

Thursday, 16 April 2026

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2 (10.00 am)
3 **MS LANGDALE:** Chair, may I please call the next witness,
4 Alex Ruck Keene, King's Counsel.
5 **ALEX RUCK KEENE KC (Hon) (sworn)**
6 **Questioned by MS LANGDALE**
7 **MS LANGDALE:** Mr Ruck Keene, you prepared an expert report
8 for the Inquiry with the input for questions from all
9 Core Participants and it's dated 19 November 2025.
10 **A.** Yes.
11 **Q.** Apart from a couple of matters you'd like to correct or
12 update in a moment, is it accurate, as far as you're
13 concerned?
14 **A.** Yes, it is.
15 **Q.** There's one typographical error which I know you want to
16 correct, and if you handwrite into it what should appear
17 there in due course we'll make sure it's correctly
18 uploaded on the website at the end of today. So take us
19 to that and what's that about, please?
20 **A.** It's just -- and I apologise -- it's paragraph 52 and
21 I managed to leave out a "not". So if you're on page --
22 it's page 28 of my report.
23 **Q.** Yes.
24 **A.** And it's the penultimate sentence: "There is, however,
25 no reason in principle"; it should be "for a care plan

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1 capacity referred to in the context of capacity to
2 commit a criminal offence. Would you like to correct or
3 qualify that issue?
4 **A.** Yes. I think it's really important to understand that
5 is a legally nonsensical idea. You simply can't have
6 capacity to commit a criminal offence if you are
7 applying the term "capacity" as it's otherwise
8 understood in English and Welsh law. You can sort of
9 understand why people might have that idea but I would
10 really strongly emphasise, it's a very, very dangerous
11 thing to start talking about, because it starts meaning
12 people start asking the wrong questions potentially of
13 the wrong people, and you start going down the wrong
14 track.
15 So I'd really want -- and I didn't cover it in my
16 report because that wasn't one of the questions asked of
17 me, but it's one thing I'd really want to make sure is
18 brought out and properly understood.
19 **Q.** To be clear, there is no suggestion among the
20 psychiatrists or generally, that the difference between
21 *mens rea* and capacity has not been understood, but --
22 **A.** Yeah.
23 **Q.** -- you're concerned to make that clear.
24 **A.** Absolutely.
25 **Q.** In paragraph 15 of your statement, you refer to primary

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1 not to be authorised". I think it is probably
2 self-evident but I don't want it to be.
3 **Q.** Of course. Is there any other matter you would like to
4 update or correct? I'm going to take you to the Mental
5 Health Act amendments in due course, so not in relation
6 to that, but anything else you'd like to say at this
7 point?
8 **A.** No.
9 **Q.** Can you then begin by giving us your qualifications,
10 your experience and expertise in this area.
11 **A.** Yes, so I am a practising barrister. I specialise in
12 mental health, mental capacity, healthcare ethics. I am
13 also a Professor of Practice at King's College London
14 where I co-lead the Mental Health, Ethics & Law masters
15 programme. I have also been involved in various law
16 reform capacities. So possibly most relevant, I was the
17 legal adviser to the independent review of the Mental
18 Health Act chaired by Sir Simon Wessely.
19 Actually, one very small correction, I'm an honorary
20 King's Counsel. My appointment is not a working title;
21 it's to reflect contributions to the law outside the
22 courtroom, specifically I think in relation to the
23 Mental Health Act and Mental Capacity Act.
24 **Q.** Understood. One issue around capacity, in the
25 proceedings or in the Inquiry's proceedings, we've heard

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1 legislation versus the Mental Health Codes of Practice.
2 **A.** Yes.
3 **Q.** Can you explain the role of each and where there may be
4 tension across them?
5 **A.** Yes. So the starting point is the law is set out in
6 statute. So for instance we have the Mental Health Act,
7 we have the Mental Capacity Act. That statute will be
8 amplified or clarified by case law, where sometimes
9 a court will provide a binding guidance as to what
10 a particular word means.
11 Statutes such as the Mental Health Act and Mental
12 Capacity Act are accompanied by codes of practice, and
13 those codes of practice are, in both instances, subject
14 to public consultation, they're widely consulted upon.
15 They're laid before Parliament so Parliament is taken to
16 have approved them. Parliament doesn't, however, go
17 through line by line. Theoretically they could but they
18 just don't.
19 The Codes of Practice have a very important role to
20 play because by and large they tend to be where people
21 look to first. Most people wouldn't look to the Mental
22 Health Act, say, or the Mental Capacity Act; they'd look
23 to the Code of Practice because it tends to be written
24 in more user-friendly English.
25 One really important thing to bring out or make

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1 clear is a Code of Practice can't make the law. The law
2 is set down in statute, as I said, amplified by case
3 law; the Code of Practice can explain law.

4 The Mental Health Act Code of Practice in
5 particular, there are two Codes of Practice, there's the
6 English one, there's the Welsh one, I'll predominantly
7 just talk about the English one, if I may.

8 **Q.** Please do.

9 **A.** That was written very much -- it's a long Code of
10 Practice and there's quite a lot in it, which makes it
11 sound like "this is the law", but quite a few times what
12 it is doing is it's setting out what the Secretary of
13 State would like people to be doing and you always have
14 to be slightly careful to go and say: well, what
15 actually does the Mental Health Act require as opposed
16 to what the Code says? And if there's a conflict
17 between the two, the statute prevails.

18 **Q.** You've highlighted, where there is a conflict in some
19 cases, between case law and the Code.

20 **A.** *(The witness nodded).*

21 **Q.** What happens in practice then in your experience? Is
22 the Code updated, is it updated not frequently enough or
23 does uncertainty remain?

24 **A.** So the example I gave in my report is in relation to the
25 Mental Capacity Act Code of Practice, there is a serious

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1 looked at, what's the timetable for consultation around
2 inclusion on the Codes of Practice?

3 **A.** So just to be clear, I was talking about updating the
4 Mental Capacity Act Code of Practice and one of the
5 things that will have to do is pick up on the fact that
6 the case law says that the original Code got it wrong.

7 The Mental Health Act 2025 is passed, given Royal
8 assent, just before Christmas and, as it were, item 1 on
9 the agenda is producing the Code of Practice. I have
10 some involvement in that. I'm not -- I can't give
11 formal evidence about the timelines, that's something
12 I think the Chair would have to get from the department
13 of --

14 **Q.** DHSC?

15 **A.** DHSC, but certainly, as I understand it, Code of
16 Practice work is taking place this year with
17 consultation, probably, I suspect, next year. So
18 depending on the timeline and the review, it would --
19 apart from anything else, in my opinion, would be
20 blindingly obviously important that any Code of Practice
21 were not finalised before any observations or
22 recommendations were made from this Inquiry, because
23 it's so directly involved in, or it's touching so
24 directly on many aspects, which, if it's not -- if
25 they're not set out and the direction of travel set out

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1 problem with the Mental Capacity Act Code of Practice
2 and it's well known to be a problem, that it is very out
3 of date. And unlike the Mental Health Act Code of
4 Practice, it was not produced at a time when a piece of
5 legislation had been enforced for a time, and people had
6 some idea how it worked. The Mental Capacity Act Code
7 of Practice was produced before the legislation came
8 into force, and it hasn't been updated since.

9 And there's a very good example of there's a clash
10 between the Code of Practice says you have to approach
11 assessment of capacity in a certain way, you start
12 thinking about does the person have an impairment or
13 disturbance in the functioning of the mind or brain, and
14 only if they have that, then you go on to think about:
15 can they understand, retain, use and weigh the
16 information?

17 There's case law, including at Supreme Court level,
18 saying that's just wrong. The Code of Practice is under
19 review now, and I should say I'm on the expert working
20 group with the Department of Health Ministry of Justice
21 and one of the people involved in there thinking about
22 it.

23 **Q.** Just pausing there before we continue and where this
24 Inquiry may or may not fit in with that. What's the
25 timetable, clearly following the Bill, the codes being

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1 in the Code of Practice would be setting things up to
2 fail really almost from the outset.

3 **Q.** Helpful, thank you.

4 Paragraph 70 of your statement is where you refer to
5 the fact that it's unfortunate that the Mental Capacity
6 Act 2005 Code of Practice does not just go beyond what
7 the primary legislation requires, but is in flat
8 contradiction to it:

9 "The Chair of the Inquiry may wish to consider the
10 practicalities of how a medical professional might be
11 expected to be aware of the clear edict from the Court
12 of Appeal as to how assessments are to be conducted so
13 that they can be aware that there is a 'cogent reason'
14 to depart from the Code."

15 Would you like to expand on that, I'm going to ask
16 you more about testing and capacity in a moment.

17 **A.** Yes, yes. So to pick up on the question you asked, as
18 I said, most people most of the time would look at the
19 Code of Practice and it's a statutory code, it's been
20 laid before Parliament, so it's entirely understandable
21 people would think: well, I'll go to the Code and the
22 Code must be up-to-date. And then how is it that people
23 know that the Code isn't up to date? And of course we
24 would expect medical professionals, healthcare
25 professionals, social care professionals, police

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1 professionals to keep themselves abreast generally, but
2 I suggest it's rather unrealistic to assume that they're
3 able to spend all day every day reading legal updates.

4 People do try and provide updates, law firms provide
5 updates, my chambers provide updates, but they're
6 entirely unofficial. They have no official status. So
7 there is a real problem where you have, just to pick up
8 on that example, you know, that the Supreme Court and
9 then again reiterated by the Court of Appeal, said the
10 Code's just wrong, but the Code is sitting there. So
11 how do you know, sitting alongside it, that you've got
12 something which you need to be looking at?

13 There might be ways around, for instance, the
14 Statutory Guidance that accompanies the Care Act 2014 is
15 online and is capable of being updated more regularly
16 than the Mental Health Act or Mental Capacity Act Code
17 of Practice, but there's always going to be a tension
18 and you can't just have a Code of Practice updated on
19 a rolling basis, but if you can't have that, then one
20 has to think about: well, what is Central Government
21 doing? What are the bodies who are expecting to be
22 responsible doing? To ensure that frontline
23 professionals are provided, you need to know X, and, as
24 it were, where the paragraph says this, replace it with
25 that.

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1 are seen as somehow alien or a problem, or something to
2 get round or something which stands in the way, and
3 just -- we will I'm sure come on to it later -- but
4 guidance relating to information sharing is incredibly
5 legalistic, as opposed to operationally, you're faced
6 with this, how should you be thinking?

7 So it's got to be, of course, legally accurate, but
8 it can't be too legalistic.

9 **Q.** Paragraph 45 of your witness statement onwards, you were
10 asked effectively about non-voluntary treatment for
11 mental disorder outside the hospital?

12 **A.** Yes.

13 **Q.** How can a psychiatrist enforce or require a patient to
14 take medication in the community? Let's focus on
15 pre-amendments to the Act as well. What's the position
16 or was the position the Inquiry is examining?

17 **A.** So we need to be careful we're distinguishing between --
18 are we talking about the cohort of people who are in
19 some ways subject to the Mental Health Act but out, so,
20 for instance, in the CTO --

21 **Q.** In the community --

22 **A.** Yes.

23 **Q.** -- in the community, not being detained in hospital.

24 **A.** Yes. So the main framework you're going to have is --
25 well, conceivably you might have someone who is on

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1 **Q.** This is a matter clearly for the GMC, for the Royal
2 College of Psychiatrists, we're going to come to some of
3 their guidance later, but updated guidance that
4 clarifies what to do in practice is important.

5 **A.** It is. I would just, though, say I don't think it's --
6 of course part of the obligations are on those bodies,
7 but also part of the obligations are on Central
8 Government, because Central Government is ultimately
9 responsible for Codes of Practice. So one has to think
10 through the different levels of obligations.

11 **Q.** Who would be best able to draft what clinicians need to
12 be assessing, and in the language that clinicians
13 appreciate and use in their daily practice?

14 **A.** I will say this as a lawyer: the very last people who
15 should be doing it are lawyers.

16 **Q.** I'm sure that's the case.

17 **A.** It's a non-trivial point, because actually I do an awful
18 lot of training and I've just about managed to learn to
19 speak doctor, just about managed to learn to speak
20 social worker, but I know I'm not a doctor, I know I'm
21 not a social worker, I'm acutely conscious I'm a lawyer
22 and I won't always speak -- I won't always get the
23 terminology right.

24 And there's also a meta level problem, which is if
25 things are always framed in very legalistic terms, they

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1 section 17 leave, so in other words, they are subject to
2 the Mental Health Act, they're on leave, authorised by
3 the responsible clinician. At that point, part 4 of the
4 Mental Health Act applies, which is -- which are the
5 compulsory treatment provisions.

6 **Q.** Just tell us what the compulsory treatment --

7 **A.** So in other words, there's quite an elaborate set of
8 frameworks around ensuring people -- making sure that
9 people have medical treatment, including against their
10 will, and after a certain period of time, which is going
11 to be condensed by the Mental Health Act 2025
12 amendments, those -- that has to be subject to oversight
13 by so-called second opinion appointed doctor.

14 Part 4 is what normally applies in a hospital
15 setting, but Section 17 means Part 4 will still apply.
16 If someone is on a so-called Community Treatment Order,
17 so in other words they are subject to the Mental Health
18 Act, but the responsible clinician, having consulted
19 with the relevant people, and in consultation with
20 an Approved Mental Health Professional, there's
21 a separate set of provisions relating to medical
22 treatment for mental disorder, Part 4A.

23 And in essence they reflect the fact that Community
24 Treatment Orders were set up -- the underlying idea of
25 Community Treatment Orders were in effect they were

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1 a robust contract. That was really their original
2 intention, that people have moved away in some ways, but
3 that was the idea: that you had a patient who had some
4 degree of appreciation that they needed to keep
5 maintaining their medication, either for their benefit
6 or the benefit of others, but they recognised -- and
7 there was an agreement -- that they needed to make sure
8 that there was a framework to make sure that happened.

9 So Community Treatment Orders was that framework and
10 it was supposed to stop endless cycles of people not
11 taking their medication, relapsing and then having to be
12 re-detained under the Mental Health Act.

13 So the ability to provide medical treatment under
14 a CTO is rather -- is more limited when you're actually
15 in the community. You can robustly persuade. In
16 an emergency you can do certain things but the real
17 zone, if the person is non-compliant with their
18 medication, how it then works is that the person should
19 be recalled and then, for instance, the medication can
20 be provided in hospital during that period of recall.

21 So it's important to understand that the sort of
22 framework of coercion and benign coercion -- I'll call
23 it a legitimised coercion, as it were -- is supposed to
24 be lesser for somebody using -- in the community,
25 subject to a Community Treatment Order, but always with

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1 **Q.** But in practice that doesn't really apply in these cases
2 or circumstances, does it? It's not used for those
3 purposes.
4 **A.** Well, theoretically it can be, and it's -- I mean I'm
5 aware of unreported cases where it can be. And just to
6 highlight that zone, because if you've got somebody who
7 doesn't have capacity to make decisions about medical
8 treatment, and so they're not taking their treatment,
9 not because they're capacitously declining but they're
10 incapacitously unable to make the decision, then the
11 requirement to make sure they have the medication
12 involves laying on of hands and restraint, that is
13 something which would be problematic under -- you can't
14 just do that under a CTO.
15 **Q.** No.
16 **A.** There have been a couple of unreported cases where
17 a Court of Protection judge has recognised that it's
18 sufficiently important that this person is maintained in
19 the community, rather than being brought back into the
20 hospital, that it's legitimate to authorise restraint on
21 that person in their own home, and so you have this
22 quite complicated -- you've got the CTO sitting there,
23 the CTO doesn't authorise the restraint. The restraint
24 is being authorised by the Court of Protection, because
25 the person doesn't have capacity and it's in their best

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1 the idea if the person is not taking their medication,
2 recall could be used.

3 Can I just make one point also, just in that? CTOs
4 are not always very well understood, and the case of *PJ*
5 in the Supreme Court made it very clear that responsible
6 clinicians can't be bluffing when using CTOs to say, "If
7 you don't take your medication, you're going to be
8 recalled immediately." That's not how they work. But
9 not taking your medication is one of the factors that
10 the responsible clinician will take into account to
11 think: if this is person doesn't take their medication
12 they will relapse and they may pose a risk to themselves
13 or others, then I'll recall.

14 So it's important to understand it's not quite as
15 simplistic as -- and I'm not remotely suggesting you are
16 saying it was -- but is not as simplistic as: if you
17 don't take your meds, you're going to come in
18 immediately. But I think one of the things to the
19 extent that CTOs are in focus here, I think one of the
20 things which does need to be thought about and discussed
21 and considered is how far one can go with that framework
22 and that language.

23 **Q.** You refer also in your report to the welfare
24 jurisdiction of the Court of Protection.

25 **A.** Yes.

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1 interests to receive that medication.

2 As I say, it's -- there are two unreported cases,
3 it's conceivable there are others out there, but --

4 **Q.** Who was the applicant in those cases?

5 **A.** They were the Trusts, Mental Health Trusts, and
6 I suspect in conjunction -- I have to admit I can't
7 remember just off the top of my head -- but it would be
8 likely to also have been there would be local authority
9 involvement but the driver would have been the mental
10 health Trust.

11 And I think it's important to understand that's --
12 it's an entirely legitimate use of the Mental Health Act
13 sitting alongside the Mental Capacity Act, but the very
14 fact you're having to think about dual jurisdictions is
15 automatically giving rise to people going: this is quite
16 complicated.

17 **Q.** The overlap, and the dual jurisdictions, is difficult,
18 isn't it?

19 **A.** Yes. That's -- it's difficult -- the primary
20 difficulties come up not so much there; the primary
21 difficulties tend to come up more in deciding which
22 framework do we use to authorise deprivation of this
23 person's liberty in the hospital setting for assessment
24 and treatment of mental disorder? But it is absolutely
25 fair to say that we have parallels in the community

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1 where two things are -- that two regimes can be sitting
2 next to each other and people are having to work out
3 which decision-making body is giving us authority, and
4 the second you've got that in place you have automatic
5 levels of complexity.

6 **Q.** Can I ask you more questions about capacity, please. It
7 would be helpful to have two pages of your witness
8 statement on the screen.

9 **A.** Yes, of course.

10 **Q.** WITN0288001, pages 32 and 33 alongside each other so
11 people can see those. In essence here, Mr Ruck Keene,
12 you state that there's "regularly referred to", at
13 paragraph 60, "the 'presumption' of capacity".

14 Presumption does not mean professionals do not need
15 to consider at what point it's necessary to assess
16 an individual's capacity, does it? Can you just explain
17 to us how that term is used and potentially misused?

18 **A.** Yes. It is a very pernicious problem and it's one,
19 I suspect if Parliament was asked to draft this piece of
20 legislation again, they wouldn't draft it this way,
21 because it's got two aspects to it. And it's got two
22 aspects to it. The first aspect is there just has to be
23 a working operation presumption in life that people have
24 got capacity to make decisions, otherwise society would
25 collapse because every time there was a-- I mean to take

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1 source of information can come in to raise those
2 concerns or doubts, can't they, about capacity?

3 **A.** Absolutely. Absolutely. And that was a quote from
4 a very -- a really -- a helpful judgment which amplified
5 or clarified the bit that the presumption's got limits,
6 and I do think it is incredibly important to understand
7 that some people have a problem with the term
8 "professional curiosity", I don't. Professional
9 curiosity absolutely should be in play and, for
10 instance, the GMC Consent Guidance really makes that
11 clear: that people should be alert to the sign that
12 somebody may not have capacity, and that alertness
13 should both be from the engagement with the person, but
14 also collateral information. And so if family members
15 get in touch and say, "I'm extremely concerned about X
16 and I'm not sure they've got capacity", that should be
17 a good reason for cause for concern.

18 **Q.** Well, they might not express it as "I'm not sure they've
19 got capacity"?

20 **A.** Of course not, yes.

21 **Q.** They could say, "they're deteriorating, they're unwell,
22 I'm worried about them", they are concerns, aren't they?

23 **A.** Yes. I should say this is a really classic example of
24 good reason for cause for concern is a very
25 straightforward term. How it's then amplified is down

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1 a silly example, every time someone went in a shop and
2 tried to buy something, the person selling it to them
3 would say, "I can't sell this to you unless I've done
4 an assessment of your capacity to enter into that
5 contract." So society would collapse without
6 an operating presumption.

7 Section 1(2) then goes on to say, to make it sound
8 like: you have to proceed on the basis that this person
9 has got capacity unless you've established they don't.
10 And what it's missing is the fact that the operating
11 presumption I've just described breaks down immediately
12 if there's reason to suspect the person doesn't have
13 capacity.

14 So if I suspect you don't have capacity, if I just
15 went on and said: well, I'm going to proceed as if you
16 did because I haven't carried out a formal assessment,
17 we have a serious problem. And that's really where the
18 serious problems start coming in.

19 **Q.** So where there's a cause for concern or legitimate doubt
20 to capacity --

21 **A.** Yes.

22 **Q.** -- then it needs to be assessed. Is it possible to take
23 a cause of concern from a number of different sources,
24 for example, family members who know the patient well,
25 other observations by professionals? Anything? Any

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1 to professional guidance, professional ethics,
2 professional curiosity. But it's a simple term which --
3 which is absolutely key to not otherwise falling into
4 traps which people fall into the whole time, which is --
5 and this is a twofold aspect to it -- sometimes people
6 think: I'm not allowed to think this person lacks
7 capacity because I haven't been able to carry out an
8 assessment.

9 I have some sympathy with that.

10 Sometimes it's -- and this is the situation I have
11 less sympathy with, which is that: if I reach
12 a conclusion this person lacks capacity, oh my goodness,
13 things are going to be more complicated and we're going
14 to have lots of meetings and best interest discussions
15 and somehow that's going to give rise to more
16 obligations on me. And if I say this person has
17 capacity, I can allocate things to lifestyle choice,
18 say, or these are choices, and I feel ethically
19 responsible or driven to think about people's choices,
20 and so that's a very bad driver towards not engaging
21 your brain and thinking: does this person actually have
22 or lack capacity? And it can be quite difficult
23 sometimes to unpick what's going on.

24 **Q.** You refer in fact to case law here, above paragraph 63,
25 that does, in fact, make clear:

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1 "If you find it difficult to judge whether a patient
2 has [the] capacity to make a decision, you should seek
3 support from someone who knows the patient well, for
4 example, another member of the healthcare team or
5 someone close to the patient."
6 **A.** Yeah.
7 **Q.** So it should be apparent and clear that gathering
8 information is possible. Something else you make clear
9 in your report is that Mental Health Act assessments
10 have to be conducted in person, but capacity assessments
11 can be done remotely. What's the reason for that, as
12 far as you're aware?
13 **A.** I think it really shows the very, very different
14 historical places that mental health legislation and
15 mental capacity legislation come from, because mental
16 health legislation -- I mean, the bones of it come from
17 the 1959 Act, and it's always very much about being the
18 regulation of coercion, in terms of admission and
19 treatment.
20 So if you come from that starting point it feels
21 very obvious that you should only be ever removing
22 someone's liberty after you have personally examined
23 them. Whereas, the Mental Capacity Act comes from
24 different places, for instance, safeguarding people's
25 property, and financial affairs, and things like that so
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1 you're unable to see them, you will have to reach that
2 conclusion based on all the collateral information
3 you've got. So the Mental Capacity Act doesn't have
4 anything in it which says, "thou shalt not reach that
5 conclusion absent sight of the person". So it's really
6 important to understand those differences.
7 **Q.** Have you seen many cases within the case law where those
8 circumstances have led to an assessment of lack of
9 capacity, just effectively non-engagement and not
10 knowing what's going on, having sufficient doubts around
11 that?
12 **A.** So I think what quite often the case law tends to be the
13 sort of situations where we can't get in to see the
14 person. Quite often it is there's a third party barring
15 access which is then going to send you down some kind of
16 route, but it could also -- the other kind of examples
17 are self-neglect cases. We can't get in to see the
18 person, but we've got enough information to think we're
19 troubled about this person's capacity and then I think
20 it's important to flag that section 48 of the Mental
21 Capacity Act allows an application to be made to the
22 Court of Protection where there are reasonable grounds
23 to believe the person may lack capacity. So it's an
24 incredibly low threshold.
25 Then you can get into court and the court can start
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1 it doesn't -- it never came from a place of really
2 thinking about coercion. It can be used for coercive
3 persons, we've got the deprivation of liberty
4 safeguards, say.
5 **Q.** It might end up in the same place, depending what the
6 decision -- (*overspeaking*) --
7 **A.** Oh, completely. Yeah, no, completely. And I think one
8 of the huge myths is that people think the Mental
9 Capacity Act is less restrictive than the Mental Health
10 Act, but you could equally end up in a mental health
11 institution being subject to non-consensual treatment
12 under the Mental Capacity Act under certain
13 circumstances.
14 I think it's -- can I just also clarify the Mental
15 Capacity Act is not just that you can carry it out
16 remotely -- and we've got case law which says that --
17 it's also possible to reach a conclusion that the person
18 lacks capacity without -- well, either has or lacks
19 capacity without even being able to see them at all,
20 because you may have a situation where, for instance,
21 you're finding it difficult to engage with the person,
22 the person is not opening the door, you can't
23 communicate with them. And you will have a reason why
24 you need to assess capacity, or reach a conclusion about
25 capacity. If you're unable to engage with that person,
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1 saying, "Well, I now need, as a Court of Protection
2 judge, to get the information I need to get in order to
3 be able to reach a conclusion about the person's
4 capacity." They will normally want to make sure they've
5 got the benefit of evidence from somebody who has
6 actually been able to see the person but, if they're
7 driven to it, they can reach a conclusion without sight
8 of the person.
9 **Q.** As we have agreed earlier, very rare, I mean you've
10 mentioned one or two cases but very rare in these
11 circumstances that that has actually been deployed
12 through the Court of Protection.
13 **A.** Well, I think -- so the rareness was not so much -- it
14 wasn't a general Court of Protection -- the rareness was
15 the CTO running alongside the Court of Protection to
16 deal with medication under restraint. But I also
17 think -- can I just make one point? I think it's
18 incredibly important to understand that you should never
19 ever start with capacity. And I think that's where one
20 of the areas where people go wrong. Because if people
21 start thinking about "I need to think about capacity as
22 a starting point," you are then left with: "Well,
23 I don't really know what I'm supposed to do if I reach
24 a conclusion a person has or lacks capacity."
25 So you'd only ever be assessing capacity in the
24

1 situation I've just been describing where, for instance,
2 you're finding it difficult to get in to see the person,
3 because the professionals who have got involved have got
4 proper reason to be concerned.

5 **Q.** And would take different steps once they've confirmed
6 that.

7 **A.** Exactly. So, as it were, the capacity assessment is
8 only going to be giving guidance as to the basis on
9 which they're engaging with the person. Because the
10 capacity assessment is only ever going to reach -- it's
11 going to allow you to say, "Well, I'm engaging with the
12 person on the basis that they lack capacity to take
13 their medication, and therefore I'm thinking about
14 potential best interests," or "I'm engaging with the
15 person on the basis that I think they're capacitously
16 refusing."

17 So that's going to send you down a different route.
18 But that all comes from having started with "Why am
19 I bothered? You know, what's the risk here? Why am
20 I concerned about medication non-compliance?" And you
21 only ever get to capacity later. And I think it's one
22 of the really troubling aspects, or "troubling" is not
23 quite the right word. One of the inadvertent
24 consequences of the Mental Capacity Act having come into
25 force and people having a real emphasis on thinking

25

1 think through properly various things which might be
2 needed to be done.

3 So it's not just legally incoherent; for my mind,
4 much more significant and problematic, it's sending
5 people down the wrong track in terms of how they should
6 be responding to the persons needs.

7 **Q.** And it fluctuates, doesn't it? Particularly the illness
8 that the Inquiry is examining in this case, psychosis,
9 paranoid schizophrenia, hallucinations, et cetera,
10 potentially lucid periods, not lucid periods. It
11 fluctuates. What's the impact on that for assessing
12 capacity?

13 **A.** Fluctuating capacity is a term which is quite -- it's
14 sometimes misused. It's sometimes misused to cover
15 professional disagreement. So in other words, one
16 person might see the person, say they've got capacity to
17 make decisions; another person might see them and
18 doesn't think they've got capacity but don't want to
19 say, "I don't agree with assessor A". So they'll say
20 they've got fluctuating.

21 So I think it's important that people don't leap
22 immediately to fluctuating capacity is in play the whole
23 time. But you certainly can have conditions, and the
24 conditions that the Inquiry is concerned with are -- not
25 quite paradigmatic, but they are undoubtedly conditions

27

1 about capacity is that they leap too quickly to thinking
2 about that, rather than how we are thinking about this
3 person's needs, how are we thinking about responding?
4 What's the right medication? Things like that. And
5 then asking themselves: where does capacity come into
6 that equation?

7 **Q.** It's not useful, is it, for clinicians to talk about
8 capacity in a general sense; it's issue specific. Would
9 you like to say something about that?

10 **A.** It's fundamentally problematic. I mean it's legally
11 meaningless to talk about capacity in a general sense.
12 It's also fundamentally problematic because you start --
13 it's particularly problematic if you have clinicians or
14 professionals who are very, very used to the Mental
15 Health Act, because the Mental Health Act is
16 status-based. You have a mental disorder of a nature or
17 degree warranting certain things.

18 If you start thinking about capacity in that way of
19 having a status of full capacity or partial capacity,
20 you're nudging yourself immediately to stop thinking in
21 a sufficiently granular way, because somebody might have
22 capacity to make decisions about certain aspects of
23 their life, but not other aspects. Unless you think
24 that through properly, you're not lining yourself up to
25 then respond and provide the appropriate responses, and

26

1 which certainly have situations where, depending on
2 what's going on, the person might well have capacity to
3 make relevant decisions, but might well not. And that's
4 the point when you need to think about the fact that
5 capacity is time-specific. So then you need to be
6 thinking -- well, there are two aspects: (a) if you're
7 thinking about a one-off, can this person make this
8 decision, can it wait? Then it might be that you could
9 wait, take steps to support them to make the decision.

10 But also if you've got a condition which is
11 fluctuating over time and someone needs to take regular
12 steps to maintain themselves, and they are simply unable
13 to do so, that might well be a situation where the
14 reality is it's not so much fluctuating capacity it's
15 longitudinally, they don't have the capacity to take the
16 relevant decisions on an ongoing basis, to make sure, or
17 for us to be able to reach a conclusion that they've got
18 capacity to take the relevant decisions.

19 **Q.** If we look at paragraph 67 of your statement, page 35,
20 and have it alongside page 36.

21 **A.** Yes, I have it, thank you.

22 **Q.** If we have 35 and 36 up, if that's possible, Sarah.

23 You set out the two-stage test to be adopted in
24 respect of capacity. Can you briefly summarise that for
25 us?

28

- 1 A. So this is actually the example I was talking about
 2 earlier, where the Code said there's a two-stage test,
 3 and it rather suggested that there was a kind of
 4 diagnostic element, and in fact the term "diagnosis"
 5 doesn't appear in the Mental Capacity Act, and it was
 6 only if you could tick that off then you then went on to
 7 move to think about whether or not the person had the
 8 capacity to make the relevant decision.
- 9 The Supreme Court in the *JB* case says no, you start
 10 with: can the person understand, retain, use, and weigh
 11 the information? And it's only if they can't do that,
 12 that you then go on to ask: well, what's the problem?
 13 Why can't they do that? And this is one of the bits
 14 where we've now got a Supreme Court case from 2021,
 15 six years later -- five years later we've still got
 16 a code guiding people in the wrong direction.
- 17 Q. Can we have a look, please, at 36 and 37 alongside each
 18 other.
- 19 A. Yeah.
- 20 Q. Can you set out for us how, when undertaking a capacity
 21 assessment, the consequences for a member of the public
 22 can also be included?
- 23 A. Yes, so the Supreme Court case in *JB* is really
 24 important, because that was the first time that the
 25 Supreme Court looked at what capacity means in the

29

- 1 Q. Do you think that's something that's sufficiently
 2 understood in this area, or would you rather leave that
 3 to clinicians and practitioners?
- 4 A. So I can't speak for clinicians and practitioners and no
 5 doubt the Inquiry will want to hear expert opinion on
 6 that, but for what it's worth, I think -- I mean, from
 7 having both worked on guidelines alongside clinicians
 8 and doing lots of training and in cases, I think it
 9 goes -- the fact that so often we've identified
 10 culturally public protection is down to the Mental
 11 Health Act, the Mental Capacity Act has nothing to do
 12 with public protection, it's the kind of stereotype,
 13 that it's only relatively recently people have begun to
 14 realise or begun to understand capacity doesn't sit in
 15 isolation; people don't sit in isolation. And sitting
 16 alongside that the fact that best interests, so in other
 17 words what sits on the other side of capacity, we've got
 18 cases which make it clear that if you harm somebody else
 19 and it's got, as it were, blow-back harm for you, that
 20 can start leading to considerations about your best
 21 interests about not harming people.

22 So you then start saying, well, it's very simplistic
 23 to have Mental Health Act public protection, Mental
 24 Capacity Act purely about the person. It's more
 25 complicated than that. And I don't know the extent to

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- 1 context of the Mental Capacity Act, and the precise
 2 context is not relevant for these purposes because they
 3 set out a kind of what to do guide at the beginning.
- 4 What they really emphasise -- and it was important
 5 that they really emphasised this because it was the
 6 first time it really came out so clearly -- that the
 7 information which is relevant to the decision, you
 8 always have to focus on the decision, then the
 9 information which is relevant to the decision, and that
 10 includes reasonably foreseeable consequences.
- 11 And traditionally reflecting almost that, as I said,
 12 the ethos where the Mental Capacity Act came from,
 13 people are always thinking: well, it was only ever about
 14 the person and one of the things the Supreme Court said
 15 is the reasonably foreseeable consequences could include
 16 consequences for other people.
- 17 So if it's reasonably foreseeable that your actions
 18 could harm somebody else, one of the things you would
 19 have to be considering, if it's relevant information for
 20 a decision, is can you understand, retain, use and weigh
 21 that fact?
- 22 Q. So for clinicians to get an understanding from
 23 a patient, whether they understand the impact of their
 24 behaviour, for example, on others?
- 25 A. Yes.

30

- 1 which clinicians still very much identify the Mental
 2 Capacity Act much more about this is P -- the
 3 person-centric, it's about empowering for the person as
 4 opposed to, actually, that's not what the Mental
 5 Capacity Act is; it's a framework for making sure that
 6 where you've got a legitimate reason to think about
 7 someone's capacity to make a relevant decision, you're
 8 thinking it through carefully.
- 9 Q. Well, arguably P and the interests of the public could
 10 be the same, couldn't they? It's in the interests of
 11 the patient that they don't commit offences and escalate
 12 offences. But the law is not interpreted like that, is
 13 it? -- (*overspeaking*) --
- 14 A. Well, I must confess there's -- I'm on record as saying
 15 it's slightly Orwellian when you start framing it like
 16 that because the traditional conception of best
 17 interests and most of the cases have been very much
 18 around focusing on the person's wishes, feelings,
 19 beliefs and values, and trying to make the decisions
 20 they would have made.
- 21 And it starts getting -- it starts feeling slightly
 22 odd sometimes to say: well, it's in your best interests
 23 not to do something bad, as opposed to being hard-edged
 24 and saying: Mental Health Act, we just want to stop you
 25 from doing something where the public interest demands

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1 that we stop it. But there's nothing in the Mental
 2 Capacity Act, and there have been cases which make this
 3 clear, that's -- the Mental Capacity Act is capable of
 4 housing it, but it's a kind of cultural place where
 5 people haven't necessarily thought through, or haven't
 6 reflected on, actually the Mental Capacity Act is not
 7 just -- I probably shouldn't use the word "cuddly" but
 8 that's sort of the potential it sometimes has. It
 9 actually is very -- can be very hard-edged.

10 **Q.** In terms of patients' best interests, where they lack
 11 capacity in respect of sharing information with their
 12 family, for example, if there's evidence that concerned
 13 family members, no undue influence or anything of that
 14 kind. Does best interest permit sharing? Is that what
 15 practitioners should be thinking about in circumstances
 16 where the next of kin is excluded from information about
 17 the patient?

18 **A.** So I think it's -- I can't -- I don't want to give
 19 a simplistic answer because annoyingly it's not
 20 simplistic, if you see what I mean, and I'm not -- but
 21 the concept of best interests is entirely capable of
 22 housing and lots of -- I mean and the guidance properly
 23 reflects this. So, for instance, the GMC Guidance
 24 perfectly properly reflects that best interests can
 25 encompass the provision of information to family members

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1 the capacity to make the decision about information
 2 sharing.

3 **Q.** So whose responsibility is it to make a best-interests
 4 decision once a patient has been deemed to lack capacity
 5 to consent to share information? If it's a community
 6 patient, would that be the person responsible for their
 7 care in the community, care coordinators?

8 **A.** So I think one of the important aspects, just to be
 9 clear about, is the Mental Capacity Act does not itself
 10 have any -- it doesn't have surrogate decision making
 11 and so just you mentioned next of kin a couple of
 12 minutes ago, for instance, there is no -- next of kin
 13 has got no status under the Mental Capacity Act, people
 14 quite often think they do. And the Mental Capacity Act
 15 doesn't have formal surrogate decision makers because
 16 it's entire ethos is people are supposed to make
 17 collaborative decisions, which is very nice, it is also
 18 profoundly problematic and one of the aspects of the
 19 Inquiry might well want to reflect on is pure
 20 collaborative decision making can lead to lack of
 21 accountability for decision making.

22 And so, in practice, one has to think through: well,
 23 who is the person who should be accountable for making
 24 sure information is shared? I always think it's much
 25 better to think about accountability than who is the

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1 and those interested in the person's welfare.

2 I do think, though, it is important to understand --
 3 and this is in a way the same sort of balance which one
 4 carries out where the person has capacity, it isn't
 5 consequence-free, disclosing information where the
 6 person, as it were, didn't want you to. And just
 7 because you don't have capacity to make a decision,
 8 doesn't mean you will always lack capacity to make that
 9 decision, and it also doesn't mean you aren't
 10 necessarily aware that something is being done that you
 11 don't want. And so one of the things which makes it
 12 more complicated is clinicians having to think through:
 13 well, what might be the impact on, for instance,
 14 a therapeutic relationship that I'm trying to maintain
 15 or build with this person if they're aware, that I've,
 16 as it were, blown through it by sharing information in
 17 the name of their best interests?

18 Which is why so much of the guidance rightly talks
 19 about making sure you've -- people have thought through,
 20 properly, the balancing.

21 **Q.** Or explained it to the patient why they're doing what
 22 they're doing, collaborating with the patient?

23 **A.** Exactly, exactly. But bearing in mind just on a best
 24 interests analysis, we are in a zone where you have
 25 reached the proper conclusion the person doesn't have

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1 decision maker.

2 **Q.** So responsible clinicians, treating psychiatrists --

3 **A.** It might well be, yes.

4 **Q.** -- people who take ultimate responsibility?

5 **A.** Well, I'm not trying to avoid the question, all I'm
 6 trying to do is frame that one has to think through:
 7 well, who is the person who we would be expecting to be
 8 accountable for thinking about relevant information
 9 being shared. And, if there is a responsible clinician,
 10 they are the logical person to be housed, but there
 11 might be circumstances under which it's someone else.

12 But the critically important thing is that there is
 13 clarity as to who should be thinking about that and
 14 coordinating the process and making sure that the
 15 balancing exercise is done, because otherwise it gets
 16 put into the box of too difficult to handle.

17 **Q.** Can we look at paragraph 94 which is page 45, please.

18 **A.** Yes.

19 **Q.** While we find that, so decision making in respect of
 20 capacity is a legal concept, isn't it, and insight,
 21 insight into illness, a clinical concept?

22 **A.** Yes.

23 **Q.** So let's have look at paragraph 94. Can you explain or
 24 tell us what you're setting out here?

25 **A.** So paragraph 94 talks about belief and then paragraph 95

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1 talks about insight, and I've talked about the two in
 2 linked ways because both are quite often seen together.
 3 So if, for instance, a patient who doesn't appear to
 4 believe medical information, but let's focus on the
 5 insight issue. As you say, insight is a completely --
 6 it is a totally coherent concept in psychiatric
 7 practice. I should say I'm not a psychiatrist, I'm not
 8 purporting to give evidence as to what psychiatrists
 9 understand about insight, but it is a coherent
 10 concept -- my understanding is partly because
 11 therapeutically it's really important to know whether
 12 the patient has insight into their condition because
 13 that's going to give you a lot of pointers to be
 14 thinking about how we're managing the situation.

15 Where it gets messy is where one starts thinking
 16 about: well, does this mean the patient has or lacks
 17 capacity to make decisions about their medication, about
 18 their treatment? And bearing in mind the Mental Health
 19 Act is not capacity-based legislation when it comes to
 20 the administration of medical treatment for mental
 21 disorder, arguably this is an enormous red herring if
 22 you're thinking purely about medical treatment for
 23 a mental disorder. But the reality is, modern day
 24 medical practice, guided by the Code of Practice, is
 25 absolutely thinking, wherever possible, we want to try

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1 one of the things which can be important is there are
 2 people who, entirely capable, saying, "I understand you
 3 think I've got X; I don't think I have," and they might
 4 be able to give an entirely coherent reason for that.
 5 And then we're into the zone of professional
 6 disagreement -- or, sorry, disagreement between patient
 7 and professional.

8 If they're detained under the Mental Health Act and
 9 the provisions of the Mental Health Act are in play,
 10 ultimately treatment could be provided in the face of
 11 that refusal because capacitous refusal is not enough.

12 Where it gets complicated is if you're thinking
 13 about somebody in the community where, as it were, the
 14 only treatment framework, if we're talking about the
 15 only treatment framework being the Mental Capacity Act,
 16 you've got to be sure you've got the right -- or
 17 properly analyse the position.

18 And it might be that the person's apparent lack of
 19 insight, or lack of insight into their mental health
 20 condition, means that it's not that they don't agree
 21 with you; it's that they can't. They've got sufficient
 22 cognitive problems that they think, for instance,
 23 everybody else is in on the conspiracy to say they're
 24 mentally unwell. And that would be the point at which
 25 you need to tell the coherent story that: I don't think

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1 and engage with patients on the basis that we're
 2 thinking about their capacitous consent, so they're
 3 having to think about capacity.

4 And where it can get complicated is you can't move
 5 immediately from "patient lacks insight in their
 6 condition" to "patient doesn't have capacity to make --
 7 medication or decisions about their medication."

8 How it works or how it should work is: well, what's
 9 that lack of insight telling us? Is it -- at very
 10 minimum it should be a probe, to go back to your earlier
 11 question, that should be a good reason for cause for
 12 concern as to whether the person has capacity. I mean
 13 that's a really good, classic example, and then --

14 **Q.** Because they don't believe they are mentally ill, so
 15 there's no point in medication.

16 **A.** Exactly.

17 **Q.** It's a factor to take into -- (*overspeaking*) --

18 **A.** Exactly, so that's a red flag for: I now need to think
 19 through carefully. And then you need to think through
 20 quite carefully: is this a person who is capable of
 21 understanding, retaining, using and weighing the fact
 22 that they've got a medical -- everybody else thinks
 23 they've got a medical condition or a mental disorder
 24 warranting some kind of treatment, but they don't agree?
 25 And that -- it's important to maintain that space. And

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1 this person can use and weigh the fact that they need
 2 medication because of the effect of whatever the
 3 relevant condition is.

4 **Q.** And then, presumably, it's a question of looking at
 5 other factors which might be in that theoretical set of
 6 circumstances. What are the consequences? Their lack
 7 of insight means they're not likely to take the
 8 medication willingly. What are the consequences of that
 9 and what are the risks? Do they understand the effect
 10 of the risks or the potential impact? Is that --
 11 (*overspeaking*) -- to assess?

12 **A.** Yes. So I suppose -- so there are two aspects to this.
 13 So the first is yes, that's all going to be relevant to
 14 the capacity consideration. But I sort of want to
 15 really just reiterate the point I made earlier is
 16 thinking about capacity -- this is a good example --
 17 thinking about capacity in isolation here is not a good
 18 idea, because actually, that comes at the second stage,
 19 as you've identified, of thinking about everybody else
 20 is going to have to have a sufficiently clear-eyed
 21 understanding reached with proper multi-disciplinary
 22 consideration as to what the actual risks are. Because
 23 imagine this was a situation where it was very low
 24 stakes, as it were, so what if the person doesn't have
 25 capacity?

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1 If it's very high stakes, then that's going to be
 2 very important to be thinking about what do we need to
 3 do, and at one level capacity starts being slightly
 4 irrelevant because even if they don't have capacity and
 5 they, you know -- decisions might be made thinking about
 6 best interests, if, for instance you can't get in to
 7 engage with them, it's all very theoretical and
 8 interesting and abstract whether or not they've got
 9 capacity; you've got a much more serious problem which
 10 is: how do we actually respond?

11 So that's why I'm always -- I keep harping on about
 12 it, but it's so important that the consideration of
 13 capacity comes within the framework of thinking through:
 14 what do we know about this person? What's going on?
 15 What information have we got, what information have we
 16 not got, what are we concerned about risk wise, and then
 17 what might the appropriate responses be? Then you can
 18 think through: well, how is that person's capacity
 19 featuring into it, if that makes sense.

20 **Q.** It does. Can we move now, please, to Mental Health Act
 21 now and sectioning under Section 2 or Section 3 of the
 22 Act.

23 **A.** Yes.

24 **Q.** Your statement can come down and we'll use the codes for
 25 this purpose, NHSE0000312, page 118 and 119. Alongside

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1 Section 3, unless there's a material change expected to
 2 their treatment plan, should detention be under
 3 Section 3 of the Act subsequently? We've got
 4 a situation with repeat admissions, just that
 5 relationship between a Section 2 and Section 3
 6 admission.

7 **A.** So I think it's -- I think I wouldn't quite say it's
 8 only where -- or I qualify that slightly because it
 9 might be that there are other new things which have come
 10 in which you've got -- you've now got materially
 11 different information about the patient's circumstances,
 12 so it's not just about the treatment plan.

13 But as a general rule, if you know -- if you know
 14 about the patient, so the medical people making the
 15 medical recommendations and the approved mental health
 16 professional, the people know about that, the patient
 17 circumstances, it's not appropriate to use Section 2.

18 I mean, there are many, many reasons it's not
 19 appropriate, but above all you get to a situation where
 20 you're starting to use something which was only ever
 21 meant for assessment purposes when what you should be
 22 doing is moving immediately to: we know what the problem
 23 is and we should be treating.

24 Can I just emphasise one point which is really
 25 a pernicious challenge here or a problem here, is people

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1 each other if we can. This is Section 2, Section 3.

2 I'd like to ask you, please, about the use of Section 2
 3 or Section 3.

4 **A.** Yes.

5 **Q.** You probably don't need them before you, but by all
 6 means wait if that's easier.

7 Page 19 as well alongside it.

8 **A.** Thank you. They're coming up, thank you.

9 **Q.** Can we have both at the same time, if that's possible.

10 Thank you. You'll see Section 2, Section 3. Can you
 11 tell us what the difference of both is, the difference
 12 between them?

13 **A.** Yes, so in effect Section 2 is supposed to be used for
 14 assessment. So in lay terms, you don't quite know what
 15 the problem is, but you need to have the person in
 16 hospital for a limited period of time to be able to
 17 identify what the problem is and potentially start
 18 formulating a treatment response.

19 Section 3 is, in layman's terms, well, you know what
 20 the problem is and you need the person in hospital for
 21 a longer period of time which can then be extended to
 22 make sure that they get the care and treatment required
 23 either in their own interests or in the interests of
 24 others.

25 **Q.** Where someone has previously been detained under

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1 are very, very concerned about the idea of restriction
 2 and very, very interested in the idea of the least
 3 restrictive approach. And there's this understanding
 4 that somehow Section 2 is less restrictive than
 5 Section 3. I mean, they're both providing for
 6 compulsory admission; they're both providing for
 7 treatment against one's will.

8 For instance, if you wanted to put into the mix if
 9 you're detained under Section 2, you don't get access to
 10 section 117 aftercare; if you get detained under
 11 Section 3, you get access to section 117 aftercare which
 12 for many people is incredibly significant.

13 So an ethos which says: I must never be restrictive,
 14 that's entirely understandable, and therefore I should
 15 never use or I should always try and steer myself
 16 towards using Section 2 because it feels less
 17 restrictive, is a problematic challenge.

18 And it is very obvious from the Code of Practice,
 19 even as it stands at the moment, that people should only
 20 be using Section 2 where it really is we don't know what
 21 the problem is. Either this is first contact or the
 22 situation has changed somehow.

23 **Q.** So not where you have an extensive history or knowledge
 24 in medical records over a period of time.

25 **A.** Well, put it this way: I'd be wanting someone to explain

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1 to me very coherently why they were using Section 2
 2 rather than Section 3.

3 **Q.** Can we have a look, please, at page 326 of the Code. So
 4 it's the same NHSE number, page 326, the "Purpose of
 5 a CTO". I'm going to take you in a moment to the
 6 proposed amendments, but can you -- you dealt with this
 7 earlier, but can you just clarify what the position and
 8 purpose as stated was for the CTO?

9 **A.** Yes. So as I said, CTOs were really intended -- they
 10 came in in 2007 and the idea was to stop so-called
 11 revolving door patients. So if people who were
 12 repeatedly detained under the Mental Health Act, their
 13 condition improved, they were then discharged and then
 14 they relapsed, either posing a risk to themselves or
 15 others, and then had to go through the whole readmission
 16 process. And it was felt better to have a framework in
 17 place which could make sure that there was stability.

18 And I think the really important thing which was
 19 really in people's minds in 2007, it was supposed to be
 20 some form of contract. So you can sort of trace that
 21 through that the original idea was you should have
 22 capacity to enter into a CTO. But now you've actually
 23 got to a position where you don't have capacity -- you
 24 don't have to have capacity to make a decision about
 25 entering into a CTO before a CTO can be made, which is

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1 carries through most of the amendments, but I had to
 2 then unofficially update for the ones which were passed
 3 later in the Bill's passage. I just wanted to make that
 4 absolutely clear. This is for the benefit of people but
 5 I can't say this is an official document --
 6 (*overspeaking*) --

7 **THE CHAIR:** No, we'll treat it as an *aide memoire*.

8 **A.** Sorry?

9 **THE CHAIR:** We'll treat it as an *aide memoire*.

10 **A.** Please do, yes.

11 **MS LANGDALE:** And it's got your witness statement reference
 12 there, so no one thinks it's otherwise, so be assured
 13 about that.

14 **A.** I'm relatively confident it's accurate, but I just want
 15 to make sure for the record that we've got that clear.

16 So with that caveat, so looking at Section 2, you
 17 can see that what's happened, or what is going to happen
 18 when these amendments are brought into force. They're
 19 not in force yet, but when these are brought into force,
 20 we will move to a situation where it has to be
 21 established, and so the -- in almost all situations
 22 these will be two medical recommendations and then it
 23 will be for the local authority Approved Mental Health
 24 Professional, or the Approved Mental Health Professional
 25 acting on behalf of the local authority, to decide the

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1 a peculiar form of contract.

2 So they've had a degree -- considerable degree of
 3 mission creep and then the Supreme Court in the case
 4 called *PJ* in 2018 said: there's been too much mission
 5 creep and in particular responsible clinicians have
 6 given the idea that conditions on CTOs have a power that
 7 they just don't have. So for instance they can't give
 8 rise to deprivation of liberty.

9 So they're a really important framework, but the
 10 framework is one which has evolved significantly beyond
 11 what I think Parliament had in mind back in 2007.

12 **Q.** That can come down. And you, helpfully, sent through to
 13 us, with amendments demonstrated in red, the amendments
 14 in the Bill. So if we can look, please, at WITN0288007,
 15 firstly at page 3. If we could have 3 and 4 on the same
 16 page, please, for us. 4 will come alongside it.

17 So setting out the "Admission for assessment". Can
 18 you tell us the differences here, please, and what
 19 they're about?

20 **A.** Yes. Can I just make more of a -- just make it super
 21 clear? What I sent through was my unofficial attempt to
 22 provide the updates because you can't read the Mental
 23 Health Act 2025 in isolation.

24 **Q.** No.

25 **A.** I've drawn on the DHSC so-called Keeling Schedule, which

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1 application is appropriate, on the basis that the person
 2 has got the "mental disorder of a nature and degree", so
 3 that stays the same; "for detention ... in hospital for
 4 assessment (or for assessment followed by medical
 5 treatment)". So that's reinforcing just to -- we're
 6 staying with the same idea: we don't know what the
 7 problem is, we need the person in, but then it's so that
 8 there's "serious harm may be caused to the health or
 9 safety of the patient or ... another person unless
 10 [they're] ... detained"; and then it's "given the
 11 nature, degree, and likelihood of the harm, the patient
 12 should be so detained".

13 Then you can see the text which was gone was -- it
 14 was "ought to be so detained in the interests of their
 15 own health and safety or with a view to the protection
 16 of [others] ..."

17 So one can talk about this as a raising of the
 18 threshold, one can also talk about this as
 19 a clarification of the threshold.

20 **Q.** The DHSC say: clarification, it's not raised, serious
 21 harm isn't defined; it needs no more than minimal harm;
 22 why do you say or why does one say it's raised?

23 **A.** Well, I think it's -- I should be careful here. I can't
 24 give evidence on behalf of the Mental Health Review, and
 25 I know you will be hearing from Sir Simon Wessely, but

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1 I was the legal adviser and I think it's important just
2 for context we know of the review took place. One of
3 the drivers for the review was the perception that there
4 were too many detentions.

5 Q. Mm.

6 A. And so there was -- and it's a very complicated picture,
7 untangling what the rising number of detentions mean.

8 So when you read the review report, you will see
9 talking about how one thinks about detention, and making
10 sure that people are not being detained unnecessarily
11 and make sure there is a proper understanding of why
12 this person is being detained.

13 And I do think it's really important. This is
14 a very, very good example, by the way, of primary
15 legislation sits here, how the Code starts to interpret
16 that legislation is going to be incredibly important as
17 that legislation then comes into force.

18 And I think almost the most important bit here is
19 where people are talking about likelihood of the harm.
20 Because this could be a -- you could interpret this,
21 depending on how one wanted to think about it, on
22 "I don't want to think about admitting this person
23 because I don't think the harm is happening right here,
24 right now." So the slow -- sometimes talk about the
25 slow motion car crash situation: "I feel I have been

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1 A. -- the likelihood is that some of the discussion in the
2 passage or when the Bill -- the draft bill was
3 scrutinised by the Joint Committee was talking about
4 slow motion car crash situations.

5 But yes, no, severity of harm is definitely a term
6 which the Code of Practice is going to have to take
7 a first run at, and the reality is there will probably
8 be a case at some point thereafter where the courts say:
9 well, actually this is what it -- well, actually this is
10 what it means.

11 Q. Interpret it?

12 A. Interpret it, yes.

13 Q. If we go to page 11, please, of this document: "General
14 provisions", "patient's nominated person".

15 A. Oh yes.

16 Q. Tell us about this.

17 A. Yes. Sorry, could I just say, do you mind if I just
18 very quickly talk about Section 3 because I've only just
19 talked about Section 2?

20 Q. Of course. Do you want it back on the screen?

21 A. Sorry, do you mind if I just go back because one
22 important point I want to make clear.

23 Q. So that was page 4.

24 A. I'm sorry about that. I took too long on the Section 2
25 answer.

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1 told by the changes in the Mental Health Act I shouldn't
2 detain."

3 That, I would say, is not a correct reading of the
4 Act, because what you're not taking into account is: if
5 we don't do something, the likelihood of that harm
6 eventuating is X; and if that's a sufficient number, as
7 it were, that means that someone should be brought in
8 either for assessment or -- and the same thing applies
9 to Section 3, brought in for treatment.

10 So this is a really good -- you're sort of doing
11 this in realtime in the sense of you're looking at the
12 Act as it's passed. It hasn't brought these changes
13 into force yet. The Code of Practice is going to give
14 the first steer from DHSC, approved by Parliament, as to
15 what we think this should mean.

16 And that's one of the areas where it might be
17 thought to be extremely important that any
18 recommendations that the Inquiry makes about how people
19 should be thinking about these terms in the real world
20 are taken on board.

21 Q. Serious harm, that's important, isn't it, how that's
22 interpreted in practice?

23 A. Completely, yes, yes. So I was only really -- I'm not
24 for one second saying that's not a perfectly --

25 Q. -- (overspeaking) --

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1 Section 3 needs to be understood in the context of
2 both European Court of Human Rights case law which
3 I referred to in my witness statement, the case of
4 *Roman*, but also the new Section 1A, which will appear
5 in the Mental Health Act 1983, reflecting that case
6 which is about the idea of appropriate medical
7 treatment. And I think it's very important to
8 understand that the idea of appropriate medical
9 treatment is trying to stop being the circular
10 definition which it is at the moment, where "appropriate
11 treatment" simply is appropriate for that person, given
12 their circumstances. I'm paraphrasing slightly.

13 "Appropriate medical treatment" in due course will
14 have a more -- a tightened definition, looking in
15 particular to the likelihood -- I'm just going to read
16 it out -- it's 1A:

17 "references to medical treatment which, taking into
18 account the nature and degree of the disorder and all
19 other circumstances --

20 "... [have] ... a reasonable prospect of
21 alleviating, or preventing the worsening of, the
22 disorder or one or more of its symptoms or
23 manifestations, and

24 "... is appropriate in the [patient's care] ..."

25 I think just for context, people need to understand

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1 that was coming from both the European Court of Human
 2 Rights case law and concern about people being so-called
 3 warehouse'd. So simply detained without any actual
 4 obvious treatment going on. And when one is thinking
 5 through, this is legislation, we've got the Code of
 6 Practice, and one of the things one thinks about in
 7 terms of possible inadvertent consequences is making
 8 sure that people think through clearly that what message
 9 is that giving and how one interprets that and not
 10 simply saying: well, this person, for instance, has got
 11 what we're going to identify as treatment-resistant
 12 schizophrenia, which means there is no point in
 13 detaining them because there is no treatment which is
 14 available. That would be too simplistic, one would have
 15 to think through.

16 So I just think it's really important to think under
 17 Section 3 we've got the clarification around the
 18 threshold and we've got that very specific reference to
 19 appropriate treatment with a further definition and
 20 I think being clear-eyed and doing this in realtime, one
 21 needs to think through how could people misinterpret and
 22 make sure misinterpretations, insofar as possible, are
 23 headed off at the pass. Sorry, if that was clear.
 24 **Q.** Understood. It is. Page 11, please, going back to the
 25 patient's nominated person.

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1 nominate someone to act as your champion, in effect. So
 2 that's the idea of nominated person.

3 So capacity will enter into there: do I have
 4 capacity to make the decision? It's not an
 5 untrammelled: I can't just appoint everyone, there's
 6 a sort of series of checks and balances, but the idea is
 7 you've got more say in who's going to be your voice.

8 That then tracks through into the nominated person
 9 will have more roles. So the role there under
 10 section 11 about application at the moment is
 11 vanishingly rare for a nearest relative to try and bring
 12 about someone's application. I mean, that's sort of
 13 historic, that's sort of Victorian people, you know,
 14 committing relatives to institutions. Nowadays it's
 15 very much more done by local authorities.

16 But nominated persons are going to have more roles
 17 in terms of, for instance, consultation in relation to
 18 treatment decisions, the idea being that if I've
 19 appointed someone to be my champion, well, it's
 20 important that they get more say.

21 I think it's also important, just to be clear,
 22 although that's the goal, very many people, as matters
 23 stand, won't have done that because people won't think
 24 I will ever be mentally unwell, so they won't have done
 25 and GPs -- you know, if you go for a routine health

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1 **A.** Yes.

2 **Q.** So the underlying basis for removal of the nearest
 3 relative or the patient nominated person.

4 **A.** Yes. Shall I just very briefly --

5 **Q.** Yes, please do. If we can have the next page 12 --

6 **A.** Yes.

7 **Q.** -- shown at the same time, that would be helpful.

8 **A.** I mean, at present there's this idea of the statutory
 9 nearest relative, so in other words there's a list you
 10 grind through in rather mechanical form to identify the
 11 person's nearest relative who has a number of roles,
 12 most importantly around consultation in the context of
 13 admission.

14 It's not necessarily a complete bar, depending on
 15 the precise circumstances, but that's really where they
 16 sit.

17 It has become very clear to many people,
 18 overwhelmingly clear, that simply having this nearest
 19 relative is problematic in many situations because you
 20 might well have somebody who is statutorily your nearest
 21 relative who is actually the person most antithetical to
 22 your interests.

23 So one of the most obvious recommendations which
 24 came out of the review was we need to move, society
 25 needs to move to an idea that wherever possible you

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1 check -- won't be saying, "By the way who is your
 2 nominated person?"

3 **Q.** What's the default position then if they lack capacity
 4 by the time --

5 **A.** The default position is going to be that the approved
 6 mental health professional has to choose a nominated
 7 person, and to going through with the sort of ethos with
 8 this idea, the default position that they choose, but
 9 they have to try to take account, if not strictly a best
 10 interests analysis, but they have to try and take
 11 account of your wishes, feelings, beliefs and values,
 12 and think essentially, if you could, who would you
 13 appoint, and then if you gain capacity or regain
 14 capacity then that nomination should stop and you then
 15 are meant to be nominating your own person.

16 So the reality is for most people, first episode
 17 psychosis or whatever, first episode of mental
 18 ill health, there won't be a nominated person in place,
 19 so it will be the Approved Mental Health Professional
 20 who is making that choose.

21 **Q.** You mentioned the AMHPs, the role of the local
 22 authority, we're going to come to information sharing
 23 after the break, but do you think there's a role for the
 24 local authority to be a convener of multi-agency
 25 working? We know there's issues with multi-agency

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1 working, particularly with this group of patients, and
2 information that would need to be shared. Do you think
3 that role could be extended to the local authority?

4 **A.** I think it's really very interesting that -- and
5 interesting isn't good -- there is so little focus on,
6 for instance, the role of the Approved Mental Health
7 Professional in all discussions and so little discussion
8 of the role of the local authority. Because actually
9 it's the Approved Mental Health Professional who is
10 ultimately responsible for deciding whether or not to
11 make the application.

12 I mean, they are the last line of defence or the
13 people who are deciding, irrespective of medical
14 recommendations. So they have a vitally important role:
15 they're acting on behalf of the local authority but
16 independently. So we've already said local authorities
17 have got a key role and actually it's the local
18 authority under section 13 who should be sending out the
19 AMHP where there's reason to believe that there's an
20 application should be being thought about. So local
21 authorities already had that role.

22 **Q.** They're experienced in multi-agency working or should
23 be: safeguarding the children, vulnerable adults,
24 convening organisations to share information?

25 **A.** Yes, and I suppose the other aspect I would -- the other

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1 allocated ultimately things like safeguarding
2 responsibilities. We have said, Parliamentary-wise, the
3 buck stops, in layman's terms, with local authorities.
4 Section 42 Care Act, where someone is at risk of abuse
5 or neglect and they've got eligible needs or may appear
6 to have eligible needs, the duty is on local
7 authorities.

8 So there is -- Parliament has said that's the kind
9 of the buck stop, which fits with local authorities are
10 the people who ultimately Parliament has said should be
11 thinking about multi-agency issues here, and they tend
12 to have the -- they have also got the responsibilities
13 for convening things like safeguarding adult boards
14 which is one of the areas where I spend a lot of my life
15 now moving between different organisations trying to get
16 them to talk to each other, and I always end up saying
17 "Could you please make sure you think about this through
18 the prism of a safeguarding adult board" because that's
19 one of the only bits where if systematically things
20 aren't happening somebody somewhere is saying: "well,
21 why aren't the police talking to the trust? Talking to
22 the local authority?" And that's the only place where
23 you've got somebody saying, "Why aren't you talking to
24 each other?"

25 **Q.** Page 20 of this document, "Community treatment orders".

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1 thing I would really want to emphasise is we place
2 a huge amount of emphasis on the Mental Health Act when
3 we think about people who have mental ill health, but
4 that's really very far down the line. Mental ill health
5 doesn't start with the Mental Health Act; mental ill
6 health or responses to mental ill health start in the
7 Care Act in England, and wellbeing under the Care Act,
8 which is one of the things local authorities have got
9 duties to uphold --

10 **Q.** People in their area --

11 **A.** -- expressly includes mental health.

12 So I think one of the real challenges is -- and
13 because we've always got the focus on the Mental Health
14 Act because it comes into play when things go bad, or
15 get very serious, we don't always recognise and take
16 account of the fact that sometimes that might well be
17 because actually what's happened is, for instance,
18 people haven't responded to the socioeconomic factors
19 underpinning mental ill health.

20 **Q.** Also, responsible clinicians and the trusts aren't
21 necessarily set up for multi-agency working, are they?
22 They're taking responsibility for decisions for patients
23 individually, but --

24 **A.** Yes, I mean, it's -- there are multiple factors, but I
25 suppose one other aspect is Parliament has also

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1 **A.** Yes.

2 **Q.** Can you briefly tell us what's happening there?

3 **A.** Yes, thank you, and can I just take the opportunity here
4 to emphasise when I drafted my witness statement this
5 was before the Bill was enacted. And so there are
6 a couple of paragraphs there which reflected the Bill as
7 it stood, in particular about the duration of Community
8 Treatment Orders. Those amendments weren't accepted so
9 the Bill, or the Act as it's passed, not these bits
10 aren't yet enforced, but this is what's been done so you
11 need to read my report or my statement in light of this.

12 **Q.** So 20 and 21, please, Sarah.

13 **A.** Thank you. I'll just wait for that other page to come
14 up. I can look at it on here, sorry.

15 **Q.** There you are. It's there.

16 **A.** Yes. So some of the changes are basically technical,
17 because Section 3 Mental Health Act won't in due course
18 be able to be used for people who are autistic or have
19 learning disorder, which is why it then starts talking
20 about psychiatric disorder, if you look in
21 section 17A(5), because psychiatric disorder is a mental
22 disorder which is not autism or learning disability.

23 I would appreciate not everybody would say autism or
24 learning disability constitutes mental disorder, but for
25 the purposes of the Act that's how they are described.

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1 So that's why 17A those are mostly technical
2 changes. Then you can see section 17A(6), one of the
3 things that the responsible clinician has to really
4 think about there is:

5 "having regard to the ... [nature] of the
6 psychiatric disorder ... other relevant factors, what
7 risk there would be of deterioration ... if [they] were
8 not detained ...(as a result, for example, of his
9 refusing or neglecting to receive the medical treatment
10 he requires for [treatment] ..."

11 There's a real focus there on why have we got the
12 CTO in place. And then you might just want to make sure
13 we turn over the page because you can then see --

14 Q. 22.

15 A. 17AA, this is new, and this reflects the fact that we've
16 got people being -- the role of the nominated person
17 having a greater role as the patient's champion, as the
18 service user's champion. And so where it's practical
19 and appropriate, the responsible clinician needs to be
20 consulting the nominated person. So they have got
21 a role to play, which is new.

22 It's also important, I should say, that one of the
23 historic problems or current problems with
24 responsible -- with CTOs is a responsible clinician
25 might well be hospital-based but actually, when the

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1 Hospital managers can discharge, and for -- they are
2 laypeople, convened by the hospital, and they're
3 effectively a lay tribunal but they don't have the
4 degree of independence required to satisfy the European
5 Convention on Human Rights, so the Mental Health
6 Tribunal also exists, so a court-like body, a court
7 body, who can also discharge.

8 The bit which is important to understand is in
9 particular in relation to discharge of patients and by
10 the responsible clinician. And that's sections -- new
11 Sections (2A) and (2B) and (2C).

12 At one level all this is really doing is
13 consolidating what should already be happening. It
14 would be extremely odd if a responsible clinician --
15 I should say my understanding is it will be extremely
16 odd, you will obviously want to hear from clinicians
17 themselves, an expert clinician -- it would be extremely
18 odd if a responsible clinician discharged a patient into
19 the community without having any consideration of what
20 might be happening upon discharge.

21 So there needs to be that consultation to have some
22 understanding. So the Act is really ensuring that that
23 is understood.

24 Q. It's imposing requirements: "the responsible clinician
25 must, if they are not the community clinician, consult

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1 patient is in the community, their responsibility is not
2 the hospital inpatient responsible clinician. So
3 there's now the community clinician, and so there has to
4 be consultation between the two otherwise it doesn't
5 work -- the community clinician has to agree, because
6 otherwise you're just handing off someone to the care of
7 someone who doesn't know and doesn't necessarily accept.

8 Q. Can we look, please, at page 40 and 41, the "Discharge
9 of patients", and while we do, you make a comment,
10 I can't find it now in your statement, about the
11 discharge of patients and in your professional view when
12 that's not appropriate?

13 A. Yes. So -- sorry, I'm double-checking which section is
14 coming up. Yes.

15 Q. So 40 and 41.

16 A. Yes, thank you.

17 Q. What should happen pre-discharge. While you're doing
18 that I'll find what you said previously.

19 A. Yes. So it's important to understand how patients are
20 discharged, and responsible clinicians have got
21 an ongoing responsibility to decide, to consider whether
22 the person meets the criteria for detention, and if they
23 don't, they should discharge them.

24 The patient's nominated person has got the ability,
25 subject to certain conditions, to try to discharge.

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1 the community clinician".

2 A. Yes.

3 Q. Also, if we look at (2B)(ii) (*sic*):

4 "[someone] who belongs to the profession other than
5 that to which the responsible clinician belongs".

6 A. Yes, although -- yes, you're right. Yes.

7 Q. What was the basis of that? What was the thinking?
8 What kind of profession?

9 A. So this is -- I think it's important to flag, this
10 actually this was a piece -- this -- these amendments
11 were brought -- or this part -- was brought in by DHSC.
12 This was not something which was specifically focused on
13 by the review so I can't speak directly to -- I can't
14 illuminate that, but I think --

15 Q. Fair enough -- (*overspeaking*) --

16 A. -- but I think it is perhaps contextually important to
17 understand that these may well have been a response to
18 the incidents which gave rise to this Inquiry. If you
19 see the timeline and you see some of the stuff which was
20 said at the time, in terms of steps which were being
21 taken to ensure that people were not discharged
22 inappropriately, but I can't comment further on that.
23 You'd have to ask DHSC.

24 Q. Fair enough. That can come down, and can we just have
25 paragraph 116 of your statement on screen, which is

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1 WITN0288001, page 54.
 2 So that page 40 can come off. A different document
 3 now to the witness's witness statement, at page 54.
 4 **A.** Oh yes. Yes.
 5 **Q.** 116, we can highlight that. So what do you say here and
 6 why do you say that?
 7 **A.** So this is in the context of the questions which were
 8 asked to me about somebody -- so the scenario here was:
 9 "A schizophrenic patient ... without capacity as
 10 regards medical treatment, [declining] to ... engage
 11 [in] mental health services or ... taking depot
 12 medication, and ... [posing] a risk of ... imminent harm
 13 ... to the public or themselves if they don't take
 14 medication ..."
 15 Then I was going through a series of iterations and
 16 so the iteration which appears here is: what happens if
 17 the person is just entirely discharged both from
 18 hospital and from the provisions of the Mental Health
 19 Act? So the person we're talking about is somebody who
 20 doesn't have capacity to make decisions about
 21 medication, is not engaging and appears to be posing
 22 risk. So the point I was making is it is challenging to
 23 see how a defensible decision could be taken at that
 24 point to say: right, this person can leave hospital.
 25 Because at that point, you've deprived -- sorry, not

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1 **Q.** What's the role there and where there's potential
 2 conflict or difference of opinion, what do you see of
 3 the legal decision making to involve there?
 4 **A.** So I think it is really important to understand that the
 5 application for admission in most cases nowadays will be
 6 made by the Approved Mental Health Professional.
 7 **Q.** Yes.
 8 **A.** And the Approved Mental Health Professional has to be
 9 satisfied that it is appropriate to make the
 10 application. So even if you have the two medical
 11 recommendations strongly saying this person should be
 12 detained, it is ultimately for the Approved Mental
 13 Health Professional to make that decision, and that
 14 bakes in multidisciplinary consideration. And that's
 15 always been very important, to be at the heart of the
 16 Mental Health Act, so it's not purely clinical
 17 perspective because an Approved Mental Health
 18 Professional won't necessarily be a social worker, there
 19 is now a wider range of people, but in many, many cases
 20 available a social worker. The one profession they
 21 can't be is a doctor. So you have people from more than
 22 one discipline.
 23 **Q.** Are there circumstances where you can realistically
 24 anticipate that the doctor's decisions around detention
 25 would be overridden(?), if you like, or overruled by the

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1 leave hospital, come outside the Mental Health Act
 2 altogether, because you've managed to deprive yourself
 3 of one of the tools which would otherwise exist to
 4 manage the risk. So all -- it all goes back to: this is
 5 the scenario where those involved are concerned about
 6 the level of risk, then what tools have they got to
 7 respond? Well, why might you be said to be depriving
 8 yourself of one of those tools? I'm not saying it's
 9 impossible, I'd just go back to -- I'd want someone to
 10 give me a pretty clear explanation as to why that had
 11 happened.
 12 **MS LANGDALE:** Thank you.
 13 I think that's a good time for the morning break,
 14 Chair.
 15 **THE CHAIR:** Right. We'll take a break until 11.40.
 16 **(11.22 am)**
 17 **(A short break)**
 18 **(11.40 am)**
 19 **Q.** Can we pick up, please, Mr Ruck Keene, something you
 20 said about the AMHPs earlier, that effectively they were
 21 the last line of defence for people who are deciding.
 22 So you've got the section 12 doctors making decisions
 23 about admissions and you've got the AMHPs, haven't you,
 24 doing assessments?
 25 **A.** Yes.

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1 AMHP in that scenario, where there are disagreements?
 2 **A.** So I think it's -- in a way, I would not want to
 3 characterise it as overridden, but I think the fact
 4 it's -- the fact it's put like that is, I think, not --
 5 I mean, I think that's how many people might perceive
 6 it, and we get into some quite complicated terrain about
 7 professional hierarchies, about organisations, about who
 8 is seen to hold power, and I think those can be --
 9 **Q.** Or accountability, if things go wrong?
 10 **A.** Completely, yes. Yes. And they can get extremely
 11 stressed in high-risk situations, because under
 12 high-risk situations, people start getting very, very
 13 stressed about: well, I've said this should happen, why
 14 is it not happening?
 15 And so approved mental health professionals are
 16 meant to be -- they act independently on behalf of the
 17 local authority, but they are independent, as it were,
 18 public bodies for Human Rights Act purposes, so they
 19 can't be dictated to by the local authority. So
 20 depending on their level of independence and they're
 21 supposed to be supported within the organisation, they
 22 can sometimes -- I'm conscious, because I do lots of
 23 training and I have done cases involving this -- they
 24 sometimes can feel -- I don't want to use the word
 25 bullied -- but they can feel strongly pressured into

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1 making an application because if it is seen that there's
2 lots of risk and they don't do it, people say: well,
3 why, didn't you?

4 But I just want to emphasise, this is a situation
5 where you have deliberately baked in multidisciplinary
6 and multi-organisational aspects. I mean that's part of
7 the point, which is good when it works, but what really
8 doesn't work is where systems under pressure require
9 very, very quick decisions and that's when people get
10 pushed into making wrong decisions, and by wrong
11 decisions I mean ones which are either legally not
12 defensible or they're decisions which don't properly
13 take into account all of the factors and I'd really want
14 to resist characterising or blaming people necessarily,
15 but it's a systemic problem which is rightly baked into
16 the Mental Health Act in a way to make sure there's
17 multidisciplinary consideration and multi-agency
18 consideration, but one needs to be clear-eyed about what
19 happens where systems are under pressure.

20 **Q.** Can we have, please, on the screen your statement
21 WITN0288001, pages 76 and 77 alongside each other.
22 Pages 76 and 77 both on the screen, please, at the same
23 time, if possible. Thank you, Sarah.

24 We see here your footnotes at 184 --

25 **A.** Yes.

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1 important about those matters?

2 **A.** So -- well, almost the most important aspect is that the
3 guidance which is produced by the different
4 organisations who might be involved, for the
5 professions, the different professions who might be
6 involved, is actually produced in a way, if it's not
7 exactly collaborative, but it's not mutually exclusive.

8 So in other words, guidance for psychiatrists
9 recognises that the police might have roles to play,
10 guidance for the police recognises that local
11 authorities might have roles to play, and it's done on
12 a mutually consistent basis. Because we have a very
13 substantial problem at the moment where, in particular
14 where systems are under pressure, that people go into
15 silos, and they revert to thinking: I'm -- this is my
16 job, I shouldn't be thinking about any other aspect.

17 And if we are aware of that at the moment, the Code
18 obviously is overarching for everybody, but to the
19 extent that professional bodies are then producing
20 guidance, it's vitally important that it's understood to
21 be guidance which, if a social worker picked up guidance
22 for the police, the social worker wouldn't go "I have no
23 idea what this guidance" -- you know, "This guidance
24 doesn't work for me legally" or "I don't understand
25 where this guidance is coming from".

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1 **Q.** -- and you're speaking about the focus of the review the
2 Mental Health Review and you say:

3 "As can be seen from the subtitle of its final
4 Report (Increasing Choice, Reducing Compulsion) - [it
5 was] therefore ... more [about] patient autonomy than it
6 was on public protection."

7 Can you expand a bit on that, please?

8 **A.** Yes. I should say I do so with a bit of reluctance
9 because I was asked to give expert evidence in terms of
10 the operation of the Mental Health Act Mental Capacity,
11 not on behalf of the review, but I'm happy to expand a
12 little bit if it would be of assistance to the Inquiry.

13 **Q.** No, if that puts you into an uncomfortable position,
14 don't worry, you set out clearly what the focus of the
15 review was. If we can just focus on a paragraph 172,
16 you say that in terms of how the Bill is implemented:

17 "... how the changes in the Bill are implemented,
18 how the Code of Practice is drafted, how professional
19 training changes, how resource pressures are managed,
20 and how cross-team and cross-organisation working is
21 supported."

22 Is clearly going to be very important.

23 **A.** Yes.

24 **Q.** Breaking that down, associated guidance, professional
25 training, you've touched on that before, but what's

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1 Because I've already made the point that I've spent
2 a lot of my life now, professional life, moving between
3 different organisations and frankly trying to explain
4 them to each other. So the more that the guidance can
5 be doing that, nothing is going to be perfect, but the
6 more that's maximising the chances, that for instance
7 there's a shared understanding, going back to the
8 discussion we had earlier, there's a shared
9 understanding about what "serious harm" means across
10 police, NHS, local authorities, because if we have
11 different understandings, we're going to have serious
12 problems from the get-go.

13 **Q.** Are there proposed reforms to enhance the level and
14 quality and community treatment to fill in any gaps, do
15 you know?

16 **A.** So I think you'd need to be asking in particular
17 NHS England, DHSC about that. The statutory reforms
18 really were limited -- in the Mental Health Act are
19 limited to particularly the patient group are not the
20 patient group we're talking about here, so we're talking
21 about autistic people, people with learning disability.
22 Yes.

23 **Q.** You see at the top of page 77 you refer to the removal
24 of police stations as places of safety, for the purposes
25 of Sections 135 and 136.

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1 Given that individuals with mental health crisis may
2 find themselves in police custody and recognising that
3 they should be a choice of last resort, what's the
4 utility of removing police cells as places of safety?

5 **A.** That's a big question. And I think it -- well, as I say
6 in the report, it is potentially placing existing
7 relationships which are already under some strain -- and
8 I know that there's been evidence given about that, and
9 it's in relation to things like Right Care, Right
10 Person -- it has the potential to place people in even
11 more complicated situations.

12 If an individual is picked up by the police, to use
13 that colloquial term, in a public place under
14 Section 136 and then where can they go and what can be
15 done legally to hold them? I think one important thing
16 to flag here is -- and this post-dated my report but
17 it's an important contextual piece -- the Mental Health
18 Act 2025 says nothing about emergency powers, but the
19 Care Minister, during the passage of the Mental Health
20 Bill, committed to a consultation about emergency
21 powers, and that was in the context of proposals to
22 expand the identities or the professional categories of
23 people who could deploy powers under 135, 136, so not
24 just police officers.

25 So that's a live issue, I don't know when the

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1 someone is identified as having a mental health crisis
2 they could be transitioned very quickly into a mental
3 health hospital. That's just not happening.

4 So then you have a very large debate about how much
5 should we reform the law to essentially respond to
6 service provision challenges. And, just to reiterate,
7 this is a live issue which is currently under
8 consideration and I think the Chair may well want to
9 hear -- if you're hearing from DHSC, that may well be an
10 issue which DHSC can assist on, precisely what their
11 thinking is there.

12 **Q.** Securing confidence among professionals, legal
13 confidence, you refer to that. From your experience, do
14 you think clinicians have a sufficient understanding of
15 the legal powers available to them across the Mental
16 Health Act and Mental Capacity Act? And if you think
17 you can't say, please do so.

18 **A.** Well, obviously I can only say at one remove in the
19 sense of my engagement with clinicians, either because
20 I'm acting for them in a case or where I'm working
21 alongside them training-wise or delivering guidance.
22 I very, very deliberately wanted not to use in my
23 report, or witness statement, the term "legal literacy".
24 I think that's not enough. It is not enough to
25 understand there is a law. It's the legal confidence

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1 consultation is coming out. I also know the Health
2 Service Safety Investigation branch, they have recently
3 published an interim report on people in emergency
4 departments in mental health crisis. They're also doing
5 an Inquiry into paramedics attending people in mental
6 health crisis.

7 So there is a very clear awareness -- so I think
8 it's important to think of two different things. There
9 is the practicality of if someone is in mental health
10 crisis, is it a good idea for them to be in a police
11 station? And why the reforms to 135 and 136 have been
12 made to remove police stations as places of safety, it's
13 really reflecting that it's not a good idea for someone
14 in mental health crisis to be in a police station.
15 I mean that's really where it comes from.

16 Sitting alongside there, and I'm a lawyer, you have
17 got a very, very complicated legal issue about what is
18 supposed to happen if you've got someone in mental
19 health crisis and, for instance, you can't get them into
20 hospital because there won't be a bed reasonably
21 available within a short period of time.

22 So there's an enormously complicated legal problem.
23 It's accentuated by service provision challenges. If we
24 had many, many more inpatient beds, it would be much
25 quicker, there would be a much faster-track process. If

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1 and it's particularly thinking through the interaction
2 between the law and the exercise of professional
3 judgement.

4 **Q.** Do you think the law, and the way it's expressed in
5 guidance, sufficiently assists in the way it's
6 explained, how it can help people to do the difficult
7 work that they're doing? Because these are difficult
8 decisions people are making.

9 **A.** I spend a lot of my time thinking about this and working
10 on this because I think there is a really serious
11 problem. Because if stuff is predominantly drafted by
12 lawyers, it reads okay to lawyers but doesn't
13 necessarily speak to healthcare professionals, police
14 professionals, social care professionals. And you can
15 get the message that the law is a barrier. And what
16 I always try and explain to people is the law is the
17 framework within which professional judgement is
18 exercised. And the Mental Health Act and the Mental
19 Capacity Act are paradigm pieces of legislation.
20 They're absolutely littered with drafting which is
21 Parliamentary code for: "We are not going to dictate to
22 you what you do, but what we need you to do is give
23 a good explanation of why you are doing what you're
24 doing."

25 So terms like "reasonable belief" in the Mental

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1 Capacity Act, or "appropriate treatment" in the Mental
 2 Health Act.
 3 So it's the law and social care, medicine working
 4 together to understand: do you understand what you want
 5 to do? Why do you want to do it? And then thinking
 6 through how is the law giving that framework. Which is
 7 why, one last time to reiterate because I just think
 8 it's so important: when people think they are told the
 9 Mental Capacity Act says, "Start with capacity" they're
 10 in the wrong place. They should be starting with:
 11 "Faced with what I know about this person about their
 12 clinical condition [which the law can't tell them
 13 anything about], what risk they might be posing [again
 14 the law can't tell them about], what would be the right
 15 response? How do I then think about that?"
 16 So I always try and guide people, if you're a
 17 clinician working with lawyers or with legal, don't go
 18 to your legal department to say, "What should we do?"
 19 That's asking the wrong question of the law. It's like,
 20 "What do we want to do? Why do we want to do it? What
 21 should the law be doing to respond?"
 22 So it always seems to me that guidance should be
 23 written predominantly from the -- it needs to be legally
 24 accurate but needs to be written from the perspective of
 25 this is written for people who are doing a difficult

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1 a Parliamentary draftsman but I sometimes find it
 2 helpful to try to draft what a law would look like so
 3 you actually crystallise it, and you will see how
 4 I tried to frame it, and it goes back to what we were
 5 discussing earlier: the circumstances when the capacity
 6 of the person must be considered, that draft
 7 section 1(5). So you know they -- reasonably understand
 8 there might be something wrong with their mind or brain,
 9 you know, they know you've got a mental health
 10 condition.
 11 It's not discriminatory to think: I need to engage
 12 my brain about whether or not you've got capacity.
 13 That's just a thing you have to think about.
 14 "Appears to be unwise, especially if they're putting
 15 themselves or others at risk". That's a trigger. It's
 16 not saying you lack capacity; it's thinking.
 17 "Significantly out of character", or "a person
 18 properly interested in ... circumstances has raised
 19 a concern".
 20 And so it's trying to frame it that we've now had
 21 too many years of people not thinking about capacity,
 22 and sometimes, as I explained earlier, that's because
 23 they're being led by the law, Mental Capacity Act, to
 24 think: I'm not allowed to think about it. But we've
 25 also got circumstances where people are hiding, bluntly,

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1 job, it recognises the difficulties, and identifies the
 2 points where within that law how you exercise your
 3 professional framework -- professional judgement.
 4 **Q.** Can we have 79 and 80 alongside one another.
 5 **A.** Yes.
 6 **Q.** And this is where you propose a duty to consider
 7 capacity rather than simply an update of the Code. Why
 8 do you think it may be necessary or relevant to consider
 9 a duty?
 10 **A.** So this goes back to the exchange we had earlier about
 11 the problems with the presumption of capacity, and it's
 12 sufficiently totemic that Parliament I don't think would
 13 want -- and I can see good reasons why Parliament
 14 wouldn't want to reopen Section 1(2) of the Mental
 15 Capacity Act.
 16 But we've now got such repeated examples over time
 17 of people not thinking about capacity when they should
 18 do, that it seems to me, or I would say, that the time
 19 has come to say we can't just keep talking about codes
 20 of practice, trying to beef it up. We actually need to
 21 say: "When you are doing a job where capacity may be in
 22 play, in terms of how you discharge your function, and
 23 there is a good reason to consider it, you must consider
 24 it."
 25 And you'll see, this is my -- I'm not

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1 behind the presumption of capacity to avoid, as the
 2 House of Lords said in 2014, the "Post-legislative
 3 scrutiny" report, hiding behind the presumption of
 4 capacity to avoid taking responsibility.
 5 A duty accompanying the legislation where you have
 6 to be thinking about capacity would wind up or stop
 7 people getting off the hook. I am a very hardened
 8 lawyer. I know simply putting stuff down in law doesn't
 9 automatically make a change, but this would be a very
 10 strong message, as it were.
 11 **Q.** Message, yes. Page 69 and 70 of your statement, please,
 12 and I'm going to move to our last topic of information
 13 sharing. We asked you about information sharing
 14 generally in the context of police officers, CPS
 15 officers, NHS, and you say at paragraph 154 on page 70:
 16 "... as a broad proposition, there is undoubtedly
 17 going to be an entitlement to report if: (1) the person
 18 consents; (2) they lack capacity and it is considered to
 19 be in their best interests; (3) (where consent is
 20 refused or cannot be obtained) where the public interest
 21 provides."
 22 What does "public interest" mean in practice?
 23 **A.** So I think I was reflecting on this ahead of the
 24 evidence session, and I think one of the really, really
 25 striking things here, and you can see this, for

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1 instance, in the GMC Guidance, it says, "this is all
2 incredibly complicated", or "law in this area is all
3 incredibly complicated."
4 And I have to say the law is complicated because
5 it's interaction between common law, data protection,
6 ECHR, and it's too complicated --
7 **Q.** Just pausing there, do you think GDPR -- we've heard
8 some evidence now how GDPR preys on the minds of those
9 working, certainly in frontline conditions on what they
10 can and can't share, and we had a striking example early
11 on in the Inquiry where VC's mother communicated with
12 the University about the serious matter of his illness,
13 and there was an issue about her using her son's email
14 address and the GDPR remedying of that.
15 Do you think that this is taking people off the main
16 judgements here, generally? I'm not asking you to
17 comment on that specific example.
18 **A.** Yes. I mean as in fact -- I mean I actually very
19 vividly remember being involved with Liberty for the
20 Bichard Inquiry, so into the Soham murders, and very --
21 I remember our involvement there being pointing
22 out: data protection legislation is not supposed to get
23 in the way of sensible responses to risk.
24 **Q.** Who is responsible if it is? I'll give you another
25 example we've heard: an officer telling us that before

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1 This is a repeated aspect that if the law -- because
2 the law is trying to juggle multiple competing
3 interests. It is incredibly important that
4 confidentiality is maintained, for instance, in trying
5 to maintain therapeutic relationships. There are those
6 aspects.
7 But if one doesn't have guidance which takes a meta
8 step back and says why do any of these things matter,
9 and give some kind of moral compass to say, then that's
10 where we all start getting it really wrong.
11 I was actually very struck, rereading the GMC
12 Guidance which is --
13 **Q.** Can we go to that?
14 **A.** Yes.
15 **Q.** I was going to suggest that some of these points we can
16 take as we go through, so say where you disagree with me
17 going through it, but this sets out pretty clearly,
18 frankly, what the position is legally?
19 **A.** Yes.
20 **Q.** It's accurate, it's helpful?
21 **A.** Yes.
22 **Q.** So my question is: is the difference between the
23 guidance and what's happening on the ground here,
24 because as we go through this we're going to see -- if
25 we go, please, Sarah to WITN0356077 -- if we look at

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1 she could have more details about someone in A&E in
2 possession of a weapon, she had -- there were various
3 forms or requirements to be met.
4 **A.** Well this -- in a way this goes back to the distinction
5 between legal literacy and legal confidence. Legal
6 literacy is understanding there is a thing called the
7 GDPR; legal confidence is understanding, well how does
8 that interact with my obligations and where does that
9 sit? And recognising that, if disclosure is justified
10 in the public interest, the breach of a duty of
11 confidentiality is, for instance, justified in the
12 public interest, it is overwhelmingly likely it will
13 also be justified for any of the purposes under the GDPR
14 or the Data Protection Act.
15 **Q.** Do you think the Information Commissioner has a role in
16 that, the communication around those issues?
17 **A.** Completely.
18 **Q.** Maybe to consider how it's working in practice, and the
19 implications of it?
20 **A.** Yes. I mean, I think it's -- it is deeply
21 disheartening. As I said, I think the Bichard Inquiry
22 was 2004 and having been involved in saying very, very
23 similar things -- I wasn't giving evidence, but making
24 submissions, making very, very similar points there, and
25 that wasn't the first Inquiry to have made these points.

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1 page 1 first:
2 "Confidentiality: good practice and handling patient
3 information."
4 So if we see "Good practice in handling patient
5 information" page 1.
6 Then when we go to page 5, it includes disclosures
7 for the protection of patients and others.
8 At the bottom:
9 "... confidentiality guidance."
10 "[to include] disclosures for the protection of
11 patients and others."
12 If we go over the page to page 8, main principles
13 set out there, very clearly what you need to tell
14 patients, how you should manage information.
15 Page 10, where you may disclose information on the
16 basis of implied consent for direct care. Disclosure
17 required by law, et cetera.
18 If we go to page 11, paragraph 18:
19 "... should satisfy yourself the disclosure is
20 required by law and should only disclose information
21 that is relevant to the request. Wherever practicable,
22 you should tell patients about such disclosures, unless
23 that would undermine the purpose, for example by
24 prejudicing the prevention, detection or prosecution of
25 serious crime.

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1 "Laws and regulations sometimes permit, but do not
2 require, the disclosure of personal information."

3 Just on this point and dealing with the protection
4 prevention and prosecution -- prevention and prosecution
5 of serious crime, there is nothing at all in this that
6 suggests that health professionals who have witnessed an
7 assault, for example, can't give a statement about
8 evidence of a crime, is there?

9 **A.** No.

10 **Q.** Nothing like that. And if we go to page 12,
11 paragraph 23:

12 "The circumstances in which the public interest
13 would justify such disclosures [where they] are
14 uncertain ... you should seek the advice of a Caldicott
15 or data Guardian ..."

16 The role of the Caldicott Guardian, we'll obtain
17 direct evidence about that, but in your view, what is
18 the significance of that role and how should it be used?

19 **A.** Just to start, I mean, I should say I think this
20 guidance is very good. I'm not quibbling with it at
21 all. But the very fact that the middle of 23 starts
22 with:

23 "The circumstances in which the public interest
24 would justify such disclosures are uncertain".

25 Is you can read this one of two ways: (a) go and
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1 doubt, don't, if in doubt do; both of those are probably
2 blanket propositions which are problematic, how is it
3 you can give that messaging?

4 **Q.** If you go to page 19 of our witness document number,
5 paragraph 60 of the statement:

6 "Medical professionals owe a duty of confidentiality
7 to their patients, but they also have a wider duty to
8 protect and promote the health of patients and the
9 public."

10 Over the page to page 20, paragraph 62:

11 "You should ask for a patient's consent to disclose
12 information for the protection of others unless the
13 information is required by law or it is not safe,
14 appropriate or practicable to do so ... or the
15 information is required by law. You should consider any
16 reasons given for refusal."

17 Again, that might be more expressed than saying,
18 "Information required by law" it might be helpful to say
19 what the information is -- (*overspeaking*) --

20 **A.** Well, I think it's important just to remember that
21 there's a difference between required by law by the
22 statute, where there are certain things where you must
23 do it, and then there's "permitted", which is there's no
24 statute saying you need to do it, but it may be
25 permitted and it's in the public interest and that's
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1 find someone who knows what they're talking about,
2 Caldicott Guardian. But (b), when you've got guidance
3 like this saying it's uncertain, that is leading you,
4 nudging you towards going "ooh, I don't know what to do
5 here."

6 **Q.** The too difficult box?

7 **A.** Exactly. I think it's exactly that sort of zone where
8 one needs to think through if you're messaging -- if
9 you're messaging because the law is uncertain, you need
10 to think: well, does the law need clarifying? If you're
11 messaging, it's not that the law is uncertain, it's just
12 that the balancing exercise in any situation is
13 uncertain, then you need to be very clear about that,
14 and help people with: well, what might you be putting
15 into the balancing exercise?

16 So, I mean, it's really that word "uncertain", when
17 you read it as a stressed -- I'm not a stressed
18 professional, healthcare professional, but one can
19 easily imagine reading that as a stressed healthcare
20 professional, uncertainty is a bad thing, to be avoided.

21 And if you've also got other messaging talking about
22 how important confidentiality is, you've got this thing
23 called the GDPR, it doesn't take too much to start
24 thinking: Well, if in doubt, don't.

25 You don't want -- obviously you don't want: if in
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1 where it feels difficult and complicated as a messaging.
2 So I think you just need to be clear in relation to that
3 aspect.

4 But yes, it's -- I mean, as I say, I don't quibble
5 at all with the legal accuracy of this guidance.
6 I think it's worth reflecting, though, on how that
7 wording is read by someone under pressure.

8 **Q.** We see at 69 and 70, it's long, isn't it, we see that
9 with policies and guidance generally --

10 **A.** Yeah.

11 **Q.** -- too long, if you're busy, going through all of this.

12 But if you have a difficult and intractable problem
13 going through it as a whole, it does take you to one
14 place, doesn't it, that it is permitted in certain
15 circumstances where there's concerns about public safety
16 or risk?

17 **A.** Completely, yes.

18 **Q.** No question about that. So if we look at page 21 again,
19 69 and 70. Seventy in particular:

20 "Decisions about whether or not disclosure without
21 consent can be justified in the public interest can be
22 complex. [Again] Where practicable ... seek advice from
23 a Caldicott ... guardian."

24 There is a section about GDPR which begins page 37,
25 our reference.

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1 Again, usefully, given that it seems to be on the
 2 ground, as it were, a concern about how the two work
 3 alongside each other, it might be helpful to have
 4 something that very specifically sets that out, ie,
 5 where this does not impact.

6 **A.** Yeah. I agree.

7 **Q.** There is, within this guidance, it does set out that
 8 it -- if we go to page 38, for example, over the page,
 9 we see it starts getting much more technical as one
 10 often sees.

11 **A.** Yes, I mean --

12 **Q.** Thirty-nine, we really get into legislation now.

13 **A.** In fairness, I think that's because this says this is
 14 the legal annex.

15 **Q.** Yes.

16 **A.** So it says if you need to know more, but I just think
 17 it's guidance -- I mean, it is very difficult because,
 18 I mean, I'm involved in writing guidance, and you
 19 always -- there's that balance between not putting
 20 enough in, and therefore missing nuance, and putting too
 21 much in and bamboozling people.

22 **Q.** The legal annex, this is a legal annex for doctors not
 23 lawyers, isn't it?

24 **A.** Yeah.

25 **Q.** So the purpose of the statute, the meaning, what it's

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1 rereading the GMC Guidance is of course it's absolutely
 2 correct to be saying, you know, the public interest can
 3 dictate or -- not dictate -- the public interest can
 4 permit disclosure but it doesn't necessarily give
 5 through -- it's not exactly worked examples, an idea of
 6 why disclosure might be important to protect. So it's
 7 how you get it to the granular level of why this sounds
 8 like it's resonating for me.

9 There is, of course, always a danger if you start
 10 giving case studies people go "Well, if it's not in this
 11 case study --

12 **Q.** It doesn't apply.

13 **A.** -- then it doesn't apply." But it's how one thinks --
 14 and there are, especially now with electronic mechanisms
 15 and the ability to click on things and generate, you
 16 know, there are things that can be done to allow you to
 17 go from the very top of the pyramid of the very
 18 high-level messaging for "I need to know more", then you
 19 can branch down and "How might this apply to me?" to
 20 allow people to get that granular level of guidance.
 21 Because the thing I'm really concerned about is, and
 22 I mean this Inquiry is very far from the first I've
 23 heard this, that people finding it too complicated, they
 24 think it's preventing them from doing things, where, if
 25 you just took a step back and said, "Well what was the

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1 trying to achieve, how is it helping you?

2 **A.** Yeah.

3 **Q.** The law is designed to help professionals in these
 4 difficult situations, something which makes it of
 5 assistance, rather than, as you say, the "too difficult,
 6 obstructive" box?

7 **A.** Yes, and I think it's also important to remember that
 8 the law is here not just to help professionals, it's
 9 here to help everybody.

10 **Q.** Yeah.

11 **A.** And if you're giving a messaging to professionals that
 12 you're putting things into the "Too difficult to handle"
 13 box, you're then inadvertently doing a disservice to
 14 other people.

15 So it's how you get the guidance. As I say, if the
 16 underlying position is that the law is quite
 17 complicated, which it is quite complicated, then one has
 18 to think about is there a legal change which is
 19 required? But if it's that actually it's like a Swiss
 20 watch, that the mechanism is incredibly complicated but
 21 the outcome, you can tell the time quite simply, then
 22 how can you make sure the guidance is giving you clarity
 23 about how to think through things in any given
 24 situation?

25 I do think one thing I really was struck by just

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1 right thing to do?", it's very obviously not the course
 2 of action which was taken but people have found
 3 themselves in the position of thinking: well, I have to
 4 do this because of X, Y and Z.

5 **Q.** That is linked, in the area we're investigating, to
 6 psychiatrists and others and their understanding of
 7 their duty to patient confidentiality, what they can and
 8 can't do around that.

9 **A.** Yes, it is. And it's -- I mean I do want to emphasise,
 10 it is not -- it could not and it should not be a default
 11 to disclose everything the whole time, because we have
 12 a huge problem at that point, especially with
 13 communities who don't historically trust mental health
 14 services. And if you have communities that don't
 15 historically trust mental health services, if they think
 16 "If we engage with mental health services they will be
 17 saying stuff left right and centre," there you have
 18 a serious problem. So it's not just individual
 19 therapeutic relationships, it's also systems trust.

20 **Q.** Can I move to a flowchart. Sorry to cut you off there.

21 **A.** Please.

22 **Q.** RLIT0000026. So this a flowchart that if you click on
 23 a link within that guidance you find, and to be fair to
 24 the GMC, it makes clear that they have other scenarios,
 25 and an interactive site of good medical practice in

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1 action. We haven't gone to that and it may be that
 2 covers the scenarios you're talking about but we'll
 3 certainly have a look at that afterwards.

4 But this is the flowchart. How useful do you think
 5 that would be to reflect the guidance we've just gone
 6 through? It's designed to be a legally supportive
 7 document, of course, given the tests they have to apply.

8 **A.** Yes.

9 **Q.** But again, that's not -- what do you say about that?

10 **A.** Well, I mean I do have a huge amount of sympathy with
 11 people trying to draft guidance. And how you -- and
 12 different -- and it's also important to recognise people
 13 have different ways for approaching information. Some
 14 people like flowcharts because it helps walk them
 15 through; some people find them very challenging because
 16 they think they are ignoring nuance.

17 So it's thinking about all the different multiple
 18 ways, but always thinking about how you draft it for
 19 someone who is under a huge amount of stress and doesn't
 20 have time to think about this properly.

21 And that's where the bad or the wrong decisions
 22 start creeping in and how is it you can highlight: this
 23 is the most vital thing to do?

24 **Q.** If we contrast it perhaps with the Royal College
 25 of Psychiatrists Information Sharing November 2017

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1 **Q.** And then to the statement of disclosure, page 5 and 6.
 2 Sorry, what were you going to say?

3 **A.** I was going to say, I think it's the second -- it's
 4 almost the second page, I think, would be -- yeah, the
 5 one which has got "... (DHSC) has produced this
 6 statement with", it's making sure we've got that up.

7 So it's really the observation to make there is this
 8 is the sort of thing which to my mind is really
 9 important and helpful because this is guidance which
 10 speaks across professions, and also speaks to people who
 11 may not consider themselves a professional at all. They
 12 might be a family member; they might be an informal
 13 carer.

14 And so as opposed to having -- of course doctors
 15 need to have guidance which relate to their duties.
 16 Police officers need to have guidance which relates to
 17 their duties. But this sort of statement is really
 18 important because it allows people to understand what
 19 the point of the exercise is, why we care, and then how
 20 the law is filtering into that. And so it's a -- when
 21 it's genuinely a consensus statement, you've got
 22 proper -- I hate that word "stakeholder", but you've got
 23 input from relevant people and it speaks, hopefully, to
 24 relevant people. And then it's accompanied by the Zero
 25 Suicide Alliance with guidance for frontline staff.

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1 guidance. That can come down, please, Sarah, and this
 2 is WITN0288006. 0288006, page 69. This is a "Public
 3 interest decisions flowchart" attached to that guidance.

4 More practical, would you say, or of assistance?
 5 Have you had a chance to look at that before?

6 **A.** Yes, I have.

7 **Q.** What do you say about that?

8 **A.** Again, it's entirely practical. It's different in form.
 9 I mean can I just make one observation? It's -- or I've
 10 been reflecting just while I was looking at that. In
 11 terms of ways of thinking about this, I think that the
 12 Inquiry would find it really helpful to think about the
 13 Consensus statement in relation to information sharing
 14 and suicide risk.

15 **Q.** Yes. Shall I put that on the screen?

16 **A.** Well, I don't say it necessarily needs -- well,
 17 certainly if it would assist the Inquiry but it's really
 18 as an approach --

19 **Q.** I'm going to put it on the screen.

20 **A.** Yes, please. Yes, sorry.

21 **Q.** DHSC0000108, page 1, please. So it's August 2021,
 22 "Information sharing and suicide prevention: consensus
 23 statement". So if we go to page 3, if we put page 3 and
 24 4 on the page next to each other.

25 **A.** Actually, it would be --

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1 So it's that process of thinking which in my mind is
 2 much -- if you start with that as opposed to starting
 3 with -- of course each professional body has
 4 an obligation to do it but they need to be doing that
 5 downstream of a shared understanding about why
 6 information sharing in the public interest might be
 7 extremely important in the context of people with mental
 8 ill health, where we're talking about risk to others,
 9 not of suicide.

10 **Q.** And similarly, do you think it would be useful to have
 11 a similar consensus document bringing agencies together
 12 for information sharing and protection -- sorry,
 13 prevention of violence towards the public?

14 **A.** Yes, completely. But I mean I should say I wouldn't
 15 underestimate the difficulty of producing that because
 16 it -- there are a lot of different factors which go into
 17 it, but the fact that someone, if one has actually gone
 18 through the exercise of doing that in a properly
 19 consultative way, you then have something which people
 20 can look to and to go "I am reassured I am doing the
 21 right thing" before they then go off and look at all the
 22 incredibly complicated law which can lead them to think:
 23 I don't know what I'm doing here.

24 **Q.** Can we just go back to the Royal College
 25 of Psychiatrists guidance.

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1 A. Sorry.
 2 Q. Not at all. That can come down, WITN0288006. I'm not
 3 going to go through all of this guidance but similar to
 4 the GMC, it actually sets out very clearly its purpose
 5 and the issues involved. If we go to page 11,
 6 paragraph 3:

"The central purpose ... is to provide members of
 the Royal College of Psychiatrists on guidance on good
 practice in dealing with confidentiality. This includes
 advice on information sharing and on disclosure,
 including handling requests for disclosure[s]."

But if we look at paragraph 6 on page 12, one
 statement that creeps in here:

"Psychiatrists should recognise that a greater
 emphasis on particular public protection (eg
 multi-agency public protection arrangements (MAPPA) and
 safeguarding adults procedures) has tended to create
 a system in which there is an assumption that
 confidentiality should be breached rather than
 maintained."

First of all, as many public inquiries have
 established, that doesn't seem to be the case, that
 information overly shared or breached when it shouldn't
 be, but I just wondered what you made of that or any
 comment on that?

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1 I think one has to be acutely aware that by definition,
 2 the sort of situations which come to here -- so
 3 an inquiry -- something has gone wrong, and has gone
 4 wrong in a way that people are then going: "We need to
 5 look back and see what happened."

So that may skew the data because what we don't have
 are the situations where patients/client -- you know,
 patient confidentiality is just breached without
 thinking, and we then don't have any, as it were, public
 scrutiny is to what happened.

So I think it's -- I think I would really -- as
 I say, I understand why that statement is there. I can
 see it may reflect situations where people aren't
 thinking and what the Royal College is trying to say is
 "Please make sure someone's thought", but my observation
 is this is exactly the sort of thing where if we could
 have a consensus statement about this involving
 stakeholders and including members of society thinking
 about well, what do we actually expect? What do we
 want? Then that provides a better framework for
 operating.

So I just think that data point one is really
 difficult to disentangle.

24 MS LANGDALE: Understood, thank you. Those are my
 25 questions, Chair. I don't know if there are others.

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1 A. Well, you can -- you can sort of see why it exists:
 2 because it's trying to remind people there are important
 3 things at stake in disclosing information, so for
 4 instance individual therapeutic alliance has been
 5 broken, also potentially producing mistrust in mental
 6 health professionals. So there is an important aspect
 7 there.

But a statement like that is one which I would
 really urge be replaced with "Here is a consensus
 statement amongst all people", so that everyone has
 a shared understanding of what assumptions might or
 might not being made, so that if assumptions start to be
 made in individual situations, people -- someone who is
 going "I'm not quite sure what's going on here", can
 look back to a consensus statement rather than
 professional guidance produced by an individual
 professional body. So --

18 Q. Have you met many -- done many cases -- obviously I'm
 19 not asking for examples or individuals -- where people
 20 have just shared things without thinking about that?
 21 Because it seemed to reflect the reverse of what is
 22 happening on the ground, is my question, that people are
 23 very cautious, overly cautious in not sharing
 24 information that they should?

25 A. I think this is an area it's extremely difficult to --

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1 I think everyone has an opportunity to ask them they you
 2 want them.

3 THE CHAIR: Yes. Does anybody else want to ask questions?
 4 I see, Mr Beggs, you seem to be shifting in your chair.
 5 Thank you.

6 Questioned by MR BEGGS

7 MR BEGGS: You probably know I'm representing
 8 Nottinghamshire Police.

9 A. Yes.

10 Q. And I'm picking up some of the themes Ms Langdale just
 11 dealt with then.

You will appreciate, won't you, that frontline
 police officers are not academics?

14 A. *(The witness nodded)*.

15 Q. They're not probably massively interested in the
 16 niceties of the law.

17 A. *(The witness nodded)*.

18 Q. And they're very often very busy.

19 A. Yes.

20 Q. And under great stress.

21 A. *(The witness nodded)*.

22 Q. As you said a moment ago, by definition, this case, this
 23 Inquiry, reflects that something that's gone
 24 horrifically wrong. We agree on that?

25 A. Completely, yes.

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1 Q. So if we are, as all Core Participants are surely
2 endeavouring to assist the Chair, if we are to prevent
3 such atrocities, do you agree with this: the law has to
4 be fit for purpose in this field, yes?

5 A. Yes.

6 Q. The practitioners have to, all of the relevant
7 practitioners, have to apply the law properly?

8 A. Yes.

9 Q. And information, as you've just been saying, must be
10 maximally shared?

11 A. Well, yes. So the reason I hesitated cautiously --
12 I mean hesitated -- maximally, I mean, maximally and
13 appropriately, yes.

14 Q. Of course.

15 A. Yes.

16 Q. Do you accept this proposition: that the law and,
17 perhaps even more importantly, the associated guidance,
18 must be kept simple?

19 A. So yes, I think it needs to be kept -- it needs to be
20 always kept as simple as possible for the person who is
21 reading it under stress, but with sufficient pointers to
22 where they can get further resource, further support,
23 and that then links to what do organisations have to
24 ensure that when someone goes "I know I don't know",
25 what have they got to respond? I because the frontline

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1 people have internalised a message that "I can't share
2 information", where that internalisation is simply
3 incorrect.

4 Q. That's the problem, isn't it --

5 A. Yes.

6 Q. -- in the practical front frontline world?

7 A. Yes.

8 Q. So do you have sympathy with this proposition: that the
9 law and the guidance, and I'm focusing on the police
10 here, should emphasise that if a police officer honestly
11 believes that a clinician needs to know something, which
12 is otherwise confidential, that that officer can report
13 that information without fear of being criticised or
14 disciplined or his force being sued?

15 A. So I think this might get into an area where it's
16 a question of whether the legal provisions, how they --
17 what do they do in the context of reasonable belief,
18 say? So in other words, if you reasonably believe you
19 need to do something, what protections exist there? And
20 to go back to some of the GMC Guidance, it is complex.

21 So this may be a situation where it's not so much
22 that guidance needs to emphasise you'll be protected if
23 you do the right -- if you reasonably are doing the
24 right thing, it may be that underpinning it is there
25 needs to be an examination of does the law provide the

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1 officer needs to have someone they can go to to
2 explain it.

3 Q. Thank you. And it's obvious from your exchanges in the
4 last ten to 15 minutes that you agree that appropriate
5 information sharing, maximally appropriate, is mission
6 critical to prevent these sort of catastrophes?

7 A. Yes.

8 Q. And I inferred from your evidence that you recognised,
9 or appeared to recognise to Ms Langdale, that there is
10 a cultural problem in many institutions of a reticence
11 to share information. Did I correctly infer that?

12 A. So I suppose what I was saying is it's difficult to work
13 out precisely what -- I mean I can't speak for
14 professional cultures across the country, but I think
15 one of the things one always needs to be troubled by are
16 examples where people seem to think the law is getting
17 in the way of doing, as it were, the right thing. And
18 one has now got too many examples of it comes to pass
19 that something happens, and then it appears that when
20 you retrospectively look at it, that people thought they
21 were being guided to do something which actually in
22 retrospect they would have said: "Why on earth -- you
23 know, if you asked me, why on earth would I do that?"

24 So I can't generalise across the country but I think
25 it's fair to say we've got enough situations where

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1 necessary protections where there is a reasonable
2 belief?

3 Q. Did you notice that I chose the word "honest" rather
4 than "reasonable"?

5 A. Sorry, yes.

6 Q. I did so deliberately so the threshold would be lower,
7 because if you add the obligation of reasonable belief,
8 honest and reasonable belief, you risk officers then
9 being more reticent: "Well, am I going to be criticised
10 after the event as having objectively got it wrong?" Do
11 you see?

12 A. I see, so the reason I defaulted to "reasonable belief"
13 is because we've got very good examples of this in the
14 Mental Capacity Act about reasonable belief and lack of
15 capacity and reasonable belief in best interests, and
16 the courts have been absolutely astute to protect people
17 where their belief was reasonable based on the
18 information they had at the time. So they don't apply
19 the so-called retrospectoscope and say, "You were
20 wrong."

21 So I'm not going to quibble about words but that's
22 where I was coming from in terms of -- and whether the
23 law sufficiently provides that protection is, I think,
24 a complicated question.

25 Q. Yes, and I'm simply striving for practical solutions --

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- 1 A. Yes.
- 2 Q. -- rather than getting involved in the academia?
- 3 A. And I don't -- I am -- above all would want any outcome
- 4 for -- at any given time, no one to be -- or people to
- 5 be in as minimal possible doubt about if they've got the
- 6 right reasoning, that if they proceed, they will be
- 7 protected. And it's how one achieves that properly.
- 8 Q. Yes. There's no dispute, is there, that the psychiatric
- 9 profession is principally the profession that has the
- 10 responsibility for detaining persons like VC in this
- 11 case?
- 12 A. Well, a psychiatric professional, together with the
- 13 Approved Mental Health Professional. I just think it's
- 14 really important that we don't leave that cohort out.
- 15 Q. I didn't intend it, but they are the ultimate
- 16 professionals in the sense that they are the ones
- 17 applying, it might be thought, the greatest level of
- 18 expertise?
- 19 A. So in terms of detention under the Mental Health Act is
- 20 not something that -- I mean, the police have only got
- 21 very, very limited powers under section 135, 136.
- 22 Q. Exactly, and the latter is really just for emergency
- 23 situations?
- 24 A. Yes, if -- yes.
- 25 Q. So it must be obvious, mustn't it, that the clinicians

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- 1 police must report to the psychiatrists, isn't it
- 2 equally obvious that the psychiatrists must report back
- 3 to the local police when you have the sort of scenario
- 4 that prevailed in this case?
- 5 A. Well, I'm going to have to be cautious there because
- 6 I've not been -- I've been very specifically not asked
- 7 to comment on the facts of the individual case.
- 8 **THE CHAIR:** Yes, Mr Ruck Keene is not dealing with this
- 9 case.
- 10 **MR BEGGS:** Let me do it generically then. If the
- 11 psychiatrists are treating someone that is going to be
- 12 released into the local community, it's, one would have
- 13 thought, completely obvious that if there are risks
- 14 there to other people, innocent people, that the
- 15 psychiatrists need to keep the local police, amongst
- 16 other agencies, informed?
- 17 A. I'm going to be cautious again because I think it's very
- 18 difficult to answer that question in the abstract.
- 19 I think it depends -- so I think it would be
- 20 inappropriate of me to go further than that.
- 21 Q. Can I just suggest one reason why that may be so? There
- 22 may be --
- 23 **THE CHAIR:** Mr Beggs, he's an expert witness on the
- 24 operation of the Act --
- 25 **MR BEGGS:** Understood.

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- 1 must have the maximum amount of information available to
- 2 them? That's an obvious concomitant of my previous
- 3 question?
- 4 A. Well, any situation where a clinician or indeed an
- 5 Approved Mental Health Professional is trying to make
- 6 decisions without proper information is one where we're
- 7 running the risk that they will make an inappropriate
- 8 decision.
- 9 Q. Which, I suggest, is why, if we set the threshold of
- 10 honest belief on the part of the police officer, we
- 11 maximise the opportunity for the clinician to have the
- 12 appropriate information?
- 13 A. So I suppose I, going back to our previous exchange, as
- 14 it were, I don't really mind how it's characterised, the
- 15 characterisation is ensuring that the legal ice is thick
- 16 underneath the police officer who has got a proper
- 17 reason to do what they do, even if it turns out after
- 18 the event --
- 19 Q. To have been wrong?
- 20 A. Yes, that's the bit and whether one talks about honest
- 21 or reasonable, we can get into a very long debate --
- 22 which is very unnecessary for the purposes of
- 23 a frontline officer or indeed the Approved Mental Health
- 24 Professional, the doctor.
- 25 Q. Finally this: that it's equally obvious that just as the

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- 1 **THE CHAIR:** -- rather that the interoperation of different
- 2 agencies.
- 3 **MR BEGGS:** I understand. I was perhaps trying to rely on
- 4 his great experience more generally, but I'll --
- 5 **THE CHAIR:** I think you've taken it as far as you can.
- 6 **MR BEGGS:** I've made my point. Thank you very much.
- 7 **Questioned by THE CHAIR**
- 8 **THE CHAIR:** Anybody else want to ask any questions, no?
- 9 Thank you.
- 10 Mr Ruck Keene, I just wanted to ask a couple of
- 11 questions and it's really in relation to, firstly, the
- 12 changes to the Mental Health Act, and I think you've
- 13 referred to the changes to Sections 2 and 3, which
- 14 haven't come into force yet.
- 15 A. Not yet, no.
- 16 **THE CHAIR:** I think that in your report you've also set out
- 17 that the interpretation of that -- and I think you've
- 18 referred to effectively the gaps and the way that things
- 19 will be viewed by those applying them, looking at the
- 20 Codes of Practice -- but serious harm is, on its face,
- 21 rather different to what was in the Act before?
- 22 A. Oh yes. I think it would be challenging to -- simply
- 23 say this is a clarification of what the Act currently
- 24 says, I think that would be a difficult thing to say.
- 25 If it is a clarification of how the Act is applied in

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1 practice, that might be more appropriate because there
 2 are many situations at present where people -- or in
 3 practice, that might well be the test people are
 4 applying, but it's definitely there is -- you can't say
 5 this is a law reform which is simply relabelling stuff
 6 which is currently done. I mean it's been done for a
 7 specific reason and, as I explained, it came from, in
 8 that footnote, the footnote explains where the focus of
 9 the reviews' work lay.

10 **THE CHAIR:** Yes, because the review is really, your terms of
 11 reference, or the Terms of Reference of the review, were
 12 quite specific, weren't they?

13 **A.** Yes, they were, yes.

14 **THE CHAIR:** And didn't include, for example, the protection
 15 of the public as a specific -- (*overspeaking*) --

16 **A.** No, they don't, it was a very different environment.

17 **THE CHAIR:** I think that, just looking at what you've told
 18 us and in your report, there has been a move in the
 19 pendulum towards patient-centric decisions rather than
 20 public-protection decisions?

21 **A.** I think it's absolutely fair to say that the review was
 22 conducted at a time when the primary focus was people
 23 being over-detained, the conditions of detention
 24 feeling -- or being undignified, and lack of choice in
 25 relation to treatment, and so therefore a very strong

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1 autonomy of the patient?

2 **A.** Well, I suppose, yes, in the sense of it feeds into the
 3 messaging or the messaging of the Mental Capacity Act
 4 can be read as there is a presumption of capacity and
 5 there's a right to make unwise decisions, feeding into
 6 "who are we to judge?" And that's a radical misreading
 7 of what the Mental Capacity Act actually says, but it
 8 feeds into that. And if you have people who genuinely
 9 want to think: I'm upholding the autonomy of the
 10 patient, it might nudge them towards going: I don't want
 11 to dig too much into this person's capacity because
 12 I want to respect them and think about them as
 13 a capacitous individual.

14 And I just think it's really important to understand
 15 the Mental Capacity Act was never telling people to do
 16 that, and my attempt to say how do you recalibrate is
 17 not to fiddle with the Mental Capacity Act, but to
 18 impose a duty on people who know that: my job is
 19 governed by the Mental Health Act, therefore, one of the
 20 things I need to think about is capacity, say, and to
 21 give them the pointers to say: these are the times you
 22 need to think.

23 **THE CHAIR:** Yes. Just in relation to the new nominated
 24 person approach --

25 **A.** Yes.

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1 focus on trying to improve the patient experience.

2 It contrasts very, very strongly with the reforms
 3 which took place leading to the 2007 Act, and I'm sure
 4 you'll remember, Chair, initially there had been
 5 proposals which looked much more, as it were, patient
 6 focused. By the time those proposals moved towards
 7 Parliament, there was a much stronger protection, public
 8 protection focus, and that explains some of the changes
 9 in the 2007 Act.

10 And then, to use that pendulum phrase, the pendulum,
 11 as it were, that swung back, and by the time the review
 12 was reporting and even during the course of the draft
 13 Bill, that was very much the focus, and it predated the
 14 horrible events which are now giving rise to this
 15 Inquiry.

16 **THE CHAIR:** Yes. Just following on from that, and the
 17 suggestion that you make of a duty to consider capacity
 18 where it's necessary, and I think you've given two
 19 reasons why that's necessary. The first is -- and I'm
 20 going to put it in colloquial terms -- that some
 21 people use that, the lack of a duty, to put it on the
 22 'too difficult to deal with' pile.

23 **A.** Yes.

24 **THE CHAIR:** Secondly is the presumption in itself. But is
 25 the third not also related to an emphasis on the

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1 **THE CHAIR:** -- and in fact in relation to discharge
 2 obviously they have various rights, but also there's
 3 a new requirement of consulting someone from another
 4 discipline, as it were?

5 **A.** Yes.

6 **THE CHAIR:** Do you know what's anticipated by that?

7 **A.** I'm going to have to ask you to ask the DHSC because
 8 this didn't come from the review, so I think it's
 9 important you get --

10 **THE CHAIR:** So it's not another involvement of AMHPs, is it,
 11 do you know?

12 **A.** That's all it says, so you're going to have to --
 13 I mean, it doesn't exclude but it doesn't -- so that's
 14 a very -- this is a very, very good example of the
 15 primary legislation is there, that is one of the areas
 16 you'd then expect to be amplified in the Code of
 17 Practice.

18 **THE CHAIR:** Yes, thank you. Well, thank you very much.

19 **THE WITNESS:** Thank you.

20 **MS LANGDALE:** Would it be a good time to take an early
 21 lunch, Chair? We've got two witnesses this afternoon.

22 **THE CHAIR:** Yes. We will stop there now and start again at
 23 1.40, thank you.

24 (12.39 pm)

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(The short adjournment)

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