Thursday, 21 May 2026

(1.45 pm)

THE CHAIR: Yes, Mr Weston.

MR WESTON: Chair, I call Dr Adrian James, please.

DR ADRIAN JAMES (affirmed)

Questioned by MR WESTON

MR WESTON: Dr James, you are the National Medical Director for Mental Health and Neurodiversity at NHS England.

A. I am, yes.

Q. In that role, you've prepared three witness statements for this Inquiry, the first dated 19 January 2026; the second, 12 March 2026; and the third, 18 May 2026; is that correct?

A. It is correct.

Q. Dr James, are those statements true to the best of your knowledge and belief?

A. They are.

Q. Can I take you to your first witness statement please, WITN0365001, page 2. Paragraph 2. You state there:

"I make this statement to adopt and attest to the following parts of NHS England's Corporate Witness Statement dated 8 December 2025 ..."

That is a statement from Mr Dale Bywater; is that right?

A. That's correct.

Q. It refers to the various parts that you are attesting to, section 1, section 2 in relation to mental health policy, section 3, patient safety; section 4, mental health datasets; and the remainder is set out there?

The Inquiry is going hear evidence from a colleague of yours at NHS England, Dr Jessica Sokolov. She's the Medical Director for NHS England's Midlands region; is that correct?

A. That's correct.

Q. She's going to assist the Inquiry with the interactions between NHS England and the Nottinghamshire Healthcare NHS Foundation Trust and particularly the commissioning of the Theemis reports and matters like that; that's right, isn't it?

A. That's correct, yes.

Q. You're here to assist us with the national picture, Dr James.

A. I am, yes.

Q. Before we do that, can we please touch upon your professional background. You became a Consultant Psychiatrist in 1994?

A. I did.

Q. You worked at a post at Langdon Hospital, Dawlish, Devon?

A. That's correct, yes.

Q. In 2001, you became the Medical Director there?

A. I did, yes.

Q. Can you assist with your clinical roles thereafter?

A. So I've been a Forensic Psychiatrist since I started at Langdon Hospital, initially as a trainee and then a consultant, in 1994. I worked in low security, medium security. I led the unit, I was the equivalent of the Clinical Director of the unit and then became the Medical Director.

I actually finished my clinical career two years ago when I took up this position. So I was responsible for the care and treatment of those with serious mental illness, who had come into contact with the criminal justice system and were mostly a risk to other people.

Q. Did you continue working at the Langdon Hospital?

A. I did, and I still have a role there in a supervisory and a mentoring capacity.

Q. In 2015, you became a registrar at the Royal College of Psychiatrists; is that correct?

A. I did. That was an elected position for five years.

Q. Then, from 2020 to 2023, you were the President of the Royal College of Psychiatrists?

A. I was.

Q. In June 2024, you took up your current role with NHS England; is that right?

A. I did, yes.

Q. You've previously acted as a reviewer and clinical expert for the Care Quality Commission?

A. I have, and I think it's right to let the Inquiry know that as from 13 July, I'm going to be seconded to the Care Quality Commission as the Interim Chief Inspector of Mental Health. I will, however, keep two of my responsibilities at NHS England, one is for the Modern Service Framework, for severe mental illness, and the other is the Chair of the Mental Health Patient Safety Improvement Group. That will be a six-months secondment and then I'll return to NHS England.

Q. Mr Bywater's corporate statement goes into some of the tail as to the role of NHS England and where it sits in the NHS ecosystem, if I can phrase it that way. I'll take you to that statement in a moment, but I think the starting point is that NHS England is not the NHS in England, it's a part of the NHS; is that correct?

A. That's correct, yes.

Q. It's an executive non-departmental body, public body?

A. That's right, yes.

Q. Let's just have a look briefly at the statutory position. Can we go to RLIT0000040, page 1, national Health Service Act 2026. 13R:

"[NHS England] must establish and operate systems

for collecting and analysing information relating to the safety of the services provided by the health services."

Do you see that?

A. That's correct, yes, I can see it.

Q. Subsection (4):

"[NHS England] must give advice and guidance, to such persons it considers appropriate, for the purpose of maintaining and improving the safety of the services provided by the health service."

A. That's correct.

Q. Subsection (5):

"[NHS England] must monitor the effectiveness of the advice and guidance given by it under subsection (4)."

And subsection (6):

"[An Integrated Care Board] must have regard to any advice or guidance given to it under subsection (4)."

Can I take you please to Mr Bywater's statement, WITN0310001 page 12. Paragraph 28.

"NHS England's primary responsibility is the co-ordination of the provision of healthcare services in England, certain commissioning and oversight of local commissioners and providers of those health care services. To achieve this, NHS England's role includes:

"... setting direction ... developing and setting national policy and strategy; managing the relationship

between the NHS in England and Government; determining NHS priorities (subject to the mandate), providing thought leadership and subject matter expertise for national priorities."

(b): "allocating resources ... leading on national workforce innovation; being responsible for financial stewardship ...

(c): "ensuring accountability and enabling improvement by: defining accountability structures; setting standards for performance; deploying resources ...

At (d): "mobilising expert networks ..."

At (e): "delivering centralised services, collecting datasets and setting minimum standards ..."

At (f): "managing NHS England medicines procurement ...

And (g): "managing performance concerns for medical, dental and optometry practitioners ..."

Can I take you forward to page 66, please, of that statement. Further down the page, the section on "Overarching policy":

"As set out at paragraph 38 above, NICE is primarily responsible for setting out guidance on the diagnosis, treatment and management of diseases and other conditions, whilst the Royal Colleges, professional

bodies and other professional societies publish clinical and professional guidance for use across the system. Providers are then required to ensure that their services meet relevant legislation and guidelines.

"... However, as part of its role in leading and overseeing national policy for the commissioning and delivery of all NHS services across England, which includes driving service improvement and ensuring high-quality care, NHS England publishes overarching policy and guidance documents that are of relevance to all NHS services nationally, as well as service models and other support that local providers and commissioners can use."

Go over the page, please. Paragraph 222:

"Practically, this means that NHS England is responsible for overseeing national mental health policy and its mental health strategy is set out in a series of key publications, as explained further in this section.

"... NHS England also considers requests for advice and guidance from the system. Often guidance is developed in collaboration with providers and other key stakeholders."

That's all correct, is it, Dr James?

A. It is correct, yes.

Q. Dr James, I want to move on to the Nottingham attacks.

In the wake of June 2023 there were a series of reviews of mental health services and they made recommendations touching upon NHS England, didn't they?

A. They did.

Q. Can I take you to them, please. First of all the CQC Report, CQCM0016518, page 1. So this is the report from 2024. Can I take you, please, to page 42. Section 3:

"We recommend that NHS England:

"... Appoints a named individual to take ownership for the delivery of these recommendations."

That's you; is that correct?

A. No, in fact that was Claire Murdoch who was then the National Director for Mental Health.

Q. Okay. Did that become you at some point?

A. It didn't, I mean it would have become our new national priority programme director, Dr Nick Broughton.

Q. Okay thank you for that clarification:

"(b) Ensures that providers' boards fully understand their role in the oversight of the needs of patients who have serious mental illness and who find it difficult to engage with services. This includes developing local services in partnership with others to provide intensive support [quite an important word that we'll come back to] in order to prevent this cohort of patients from falling through the gaps."

We'll come on to this and focus on it in some detail, this is pointing towards Assertive Outreach in those policies, isn't it?

A. That's correct, yes.

Q. "(c): Ensures every provider and commissioner in England undertakes a review of the model of care in place for patients with complex psychosis who typical services struggle to engage and who present with high risk."

That's, again, an Assertive Outreach function there. We'll come back to that.

A. *(The witness nodded)*.

Q. At "(d): [it requires] ... evidence-based guidance setting out the national standards for high-quality, safe care ..." to be produced.

Over the page at (e), a further requirement:

"Within 3 months [for] ... the publication of national standards for high-quality, safe care for people with complex psychosis and paranoid schizophrenia ..."

I'm going to come on to the guidance that was issued in light of this recommendation in a moment.

If I can take you to (g):

"Together with the Royal College of Psychiatrists:

"reviews and strengthens the guidance to clinicians relating to medicines management in a community setting.

"reviews how legislation is used in the community to deliver medication [...]"

We'll come on to the guidance in a moment, but this is matters that have been taken up in relation to depot medication --

A. *(The witness nodded)*.

Q. -- and Community Treatment Orders; is that correct?

A. That's correct, yes.

Q. There was a Theemis Report as well. Can I take you to that, please, NHSE0000298, page 1. Could I take you to page 24. The recommendations: "Area for improvement 1 - Care delivery." Then further down it says.

"Recommendations:

"NHS England and other national leaders, including people with lived experience, should come together to discuss and debate how the needs of people similar to VC are being met and how they are enabled to be supported and thrive safely in the community."

It then goes on to say:

"National leaders should, in the next six months ... as part of the debate, consider the following ... areas:

"The demands on mental health services have increased over recent years."

It goes on to say:

"People who use mental health services frequently

have multiple needs that require significant support to enable them to live well."

Just over the page. One of the recommendations is the consideration of:

"What safe and effective delivery of care should look like for those with severe and enduring mental illness. This should include the consistency of oversight of care across inpatient and community services including the use and application of the relevant parts of the Mental Health Act."

The next bullet point turns to the:

"The debate should ensure the resources for the community model of care are sufficient to meet the needs for severe and enduring mental illness and is supported by an appropriate number of inpatient beds [...]"

I'm going to come back to that a little later with regards to beds, out-of-area beds, in that particular issue:

"This must be supported by sufficiently trained and developed workforce ..."

Two bullet points down:

"The community mental health framework may have led to an unintended consequence of easing of oversight of some people with significant needs through the removal of the Care Programme Approach aspect of care."

Do you think that's correct, Dr James?

A. I think -- that an impression was given of that -- of that -- what's identified here, yes. I think that's fair comment.

Q. Do you think that was the case: that there was an easing of oversight of some people with significant needs through the removal of the Care Programme Approach?

A. I think there was an approach that said the Care Programme Approach was not working, it was overly bureaucratic, it wasn't patient centred, and I think it is fair to say there was a gap between if you are not going to do the Care Programme Approach, what were you going to put in its place in a robust way.

Q. You refer there to the care package and providing care, but just those words, "the easing of oversight", it may be that it seems to be pointing towards supervision oversight, something like that. Do you think there was a gap in that particular respect prior to the Theemis Report?

A. I don't think that any service would have stopped reviewing the care of their patients or of establishing a care plan of reviewing the care plan, of assessing patients. That's certainly how the care should have been delivered. That overall framework was never withdrawn, but there wasn't a very specific approach

that came from the centre.
Q. Next bullet point:
"That care for those with severe and enduring mental illness is commissioned and delivered in line with evidence-based practice ..."
When it's referring to evidence-based practice, that's literature and academic studies that support the efficacy of particular ways of doing things; is that right?
A. That is correct, yes.
Q. Can I take you over the page, please, page 26: "Area of improvement 2". So we've just touched upon care delivery, we're now looking at "Risk":
"We found that risk, both to the individual and potentially to others, was not fully understood, managed, documented or communicated in VC's case."
Then further down we have the recommendations:
"NHS England should, in the next six months consider:
"How mental health and social care understand the concept of risk, risk assessment and risk management systems to ensure the effective identification and evaluation of risk across all care and public settings, together with the appropriate implementation of adequate safety measures."

So that's really looking at risk assessment, risk management.
Then the next bullet point:
"What mechanisms are in place to communicate risk multiple agencies ..."
That's the communication of risk between various agencies. It then turns to:
"How current mental health services take a dynamic approach to risk management, adapting to manage individuals' fluctuating risk and need."
Then finally it says:
"Given that The National Confidential Inquiry into Suicide and Safety in Mental Health ... is no longer funded to carry out data collection, analysis, and research on patient homicide, there is a requirement at a national level for data that accurately assists with the identification and the likelihood of the risks of particular outcomes."
Now, in response to that, NHS England restarted the funding for the National Confidential Inquiry to look at the issue of homicide; is that correct?
A. It did, yes.
Q. Can I just take you to the terms to of that. NHSE0000467, page 1. Under the heading "National patient homicide data collection":

"We, [the National Confidential Inquiry] propose a new focus on national learning following homicide, and on improving patient and public safety through comprehensive data collection on homicide by people under the recent care of mental health services. [We] will re-instate the national homicide inquiry that ended in 2018, and will add to the previous methodology, in response to current concerns."
Do you agree that the collection of data by the National Confidential Inquiry helps to improve patient and public safety?
A. I do, yes, and that's why I was really ultimately responsible for recommissioning the work.
Q. Can you assist with how much the cost, the annual cost, of recommissioning this work is?
A. We can get back with the details, the figure of about 2 million, I think, actually does -- it's quite a major piece of work, but we can get back to you with the exact figure.
Q. I want to turn -- we've looked at some of the NHS England responses as we went through that, but I want to look at some of the documents because it's important to set out the framework of how this is done and the way information has been passed down to Integrated Care Boards.

Can I take you please to NHSE0000046. This is guidance provided by NHS England to Integrated Care Boards on intensive and assertive community mental health care.
We see the date at the top, 26 July 2024, so that's post-the CQC, but when it was first published it was before the Theemis Report; is that right?
A. That's correct, and this was just after I started at NHS England. So I wasn't very much involved in the generation of this at the time, there was later guidance that I was more involved with.
Q. It was updated on 13 February 2025.
A. Yes, that was -- *(overspeaking)* --
Q. You'd have been involved in that update?
A. I was, yes.
Q. That was post-the Theemis Report?
A. That's correct, yes.
Q. What we have here is essentially a document that's responding to both of those sets of recommendations that we've just looked at?
A. That's correct, yes.
Q. Introduction, slightly further down the page, please.
"Many people who experience psychosis are able to receive evidence-based care and treatment which enables them to recover from their psychotic episode and/or be

supported to live a life that is meaningful to them alongside the management of ongoing symptoms. Some people who experience psychosis, particularly where paranoia is present, struggle to access evidence-based care and treatment".

So this is really focused at the sort of issue that we are concerned with with VC and that sort of cohort of patients; is that fair?

A. Yes, that's correct, yes.

Q. If you go over the page, please, to page 2, at the very top there:

"People with these needs can be very vulnerable to harm from themselves and from others; for a very small number of people relapse can also bring a risk of harm to others."

That's an important focus, isn't it, in light of the Nottingham attacks and the purpose of this document, is harm to others.

A. It is, yes.

Q. Page 4, please.

This touches upon it, "Intensive and assertive community care", saying that it requires dedicated staff:

"Systems have a responsibility to ensure they commission the right mix of services to support the

needs of their local populations. This includes a dedicated resource to provide intensive and assertive care for those individuals w[h]o need it."

Right at the beginning of this guidance you're identifying this as one of the key issues?

A. Yes, we are, very much so.

Q. You then go on to talk about the "'No wrong door' approach":

"Community mental health services should be operating a 'no wrong door' approach and [will be] joined up with other statutory services and Voluntary Community Social Enterprise ... partners to identify people who might require intensive and assertive care and who are less likely to present via standard routes."

The 'no wrong door' approach, we'll come onto it in a moment, that's in relation to the neighbourhood mental health centres; is that correct?

A. It is, yes.

Q. It's about ensuring that patients are not discharged completely out of the service; is that correct?

A. It's really about if you, in a sense, go through an NHS door, and that either that service would provide for your needs and provide your care, but you would, if that wasn't the appropriate service, that they would themselves find what the appropriate service was, rather

than say, "You're in the wrong service, you need to be referred to another service". So once you go through the sort of the mental health portal, if you like, that then becomes the responsibility of the whole service to ensure that you get the care that you need.

Q. So two -- if I can put it this way, two conceptualisations of models of care. I'm going to come back to that in a moment if I may, but just to continue with this document, page 12, please, the service failure identified there is:

"Lack of, or poor involvement of carers or family members."

Then can I take you, please, to page 17. I should say I'm going to return to that issue of interaction with family members in a moment, if I may. Just to continue with the document, page 17:

"Poorly planned, precipitous discharges from hospital."

There is reference there to:

"Detailed guidance on proactively planned and effective discharge from acute inpatient mental health services ..."

And then to the NHS England website.

What has changed from an NHS England perspective since June 2023 in relation to discharge guidance,

please?

A. So we did a number of things. We asked all systems about whether they had Assertive Outreach teams or an Assertive Outreach approach, and so that was the first thing we agreed to do and essentially they came back and said a third of systems had Assertive Outreach teams, a third had an approach, and a third couldn't say that they had anything in particular.

We were aware that in Nottingham they had a policy that said, if you didn't attend on two occasions, that you should look to discharge the patient. We sent out a communication to systems that said could they confirm that this isn't the case, and all systems later confirmed that where they had this policy, that it had been withdrawn, and that no patient would be discharged from the service purely because they hadn't attended.

And of course, this is incredibly important, because the sort of patients that we're talking about, it's an intrinsic part of their illness at some times that some people would withdraw from services. So you must have a facility where you reach out to them, because they may not welcome treatment, and they may not want treatment, and they may not come to you.

Q. So you obtain reassurance from Nottinghamshire Healthcare on that particular point.

A. But also from every other healthcare organisation as well.

Q. I'm grateful for that clarification.

Can I take you, please, to page 19. The use of, at the bottom of the page there: "The use of community treatment orders and depot medication". It refers to the fact that:

"... [When] there is a history of poor engagement, consideration should be given to the use of supervised treatment within the framework of a community treatment order for eligible individuals (usually those subject to section 3).

"A decision to use community treatment order should be based on individual circumstances, however there may be shared factors which may be of relevance to this decision, including:

"the presence of severe mental illness including psychotic presentations, in which an individual shows a poor awareness of their illness (including the need for treatment and their risks associated with relapse).

"evidence of previous positive response to treatment.

"previous poor compliance with the treatment plan ...

"previous hospital detentions due to the risks they

pose during relapse to their on health and safety and to others.

"disorganised behaviour/avoidance of contact resulting in being lost to follow up.

"unsuccessful prior attempts to engage the individual with a less restrictive approach."

Just assist me with what the purpose of this is here. The CTOs are in place in June of 2023. This is NHS England effectively reminding Integrated Care Boards and therefore Trusts, that they need to look at the use of this more so; is that fair?

A. Yes, to raise awareness that this is something which should be considered, particularly when a patient met that -- the criteria that you have read out.

So it was an encouragement to make people aware of it and use it where it's appropriate, and because this had been raised in the two reports, the CQC Report and the Theemis Report.

Q. Does it follow that NHS England's view was that CTOs were under-used before June of 2023?

A. Well, it certainly became apparent that there was concern from a number of individuals that that might not have been considered to the degree it should have been in VC's case. And therefore, we wanted to make sure that in other similar cases, that at least the

consideration was there. It wasn't telling people to use CTOs more often, I guess because we were reminding systems that would be a natural following, and in fact what has happened is that the use of CTOs has gone up in -- over the last 18 months, the latest figures show.

Q. Just to clarify, you said there were concerns from a number of individuals that they were underused; is that a concern that was shared by NHS England?

A. It was clearly the case that there was concern that it hadn't been used in this case and it seemed an obvious thing to consider.

Q. Can I take you over the page, please. The first long paragraph there, it says:

"A related issue is the consideration of depot antipsychotic medication for those with psychotic illnesses, with or without the use of a community treatment order. For individuals with a pattern of poor engagement as described above, there may be a history of inconsistent treatment due to disorganisation and/or a refusal of treatment. While this subject has proved challenging to study, a large real-world observational study concluded that depot antipsychotic injections were substantially more effective than oral antipsychotics ... in reducing the risk of rehospitalisation [and of] ... any treatment failure (defined as discontinuation or

switch of antipsychotic medication)."

When was that observational study from, please?

A. If I'm honest, I couldn't give a date, but again we can get back to you with the exact date. But it's a fairly contemporary study.

Q. But that proposition, that it's substantially more effective than clozapine, for example, that's not a controversial point, is it?

A. It's not, no. I mean it is disputed by some individuals, but it's not, I would have -- the majority of the psychiatric literature would support that.

Q. It then goes on to say:

"Therefore, in this specific patient cohort, the administration of regular depot injection may be the only way to ensure individuals are getting the medication they need, it also provides more frequent opportunities for clinical monitoring."

So again, a reminder of a medical part of the medical picture, that psychiatrists would know about in any event, but a reminder there that this is something they can use in this particular cohort of patients.

A. It is, yes.

Q. Were NHS England concerned before June 2023 that depot medication was being underused?

A. There were -- within the psychiatric community, there

was a range of views and certainly there were many psychiatrists who felt that we weren't doing enough to ensure that people received depot medication where it seemed the obvious thing to administer.

Of course it is complex. You can administer depot medication under the Mental Health Act. You would normally not want to do that. You would normally want to explain to the patient what the benefits are to ensure that they remain well. For many patients the taking medication is difficult to remember on a daily basis, so from a pragmatic point of view, from the patient's point of view, I would always try to explain that.

But on some occasions, if somebody is refusing oral medication, you may have to give it under the Mental Health Act. But it's the least best option, because you are then obviously going against what the patient wants, and then, if you are going to want the patient to take that depot in the community, you have then got to re-establish trust and the relationship so that they will really understand that this is in their best interests and continue to consent to it.

Of course if you use a Community Treatment Order, you have sanctions to ensure that if they stop their medication and there are signs of illness, you can

re-call them to hospital. So that's why the guidance that is about the depot medication, but also a legal framework that can make it more likely that somebody takes the depot, then it's -- the two must work in tandem. I mean my experience is very often patients can be persuaded, they see the benefit of it, and that's obviously what we would want to see.

And particularly when you, if you have to give a patient a depot injection when they're very unwell, they're refusing it because they're so unwell, when they start to recover they recognise the recovery, you can then say, "Well, this is because you're on the depot injection, look at the benefits. It's going to allow us to give you leave and eventually move towards discharge."

In my experience, it's very often possible to actually persuade the patient, and even for the patient to want to take the depot. And of course, the Assertive Outreach Teams, that's one of the things that they really major on. They have patients who are seen by a regular group of staff, they establish a rapport, they meet the patient where they want to be met, they can really engage on a daily basis with discussions around what's in the best interests of the patients. And that approach, if you speak to people in Assertive Outreach

teams, is very often successful.

Q. You refer to it as the "least best option" but often it's --

A. Well, it's a very necessary option, but clearly for anybody in any healthcare environment, it's much better that a patient wants to take medication and agrees to it. So it is -- it's a route you would reluctantly go down, because it immediately sets up a confrontation that you then, you have to work with, in order to get the patient actually agreeing that this is the best thing, if you're going to discharge the patient.

Q. By giving that advice, you are urging psychiatric services to use this medication when necessary.

A. When necessary, that's right. I mean there are patients who take their oral medication regularly, they see the value of it, they don't forget we can support patients in making sure they remember to take their medication. And of course clozapine is mentioned, you raised it, that clozapine is probably the most effective antipsychotic medication. It has a downside. And so there are some patients who are better off on clozapine than on a depot, and where that's best for them, then that's something that's considered. However, sometimes -- and I've had patients who will initially agree to take clozapine, they repeatedly will stop

taking it, you readmit them and then you get to a stage where even though you know it benefits, if in the longer term they're just not going to take it repeatedly, then you have to actually say in the end, "Well, it's really got to be a depot," you establish that as an inpatient, and then you discharge them on a depot.

But you, within the community, I think it's important to say that the Mental Health Act doesn't allow you to give an injection in the community to the patient. This was debated when the Community Treatment Orders were established, when the passage through Parliament, but if somebody stops taking their depot you can recall them to hospital, and so it's quite a powerful lever that you can say, "Look, you -- I can't stop you from refusing medication, but if you do and there are signs that you're becoming unwell," normally if you're having that discussion, there are those signs, you can then recall somebody to hospital. So very often somebody will agree to carry on taking it; not always, but it's a very powerful lever.

Q. That reminder, that lever, is something you're asking clinicians to remember by providing this advice.

A. Yes, to consider. It's highlighting the need to consider all the options when that is the right thing to do for the patient.

Q. The fact that you needed to highlight this, is that because there was a concern that in relation to some patients, depot medication wasn't being used when it was necessary?

A. I think there was a background concern. There are, I would certainly speak to groups of psychiatrists who would say, "I don't understand why we don't use depot injections more." There was an accumulation of evidence both in terms of risk, but risk to them, risk to themselves, as well as being more likely to ensure that somebody remained well.

So there was the background concern that it's always been within NICE guidance, it's very clear the role of depot injections is there and very clear, but I guess this was a reminder that it was, it's something that people should consider.

Q. That background concern that it was underused, that's not new; that's something that's been around for quite some time, hasn't it?

A. I guess there was always -- and it is also true in clozapine, and it's -- I think the root of that is for clozapine there are side effects and you have to do blood monitoring, and for depots, clearly some patients find them very unpleasant, having an injection, and some refuse.

Q. So we're looking at the guidance to Integrated Care Boards. I'm going to come back to this document when we look at particular themes, if I may.

Can I just look at one other document which deals with NHS England's response, in particular to the Theemis Report. Can I take you to NHSE0000048, page 1, please. This is a letter dated 5 February 2025. Who was this circulated to, please? I think we can see further down: "integrated care boards" and mental health Trusts as well, so a very wide circulation?

A. Yes.

Q. Over the page, please, page 2, at the top it's thanking those bodies for "taking forward to improve intensive and assertive community treatment". That's the document we just looked at in particular and their response to it.

Then further down, and it just, I should say in this paragraph, this is a direct response to that Theemis report trying to put the learning out there, requiring all those who are reading this letter to read the report. And then in terms of "Next steps", further down, it says:

"In line with your commitment to keep these plans under regular review, we now ask that you review your local action plans, ensuring they address the issues

identified in the independent review with particular attention to:

"personalised assessment of risk across community and inpatient teams".

So again the issue of risk, which we saw in the CQC Report, is repeated here:

"joint discharge planning arrangements between the person, their family, the inpatient and community team ..."

We've seen some of that in the guidance that we just looked at, which I'm going to come back to in a moment, and then:

"multi-agency working and information sharing", which I also return to:

"working closely with families".

And:

"eliminating Out of Area Placements in line with ICB 3-year plans."

Another topic I'd like to come back to. What I'd like to do then is, having looked at both the recommendations and looked at the response, is pick up key themes and explore them in a little more detail, if I may.

Can I start, please, with models of care. The CQC report recommended a review of models of care and

specifically mentioned the provision of intensive support.

Can I take you back to the NHSE guidance in relation to that. So that's NHSE0000046, page 20. Section 4, features of intensive and assertive community care:

"This guidance uses the term 'intensive and assertive community care' to describe service provision that is designed to meet the needs of the group of people described in chapter 2. This care involves high frequencies of contact with individuals (intensive) alongside an assertiveness of approach to ensuring people get the right treatment and care.

"This includes 'assertive outreach' which is a distinct, evidence-based service model for people with psychosis who for various reasons are not engaged with secondary psychiatric services."

Just on that particular point, it's right that in terms of Assertive Outreach and the efficacy of Assertive Outreach teams, there is quite a clear evidence base, isn't there, to support the efficacy of that.

A. There is, indeed, particularly in urban settings.

Q. In your personal witness statement to this Inquiry, one of your recommendations is greater use of Assertive Outreach. Can I take you, please, to WITN0365001.

Page 9, paragraph 19 at the bottom:

"To avoid a recurring cycle of crisis intervention, it is essential that patients with severe mental illness receive assertive outreach to ensure sustained engagement with services including recovery and rehabilitation services. Early intervention and assertive outreach typically lead to better outcomes. Where the full pathway is unavailable, pressure is placed on inpatient capacity, potentially resulting in inappropriate out-of-area placements. This increases the likelihood of further admissions that might otherwise have been preventable."

The Inquiry has heard evidence from a Consultant Psychiatrist specifically on Assertive Outreach and I just want to explore what he told the Inquiry with you, if I may, please, because you're clearly supportive of it, and he was as well, but I just want to understand where you stand on some of the points that he makes.

Can I please take you to WITN0412001, page 1. That's the witness statement of Dr Dissayanaka. Page 9, please.

Apologies, page 11.

Paragraph 21. Dr Dissayanaka refers to the REACT study. That created some doubt about the use of Assertive Outreach in 2006, didn't it, because it wasn't

reducing hospital admissions?

A. That is correct, although there is other evidence which shows that it does reduce the use of beds.

Q. Dr Dissayanaka, in the third line there, he's concerned that those studies didn't look at the risk -- the violence risk being reduced, which he thought was a critical factor or focus of this particular intervention. He goes on to say:

"The subject of violence risk is fraught with disinformation, fear and stigma and one that is largely still avoided."

Further down, at paragraph 22, he refers to a study from Fazel and colleagues, in an umbrella review. And towards the bottom, he concludes, second line from the bottom:

"Assertive Outreach is the obvious evidence-based approach for this group. These findings are echoed by Baird et al's national case-control study of homicide by men diagnosed with schizophrenia, one of the authors being Professor Sir Louis Appleby, who is ... Director of the National Confidential Inquiry."

You'd agree with that, wouldn't you, that --

A. -- *(overspeaking)* --

Q. -- there's evidence base for Assertive Outreach, and --

A. -- *(overspeaking)* -- yes, I do.

Q. Let me take you to his evidence, please, if I may, Dr Dissayanaka's evidence, INQT00000501, page 17. Bottom right, please.

Towards the bottom of that column at page 17, so if we could focus -- yes, I'm grateful. The question is:

".... 'assertive Community Treatment is one of the most extensively evaluated mental health interventions, with 15 systemic reviews and over 75 randomised controlled trials, showing good evidence for its efficacy?"

"Yes," is the answer to that.

If I can take you over the page, please, page 18, top right towards the bottom there, Dr Dissayanaka says:

"The Fidelity Scale has either 26 or 28 items, depending on the version. But what it does reflect is that Assertive Outreach [...] can do ... what Community Mental Health Teams can't manage."

He is then asked about a phrase "Assertive Outreach approach". That's at page 19, please. Half bottom left corner, halfway down. He says:

"I don't think the Theemis Report is on its own. Assertive Outreach. There is a phrase 'Assertive Outreach approach' which I don't really understand, and I think it just means trying to be more proactive with people who might be disengaging."

Then over on the other column to the bottom right there, internal page 76, he says:

"I don't really understand what it means. Assertive Outreach is a very clearly defined model, it has a Fidelity Scale which most services don't have anything like that, it's a stand-alone model. ... it is not just Theemis, it's ... the Royal College of Psychiatrists. I think in NICE guidance [as well] ..."

And he goes on to some other resources there.

Finally from Dr Dissayanaka, can I just take you to his witness statement on this point, just to round up his views before I ask you for your position. WITN4120001, page 6. Paragraph 14, second half there:

"Standard community teams cannot offer this and hybrid approaches, as well as lacking a positive evidence base, have been shown to lose the benefits such as decreased hospitalisation rates. Low fidelity teams drift towards office-based interventions, decreased intensity, less intensive reactive care as well as increased staff burnout due to risks and complexity of the patient group."

Do you agree that if you don't have a focused, assertive intervention team, there is a risk of drift towards other responsibilities?

A. There is a risk of drift and the ideal model is the full

Assertive Outreach Team, with a Fidelity to that model.
Q. It's said there that hybrid approaches lack a positive evidence base; do you agree?
A. I do. I mean, it's inherent in research that if you have a hybrid model it's much less easy to prove its effectiveness.
Q. So the NHS England guidance that we looked at, it advised an assertiveness of approach, it said one of those approaches is to have Assertive Outreach Team?
A. Yes.
Q. But it didn't go as far as mandating that or saying that was required. So just to be clear, that bit of guidance, in relation to moving towards an assertive approach, that's not evidence based, is it?
A. Well, can I just explain what that was really all about. The evidence base around Assertive Outreach is strongly linked to an urban area, where you have a greater concentration of individuals, greater concentration of people with mental illness, where it is much easier to get a team together, with very particular characteristics, as outlined which can be very highly responsive to the needs of an urban population, one of the issues with Assertive Outreach is that you need a timely response. There isn't any point in saying that you're going to go and see somebody on a very delayed

basis.

I guess, we know that we don't have all these teams everywhere, and what we didn't want to happen was that people would then ignore the need to have that sort of approach. So if you had a team, particularly in a rural area, where it might be impractical to have a team in every town, that you shouldn't just then say, "Well, we can't do this." Because the evidence base isn't there, it doesn't mean that they're not effective, and, for me, it makes clinical sense that if you -- and there is a timescale issue here. You can't -- even though we said to the system that you should develop these teams, and that the ideal that people would know, clinicians would know, is the Assertive Outreach Team, that it takes a time to develop those teams, train them, get the necessary workforce.

So whilst that is happening, you certainly wouldn't want people to ignore the approach; you would want to make sure that it happens everywhere. So if a -- so exactly that, the scenario where somebody says, "I don't want to engage with your service," you have somebody within your team, or preferably a number of people, who is actually going to reach out to that individual, establish a rapport, even if you can't establish the whole team.

So I guess my job is to translate the evidence into practice on the ground. Where we can, where we have the necessary resources to do it in a FIDELITY to the model, but where that is either impractical or rurality -- I have worked in Devon -- it may be impractical to have a team everywhere, and so you would want the approach to be there.

So I think there is a need for flexibility. There hasn't been so much of a research base around if you apply the approach that in a more rural area, without absolute fidelity to the model, that that can be proven to be effective; it doesn't mean it's not effective and, say, from a research point of view it's inherently more difficult to prove.
Q. Of course difficulties between urban and rural areas, practical issues as you've set out, the assertiveness of approach, that phrase that's used in the guidance, just assist me: is there an evidence base for that being efficacious?
A. I think there is a clinical, in terms of clinical expertise, that it is manifestly true, that in every part of the country you will have people with psychosis who will not want to engage with your service, and that you would need to have people within your team who were going to reach out to them. So I think it is seen to be

clinically effective. Are there a number of studies that have been repeated in the areas to show that it's effective? That is much less obvious.
Q. Where there is an evidence base is in relation to Assertive Outreach teams. One option is to ask that -- to ask the Trusts to set up Assertive Outreach teams where that is practicable.
A. Yes, one would assume that that's what they would do, and that was part of our approach that you would --
Q. That's not what the guidance says, does it? You could have asked for Assertive Outreach teams to be set up where practicable because that's where the evidence basis is.

For this other assertiveness of approach, where we don't have an evidence basis but we have some observational information, that can be used in other areas.

Why not go on the evidence rather than on the observations of clinicians?
A. I think the evidence is clearly set out, and the local commissioners and the local clinicians certainly would be aware of that evidence. So it is for the local commissioning groups, so the ICB, to commission the services that meet the needs of their population, so they would need to -- so we're highlighting a need that

we were concerned -- in fact we had evidence -- that it was being missed, but they would still need to go through the process of assessing the needs of, in this case, people with psychosis, looking at the evidence base as to how you can meet that need, and setting up teams accordingly.

But of course in some parts of the country there had been people who have operated effectively within other teams, and where that was working very well, particularly in a local rural area, we certainly wouldn't want them to stop doing that where it was judged by the ICB to be effective.

Q. NHS England is setting standards here, aren't they?

A. They --

Q. It's assisting in terms of what is expected from the top, if I can put it that way, to assist with this cohort of patients. So why, in those circumstances, leave it to the Trusts, given the difficulty we know with Assertive Outreach teams, the fact they need their own funding? Why not assist them by pushing them further towards the actual team approach?

A. I think it's in inherent in the guidance. We're very clearly highlighting this as an evidence-based approach. We mention the teams and there has naturally been, amongst the professional community, quite a lot of

discussion, presentations. I've seen them myself. So you would expect people to be able to reach out and access that evidence.

I mean you could -- I mean I'm very happy to go and look at it and make it absolutely clear that where it is practical and where it is -- that this is the -- this is the ideal that they should be looking at, and we could do that but I think it is inherent in the guidance that we've given: it highlights the need, the approach, and it very specifically is a call to action around this important group of patients.

Q. Can I take you to NHSE0000524, page 1, please. This is the: "Fit For the Future 10 Year Health Plan", dated 1995. Can I take you to page 5, please. Top right-hand corner, there is a bullet point. It refers to:

"people with severe and enduring mental illness face being bounced from one service to another with little to no continuity."

It then goes on to refer to effectively the 24/7 neighbourhood mental health teams and then concludes by saying:

"We will improve Assertive Outreach care and treatment to ensure 100% national coverage in the next decade, with a focus on narrowing mental health inequalities."

Can I just understand what that means. When there's a reference there to Assertive Outreach care and treatment, that is not to the establishment of Assertive Outreach teams; that is to an assertiveness of approach?

A. It is. That's what's very clearly there, but within that, you would expect the local commissioners to look at exactly what that means in their area and act accordingly. And actually, that's what some -- I know some ICBs have already done.

Q. In terms of coverage, it's easy to tell whether a particular Trust has an Assertive Outreach Team.

A. *(The witness nodded)*.

Q. Whether it's got an assertiveness of approach is more amorphous, isn't it?

A. Well, we would expect people to show that that is what they are doing. I mean, for example, the neighbourhood mental health approach, which is also mentioned in this document, I visited a number of them, and they are testing to see how much outreach they can do to this patient group. That's a completely new approach, and we certainly wouldn't want to stifle innovation where it brings other additional benefits. And, for example, the 24/7 neighbourhood approach is formulated on the basis that the service is so attractive that people want to engage with it, so they are less likely to disengage.

Now we don't know if those services will ultimately achieve that. There certainly seems experience on the ground to suggest that that is what they are already doing, but we need a proper evaluation, and where people don't access -- people I know have already discussed the open door approach, that if people won't go through the open door, they have a facility to reach out to them.

So I wouldn't want to stifle that innovation that might get rid of some of the challenge in the first place by making the service so local and engaging that people actually want -- are drawn to the service.

In the back of my mind, and it is something we have discussed with the team who are leading on this, we don't know how far they can push that, and it might be that you have in an area a number of neighbourhood teams if the approach is shown to be accessible, and you might need to have an Assertive Outreach Team sitting above that in addition.

But you wouldn't want to stop the service reaching out to people who don't come through the open door, and one of the examples that's been given is the homeless population who may be a particular group who are less likely to walk through the open door and you might need to reach out to them.

Q. In terms of that neighbourhood mental health centres,

that particular model, please, there are six health centres already established?
A. There are, yes.
Q. 16 associate sites in receipt of a formal implementation support offer; is that right?
A. That's correct. That's correct, yes.
Q. What is the plan, in terms of -- because that's quite limited, isn't it, in terms of national coverage. What's the plan in terms of expanding that and in what time scale, please?
A. So the -- we have an evaluation that is ongoing that we hope will report over the summer, and clearly, when you're setting up new models of care and this brings evidence from all over the world, we're testing to see whether that is a model that we can use in the English context, and if we do, then what exactly would it look like?

So first of all we need to see whether it works, what is it about it works, and we, if it is successful, then we will spread the approach, and there is capital funding that will -- that is available already to all systems to develop these centres locally.

It won't at this stage, produce a hundred per cent coverage. And at the moment there's no revenue to fund them, but one of the reasons for having the six models

that we're evaluating is that some of the evidence seemed to suggest that they reduce the need for beds, and reduced the need for other types of care.

So if indeed they do do that, they should fund themselves. But we don't know that yet, we just need to see whether that's what happens.
Q. So effectively this Model of Care is being road-tested?
A. It's being properly -- or it's not only road-tested; it's being evaluated to see what works, what doesn't, what's the feedback from those who use the services, what is the impact on the use of other services, on emergency departments, for example, on use of inpatient patient beds? So it's a proper evaluation.
Q. If it's not evaluated to be successful, then it won't progress. But also, there is, in the absence of any resources now, it could just fall away in the next few years, couldn't it?
A. It's a possibility. I mean you wouldn't get any innovation, unless you were prepared to take some risks and try some models, and the Model of Care for people with severe mental illness has been criticised over many years, so this is an attempt to try and see if we can do something really innovative and really different. And it would be wrong to say it looks good, let's roll it out. We need to actually make sure that it is good.

Q. But even if it looks good, there's no revenue stream to fund it going forwards. There's --
A. -- *(overspeaking)* --
Q. -- a lot of decisions would have to be made. So this central part of the NHS England plan has got a big question mark next to it, doesn't it?
A. There would be a question mark where there is funding, and the question mark is: does the evidence base actually deliver on reducing the need for other services? And so can it be self-funding? If it's not, is it such a good approach, even though it doesn't replace many other services? Is it something that would be funded centrally in extra funding? And of course that brings us to the next spending review, and we can't, and no government would, commit at this stage to what they may or may not fund in any part of public life.
Q. The neighbourhood teams, they're situated in one place, one building, usually, where a number of different needs can be met for patients?
A. That's correct, yes.
Q. You've already said that one of the ideas is to make it a place that encourages people to engage.
A. *(The witness nodded)*.
Q. There will always be some patients who don't want to it

engage.
A. *(The witness nodded)*.
Q. Who don't recognise they have a mental illness. For those sorts of patients, this sort of neighbourhood team is not going to be of assistance, is it?
A. I mean it is a question I've asked every single one of them what -- you know, it's nice to have the open door approach. What if you don't want to walk through the door or can't walk through the door?

And so it remains to be seen what other services you need to have around the neighbourhood. I mean clearly they've had very good publicity, they work with local communities. I visited the one in Sheffield that the Local Residents Association were very much involved with it. The local community seemed to be speaking very highly of it, they were engaged.

So I think the chances of people in the end wanting to engage are greater because word goes around that it's a good therapeutic place with people who want to engage with you, where you can get a lot of help, not just for your mental health but all the other things that keep you well.

But you're absolutely right, we don't know how far that can go. So if, for example, it can't meet the needs of people who at the moment we're saying need

an Assertive Outreach approach, we might need those teams as well.

Q. So two different models of care that we've touched upon. Is there a tension, at least from a funding perspective, of trying to push forward these two models of care at the same time?

A. There are always funding tensions, yes.

Q. Is there a tension from a clinical perspective of trying to push these two systems forward at the same time, in terms of how mental health practitioners understand, and what their efficacy is and what their purpose is?

A. It's always a challenge. You -- the problem is that you would never innovate; you would effectively say, "We're going to keep the system exactly as it is," unless you were prepared to try out new models. I know that the clinicians and the Trusts involved in these new models are very enthusiastic and committed to the approach. And the number of people who wanted to be one of the pilots I think showed that people wanted to do something differently.

So there is a tension, and in terms of funding the teams, we did actually ask local systems if they were finding it difficult to implement Assertive Outreach teams, what were the challenges, were they workforce, were they funding? And essentially there are two routes

to funding. One is a central one where the central team at NHS England can say, "This is a priority approach and we want you to do it." They can, through the planning guidance, they can say, "This is a priority approach and here's some money to help you do it."

Or you go through the Integrated Care Boards, the ICBs, and they have the overwhelming responsibility for assessing the needs in their area and commissioning the correct -- the correct care that's needed in, in this case an Assertive Outreach Team or approach.

So we went both ways as the mental health team. We put submissions into the spending review. They were not successful. But also we asked ICBs to look at their needs locally, and I'm aware that some ICBs have been able to release funding to develop those teams, and, for example, the Thames Valley ICB found 3 million in the next year to develop these services.

So that would be the ideal: the local commissioner assesses the need and develops the service. Where that's not possible, we need to look at a national approach. But there has been a move away from national approaches saying, "You must do this." And the emphasis is very much on local systems.

Q. I want to move on to a different topic, please. One of the key recommendations that we saw in both the CQC and

the Theemis Report was enhancing understanding of the concept of risk, risk assessment and risk management.

Can I take you back, please, to the NHS England guidance to Integrated Care Boards, please. NHSE0000046, page 7. We have there a "Service failure identified", and the guidance given to Integrated Care Boards as regards:

"Missed 'red flags' of earlier minor offending/not reflected in risk assessments".

Do you see that?

A. Yes, I do.

Q. Then if we go over to page 9, please. At the bottom of the page, it says:

"A good risk assessment is not predictive but seeks to understand the types of situations where the person has been risky in the past. Eg environmental factors like access to drugs. In line with NICE guidance, services should avoid using risk assessment tools as a predictor of future risk".

And the NICE guidelines 2020, NG225, are cited there:

"Rationale and impact risk assessment tools scales 2.

"Instead, assessment should focus on the person's ..."

And this seems to be a quote from the NICE Guidelines:

"... 'focus on the person's needs and how to support their long-term psychological and physical safety. Mental health professionals should undertake a risk formulation as part of every psychosocial assessment'."

And again, that's reciting NG225.

Can I take you to that guidance, please. WITN0433011, page 1, please. Dr James, this is guidance about self-harm: "... assessment, management and preventing recurrence". Do you see that?

A. I do, yes.

Q. Then if we go, please, to page 6, "Overview":

"This guideline covers assessment, management and preventing recurrence for children, young people and adults who have self-harm harmed. It includes those with a mental health problem, neurodevelopmental disorder or learning disability and applies to all sectors that work with people who have self-harmed.

"In this guideline, self-harm is defined as intentional self-poisoning or injury, irrespective of the apparent purpose."

Page 12, please. At the bottom there, there is a reference to psychosocial assessments. It refers at 1.5.2:

"Do not delay the assessment until after medical treatment is completed."

That's probably referring to after self-harm, isn't it?

A. It is, yes.

Q. It then goes on to say:

"If the person who has self-harmed is intoxicated by drugs or alcohol, agree with the person and colleagues what immediate assistance is needed ..."

Then over the page, 1.5.5:

"If the person is not able to participate in psychosocial assessment, ensure they have regular references, and complete a psychosocial assessment as soon as possible."

Then at 1.5.9, it refers to guidance:

"During the psychosocial assessment, explore the functions of self-harm for that person."

It then gives a list of matters of self-harm to be taken into account.

So this is the NICE guidance that was referred to in the guideline that you provided to Integrated Care Boards, but it applies to self-harm, not risk to others, doesn't it?

A. It does, but it's a general principle that covers all risk assessment. And unfortunately, we don't have

tools -- people have tried to develop them -- that can robustly predict an individual who will take their own life, and that's also true for predicting somebody who is going to cause serious harm to others or kill others.

We always -- we wish we had those tools, and sometimes people have felt, for example, a RAG rating, red, amber, green, that we should classify people, for example, their risk of self-harm as being high, medium or low risk. The evidence base, it comes very much from the National Confidential Inquiry, suggests that we miss the majority of those who are at risk of suicide if we -- because they actually sit within those who are assessed as low risk, so we must make sure there's a safety management plan for everybody, and we have just published a new document, Staying Safe from Suicide.

But it's -- the idea that we could predict who might either take their own life or commit an act of serious violence to others, within forensic circles and -- has never been part of what people have done. They've tended not to rate people as high, medium and low.

So this was a very particular move that needed a change in the assessment of risk to self. That particular approach was never particularly part of the approach in risk to others.

Q. So the guidance, which was assisting Integrated Care

Boards to look at the risk to others following VC's attack, refers to this guidance on self-harm. Do you consider that's the appropriate guidance for Integrated Care Boards and Trusts to be referred to?

A. Well, I think it highlights the -- that you needed a personalised approach to risk management overall, and so that you needed a -- I mean, we -- in the guidance that we sent out, we very much highlighted that you needed to make sure that you had information from a variety of sources, a care plan, a risk management plan. And we have really got to the end of developing the personalised care framework, which was again an ask from both the CQC Report and the Theemis Report, and that was quite a big piece of work. It looked at the framework, including risk to other people, and it sets out a framework to assess risk, and it very clearly states that you need to have a full history, history from a number of sources, particularly family.

That then needs to be interagency working and information sharing, where necessary, that you need to identify the risks that somebody poses, that will be mostly from historical records, but not exclusively. The clinical issues that make somebody more or less risky, what support they have, what help they could have that would reduce the risk, what are the situations that

increase the risk and what should you do, and what are the situations that highlight that somebody is beginning to relapse? And again, what should you do?

So that's in the Personalised Care Framework. It hasn't been published. It's actually sitting with ministers at the moment. They need to sign that off.

Q. The guideline points trusts and ICBs to this particular NICE guideline. That guideline doesn't refer at all to risk to others, does it?

A. That's correct, yes.

Q. Indeed, there's another NICE guideline that does refer to risk to others?

A. There is, in relation to the management of risk in an immediate situation, on a-- particularly an inpatient ward.

Q. Let me take you to that document, please. RLIT0000018, page 1. This is the NICE guidance on Violence and aggression: short-term management in mental health, health and community settings? So it applies to community settings, doesn't it?

A. It does, but it's primarily aimed at inpatient setting.

Q. Well, the title says it's aimed at community settings; do you disagree with that?

A. No, it does, but my -- having read it, I think it primarily applies to inpatient settings, and it is

around short-term management rather than long-term prediction.

Q. Page 25, please, 1.2.8:

"When assessing and managing the risk of violence and aggression use a multidisciplinary approach that reflects the care setting.

"Before assessing the risk of violence or aggression:

"Take into account previous violent or aggressive episodes ..."

There is nothing to do with taking into account previous violent episodes in the other NICE guidance, is there?

A. Not about aggressive episodes, but certainly around episodes of self-harm, that's correct.

Q. Going over the page to 1.2.10:

"Carry out the risk assessment with the service user ... if they agree, their carer. If this finds that the service user could become violent or aggressive, set out [the] approaches [and] address:

"Service user-related domains in the framework ...

"Contexts in which violence and aggression tend to occur."

That's essential, isn't it, in a violence risk assessment?

A. It is, yes.

Q. Nothing in the NICE guidance that NHS England provided to trusts, nothing to do with that in there, is there?

A. There is within the personalised care framework.

Q. I'm talking about the guidance that was provided in the light of the June 2023 attacks. That guidance pointed to the other NICE guidance. There is nothing in that guidance about violence and aggression and understanding the context in which that occurs, is there?

A. But this --

Q. Do you agree with that, first?

A. It -- I think it does need to be explained, because the -- the principles that underline assessment of risk to self and that assessment over a long period of time, those principles apply just as well in terms of longer-term risk to others. This document is really about short-term management and short-term -- *(overspeaking)* --

THE CHAIR: I think you're being asked about whether there is any reference to the history of violence and aggression in the other guidance to which the document, the NHSE document, refers? And the answer is no, isn't it?

A. That's correct, yes.

THE CHAIR: Thank you.

MR WESTON: Further down, 1.2.11:

"Consider using an actuarial prediction instrument such as BVC (Broset Violence Checklist) or the DASA-IV ... rather than unstructured clinical judgement alone, to monitor and reduce incidents of violence and aggression and to help develop a risk management plan in inpatient psychiatric settings."

So there's reference there to inpatient psychiatric settings.

A. Yes.

Q. That is, in terms of using tools, that is something that's actually contradicted by the NICE guidance that you disseminated to trusts?

A. I think you're looking at two different things. One is how do you manage longer-term risk to other people, and this is about how do you manage a specific situation where there is violence and aggression. I think they are very different things. And in relation to this NICE guidance, it doesn't really apply to those situations. But I -- I agree it's a gap, and I can tell you what I've done.

I have had discussions, as you will be aware, there is Royal College guidance, I think that was published in 2016. There is the Department of Health and Social Care guidance, and that largely comes down in favour of

structured clinical judgement. It lays out what that means. And I have had discussions with the Royal College about updating that. They are considering it, but there is doubt about whether there is a new evidence base around long-term prediction and management of risk beyond structured clinical judgement.

But what I have done is we, at NHS England, have commissioned a piece of work from the National Institute for Health Research to say: are we sure? Can we test every database, both in terms of the UK literature but the world literature, to see is there? Can we be sure there is no additional evidence that shows that we can predict risk in the longer term.

Of course, if there is, this is something that every psychiatrist would want to have, but if it doesn't exist, it's wrong to pretend that we have it. That can give people a false sense of security and actually heighten risk.

Q. The approach advocated in NG10, this document, is radically different to the one set out in NG225, isn't it?

A. It's because it's about -- *(overspeaking)* --

Q. First of all, do you agree with that as a --

A. Well, it is because it applies to a different situation, you wouldn't -- *(overspeaking)* --

Q. I understand that. This is the guidance in relation to violence and aggression that NICE have provided in community settings. This is the NICE guidance if you're going to be pointing trusts to NICE guidance, this is the correct guidance, isn't it?

A. It is for an immediate management of risk. So somebody who is either immediately at risk of aggression or is behaving in an aggressive way, then this is the right guidance. And that's where it's real and obvious that there is a situation that is there.

I think what we are, in terms of the other guidance and the guidance within the personalised care framework, we are looking at something different where there is no immediate, obvious indication that risk has been heightened, if there was, you would take immediate action, but predicting risk -- how do you manage that risk to other people in the longer term on a continuous basis?

Q. Can I take you, please, to WITN0058002. CR201, Royal College of Psychiatrists: Rethinking risk to others in mental health services.

This is guidance you referred to a moment ago. This applies throughout mental health services, doesn't it?

A. It does, yes.

Q. Long term and short-term risk?

A. That's correct, yes.

Q. Can I take you to page 19, please. Sorry, page 21. It says there: "Approaches to risk assessment" from the Royal College of Psychiatrists:

"The use of structured risk-assessment instruments is subject to debate, but it can add to the quality of clinical assessment. Even the best-structured instruments, such as the HCR-20, will have limitations but are appropriate in the range of settings in which they have been validated."

Can I take you over to page 23, please. Refers to different types of structured risk assessment tools have been developed by experts in the field over the last 15 years. It then goes through a number of them and then discusses pros and cons of them.

Further down the page:

"Risk assessment tools are used by ..."

Halfway down that column:

"Risk assessment tools are used by mental health professionals to assess patients in a range of forensic contexts as well as in both general adult and child and adolescent mental health services."

So it's a universal reference here in terms of the advice that's been given.

Then if you go over to the other column, bottom

right-hand corner, last paragraph:

"The College continues to see structured risk assessment as valuable, if it is part of a process rather then a standalone toolkit, in capturing the dynamic features of patient risk."

Can I then take you to page 26, summary of best practice:

"A structured professional judgement approach is a helpful adjunct in certain settings. This adds to the primary process of risk assessment for psychiatrists, a structured history, mental state examination and clinical formulation, including risk formulation. Risk assessment should maximise the involvement of patients and carers."

The last paragraph:

"The college advocates a consistent approach across the UK rather then a variety of locally based strategies."

So a role here for structured professional judgement. A role for tools. That's the advice of the Royal College of Psychiatrists. But the guidance you gave to trusts has absolutely no mention of that, does it?

A. We are developing that we have completed a piece of work that will actually give them that guidance.

Q. You've given the wrong guidance, haven't you, in that? You've referred to the wrong NICE guideline and you've given guidance that doesn't sit with the professional consensus, albeit that there's some differences in how it's supposed to be done, there is a key message in terms of structured professional judgement, plus or minus some tools. That's not -- you've not provided that information, have you?

A. I think this, in terms of these structured tools, as you see when you were reading from the paragraph, it goes on to immediately mention the HCR-20, a structured tool that I'm very familiar with and trained in. And that is -- and it's mentioned here -- it is a very good tool. However, it takes quite a lot of training and it takes quite a lot of time, sometimes it's many hours --

Q. Let me interrupt you there. There's a number of different tools. We've heard about different tools. Pros and cons from different ones. But the consensus is structured professional judgement and some tools if you think it's appropriate. The NG225 that you've sent talks about a psychosocial assessment and about assessing people in terms of self-harm. That's the wrong guidance to give to Integrated Care Boards and trusts, isn't it?

A. But I think within --

Q. Do you agree with that proposition before responding to it; can I just ask that?
A. I think we -- I mean, I don't think that we wanted to avoid the whole, that very often the risk to yourself and others, go hand in hand. There's a very similar approach. I can understand that may be the inference, but I don't think it is what was intended.
Q. The college advocates a consistent approach by giving a self-harm guidance rather than referring to the NICE guidance from 2015 or this guidance. NHS England, far from clarifying things, is promoting an inconsistent approach nationally, isn't it?
A. But we needed to have a much closer look at it, get the -- and the Royal College says that it's -- we need a consistent approach, that often requires getting people together. We did get a group of people with lived experience, experts, psychiatrists, clinicians, people working in services, together to look at the Personalised Care Framework and it will appear in that. And meanwhile, as I've already said, we do want to look at what is the current evidence base around tools.
Q. The CQC and Theemis both required NHS England to provide relevant guidance on assessing risk following the Nottingham attacks. But the guidance you've given is not relevant, is it?

A. Well, I think the principles are relevant and many of the principles you see in the Royal College guidance, which I know it says as a review date, but it was still current, the evidence, the guidance that was from DHSE still current so it didn't exclude people looking at that.

But we did need to take a much more detailed look, and it's -- you know, we really wanted to say: well, look, people are talking about tools. Is there any immediate evidence? I discussed it with NICE, we've now commissioned a piece of work. So it's very important that that is accurate and up to date. So that's been our approach.
Q. That's not the message in the -- I'm going to move on after this, but that's not the message in the guidance you've provided. It's not "We're taking a closer look at this, we might be developing new ways of doing this," you essentially are telling Trusts to put risk assessment tools to one side and to use the self-harm approach.
A. I mean, agree, the evidence could have been better.
Q. Can I move to a different but related issue? The Theemis Report identified the importance of mechanisms to communicate risk in real time. Can I take you to your guidance, please: NHSE0000046.

Chair, I'm just looking at the time actually. Before moving on to this topic, would it be a good time for a break?
THE CHAIR: Yes, I was just thinking it might be useful to have a break now. We'll start again at 3.35. Thank you.
(3.18 pm)
(A short break)
(3.35 pm)
MR WESTON: Dr James, before the break, we looked at models of care, we looked at risk assessment. I want to move on to information sharing. The Theemis Report identified the importance of mechanisms to communicate risk in realtime. That was one of the recommendations for NHS England, wasn't it?
A. *(No audible answer).*
Q. Can I take you to the NHS England guidance to it, NHSE0000046, so again the guidance you've provided to Integrated Care Boards. Page 7, please. It touches here upon lack of continuity of care, missed red flags, and addresses what should happen. Can I take you over the page, third of the way down:

"Access to the most important information is vital, particularly given the likely staff changes within services over the longer term. Information gathering

and collection should be multi agency and not just health focused."

Do you think it would assist if the guidance you gave gave examples of the agencies that information could be collected from?
A. It might have improved it but I -- I mean I personally think it's fairly obvious, really, that it would be local authorities, if somebody is in educational establishment from them, from the police, where necessary.
Q. You're providing guidance here. You're trying to ensure that things aren't missed as they might have been in other cases. Is that sort of information not helpful for Trusts so that they can start preparing local policies that do make that specific mention of what the other agencies are that are relevant?
A. I think, if -- you know, to be honest, if any local organisation receives a thing saying, "Collect from multi-agencies", you wouldn't want to leave any agencies out, there may be others that they are aware of, I think -- *(overspeaking)* --
Q. You could, for example, have a list, couldn't you? It doesn't have to be prescriptive.
A. You could have a list but I personally feel that it wouldn't be difficult for local areas to establish what

they were and they may be different in other -- in different areas. So for example, the voluntary sector may have different agencies operating in different parts of the country. So we could have supplied it, yes, but I do honestly believe that it's pretty obvious who the people would be.

Q. One barrier to information sharing is clinicians' understanding of confidentiality and data law. The guidance does come to that. Can I take you to page 12, please. This is under the section "Lack of, or poor involvement of carers or family members", and further down the page on the right-hand column it talks about:

"A lack of understanding about the limits of confidentiality is often a barrier to listening to the views of families and carers."

Then if you go over the page -- sorry, just stay on that page. I do apologise. Towards the bottom it talks about the "need to be clear about the limits of confidentiality and what this means in practice when talking to and listening to relatives, friends and carers".

And then recites the Royal College of Psychiatrists guidance from 2017. It then talks about:

"Local confidentiality guidance should be available to support staff to engage appropriately with family

members, friends and carers."

So encouraging Trusts to have local guidance in relation to confidentiality involvement with family, but nothing pointing to clinicians as regards the issue of confidentiality with other agencies. Would that guidance not be helpful at Trust level as well?

A. I think this is dealing with that specific point of engaging families which is clearly very important. And it's making the point that you do need a clear local policy. And, for example, something that people sometimes miss is that if a patient, for example, says you can't give information about my care to the family, I mean, first of all you'd probably want to be saying it could be very helpful, you'd want to be reviewing that. It doesn't stop the family from contacting you and actually giving their views. So I think it's dealing with one very specific issue.

I think there is lots of guidance on information sharing. There's legal guidance, there is a professional guidance from the General Medical Council. So I think that does exist in a pretty widespread -- or I could supply a list, I couldn't do it off the top of my head now, but there is very widespread guidance on the law around this, GDPR, for example, but why it is necessary to share information and the

circumstances in which that should be done.

Q. This document was about helping trusts to learn from the VC case. You said there was a clear need for local policies in regards to confidentiality with families. There was also a clear need for local policies in relation to confidentiality and data in relation to other agencies; do you agree?

A. There is a need for that. Absolutely, yes.

Q. And that's not in the guidance that you've provided, is it?

A. No, but interagency working was and it's an intrinsic part of that is the information sharing --

Q. Yes, it says share information, but it doesn't deal with that knotty issue about confidentiality and data in the same way that it does with families, does it?

A. It -- well, it talks about multi-agency working, so I think that would --

Q. That's enough, is it? That --

A. Well, I think a natural part to that multi-agency working is what information is it important to share, what are the limits, and what shouldn't you be sharing?

Q. WITN0412015, please. This is a document that was produced by Dr Dissayanaka. We've seen some of his evidence from before from his Trust. The Leeds and York Partnership NHS Foundation Trust.

It is the product of a mechanism that was developed between that Trust and the local police force in terms of trying to provide a simple format for information sharing between agencies. The document, as you've seen, provides details of who's asking for the information, crucially, at the bottom of page 1 it has a tick box for clinicians to provide what legal basis they're asking for the information in relation to, and then over the page, further matters about assessed risk and information sought, why it's being sought, and various details there.

So an agreement between two agencies as to the information that's needed to get information that's necessary without a back and forth or a legal tangle. I'm sure you agree that this sort of template to facilitate information sharing is really useful for commissions?

A. It is, and in my experience most, if not all, trusts have that -- this sort of thing available. I saw one from South London in Maudsley just the other day.

Q. Sorry, just so I can understand: most trusts have this document, do they?

A. Not this document, but they would have --

Q. Similar document --

A. -- good practices that you work together on a whole

range of issues as to the information that you would share, how would you work together under -- *(overspeaking)* -- circumstances, and that you would then say: well, how do we operational is that? We would have a form. The best forms are drawn up between the two agencies, so there is no room for disagreement. It's a joint document, and you understand the reason to share information, but also the limitations. It guides you through it. So it is good practice.

Q. There is certainly a lot of guidance about working together.

A. *(The witness nodded)*.

Q. This particular type of form, is this one that most trusts have, and what is that evidence based upon, please?

A. In -- I know that I've used them in my own Trust. I -- when I had a discussion with somebody from another Trust, they produced their form pretty well instantly. This is the one for Leeds. Have I done a survey of every single Trust to see do they have a form? No, I haven't. But it's not the lack of a form or seeing it as good practice hasn't been -- I mean, I don't think there is any health organisation that hasn't requested at some point information from the police, and they would always need to have a form. You can't pick up

a phone and just say, "Can you share the information?"

So my assumption is that they would all have such a form.

Q. Is it worth checking that assumption and requiring this sort of form -- because we know there's gaps -- is it worth assessing and auditing where the gaps are and making sure that all trusts have something like this mechanism, this working relationship between the Trust and the police in place. That would be a good step, forward, wouldn't it?

A. We could -- we could do that, yes.

Q. There's Department of Health guidance from August 2021 entitled "Information Sharing and Suicide Prevention Consensus Statement." So that is drawing together -- sorry, can you take that document down off the screen. So that document, Information Sharing and Suicide Prevention Consensus Statement draws together learning as regards information sharing in the context of suicide prevention.

Is there a similar document produced by the Department of Health or NHS England in relation to the risk of violence to others?

A. I think that document was a very particular attempt to overcome some of the barriers when you have a patient who might be giving you an indication that they are

experiencing thoughts of harming themselves, but saying, "I don't want anybody to know about it."

So I think it was, it's giving a clear nudge to the system to say that you should never just accept that. That if you feel that somebody is at risk, then you must share that information with families, because they can then be part of actually making the patient safe. I mean in a sense the same sort of issue doesn't exist in relation to risk to others. It's not a-- *(overspeaking)* --

Q. There's no barriers there to getting information in relation to those who pose a risk to others?

A. There -- well, there is guidance and there's the legal side, that if you feel that an individual is at risk to other people, then there are very clear set of circumstances where you can share that. That's in GMC Guidance, it's in professional guidance. And clearly, if there are a significant risk of serious harm, to prevent a serious deterioration in the individual's condition, whether as safeguarding issues in relation to children, those circumstances, they -- I can't say in every case that they are applied in an appropriate way, but they are very clearly drawn up.

Q. The GMC Guidance could apply to patients that have a risk of suicide or a risk of violence. But

nonetheless the Department of Health has considered there needs to be a consensus statement for patients with a risk of suicide, and you've explained that's because there are barriers to understanding the level of their risk and they might not want to give the full information to clinicians.

A. Mm-hm.

Q. That is exactly the same sort of concerns that one would have with patients that don't have insight into their care. So is this sort of consensus statement not a good idea to assist nationally, in terms of information sharing between Trusts and other agencies?

A. I could certainly take that away, discuss with professional groups, and look at that.

Q. There's been a focus, hasn't there, more so upon suicide and self-harm in the last few years, rather than -- before June of 2023, certainly, rather than risk of violence to others?

A. I think there is a focus on both areas. So certainly that's my experience. I -- suicide clearly is a very real and apparent issue, and I mean, it's a matter of fact that the numbers are very much greater. So you're dealing with a very much larger number of people. I've never seen one or other as being more important. I think you need to look at both. With every patient

you must always look at the potential risk to themselves and to others.

Q. The risk assessment guidance certainly favoured the self-harm angle, didn't it? It didn't even refer to the risk of violence against others. You've got a consensus statement about suicide, there's a theme here, isn't there?

A. Well, I think there --

Q. There's been a lack of attention to risk of violence to others?

A. I think most of that has been within the discussions around the Mental Health Act, and clearly, unlike the rest of medicine, other than in very rare circumstances, public health, we have a specific Act of Parliament that deals with just that, and one of the three main criteria are risk to other people.

So it's very much something which is in the minds of psychiatrists, because we have to apply a law under the right circumstances. So in my experience when I meet psychiatrists, when I meet mental health professionals, it is always -- the risk to other people is always part of that, and there are many people detained in hospital because of the risk they pose to others. It's a very clear indication it's an issue of *(unclear)*.

Q. Theemis pointed towards mechanisms to communicate risk

in realtime. Would the best way to deal with that not to have some kind of multi-agency working framework where meetings can take place, where the responsibilities are very clear, where there's probably a lead agency, potentially the local Community Mental Health Team or the local authority, but in the high-risk patients, can share information and can make sure the risk assessment remains up to date. Is there a role for that?

A. I think we do have the MAPPA arrangements, the --

Q. That involves those that have been in a forensic setting, doesn't it?

A. Not necessarily. It may be more in a forensic setting because the -- you're likely to people who are more likely to be a risk to other people, but MAPPA applies to all services, but obviously only where there is a significant risk that's been identified, and it's particularly where you need multi-agency working in order to address that risk, and again an inherent part of those MAPPA meetings, they're normally led by criminal justice system, either probation or the police, is a sort of tiered system where you rate somebody's risk and you also look to see is this a risk that can be managed within one agency? Is it a risk that can -- health can completely own or the local authority, or do

you need multi-agency working?

Q. So your view is no further multi-agency working in that kind of formal sense, beyond what MAPPA offers?

A. I think there is always room to look at this, and this in the recent policy around Right Care, Right Person, this is clearly is a subject to consideration and debate and there's an overarching group that's looking at the arrangements between police and health and, in relation to the Mental Health Act there will be a further consultation, piece of work, on those working arrangements in relation to the legal side of that, under section 136.

Q. We've heard a lot of evidence about out-of-area placements. Something no doubt that you would agree is a concerning trend and something to be avoided if possible?

A. It is. I mean, it is necessary for some individuals to get highly specialist care to be transferred to a unit that is not in their local area. But for ordinary conventional acute psychiatric care, whether they're a child or whether they're an adult, in my view it is totally unacceptable, wouldn't happen within a physical health setting that somebody sometimes has to be -- find themselves admitted, you know, from a unit in one part of the country to another. And it is policy now that we

want to eliminate out-of-area placements, the ones that really shouldn't happen, that -- by next year.

Q. A number of NHS plans have sought to eliminate out-of-area placements, haven't they?

A. They have, and I was part of a report that the former Chief Executive of NHS England, Lord Crisp, did for the Royal College of Psychiatrists, and they asked for a target to be set to eliminate out of areas. I've always been in favour of that. The NHS did in the end set a target, it was later than Lord Crisp had recommended and that target was missed and it is part of my daily consideration with trusts and with systems.

And what we've shown, for example, in Manchester is that where there is good leadership in this, where there is really assertive management around this, you can find ways of establishing the necessary services locally and NHS England, in order to meet that challenge, has made both capital and revenue available. I think about 50-70 million in each case. So this is a serious problem.

I, in my new position, I'm determined that this will be sorted. And it is a risk issue as well. We know that people who are sent far from home, they're away from their friends and family, which is clearly is difficult, away from their sources of support, they're

away from their local team, it's more difficult to get that continuity of care, and they're at greater risk of harming themselves. And the National Confidential Inquiry has shown this.

Q. The Lord Crisp report is from 2016, isn't it, and that aimed to phase out out-of-area placements by October 2017.

A. That's correct and that's what I said yesterday --

Q. Further plans after that again were made and those weren't met?

A. Yes, I believe it was a failure of the system.

Q. And out-of-area placements, we can go through the various documents, but in terms of the Rule 9 response from NHS England you provided a lot of data about this. If anything, the position is going upwards, isn't it?

A. It did go up, and I believe it's now going down.

Q. Okay. Well, certainly the data we have, do you agree, that you've provided up to March of 2024 which is where it stops, there was a slight, but an upward trend? It certainly wasn't going down.

A. No, that's right. Absolutely. As I said, I think it was a failure.

Q. Now if Theemis are recommending the end of out-of-area placements or pointing towards that, and the letter that we've looked at from NHS England now says it will

eliminate out-of-area placements in line with ICB three-year plans. Why is this occasion, why is this target going to be met when so many others have not even?

A. Well, I think it would be wrong for me to say, to guarantee that it would be met, given that we have -- and I would not want to be complacent, but I know that our National Priority Programme Director feels very strongly. He's very focused on this. We've done some very good project work with some systems. We have central support to help systems that has been successful, we've demonstrated that.

We've had revenue and capital that's been available. It is within the ten-year plan, it's within the planning guidance, it highlights it as a priority, it's an absolute must do. So I am more optimistic than I was, and I will make it my job to ensure that that is met.

Q. We've looked at the recommendations that came from the CQC and Theemis. We've just considered the NHS England response to them. I want to now go back, and I want to look at the period before the attacks, please. To properly put this in context, I want to go back in fact before NHS England was formed, or before it became operational in 2013. And I want to go back to the

landmark Inquiry into the care and treatment of Christopher Clunis. The report was prepared by Jean Ritchie QC and her team. Can I take you, please, to DHSC0000160, please.

This report was completed on 24 February 1994. It investigate the tragic killing of Jonathan Zito at the hands of Christopher Clunis on 17 December 1992. You're no doubt very familiar with -- *(overspeaking)* -- in this report.

A. I'm very familiar with this report, yes.

Q. Can I take you to page 117, please. This is the section on "Deficiencies in the care given ..."

At the bottom of the page, it talks about important failures:

"... to communicate, pass information ... liaise between all those who were or should have been concerned with Christopher Clunis' care in the widest sense of that word; Consultant Psychiatrists and members of the Consultant Team; Nursing Staff; [GPs] ... Community Psychiatric Nurses; Social Workers; the Police; the Crown Prosecution Service; the Probation Service; hostel staff; people who provided care from the private sector; and [over the page] Christopher Clunis' family. Without proper communication and liaison, there cannot be effective care either in hospital or in the community."

So in line with what we've seen in the CQC and Theemis reports here, information sharing was a critical issue which was identified back in the Ritchie Report.

Number 2 it talks about:

"to contact and involve patient's family, and General Practitioner in the provision of care."

Number 3:

"to obtain an accurate history, or to verify it.

"4. To consider and assess ... [the] past history of violence and assess his propensity for violence in the future."

Again, something we've seen in the Theemis CQC reports.

"to plan, provide or monitor for S[ection] 117 [mental health care] ..."

That's also a feature this Inquiry has noted.

"to manage or oversee provision of health and social services for the patient/client

"to provide assertive care when the patient is living in the community and to note and act upon warning signs and systems ..."

So the issue of assertive care was raised in this report in 1994.

Can I take you to page 113 *(sic),* please. At the bottom of the page, one of the -- [page] 124, apologies.

At the bottom of the page, please. There is a reference there and an endorsement of, in this report, supervised discharge orders. They were the precursor of Community Treatment Orders, effectively, weren't they?

A. That's absolutely right. They were -- that was the name which we now ascribe to Community Treatment Orders. That's right.

Q. On the next page, the recommendation is at 46.0.8 at the bottom of the page, please:

"A patient who is detained for treatment under the Mental Health Act ... may be made the subject of a Supervised Discharge Order."

Then if you go over the page, 47, bottom half of the page, there's quite a lot of detail about the Special Supervision Group. This is the group that the report identified need Assertive Outreach teams.

I want to look -- can we take that down, please -- I want to look at what happened in the wake of the Clunis Inquiry. One of the first things that was done was the setting up of the National Confidential Inquiry into Suicide and Homicide, as it was then called. That happened in 1996, so just two years afterwards.

Can I take you, please, to WITN0069001, page 2. This is the witness statement of Professor Sir Louis Appleby, the Director of the National Confidential

Inquiry into Suicide and Safety in Mental Health, as it's now called.

At the bottom of the page, paragraph 7 tells us that it was set up in 1996:

"... in response to public concern over the safety of mental health services, specifically over risks to the public from community mental health care. Its objectives were to enhance [the] monitoring and safety of mental health services, identify patterns and risk factors associated with suicide and homicide, provide recommendations to improve clinical practice, service delivery, and patient and public safety."

That was the Terms of Reference, or the role of the National Confidential Inquiry, and it performed that, didn't it?

A. It did, yes.

Q. A few years on, after 1996, Assertive Outreach. That was one of the key recommendations of the Ritchie Report, wasn't it? That was progressed to a national level in 1999.

A. That's correct, under the National Service Framework.

Q. Following lobbying, amongst others, by Jayne Zito, the widow of Jonathan Zito.

Can I take you to WITN0412001, please. This is Dr Dissayanaka, who is an expert in Assertive Outreach,

and has provided his detailed evidence on this particular point.

Can I take you to page 7. Paragraph 16, talks about the independent Inquiry:

" highlighted a systemic failure in healthcare for those with severe mental illness ... were poorly engaged with services, inadequate clinical assessment, and lack of robust risk assessment and poor coordination of care between hospitals, the community and primary care".

At the bottom of the page at 17, it says:

"With ... regard to Assertive Outreach, in its section on 'The Special Supervision Group' ... the Ritchie report stated that it had taken evidence about the setting up of Specialist Teams with cap of 12 patients per worker in the team."

Then, please, page 9. There's reference there to the 1999 National Service Framework for mental health, it was a 10-year strategy by the government which set out mandatory evidence-based standards for adult mental health services in England.

Further down:

"A milestone was established in the NSF [and] by 2002 Assertive Outreach would be in place for all ... users on a CPA who were at risk of losing contact with services. ..."

So complete coverage was achieved by 2002 with Assertive Outreach; is that right?

A. That's correct, yes.

Q. 263 teams. A very impressive piece of work to set that up, to get to those that exactly this Inquiry is concerned about. Unfortunately, that was scaled back, wasn't it, from 2010?

A. That's correct. These teams, there was never a national directive or approach that said decommission these teams. But it wasn't -- they weren't prioritised, so they didn't, for example, appear in the National Planning Guidance, so it was up to local services to decide whether they wanted these teams.

I think it has to be said also that there was some concern, and this is another concern that's been raised in relation to this area, which is fragmentation of teams. And we did have a proliferation of teams, we've already talked about early intervention and Assertive Outreach teams. There were other teams. And there was, I think, in some areas a concern that there was fragmentation that for a patient that they might have to access these different types of care during their care journey, and that they -- there was no continuity.

So in some areas, and to some degree, the Community Mental Health Framework was about bringing more people

together, less barriers. So there was a tension, and it was a real tension between lots of specialist teams, fidelity to the model, and less specialisation, more generalisation, but less barriers, and I think that tension is still there.

And I think we -- my -- I think one of the issues that we've had is because funding is very tight, we've tended to focus on one area, and then we've neglected another area, because there isn't enough money to fund all of it. And that's why -- and I said it at my interview when I started at NHS England, I think there is a need for a comprehensive view. We can look at Assertive Outreach, we can get that absolutely right, but it's no good doing that and then another part of the pathway is then stripped of its staff. And with a finite amount of money, unless you can find huge efficiencies, that is what's going to happen.

So I argued for a review of -- a comprehensive review of all mental health services for those with severe mental illness. We started to look at that and then we had the development of the 10-year plan and it was included within that within the Modern Service Framework. So I lobbied for that. We do now have a new Modern Service Framework; the last one, the National Service Framework, did result in some very positive

developments. And we still have Early Intervention teams, we still have some Assertive Outreach teams, but we need to look at the whole pathway, including neighbourhood, and make sure that we have a consistent, very clear, a pathway for patients, one that they understand and one that commissioners know that they understand that they have to commission.

And I think we sometimes have been too piecemeal around how we've gone about that. So we do have the Modern Service Framework. It's a piece of work that's going on at the moment and I'm one of three co-Chairs.

Q. You mentioned right at the beginning of that answer a tension between community teams and Assertive Outreach.

Just to go back to the theme we discussed earlier, that's why it's important, where practical, to have specific Assertive Outreach teams, isn't it?

A. It is. I -- my own experience is that it is very difficult, if you have a team that's doing everything, to prioritise Assertive Outreach because, for example, if you have somebody who is in crisis and is asking for help or you're getting calls about, you will naturally prioritise those individuals. If you have somebody who is prone to just disappear, albeit they may get into crisis themselves, then it is very difficult, unless you

have a very particular approach -- I don't think it's impossible, but it just tends to be eroded as an approach, unless you've got a team where that is their very clear remit. And I think that is the gold standard.

Q. Can I take you to WITN0310001. Page 97, please. Paragraph 318. This is Mr Bywater's corporate statement, which is the part you've attested to. Sorry, 319, it says that:

"... NHS funding challenges in 2010 and questions about the efficacy of [Assertive Outreach teams] ... through research led to national disinvestment in these services".

That's correct, isn't it, there was a nationwide disinvestment in these services?

A. There was a -- it was never a national, you know, you must disinvest, but it is what happened -- *(overspeaking)* --

Q. There wasn't positive encouragement from NHS England either, was there?

A. Absolutely. No, there was not, and in my view we need to make sure that we have a very clear view about what should be being provided at any one time, and that's what I'm hoping that the Modern Service Framework will deliver.

Q. So one of the key recommendations of the Ritchie Inquiry intended to protect the public from mental health homicides, that was deprioritised at a national level by NHS England and also by Trusts; do you agree with that?

A. Yes, it wasn't -- it wasn't purposefully deprioritised, but it was -- that is what happened: that when people had to weigh up all the various parts of the system that they had to fund, I think the concern about the efficacy was mostly around some evidence that they didn't reduce the number of beds.

In my view, they -- there were other benefits. It shouldn't just be about reducing beds. Primarily, in everything that we do, it should be about prioritising excellent care for patients. That's really what we should always be talking about. And very often that has a secondary effect: if you provide good care early on, you can provide less beds. But that shouldn't, in my view, be an objective in itself.

Q. I presume, in this period from 2010 to 2023, NHS England knew this deprioritisation was happening?

A. I'm sure there must have been an awareness, yes.

Q. Was there any impact assessment as to what the loss of Assertive Outreach Team would mean in terms of public safety?

A. I couldn't -- I don't have any knowledge on that. We

could get back to you. It would be wrong for me to say there was or there wasn't. But --

Q. You know that the Ritchie report and what has happened from there is a crucial issue of the evidence you were giving today.

A. Yes.

Q. That's something that's been flagged up. If there was any impact assessment, any study from NHS England that suggested this was a good idea, you would know about that, wouldn't you?

A. I'm -- well, I -- this is going back now 16 years, when I wasn't in any position. So I don't think I would know about that. What I can say, and I really want to be very clear about this, I don't think they should have been -- they should have continued to be commissioned. I think it's unacceptable to not have these teams within your service, because it is a natural part of the care pathway of a patient that we know about. So it wouldn't happen in cancer; it shouldn't happen in mental health care.

Q. Around the same time, NHS England reduced the scope of the National Confidential Inquiry, didn't it, in 2018?

A. It did, yes.

Q. From that point onwards, the National Confidential Inquiry did keep numbers of homicides --

A. Yes.

Q. But no analysis of that particular issue from 2018 onwards?

A. That's correct, yes.

Q. The focus instead -- and this was funded by NHS England -- was upon self-harm and suicide?

A. That's correct, yes.

Q. So by taking away the National Confidential Inquiry's analysis, that's another protective pillar that was set up in the wake of the Ritchie -- the Clunis Inquiry that was taken away in terms of public protection?

A. That's correct, yes.

Q. Can I take you to WITN0069001.

A. I think it is important to say --

Q. Let me just take you to the document first, if that's okay, and I'll ask a question. Can I take you to page 3, please. This is Professor Appleby's evidence, we'll be hearing from him next week. At paragraph 10 he says:

"In June 2018, the Independent Advisory Group ... established by our commissioners the Healthcare Quality Improvement Partnership ... made the decision to discontinue comprehensive homicide data collection. IAG membership includes funders from all four UK countries and individuals with subject expertise. This decision

was based on their assessment of priorities in the context of a reduction in funding, a competing priority being the extension of our studies of suicide by mental health patients to groups of concern within the general population. Informal discussions also referenced: the growing maturity of NHS serious incident investigations in cases of patient homicide; concerns that regular publication of our homicide findings may inadvertently perpetuate stigma towards people with mental illness; and that the core learning from our homicide findings had now been sufficiently achieved."

Perpetuating stigma. The way to reduce stigma is to increase transparency, isn't it?

A. It is.

Q. Not to reduce it, as was done here.

A. That's right. I mean I have always felt that if you have a very clear evidence-based finding and it is very clear that, for example, people with a diagnosis of schizophrenia are more likely to be involved in violence to others, they're actually much more likely to experience it themselves, but then the rest of the population, that it is -- that risk is there. We need to be open and transparent.

It is also important to say that these are still a very, very small group of individuals. They are in

a very important group, and we need to ensure that we have services for them, but I think the issue around stigma was that we shouldn't conflate that with all people with a mental illness are dangerous, or even all people with schizophrenia, because the overwhelming majority are not.

But I personally think it is clearly not right that we don't make it absolutely real and apparent if there is an increased risk, we make sure that there is awareness of it, and most importantly, we do something about it.

Q. One of the other reasons Professor Appleby has stated that he understood why the funding was stopped was in that last sentence:

"... the core learning from our homicide findings had ... now been sufficiently achieved."

That was a dangerous over-confidence, wasn't it?

A. I don't think that by that -- I don't think he meant that -- you can obviously ask Professor Appleby when he gives evidence. I don't think that he was implying that -- I think he said the learning was there, but I guess the question is: was enough being done about it?

And again, it's something that I felt, when I started this post, and that is why I set up the Mental Health Patient Safety Improvement Group, because I think

the NHS itself should be collating learnings from Inquiries, particularly those homicide Inquiries, that we should be collating the learning, prioritising what needs to be done, making sure that we have policy initiatives to actually address those issues. We need to --

Q. Sorry to interrupt. Can I bring you back to the period when this decision was made in 2018, rather than looking at the situation now.

A. Yes.

Q. One of the other matters that was focused upon by those cutting the funding was "the growing maturity of NHS serious incident investigations in cases of patient homicide."

And indeed, those can be learnt from, can't they? And NHS England commission a number of independent reports every year about homicides and serious incidents and other such matters.

A. They do.

Q. We and to look at the work that was done in relation to that, please. WITN0310001, page 126. This is Mr Bywater's statement. Paragraph 415. "Annual Independent Investigation Reports":

"The IIGC published some Independent Investigation Annual Reports, although it was not required to do so."

It goes on to say:

"... [They] provided an overview of the work undertaken by the ... NHS Regional Independent Investigation Teams ..."

And the sentence further on says:

"They include information on investigations commissioned and completed, key learning themes, governance arrangements, and financial data."

All helpful information, in terms of understanding serious incidents.

If you could just go, please, to page 130:

"These annual reports, previously commissioned by the IIGC, are no longer commissioned as the reports were considered to be of limited value for the resources required to create them".

The last report was in 2021, wasn't it?

A. Yes, that's correct, yes.

Q. So another measure. You've got the National Confidential Inquiry, you're taking away the analysis, NHS England is of independent investigations.

In terms of what was being done and not done, we've looked at the risk assessment point. There was DHSC guidance from 2010, followed in 2015 by the NICE guidance which we've looked at on violence and aggression, the Royal College guidance in 2016. There

was no update from the Department of Health or NHS England in relation to risk assessment, was there, following that further information, that further best practice from NICE and the Royal College of Psychiatrists?

A. No, there was no update, and I think the time that the Royal College were looking to update it fell in the middle of the pandemic, and I think there is --

Q. That's the Royal College, but no update from NHS England or the Department of Health following that further progress?

A. No, that's correct, but the evidence, in fact, you know, looking at it, the guidance, I think is -- if people follow the guidance, it's actually still very good. But, as already indicated, that we're looking into the evidence and we are issuing new guidance through the Personalised Care Framework.

Q. Can I take you to NHSE0000015, please, page 15. This is the Community Mental Health Framework from September 2019. At the bottom, it talks about coordinating and care planning care under the framework.

At the bottom of the page, it says:

"This framework subsumes the important aspects of the CPA for community mental health services, including care planning and care coordination, and reframes them

in a system that will work for everyone, will focus on improved outcomes and will deliver place-based integrated mental health care to people whatever their level of need. This framework envisages a shift away from risk assessments and ineffective predictive approaches to safety planning and 'positive risk taking', with staff supported by managers and to do so under progressive, partnership clinical governance arrangements."

There is no differentiation there for risk assessments for those who self-harm or violence, and what we are having here again is the confusion in relation to what should be done in terms of risk assessments that we looked at from your guidance in 2024. That was already central in the information being provided by NHS England back in 2019, wasn't it?

A. Well, I think there was a consistency in these risk assessments using a sort of predictive approach, as I've mentioned before, the sort of RAG rating, which we know doesn't -- it doesn't have predictive value. And moving towards a framework where we did a personal care plan, a risk formulation, and a risk management plan for every individual, not assessing the risk, saying well, the risk is low, we don't need to do anything. That is -- that's either for homicide or for self-harm, and that

there is a need to look at those plans for everyone.

So I don't -- I don't think -- the fact that the risk assessment is used and move away from it, it doesn't say that safety is less important. In fact it's saying it's more important, because we need to make sure that there are plans for everybody, because, for example, in the case of suicide, that if we don't have plans for those who are perceived to be low risk, we miss most of the people who actually turn out to be at risk of suicide.

Q. Depot medication and CTOs. We've seen the advice from NHS England in July 2024, we've been through that. We've discussed the reasons why that's helpful and why guidance was required. CTOs came into force in 2007. You can take that document down, thank you.

They came into force in 2007. NHS England into operation from 2013. Before 2024, NHS England didn't provide any guidance on the CTOs, did it?

A. It's within the Code of Practice for the Mental Health Act, yes.

Q. NHS England didn't provide any guidance on CTOs?

A. Yeah, because it's -- that's by -- they are part of the Mental Health Act and the guidance is within the Code of Practice.

Q. Likewise, depot medication. No guidance on that before

2024 at all from NHS England?

A. Well, the guidance, the -- and the evidence base is within NICE guidance.

Q. So because it's in NICE guidance, NHS England doesn't have to do anything about it? Notwithstanding what it did in 2024?

A. Well, I think there was very real concern that NICE guidance wasn't being followed, and therefore that it was essential that we highlight that.

Q. So Dr James, by the time we reach June of 2023, Assertive Outreach had been deprioritised at a national level, funding to understand serious incidents as well as mental health homicides via the National Confidential Inquiry and via the collection of independent reports, that's all been cut back. Risk assessment guidance on violence to others was confused. There's no guidance at all from NHS England on CTOs and depot medication.

Then we have a whole range of measures brought in post the Nottingham attacks. But those measures, they're newly introduced, but they're not new ideas, are they? They're just the rebirth of old ideas going back to the nineties from the Ritchie Inquiry, largely, aren't they?

A. Many of them are, and I think they still remained things that were evidence based.

Q. But by 2020, if not earlier, those protective measures had either been dismantled or weakened; do you agree?

A. Yes, those particular ones, but we --

Q. But they're the main features, aren't they, in terms of protecting the public from those that pose a risk of violence, those themes that we've been through?

A. You've just drawn my attention to the Community Mental Health Framework. As part of that, there was an extra investment in mental health services. There was a billion pounds invested per year in framework. The numbers of staff increased very substantially. There were all sorts of other things that are very important to provide good care, were included in the Community Mental Health Framework.

Q. The general guidance, but in terms of mental health related violence and homicide, that simply wasn't a prominent feature of NHS England thinking and guidance before June 2023, was it?

A. It -- what you're saying is factually correct, clearly.

Q. The focus instead was on self-harm and suicide and not risk to others.

A. There was a focus on suicide and self-harm.

Q. And as regards patients, the focus was on meeting their autonomy and needs, as is appropriate, but potentially at the expense of public protection.

A. I don't believe that that is the case. I think it is -- I think it is very important to say that first of all, that patients who engage with their care, that that is the safest care. The most unsafe care is when patients disengage. So it is right that we try to create an environment where we do pass as much autonomy back to a patient as possible. They feel involved in their care. If that happens, they're much more likely to engage in care. So I think these aren't trivial matters; they are also important to safety of the patient and the safety of the public, and I think they shouldn't be dismissed.

So I think even the framework of the new Mental Health Act, I think -- I have worked through the whole of my professional time in working in restrictive practices. I have pretty well every patient I've ever looked after, I've used the Mental Health Act as the framework of care. But I also am aware that you do need to work with patients, and you need to encourage them to take back responsibility where that's safe to do so. And I think that is a good thing.

But you also, very clearly, need to act in an assertive way, and using the Mental Health Act and all the powers that that gives you, where the assessment is that they are a risk. And I think it's also

important to say that there are about a half a million people who have a diagnosis of schizophrenia in this country and the overwhelming majority of them, even at a time when we have moved from a primarily inpatient-based service, 150,000 beds, when I started in psychiatry, down to 20 beds and the overwhelming majority of those half a million people have been provided with safe care where these things have not happened.

So the system, in spite of the -- I think the inherent challenges of an illness like schizophrenia, and of providing care under very challenging circumstances, the -- due to the hard work of individuals up and down the country and the approaches we do have, the overwhelming majority of them have been safe.

I am absolutely not minimising the absolutely tragic impact of when these things do go wrong. In fact I devoted my professional life to that particular group, so it's something I take very seriously, but I think we do need to -- the overwhelming majority of care is safe and appropriate. It could be better. Again, I wouldn't be doing my job if I didn't come to do my job because I thought everything was good; I thought we could do very much better.

THE CHAIR: Yes, thank you.

MR WESTON: Chair. I see the time. One more issue in relation to Mental Health Act and hopefully I can deal with it in about five minutes.

THE CHAIR: I think we'll just leave it there.

MR WESTON: Of course.

THE CHAIR: It can be dealt with with somebody else. Thank you.

Yes, Mr Moloney.

Questioned by MR MOLONEY

MR MOLONEY: Dr James. May I ask you about a topic you've just recently been asked about: the National Confidential Inquiry, and how funding for the comprehensive data collection on homicide by the National Confidential Inquiry ceased in 2018.

Can we look at the corporate witness statement of NHS England, which is WITN0310001, and to page 80, once we get there, if we could, please. This is written by Dale Bywater but it's the corporate statement of NHS England. Page 80, and to paragraph 269.

Just to give a little bit more detail in relation to that ceasing of funding, funding ceased in 2018. 11% of people convicted of homicide were mental health patients at the time that funding ceased, according to that statement. And so just over one in ten homicides. So

a significant subset of homicides, you'd accept?

A. That's correct, yes.

Q. And were you aware that the 2017 figures establish that just under half of those patients convicted of homicide, 49%, were either non-concordant with medication or had had recent non-engagement with services?

A. That's correct, and that's why the Assertive Outreach approach is so important.

Q. Can we -- sorry, yes, thank you -- can we go to paragraph 272, please, which just over the page. And this is 272, (a) and (b), where at (a), something you've just accepted, that:

"in recent years, the focus of risk from harm has predominantly been the risk of self-harm ..."

But more importantly (b):

"as part of the Culture of Care inpatient improvement programme ... the [National Confidential Inquiry] ... are delivering support to every provider of NHS commissioned inpatient services to move away from the use of predictive risk tools to a personalised approach to risk management (in relation to risk to self)."

Do you see that?

Now, as you've told the Inquiry today, NHS England has been instrumental in ensuring the refunding of the

National Confidential Inquiry into comprehensive data collection on homicide.

A. *(The witness nodded)*.

Q. We've just looked at that more personalised approach to risk management in relation to risk to self. Will the National Confidential inquiry, so far as you know or expect, undertake work in relation to improving the quality of risk assessment for risk to others?

A. I think where there is learning, that we -- it is -- that will happen. I think what we have struggled to develop is a system to ensure that when, for example, the National Confidential Inquiry actually comes across some evidence, or a homicide Inquiry or another Inquiry, then we put it into a system where we can identify what the learning is, prioritise that learning, and make sure that we do something about it.

And that's why it's so important that we have the Mental Health Patient Safety Improvement Group, because it will be designed to do just that in order to collate all the learning, prioritise it, look at the themes, identify what needs to be done, but also, we're looking at a system where you can actually monitor whether there has been a response, what the response is, and also identify areas that have been successful in actually following up on the learning so that other areas can go

to them if they have a similar challenge.

So I think we have lacked that system, and that's the one that I am creating at the moment.

Q. Yes. And so far as you know or expect, will the National Confidential Inquiry be undertaking work to assist in that?

A. They will. In fact they are -- they sit on the group that I chair. The Department of Health and Social Care also sit on that group. So we want to make sure that we get all the learnings, all the themes, but most importantly, we can actually do something about it.

Q. Now we heard very early in your evidence today about the development of guidance on discharge, since June 2023. The bereaved families in this case were very influential in bringing in to the spotlight the inadequacy of previous discharge policy and practice by highlighting what happened in this case, weren't they?

A. They were, and also influence some of the changes in the Mental Health Act.

MR MOLONEY: Thank you very much, Dr James.

THE CHAIR: No? Thank you.

Questioned by MS HEAVEN

MS HEAVEN: Good afternoon. Just some questions on behalf of VC's family, please.

Can I ask you about a document that you reference in

your witness statement, it's Old Problems, New Solutions, that's commissioned by the Royal College of Psychiatrists on improving acute psychiatric care for adults and I think you were involved in that; that's correct, isn't it?

A. I didn't sit on the group, but when they reported, I was involved in, you know, what happened --

Q. You're familiar with the report?

A. I'm very familiar with the report, yes.

Q. WITN0263130. That's the front page there, just to confirm the date, this is February 2016, isn't it?

A. That's correct, yes.

Q. I want to ask you about -- and it's internal page 73 -- the matters that were looked at and concluded on in relation to carer experience. So I'm just going to pick up on the bottom left-hand side here:

"The commission heard that carers want better information and support and good communication with services."

Then if we go up to the top:

"In particular, they want to feel they can cope if and when a crisis develops and to learn appropriate coping strategies as well as what action they can take."

Before I ask you about that, I'm just going to ask you about one further point, which is in the next

paragraph down, please.

"The Commission believes that mental health providers should introduce Carer Support Workers who can support carers along the recovery journey and enable them to learn the pathways and strategies that are successful in supporting someone in distress".

So essentially, based on this research, including what carers were asking for, is help and strategies for dealing with people when they were in distress, knowing what action they could take, that was one of the reasons why carer support workers were being promoted at this time; is that fair?

A. That's correct, yes.

Q. But I think by this stage in 2016, and actually let's look at it, it's the next page, please, 74, top of page 74.

"The Carers Trust ..."

No, that's a different point, that's triangle of care. As I understand it from this document, though, there were already care and support workers being used across various trusts and there are, I think, some examples, the Chair can look at them later, of good practice?

A. Yes, that's correct, yes.

Q. Then finally, in relation to Triangle of Care, which was

going to be my next point, that is where we were at at the top left. I read this to a witness earlier on in the week:

"Carers Trust has developed [that] ..."

That was in 2010, wasn't it?

A. That's correct. Yes, correct.

Q. That's broadly the principle that should be applied in triangle of care; that's fair, isn't it?

A. That's correct, yes.

Q. One final point then, please, and that's going back to a matter that you were just asked about in relation to the homicide review and this is page 78, please. This is the National Confidential Inquiry findings about carer involvement. Okay.

If we look at box six:

"The report also estimates [so this is the 2015 report] that incidences of homicide in England could have been reduced if there had been greater contact with families in 18% of cases."

I think, if we just go further down:

"The Inquiry's 2015 report recommends that services consult with families from first contact, throughout the care pathway and when preparing plans for hospital discharge and crisis plans."

So very clear recommendations certainly being given

on data in 2015, that carer involvement was actually critical in reducing the risk of homicides. That's fair, isn't it?

A. That is fair, yes.

MS HEAVEN: Thank you very much. Those are my questions.

THE CHAIR: Thank you.

Questioned by THE CHAIR

THE CHAIR: Yes. I just wanted to raise a couple of questions with you, particularly in relation to prediction tools or risk assessment tools. Are you aware of Professor Fazel's work?

A. In Oxford?

THE CHAIR: And the OxMIV tool?

A. I have to say I'm not very familiar with it but I am aware that he has published some work and -- *(overspeaking)* --

THE CHAIR: There's quite a bit of publication, and he gave evidence earlier in the Inquiry that it's really now incontrovertible that there's certainly a link between schizophrenia and increased levels of violence.

A. That's --

THE CHAIR: -- *(overspeaking)* -- would you --

A. That's absolutely incontrovertible.

THE CHAIR: As far as tools are concerned, you've given us evidence and I think the last, that something like half

a million people have schizophrenia, of whom a small percentage go on to commit very -- acts of very serious violence.

Do you not think that tools, when used with other areas of psychiatry, particularly getting to know the patient, making a clinical assessment as well as using tools, can identify or seek a smaller group out of that number who might be more targeted in relation to, for example, Assertive Outreach?

A. I think what the tools do at the moment, including the HCR-20, is that they are very useful in collating all the risk-related information, and across a whole historical areas, clinical and core risk issues, and then pulling that together into a risk formulation, and then action.

Even for the HCR-20, there is not evidence that you can then identify over a period of time, amongst a pool of individuals. So out of a huge pool of half a million, you may have a smaller pool of people who you might think are at risk. Still the overwhelming majority of them will actually be safe.

So within those people, within that group, where you might get a lot of these factors, that's one of the issues, to then overwhelmingly they will be safe, but identifying the people who will be clearly very unsafe,

at the moment, there are not tools that can do that in a reliable way.

I know it's been raised by the Oxford group and I've asked the National Institute for Health Research to look at those tools so that we get a really robust approach, because one person with a few reports is really important. We do need to look at that, but we need to see whether they are widely applicable.

THE CHAIR: Yes, but could reduce a very large number by a percentage, couldn't it --

A. It could.

THE CHAIR: -- *(overspeaking)* -- those who don't have those risk factors?

A. If we had a tool that was effective that could identify, clearly that would be the whole of my professional life, that would have been something I would have been very much wanted, but we need to make sure that it's genuinely predictive, rather than -- I mean, for example, many of the people I looked after, they -- if you looked at the risk factors that were there when somebody carried out an act, many, many people actually had those risk factors. So although it was useful to note them and to manage them for each and every one, it didn't select -- from the wider group, it didn't select the smaller group.

Clearly that's something I wish that we had.

THE CHAIR: And in terms of the statistics, you've said obviously that a very small number of the half a million or so who have schizophrenia would go on to commit violence. But the other side of that is that when you get a figure of over 10% annually of homicides being committed by those with mental health, particularly with largely schizophrenia, but some other mental health diseases, if you like, or -- then that's a big number, isn't it, in terms of homicides? You know it depends what statistic you --

A. It's a very significant --

THE CHAIR: -- *(overspeaking)* -- pick, isn't it?

A. It's a very significant proportion.

THE CHAIR: And those have significant costs outside the Health Service, to those who are affected, to the criminal justice system. The costs are much more widely spread when that happens, aren't they?

A. They are, absolutely, but there are now between four and five million people per year who are in contact with secondary mental health services, and I'm absolutely not minimising the terrible, terrible effects of then what happens and the need to do all we possibly can, but the overwhelming majority of people who are in contact with secondary mental health services don't go -- don't act

in this way at all. So we absolutely need to do all we can to identify who those people are, and I accepted, and I think the team in Nottingham have accepted, that there were clear failures that need to be addressed.

THE CHAIR: Yes. Well, one size doesn't fit all, does it. So you may need different approaches to, as you say, the 4 million people who are within the health services for mental health reasons, to those who have serious and enduring mental health illnesses, such as schizophrenia, with the risks that those engaged in. That I think would you -- and I think you have agreed, requires something like Assertive Outreach, doesn't it?

A. I absolutely agree. They also require very effective Early Intervention Services. We know the earlier we treat individuals, the better their outcomes in the long term. We need the right number of mental health beds and we need good community services that can avert crisis. So I think we need the whole of that, and that's what I feel the Modern Service Framework needs to deliver.

THE CHAIR: In terms of the research, which you say is useful, Professor Fazel told us that because there was so little data gathered in this country, a lot of the data they'd had to use was from Sweden, from large cohorts where that is gathered.

Is the level of gathering of data now under the revised scheme under the national -- the confidential Inquiry, going to provide that level and granularity, if you like, of detail?

A. I mean, that will give us a lot more data, but what they have in Sweden, and in Scandinavia, it's been a tradition amongst -- all of their healthcare, that their communities have agreed to having very big databases of pretty well the whole of the population from a very early age, and that you can plot what actually happens to a whole population or very large chunks.

So these are people who might start with no evidence of mental illness, they are just a child, like anybody else, and then you can see what are the factors that then some develop schizophrenia or some develop another illness, a physical illness. So it gives you, over a long period of time, a much better database in order to have some sort of predictive value and what happens to certain people that means that they develop certain conditions.

We don't have that database, as a country, and -- but the National Confidential Inquiry will give us much more data.

THE CHAIR: Any reason why it was stopped?

A. Well, I believe --

THE CHAIR: -- *(overspeaking)* --

A. I think it was the -- it was funding, really --

THE CHAIR: Funding? And a lack of comparability at the time between that and suicide, in terms of interest.

A. Yes, I mean, it -- when there were -- things had to be deprioritised. It was felt that suicide was the one that needed to be prioritised, and obviously I have now reversed that.

THE CHAIR: Just finally in relation to this case, you've been involved in the -- obviously you're aware of what changes are to be made in the 2025 Mental Health Act. Do you consider that the changes for the -- the criteria for Section 2 and Section 3 are going to assist in cases of this kind?

A. I think it's -- the review of the Mental Health Act was set up because there was concern that we were using the Mental Health Act too much. That was a -- the commission --

THE CHAIR: Well, I've asked you a specific question because it's obviously what this -- *(overspeaking)* --

A. Well, I don't -- I don't believe that it will put more people at risk in the community and I think there are aspects within it that will actually make people safer. So, for example, the advanced choice document, the

statutory care --

THE CHAIR: I was asking specifically about the criteria under Section 2 and Section 3.

A. I think it will focus people's minds to make sure we have the right people in hospital. We don't have people who shouldn't be in hospital in hospital. That will then free up beds, so we have a system that is more dynamic, and you can more easily admit the people that you really need to be in hospital.

So I think, on balance, there is an understandable concern. We don't know what's going to happen. I think what's really important, within the Code of Practice, that we make sure that the granularity of this, what are we talking about when we're saying that the level of risk that you must pose, and make sure that we have the sorts of scenarios where we know that people should be in hospital, that there is an awareness and, very importantly, the training that will come after the Code of Practice that that is effective and highlights these very important areas.

THE CHAIR: Thank you.

Right, well, we'll finish there and we'll start again on Tuesday, I think. Tuesday.

(4.51 pm)

(The hearing adjourned until 10 am, Tuesday, 26 May 2026)