Psychiatric Bulletin (2008), **32**, 307–309. doi: 10.1192/pb.bp.107.017020

special articles

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Oxford serious incident review: 7 years on

In 2000, an article published in this journal described a method of reviewing serious incidents based on peer group discussion, a model then in its sixth year (Rose, 2000). This paper describes how the model has changed in response to the National Health Service (NHS) developments since then.

The original purpose of the review had been to expand the range of people involved in identifying lessons from 'bad clinical outcomes'. Staff of all grades and from every mental health discipline were included, as well as other professionals such as the police, the fire brigade, medical ethicists, health and safety experts, and lawyers. The reviews took place three times a year, lasted 3 hours, used external facilitators, and resulted in a report being forwarded to the organisation's operational board. Progress on implementing recommendations was fed back in subsequent meetings. The reviews proved popular, partly because of the sense of local ownership the process fostered, and partly because they were an opportunity to discuss difficult cases from a wide range of perspectives.

Since 2000, three particular changes in the NHS have influenced how the reviews have developed: the expansion of formal management procedures for dealing with 'bad outcome' incidents; the appearance of new ways of delivering the clinical service; and a greater interest in analysing the failure of systems rather than individuals. Although these influences have shaped the content of the peer reviews, the basic structure has remained unchanged.

How the peer reviews have changed since 2000

Compared to 10 years ago, serious incidents are now much more likely to be the subject of a formal management-led review, frequently with external input. The peer group review has therefore moved from often being the sole form of inquiry, to usually complementing a prior management-led one. As a result, the findings of these inquiries are now routinely presented at the peer review meetings. This is usually done by members of the inquiry team, in addition to a presentation by the relevant professionals involved in the case. The fact that this arrangement works reflects the gradual build-up of trust in the process over time, helped by tough adherence to a 'no blame' culture. As a result, the interests of good patient care are served by an extremely inclusive review process, which combines peer group frontline expertise with managerial inquiry skills. Clinicians and other professionals benefit through regular participation in case-centred discussions about managing risk, while management benefits through enabling frontline staff to be part of the process of identifying and learning lessons from bad outcomes.

The complexity of psychiatric care delivery has increased in recent years, with the development of a great many more specialist teams working alongside each other, especially in the community. One of the unintended consequences of this more compartmentalised way of meeting needs is that service users often seem to get into trouble at team boundaries (Appleby, 2006). The peer review process, because it draws its participants from across and beyond the organisation, has therefore become a key tool for taking a cross-boundary system-wide approach. This has been as important within and between clinical departments as it has been between agencies.

During the 1990s, as mental health services moved increasingly into the community, they became more politicised. One of the consequences was the development of a serious incident culture, fed by the media and politicians, where blame was legalistically apportioned (Salter, 2003; Neal, 2004). However, this culture has been increasingly challenged and seen as producing little new knowledge at considerable cost. Salter (2003) writes of inquiries as being essentially unhelpful because they all reach similar conclusions, the implication being that serious incident inquiries imposed from above may not be sufficient in themselves at getting people to learn from bad outcomes. More inclusive ways need to be found which will recruit as many staff as possible in order to achieve better ownership of reviews and their recommendations. But this was not easy in the highly politicised serious incident climate of the 1990s.

Arguably, this politicisation has abated a little in recent years, or at least been deflected onto other areas of medicine. This has coincided with a slight shift in thinking about bad outcomes, and the realisation that the causes of untoward events in large organisations often have complex interrelationships and need to be reviewed in this light (Andersen & Fagerhaug, 2000; Vincent *et al*, 2000; Neal, 2004). The peer group review has from the start taken a more inclusive systems approach to understanding bad outcomes, and recently this has become even more evident. Importantly, it has also become the norm in local management-led inquiries. This is exceptionally important, for a peer group review system will find it hard to survive in an organisation that tends to blame individuals.

One final change over the years, in response to internal demand rather that outside circumstances, has been to use the review as a platform for presenting general information on risk. Areas covered have included nationally publicised inquiries, local audits, the National Confidential Inquiry reports (Appleby, 2006), Driver and Vehicle Licensing Agency and gun law briefings, evidence-based reviews, and presentations from the local Multi Agency Public Protection Arrangements, Multi Agency Risk Management, and the NHS counter fraud and

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security management service. Where possible, these presentations are linked to local incidents or circumstances.

Before and after 2000

Incidents reviewed

Table 1 lists the incidents reviewed during the years 1994–2007. The range of incidents appears to have broadened post-2000, and for the first time included sexual assaults and sexually inappropriate behaviour, driving and firearms incidents, the stalking of staff, illicit drug use on in-patient units, and system failures such as boundary problems between teams, and temporary ward closures due to escalating challenging behaviour. The reason such incidents were not covered before 2000 may reflect a different perception of review priorities, which in the 1990s were dominated by a newly introduced government target for reducing suicides. The inclusion of sexual incidents after 2000 may reflect a growing awareness of the difficulties of looking after acutely ill in-patients on mixed-gender wards, where those with challenging behaviour may be nursed alongside people who are both vulnerable and exploitable. It is also possible that higher thresholds for admission combined with bed losses have concentrated behaviour problems in a way that makes sexual incidents more likely. However, since early data collection on the frequency and severity of such occurrences is unreliable, it is difficult to be certain about this. The concentration of challenging behaviour effect may also have contributed to the more alarming occurrences of hostage taking, police use of CS gas, and ward closures due to escalating behaviour problems. The serious incidents of illicit drug use on hospital property appeared to reflect a growing problem in the local community since the late 1990s.

Table 1. Oxford serious incident reviews 1994–2007

Incidents reviewed	1994–2000	2000–2007
Suicide	27	29
Homicide	1	2
'Near miss' of suicide or homicide	11	3
Physical assault (in hospital)	14	9
Sexual assault (in hospital)	–	8
Inappropriate sexual relationship (in hospital)	–	3
Hostage taking (in hospital)	–	2
Use of CS gas (in hospital)	–	1
Illicit drug use (in hospital)	–	3
Offending while on leave	–	1
Psychiatric system difficulty	–	3
Firearms issue	–	4
Driving issue	–	1
Stalking of staff	–	2
Arson on hospital property	7	1
Hypothermia while AWOL	1	–
Cardiac arrest during ECT	1	–
Patient found unconscious in disused part of hospital	1	–
Total number of incidents	63	72

AWOL, absent without leave; ECT, electroconvulsive therapy.

Lessons learned

Lessons learned as a result of the reviews can be grouped into the following five categories: reduction of means of injury; care quality; training; clinical practice and procedures; and staff needs.

1. Reducing the means of self-injury and improving response to emergencies were themes that often dominated reviews in the 1990s, and led to much work on training, ward design and equipment availability. Training particularly focused on risk assessment, resuscitation, emergency response, management of challenging behaviour, and the implementation of special nursing observations. Recently, however, these themes have become less central, possibly because more robust systems have been put in place and maintained.
2. In contrast, issues relating to care quality have stubbornly persisted despite apparent service improvements, and these remain challenges for the future. Sensitivity to the needs of women, and of relatives and carers, as well as meeting the psychological treatment needs of in-patients appear to be tenacious themes that recur despite attempts to improve services. This could partly be attributed to rising expectations, but may also reflect stretched resources, poorly targeted training, or attitudinal resistance of staff. Important new themes that emerged since 2000 were meeting the needs of bereaved relatives, and safely caring for vulnerable adults on busy units.
3. Training in dealing with risk and emergencies dominated the early years of the review, but since 2000 additional themes have included the need to acquire skills in managing individuals with personality disorder, in helping families and carers, and in detecting children or elderly people who may be at risk. The need for more comprehensive staff-induction programmes, greater awareness of driving and firearms issues, and the training of service users working as volunteers, were also highlighted.
4. The main emphasis in relation to clinical practice and procedures appeared to shift away from more intra-team issues such as absent without leave (AWOL) procedures, use of special observations and discharge processes that characterised pre-2000 reviews, towards a greater focus on collaborative working between teams and between agencies. The main agencies involved were the police, the crown prosecution service, public protection committees and general medical services. Within the mental health organisation, operational relationships between the new generation of specialist acute and rehabilitation community teams and the rest of the service were a recurrent theme. This seemed to be in response to a perceived greater compartmentalisation of clinical services. The opportunity for different parts of the service to get together and discuss the journey of care where the outcome had been

https://doi.org/10.1192/pb.bp.107.017020 Published online by Cambridge University Press

bad became particularly important during this time, for example in relation to a series of incidents involving the emergency home treatment team.

5. Finally, staff needs have remained an enduring theme throughout, not surprisingly since bad clinical outcomes are stressful for the professionals involved. Issues such as access to psychological help, security arrangements, and the way the organisation responds to wilful assaults on staff give important signals to the workforce, and all have been improved over the years. But perhaps the most influential factor is the staff's perception of whether the organisation fosters a no blame culture when conducting serious incident inquiries. This is hard to measure, and is obviously highly subjective, but may have a profound effect on morale if the balance is wrong. The perceived culture of the organisation has been a recurrent topic for discussion at peer review meetings, and although there is an inevitable tension around this issue (after all, the organisation must hold its staff to account for their actions), certain characteristics of the meeting encourage transparency in a way that makes it harder for the organisation to be seen as blaming if it in fact isn't. These include the presence of senior executives at meetings, and the presentation of inquiry outcomes by their authors.

Constraints and difficulties

Not all bad clinical outcomes can be put down to system problems. Individuals can make serious mistakes, or be negligent, and need to be held accountable. In these situations, particularly if there appear to be no wider lessons to be learned, an incident may be less suitable for a peer group approach, or perhaps may need to be looked at anonymously. For the aim is not to have a witch-hunt, but to look at bad outcomes in an atmosphere that fosters trust, openness, and self-reflection, but does not shy away from asking penetrating questions.

Conclusion

A long-established peer group serious incident review has adjusted to recent NHS changes, with its importance, if anything, growing over time. This is partly because it enables as many clinical staff as possible to contribute to the organisation's thinking about risk management, and partly because it serves as an effective educational tool. This latter role will become of ever greater importance as the education agenda of Modernising Medical Careers takes effect, with its emphasis on self-reflectivity and learning within the clinical context. In fact, one of the challenges for all health systems trying to improve clinical care is to design effective structures and feedback loops for learning from bad outcomes, and for these to become deeply embedded within an organisation's learning culture. It is hard to envisage peer reviews not playing a key part of this learning and governance philosophy in the years ahead.

Declaration of interest

None.

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Psychiatric Bulletin (2008), **32**, 309–311. doi: 10.1192/pb.bp.107.018242

KEITH HAWTON, SUE SIMKIN AND SIAN REES

Help is at hand for people bereaved by suicide and other traumatic death

Bereavement following suicide is traumatic. Guilt, shame, stigma and feelings of rejection and isolation set it apart from the sadness following other kinds of death and may make it difficult for the bereaved person to obtain help (Harwood *et al*, 2002; Hawton & Simkin, 2003; Beautrais, 2004). The necessary official processes surrounding death by suicide, like the police and coroner's investigations, can add to the trauma (Biddle, 2003). This may be compounded by inaccurate or insensitive media reporting. Bereaved individuals are at risk of increased morbidity from abnormal grief reactions (Mitchell *et al*, 2005) and suicide (Qin *et al*, 2002), and they often need considerable support (de Groot *et al*, 2006; 2007).

Bereavement through suicide is not uncommon. There are about 5500 deaths by suicide each year in the UK and it is suggested that on average 6 people are deeply affected by each one, which amounts to at least 30 000 bereaved individuals per year. If we take into