

Thursday, 21 May 2026

1  
2 (1.45 pm)  
3 **THE CHAIR:** Yes, Mr Weston.  
4 **MR WESTON:** Chair, I call Dr Adrian James, please.  
5 **DR ADRIAN JAMES (affirmed)**  
6 **Questioned by MR WESTON**  
7 **MR WESTON:** Dr James, you are the National Medical Director  
8 for Mental Health and Neurodiversity at NHS England.  
9 **A.** I am, yes.  
10 **Q.** In that role, you've prepared three witness statements  
11 for this Inquiry, the first dated 19 January 2026; the  
12 second, 12 March 2026; and the third, 18 May 2026; is  
13 that correct?  
14 **A.** It is correct.  
15 **Q.** Dr James, are those statements true to the best of your  
16 knowledge and belief?  
17 **A.** They are.  
18 **Q.** Can I take you to your first witness statement please,  
19 WITN0365001, page 2. Paragraph 2. You state there:  
20 "I make this statement to adopt and attest to the  
21 following parts of NHS England's Corporate Witness  
22 Statement dated 8 December 2025 ..."  
23 That is a statement from Mr Dale Bywater; is that  
24 right?  
25 **A.** That's correct.

1

1 **Q.** In 2001, you became the Medical Director there?  
2 **A.** I did, yes.  
3 **Q.** Can you assist with your clinical roles thereafter?  
4 **A.** So I've been a Forensic Psychiatrist since I started at  
5 Langdon Hospital, initially as a trainee and then  
6 a consultant, in 1994. I worked in low security, medium  
7 security. I led the unit, I was the equivalent of the  
8 Clinical Director of the unit and then became the  
9 Medical Director.  
10 I actually finished my clinical career two years ago  
11 when I took up this position. So I was responsible for  
12 the care and treatment of those with serious mental  
13 illness, who had come into contact with the criminal  
14 justice system and were mostly a risk to other people.  
15 **Q.** Did you continue working at the Langdon Hospital?  
16 **A.** I did, and I still have a role there in a supervisory  
17 and a mentoring capacity.  
18 **Q.** In 2015, you became a registrar at the Royal College of  
19 Psychiatrists; is that correct?  
20 **A.** I did. That was an elected position for five years.  
21 **Q.** Then, from 2020 to 2023, you were the President of the  
22 Royal College of Psychiatrists?  
23 **A.** I was.  
24 **Q.** In June 2024, you took up your current role with NHS  
25 England; is that right?

3

1 **Q.** It refers to the various parts that you are attesting  
2 to, section 1, section 2 in relation to mental health  
3 policy, section 3, patient safety; section 4, mental  
4 health datasets; and the remainder is set out there?  
5 The Inquiry is going hear evidence from a colleague  
6 of yours at NHS England, Dr Jessica Sokolov. She's the  
7 Medical Director for NHS England's Midlands region; is  
8 that correct?  
9 **A.** That's correct.  
10 **Q.** She's going to assist the Inquiry with the interactions  
11 between NHS England and the Nottinghamshire Healthcare  
12 NHS Foundation Trust and particularly the commissioning  
13 of the Theemis reports and matters like that; that's  
14 right, isn't it?  
15 **A.** That's correct, yes.  
16 **Q.** You're here to assist us with the national picture,  
17 Dr James.  
18 **A.** I am, yes.  
19 **Q.** Before we do that, can we please touch upon your  
20 professional background. You became a Consultant  
21 Psychiatrist in 1994?  
22 **A.** I did.  
23 **Q.** You worked at a post at Langdon Hospital, Dawlish,  
24 Devon?  
25 **A.** That's correct, yes.

2

1 **A.** I did, yes.  
2 **Q.** You've previously acted as a reviewer and clinical  
3 expert for the Care Quality Commission?  
4 **A.** I have, and I think it's right to let the Inquiry know  
5 that as from 13 July, I'm going to be seconded to the  
6 Care Quality Commission as the Interim Chief Inspector  
7 of Mental Health. I will, however, keep two of my  
8 responsibilities at NHS England, one is for the Modern  
9 Service Framework, for severe mental illness, and the  
10 other is the Chair of the Mental Health Patient Safety  
11 Improvement Group. That will be a six-months secondment  
12 and then I'll return to NHS England.  
13 **Q.** Mr Bywater's corporate statement goes into some of the  
14 tail as to the role of NHS England and where it sits in  
15 the NHS ecosystem, if I can phrase it that way. I'll  
16 take you to that statement in a moment, but I think the  
17 starting point is that NHS England is not the NHS in  
18 England, it's a part of the NHS; is that correct?  
19 **A.** That's correct, yes.  
20 **Q.** It's an executive non-departmental body, public body?  
21 **A.** That's right, yes.  
22 **Q.** Let's just have a look briefly at the statutory  
23 position. Can we go to RLIT000040, page 1, national  
24 Health Service Act 2026. 13R:  
25 "[NHS England] must establish and operate systems

4

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

3 Do you see that?

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

5 **Q.** Subsection (4):

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

10 **A.** That's correct.

11 **Q.** Subsection (5):

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

14 And subsection (6):

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

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

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

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

5

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

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

14 Go over the page, please. Paragraph 222:

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

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

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

24 **A.** It is correct, yes.

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

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

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

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

11 ...

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

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

15 At (f): "managing NHS England medicines procurement  
16 ...

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

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

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

6

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

4 **A.** They did.

5 **Q.** Can I take you to them, please. First of all the CQC  
6 Report, CQCM0016518, page 1. So this is the report from  
7 2024. Can I take you, please, to page 42. Section 3:

8 "We recommend that NHS England:

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

11 That's you; is that correct?

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

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

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

17 **Q.** Okay thank you for that clarification:

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

8

1 We'll come on to this and focus on it in some  
2 detail, this is pointing towards Assertive Outreach in  
3 those policies, isn't it?  
4 **A.** That's correct, yes.  
5 **Q.** "(c): Ensures every provider and commissioner in England  
6 undertakes a review of the model of care in place for  
7 patients with complex psychosis who typical services  
8 struggle to engage and who present with high risk."  
9 That's, again, an Assertive Outreach function there.  
10 We'll come back to that.  
11 **A.** (*The witness nodded*).  
12 **Q.** At "(d): [it requires] ... evidence-based guidance  
13 setting out the national standards for high-quality,  
14 safe care ..." to be produced.  
15 Over the page at (e), a further requirement:  
16 "Within 3 months [for] ... the publication of  
17 national standards for high-quality, safe care for  
18 people with complex psychosis and paranoid schizophrenia  
19 ..."  
20 I'm going to come on to the guidance that was issued  
21 in light of this recommendation in a moment.  
22 If I can take you to (g):  
23 "Together with the Royal College of Psychiatrists:  
24 "reviews and strengthens the guidance to clinicians  
25 relating to medicines management in a community setting.

9

1 have multiple needs that require significant support to  
2 enable them to live well."  
3 Just over the page. One of the recommendations is  
4 the consideration of:  
5 "What safe and effective delivery of care should  
6 look like for those with severe and enduring mental  
7 illness. This should include the consistency of  
8 oversight of care across inpatient and community  
9 services including the use and application of the  
10 relevant parts of the Mental Health Act."  
11 The next bullet point turns to the:  
12 "The debate should ensure the resources for the  
13 community model of care are sufficient to meet the needs  
14 for severe and enduring mental illness and is supported  
15 by an appropriate number of inpatient beds [...]"  
16 I'm going to come back to that a little later with  
17 regards to beds, out-of-area beds, in that particular  
18 issue:  
19 "This must be supported by sufficiently trained and  
20 developed workforce ..."  
21 Two bullet points down:  
22 "The community mental health framework may have led  
23 to an unintended consequence of easing of oversight of  
24 some people with significant needs through the removal  
25 of the Care Programme Approach aspect of care."

11

1 "reviews how legislation is used in the community to  
2 deliver medication [...]"  
3 We'll come on to the guidance in a moment, but this  
4 is matters that have been taken up in relation to depot  
5 medication --  
6 **A.** (*The witness nodded*).  
7 **Q.** -- and Community Treatment Orders; is that correct?  
8 **A.** That's correct, yes.  
9 **Q.** There was a Theemis Report as well. Can I take you to  
10 that, please, NHSE0000298, page 1. Could I take you to  
11 page 24. The recommendations: "Area for improvement 1 -  
12 Care delivery." Then further down it says.  
13 "Recommendations:  
14 "NHS England and other national leaders, including  
15 people with lived experience, should come together to  
16 discuss and debate how the needs of people similar to VC  
17 are being met and how they are enabled to be supported  
18 and thrive safely in the community."  
19 It then goes on to say:  
20 "National leaders should, in the next six months ...  
21 as part of the debate, consider the following ... areas:  
22 "The demands on mental health services have  
23 increased over recent years."  
24 It goes on to say:  
25 "People who use mental health services frequently

10

1 Do you think that's correct, Dr James?  
2 **A.** I think -- that an impression was given of that -- of  
3 that -- what's identified here, yes. I think that's  
4 fair comment.  
5 **Q.** Do you think that was the case: that there was an easing  
6 of oversight of some people with significant needs  
7 through the removal of the Care Programme Approach?  
8 **A.** I think there was an approach that said the Care  
9 Programme Approach was not working, it was overly  
10 bureaucratic, it wasn't patient centred, and I think it  
11 is fair to say there was a gap between if you are not  
12 going to do the Care Programme Approach, what were you  
13 going to put in its place in a robust way.  
14 **Q.** You refer there to the care package and providing care,  
15 but just those words, "the easing of oversight", it may  
16 be that it seems to be pointing towards supervision  
17 oversight, something like that. Do you think there was  
18 a gap in that particular respect prior to the Theemis  
19 Report?  
20 **A.** I don't think that any service would have stopped  
21 reviewing the care of their patients or of establishing  
22 a care plan of reviewing the care plan, of assessing  
23 patients. That's certainly how the care should have  
24 been delivered. That overall framework was never  
25 withdrawn, but there wasn't a very specific approach

12

1 that came from the centre.

2 **Q.** Next bullet point:

3 "That care for those with severe and enduring mental

4 illness is commissioned and delivered in line with

5 evidence-based practice ..."

6 When it's referring to evidence-based practice,

7 that's literature and academic studies that support the

8 efficacy of particular ways of doing things; is that

9 right?

10 **A.** That is correct, yes.

11 **Q.** Can I take you over the page, please, page 26: "Area of

12 improvement 2". So we've just touched upon care

13 delivery, we're now looking at "Risk":

14 "We found that risk, both to the individual and

15 potentially to others, was not fully understood,

16 managed, documented or communicated in VC's case."

17 Then further down we have the recommendations:

18 "NHS England should, in the next six months

19 consider:

20 "How mental health and social care understand the

21 concept of risk, risk assessment and risk management

22 systems to ensure the effective identification and

23 evaluation of risk across all care and public settings,

24 together with the appropriate implementation of adequate

25 safety measures."

13

1 "We, [the National Confidential Inquiry] propose

2 a new focus on national learning following homicide, and

3 on improving patient and public safety through

4 comprehensive data collection on homicide by people

5 under the recent care of mental health services. [We]

6 will re-instate the national homicide inquiry that ended

7 in 2018, and will add to the previous methodology, in

8 response to current concerns."

9 Do you agree that the collection of data by the

10 National Confidential Inquiry helps to improve patient

11 and public safety?

12 **A.** I do, yes, and that's why I was really ultimately

13 responsible for recommissioning the work.

14 **Q.** Can you assist with how much the cost, the annual cost,

15 of recommissioning this work is?

16 **A.** We can get back with the details, the figure of about

17 2 million, I think, actually does -- it's quite a major

18 piece of work, but we can get back to you with the exact

19 figure.

20 **Q.** I want to turn -- we've looked at some of the NHS

21 England responses as we went through that, but I want to

22 look at some of the documents because it's important to

23 set out the framework of how this is done and the way

24 information has been passed down to Integrated Care

25 Boards.

15

1 So that's really looking at risk assessment, risk

2 management.

3 Then the next bullet point:

4 "What mechanisms are in place to communicate risk

5 multiple agencies ..."

6 That's the communication of risk between various

7 agencies. It then turns to:

8 "How current mental health services take a dynamic

9 approach to risk management, adapting to manage

10 individuals' fluctuating risk and need."

11 Then finally it says:

12 "Given that The National Confidential Inquiry into

13 Suicide and Safety in Mental Health ... is no longer

14 funded to carry out data collection, analysis, and

15 research on patient homicide, there is a requirement at

16 a national level for data that accurately assists with

17 the identification and the likelihood of the risks of

18 particular outcomes."

19 Now, in response to that, NHS England restarted the

20 funding for the National Confidential Inquiry to look at

21 the issue of homicide; is that correct?

22 **A.** It did, yes.

23 **Q.** Can I just take you to the terms of that.

24 NHSE0000467, page 1. Under the heading "National

25 patient homicide data collection":

14

1 Can I take you please to NHSE0000046. This is

2 guidance provided by NHS England to Integrated Care

3 Boards on intensive and assertive community mental

4 health care.

5 We see the date at the top, 26 July 2024, so that's

6 post-the CQC, but when it was first published it was

7 before the Theemis Report; is that right?

8 **A.** That's correct, and this was just after I started at NHS

9 England. So I wasn't very much involved in the

10 generation of this at the time, there was later guidance

11 that I was more involved with.

12 **Q.** It was updated on 13 February 2025.

13 **A.** Yes, that was -- (*overspeaking*) --

14 **Q.** You'd have been involved in that update?

15 **A.** I was, yes.

16 **Q.** That was post-the Theemis Report?

17 **A.** That's correct, yes.

18 **Q.** What we have here is essentially a document that's

19 responding to both of those sets of recommendations that

20 we've just looked at?

21 **A.** That's correct, yes.

22 **Q.** Introduction, slightly further down the page, please.

23 "Many people who experience psychosis are able to

24 receive evidence-based care and treatment which enables

25 them to recover from their psychotic episode and/or be

16

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

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

9 **A.** Yes, that's correct, yes.

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

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

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

19 **A.** It is, yes.

20 **Q.** Page 4, please.

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

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

17

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

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

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

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

17 "Poorly planned, precipitous discharges from  
18 hospital."

19 There is reference there to:

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

23 And then to the NHS England website.

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

19

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

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

6 **A.** Yes, we are, very much so.

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

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

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

18 **A.** It is, yes.

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

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

18

1 please?

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

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

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

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

20

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

3 Q. I'm grateful for that clarification.

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

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

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

17 "the presence of severe mental illness including  
18 psychotic presentations, in which an individual shows  
19 a poor awareness of their illness (including the need  
20 for treatment and their risks associated with relapse).  
21 "evidence of previous positive response to  
22 treatment.  
23 "previous poor compliance with the treatment plan  
24 ...  
25 "previous hospital detentions due to the risks they

21

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

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

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

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

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

23

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

3 "disorganised behaviour/avoidance of contact  
4 resulting in being lost to follow up.  
5 "unsuccessful prior attempts to engage the  
6 individual with a less restrictive approach."  
7 Just assist me with what the purpose of this is  
8 here. The CTOs are in place in June of 2023. This is  
9 NHS England effectively reminding Integrated Care Boards  
10 and therefore Trusts, that they need to look at the use  
11 of this more so; is that fair?

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

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

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

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

22

1 switch of antipsychotic medication)."

2 When was that observational study from, please?

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

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

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

12 Q. It then goes on to say:

13 "Therefore, in this specific patient cohort, the  
14 administration of regular depot injection may be the  
15 only way to ensure individuals are getting the  
16 medication they need, it also provides more frequent  
17 opportunities for clinical monitoring."  
18 So again, a reminder of a medical part of the  
19 medical picture, that psychiatrists would know about in  
20 any event, but a reminder there that this is something  
21 they can use in this particular cohort of patients.

22 A. It is, yes.

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

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

24

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

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

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

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

25

1 teams, is very often successful.

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

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

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

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

27

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

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

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

26

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

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

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

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

28

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

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

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

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

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

29

1 identified in the independent review with particular  
2 attention to:

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

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

7 "joint discharge planning arrangements between the  
8 person, their family, the inpatient and community team  
9 ..."

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

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

15 "working closely with families".

16 And:

17 "eliminating Out of Area Placements in line with ICB  
18 3-year plans."

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

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

31

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

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

11 A. Yes.

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

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

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

30

1 specifically mentioned the provision of intensive  
2 support.

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

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

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

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

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

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

32

1 Page 9, paragraph 19 at the bottom:

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

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

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

22 Apologies, page 11.

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

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

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

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

11 "Yes," is the answer to that.

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

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

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

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

35

1 reducing hospital admissions?

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

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

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

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

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

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

23 **A.** -- (overspeaking) --

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

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

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

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

9 And he goes on to some other resources there.

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

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

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

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

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

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

8 So I think there is a need for flexibility. There  
 9 hasn't been so much of a research base around if you  
 10 apply the approach that in a more rural area, without  
 11 absolute fidelity to the model, that that can be proven  
 12 to be effective; it doesn't mean it's not effective and,  
 13 say, from a research point of view it's inherently more  
 14 difficult to prove.

15 **Q.** Of course difficulties between urban and rural areas,  
 16 practical issues as you've set out, the assertiveness of  
 17 approach, that phrase that's used in the guidance, just  
 18 assist me: is there an evidence base for that being  
 19 efficacious?

20 **A.** I think there is a clinical, in terms of clinical  
 21 expertise, that it is manifestly true, that in every  
 22 part of the country you will have people with psychosis  
 23 who will not want to engage with your service, and that  
 24 you would need to have people within your team who were  
 25 going to reach out to them. So I think it is seen to be

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1 basis.

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

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

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1 clinically effective. Are there a number of studies  
 2 that have been repeated in the areas to show that it's  
 3 effective? That is much less obvious.

4 **Q.** Where there is an evidence base is in relation to  
 5 Assertive Outreach teams. One option is to ask that --  
 6 to ask the Trusts to set up Assertive Outreach teams  
 7 where that is practicable.

8 **A.** Yes, one would assume that that's what they would do,  
 9 and that was part of our approach that you would --

10 **Q.** That's not what the guidance says, does it? You could  
 11 have asked for Assertive Outreach teams to be set up  
 12 where practicable because that's where the evidence  
 13 basis is.

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

18 Why not go on the evidence rather than on the  
 19 observations of clinicians?

20 **A.** I think the evidence is clearly set out, and the local  
 21 commissioners and the local clinicians certainly would  
 22 be aware of that evidence. So it is for the local  
 23 commissioning groups, so the ICB, to commission the  
 24 services that meet the needs of their population, so  
 25 they would need to -- so we're highlighting a need that

40

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

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

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

14 **A.** They --

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

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

41

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

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

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

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

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

15 **A.** Well, we would expect people to show that that is what  
16 they are doing. I mean, for example, the neighbourhood  
17 mental health approach, which is also mentioned in this  
18 document, I visited a number of them, and they are  
19 testing to see how much outreach they can do to this  
20 patient group. That's a completely new approach, and we  
21 certainly wouldn't want to stifle innovation where it  
22 brings other additional benefits. And, for example, the  
23 24/7 neighbourhood approach is formulated on the basis  
24 that the service is so attractive that people want to  
25 engage with it, so they are less likely to disengage.

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

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

12 **Q.** Can I take you to NHSE0000524, page 1, please. This  
13 is the: "Fit For the Future 10 Year Health Plan", dated  
14 1995. Can I take you to page 5, please. Top right-hand  
15 corner, there is a bullet point. It refers to:

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

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

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

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

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

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

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

25 **Q.** In terms of that neighbourhood mental health centres,

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1 that particular model, please, there are six health  
2 centres already established?

3 A. There are, yes.

4 Q. 16 associate sites in receipt of a formal implementation  
5 support offer; is that right?

6 A. That's correct. That's correct, yes.

7 Q. What is the plan, in terms of -- because that's quite  
8 limited, isn't it, in terms of national coverage.

9 What's the plan in terms of expanding that and in what  
10 time scale, please?

11 A. So the -- we have an evaluation that is ongoing that we  
12 hope will report over the summer, and clearly, when  
13 you're setting up new models of care and this brings  
14 evidence from all over the world, we're testing to see  
15 whether that is a model that we can use in the English  
16 context, and if we do, then what exactly would it look  
17 like?

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

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

45

1 Q. But even if it looks good, there's no revenue stream to  
2 fund it going forwards. There's --

3 A. -- (*overspeaking*) --

4 Q. -- a lot of decisions would have to be made. So this  
5 central part of the NHS England plan has got a big  
6 question mark next to it, doesn't it?

7 A. There would be a question mark where there is funding,  
8 and the question mark is: does the evidence base  
9 actually deliver on reducing the need for other  
10 services? And so can it be self-funding? If it's not,  
11 is it such a good approach, even though it doesn't  
12 replace many other services? Is it something that would  
13 be funded centrally in extra funding? And of course  
14 that brings us to the next spending review, and we  
15 can't, and no government would, commit at this stage to  
16 what they may or may not fund in any part of public  
17 life.

18 Q. The neighbourhood teams, they're situated in one place,  
19 one building, usually, where a number of different needs  
20 can be met for patients?

21 A. That's correct, yes.

22 Q. You've already said that one of the ideas is to make it  
23 a place that encourages people to engage.

24 A. (*The witness nodded*).

25 Q. There will always be some patients who don't want to it

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

4 So if indeed they do do that, they should fund  
5 themselves. But we don't know that yet, we just need to  
6 see whether that's what happens.

7 Q. So effectively this Model of Care is being road-tested?

8 A. It's being properly -- or it's not only road-tested;  
9 it's being evaluated to see what works, what doesn't,  
10 what's the feedback from those who use the services,  
11 what is the impact on the use of other services, on  
12 emergency departments, for example, on use of inpatient  
13 patient beds? So it's a proper evaluation.

14 Q. If it's not evaluated to be successful, then it won't  
15 progress. But also, there is, in the absence of any  
16 resources now, it could just fall away in the next few  
17 years, couldn't it?

18 A. It's a possibility. I mean you wouldn't get any  
19 innovation, unless you were prepared to take some risks  
20 and try some models, and the Model of Care for people  
21 with severe mental illness has been criticised over many  
22 years, so this is an attempt to try and see if we can do  
23 something really innovative and really different. And  
24 it would be wrong to say it looks good, let's roll it  
25 out. We need to actually make sure that it is good.

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1 engage.

2 A. (*The witness nodded*).

3 Q. Who don't recognise they have a mental illness. For  
4 those sorts of patients, this sort of neighbourhood team  
5 is not going to be of assistance, is it?

6 A. I mean it is a question I've asked every single one of  
7 them what -- you know, it's nice to have the open door  
8 approach. What if you don't want to walk through the  
9 door or can't walk through the door?

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

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

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

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

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

7 **A.** There are always funding tensions, yes.

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

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

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

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

3 Can I take you back, please, to the NHS England  
 4 guidance to Integrated Care Boards, please.  
 5 NHSE0000046, page 7. We have there a "Service failure  
 6 identified", and the guidance given to Integrated Care  
 7 Boards as regards:  
 8 "Missed 'red flags' of earlier minor offending/not  
 9 reflected in risk assessments".

10 Do you see that?

11 **A.** Yes, I do.

12 **Q.** Then if we go over to page 9, please. At the bottom of  
 13 the page, it says:  
 14 "A good risk assessment is not predictive but seeks  
 15 to understand the types of situations where the person  
 16 has been risky in the past. Eg environmental factors  
 17 like access to drugs. In line with NICE guidance,  
 18 services should avoid using risk assessment tools as  
 19 a predictor of future risk".

20 And the NICE guidelines 2020, NG225, are cited  
 21 there:  
 22 "Rationale and impact risk assessment tools  
 23 scales 2.  
 24 "Instead, assessment should focus on the person's  
 25 ..."

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1 to funding. One is a central one where the central team  
 2 at NHS England can say, "This is a priority approach and  
 3 we want you to do it." They can, through the planning  
 4 guidance, they can say, "This is a priority approach and  
 5 here's some money to help you do it."  
 6 Or you go through the Integrated Care Boards, the  
 7 ICBs, and they have the overwhelming responsibility for  
 8 assessing the needs in their area and commissioning the  
 9 correct -- the correct care that's needed in, in this  
 10 case an Assertive Outreach Team or approach.  
 11 So we went both ways as the mental health team. We  
 12 put submissions into the spending review. They were not  
 13 successful. But also we asked ICBs to look at their  
 14 needs locally, and I'm aware that some ICBs have been  
 15 able to release funding to develop those teams, and, for  
 16 example, the Thames Valley ICB found 3 million in the  
 17 next year to develop these services.  
 18 So that would be the ideal: the local commissioner  
 19 assesses the need and develops the service. Where  
 20 that's not possible, we need to look at a national  
 21 approach. But there has been a move away from national  
 22 approaches saying, "You must do this." And the emphasis  
 23 is very much on local systems.

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

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1 And this seems to be a quote from the NICE  
 2 Guidelines:  
 3 "... 'focus on the person's needs and how to support  
 4 their long-term psychological and physical safety.  
 5 Mental health professionals should undertake a risk  
 6 formulation as part of every psychosocial assessment'. "  
 7 And again, that's reciting NG225.  
 8 Can I take you to that guidance, please.  
 9 WITN0433011, page 1, please. Dr James, this is guidance  
 10 about self-harm: "... assessment, management and  
 11 preventing recurrence". Do you see that?

12 **A.** I do, yes.

13 **Q.** Then if we go, please, to page 6, "Overview":  
 14 "This guideline covers assessment, management and  
 15 preventing recurrence for children, young people and  
 16 adults who have self-harm harmed. It includes those  
 17 with a mental health problem, neurodevelopmental  
 18 disorder or learning disability and applies to all  
 19 sectors that work with people who have self-harmed.  
 20 "In this guideline, self-harm is defined as  
 21 intentional self-poisoning or injury, irrespective of  
 22 the apparent purpose."  
 23 Page 12, please. At the bottom there, there is  
 24 a reference to psychosocial assessments. It refers at  
 25 1.5.2:

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1 "Do not delay the assessment until after medical  
2 treatment is completed."  
3 That's probably referring to after self-harm,  
4 isn't it?  
5 **A.** It is, yes.  
6 **Q.** It then goes on to say:  
7 "If the person who has self-harmed is intoxicated by  
8 drugs or alcohol, agree with the person and colleagues  
9 what immediate assistance is needed ..."  
10 Then over the page, 1.5.5:  
11 "If the person is not able to participate in  
12 psychosocial assessment, ensure they have regular  
13 references, and complete a psychosocial assessment as  
14 soon as possible."  
15 Then at 1.5.9, it refers to guidance:  
16 "During the psychosocial assessment, explore the  
17 functions of self-harm for that person."  
18 It then gives a list of matters of self-harm to be  
19 taken into account.  
20 So this is the NICE guidance that was referred to in  
21 the guideline that you provided to Integrated Care  
22 Boards, but it applies to self-harm, not risk to others,  
23 doesn't it?  
24 **A.** It does, but it's a general principle that covers all  
25 risk assessment. And unfortunately, we don't have

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1 Boards to look at the risk to others following VC's  
2 attack, refers to this guidance on self-harm. Do you  
3 consider that's the appropriate guidance for Integrated  
4 Care Boards and Trusts to be referred to?  
5 **A.** Well, I think it highlights the -- that you needed  
6 a personalised approach to risk management overall, and  
7 so that you needed a -- I mean, we -- in the guidance  
8 that we sent out, we very much highlighted that you  
9 needed to make sure that you had information from  
10 a variety of sources, a care plan, a risk management  
11 plan. And we have really got to the end of developing  
12 the personalised care framework, which was again an ask  
13 from both the CQC Report and the Theemis Report, and  
14 that was quite a big piece of work. It looked at the  
15 framework, including risk to other people, and it sets  
16 out a framework to assess risk, and it very clearly  
17 states that you need to have a full history, history  
18 from a number of sources, particularly family.  
19 That then needs to be interagency working and  
20 information sharing, where necessary, that you need to  
21 identify the risks that somebody poses, that will be  
22 mostly from historical records, but not exclusively.  
23 The clinical issues that make somebody more or less  
24 risky, what support they have, what help they could have  
25 that would reduce the risk, what are the situations that

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1 tools -- people have tried to develop them -- that can  
2 robustly predict an individual who will take their own  
3 life, and that's also true for predicting somebody who  
4 is going to cause serious harm to others or kill others.  
5 We always -- we wish we had those tools, and  
6 sometimes people have felt, for example, a RAG rating,  
7 red, amber, green, that we should classify people, for  
8 example, their risk of self-harm as being high, medium  
9 or low risk. The evidence base, it comes very much from  
10 the National Confidential Inquiry, suggests that we miss  
11 the majority of those who are at risk of suicide if  
12 we -- because they actually sit within those who are  
13 assessed as low risk, so we must make sure there's  
14 a safety management plan for everybody, and we have just  
15 published a new document, *Staying Safe from Suicide*.  
16 But it's -- the idea that we could predict who might  
17 either take their own life or commit an act of serious  
18 violence to others, within forensic circles and -- has  
19 never been part of what people have done. They've  
20 tended not to rate people as high, medium and low.  
21 So this was a very particular move that needed  
22 a change in the assessment of risk to self. That  
23 particular approach was never particularly part of the  
24 approach in risk to others.  
25 **Q.** So the guidance, which was assisting Integrated Care

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1 increase the risk and what should you do, and what are  
2 the situations that highlight that somebody is beginning  
3 to relapse? And again, what should you do?  
4 So that's in the Personalised Care Framework. It  
5 hasn't been published. It's actually sitting with  
6 ministers at the moment. They need to sign that off.  
7 **Q.** The guideline points trusts and ICBs to this particular  
8 NICE guideline. That guideline doesn't refer at all to  
9 risk to others, does it?  
10 **A.** That's correct, yes.  
11 **Q.** Indeed, there's another NICE guideline that does refer  
12 to risk to others?  
13 **A.** There is, in relation to the management of risk in an  
14 immediate situation, on a-- particularly an inpatient  
15 ward.  
16 **Q.** Let me take you to that document, please. RLIT0000018,  
17 page 1. This is the NICE guidance on Violence and  
18 aggression: short-term management in mental health,  
19 health and community settings? So it applies to  
20 community settings, doesn't it?  
21 **A.** It does, but it's primarily aimed at inpatient setting.  
22 **Q.** Well, the title says it's aimed at community settings;  
23 do you disagree with that?  
24 **A.** No, it does, but my -- having read it, I think it  
25 primarily applies to inpatient settings, and it is

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1 around short-term management rather than long-term  
 2 prediction.  
 3 **Q.** Page 25, please, 1.2.8:  
 4 "When assessing and managing the risk of violence  
 5 and aggression use a multidisciplinary approach that  
 6 reflects the care setting.  
 7 "Before assessing the risk of violence or  
 8 aggression:  
 9 "Take into account previous violent or aggressive  
 10 episodes ..."  
 11 There is nothing to do with taking into account  
 12 previous violent episodes in the other NICE guidance, is  
 13 there?  
 14 **A.** Not about aggressive episodes, but certainly around  
 15 episodes of self-harm, that's correct.  
 16 **Q.** Going over the page to 1.2.10:  
 17 "Carry out the risk assessment with the service user  
 18 ... if they agree, their carer. If this finds that the  
 19 service user could become violent or aggressive, set out  
 20 [the] approaches [and] address:  
 21 "Service user-related domains in the framework ...  
 22 "Contexts in which violence and aggression tend to  
 23 occur."  
 24 That's essential, isn't it, in a violence risk  
 25 assessment?

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1 **MR WESTON:** Further down, 1.2.11:  
 2 "Consider using an actuarial prediction instrument  
 3 such as BVC (Broset Violence Checklist) or the DASA-IV  
 4 ... rather than unstructured clinical judgement alone,  
 5 to monitor and reduce incidents of violence and  
 6 aggression and to help develop a risk management plan in  
 7 inpatient psychiatric settings."  
 8 So there's reference there to inpatient psychiatric  
 9 settings.  
 10 **A.** Yes.  
 11 **Q.** That is, in terms of using tools, that is something  
 12 that's actually contradicted by the NICE guidance that  
 13 you disseminated to trusts?  
 14 **A.** I think you're looking at two different things. One is  
 15 how do you manage longer-term risk to other people, and  
 16 this is about how do you manage a specific situation  
 17 where there is violence and aggression. I think they  
 18 are very different things. And in relation to this NICE  
 19 guidance, it doesn't really apply to those situations.  
 20 But I -- I agree it's a gap, and I can tell you what  
 21 I've done.  
 22 I have had discussions, as you will be aware, there  
 23 is Royal College guidance, I think that was published in  
 24 2016. There is the Department of Health and Social Care  
 25 guidance, and that largely comes down in favour of

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1 **A.** It is, yes.  
 2 **Q.** Nothing in the NICE guidance that NHS England provided  
 3 to trusts, nothing to do with that in there, is there?  
 4 **A.** There is within the personalised care framework.  
 5 **Q.** I'm talking about the guidance that was provided in the  
 6 light of the June 2023 attacks. That guidance pointed  
 7 to the other NICE guidance. There is nothing in that  
 8 guidance about violence and aggression and understanding  
 9 the context in which that occurs, is there?  
 10 **A.** But this --  
 11 **Q.** Do you agree with that, first?  
 12 **A.** It -- I think it does need to be explained, because  
 13 the -- the principles that underline assessment of risk  
 14 to self and that assessment over a long period of time,  
 15 those principles apply just as well in terms of  
 16 longer-term risk to others. This document is really  
 17 about short-term management and short-term --  
 18 (*overspeaking*) --  
 19 **THE CHAIR:** I think you're being asked about whether there  
 20 is any reference to the history of violence and  
 21 aggression in the other guidance to which the document,  
 22 the NHSE document, refers? And the answer is no, isn't  
 23 it?  
 24 **A.** That's correct, yes.  
 25 **THE CHAIR:** Thank you.

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1 structured clinical judgement. It lays out what that  
 2 means. And I have had discussions with the Royal  
 3 College about updating that. They are considering it,  
 4 but there is doubt about whether there is a new evidence  
 5 base around long-term prediction and management of risk  
 6 beyond structured clinical judgement.  
 7 But what I have done is we, at NHS England, have  
 8 commissioned a piece of work from the National Institute  
 9 for Health Research to say: are we sure? Can we test  
 10 every database, both in terms of the UK literature but  
 11 the world literature, to see is there? Can we be sure  
 12 there is no additional evidence that shows that we can  
 13 predict risk in the longer term.  
 14 Of course, if there is, this is something that every  
 15 psychiatrist would want to have, but if it doesn't  
 16 exist, it's wrong to pretend that we have it. That can  
 17 give people a false sense of security and actually  
 18 heighten risk.  
 19 **Q.** The approach advocated in NG10, this document, is  
 20 radically different to the one set out in NG225, isn't  
 21 it?  
 22 **A.** It's because it's about -- (*overspeaking*) --  
 23 **Q.** First of all, do you agree with that as a --  
 24 **A.** Well, it is because it applies to a different situation,  
 25 you wouldn't -- (*overspeaking*) --

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

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

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

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

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

24 **A.** It does, yes.

25 **Q.** Long term and short-term risk?

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1 right-hand corner, last paragraph:

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

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

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

15 The last paragraph:

16 "The college advocates a consistent approach across  
17 the UK rather than a variety of locally based  
18 strategies."

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

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

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1 **A.** That's correct, yes.

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

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

11 Can I take you over to page 23, please. Refers to  
12 different types of structured risk assessment tools have  
13 been developed by experts in the field over the last  
14 15 years. It then goes through a number of them and  
15 then discusses pros and cons of them.

16 Further down the page:

17 "Risk assessment tools are used by ..."

18 Halfway down that column:

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

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

25 Then if you go over to the other column, bottom

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

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

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

25 **A.** But I think within --

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

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- 1 Chair, I'm just looking at the time actually.  
2 Before moving on to this topic, would it be a good time  
3 for a break?
- 4 **THE CHAIR:** Yes, I was just thinking it might be useful to  
5 have a break now. We'll start again at 3.35. Thank  
6 you.
- 7 (3.18 pm)
- 8 (A short break)
- 9 (3.35 pm)
- 10 **MR WESTON:** Dr James, before the break, we looked at models  
11 of care, we looked at risk assessment. I want to move  
12 on to information sharing. The Theemis Report  
13 identified the importance of mechanisms to communicate  
14 risk in realtime. That was one of the recommendations  
15 for NHS England, wasn't it?
- 16 A. (No audible answer).
- 17 Q. Can I take you to the NHS England guidance to it,  
18 NHSE0000046, so again the guidance you've provided to  
19 Integrated Care Boards. Page 7, please. It touches  
20 here upon lack of continuity of care, missed red flags,  
21 and addresses what should happen. Can I take you over  
22 the page, third of the way down:  
23 "Access to the most important information is vital,  
24 particularly given the likely staff changes within  
25 services over the longer term. Information gathering

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- 1 A. Well, I think the principles are relevant and many of  
2 the principles you see in the Royal College guidance,  
3 which I know it says as a review date, but it was still  
4 current, the evidence, the guidance that was from DHSE  
5 still current so it didn't exclude people looking at  
6 that.
- 7 But we did need to take a much more detailed look,  
8 and it's -- you know, we really wanted to say: well,  
9 look, people are talking about tools. Is there any  
10 immediate evidence? I discussed it with NICE, we've now  
11 commissioned a piece of work. So it's very important  
12 that that is accurate and up to date. So that's been  
13 our approach.
- 14 Q. That's not the message in the -- I'm going to move on  
15 after this, but that's not the message in the guidance  
16 you've provided. It's not "We're taking a closer look  
17 at this, we might be developing new ways of doing this,"  
18 you essentially are telling Trusts to put risk  
19 assessment tools to one side and to use the self-harm  
20 approach.
- 21 A. I mean, agree, the evidence could have been better.
- 22 Q. Can I move to a different but related issue? The  
23 Theemis Report identified the importance of mechanisms  
24 to communicate risk in real time. Can I take you to  
25 your guidance, please: NHSE0000046.

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- 1 and collection should be multi agency and not just  
2 health focused."
- 3 Do you think it would assist if the guidance you  
4 gave gave examples of the agencies that information  
5 could be collected from?
- 6 A. It might have improved it but I -- I mean I personally  
7 think it's fairly obvious, really, that it would be  
8 local authorities, if somebody is in educational  
9 establishment from them, from the police, where  
10 necessary.
- 11 Q. You're providing guidance here. You're trying to ensure  
12 that things aren't missed as they might have been in  
13 other cases. Is that sort of information not helpful  
14 for Trusts so that they can start preparing local  
15 policies that do make that specific mention of what the  
16 other agencies are that are relevant?
- 17 A. I think, if -- you know, to be honest, if any local  
18 organisation receives a thing saying, "Collect from  
19 multi-agencies", you wouldn't want to leave any agencies  
20 out, there may be others that they are aware of, I think  
21 -- (overspeaking) --
- 22 Q. You could, for example, have a list, couldn't you? It  
23 doesn't have to be prescriptive.
- 24 A. You could have a list but I personally feel that it  
25 wouldn't be difficult for local areas to establish what

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

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

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

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

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

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

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1 circumstances in which that should be done.

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

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

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

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

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

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

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

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

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

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1 members, friends and carers."

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

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

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

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

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

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

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

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

24 **Q.** Similar document --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 **A.** Mm-hm.

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

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

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

19 **A.** I think there is a focus on both areas. So certainly  
 20 that's my experience. I -- suicide clearly is a very  
 21 real and apparent issue, and I mean, it's a matter of  
 22 fact that the numbers are very much greater. So you're  
 23 dealing with a very much larger number of people. I've  
 24 never seen one or other as being more important.

25 I think you need to look at both. With every patient

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

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

8 **A.** Well, I think there --

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

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

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

25 **Q.** Theemis pointed towards mechanisms to communicate risk

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1 you need multi-agency working?

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

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

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

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

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

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

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

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

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

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

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

13 And what we've shown, for example, in Manchester is  
 14 that where there is good leadership in this, where there  
 15 is really assertive management around this, you can find  
 16 ways of establishing the necessary services locally and  
 17 NHS England, in order to meet that challenge, has made  
 18 both capital and revenue available. I think about  
 19 50-70 million in each case. So this is a serious  
 20 problem.

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

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

5 Q. The Lord Crisp report is from 2016, isn't it, and that  
6 aimed to phase out out-of-area placements by October  
7 2017.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 Number 2 it talks about:

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

7 Number 3:

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

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

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

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

16 That's also a feature this Inquiry has noted.

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

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

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

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

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

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

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

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

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

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

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

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1 and has provided his detailed evidence on this  
2 particular point.

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

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

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

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

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

21 Further down:

22 "A milestone was established in the NSF [and] by  
23 2002 Assertive Outreach would be in place for all ...  
24 users on a CPA who were at risk of losing contact with  
25 services. ..."

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

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

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

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

16 **A.** It did, yes.

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

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

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

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

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

3 **A.** That's correct, yes.

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

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

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

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

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

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

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

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

6 **Q.** Can I take you to WITN0310001. Page 97, please.  
7 Paragraph 318. This is Mr Bywater's corporate  
8 statement, which is the part you've attested to. Sorry,  
9 319, it says that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 could get back to you. It would be wrong for me to say  
 2 there was or there wasn't. But --  
 3 **Q.** You know that the Ritchie report and what has happened  
 4 from there is a crucial issue of the evidence you were  
 5 giving today.  
 6 **A.** Yes.  
 7 **Q.** That's something that's been flagged up. If there was  
 8 any impact assessment, any study from NHS England that  
 9 suggested this was a good idea, you would know about  
 10 that, wouldn't you?  
 11 **A.** I'm -- well, I -- this is going back now 16 years, when  
 12 I wasn't in any position. So I don't think I would know  
 13 about that. What I can say, and I really want to be  
 14 very clear about this, I don't think they should have  
 15 been -- they should have continued to be commissioned.  
 16 I think it's unacceptable to not have these teams within  
 17 your service, because it is a natural part of the care  
 18 pathway of a patient that we know about. So it wouldn't  
 19 happen in cancer; it shouldn't happen in mental health  
 20 care.  
 21 **Q.** Around the same time, NHS England reduced the scope of  
 22 the National Confidential Inquiry, didn't it, in 2018?  
 23 **A.** It did, yes.  
 24 **Q.** From that point onwards, the National Confidential  
 25 Inquiry did keep numbers of homicides --

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1 was based on their assessment of priorities in the  
 2 context of a reduction in funding, a competing priority  
 3 being the extension of our studies of suicide by mental  
 4 health patients to groups of concern within the general  
 5 population. Informal discussions also referenced: the  
 6 growing maturity of NHS serious incident investigations  
 7 in cases of patient homicide; concerns that regular  
 8 publication of our homicide findings may inadvertently  
 9 perpetuate stigma towards people with mental illness;  
 10 and that the core learning from our homicide findings  
 11 had now been sufficiently achieved."  
 12 Perpetuating stigma. The way to reduce stigma is to  
 13 increase transparency, isn't it?  
 14 **A.** It is.  
 15 **Q.** Not to reduce it, as was done here.  
 16 **A.** That's right. I mean I have always felt that if you  
 17 have a very clear evidence-based finding and it is very  
 18 clear that, for example, people with a diagnosis of  
 19 schizophrenia are more likely to be involved in violence  
 20 to others, they're actually much more likely to  
 21 experience it themselves, but then the rest of the  
 22 population, that it is -- that risk is there. We need  
 23 to be open and transparent.  
 24 It is also important to say that these are still  
 25 a very, very small group of individuals. They are in

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1 **A.** Yes.  
 2 **Q.** But no analysis of that particular issue from 2018  
 3 onwards?  
 4 **A.** That's correct, yes.  
 5 **Q.** The focus instead -- and this was funded by NHS  
 6 England -- was upon self-harm and suicide?  
 7 **A.** That's correct, yes.  
 8 **Q.** So by taking away the National Confidential Inquiry's  
 9 analysis, that's another protective pillar that was set  
 10 up in the wake of the Ritchie -- the Clunis Inquiry that  
 11 was taken away in terms of public protection?  
 12 **A.** That's correct, yes.  
 13 **Q.** Can I take you to WITN0069001.  
 14 **A.** I think it is important to say --  
 15 **Q.** Let me just take you to the document first, if that's  
 16 okay, and I'll ask a question. Can I take you to  
 17 page 3, please. This is Professor Appleby's evidence,  
 18 we'll be hearing from him next week. At paragraph 10 he  
 19 says:  
 20 "In June 2018, the Independent Advisory Group ...  
 21 established by our commissioners the Healthcare Quality  
 22 Improvement Partnership ... made the decision to  
 23 discontinue comprehensive homicide data collection. IAG  
 24 membership includes funders from all four UK countries  
 25 and individuals with subject expertise. This decision

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1 a very important group, and we need to ensure that we  
 2 have services for them, but I think the issue around  
 3 stigma was that we shouldn't conflate that with all  
 4 people with a mental illness are dangerous, or even all  
 5 people with schizophrenia, because the overwhelming  
 6 majority are not.  
 7 But I personally think it is clearly not right that  
 8 we don't make it absolutely real and apparent if there  
 9 is an increased risk, we make sure that there is  
 10 awareness of it, and most importantly, we do something  
 11 about it.  
 12 **Q.** One of the other reasons Professor Appleby has stated  
 13 that he understood why the funding was stopped was in  
 14 that last sentence:  
 15 "... the core learning from our homicide findings  
 16 had ... now been sufficiently achieved."  
 17 That was a dangerous over-confidence, wasn't it?  
 18 **A.** I don't think that by that -- I don't think he meant  
 19 that -- you can obviously ask Professor Appleby when he  
 20 gives evidence. I don't think that he was implying  
 21 that -- I think he said the learning was there, but  
 22 I guess the question is: was enough being done about it?  
 23 And again, it's something that I felt, when  
 24 I started this post, and that is why I set up the Mental  
 25 Health Patient Safety Improvement Group, because I think

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

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

10 **A.** Yes.

11 **Q.** One of the other matters that was focused upon by those  
 12 cutting the funding was "the growing maturity of NHS  
 13 serious incident investigations in cases of patient  
 14 homicide."  
 15 And indeed, those can be learnt from, can't they?  
 16 And NHS England commission a number of independent  
 17 reports every year about homicides and serious incidents  
 18 and other such matters.

19 **A.** They do.

20 **Q.** We and to look at the work that was done in relation to  
 21 that, please. WITN0310001, page 126. This is  
 22 Mr Bywater's statement. Paragraph 415. "Annual  
 23 Independent Investigation Reports":  
 24 "The IIGC published some Independent Investigation  
 25 Annual Reports, although it was not required to do so."

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

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

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

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

18 **Q.** Can I take you to NHSE0000015, please, page 15. This is  
 19 the Community Mental Health Framework from  
 20 September 2019. At the bottom, it talks about  
 21 coordinating and care planning care under the framework.  
 22 At the bottom of the page, it says:  
 23 "This framework subsumes the important aspects of  
 24 the CPA for community mental health services, including  
 25 care planning and care coordination, and reframes them

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1 It goes on to say:  
 2 "... [They] provided an overview of the work  
 3 undertaken by the ... NHS Regional Independent  
 4 Investigation Teams ..."  
 5 And the sentence further on says:  
 6 "They include information on investigations  
 7 commissioned and completed, key learning themes,  
 8 governance arrangements, and financial data."  
 9 All helpful information, in terms of understanding  
 10 serious incidents.  
 11 If you could just go, please, to page 130:  
 12 "These annual reports, previously commissioned by  
 13 the IIGC, are no longer commissioned as the reports were  
 14 considered to be of limited value for the resources  
 15 required to create them".  
 16 The last report was in 2021, wasn't it?

17 **A.** Yes, that's correct, yes.

18 **Q.** So another measure. You've got the National  
 19 Confidential Inquiry, you're taking away the analysis,  
 20 NHS England is of independent investigations.  
 21 In terms of what was being done and not done, we've  
 22 looked at the risk assessment point. There was DHSC  
 23 guidance from 2010, followed in 2015 by the NICE  
 24 guidance which we've looked at on violence and  
 25 aggression, the Royal College guidance in 2016. There

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1 in a system that will work for everyone, will focus on  
 2 improved outcomes and will deliver place-based  
 3 integrated mental health care to people whatever their  
 4 level of need. This framework envisages a shift away  
 5 from risk assessments and ineffective predictive  
 6 approaches to safety planning and 'positive risk  
 7 taking', with staff supported by managers and to do so  
 8 under progressive, partnership clinical governance  
 9 arrangements."  
 10 There is no differentiation there for risk  
 11 assessments for those who self-harm or violence, and  
 12 what we are having here again is the confusion in  
 13 relation to what should be done in terms of risk  
 14 assessments that we looked at from your guidance in  
 15 2024. That was already central in the information being  
 16 provided by NHS England back in 2019, wasn't it?

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

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

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

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

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

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

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

25 **Q.** Likewise, depot medication. No guidance on that before  
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1 **Q.** But by 2020, if not earlier, those protective measures  
 2 had either been dismantled or weakened; do you agree?

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

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

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

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

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

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

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

23 **Q.** And as regards patients, the focus was on meeting their  
 24 autonomy and needs, as is appropriate, but potentially  
 25 at the expense of public protection.  
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1 2024 at all from NHS England?

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

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

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

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

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

24 **A.** Many of them are, and I think they still remained things  
 25 that were evidence based.  
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1 **A.** I don't believe that that is the case. I think it is --  
 2 I think it is very important to say that first of all,  
 3 that patients who engage with their care, that that is  
 4 the safest care. The most unsafe care is when patients  
 5 disengage. So it is right that we try to create  
 6 an environment where we do pass as much autonomy back to  
 7 a patient as possible. They feel involved in their  
 8 care. If that happens, they're much more likely to  
 9 engage in care. So I think these aren't trivial  
 10 matters; they are also important to safety of the  
 11 patient and the safety of the public, and I think they  
 12 shouldn't be dismissed.

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

22 But you also, very clearly, need to act in  
 23 an assertive way, and using the Mental Health Act and  
 24 all the powers that that gives you, where the assessment  
 25 is that they are a risk. And I think it's also  
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1 important to say that there are about a half a million  
2 people who have a diagnosis of schizophrenia in this  
3 country and the overwhelming majority of them, even at  
4 a time when we have moved from a primarily  
5 inpatient-based service, 150,000 beds, when I started in  
6 psychiatry, down to 20 beds and the overwhelming  
7 majority of those half a million people have been  
8 provided with safe care where these things have not  
9 happened.

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

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

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1 a significant subset of homicides, you'd accept?  
2 **A.** That's correct, yes.  
3 **Q.** And were you aware that the 2017 figures establish that  
4 just under half of those patients convicted of homicide,  
5 49%, were either non-concordant with medication or had  
6 had recent non-engagement with services?  
7 **A.** That's correct, and that's why the Assertive Outreach  
8 approach is so important.  
9 **Q.** Can we -- sorry, yes, thank you -- can we go to  
10 paragraph 272, please, which just over the page. And  
11 this is 272, (a) and (b), where at (a), something you've  
12 just accepted, that:  
13 "in recent years, the focus of risk from harm has  
14 predominantly been the risk of self-harm ..."  
15 But more importantly (b):  
16 "as part of the Culture of Care inpatient  
17 improvement programme ... the [National Confidential  
18 Inquiry] ... are delivering support to every provider of  
19 NHS commissioned inpatient services to move away from  
20 the use of predictive risk tools to a personalised  
21 approach to risk management (in relation to risk to  
22 self)."

23 Do you see that?

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

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1 **THE CHAIR:** Yes, thank you.

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

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

6 **MR WESTON:** Of course.

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

9 Yes, Mr Moloney.

#### 10 **Questioned by MR MOLONEY**

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

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

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

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1 National Confidential Inquiry into comprehensive data  
2 collection on homicide.

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

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

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

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

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1 to them if they have a similar challenge.  
 2 So I think we have lacked that system, and that's  
 3 the one that I am creating at the moment.  
 4 **Q.** Yes. And so far as you know or expect, will the  
 5 National Confidential Inquiry be undertaking work to  
 6 assist in that?  
 7 **A.** They will. In fact they are -- they sit on the group  
 8 that I chair. The Department of Health and Social Care  
 9 also sit on that group. So we want to make sure that we  
 10 get all the learnings, all the themes, but most  
 11 importantly, we can actually do something about it.  
 12 **Q.** Now we heard very early in your evidence today about the  
 13 development of guidance on discharge, since June 2023.  
 14 The bereaved families in this case were very influential  
 15 in bringing in to the spotlight the inadequacy of  
 16 previous discharge policy and practice by highlighting  
 17 what happened in this case, weren't they?  
 18 **A.** They were, and also influence some of the changes in the  
 19 Mental Health Act.  
 20 **MR MOLONEY:** Thank you very much, Dr James.  
 21 **THE CHAIR:** No? Thank you.  
 22 **Questioned by MS HEAVEN**  
 23 **MS HEAVEN:** Good afternoon. Just some questions on behalf  
 24 of VC's family, please.  
 25 Can I ask you about a document that you reference in  
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1 paragraph down, please.  
 2 "The Commission believes that mental health  
 3 providers should introduce Carer Support Workers who can  
 4 support carers along the recovery journey and enable  
 5 them to learn the pathways and strategies that are  
 6 successful in supporting someone in distress".  
 7 So essentially, based on this research, including  
 8 what carers were asking for, is help and strategies for  
 9 dealing with people when they were in distress, knowing  
 10 what action they could take, that was one of the reasons  
 11 why carer support workers were being promoted at this  
 12 time; is that fair?  
 13 **A.** That's correct, yes.  
 14 **Q.** But I think by this stage in 2016, and actually let's  
 15 look at it, it's the next page, please, 74, top of  
 16 page 74.  
 17 "The Carers Trust ..."  
 18 No, that's a different point, that's triangle of  
 19 care. As I understand it from this document, though,  
 20 there were already care and support workers being used  
 21 across various trusts and there are, I think, some  
 22 examples, the Chair can look at them later, of good  
 23 practice?  
 24 **A.** Yes, that's correct, yes.  
 25 **Q.** Then finally, in relation to Triangle of Care, which was  
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1 your witness statement, it's Old Problems, New  
 2 Solutions, that's commissioned by the Royal College of  
 3 Psychiatrists on improving acute psychiatric care for  
 4 adults and I think you were involved in that; that's  
 5 correct, isn't it?  
 6 **A.** I didn't sit on the group, but when they reported, I was  
 7 involved in, you know, what happened --  
 8 **Q.** You're familiar with the report?  
 9 **A.** I'm very familiar with the report, yes.  
 10 **Q.** WITN0263130. That's the front page there, just to  
 11 confirm the date, this is February 2016, isn't it?  
 12 **A.** That's correct, yes.  
 13 **Q.** I want to ask you about -- and it's internal page 73 --  
 14 the matters that were looked at and concluded on in  
 15 relation to carer experience. So I'm just going to pick  
 16 up on the bottom left-hand side here:  
 17 "The commission heard that carers want better  
 18 information and support and good communication with  
 19 services."  
 20 Then if we go up to the top:  
 21 "In particular, they want to feel they can cope if  
 22 and when a crisis develops and to learn appropriate  
 23 coping strategies as well as what action they can take."  
 24 Before I ask you about that, I'm just going to ask  
 25 you about one further point, which is in the next  
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1 going to be my next point, that is where we were at at  
 2 the top left. I read this to a witness earlier on in  
 3 the week:  
 4 "Carers Trust has developed [that] ..."  
 5 That was in 2010, wasn't it?  
 6 **A.** That's correct. Yes, correct.  
 7 **Q.** That's broadly the principle that should be applied in  
 8 triangle of care; that's fair, isn't it?  
 9 **A.** That's correct, yes.  
 10 **Q.** One final point then, please, and that's going back to a  
 11 matter that you were just asked about in relation to the  
 12 homicide review and this is page 78, please. This is  
 13 the National Confidential Inquiry findings about carer  
 14 involvement. Okay.  
 15 If we look at box six:  
 16 "The report also estimates [so this is the 2015  
 17 report] that incidences of homicide in England could  
 18 have been reduced if there had been greater contact with  
 19 families in 18% of cases."  
 20 I think, if we just go further down:  
 21 "The Inquiry's 2015 report recommends that services  
 22 consult with families from first contact, throughout the  
 23 care pathway and when preparing plans for hospital  
 24 discharge and crisis plans."  
 25 So very clear recommendations certainly being given  
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1 on data in 2015, that carer involvement was actually  
2 critical in reducing the risk of homicides. That's  
3 fair, isn't it?  
4 **A.** That is fair, yes.

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

6 **THE CHAIR:** Thank you.

7 **Questioned by THE CHAIR**

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

12 **A.** In Oxford?

13 **THE CHAIR:** And the OxMIV tool?

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

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

21 **A.** That's --

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

23 **A.** That's absolutely incontrovertible.

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

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

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

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

11 **A.** It could.

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

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

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

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

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

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

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

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1 Clearly that's something I wish that we had.

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

12 **A.** It's a very significant --

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

14 **A.** It's a very significant proportion.

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

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

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

5 **THE CHAIR:** Yes. Well, one size doesn't fit all, does it.  
6 So you may need different approaches to, as you say, the  
7 4 million people who are within the health services for  
8 mental health reasons, to those who have serious and  
9 enduring mental health illnesses, such as schizophrenia,  
10 with the risks that those engaged in. That I think  
11 would you -- and I think you have agreed, requires  
12 something like Assertive Outreach, doesn't it?

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

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

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1 **A.** Well, I believe --

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

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

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

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

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

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

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

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

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

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

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

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

25 **THE CHAIR:** Any reason why it was stopped?

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1 statutory care --

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

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

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

21 **THE CHAIR:** Thank you.

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

24 (4.51 pm)

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

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<b>via [3]</b> 18/14 102/13 102/14 <b>view [11]</b> 22/19 25/11 25/12 39/13 79/2 79/21 89/12 91/21 91/22 92/11 92/18 <b>views [4]</b> 25/1 36/12 69/15 70/16 <b>violence [30]</b> 34/6 34/9 54/18 56/17 57/4 57/7 57/22 57/24 58/8 58/20 59/3 59/5 59/17 61/2 74/22 75/25 76/18 77/5 77/9 84/10 84/10 95/19 98/24 100/11 102/16 103/6 103/16 113/20 114/3 116/5 <b>violent [3]</b> 57/9 57/12 57/19 <b>visited [2]</b> 43/18 48/13 <b>vital [1]</b> 67/23 <b>voluntary [2]</b> 18/11 69/2 <b>vulnerable [1]</b> 17/12	<b>W</b>	<b>wake [3]</b> 8/1 85/18 94/10 <b>walk [3]</b> 44/23 48/8 48/9 <b>want [50]</b> 7/25 15/20 15/21 20/22 25/7 25/7 25/18 26/7 26/18 26/22 33/15 33/17 38/3 38/18 38/18 38/21 39/6 39/23 41/11 43/21 43/24 44/8 44/11 44/19 47/25 48/8 48/19 50/3 50/24 60/15 65/20 67/11 68/19 70/13	<b>wake [3]</b> 8/1 85/18 94/10 <b>walk [3]</b> 44/23 48/8 48/9 <b>want [50]</b> 7/25 15/20 15/21 20/22 25/7 25/7 25/18 26/7 26/18 26/22 33/15 33/17 38/3 38/18 38/18 38/21 39/6 39/23 41/11 43/21 43/24 44/8 44/11 44/19 47/25 48/8 48/19 50/3 50/24 60/15 65/20 67/11 68/19 70/13	

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