

Witness Name: Adrian Gerard West

Statement No: WITN0338001

Dated: 5 December 2025

## THE NOTTINGHAM INQUIRY

### FIRST WITNESS STATEMENT OF ADRIAN GERARD WEST

This witness statement is made to assist the Nottingham Inquiry (the “**Inquiry**”) with the matters set out in the Rule 9 Request I received, dated 16 October 2025 (the “**Request**”).

I, Adrian Gerard West, will say as follows: -

1. I am providing this statement both as a private citizen and in my role as a Practitioner Psychologist with Health and Care Professions Council (HCPC) registrations in Forensic and Clinical Psychology. Since I hold both HCPC registrations, I am referred to as a Forensic Clinical Psychologist.<sup>i</sup>
2. The observations, opinion and recommendations which I set out in this statement do not represent those of the National Crime Agency.
3. This statement is submitted in response to the questions set by the Inquiry which I received on 16 October 2025. I have attempted to address the questions which are relevant to my experience and competence.

## Summary

4. Effective care in mental health services requires understanding of both a person's needs and the risk of harm they may present to themselves and others. My concern is that the values and philosophy underpinning the current approaches of some professionals in mental health services appears to have over emphasised service user autonomy and empowerment at the expense of consideration of their role in protecting the public. In my opinion, there appears to be a distance between mental health services and the other services focussed on public protection. The ideology of Positive Risk Management, however unintentionally, can deny the reality of the link between serious mental illness and violence. 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. I acknowledge that Trauma Informed Care recognises the vulnerability of victims and offenders, but Positive Risk Management and terms like Positive Risk Taking in the context of mental health services can be misunderstood and wrongly applied. Risk should refer to threat of harm and not to benefit.
  
5. My experience as a Forensic Clinical Psychologist in working with the Police Service has significantly changed my understanding of the assessment of offenders and their offences. Our starting point for understanding their actions and motivation should always be the collateral sources of information that are available

from the court and related services. Such information should be more widely available to inform both our efforts at care and rehabilitation as well as risk assessment and management. The current limitations of risk assessment methods should not be overlooked and it is time for a reconsideration of their current application. Importantly, my experience of the Police Service has also revealed how it operates as a victim focussed service and how in contrast, the other victim sometimes seems to be so easily forgotten in mental health services.

### **Qualifications and career**

6. I have a BA (Hons) degree in Psychology from the University of Warwick (1980) and a Doctorate in Psychology from the University of Surrey (2000). I gained the British Psychological Society Diploma in Clinical Psychology in 1989 and the BPS Chartership in Forensic Psychology in 2004.
7. In June 1996, I completed police hostage negotiator-training course at the Metropolitan Police Training School, Hendon. I have continued to advise the Police Service on hostage and crisis incidents in operational deployments since that time.
8. In 2004, I was awarded the inaugural Association of Chief Police Officers (ACPO) homicide award for a non-police specialist's outstanding contribution to the investigation of homicide.

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9. In 2016, I completed the Professionally Qualified Officers Commissioning course at the Royal Military Academy Sandhurst. I remain a commissioned officer in the Army Reserve.

### **Career and roles across mental health and law enforcement**

10. Throughout my career, I have worked as a Forensic Clinical Psychologist in high secure and medium secure psychiatric settings where, as a practitioner and member of a multidisciplinary clinical team, I have contributed to the multidisciplinary assessments of patients who have committed violent and sexual offences. These assessments typically involve repeated interviews and psychometric assessments to understand an offender's mental state, developmental and background history, personality, criminal history, motivation and risk of re-offending.
  
11. As a trainee and then on qualification as a Clinical Psychologist in 1989, I worked at Broadmoor High Secure hospital as a multidisciplinary team member involved in the assessment and treatment of those detained there. From 1993 until 2003, I then worked at Ashworth High Secure Hospital in a similar role. From 2003 until 2007, I worked at the Guild Lodge medium secure unit (Goosnargh, Lancashire) as a Consultant Forensic Clinical Psychologist. From 2007, I was a Consultant Forensic Clinical Psychologist and head of the Psychology Department at the Edenfield Centre, Prestwich Hospital, Manchester until 2015 when I was made redundant. From October 2021 until April 2023, I returned to the Edenfield Centre to work one day a week as a Clinical Psychologist in the multidisciplinary team that

was involved in the assessment and treatment of men who had been transferred there from prison. Some of my previous criticisms concerning the situation at the Edenfield Centre were noted in the Shanley Report (NHS, England, 2024). NHSE0002741

12. Since 1994, I have applied my forensic clinical experience as an advisor to the police service in many serious violent and sexual crimes and other complex investigations. Currently, I have a part time role as a Forensic Clinical Psychologist advisor in Major Crime Investigative Support, (MCIS), National Crime Agency (NCA), where I am involved in a multidisciplinary team of advisors who assist the police service in the UK, and sometimes overseas, in the investigation of homicides, serious sexual assault, arson and complex crime. Risk and threat assessment are included in my role.

13. The knowledge and skills underpinning my role in law enforcement are grounded in extensive forensically based clinical work as a Forensic Clinical Psychologist in a variety of settings from various times in my career (e.g. secure mental health units, outpatient clinics, in reach prison services, Multi-Agency Public Protection Arrangements,(MAPPA)). I have also participated in court and related judicial hearings (Mental Health Review Tribunal; Parole Board; HM Coroner) either as a professional or expert witness, including, for example, to HM Coroner in relation to the West Cumbria shootings (June 2010). My practice is also informed by comprehensive knowledge of relevant theories and research studies. These include theories, models and typologies from Investigative and Forensic Psychology, Criminal Psychopathology, Clinical Psychology and Forensic Psychiatry (West, 2000). WITN0338025

14. The role of the Forensic Clinical Psychologist in criminal investigations is multifaceted, involving judgements and advice about human behaviour, criminogenic factors, mental health issues/disorders, offenders' potential risk to self and others, appropriate police interview strategy, hostage and crisis negotiations and sometimes direct interactions with suspects and witnesses. It typically involves the assessment of dynamic factors (that is, characterised by a rapidly changing situation) and often requires urgent investigative advice. My role is essentially to apply my clinical understanding of offenders in conjunction with my knowledge of Psychopathology and the behavioural science evidence base into workable investigative ideas within a major incident room.

15. I am not currently employed in mental health services as a Forensic Clinical Psychologist though I remain involved in supervision. Also, my role as an advisor in hostage and crisis negotiation means that I am sometimes in contact with clinicians in mental health services in situations when I am seeking clinical and risk information, to assist officers in the management of an acute crisis. My role has meant that in the investigation of stranger homicides, I have frequently either sent letters or directly contacted local mental health services to seek their help, in accordance with their responsibility to prevent harm, in order to consider any service users who have come to notice because of relevant disclosures or concerns about their non-compliance with treatment.

16. Recently, I have been an expert witness to Parts 1 and 2 of the Angiolini Inquiry.

17. I am a practitioner and not an academic. I am not a specialist in Mental Health law. I am not a specialist in the epidemiology of mental illness and its link to violence.

### **Limitations**

18. In writing this statement, I have not provided a systematic review of the relevant evidence-based literature on risk assessment or the principles and application of Trauma Informed Care and Positive Risk Management. Therefore, I am aware that my opinion can be challenged for being too anecdotal and impressionistic. However, my statement reflects my clinical and investigative experience of the past thirty years.

19. I acknowledge that despite my best efforts to remain objective, my perspective is unavoidably shaped not only by my investigative experience, but also by my experience as a clinician of violence perpetrated by mentally disordered offenders against staff and other patients in in-patient settings.

### **Contact with the Nottingham Inquiry**

20. As a private citizen, I first contacted the Nottingham Inquiry on 6 October 2025.

21. As the basis for that note, I had read the report of the Independent Investigation into the Care and Treatment provided to Valdo Calocane (VC) (Theemis, 2025) for information about the history of VC and the Sentencing Remarks (Courts and

Tribunals Judiciary, 2024) for the circumstances of this offence. I was not involved in the police investigation of the homicides and other injuries perpetrated by Valdo Calocane. Nevertheless, my awareness of other homicides committed by individuals who were either engaged with mental health services or should have been, combined with the impact of the violence and grief caused by the incidents in Nottingham, influenced my decision to contact the Inquiry.

NHSE0000298

CPSE0000160

22. When I first contacted the Inquiry on 6 October 2025, I referred to the recorded failings in the management of VC’s mental disorder and failings in risk assessment and management: These include that:

- Risk assessments minimised or omitted key details and did not make explicit the serious nature of the risk VC posed to himself and others based on previous behaviour.
- VC’s family contacted NHFT to raise concerns on a number of occasions but the information they provided was not consistently act on.
- *“The prioritisation of a positive risk management approach may have impacted the ability to achieve medication concordance, engagement with services and an increased level of insight”* (Theemis, 2025:127). NHSE0000298
- *“[It] appears that each admission was seen isolation with a lack of cumulative perspective ... VC appeared to recover quickly from each psychotic episode when an inpatient ... VC would then assure staff that he was willing to engage*

*with the EIP team in the community and take his medication” (Theemis, 2025:128).* **NHSE0000298**

- *“The inpatient team involved in VC’s care were trying to treat VC in the least restrictive way and took on board VC’s reasons for not wanting to take depot medication ...” (Theemis, 2025:142).* **NHSE0000298**

23. I noted that VC had four relatively short admissions over the space of two years. Non-compliance with medication was recorded from early on. There was evidence that he could present a risk to others when he was relapsing. In the community he had a repeated pattern of disengaging from mental health services and not taking medication. He was consistently hard to engage. Ultimately, his failure to engage with follow-up seems to have been respected as a personal choice, and he was discharged from the mental health service (Whittaker, 2024). **WITN0338027**

24. Like others, I found it necessary to refer to the case of Christopher Clunis and the findings of the report which followed (Ritchie et al., 1994). Parallels with the situation of Valdo Calocane have been made, suggesting that both cases exemplify longstanding systemic problems in the provision of mental health services. **DHSC0000160**

25. In December 1992, Jonathan Zito, an Italian American, aged 27 years, was also killed in a random and unprovoked murder by Christopher Clunis, a mentally ill

young man.<sup>1</sup> The Report of the Inquiry into the Care and Treatment of Christopher Clunis (Ritchie et al., 1994) revealed a 'catalogue of failures' in his assessment and care (Coid, 1994:449). In that case, there was also a tendency to underestimate the seriousness of his behaviour; the police failed to charge Christopher Clunis following violent incidents (for example, in June 1989, he attempted to stab a police officer but there were no criminal charges); a desire to help and not stigmatise prevailed; he had frequent admissions which were linked to non-compliance with medication and once in hospital with his medication resumed and his illness under control, he was discharged rapidly; and significantly, *"each episode of illness was treated separately rather than as part of a continuing illness"* (Ritchie et al, 1994:13). Professor Jeremy Coid, a respected Forensic Psychiatrist, concluded at that time,

*"Jonathan Zito died because the ideology and organisation of mental health care services, the training of healthcare professionals, and the facilities available are simply inadequate for patients whose conditions remain intractable and render them uncooperative with care in the community. The legislation which might have rendered some chance of his receiving treatment outside of hospital does not exist. Furthermore, the type of in-patient facility that he truly needed has been closed in much of the UK. If ever a patient required prolonged institutional care, it was*

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<sup>1</sup> On Thursday, 17 December 1992, Jonathan Zito, had stood waiting for a tube train with his brother on a platform of the London Underground. Without any warning a man who had been close by and acting in a bizarre manner stabbed him three times in the face. One of the wounds penetrated upwards over his eye, into his brain. The killing of Jonathan Zito occurred during daylight hours in a busy urban location accessed by everyday commuters. The common place nature of such an unprovoked and random fatal stabbing undermined the public's sense of safety. Furthermore, the case of Christopher Clunis came to be used as the primary example of the failure of the NHS Community Care Act, (1990) during a time of growing concern about mental health care.

*Clunis. Sadly, it was only after he killed an innocent member of the public that he could receive it* (Coid, 1994:452). DHSC0000160

26. The requirement for longer-term in-patient services for patients who cannot be managed in the community remains (Thomas et al., 2019). WITN0338022

### **The relevance of other Inquiry Reports**

27. There are many other Inquiries, some from many years ago as well as the more recent, that remain relevant to the Nottingham Inquiry. For example, Blom-Cooper et al. (1995) reported on the 1993 homicide of Occupational Therapist Georgina Robinson by an inpatient at the Edith Morgan Centre, Torbay, that, *“It was entirely predictable that one day Andrew Robinson if he was not maintained on medication under proper supervision, would attack someone (probably a young woman) and that steps should and could have been taken to prevent such an eventuality. That the necessary steps were not taken is the burden of our report. Mrs Wendy Robinson (Georgina’s mother) was not overstating the case when she told us that her daughter’s life was sacrificed to the inadequate care and treatment provided by mental health policy and practice for the severely mentally disordered people in the country”* (Blom-Cooper et al., 1995:6). WITN0338004

28. Blom Cooper et al., (1995:175) identified again that the details of the index offence first committed by the perpetrator were not fully considered in assessing his likely progress. Reassuring assessments by clinicians outweighed the reporting of ominous signs of danger obvious to his parents and friends; the clinical team

gave insufficient weight to his clear history of life-threatening violence: *“The picture was clearly emerging of a young man with a long history of severe psychotic disturbance, who had a demonstrable and therefore, predictable pattern of deteriorating mental health whenever medication was discontinued, whose behaviour was attracting the attention and concern of a range of agencies, and who was resisting engagement with the treatment packages that were on offer. Alarm bells should have been ringing loud and clear”* (Blom-Cooper et al., 1995:100). WITN0338004

29. McGrath and Oyebode (2002) in a qualitative analysis of the findings and recommendations of 79 homicide inquiry reports published between 1994 and 2001 found that the same issues featured repeatedly, suggesting that there was a failure to learn from past mistakes or to implement lessons learned in policy and practice. A significant focus of the recommendations was on the importance of a comprehensive and accurate clinical record that included detailed information about the patient’s previous treatment, previous convictions, episodes of violence and the views of the family and carers. Recommendations included that this information should be readily available to all of the clinicians involved in the patient’s care and combined with the information from other relevant agencies. Risk assessments should be carried out consistently and regularly with a standardised tool with information about a patient’s substance misuse, history of violence and evidence of non-compliance and should incorporate information from the family. Partnership working is emphasised with joint policies on risk assessment between health, social services, criminal justice and housing agencies. Listening to carers and families is emphasised. Regular multi-agency

care planning meetings should be held to exchange information and to provide opportunities for people to voice concerns. Access to and exchange of information in collaborative and joint working should be allowed without loss of confidentiality between agencies. Post discharge after care planning should include the patient, a GP and family and carers. Staff should be supported in supervision through the guidance of more experienced clinicians. **WITN0338018**

30. It is also relevant that these independent inquiries represent a significant financial cost to the NHS each year.

31. More recently, The One Hundred Families charity, which supports families affected by homicides committed by people with serious mental illness, listed on their website the causes they have identified for “why [homicides] keep happening.” These include the denial by campaigners and mental health services of the link between mental illness and violence, inadequate investigations and subsequent reports by mental health trusts and their refusal to commission mandatory independent inquiries, limited public scrutiny, repeated failures without improvement, and the culture of ‘service user centrality’ – an approach that may not be suitable when a patient is very psychotic and lacks insight. The One Hundred Families website provides access to many independent inquiry reports as well as the details of 2400 known cases of homicide by a person with mental illness that have occurred since 1992. A cursory review of these inquiry reports, amongst other things, confirms instances across many trusts of inadequate internal investigations; failures in the duty of candour to carers, families and victims; problems with multidisciplinary working exacerbated by caseload pressures;

inadequate information sharing and lack of multiagency liaison and working; superficial risk assessment and risk management planning; repeated patterns of service user disengagement, non-compliance and relapse, inadequately resolved through short-term acute intervention, followed by discharge; discharge for disengagement and non-attendance despite ongoing mental health issues and risk; and limited assertive outreach services (see, for example, Duncan and Johnstone Consultancy Ltd., 2022). **NHSE0000269**

### **Trauma Informed Care**

32. Trauma-informed care is now the prevailing approach in many mental health services. It is defined as a strengths-based service delivery approach *“that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment”* (Hopper, Bassuk, & Olivet, 2010, p.82). Within secure forensic mental health settings, this approach to care and rehabilitation is characterised by such maxims as, ‘See the person before the offender.’ **WITN0338015**

33. I acknowledge the potential benefits of trauma aware mental health services in the provision of improved supervision for staff and more compassionate, sensitive and responsive assessment and intervention practices for service users. I also acknowledge the pervasive impact of trauma on those who have been harmed through abuse and neglect - they are more likely to exhibit pronounced symptoms and consequences, including substance abuse, mental illness, and health

problems (Substance Abuse and Mental Health Services Administration, 2014). Trauma informed care has also been applied beyond mental health services. For example, it has been promoted as a response to victims and offenders in some police forces in the United Kingdom, emphasising empathy, increased sensitivity to cultural and gender issues and the need to understand the impact of trauma on a person's presentation (Lewis and Bradley, 2023). WITN0338021 WITN0338017

### **Best Practice in Managing Risk (2009)**

34. When I first contacted the Inquiry on 6 October 2025, I referred to Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services (Department of Health, 2009). I acknowledge that this document was written some years ago and that changes in the socio-economic landscape have occurred since then. Nevertheless, the principles it sets out which emphasise service users' strengths, autonomy and recovery - hence its positive risk-taking stance and implicit trauma informed approach - continue to influence stated best practice in risk assessment and management within mental health services (Royal College of Psychiatrists, 2017:9). DHSC0000038 WITN0058002

35. It is noteworthy that the second line of the Foreword by Professor Louis Appleby includes, "*Patient autonomy has to be considered alongside public safety.*" The guidance emphasises, amongst other things, that, "*Risk management must be built on a recognition of the service user's strengths and should emphasise recovery*" (Department of Health, 2009:8). It states that 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 (Department of Health 2009:22). It states that the philosophy underpinning the guidance, *“is one that balances care needs against risk needs”* and which emphasises Positive Risk Management (PRM) as, *“a required competence for all mental health practitioners”* (Department of Health, 2009:8). DHSC0000038

### **Positive Risk Management**

36. Positive Risk Management (PRM) in social and health care advocates a collaborative, strengths-based approach to the risk management of service users. Whereas *“Choosing the safest possible option for care and treatment can be disempowering for the service user and counterproductive for his/her recovery”* (Department of Health, 2010:11), PRM has empowerment as its primary aim. It recognises and amplifies strengths and by instilling hope, drives engagement and recovery (Just et al., 2021). DHSC0000038

37. In contrast to the traditional meaning of risk as exposure to potential harm, PRM begins by considering the potential benefits and is encapsulated in the statement *“It should be remembered that the impact of a risk can be positive and that not all risks will require management.”*<sup>2</sup> In this sense, positive risk taking is assumed to lead to personal change or growth, thereby enhancing the service user’s quality of

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<sup>2</sup> See for example, Gloucestershire.gov.uk: Good Practice Guide – Positive risk taking and personalising choice and control.

life and ultimately their recovery. PRM also promotes the idea that service users are capable of managing risks themselves: *“People can and do become skilled in managing their own risks and only exceptionally need others to temporarily (sic) intervene or take control”* (Boardman and Roberts, 2014:12). A conceptual and practical shift is advocated from the traditional risk assessment approach to one that actively involves the service user in *“person centred safety planning”* (Boardman and Roberts, 2014). **WITN0338016** **WITN0338005**

38. The 2009 Best Practice in Managing Risk guidance relates to three main areas of risk: Violence (including antisocial and offending behaviour), self-harm/suicide, and self-neglect. Collaboration with the service user in the assessment of risk is considered central: *“Risk assessment involves working with the service user to help characterise and estimate each of these aspects: Information about the service user’s history of violence, or self-harm or self-neglect, their relationships and any recent losses or problems, employment and any recent difficulties, housing issues, their family and the support that’s available, and their more general social contacts could all be relevant. It is also relevant to assess how a service user is feeling, thinking and perceiving others not just how they are behaving”* (Department of Health, 2009:15). In contrast to the collaborative and open approach to risk assessment and management which “assures” engagement with the service user in planning for risk, defensive practice is assumed to lead to a negative experience for the service user and their disengagement from services with no strategy in place to manage risk positively. The guidance stated, *“Over defensive practice is bad practice. Avoiding all possible risks is not good for the*

*service user or society in the longer term, and can be counterproductive, creating more problems than it solves” (Department of Health, 2009:9). DHSC0000038*

39. Other guidance from the Department of Health Northern Ireland in 2010 appears to echo the same messages. Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (Department of Health, 2010) includes:

- *“Individual practitioners must be confident to make Positive Risk Management decisions within a supportive organisational culture” (Department of Health, 2010:8).*
- *“Mental health services must support personal recovery, move beyond risk avoidance and towards positive risk taking, by providing care that is personally meaningful to the individual service user and his/her family” (Department of Health, 2010:10).*
- *“Defensive practice is inappropriate, as it creates a focus on staff rather than the service user” (Department of Health, 2010:11).*

40. I am not a medical practitioner. However, I anticipate that the core principles of medical ethics (autonomy, beneficence, non-maleficence, justice) have informed the principles that underpin PRM. Namely, respect for an individual’s autonomy recognises that service users have the right to self-determination and to make informed decisions about their medical care. This obligation seems to underpin the stated imperative of collaboration. Beneficence involves a duty to act in the best interests of service users whilst Justice implies that they should be treated fairly and equitably. Non-maleficence involves the obligation to do no harm.

41. From a Trauma Informed and Positive Risk Management perspective, it may be considered that the primary concern of a psychiatrist and their multidisciplinary team is the care and welfare of the individual service user and that protection of the public is secondary. It may also be considered that the reference to the low base rate of serious violence perpetrated by the mentally ill implicitly substantiates this position (Royal College of Psychiatrists, 2017). WITN0058002

### **Alternative views to the 2009 Framework Document**

42. When I first contacted the Inquiry on 6 October 2025, I requested the Inquiry to review the philosophy and principles that currently underpin risk assessment procedures and risk management as well as the standards of related training and delivery in Health, Probation and other services. I stated that recommendations to address competence in risk assessment by frontline staff and to improve the standards of supervision and oversight by management have featured frequently in previous inquiries in serious further offence and homicide reviews by Health, Probation and related services (for example, HM Inspectorate of Probation, 2023). WITN0338012

43. I also recommended that the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) should reintroduce data collection, analysis, and research on patients known to mental health services who have committed homicide. The findings of the NCISH could then help to identify and address the systemic failures in the delivery of early intervention for and responses to disengagement by service users with psychotic illness by mental health services.

I note that the NCISH has changed its title from the National Confidential Inquiry into Homicide and Suicide by People with Mental Illness to its current form. However, I do not know the reasons for this change but note the absence of Homicide in its title.

44. I was motivated to contact the Inquiry, because in my view it is difficult to reconcile such maxims as *“Over defensive practice is bad practice”* when set against the purpose and cause of this Inquiry. I acknowledge that a significant body of research indicates that individuals with mental illness are more likely to be victims, rather than perpetrators, of violent crimes. I also acknowledge that most people with serious mental illness are not violent and therefore it is important not to amplify the perception that people with serious mental illness are violent. Nevertheless, there is an alternative utilitarian view that states that *“Cautious practice is good practice”* and that the resulting approach may actually be safer for the protection of the service user and the public.

45. I was concerned that the homicides and injuries in Nottingham should be seen not as an exception but as a terrible reminder of a larger number of homicides and injuries perpetrated by people who are mentally disordered who have disengaged from services.

46. It can be argued that by adopting a PRM approach, mental health services position themselves at a distance from those other agencies which are primarily concerned with public protection. From this perspective, it can appear as if the 2009 principles are so skewed towards the autonomy of the service user, that they

are in effect denying that risk of harm can be associated with some states of serious mental disorder. Such an approach may be motivated to limit the damaging effects of the stigma associated with mental illness and to ensure that those who are in need of mental health services are not inhibited from accessing them. There are also legitimate concerns about unnecessary coercion. Nevertheless, it seems reasonable to assert that the protection of the public involves significantly more than remaining aware of “safety needs.” Perhaps this Inquiry provides an opportunity for Psychiatry and the other mental health professions to consider carefully their responsibility and expertise in protecting the public. In my opinion, protection of the public should not be secondary.

47. It is not insignificant in this regard that of the 89 clinicians, academics, bureaucrats, service users and others who developed and advised on the 2009 guidance document, the list included only one Police Inspector and one analyst from a police homicide prevention unit. The limited representation from law enforcement across the country and the absence of senior command from the Police Service, including those involved in the investigation of homicides perpetrated by the mentally ill, points to an obvious bias, however inadvertent. I also note the absence of personnel from other protective services, including Ambulance and Emergency Department hospital staff who provide frontline responses to crisis situations involving service users and their carers. Whilst I am aware of street triage and combined Police and Mental Health response teams in some control rooms, I question whether there are some mental health services which see themselves as different and separate from other protective services. Instead of explicit statements about its assumed obligation to contribute to inter

agency collaboration to protect the public, it can be seen that the guidance appears to rely on more anodyne euphemisms such as, "Safety First." Rather than saying directly that a service user's lack of insight and noncompliance with antipsychotic medication can greatly increase their risk of harm to themselves and others, this situation is characterised as a particularly challenging aspect of the relationship between the service user and the practitioner. Rather than stating that, *"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 behaviours"* (Department of Health, 2009:10), it may be more useful to state that lack of insight increases risk of harm.

DHSC0000038

48. As stated, as a clinician, I am aware of the relevance of Trauma Informed Care and its potential to promote an ethos that takes account of the vulnerability of victims and offenders. Nevertheless, I am concerned that some proponents of Trauma Informed Care and Positive Risk Management may be at risk of denying the fact that when some people are psychotic or overwhelmed by delusional beliefs and they are not adequately supervised or compliant with medication, then they can present an increased risk of harm to themselves and others. I am concerned that these approaches risk enshrining a naivety that in effect denies the reality of the harm that those suffering from mental disorders can inflict on themselves and others when they are unwell, as in:

*"Once you become aware of the significance of traumatic experiences in clients' lives and begin to view their presentation as adaptive, your identification and classification of their presenting symptoms and behaviors can shift from a "pathology" mindset (i.e., defining clients strictly from a diagnostic label, implying*

*that something is wrong with them) to one of resilience—a mindset that views clients' presenting difficulties, behaviors, and emotions as responses to surviving trauma. In essence, you will come to view traumatic stress reactions as normal reactions to abnormal situations. In embracing the belief that trauma-related reactions are adaptive, you can begin relationships with clients from a hopeful, strengths-based stance that builds upon the belief that their responses to traumatic experiences reflect creativity, self-preservation, and determination” (Substance Abuse and Mental Health Service Administration, 2014:13).*

49. My clinical and investigative experience and the 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 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.

50. I am also aware of instances when a trauma informed approach appears to have allowed an individual to absolve themselves from their agency and responsibility in perpetrating harm. I have been concerned that some clinicians have endorsed this attribution of cause to the extent that they have failed to give sufficient consideration to the nature of the harm perpetrated. Mental health clinicians are

not qualified or employed to provide absolution. However, it is one of their purposes in the clinical assessment, risk assessment and risk management of offenders with violent and sexual offence histories to identify and describe as accurately as possible the distal and the proximal conditions or pathways that have led to an offender's current legal situation. This facet of assessment requires considerable skill and sensitivity. But in order to protect the service user and the public, the clinician should be ready to set out as clearly as possible what is known about the nature of the index harmful event or offence, namely, to set out the how as well as the why. This requires focus on the details of the harmful event or offence.

51. It is my opinion that in its current form and broad application to mental health services, Positive Risk Management can be considered ideological, idealistic, naïve and ultimately confusing. In the context of mental health services, risk should be operationalised in its meaning as it relates to harm and not, in its PRM transformation, to relate to benefit. The primacy of PRM in policy and practice in mental health services should be reconsidered. There should also be a readiness to explicitly acknowledge that there are and will be service users who are very unlikely to attain an understanding of themselves that is sufficient to allow them to manage the risk of harm that they may present to themselves and others. Just et al. ( 2022 ) in a detailed systematic review of UK policy and guidelines on PRM, identify that it is frequently described in different and contradictory terms, making it challenging to identify what it is, when it should be employed and by whom. Terms such as Positive Risk Taking can indeed be, *“easily misunderstood and*

*often confused with casual, permissive or reckless attitudes”* (Boardman and Roberts, 2014:8). **WITN0338005**

52. Practitioners and policy makers should also be aware of the many serious case reviews and homicide inquiry reports which have revealed the risks of an unwarranted or unchecked optimistic attitude about an offender<sup>ii</sup> or service user, that have resulted in over optimistic assessments of improvements during a treatment programme and inadequate risk assessments (HM Inspectorate of Probation, 2006). **WITN0338011**

**Royal College of Psychiatrists (2017) Rethinking Risk to Others in Mental Health Services (Council Report 201).**  
**WITN0058002**

53. I have been asked to comment on this document, from which I endorse the following:

- Risk assessment should be part of, based on, and integrated within a thorough clinical assessment.
- Risk is dynamic and can be affected by circumstances that can change over the briefest of timeframes. Therefore, risk assessment needs to include a short-term perspective and frequent review.
- There is a continuing need for robust multiagency information sharing agreements facilitating timely, inter agency sharing of potential risks
- Some risks are specific, with identified potential victims

- Risk of violence increases in the teen years, with a peak from late teens to early 20s, then a dramatic reduction in the late 20s and a slow reduction until the 60s, when there is another marked reduction.
- Empirical research cannot be relied upon to identify all risk factors.
- Specialist risk assessment may be required (e.g. sex offending).
- Assessment of drug and alcohol use is a key priority when assessing risk to others.

54. The guidance also appears to illustrate the tension that some psychiatrists may experience in integrating their duty to protect the public *“with their primary duty to assess and treat their patients”* (Royal College of Psychiatrists, 2017:3). Justifications for this potential ambivalence are evident in 1) the apparent reticence to acknowledge the link between mental illness and violence and 2) the emphasis on substance and alcohol misuse as the main causes of violence: WITN0058002

- *“Although there is some evidence that some mental states make a small contribution to the risk of violence, the overwhelming evidence is that the majority of mental health patients will never pose any risk to anyone else”* (Royal College of Psychiatrists, 2017:11).
- *“There is variable empirical support for psychotic symptoms as a driver for violence...”* (Royal College of Psychiatrists, 2017:12).
- *“Evidence suggests that drug and alcohol use are more significant risk factors for violence to others than mental illness alone”* (Royal College of Psychiatrists, 2017:4).
- *“There is a small but significant association between some types of serious mental illness and a propensity to violence or homicide (Brennan et al, 2000), but*

*the overall contribution of mental illness to the incidence of serious violence in society is small*” (Royal College of Psychiatrists, 2017:12). WITN0338006

- *“Once substance misuse is taken into account, most acts of harm to others perpetrated by patients with mental disorder are not primarily related to their mental illness (Monahan et al, 2001; Elbogen & Johnson, 2009; Van Dorn et al, 2012)”* (Royal College of Psychiatrists, 2017:13). WITN0338023 WITN0338009

55. The guidance also includes that on average, 75 people with mental illness per year commit homicide (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2014), which is less than 15% of the total number of homicides. I acknowledge that it may well be necessary to specify the base rate for homicide by people with mental illness in order to defend against the challenges of stigmatisation in the face of continued homicide inquiries. I am also aware that it has been said for a long time that it is of little comfort to the victims of violence to be told that the mentally disordered are rarely violent and even more rarely homicidal (Crichton, 1995:9).

56. However, whilst the homicide base rate might indicate the costs borne by families and the wider society of homicides by people with mental illness, it is not a measure of the other forms of the non-fatal/near miss harm caused by people with mental illness to their families, staff, and the public. It is very well known that in the acute and deteriorating phases of illness, many individuals come to the notice of the police and emergency services because of their aggressive, threatening and disturbing behaviour: In the year ending March 2024, there were 31,213 detentions under section 136 of the 1983 Mental Health Act involving the police service in

England and Wales (Home Office, 2025). Many of the incidents that surround the section 136 detentions to a place of safety do not result in criminal charges or convictions. The Police Inspectorate have stated that the Police Service is left to pick up the pieces because too many aspects of the broader mental health system are broken (HM Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS), 2023). **WITN0338014**

57. It might also be said that my concerns about a lack of victim focus are exemplified further by the sentence which follows the reference to base rates in the 2017 guidance, namely: *“Media attention on [the homicides] has exaggerated their significance”* (Royal College of Psychiatrists, 2017:8). Besides its insensitivity, such an assertion has to be set against the findings of avoidable failings in policy and practice in numerous homicide inquiries. It is not, therefore, an unrealistic expectation to identify that, had some things been done differently, then risk might have been eliminated and a homicide might have been prevented. It is noteworthy that the apparent resignation about the base rate for homicide by people with mental illness is in contrast to the determination to reduce the number of suicides.

**WITN0058002**

58. I acknowledge again that amplifying or exaggerating the link between violence and forms of mental illness risks reinforcing negative stereotypes and stigma. I also take account of base rates and the protection that results from ensuring compliance with medication, consistent therapeutic relationships and effective supervision. However, NHS England statistics as of September 2025 reveal that in England and Wales there is still a need for approximately 7,700 secure hospital beds for adults (High secure: 800; Medium secure: 3200; Low Secure: 3700) and

for the period 2024 – 2025 in England there were 6,575 new Community Treatment Orders (NHS Digital, 2025). **WITN0433019**

59. Certainly, the denial or significant diminishing of the risk of harm that permeates this guidance is curious to witness. It is as if the continuing emphasis on a recovery and strengths-based focus is functioning as a defence against accepting this possibility:

*“There is a human tendency to focus on negative consequences, not positive ones, so the possibility that good things will come from taking a chance is often given less weight, and the patient’s claims to positive strengths are ignored”* (Royal College of Psychiatrists, 2017:11). **WITN0058002**

### **On the differences between general psychiatry and forensic services**

60. In writing this statement, I have become increasingly aware of the divide between forensic psychiatry and general psychiatry and the differences in their populations and priorities. Significantly, in forensic psychiatric settings, risk to self and others is considered crucial because most of the individuals who are detained there have committed serious violent and sexual offences.

61. In general psychiatric settings, where admission is typically not related to the commission of a serious offence, the primary concern appears to be the risk an individual poses to themselves. Since patients are most often admitted for inpatient care during the acute phase of a severe mental illness or following a recent suicide attempt and hospitalisation is linked to a substantially increased risk of suicide,

especially during the early stages of admission and immediately after discharge, this focus on risk to self is necessary.

62. When I first contacted the Inquiry on 6 October 2025, I also stated that however laudable the underpinning philosophy of the 2009 guidance might have been in recognising a service user's autonomy and the legitimacy of recovery-oriented care, it also relied on the optimal provision of staffing resources and capacity to provide effective monitoring and risk management within communities. However, there is a general consensus amongst mental health practitioners that such provision has not existed for a long time.

63. My experience of current general psychiatric settings is limited.<sup>3</sup> However, as I have prepared this statement, my discussions with colleagues have included frequent references to the damaging effects of a reduction in bed numbers and inadequate staffing in mental health services. I acknowledge that these reported concerns need to be articulated by the professions more directly involved. Nevertheless, it has been reported that the current pressure on beds and resources in general psychiatry has reinforced 'a culture of exclusion' meaning that there is increased pressure to exclude people in need (Beale, 2021); there is pressure to discharge patients after shorter admissions; and there is pressure to treat within the community and to avoid hospital admission. As a consequence, brief and limited in-patient admissions that focus on the treatment of an acute mental health crisis and discharge may be incomplete in their assessment and understanding of

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<sup>3</sup> Forty years ago, I worked as a nursing assistant for 2 years on an acute admissions ward at the Bethlem Royal Hospital, Beckenham.

the life outside of the hospital situation of the service user and the risk of harm they may pose to themselves, their families and others. In contrast, patients detained under sections of the Mental Health Act within secure forensic mental health services typically remain there for extended periods. Consequently, assessments and interventions are generally conducted over longer timeframes, when compared to the shorter durations characteristic of admissions to general psychiatric settings. **WITN0338003**

**My altered perspective on risk assessment because of exposure to major crime investigations**

64. At the start of my career, I had a strong conviction that the rehabilitation of patients could be achieved through intensive, insight-oriented individual and group psychotherapy. This approach relied on the development of the therapeutic relationship or alliance as it is sometimes called, which is presumed to foster trust between the psychologist and the offender patient and so enable the exploration of an individual's personal and offending history, leading to the development of insight - that is, how an offender understands himself and his needs and the likely consequences of his behaviour and decisions in his dealings with other people. It is intended to provide a way for the psychologist and the offender to arrive at an understanding of the meaning of the index offence and ultimately an understanding of the ways and means in which the offender could be at risk of involvement in violence in the future in order to prevent its reoccurrence. Importantly, this includes understanding of the interpersonal and situational determinants, in other words the circumstances, in which they may be at risk of harming themselves and other

people. This might also include an understanding of the onset and development of their symptoms of mental illness, the signs of relapse, and the stressors or precipitants that are more likely to lead to illness.

65. This approach which, characterised my perspective at the start of my career in secure mental health services, relied on a benevolent stance towards the offender patient and an attitude which was hopeful, optimistic and reparative. It anticipated that the patient's offending could be understood as an inevitable consequence of trauma and damaged attachments.

66. I am now more aware that for some patients and prisoners, insight may be to varying degrees limited or superficial, and sometimes because of impairments in language ability, understanding and empathy, it cannot be achieved at all. There are also occasions when patients and prisoners minimise, distort, mislead and deceive about the nature and intensity of their symptoms and their risk of harm because they are motivated to find an outcome that suits their purposes - which ultimately, may be self-defeating and harmful to themselves and others. I am also aware of situations where a service user has been deteriorating and without insight into their need for assessment and intervention, and yet because of the imperative to respect an individual's autonomy, they themselves are expected to notify the relevant service.

67. My values and attitudes about psychological assessment and treatment began to change because involvement with the Police Service meant attendance at incident rooms, the immediacy of crime scenes, post-mortems, and importantly, an

increased awareness of the victim focus of the police. This way of working has not been without strain at various times. Whilst my role within law enforcement has in the main been appreciated, my experience of the attitude of some in the health service towards my role in advising the police service has been inconsistent and sometimes very critical.

68. Police work revealed that the victim as a person is very present in major incident rooms. In briefings and conversations, I heard police officers refer to the murder victim by their first name day in day out and indeed, it was not unusual for them to have an image of the victim in their notebooks. This awareness of the named victim in police work stands in marked contrast to the situation observed in clinical settings. Consequently, amongst other issues relating to patient safety and the safety of staff, it meant that I was more ready to notice and challenge the apparent absence of a victim focus in forensic clinical work.

69. Countless instances have also taught me that in any assessment of risk of violence, it is ill advised to rely solely on a patient's account of their motivation and actions in a violent incident or offence.

70. In working with the Police, I also began to notice that despite the instruction of the Home Office about what should be included in reports for mental health review tribunals, the explanations as to why the index offence was committed, often included scant reference to how the offence was committed. Exposure to crime scenes caused me to focus instead much more on the actions of the offender in the commission of the offence. Why that particular weapon; why the force and

focus of those injuries; why that victim? This detailed investigative focus is still not a typical component of risk assessment when it would seem obvious that we should begin with a detailed description of what an offender has done (West, 2000). Its absence remains one of the most significant challenges in this area with the risk that a story of an offence can develop that can be a long way from the truth.

WITN0338025

71. It may surprise outsiders to learn that many forensic clinicians do not routinely access the depositions that can provide information from forensic pathologists, forensic scientists and other investigative specialists about the crime scene and interview transcripts, witness statements and related reports about the history and actions of an offender. I acknowledge that disclosure by police and the CPS of such material to mental health multidisciplinary teams is variable but even when the material is provided, some clinicians may choose to disregard it – because it can be a challenge to hold in your mind at the same time the suffering and needs of a mentally ill patient as well as a detailed awareness of the suffering that they have caused. However, for far too often, across my career, I have attended case conferences where the clinicians can neither name the victim nor describe in any significant detail how the victim was harmed - as if they have lost sight of the victim and their bereaved families.

72. I speculate that this avoidance of how a victim has been harmed may result from what Psychologists refer to as cognitive dissonance (Festinger 1957), namely, the tension which arises from a situation which provokes thoughts and feelings which are not easily held together: Our clinical purpose is to understand the service user, build trust and rehabilitate him. Imbalance or dissonance occurs when our clinical

purpose is made to confront the reality of the harm done. In order to reduce the effect of this contradiction, those who see offender patients as victims of trauma may be motivated to avoid information about the victim. Others may be motivated to decrease this dissonance by refusing to assimilate or consider information about the detrimental effects of earlier abuse or neglect. Either way, the consequences of such dissonance can pervade our clinical practice. Awareness of its effects are critical to clinical supervision and practice if we are to optimise our efforts at rehabilitation and the protection of the public.

### **Mental disorder and violence**

73. There is a link between mental disorder and violence. The DSM-5 psychiatric disorders (American Psychiatric Association, 2013) that have been found to be associated with violence include substance-abuse disorders, bipolar disorder, depression, schizophrenia and other psychotic disorders, antisocial personality disorder and borderline personality disorder.

### **Psychosis and violence**

74. Understanding the causes of violence by those suffering from psychosis is complex – there is no single ‘dangerous symptom’ and any meaningful assessment has to consider the mediating effects of other co-occurring factors including, for example, the situation, personality disorder, substance abuse and non-compliance.

75. The majority of people with schizophrenia and other mental illnesses are not violent (Swanson, 1994). However, rates of violence have been found to be relatively higher in people with schizophrenia and other severe illnesses compared to the general population (Hodgins et al., 1996). It is also well established that there is a general association between suffering from a psychotic illness and risk of violence. In the context of psychotic illness, violence is likely to be directed towards nearest relatives, especially mothers, or close social associates. Violence is more likely to occur when delusions and hallucinations are more severe but the anger, irritability, agitation and hostility associated with a psychotic illness may also play a part. It also recognised that the combination of substance misuse and psychosis is associated with an especially high rate of violence (Clark, 2018).

WITN0338013

WITN0338007

76. Unprovoked lethal assaults can arise as a result of acute psychotic illness, particularly during a first episode, that is, in the earlier stages (typically late adolescence and early adulthood in males) of the onset of schizophrenia. Whilst family members or close associates are more frequently the victims of homicide committed during psychotic illness (and stabbing is a common method), unprovoked assaults against strangers can occur. Typically, an assailant believes that they are facing some kind of violent or lethal harm from the victim. They may also experience instructions (auditory command hallucinations) about reasons or means to harm the victim. It is also well established that illegal street drugs (cannabis skunk, amphetamine, cocaine, illegal highs) can also increase the risk of violence by people suffering from psychotic illness.

77. In a recent in-depth study of 50 homicide cases, the Violence Reduction Unit of the Mayor of London's Office, identified 11 cases where poor or deteriorating mental health contributed to the homicide of a victim known to the offender. Gadenne et al. (2022) identified a slow escalation of risk to the victim as the offender missed scheduled appointments with mental health services or decided to change their medication without advice – again indicating that disengagement from services through unexpected or persistent absences could be a critical signal for intervention. This awareness of lack of engagement with mental health services could also be shared with other partner agencies. The authors acknowledge that they relied on a small and unrepresentative sample, and that their cases involved a range of mental health conditions, however, *“they skewed towards more severe conditions including psychosis and Schizophrenia”* (Gadenne et al., 2022:19); **WITN0338010**

### **Delusions and violence**

78. There is consistent evidence of a general association between delusions and violence. Delusions of persecution, infidelity, jealousy and misidentification and feelings of being controlled or that a person's thoughts are being broadcasted are implicated. Persecutory delusions, for example, are fixed, false and inflexible beliefs where the subject falsely believes that they are at risk of harm because others are engaged in a plot or plan to harm them. Such beliefs are not just held without evidence, but even in the face of contradictory evidence, they cannot be shifted. People with persecutory delusions are preoccupied with the intentions of others; the individual believes that the persecutor intends to cause the harm or

harm is occurring because of them. Persecutory delusions are preoccupying, obtrusive and distressing, and stand out as directly related to serious violent crime because patients sometimes act on their persecutory delusional beliefs, particularly when they are significantly distressed or frightened by the belief.

### **Bipolar disorder and violence**

79. In bi-polar disorder (commonly known as manic depression), periods of prolonged and severe depression alternate with periods of excessively elevated and or/irritable mood, known as mania. The symptoms of mania characteristically include a decreased need for sleep, pressured speech, increased libido, grandiosity and reckless behaviour without regard for consequences. In severe cases, there may be psychotic symptoms, including delusional beliefs and auditory hallucinations. Research has highlighted that the risk of offending, particularly involving the homicide of family members, should not be overlooked in the depressive phases of Bipolar 1 disorder (Jeong-Yoon Hoon et al., 2012). WITN0338026

### **Autistic spectrum conditions and violence**

80. The association between Autistic Spectrum Conditions and violence remains under researched. While violence in autism is rare, when it occurs, it can be extreme (Allely et al., 2017). Investigative experience of offences of stranger homicides and other cases with unusual presentations has indicated the involvement of individuals whose subsequent post offence assessments have

revealed problematic developmental histories and related social and communication difficulties. WITN0338002

### **Risk Assessment**

81. Blom-Cooper et al (1995) state that all risk management strategies comprise the same five basic components: WITN0338004

- The need to be alert and vigilant to hazard: *“It is simple to walk around a ward, a hospital or a community team office and identify potential hazards for the workforce; it is far more difficult to constantly be alert to identifying the individual patients as being a potential risk. A clinical assessment of mental state which included searching questions designed to justify potentially dangerous thoughts or actions is not yet routine, although we believe it should be”* (Blom-Cooper et al., 1995:174).
- Consider who might be harmed and how.
- Consider whether current arrangements adequately address the risk and decide whether further measures need to be taken.
- Record in writing exactly what risks are thought to be present, what action has been taken and what level of risk is being accepted for an individual, bearing in mind the practical constraints, resources available and the rights of the individual to be treated in the least restrictive manner compatible with minimal risk.

- Ensure that a regular review system is established so that levels of risk can be revised in the light of more recent information.

82. The guidance they provided thirty years ago emphasised that thoroughness and detail are necessary in order to have a clear understanding of the context in which past violence occurred - whilst the patient was psychotic, taking illicit drugs or under the influence of alcohol. Did the violence occur in the context of the family, a close relationship or was it aimed at a stranger (Blom-Cooper et al., 1995:178)? Past records should be requested and accessed "as a matter of routine" including witness statements and case details in order to understand the circumstances of any violence. They recommended the compilation of an extended psychiatric and psychosocial summary, listing all significant events and all contacts between the patient and professionals, including extracts from witness statements, previous reports and letters in order to create a running chronology of the case. Significantly, they recommended that, *"Teams with responsibility for managing a patient's risk must be sufficiently in touch with the patient and his or her carers to be aware of and respond to circumstances which increase risk of violence. One of the commonest circumstances is when the patient, known to become violent when psychotic, has stopped taking medication .... A patient who is relapsing may well default on routine appointments, and teams must promptly visit and assess patients in the community and admit to hospital, if necessary"* (Blom-Cooper et al., 1995:181).

83. Blom Cooper et al., (1995) also recognised the danger of staff not wanting to discover a past history of violence: *“It is understandably easier to engage in a superficial therapeutic relationship when such matters are not raised, and the patients’ account is accepted uncritically at face value, although the relationship cannot be truly therapeutic when such vital pieces of history are left unsaid or obscure”* (1995:179). WITN0338004

84. In considering, amongst others, Blom-Cooper et al. (1995) and McGrath and Oyebode (2002), it could be argued that guidance about best practice in risk assessment has existed for decades. Such advice predated the proliferation of risk assessment tools and its significant literature. However, it appears that such guidance has not been incorporated into the policy, training and the everyday practice of mental health services: WITN0338004 WITN0338018

### **Risk Assessment and Structured Professional Judgment approaches**

85. There is an extensive literature on the evidence base and practice of risk assessment in mental health. Given its scale and my own background as a practitioner, I am unable to provide a satisfactory comprehensive review of this material for the purposes of the Inquiry.

86. I am aware that the early 1990s saw a shift away from ‘dangerousness’ as a static disposition of the person towards the broader concept of the dynamic nature of risk and its assessment. Criticisms of the unstructured clinical and subjective basis of previous dangerousness assessments provided the impetus for more rigorous research into the factors associated with violence and the development of risk

assessment methodologies. Alongside the proliferation of various risk assessment tools, risk management as a concept was increasingly introduced into practice on the assumption that as risk changes over time, it can be managed effectively.

87. Within clinical practice, there are two major risk assessment approaches: those which rely on various actuarial (statistically derived) risk assessment instruments (ARAs) and those which rely on structured professional judgement protocols (SPJs). Although approaching the task from different perspectives, ARAs and SPJs encourage practitioners undertaking risk assessments to consider the range of empirical factors associated with violence or sexual recidivism.

88. I am aware that in forensic mental health services, there is a reliance on structured professional judgements tools, which include notably, the HCR-20v3, version three of the 'Historical, Clinical Risk-20' (Douglas et al., 2014). This is referred to frequently as 'the gold standard SPJ' - such product descriptions can function to position the protocols beyond challenge. **WITN0338008**

89. The HCR-20v3 lists 20 empirically supported historical, clinical and dynamic items associated with violence that can be considered in conjunction with the practitioner's clinical judgment of the individual case. Ratings for each item are coded on a 3-point scale both for the item's presence (no, partially present, yes) and the item's relevance (low, moderate, high).

90. In my experience, individual clinicians in preparing reports for the court or mental health review tribunals, typically employ considerable diligence and careful

consideration when using such protocols. Since they are often used to substantiate an opinion, clinicians are aware that they may be cross examined about the validity of the ratings and opinion presented. This applies especially when more specialist SPJs have been used, for example, in the assessment of sex offenders.

91. However, within the multidisciplinary context of mental health services, it should be remembered that the teams remain medically led. In my experience, the reliance and weight given to these risk assessment tools therefore depends on the approach of the Responsible Clinician and there is, sometimes, a lack of consistency in their application. There are those who in using the HCR-20, apply the scoring criteria diligently in an attempt understand a patient's violence risk prediction, often paying particular attention to the possible scenarios in which violence may occur. However, others who justifiably advocate that is very difficult to make predictions about the future, typically give less attention to this exercise, often leaving its completion to other members of the team. Time and caseload pressures often meant that the task of completing forms was seen as another administrative burden and their content was not considered integral to understanding the patient's situation, risk or risk management. Delegated to an Assistant (unqualified) Psychologist, there was often a reliance on cut and paste options from previous reports.

92. Best practice indicates that these protocols require a considerable investment of time in order to access and incorporate the collateral information that is required. However, in the absence of depositions, there is also a risk again that a

psychological formulation and 'understanding' of a patient's previous history and offending can lead to the compilation of a narrative that is to varying degrees inaccurate and unreliable.

93. My concern has been that over reliance on Structured Professional Judgements and other risk assessment tools might have allowed, however inadvertently, at best a superficial analysis of an offender's actions. In my opinion, whilst the use of a SPJ tool may assist in the overall assessment of an individual's risk of future violence, it should not be utilised as the sole measure, though because of their universality, they tend to be relied on as if they are. 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 (West 2000). 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.

WITN0338025

94. Others have also commented on the over reliance on Structured Professional Judgements in spite of their many limitations. Notably, Silva (2022:270), amongst others, has stated, *"not that risk assessments should be abandoned, only that we should be much more circumspect about their power, utility and explanatory value and recognise how narratives may mislead as well as explain."* He notes how risk assessment tools for and scales to predict future suicide and repetition of self-harm

are no longer recommended because they are of no practical use. I share Silva's view and think that the mandated use of the HCR-20v3 should cease. The emphasis on risk assessment can also override the importance of relational security in containing and managing those patients who are at risk of causing harm: *"In the long run maintaining a therapeutic alliance, particularly with difficult and objectionable patients, which promotes treatment compliance and maintains necessary social and interpersonal supports, is a greater contribution to reducing violence than the finest skills in risk assessment"* (Mullen, 1997:172).

WITN0401010

WITN0338020

### **Risk assessment in everyday clinical practice**

95. Within every day clinical practice on a ward in a forensic mental health unit, the handover between teams provides an opportunity to share relevant information on the presentation of the patient. This typically includes detailed information about a patient's mental state, compliance, substance misuse, leave information and the development or presence of any other on-going stressors or signs (for example, disinhibition, irritability, self-neglect) indicative of deterioration or problematic issues with either staff, other patients or external influences that might lead to an increase in risk of violence or sexual harm. Ward meetings and case conferences about an individual patient provide further opportunities to discuss in detail their personal background, the course of their mental disorder, their diagnosis and the progress of their admission with particular reference to any entries on the Datix Risk Management System and the progress of any treatment interventions. These meetings are also more likely to focus on developing a detailed understanding of the patient's risk and relapse signatures. At their most effective functioning, they involve members of external agencies, for

example, the Prison Service or Probation but very rarely the Police Service. Social Workers are still the main link between patients and their carers and families. However, nursing staff and occasionally other disciplines would be involved in home visits – my experience of such visits was that they were invaluable for understanding the patient's history and situation.

## **MAPPA**

96. It is a number of years since I have attended a MAPPA meeting. However, my previous experience of them as a forum for multi-agency collaboration and sharing information sharing was very positive. Often, such meetings presented the first opportunity for the agencies involved to meet face to face and have more open and frank exchanges of opinion. Importantly, case discussions allowed an understanding of different perspectives on agencies' expectations of each other both in short-term acute risk situations and the longer-term. In my view, the police service was more ready to share information than health, who are still often constrained by adherence to medical confidentiality and consent. All agencies remain acutely aware of the complexities and requirements that govern information sharing. However, public inquiries, serious case reviews and domestic homicide reviews repeatedly identify the need for more open and transparent information sharing to prevent harm.

## **Recommendations**

I now provide the following recommendations:

97. In line with the Royal College of Psychiatrists recommendation for improved, tiered risk assessment and interventions at a local and national level, Thomas et al., (2019) describe the work of a Risk Reference Panel as an example of one such innovative approach. This is a group of multidisciplinary experts from Social Work, Nursing, Forensics, Intellectual Disability and General Adult Psychiatry that provide advice in the management of complex and exceptional cases where risk of harm is significant but unclear, and clinical teams have ongoing concerns about risk assessment and management. The purpose of the panel is to support staff “to reduce the risk of harm associated with mental illness” (Thomas et al., 2019:67). Of the 48 cases reviewed for the purposes of their article, it is noteworthy that “only some of the cases had crime convictions” but the various (combined) manifestations of risk to others was 1.5 times higher than the risk of self-harm or suicide. I recommend the setting up of such multidisciplinary and interagency Risk Reference Panels (and to include the Police Service) which may be able to assess and intervene in those problematic or otherwise developing situations that would not reach the threshold for MAPPA notice where the understanding of the risk a person presents needs to be improved and specialist opinion and assessments may need to be sought and interagency care plans developed. Importantly, disagreement within teams over diagnosis and level of risk could also be addressed with the help of this type of external oversight. WITN0338022

98. Where relevant, the absence of a victim focus in mental health services needs to be addressed. This can be achieved through the development of policy and practice whereby, with the necessary safeguards, the victim of an event or offence

who has been harmed by a service user is named, and the circumstances of that event or offence are explicitly stated in conference discussions and related notes. This practice requires improved access to court depositions, witness statements and related reports which should be routinely retrieved and form part of a service user's case file.

99. In order to address the link between violence and substance misuse and related on-going substance misuse issues in mental health services, there should be increased police liaison, intelligence sharing and investigations between Police and Health.

100. There should be improved access for the Police Service to specialists in mental health to assist in their day to day understanding of mental disorder and violence and the risk assessment and management of vulnerable people. Measures could include specialists being seconded and/or employed into forces, to provide more locally focussed liaison between mental services and front-line policing, for joint interventions as well as improved in house training.

101. In the safeguarding and public protection training for mental health clinicians there should be a requirement to read, understand and apply the findings and recommendations from the many available homicide and domestic homicide reviews. The identification of the same recommendations and lessons learned from inquiries across the decades and the apparent failure to implement these recommendations points to systemic obstacles and resistance to their ongoing translation into policy and practice. The lessons and recommendations should at

least be incorporated into the basic and development training of all professions involved in mental health services.

102. Without the monitoring and guidance that long term, close and experienced supervision can provide, there will remain those service users who are unable to manage the stressors, relationships and situations in their lives that ultimately can lead to relapse and harm. This requires a review of the longer stay in patient bed capacity across the mental health services. It also requires the development and resourcing of the Assertive Outreach and Crisis Intervention services such that they are able to respond more urgently to instances when service users have come to notice for non-attendance and non-compliance.

103. The protection of the service user and the public should be improved by developing better interagency cooperation and information sharing between police, health, Probation and specialist forensic mental health services. There should be a reconsideration that all services have a primary responsibility to protect the public and in that shared purpose, barriers to required information sharing are removed.

104. It is my opinion that Positive Risk Management is ideological, idealistic, naïve and ultimately confusing. In the context of mental health services, risk should be operationalised in its meaning as it relates to harm and not to benefit and the primacy of PRM in policy and practice in its application to mental health services should be reconsidered. There should also be a readiness to explicitly acknowledge that there are and will be service users who are very unlikely to attain

an understanding of themselves that is sufficient to allow them to manage the risk of harm that they may present to themselves and others.

105. **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 5 December 2025

**References to First Witness Statement of Dr Adrian West**

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<sup>i</sup> It may be necessary to bring to the attention of the Inquiry the differences in training and practice that exist between the Clinical Psychologist and the Forensic Psychologist as the two are not the same but are sometimes presumed to be so. The British Psychological Society and the Health and Care Professions Council are able to provide detailed information on the training and competencies of the respective roles. In brief, it is my understanding that the Forensic Psychologist's competencies and training relate to the application of Psychology and the Behavioural Sciences to the assessment and understanding of offenders and the delivery of related interventions. Qualification is usually gained through the submission of a portfolio which sets out the competencies gained, usually through supervised practitioner experience in prisons. In recent years, a number of Forensic Psychologists have been employed in mental health services. Clinical Psychology qualification is by a 3-year postgraduate doctoral course which combines academic study with clinical experiences in general and specialist mental health services. Clinical Psychologists are also working in prison and secure mental health settings.