Friday, 29 May 2026

(10.00 am)

THE CHAIR: Yes, Mr Weston.

MR WESTON: Chair, I call Professor Sir Louis Appleby.

PROFESSOR SIR JAMES LOUIS JOHN APPLEBY (sworn)

Questioned by MR WESTON

MR WESTON: Professor Appleby, you've prepared a witness statement for this Inquiry dated 24 October 2025.

A. Yes.

Q. Is that statement true to the best of your knowledge and belief?

A. Yes.

Q. Professor Appleby, you are the Director of the National Confidential Inquiry into Suicide and Safety in Mental Health?

A. Yes.

Q. The National Confidential Inquiry was established in 1996?

A. Yes.

Q. And you were involved in it from the outset; is that correct?

A. Yes, it had existed for a couple of years before that but it moved to Manchester and I became Director in 1996.

Q. I'm grateful for that clarification. Could you please

briefly summarise your professional qualifications and experience prior to 1996.

A. Before 1996. Well, I'm a psychiatrist. I graduated in medicine in 1980. I have trained in psychiatry, qualified as a psychiatrist, became a Consultant Psychiatrist in 1991, and became Professor of Psychiatry at the University of Manchester around about the same time I became Director of the Inquiry, 1996.

Q. And you remain an Honorary Consultant Psychiatrist at Greater Manchester Mental Health Foundation Trust; is that correct?

A. Yes.

Q. Between 2000 and 2010, you were the National Director for Mental Health in England as part of secondment to the Department of Health?

A. Correct.

Q. From 2010 to 2014 you had another role with the Department of Health as National Director of Offender Health?

A. Yes.

Q. From 2013 to 2019 you were a Non-Executive Director of the Care Quality Commission?

A. Yes.

Q. Can I take you back to 1996 when the National Confidential Inquiry moved to Manchester. At that time

the name was the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness; is that correct?

A. Yes.

Q. When was the name changed to its current name, so National Confidential Inquiry into Suicide and Safety in Mental Health?

A. That change was made when our remit changed, which was in 2018, and homicide was removed from our remit so of course it had to come out of our title as well.

Q. I will come to that in a little detail, if I may, shortly.

In terms of the initial establishment of the National Confidential Inquiry, or when it moved to Manchester in 1996, can you just tell me why that happened and how it was funded initially, please?

A. So the context was public concern over the safety of community care. This was -- there had been a number of incidents causing public and political concern, and the -- there was a tradition in the health service of conducting confidential inquiries, in other words asking confidential questions to clinicians about safety incidents, and so the decision was made, I wasn't part of that at that time, but to initiate a confidential inquiry on suicide and on homicide. So the context was

in fact concerns over community care homicides.

Q. How was it funded, please?

A. It was funded by the Department of Health, initially, initially.

Q. Can I take you to your statement, please, WITN0069001_003. And just on the lower page there, it says:

"Its objectives were to enhance monitoring and safety in mental health services, identify patterns and risk factors associated with suicide and homicide, and provide recommendations to improve clinical practice, service delivery, and patient and public safety."

So those were the objectives --

A. Yes.

Q. -- of the National Confidential Inquiry. Can I take you, please, to the Confidential Inquiry's annual report for 2017, please. WITN0069003_001, please. Can we take you to the first page, I'm grateful.

This is the annual report from 2017. You've told us that comprehensive data collection in regards to homicide stopped in 2018, a year later. So I want to understand the data and learning that the National Confidential Inquiry had reached up to that point, if I may.

Can I take you to page 44 of this document. There's

a section towards the bottom there headed "PATIENT HOMICIDE" and, just to be clear, if you can just zoom out again, this is a part of the report that's talking about patient homicide in England, so it's not all of the UK, just England in this particular part. You do look at all the different regions and put it together in a different part of the report, don't you.

A. Yes.

Q. I'll come onto that a little while later.

Can I focus back on 109, please. It refers there to:

"... 632 confirmed patient cases plus an additional 8 cases for 2015 and 1 for 2014 ..."

Then the total it says, is a figure of 641:

"This represents an average of 58 homicides per year. There were 674 victims, an average of 61 per year."

So you are recording both the number of offenders, patients, if I can put it that way, and the victims in that particular paragraph; is that fair?

A. Yes.

Q. Then just over the page to page 46, please. We see -- and I'm not going to take you through the table now, because I want to understand the methodology first -- but we can see this table at the top. It says the

number is 641, so that's that the same group that has been analysed in some detail here; do you see that?

A. Yes.

Q. I'm going to refer to this as the primary patient group, if I may, because there's some complexity about methodologies that I want to go through, but I want to understand the methodology in particular for this particular group.

Can I take you, please, to page 7 of the report. This is a section referred to as methodology, and this is where you set out what I'm going to call the primary methodology for that particular group of 641 patients.

At point one, you state that you rely upon clinicians, responses from clinicians, and the response rate is very good, 95%, is that correct, in terms collecting your data.

A. Yes, that's very high.

Q. I want to come back to the way in which you collect that from the clinicians in a moment because there's a questionnaire, it's quite detailed, and I want to touch upon that in a moment, if I may.

At point 2, you say:

"Suicide and homicide are defined legally, eg inquest conclusion or determination by a court. This provides consistency of definition but may underestimate

because of the high standard of evidence required."

So there needs to be for homicides, there needs to be a determination by a court. That could be a conviction for murder or manslaughter, but it could also be a finding of insanity or fitness to plead. Some sort of court determination?

A. Yes.

Q. You accept that because of that high standard, there could be an under-representation, but there needs to be a methodology, doesn't there?

A. Yes, in research definition is everything, and the most valid definition is a legal determination.

Q. Just so we can be clear what the limitations are, then, if a patient commits a homicide but then takes their own life and it never gets to court determination, then they wouldn't come within this primary methodology, would they?

A. We would report them separately, so they wouldn't be in this -- in a description of people legally determined because they weren't legally determined, but they would be in our data.

Q. So in terms of the 641 that we're going to come to look at in a moment, they're not within that primary group?

A. Correct.

Q. But you do still collect data in relation to those who

fit within that characteristic of attack followed by suicide before a determination?

A. Yes.

Q. That's analysed separately; is that correct?

A. Yes.

Q. Point 3:

"Patients are defined by recorded contact with specialist mental health services in the 12 months prior to suicide/homicide - this omits some contacts, eg those seen in A&E but not referred to mental health."

So in terms of this primary group of patients that we're looking at, that 641, if they have not been in contact with mental health services, then they don't come within the group.

A. They didn't come within our remit if they weren't patients, yes.

Q. Even if they may have expressed mental health concerns to A&E or to a GP, or something like that, they're not within your particular group because it needs to be in contact with mental health services?

A. They weren't within our definition of patients, no.

Q. Thank you. It also excludes, in this primary group, contact, those who have had contact more than 12 months before the homicide?

A. Yes, although we also recorded those cases separately.

Q. So those separate cases, because they can be quite important, can't they, because they're very hard to reach, hard to engage patients; what do you do with the data in relation to that, that particular group?
A. Well, we reported data on what we thought were the 12-month samples, so contact within 12 months, then we also reported -- particularly in the first years of where we were trying define the different groups, we reported the whole group, so that's contact at any time in the past, without the 12-month criterion, we would report data on that group too.
Q. But in the table we are going to come into, that particular cohort is not included in the 641?
A. That's right.
Q. So once you've identified a cohort of patients, you then seek data in relation to them via a detailed questionnaire that you send to treating clinicians. Is that usually sent to the Consultant Psychiatrist?
A. Yes.
Q. 95% is the response rate. Do psychiatrists ever have any concerns about giving you the patient data when you're asking for it?
A. It's a very sensitive subject and they are very concerned about how we will handle their data, so yes, they have concerns, but despite that the level of

cooperation I have from them, I have to say, is very high for a national study.
Q. The questionnaire you sent, that's been disclosed to the Inquiry. I'm not going to take you to it now, it's very detailed, isn't it?
A. Yes.
Q. It looks at a range of matters including diagnosis, presence of psychosis, medication and treatment, alcohol and drug use, previous violence, discharge, and looks at them in various different time periods and blocks, doesn't it?
A. Yes.
Q. It also asks the clinicians about risk assessment and how the homicide might have been avoided in that particular case.
A. Yes.
Q. Can I take you back to page 46, please, in the table we touched upon before. I think now we've understood the methodology of how this particular information is obtained, we can see that of your 640 -- this is for the period 2005 to 2015; is that correct?
A. Yes.
Q. 85% demographic "Male"; 82% "Unemployed/on long-term sick"; 19% "Black and minority ethnic group"; 7% "Homeless".

In terms of behavioural features: "History of self-harm" in 50% of cases; "History of violence" in 53%; "Any previous convictions" in 77% of cases; "History of alcohol misuse" in 73% of cases; "History of drug misuse" in 78% of cases.

It then gives a figure for "Abnormal mental state at the time of the offence" and it's 36%. That jumps out as perhaps a little low, given the sort of cohort we're looking at and the potential links between mental health and the actual homicides. Can you just elaborate on that at all?
A. Yes, well even the patient group is not a homogeneous group, so although our primary remit was -- and still is, will be again, I should say -- the potential problems of community care, we were -- the patients who we detect through that methodology include people with schizophrenia, who I suppose are the primary group because they're the people who might be subject to community care, but it also includes people with other diagnoses, alcohol, drugs, personality disorder, and those are people whose mental state at the time of the offence may not be different or very different from their usual mental state. And we often knew about that not through the clinicians but through information provided by court reports.

Q. Going down the page the "Final Outcome", 51% in the period you looked at in 2005 to 2015 was an outcome of murder, manslaughter by reason of diminished responsibility in 16% of cases, another form of manslaughter in 31%.

And then "Sentencing Outcome", prison in 73% of the cases you looked at, and hospital order in 24%.

Can I take you to page 47, please. Paragraph 113:

"The relationship of victim to offender was acquaintance [in 46% of cases] ...family member ([in] 19%); spouse/partner ([in] 18%); and [then] stranger ([in] 16%)."
A. Yes.
Q. Then in 115:

"There were 356 homicides by people [...] with a history of schizophrenia ..."

This information about people with schizophrenia, is that the same methodology we've looked at, or is a different methodology being applied here?
A. It's an additional methodology because it's identifies people who are not patients.
Q. Understood. Can you explain how you do that?
A. That's through going to the courts where psychiatric reports are -- it's actually quite a variable phenomenon now but historically have been prepared on people facing

a homicide charge. So those psychiatric reports were an additional source of data. So our primary source was about patients but in addition we collected information on people who had schizophrenia but who were not patients. That's the group that's being referred to here.

Q. Those psychiatric court reports, is that information you've collected throughout the period 2005 to 2015?

A. On schizophrenia, yes.

Q. Further down, at the end often that paragraph it says:

"281 (92%) had symptoms of psychosis (delusions and/or hallucinations) at the time of the offence."

That's within the cohort of those suffering from schizophrenia; is that correct?

A. Where are we? Yes. Yes, it is.

Q. At paragraph 117:

"65 (32%) of patients with schizophrenia were non-adherent with drug treatment in the month before the homicide, an average of 6 per year."

A. Yes.

Q. Apologies, I may not have read it out but the second sentence of paragraph 115:

"[Just] 6% of all those convicted of homicide, an average of 32 per year."

Were those with schizophrenia, so 6% of the whole --

of all homicides?

A. Yes.

Q. Just returning to paragraph 117, final sentence in total:

"In total 116 (59%) were either non-adherent or missed their final contact with services. There was a fall overall in this group over the reported period."

A. Yes.

Q. You go on to say 118:

"192 (88%) of patients with primary diagnosis of schizophrenia had a history of alcohol and/or drug misuse, ie, it was unusual (12%) for patients with schizophrenia to be convicted of homicide unless they also had a history of alcohol and/or drug misuse."

A. Yes.

Q. Half of all patients with schizophrenia misused cannabis, that's 50%, 48% misused alcohol whilst 35% misused stimulants.

A. Yes.

Q. Can I take you to page 116, please. This is a summary of the UK-wide data in relation to patient homicide. The figure at 355 is that:

"During 2005-2015 there were 835 mental health patients convicted of a homicide offence."

A. Yes.

Q. The number of convictions has fallen steadily during this period and at 356:

"11% of people convicted of homicide were mental health patients. ... This figure varied a little across the UK countries ..."

Then, at 357, you repeat that 6% figure for those with schizophrenia.

A. Yes.

Q. Can I take you to a later annual report, please, for 2018, WITN0075013, page 6. So there is a useful summary here at (xxxi), just over halfway down the page:

"Our detailed analysis of patient homicide since 1997 has highlighted:

"the victim is most likely to be an acquaintance and less likely to be unknown to the perpetrator than in homicides by non-patients

"most patients had a history of alcohol or drug misuse; homicide in the absence of co-morbid substance misuse is unusual

"around half of patients were not receiving care as intended, either through loss of contact or non-adherence with drug treatment

"patients are also at high risk of being victims of homicide."

A. Yes.

Q. So that finding about loss of contact or non-adherence with drug treatment being a key learning, is that based upon the primary -- that primary group that we've looked at with the methodology, or the various methodologies that you've touched upon?

A. Well, it's primarily about the patients because it's about whether they received the care that was intended. You can see signs of it in other groups, but our main remit was to look at the care that current and recent patients were receiving, and it's a striking and consistent finding that they are often not receiving the care that was intended.

Q. One of your recommendations which we'll come to is as regards Assertive Outreach --

A. Yes.

Q. -- and that would be a step that goes directly to this particular point of learning, doesn't it?

A. Yes.

Q. You also refer to non-adherence with drug treatment. Again, Assertive Outreach plays a role there, as well, doesn't it --

A. Yes.

Q. -- in terms of remedying that problem? As might Community Treatment Orders, which is another one of your recommendations?

A. Yes.
Q. Can I take you, please, to WITN0069005, page 1. This is an academic paper that you co-authored. This not a National Confidential Inquiry document; is that correct?
A. It's not a report; it's an academic -- we're an academic unit. It's an academic paper.
Q. It's not one of the reports or annual reports --
A. Correct.
Q. -- it's an academic paper.
A. Correct.
Q. Now, in this particular study, you used some of the data from the National Confidential Inquiry, you used data up to 2012, and this is a 2020 paper, but you used data up to 2012; is that correct?
A. Yes.
Q. You also used, and this is where it goes beyond, perhaps, what's in the other reports, you also used a control of 542 patients who had schizophrenia but had not been convicted of homicide; is that correct?
A. Correct.
Q. To ensure comparison between the datasets or proper comparison between the datasets, you limited your analysis to patients who had a history of inpatient treatment?

A. Yes, that was -- related to the source of the control group. They were people who had -- were on a database where being an inpatient was the important qualification.
Q. So to more closely match the control group, you trimmed the data that you had from the National Confidential Inquiry to more closely match what's there?
A. Yes.
Q. Can I take you, please, to page 4. Bottom right-hand corner. We have a "Summary of [the] main findings":

"In this national ... case-control study of previous admitted male patients diagnosed with schizophrenia, those who were convicted of homicide were more likely to be non-adherent with their treatment plan, to have lost contact with services prior to the offence, to have a history of violent criminality, to have a comorbid personality disorder or drug use disorder, to have been admitted multiple times, or to belong to [the] ... BAME group. Homicide perpetrators were less likely to have had recent routine contact with services and to have been recently discharged from hospital. Some observed differences between cases and controls, including the outcome (homicide), were attributable to differences in treatment. These findings suggest that much of the risk of serious violence in schizophrenia is related to

comorbidity, and that maintaining satisfactory levels of care and follow-up may be linked with reduced risk of serious violence. Almost all (94%) of those who committed homicide either had a history of alcohol or drug misuse or had not received treatment and care as planned. Among the 160 homicides committed by this patient group during the 15-year observation period, only 9 occurred in the [presence] ... of these clinical features -- fewer than 1 per year."

A. Correct.
Q. Can I take you, please, to page 7. You touched there on the "Implications for clinical practice and health services", and it says this:

"This study adds to the evidence for the relationship between schizophrenia and serious violence. It has been reported previously that much of the elevated risk among these individuals is explained by comorbid substance misuse rather than their mental illness and our findings appear to support this notion. In this study, features of mental healthcare were also associated with homicide, the findings suggesting that maintaining routine treatment and regular contact and avoiding non-adherence to medication and loss of contact are protective. In this clinical population it was exceptionally rare for patient homicide to occur without

comorbidity or problems in delivering standard clinical care.

"Prevention of serious violence and schizophrenia should therefore focus on addressing comorbities and maintaining treatment and service contact. This requires collaborative working between mental health and substance misuse services and the introduction and evaluation of models of intensive support from community mental health teams."

Intensive support: one example is Assertive Outreach which we'll come on to in a moment.

A. Yes.
Q. Could you take that down, please. Professor Appleby, in 2018, the National Confidential Inquiry stopped it's comprehensive data collection in relation to homicides.
A. Yes.
Q. Can I take you to your witness statement, please, WITN0069001, page 3. At the bottom, paragraph 10, you say that:

"In June 2018, the Independent Advisory Group ... established by our commissioners the Healthcare Quality Improvement Partnership ... made the decision to discontinue comprehensive homicide data collection."

The Healthcare Quality Improvement Partnership, that's primarily funded by NHS England; is that correct?

A. Yes.
Q. And your primary funder up to until 2018 was also NHS England?
A. Yes.
Q. It was the Department of Health --
A. Through -- yeah --
Q. -- when it started, but NHS England took that over; is that correct?
A. Correct, yes.
Q. Just going over -- well, just continuing there before:

"IAG membership [it says] includes funders from all four UK countries and individuals with subject expertise. This decision was based on their assessment of priorities in the context of a reduction of funding [and] ... Competing priority being the extension of our studies of suicide by mental health patients to groups of concern within the general population. Informal discussions also referenced: the growing maturity of NHS serious incident investigations in cases of patient homicide; concerns that regular publication of our homicide findings may inadvertently perpetuate stigma towards people with mental illness; and ... the core learning from our homicide findings had by now been sufficiently achieved."

Quite a lot to unpack, there. So can I just start

with the reduction of funding. What did you understand about that, please?
A. Well, that was an important context. There was going to be less money, and so something would have to be -- come out of our remit.
Q. Less money generally, less money for mental health, less money for mental health research? Did you have any insight as to -- or perhaps all of them -- as to where and how that was communicated to you?
A. Well, no, this was specifically the funding available to us.
Q. You've said there that suicide was going to be prioritised. Why was that, please?
A. Well, it was -- at the time there were a number of groups at risk of suicide where people wanted to know more. It was a time when the rate of suicide in young people had been rising. There had been concerns about middle-aged men who are the group at highest risk of suicide, and so people with an interest were looking to us to collect information on those important groups, and so the question is arising: can you extend the kind of data collection you carry out beyond people who are under mental health services to the wider population.

So there was, you know, in some ways a reasonable argument: can we help understand these other phenomena

in suicide prevention, not just about patients but in other risk groups?
Q. You're 2017 annual report notes that suicide amongst patients was falling. So in terms of the work you we're doing there, this was a downward trend, but this was looking at a different group, effectively?
A. Correct. People who weren't patients.
Q. You mentioned there informal discussions. Who did you have those informal discussions with, please?
A. I think people from HQIP and people who are the commissioners and people from NHS England.
Q. Can you remember who specifically you discussed these matters with?
A. Mm, that's a difficult question, because it means I'll have to remember individuals who -- who were part of that discussion. That's more difficult to remember. And also I have to admit to a slight discomfort about people who are acting on behalf of an organisation who might then be named publicly in an Inquiry.
Q. Was it one discussion? Was it several discussions? Was it one person? Were there several people?
A. There were several discussions about this.
Q. Okay, well you give a lot of information about these informal discussions, so perhaps we'll go through them and you might be able to recall who said what as we go

through it.

You say first of all that there was a reference to "the growing maturity of NHS serious incident investigations in cases of patient homicide". Do you recall who told you they thought there was a growing maturity of NHS serious incident investigations in cases of patient homicide?
A. I think this particular point came up when we were discussing the reasons for removing funding at the meeting itself, the advisory group meeting. I don't think that was -- it's a number of years ago. I'm not sure I can remember exactly but that would have been part of the broader advisory group discussion.
Q. So discussions with the Healthcare Quality Improvement Partnership?
A. Well, the advisory group convened by them, yes.
Q. So was this the view that you understood to be coming from that advisory group?
A. Well, from people within the advisory group, yes.
Q. And the advisory group was made up of who, please?
A. It's -- it was --
Q. If not specifically, where did they come from? Which organisations?
A. Well, it's primarily -- it was primarily run by the funders, so NHS England, but also the governments of the

devolved nations in the UK, and then people who were there because they had an individual expertise to offer. So they weren't there in a representative role.

Q. Can I take you, please, to your statement, WITN0069001. In fact we're already on it. So can we go to page 6, please. Paragraph 18 at the bottom:

"The National Confidential Inquiry previously conducted a thematic analysis of recommendations from NHS serious incident investigations into patient homicides ... published between 2002 and 2009, and presented the findings in a series of reports, with our final report in 2010. We have not assessed these investigations more recently. We have not carried out research into any other form of public inquiry."

Then your conclusions are at paragraph 19, that (a):

"Recommendations lacked specificity, were vague and difficult for mental health trusts to implement or monitor.

"Investigations panels were often small, making it hard to ensure they contained the necessary breadth of expertise.

"The inquiry process took too long, even in uncomplicated cases.

"Reports often lacked an implementation plan with deadlines to ensure delivery.

"Recommendations were often repeated from one report to another, suggesting the inquiry system was not leading to changes in care."

So in 2010, the National Confidential Inquiry certainly had concerns about patient safety investigations into homicides.

A. Yes.

Q. Can I take you, please, to WITN0310001, that's the statement of Mr Bywater and page 110, please.

Mr Bywater is the Regional Director of NHS England. He has provided the corporate statement on behalf of NHS England to this Inquiry. At paragraph 360, he says:

"As set out in the NHS Patient Safety Strategy ... (published in 2019), 'compelling evidence from national reviews, patients, families, carers and staff and an engagement programme in 2018 revealed that organisations struggle to deliver' the expectations in the [Safety Incident Framework]. As a result, the Patient Safety Incident Response Framework ... was developed, tested and launched".

So certainly from NHS England's perspective, the current framework was struggling to deliver adequate incident investigations in 2019?

A. Yes, that's how it looks, yeah.

Q. Can I take you back, then, to your statement, please,

page 4. Just coming back to this:

"Informal discussions also referenced: the growing maturity of NHS serious incident investigations in cases of patient homicide ..."

Your review from 2010, the information from NHS England, does not suggest that there was a growing maturity, does it?

A. Well, that wasn't our experience, but I think it's fair to say that I think there were some changes after that, they were -- which probably did give the -- these individual homicide inquiries a greater focus, but we never evaluated them, so it's not something I can comment on because we didn't do any further work on it. But it was my impression that the sense from us and from other people that they weren't doing their job did lead to some changes. So it wasn't a completely unreasonable point to make.

I didn't think it was a reasonable reason to end the National Confidential Inquiry's data collection, however.

Q. So your view that you thought it wasn't unreasonable was not based upon studies or information, but just impressions that you'd been given?

A. Yes.

Q. By those at the advisory group?

A. Well, no, because the Serious Incident Framework was relatively recent in relation to our review. So we looked at an early period in the history of individual homicide inquiries. In the early 2000s, the Inquiry reports that were published then, and we were very critical of them. I think there were some changes after that and a Serious Incident Framework was part of that, but clearly that's been superseded by a different approach now.

Q. So in terms of your impression that there was a growing maturity, that was based upon just conversations you had with the advisory group?

A. It was based on the intention of the Serious Incident Framework and the way it attempted to address the kind of criticisms that we had made.

Q. Your statement goes on to say, refer, to a reference to:

"... concerns that regular publication of our homicide findings may inadvertently perpetuate stigma towards people with mental illness."

Where did that information come from in 2018?

A. It was a point raised at the advisory group.

Q. Are those concerns you shared?

A. No.

Q. Can you just tell us why?

A. Well, our -- first of all, it's important to have the

facts, and we were about -- our aim was to collect the data and make the information publicly known. So that in itself, I think, is enough reason to publish.

The issue of how that relates to stigma, and this is a very sensitive issue in mental health. People in mental health do feel that the subject of homicide creates an impression with the public that could rebound on people with mental illness. It could lead to an impression that more people with mental illness are at risk of being violent than is true.

So it is certainly a risk that the regular publication, the annual publication, of data, it's reasonable to question whether it could have that risk.

I disagree with it, as I say, I disagree with that because from my point of view it is not talking about this issue that carries the risk of adding to stigma, it's not making the figures available, it's not acknowledging the risk and I suppose, by implication, not taking it seriously enough.

Q. It's through learning and improvement and reducing the number of homicides that that stigma can be reduced?

A. Well, the worst thing that could happen to stigma is when incidents occur that cause public anxiety. So if we can help improve the safety of services in a way that makes these incidents less frequent, then that's the way

to defeat stigma, not by deciding that we'd rather not talk about it.

Q. It then goes on to say in your statement that there was reference to:

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

Where did that come from, please?

A. That was a point made at the advisory group.

Q. So the message coming from the advisory group was that all the core learning had been sufficiently achieved, there was limited purpose in ongoing learning, and that's quite a dangerously complacent attitude; do you agree?

A. Well, I didn't agree with it. In repeated reports and repeated publications we had highlighted the risks in severe mental illness of people not receiving treatment, and people whose illness was complicated by drug or alcohol misuse, which has an important relationship to non-adherence with treatment. So it's part of an overall picture where people who are taking drugs, their mental state's being destabilised by the substances they're taking and the relationship between that and refusing medication is quite a close relationship. So it was all part of an overall picture.

And we had repeatedly highlighted the importance of

that combination where patient homicides had occurred, in people with severe mental illness. So from our point of view there was an absolute justification in repeatedly making this, drawing attention to this problem.

I think the point that was being made was that that message had been heard. We'd said it a number of times, and that maybe we didn't need to keep saying it.

Q. Learning doesn't stop?

A. Well, it depends what you mean by learning. I think there is learning which is that people are aware of something and there is learning when people are doing something about it. So they may have been aware, but I think the evidence from our repeated analysis of the data was that it hadn't improved.

Q. But without the work from the National Confidential Inquiry in relation to homicides, the learning was stopping and the information dissemination was stopping as well from you?

A. From us, yes.

Q. So both the learning and the information side ended?

A. From us, yes.

Q. To suggest that there isn't more to be learned, to suggest there isn't more information to put out to politicians or to the public, that's quite complacent,

isn't it?

A. I think it's misguided. I think it's fair to say that that's not the only subject that we had information on, as well. So there are -- and part of the new Homicide Inquiry, now that it's been re-established, will be to make clear that this is an evolving concern, and so there are other issues that we want to make -- to highlight as well.

But yes, I think the assumption that the NHS had already learnt this, I think, is misguided. My own view is that part of the problem on this issue is that even when services learn, over time, that learning fades away, and so the learning is lost, so you can't just learn once and then that's the end of it. That learning stays with you forever and influences your practice. The learning fades and the unlearning, if you like, of important clinical data is a real danger.

Q. Indeed, the VC case, and all the concerns explored during this Inquiry, make clear that learning was not sufficiently embedded?

A. Yes.

Q. So this misguided decision was not only misguided, it was dangerous as well, wasn't it?

A. Well, it puts people at risk, so yes.

Q. So, in 2018, you had an impression that there may have

been a growing maturity, but it wasn't something you were actively studying. You didn't share the views as regards stigma, and you considered that it was misguided, dangerously misguided, to think that learning and information had come to an actual close or that all lessons had been learned.

Did you, therefore, feel properly consulted when this was stopped in 2018?

A. Well, we were consulted. I suppose consulting obviously does not imply agreement, so we were consulted and we gave our view.

Q. I can take it from what you are saying, can I, that as an expert in your field that stopping funding for the National Confidential Inquiry to look at comprehensive homicide data in 2018 was, you consider, a mistake?

A. Yes.

Q. Did you -- you shared your concerns in the advisory group?

A. Yes.

Q. With the advisory group? Did you share it with anyone else?

A. Hmm, I'm not sure I did. I mean, we shared our concern with members of the advisory group and with our commissioners, but that discussion was properly taking place at the advisory group, and we alerted the advisory

group to the risks here that it was our view that the Homicide Inquiry would have to be recommissioned at some stage.

Q. You told them that, that at some stage it would have to come back?

A. Yes. That was the reason we continued to collect minimal data because we didn't want to lose the data collection pathways that we relied on, because setting them up again is much more difficult.

Q. So things were being stopped but there was no funding for that; is that correct?

A. No, there was no funding.

Q. So you took a decision without funding to continue counting the number of homicides so you could try and, if you had to, fill in the gap?

A. Yes, so to be fair, the advisory group agreed we should do that, but it was our attempt to maintain, even in minimal form, data collection on homicide which we could use as the basis of future studies, short-term studies, and at some point I suppose I rather assumed that the public anxiety would return and we would -- and it would be necessary to re-establish the kind of data collection that we'd previously had.

Q. We've heard evidence that from about 2010 Assertive Outreach teams, which had been rolled out almost across

the country from about 1999, were reduced and we were down to about a one-third coverage at around this same sort of time.

Now Assertive Outreach is something you recommend to this Inquiry. Were you concerned in 2018 that this data was no longer being collected, this analysis was no longer being done, and this intensive form of intervention was gradually disbanding? Was that a concern to you, that picture?

A. Yes. So I should declare an interest here. I was National Director for Mental Health at the time when we introduced Assertive Outreach. I was National Director at the time we introduced the Community Treatment Order.

So I felt -- I suppose in some ways I'm not an unbiased observer of what was evolving in clinical services. These were two very important ways in which we could ensure, or at least make more likely, the proper receipt of planned care. And so the gradual erosion of Assertive Outreach, after 2010, was -- I think it probably started slightly before then actually, but that gradual erosion was a big sort of regret for me.

Q. Can I take you to your recommendations, please. WITN0069001, page 8. Can we start -- yes, page 8. Paragraph 22.

"Based on the findings from my research group above and on what I know about the Nottingham tragedy, the key areas for recommendations should be the maintenance of treatment in the community, the response of services to signs of risk or relapse and oversight of evidence-based safe care.

"With respect to maintaining treatment in the community, I believe the Inquiry should offer unequivocal support to:

"... Community Treatment Order[s] ... "

You say there they're introduced in 2007:

"... which the new Mental Health Act supports despite opposition from some mental health leaders and parliamentarians ..."

You declare your interest there, that you were "National Director for Mental Health and adviser to the Government in 2007".

"The evidence for improved outcomes from CTOs is equivocal but in part this reflects the problem of conducting clinical trials with high-risk patients. Individual case histories are less equivocal, as in Nottingham."

You refer there to there being "opposition from some", and indeed we've heard that one of the concerns in the passage of the latest Mental Health Act was that

CTOs were being overused. Why or for what reason do you think that opposition exists, please?

A. It's a cultural problem in mental health and it probably has humane origins, a concern about the -- what might be seen as coercive practice by some, but you have to see the cyclical way in which that culture evolves.

So in the 1990s there was considerable concern about community care and that was -- that eventually led to the establishment of the Community Treatment Order so that increased focus on the receipt of care as planned -- don't forget we're not really talking about any very unusual care, this was routine care being properly received. So the Community Treatment Order is a way of ensuring that.

So that whole movement, that shift in opinion, as a result of what happened in the nineties, affected decisions made about policy and practice in the 2000s. But after that, and this, for me, is the biggest risk, that once that initial public concern begins to die down and once initial decisions are made about policy and practice, the learning begins to erode, and so people began to forget all the reasons why we needed a Community Treatment Order and the -- and from my point of view rather incredibly began to argue that maybe we didn't need one at all.

That, to me, was astonishing, and a clear example of forgetting the lessons that we had had to learn through previous tragedies.

Q. You say that:

"The evidence from improved outcomes ... is equivocal ... in part this reflects the problem of conducting clinical trials with high risk patients."

Can you just explain that, please?

A. Well, it refers in particular -- there are different trials. It isn't easy to do a trial in this area because, by definition, your subjects, the patients in a trial are people at high risk, otherwise they wouldn't be eligible for a Community Treatment Order. And if your subjects are high risk, that sometimes means they can't take part in a trial because a trial, if it's a randomised control trial, involves people not receiving the intervention.

So it would be ethically very dubious to take high-risk people and make a decision that they could enter a trial where they might not receive the, I suppose, guarantee of the Community Treatment Order that their care would be delivered.

So there's a well-known trial in -- conducted in this country which has proved very influential in how people have viewed Community Treatment Orders and has

given the impression that they don't achieve anything. And that trial became very popular, I have to say, amongst people who were engaged in the debate about CTOs. Research doesn't always have that level of support, but it was a very popular trial to be quoted and I think it did influence a lot of people. But it's very important to know that that trial can't ever be the word on the success of Community Treatment Orders. It had to exclude a number of people, the high-risk people I'm referring to; it's debatable whether it's possible to have the right outcome, because you're trying to prevent a very rare -- well, not very rare, but an unusual outcome, and in the lifetime of a clinical trial that's rather difficult and so you need proxy outcomes.

So the trial evidence is equivocal, I think we have to admit that, but that is partly because for methodological reasons, and the overemphasis on one or two trials I thought was misplaced.

In the end, Community Treatment Orders are not a treatment; they are a way of delivering treatment. And if you believe that the treatments we have in mental health are effective, then a way of delivering those treatments is bound to carry benefits if it can be successfully implemented.

Q. You refer to "Individual case histories are less

equivocal". Can you just elaborate on that?

A. Well, I mean, I suppose everybody in mental health has watched the discussion about the Nottingham tragedy and the clinical care, and the clear message that's come from, as I see it, from the CQC Report, from NHS England's commissioned report and from the evidence that's come to this Inquiry, is about the importance of ensuring delivery of what I would regard as routine care: the delivery of medication, the support for people in the community.

So those individual case histories are absolutely compelling in relation to Community Treatment Orders.

Q. So just so it can be understood what you're recommending, you consider there is a greater role, where appropriate, for use of CTOs, where they can be used under statute following detention under Section 3 of the Mental Health Act?

A. I think we -- I'm saying that this is part of the problem of culture in mental health and I think we need to recognise that we are always trying to achieve the right balance between patient autonomy and self-determination by patients, voluntary care, decision -- respecting decision making, patient autonomy on the one hand, and on the other hand, our responsibility for public and patient safety. And that

social responsibility is sometimes outweighed by that respect for autonomy, and for me, that is a constantly shifting balance.

And the argument over the Mental Health Act, for me, was in danger of allowing that balance to be in the wrong place. And I think culturally in mental health, once we had the Community Treatment Order in place, that balance was allowed to shift away from our social responsibility. We're publicly funded, we work in a public service, we're responsible to the public and public safety should be one of our key concerns. It is one of our key concerns, but it should be explicitly one of our concerns.

And so my reason for suggesting that, if that's okay, to this Inquiry, was to try to prevent that unlearning, to prevent that fading away of the public concern, the clinical determination to do better, because over time, that determination fades, and this Inquiry, I would suggest, can do something very valuable by setting out why that loss of -- that fading, that loss of determination over CTOs should not be allowed to happen.

Q. Any other ways in which that cultural balance can be addressed, in your view?

A. Well, we've touched briefly on Assertive Outreach teams.

Q. Yes.

A. That's one very important part. Those two things, I think, are the key.

But whenever we're talking about culture, culture can be an excuse sometimes for something so vague that we don't know what to do about it, but culture in this case is about leadership. And it is the leadership of the service which needs to be clear about -- well, monitoring issues of safety, about ensuring that individual local services are following up on their social responsibility for safety, and that that leadership cascades from a national level through to regional organisations, they're currently known as ICBs, and into individual trusts and clinical services. So that sense throughout the system of providing leadership on the importance of safety.

Q. Can I take you, please, to INQY0000031, page 158. This is Section 118 of the Mental Health Act 1983. Can I take you down to section (2B)(i). Sorry, over the page, apologies. This is in terms of guidance of what needs to be in the Code of Practice in relation to the Mental Health Act. One of the matters that's addressed there is public safety at (i).

Can I take you, please, to the Mental Health Act 2025, so that's RLIT0000036, page 1.

We see there at section 1 "Principles". "Least restriction" references to:

"Minimising restrictions on liberty so far as consistent with patient wellbeing and safety and public safety."

Sorry, just to explain, this is setting out a new Section 118 for the Mental Health Act under the new legislation. So in both the existing guidance about the statute about the Code of Practice and the new, there is an emphasis there upon public safety within the statute; do you see that?

A. Yes.

Q. Can I take you to the Mental Health Act Code, please, NHSE0000312, page 23. This is the Code which will often be what clinicians actually go to look at when they're trying to understand how to apply the Mental Health Act.

Can you see the section:

"Least restrictive option and maximising independence"?

A. Yes.

Q. It says:

"Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and

supported with a focus on promoting recovery wherever possible."

So the word "patient safety" is there, but no mention of public safety, is there, as per the statutes that we've looked at?

A. That's correct, yeah.

Q. Indeed, I won't take you to it, but nowhere within section 1, which is talking about the guiding principles for clinicians, is there any mention of public safety. Indeed, public safety doesn't appear in the Code at all, save in an entirely unrelated context in relation to particular orders.

So safety, as drafted there, could be patient safety, it could include public safety, potentially, analogously, but it's not very clear, is it? It's not emphasising patient safety as part of the moral responsibility, the social responsibility, of the clinicians involved; do you agree?

A. In that paragraph, no.

Q. Do you consider that public safety is something that should be emphasised to a greater degree within the Code?

A. Yes.

Q. I think it follows from what you said before that public safety is something that should be emphasised at all

levels of mental health treatment so that the focus is not lost in the way you've described?

A. Yes, the leadership on the issue continues, that it doesn't -- it doesn't become possible for it to become less important over time, as time passes and people forget about some of the tragedies that happen, tragic though it might be to think that these incidents eventually lose their public impact. That is the history, that is what happens and the culture shifts away from that social responsibility.

Q. I'm going to come back on to another recommendation of yours about oversight bodies in a moment. Can I look at Assertive Outreach, please. Can we go back to your statement, WITN0069001, page 8.

So we've looked at the first bullet point about Community Treatment Orders; the second, you refer to:

"Outreach teams (also referred to as assertive outreach) whose purpose is to ensure that care is delivered to patients who have a history of disengagement and treatment refusal, often associated with previous drug or alcohol misuse. Outreach teams were national policy in England in the 2000s, were subsequently discontinued in most areas, and are again a commitment in the recent 10 Year ... Plan."

Can I take you to the 10-year plan, please,

NHSE0000524, page 35.

On the top right-hand side, there is a bullet point headed:

"People with severe and enduring mental illness face being bounced from one service to another ..."

Towards the bottom, the last third that paragraph, it says:

"We will transform mental health services into 24/7 neighbourhood care models."

We're going to hear another witness on that particular topic later today.

It then goes on:

"We will improve Assertive Outreach care and treatment to ensure 100% national coverage in the next decade ..."

Now we've heard evidence from NHS England, from Dr Adrian James, that that 100% coverage refers to assertiveness of approach rather than necessarily Assertive Outreach teams. Assertiveness of approach, is that a Model of Care that you recognise?

A. Well, I recognise the argument. But Assertive Outreach refers to something quite specific. It has a number of components that are fairly clearly set out in clinical descriptions. So the concern here would be that anything other than Assertive Outreach is not Assertive

Outreach, even if it uses the word "assertive".

Q. Can I take you to WITN0412001, page 6. This is the witness statement of Dr Nuwan Dissanayaka. He's an Assertive Outreach clinician and he's given evidence to the Inquiry in relation to Assertive Outreach.

In his witness statement he discusses a number of the fidelity principles. Those are those specific principles that you were referring to, no doubt, that make Assertive Outreach Team intervention effective.

He then goes on to say this at paragraph 14 in the second half:

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

Do you agree with Dr Dissanayaka that this hybrid approach doesn't have a positive evidence base?

A. Yes, I do agree. This is what happened, actually, in the -- in 2010 and around about then, because the essence of Assertive Outreach is a low caseload. So

experienced clinicians, they can be nurses but they can be social workers, experienced people in the clinical team with a small number of patients to maintain contact with who have a history of complex mental health problems, usually schizophrenia, and who don't easily accept treatment.

So you can only provide the right amount of time to those individuals if you don't have a large caseload. And in a standard Community Mental Health Team the caseloads are too large to allow what I would recognise as Assertive Outreach.

Q. So when you're making a recommendation about Assertive Outreach, it's Assertive Outreach teams?

A. Yes. Can I just say one thing about that, if it's okay. When we introduced Assertive Outreach in the 2000s, it was very tightly performance managed by the government. These are in the days of targets and central control, central direction, which went out of fashion. And almost every part of the country where we were asking them to set up a team said that they felt they were slightly different from the national model, almost every part. And they may have been correct, maybe there were differences, but those differences weren't great enough to mean that they didn't need Assertive Outreach as it was defined.

And so a degree of flexibility is possible. For example, in rural communities, which are more dispersed, transport links are less reliable, perhaps. So there may be reasons for being flexible on some of the less important features, but the core features, a lower caseload, experienced staff, ability to work not just on clinical care but on the social supports that accompany it, these are essential and you can't compromise on those things.

Q. So if the 10-year plan is just about assertiveness of approach, we're not really moving forward from the position we had from 2010 to 2023, are we?

A. Well, there's a risk of -- I mean it's a good thing that Assertive Outreach is now back on as a requirement under government policy, but it will be going back in to the -- it risks going back to the same problem if we allow the interpretation to be sufficiently flexible that we lose those core features. Assertive Outreach means certain things and they have to be maintained.

Q. Can I take you back to your statement and your recommendations, please. WITN0069001, page 9, please. Thank you. Paragraph 24:

"The Inquiry should aim to strengthen the rights of patients' families to request assessment, acknowledging that they are often in the best position to identify

deterioration and risk. Services might respond to this with concern about excessive demand but this has to be considered beside the high risk of not only violence but suicide and self-harm in mental health patients, and the benefit of providing reassurance to worried families, even when assessment leads to no further action. A period of piloting would be needed and presumably a protocol to limit repeat requests. The Inquiry could consider:

"A right for families to assessment for patients with a history of high risk, as exists for patients subject to Mental Health Act powers."

Then the second bullet point:

"A right to a second opinion, equivalent to Martha's Rule in acute health care".

Can you just elaborate, explain that first bullet point, please?

A. Well, families are often the people who know best about the deterioration, they can spot the times, and they have valuable information. The way we work with families is a crucial part of safe care.

Now, sometimes, for a variety of reasons, that doesn't happen and families find it hard to alert services to their concerns.

We have to develop a service that has a more

collaborative style working with families. This is true it's not just about homicide, it's about suicide as well. And do you know, in the data that we collect, where we ask clinicians -- you referred to it earlier -- we ask clinicians what might have made an incident less likely, working more closely with families is one of the things that clinicians themselves say would have made a difference.

Q. So in what circumstances would a family be able to request assessment, do you envisage there?

A. I do think this needs further working. It's clear when somebody is under the Mental Health Act, because there are legal rights to assessment.

Q. Yes.

A. So my -- what I'm suggesting here is that we need to be able to look for an equivalent right for patients who were informal patients when there is sufficient concern.

Now, and I accept that isn't straightforward, because the legal powers are not there, but we still need to find a route thorough which families find ease of access to services when they're worried and don't find themselves in the position of being unsure of where to turn, or asking -- and it does happen -- asking for assessment and finding that their word, their evidence, is not taken as seriously as they feel it should be.

So I'm suggesting an equivalent right, but I am acknowledging that it may need some working through as to exactly what that right might be outside the scope of the Mental Health Act.

I'm referencing Martha's Rule because it's been such an important development in acute healthcare and there the right is to a second opinion, so it's a slightly different outcome.

It seems to have been beneficial in acute healthcare and I do think it's something that we should be considering for mental health, but both of these things are, I suppose, my suggestions as to how we might take forward this very important discussion about the access that families can bring about to assessment at times of impending crisis.

Q. Just to give an example of what sort of decisions or aspects of clinical care could that Martha's Rule apply to? Detention, I suspect? Or discharge?

A. *(The witness nodded)*.

Q. Whether there needs to be a CTO, medication, all of these sorts of features could be something where a family ask for a second opinion?

A. Yes, yes.

Q. Paragraph 25, just further down. You say:

"After a devastating incident there is often an

immediate determination in mental health services to prevent further incidents above other priorities but over time this tends to subside."

That's a theme that you've touched upon a few times in your evidence.

A. Yes.

Q. "I believe, that in the merged DHSC/NHS England, a new national oversight body is needed to ensure that evidence-based and safety-critical mental health interventions are implemented, maintained and monitored."

So you have in mind there a body that reviews the steps taken by the Department of Health and by the NHS to meet recommendations made in inquiries and investigations?

A. Yes, but also evidence from other sources, I suppose, the re-established National Confidential Inquiry will have regular evidence. It's also about the signal that it sends out about the priorities of mental health care. That if there is renewed oversight and that oversight and leadership follows through from a national level down to clinical care in individual Trusts, then I think we're talking about a better chance, at least, of maintaining the social responsibility that I'm referring to.

Q. So to have that oversight, there needs to be independence from the Department of Health and NHS itself?

A. Well, there would need to be independent input, but sometimes independent bodies, I think you also need -- it needs to be part of the system as well, it needs to be part of the system of care from the Government through to the frontline.

Q. The aim of this is to try and ensure that the learning that we had from the 1990s onwards with the National Confidential Inquiry, with Assertive Outreach, that these sorts of things aren't just dissipated with time and the lessons are properly embedded and not just moved with cultural changes.

A. Yes, so it's, I suppose, the opposite of what was suggested about the National Confidential Inquiry; the repetition of lessons becomes unhelpful. In the end the repetition of -- of course it won't always be repetition, but the repetition of some lessons, the reminder to the service about the importance of some aspects of clinical care, that can only be beneficial, maintaining a sort of high, a strong focus from frontline clinicians, from Trusts and others on this issue.

So looking at new evidence, monitoring practice,

reporting back on experience, just a level of -- an intensity of focus that I think naturally does fade, and we -- it is absolutely extraordinary we're in the position of discussing the same things that we were discussing 30 years ago.

So we have to understand why that has happened and understand the cultural pressure to move that balance of autonomy against social responsibility, the way in which that balance naturally shifts, and this is part of my suggestion as to how that might be prevented: a continuing, official, and high-level focus on safety.

Q. Are there any other recommendations you would like to touch upon? We've covered all the ones in your witness statement -- *(overspeaking)* --

A. Yes. That's fine.

Q. Is there anything else?

A. I do think that -- there is one other thing to mention, perhaps, and that is that I do think we need to consider, take a fresh look at models of risk assessment, and that would be part of what this group, this group might do. I think, having watched the proceedings, we need to recognise that recommendations about strengthening risk assessment have been a permanent feature of this discussion for about 30 years, and yet here we are still talking about it.

We have to take a step back and understand why it is that risk assessment is still problematic, and, if I say so, it won't be enough for this Inquiry to recommend a strengthening of risk assessment practice. I think it has to take a fresh look at what we require of services in the management of risk. And it's not just about assessment, it's about action; it's about this cultural balance that I was referring to. It's a different approach that might be needed, otherwise there's a risk that the learning will be lost, as I've been saying.

MR WESTON: Yes, thank you. I don't have any further questions, but others might.

THE CHAIR: Yes, thank you.

Mr Moloney.

Questioned by MR MOLONEY

MR MOLONEY: Funding has now been restored for the National Comprehensive *(sic)* Inquiry comprehensive data collection relating to homicide. How long is the commitment to fund that comprehensive data collection in relation to homicide?

A. So it's NHS funding which tends to be confirmed annually, so we're not yet at the end of year one, but funding for year two has been confirmed.

Q. And so it will be on a rolling basis without you really having any commitment to it being, say, for five years

or 10 years, or anything like that?
A. I'm -- certainly we've made the point that this has to be a long-term commitment. There is no sense in setting it up again and then in a few years' time discussing whether it is needed or not. It's a long term commitment, and my impression is that is understood and accepted, but in the nature of funding, it has to be renewed more frequently.
Q. Yes.
GPs, such as Dr Kumar, treat a lot of poor mental health which might not require specialist mental health services, especially depression. In terms of your data collection, would homicide by such patients only come within your study if you received court reports which revealed that they had been subject to treatment by their GP for poor mental health?
A. Yes, although -- so people with depression, yes. So our core remit, I make clear, our core remit is about patients, people who are in close proximity to services. They're the people where prevention is most possible, and that means -- and it has a focus on people with severe mental illness which equates to more or less to schizophrenia. Most of the people in primary care with schizophrenia are also -- most, but perhaps not all -- are also under specialist services, at least in our

database. So most primary care patients of that kind would be people we would know about anyway. Otherwise, we would rely on court reports.
Court reports are no longer mandatory, and so it's not absolutely reliable that we'd pick up every case in primary care, but if a diagnosis had been made and if the court wanted to use mental health information then we should be able to get the court report, but it's not a hundred per cent reliable, I'm afraid.
Q. Thank you, Sir Louis, and finally, you've spoken of the importance of families to care and to mental health outcomes. Families themselves are not homogeneous as an entity though, are they; they are very diverse; some are close and supportive; some are fractured and distant.
Given the importance of family support to mental health outcomes, would there be any role in Assertive Outreach in encouraging family support to a patient?
A. Yes, it should be part of the Assertive Outreach approach.
MR MOLONEY: Thank you very much, Sir Louis.
Questioned by THE CHAIR
THE CHAIR: Yes, thank you.
Yes, I just wanted to ask -- thank you, Sir Louis, for that very helpful information -- just in relation to

one or two points that you've raised, I think you may be aware that the Inquiry itself has done an analysis of, I think, 580-odd cases, in one sense spanning that gap which has been caused by the finishing of your gathering of information, but not in the same way. And I think you've seen that report, haven't you?
A. Yes.
THE CHAIR: There are very few of those cases where CTOs were in operation. Has that been your experience, anecdotally at least, since you've been looking at this area?
A. Yes. In our database we have found only three people who committed a homicide while on a current CTO.
THE CHAIR: Yes.
A. So given the number of cases we're talking about over a long period of time, that's a very small number. So it can happen, because the effectiveness depends on how rigorously it's applied, but it's unusual. And it's possible we are missing cases, but three is a small number in our very large database. We found eight people who had previously been on a CTO, but no longer, who had been convicted of a homicide offence.
THE CHAIR: And they'd come off the CTO --
A. They'd come off the --
THE CHAIR: Before the commission of the offence?

A. Yes.
THE CHAIR: Yes. As far as the actual CTO is concerned, you've made the point that, in fact, it's a structure, isn't it, rather than a treatment in itself?
A. Yes. It's a way of delivering good care.
THE CHAIR: Yes.
Just one further point about Martha's Rule. In relation to detention and mental health assessments, you do have to get two opinions, don't you? You have two mental health clinicians who look and make the assessment prior to detention under the Mental Health Act.
A. Under the Mental Health Act, yes.
THE CHAIR: Yes. Do you think that that bodes well for an additional second opinion at various stages?
A. Well, I'm --
THE CHAIR: Perhaps if they do it separately rather than together, it might help.
A. I'm admitting that. I think we need to work out what the equivalent would be in mental health, but the principle here of worried families having somewhere to go with their concern when they feel that a response in an urgent situation has not been sufficient. I think we need to allow families a way to -- a place that they can take that concern. And so the suggestion earlier that

this might apply to a sort of an emergency response to somebody who was in mental health crisis is the near equivalent to what Martha's Rule has been about.

THE CHAIR: Yes.

A. The Mental Health Act itself is in one sense covered by current legislation, but for some people, they won't be under the -- they won't have the advantage of the Mental Health Act. So my suggestion is how we go -- what we do for people who don't already have that right.

THE CHAIR: Do you think there's enough use of the Mental Capacity Act as an alternative in some cases?

A. I suppose the simple answer to that is probably no, but I'm concerned about the way that the two Acts can sometimes be confused in frontline practice.

The Mental Health Act is not based on capacity, it's based on risk and so our social responsibility is about the risk and we don't need to establish capacity in order to take action under the Mental Health Act. So the Mental Health Act should be enough in most situations of acute risk.

THE CHAIR: Yes, but in terms of the treatment of the patients, sometimes it may be necessary to look at that as an alternative?

A. Yes, yes, it's not irrelevant, but in an acute situation, I suppose I'm thinking of the powers that

people -- that clinicians need to respond in a safe way, and those powers are already there within the Mental Health Act.

THE CHAIR: Just again, you've mentioned, effectively, if you like, the arc since the last public inquiry of this kind, which was the Clunis Inquiry, the Ritchie Inquiry, 1994. You've referred to effectively the effects wearing off and people forgetting about this, the reasons for introducing some of the recommendations of that Inquiry and how depressing, from your point of view, it is that we're not talking about the same things.

Do you think that the current position, the current balance as represented by the new Mental Health Act is sufficiently enabling of public safety?

A. Well, I think the first thing to say is I think the Mental Health Act team did a good job in trying to get to the right balance. So I think they recognised the danger. I should say I was on the broader group, I wasn't directly involved with writing the Bill, but I was on the advisory group.

THE CHAIR: All the better to ask you then, right.

A. So I think they did a good job in recognising that there was a risk in allowing that balance that I'm referring to to tip too far away from social responsibility, away

from the use of Community Treatment Orders, for example.

But that risk is still there and it's -- in the end, there is only so much that can be written in the law. In the end, we're talking about clinical practice, we're talking about experienced clinicians assessing patients at times of urgent need and the letter of the law is important in that situation, but so is the understanding of clinical practice, the beliefs of the mental health culture, the kind of assessment that a clinician does.

So -- and all of that is about good clinical care. And the law is there to back up good clinical care rather than dictate good clinical care, so we still need clinicians to be thinking about safety, to be thinking about public safety, to be making the safe decisions. And of course the law needs to be observed, but that clinical safety is their primary function.

THE CHAIR: Because ultimately there's two parts of this equation, aren't there? There's the patient and then there's the community that they are operating in and being treated in, and that's the public, isn't it.

A. Yes. It's perhaps not all that surprising that clinicians think first about the patient who is in front of them.

THE CHAIR: Well, I noticed, and I'm sure that you have too, that public safety is the last on that list of

requirements which have been taken into account, I think, in the NHS England orbit.

It should be a balance, shouldn't it, and the rights of the community and the importance of keeping people safe in the community, as well as the patient safe, are very important.

A. Yeah, well it should, it should certainly be a balance and it should be a routine part of what we consider when we're assessing safety. But I just think we need to see that culturally, we should maybe expect that clinicians should see their first responsibility to the patient because that's their daily job, and we have to ensure that this other part of safety, this responsibility of public services to the public, is sufficiently high on there as part of their assessment, and I think that's less natural, and it comes with a certain amount of unease in mental health where culturally, staff worry about the place of coercion, they worry about their relationship with the patients deteriorating because of that, and they worry about the message that goes out about mental health care as being less therapeutic and more about detention.

So this is all part of the cultural mixture that we are working in, that clinicians work in. We just need to see that although those are legitimate concerns, they

don't allow us to lose our -- the responsibility to the public in the way we're talking about.

THE CHAIR: Yes, just on risk assessment, do you think that there's a real -- there's a resistance to using any of the diagnostic tools, the risk assessment tools, that have been developed over the years, a number of which have been referred to in this inquiry, which I'm sure you're aware of, and research is continuing into ways of looking at it. And obviously it's not going to be like an X-ray where you can look inside somebody's head and provide a clear picture. But do you think that currently, as it were, the perfect is being the enemy of the good?

A. Well, I think the approach is the wrong approach. And I say that as somebody who has talked in the past about the need for better tools and more rigorous risk assessment, but we have to -- there's a logic to it, there's an appeal to it, and there's bound to be a sense in any Inquiry that if we can just get risk assessment to be better, then that might help the safety of services. But that's what -- that's more or less what we've been saying for 30 years. And so we have to stop and say: why is it that that approach, in different forms, has led us to where we are now?

And I think the -- it's -- we have to look at

whether that approach is the right approach, and it just so happens that in suicide prevention there's been a shift towards a different style of assessment of risk, which is more about what actions need to be taken, it's about identifying the personal history, the personal risks of an individual rather than you could say the generic risks identified by risk tools.

So understanding what is it that puts this particular individual at risk at a particular time, and have we got a plan for their care which accommodates those points of risk?

And when we're talking about patient homicide, a lot of the risk comes from violence, previous violence, not receiving care as planned, and drug and alcohol misuse. So if we have care plans that take action on those issues, ensure that they're addressed, then that gives us our best chance of improving public safety.

And placing in the process the complexity of a relatively under-developed risk tool I think is the wrong direction. We've got a -- we need a different risk model which is more personalised, more about the dynamic nature of risk, what will happen tomorrow to this patient, what will happen at the weekend, how will they be when they're no longer being looked after by their family, that dynamic sense of what will change in

a patient's life and our risk management has to reflect that.

So action-focused rather than assessment-focused.

THE CHAIR: If there's no -- I'm going to call it a tool or perhaps a protocol, if I can put it that way -- if there's no protocol then people simply do their own thing, whereas you've just set out there a number of things that you should be doing and taking into account, and that's not always done. So is it not necessary to have some sort of approach which is a common approach, and then a tailored approach?

A. I think it's vital to have some kind of structure because otherwise it's easy to omit key risks. So that has to happen.

I'm suggesting that that can happen as part of a clinical assessment of an individual's risk, without the need to then apply risk tools, which can be complicated for staff to deliver. When we've examined the use of risk assessment tools in suicide prevention, there's a large number of tools that have been developed by services themselves. So they have no validity, but what they do have, they act as a kind of aide-memoire to services to ask the right questions. That's reasonable. That's about structured assessment. And then on top of that, what we need is a way of adapting that risk

assessment to this particular individual. What is it about this individual that might put them at risk?

And that doesn't need a -- the complexity of an actuarial assessment of risk, we don't need to know exactly what the risk is in numerical terms, we just need to know that the risks that this particular patient presents are part of our plan of management. So our care is addressing each one of those risks.

And as I've said in relation to patient homicide, those key risks are clear. They're about the management of violence, drugs, alcohol, and non-receipt of care. If all of our care plans effectively addressed those things, then risk would reduce.

THE CHAIR: Yes, and medication, obviously?

A. As part of care, yes. Indeed.

THE CHAIR: Yes, thank you very much. We'll take a break now until 11.50.

(11.33 pm)

(A short break)

(11.51 am)

THE CHAIR: Yes, Mr Blake.

MR BLAKE: Thank you, Chair. Can I please call Dr Adrian West.

DR ADRIAN GERARD WEST (sworn)

Questioned by MR BLAKE

THE CHAIR: Please sit down.
Yes?
MR BLAKE: Thank you, Dr West. You produced a witness statement for this Inquiry, dated 5 December 2025. That has a unique reference number of WITN0338001; is that statement true to the best of your knowledge and belief?
A. Yes, it is.
Q. Thank you. You are a forensic clinical psychologist; is that correct?
A. I am.
Q. Your qualifications are set out in your witness statement. Importantly, for the purposes of today, you've held several roles relating to matters of serious violence and crime; is that right?
A. Yes.
Q. That includes, for example, working in high and medium secure psychiatric settings; is that right?
A. Yes.
Q. You've advised the police and you currently advise or are employed by the National Crime Agency?
A. Yes, I am, though I am presenting myself today not as a representative of the National Crime Agency, but as a private citizen.
Q. Thank you. You also are an advisor in hostage and crisis negotiation amongst other things?

A. I am.
Q. As you say, you're giving evidence in a personal capacity today having approached the Inquiry yourself; is that right?
A. Yes.
Q. You have educated yourself in respect of this case, so you've read and you've set out in your witness statement, you've read the Theemis report, you have read the sentencing remarks in the criminal prosecution; is that right?
A. And the CQC Report.
Q. Thank you. I won't be asking you about VC's case specifically today because you haven't had the benefit of all of the evidence relating to VC. What I want to ask you today is about your observations relating to current policy and practice, and also about some recommendations that you've proposed in your witness statement?
A. Yes.
Q. I'd like to start with the Department of Health policy Best Practice in Managing Risk. We can find that at DHSC0000038, and that's the March 2009 policy document.
There are several passages that you've identified in your witness statement and I'll just take you to a few now.

If we start on page 6, in the foreword by Professor Appleby, you've highlighted that first paragraph where he says:
"Safety is at the centre of all good healthcare. This is particularly important in mental health but it is also more sensitive and challenging. Patient autonomy has to be considered alongside public safety. A good therapeutic relationship must included both sympathetic support and objective assessment of risk."
If we turn over, please, to page 8 in the summary, under "Fundamentals", you've highlighted paragraph 4 which states:
"Risk management must be built on a recognition of the service user's strengths and should emphasise recovery."
Then if we please turn to page 24, you've highlighted the section here that states: "Providing care proportionate to risk". If we scroll down slightly, thank you. I'll just read that first sentence. It says:
"A fundamental principle of mental health care is that the level of security to which a service user is subjected should be as non-restrictive as possible and should be proportionate to the degree of risk that they actually present at the time."

Now, those are just a few examples that you have highlighted amongst others. Can you assist us with what your view is as to those statements in that policy document?
A. I had read this guidance closely, but in the context of the reasons why we are here today, and had noted, as I have done previously across the years, that I was concerned that in endorsing and continuing, understandably, to emphasise the principle of least restrictive practice and related issues of patient autonomy and empowerment and positive risk management and related initiatives or policies that emphasise the right of the patient, there seemed to me to be the possibility that the place of the victim, who had been harmed by patients when we're considering matters of risk, was overlooked.
Q. One of the focuses that you've identified in your witness statement is positive risk management. If we please could turn to page 11 of this document. I'll just read to you that first paragraph under the heading "Fundamentals". It says there:
"Decisions about risk management involve improving the service user's quality of life and plans for recovery, while remaining aware of the safety needs of the service user, their carer and the public. Positive

risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective. Positive risk management can be developed by using a collaborative approach. Over-defensive practice is bad practice. Avoiding all possible risks is not good for the service user or society in the long term, and can be counterproductive, creating more problems than it solves."

Do you consider that positive risk management has changed the focus perhaps away from public protection?

A. Absolutely. I have to remind myself, you know, that I work with a number of psychiatrists, psychologists, nurses, social workers, who try their best to intervene and help, but that there are policy directives that sometimes underpin our practice that, in my experience, I believe, are idealistic, naive, and currently are at the expense of victims and our understanding consequently of how we manage risk.

I add that when I started my career, I probably had the same idealism, but for acts -- by accident more than by design, I ended up working with the police service some 30 years ago, and in working with the police service, there is -- what happens is on a very frequent basis, you encounter the damage that has been done, and

when you see the damage that has been done, it acts as a considerable counterweight to some of the principles that are set out here.

And I've tried to speak about the need for that counterweight across the decades, hence the reason why I, in the first place, as a private citizen contacted the Inquiry.

Q. We see there in terms of positive risk management reference both to the service user, their carer, and the public. Is there, in your view, a distinction to draw between the risk and risk management when it comes to the self versus to the public? So in terms of potential risks to the individual patient and the public?

A. In my statement, I made reference to a review, a very comprehensive and detailed review, that had been made by a clinical psychologist called Daniela Just where she reviewed almost 5,000 policy-related documents, and her understanding of it was that the whole kind of notion of positive risk management is confusing for many of us in terms of what it means, its contradictions. But importantly, she also highlighted some of the differences as risk management might apply to those differentiated as service user, carer, and public.

And, of course, risk management espouses, you know, strengths-based, hopeful, recovery-oriented, where you

are hoping that a service user is going to be able to manage their own risk, they say, in this. And by managing their own risks ultimately, in one of the recommendations, become more independent of services. But, of course, critically, that does depend on the insight, the mental state, the understanding of the service user. And that probably is the most important focus for the other -- amongst the three that are outlined.

Q. If we stick with the topic of insight, if we turn over the page, please, to page 12, there's a passage that you've highlighted in your statement, it's the second sentence here on the screen:

"Psychopathological symptoms can seriously impact on a service user's ability to critically assess the implications of some of their actions, and this can result in unpredictable and potentially dangerous behaviour."

What's your issue with the words that are used here?

A. I think I said in my statement would it not be more straightforward just to say that if the service user has poor insight then they're likely to be dangerous.

Q. Is the idea that service users are capable of managing risks themselves, and that that is inappropriate in cases where they lack insight?

A. I'm sorry, say --

Q. Is your concern essentially that where somebody lacks insight, the focus on service users managing risks themselves is not appropriate?

A. Again, there's a considerable literature on insight, but my understanding is that there would be an expectation that the service user would be, first, able to recognise that there was a change in the way that they were perceiving and interpreting their experience so that they thought: I think I'm relapsing, I think my mental illness is starting again; and secondly, that they would then begin to attribute the causes of that to illness and the need for them to have treatment.

If those three aspects of insight are not working as they should, then that's when I struggle with how it impacts on their own ability to manage their own risk.

Q. And the phrase that you develop in your statement is "cautious practice is good practice". What do you mean by that?

A. I can understand -- well, I have a reputation for being cautious, again, probably informed by my experience of working with a unit that day in, day out, is involved in the investigation of serious and violent crime, and I think to say over-defensive practice is bad practice, to me makes no sense, I think.

Q. In your statement you've said that in your understanding, this policy was developed without significant policing input. Is that something you're aware of?

A. Well, I counted the number of attendees who'd advised in 2009 and I think I'd said amongst the -- understandably, you know, we have service users, experts by experience, bureaucrats, policy advisers, many clinicians, but amongst the 89 that I counted, and I could be wrong, I noted that there was one Police Inspector and one crime analyst and, for me, that just seemed to indicate a bias in the way that Mental Health Services were addressing management of risk.

I did say there was no representation from senior investigating officers who had been involved in the situation of homicides committed by mentally disordered offenders or patients. There was no representation, as far as I could see, from emergency department staff, and more broadly, it did not include senior command in policing.

Q. Thank you. Could we please bring up on screen paragraph 49 of your statement, that's at page 23.

You say there:

"My clinical and investigative experience and evidence base have taught me that there are occasions

when Trauma Informed Care may also need to be practiced in conjunction with Risk of Harm Informed Care. Namely, it is reasonable to be mindful that as a consequence of repeated or chronic trauma, there are people who may experience distressing hallucinations and beliefs that they are going to be harmed, to a degree that they are at risk of perpetrating harm to themselves and [to] other people. It is again fully acknowledged that there are negative stigmatising effects in highlighting the potential link between mental illness and violence. However, it is confusing and misleading to service users, their families, the public and the victims of any related offences to diminish or deny that link."

What do you understand by trauma-informed care and how does that sit alongside risk of harm-informed care?

A. My understanding of trauma-informed care in brief would begin with the work of Sir John Bowlby, a psychiatrist who has spent his career looking at the effects of separation on children, and he had various maxims, one of the most fundamental being "As we start, we tend to go on", and if a child has experienced neglect, emotional harm, sexual and violent abuse, the harm that we see associated with deprivation, then that would be understood in a more universal category of trauma, and that having given -- having seen that adverse child

experiences are going to then affect how somebody goes on, we know that, those experiences can impact on emotional, physical and mental health for the life course.

That's what I understood trauma-informed care to be.

Q. And what about risk of harm-informed care? Is that your own idea or is that somebody else's?

A. It's mine, but it won't go down well.

Q. What do you mean by that?

A. Well, as in I think it will be seen as -- it'll be seen as an emotional and pejorative term. I see it as a counterweight whereby it allows consideration of the harm that has been done.

Q. Is there not a risk that if you shift too much in that direction, a patient might be less open, might be less accepting of treatment?

A. Yeah, there is that risk, yeah. Absolutely, yeah. But some of us work within the context of that risk all the time, and recognise that in trying to have an understanding of how and why somebody has caused harm, there's a requirement for probing, searching questions, but in a way that's still sensitive to the experience of the patient.

Q. One of the examples you gave in your witness statement was an HM Inspectorate of Probation report in the case

of Anthony Rice, and I'll bring that up onto screen, that's WITN0338011. That's a 2006 report. If we turn over to page 2 we can see the background. It says there:

"In October 2005 Anthony Rice was convicted of the murder of Naomi Bryant on 17th August 2005, at a time when he was being supervised on a Life Licence by Hampshire Probation Area. A number of other agencies had been working jointly with the Probation Service on this case through the Hampshire MAPPA ..."

If we turn over to page 5, we see "Principal Findings and ... Recommendations". This is "Principal Finding [number] 3" you've pointed to. If we scroll down, "Principal Finding [number] 3" says as follows:

"Based on the reports received about the progress that he had made during his sentence and his proposed resettlement plan, the Parole Board made a final decision in 2004 that Anthony Rice, who was five years past his 'tariff date', was safe to release. We consider that in doing so they gave insufficient weight to the underlying nature of his Risk of Harm to others, and we think this happened for a combination of reasons".

And it's the second reason that you point to in your witness statement, that is that:

"They received cautiously encouraging but ultimately over-optimistic reports of Anthony Rice's progress under treatment."

Now this is only a single case. Is there, to your knowledge, a body of evidence that suggests there are overly optimistic attitudes in the context of treatment of those pose serious risks?

A. I can't comment on the number of Serious Case Reviews in relation to homicides by men released from prison, but in the review that I tried to make of the cases, say, that are contained in the Hundred Families dataset, there are numerous examples pointed out where clinicians appear to have, as is stated, omitted and minimised the seriousness of past violence, given undue consideration to the possibility of future violence, and have disregarded ominous signs or warning signs that have been made by families, which in some, I think, are understood as then clinicians and others presenting to either Mental Health Review Tribunals or Parole Board what could, with hindsight, then be considered as over-optimistic reports.

Q. Can we now bring on to screen the Royal College of Psychiatrists report, that is at WITN0058002. The Inquiry has already seen this report and heard from Professor Morgan in relation to this report.

If we please turn to page 5, we can see the executive summary there. On the right-hand side the third paragraph down, it says as follows, it says:

"Tensions remain, and psychiatrists' duty to protect the public needs to be integrated with their primary duty to assess and treat their patients. Thus 'risk to others' gets to the heart of our profession, and our ability to assess and manage risk is a key part of our professional identity".

Is this in some way a shift towards the kind of protection that you're talking about, or not?

A. Yes, it's a shift, but I respect my Royal College of Psychiatrist colleagues, but as the paragraph begins, "Tensions remain", and perhaps sometimes ambivalence remains, and my own personal code is that, as a clinician, or a citizen involved in, you know, the role that I have, for me, protection of the public is my primary responsibility.

That does not in any way stop me from having the compassion and respect that I need to have towards the service user in assessing or providing intervention. But alongside it, I just think I need to recognise that in some instances there is a risk of harm, and that I need to take account of that. First, meaning I have a primary responsibility, as indeed it seems to be other

services more easily recognise, in protecting the public.

Q. You've pointed to one of the key findings in particular. If we turn over the page, please, at paragraph 5 there, it says:

"A pre-occupation with risk to others that leads to over-simplistic responses ... can skew professional practice, with unintended consequences. Striving to assess and manage such risks is an essential professional duty. However, rates of homicide by patients have not varied greatly, despite considerable changes in professional practices. A nuanced approach is required, acknowledging that our patients are more [at] risk to themselves or from others, than posing risks to others. This is by a large order of magnitude."

What is your concern about that approach?

A. That, again, I think you might refer to it as hedging, as in there's an attempt to acknowledge the rate of homicide by patients. But at the same time, it seems to diminish what that risk might be. You will know that the Homicides committed by mentally ill service users, it's a rare event.

Nevertheless, there's an average rate of anything that's listed between 50 and 75 per year. I think that

there's a need for the professions and disciplines involved to actually considerably review their practice and attitude towards that figure.

Everywhere, when we look in the risk literature, not everywhere, but you'll see in many papers and indeed in conference presentations, there's always the beginning that patients are more at risk to themselves or from others than posing a risk to others. I don't deny that. But there are also those patients who we have to accept can be, when they are not treated, supervised, or otherwise adequately safeguarded, they can be very dangerous. And there seems to be a lack of acknowledgement sometimes to say that publicly.

Q. You mentioned that the 50 to 70 figure, we've heard evidence from Dr Faizal that there are about 50 homicides committed each other, but that figure is limited to those who had contact with mental health services in the previous 12 months so perhaps that understates the overall figure.

A. Indeed.

Q. What is your view about the collection of data in this respect?

A. Well, up until, I think it was, 2018, the National Confidential Inquiry into Suicide and then as it was named homicide, an Inquiry that was based, and remains

based, at the University of Manchester was exceptional in its diligence in collecting data, but that changed, though I understand that that may have been reinstituted.

Q. Should, for example, data be collected in respect of serious harm in addition to homicide, or do you have any other views as to the collection of data?

A. I've said in my statement that I think that the homicide rate is an inaccurate or not a very valid metric of harm done, and what I also highlighted, for example, was in the year ending 2025, I think there were 32,000 Section 136s where the police had been involved in taking somebody to a place of safety. Of course those incidents may involve where individuals have been at risk of suicide but also frequently they involve occasions when the police are involved in trying to address a situation where there's violence.

We also know that there's often violence within the family that gets unreported, there's certainly violence on psychiatric wards that gets unreported. So I don't think the homicide rate is an accurate metric.

Q. I'll move on now to recommendations. The first of several recommendations that you make relates to inter-agency risk reference panels?

A. Yes.

Q. What is it you have in mind there?

A. Well, I was just in my kind of research around MAPPA, and other alternatives. The reason why I made that recommendation was that if there is going to be improved inter-agency co-operation and sharing of information, then perhaps we need to extend the services that are available beyond MAPPA. And whilst MAPPA functions very effectively, there seem to be instances, particularly again where police, social services, health are involved, where an individual has not committed an offence of a kind that brings them to the attention of MAPPA, and perhaps we need to have an extra service that might usefully consider, importantly, sharing of information and shared responsibility in managing somebody's risk. And that Risk Reference Panel, because it involved agencies like Housing, Social Care, Health, and maybe the police, that seemed to offer an option.

Q. So it is something that has been implemented at some point?

A. I think it's implemented in parts of Wales, I think.

Q. Where would you set the threshold, in terms of involvement?

A. Ah ...

Q. Or what factors might you consider?

A. Risk of harm, but not necessarily where someone has come

to the attention of law enforcement of having been convicted, where we have had, for example, instances of continuing disruption, social harm, where there have been occasions when significant emergency services have had to respond to a situation but where there has not necessarily been a conviction subsequently, those kind of occasions.

Q. Moving on to another recommendation, you say that there should be greater focus on the victim in mental health services. Can you expand on how you say the police operate as a victims'-focused service?

A. Well, this issue gets to the heart of perhaps some of the reasons why I was motivated to send a note in originally, and again, it goes back to my experience as a clinician, and this is not to castigate, you know, my mental health colleagues; this is about custom and practice over years.

I'm sorry if it might require a longer answer, but essentially, as I worked through my career as a Forensic Clinical Psychologist, I would have many occasions to attend case conferences and discussions. And it may come as something of a surprise to a lay audience, but this not an exaggeration and will still be ongoing of countless instances of attending case conferences about an offender-patient where the victim of any offence

cannot be named, the nature of the injuries will not be known, and yet we're making decisions about the risk that they present. And that was brought into sharper focus when I was working with the police.

Again, it sounds rather emotive but, you know, you go to a murder incident room and for all the criticisms that the police may face, when they are operating in that circumstance, I have seen them, they'll have a notebook, the victim will be referred to by their first name, habitually, they will carry oftentimes a photograph of them in their notebook. They'll talk about him or her in terms of the parents are arriving or, you know, and there is this presence of a victim.

And I've found that, as my involvement with the police continued, to be in absolute marked contrast to what was happening when I was working in hospitals, and I found it hard to reconcile.

Q. How do you translate that into a mental health service?

A. I think, within the policy recommendations. Again, you know, I'm trying to be dispassionate about this, but I think that if we're trying to understand why the patient in front of us has ended up, say, in a forensic setting where there is a criminal history and a history of violence, sexual violence, then where appropriate, we should have in our records the name of that victim, and

we should have a detail of the injuries and circumstance, the circumstances in which the injuries were sustained. We should have more access to the sentencing remarks from trial. We should have more access to the collateral sources of information about an investigation, because otherwise we can rely, sometimes solely, on the account that's provided by the offender-patient, and my experience can tell you frequently that that account can be at a considerable distance from what has actually happened.

Q. In terms of detail about the underlying offence, you've said in your statement that when it is provided, it is disregarded. Do you have personal experience of that?

A. It's not always -- it's not always disregarded. It's sometimes disregarded. What I've tried to say is that we have a situation where we are expected, and indeed are duty bound to be compassionate and respectful to the patient in front of us, and that has a trauma-informed ethos in our approach. And yet, at the same time, we have to also confront the fact that they have inflicted harm.

When you have those two elements, they can be very uncomfortable for people to keep in mind at the same time. I'm not trying to be clever in terms of psychological theory, but there's something called

cognitive dissonance. It's not easy to hold two conflicting sets of information at the same time, and, therefore, sometimes people are minded to avoid information or situations that kind of increase that, you know, what's called dissonance. And that's why it can be disregarded.

Q. I want to explore with you how that can sit alongside formal risk assessment processes. If we can bring up on to screen paragraph 93 of your statement, that's at page 44. Halfway down that paragraph, you say:

"My experience, having applied such tools, is that they can miss significant (victim, location, weapon, duration, injury) details of the index offence, the actions of the perpetrator and the social, cultural and lifestyle context in which the offending has occurred -- all of which should be the starting point of any assessment of risk of harm ... However, to achieve this kind of understanding of risk, forensic clinicians may need to develop an investigative focus and a readiness to consider more carefully the nature of the injuries, the method by which they were inflicted on a victim and the circumstances in which the patient and the victim lived and interacted."

How can that be incorporated into a risk assessment tool or can it, or does it need to be considered

separately?

A. It can be incorporated into risk assessment. But that -- what I refer to as an investigative focus has probably been significantly influenced by my experience of working on major crime investigations, where I have necessarily had to read and review forensic pathology, other forensic-related reports. I've been with investigators, police officers, and related multidisciplinary investigative specialists. So you develop an understanding where you become much more focused on the detail, granularity, of what has happened and how that helps you make sense of what this offence meant to the offender.

Just if an offence happens, if somebody is attacked from the front, that's a very different offence than if somebody is attacked from behind. You know, the weapon that is used, if it's a kitchen knife, it's a very different from if it's a hammer. You know, I have ended up going into that kind of detail and I think it's that kind of detail that we need to inform risk.

Q. Does that require a closer relationship between the police and the mental health services?

A. Yes.

Q. And presumably an increased role for the police. We have heard in evidence about Right Care, Right Person,

which reduces, intentionally reduces, the amount of time the police spend responding to mental health incidents. Are you saying that actually what is required is greater involvement by the police in risk assessment?

A. Well, Right Care, Right Person isn't universally accepted by everyone, but it's probably a separate notion or domain. I'm talking about perhaps a readiness to involve the police who are over an original investigation, to sit down with them, to have a better understanding of the nature of the offence. Yeah, I think that should happen.

Q. Another recommendation you've made is, or suggested, is improved access for the police to specialists in mental health?

A. Yes.

Q. For what purpose?

A. Because there are repeated observations made, especially in recent years, about how broken mental health services are, and that the police are left to pick up the pieces, and we expect the police service to then step in, and sometimes, despite, you know, their best efforts, there should be more immediate access, I think, to specialists, because sometimes you need that specialist help.

There are initiatives like Street Triage, and there

are some clinicians in incident rooms, but I think that we need to have more involvement.

Q. Final topic, training. What is your concern about the current state of training in this regard?

A. Relating to?

Q. The matters that you've raised today in your evidence.

A. Well, I've suggested that, as an absolute basic, clinicians should have to read some of the Inquiry reports that go back across these 30 years where obviously lessons appear not to have been learned.

I've asked that, you know, as recently as a couple of weeks ago, I sit down with a group of psychiatrists and I say "Who's read the falling shadow about Georgina Robinson?" Nobody. "Who's read the Clunis Report?" Nobody."

You know, we need to have lessons learned, instilled, not into policy directives, but into training, across the board.

Q. Is your focus there on early stage training, ongoing training, or something else?

A. Well, early stage and continuous professional development training, and then there's this whole other area of how to increase this what I've referred to as an investigative focus in trying to supplement better our understanding of risk.

MR BLAKE: Thank you, Dr West. Those are all the questions I have to ask. There are some questions from Core Participants.

THE CHAIR: Yes, Ms Cartwright.

Questioned by MS CARTWRIGHT

MS CARTWRIGHT: Good afternoon, Dr West. I ask questions on behalf of the survivors.

Can I just seek clarification, please, in respect of some of the evidence you've given to Mr Blake. You told us there are policy directives that underpin our practice that are in your experience, idealistic, naive, and currently at the expense of victims and our understanding consequently of how we manage risk.

Can I just be clear when you say "policy directive", what you're referring to?

A. Perhaps policy directives -- I mean, it's right for the clarification. I think there are Best Guidance Frameworks and then there are guidance that comes out from NHS England and others, where there seems to be an emphasis on, for example, positive risk management, trauma-informed care.

Perhaps they're not coming out as directives, but they are implicitly, through their recommendations, giving guidance on how they expect clinicians to behave and the attitudes that they should have to support that

conduct.

Q. Thank you. Then just perhaps building on that, could I just briefly have displayed paragraph 4 of your witness statement, WITN0338001 at page 2. Thank you. Paragraph 4. Just building on where you say in the middle of the page:

"While concerns about stigma and unnecessary coercion are valid, and the majority of people with schizophrenia and other mental illnesses are not violent, public protection goes beyond mere awareness of 'safety needs'. The Inquiry could therefore serve as an opportunity for the Royal College of Psychiatrists and other professions to reflect on their responsibilities in protecting the public, which in my view should be their priority."

So really, are you expecting guidance from the Royal College of Psychiatrists to make clear what's required when making assessments of risk?

A. Yes.

Q. Can I just be clear, when you're referencing "other professionals", who are you thinking of, by way of those other professions?

A. So within mental health services there would be representation by nursing, social work, psychology, and other, you know, ancillary professions.

Q. Thank you. Now obviously noting your experience as having worked in high and medium secure facilities as you've detailed in your witness statement, you've already explained what you mean by trauma-informed care and I think you've made some reference to Bowlby's attachment theory. But you said this also in evidence:

"Answer: ... in trying to have an understanding ... how and why somebody has caused harm, there's a requirement for probing, searching questions, but [that are] ...still sensitive to the experience of the patient."

And really would you agree that there should be an absolute minimum where there's been a harm event for those searching, probing questions you've identified to take place with a patient?

A. Yes, and the problem is that the reasons why I have tried to emphasise this emphasis on the nature of the offence is because, again, in my experience, and this is recorded by, you know, other colleagues, they will say that consideration of the index offence is sometimes a very second thought, which is only given thought when the patient is about to be discharged.

MS CARTWRIGHT: Okay. Thank you very much, Dr West.

THE CHAIR: Thank you.

Ms Grey. Ah, Mr Williamson.

Questioned by MR WILLIAMSON

MR WILLIAMSON: Dr West, I ask questions on behalf of Nottinghamshire Police.

Just two brief topics, please, expanding on some of the matters in your statement and which Mr Blake dealt with with you, can we have your witness statement at page 21. This is just developing, in paragraph 46, something you were asked about by Ms Cartwright. I just want to draw out the passage that says:

"Perhaps this Inquiry provides an opportunity for Psychiatry and other mental health professionals to consider carefully their responsibility and expertise in protecting the public."

What is the expertise in protecting the public you're referring to there, please?

A. So, psychiatry and related disciplines, I'm a Forensic Clinical Psychologist, have an extensive history of trying to understand the causes of violence, including sexual violence. That involves incorporating a range of disciplines, criminology, investigative psychology, abnormal psychology, psychopathology. There's a whole research, evidence -- a research base, a theoretical evidence base, as well as the experience that those professions have had in attempting to assess and deal with those offenders, and I think that across the years,

then, they've developed specialist knowledge of how to apply that understanding from the evidence base as well as the clinical experience, to protect the public.

Q. So that applies across the spectrum of different mental health services, not just psychiatry?

A. It's not just psychiatry, no.

Q. And you were asked by Mr Blake about Right Care, Right Person in relation to the police --

A. Yeah.

Q. -- and reducing the involvement of the police. Police officers don't have that same expertise that you've been describing there, do they?

A. No, they do not.

Q. They don't have the expertise required to deal with people with complex or high risk mental health problems.

A. No, and indeed, in my preparation, you know, I highlighted the work that had been done by Zoë Billingham again in trying to address the deficits in other services who then, either through resource constraints or other demand, are left to leave the responsibility for dealing with mental health crises, you know, to the police. And I know that, you know, police training is under review, but I do think that there is a place for increased awareness of mental health -- mental illness presentations, but we can't

expect them to be specialists when specialist help is needed.

Q. Ultimately, as a 24/7 service the police may become involved, become responsible, and they may not be the right service to do so?

A. Well, indeed, yeah. One of the things I -- again, in preparation and reflection, the police service are 24-hour, always there, and I think, you know, sometimes they are wired differently to other services, in terms of response to urgent need. I don't think -- "urgent" in mental health doesn't seem to have the same meaning as what "urgent" has to the police.

Q. What that means in practice is that already over-stretched police officers can't always respond appropriately.

A. No, they can't.

Q. And there is only so much that they can do. Do you agree that public services need to work together to prevent the need for a crisis response in the first place?

A. I have experience, although I'm limited in affiliation, but I'm also a Special Constable, so I have some first-hand experience of immediate response in its having to deal with crises. And again, you know, I'm not demeaning the efforts of those other agencies. Many

agencies, partners, will say they're overwhelmed. I just think that somehow we have to be able to improve the way we work together, and so much of that seems to be limited by the constraints around information sharing. And the readiness of some of those other services to help, instead of saying "There's no evidence of enduring and severe mental illness, the problem's yours," you know, there has to be more evidence to help, collectively.

Q. Before I move to information sharing, professional help with the right expertise needs to be available and provided whenever the patient or potential patient needs it?

A. Yes.

Q. And those needs, like mental health crises, don't just arise during office hours?

A. No, they don't.

Q. Information sharing, please. Can we have on screen page 21 of the statement. Paragraph 47, please. Dr West, looking at the last three lines from the bottom of that paragraph, you say:

"... I question whether there are some mental health services which see themselves as different and separate from other protective services."

Do you see that?

A. *(No audible answer).*
Q. Are the police one such protective service who you consider are treated as separate by mental health services?
A. I think I saw it the other way round. I think that the police service sees itself as fundamentally protecting life and limb, and I see that as at the core of what it tries to deliver all the time, and I think sometimes mental health services don't have that same underlying value about where they sit in protecting the public.
Q. I see. Can we now have on screen page 33, paragraph 70, please.

This has been touched on already but I just want to deal with where you say:

"In working with the Police, [you] ... began to notice that despite the instruction of the Home Office about what should be included in reports for mental health review tribunals ... explanations as to why the index offence was committed, often included scant reference to how the offence was committed."

In your view, is there greater scope for mental health services, when managing a patient, to have contact with the police in order to obtain more information, including about how the offence was committed?

A. Yes, there is greater scope. In my own experience, I have been able to contact police officers involved, and had sometimes meetings with them. The information, then, that they've been able to provide in terms of how the offence was committed has considerably enhanced my understanding of the causal pathways of that offence, and then its implications for the treatment of the person, and subsequently how their risk is assessed.
Q. More information about victims, the victim focus that you've talked about.
A. Yeah.
Q. Also to gain more information generally, for example, wider details of police involvement with that individual?
A. Definitely.
Q. Or details of, or reasons for, any particular criminal justice outcome?
A. Including when there has not been a progression to court.
Q. Do you agree that the police may be well placed to provide information if asked, but which they may not offer or volunteer because the potential clinical significance may not be recognised by them?
A. Yeah, that's possible, yeah.
Q. Because the police don't have the relevant clinical

expertise?
A. Again, yeah, that's possible, yeah.
Q. The police are unlikely to have the same level of contact with a patient?
A. Well, it depends on whether we're dealing with somebody who is well known to them or not, but again, this is about the more information that we have available to us from the various services involved, whether that means a GP, a health visitor, a teacher, there are times when we need to be able to get over the constraint around confidentiality and recognise that there is a risk of harm, and in the sharing of information, should that require breaching of confidentiality, providing we're doing it for the best interests of the person and the person who may be harmed, then I think we need to find ways of improving our information sharing.
Q. But in terms of patient contact, a person who is an inpatient for, say, a number of weeks, mental health services are likely to have had more contact with them than the police would in perhaps effecting an arrest or something of that nature?
A. Yeah.
Q. Page 45, please, paragraph 95, under the heading "Risk assessment in everyday clinical practice", you describe there handovers, case conferences, meetings and then you

say in the last three lines:

"These meetings are also more likely to focus on developing a detailed understanding of [a] patient's risk and relapse signatures."

Do you see that?
A. Yes.
Q. Pausing there, I asked you about mental health services obtaining information from the police. Is there also greater scope, for example when a patient is being discharged into the community, for them to contact the police and provide information in respect of a patient's risk and relapse, which may be relevant to the risk posed to the wider public?
A. Yes, indeed, and perhaps that goes to the heart, again, of some of the implications of what I am trying to address. The constraint is around the restrictions and impositions on confidentiality and the sharing of information, and if that's done in a wrong way, people can, clinicians, can face sanction from their professional bodies.
Q. You go on within that paragraph, you say:

"At their most effective functioning, they involve members of external agencies, for example, the Prison Service or Probation but very rarely the Police Service."

Looking forward, do you consider that that very rare involvement of the police service does need to change?
A. It does need to change and, again, that probably reflected, you know, my experience of a particular unit. There may be other units where there are -- where there's more consistent police involvement. I think that our medium secure units could significantly benefit from having more organised, consistent, presence from the police service. Not only to facilitate exchange of information, but also because, you know, sometimes units are almost like a semi-permeable membrane in terms of drugs that are getting in, other things that are happening. All those things could be addressed if we had more of a presence rather than what is sometimes understandably an *ad hoc* presence.
Q. Might that also be one way to strengthen risk assessments?
A. Absolutely it would strengthen risk assessment.
Q. Finally this, please: in terms of the recommendations and changes that you have dealt with, are you able to say from your experience whether the resource of the police service would require augmentation to enable the police to assist mental health practitioners in the regard that you've outlined?
A. I think the augmentation needs to come first in

training, but also in the hoped-for involvement of other services, perhaps seconded in to police stations so that there's more joint working.
Q. But in terms of what you envisage, it would a represent significant additional burden on the police service?
A. Oh, it would, yeah. It would, yeah. They won't be glad that I've made that recommendation.
MR WILLIAMSON: Thank you, doctor. Thank you, Chair.
THE CHAIR: Thank you. We'll finish there now and start again at 2.00, thank you.
(12.59 pm)
(The short adjournment)

I N D E X