Witness Name: JULIAN HENDY

Statement No: WITN0258001

Dated: 2 November 2025

THE NOTTINGHAM INQUIRY

FINAL WITNESS STATEMENT OF JULIAN HENDY

I, Julian Nicholas Hendy, will say as follows: -

INTRODUCTION

1. I am the founder and chief executive of the Hundred Families charity, a national charity, registered with the Charity Commission, supporting victims of mental health related homicides in the United Kingdom.

2. This witness statement is made to assist the Nottingham Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 26 August 2025 (the "Request").

BACKGROUND

3. I have been asked to set out an outline of the work of the charity, my experience working with families who have lost loved ones as a result of

mental health related homicides, and some of the problems such families typically encounter.

Career and background

4. I was a documentary film maker and investigative journalist for ITV, Channel 4 and the BBC for over 25 years. I have made a number of films about serious subjects - terrorists, arms dealers, war criminals, and covered civil wars in the Philippines and Bosnia, as well as the genocide in Rwanda. I was fortunate to receive two Royal Television Society awards for the quality of my work. I have also made several films about people with serious mental illness, including the plight of offenders with schizophrenia in prison, people detained illegally in US psychiatric hospitals, and vulnerable people in the 1970s who were given lobotomies to manage their behaviour whilst still conscious (and being filmed). These experiences affected me greatly.

5. I have a master's degree in international history from the London School of Economics and was trained to evaluate evidence from a variety of sources which has helped me in my professional career. Similarly, I received extensive legal advice from ITV and BBC lawyers on the need for strict accuracy, fairness, and truthfulness of any statement or information included in my films, a practice which I have tried to follow to the best of my ability in my current work.

6. I founded the Hundred Families charity after my own father was murdered in Bristol in 2007 by a psychotic man with a documented history of serious mental illness, drug abuse, and violence.

7. They were complete strangers to each other.

8. Although they had had no conversation or other previous interaction, I later discovered the offender believed my father was involved in a conspiracy with President Bush and Prince Charles to clone his children and give them sex changes to make them look like the singer Kylie Minogue.

9. I learned that just days before the fatal assault the offender's family had been raising serious concerns to local mental health services about his deteriorating mental state, and that he was consuming, what was described in court as, 'industrial quantities' of amphetamines. Despite these warnings mental health services took no effective action, leaving him psychotic, dangerous, and at liberty on the day he killed my father.

10. When I tried to discover what had happened with his previous care and treatment in order to help me understand and better come to terms with what had happened, I found almost an impenetrable wall of silence from the mental health trust in Bristol. They said I had no right to know.

11. Despite my 25 years professional experience as an investigative journalist, I found it extremely difficult to obtain any useful information at all to help me and my family cope and recover. I thought if it was that difficult for me to find out, what must it be like for any other family without such experience?

12. I later learned that on the day after the offender killed my Dad, the mental health Trust has called the offender's family to say how sorry they were but made no attempt to contact me or my family. It took me well over a month for

me to get a meeting with the Trust's medical director to discuss the case. That felt unnecessarily cruel and unfair.

13. After the offender was convicted in October 2008, I was commissioned to make an hour-long documentary film for BBC2 about what happened in my case and four other similar cases around the country. I can make the film available to the Inquiry if required. In the film I found that many families experienced very similar problems, not only with the previous care of the offender, but also in the dismissive way they were treated in the aftermath.

14. I thought this was not right, and that something had to be done to try and improve the situation for affected families, and despite having no experience running a charity I thought I had some relevant skills and experience and so I established the Hundred Families charity.

15. Hundred Families is so called because there are on average 100 – 120 mental health related homicides across the United Kingdom every year. (The supporting evidence is attached as exhibit WITN0258002)

16. After five years gaining experience and developing our work Hundred Families was officially registered with the Charity commission in 2015.

17. Essentially, we aim to do three things:

    - support and advocate for affected families,
    - work with the NHS, Ministry of Justice, and other agencies to secure improvements to services, and
    - carry out research and training around mental health related homicides.

18. After my father was killed I wanted to know how often these killings were happening, how many had happened previously in the local area, and what if anything had been learned by the various inquiries into previous mental health related homicides.

19. In 1994, following a number of highly concerning mental health related killings, the Department of Health introduced a requirement on the NHS (HSG (94) 27) to conduct independent investigations after killings by recent NHS mental health patients.

20. I found that nobody could tell me what had been effectively learned from previous inquiries and discovered there was no accessible index of such cases or even a repository for NHS inquiry reports.

21. Remarkably I found that some mental health trusts didn't even keep copies of independent investigations into killings by their own patients, so couldn't demonstrate they were learning anything.

22. Around the time I was making the film for the BBC in 2009 I discovered, from previous press reports, that there had been at least 22 previous killings by local mental health patients in Bristol (between 1993 and 2007) and that there had been at least four NHS independent investigations which had all found very similar problems in the care of seriously unwell people who were either unable, or unwilling, to access effective mental health care and treatment.

23. The exact same problems were later documented in the NHS independent investigation into my father's case which again demonstrated to me that

nothing was being learned effectively by NHS mental health services to prevent such tragedies in future.

24. It appeared to me that it would be helpful to start and make available a database of such cases from press reports and other sources in the public domain (following conviction or other disposal) to ascertain how common these incidents were and where they occurred.

25. Additionally, I thought it would be useful to make available as many inquiry reports, investigations, and other official documents as possible, as a public service as an aid to public education and learning.

26. At the time of writing, I have documented 2396 such mental health related killings in the United Kingdom since 1993 and make available 1032 inquiries and reports on the Hundred Families website.

27. In Nottingham and the East Midlands area for example I list 135 known mental health related homicides and make available 75 official reports. (A copy of the webpage is attached as exhibit WITN0258003)

28. I know however that the cases I have been able to document are a clear underestimate of the total number of mental health related homicides as not every case is reported.

29. So far, I have assisted around 300 families who have all been affected by mental health related homicides in the UK. The charity has seven trustees who have all been personally affected in this way.

30. Some families have helped raise specific concerns in parliament, with individual state agencies and at Inquests which we share to assist improvement and learning. Other families have been extremely generous with their time and effort to help fundraise for us.

31. I have been, and am a member of a number of advisory committees including:

- Ministry of Justice victims' panel
- National Victims Commissioner advisory panel
- London Victims Commissioner advisory panel
- Care Quality Commission Expert Advisory Panel on NHS investigations following deaths of patients in England
- Mental Health Act Review group
- NHS England Independent Investigations Review Groups in the South-West, Midlands, and South-East regions
- NHS England National Publication Practice Working Group
- Scottish Government Advisory panel on the Victims of Mentally Disordered Offenders Notification Scheme.
- Mental Welfare Commission for Scotland Homicide Investigation proposals group
- Welsh Government Single Unified Safeguarding Review – preparatory and victims and families' groups
- FLACSS (Police Family Liaison and Coordination of Support Services) panel member.

32. I was an invited speaker to both the Royal College of Psychiatrists' International Conference (June 2025) and their Forensic Conference (March 2020).

33. I have also presented on victims and mental health homicides to many NHS mental health trusts, probation services, social workers, and Police Forces across the country.

34. I have contributed to academic research on mental health homicides in the United Kingdom, Australia, and New Zeeland, and have written a chapter on best practice in engaging families in a published book on Patient Safety Investigations.

35. The Hundred Families charity is also a commissioned service of Victim Support's Homicide Service.

Information gathering/research process

36. After my father was killed I began to collect press and other reports to try and understand the frequency of mental health related homicides across the Bristol area and ultimately across the United Kingdom and to see how services were learning to try and prevent these incidents.

37. I began collecting press reports from 1993 (to reflect the introduction of the requirement for Independent Investigations) until the present day.

38. The information mainly comes from published press reports (and from newspaper archives), published NHS investigations, public NHS Trust board papers, judicial sentencing remarks, Court of Appeal hearings, records of

Inquests and coronial Preventing Future Deaths reports, domestic homicide and other similar safeguarding reviews, as well as Freedom of Information requests.

39. I assess the information to ascertain if there has been, or appears to be, a significant mental health component to the killing, and/or that a plea of diminished responsibility has been made, and/or that the offender was, or had been, known to mental health services.

40. I acknowledge this may be a subjective view and that others may have a different opinion, particularly if they have access to different information. I try to take a reasoned and balanced approach.

41. I am concerned that many criminal justice and mental health professionals often claim that these killings are 'rare' (with the impression that they are unavoidable and therefore unimportant) when there are 100 – 120 such cases annually (two a week). Given there were 570 offences currently recorded as homicides for 2023/34 in the official ONS statistics, (a copy of the relevant table is attached as exhibit WITN0258004) this constitutes around 17-21% of all homicides in the UK. This, to my mind, is not an insignificant number. These cases are not 'rare.'

42. Research in the British Journal of Psychiatry from 2020 showed that whilst the rate of homicide in the general population has been declining, *'the relative contribution of mental disorder as a proportion of all homicide has increased.'* (A copy of the publisher's abstract webpage is attached as exhibit WITN0258005)

43. This is a matter of serious concern for our families. It appears the problem is getting worse.

44. I was also concerned to discover that the main officially funded source for mental health homicide related data (the National Confidential Inquiry into Suicide and Homicide – NCISH - at the University of Manchester) only provide figures which significantly underestimate the true total of victims of such killings.

45. This is because they only count :

    a) offenders, not victims – so if a mentally ill person kills their family or more than one person, this will be recorded by NCISH as a single incident;

    b) offenders who have been *convicted* - so miss those who are not convicted – e.g. those kill themselves after killing others (murder suicides), or who die from natural causes before trial, or where there is no prosecution (as in some cases where the offender has dementia) and;

    c) offenders who are in *recent receipt of mental health services from secondary mental health trusts*, so miss out mentally ill people who are only in contact with their GP, A&E department, or who are otherwise unable or unwilling to access such services.

46. To give just one example: Derrick Bird shot and killed 12 people in Cumbria in June 2010. Forensic psychiatric evidence at the Inquest said he was mentally disordered at the time. These 12 killings would have only been recorded as

one incident in the NCISH data if he had survived and been a recent patient of the local mental health trust. But Derrick Bird killed himself so there was no trial, no conviction, and so none of these twelve mental health related killings would have been included in the NCISH figures at all.

47. I question the value of such under-reporting as, in my view, it makes learning from these very serious events far more difficult. If we don't understand the true scale of the problem, how can we start to address it effectively?

48. The data on mental health homicides I have collected is entered into a database and published with any relevant official report(s) on the regional victims' pages of our website. (A copy of the webpage is attached as exhibit WITN0258006)

49. The aim is to be as open and transparent as possible and to give families and professionals an idea of the frequency of these cases in their local area and to show what has been investigated before and what, if anything, has been learned from them.

50. Some forensic psychiatrists have contacted me to say our database is a valuable resource for them.

51. One told me he could only find the Inquiry report relating to a previous killing committed by his patient on our website as it wasn't included in the patient's clinical record available to him.

52. I understand an Inquiry database and repository has now been established for NHS mental health professionals but has not been widely publicised and is unavailable to the public.

NHS Investigations

53. As previously mentioned, the Department of Health originally issued guidance mandating NHS Independent Investigations follow patient homicides in 1994. The investigation system has gone through several iterations since then with the most recent being NHS England's 'Serious Incident Framework' (2015) and more recently the Patient Safety Incident Response Framework – PSIRF (2020/22). (The relevant guidance is attached as exhibits WITN0258007 and WITN0258008)

54. In general, all cases of recent patients of NHS mental health trusts who have committed a homicide should result in a Patient Safety internal investigation by that Trust, which should examine the care and treatment of the patient to see if there were any problems in care, which, if corrected, might assist learning and improvement in services to help prevent similar incidents in future.

55. We are aware from Freedom of Information requests however that some NHS mental health trusts do not always undertake serious incident investigations after a homicide is committed by one of their patients.

56. These investigations should consult all available sources of information including patient records, and interviews with staff and the affected families of the perpetrator and the victims. This does not always happen.

57. According to the official NHS PSIRF guidance the draft report must be shared with families '*before it is finalised, and those affected given a realistic opportunity to influence the content before it is finalised'* . (The relevant

guidance is attached as exhibit WITN0258009). Again unfortunately this does not always happen and if so, in my experience causes great distress to many families.

58. The Trust internal reports are generally not published or made available to a wider audience outside of the mental health trust and NHS England.

59. There is substantial evidence from previous NHS Independent Investigations that some internal Trust investigations are not as robust or as inquiring as they should be. (I can supply examples if required.) This may be because they are investigating themselves and are not independent from the services they are investigating.

60. When completed Trust internal investigations are submitted to NHS England Regional Review groups for consideration whether there should be a further Independent Investigation commissioned by NHS England.

61. There have been several hundred such Independent investigations published since 1993. I make many of them available on the website as a public service to chart what problems in care have previously been documented in any particular region.

62. Independent Investigations used to be routinely published on the NHS England website to promote effective learning and to ensure transparency and confidence in public services.

63. Since 2023 however NHS England has stopped publishing Independent Investigations in full, citing patient confidentiality issues. I think this practice is wrong, ill-advised, and hinders effective learning and improvement.

64. I think all Independent Investigations should always be published in full to promote transparency and effective learning, unless there are substantial reasons, that are publicly explained, not to do so (such as child safeguarding).

65. I have repeatedly argued to NHS England and the Department of Health and Social Care that patient confidentiality is not absolute and that there is substantial case law and official guidance allowing the lawful publication of such patient information. The previous care and treatment of a patient who kills is a matter of significant public interest, such cases arouse deep public concern about the safe operation of mental health services, and transparency is essential to ensure effective learning for the prevention of further similar crimes.

66. In the Nottingham case, NHS England initially decided that only an executive summary of the Independent investigation would be published (again citing legal advice about patient confidentiality concerns) which was only overturned after the complaints of the families, national press coverage, and the intervention of the Secretary of State.

67. I found it very puzzling how the legal advice NHS England claimed to rely on to prevent publication in full could be discarded so easily and so quickly following such public scrutiny. It suggested to me that the legal advice was not as robust or definitive as NHS England claimed it to be.

68. I understand the current position is to leave it to NHS England regional groups to determine how much, if any, of an investigation should be published. Typically, today only a brief ‘learning summary’ will be published which does

not even name the NHS mental health trust involved. I do not believe this is transparent or sufficient to satisfy public concerns after these killings

69. **I would respectfully suggest the Inquiry could make a recommendation for much greater openness and transparency around the publication of inquiry reports as these are incidents are always matters of significant public interest and concern.**

Learning and Recommendations

Structure and principles of the MHA 1983

70. I am concerned that one of the main principles of the Mental Health Act (MHA) is ‘least restriction.’ In the cases I see this often appears to be construed by clinicians as a reason not to offer effective and timely care in hospital to unwell people who are a danger to themselves or others - in the hope that such care and treatment can be safely managed in the community, often by overstretched community teams.

71. My experience is this hope has often been misplaced and has led to seriously unwell people killing others.

72. I understand the focus on least restriction is claimed to protect the rights of patients, although often there appears to be little if any consideration of the rights of others.

73. In my experience the focus on least restriction of the patient can sometimes put the patient, their families, friends, and others at risk of serious harm.

74. My experience of many homicide cases is that many seriously unwell people do not realise they are ill and will not attend appointments, take medication, or consent to treatment, and until they are seen to do something dangerous or commit a serious crime they will not be detained in hospital.

75. I am concerned that current proposals for reform of the MHA will make it more difficult for seriously unwell people to obtain effective care in hospital, as I understand there will be a requirement on clinicians to predict that the patient will commit *serious* harm, and *when* that serious harm will occur.

76. I know of no psychiatrist who will be able to do this. I fear these proposals will have serious unintended consequences and will contribute to further deaths of patients, their families, and members of the public.

77. I respectfully suggest the Inquiry could usefully consider making a recommendation that for potentially dangerous patients or those with a history of previous violence there should be clearer MHA guidance reminding staff of the need to safeguard and be cognisant of the needs of patient's families and for public protection generally, rather than have a sole fixed focus on the needs of the patient.

78. The MHA guidance should also be clearer to remind clinicians and staff of their obligations to victims (particularly for access to information following conviction) under the statutory Victims Code of Practice.

Patient engagement

79. The current system of delivering mental health care is largely based on an unwell patient recognising they are ill and wanting to be treated. This is often

not the case with seriously unwell people. (There is a recognised condition for this – Anosognosia). This means that patients who are potentially dangerous to themselves or others can easily fall through the net and receive no appropriate care and treatment at all.

80. If a seriously unwell person is deemed to have 'capacity' mental health professionals will often claim they have no legal means to ensure the patient is treated and that there is nothing they can do.

81. In cases I have seen often an assumption will be made that a patient has 'capacity' without undertaking a full capacity assessment to assess this.

82. This can leave potentially dangerous people seriously unwell, untreated, and at liberty in the community.

83. This is often compounded by a failure of services to hear patient's families raising concerns about a deterioration in a seriously ill person and take effective measures to keep them safe.

84. Both of these are common features of many of the cases with which I am involved.

Medication compliance

85. Research shows that adherence to anti-psychotic medication can prevent relapse and negative symptoms in people with serious mental illness and can help keep patients, their families, and the public safe. (A copy of recent research demonstrating this is attached as exhibit WITN0258010)

86. I'm aware some anti-psychotic medication can have side effects which sometimes can be unpleasant for patients.

87. If a patient is on a depot (long acting injectable) medication, then services and the patients' families can be assured that the patient is compliant with their medication. When they are just prescribed oral medication, this assurance can be lost.

88. My experience is, and I believe academic evidence shows, that depot medication can keep people safe and well. (A copy of some research demonstrating this is attached as exhibit WITN0258011)

89. I do have concerns that some potentially dangerous patients can refuse depot medication without sufficient challenge or encouragement. (I understand some heavily tattooed patients have successfully refused depot injections because they have claimed to be afraid of needles).

90. I have also seen however that the necessary assertive follow up to ensure potentially dangerous patients on oral medication are compliant does not always happen, which can lead to serious problems and deaths.

91. In cases where seriously unwell people have no insight into their illness and do not think they are ill, they will often fail to take their medication, despite assuring professionals that they are complying. (I have seen many cases where stockpiles of medication have been found in a patient's house after a serious incident).

92. We have had many cases unfortunately where busy community mental health workers have not adequately checked a patient's compliance with taking their medication.

Assertive mental health care

93. I am aware that there is a severe shortage of psychiatric beds in the United Kingdom down from around 150,000 in 1954 to less that 18,000 today (A copy of the recent statistics is attached as exhibit WITN0258012) which has meant that seriously unwell people are unable to receive effective care in hospital, and that those who are in hospital can be released too early before they are properly well.

94. This is a clear risk to patient and public safety.

95. There appears to be a culture within mental health services of 'gatekeeping' and actively avoiding the admission of seriously unwell people for treatment in hospital in the hope that they can be effectively treated in the community. This does not always happen.

96. In my experience the vast majority of mental health related homicides involve people who have either been unable, or unwilling, to access timely and effective mental health care and treatment.

97. In the cases I see many mental health staff have just appeared to accept what a seriously unwell patient tells them without sufficient challenge or corroboration. This appears to be out of a fear of alienating the patient which may lead them to disengaging from services.

98. Such patients can however often be inaccurate informants, leaving staff ill-informed about the patient's actual mental state, compliance with medication, abstinence from street drugs, and potential for risk to themselves or others.

99. In my opinion such patients do need more assertive and regular contact and support from specialist mental health services to keep them safe and well and to safeguard their families, and the public.

100. The provision of and access to such assertive services would, in my opinion, reduce the number of patient homicides and suicides.

101. In the aftermath of the Nottingham and Southport murders NHS England asked NHS Integrated Care Boards to report on the state of their assertive outreach services. Although this was a public request I was concerned after I made a Freedom of Information request for the responses to be told that they were secret and couldn't be disclosed as "*releasing information would be likely to generate extremely unhelpful discourse.*"

102. This is hardly open and transparent and, in my opinion, gives the impression that there aren't yet sufficient assertive mental health services across the country.

103. Although there has been government pressure for NHS providers to establish (or reinforce) assertive outreach mental health services I understand that no new funding has been allocated for this, which is concerning.

Confidentiality

104. I am extremely concerned about the lack of transparency and accountability in the current mental health system. This appears to be often based on a claimed, but in my view erroneous, need for 'patient confidentiality' to be upheld in all circumstances.

105. My understanding of the law (and I am not a lawyer) is that the requirement for patient confidentiality is not absolute, particularly for patients who commit serious crimes.

106. In my view patients who kill and have been convicted in open court will have a reduced expectation of privacy (because of their criminal acts) than other patients who have committed no such offences.

107. In my view every mental health patient homicide is of significant public interest. I have never received an answer when I have asked NHS England which mental health killing is not of public interest.

108. I have seen no evidence that NHS mental health services are sufficiently able to determine 'public interest' fairly.

109. Failing to be open and transparent can also raise victims' suspicions that mental health services have something to hide and may be more concerned with management of reputational risk than in assisting victims.

110. Current NHS national guidance (particularly the Duty of Candour and PSIRF) requires NHS providers to be open and honest with affected persons after patient safety incidents such as homicides. I'm aware of many cases however

where the official guidance has just been ignored, apparently without consequence.

111. I am aware of cases where concerned families of those who are seriously unwell and potentially dangerous have been denied crucial information because of alleged patient confidentiality.

112. Killings committed by people with serious mentally health problems are matters of significant public interest and concern. They raise serious questions about the safety and effectiveness of mental health services to protect the public. If there are problems in care that contributed to what happened, the public will want to know they won't be repeated in further killings.

113. In the current system the killer can determine how much information their victims receive, if any. This is because mental health services will often only share information with bereaved families if the offender consents (as happened in my case).

114. If the killer declines to give their consent, then the family will often not receive the information they need to help them cope and recover from the murder.

115. This is unfair and often retraumatising. It is often experienced as yet another devastating blow by the killer to a grieving family they have harmed so terribly.

116. In my opinion this is cannot right. It is cruel and inhumane and an affront to any form of natural justice.

117. **I would respectfully suggest that the Inquiry could make a recommendation for reform of patient confidentiality to provide greater transparency and openness where patients have committed very serious crimes.**

Risk assessment and public protection

118. In my view the assessment of risk for patients in mental health services should be a relatively simple process. It is about accurately understanding what has happened in the past when a patient was unwell, and then making adequate plans should they become unwell again in future.

119. It is not about predicting when such harm or violence will occur, it is about doing everything possible to prevent future harm.

120. Very many thematic reviews of NHS Independent Investigations find repeated problems to assess and manage the risk effectively for potentially dangerous patients. (A copy of one such review is attached as exhibit WITN0258013).

121. Typically, the risk will be assessed only *to* the patient, not the risk *from* them – i.e. the risk they pose to others.

122. In many cases it appears that the risk is assessed largely on the patient's self-report, with little if any attempt to corroborate what they say from other sources (including families). Often these self-reports can be inaccurate and self-serving. The lack of 'professional curiosity' is a common feature highlighted in Independent Inquiry reports after patient homicides.

123. In some NHS mental health trusts a patient's risk is assessed based on what has been recorded as 'current' and 'historic' risks. Historic risks can be anything over two weeks ago. In my experience 'historic' risks have often been disregarded or ignored even though they have been very serious.

124. Ignoring risks over two weeks ago can lead to a catastrophic failure to assess and manage the risk properly.

125. As much mental health care is based on the recovery model (that all patients can get better) and given that a longitudinal view of a patient's risk history is not always considered, many of the homicide cases I have seen have frequently been assessed inaccurately as 'low risk.' A more detailed and assertive examination of the history and available evidence would have likely assessed the actual risk of harm to be at a much higher level.

126. Mental health professionals often express surprise when a catastrophic incident happens when they have not sufficiently considered all the evidence and erroneously concluded the actual risk was low.

127. Professionals can also exhibit '*Optimism Bias'* – a positive outlook that things will be well - disregarding when serious concerns have been raised, which can hinder the delivery of safe and effective mental health care.

128. When risk of serious harm is known to mental health services from their patients to named individuals there can often be a failure to notify the Police (so they can issue an Osman warning) or inform and warn the individuals at risk themselves so they can take preventative and protective action. This is a failure to safeguard and protect the public.

129. Safeguarding practices often appear to be primarily for the benefit of the patient and not to safeguard and protect vulnerable others.

130. I'd respectfully suggest the inquiry could recommend that services be more aware of the risks to others and the need to safeguard them rather than solely focus on the needs of the patient. In my view Mental Health Services need to take public protection far more seriously.

131. A failure to assess and manage risk properly can often result in catastrophic incidents affecting patients, families and local communities for life.

Community Treatment Orders

132. I believe Community Treatment Orders (CTOs) can be extremely helpful for keeping seriously unwell people safe.

133. As mentioned above, most of the problems I see occur in people who are either unable, or unwilling, to access effective care and treatment. Making sure people who are potentially a risk to themselves, their families, or others, to remain engaged with treatment is important for patient and public protection.

134. The objections to CTOs often appear to be based on a single flawed academic study, based on a questionable premise, which ignore other more favourable studies. (See for example the academic research attached as exhibit WITN0258014)

135. Objectors to CTOs can also claim that they are not the 'least restrictive' measures and therefore go against the principles of the MHA.

136. I have seen many cases where seriously unwell patients are treated in hospital, given medication which stabilises them, they are released, fail to take their medication and become unwell again and are sent back to hospital – as an almost revolving door.

137. I am aware of cases where a CTO was prematurely rescinded, the patient quickly became seriously unwell again and ended up killing a member of their family

138. It appears to me that keeping people safe and well and in treatment through CTOs for extended periods can only be beneficial.

Listening to families

139. A common problem highlighted in many independent and other investigations following a patient homicide is a failure of services before the incident to listen to and act on concerns of families.

140. Around 80% of patient homicides happen within families and friends and they are often best placed to notice a serious deterioration in a patient's mental health and alert appropriate mental health services.

141. Currently there is no active plan for concerned families to seek an independent second opinion to escalate concerns if they are not being listened to. There is currently no operational 'Martha's Rule' for mental health services.

I would respectfully suggest it would helpful if the Inquiry could consider making a recommendation on this.

The criminal justice system and mental health related homicides.

i) Prior to the incident

142. In several homicides cases I have been involved with there have been significant problems with the exchange of risk information between Police and mental health services before an incident. This can mean both sides are not sufficiently informed about the risk a patient poses to others and are consequently hampered to take effective steps to prevent a serious incident.

143. I've had cases where street triage services have deemed a seriously unwell patient not a risk without a full examination or without access to all relevant patient information.

144. On occasion Doctors and social workers undertaking an MHA assessment in Police custody have inappropriately relied on the word of custody sergeants about the degree of a detained person's mental illness. In one case, late at night, the custody sergeant reported no problems as the patient had been asleep since they had recently come on shift. This was apparently sufficient for the assessment team for the man not be deemed to require detention under the MHA. When he was released, he later went on to kill a child and severely injure other children.

ii) Prosecution

145. Although victims have (soon to be statutory) rights under the Victims Code of Practice, particularly to be kept informed about the progress of a prosecution, this is often an area where the CPS appears to struggle, and often does not engage sufficiently well, or early enough, with bereaved families.

146. Sometimes meetings with the CPS take place very shortly before, or on the day of the hearing, if they take place at all.

147. I have known cases where the CPS has refused to share information with bereaved families that has been delivered in open court and is a matter of public record.

148. There is, in my experience, a particular problem with Diminished Responsibility cases.

149. Often the psychiatric evidence on which these convictions rely are not shared with families or sufficiently questioned or discussed in open court.

150. We have seen numerous occasions where psychiatrists giving evidence have clearly strayed outside of their area of medical expertise, without any comment or sanction from the court.

151. Many families consider this to be *'Trial by Doctor'* rather than Open Justice.

iii) Disposals

152. Many of the families I have supported express serious concerns about Hospital Orders.

153. Many families of the families I support believe that cases of diminished responsibility should involve a penal element to address the retained responsibility, which is why many families would prefer to see greater use of Section 45a hybrid orders.

154. When offenders are sentenced '*indefinitely*' under Sections 37 and 41 of the mental health act, judges and psychiatrists will often state that the offender '*may never be released'* (and as happened in the Nottingham trial).

155. This is, in my view and experience, highly misleading and inaccurate.

156. In 2017 the National Institute of Health Research conducted a study of the length of stay of mentally disordered offenders in high secure and medium secure psychiatric hospitals. (A copy of the relevant finding is attached as exhibit WITN0258015).

157. They found that 87% of patients stayed less than 10 years in high secure hospitals and 98% stayed less than 20 years. In medium secure hospitals 99% of offender patients were released after serving less than 10 years.

158. In our experience it is not unusual for mentally ill offenders who have killed and been sentenced to hospital orders to be discharged into the community after three to five years.

159. Under current provisions restricted patients who have killed can apply for release within six months of sentencing.

160. Such offenders may have strict monitoring for the first year or so on release, but in my experience that responsibility for their supervision will often be transferred from specialist forensic teams to more generic community teams, after a few years, with less regular contact and supervision which can be when problems can arise.

161. I am aware of at least 30 cases where mentally disordered offenders, restricted patients, who have previously been convicted of very serious crimes (some had killed), and sentenced to hospital orders *have killed* following their discharge by Mental Health Tribunals.

162. These killings often occurred a few years after their release from hospital and when they had been only irregularly monitored by mental health staff.

163. It is also claimed that if such offenders were sentenced to a hybrid order and had to serve part of their sentence in prison, they could refuse their medication, become unwell again and pose a risk to others.

164. I do not understand why in such cases a mental health treatment requirement, (or some prison equivalent of a CTO), could not be imposed to ensure medication and treatment compliance. This would, in my opinion, result in a fairer system which would recognise that the responsibility was diminished but not extinguished.

Mental Health Tribunals (First Tier Tribunals (mental health))

165. There is a severe lack of transparency and open justice around mental health tribunals considering the release of dangerous patients who have killed.

166. They operate in secret and are, as far as I am aware, not subject to any form of public scrutiny whatsoever.

167. We are not allowed to know the names of the judges, the evidence heard, how they come to reach their decisions, and whether those decisions are safe and in the interests of justice.

168. We have no way of telling if they are routinely racist or biased.

169. We do not know if they are even acting lawfully when discharging dangerous patients as there is no evidence publicly available to assess and confirm this.

170. They are, in my opinion, the last secret courts.

171. All we have are some basic statistics from the Care Quality Commission about the number of hearings and discharges. This is insufficient for adequate public scrutiny. (A copy of the latest CQC report is attached as exhibit WITN0258016).

172. Out of many tens of thousands of restricted patient tribunal hearings, I understand only four have ever been held in public. (viz. Jared Brittin, Ian Brady, Albert Haines, and a case known as 'T').

173. In the family courts cases concerning the fate of young children (who have committed no crime) by contrast can be held in public and reported on (with some conditions to protect anonymity). In family courts the public can see decisions are taken openly and lawfully. This is not the case with mental health tribunals.

174. From the limited information currently available mental health tribunal panels effectively appear to be a 'closed shop' with judges typically appointed from solicitors who have previous extensive experience representing patients, medical members who are doctors who have treated psychiatric patients, and a specialist member who is typically a social worker who has professional experience of working with mentally unwell patients. There is no independent

voice or oversight to represent the interest of the public, or to ensure decisions are taken to protect public safety.

175. In my experience the mental health tribunal often appears to be far more concerned with preventing the unjustified detention of the patient rather than ensuring the safety and protection of the public.

176. I have seen no recent analysis of the outcome of tribunal decisions after discharging Restricted Patients.

177. Until our charity campaigned on the matter tribunals did not always have access to the judge's sentencing remarks from the index offence, did not have full information on what had happened, and yet were regularly making decisions to discharge previously very dangerous patients without this vital information. Since our campaign I understand the MoJ now does supply these remarks, which I have been told have been found to be helpful.

178. As mentioned earlier, I am aware of at least 30 cases where restricted patients who have previously been convicted of serious crimes (including homicide) have killed following their subsequent discharge from hospital by mental health tribunals. I am happy to supply further details if required.

179. In my experience unlike the Parole Board, Mental Health Tribunals have been extremely reluctant to disclose any information to victims, despite having wide discretionary powers.

180. I was shocked to learn that victims are not considered to be 'interested parties' in a legal process about the release of their loved one's killers.

181. Affected families are not allowed to appeal any Tribunal decision as they are not interested parties.

182. The decision to release previously dangerous patients are matters of serious public and not strictly private concern.

183. Victims currently are only allowed to make submissions on conditions of discharge and on no other matter. Many find this patronising and offensive.

184. I understand the tribunal judiciary actively fought the introduction of Victim Impact Statements to tribunals under the Victims and Prisoners Bill and was successful in limiting such statements to just terms and conditions.

185. Tribunals do not seem to have any understanding or received any training in the needs of victims.

186. This was manifest in the *Maher* Judicial Review where I was invited to submit a witness statement (which I am happy to make available).

187. The Judicial Review found the Deputy Chamber President of mental health tribunals had acted unlawfully in refusing Mrs Maher's request for a copy of the tribunal decision that allowed the release of her son's killer.

188. The decision found that in terms of the general progress of other jurisdictions to openness and transparency the approach of mental health tribunal system *'is something of an outlier.'*

189. I believe it is not just or fair for a bereaved family to have to go to the lengths of funding and submitting a judicial review to obtain even basic information

about the release of extremely dangerous and previously homicidal offenders who killed their loved ones.

190. **I would respectfully ask the Inquiry to make a recommendation for steps to be taken to ensure much greater openness and transparency in the tribunal system so that families and the public can be assured that safe, proportionate and lawful decisions are being made about the release of mentally ill offenders who have previously committed serious crimes. There needs to be open justice in the Tribunal system**

Assistance to the Nottingham families

191. Although I was very aware of the case from the day of the killings, I first became involved with all three of the bereaved Nottingham families in September 2023 following a referral I received from Victim Support Homicide Service. I have supported them ever since.

192. I have been able to outline to them all the processes they were likely to encounter following the killings, with the criminal prosecution, NHS and other investigations and in conversations with official agencies, based on my experience with many other similarly affected families.

193. I attended all three days of the sentencing hearing in Nottingham in January 2024 and have accompanied and supported them in meetings with the Crown Prosecution Service, Nottinghamshire Healthcare NHS Foundation Trust, NHS England, HMCPS Inspectorate, Independent Office of Police Conduct, Government ministers and officials, and others.

194. I have also supplied them with background information, statistics and reports to help their understanding of mental health related homicides in the UK.

Nottingham Inquiry Questionnaire

195. I have been asked by the Inquiry to help distribute the Inquiry questionnaire and support affected families in the process. I produced a briefing document and shared it with over 240 affected individuals as well as other charities working with families who have been bereaved by homicides.

196. The briefing document is attached as exhibit WITN0258-017.

Principles for improvement

197. I believe there should be far more openness and transparency generally in mental health services and particularly for victims. There needs to be far greater accountability when things have gone wrong. Mental Health Services need to understand they are accountable to public concerns. Criminal justice agencies, the tribunal system and mental health services must all improve the way they relate to and support victims of mental health welted homicides. We must learn from these awful tragedies so that as far as possible the same mistakes are never repeated. Avoidable killings must be prevented. The deaths of our loved ones matter.

Statement of Truth

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

Signed:

GRO-B

Dated: 2 November 2025

Index to Final Witness Statement of Julian Hendy;

No.	Inquiry URN	Document Description
1	WITN0258-002	Referred to as exhibit JH/1. Table 12 - covering the Number of homicide victims of patients or people with mental illness at the time of the offence; Number of apparent / actual / suspected [patient] homicides.
2	WITN0258-003	Referred to as exhibit JH/2- Statistics on victims in the East Midlands from hundredfamilies.org.
3	WITN0258-004	Referred to as exhibit JH/3- Table containing statistics regrading offences initially recorded as homicide from December 1960 to March 2024.
4	WITN0258-005	Referred to as exhibit JH/4- Article from Cambridge University Pres dated 6 July 2020 titled: Mental disorder in people convicted of homicide: long-term national trends in rates and court outcomes.
5	WITN0258-006	Referred to as exhibit JH/5- Statistics of victims by region from hundredfamilies.org.
6	WITN0258-007	Referred to as exhibit JH/6- Extract from NHS England's Serious Incident Framework from 2020.
7	WITN0258-008	Referred to as exhibit JH/7- Extract from NHS England titled: Patient Safety Incident Response Framework.
8	WITN0258-009	Referred to as exhibit JH/8- Extract titled: Patient Safety Incident Response Framework supporting guidance. Engaging and involving patients, families and staff following a patient safety incident.
9	WITN0258-010	Referred to as exhibit JH/9- Extract of article from BMJ titled: Clinical care for patients at risk of psychosis related violence.
10	WITN0258-011	Referred to as exhibit JH/10- Extract of article titled: Use of Depot Antipsychotic Medication and Nonadherence in Schizophrenia.
11	WITN0258-012	Referred to as exhibit JH/11- Statistics from NHS England covering Bed Availability and Occupancy Data Overnight from April to June 2025.
12	WITN0258-013	Referred to as exhibit JH/12- Extract from article titled: An independent thematic review of investigations into the

		care and treatment provided to service users who committed a homicide and to a victim of homicide by Sussex Partnership NHS Foundation Trust. Prepared by Caring Solutions (UK) Ltd.
13	WITN0258-014	Referred to as exhibit JH/13- Extract from OCTET Study: flawed by type 2 error, dated 2nd January 2018.
14	WITN0258-015	Referred to as exhibit JH/14- Table 11 Length of stay by category groups in high and medium secure samples.
15	WITN0258-016	Referred to as exhibit JH/15- Extract containing Figure 10: Outcomes of applications against detention to the first-tier Tribunal (Mental Health) 2023/24
16	WITN0258-017	Briefing note on the questionnaire distributed to families on behalf of the Inquiry.