is almost impossible to show that such deficiencies were related to the final outcome. For example, while CPA meetings of all involved members of a multi-disciplinary team, representatives from other agencies, together with the patient and carers may not have occurred regularly, would such meetings have led to different clinical decisions? For most decisions, it is impossible to know.55

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54 E.J. Emanuel and L.L. Emanuel, op.cit., at 237. “Health care is currently too complicated, with too many parties consisting of diverse relationships, to be encompassed in only one model [of accountability]”.

The expansion of accountability in mental health care arguably intensifies a whole new crop of problems that are particularly visible in IHI cases. If “no single actor has all the knowledge required to solve complex, diverse, and dynamic problems”, the individual effects produced by decisions in the mental health care system inevitably become difficult to discern in homicide cases. At least some clarity can be brought upon this problem by considering the extent to which the mental health care profession has become an archipelago of professional and administrative locales and intersections.

The various intersections of decision making and liaison between mental health professionals arguably complicate the process of accountability in IHI cases. It is common to encounter the criticism that IHIs of the 1990s in particular were not rigorous enough in their investigations. They focused largely on human error as a cause and not a symptom of the unwanted event. Since then, scholars and policy makers have become more aware of how complex mental health care provision actually is. Rather than error and blame being the guiding beacon of ‘truth’ in cases, the complexity of mental health care provision appears to have shifted towards a discourse of ‘systems and processes’ when it comes to holding individuals to account. In one IHI Report reviewed for Chapter 6, the IHI Panel:

looked primarily at organizational systems and processes, and in particular how different agencies worked together and at the governance arrangements supporting inter-agency working.

IHIs clearly form part of an expanding mass of administrative regulatory mechanisms that appear to ‘look past’ individuals and towards ‘systems and processes’. In other words, IHIs appear to be insensitive to the influences individuals have historically been considered to exert through their decision making in mental health care.

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56 J. Black, op.cit., at 107.
57 N. Rose, ‘Psychiatry as a political science: advanced liberalism and the administration of risk’, op.cit., at 1.
58 E. Munro, ‘Mental health tragedies: investigating beyond human error’, op.cit., at 476.
5.5 Accountability and Individuals in Independent Inquiries: The Problem of ‘Too Many Hands’

The influence of individual professional decision makers in mental health care contexts has been explored by Peay. She documents how multi-disciplinary decision making, where two or more mental health professionals group together to make decisions about patients, is a common occurrence.\(^{60}\) If looked at through the lens of systems theory, the potential for misunderstandings in such scenarios is plentiful. This is because issues are raised regarding the extent to which professionals affiliated with a number of different social systems of communication can meaningfully communicate about patients. Not only might a clash of communicative meanings be relevant, but the way in which parties can exert insidious influence over one another is another important factor which can alter the dynamics of professional relationships in mental health care.\(^{61}\)

In a burgeoning mental health care profession, conducting accountability relationships will inevitably be fraught with complexities like these. Such complexities were sometimes explicitly recognized by the IHI Reports reviewed in Chapter 6:

> Part of the complexity of this case related to the number of agencies that had contact with Mr G at any one time, not always with the knowledge of others.\(^{62}\)

The outcome of a particular decision made about a patient might well be disputed or open to wide interpretation, depending on the background, knowledge and experience of those making those judgments. IHI Panels are not immune from these problems because they too must form accountability relationships with mental health professionals and also endeavour to understand how other accountability relationships formed between professionals at the time care was provided, at least. Furthermore, if treatment decisions coalesce as part of a system of communication\(^{63}\) and not in any one individual, as this thesis is arguing, Bovens’ “problem of

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61 Ibid., p 264 – 265.
63 P. Hobbs, op.cit., at 158
many hands” certainly reappears in the IHI context. In other words, the systems-theoretical view that individuals are semantic artefacts can be taken further by arguing that the decisions mental health professionals make about a patient who goes on to commit a homicide have effects which cannot be traced in complex decision making networks of care. This can be folded into a concept of accountability in order to provide a more nuanced view of how IHIIs render the relationship between care and homicide meaningful. Firstly, there is a reported difficulty untangling “who has contributed in what way to the conduct of [an] agency or to the implementation of a policy and who, and to what degree, can be brought to account for it”. The wide-ranging delegation of duties and discretionary power in mental health law and policy is a testament to this view, which has been said to render narrow versions of accountability fictional or outdated.

Secondly, relationships between individuals arguably occur in a regulatory space of activity involving two-way, three-way and four-way relationships. Diversity in accountability relationships is rather the rule as opposed to the exception. This is somewhat related to the notion of ‘nodal governance’. Nodal governance “explains how a variety of actors operating within social systems interact along networks to govern the systems they inhabit”. Accountability in IHIIs can be seen as an offshoot of nodal governance. Accountability, as a communicative construct for the IHI, funnels meanings about homicide cases between individuals connected to the IHI process, as a way of adapting to the complexities of the

64 M. Bovens, op.cit., at 457.
65 Ibid.
67 L. Hancher and M. Moran, ‘Organising Regulatory Space’ in L. Hancher and M. Moran (eds.) Capitalism, Culture and Regulation (Oxford: Clarendon Press, 1989), p 277. Hancher and Moran use the notion of a ‘regulatory space’ as an analytical device. They contend that the term denotes a space which is occupied unevenly by actors in a regulatory process that typified by competition, contestation, struggle and power over resources.
68 J. Black, ‘Decentering Regulation: Understanding the Role of Regulation and Self-Regulation in a ‘Post-Regulatory World’, op.cit., at 109; L. Hancher and M. Moran, ‘Organizing Regulatory Space’, op.cit., p 276. Hancher and Moran write that “organizational alliances are constantly forming and reforming without any reference to a conventional public-private divide, parties bargain, co-operate, threaten, or act according to semi-articulated customary assumptions”.
69 B. Stone, ‘Administrative Accountability in the ‘Westminster’ Democracies: Towards a New Conceptual Framework’ 8(4) (1995) Governance 505 at 511. This may include contexts such as Parliamentary control (supervision/command), managerialism (fiduciary/contract), judicial review or quasi-judicial review individual rights/procedural obligations), constituency relations (representation/responsiveness) and the market (competition/sovereignty) are in abundance.
70 S. Burris, P. Drahos and C. Shearing, op.cit., at 33. More specifically, ‘nodes’ are “institutions with a set of technologies, mentalities and resources…that mobilise the knowledge and capacity of members to manage the course of events”.

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environment (mental health care).⁷¹ These adaptations can be said to form highly specific nodes of governance through accountability relationships between the IHI Panel and account-renderer, of which the IHI process is the mediating form. And since mental health professionals are the main point of focus during an IHI investigation, which is understandable given that the communications used to make sense of their actions are primarily psychiatric, the prospect of individual nodes overlapping or ‘communicating’ with each other is limited.⁷²

If systems theory is taken seriously as a guiding theoretical beacon for a concept of accountability however, the ‘problem of many hands’ is one which enhances the contingency associated with exploring past decisions. If those many ‘hands’ are analysed in terms of what would have happened if another set of hands were used instead (otherwise known as post-decisional regret (see Chapter 4)), reaching a meaningful conclusion about the effects of an individual’s previous decisions becomes more difficult to make. This is understandable in a proliferating regulatory state where the creation of administrative agencies and new methods of government appear to have rendered core definitions of accountability obsolete. After all, since the 1990s, “there have been various efforts to create more complex structures which typically devolve more authority downwards, reduce the number of layers (and hence the capacity for close supervision), and which recognize and encourage a more diverse range of relationships with actors outside the traditional hierarchy”. ⁷³ Accountability, in terms of its meaning and significance, certainly must be seen to change constantly and is largely determined by the context in which it is practiced.⁷⁴

The amendments to HSG(27)94 in 2005 have certainly signalled a more meaningful attempt to ‘make sense’ of the ever-increasing complexity of mental health care. In crafting an approach that focuses upon the underlying systemic causes of human error using RCA, IHIs appear to be reducing the complexity of modern day mental health services. This is an important

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⁷¹ Ibid., at 34. Through their actions, interactions and ways of doing things, collectivities (according to Burris et al.) produce measurable outcomes that depend on the making of causal connections between elements of that collectivity and the outcomes themselves. This is achieved through the use of heuristics (RCA could be an example in the context of IHIs). The authors note that the identification of outcomes “must stop time...when in fact they exist dynamically in time” (see Chapter 2).

⁷² Ibid., at 39. “Nodes have different capacities to interact with, and influence, other nodes and course of events. The capacity of a node to influence or regulate depends in large part upon its resources”.

⁷³ B. Stone, op.cit., at 509.

⁷⁴ A. Sinclair, op.cit., at 219.
point, for it is the view of the present chapter that IHIs present a vivid opportunity to further reformulate the concept of accountability. As a law and policy creation designed to deal with issues beyond the reach of the law, IHIs are a flexible device. They possess the communicative tools necessary to make sense of a burgeoning mental health profession, but this process appears to look past individuals and towards the systems and processes of which they form apart.

5.6 Accountability, Time and the Connection between Past and the Future

If the accountability relationship between an IHI Panel and a witness is a communicative construct, it may also be argued that such relationships must make sense of time. After all, systems theory can be used to claim that IHIs locate meaning in individual roles and events by examining the past. As Chapter 4 argued, the past that IHIs examine is simultaneously constructed using communications that fill that past with a selection of meaningful content. The present chapter develops this line of systems-theoretical argument further by claiming that accountability is better understood as a meaningful connection between the past and the future. This is opposed to the view, bootlegged by the more traditional concepts of accountability, that the latter is simply a vehicle through which individuals are questioned and answers given in order to establish facts or, more ambitiously, the ‘truth’.

IHIs can be said to create a meaningful experience of time that is distinct from other experiences of time typical of social systems that make up the environment of the social systems of communications used by it. This, in turn, facilitates communications in the present about how to address the problems identified in cases going into the future. This necessitates establishing an initial relationship of core accountability however because this is the only way that enough information can be extracted by an IHI Panel for the purposes of advancing clear recommendations going forward. This information exposes a dense tapestry of interlinked mental health care decisions that, as Chapter 4 argues, obscures the effects of individual decisions. Establishing individual accountability for deficiencies in care as opposed to establishing it as an immediate response to homicide events is an anomaly which existing concepts of accountability fail to recognise. And despite this anomaly, IHIs are nevertheless able to conclude their investigations and advance recommendations. How should accountability be understood in light of this?
Using systems theory, accountability is best conceived of as a meaningful communicative link between the past and the future in the present. This is because in attempting to make the provision of future mental health services safer, IHI Panels must not only elicit answers to their questions in the present using communications, but they must also act on that information in accordance with those communications also. In IHI processes, accountability serves this purpose. After all, adverse events “present opportunities for causal attributions which relate (or blame) their occurrence on past decisions” Accountability facilitates this because the construction of a meaningful understanding of the past through communication allows a connection to be ‘fed’ into the present and ultimately into the future, in terms of informing recommendations and their subsequent implementation. These events continue a chain of decisional causality from the chaotic past of decisions into the unknown future of consequences. Accountability in IHI processes is therefore an essential tool IHI Panels use to forge meaningful connections between past and future.

5.6.1 Accountability and the Future in Independent Homicide Inquiries

Despite few formal mechanisms available for following up the findings of IHIs and how recommendations work in practice, it is clear that IHI recommendations are profoundly future-oriented in terms of the changes they instigate. Recommendations are based on the judgment and scrutiny lauded upon mental health professionals during the process of core accountability carried out by IHI Panels. Recommendations are instrumental in prompting organisations to assimilate and learn from different messages and the formation of an accountability relationship makes this happen.

When it comes to delivering findings and steering towards a safer delivery of mental health services however, IHIs appear to enlarge accountability and direct it in different directions. The findings and recommendations of IHI Reports are mainly directed toward officials at the higher levels of the NHS Trust, although IHI findings often find their way to a variety of different places. They may be relevant to coroners, civil litigation suits, criminal prosecutions and the

77 D. Carson, op.cit., p 123.
media. In terms of establishing more direct relationships of accountability however, IHI Reports are commissioned and published specifically for NHS managerial figures to review and implement. Although IHI Reports did at one time have the ability to engage wider law and policy debates, this has somewhat been diminished. Contemporary IHIs are quite localised, instigating changes that correspond to the idiosyncrasies of a particular mental health service. The service provided under an NHS Trust may have high staff attrition rates or reduced resource allocation, which an IHI will attempt to address in its recommendations. These issues are highly local. It is rare for IHIs to acquire ‘cult’ status nationally in the same way as the Ritchie Report or The Falling Shadow, although high profile cases will still receive widespread media coverage. This chapter argues that this enlargement of accountability (which occurs through creating further space for decisions to be taken) is necessary for the future (in terms of future decision making) to be rendered meaningful. Accountability facilitates an endless cycle of decision making. It is a functional aspect of social systems because it ensures that the communications continue.

To reiterate a theme from Chapter 4, all decisions are inhered with contingency and risk, according to Luhmann. Decisions, by definition, have future consequences. They furthermore have to be selected from a range of possible alternatives in order to ‘be’ decisions. The unknown future therefore places decision makers into an inescapable dilemma. This dilemma – selecting one decision from a number of possibilities with a view to reducing future loss that may or may not materialise – is risk, according to systems theory. There is always a missed opportunity every time a decision is made, whether that involves retrospectively examining past decisions or making decisions in the present based on such examinations. Accountability relationships expose this contingency. Accountability is both the procedural lens through which communications about mental health homicide cases are channelled and the foundation upon which new meaningful communications about the future provision of mental health services, in the form of recommendations, can be made.

Interestingly, IHI recommendations are rather broad. Rather than being directed towards those individuals being held to account, they are instead directed towards others in an attempt to modify how procedures and routines are carried out. For instance, the Community Practice Nurse

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78 For example, R. Francis, J. Higgins and E. Cassam, Report of the independent inquiry into the care and treatment of Michael Stone, South East Coast SHA, Kent County Council, Kent Probation Area (September 2006).
giving evidence before an IHI is not subsequently saddled with implementing recommendations to stage more regular multidisciplinary meetings. Instead, recommendations are directed towards the NHS Trust generally and even to specific NHS officials higher up in the chain of authority who wield the power to implement those recommendations. Recommendations usually require the implementation of certain arrangements, such as staff training programmes, extra recruitment, improved resources and an increase in the frequency of inter-team meetings. Some IHIs may even set time limits on the implementation of recommendations.\textsuperscript{79}

What this thesis does therefore is confirm the elusiveness of accountability. Not only does accountability in IHIs shift in different directions, it also disappears underneath the complexity of each case. Existing concepts of accountability are at a loss to cope with this aspect of IHIs. A systems-theoretical concept however can be argued to cope with this. The IHI Panel begins with individual professionals, exploring their past decisions, gleaning judgments about how they acted and whether they should have acted differently or not. This exercise is nevertheless clearly used as a platform upon which a constellation of complexity about mental health services is built, thus obscuring the effect of individual decisions and ultimately individual accountability for past actions. This provides a basis upon which wider accountability connections can be made with other NHS officials in order to create a link between the complex past and uncertain future. The machinery of the State (the NHS Trust), as opposed to specific individuals connected with the case, is thus placed beneath the spotlight of accountability when it comes to investigating mental health homicides. Consistent with Chapter 4, this enlargement of accountability within IHI cases may well contribute to the obfuscation of direct links between individual decision makers and the adverse event.\textsuperscript{80}

5.6.2 Accountability and the Setting of Recommendations

IHI recommendations, by definition, have future consequences. The expectation that the NHS Trust will act on those recommendations is once again linked with the IHIs concern to make the future provision of mental health services safer. Under systems theory, IHIs aim to minimise

\textsuperscript{79} See, for example, M. Dineen, M. Clarke, J. Liversley and M. Jackson, Independent Investigation into SUI 2006/4924, NHS Yorkshire and the Humber, Consequence UK (June 2009). The IHI Panel in this case recommended that a partnership audit be conducted between specialist mental health adult services, the prison in-reach team and the prison primary care team within the six months of the publication of the report.

future loss (the reoccurrence of homicide) in this way. A theme from Chapter 3 however was that making judgements about the future is inherently uncertain, especially if decisions are being made that are targeted towards a shifting, operationally-closed mental health profession. Chapter 3 discussed how operationally-closed communications cannot exert a direct influence over their environment. Those communications are fundamentally different and any changes that do occur from those attempts to make changes to the environment will be unpredictable, uncertain and prone to catastrophe. It is for this reason that the present chapter argues that the holding of the NHS Trust to account by setting them recommendations to implement and targets to reach enhances future uncertainty. This is despite the way in which accountability relationships facilitate a meaningful link between the past and future. For instance, IHIs are arguably communicatively miscorrelated to the nuances of the NHS Trust. These nuances include a range of communications germane to the inner workings of the NHS Trust, such as economic, moral, psychological and administrative communications relating to staff members that may go unrecognised. An IHI, under systems theory will either not recognise or reconstruct these communications using the bundle of communications at its disposal. Recommendations will consequently be made that are miscorrelated to these nuances. In short, recommendations are risky to make.

The riskiness of these recommendations will nevertheless not be apparent to an IHI. The communications they employ are utilised on the level of first-order observation. In other words, they do not ‘see’ the binary codes that make up their communications as codes in the same way that systems theory does. IHIs are simply guided by an ‘objective’ belief that the tools they use and the judgements they make can effect precise changes to the provision of mental health care services in homicide aftermaths.

5.6.3 The Expansion of Accountability and Risk
IHIs clearly incorporate a panoramic view of accountability. The argument advanced thus far is that IHIs enlarge accountability in order to ensure that a meaningful connection is made between past and future mental health care when responding to mental health homicides. How do they achieve this? The answer is through recommendations. Recommendations are targeted at those equipped with the power to make important decisions relating to the provision of mental health
services generally. Rather than focusing on the future conduct of those individuals held to a core version of accountability earlier on in the IHI process, IHIs shift the plain of accountability by focusing on the intersection between NHS management and third sector agencies. For example, one IHI required that:

The Chief Officer for Volition initiate a meeting with those third sector agencies who work most closely with specialist mental health services and assess the feasibility of using a common design, or content specification, of consent form.81

In IHI findings, it is the wider system of care that is important, as opposed to the individuals intimately connected with the case. Is there an explanation for this enlargement of accountability?

It may be argued that the wider obligations imposed on the State by Article 2 of the ECHR have, at least in part, brought this expansion about. Scholars have already posited that the growth of legal rights and obligations enlarges accountability across society more generally,82 leading to a heightening of expectations surrounding the future performance of its elite members.83 It also leads to the creation of what Luhmann calls future-oriented programmes of the political system.84 In short, the expansion of legal accountability has brought with it a greater expectation that elite professions of society (such as mental health professionals) safeguard the health and well-being not only of patients but the public also. This is illustrative of IHIs, where the fulfilment of legal obligations under Article 2 of the ECHR requires that mental health professionals and the NHS Trust are held to account during IHI investigations.

A general distrust in law and policy to effectively tackle future-oriented problems85 has arguably given rise to administrative measures, such as IHIs. These measures are considered able

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82 See M. Galanter, ‘The Turn Against Law: The Recoil Against Expanding Accountability’ 81(1) (2002) *Texas Law Review* 285 at 287. The expansion of law in the US at least has led to the enlargement of accountability among societies elites. Galanter writes that, as a result, “there were more opportunities for successful assertion of rights by outsiders, dependents, and subordinates against society’s managers and authorities”.
83 Ibid. “Civil rights, enlarged tort liability, the emergence of poverty law, consumerism, and environmentalism all reflected higher expectations of institutional performance by manufacturers, doctors, and government”.
84 See ibid. Government responded to and promoted rising public expectations by launching a “War on Poverty” as well as enacting a wave of civil rights, consumer, and environmental legislation”.
85 A. J. Wistrich, op.cit., at 784; S. Prasser, ‘Public Inquiries in Australia: An Overview’ 44(1) (1985) *Australian Journal of Public Administration* 1 at 1. Prasser contends that there has “a malaise in the body politic, such as the
to penetrate the detail of complex adversities in health care.\textsuperscript{86} The creation of various quasi-legal agencies, panels and organisations have been regarded as a “fourth branch of government”\textsuperscript{87} that has been able to address problems previously considered to be beyond the purview of traditional law and policy methods. The delegation of power and responsibility to NHS Trusts and ultimately to IHI Panels has typified this explosion.\textsuperscript{88} After all, conducting investigations is a central aspect of administrative regulation. The purpose of it is to solicit “input from those to be regulated and the public before creating rules to govern future (my emphasis) conduct”.\textsuperscript{89} ‘Filling the gaps’ left by technical areas of expertise that the legislature has been unable to reach\textsuperscript{90} has been considered to be a mainstay of administrative regulation. This is, once more, illustrative of what the IHI does.

Pursuant to the arguments advanced in Chapter 4, these concerns can certainly be linked to the way in which law’s unique time orientation ‘lags behind’ the time orientation of a dynamic health care profession,\textsuperscript{91} thus calling out for alternative forms of redress to address perceived failings. IHIs are a perfect example of this attempt to overcome the obstacles of time, and more importantly, risk associated with traditional legal methods. After all, it was argued in Chapter 4 that the onset of a risk-oriented society has procured anxiety and confusion about what causes adverse events in mental health care to happen. Not only science but law and politics now have an ‘equal say’ in how the risky challenges presented by social and technological progress should be addressed. Adverse events have exposed the fallibility of science and law in particular, opening up what were once monopolised debates about how to make the world safer following a catastrophic event. The ‘problem of many hands’ regarding issues of causality appear to create an

distrust of government”. This goes some way to explain the increasing need for independence when investigating with crisis situations.

\textsuperscript{86} This is not surprising, given that the ability of legal reform to transform society has been rigorously doubted since the 1970s (see M. Galanter, op.cit., 285 at 296).

\textsuperscript{87} A.J. Wistrich, op.cit., at 784.

\textsuperscript{88} Ibid.

\textsuperscript{89} Ibid., at 785.

\textsuperscript{90} Ibid., at 786

\textsuperscript{91} L.G Pawlson and M.E. O’Kane, ‘Professionalism, Regulation, And The Market: Impact of Accountability For Quality Of Care’ 21(3) (2002) Health Affairs 200 at 204. The authors write that the “regulation and legislation frequently lag well behind the dynamic forces of the health care market, as for example the recent spate of “patients’ rights” bills at a time when HMO have improved their practices and their influence is in decline. While there have been attempts to create regulations that are more responsive to consumerism, there has been no concerted effort to examine current regulations in light of the evolution of the health care market and its forces”
overly-detailed picture of reality which traditional law and policy measures have been increasingly unable to appreciate. The IHI can be said to have ‘filled the gap’ in this respect.

The indeterminacy of IHI findings however enhances the uncertainty associated with holding the NHS Trust to account. This uncertainty is hallmarked by efforts to improve mental health services through the making of recommendations in a shifting climate of communications and the unpredictable effects of decisions. And with the effects of individual decisions in and around the corpus of care being untraceable within the mass of decisions made about a patient, establishing a meaningful connection between the past and the future can only come by way of enlarging accountability and holding the wider NHS management to account.

In expanding accountability throughout the hierarchical chain of the NHS Trust, IHIs can be said to enhance risk also. On the one hand, recommendations are aimed at a variety of individuals responsible for the general provision of care. This often covers ground relating to recruitment, training and the auditing of services. Not many ‘stones’ are left unturned in this respect. This is understandable if juxtaposed against the indeterminacy of IHI findings and the realisation that not one single cause can be attributable to the homicide. There is no one individual that can be identified as being solely accountable. It is rather a collective form of accountability at play which compels a meaningful connection between the past and future to occur. This preserves the flow of time for those social systems of communication at the heart of the IHI process. The alternative is simply to halt the flow of time by not establishing accountability, which would jeopardise the integrity of the investigation and those social systems of communication utilised within it.

What the enlargement of accountability also does however is increase the machinery of risk.\textsuperscript{92} The indeterminacy of IHI findings obscures the establishment of firm answers to questions in the aftermath of a homicide. The consequent uncertainty about how to address these questions and provide solutions going into the future (otherwise known as risk awareness) arguably breeds distrust:

\textsuperscript{92} N. Luhmann, \textit{Risk: A Sociological Theory}, op.cit., p 145. Although writing in the context of politics, Luhmann envisaged generally that the growth of accountability results in “a gigantic and uncontrollable machinery for risk”. He writes that regulative politics lends itself to intervention in a wide range of matters relating to the economy in the form of taxation, changes to divorce law, education policy, scientific funding and so on.
The result is that we feel it increasingly appropriate to complain about and to attack decision makers, in particular those responsible (and therefore attracting attribution) at high levels.93

And with the establishment of new levels of accountability in the aftermath of a mental health homicide, there is simply a recapitulation of expectations. With increased demands on the NHS Trust to make even better decisions, those decisions are nonetheless made by decisions makers who make decisions about others in an operationally-closed reality of communications. And with the effects of decisions in any walk of life, “[t]here are always many more causes and many more effects than we can take into account”.94 In enlarging accountability, IHIs undoubtedly generate further ground for risky decisions to be made on. Establishing accountability in IHIs and risk are therefore closely linked. After all, any attempt to steer society’s social systems (the mental health care system being the relevant case in point) is a self-sustaining exercise. By increasing accountability, more demands are placed on decision makers and thus more potential for clashing interests, misunderstandings and risky decision making.95 And furthermore, the measures selected by an IHI Panel are not guaranteed a safe passage, in the sense that “there is no safe way to achieve the desired results without running the risk of effects that may lead to post-decisional regret or, even more likely, to the risk of not achieving the intended results in spite of high costs, including opportunity costs”.96

5.7 Conclusion

This chapter has sought to add further complexion to the main theme laid down by this thesis thus far, namely, how an IHI renders the relationship between mental health care and homicide meaningful, despite the indeterminacy of IHI findings and the pervasiveness of post-decisional regret. This chapter recruits a systems-theoretical concept of accountability in order to achieve this, holding that accountability relationships are a necessary vehicle through which the past

94 Ibid., at 228.
95 Ibid. Luhmann argues that “reducing differences always requires producing differences. You never get a system which no longer deviates from expected values. By reducing unemployment you may produce inflation. By reducing pollution figures you may increase bankruptcy figures dramatically. In this sense, steering seems to be self-sustaining business”.
96 Ibid.
provision of mental health care can be excavated in order for future decisions to be made by NHS Trust officials. As Chapter 2 and 3 made clear, social systems of communications are the building blocks of meaning about mental health homicides and time. IHIs nevertheless must channel these communications in such a way so as to orchestrate a flow of time from the complex past to the uncertain future. They do this by holding mental health professionals to account.

As this chapter has shown however, accountability is elusive in an increasingly complex society. Scholars have mapped its different forms, but IHIs raise new challenges regarding how a concept of accountability should be understood. The present thesis holds that IHIs look back into the past using operationally-closed communications. This chapter argues that this is essential for holding individuals to account. Identifying mental health professionals, asking questions and eliciting answers require the production of meanings that can only be provided through certain social systems of communication. Making sense of the past is similarly dependent on the utilisation of communications within the IHI process. Accountability is therefore communicative.

More generally, this chapter has sought to reorient the concept of accountability. The thesis that IHI investigations are unable to acknowledge the influences that individual mental health professionals have through their decisions puts IHIs in a difficult position. Despite this indeterminacy in their findings, IHIs must still make arrangements in the present that have future consequences. They must connect the past with the future. Without this connection, IHI investigations would cease and a loss in confidence in mental health services would occur.

The only meaningful way in which IHIs can connect the past and future is by expanding accountability through their recommendations. They do this by absorbing responsibility for ‘improving’ mental health services through the NHS management structure. According to this thesis however, expanding accountability increases the machinery of risk. More risky decision making is generated by the IHI. The effects of these decisions (decisions to recruit more staff, new strategies of care and new training regimes) are uncontrollable, in the sense that they will germinate in meaningful contexts that are fundamentally different from those contexts affected by those decisions. This increases the riskiness of IHI recommendations and the decisions necessary to fulfil them. Thus far the present thesis has argued that the stated intentions of law and policy-makers to learn lessons from mental health homicides, investigate their potential causes and to improve services, are stifled due to the complexity of individual cases.
Compounding this complexity are the communications IHIs utilise in order to distil this complexity into meaning. This is further aggravated by the focus of these communications, namely, individuals, events, concepts and time. IHIs are able to distil these ‘artefacts’ into meaningful communications, but only to a certain extent. The present chapter has argued that this is done by holding persons to account, but that this process yields a wealth of possibilities about the case history that are not amenable to straightforward causal theories. Instead, the accumulation of account-renderings and causal attributions lead an IHI to the conclusion that individual decision makers cannot be held to be causally related to the fatal incident. What is more, the sheer complexity of cases and the communicative tools used to distil them appears to obscure the influence of individuals completely; it is clear that without the making of decisions, the homicide would never have occurred but locating a linear path of causality between decisions and the fatal incident is not possible.

It is at this point that the present thesis seeks to corroborate this argument in the context of a thematic analysis. It was mentioned in Chapter 1 that this approach can provide essential context to abstract theoretical issues. Chapter 6 therefore sets out how the theoretical arguments discussed over the course of this thesis can be exemplified using 30 recent IHI Reports commissioned by six different SHAs across England.
Chapter 6

Investigating Homicide

6.1 Introduction
Chapter 3, 4 and 5 unfurled a theoretical case for using systems theory in order to explain how IHIs address mental health homicides. Broken into its constituent parts, this comprises Luhmann’s general theory of social systems, the concept of risk and a systems-theoretical concept of accountability developed by this thesis. The present chapter however creates a new space for this theoretical case to be explored. It is based on the analysis of a sample of IHI Reports in a bid to flesh out, corroborate and perhaps challenge, where appropriate, the theoretical framework set out hitherto. This is connected to three subsidiary aims. The first is to consider what IHIs conclude from the information gathered during an investigation. The second is to observe how they act on this information, in terms of what recommendations IHIs make and who these are targeted towards. The third aim of this chapter is to explain what it is about the IHI that exposes it to contingency and prompts it into making findings of causal indeterminacy. In order to do this, several important thematic issues hitherto covered by the present thesis shall be resurrected and discussed.

6.1.1 Thematic Issues
A theme “captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set” On the one hand, the concept of time and risk are explored, in this respect. It is the concept of post-decisional regret specifically – a sub-theme of Luhmann’s concept of risk discussed in Chapter 4 - that is useful for the purposes of this exploration. Post-decisional regret is an expression Luhmann used to describe the contingency of decisions; decisions are always open to the suggestion that other, more advantageous decisions could have been taken after the fact. Under Luhmann’s thesis, post-

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1 See R. Mulgan, ‘Accountability’: An Ever-Expanding Concept (78(3) (2000) Public Administration 555 at 555. This is the concept of ‘core accountability’ discussed earlier (supra. 4.1).
2 V. Braun and V. Clarke, ‘Using thematic analysis in psychology’ 3(2) (2006) Qualitative Research in Psychology 77 at 82.
decisional regret is integral to risk. This is because decisions and their future consequence are never certain and are always open to the view that they could have been decided differently. Decisions are always open to objection, criticism, regret and the added irritation of their aims by the making of other decisions taken simultaneously. In other words, the effects of these other decisions clash, converge and irritate other decisions and their effects also. Chapter 4 discussed the retrospective nature of an IHI. Looking back into the past necessitates communications to be made about the past, specifically the past decisions of mental health professionals. For obvious reasons, the concept of time is important in that context because, in a bid to secure a better and safer mental health care service for the future, IHI's must inevitably look back into the past. It is therefore hugely apposite to consider the extent to which an IHI expresses post-decisional regret and, more importantly, its correlation with Luhmann’s concept of risk. The present thesis is of the view that the scope for expressing post-decisional regret towards the past decisions of mental health professionals is considerable, bearing in mind the number of decisions under scrutiny in cases and the wide potential for causal conjecture between these decisions, their effects and the fatal event.

The concept of accountability, moreover, is resurrected in the present chapter in order to distil further the extent to which IHI's are faced with the contingency of past mental health care decisions and the contingency of their own decisional reactions to the fatal event. It was argued in Chapter 5 that existing theories of accountability are overly-focused upon the answerability of individuals. The present thesis addresses this limitation by developing a concept that considers how the interactions within accountability relationships are constructed (through social communication) and how the information extracted by the IHI Panel from multiple account-renderers across multiple accountability relationships accumulates, placing a heavier onus on the IHI to convert causal complexity into meaningful findings. Some themes in the accountability literature have proved useful however in clarifying the challenges IHI's face, particularly the ‘problem of many hands’ expressed by Bovens and others. What the present chapter intends to do is develop this line of enquiry contextually by referring to how IHI's hold individuals to account and what communications IHI's utilise to accomplish this. What is more, the present chapter documents the way in which IHI's ‘layer’ their investigation with findings from various

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3 Supra., 5.5.
accountability relationships, thus building up a constellation of contingencies about how the homicide could have been averted, or at least how the patient’s care could have been improved. The ultimate aim of resurrecting the concept of accountability in this way is to connect it to the thesis that IHIs embody risk because they are perpetually contingent in their observations and decisions. The chapter corroborates the argument in Chapter 5 that a concept of systemic accountability is needed because, in light of these contingencies, reducing IHI investigations to direct causative links between individual decision makers, their effects and the fatal event is meaningless.

6.2 The Reports
This chapter is based upon a sample of 30 IHI Reports commissioned by five Strategic Health Authorities (SHAs) in England. This involved a selection of six of the most recent IHI Reports published before February 2012 in each SHA. They included London, South West, East of England, East Midlands and Yorkshire and the Humber.

6.2.1 Methodological Issues
A sample size that is “large enough” is a common concern amongst social researchers. In achieving an adequate sample size, two of the most important variables are time and cost. The general view is that larger sample sizes are less cost-efficient and more time consuming to analyse. The present chapter has constructed a sample size that will be large enough to facilitate a credible analysis of how IHIs function, why IHIs need to make sense of past mental health care decisions and create the conditions for better future ones. Enhancing the level theoretical saturation (discussed below) is possible through this method. Furthermore, a study’s representative value is the extent to which an observed relationship can be inferred from the study. The smaller the study, the less representative value it has (the sample frame in the present context being the complete list of IHIs published since the 1994 (as amended) Department of

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5 Ibid., p 180.
7 See 6.2.4.
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Health guidance came into being). The thesis has chosen a sample size of 30 IHI Reports. This will provide enough coverage to identify central themes flagged up by the theoretical framework. Establishing a thematic analysis which can inform the extent to which IHIs are able to attribute causes to homicide events and illuminate how law and policy is able to establish meaningful ‘contact’ with mental health care is an important aim.

6.2.2 Ensuring Reliability and Theoretical Relevance

Non-participation in sampling is also common. These problems are escaped in the present context, for the following reasons. Since the Department of Health issued guidance in 1994 making IHIs mandatory, many IHIs have been staged. This guidance, instigated by the State’s obligations imposed by Article 2 of the ECHR, requires the NHS Trust to commission an appropriate vehicle through which the causes of a mental health homicide can be properly investigated. Although IHIs are carried out by private companies most of the time, they are commissioned by the NHS Trust and are thus “public bodies” for the purposes of the ECHR. Public bodies are decision makers whose procedures must conform to the principles of natural justice. As a consequence, most (if not all IHIs) share very similar Terms of Reference and investigation strategies. Of importance therefore was the need to check that each IHI Report had been clearly commissioned pursuant to HSG(94)27 (as amended). This way, the reliability of the study could be ensured; each Report could be relied upon for being largely similar in structure and approach. And lastly, in selecting the most recent IHI Reports that had been published, the thesis is better positioned to elicit the contemporary concerns affecting IHIs. A more ‘outdated’ sample will have less applicability to these concerns. For instance, the fact that private consultancies are commonly commissioned by the NHS Trust to investigate is an important methodological consideration. This never used to be the case and so creating a study that featured investigations conducted in this manner was necessary to achieve relevance.

Even though the IHI Reports selected for this chapter germinated in a context far-removed from the theoretically-grounded preoccupations particular to the present thesis, the latter is of the view that a legitimate focus on exploring the function of IHIs and how they reach their

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9 The reasons for focusing on IHI Reports published after 2005 is explained in further detail below.
findings is achievable. For instance, it is not as if IHIs are a haphazard event. Being mandatory and subject to the same legal and policy framework reduces the presence of extraneous variables that might prejudice the findings of the case study. Again, it also renders the sample more reliable.

More broadly, this chapter aims to provide a useful illustration of how the theoretical framework set out in previous chapters can be vindicated. The obvious disadvantage relating to this is that the findings of this thesis will lack maximum representative value. Nevertheless, this thesis seeks to develop a previously untouched, two-fold theoretical nexus. The first nexus is between systems theory, accountability theory and risk theory. The second nexus forges a link between these theoretical considerations and their ability to explain how IHIs provide a unique vehicle through which mental health care services are communicated about. This provides a useful and practical context to this thesis.

6.2.3 Achieving Theoretical Saturation

Theoretical saturation, on the other hand, refers to the situation where after a sample has been selected and an analysis has been conducted, “no new insights are obtained, no new themes are identified, and no issues arise”.11 Reaching theoretical saturation provides a study with significant reliability. It is not necessarily associated with sample size, although it may be insofar as size is “related to judging the extent to which issues of saturation have been carefully considered.”12

Theoretical saturation presents another small crop of methodological challenges. Firstly, for reasons alluded to earlier, the thesis is predominantly theoretical and attempts to expose a series of links between systems theory, risk theory, accountability theory and the IHI process. The theoretical diversity associated with this agenda requires a degree of clarification which leaves little space for practical consolidation. That said however, this chapter is solely dedicated to providing a requisite level of contextual consolidation. What is more, it is creating a wholly different platform for the issues raised in previous chapters to receive greater exposure and development.

12 Ibid.
Secondly and similar to an earlier point, the theoretical framework constructed hitherto licenses a detailed foray into how IHIs attribute causes to mental health homicides. This goes to the issue of how the scope of the thesis’ documentary analysis can affect the attainability of theoretical saturation. The scope of Luhmann’s work in particular is all-encompassing. Practically consolidating his theoretical contribution within the confines of one thesis chapter requires a certain amount of selectivity. More specifically, Luhmann’s concept of communication is almost infinite in its scope and comprehensiveness. His view that nothing exists except communication, with each communication serving an autopoietic function, opens up endless opportunities for conjecture. From the most significant event to the most mundane, Luhmann’s work is widely applicable. The present chapter is, accordingly, constructed around a few key themes extracted from the sample which can serve as a strong element of consolidation for the theoretical agendas rooted in systems theory, risk and accountability. Some cases illustrate these themes more than others. It is therefore common throughout the chapter to explore certain cases in more depth than others which harbour less salient themes.

Each IHI case, to varying extents, involved noticeable attributions of mental health homicides to a variety of causes within the corpus of mental health care. With this narrow, yet pertinent contextual point brings an enhancement of theoretical saturation. A broader scope of study would require a greater amount of time in terms of achieving it.\(^\text{13}\) This is somewhat acute in the present case because the documentary analysis is confined to one chapter also. Nevertheless, it is enough in order to corroborate (or challenge) the theoretical framework constructed in Chapter 3, 4 and 5.

A relatively minor sub-species of emphasis relevant to this chapter relates to complex IHI cases of multi-agency involvement. This refers to instances where the patient’s condition is aggravated by personality disorder, dual diagnosis and criminal activity. These cases often require wider input from and liaison between mental health services, the criminal justice system and social care agencies. A theme of this chapter is that the more complex cases (where there is considerable professional involvement) produce more indeterminate causal attributions. This, in turn, points to concerns regarding the ability of IHIs to penetrate case complexity with their investigations. Combined with external influences (resource allocation issues, electronic database

\(^{13}\) J.M. Morse, ‘Determining Sample Size’ (2000) 10 *Qualitative Health Research* 3 at 5.
incompatibilities, cultural problems and so on) complex patient presentations challenge the ability of IHIs to establish causes in their findings.

6.3 Decisions and Post-Decisional Regret

Mental health homicides clearly create a situation of uncertainty that calls for a more certain future to be secured:

The purpose of this Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help improve the reporting and investigation of similar serious events in the future.\(^{14}\)

A range of actions and decisions carried out by mental health professionals were identified as being regrettable by each Report. These decisions are too numerous to mention in full, but they include failures of professionals to properly manage health records by implementing parallel systems of recording,\(^ {15}\) make reports available to others,\(^ {16}\) update health records,\(^ {17}\) liaise with

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\(^{15}\) T. Hussain, E. Ewart and R. Ramsay, *An Investigation into the Care and Treatment of service user Y*, NHS London SHA, Verita, (February 2012), p 52. The IHI commented that had a professionals’ meeting taken place, a shared cared plan for Y and the victim would have been produced. Nonetheless, the IHI found that both the patient and the victim were *known (my emphasis)* to have an "entwined relationship" (they were mother and son) but that nothing was done to address these issues.


\(^{17}\) J. Smith, M. Clifton, C. Dale and M. Rosenberg, *Independent Investigation into the Homicide of Mr A by Mr B*, South West Strategic Health Authority, Caring Solutions UK (October 2011), p 29. Mr B acquired Obsessional Compulsive Disorder as a result of his brain injury. The IHI commented that “[i]nformation was available within the health record to construct an adequate clinical formulation that could have been reviewed and updated as it came to the attention of the clinical team”. The IHI concluded that “the CMHT could have done more to appreciate the complexity and severity of Mr B’s OCD. See also M. Dineen, J. Nixon, T. Jolley and J. Lawrence, *Independent Investigation into the care and treatment provided to SU*, NHS London Strategic Health Authority, Consequence UK (February 2012). SU had suffered a brain injury some years before committed the homicide. The IHI regarded the communication failure between the CMHT and Headway, the brain injury association, as “a missed opportunity” to provide more informed care. A Consultant had produced a report providing “a good understanding of the MHSU’s [patient] injury and diagnosis” (at p 70). The IHI were of the view that the loss (the communication failure) was due to a controllable set of circumstances; at p 69, the Consultant’s report appeared to support the finding that “[t]he onus for establishing and maintaining this communication was on the community mental health team as part of its role in delivering effective care coordination”.
other professionals \(^{18}\) and the consideration of “too many variables” when constructing communication pathways between teams when patients were referred for assessment.\(^{19}\) There were clear instances however where the regret expressed supported the view that the homicide could have been averted had different standards been in place. An independent investigation into the care and treatment of a person using the services of Leicestershire Partnership NHS Trust involved a random attack on a woman by a schizophrenic patient who was at the time being treated in hospital. An agreement had been made between two Consultant Psychiatrists and the Crisis Resolution and Home Treatment (CRHT) Team to keep the patient in hospital for a fuller assessment:

> [h]ad the above stated standard and system been in place [electronically controlled ward access] in July 2005 the incident involving the MHSU would not have happened\(^{20}\).

Other IHI Reports appeared slightly more reticent about whether the homicide could have been avoided, but were still regretful about significant aspects of care provided. In An independent investigation into the care and treatment of a person using the services of Leicestershire partnership NHS Trust, the patient was unfit to drive her car. She experienced hallucinations behind the wheel commanding her to collide with the victim. The IHI Panel was particularly concerned with the level of contact mental health services had with the Driving and Vehicle Licensing Authority (DVLA) and also the timing of the medication administered by staff:

> With regard to the administration of an antipsychotic medication and a sedative at an appropriate time of the evening/night, there are no absolute guarantees that the MHSU would not still have been

\(^{18}\) See M. Rae, C. Robinson and N. Georgiou, Report of the independent investigation into the circumstances surrounding the care and treatment of Mr A, NHS London Strategic Health Authority, Caring Solutions UK (February 2012). At p 44, the IHI commented that the “[u]se of cannabis was listed in ‘Relapse Indications’ in his last CPA document from June 2007 and in retrospect staff have indicated that they think it would have been helpful to try to utilise the Dual Diagnosis Service”. This was despite the MHSU’s attempts to conceal his habit.


overcome by command hallucinations and driven her car as she did on the morning of 30 January 2007. However, the IIT believes that the chances of this occurring may have been reduced.”

It is for this reason that IHI Reports appear highly idiosyncratic and sometimes quite tenuous in the way they attribute causality between adverse events and decisions. An independent investigation into the care and treatment of Mr SU, the patient underwent a profound personality change as a result of a head injury suffered in an accident. The IHI Panel was particularly concerned with the level of knowledge held by professionals when making their decisions. More specifically, they were interested in the level of awareness staff held about the effects of brain injury. Referring to a ‘snippet’ of information found on Wikipedia, the IHI Panel commented that:

This snippet of information alone would have alerted the mental health professionals against making judgements regarding Mr SU’s apparent choices and lifestyle behaviours.

Similar tenuous links were drawn in other cases. In the DVLA case discussed above, the IHI Panel pointed to the lack of education about fitness-to-drive issues in the 32 medical schools across England as being a factor that played a role in the patient not checking with the DVLA about her driving ability.

Post-decisional regret is thus clearly evident and is manifested in each IHI Report multiple times on a number of different health care issues. It makes for a very complex picture of mental health care. This would sometimes involve the IHI giving a somewhat ‘fictional’ narrative of what decisions would have followed on from an earlier decision that should have been taken but was not. In An investigation into the care and treatment of service user Y, the patient was in contact for many years with mental health services. He received treatment in hospital over this period, but his diagnosis was a source of disagreement. The local Council also

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22 External Investigation Into the Case of Mr F, NHS London Strategic Health Authority, Caring Solutions UK, (February 2012) (identity of authors not disclosed).
aborved itself of the duty to house the patient on the basis that the latter intentionally made himself homeless:

In light of Y’s long history of risk to others, a safeguarding referral would probably have led to a case review. One outcome of such a review would have probably been to put in place a set of protocols for communication and sharing of information between the two teams looking after Y and his mother.25

An overarching theme of regret that was prevalent throughout the study was the view that the homicide should not have happened.

The cases nevertheless confirm that post-decisional regret is oriented differently from case-to-case. On the one hand, homicides were regretted but could have been avoided if the patient had acted differently. An investigation into the care and treatment of Tennyson Obih involved input from a range of professionals, including probation officers, the GP and specialist mental health services. A transferral of care over to a new community mental health team care coordinator however resulted in reduced engagement with the patient:

[w]e consider that the homicide might have been prevented if there were actions that professionals should have taken which they did not take and if those actions probably should have made a difference to the outcome. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy (my emphasis).26

Interestingly, only 2 out of the 30 cases reviewed found that the homicide could have been prevented.27 22 cases considered that the event was either not preventable or that it could not be said with any degree of certainty that it could have been. One case concluded that it was “possible” and that the homicide could have been averted28 and another was “not certain”.29

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Strangely, 4 cases did not even conclude on the issue of preventability, or at least did not refer to it.\textsuperscript{30} And yet, post-decisional regret was found in every case and a direct link between an identifiable decision and the fatal event was never found. A very small number of cases were able to draw a direct link between the care provided and the fatal event, but this was couched in general terms that did not specify identifiable decisions \textit{per se}. In \textit{An Independent Investigation into the Care and Treatment of Mr R}, the patient was being treated for antisocial and borderline personality disorder in a Medium Secure Unit when he was admitted to hospital with chest pains. He later absconded and killed a pensioner:

The underlying staffing and management issues within the THU [the Medium Secure Unit] were in large part the root cause of the second absconsion…But for the absconsion of Mr R from King’s College Hospital, the murder of Mr Q would not have taken place.\textsuperscript{31}

Paradoxically, even those cases where nothing could have been done differently and that the care provided was appropriate prompted instances of post-decisional regret:

The Investigation Team concludes that there was nothing the mental health services could have done to prevent the attack by the MHSU on this [sic] wife on 2 April 2006. It is also important to note that the family of the victim in no way holds any of the mental health services responsible for what happened…However there are three important learning \textit{reflection points (my emphasis)} for the service.\textsuperscript{32}

\begin{thebibliography}{9}
\bibitem{31} G. Roberts, N. Moor, C. Gaskell and S. Mikhail, \textit{An Independent Investigation into the Care and Treatment of Mr R}, NHS London, Niche Health & Social Care Consulting (February 2012), p 55.
\end{thebibliography}
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In 19 cases, the IHI Report explicitly mentioned that there had been ‘missed opportunities’ during the time care was provided, regardless of the quality of care received. The ‘lost’ or ‘missed opportunity’ was common throughout the cases. *An independent investigation into the care and treatment of a person using the services of the former Norfolk and Waveney Mental Health Partnership NHS Trust* involved a patient who, from 1985, was treated for symptoms of paranoia and depression. He was later known for committing violence, courting the attention of the police and later remanded at prison before being transferred to hospital. He was treated and later received forensic community follow-up visitation at his home and would attend his GP surgery for regular depot injections. The IHI found that the care provided to the patient could have been more assertive:

> It is the contention of the IIT [that] there were a number of lost opportunities in the care and management of the MHSU. Had different actions been taken at these points the death of Mr Raynor on 24 May 2006 may not have occurred.\(^{34}\)

Other cases exhibited a similar theme. In *The Report of the Independent Investigation into the Care and Treatment of JW*, the patient required input from the Crisis Team during emergencies, an outpatient clinic, the police when the patient was aggressive and a Support Worker. The patient was also difficult to manage, refusing medication. The IHI however felt that more could have been done:

> we consider that there may have been other opportunities for the offer of a Carers Assessment to be reiterated and that the offer may have been more acceptable to DG had it been linked to the prospect of immediate, practical help or respite.\(^{35}\)

Post-decisional regret furthermore appeared to be used to express the concern that more decisions could have been taken in the circumstances by the professionals involved. One case involved input into the patient’s care from a number of professionals, including a care

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33 Although in all of the cases analysed, the IHI Panel felt that care could have been provided differently and better in certain respects.
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coordinator, Consultant, CPN and a GP. The patient’s complex presentation, which included PTSD, social problems and unresolved psychological issues was seen to expose gaps in the knowledge of those caring for the patient. This fuelled wider speculation regarding what individual professionals involved the in case could have done to narrow these gaps and provide better care:

The Independent Investigation Team believes that the CPN/Care Coordinator could have continued to support Mr. X in ways that were acceptable to him. If, for example, she had worked with him regarding his Court case, pending breach, and his financial situation, a rapport may have been built and future interventions regarding his PTSD could have been advanced.36

Despite identifying certain key professionals relevant to the case, drawing direct causative links between their decisions and the homicide was never done. More common was a ‘grappling’ with the various influences that apparently impacted on the care and treatment provided:

Mr G’s experience of the health, social care and criminal justice systems was influenced by the application of a number of procedures aimed at improving multi-agency assessments, risk formulations and treatment plans.37

The difficulty in investigating the causes of the homicide was openly acknowledged in a run of cases,38 despite high standards of care.39 As the Tennyson Obih case confirmed and as will later be discussed, the sheer scope of post-decisional regret evidenced in each Report reviewed made it difficult to ascertain a single direct influence on the fatal event. The tapestry of care confronting

39 See J. Hall, R. Amin, A. Watson and T. Coldham, op.cit., p 83: “[E]ven with the best processes and systems health care professionals often struggle to adhere to Trust policy and procedure when service users with complex needs are difficult to engage”.

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IHI Panels conveyed a dense bed of actions, incidents, decisions and events that interconnected over considerable periods of time.

6.4 In What Way Do Independent Homicide Inquiries Embody Risk?

The study largely based its findings on the extent to which the decisions of mental health professionals conformed to the standards of best practice. The standards were contained in a litany of NHS Trust and DoH documents that IHIs used to benchmark the care provided. In fashioning a picture about the style of post-decisional regret expressed by the IHI Reports reviewed and what benchmarks were used, it was overwhelmingly driven by policy documents produced by the DoH and the NHS Trust. In one case, 55 NHS Trust documents were referenced by the IHI. Policy documents, on a range of issues such as safeguarding patient vulnerability, were crucial in fashioning a particular style of post-decisional regret that ‘benchmarked’ the quality of care given:

Had the vulnerable adults procedure been followed at this juncture, there would have been a greater likelihood of the police knowledge/intelligence regarding Mr A’s history of violent offending would have been shared with the CMHT. It would also have ensured the consideration that Mr B himself was also a potentially vulnerable adult.

Following on from themes in Chapter 3 and 4, it is unsurprising that disparities between policy documents and the mental health care provided to the patient occurred. Policy documents, under the theoretical framework advanced by this thesis, germinate in an entirely different social and temporal context to that of the mental health professional responsible for making decisions about a homicidal patient. These are two distinct universes of meaning that will inevitably diverge, thus leading to the prospect of post-decisional regret or objection.

Legal requirements were also relevant in some cases when it came to expressing regret about the way mental health care was provided:

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40 National Confidential Inquiry of 1999 and the NICE guidelines.
41 An Independent Investigation into the Care and Treatment of Mr R, NHS London (February 2012), p iii.
42 J. Smith, M. Clifton, C. Dale and M. Rosenberg, Independent Investigation into the Homicide of Mr A by Mr B, South West Strategic Health Authority, Caring Solutions UK (October 2011), p 23.
The application of the Mental Health Act (1983) was appropriate where inpatient treatment was required. However, the application of Section 117 discharge planning was not used as a means of engaging Mr Y with services. It might have been appropriate to use Section 117 to enable Mr Y to pursue more constructive activities.43

Similar expressions of post-decisional regret would often converge on the apparent failure of staff to carry out the correct procedures for granting leave under section 17 of the MHA 1983.44 Post-decisional regret was therefore very much guided by the law and policy information available to investigators. Again, non-conformity of mental health services provided to a patient with legal communications could, from the point of view of the theoretical framework posited in earlier chapters, represent two distinct dimensions of communicative meaning that are miscorrelated. It is this miscorrelation that points to a conflict between these two universes of meaning. What is more, the fact that there were a range of benchmarks (legal, non-legal, policy-based) against which the conduct of mental health professionals was judged to be satisfactory did not preclude the expression of post-decisional regret. For instance, one case found that the patient was not detainable under the MHA 1983 and that legality was not an issue, but nevertheless showed concern at the way discharge care was organised; a distinctly non-legal form of post-decisional regret:

The Panel are not entirely clear about the extent to which JMcF’s occupation was considered when organising discharge care by the health professionals conducting the assessment.45

Post-decisional regret was arguably intensified by the apparent lack of structure put in place by the NHS Trust. This could be interpreted to mean that in addition to scolding mental health services for being miscorrelated to law and policy, the IHI Panel considered that it was regrettable that the NHS Trust did not implement the appropriate policy infrastructure so as to appropriately guide mental health professionals in their practices.

45 L. Wilson and S. Wicks, An Independent Investigation into the Care and Treatment of JMcF, NHS East of England, Niche Health & Social Care Consulting (October 2011), p 66. In the case, the discharge care plan had not taken into account the MHSU’s occupation as a slaughterman, which placed him in direct contact with the tools that subsequently enabled him to commit the homicide.
This, again, demonstrates a further instance of post-decisional regret being expressed upwards towards NHS policy-makers and arguably an instance of accountability for mental health service failures being directed upwards also. For example, concern was expressed in one case about the clarity of NHS policies and clinical governance processes:

> Concern has been expressed by staff about…the Trust reconfiguring its clinical services into service lines. The Trust should have clear governance processes in place to ensure that clinical care is not compromised as an outcome of reconfiguration.46

Themes relating to organisational and cultural upheaval at the time care was being provided was evident in other cases too:

> [a] culture of flux in staff members, ambiguity over boundary issues and changing nursing management styles affected and impacted on the environment.47

The above IHI finding was subsequently translated into post-decisional regret:

> Patients with the forensic and complex history of Mr R, with known challenging behaviours, should not have been delegated to the care of inexperienced staff from outside of the service.48

Issues relating to time therefore appeared to intensify post-decisional regret for the IHI. Identifying the underlying causes to the fatal outcome was noticeably more difficult due to the evolving structure of the NHS Trust, particularly the time taken for it to evolve updated policies that were conducive to the provision of care on the ground.

This supports the claim advanced in Chapter 4 that time is best understood within a systems theory framework; if mental health care consists of many social subsystems that construct different meanings of time, then the finding above demonstrates that certain features of NHS Trusts (such as policy development) evolve at a different rate inside agendas that are not

46 External Investigation into the Case of Mr F, op.cit., p 13.
48 Ibid., p 37.
conducive to the provision of care. As will later be discussed, this apparent intensification of post-decisional regret is somewhat related to the finding that the entire study was never able to identify a single, direct cause of the fatal outcome. This was due to the sheer scope of post-decisional regret expressed in each case and the compounding factor of correlating the conduct and decision making of professionals with operationally-closed legal, policy and psychiatric communications.

Following on from the law and policy emphasis IHIs base their expression of post-decisional regret on, each case gave considerable attention to how previous investigations fared when fashioning expressions of it. One case found a lack of effective systems for section 117 leave being in place during the patient’s care, although this appeared “not to have been recognised until 2005, after the publication of an initial investigation report into a homicide by Richard King in 2004. This was some four years after the MHSU was transferred…”. Previous IHI investigations therefore carried a clear potential to procure an awareness of certain risks that could not have been recognised at the time care was provided. References to separate IHI investigations that had already been concluded were, admittedly, extremely rare throughout the study. There was nevertheless a commitment by each case to refer back to previous investigations conducted internally by the NHS Trust.

HSG(94)27 stipulates that in the event of a homicide, local investigation processes must begin as soon as possible and that an internal investigation should take place. The main rationale for this policy is that the longer time elapses, the less likely an investigation can precisely locate the possible causes of the homicide. The issue of time is once again important to the concept of post-decisional regret here because the constant flow of communications in the present will have effects that obscure the effects of communications and decisions prior in time; in other words, IHIs embody the risk that the passage of time between the fatal event and the commencement of an IHI will obfuscate the ability of the latter to precisely locate causes. Needless to say, the

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49 See R. Nobles and D. Schiff, *Observing Law Through Systems Theory* (London: Hart Publishing, 2012), p 132: “[F]or if a system’s reactions to its environments take time, and its environment is not stable, then the difficulties of having a stable relationship with its environment are increased by the time taken for its operations, namely the time it takes to construct and reconstruct its reactions”.


51 See N. Luhmann, *Risk: A Sociological Theory*, op.cit., p 118. “Causality, however, is a schema of primary observation, embedded in an infinity of further causes and further effects. The further the time horizon retreats, the more comes into sight”.
present thesis advances the claim that the obfuscation of causes and the effects of decisions already occurs at the level of the investigation. IHI Panels must consider the prospect that exploring the accumulation of these decisions and their effects will yield indeterminate conclusions and more specifically a weaker basis for setting recommendations about how mental health services are to be provided going into the future. In short, the passage of time intensifies the dilemmas facing an IHI at the recommendation stage.

This somewhat reflects the willingness of the IHI to regretfully admonish its own processes, procedures and ultimately their own findings. For instance, the IHIs reviewed commonly questioned their own capabilities, particularly when it came to avoiding hindsight bias:

It is not difficult to be influenced by the incident that occurred on 24 November 2006, when commenting on the overall quality of the risk management and relapse prevention plans documented in the AOT records. However this would be to introduce hindsight bias and this is not reasonable.\(^{52}\)

The awareness that hindsight bias was a potential ‘threat’ to the integrity of the investigation was evident in a series of cases.\(^{53}\) Some Reports nevertheless willingly engaged in such bias as way of expressing post-decisional regret about the case:

With hindsight, it might have been beneficial for those involved (probation, police, GP, mental health services) to convene a case conference to agree joint handling strategies.\(^{54}\)

\(^{52}\) M. Dineen, A. Maden, J. Chase and S. Smith, op.cit., p 47.


\(^{54}\) B. Ward and C. Brougham, op.cit., p 45.
Chapter 6 – Investigating Homicide

The willingness of IHI to admonish not only the decisions of mental health professionals and the NHS Trust but its own judgements regarding how the fatal outcome came to pass confirms that decision making in these contexts is intrinsically uncertain.

The IHI sampled subjected internal reports to sizeable scrutiny; a significant majority of Reports sampled were critical of the Trust’s internal report and findings:

The process for carrying out the review was not managed in a timely and effective manner, this led to the report taking eleven months to complete which had a detrimental impact of the learning from this incident.\(^{55}\)

Other reasons for expressing post-decisional regret towards the NHS Trust’s internal investigation ranged from inadequate expertise on the part of the authors to the omission of factors that the IHI felt could have led to more clarity about the care provided:

The level 2 (internal investigation) did not examine compliance with local and national policies in any detail. Therefore, there was limited evidence of scrutiny of the application of contemporary guidelines, policies and procedures.\(^{56}\)

The regret expressed towards the internal investigation extended to the lack of documentation provided to the IHI:

The letters inviting staff to interviews by the internal investigation team were not included in the documents that accompanied the report so it was not possible to comment on their content and approach.\(^{57}\)

This is despite evidence acknowledged in the same Report that the process appeared to be open:

The interviewees we saw who had taken part in the internal investigation felt that the process was open and transparent.\(^{58}\)

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\(^{55}\) *External Investigation into the Case of Mr F*, op.cit., p 27.

\(^{56}\) A. Thompson, N. Georgiou and D. Ndegwa, op.cit., p 23.

\(^{57}\) Ibid., p 21.

\(^{58}\) Ibid.
The overwhelming tendency to criticise previous decisions by the NHS Trust in this way confirms again that post-decisional regret exists at many levels of an IHI investigation. Not only are the decisions of mental health professionals subject to scrutiny and regret, but also the decisions taken by the NHS Trust regarding its internal response to the homicide.

6.5 Risk and the Concept of Time

The previous section touched upon the importance of analysing time in the context of decisions being made in a continuous flow. Time is composed of decisions and their effects, founded on communications, which form the fabric of time. The argument advanced by this thesis is that the flow of time obfuscates the effects of past mental health decisions, thus challenging the IHIs ability to meaningfully extract direct causality between mental health care decisions, their effects and especially between those decisions and the homicide. Time is important in other ways also. The study was particularly memorable for its detailed chronologies of the patient’s care. These consisted of a sequence of dates (starting from when the patient first came to the attention of mental health services) to the date of the homicide. As a universal way of describing time, chronology offers an unremarkable look into how the mental health care system ‘moves’ to a series of dates. As discussed in Chapter 4, social systems can be conceptualised as ‘moving’ according to a series of dates. There is a sequence.

Every Report created chronologies of care that appeared in sequential order. This is a feature which Luhmann describes as something organisations do in their decision making processes as a way of maintaining coordination. Luhmann however insisted that a concept of time required meaning, produced through communication. In other words, chronologies must be filled with meaningful content to be of any workable relevance to social systems of communication. IHIs exhibit this characteristic. Like courts of law, IHIs delineate significant dates of interest and conduct their investigation around them. In locating dates of interest, IHIs simultaneously locate meaning in those dates. For instance, their chronologies of time always begin at the moment when the patient first made contact with mental health services, with every individual contact thereafter being placed at its relevant point on the timeline.

The patient’s contact with mental health services is a meaningful communication about time. These contacts are realisable as contacts by virtue of the clinical relationship between the patient and mental health services, which requires meaningful psychiatric communication. This also renders time meaningful because it is filled with communicative content to render it realisable. This is consistent with the social concept of time developed in Chapter 4; the meaning and significance of certain events relating to the mental health of the patient was what made time (from the point of view of the IHI Panel) meaningful:

The terms of reference for this investigation were to…produce a comprehensive chronology of the contacts between Mr G and the health and social care agencies and other appropriate agencies from the date of his first contact with the NHS in 1991.  

This is representative of all the IHI Reports reviewed for this chapter. Each case began their investigations from the point in time that the patient first came into contact with mental health services. This demonstrates that in addition to their being a chronological movement to each case, this chronology was accompanied by a series of events that are meaningful to the social system of psychiatry.

Given that IHI Panels consist of mental health professionals who utilise communications specifically at the level of their expertise (psychiatric, nursing, social work and so on), it is understandable that time is rendered meaningful pursuant to that expertise. On the one hand, what the criminal law judged to have triggered a fatal incident was somewhat different from the IHI’s judgment:

His Honour Judge Cottie, at the trial of Mr A.T., concluded that while Mr A.T. was suffering from a mental illness at the time he killed Miss S it was “the excessive consumption of alcohol” which triggered his violent behaviour.  

The IHI preferred an interpretation of the past that considered the need to consider communication and intervention at critical points during the provision of care. The excessive

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consumption of alcohol, whilst acknowledged by the IHI Panel, took on a different significance when compared to what was judged at the criminal trial:

She [the patient’s mother] complained that no-one spoke to her or sought her understanding of her son. Had they done so it is possible that those clinicians dealing with Mr AT might have conceptualised his behaviour differently and considered a different pattern of assessment and intervention.62

The patient in the above case was convicted of murder, the rules of which allow for a relatively simplistic version of causality; responsibility for the fatal incident does not extend beyond the perpetrator. IHIs however attribute a different meaning of causality to the homicide event due to their construction of time using the social systems of communication at their disposal.

Causal attribution in IHI cases is informed by past mental health care activity, investigatory techniques, law and policy factors. The individual actions of the patient on the fateful day are not a prominent part of the IHIs focus. What is more, the study appeared to create a version of the past that those mental health professionals responsible for taking decisions about the patient could not have possibly been aware of. It is therefore demonstrable that in reaching its findings, IHIs take a far more dense, rich and complex version of the past than, say, courts of law. This supports the argument that IHIs, using a bundle of operationally-closed communications, similarly construct operationally-closed versions of time that, to some outsiders to the process at least, will appear artificial and alien. After all, these communications define the premises upon which they deal with a particular case and will place the investigation on a highly distinct trajectory:

[t]he Trust witnesses expressed their belief that the death of the victim on 30 December 2006 was not a result of the service-user’s mental health and this appears to be borne out by the nature of the conviction and sentence that the service-user received for this crime…however the investigation team does believe from reviewing the evidence that the Trust could have engaged in a more proactive therapeutic alliance, which would have better captured the risks associated with the service-user’s mental health and substance misuse problems.63

62 Ibid.
63 M. Clay, S. Adams, V. Bridges, S. Callens, P. Menon and M. Suett, op.cit., p xi,
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Another case referred to the way in which the faulty manner in which section 117 leave was administered by mental health professionals was only ever realisable at least four years later when a separate IHI was concluded highlighting similar failings. This supports the view that previous IHI investigations have the potential to render the past meaningful for present IHI investigations and expose risks that were not recognisable at the time.

More generally, it confirms that IHIs create their own version of the past in order to carry out a meaningful investigation. In a similar vein, there were instances in the study where during the period of time care was being provided, the NHS Trust was undergoing changes in policy that impacted on the quality of care provided. This covered aspects of care before and after the fatal incident:

> It would be important to seek assurance that any new governance system takes account of any current outstanding action plan with regard to ongoing monitoring and compliance.

This visible concern regarding the need for new governance systems to respond to current action plans is indicative of the theoretical arguments posited in Chapter 4 regarding the concept of time. Time can be understood to be specific to different aspects of the mental health care system and that these require time in order to react to existing stimuli in the environment. Current action plans are a typical case in point.

Other issues identified by IHIs included the ongoing changes and improvements in the way care systems, processes and policies were carried out since the failings were identified. Ongoing changes in NHS Trust structure during the IHI investigation were also a relevant concern, in this respect. What follows is the impression that the mental health care system is not

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static. Consistent with themes in Chapter 3, IHI investigations appear to grapple with a constantly shifting peninsula of NHS Trust strategies, policies and ways of doing things:

It is recognized that prior to 2008 monitoring and performance were not well developed and varied across the PCT areas. Since then work has been done to improve the contract performance arrangements through the introduction of monthly meetings held with the provider Trust.

IHI’s moreover often depict themselves as observers of moving targets. Whilst on the one hand they attempt to locate the causes of the fatal incident, they are nonetheless burdened with evidence that the NHS Trust was in a constant state of flux during the period of time care was being received. The shifting circumstances surrounding of a homicide event cannot be scrutinised in the same way that a scientific experiment in a laboratory can be conducted.

On the other hand, instances where responses to the introduction of new concepts were slow to emerge also confirmed the systems theory-based view that in order for social systems to exist as systems, they need time to react to their environment:

Safeguarding was a new concept in teams at the time of the homicide and was not yet embedded in team culture. The safeguarding lead said: “I think possibly nationally and not just within ourselves, I don’t think people fully appreciated and valued the identification of safeguarding from an adult perspective”.

The mental health professionals in the above instance clearly had not reacted appropriately to the introduction of new concepts into the corpus of care, thus creating problems in care that depended on an effective uptake of such concepts. Again, this confirms the systems-theoretical insights expressed in Chapter 4 regarding the concept of time; the very notion of a social system needs time, for the difference between a system and its environment is made up of the time it takes for a system to respond to environmental stimuli. If social systems were able to react immediately to such stimuli, they would be indistinguishable from their environment and thus not

68 Supra. 3.3.2
exist. A simultaneous, point-for-point correlation between a social system and its environment negates the very notion that a social system is in existence.

These points also confirm that aspects of mental health care, law and policy are not synchronized temporally. Luhmann offered a concept of time that disconnects it from mere chronology. He argues that social systems address time not only sequentially but also structurally, using their communications. In other words, meaning is produced about certain events amenable to that system’s code. A frame of the past is constructed that looks different from one social subsystem to the next. It is therefore feasible to envisage why NHS policies might be ‘out of kilter’ with practices on the ground. ‘Irritations’ to the provision of care, such as the introduction of new concepts contained in policy documents, must take time to achieve meaningful resonance. What is more, there is no guarantee that this resonance will be achieved in the way that the policy maker intended. This miscorrelation of time visible in the Reports arguably intensifies post-decisional regret for the IHI, for it represents yet another possible cause of mental health homicide alongside a host of others that compete for attention.

6.5.1 The Complexity of Time in IHI Investigations

IHI investigations appear burdened when they involve long, dense periods of care and treatment in multiple geographical locations:

This has been a complex case to analyse. It has involved conducting a comprehensive investigation into the care and treatment that Mr. X received from three statutory health service providers over a seven-year period...Two main issues provided a consistent challenge to the work of the Independent Investigation Team, the first being the passage of time which hindered the recollection of clinical witnesses, and the second being the poor standard of the information available within the clinical record.

The above IHI investigation ran to 333 pages, making it the largest IHI Report within the study. The sheer scale of care provided, together with all the various policies and decisions that were

71 Luhmann, N, ‘The Future Cannot Begin: Temporal Structures in Modern Society’ 43(1) (1976) Social Research 130 at 135. “[W]e may have several times and one integrating chronology”.
72 A. Johnstone, Independent Investigation into the Care and Treatment of Mr X by the Lincolnshire Partnership NHS Foundation Trust and the Avon and Wiltshire Mental Health Partnership NHS Trust, NHS South West SHA and East Midlands SHA, Health and Social Care Advisory Service (undated), p 15.
made over the 7-year period, made for a document-heavy investigation. It conjectured thoroughly about what could have been done differently in the circumstances. This is a testament to Luhmann’s argument that the attribution of risks to decisions necessitates an increasingly complex range of casual attributions the further one looks back into the past.\footnote{N. Luhmann, *Risk: A Sociological Theory*, op.cit., p 118. “The further the time horizon retreats, the more comes into sight”}.

Despite this extreme complexity, IHI’s do find ways to conclude their investigations and finalise their Reports with findings and recommendations. Under the theoretical framework outlined in this thesis hitherto, particularly in Chapter 3, IHI’s manage this complexity by referring to communications made within social systems, namely, previous medical communications about the patient, previous findings of the NHS Trust’s internal investigation, existing NHS Trust policy and legal communications relating to the requirements of legislation. Luhmann’s claim that the reduction of complexity leads to greater complexity is nonetheless very apparent here. Communicating about the past provision of mental health care simply generates discourse that ossifies the autonomy of the mental health care system *vis-à-vis* its environment (other social systems). This, in turn, arguably renders the effects of decisions more contingent and unpredictable. Those decisional effects are, after all, germinated in a functionally differentiated social system. They will inevitably clash with the effects of other decisions, thus producing unpredictable effects and combinations further on in time. A continuation of dilemmas in the present, objection and heightened regret is therefore more likely. Paradoxically, further decision making would be required to address these outcomes.

What is more, despite previous IHI findings providing clues to previously unrecognised risks (as was demonstrated in one particular case cited above, which identified the Richard King inquiry as a source of learning)\footnote{See M. Dineen, K. O’Neill-Byrne, M. Thomas and R. McLean, op.cit., p 79. See generally Lady Wall, M. Tanner, S. Champion and G. Williams, ‘Looking Through the Reeds’: The Report of the Independent Inquiry into the Care and Treatment of Richard King, NHS East of England SHA (June 2008).}, the sheer scope for causal attribution in these cases is great. The apparent contingency of decisions, expressed through post-decisional regret, is palpable throughout each Report and throws up a range of possible causes of a homicide. To base a set of recommendations on such findings with a view to generating improvements to mental health care provision is arguably a difficult task. What is more, this task is performed against a background of passing time where other social systems of communication (law, politics and the media, for
example) respond to an external environment.\(^{75}\) This complicates the search for causality due to the lack of temporal synchronization between different parts of the mental health care system. IHI Panels clearly do acknowledge the shifting ‘tectonic plates’ of mental health care, but in a way that is perhaps much narrower than what this thesis has identified. IHIs remain resolute in their ability to reveal the causes of a homicide and to construct a set of recommendations that can solve the perceived problems identified. A concern of this thesis however is that, given the contingency of decision making and the scope for uncertainty, constructing recommendations that facilitate the making of equally contingent decisions is quite a risky (and unavoidable) exercise to engage in.

### 6.6 Establishing Causality in ‘the System’

Within the IHI Reports reviewed, attempts at establishing causality were made using various means. This included reviewing statistical trends,\(^{76}\) conducting surveys\(^{77}\) and exploring historical evolutions in NHS Trust organisation. Even more crucial was the sample’s reliance on RCA. RCA was explained in Chapter 2, so there is no need to discuss it at length here. Briefly, RCA is an exploratory technique. It facilitates better understandings of what causes identified problems. The main purpose of RCA is to identify the ‘root’ of the problem and extract it so that the problem does not ‘grow back’. This is carried out using ‘human factor taxonomies’ that incorporate a range of headings.\(^{78}\) It is useful for highlighting areas of concern that are often attributed as a ‘cause’ of the adverse event. These causes consist of categories. The main two most commonly found in the study were ‘root’ and ‘contributory’ causes, with the latter outnumbering the former considerably.

It has already been advanced by this thesis that IHIs face the difficult task of ascertaining causal links in decision making when investigating mental health homicides. IHIs utilise operationally-closed communications, which in turn facilitate the construction of distinct complexions of time throughout a series of accountability relationships. These relationships yield

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\(^{75}\) R. Nobles and D. Schiff, op.cit., p 132: “For something to have internal reactions to an external environment takes time”.


\(^{78}\) Patient, individual practitioner/staff member, workforce and team issues, environmental and equipment issues, task and process, organizational issues and external stakeholder/legislative issues (see Consequence UK, ‘Root Cause Analysis (RCA) – what is it?’, http://www.consequence.org.uk/root-cause-analysis/ (accessed 20 August 2013)).
information that lead to the accumulation of different possibilities and contingencies about the link decisions have with their effects and ultimately the fatal event. Despite this, being aware of the causal relationships in cases is crucial for RCA investigators. Fishbone diagrams can be used as part of RCA to identify contributory factors also. These were seldom used in the sample however, with only two Reports incorporating this feature.\(^{79}\) RCA in general was however important to the sample’s search for causal links. But if it is accepted that post-decisional regret is a fact of life for IHIs and that the scope of their investigations are wide ranging, can causal relations be genuinely established amongst such complexity? And if not, what implications does this have for existing concepts of accountability?

6.6.1 Holding Identifiable Figures to Account

On the surface, IHIs mirror a ‘core’ concept of accountability\(^{80}\):

> Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice.\(^{81}\)

The process of calling to account is somewhat formalised in IHIs, involving the dissemination of ‘Salmon Letters’. This requires that IHIs notify those who it intends to interview by a formal letter outlining what the IHI process consists of and what those being asked to render accounts should expect from the process. Core accountability is clearly present. The forum (the IHI Panel) is clearly positioned as a questioner of those who interests it. In fact, there is perhaps a case for advancing a ‘purer’, more nuanced form of accountability that was not immediately obvious from the discussion conducted in Chapter 5. Not only does the process consist of a forum before which individuals provide accounts and answer questions, there is also a preparatory stage in which those called to account are given information about the IHI process and what is expected. This component of ‘pre-knowledge’ arguably makes for a more dynamic interaction that accountability theorists should take more seriously. Despite being beyond the scope of this thesis,

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\(^{80}\) Supra., 4.1.

\(^{81}\) J. Hall, R. Amin, A. Watson and T. Coldham, op.cit., p 4.
it is arguable that this aspect of accountability will ultimately influence the way in which an accountability relationship will play out.

The nuances of accountability appear not to end there. Not only are individuals identified as a focus of accountability in IHI Reports, the latter fully acknowledge the NHS Trust ‘body’ also:

Clinical governance is the system through which NHS organizations are accountable for continuously improving the quality of their services.\(^82\)

The IHI is an external body which mental health professionals (as ‘individuals’)\(^83\) or NHS Trusts (as ‘bodies’) must render an account to. This involves social interaction and exchange in interview with a series of questions which mental health professionals are expected to answer.\(^84\)

Every IHI investigation reviewed involved interviews with a range of protagonists to this end and contains most of the essential ingredients of ‘core accountability’, but with further characteristics not contained inside the core definition. For instance, IHIs are furthermore steered by a specific concept of time when demarcating the boundaries of accountability for mental health professionals. It was argued earlier that IHIs formulate very specific versions of the past that are unique to the mental health care system. As part of this, IHIs also make clear when accountability begins:

It is essential that all crisis resolution and home treatment MHPs understand that their accountability and responsibility for a service user commences at the point they make the decision to accept this service user for home treatment.\(^85\)

Accountability therefore is dependent on the meaning of time that IHI Panels use to make sense of the evidence.

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\(^82\) H. Waldock, L. Chenery and A. Irons, op.cit., p 105.
\(^83\) Systems theory would call for ‘persons’ to be regarded as physical bodies that are given shape by the social system of mental health care.
\(^84\) See R. Mulgan, op.cit., at 555.
There is thus scope to argue that the concepts of time and accountability are linked. If the theoretical framework of this thesis is taken seriously, accountability can only be established if those who are questioned are questioned about past events which have a particular meaning for the forum. That meaning, whether it is a psychiatric, legal or scientific meaning for the purposes for RCA, can only be produced using communications.

6.6.2 Accountability and Sanctions

The inapplicability of a ‘core’ concept of accountability becomes even more apparent on the issue of sanctions. This was discussed in Chapter 5. Briefly, core accountability requires “rights of authority, in that those calling for an account are asserting rights of superior authority over those who are accountable, including the rights to demand answers and to impose sanctions”. 86 This aspect of core accountability – the implementation of sanctions - is absent in IHI proceedings. This was confirmed almost explicitly by one case, it commenting that “[t]his investigation was not a disciplinary process”. 87 IHI Panels nevertheless attempt to balance “individual accountability with criticism of organisational systems and processes”, 88 although it is difficult to see this balance being struck in the study; the sample of Reports selected were overrun with conclusions about the failure of systems and processes as opposed to individual error.

Although avoiding blame and recrimination is central to the work of an IHI Panel, they are willing to criticise if pushed. It is arguable that criticism is a form of sanction. If it is accepted that accountability can be formal and informal, it may also be argued that sanctions too can be formal and informal. Criticisms of professionals by IHIs appears to be a type of informal sanction, but potentially serious nonetheless. As discussed in Chapter 2 and 3, IHIs have long been feared by professionals on the basis that they can have a ‘name and shame’ effect on those who become the focus of criticism. What is more, whilst IHIs hold professionals to account, the scale and density of accountability relationships as a whole do not facilitate determinate and conclusive investigations in any fundamental sense.

88 Ibid., p 4.
The accountability relationships established are instead better understood as a platform for wider attributions of causality to be made towards the NHS Trust generally. The interconnections between the decisions of mental health professionals do not yield answers that point to individual causes, especially if an IHI conducts many accountability conversations that contain considerable post-decisional regret. Not one Report concluded that there was a single, direct cause to the homicide. Eight IHIs came close to inferring a direct link. One IHI Report remarked that:

The death of Mr Raynor on 24 May may not have occurred had the decisions and actions of the clinical team been different between 5 and 24 May. However, preventability of his death is by no means certain.

In the above case, the IHI Panel was able to identify a cluster of decisions as being causative of the fatal event. It was nevertheless the case that identifying a single, linear cause of the homicide was not possible. The causative links made by these eight cases were characterised generally as emanating from the general care provided or groups of decisions made at a certain point in time. In this sense, there was a tendency to identify an accumulation of causes as being the precipitator of the homicide.

In addition to these more nuanced features of a concept of accountability, IHIs also exhibit other extended forms of accountability that apply “to various methods of imposing control over public organizations”. To reiterate a theme from Chapter 2, control is a theme close to systems theory. Social systems seek to exert control over a chaotic environment through their operations. In the context of IHIs, mental health professionals and NHS Trust officials are clearly expected to answer questions, explain their past decisions and accept the consequences. This holding to account however sets the stage for the implementation of methods that seek to exert

91 R. Mulgan, op.cit., at 563.
92 Supra. 2.4.
control of different areas of mental health services. The use of audit, which commonly featured in many recommendations advanced by the IHI Reports reviewed, is a primary example:

The trust should continue to audit compliance with its observation policy and provide evidence of the audit outcomes to its lead commissioners.  

Instigating and determining the content of ongoing reviews of systems, processes, policies and caseloads was also a form of control that IHIs oriented towards in their recommendations to the NHS Trust.

The Trust should ensure that any further internal review must take account of all those involved in the patient’s care.

The role audit plays in being an explicit calling to account of public officials is rather clear in the cases. This nevertheless represents a shifting sand of accountability within IHI processes. It begins with mental health professionals at the earlier stages of an investigation but ends with a focus on the NHS Trust.

When it comes to tracing the contours of accountability in IHI processes, it certainly reveals a chameleon–like quality. This is understandable if IHI findings are indeterminate and complex. In light of this complexity, a meaningful link between the deficiencies of the past and the future-oriented remedies of the present (recommendations) must be made or else the purpose of the IHI becomes illogical. This meaningful link requires an abstraction of accountability away from the individual and towards the larger monolith of the NHS Trust.

### 6.6.3 Accountability and Causality

The theme of this section is to depict a situation of IHI processes involving many different constructs of the mental health care system (mental health professionals, NHS Trust officials and

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94 P. Shirley op.cit., p 7.

so on) that are each ‘held to account’ with a formalized, ‘core’ type of accountability at its heart. The lack of formal sanctioning power characteristic of IHIs, in combination with the apparent layering of accountability relationships that ‘build-up’ during the investigative process, appears to create a complex picture of causality that existing concepts fail to appreciate. The sheer scale of post-decisional regret expressed during the process is also a testament to the way holding decision makers and bodies to account contains much objection about the way decisions were made and whether events could have turned out differently. The present thesis posits that existing concepts of accountability fail to acknowledge this characteristic. The thesis seeks to develop a fuller concept of accountability that explains how holding ‘persons’ and ‘bodies’ to account can create causal complexity, resulting in a loss of human agency.

The aims of an IHI are to learn lessons from homicide events by highlighting aspects of care that were directly causative, or contributed to, their occurrence. Luhmann posited that the accumulation of effects produced by decisions in social systems prevent the pin-pointing of individual decision makers as causative. He remarks that “[a] given threshold being passed, an irreversible shift in ecological balance or the occurrence of a disaster is often not attributable to any particular individual decisions [sic].” 96 “Decision trees” emerge, creating conditions that “actuate losses without being attributable to decisions”. 97

It was also the responsibility of the Independent Investigation Team to determine whether a broad range of independent clinical opinion was required than that contained within the Independent Investigation Team to enable a proper consideration of what a reasonable group of similarly qualified clinicians would have done in similar circumstances. This is what the National Patient Safety Agency (NPSA) refers to as the “substitution test” in its incident decision tree. 98

Interestingly, the NPSA incident decision tree “aims to help the NHS move away from attributing blame and instead find the cause when things go wrong. The goal is to promote fair and

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97 Ibid. Luhmann cites the example of the decision to start car engines and the effects of car exhaust fumes. He contends that “it would not be possible to classify starting up a car engine as a risky decision”. This is because the conditions of loss in Luhmann’s example are created by “a vast accumulation of decisions” as opposed to an isolated instance of decision making.
consistent staff treatment within and between healthcare organisations”. Even in those cases where there was no express reference to the NPSA incident decision tree, every case built up a number of causative factors that mirrored the level of decisional activity associated with the case.

For instance, Independent Investigation into the Care and Treatment of Mr X involved an extensive investigation spanning many years and across different health authorities. The sheer volume of decisions made relating to the patient, together with the accumulation of evidence before the IHI Panel, made for an indubitably complex case. Many lines of decision making were reviewed and many accountability relationships were established during the IHI process. Within these relationships, considerable light was thrown on how decisions could have been taken differently. Events were scrutinised for their controllability. The Report, running to 333 pages, reflected the sheer magnitude of the care decision chain surrounding the patient. There are clear parallels here with Luhmann’s claim that individuals in systems do not exert control or have effects which are recognisable. Writing on adverse events generally, he remarks that “it is clear that without decisions having been made such detrimental effects would never have occurred”. Luhmann furthermore writes that the inability to identify individuals as causative forces is bound to occur in any walk of life, which is understandable if his fundamental tenet that individuals cannot communicate is taken into account.

Not one case in the sample however was able to locate an identifiable figure who could be ‘blamed’ for the fatal outcome. A collection of disparate causes were instead identified that varied from case to case:

The themes we have identified are those that had a direct bearing on Mr G’s profile. We identify several missed opportunities that would have provided a more systematic and organized approach to Mr G’s care and treatment.

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100 A. Johnstone, op.cit.
101 N. Luhmann, Risk: A Sociological Theory, op.cit., p 26. Luhmann argues that it is possible to invent a decision so that it can be attributed to the damage caused, for example the decision not to prohibit the use of cars.
102 Ibid., p 120.
Some cases were unable to identify any root causes. Some identified only contributory causes, such as poor risk assessment and clinical management. Other cases highlighted both root and contributory causes. Even where individual factors emerged as relevant, this related to giving staff improved access to training and supervision. Individuals were in no circumstances judged to be causative forces within the network of care that led to the eventual outcome. Some cases appeared more ambiguous in their descriptions of how “sub optimal processes” consisting of organisational factors, patient factors, communication factors, education factors, working conditions, team and social factors and also individual factors would cut across the service that was provided. Other cases were similar, citing no root causes but “a combination of proximal factors”:

The IIT does not believe there was any specific, single, “root causes” …However, there were a range of factors that the IIT believes were significant in influencing the way in which the MHPs conducted their assessment. These included a combination of proximal factors, i.e. those directly relating to the individual practitioners involved, and system factors, i.e. those relating to the systems and processes designed to deliver a consistently high service in the CRHT.

What this shows is that even where the IHI Panel might have been of the opinion that individuals were causative in some way, it was impossible to divorce their actions from the system that surrounded the patient. The reliance on there being “proximal factors” relating both to individual and system that combined with each other appeared to provide a convenient ‘catch-all’ concept for the IHI. This thesis argues that it also represents a ‘coming to terms’ with the considerable

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105 H. Waldock, L. Rowland, A. Johnstone, I. Allured, op.cit., p 10 (policy and system changes); M. Dineen, M. Clarke, J. Liversley and M. Jackson, op.cit., p 18 (staff attrition); M. Dineen, M. Devlin, M. Foster and M. Potter, op.cit., p 28 (survey conducted in other Trusts to gauge attitudes towards duty of confidentiality); P. Shirley, op.cit., pp 24 and 31 (the IHI found the geographical areas of GP and WCC to be disjointed, creating gaps in care and communication); M. Dineen, J. Nixon, T. Jolley and J. Lawrence, op.cit., p 50 (Trust financial concerns); A. Thompson, N. Georgiou and D. Ndegwa, op.cit., pp 25, 26, 30, 44, 50, 52, 58, 61 and 65 (resource and budget constraints); G. Roberts, N. Moor, C. Gaskell and S. Mikhail, NHS London SHA, pp 23 and 24 (staff attrition); T. Hussain, E. Ewart and R. Ramsay, op.cit., p 34 (unknown electronic record anomalies); External Investigation into the Case of Mr F, op.cit., pp 9, 55 and 58 (Trust financial constraints).
107 P. Shirley, op.cit pp 5, 27 and 29.
causative complexity inhered in each case. In other words, forging a meaningful way forward meant abstracting away from the notion that individuals had a direct causative ‘hand’ in the fatal event.

A linear pathway of causality was indeed something the sample was not adept at establishing.\textsuperscript{111} In one case, the IHI remarked that:

> In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the care and treatment that a service user receives and a subsequent homicide perpetrated by them.\textsuperscript{112}

Of interest is the way in which IHI Reports would acknowledge the difficulty in establishing causality by expressing post-decisional regret about what could have been done that was not done. In \textit{Norfolk and Waveney Mental Health Partnership NHS Trust}, a number of managers in interview confirmed that there was a lack of effective systems and processes in the locality in general.\textsuperscript{113} Similarly in the \textit{Y} case, breakdowns in joint-working culture were considered to have been a main causative factor in the homicide. Similar issues emerged in at least seven other cases sampled.\textsuperscript{114} One case found that a disjointed picture of organisational, practice, policy, procedural, environmental and individual issues all contributed to the failures in care.\textsuperscript{115} Even instances of

\textsuperscript{111} See also L. Wilson and S. Wicks, op.cit., p 6. The IHI concluded that JMcF required additional therapy, but the ambiguity surrounding his condition and the additional expertise this required exacerbated the fear of breaching confidentiality; there was staff reluctance to share information with additional parties (in the \textit{JMcF} case the additional party was a private therapist) for fear of breaching confidentiality. This fear – an unintended consequence of the legal framework – was arguably correlative to the degree of involvement of different professional parties; M. Dineen, M. Clarke, J. Liversley and M. Jackson, op.cit., p 5. The IHI in \textit{AL} (P. Shirley, op.cit., p 24) found that communication between the mental health, police and court liaison services broke down, leading to a consequent deterioration in the patient’s care. In the \textit{AL} report the complexity of care was found to be rooted in the violent temperament of the patient, which received attention from the GP, mental health services, the Police and housing authorities. Relevant information was found to be freely shared between mental health staff, but it was not released to the aforementioned parties.

\textsuperscript{112} P. Shirley, op.cit., p 65.

\textsuperscript{113} M. Dineen, K. O’Neill-Byrne, M. Thomas and R. McLean op.cit., p 64.


\textsuperscript{115} T. Hussain, E. Ewart and R. Ramsay, op.cit., p 54.
‘capture’ were reported by IHIs.\textsuperscript{116} Those holding social care roles, interviewed during the process, appeared to have become “distilled into all things pertaining to Mental Health Act(s) generally”.\textsuperscript{117} Holding diverse mental health professionals to account appeared to throw up problems about what roles they were fulfilling. What follows is that the interaction and exchange between IHI investigators and those they hold to account appeared to lead to more questions than answers:

> it was the understanding of CPN-A2 that section 117 after-care was the responsibility of social care not healthcare. This also contributed to the lack of awareness of the need for the care coordinator to ensure that the section 117 meetings continued until such time as the MHSU was discharged from section 117. This was a significant weakness in the systems and processes operating in the Trust at the time.\textsuperscript{118}

The accountability process in IHI investigations therefore appears to involve a level of exchange and interaction that is not straightforward or linear.

The activities of mental health professionals were furthermore put under the monocle of scrutiny as a result of issues raised by other interviewees inside other accountability relationships. The progression of the ‘5 Why’s’ model by the IHI Panel (see Fig. 1) clearly reveals how after each question, a new figure of accountability comes into view. The Care Coordinator is initially implicated but this soon is converted into an issue about training, which the NHS Trust is ultimately accountable for. As discussed in Chapter 3 and 5, recommendations are the principal vehicle through which NHS Trusts are held to account. More specifically, many IHIs secure ongoing accountability by requiring NHS Trusts to implement recommendations according to a series of deadlines.\textsuperscript{119}


\textsuperscript{117} T. Hussain, E. Ewart and R. Ramsay, op.cit., p 54

\textsuperscript{118} Ibid., p 64.

\textsuperscript{119} See Fig.1 below.
CPA assessments did not include the views of all appropriate stakeholders (particularly the carers)

**WHY?**

CC1 did not invite key stakeholders to CPA review meeting

**WHY?**

Lack of understanding about importance of multidisciplinary input into service-user care planning

**WHY?**

Lack of CPA training & competency assessment (ROOT CAUSE)

Inadequate supervision

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**Fig. 1**

Accountability relationships, in their chameleon-like character, appeared to connect to each other at various times through the entire IHI process and potentially present conflicting versions about the past. This undoubtedly intensifies causal attribution and post-decisional regret. Account-renderings reveal information about what was understood at the time and what was expected from others. What is more, this creates the impression of an overall weakness in the system, as opposed to the failing of just one individual. The accountability process is therefore undercut with revelations that engulf the IHI investigation in a haze of interfaces between different actors. These interfaces are ‘revealed’, in the sense that they were not ‘visible’ at the time care was being provided:

> [t]his issue [the little emphasis on mainstream social work by the Trust] is in our minds indicative of the systemic relationship and cultural difficulties in the interface between health and social care : i.e., between Mental Health Trust and the Local Authority. The section 75 agreement for partnership

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appears to have been a historic document made for pragmatic and legal purposes rather than a living and dynamic relationship. Once Local Authority staff members were seconded into the Trust a new routine was established whereupon, to our minds, two damaging cultural constructs developed over time.\textsuperscript{121}

Other cases similarly stressed problems with interfacing health and social care services as opposed to individuals acting alone.\textsuperscript{122} The causative factors identified by the sample were overwhelmingly systemic or cultural. Individuals were virtually non-existent,\textsuperscript{123} supporting the thesis that human agency is absent in IHI investigations. Decisions clearly matter, for without them there would be no cases to investigate. But individual decisions apparently do not, pursuant to the findings of this chapter. IHI findings appear oriented towards the ‘bigger picture’. The ‘bigger picture’ is seemingly the only picture that is visible to the IHI Panel. The sample’s apparent ignorance of individuals exerting effects in mental health care cases even extended to instances where there was no evidence of an individual or systemic failure. In one case, the IHI Panel was:

not presented with any evidence which pointed to any failure either of individual or services which could have predicted or prevented his presence in the company of Mr D (the perpetrator) at the time of the SUI.

This was not common in the study. It is nonetheless a sobering point. IHIs can become susceptible to frustration, in the sense that no meaning whatsoever could be gleaned from the evidence.

\textbf{6.6.4 The ‘Snowball Effect’}

The onerous task of deciphering the causal links between decisions and homicide appeared to be exacerbated by the realisation that practical steps required to secure an answer to the causation

\footnotesize{\textsuperscript{121} M. Dineen, K. O’Neill-Byrne, M. Thomas and R. McLean, op.cit., p 75.  
\textsuperscript{122} Differences between health and social care were visible in other cases also (see generally Lady Wall, M. Tanner, S. Champion and G. Williams, op.cit., p 79).  
\textsuperscript{123} Ibid., p 140: “It is relatively straightforward to identify mistakes made by individuals, but it is more important to understand how these mistakes occurred in the context of the systems in which they were working”; M. Clay, S. Adams, V. Bridges, S. Callens, P. Menon and M. Suett, op.cit., p 13: the principal Care or Service Delivery Problems (C/SDPs – acts of omission or commission) within the case. However, as with many mental health investigations these tend not to be specific errors or omissions by individuals but more themes and areas for concern.}
question was simply too onerous to shoulder. The burden simply created evidential obstacles that could not be overcome. One case remarked that it was “not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations”. It went on to state that:

[w]hat caused his situation to unravel is not clear. However it would appear that a sequence of events occurred that destabilised his life and resulted in an abrupt change to his wellbeing.¹²⁴

The problem of there being no ‘final trigger’ to the fatal outcome was clearly evident in a series of cases sampled, epitomizing Luhmann’s argument that adverse events, or the unravelling of the situation, may involve the effects of decisions which over the passage of time have become untraceable.

This confirms that, in conjunction with the concepts of time and risk developed by the present thesis, the concept of accountability can also be used to support the notion that causality in IHI cases has become almost mythical; in the same way that the contingency of decisions preclude certainty for the purposes of making decisions in the present that have equally uncertain future consequences, the process of accountability in IHI cases similarly precludes certainty in causal determinations due to the ‘problem of many hands’ identified by accountability scholars. The case of Mr X, cited earlier, is a clear demonstration of how the accumulation of decisions in some cases was consistent with a dense and lengthy history that would create a ‘snowball effect’:

It is the view of the Independent Investigation Team that these failings were cumulative over time and that each separate failing impacted one upon the other in a ‘snowball effect’ over the years.¹²⁵

An intricate tapestry of care emerges from the IHI accountability process. This is despite the openness of that process to acknowledging individuals in each accountability relationship established. The sheer scope of the evidence challenges the ability of IHIs to fully comprehend the decisional effects that appeared to lead to the homicide:

¹²⁴ A. Johnstone, op.cit., p 95.
Taking a longitudinal view of Mr Y’s life it could be seen that, with a snowball-like effect, everything that happened to him contributed to make him the troubled young man that he was. His family, statutory services and Mr Y himself all played significant roles in determining the care and treatment pathway that he undertook and the successes and failures that were encountered along the way.\(^\text{126}\)

The tendency to attribute failure to systems as opposed to individuals was prominent in such dense and complex cases.\(^\text{127}\) The ‘snowball’ analogy was particularly apposite for sizeable investigations. The ‘snowballing’ of causal attribution, to the extent that it became untraceable, was a persistent feature throughout the Reports reviewed.\(^\text{128}\) The pursuit of root causes in any given case was potentially without limit.\(^\text{129}\) Even illustrative devices would sometimes be used in order to make sense of the complexity. One case was memorable for its use of ‘fishbone’ diagrams in order to demonstrate how certain contributory causes ‘fed’ into root causal attributions.\(^\text{130}\) What is more, some fishbone diagrams were more complex than others.\(^\text{131}\) These diagrams were clearly helpful in delineating linkages between actions or inactions.\(^\text{132}\)

\(^{126}\) H. Waldock, L. Rowland, A. Johnstone, I. Allured, op.cit., p 16: Here, the patient was a complex and troubled man who had received care and treatment for over a period of twenty years.

\(^{127}\) Ibid.

\(^{128}\) M. Dineen, C. Cutland, S. Davies, S. Smith, op.cit., p 33. See also M. Dineen, J. Nixon, T. Jolley and J. Lawrence, op.cit., p 70. In the latter case, despite attempting to probe the reasons behind this miscommunication, which is tantamount to investigating the cause of a possible cause of the fatal event, the IHI could not determine those reasons. A communication failure within the CMHT, in the form of a lack of senior input into SU’s care, was found by the IHI. The IHI commented that “there is no evidence that Mr SU’s care co-ordinator, or any other of the community mental health team staff occasionally involved in his care, communicated or tried to communicate directly with the consultant psychiatrist in psychological therapies at any time. The Independent Investigation Team finds this disappointing, especially in view of the team managers comment that “[the consultant psychiatrist] was the best person to care for [Mr SU] because he had experience in neuropsychiatry and psychotherapy. He could have given us more advice.” On the one hand, the lack of senior input is considered to be a loss, yet the same loss was causally attributed to the failure to appreciate SU’s complexity; M. Dineen, K. O’Neill-Byrne, M. Thomas and R. McLean, op.cit., p 116. The IHI found that the lack of a therapeutic relationship between the CMHT and the patient to be a root cause, but went on to state that this was linked to other root causes also, namely, cultural awareness problems, lack of supervision and lack of monitoring.

\(^{129}\) M. Dineen, K. O’Neill-Byrne, M. Thomas and R. McLean, op.cit., p 116. This raises previous themes related to how root causes are linked to the practicality of an investigation. The NPSA consider RCA to be a continual probing of causes, which theoretically can expand the range of causal attribution to infinite proportions. More specifically, this relates to the NPSA’s insistence that there must be a continual asking of ‘why’ an event occurred in order to appreciate the root cause. In the flowing section however, I address the inherent anomaly of this form of investigation by considering the impact of ‘decision accumulation’.

\(^{130}\) See Fig. 2.

\(^{131}\) See Fig. 3.

\(^{132}\) See Fig. 4. These linkages are shown with black arrows.
In Fig. 3, the lack of a therapeutic relationship between mental health professionals and the patient was considered to have led to a lack of understanding and knowledge of the latter. A closer look at this aspect of the diagram is given overleaf. This, in turn, was held to have had a detrimental effect on communication between staff and also the attitude of individual staff members. This supports the argument that even though individuals might be a relevant factor on the surface of investigations, they are a) communicated about in terms of the roles they occupy and b) they are coalesced into a ‘busy’ causative link involving patient factors, the actions of other staff members, education, training and so on. All of these factors, which represent clusters of decisions in various different locales of the mental health profession, are presented in IHIs as inter-connected and thus appear to negate the notion that individual control over the fatal outcome was ever possible. Although Fig. 1 to 4 show crucial points about how human agency and accountability relationships are assimilated into a range of other factors that can only be described as ‘systemic’, their use was not a common theme.

![Diagram](image-url)

Fig. 2

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Fig. 2, 3 and 4 were confined to one case. 14 Fishbone diagrams and 2 ‘5 Why’s’ models were used in this particular case with each illustration tailored to a specific problem (or what the IHI called a “Service and Care Delivery Problem”). Fishbone diagrams were found in 3 other cases.\textsuperscript{134}

The difference between some cases, as Fig. 1 to 4 illustrate, is that some cases are better at demonstrating this than others. Some prefer to combine the method of the narrative with illustrations, such as the Fishbone diagram, whilst others prefer to rely solely upon the method of the narrative. Whatever method IHI Reports adopt, what is clear is that the way they are used support the thesis that attempts to establish certainty through past understandings of causality set

\textsuperscript{135} Ibid., p 104.
the stage for a proliferation of untraceable causal relations throughout the corpus of care provided.

Fig. 5 (below), on the other hand, features in the Tennyson Obih case as an illustration of ‘incident causation’, which:

likens human systems to multiple slices of Swiss cheese, stacked together side by side. It has gained widespread acceptance and use in health care, in the aviation safety industry and in emergency service organisations. It is known as the cumulative act effect. We have used this model as it provides a useful method for analysing the effects of policy decisions (such as service reductions) on clinical practice.\textsuperscript{137}

\textsuperscript{136} Ibid.
\textsuperscript{137} Ibid.
these illustrations are however the most vivid expression of a general underlying theme running through all of the IHI Reports reviewed, namely, that ascertaining direct and fundamental causes in IHI cases is never possible. Common themes of multiple causalities and a distinct lack of human agency in individual cases was the norm.

As will be discussed towards the end of this chapter and in Chapter 7, prompting the NHS Trust to change the way in which mental health services are provided is a risky process. On the surface, it appears to those involved in the process that certainty is being restored. This perceived restoration of certainty however is arguably riddled with ignorance of the contingency of decisions. IHIs appear to be embroiled in a cyclical process whereby the contingency of decisions creates doubt about them during crisis events further on in time, leading to new, equally contingent decisions in the present that fuel change to the mental health care system. This cyclical process is arguably inimical to a foundation of security. Decisions themselves necessitate further uncertainty in the form of a backdrop of perpetual risk that is coated with meaning, through communication, about what those risks are and how amenable they are to reduction.

6.6.5 Causality and Political Complexities

The ‘snowball effect’ in the *Mr X* case was clearly evident in other cases reviewed. Some IHI investigations were more complex than others, particularly those involving personality disordered patients.\(^{139}\) The complex nature of personality disorder usually requires inputs from mental health services, the criminal justice system, child and adolescent protection services, housing agencies and so on. In addition to intersecting with general bureaucratic concerns common to all the cases sampled, including resource issues,\(^{140}\) policy issues tended to appear more prominently in cases of personality disorder, particularly its politically-defined counterpart Dangerous and Severe Personality Disorder (DSPD).\(^{141}\) This posed difficult challenges in some cases.\(^{142}\) The fact that personality disordered patients are connected to a plurality of services and institutions widens the ambit of accountability, thereby raising theoretical concerns regarding the extent to which this inhibits the pursuit for causality and conclusive findings generally.

On the one hand, the study revealed that this heightened sense of multi-agency involvement was perceived to place considerable demands on administrative capabilities and resources:

> they [the GP surgery] often feel overrun by forms to complete and the presentation of this form did not communicate its gravitas”\(^{143}\).

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\(^{140}\) A. Thompson, N. Georgiou and D. Ndegwa, op.cit. What is more, under-funding of both mental health and drug and alcohol services, in conjunction with the existing CPA policy at the time were found to have contributed to a general breakdown of effective communication between the relevant agencies engaged in Mr D’s care.

\(^{141}\) Ibid., p 49. The IHI found that “[n]ew policy and practice guidelines were issued just over a year after the incident” by the Department of Health. It concluded that [w]hilst it would be easy to criticise the service offered to Mr D during the 1990’s if we used the accurate implementation of the above standards as a yardstick, this would, we felt, be both unrealistic and unfair. The effectiveness of services throughout the country, at that time, in rolling out robust CPA policies and procedures was varied”.

\(^{142}\) M. Dineen, M. Clarke, J. Liversley and M. Jackson, op.cit., p 17. The IHI commented that due to the complex multi-agency input the MHSU was receiving, “it would have been improbable if not impossible for a single care coordinator/team/agency to maintain oversight of Mr G’s care and risks without robust communication and collaboration between services and agencies involved in his care”.

\(^{143}\) Ibid. The care co-ordination efforts between the GP and the prison healthcare team: The IHI also reported on the simplistic design of the GP forms required to be completed, which arguably added to pressure of co-ordinating care effectively.
Patients with DSPD received an enhanced level of care that would sometime intersect with the Ministry of Justice (MoJ) and Home Office (HO). Communications from these governmental departments would often be susceptible to misinterpretation or delay by mental health professionals, thus heightening the sense of post-decisional regret directed towards the case in the Final Report:

The investigation team formed the view that there was misunderstandings between the Home Office and the THU regarding the use of handcuffs during the transfer for medical appointments outside the secure perimeter of the THU. 144

It is arguable, on the one hand, that mental health professionals involved in these cases were confined within the overarching conditions created by external political ties. This would go some way to explaining why IHIs found it especially difficult to establish firm causes between individual decisions and the final outcome. Not only did these cases exhibit political overtones that were open to misinterpretation, they would also exhibit post-decisional regret relating to other flaws that were more localised and due to poor service provision:

The Mental Health Act 1983 was in force at the time of Mr R’s admissions in 2005 and 2007. It is intended to provide safeguards for the patient and public in the considerations required for the care and treatment of patients. There were some serious shortfalls in the practical application of the Act in Mr R’s case. 145

The scope of post-decisional evident in each case, particularly cases involving DSPD, appeared to be wider. What the outcome of the case was attributable to was not certain, translating more into an emphasis on the general conditions of tight resources, organisational flux 146 and chaotic interagency relationships. 147 Cases of personality disorder appeared to ossify

144 G. Roberts, N. Moor, C. Gaskell and S. Mikhail, op.cit., p 26. More specifically, the Home Office failed to seek written assurances from the Responsible Medical Officer on the use of handcuffs, contrary to its belief that these assurances could be provided over the telephone by Home Office personnel.
145 Ibid., p 35.
146 Ibid., p 24. High staff vacancy rates, transfers of responsibility, clustered performance management reviews and the implementation of a Service Level Agreement were said to have contributed to a loss of service oversight on the part of those involved with the case.
147 Ibid. The main failures reported were the mistaken assumption by the Police that the prison service was responsible for transferring Mr R (ibid., p 25), the omission of Social Work input into Mr R’s care (ibid., p 29), lack
this finding, particularly as the relevance of policy and resources rendered the management of care appear more complex and less controllable from the point of view of mental health professionals. Human agency appeared virtually non-existent in the labyrinth of post-decisional regret articulated by these cases.

6.7 Invisible Individuals

The evidence reviewed hitherto does not deny the existence of individuals. It is clear that physical bodies and organisations are held to account in IHI proceedings. The layers of accountability evident in IHI processes and the vastness of post-decisional regret expressed in the Reports nevertheless confirm that individuals cannot exert any real control over the direction in which mental health care is delivered. One NHS Trust procedure document which was acclaimed by the IHI stated that:

Human error is routinely blamed for untoward incidents, and while an act or omission by a member of staff may appear to be the immediate cause of an incident, investigation often identifies a series of events and departures from safe practice influenced by the working environment and wider organisational issues (my emphasis).  

This mirrors what Luhmann was referring to when he argued that humans cannot communicate.  

A prominent trend was that actions, decisions and attitudes were always considered to be team-based as opposed to being based around individuals. For example, the “disassociation between senior management team and front line staff” and the general disengaged professionals experienced in their work. Such insights were nonetheless sparse and co-existed with many other causative factors that impacted on the case.

The only thing that is certain in these cases is that a cosmology of mental health care decisions facilitated the outcome, albeit without directly causing it. Scrutiny of the mental health care constellation in each case however was overwhelmingly unable to isolate individual figures of multi-disciplinary assessment (ibid., p 30), poor leadership over transfer and nursing arrangements (ibid., p 31 – 32) and the failure to apply restrictions under s 49 of the MHA 1983 (ibid., p 35). Inadequate staff training and induction was also a recurrent theme (id., pp 33, 34, 37 and 38).

148 J. Hall, R. Amin, A. Watson and T. Coldham, op.cit., p 120.
150 H. Waldock, L. Chenery and A. Irons, op.cit., p 64.
as being directly causative of the homicide. This is at odds with views insisting on how the systemic nature of a crisis must be correlative to a grappling “with its causes on that level”.\textsuperscript{151} This strikes a connection with Hutter and Rudd’s claim that:

\begin{quote}
[e]xperience tells us that risk failure events spark a blame culture that offers up individuals as scapegoats; system faults themselves are either ignored, denied or both. This resonates with the writings of the German social theorist Niklas Luhmann who argues that risk tends to be associated with detrimental decisions attributable to a decision maker. Therefore, individuals and their decisions become the focus of blame rather than the circumstances surrounding any risk event. But we cannot attribute a crisis this deep and widespread simply to the failures of individuals.\textsuperscript{152}
\end{quote}

This statement contradicts the findings of the present chapter. Firstly, the present finding that IHIs regularly blame systems and processes for communication failures does not correlate with the claim that individuals become the focus of blame surrounding risk events. IHIs are well-known for expressing their reluctance to blame individuals. IHIs may well have been more inclined towards a blame approach at one time, although it can be shown from the present chapter’s findings that the concept of individual blame no longer features with any significance. Although Hutter and Rudd are writing in the context of the financial crisis, they clearly make general statements about why the blaming of individuals for a risk event occurs. Reinforcing this point is their interpretation of Luhmann’s risk thesis. They claim that because Luhmann’s concept of risk involves the attribution of causes to decisions, this explains why individuals are blamed for crises.

6.8 A Concept of Systemic Accountability

This chapter advances a concept of ‘systemic accountability. IHIs, whilst being consistently unable to identify individual decisions as being causative of adverse events, are nevertheless able to instigate arrangements to improve mental health services. To reiterate, IHIs place a heavy emphasis on discovering the ‘root causes’ of adverse mental health care events\textsuperscript{153}, combined with

\textsuperscript{151} B. Hutter and N. Dodd, ‘Social systems failure? Trust and the credit crunch’ (2008) Risk & Regulation 4 at 5.
\textsuperscript{152} Ibid.
\textsuperscript{153} See J.L.Rooney and L.N. Vanden Heuvel, ‘Root Cause Analysis for Beginners’ (2004) Quality Basics 45 at 46. The authors acknowledge that there is substantial debate about the definition of a ‘root cause’. They provide a
the impossibility of knowing certain facts about some cases and mounting layers of accountability during the interviewing process. IHIs are consequently oriented towards holding the entire mental health care system (the NHS Trust) to account through a conglomerate of causative links established during the investigation.

This form of systemic accountability seeks to build on those conceptions of accountability discussed in Chapter 5. The latter discussed conceptions of accountability that were humanist in their substance, with an emphasis on individual answerability and small-scale interactions between individuals and a forum. The present thesis however contends that such an approach is too simplistic. IHIs demonstrate that although most of the essential features of core accountability might well be a feature of such processes, these are used to build up layers of causation between various decisions and the fatal outcome. This arguably leads to the removal of human agency, which is confirmed in the overwhelming tendency to find no direct link between the care provided and the homicide incident.

Ironically, the most dense and voluminous IHI Report was the only one to confirm a direct link between the care and treatment provided and the homicide incident:

The trial judge when sentencing Mr X late in 2008 made a direct link between his untreated mental state and the subsequent deaths of both Mr. and Mrs. X senior. This is a link that the Independent Investigation Team also makes.  

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A. Johnstone, op.cit., p 14: “whether or not mental health services could have altered the outcome of events of the 26/27 November 2007 as there are many facts that remain unknown about the lives of Mr. X and Ms. Halimah Ahmed [the victim]” remaining as “conjecture”. At p 114, the IHI also commented that “the Independent Investigation Team was not able to understand what exactly led to Ms. Halimah Ahmed’s death. It is possible that Mr. X’s mental state contributed to his losing control of his temper, it is also possible that Mr. X’s actions had absolutely nothing to do with his mental state. It cannot be known or proved and no causal link can be made”.  

Ibid., p 15.
6.8.1 After Systemic Accountability

What do IHIs do with their findings and how can they properly be converted into a meaningful plan for addressing homicide events? After all, holding the ‘system’ to account by documenting a collective of different failures that are not singularly causative of a homicide precludes localised remedial action. Such action requires a certain level of precision at least. Recommendations can run into their dozens, spanning across many different locales of activity. By way of contrast, law has the communications at its disposal to hold individuals to account by constructing them as defendants and sentencing them on a verdict of guilty. It may be contended that IHIs do not share this level of ‘sophistication’ and are prone to advancing ‘ham-fisted’ arrangements through their recommendations that do not target failures in the desired manner. Is this a fair assessment? It is one thing to ‘blame’ the system for a lapse in care but another to forge a solution which holds a giant entity to account for those failings. How is accountability concretised in the IHI process?

6.8.2 IHI Recommendations and their Role

This section considers the implications of making recommendations. More specifically, this relates to how holding NHS Trusts to account enables IHIs to reproduce mental health care decisions in an autopoietic cycle that supports the continuance of the mental health care system in general. The inherent contingency of past decisions is laid bare by a homicide event and subsequent investigation, the latter being a vehicle for exposing previous decisions as objectionable; there are potentially many opportunities for causal attributions and many ‘missed opportunities’ that haunt the many decisions made throughout the history of the patient’s past. IHIs orchestrate this objection and set about creating conditions in the present that facilitate new decisions to be made in order to close the chasm of uncertainty about previous decisions created by the homicide event.

That new decisions have to be taken clearly amounts to a reproduction of decisions in an autopoietic cycle. The mental health care system once more is given the scope to make changes to services by communicating about itself and its future in the form of changes to current practices. The entire sample of IHIs advanced recommendations calling for certain actions to be carried out in a bid to address the failings uncovered by the investigation. In total, the sample advanced 426 separate recommendations. These all varied in content to reflect the individual
findings in each case and are too numerous to list here. It was commonplace to find IHI's recommending that developments and clarifications be made about operational policies and for new monitoring systems to be installed. Other common recommendations involved the implementation of staff training programmes and the imposition of group meetings between teams with a view to facilitating better communication between teams and professionals.

What is more, recommendations were directed principally towards the NHS Trust. Some cases ventured further and identified specific officials within the NHS Trust bureaucracy to whom the recommendations were targeted at. The IHI therefore appear to act as a mirror for the NHS Trust. The IHI is commissioned to investigate, report its findings and advance suggestions which the NHS Trust almost always implement (unless they have already taken necessary action during the IHI investigation). The IHI, moreover, appears to be engaged in a process of decision reproduction. In identifying the uncertainty of past mental health care decisions, but without an individual direct cause being attributed to the homicide, IHI's appear to use recommendations as a way of facilitating new decisions about mental health care services. These arrangements have noble intentions, but according to the present thesis, they can never achieve their desired objectives. Recommendations are meaningful only within operationally-closed communicative contexts. What is more, they are communications based upon a unique description of the past. As mentioned previously, even cases where the care provided was deemed appropriate, learning and reflection points were advanced by the IHI in a bid to prompt the NHS Trust into communicating about itself and making changes that were consistent with those points.

6.8.3 IHI Recommendations and Autopoiesis

Chapter 4 reviewed Luhmann's argument that if decisions are seen as being made at the level of social systems (in the present case, decisions made pursuant to the code *ill/healthy* and

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158 N. Luhmann, *Risk: A Sociological Theory*, op.cit, p 26. Luhmann cites car pollution problems as the archetypal example where causal relations are no longer traceable. The decision to start up a car engine is one of millions happening every day at each passing moment, with each one contributing to general conditions that actuate losses but are individually not causally attributable to the pollution problem. In that case, “[w]e would, so to speak, have to invent decisions to accept the attribution – for example, a decision not to prohibit motoring”.
sanity/insanity) and are inherently contingent, post-decisional regret is inevitable. This has been verified in the IHI Reports reviewed for this chapter. It is essential to post-decisional regret however that new decisions are made in the present that seek to address regret and restore certainty. IHIs clearly do this, or at least facilitate the making of future decisions by recommending that the NHS Trust communicate about mental health services through decisions to alter the way care is provided:

[i]t is essential that there is an increase in the provision for dedicated medical sessions to the County South AO Team.  

This theme of system regeneration permeates all 426 recommendations. They include practice-based training for qualified community staff, the introduction of registers to monitor patients on section 117 after-care and extra recruitment. This appears to support the argument alluded to earlier that IHIs lead to the creation of new decisions about the mental health care system in what is a perpetual cycle of change. This furthermore tallies up with the view that decisions are inescapable. Decisions can only exist by virtue of decision making previous decision making, on the basis that their contingency will necessitate reappraisal at some point in the future.

6.8.4 The Anomaly of IHI Recommendations

Recommendations, as decisions, are a potential cause for post-decisional regret. They may not prove successful because the future can never begin. In other words, the future present is arguably inaccessible to decisions until it becomes a present future. Further reinforcing these claims is the argument that recommendations are founded on past understandings of causality. The present – anchored in the making of an IHI recommendation – is based on the finding that a

160 M. Dineen, C. Cutland, S. Davies, S. Smith, op.cit., p 84.
161 Ibid., p 86.
past decision proved regrettable or possibly regrettable and that a change to service provision is required in order to avoid future regret. This is paradoxical because past attributions, feeding into present decisions to change the system, arguably reach a stage where those present decisions become past. Present decisions, in turn, become similarly attributed to perceived losses in the future. In short, present decisions to advance recommendations eventually become future past causal attributions that feed into future decisions about how mental health care is carried out. Taking into account the sheer unpredictable nature of communication, if observed through the lens of systems theory, risky and regrettable decision making is the rule as opposed to the exception.

Luhmann’s insight that “the ‘tragedy’ of decisions is that the affected system is also the cause of its own damage” is quite fitting to the current context. IHIs make recommendations for change that are implemented, but pose an apparent risk to the mental health care system itself because those changes are not guaranteed to succeed in their stated objectives. According to the present thesis, decisions are inherently uncertain because there are always opportunities to regret them at a later date, no matter how resolute the decision appears to be at the time it is taken.

What is more, the effects of decisions have a unique rationality at their centre. They will converge with the effects of other decisions that have a different rationality at their centre also, creating conflict, subsequent objections, the appearance of error and a need to make further decisions to amend the perceived disruption. There is no guarantee that changes to mental health services recommended by IHIs will have intended effects because, at the very least, “people reject decisions simply because it was not they but others who made the decision”. Given that mental health homicides continue to occur (albeit rarely), there is a reason to doubt that IHI recommendations can address the uncertainty in these cases. This chapter advances the argument that this is due to the inherent uncertainty of decision making in a functionally differentiated society. What is more, this uncertainty functions to keep the mental health care system afloat; post-decisional regret creates a picture of systemic failure that prompts changes across the system.

166 See M. King and C. Thornhill, op.cit., p 185.
168 N. Luhmann, Risk: A Sociological Theory, op.cit., p 26. Risk “does not indicate a fact existing independently of whether and by whom it is observed”. Mental health professionals do not make decisions and ascertain risks on the basis of what occurs elsewhere in the Trust organisational structure. For this reason, those occurrences will amount to ‘danger’ vis-à-vis frontline staff.
Chapter 6 – Investigating Homicide

spectrum of care, thereby creating the conditions for the mental health system to communicate about itself.

6.9 Conclusion
At its core, the study is comprised of four components. The first is the finding that IHIs continually probe past decisions for their contingency. They scrutinise these decisions and ask that if they had been decided differently whether the homicide would have occurred or not. This evidences post-decisional regret. Post-decisional regret is an aspect of Luhmann’s thesis on risk. His thesis stipulates that social systems are inhered with risk. Decisions reflect how functionally differentiated social systems are presented with alternatives to decisions, coupled with the possibility of loss occurring if any alternative is taken. Since only one alternative can be taken, missed opportunities are always guaranteed (even if the decision maker is certain about the correctness of his or her decision). Post-decisional regret is essentially a lament that there may have been a missed opportunity. Under this view, IHIs are inhered with risk. Risk is inescapable, despite the efforts of the IHI to avoid risk and create more certainty.

The second aspect of this study relates to the concept of accountability. Chapter 5 called for the view that IHIs consist of dynamic accountability relationships between the forum (the IHI Panel) and those called to account by it. These relationships are authored by the very communications required to create them. They are communicative, in terms of the parties and issues under scrutiny being meaningful primarily because certain social systems of communication (psychiatric, legal and so on) are being used by the IHI Panel to make sense of past reality. The present chapter sought to reveal the mechanics of risk through this concept.

The third aspect of this chapter argued that the intention of IHIs to establish the causes of homicide by scrutinising past mental health decisions is obstructed by the scale of decisions revealed by accountability relationships. That many decisions are often made in each case, in conjunction with the many perceivable effects that they have in the many conversations that occur, create sizeable decision-chains that appear to envelope human agency. This is consistent with Luhmann’s tenet of systems theory that individuals have no objective, independent existence. This thesis adds however that the effects individuals have through their decisions are furthermore meaningless when it comes to investigating them.
The fourth and final aspect of this chapter relates to how an IHI’s past understanding of causality and the way they are reached are used to facilitate decisions in the present and future about mental health care. Recommendations provide a crucial outlet for IHIs to do this. They exert pressure on NHS Trusts to make decisions about the way mental health care services are provided. This would often require many changes to services. Under the theoretical framework presented throughout this thesis, the facilitation of new decisions in the present (by the NHS Trust) is a contingent process. They too are a selection from a range of possible alternatives, thus implying that other options could have been considered which could prove more advantageous if taken. The wide possibilities for post-decisional regret, combined with the inherent uncertainty of a future world of decision making, lead to the conclusion that IHI processes are inherently risky. IHI processes can also be seen to be autopoietic. The pursuit for certainty and security in mental health homicide cases paradoxically requires further decisions that continually reproduce conditions of risk and uncertainty.

If it is accepted that IHIs are a vehicle through which risk and uncertainty about the provision of mental health services are proliferated, it is perhaps reasonable to conclude that the stated legal and policy objectives of IHIs are not achievable in the way law and policy-makers intended. It is nevertheless clear however that this thesis supports the view that risk and uncertainty are omnipresent features of modern decision making. In utilising Luhmann’s thesis of social systems and risk, it can be said that any form of process designed to address a crisis, let alone an IHI, is open to the claim that the future consequences of such processes are inherently unpredictable. The concluding chapter to this thesis takes stock of this claim. It considers what options law and policy-makers have when it comes to learning lessons from mental health homicides and whether the contingencies and risks associated with mental health homicide investigation can be alleviated.
Chapter 7

Conclusion

So much for tragedy and epic, the number and variety of their forms and component parts, the causes of their success and failure, and criticisms and solutions.¹

7.1 Main Themes: A Summary

Aristotle’s vision above is similar to the vision IHIs encounter in their investigations.² It is a complex vision, involving a long line of emotionally-driven incidents and responses. Disbelief, fear, anxiety and regret pervade IHIs at many stages. They raise questions about how IHIs make sense of homicide events and their aftermath. It was stated in Chapter 2 that the current state of research in this area comprises a variation on a theme.³ This theme – the extent to which an IHI can facilitate the learning of lessons from homicide events and the identification of their causes – is something that this thesis has attempted to comprehensively explore in a distinctly theoretical way.

What is more, the problems associated with IHIs highlighted by the literature (hindsight bias, the dizzying range of professional input in cases, the technical issues raised and the prospect of examining the minutiae of individual decisions) all seem to be underpinned by one argument. This is the argument that the reality of mental health care (the different roles, procedures, routines, time orientations and decisions made) is produced by IHIs through a bundle of operationally-closed communications.

7.1.1 The Independent Homicide Inquiry is a Contingent Process

Chapter 4 posited that mental health care decisions, like all decisions pursuant to Luhmann’s concept of risk, represent an inherent dilemma. They represent the selection of one decision over a range of possible others. What is more, the advantages of those other possibilities can only be

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² Although it can be said that the legal culpability of each of the perpetrator in the cases reviewed for this thesis does not licence the view that these are tragedies, in the sense that they were committed by individuals found to have a criminal level of responsibility. See supra 3.3.
³ Supra 2.3.
realised if they are taken. The ‘missed opportunity’ is therefore inevitable. IHIs inadvertently expose this contingency in their investigations. They are only ever able to make sense of reality after events have occurred because the sheer unpredictability of decision making renders the future completely uncertain. Decisions germinate inside a plurality of meaningful contexts. IHI investigations attempt to trace these decisions and their effects. But according to the theoretical framework laid out by this thesis, these effects can potentially clash, converge, disappear and ultimately prompt the making of further decisions as part a temporal labyrinth of mental health care. Mental health care decisions are, therefore, risky. IHIs confront this risk in the present and embody it because they too must facilitate decisions about the mental health profession. They continue the decisional cycle, principally by holding the NHS Trust to account. They are part of a cycle of perpetual corrective decision making which cannot feasibly stop. The past must proceed into the future in the present through the vehicle of accountability. The currency used to keep this process going is decision making. It is impossible to conceive of time and social systems of communication even surviving, without decisions.

IHIs confront risk because they consistently explore past decisions that are self-attributable, self-contained and polycentric. Decisions rely on a self-produced ‘authority’ through an internal binary code. A decision to administer a certain amount of medication, for example, is founded on a psychiatric communication to improve the health of the patient. The decision maker must rely on their professional psychiatric judgement, which involves a series of options (options to check the amount of medication being administered and monitor the patient for other signs of illness, for example) that can be considered to be ‘micro-dilemmas’ – decisions guided by the internal logic of a binary code but require the self-referential resolution of a dilemma to do or not do something. This can be applied to all decisions, significant or trivial. Mental health homicides are unwanted realisations of risk because previous decisions, made under the ‘controlling’ hand of self-attributable, functionally differentiated psychiatric judgements for example, led to their occurrence. It was ‘this’ judgement and no other that could have been applied differently or ‘better’ in the circumstances.

And yet decisions connect the past and the future together within communicative ‘nodes’. A node is a site within which a collective of “knowledge, capacity and resources are
Chapter 7 – Conclusion

mobilized to manage a course of events”.\(^4\) Nodes also differ in their ability to establish information flows and communication.\(^5\) It is not tenuous to assert that IHIs function similar to nodes, in terms of having resources (NHS funding), technologies (different experts in mental health issues and RCA that can formulate recommendations in order to influence a course of events), mentalities (the ways of thinking about homicide, for instance through causal analysis and references to standards of care) and institutions (the NHS Trust). What is more, decisions made within the nodes of mental health services produce ‘outcomes’, intended or not, that lead to problems which could have been avoided.

Making the ‘correct’ decision is something that a social system of communication cannot guarantee due to the inherent uncertainty of the future. In terms of embodying the concept of risk, IHIs (in response to their findings) must select recommendations that have unpredictable effects on the provision of mental health services. Those recommendations are risky to make because they too could have always been decided otherwise. Secondly, the meaningful effects of past mental health care decisions converge, clash and constantly require future adjustment through more contingent decision making. This is confirmed by the extension of the labyrinth of mental health care decisions relating to a patient and the way in which IHI recommendations require further decisions to be made at the level of the NHS Trust. The effects of individual decisions thus become obfuscated inside this labyrinth of care and are thus untraceable for the purposes of establishing causal links between decisions and homicide. This is supported by the finding in Chapter 6 that IHIs are consistently prone to causal indeterminacy in their findings.

This thesis also illustrated how the issues relating to IHIs – causal indeterminacy, risk and the meaning of time - affect the way IHIs hold mental health professionals to account. Chapter 5 reviewed existing concepts of accountability and found them to be ill-equipped to explain what actually happens when IHIs construct the relationship between mental health care and homicide. To reiterate, this is because the causal indeterminacy running through the findings of IHIs obscures the effects of decisions made by individuals. Existing concepts of accountability are rather narrow. They focus on individual answerability and interaction between witnesses and the forum of accountability. They also eschew a consideration of how rendering those accounts

\(^5\) Ibid., at 36.
form part of a larger mosaic of findings about how those individuals are part of a wider system of
decision making. It is for this reason that Chapter 6 advanced a concept of systemic
accountability in order to fully appreciate the way IHIs render individuals even more invisible
than systems theory perhaps envisaged.

Teubner’s view is that great analytical and practical power is only possible if a theory
“stops claiming to be able to explain individual events and concentrates instead on explaining
structural patterns”.\textsuperscript{6} This is what the present thesis has sought to do. It has sought a more
structural explanation of homicide events in these circumstances. The importance of systems
theory for the present thesis lies in its ability to question some taken-for-granted assumptions
regarding how mental health care can be understood in the aftermath of homicide. If it can be
argued that the IHI is a convoluted, indeterminate process that requires a considerable
mobilisation of resources and emotion (as this thesis has shown), is it possible to flag up other
methods of investigation that are more determinate, less costly and less antagonistic towards the
mental health profession?

7.2 The Possibility of Normative Change Using Systems Theory

Not only does systems theory inform a new understanding about the extent to which IHIs can
learn lessons, investigate causes of homicide and instigate accurate change in mental health care
services, it also raises issues about the possibility of social theory being used to inform law and
policy. Luhmann’s theory is highly critical of humanist theories. Humanist theories ascribe
primary importance to the individual and the latter’s ability to steer society towards an ideal. A
classic example is Marxism. Marxism places faith in the individual to make fundamental changes
to all areas of society through control over the economy. Marxism is a second-order theory of
society, according to Luhmann, which means that it observes society observing itself and
prescribes an alternative observation that it considers to be better. Luhmann claims that such
theories make assumptions about the abilities and importance of the individual whilst ignoring
that those assumptions are themselves constructions that germinate from within society.

Luhmann argues that human beings are operationally-closed living systems that exist in
an environment of social systems of communication. There is no direct influence between

individuals as living systems and social systems of communication, according to this view. Nor is there any direct influence between different social systems of communication. Operationally-closed systems of communication cannot traverse the boundary of their meaning. Law can only be law and not something else. The same holds for medicine, psychiatry and science. The notion of individuals instigating effects throughout society, in each of its social subsystems, would be to accept that those subsystems have an identical logic that is mutually understandable and receptive to that logic. According to Luhmann, decisions made at the level of social systems, for instance in politics, are bound to have some adverse or illogical effects from an economical point of view. An example would be a political decision to increase tax. This would restrict the level of income or profit that persons may receive (for the social system of economics prioritises the positive value of profit over loss). Any ‘advantageous’ or ‘successful’ effects which decisions are deemed to have are purely accidental, from the point of view of systems theory. When it comes to making assumptions about the importance of the individual, therefore, this can only be achieved through communication. As these communications are highly contingent (they occur because other communications happen), the status of individuals is radically altered.

At the centre of Luhmann’s radicalism rests his concept of communication, his own theory not being exempted from its application. In addition to Luhmann’s thesis that communication is improbable and that any attempt to effect change or make normative statements about how society should be designed (whether through economic, legal or political reform, for instance) is not possible, these claims are applicable to systems theory also. Systems theory is, too, a self-referential form of communication that produces specific meanings about society:

> because it claims universal validity for everything that is a system, the theory also encompasses systems of analytic and epistemic behavior. It therefore itself appears within the real world as one of its own objects, among many others.

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7 This poses a direct challenge to critics of Luhmann who argue that his theory is anything but radical.
Brans and Rossbach provide a succinct illustration of this unusual feature of systems theory. They state that “a theory of social systems is part of the reality it attempts to describe”.\(^9\) On the surface, systems theory is self-defeating. This is because it denies that universal meanings about reality can be shared by social systems. Systems theory is simply another form of meaning about the world. It produces this meaning and makes distinctions, separating aspects of the world from what it is not. It is potentially a ‘victim’ of its own analysis. After all, Luhmann was well aware that a self-description of society, whether through the legal system, economic system or systems theory, cannot provide a privileged view of society. No one view of society has the ability to objectively encapsulate all the meanings within it because meaning is only ever possible from one particular standpoint. This carries implications about the way in which systems theory should be used as a reliable tool for making statements about whether IHIs can fulfil the law and policy objectives set for it.

The implication of this is that an attempt to use systems theory as a normative tool for effecting change in society cannot be achieved. Luhmann accepts that observing the codes of social systems is an empirical exercise and does not involve making a normative judgement about how those codes should be applied. To do so would be to recapitulate first-order observations. In other words, it would verify that which systems theory denies, namely, the ability to accurately steer society. The reported “inability of systems theory to come up with any answers to regulatory problems”\(^10\) is symptomatic of this issue.\(^11\)

According to Luhmann at least, systems theory cannot licence the view that law, policy or any other mechanism (such as IHIs) can improve mental health services in the way they intend. Neither does systems theory accept that these mechanisms can be improved in order to exact greater control over society. Any attempt to shoehorn systems theory into a normative agenda of improvement would be to accept that systems theory itself contains a ‘higher code’ which social systems of communication like law, politics and science can refer to in order to create a


\(^10\) N. Luhmann, Social Systems, op.cit., p 83.

meaningful reality. 12 This is a distinctly anti-Luhmannian viewpoint. It nevertheless has implications for the way in which systems theory can be used to advance an agenda for socio-legal research.

7.2.1 Luhmann, Systems Theory and Socio-Legal Research

Luhmann never made an explicit link between systems theory and empirical research. Although the present thesis is not an empirically-based study, its use of a thematic documentary analysis of IHI Reports raises questions about the extent to which such a method can resonate with systems theory. According to Luhmann, such methods require operationally-closed communications to be meaningful. The notion of informing systems theory with that which it claims to be operationally-closed and impervious to mutual understanding is nonsensical.

In addition, using systems theory to inform an understanding of society may well have an ‘unsettling’ and unpredictable effect on first order observations, as opposed to facilitating an accurate relationship between abstract theory and practice:

[w]here social theories are too abstract or general, too remote from accepted ways of seeing the world, or too complex to be simply transformed into decisions, practising lawyers, politicians or civil servants are quite capable of ignoring them and proceeding with their business as if they had never been formulated. 13

A central aim of this thesis is whether the law and policy objectives set out by Article 2 of the ECHR and HSG(27)94 can be achieved through the staging of an IHI. It is possible however to question whether systems theory can provide the theoretical lens necessary to conduct such an examination. To reiterate a theme from Chapter 2 and 3, systems theory argues that meaning is necessary for a system to ‘be’ a system. 14 Systems theory, according to its own logic, constitutes meaning also. 15 Concerns over the “inability of systems theory to come up with any answers to regulatory problems” 16 is symptomatic of a general debate about the extent to which systems

12 Ibid., p 45. King follows Luhmann in this regard by claiming that law cannot be ‘reflexive’.
13 M. King, ‘What’s the Use of Luhmann’s Theory?’ op.cit., p 38.
14 Supra., 1.4.1.
15 Supra., 2.4.1.
16 M. King, ‘What’s the Use of Luhmann’s Theory?’ op.cit., p 83.
theory can propel normative claims about the capability of law and policy to effect ‘change’ in society.\textsuperscript{17} This raises issues for the study of the relationship between mental health homicide and mental health care. A theoretical framework that claims the basis of this relationship is meaningful communication must address the question about whether that same theoretical framework is similarly composed of meaningful communication, thus being fundamentally different to its object.

King argues that systems theory is simply too different to be of any use to law and policy-makers. The notion of systems theory being used to modify law and policy is tantamount to imposing one virtual reality steeped in research methods and publishing onto another virtual reality that is steeped in the practicalities of administration and procedure.\textsuperscript{18} Both are radically different species. The latter rarely has time for the former. They cannot communicate with each other. They can only communicate \textit{about} each other, in accordance with their internal logics. Teubner, Nobles and Schiff however provide an interesting alternative to this approach. They contend that systems theory has “nothing to do with the instrumental manipulation of actors or systems”.\textsuperscript{19} Its importance lies “in its analysis of the way new and unexpected worlds of meaning emerge by processes which create their own reality”.\textsuperscript{20} Although King claims that this view trivialises systems theory,\textsuperscript{21} it need not do so. Systems theory may be used to advance alternative ways of addressing mental health homicides. These alternative ways may in fact reveal those aspects of ‘reality’ that IHIs might be missing in their observations. What might these alternatives methods look like?

### 7.2.2 Learning Better Lessons from Homicide?

To reiterate a point made earlier in this chapter, IHIs expose the unpredictable and contingent nature of mental health care decisions. This is reflected in the indeterminacy of their findings. What is more, the effects of mental health care decisions can be said to converge, clash, conflict and irritate one another. This obscures the effects of a decision at a particular time, making it

\textsuperscript{17} Supra. n. 10.
\textsuperscript{18} M. King, ‘What’s the Use of Luhmann’s Theory?’, op.cit., p 40.
\textsuperscript{20} Ibid.
\textsuperscript{21} M. King, ‘What’s the Use of Luhmann’s Theory?’, op.cit., p 50.
impossible to genuinely trace the effects of a decision in a linear fashion. IHIs explicitly face this in their investigations. According to this thesis, it is the root of their uncertainty and indeterminacy. Forging a coherent way forward into the future, through the advancement of recommendations, is similarly afflicted by this uncertainty and unpredictability. Making decisions about dangerous patients or what recommendations to make after a homicide has been committed, places considerable demands on decision makers to ‘make the right call’. There is never an escape from the risky impasse inherent in such dilemmas.

It is on this basis that this thesis asks whether IHIs should be abandoned, modified or accompanied by other measures that can avoid some of these problems. If it is accepted that the node of an IHI is a collective of different social communications, can this node be reconfigured or merely just ‘added’ to, so that broader lessons can be learned from mental health homicides? On the contrary, it is only through discovering what ‘works’ that a real opportunity to learn lessons can be opened up, so as to improve mental health service provision and reduce the likelihood of homicide. This will not be a perfect solution however. From the point of view of systems theory, learning lessons will always have its ‘blind spots’, no matter what measures are taken. For policy makers to implement further resources, technologies, mentalities and institutions will simply introduce more complexity into their attempts to investigate these dreadful events and paradoxically reveal more of what we do not know. Whilst the resources at the disposal of an IHI are plentiful, the issues raised over the course of this thesis suggest that these resources are being mobilized without consideration for the contingent nature of investigations. Can contingency be reduced? What other possibilities are available which could help reduce such contingency? This leads to a theoretical impasse under systems theory because contingency is perpetual, whether or not measures are taken to address it.

It was mentioned earlier in this thesis that scholars have advocated the replacement of IHIs with auditing regimes. What would an auditing regime look like? According to Eastman, an audit would assess the risk assessment skills of mental health professionals employed by the NHS Trust under whose watch the homicide took place. An audit would also require mental health professionals to demonstrate their knowledge and skills and demand that local criteria for the admission of patients in the “severe violent risk” category is agreed, along with and protocols for
risk assessment and management.\textsuperscript{22} The triple aim of an IHI - to establish causes and assess professional skill, practice and culpability – has been said to be incapable of maximising “learning from experience”.\textsuperscript{23} Interestingly, Eastman argues that issues of causation and culpability should be separated, with IHIs being limited to the investigation of the former.\textsuperscript{24} Buchanan similarly suggests that IHIs should sharpen their focus.\textsuperscript{25}

Eastman and Buchanan were writing in 1996 and 1999 respectively however, before the amendments to HSG(94)27 and before the routine use of RCA was established. The latter has diluted issues of individual culpability considerably, with a concomitant sharpening of focus on issues of causation. Chapter 6 however revealed that IHIs still continue to ask whether homicides could have been prevented, which Buchanan claims is not a productive line of questioning. Such questions necessitate an answer to the question of ‘why’ (not only how) a homicide occurred.\textsuperscript{26} For example, consider the ‘5 Why’s’ model used by IHIs.\textsuperscript{27} Accounts which gravitate around why a homicide occurred arguably open up more problems than they solve. These accounts ask:

the question of whether our actions are determined by chains of cause and effect which operate according to laws and, hence, predictably? This has detained philosophers and social scientists for centuries. Concentrating on “the chances of a homicide occurring” would avoid the necessity for inquiries to defer to Aristotle.\textsuperscript{28}

Similarly, this thesis has sought to expose the IHIs fetish for such questions and provide a theoretical explanation for them. Such questions arise because Luhmann’s systems theory facilitates a vision of “contingency, unpredictability of social events, explicable only in retrospect and then only by using one or other of the available social systems”.\textsuperscript{29} Remaining faithful to the theoretical framework of this thesis would be to deny that replacing IHIs with an auditing regime would eliminate the problems associated with contingency and indeterminacy. No system of

\begin{itemize}
\item \textsuperscript{22} N. Eastman, ‘Inquiries into homicides by psychiatric patients: systematic audit should replace mandatory inquiries’ 313 (1996) \textit{British Medical Journal} 1069 at 1070.
\item \textsuperscript{23} Ibid., at 1069.
\item \textsuperscript{24} Ibid.
\item \textsuperscript{25} A. Buchanan, ‘Independent inquiries into homicide: Should share common methods and be integrated into new quality systems’ 318 (1999) \textit{BMJ} 1089 at 1090.
\item \textsuperscript{26} Ibid.
\item \textsuperscript{27} Supra., 6.6.4.
\item \textsuperscript{28} A. Buchanan, \textit{op.cit.}, at 1090.
\item \textsuperscript{29} M. King, ‘What’s the Use of Luhmann’s Theory?”, \textit{op.cit.}, p 41.
\end{itemize}
enquiry, audit or investigation can fully appreciate all the nuances of that which is being observed. This is abundantly clear, from the point of view of systems theory.

What systems theory can do however is help produce practical options through an ‘aesthetic’ technique. This is an approach articulated by Teubner, Nobles and Schiff. In other words, rather than attempting to establish complete control over the future by securing the elimination of mental health homicide risks, experimenting with different forms of investigation might well be the most acceptable option. Rather than attempting to fix the perceived flaws of the IHI system, it is best to reveal aspects of mental health homicides which current IHIs are unable to expose. King may complain that this does not take systems theory seriously, but is this just an assumption?

Moreover, an alternative system of investigation can be said to provide ‘crash barriers’ for law and policy-makers. Although mental health homicides attract a diverse set of responses (coroner verdicts, litigation, the establishment of pressure groups and sometimes statutory reform), IHIs have a significant impact on the way mental health services are provided. What is more, they have been known to influence the attitudes of the mental health profession negatively, in the form of defensive medicine. Perhaps reducing the influence of the IHI, or abandoning it all together, might reduce or even eliminate these particular ‘side effects’. Or at the very least, alternative techniques could be used to reveal insights about mental health homicide which were previously not visible.

7.3 Moving Forward
Aside from the view of this thesis that the stated aims and objectives of IHIs are virtually impossible to meet, this work seeks to extrapolate the implications of this for a research agenda in systems theory. After all, it was stated toward the beginning of this work that a novel link

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31 The amending Mental Health (Patients in the Community) Act 1995 was preceded by a series of Parliamentary debates that openly referred to high-profile mental health homicide cases as a motivation to enact legislation. One politician remarked that “a number of high profile cases have inspired the legislation that is before us today – the stabbing and killing of Jonathan Zito by Christopher Clunis in 1992, the murder of occupational therapist Georgina Robinson and the injuries received by Ben Silcock after he climbed into the lions’ enclosure at London zoo” (see HL Deb, vol. 262, col. 169, 20 June 1995).
32 See P. Munro, op.cit., p 247.
between systems theory, risk theory and accountability theory could be developed so as to illuminate the contours of the law, policy and psychiatry interface. The context of an IHI has provided a very fruitful way of achieving this.

This thesis does not attempt to completely reform systems theory. This thesis prefers to regard systems theory is a useful tool that can help challenge some taken-for-granted assumptions about how IHIs operate and what their effects are. This correlates with a growing scepticism expressed by law and policy-makers generally of the attainability of their goals. These goals, namely, the learning of lessons and the prevention of future homicides, have demanded an increasingly cautious approach. For example, this thesis has demonstrated that the incorporation of RCA and the greater involvement of mental health professionals in investigations over the past decade is representative of law and policy-makers call for more ‘objectivity’ when it comes to investigating mental health homicides. In this sense, therefore, law and policy-makers share a similar scepticism to that expressed by the present thesis.

The latter, nevertheless, goes further by isolating law and policy-makers call for more objectivity as equally problematic; the implications of using systems theory in the way advanced in this thesis does not take the quest for objectivity for granted. This quest, which law and policy-makers commit to wholeheartedly, is something that is equally inerred with distinct meanings. These meanings, regardless of their scientific appearance, have a self-producing life of their own. They are impervious to shared understandings in communities that are inerred with different meanings. They reinforce the communication systems from which they form. Systems theory will ensure that the paradox in communicating continues to re-appear. As a consequence, the goals of ‘learning lessons’ and ‘preventing future homicides’ are not really goals at all. They are symbols which obscure the non-instrumental character of social systems. This can be distinguished from the ‘first-order’ point of view of mental health professionals, law-makers and policy-makers. These consider the extent to which these ‘goals’ are attained, which is not that often or even at all. It just so happens that their ‘target’ – learning lessons and preventing future homicides – is elusive and unreachable due to the high level of complexity and contingency contained in their investigations. Even if their ‘target’ was reached, it would not detract from the argument advanced by this thesis, namely, that the way IHIs function is not normative. They are non-
instrumental expressions of social systems communicating about mental health homicide autopoietically.

With this in mind, there is scope to consider the way in which the IHI performs other, less visible roles as an off-shoot of its non-instrumental character. These less visible roles could be the facilitation of psychological closure for families, the need for transparency in public services and so on. It could be said that the arguments regarding accountability in IHIs advanced in Chapter 5 could be developed into a wider concern about the public’s need for greater transparency; does the obfuscation of human agency in multiple accountability relationships reposition the public’s expectations of transparency when it comes to accounting for decisions in cases such as these? When looking at IHIs, is there more to recognising their attempts to communicate and apparently failing to do so? These are further points to consider.

The all-encompassing breadth of systems theory however gives it an incredibly inflexible appearance. What this thesis has sought to do is to introduce some flexibility into the theory without changing it. The pertinent links made with risk and accountability theory especially have allowed for rich contextualisation. At the same time, the work has sought to maintain a link between Luhmann’s systems theory and his theory of risk, which one scholar argued was somewhat absent in the latter. Systems theory is known for its excessive abstraction, so by taking the trajectory that it has, this thesis has sought to meet the challenge of this criticism and make the former practically relevant.

What is more, this thesis has done this by answering a series of interconnecting questions about what systems theory can teach us about adverse events and our responses to them. Adverse events, mental health homicides being an obvious example, are just one current source of risk debate. Combined with a growth of administrative mechanisms designed to address such adverse events, implications arise about how individuals, connected by decision making relationships, are held to account in an increasingly complex society. This is a challenge which potentially obscures what may have been once a relatively simplistic connection between law, policy and psychiatry. But with the onset of new quasi-legal mechanisms, such as the IHI, having the ability to penetrate complex areas of decision making, new theoretical tools are needed to

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33 Luhmann’s writings on risk have been described as being the “least autopoietic” of his writings (see A. Phillipopoulos-Mihalopopulos., *Absent Environments* (Oxon: Routledge-Cavendish, 2007), p 120.
conceptualise these developments. Systems theory is a suitable starting point in this respect but it need not be an end point.

The task for any future research agenda in this area is to appreciate that the links between law, policy and their target area, whether that is mental health care, workplaces, banking institutions or oil platforms, can be illuminated considerably in the context of adverse events and disaster responses. Using systems theory to do this is essential because it possesses the conceptual apparatus necessary to explain why these responses are prone to what would be considered by many as failure, indeterminacy and outright confusion.

Luhmann’s systems theory is known for its pessimism however, 34 arguably ‘diminishing’ (or changing, depending on one’s viewpoint) the status of, but not exactly ‘doing away’ with, the individual. This need not be the case if systems theory is regarded as one tool of many which is adept at explaining why adverse events happen and why responses to them appear unsatisfactory. Scope for further theoretical development is possible too, perhaps in the form of using systems theory in conjunction with governance theory. This was mildly alluded to at various points throughout this thesis. Systems theory nevertheless represents a potential source of greater appreciation for how the complexity of technical decision-making industries can be understood. Indeed, it was Luhmann who argued that a theory must become more complex in order to be better able to deal with social phenomena. 35 This is certainly something which traditional theories are increasingly becoming less able to accomplish. This thesis argues that systems theory and its different styles of application, whether that is in the context of risk or accountability, can meet this challenge.

34 Ibid., p xi.
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