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Homicide and Health Care: Context and Complexity

1. INTRODUCTION

Health care services treat thousands of mentally-disordered individuals every day. Many of these individuals are considered to be a public danger by the professionals they are treated by because they behave violently or show indications of future violent behaviour. A minority of these individuals have gone on to commit homicide. These events are dreadful. They severely impact the families of the victim and the perpetrator. They unsettle the local communities in which they occur. They are sensationally reported in the media. They jolt important legal and governance mechanisms into action. An important governance mechanism is an independent investigation (or inquiry) into health care services. These investigations animate what the author refers to as the patient homicide governance space. The patient homicide governance space refers to an investigatory domain constituted by diverse communications systems (eg, medicine, law, politics, morality, mass media) about patient homicide. The author rigorously examines the space through a novel appeal to social theory and empirical methods.

The author’s focus however is a process of ‘looking through’. It is concerned with looking through common descriptors like ‘investigation’ and ‘inquiry’ and embarks on an original, yet demanding, analysis of how patient homicide and health care resonate through the patient homicide governance space and indeed how they resonate throughout society. These descriptors indicate, rightly, that there is a procedure through which health care services are placed under scrutiny, accountability established and truth-seeking carried out. These terms however provide only a partial description of what these investigations are. They are much more than these descriptors suggest. A fuller, more comprehensive and original, account of these investigations requires conceptualising them as moments of observation and sense-making about a range of different ‘events’ by different observers. Independent investigations into patient homicide are more reliably understood as being constituted by moments of observation and sense-making about homicide and health care services.

These moments of observation and sense-making assume different forms. For example, an observation about a homicide incident may be carried out by an investigator or a health care professional merely through thinking about it; it is the minds of these actors that observe. The ‘stuff’ out of which these observations are made is consciousness (or cognition). Consciousness is invisible to others. We are unable to look into someone else’s mind and observe what their mind observes. We are however able to observe the utterances of information by others (eg, a spoken word, a hand gesture) and form an understanding of what the information means. For example, an investigator commissioned to investigate health services after a patient homicide may observe the ‘facts’ of the incident by uttering information that is understood in one or more senses, in society. The investigator may use a specific investigatory technique, accredited by science and recognised by others as such, because it serves the purpose of establishing truth about the case. On the other hand, an investigator’s finding might be later referred to by a judge or a lawyer in a legal action for judicial review. Consciousness, albeit crucial to the operation, ceases to play a direct role in producing the scientific and legal meanings in these scenarios. These meanings are observable and accessible throughout society generally; persons could be hundreds of miles apart and not interact with each other in any way, but they may all engage or step into science and appreciate the scientific ‘truth’ of a patient homicide event. In similar fashion, everyone may step into law to understand the same event. Scientific and legal meanings are produced within overarching, yet distinct, structures of life that everyone is familiar with and may step into, despite the physical barriers that may exist between persons. In short, science and law have social significance. Both have distinct, widely-recognisable functions and they are accessible to everyone.

The book’s core argument is that the patient homicide governance space produces a range of socially-available, yet highly distinct, meanings through a specific form of observation: social communication. The book’s argument is developed through the lens of Niklas Luhmann’s general systems theory. Systems theory will be fully explained in later chapters. For now, it is sufficient to comment that Luhmann’s theory provides the important conceptual material required for making the book’s argument come to life and say something original about how patient homicides are addressed and understood in society.

Luhmann’s work helps illuminate a diverse range of social phenomena that other, more conventional approaches, are unable to do. Conventional approaches, such as looking at investigations from an ideological perspective or from a legal-political perspective (eg, as forms of public accountability) are unable to capture the level of detail behind these processes that systems theory is able to capture. Systems theory, moreover, avoids the assumptions adopted by conventional theoretical approaches. Conventional approaches focus on whether governance procedures are well-positioned to establish ‘the facts’ or ‘the truth’, whereas the theoretical approach adopted here refrains from assuming that ‘the facts’ or ‘the truth’ are out there waiting to be discovered. Rather, ‘the facts’ and ‘the truth’ are constructed within closed function systems of social communication. For example, ‘the facts’ and ‘the truth’ are internally constructed within each system as an event of significance. ‘Facts’ and ‘truth’ have economic significance in the function system of the economy, legal significance in the function system of law and so on. Each instance of significance is a construction with a closed structure of communication that is unable to directly communicate with other structures of communication for the purpose of deriving an objective understanding about events in the world.

The widespread assumption, then, that pre-defined change to health services after patient homicide through the implementation of policy techniques and decision making is possible is open to question. Indeed, the book’s contribution radically questions contemporary policy approaches to patient homicide using the novel theoretical approach summarised thus far. In particular, it seeks to moderate the expectations that are formed around patient homicide governance. The book is therefore important for policy makers and academic scholars. It showcases an ambitious approach to a controversial area that is often loaded with the expectation that truth can be gleaned and lessons can be learned. The author however suggests that these expectations oversimplify the governance arena.

1. PATIENT HOMICIDE AND HEALTH CARE

In March 2013, Christina Edkins was randomly stabbed to death on a bus by Phillip Simelane. Phillip was known to local health authorities prior to the incident. He had been receiving mental health care and treatment for his schizophrenia and an independent inquiry was set up after the killing. Its panel judged that those responsible for Phillip’s care and treatment had not properly diagnosed his condition. The incident raised important questions: if Phillip’s condition had been properly diagnosed, would Christina still be alive today? If his condition had been managed differently, would the hallucinations that commanded him to commit the crime that day have occurred? Would better management have enabled staff to recognise his deteriorating condition much earlier and take timely action? Similar questions were raised in relation to a double homicide committed in 2015. The perpetrator killed his mother and sister. Like Phillip Simelane, the perpetrator was well-known to the authorities. He had previous convictions for robbery, assault, drug possession and received an official diagnosis of paranoid schizophrenia and personality disorder in 2014. He was imprisoned for a period of time and was scheduled to attend an outpatient appointment on his release to ensure that his condition could be properly managed. An independent investigation set up in response to the killings found that the perpetrator failed to attend his appointment and that he did not experience any contact with mental health services between the time of his release from prison and the incident.[[1]](#footnote-1) In the same year, a patient in receipt of mental health services in Greater Manchester punched a man in a public house, causing fatal brain injuries. The patient had a long history of contact with the police and mental health services. The incident raised a familiar set of questions about the care and treatment received prior to the attack. An independent investigation found that the patient’s actions were ‘predictable’.[[2]](#footnote-2) In more recent times, in an event that made national news, Jeroen Ensink was stabbed to death outside his home. Jeroen had briefly left his house to post letters announcing the birth of his new baby daughter. He encountered the perpetrator shortly after leaving his home and was fatally stabbed. The perpetrator was not known to local health authorities, although he was known to the police and had a history of receiving mental health care in Nigeria.[[3]](#footnote-3) Again, questions surfaced over whether public authorities could have done more to address the perpetrator’s condition prior to the killing.

 According to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), 11% of all homicide convictions in the United Kingdom between 2005 and 2015 were committed by mental health patients.[[4]](#footnote-4) There were, according to the figures, 835 patient homicides over the NCISH’s report period and an average of 76 homicides per year.[[5]](#footnote-5) Patient suicides are far more common; 1,538 occurred in 2015.[[6]](#footnote-6) Unlike mental health suicides however, mental health homicides resonate in society more acutely. The rate of patient homicides in England since 2009 has declined, but they are still reported widely in the media because they prompt questions of public safety in ways that suicides do not. Local communities are gripped by the realisation that an individual treated by health professionals for his or her mental disorder subsequently goes on to commit acts of violence. The relatives of the deceased express anger, disbelief and frustration at the authorities; how could an individual, known to the authorities, go on to commit a dreadful act leading to loss of life? What care and treatment did the perpetrator receive and was it adequate? Who is to blame? These questions often get asked. An inquiry is set up. The learning of lessons is made a priority. The same questions and concerns are voiced when new incidents happen. The procedural and emotional cycle starts over: anger, disbelief and frustration are expressed. A slew of familiar questions are asked that the authorities are called upon to answer.

The author goes behind the process of investigation and questioning around homicides committed by mental health patients. It rigorously examines the investigation’s dynamics as a governance space replete with ambitions, conflicts, tensions and challenges. It forges a new understanding of the complexities within, drawing attention to a neglected area of concern. The purpose of the present chapter, in particular, is to provide essential context for the book. It describes the wider context in which these investigations are situated and identifies relevant theoretical issues, followed by a short list of central research questions.

1. BACKGROUND AND CONTEXT

The killing of a human being by another is known in law as a homicide. Homicide is a criminal offence and two forms of the offence exist. The first is murder and it requires an intention to kill or commit grievous bodily harm.[[7]](#footnote-7) The second is manslaughter. Manslaughter does not require an intention to kill or commit grievous bodily harm. If any of these two offences are committed, a series of other legal and quasi-legal measures and responses are triggered. On the one hand, the perpetrator is arrested, charged, sent to trial and is usually given a custodial sentence if found guilty. On the other hand, a coroner’s inquest will be held. A death certificate will be signed. The family of the deceased may initiate legal action in the civil courts. If the perpetrator was receiving care and treatment for a mental disorder at the time of the offence, an independent investigation or inquiry[[8]](#footnote-8) into that care and treatment must be conducted.[[9]](#footnote-9)

 Mental health care and treatment in the United Kingdom is delivered by health professionals employed by the National Health Service (NHS). As a publicly-funded institution, the NHS is an arm of the state.[[10]](#footnote-10) It employs clinicians and nurses to make important decisions about the physical and mental health of individuals. These employees also make important decisions about individuals who present public safety concerns. Many individuals treated by the NHS exhibit violent behaviour or tendencies because they have serious mental health problems. These patients are treated in spaces of legal, regulatory and administrative activity. It is apposite to provide an overview of these spaces with a view to adding context to the governance landscape.

1. **The General Legal Context**

All EU Member States have a legal duty to respect citizens’ right to life under Article 2 of the European Convention on Human Rights (ECHR). A Member State’s duty to respect Article 2 is *prima facie* breached if a citizen is unlawfully killed.[[11]](#footnote-11) The European Court of Human Rights (ECtHR) has accepted that the obligation is activated in ‘a variety of situations where an individual has sustained life-threatening injuries, died or has disappeared in violent or suspicious circumstances, irrespective of whether those allegedly responsible are State agents or private persons in violation of Article 2.[[12]](#footnote-12) These investigations must have special qualities: independence, effectiveness, speed, transparency and next-of-kin involvement.[[13]](#footnote-13) Homicides committed by mentally disordered individuals who, at the time of the offence, were under the care of NHS professionals activate the Article 2 duty to investigate.

Article 2 jurisprudence relating to the duty to investigate germinated in challenges to the quality of investigations into loss of life caused by the state’s use of force.[[14]](#footnote-14) The ECtHR heard a series of cases and reasoned that there exists an implicit procedural requirement to hold an official investigation in such circumstances.[[15]](#footnote-15) It was argued in *Ergi v Turkey* that the Article 2 investigatory requirement was confined to cases where the state had, in fact, caused loss of life. The ECtHR however rejected the argument. The court, furthermore, did not specify the situations which could activate the implicit requirement however, thus creating broad scope for the duty to be etched into a range of situations involving loss of life.

The ECtHR’s early jurisprudence set the stage for later judicial developments in the area of hospital fatalities. It was successfully argued in *Powell v United Kingdom* that the duty to investigate was triggered where a surgical or medical procedure led to the loss of life. The reason that the argument succeeded was founded on the view that the state must ‘take appropriate steps to safeguard the lives of those within its jurisdiction’.[[16]](#footnote-16) The ECtHR therefore interpreted Article 2 broadly, albeit with the caveat that it was a procedural right. It referred to previous case law relating to the use of force and ruled that the state must create an effective investigation framework into losses of life in hospitals.

The NHS is an agent of the state for Article 2 purposes and the duty to conduct an official investigation is therefore a compelling one for public health authorities in the UK. The Court in *Powell* held that where a Member State makes adequate provision for securing high professional standards and affords adequate protection for lives, matters such as medical judgement errors or negligent coordination between professionals are sufficient, of themselves, to trigger the duty to investigate in the event that life is lost.[[17]](#footnote-17) Governments must therefore create the conditions for these events to be effectively investigated and the causes identified.

Different types of investigation (eg, a police investigation, a coroner’s investigation, litigation) may fulfil the Article 2 obligation. Investigations assume different forms, do different things and have different purposes depending on the circumstances. The investigation conducted by the police is different to that conducted by the coroner, for instance. All investigations however must be effective if they are to comply with Article 2. It is crucial that an effective investigation of any type must establish and examine the relevant facts. If a patient in the care of health professionals commits a homicide, then an investigation into the health services provided prior to the incident must occur if it is to be effective under Article 2. The services provided are, after all, fundamental to the relevant factual background. Establishing the relevant facts however requires special knowledge and skill. Clinical experts, knowledgeable of health care services, are regarded as best-placed to effectively establish these facts.

1. *Regulatory and Administrative Context*

The regulatory and administrative context of investigations is equally crucial. The NHS is expanding in size and complexity. Investigators must investigate it or at least a part of it when things go wrong. One million patients are treated by the NHS every thirty six hours.[[18]](#footnote-18) It employs almost 1 million people. For the 2016/17 financial year, the Department of Health allocated £117.6 billion in revenue funding,[[19]](#footnote-19) with approximately £110 million allocated to commissioning expenditure alone.[[20]](#footnote-20) Mental health services represent a smaller fraction of NHS activity, but thousands of health professionals are involved in it; hundreds of hospitals, clinics and agencies around the country underpin these services. They manage patients with complex mental disorders, chaotic histories, drug problems, nomadic behaviour patterns and violent tendencies.[[21]](#footnote-21) The hundreds of decision-making sites that manage these individuals form complex networks of responsibility. The investigation of health services after a patient homicide is therefore challenging. Ethical controversies emerge out of these incidents.[[22]](#footnote-22) Perpetrators are sometimes shown to have experienced contact with public services outside traditional health services. The police, probation services, courts, prisons and social housing agencies may have been involved with the perpetrator at any one time. It is common for investigations to focus on a number of different sites of decision-making that appear separated-out from each other and differentiated along functional lines. For instance, investigations focus on decision makers in medicine primarily, but also engage decision makers in politics, law and regulation. Investigations are compelled to understand these spheres of operation. They examine an environment of different technical disciplines, administrative procedures, governance mechanisms and market-based practices.

The regulatory and administrative environment of independent investigations into health services after patient homicide is hard to define, but the ‘regulatory state’ is a well-known conceptual tool which may be used to produce a useful sketch. The ‘regulatory state’–at its core–is an analytical construct that depicts complex changes in how the state is configured.[[23]](#footnote-23) These changes are varied, but they include elaborate governance practices: the privatisation of State-owned assets, the ‘contracting out’ of state functions to the private sector,[[24]](#footnote-24) the growth of independent regulatory agencies, the separation of policy-making and service delivery functions, the increasing reliance on rules and standards and new forms of economic organisation (eg, incentives).[[25]](#footnote-25) The regulatory state refers to a ‘style of governance away from the direct provision of public services associated with the welfare state and towards oversight of public services by others.[[26]](#footnote-26)

These developments have been accompanied by the growing concern that governments are incapable of addressing social problems. Governments are publicly distrusted even. A variety of forums (eg, interest groups, the media) have become the vehicles for the expression of doubt about the competency of government to manage services for the greater good. Administrations are often perceived as failing to achieve their aims and objectives.[[27]](#footnote-27) Scandal, disaster and incompetence all contribute to the negative perception of governmental competence. A distrust of those traditionally considered to be best-placed to resolve these problems (ie, politicians) has set in.[[28]](#footnote-28)

Governments increasingly delegate more important tasks to external agencies and expert bodies however as a way to manage complexity in society more reliably. For example, independent regulators and non-departmental public bodies exercise authority over vital areas of life that were once the sole province of governmental authority.[[29]](#footnote-29) Governments, traditionally, have relied on cumbersome procedures of the legislature, courts and policy domain to solve society’s problems. The advent of the regulatory state, loosely defined, however has meant that independent expertise now wields greater power and authority. It involves the exercise of power and authority in highly flexible ways for the purpose of becoming more responsive to society’s problems. It operates on an *ad hoc* rule-making basis and applies special skills designed to address complex problems quickly and effectively.[[30]](#footnote-30)

There has also been a noticeable shift towards delegating responsibility over public services from the policy domain to independent experts versed in managing and cultivating market conditions. The progressive marketisation of the NHS is a salient example.[[31]](#footnote-31) In 1990, health care providers were required–for the first time–to compete with each other for contracts with health service commissioners. These requirements prepared the ground for subsequent measures to be implemented that made it easier for private firms to enter the health care provider market. The most recent round of significant reform that further crystallised market-based conditions in the NHS was instituted by the Health and Social Care Act 2012. The 2012 Act marked a return to the efficiency-inspired reforms of the 1980s.[[32]](#footnote-32) The 2012 Act also signaled a heightened emphasis on arms-length economic regulation, independent regulatory power and competition between market players.[[33]](#footnote-33)

NHS regulation, governance and administration are therefore typified by developments that underline the emergence of what may be described as the regulatory state. Traditional lines of hierarchical accountability in the NHS have been altered. The NHS, once known for being an iron cage of ‘top-down’ bureaucracy, is now a fragmented edifice of independent agencies, expert bodies, public and private providers, Ministerial involvement, consumer champions and local patient groups. These sites of activity interconnect with each other, co-exist on a complex regulatory terrain and they administrate the practice of medicine and psychiatry in particular.[[34]](#footnote-34)

The regulatory state concept is not uncontested however. Scholars disagree on how best to capture the changes described above and they advance a variety of conceptual formulations.[[35]](#footnote-35) It is beyond the scope of the book to conduct a detailed examination of the regulatory state concept and the debate over its cogency. The concept simply helps provide initial context for beginning an appreciation of the complex conditions in which homicide and health care occur. Despite its imprecision,[[36]](#footnote-36) the regulatory state concept helps to indicate the broader governance arrangements underpinning patient homicide investigations. There is much complexity and fragmentation which the author takes as a vital cue for further theoretical development.

Independent investigations of health services after patient homicide, like the NHS generally, are market-based and technocratic. NHS England is the independent expert body responsible for overseeing the commissioning of health care services in England and regulations enable it to procure tenders from investigators and contract-out the Article 2 investigative function to private companies.[[37]](#footnote-37) Furthermore, independent investigators interact with dozens of expert agencies and organisations. They also regularly connect with affected families that are not experts, which is a marked contrast to what investigations are usually expected to do. They are expected to engage with experts and market-based practices, but they are also compelled to engage bereaved families and tenacious journalists. It is important that these dynamics are acknowledged and examined for the purpose of providing an original and reliable account of their complexity. After all, these dynamics constitute important terrain in the patient homicide governance space.

On the other hand, different disciplines and rationalities operate in and around health services that investigators are expected to understand and judge at times of crisis and uncertainty. These disciplines and rationalities inform conflicting aims and goals. For example, the aim of medicine is completely different to the aim of politics. Regulatory actors may not see eye-to-eye. Some actors may not even realise what others are doing. Things go wrong. Lawyers, policy-makers, interest groups and the media respond by making sense of such difficulties. The risk however is that they may disagree with each other and engage in conflict.

Independent investigators of health services after mental health homicide are unique because they are commissioned to make sense of these uncertainties. They are expected to untangle the wild entanglement of reeds that make up health services.[[38]](#footnote-38) They are, furthermore, expected to do so in a convincing and rigorous manner by engaging in a series of complex tasks: the questioning of health care professions, the scrutiny of medical documentation, the establishment of facts, the compilation of a report demonstrating their findings and the forwarding of recommendations. These are difficult tasks because the NHS is a complex institution. There are surprises around its every corner. Medical treatment is carried out by legions of personnel. Decisions may have unintended consequences. Lines of communication may fail. Budgets may become strained. Journalists may dig too deeply. Patients may become violent.

Again, health service complexity is relevant here because it may intimidate. The author interviewed an investigator who commented that some cases are beyond her resource capabilities:

Most of the cases I’ve worked on are cases where you’re looking at management…there are cases where you need to rummage around in the commissioning arms of what’s going on, big companies rather than I are better off at doing that because they have a longer reach, bigger resources at their disposal. It’s not the sort of stuff that floats my boat. I much prefer to work with incidents where I’m working with a cluster of organisations or local agencies and looking at it with them. Things like judicial reviews…I just wouldn’t put myself in the line for those, even if I was doing it in partnership with one of my competitors, which I could do; I get on very well with my competitors and I could co-work with them on a case if I wanted to, but I prefer to work at ground level with staff. **Investigator 2**

The issue of resources is therefore important. The investigator’s comment suggests that there is a division of labour between investigators. Some investigators are more comfortable with cases involving small groups of individuals and agencies and some are more comfortable with large, demanding investigations.

The issue of change is crucial to health care policy and practice also. The NHS is a moving target for investigators because it frequently undergoes politically-driven change and relies on continuous decision-making. Investigators must investigate the past, identify decisions made in it and compare these decisions to how decisions in health services are made in the present. There is always a *prima facie* case for arguing that inadequate mental health care was provided to a mentally-disordered patient perpetrator of homicide.[[39]](#footnote-39) If care failings are found, it is important for investigators to establish whether these failings are happening in the present because it enables them to advance reliable recommendations for changes in practice. Health services cannot, however, stand still while investigators prepare their inquiry and do their work. Indeed, health services are unique because they carry on, even after the most serious failures.[[40]](#footnote-40) Services are constantly engaged by health care users before, during and after an investigation. Employees come and go. Teams and agencies are disbanded and created, sometimes over brief periods of time. What is more, investigations are completed four years after a homicide incident has occurred, on average. Significant change in services is likely to occur during the intervening period. Investigators face the prospect of investigating services that bear little resemblance to the arrangements in place at the time of the homicide.

Investigating services provided to a perpetrator before the Health and Social Care Act 2012 came into force is particularly demanding because the legislation brought about a radical reorganisation of services. Commissioning authorities were abolished and replaced with bodies staffed with different personnel, competition between providers was strengthened and new legal obligations were imposed on regulatory actors. It is almost impossible for (some) investigators of mental health services provided to patient perpetrators prior to 2013 to conduct a straightforward investigation because services have undergone change. Yet, investigators are expected to chase shadows and make judgements on services then and now which policy-makers and health care providers are expected to use to procure change.

These points raise a curious question: if past care and treatment arrangements do not resemble current arrangements, can reliable findings be produced by investigators and logical change implemented? An investigator interviewed by the author commented that suggesting and implementing change in services should be approached with caution: [The NHS] is a very complex environment to be dictating change [to]. **Investigator 2**

The investigator’s comment is understandable. Health care systems are a collection of fragmented and ambiguous disciplines that conflict with each other.[[41]](#footnote-41) Services change. Investigations are yet another source of change. Investigators tread cautiously. At the same time, they must re-inspire trust and confidence in services. However, the anxiety surrounding investigations makes for a difficult experience. Health professionals identified for questioning have been known to feel witch-hunted. The media publish attention-grabbing headlines. NHS Trust directors may await investigation findings with trepidation. Families grieve and want answers.

1. *Sites of Resistance*

The fierce criticism often levelled at health services poses an additional challenge for investigators to overcome. In particular, the families of mental health homicide victims often question whether health authorities take public safety seriously. Family questioning is often extended toward those tasked with investigating the perpetrator’s care and treatment. An investigator who was interviewed for the research described the relationship between inquiries and families as tumultuous. He commented further and that these relationships work better when investigators take their mandate from the victim’s relatives:

I think the most powerful thing I learned from doing one of the inquiries was meeting the mother of the daughter who was killed one evening and really trying to get my remit from her. In other words, what were the questions she wanted to know, pretty obvious ones. We would have done that anyway. But her believing, which I think was right, that we were acting much on her behalf than on the organisation that commissioned us I think was really important. It was really important to her. And, I use phrases like the ‘mandate coming from the family’. That’s my authority, as much, if not more so, than the people actually paying me. **Investigator 6**

The investigator went onto agree that the mandate he refers to is a form of ‘moral authority’. Inquiries, then, are not just a procedure. They mean something. To the investigator above, investigating has a strong moral component.

Moral components are not always visible on the surface of an investigator’s final inquiry report. These reports are rarely explicit about the moral status investigators afford families. All inquiry reports express sympathy towards families and describe them as important to the investigation process. The interviews conducted by the author with investigators however show differences between investigators in how the role of families is regarded. Some investigators, like the one above, think that input from families is a good thing. Families are reported to be a source of moral authority for the investigation. Others, however, think that family input is a problem (eg, interfering, costly). It is extremely unlikely that an opinion of family involvement in investigations as ‘interfering’ and ‘costly’ would be publicised in an inquiry report. One investigator commented during interview that his opinions on family involvement would be ‘career-limiting’ if they were made public. He acknowledged that the victim’s families have a story to tell about their experience, but opined that their value to an investigation is minimal because they were not at the scene of the crime, they did not know the perpetrator and have no knowledge about the treatment provided to him or her. The investigator expressed criticism of what he regarded as a growing expectation that the experiences of families are made relevant to a difficult investigation, despite the existence of separate processes that cater to families and their experience as victims (eg, victim impacts statements in court, police liaison officers). He emphasised that investigations are not designed to provide ‘succour’ to victims of crime, but that requirements imposed by NHS England South that an investigation panel member be appointed to oversee family-related issues was burdensome.[[42]](#footnote-42) The interviews conducted by the author therefore show a mixed picture about how investigators regard families. Inquiry reports are perceptive, but they are coy about how investigators frame the role of families.

The author refers to inquiry reports, on occasion, at different points throughout the book however. These reports are still a valuable resource. The interview data is nevertheless more important because, when combined with the book’s rigorous theoretical design, it helps produce a detailed and more accurate picture of the patient homicide governance space. A total of fourteen interviews were conducted, primarily with independent investigators who collectively have conducted hundreds of investigations between them. These investigators enter into contractual arrangements with NHS England after submitting a bid in response to a tender. They form a relatively small community. As one investigator remarked: [t]here’s not a huge number of people who’ve got the expertise really to comment on others when there’s been such a tragedy. **Investigator 6**

An interview was also conducted with Julian Hendy, the trustee of the charity 100 Families. Julian has represented hundreds of family members involved in independent investigations and he also sits as a lay member on NHS England South’s Independent Investigations Governance Committee. The Committee’s aim is to ensure quality and learning after independent investigations.

1. THINKING ABOUT COMPLEXITY

The author casts extensive light through the patient homicide investigative process and its wider context, in order to provoke further discussion about its dynamics and what it is capable of. Policy-makers are increasingly asking whether these investigations need to be reformed; a public consultation in 2018 was completed on the need to reform the mental health homicide investigation procedure in Scotland.[[43]](#footnote-43) The author has also received personal communications from a non-executive NHS Trust director who has been tasked to review a series of investigations in England as part of a wider process of change planned in England. In writing the book however, the author avoids taking sides in normative debates about how best to conduct investigations, although policy makers and scholars may indeed use its contents to inform and evaluate their normative claims. The book draws attention to the limitations of normative arguments in policy making by advancing a theoretically distinct account of the dynamics that work in and around investigations. For example, the economic cost of investigations is relevant to the issue of what these investigations are (ie, economic observations) and what their purpose is. Similarly, the moral components of investigations or their relevance to law in the form of judicial review applications is relevant to the issue of what these investigations are also (ie, moral and legal observations).

An investigation framed in moral terms is bound to jar with an investigation framed as a news item with informational value or as an endeavour constrained by economic costs. Families may want moral vindication or justice in the courts, but morality and justice are a far-cry from the media’s construction of the incident and subsequent investigation as a ‘story’. The intentions of investigators remain noble throughout (eg, that ‘lessons must be learned’). Yet, these intentions arguably downplay the complexity of health services and the varied interests of those relevant parties connected to them. What is more, certain actors (eg, investigators, families) claim to occupy a privileged vantage point from which the issues raised during an investigation may be accurately appraised. The scholarship is clear however: ‘no single actor has all the knowledge required to solve complex, diverse and dynamic problems’.[[44]](#footnote-44) It is questionable whether there is a supreme vantage point from which social and regulatory complexity can be viewed and wholly appreciated.[[45]](#footnote-45) It is impossible to get a comprehensive picture of what goes on in the NHS. Taking action on issues that relate to health and public safety is also difficult. Mental health homicides vividly demonstrate the point.

The issue of complexity in public health services provides an appropriate entry point to begin thinking about these matters theoretically. Many theories of complexity have been advanced over the years. Systems theory in particular offers a reliable and precise way of thinking about modern legal, political and administrative complexity. When used, it creates a degree of theoretical manoeuvrability that other theories are unable to achieve. It illuminates a diverse range of social relationships and events and the couplings between them. As a highly influential contribution to a range of studies of society, law, regulation and governance, Niklas Luhmann’s theory of social systems is of particular interest here.

1. **Luhmann’s Systems Theory**

Luhmann’s work is uniquely sceptical of the longstanding assumption that our efforts to understand society’s complexity and organise our affairs are achievable through cause-and-effect reasoning. The procedural and emotional cycles that typify the experiences of those connected to mental health homicides involve relentless pursuits to minimise future homicides, create conditions of public safety and provide adequate support for bereaved families. Yet, these aspirations are made the subject of initiatives that are predicated on a cause-and-effect model; something awful has happened and measures must be put in place to fix the harm caused and make society a better place. That has failed to happen because, occasionally, patient homicides continue to occur. The emotional and procedural cycle therefore continues. In addition to providing an reliable account of the investigatory governance space after patient homicide, the author questions why the tumultuous investigatory cycle occurs and whether there is scope for policy makers to re-evaluate their normative commitments. Niklas Luhmann’s general theory of social systems provides the tools for such a novel and far-reaching examination.

Niklas Luhmann developed an influential, albeit unorthodox, understanding of complexity. He claims that there is no privileged perspective from which society can be viewed and objectively understood. Neither the policy-maker in Whitehall who seeks to implement reforms for the purposes of improving social cohesion nor the economist at the World Bank who seeks to eradicate poverty can–contrary to common assumption–occupy such a privileged position. Rather, Luhmann questions whether ontological or anthropocentric approaches to the study of society can provide an adequate explanation for how society works. Ontological questions seek to define the world or an aspect of it, *a priori* (eg, Kant’s concept of Reason). Anthropocentric questions consider humankind to be the most significant aspect of the world and that the most reliable interpretations of the world can be reached using human values. Ontological and anthropocentric approaches dominate academic and political life. They share one thing in common: they are both humanist in design. According to Luhmann, both approaches are questionable as starting points for understanding society. Luhmann advances a functional analysis of society that removes human beings, as traditionally conceived, from the equation.

Luhmann heads into novel philosophical territory with his approach because it goes against intellectual custom; his theory has been compellingly described as the fourth major insult to Western intellectual vanity.[[46]](#footnote-46) Luhmann’s theory however consists of concepts unfamiliar to students and scholars steeped in the ‘Old European’ tradition. Luhmann’s dense, abstract and soporific writing style does not help matters. Scholars admit that his writings have sent them to sleep.[[47]](#footnote-47) Luhmann’s writings have much to offer however because they provide the tools for identifying social phenomena previously unrecognised by the reductionist categories advanced thus far in Western intellectual thought. A price is nonetheless payable for these benefits. Students and readers new to Luhmann are asked to jettison all of the theories, concepts and assumptions that they commonly use to understand society; a huge demand by anyone’s standards.

 Luhmann’s theory relates to how meaning in society is produced. It argues that meaning is produced by communication and that communication constitutes society. For something to be meaningful to everyone it must be communicated about and made socially-available to everyone. A bottle of milk may be communicated economically by referring to its price, but it may be communicated about medically if its spoiled contents have been consumed. Such communications, therefore, are significant for society’s function systems (eg, the economy and medicine). That which lacks social significance meaning (ie, the thoughts inside someone’s head, the biological material in their bodies) is outside of society.

Organic matter and mental processes are the two ‘systems’ that Luhmann contends are outside of communication and hence outside of society; these things can be communicated about within society, but they do not form part of society because they do not *directly* produce socially-relevant meanings. Systems of organic life (eg, our circulatory system) produce biological reactions (eg, oxygen supply) and our psychological systems produce cognition (eg, the way we feel about life). Oxygen supply and human cognition have no *direct* purchase in society, according to Luhmann. The point may be rephrased by positing two questions: is it wholly logical to conclude that our circulatory systems play a direct role in how economic transactions are made? Is it wholly logical to conclude that our (invisible) thoughts can perturb someone else’s behaviour from across the room? The answer to these questions is a resounding no. Blood circulation and consciousness are the primary movers responsible for oxygenation and cognition respectively, but they have nothing directly to do with making monetary payments. Something else must occur if making these payments is to have (economic) significance for others involved in the transaction. What is the ‘something else’? Luhmann’s answer is *communication*.

There are, then, three separate systems of observation for Luhmann: biological, psychic and communication (or social) systems. Luhmann’s tripartite distinction between these systems is a cornerstone of his sociology. Furthermore, Luhmann describes these systems as operationally-closed; they operate autonomously, lack a direct mutual connection and involve no overlap. Thoughts can only produce more thoughts. Biological matter, such as cells, can only produce more biological matter (ie, cell reproduction). Communications (ie, socially-available meaning) produce communication only. There is, thus, no direct relationship of influence or causality between thoughts and cells. People cannot reproduce a cell by thinking about one and the thoughts in a person’s head cannot reproduce cells in the thinker’s body. Communication, as socially-available meaning, is unable to directly access human thoughts or biological cells. Rather, communication structures life independently of the bodies, intentions and motivations of persons.[[48]](#footnote-48) Communication provides a structure of life whereby organic matter and thoughts may be communicated about by individuals who step into these structures. ‘As organisms, “persons” use “life”, and as minds, they use “consciousness” to persist’.[[49]](#footnote-49) The third element of the tripartite distinction is communication; persons–as biological and psychic systems–persist *in society* as communicative constructs.

Yet, each of these systems operates because the others do. For example, psychic systems function to produce thoughts only, but an oxygen supply guaranteed by our circulatory (biological) system is necessary for thinking to happen. A person with the relevant qualifications may be regarded by everyone as a ‘doctor’ because the role has a distinct meaning provided by a communicative structure we call medicine, but the existence of a psychic system socialised into recognising why a doctor is a doctor is essential for a doctor to be recognised as such A person’s biological and psychic systems are necessary for constructing roles in society, but at the same time they are not responsible for the construction. For Luhmann, human beings are constituted by separate systems (eg, biological, psychic) that are outside of society. They are an environment for society that society communicates about. It is more precise, therefore, to argue that human beings participate in society as incomplete persons.[[50]](#footnote-50) The physical bodies of humans and their minds are outside of society. Persons have nothing whatsoever to do with the structures already in place (ie, communication) that produce socially-available meanings *about* the world.

1. *Society’s Subsystems*

It is more logical, according to Luhmann, to claim that human beings–as physical bodies and psychological entities–are rendered into socially-meaningful constructs in society’s subsystems. These constructions are formed in different ways and they correlate to society’s subsystems. These subsystems (eg, law, medicine, politics) construct ‘persons’ as having roles that pertain to a subsystem’s function. Persons are ‘lawyers’ in law, ‘doctors’ in medicine, ‘politicians’ in politics and ‘stories’ in the media. The entities that we refer to as human beings are, for Luhmann, *communicated* *about* in society within society’s social subsystems of communication.

There are many social subsystems. They are distinct from one another in the same manner that biological, psychic and communication systems are distinct from one another. The non-replicability and non-substitutability of social subsystems may be compared to the non-replicability of biological and psychic systems. For example, scientific communications produce truthful scientific facts about science’s environment (eg, biological systems, psychic systems) in the form of disciplines like biology and psychology. Science may, furthermore, communicate about other social subsystems (eg, religion) in its environment, albeit scientifically (eg, rejecting religion on scientific grounds). Scientific knowledge is produced through an appeal to scientifically-accredited methods. Scientifically-truthful statements about other social function systems are the province of science only. For instance, if the world’s scientists were replaced by priests and an attempt was made by these priests to establish truthful facts about the world using religious doctrines, the result would be unconvincing. The results would be rejected as unscientific and false.

It is tempting to regard social subsystems as interpreters of objective facts that exist ‘out there’. Luhmann’s argument however is that systems of life, thought and communication are wholly distinct and closed-off from each other; the social subsystems that make up society construct reality from within and not without. They produce meaning about the world on their own terms.[[51]](#footnote-51) Meaning, so the argument goes, is produced through a self-validating network of communication within each of society’s communication systems. For example, law is law because legal communications determine what law is. The question of what law is (ie, distinguishing between legality and illegality) cannot be answered by appealing to what law is not (eg, religion). To argue otherwise would be to assume that social subsystems of meaning are hierarchical, replaceable and amenable to direct manipulation through a particular perspective; a misleading assumption according to Luhmann’s theory because it fails to stand up to close scrutiny, ignores systemic complexity and represents too imprecise a starting point for reliably analysing society.

The theoretical design advanced thus far shows that social subsystems, like science, produce facts by referring to the same type of communications on subsequent occasions. A condition of self-reference is created for that system alone and by it, to the point where it becomes autopoietic. In other words, the meanings produced by that system are wholly derived from its own communicational elements. Science refers to *scientific* concepts and theories, verified by *scientific* methods, in order to establish *scientific* truth. The system of psychiatry constructs reality on the basis of what kind of *psychiatric* disorder a patient is suffering from and what treatment they should receive; identifying *psychiatric* disorders and appropriate treatment is only possible by appealing to communications accredited by *psychiatric* experts about what *psychiatric* health and ill-health is and what *psychiatric* medications are appropriate. *Legal* communications are produced by a *legally* constituted court tasked to refer to previous *legal* communications in order to produce *legal* facts in cases recognised as *legally* relevant. Social subsystems, then, operate self-referentially rather than appealing to other social subsystems and extracting information from them in order to operate as if they were grabbing something ‘off the rack’.[[52]](#footnote-52)

Social subsystems are distinguishable from each other according to the meaning that they produce about events recognised as part of their environment (ie, other social subsystems, biological systems, psychic systems). Social events acquire meaning within social systemic communications and these communications structure life for the human participants who step into them. Law, economics, education and politics are communication systems that are differentiated from each other because they produce distinct functional meanings about their environments. Law communicates about its environment by distinguishing legality from illegality and by extension law from non-law. Medicine communicates about its environment distinguishes health from illness and by extension distinguishes itself from non-medical systems of communication. Law and medicine are able to communicate about each other (both are environments for each other), but it is impossible for both systems to replicate each other’s communications. Law is always law. Medicine is always medicine. Law and medicine are unable to assume each other’s meaning. For example, a court battle is fought, not by demonstrating first aid skills, but by making legal arguments. In similar fashion, demonstrating legal skills will not get a person very far in a medical emergency.

One of the implications of social autopoiesis is misunderstanding between two or more social systems. By way of illustration, psychiatric expert witnesses in court often experience difficulty understanding the legal defence of insanity. The defence has no meaning in the world of psychiatry; psychiatrists did not contribute to the defence’s establishment and they do not refer to its rules in their practice. The rules, theories, taxonomies, processes and procedures of psychiatry have no direct bearing on law and vice versa.[[53]](#footnote-53) The legal system may communicate *about* psychiatric communications, but only insofar as they are relevant to the legal system’s operations (eg, as evidence to prove the defendant’s guilt).

Luhmann’s systems theory represents a radical reformulation of the individual. Each social subsystem constructs the individual in accordance with what previous communications have been validated as meaningful by that system alone. Humans, in their systemic plurality, participate in these systems of meaning as constructs only and not as essential beings with Reason or a soul. Luhmann therefore renounces an objective concept of the human being. An objective concept of the human being is, for him, the stuff of Enlightenment philosophy and should be rejected for being too imprecise. Enlightenment philosophy inadequately describes reality. It wrongly conflates the three systemic realms (ie, biological, psychic and communication systems) that make up the human being.

Individuals remain important in Luhmann’s theory however because their systemic dimensions enable society to exist. To describe human beings as having a body and soul however, with the soul defining the essence of human reality, is criticised by Luhmann as too much of a stretch. There is no evidence available upon which the body (ie, biological systems) is subservient to any other system.[[54]](#footnote-54) A serious study of society must, therefore, involve the construction of a ‘supertheory’ that is able to account for the systems that operate biologically, psychically and socially. The tripartite distinction between biological, psychic and social systems forms the basis of Luhmann’s ‘supertheory’. It reappraises the status of the human being in society and enables the concept of communication to be articulated as a central reference point for describing how society functions.[[55]](#footnote-55) Biological and psychic systems have, as we have seen, no direct influence or connection to communication systems. To argue otherwise would suggest that the biological and psychic systems that make up human beings can directly produce communication. Under Luhmann’s theory, human beings are unable to directly produce communication.

1. *Homicide, Health Care and Society*

The unusual theoretical arguments postulated thus far may seem alien to the context of mental health patient homicides. A brief demonstration however is apposite to show the link. When a patient’s thoughts of killing another person (ie, psychic systems) are accompanied by the muscular movements required to pick up a knife and cause physical injury to another (ie, biological systems), the social subsystem of law will communicate about these events legally (eg, that a crime has been committed, that the perpetrator intended to commit murder). The social subsystem of economics will communicate about these events economically (eg, legal costs, compensation for the victim’s families). The social subsystem of politics may communicate about these events politically (eg, opposition parties blaming government for policy failures in the area of mental health care, for electoral purposes).

Luhmann’s theory however is quite open to the idea that there are penetrable barriers between function systems.[[56]](#footnote-56) Luhmann is, indeed, adamant that social subsystems of communication are too different to be directly controlled by other social systems, but he argues that they may *perturb* or *irritate* each other’s communications. Perturbation or irritation involves inadvertent coupling relationships known as ‘interpenetration’. Interpenetration may occur between wholly different systems. Biological and psychic systems may interpenetrate. Social systems and biological systems may interpenetrate. Social subsystems may interpenetrate. Interpenetration may be demonstrated by returning to the illustration above relating to homicide and health care. An event in the biological system (eg, the muscular movements and organic reactions respectively involved in picking up a knife and plunging it into the chest of another person) and the psychic system (ie, the thoughts produced in someone’s mind about stabbing another person) are environments for each other. Each system is wholly separate. Each is unable to directly influence the other’s operation (ie, thoughts do not directly produce the relevant muscular movements involved in the stabbing). Each system however is *dependent on the existence of the other to operate and continue their functioning*. Biological and psychic systems are environments for each other and, in the process, are mutually necessary for the purposes of their operation. Biological and psychic systems are also environments for the social systems of law (the crime of homicide) and medicine (treatment and diagnosis). Each system–social and otherwise–is a point of perturbation for the other. They are coupled and function in those moments because other systems function in those moments, but they all remain distinct as autopoietic systems. In systems-theoretical parlance, social systems are normatively-closed, but cognitively-open to their environment. These observations are unorthodox, but they revolutionise how society may be understood and, in particular, help articulate the unexplored relationship between homicide, health care and society.

The attempts, by philosophers, to provide supreme explanations of society are a familiar tradition. The primacy given to law or politics, despite the reported lack of trust that has bedded in societies, in situations of crisis is a common habit that remains unbroken in modern times, particularly in the context of vital public services. If something goes wrong, the politicians and the lawyers must fix it. Western societies have conditioned themselves to follow a predictable routine. It is a routine of identifying problems, implementing solutions, recognising new unforeseen problems and proposing–once more–to finally bring about a better society with another solution. For Luhmann, it is a routine that is *the* problem. Moeller puts it best when he writes that rather than looking for better solutions to problems, Luhmann asks what the problem is in the first place.[[57]](#footnote-57) The problem is the how Western philosophical thought conceptualises society.

Western conceptualisations of society consider society to be directly amenable to steering by individuals. Moreover, they continue to have major influence on the problem-solving approaches taken by society’s elites (eg, economists, regulators, judges, politicians). Elites often reduce society’s problems to simple categories (eg, political incompetence, class divisions) and propose solutions (eg, regulation, law reform) for them. These practices are supported by well-intentioned ambitions (eg, making society a better place). These ambitions are perceived by some as realised to some degree. For Luhmann however, society is far from being a pre-ordained configuration of affairs amenable to control. Successes are merely constructed. Society is typified by different forms of communication that do not read from the same script. Society is contingent and unpredictable. Solutions forged in one area (eg, politics) are known to raise unforeseen problems in another (eg, the economy). For instance, medicine is generally considered to be a well-intentioned discipline that avoids harm, but it has been criticised for unwittingly doing harm to human bodies and interests.[[58]](#footnote-58) Indeed, medicine and psychiatry have complex and controversial histories.[[59]](#footnote-59) At the same, medicine and psychiatry have been described as facilitating inclusion.[[60]](#footnote-60)

Luhmann’s systems theory provides a framework of understanding the complex maelstrom of contingency in society. The author has, thus far, sought to craft an early summary of Luhmann’s sociology with two aims in mind. First, the summary situates Luhmann’s work against established theoretical orthodoxy. Second, the summary prepares those readers who are unfamiliar with Luhmann’s position. The summary is rounded-off here by emphasising Luhmann’s non-normative posture; it avoids commitment to ideology or morality. Luhmann criticises the Western intellectual tradition for naïvely making these types of commitments however. For him, such commitments are unreliable because they are too reductionist. The author similarly adopts a non-normative position. The book’s analysis avoids questions regarding what is right and wrong in the context of homicide investigations. Rather, it explores the significance of complexity surrounding independent inquiries, reframes what it means to explore adverse events in public health services and urges policy making elites to re-evaluate their normative commitments. Luhmann’s theory of social systems is, understandably, controversial and the details of the controversy will be explored in later chapters.

1. CENTRAL QUESTIONS AND THEMES

A central focus of the author is to examine whether the objectives set by independent inquiries are achievable. These objectives generally comprise the following series: the learning of lessons from patient homicides; the investigation of their causes; and the subsequent improvement of mental health services. Independent inquiries are however controversial because they are regarded as invasive and humiliating.[[61]](#footnote-61) They are described as having little value because they are expensive, time-consuming, biased and incapable of answering basic questions about what happened.[[62]](#footnote-62) The author’s reliance on systems theory to organise the book’s focus raises the question of whether a non-normative position that rejects the possibilities of reaching privileged observational vantage points and societal steering excludes itself as a privileged seat of observation. Luhmann claims that there is no privileged seat of observation, his own theory included: ‘the epistemologist becomes him/herself a rat in the labyrinth and has to reflect on the position from which he/she observes the other rats’.[[63]](#footnote-63) He writes that systems theory appears in the real world as one of its own objects: ‘[b]ecause it [systems theory] 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.’[[64]](#footnote-64) It is ‘part of the reality it attempts to describe’.[[65]](#footnote-65) King describes Luhmann’s theory as 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’.[[66]](#footnote-66)

The author, in similar fashion, does not claim a privileged seat of truth or observation. Rather, it draws attention to an area that has been forgotten, neglected and criticised for the approach policy-makers have taken in relation to patient homicides. It attempts to perturb academic and policy custom around what it means to investigate the overlooked space of patient homicide governance. An empirical examination of the patient homicide governance space in England is conducted for these purposes. Fourteen patient homicide investigators and one family representative were interviewed. The data from these interviewed provides a supplementary, yet vital and original, mechanism of support for the book when combined with the novel theoretical design built in throughout. The data combines with the book’s unique theoretical direction for the purposes of producing a comprehensive and novel understanding of the patient homicide governance space.

1. *Subsidiary Themes*

A group of important subsidiary themes emerge throughout the author’s work. The vexed debate over whether promulgating desired change in spheres of public life pursuant to pre-defined goals can be made through decision-making is one of these themes. It underscores thinking across a range of academic schools; Teubner’s concept of reflexive law,[[67]](#footnote-67) governmentality[[68]](#footnote-68) and Giddens’ structuration theory.[[69]](#footnote-69) The book engages generally with the aforementioned theme in its analysis and discussion, further enhancing the book’s originality and rigour.

 The book is also a timely contribution. A series of investigators interviewed for the research stated that their investigations aim to deconstruct lapses in care and establish a better perspective. There is ambition on the part of investigators to occupy a specific vantage point in order to procure desired change in accordance with pre-defined goals. These goals and the change that follows is informed by the knowledge, skills, expertise and experience of investigators that cohere into a vantage point that Luhmann’s theory of social systems would regard as unable to represent the complexity of the problems at hand.

Social systems theory is an important theoretical framework for the book, but three additional conceptual elements of the book’s approach are placed within the framework: the concepts of accountability, time and risk. These concepts help establish a novel look into the finer dynamics and challenges within the patient homicide governance space. These concepts are familiar to the Western intellectual tradition. One of the author’s tasks, however, is to revise the concept of accountability in particular within a systems-theoretical framework.[[70]](#footnote-70)

At a general level, time is relevant because inquiries are mainly retrospective. Accountability is relevant because inquiries elicit information from health professionals (among others) about past decisions. Risk, too, is relevant because inquiries attempt to reduce the risk of future mental health homicides through the learning of lessons. These concepts, in various ways, are familiar to the Western philosophical tradition. They are often channelled into narrowly-focused understandings about how problems in society should be understood and resolved. For example, time is often regarded as a universal experience for everyone. Accountability is commonly regarded as a process of direct information transmission between individuals. Risk is famously associated with the destructive potential of technology.[[71]](#footnote-71) Luhmann’s work raises questions over all of these claims.

The present book draws on Luhmann’s work in order to examine the aforementioned concepts and apply them for the purposes of advancing a comprehensive understanding of the patient homicide governance space. In doing so, the book inspires theoretical enquiry in other spaces of governance that share conventional policy making orthodoxies. A short overview of how the book engages the concepts of accountability, time and risk is apposite for introductory purposes.

Establishing accountability for past conduct involves selecting persons from whom an account is to be elicited. An account will be meaningful to the relevant parties, as determined by a particular set of communications; independent investigations into patient homicides will, primarily, involve persons giving accounts about medical treatment and diagnosis given to the perpetrator (ie, medical communications).

Time is important also because accountability is concerned with producing communications about the past. It also entails making sense of the accounts given in the present and minimising the occurrence of an adverse event. Communications take time to be triggered, thus raising yet another dimension of time; an adverse event may be registered by a social subsystem, culminating in reactions from the medical and legal professions at different speeds. Law is notoriously slow to communicate. Litigation on a legal issue may take up to a decade to reach a conclusion.

Risk is important to time because it relates to possible future loss. Furthermore, risk has different meanings. [[72]](#footnote-72) *Legal* risks (eg, the risk of litigation) are wholly different from *medical* risks (eg, risks to the physical body posed by medication). The risk of a mental health homicide occurring in the future may invite diverse interpretations from different experts[[73]](#footnote-73) and create a gulf between them over how they understand it.[[74]](#footnote-74) Independent investigators instigate processes of decision-making through their findings and through their recommendations. Their recommendations may lead to change for the purposes of minimising the likelihood of an adverse event happening again. Recommendations are made with an eye on their future consequences. An inquiry might also engage a specific form of communication when forging a set of recommendations for change to health care provision. For instance, they may recommend the creation of new clinical posts (ie, a medical communication). In turn, health service personnel may construct the same recommendation as an issue about having the resources to create these posts (ie, economic communication). The future consequences of adopting recommendations may, furthermore, involve a clash of meanings with other closed spheres of communication produced elsewhere about the homicide incident or the health care services connected to the incident. Recommendations, if implemented, may therefore lead to error, objection, rejection and regret. They are a risk to make.

1. CONCLUSIONS

The present chapter sets a general context for the rest of the book. On the one hand, it appraises the legal, administrative and regulatory environment of the patient homicide governance space. Patient homicides trigger legal obligations under Article 2 of the ECHR to conduct an independent and effective investigation. These investigations occur within a complex labyrinth of NHS administrative activity, decision making and competing rationalities. There are thousands of decision makers who make decisions. These decisions affect thousands of vulnerable individuals. These decisions are, furthermore, informed by medical rationalities, political rationalities and economic rationalities, among others. These rationalities inform different aims and objectives for decision makers. There is conflict and disagreement between decision makers informed by different values and logics. There is conflict between staff and between organisations. Decision making elites (eg, regulators, politicians) are reported to be widely distrusted by patients, citizens and other decision makers. Elites are often criticised for failing to recognise the diversity of interests that occupy the legal and regulatory space of the NHS and patient homicide governance.

In particular, market conditions, the logic of competition and technocratic decision making have become dominant forces in NHS provision, commissioning and patient homicide governance. Important regulatory actors (eg, hospitals, NHS Trusts, commissioners) are increasingly required to behave in ways that are consistent with the rhythms of a dynamic health care market. There is, now, an emphasis on speed, efficiency, contracting and cost. As subsequent chapters will allude to, patient homicide investigators are clinically-trained specialists. They are required to enter into contracts with commissioners to conduct their investigations. They, furthermore, must compete with other investigators for these contracts and remain within strict budgets if they are commissioned. Investigators are continually pressured to complete their investigations in shorter time-frames too, despite being required to investigate swathes of health service activity that previously were not part of the investigatory remit. The voice of families affected by patient homicide is increasingly vociferous also and investigators are increasingly expected to engage them during their investigations.

In the light of the competing rationalities that ventilate the NHS governance space, patient homicide investigators encounter the difficulty of managing a variety of situations (eg, engagement with commissioners, engagement with family members) that are very different from each other. These situations are informed by different values. They set a stage for conflict, disagreement, resistance and complexity to flourish.

Modern society is typified by complexity. A major task assumed by scholars since the 20th century has been to form adequate understandings of society and to evaluate the extent to which existing approaches sufficiently enable precise, accurate and reliable studies of society. Luhmann’s systems theory is unique as an understanding of society. It questions the dominant conceptual underpinnings of Anglo-American scholarship: the ‘Old European’ Enlightenment concept of the individual. Luhmann argues that the individual is a fragmented entity of psychic and biological systems that exist in society as a self-construction in one of society’s social communication systems. As the book will later explain, Luhmann’s thesis challenges conventional ways of understanding how change in society occurs, especially in the context of elite practices (ie, decision makers and policy making). These practices are known for their diversity, unpredictability, failures and unintended consequences. Luhmann’s work provides a conceptually rigorous framework for understanding why such practices are questionable. In particular, patient homicide governance–despite being overlooked–is an area typified by unpredictability, failure and unintended consequences. It is punctuated with conflict, disagreement, and new patient homicide incidents. The present book utilises Luhmann’s theory of social systems with a view to formulating a novel, yet reliable, understanding of the patient homicide governance space. It explains that patient homicides resonate throughout society in different ways (eg, politically, medically, legally). It draws a series of novel conclusions on why conflict, disagreement and resistance between decision makers and affected parties occur within the space. In supporting the book’s central task, the present chapter summarises Luhmann’s theory and prefaces subsequent chapters that engage it closely. In doing so, it provides an essential introduction for readers who are unfamiliar with Luhmann’s work; Luhmann’s theory of social systems is abstract and challenging because it requires readers to abandon the conventional theoretical tools they use to understand society.

1. See D Hunter and P Cheeseman, *Domestic Homicide Review Incorporating an NHS Independent Investigation [Mental Health]: ‘Nina’ and ‘Jenny’*, Overview Report Post Quality Assurance Panel (Sefton Safer Communities Partnership, November 2017). [↑](#footnote-ref-1)
2. C Rooney, *An independent investigation into the care and treatment of a mental health service user (B) in Greater Manchester*: Executive Summary (Niche Health & Social Care Consulting Ltd, March 2017) p 8. [↑](#footnote-ref-2)
3. See G Jenkins and N Moor, *An independent investigation into the care and treatment of P in the West Midlands* (Niche Health & Social Care Consulting Ltd, June 2017). [↑](#footnote-ref-3)
4. Mental health patients refer to individuals who receive NHS care and treatment for a mental disorder. Independent investigations are triggered if perpetrators of homicide are mental health patients up to six month prior to the crime. [↑](#footnote-ref-4)
5. Jenkins and Moor, p 5. [↑](#footnote-ref-5)
6. L Appleby et al, *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*, *Annual Report 2017: England, Northern Ireland, Scotland and Wales* (Manchester, University of Manchester, 2017) p 4. [↑](#footnote-ref-6)
7. See *Attorney-General’s Reference (No 3 of 1994)* [1998] AC 245 (HL). [↑](#footnote-ref-7)
8. The terms ‘investigation’ and ‘inquiry’ are used interchangeably throughout the book. [↑](#footnote-ref-8)
9. Department of Health, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, NHS Executive, HSG(94)27. [↑](#footnote-ref-9)
10. National Health Service Act 1948. [↑](#footnote-ref-10)
11. See European Convention on Human Rights, Article 2. [↑](#footnote-ref-11)
12. See *Osman v United Kingdom* (1998) 29 EHRR 245; *McCann v United Kingdom* Series A no 324 (1995) 21 EHRR 97; European Court of Human Rights, *Guide on Article 2 of the European Convention on Human Rights*, 1st edition (Council of Europe, 2018) p 28. [↑](#footnote-ref-12)
13. *R (Amin) v Secretary of State for the Home Department* [2003] UKHL 51. [↑](#footnote-ref-13)
14. See generally J Chevalier-Watts, ‘Effective Investigations under Article 2 of the European Convention on Human Rights: Securing the Right to Life or an Onerous Burden on a State? (2010) 21(3) *European Journal of International Law* 701. [↑](#footnote-ref-14)
15. *McCann v United Kingdom* Series A no 324 (1995) 21 EHRR 97; *Ergi v Turkey* [1998] 32 ECHR 18. [↑](#footnote-ref-15)
16. *Powell v United Kingdom* [2000] 30 EHRR 362. [↑](#footnote-ref-16)
17. ibid. [↑](#footnote-ref-17)
18. Department of Health, ‘Chief Executive's report to the NHS’ (London, Department of Health, December 2005). [↑](#footnote-ref-18)
19. Department of Health, *Department of Health: Annual Report and Accounts 2016-17* (London, HMSO, 2017) p 2. [↑](#footnote-ref-19)
20. HM Treasury, *Public Expenditure: Statistical Analyses 2018* (London, HMSO, Cmnd 9648, 2018) p 15. [↑](#footnote-ref-20)
21. See generally J Shaw et al, ‘The role of alcohol and drugs in homicides in England and Wales’ (2006) 101(8) *Addiction* 1117; PJ Taylor, ‘Psychosis and violence: stories, fears, and reality’ (2008) 53(10) *The Canadian Journal of Psychiatry* 647; M McGrath and F Oyebode ‘Characteristics of perpetrators of homicide in independent inquiries’ (2005) 45(3) *Medicine, Science and the Law* 233, 243. [↑](#footnote-ref-21)
22. See H Packer, *The Limits of the Criminal Sanction* (Stanford, Stanford University Press, 1968/1999) p 74. See also SJ Pfohl, ‘Predicting Dangerousness: A Social Deconstruction of Psychiatric Reality’ in LA Teplin (ed) *Mental Health and Criminal Justice* (California, Sage, 1984) p 201. [↑](#footnote-ref-22)
23. K Yeung, ‘The Regulatory State’ in R Baldwin et al (eds), *The Oxford Handbook of Regulation* (Oxford, Oxford University Press, 2012) p 65. [↑](#footnote-ref-23)
24. Examples include the creation of contractual agreements, with built-in incentives, between mental health professionals, law enforcers and the state (see generally N Wolff, ‘Interactions Between Mental Health and Law Enforcement Systems: Problems and prospects for Cooperation’ (1998) 23(1) *Journal of Health Politics, Policy and Law* 133, 152–154). [↑](#footnote-ref-24)
25. ibid. See also GD Majone, ‘From the Positive to the Regulatory State: Causes and Consequences of Changes in the Mode of Governance’ (1997) 17(2) *Journal of Public Policy* 139; J Black, ‘Tensions in the Regulatory State’ (2007) *Public Law* 58; M Lodge and L Stirton, ‘Accountability and the Regulatory State’ in Baldwin et al, *Oxford Handbook*, 349-370; D Campbell, ‘Luhmann without tears: complex economic regulation and the erosion of the market sphere’ (2013) 33(1) *Legal Studies* 162 at 162; DP Horton and G Lynch-Wood, ‘Rhetoric and Reality: User Engagement and Health Care Reform in England’ (2018) 26(1) *Medical Law Review* 27. [↑](#footnote-ref-25)
26. C Scott, ‘Accountability in the Regulatory State’ (2001) 27(1) *Journal of Law and Society* 38 (footnote omitted). [↑](#footnote-ref-26)
27. AJ Wistrich, ‘The Evolving Temporality of Lawmaking’ (2012) 44 *Connecticut Law Review* 757at 784. [↑](#footnote-ref-27)
28. ibid, at 784. See also S Prasser, ‘Public Inquiries in Australia: An Overview’ (1985) 44(1) *Australian Journal of Public Administration* 1, 1. [↑](#footnote-ref-28)
29. See F Vibert, *Rise of the Unelected* (Cambridge, Cambridge University Press, 2007). [↑](#footnote-ref-29)
30. ibid. [↑](#footnote-ref-30)
31. See A Pollock, *NHS Plc* (London, Verso Books, 2004); DP Horton and G Lynch-Wood, ‘Technocracy, the Market and the Governance of England’s National Health Service’ (2018) *Regulation & Governance* (forthcoming). [↑](#footnote-ref-31)
32. L Stirton, ‘Back to the future? Lessons on the pro-competitive regulation of health services’ (2014) 22(2) *Medical Law Review* 180. [↑](#footnote-ref-32)
33. ibid; ACL Davies, ‘This time it’s for real: the Health and Social Care Act 2012’ (2013) *Modern Law Review* 564; Horton and Lynch-Wood, ‘Technocracy, the Market and the Governance of England’s National Health Service’.

See generally Vibert, *Rise of the Unelected*. [↑](#footnote-ref-33)
34. See N Rose, ‘Psychiatry as a political science: advanced liberalism and the administration of risk’ (1996) 9(2) *History of the Human Sciences* 1, 5. [↑](#footnote-ref-34)
35. See generally G Lawson, ‘The rise and rise of the administrative state’ (1994) 107(6) *Harvard Law Review* 1231; P Tucker, *Unelected Power: The Quest for Legitimacy in Central Banking and the Regulatory State* (Oxford, Princeton University Press, 2018). [↑](#footnote-ref-35)
36. Yeung, ‘The Regulatory State’, 68. [↑](#footnote-ref-36)
37. See generally Health and Social Care Act 2012, s 75; Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013. [↑](#footnote-ref-37)
38. ‘We 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’ (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). [↑](#footnote-ref-38)
39. A Buchanan ‘Independent inquiries into homicide: Should share common methods and be integrated into new quality systems’ (1999) 318 *BMJ* 1089, 1089. [↑](#footnote-ref-39)
40. K Walshe and SM Shortell, ‘When things go wrong: how health care organizations deal with major failures’ (2004) 23(3) *Health Affairs* 103, 109. [↑](#footnote-ref-40)
41. See N Eastman and J Peay ‘Law without Enforcement: Theory and Practice’ in N Eastman and J Peay (eds) *Law without Enforcement: Integrating Mental Health and Justice* (Oxford, Hart Publishing, 1999) pp 8–9. See also A Perron et al, ‘Citizen minds, citizen bodies: the citizenship experience and the government of mentally ill persons’ (2010) 11(2) *Nursing Philosophy* 100, 107. Perron et al 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.

 Buchanan ‘Independent inquiries’, 1089. [↑](#footnote-ref-41)
42. Cf MJ Gregory, ‘Managing the homicide-suicide inquest the practices of coroners in one region of England and Wales’ (2014) 42(3) *International Journal of Law, Crime and Justice* 237, 249. Gregory’s study found that coroners, when conducting inquests, demonstrate awareness of family bereavement, although a coronial lack of expertise in these matters was apparent. [↑](#footnote-ref-42)
43. Scottish Government, *Review of homicides by people with recent contact with NHSScotland mental health and learning disability services: A Consultation on the Mental Welfare Commission for Scotland’s proposal* (Edinburgh, Scottish Government, 2017). [↑](#footnote-ref-43)
44. J Black, ‘Critical Reflections on Regulation’ (2002) 27 *Australian Journal of Legal Philosophy* 1, 5. [↑](#footnote-ref-44)
45. See N Luhmann, *Risk: A Sociological Theory* (New Jersey, Aldine Transaction, 1993) p 22. [↑](#footnote-ref-45)
46. See HG Moeller, *The Radical Luhmann* (New York, Columbia University Press, 2012) p 28. Freud outlined three major insults: the Copernican revolution, Darwin’s theory of evolution and his own theory of the unconscious. Moeller writes that ‘Luhmann now adds another insult to this list–one that could be called the *sociological insult*.’ [↑](#footnote-ref-46)
47. ibid. [↑](#footnote-ref-47)
48. M King and C Thornhill, *Niklas Luhmann’s Theory* *of Politics and Law* (Basingstoke, Palgrave-MacMillan, 2003) p 163; J Jalava, *Trust as a Decision: the problems and functions of trust in Luhmannian systems theory* (Helsinki, University of Helsinki, 2006) p 71. [↑](#footnote-ref-48)
49. S Fuchs, ‘Niklas Luhmann’ (1999) 17(1) *Sociological Theory* 117, 119. [↑](#footnote-ref-49)
50. See M King, ‘Child Welfare within Law: The Emergence of a Hybrid Discourse’ (1991) 18(3) *Journal of Law and Society* 303 at 304. [↑](#footnote-ref-50)
51. See M King, ‘The ‘Truth’ about Autopoiesis’ (1993) 20(2) *Journal of Law and Society* 218, 220. [↑](#footnote-ref-51)
52. N Luhmann, *Social Systems* (Stanford, Stanford University Press, 1995) p 140. [↑](#footnote-ref-52)
53. See Eastman and Peay,‘Law without Enforcement: Theory and Practice’ p 21; T Ward, ‘The Sad Subject of Infanticide: Law, Medicine and Child Murder, 1860-1938’ (1999) 8(2) *Social & Legal Studies* 163, 174; M King and C Piper, *How the Law Thinks About Children*, 2nd ed, (Aldershot, Arena/Ashgate Publishing, 1995) p 49. [↑](#footnote-ref-53)
54. See generally HG Moeller, *Luhmann Explained: From Souls to Systems* (Chicago, Open Court, 2006) p 81. [↑](#footnote-ref-54)
55. See generally D Baecker, 'Why Systems?' (2001) 18(1) *Theory, Culture & Society* 59, 59. [↑](#footnote-ref-55)
56. See R Nobles and D Schiff, *Observing Law Through Systems Theory* (London, Hart Publishing, 2012) p 132. [↑](#footnote-ref-56)
57. Moeller, *Radical Luhmann*, p ix. [↑](#footnote-ref-57)
58. See generally I Illich, *Limits to Medicine: Medical Nemesis: The Expropriation of Health* (London: Penguin, 1990); JP Davies, B Heyman, PM Godin, MP Shaw and L Reynolds, ‘The problems of offenders with mental disorders: A plurality of perspectives within a single mental health care organisation’ (2006) 63 *Social Science and Medicine* 1097, 1097. [↑](#footnote-ref-58)
59. See M Foucault, *Madness and Civilisation* (London, Routledge, 1971/2008); R Porter, *A Social History of Madness* (London: Weidenfeld and Nicholson, 1987); A Scull, ‘The domestication of madness’ (1983) 27(3) *Medical History* 233; I Hacking, *Mad travelers: reflections on transient mental illness* (Richmond, Virginia: University of Virginia Press, 1998). [↑](#footnote-ref-59)
60. EJ Novella, ‘Mental health care and the politics of inclusion: A social systems account of psychiatric deinstutionalization’ (2010) 31 *Theoretical Medicine and Bioethics* 411, 421-422. Novella argues that the shift from asylum-based psychiatry to community-based psychiatry necessitates the inclusion of patients in society’s function 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. [↑](#footnote-ref-60)
61. G Szmukler ‘Homicide inquiries: what sense do they make? (2000) 24 *Psychiatric Bulletin* 6, 9. [↑](#footnote-ref-61)
62. ibid, 7 and 8. [↑](#footnote-ref-62)
63. See N Luhmann, ‘Cognition as construction’ in Moeller, *Luhmann Explained*, p 250. [↑](#footnote-ref-63)
64. Luhmann, *Social Systems*, p 11. See also P. Barbesino and SA Salvaggio, ‘How is a Sociology of Sociological Knowledge Possible’ (1996) 35 *Social Science Information* 341. Luhmann’s theory of social systems has been regarded as ‘a sociology of sociological knowledge’. [↑](#footnote-ref-64)
65. M Brans and S Rossbach, ‘The Autopoiesis of Administrative Systems: Niklas Luhmann on Public Administration and Public Policy (2002) 75(3) *Public Administration* 417, 418. [↑](#footnote-ref-65)
66. M King, ‘What’s the Use of Luhmann’s Theory?’ in M King and C Thornhill (eds) *Luhmann and Law and Politics: Critical Appraisals and Applications* (Oxford, Hart Publishing, 2006), p 41. [↑](#footnote-ref-66)
67. G Teubner, ‘Substantive and Reflexive Elements in Modern Law’ (1983) *Law and Society Review* 239–285. [↑](#footnote-ref-67)
68. M Foucault, *The Order of Things: An archaeology of the human sciences* (London, Routledge, 2004); C Gordon et al (eds) *The Foucault Effect: Studies in governmentality* (Chicago, University of Chicago Press, 1991). [↑](#footnote-ref-68)
69. A Giddens, *The Constitution of Society*: *Outline of the structuration theory* (Cambridge, Polity, 1984). [↑](#footnote-ref-69)
70. The concepts of time and risk receive close attention in Luhmann’s writings. [↑](#footnote-ref-70)
71. U Beck, *Risk Society: Towards a New Modernity* (London, Sage Publications, 1992). [↑](#footnote-ref-71)
72. Luhmann, *Risk*. [↑](#footnote-ref-72)
73. J Peay, ‘Working with Concepts of ‘Dangerousness’ in the Context of Mental Health Law’ (2003) 51(1) *Criminal Justice Matters* 18, 19. [↑](#footnote-ref-73)
74. See generally J Peay, *Decisions and Dilemmas: Working with Mental Health Law* (Oxford, Hart Publishing, 2003) p 29. [↑](#footnote-ref-74)