Commentary on "Inquiries: who needs them?"

Adrian Grounds

Matt Muijen's paper adds to a chorus of recent criticism of independent homicide inquiries. Others have similarly called for a more curtailed, selective approach to carrying out independent reviews following such events, arguing that a model of clinical audit with low-key hearings held in private would be appropriate and less damaging (e.g. Eastman, 1996*a*, 1996*b*; Lingham & Murphy, 1996).

I agree with Dr Muijen that some central coordination of present arrangements is needed. However, the claim in his paper that inquiries are redundant is mistaken. The argument is too dismissive, fails to take proper account of the public interest, and ignores the lessons of history. The reply to the question in the title – 'Inquiries: who needs them?', is that the bereaved need them, the public needs them, and psychiatry needs them.

The most compelling reason for holding independent inquiries, and for public rather than private hearings, is their importance for the families who have been bereaved. Rock's (1996) study of families bereaved by homicide should be widely read. Families have two overriding concerns: first, that they should know what happened, even if the process of learning is an ordeal; secondly that what happened to them should not happen to others in the future. Rock observes:

> "Monetary compensation or retribution are not always principally at issue, although the consequences of death can be expensive and painful. Rather, the search should be seen in part as a quest for a special form of redress to the victims and those who mourn them. There is a need for the reassertion of moral balance that can be achieved only by emphasising responsibility and accountability when wrongs or mistakes are committed, and there is more involved; it is as if those with responsibility in the criminal justice system and health services should be required to work hard to mark the gravity of the homicide itself, to behave as if they regard murder and manslaughter in a manner considered seemly by the bereaved.
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> "At issue too is a desire to be represented, to be considered formally a participant in procedures that touch their own affairs so closely, to be acknowledged and respected, to be given dignity . . . There are often sound practical needs behind the demand for representation; the bereaved may be moved by the wish effectively to communicate what is known to them alone; they would wish to learn as much as they can, and most would wish to ensure that what had afflicted them should not afflict others. But there are symbolic demands as well. At stake, it may be supposed, is the analogical reasoning that asserts that recognition of their worth and their right to be accepted may be read as signs of their own emotional investment in the death, the consequentiality of the victim and the suffering that his or her death has wrought" (Rock, 1996; p 117–118).

Inquiries are a means of public education. An inquiry that is thorough, questioning and also self-questioning in its examination of a set of services and a psychiatric case history is a vehicle not only for exposing failures of good practice where they occur, but also for conveying a better understanding of the nature and limitations of psychiatric skills, mental health services, and the social expectations that surround them. An inquiry report may also be a means of publicly correcting the unfair criticism and victimisation of individual clinicians that often characterise early press reports following a homicide. Contrary to Dr Muijen's assertion, the methodological problems of inquiries – such as hindsight bias (Fischoff, 1975) – can be avoided, and the conduct of an inquiry can be a self-critical process (Blom-Cooper *et al*, 1996).

Psychiatry needs inquiries because external criticism helps shape our history. In the short term, inquiries raise the profile of mental health services and provide leverage for resources, improvement and change. They draw the attention of politicians and purchasing authorities to the services when otherwise this area of medicine could remain relatively neglected.

One notable feature of inquiry reports is that although they are about local disasters, they are seen as conveying messages of general importance, and indeed reports have produced a wide range of general recommendations. But, contrary to Dr Muijen's suggestion that this is a recent departure, a reading of previous reports reveals that inquiries into local services have always tended to make recommendations on matters of national application (Sheppard, 1996). The first of the hospital inquiries into Ely Hospital, Cardiff, in 1969 (National Health Service, 1969) had terms of reference with a local focus, but

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nonetheless made recommendations about the NHS administrative structure, the need for a national system of inspection of mental hospitals, and revised procedures for complaints and inquiries. In the long term inquiry recommendations help change policy.

During the series of inquiries into psychiatric hospitals during the 1960s and 1970s there was a similar reaction of opposition within the profession. In 1979, Edwards & Inskip (who had been chairmen of the South Ockenden and St Augustine's Inquiries) commenced their paper in the *Lancet* on Mental Hospital Inquiries:

> ". . . inquiries burn up money that is desperately needed to improve the Health Service, disrupt the work of the hospital, and often have a devastating effect on individual and group morale, leaving in their wake a legacy of corrosive bitterness. They should be avoided wherever possible." (Inskip & Edwards, 1979; p 658)

The immediate effects of these inquiries were similar to those experienced today. The professionals involved suffer severely, traumatised staff may leave for other jobs, and the local service as a whole may become less willing to accept responsibility in the future for similar patients. However, the parallels with the earlier inquiries suggest that we should not judge the effects of the recent homicide inquiries too early. There is now wide acceptance that in the long term the hospital inquiries were important in reforming services. As Martin's (1984) analysis persuasively demonstrates, the hospital inquiries helped shape our current concepts of good and bad practice, and our understanding of the causes and constituents of poor clinical care. They also contributed to the case for new legal and administrative safeguards for hospital patients.

In a generation's time the current series of homicide inquiries may come to be seen in a similar light. They are not to be dismissed as a moral panic. They may be telling us something about the state of psychiatry, about its failure in the reforms of recent decades to provide the security and public protection of the past. The truth is that contemporary psychiatric services are not primarily designed to protect the public. If that was the primary aim we would not have a mental health policy emphasising community based care wherever possible, placement in the least restrictive alternative setting, contraction of the hospital estate, minimal use of compulsory powers and of hospital beds, and gatekeeping to secure provision so powerful that even criminal courts cannot direct entry into it. In terms of the balance of provision, legal arrangements and ideology, the services are not designed to deliver public safety as a priority. (Why is it that the more violent an acutely ill patient is, the more difficult it is to obtain immediate hospital admission?) The new panaceas of risk assessment (Royal College of Psychiatrists, 1996), assertive follow-up and strengthened supervision are not discriminating or powerful enough to provide a replacement means of social defence against serious offending by the mentally disordered. Nor is it the primary function of a hospital to provide crime prevention. The main criterion for entry to hospital is serious illness, not the need for social control. But in the public mind, and in the structure of mental health law, hospital is still seen as a place of custody.

Psychiatric scandals are important levers of longer-term reforms. The prevailing criticism of psychiatry in our age is not its excess of social control, but its failures of social control and public protection. We may be in the throes of a painful transition: at the present time it may be the voices of families and victims that are prophetic in showing where we need to move, as they articulate a need for services more sensitive to their concerns, and a need for changes in professional attitudes that may be taken for granted in a generation's time.

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