Witness Name: John F Morgan

Statement No:WITN0058001

Dated: 3/12/2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF PROFESSOR JOHN MORGAN

I, **Professor John Farnill Morgan**, will say as follows:

Introduction

1. I am a medical doctor and consultant psychiatrist by training, now retired from the NHS since 2021.

2. This witness statement is made in response to a Rule 9 Request dated 4 September 2025. It addresses my involvement as Chair of the Royal College of Psychiatrists' ("**the College**") Patient Safety Expert Guidance Working Group, which produced *CR201: Assessment and Management of Risk to Other People: Good Practice Guidance* (2016) ("**the Report**") **[WITN0058002]** together with the accompanying *Good Practice Guide* ("**the Guide**") **[NHFT0015099]**.

3. I provide this evidence on the basis of my historic role in the development of the Report and the Guide. My involvement with College policy on risk management ceased following the publication of the Report in 2016, and since then I have not been engaged in related work. I therefore cannot speak to subsequent policy developments or current practice, and I defer to the College, the Chair of the Working Group, and other experts for more up-to-date evidence.

4. I wish to emphasise at the outset that my expertise is historic. From 2016 onwards, I specialised in eating disorders, running NHS services in Leeds,

before retiring completely from the NHS in 2021. I have not been involved in risk-to-others policy or practice since my retirement, and I have no direct knowledge of any revisions to the Report, any updated College guidance, or any guidance issued by NHS England, the Department of Health, NICE, SIGN or the CQC in this area.

5. This statement should therefore be read with the caveat that my evidence reflects only my involvement in the production of the Report and the Guide up to 2016.

Career and Role

6. I graduated in medicine from the University of Cambridge (MB BChir) and subsequently undertook psychiatric training. I obtained an MD and was elected a Fellow of the Royal College of Psychiatrists.

7. Over my career I held a number of academic and clinical posts. I was Consultant Psychiatrist, Honorary Senior Lecturer and Visiting Professor at St George's Hospital Medical School, London; Associate Medical Director at Leeds and York Partnership NHS Foundation Trust.

8. My principal clinical expertise was in the field of eating disorders. I led NHS eating disorder services in Leeds for a number of years, published extensively in this area.

9. In terms of College involvement, I was at different times a member of policy committees, and in 2013 I was appointed Chair of the Royal College of Psychiatrists' Patient Safety Expert Guidance Working Group.

10. The Working Group was tasked with revising and updating earlier College guidance on risk assessment and management (CR150: *Rethinking Risk to Others in Mental Health Services*, 2008) [**WITN0058004**]. Under my chairmanship, the Group produced *the Report:* published in 2016, together with the accompanying Good Practice Guide.

11. I retired fully from NHS practice in 2021 and have had no subsequent role in risk management policy. Since 2016, I have not followed developments at the

College or in wider policy regarding risk to others, but was active in the specific, but unrelated, field of Eating Disorder risk management.

Background to the Patient Safety Working Group

13. The Royal College of Psychiatrists has, over many years, taken an active role in considering risk in mental health services. In 2008 the College published *CR150: Rethinking Risk to Others in Mental Health Services*, which was itself a response to public concern following high-profile incidents involving psychiatric patients and questions about risk management.

14. By 2013 the College decided that a revision was required, in light of changing commissioning arrangements in the NHS, evolving service structures, and ongoing concerns about how risk was conceptualised and managed. The Patient Safety Expert Guidance Working Group was therefore convened to review CR150 and to provide updated guidance.

15. The Working Group brought together psychiatrists from a range of subspecialties, along with patient and carer input, reflecting a multidisciplinary and multi-perspective approach. Membership included practising psychiatrists with expertise in forensic psychiatry, general adult psychiatry, liaison psychiatry, and other specialties. The College also invited distinguished external contributors.

16. I was appointed Chair of the Working Group. My role was to coordinate the contributions of members, oversee the drafting process, and ensure that the recommendations reflected a balanced synthesis of clinical, policy, and service perspectives. Although the published report lists me as Chair, it should be emphasised that the Report and Guide were the product of collective authorship, with many colleagues contributing expertise.

17. Evidence was gathered from a variety of sources, including existing literature, prior College surveys, input from the College's faculties and divisions, and expert testimony. The Group also considered wider public and political debates about risk, including the potential dangers of an overly simplistic "tick-box"

approach, and the risk that such forms of practice could obscure rather than enhance professional judgement.

18. The Group's overall task was to provide a framework for psychiatrists and other clinicians that moved away from either extreme — neither unstructured reliance on individual clinical judgement, nor the excessive use of actuarial tools detached from context — but instead a structured professional judgement model that integrated clinical expertise with structured consideration of known risk factors.

The Report and the Guide

19. The Working Group's output was published in 2016 as *the Report*, together with an accompanying Good Practice Guide. Both documents remain available on the College website.

20. The intention of the Report was to set out principles of best practice in risk assessment and management for psychiatrists and mental health teams. It sought to acknowledge the limitations of prediction while emphasising the responsibilities of psychiatrists to assess, formulate, and manage risk as part of holistic clinical care.

21. The Good Practice Guide was written as a more accessible aide-mémoire, intended for use by clinicians in day-to-day settings. It summarised the key steps in risk assessment and risk management, emphasising that risk assessment is not an end in itself but should inform treatment planning, safety planning, and ongoing care.

22. The process of drafting the Report involved extensive consultation. Draft sections were circulated among the Working Group for review, and external feedback was sought from College committees, including the Policy and Public Affairs Committee. The Report was then endorsed by the College as a Council Report, giving it formal status.

23. The recommendations made in the Report therefore represented the consensus of the Working Group, supported by the College, rather than the

views of any one individual. My own role was to facilitate this process rather than to act as sole author.

When Should an Assessment of the Risk to Others Be Undertaken?

24. Risk assessment is a core responsibility of psychiatrists and other mental health professionals. An assessment of risk to others should be undertaken whenever a patient presents with symptoms, behaviours, or circumstances that could plausibly give rise to concerns about harm to others.

25. Such assessments are not restricted to forensic or secure settings but form part of routine psychiatric practice in community teams, general adult wards, liaison services, and crisis settings. They are particularly necessary when patients present with new or worsening psychotic symptoms, express threats or violent ideation, disengage from treatment, misuse substances, or experience significant psychosocial stressors.

26. The Report emphasised that risk cannot be eliminated, but it can and should be rigorously assessed and managed. Risk is dynamic rather than static, and therefore requires regular review, particularly at times of transition between services, on discharge from hospital, or when clinical presentation changes.

The Importance of Information Gathering and Third-Party Input

27. The quality of any risk assessment is dependent on the quality of information available. While direct clinical interview and examination of the patient remain central, collateral information from third parties is often crucial in obtaining an accurate picture.

28. Such collateral information may include medical records, prior psychiatric notes, GP records, police or probation reports, court documents, and accounts from carers or family members. These sources can often highlight patterns of behaviour or antecedents to violence that may not be disclosed by the patient themselves.

29. The Report emphasised that psychiatrists should, wherever possible, actively seek such information. This may involve liaison with the police, probation services, social services, or primary care. It also requires sensitivity in involving families and carers, balancing issues of confidentiality with the need to protect the public.

30. The practical impediments to obtaining and sharing such information are considerable. Clinicians often face difficulties due to fragmented services, incompatible information systems, and the constraints of data protection and confidentiality. Particularly in emergency settings, access to comprehensive records may be absent, and psychiatrists must sometimes make decisions on the basis of limited information.

31. Following the assessment, the sharing of relevant information with third parties is equally important for public safety. This may require communication with GPs, care coordinators, social workers, or MAPPA (Multi-Agency Public Protection Arrangements) where appropriate. The guiding principle is that information should be shared where necessary to protect others from harm, in line with GMC and NHS guidance on confidentiality.

Risk Factors Relevant to Violence

32. The Report and its supporting literature identified a number of factors that increase the likelihood of violence to others in psychiatric populations. These include:

    32.1 **Sex and age**: Men in late adolescence and early adulthood have a higher statistical risk of violence than women or older adults, though this is a group level observation and should not be over-applied to individuals.

    32.2 **Concordance with treatment**: Disengagement from treatment or non adherence to prescribed medication increases risk, particularly in psychotic disorders.

32.3 **Psychosis and schizophrenia**: Active psychotic symptoms, especially persecutory delusions or command hallucinations, can heighten the risk of violence, particularly if combined with hostility, fear, or lack of insight.

32.4 **Substance misuse**: Alcohol and illicit drugs are significant amplifiers of risk, both independently and in combination with mental illness. Dual diagnosis of mental illness and substance misuse is strongly associated with increased violence.

32.5 **Other factors**: Personality disorder, previous history of violence, impulsivity, and environmental stressors (such as loss, conflict, or housing instability) are also recognised as contributory.

33. At the same time, the Report stressed that most patients with mental illness pose a greater risk to themselves than to others, and that any assessment of risk to others should be contextualised within an appreciation of protective factors, strengths, and the patient's own narrative.

Approaches to Risk Assessment

34. Psychiatrists and allied professionals have historically adopted a variety of approaches when assessing the risk of violence to others. Each has strengths and limitations.

35. The most traditional approach is **unstructured clinical judgement**, in which the psychiatrist relies upon their training, experience, and intuition to weigh up the available information. While this has the advantage of flexibility and responsiveness to individual circumstances, it is prone to bias, inconsistency, and limited reliability between different clinicians.

36. At the other end of the spectrum are **actuarial tools**, which use statistical models to combine empirically identified risk factors into an algorithm or score. Examples include the Violence Risk Appraisal Guide ("**VRAG**") [**WITN0058005**]. These tools can be useful for ranking patients relative to one another in terms of risk, but they may lack clinical nuance, are often validated

only in specific populations (e.g. forensic or prison samples), and do not always translate well to general adult psychiatric practice.

37. Between these two sits the **Structured Professional Judgement ("SPJ") approach**, which was endorsed in the Report as best practice. SPJ tools, of which the Historical Clinical Risk Management-20 ("**HCR-20**") **[WITN0058006]** is the best known, combine a checklist of empirically validated risk factors with the clinician's own judgement. This approach encourages a systematic assessment of key historical, clinical, and risk management variables while allowing clinicians to consider individual circumstances, protective factors, and dynamic change over time.

38. In practice, the SPJ approach provides a structured framework while still permitting professional discretion. It was designed to avoid the pitfalls of "tick box" risk assessments, which risk becoming static and bureaucratic, while also avoiding over-reliance on unstructured intuition.

39. The Report emphasised that **structured risk assessment is not an end in itself** but part of a broader process of risk formulation and management. A risk assessment should always feed into a narrative formulation of the patient's risks, needs, and protective factors, which in turn should inform a management plan.

The Historical Clinical Risk Management-20 (HCR-20)

40. The HCR-20, at the time of the Report's publication, was the most widely used structured professional judgement tool in the UK. The third edition ("**HCR-20 V3**") was published in 2013 **[WITN0058007]**.

41. The tool is organised around 20 items grouped into three domains:

    41.1 **Historical** (e.g. previous violence, early maladjustment, personality disorder, substance misuse);

    41.2 **Clinical** (e.g. lack of insight, active symptoms of mental illness, negative attitudes, impulsivity);

41.3 **Risk Management** (e.g. feasibility of plans, stress, exposure to destabilising factors, lack of personal support).

42. Each item is rated by the assessor, but the tool is not intended to produce a mathematical score. Rather, it structures the assessment process and guides the clinician towards a final risk formulation.

43. In terms of time, completing the HCR-20 can take between 60 and 90 minutes if sufficient information is available, and may require collateral input from records, carers, or criminal justice agencies. It is important to stress that the Report did not endorse the routine use of HCR-20 V3 across general psychiatry, and its role was understood at the time to be largely confined to forensic and secure settings rather than community or general adult practice.

44. Research has supported its predictive validity, particularly in forensic populations. For example, Douglas et al. (2014) **[WITN0058008]** found it had significant value in predicting violent recidivism. However, it is less practical for use in acute emergency settings, where time is limited and collateral information may not be accessible.

45. Criticisms of the HCR-20 include its length, resource intensity, and limited validation outside forensic populations. Some have argued it can give a false sense of security if used mechanistically or without proper training. The Report therefore stressed the importance of training, supervision, and embedding the tool within a broader clinical process.

Predictive Value and Definition of Violence

46. One of the key debates in risk assessment concerns **predictive value**. Even the most robust structured tools cannot predict violence with certainty at the level of an individual patient. What they can do is stratify risk within populations and support clinicians in developing management strategies.

47. Risk assessment tools vary in their ability to differentiate between **short-term and long-term risk**. Some may better capture chronic vulnerability (e.g. history

of violence, substance misuse), while others are sensitive to dynamic and situational factors (e.g. acute psychotic symptoms, current stressors).

48. Tools and clinicians must also consider not only the **probability** of violence but also the **magnitude of potential harm**. A low-probability but high-impact event (e.g. homicide) may warrant significant preventative intervention.

49. In practice, "violence" is understood broadly in clinical risk assessment. It includes not only direct physical assaults but also threatening behaviour, intimidation, or actions that could indirectly cause harm (for example, behaviour provoking others to act, or creating circumstances in which a victim puts themselves at risk while fleeing). The Report emphasised that clinicians should adopt a nuanced, inclusive understanding of violence in order to identify and manage risks effectively.

Best Practice in Risk Management Planning

50. A risk assessment, however thorough, is of limited value unless it is translated into a clear and practicable **risk management plan**. The Report emphasised that risk management must be integrated into the overall care plan, rather than existing as a stand-alone document.

51. **Use of the Mental Health Act 1983.** At times of acute risk, the Mental Health Act provides an essential legal framework for ensuring treatment and public safety. Detention under the Act can be justified where a patient presents a serious risk of harm to others (or themselves), particularly when insight is limited and engagement with treatment has broken down. The Act also provides for conditions and safeguards, such as restricted orders, which may be necessary in higher-risk cases.

52. **Community management and Community Treatment Orders ("CTOs").** Where patients are discharged from hospital with ongoing risks, CTOs can provide a framework for monitoring and support in the community. They allow for recall to hospital if a patient's condition deteriorates or if risk escalates. Their use has been debated, but the Report recognised that CTOs can play a role in

structured risk management, provided they are used proportionately and with proper regard to patient rights.

53. **Medication and concordance.** Non-concordance with prescribed treatment, particularly antipsychotics, is a well-recognised risk factor for relapse and violence. Best practice is to address non-concordance proactively, through psychoeducation, shared decision-making, and close follow-up. In some cases, depot medication may be considered to reduce relapse risk. The use of medication should always balance effectiveness with side-effect burden, as poor tolerability is itself a cause of disengagement.

54. **Capacity and refusal of treatment.** Where patients decline medication or disengage from services, capacity assessment is crucial. If a patient retains decision-making capacity, their autonomy must be respected, even if this carries some degree of risk. If capacity is impaired, treatment under the Mental Health Act may be required. The Report emphasised the need for clear documentation of capacity assessments and the reasoning behind decisions.

55. **Rapid tranquillisation.** In in-patient or community settings where there is immediate risk of violence, rapid tranquillisation can be necessary. Its use must follow established protocols, prioritising safety, proportionality, and the least restrictive option. The Report highlighted that de-escalation and engagement should always be attempted first, and that the use of medication for behavioural control requires close monitoring and review.

56. **Risk formulation and early warning signs.** Effective risk management planning depends upon a structured **formulation** that identifies not only risk factors but also protective factors, triggers, and early warning signs of relapse. The plan should specify what to look for (e.g. increased paranoia, substance use, social withdrawal), who should monitor for these signs, and what actions should follow.

57. **Multi-agency collaboration.** The Report strongly advocated for shared responsibility across services, including general mental health teams, forensic services, primary care, police, probation, and social care. MAPPA (MultiAgency Public Protection Arrangements) were highlighted as a formal vehicle for

information sharing in high-risk cases. Effective collaboration reduces the likelihood of gaps in care, particularly during transitions between services.

58. **Documentation and communication.** The plan must be written clearly, communicated to all relevant professionals, and regularly reviewed. Failures in handover, particularly during transitions of care, have been identified repeatedly in inquiries into serious incidents. The plan should be shared with the patient and, where appropriate, carers, both to encourage engagement and to strengthen protective factors.

59. **Proportionate and dynamic planning.** A key principle of the Report was that risk cannot be eliminated. Instead, management must focus on proportionate and justifiable actions, responsive to change over time. Risk management should support recovery and autonomy as well as public safety, recognising that excessive restriction can itself worsen outcomes.

Updated Position

60. My direct involvement in policy development in this area ended with the publication of the Report and the accompanying Good Practice Guide in 2016. Since that time I have had no role within the College relating to patient safety, nor have I followed developments in the field of risk to others. From 2017 until my retirement from the NHS in 2021, my clinical practice was confined to specialist eating disorder psychiatry, a field in which structured violence risk assessments such as HCR-20 were not generally applicable. I have therefore not been involved in subsequent policy revision or dissemination.

61. The Report was intended for revision in 2021. I am not aware whether this revision took place, nor whether other guidance has since been issued by the College or by other national bodies. I cannot speak to the reasons for any delay or decision-making in this respect. I confirm that I have undertaken no work in this field since 2016 and have no personal knowledge of subsequent College policy, NHS England or Department of Health guidance, or the work of NICE, SIGN or the CQC on this topic.

62. As to whether the recommendations in the Report remained good practice in 2023 or in 2025, I cannot give a definitive answer. I can only say that at the point of publication in 2016, the principles represented a consensus of good practice, balancing structured approaches with clinical judgement, emphasising multiagency collaboration, and discouraging overreliance on "tick-box" methods. I would expect many of these principles to retain enduring value, but I defer entirely to those currently active in the field as to whether further research, training, or new tools have since altered best practice.

63. With regard to structured risk assessment tools, the Report recognised HCR-20 V3 as the most widely validated structured professional judgement instrument in forensic psychiatry. However, it was not endorsed for routine use across general psychiatry. The report explicitly noted that while such tools had value in specialist forensic and secure settings, they were often impractical in general adult services, not validated in non-forensic populations, and too time-consuming for busy crisis or community teams. The Report therefore placed greater emphasis on dynamic risk formulation, clinical assessment, and multi-agency communication, rather than reliance on any single tool.

64. I am not in a position to advise on whether HCR-20 V3 or other tools remain in use, or whether new instruments have since been developed or endorsed. I am also not in a position to comment on whether their use should now be standardised or mandated between NHS Trusts. At the time of the Report, the consensus was that structured tools could provide a valuable framework when embedded in a broader clinical process, but that they should not be applied mechanistically. That remains, in my personal view, a cautionary principle.

65. In summary, I cannot speak to developments since 2016. My contribution to this Inquiry must therefore be read as historic, based upon the work of the Working Group at that time. I defer to current College representatives and experts in forensic psychiatry for the contemporary position.

Dissemination, Guidelines, Training and Clinical Practice

66. My recollection of the dissemination of the Report is limited. As Chair of the Working Group, I was aware that the Report was published on the Royal College of Psychiatrists' website and circulated via College channels. I believe it was featured in College communications at the time, and I recall presenting aspects of it at internal College meetings and in professional forums. I also understood that elements of the Report informed teaching materials within psychiatric training curricula. However, I cannot provide a comprehensive account of how systematically the guidance was disseminated beyond these channels.

67. My impression, based on professional experience in the years immediately following publication, was that while the Report was accessible, the degree of active adoption into everyday clinical practice varied. In my own medico-legal work at that time I often encountered risk assessments that remained overly reliant on checklists or "tick-box" pro forma, which seemed to run counter to the spirit of the Report. I was left with some concern that the principles of the Report were not being fully embedded in day-to-day practice, as many of the assessments I encountered still relied heavily on checklist-style approaches. That said, these impressions were subjective, anecdotal, and limited to cases in which I had professional involvement, and should not be generalised.

68. I cannot speak with certainty as to the role of NHS England or the Department of Health in adopting or incorporating the Report into their guidance. I have no direct knowledge of whether the Report was explicitly referenced in national policy or guidance documents. It may have been, but I am unable to confirm this.

69. Similarly, I am not aware of NICE, SIGN, or the Care Quality Commission having developed specific guidance on the management of risk to others in direct response to the Report's recommendations. At the time of my involvement, the College expressed the view that such work would be desirable. Whether it has occurred subsequently is not something on which I can offer evidence.

70. As to local adoption, I cannot speak for Trusts generally or for Nottinghamshire Healthcare NHS Trust in particular. Within Leeds and York Partnership NHS Foundation Trust, where my clinical practice was based, I was aware of the Report being referenced in risk training materials. However, this was not within my direct sphere of responsibility and I cannot comment on the extent to which the Report was embedded in formal policies or local practice.

71. On the broader question of integration into psychiatric clinical practice, my impression is that many psychiatrists continued to view risk assessment primarily through their own specialty lens. In forensic settings, structured tools such as the HCR-20 were used, whereas in other specialties—including my own field of eating disorders—alternative risk frameworks were more relevant, such as the "MARSIPAN" guidelines on the medical risks of anorexia nervosa. The Report's general principles of combining structured and clinical judgement approaches may therefore have been unevenly integrated across different specialties.

72. In conclusion, while I can attest to the intentions and principles of the Report as published in 2016, I am unable to provide authoritative evidence on how far it was disseminated or embedded in practice nationally or locally thereafter. I would defer to current College representatives and service leaders to provide up-to-date information. My role as Chair of the Patient Safety Expert Working Group concluded in early 2016. The minutes of the meeting held on 28 January 2016 record the handover of the Chair to Dr Huw Stone. This underlines that my active involvement with the Working Group and College policy on risk ended almost a decade ago, and I have played no role since that time. From that point, I had no further involvement in the work of the Group or the Royal College's subsequent development of policy in this area. I therefore emphasise that any comments I have provided about developments after 2016 are based on my personal recollection and general impressions only. They should not be taken as authoritative, and I defer entirely to the current leadership of the College and other experts actively working in this area.

Recommendations

73. Given that my formal involvement in this area ended with the publication of the Report in 2016, I am cautious about making prescriptive recommendations. Much work may have been undertaken since, and I defer to current experts, professional bodies, and service leaders for authoritative, up-to-date views. Nevertheless, I would make several observations which may be of assistance to the Inquiry.

74. The core principles of the Report remain relevant. These include:

    74.1 that risk assessment should be integrated with, and not separated from, the wider clinical assessment;

    74.2 that structured professional judgement has advantages over purely unstructured or purely actuarial approaches;

    74.3 that risk formulation should be dynamic, strengths-based, and linked to an active management plan;

    74.4 that patients and carers should, where possible, be involved in risk discussions and safety planning; and

    74.5 that risk assessments should be recorded clearly, communicated effectively, and regularly reviewed.

75. In my personal view, one of the greatest ongoing challenges in psychiatric services is the fragmentation of care. In my later medico-legal work, I frequently encountered patients being seen by a rotating sequence of crisis team staff, with limited relational continuity or depth of engagement. Families often expressed frustration at repetitive contacts with multiple clinicians, none of whom seemed to know the patient well. This can create a sense of abandonment and disorganisation, and may undermine both patient trust and accurate risk assessment. By contrast, models of care that emphasise continuity of relationship and long-term knowledge of the patient, as in assertive

outreach or more traditional community mental health teams, can support more accurate and compassionate assessment of risk.

76. The role of crisis teams deserves particular scrutiny. While designed to provide rapid response, they can at times become over-stretched and reliant on junior or temporary staff delivering brief, checklist-style interventions. In my own career, both in the NHS and in medico-legal settings, I have seen how such approaches may give a false reassurance of "activity" while not necessarily improving patient safety. Although my perspective is now historic, I would urge the Inquiry to consider how relational continuity, clinical experience, and meaningful engagement can be better preserved in today's services.

77. More broadly, training in risk assessment should continue to emphasise curiosity, compassion, and clinical judgement, not merely the completion of forms. The principles of structured professional judgement remain valuable, but they should be embedded within a culture of reflective practice and multidisciplinary collaboration, not used as defensive tools.

78. Finally, while the Report emphasised the importance of multi-agency working, this remains a challenge. Risk assessment and management is only as good as the information available, and timely sharing between health, social care, and criminal justice agencies is essential. I would endorse efforts to strengthen these pathways, while recognising that confidentiality and professional boundaries also need to be respected.

79. In summary, I would recommend that the Inquiry consider:

    79.1 reaffirming the enduring principles of the Report as still relevant;

    79.2 encouraging service models that promote continuity of care and depth of clinical knowledge of the patient;

    79.3 reviewing the role and function of crisis teams in delivering safe and effective risk management;

79.4 supporting structured approaches to risk that are clinically integrated and dynamic; and

79.5 strengthening multi-agency information-sharing and collaboration.

80. These reflections are based on my past involvement in the Report and subsequent clinical and medico-legal work, but they do not represent current policy. I defer to present experts and organisations for up-to-date recommendations.

Personal Reflections

81. What follows is offered as personal reflection rather than formal policy advice, and should be read in that spirit. In 2013, I contributed to the *BMJ* "Maudsley Debate" [**WITN0058009**] on whether the emphasis on risk in psychiatry served the interests of patients or the public. My position was that, although psychiatric risk assessment processes were flawed, risk remained a fundamental component of psychiatry, as in all medicine. I argued that we should not abandon our public responsibilities, but rather reintegrate risk assessment with careful clinical examination.

82. In that article, I expressed concern that risk assessment had become "horribly separated from clinical examination," that undue focus on rare outcomes such as homicide could distort priorities, and that tick-box approaches risked subverting clinical skill. I noted that risk assessment tools should be regarded as aide-mémoire, not substitutes for a systematic history and mental state evaluation.

83. Those reflections were written during my active involvement with College policy, and they remain my personal view. They underline a theme that runs through the Report: that risk assessment must be dynamic, contextual, and closely linked to clinical care, rather than bureaucratic or defensive.

84. I emphasise that these comments are offered as personal reflections, based on my own practice and publications at the time. They should not be taken as

current policy advice, and I defer to present experts, professional bodies, and services for updated evidence and recommendations.

Statement of Truth

I believe the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: GRO-B

Dated: 3rd Dec 2025

Index to First Witness Statement of Professor John Morgan

Exhibit	URN	Document Description
1	WITN0058002	College Report 201 dated May 2017, compiled by the Royal College of Psychiatrists titled: Rethinking risk to others in mental health services.
2	NHFT0015099	Guidance dated August 2016, Re: Assessment and management of risk to others, Good Practice Guide, the Royal College of Psychiatrists.
3	WITN0058004	College Report 150 dated 2008: Rethinking Risk to Others in Mental Health Services
4	WITN0058005	Violence Risk Appraisal Guide (VRAG-R) 2013
5	WITN0058006	Historical Clinical Risk Management-20
6	WITN0058007	Historical Clinical Risk Management-20 (V3)
7	WITN0058008	Douglas et al 2014, Historical-Clinical-Risk Management-20, Version 3 (HCR-20v3): Development and Overview
8	WITN0058009	BMJ Head to Head Maudsley Debate, 12 February 2013 – Does the emphasis on risk in psychiatry serve the interests of patients or the public? Yes