Witness Name: Mark Henry Taylor
Statement No: WITN0388001
Dated: 10th February 2026

**THE NOTTINGHAM INQUIRY**

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**FIRST WITNESS STATEMENT OF DR MARK HENRY TAYLOR**

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I, Dr Mark Henry Taylor, will say as follows: -

## INTRODUCTION

1. I am a consultant forensic psychiatrist at Nottinghamshire Healthcare NHS Foundation Trust ("**NHFT**"). I have set out further information on my role and my career as a forensic psychiatrist below.

2. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 15 December 2025 (the "**Request**"). The Request asks for a statement to be prepared by a Consultant Psychiatrist working, or with experience of working in, Forensic Psychiatry or another suitably qualified person. The Trust Executive Medical Director approached me and asked me to assist, and I agreed. It requests that I set out information on my career and role, the practice of forensic psychiatry generally. The Request also asks specific questions on when patients who are being treated by the Early Intervention in Psychosis ("**EIP**") team may be referred to forensic psychiatric services.

3. This witness statement was drafted on my behalf by external solicitors and counsel acting for the Trust in respect of the Inquiry, with my oversight and

input, following discussions in writing by email and by video conference. I also sought advice from my Medical Defence Union.

## CAREER AND EXPERIENCE

4. I completed my primary degree in Medicine (MBChB) in 2000, and became a member of the Royal College of Psychiatrists (MRCPsych) in 2005. I embarked on higher specialist training and obtained my Certificate of Completion of Training (CCT) in forensic psychiatry in 2008. I have practised as a consultant forensic psychiatrist since then.

5. During my training in forensic psychiatry, I worked in high, medium, low secure, and community forensic settings, as well as in prison. As a consultant, I have worked clinically in low secure units, community forensic, and prison settings. I currently work part-time clinically on a male low secure admissions ward (Trent Ward, Wells Road Centre, Nottingham). For over ten years I have not practised in a community forensic setting as a core part of my role, other than by providing interim consultant cover for absent colleagues.

6. In 2013 I was part of a working group which devised the Quality Network for Forensic Mental Health Services (QNFMHS) *Standards for Community Forensic Mental Health Services*. QNFMHS is one of the Quality Networks of the Royal College of Psychiatrists, the professional medical body responsible for supporting psychiatrists throughout their careers and setting and raising the standards of psychiatry in the UK. The 2013 *Standards* set out a series of guidelines for the delivery of community forensic mental health services in the UK. These standards were produced against a backdrop of community forensic services being developed on an ad-hoc, local level, without a centralised set of standards or specifications. The standards were agreed by QNFMHS, but did not lead on to a peer reviewed system of service accreditation as happened for medium and low secure services. There were some similarities in a later NHSE pilot model, which is described later at paragraph 76.

7. I was Clinical Director of NHFT's Low Secure and Community Forensic Care ("**LSCF**") Unit between 2015 and 2021. Since 2021 I have been an Associate Medical Director in the Forensic Services Care Group. The current scope of this group includes NHFT's medium, low secure, community forensic, and related services. My role is a medical managerial role. I am part of the Trust medical leadership team, led by the Executive Medical Director, and am also part of the Forensic Services Care Group leadership team. I line manage the Clinical Directors of two medium secure services, Arnold Lodge and Wathwood Hospital, as well as the Clinical Director of the LSCF care unit.

8. In my role as a consultant psychiatrist working for NHFT, I did not have any direct involvement in the treatment of VC by mental health services in the lead-up to his attacks on 13 June 2023. However, I was a relevant point of contact to the operational and service managers responsible for the custody-based Liaison and Diversion ("**L&D**") team and the Forensic Services Care Group leadership team. I attended the incident follow-up emergency response meeting, which was set up at executive level. I also recall being aware of VC's case due to BBC news coverage of the attacks on 13 June 2023. I emailed the leadership team for the L&D service that morning offering myself and my Clinical Director colleague as contacts were any high-level support or advice needed from forensic services [**WITN0388015**].

9. I recall being contacted by the L&D service manager at some stage on 13 June 2023. A MITIE clinical assessor had raised concerns, through the L&D clinician, about VC's fitness to be interviewed and detained in police custody. It was unclear whether the L&D service manager was asking about early diversion to hospital. This is something that may occur in a case of low-level offending. In my experience, for high-level offenders it would be more usual to charge and remand the patient to custody, with future transfers occurring via that process. I recommended to the service manager that escalation occur within MITIE, with a view to a further assessment being carried out by a senior practitioner on the

issue of fitness to be interviewed. I updated on-call senior Trust leaders via email to this effect late evening on 13 June 2023 in case there were further developments overnight **[WITN0388013].**

10. I then contacted the service manager via email on the morning of 14 June 2023 and was informed that no further issues were raised. I was told that the custody sergeant had noted plans to interview VC, and that he would likely remain in custody for a further two days **[WITN0388016]**. I inferred from this response that my advice had been followed, and VC had been assessed as fit to be interviewed. I was subsequently made aware that an L&D advice report would be submitted to the court, and VC would likely be remanded in custody to either HMP Nottingham or Manchester. I asked that appropriate clinical handover occur with the receiving prison healthcare team **[WITN0388012]**.

11. In consultation with the then Care Group Director, and the Clinical Director at Rampton Hospital, I assisted in setting up a Microsoft Teams meeting for the afternoon of 16 June 2023 involving several Rampton Hospital clinicians.. This was set up in case an urgent need for high secure assessment with a view to admission was identified. The meeting was stood down when news arose that VC had been charged and was due to be remanded to prison **[WITN0388014]**.

12. In July 2023 Rampton Hospital received a request from HMP Manchester that VC be assessed with a view to transfer to high secure care. Having consulted with the Forensic Services Care Group Director, Rampton Hospital Clinical Director, and the Trust Medical Director, I wrote to NHSE ("**NHSE**") on 24 July 2023 to request mutual aid on behalf of the Trust. I understand mutual aid to be the collaboration and cooperation that occurs amongst the three English high secure hospitals (Broadmoor, Ashworth and Rampton). In this specific context, this meant to request that another hospital conduct the initial clinical assessment or seek to admit the patient if admission was recommended. In the request I asked that one of the other two high secure hospitals carry out the assessment **[WITN0388018]**. NHSE responded via email on 24 July 2023 to ask that

Rampton Hospital proceed to assess VC in the first instance **[WITN0388017]**. NHSE said that they would consider the mutual aid issue after this. Having reviewed the referral documentation I had some concern about this on the basis of clinical urgency, but it was agreed with the Trust Medical Director and Rampton Clinical Director that the Rampton assessment should proceed.

13. I was party to the Rampton Hospital assessment outcome on 8th August 2023 via email and the written report on 11th August 2023. The assessment supported admission to high security. Given that I had engaged NHSE previously I intended to contact them again to request mutual aid. I was unable to do this due to urgent compassionate leave, and so I asked that the Rampton Clinical Director do so instead on 13th August 2023 in an email. The Rampton Clinical Director confirmed that he would do so. My understanding from emails on 14th August 2023 is that the Care Group Director had further dialogue with NHSE to progress this matter **[WITN0388020]**. I have no recollection of being involved beyond this stage.

14. Other than the above, I had no direct involvement with VC either before or after 13 June 2023. I had no involvement in his care prior to the attacks, nor did I have any involvement in operational decisions that were taken about VC once he was in custody.

## BACKGROUND TO FORENSIC PSYCHIATRY

15. I have been asked to briefly describe the forensic mental health services provided by NHFT, covering:

    a. The patients typically treated by forensic psychiatry;
    b. The process for referring patients into forensic psychiatric services;
    c. The process for determining whether to accept a referral;
    d. The assessments and treatments undertaken by forensic psychiatry; and

e. The assessment of risk of violence by forensic psychiatry.

16. I have set out information on each of these matters, in relation to both secure and community forensic services, below. I have referred to national, regional and NHFT sources to inform the answers given, as well as my own clinical experience. In my view it is important to distinguish between secure forensic and community forensic services when considering these topics.

17. Historically, forensic psychiatry was focused on the provision of care and treatment for patients in high secure hospitals. Following the publication of the Butler Report in the 1970s [**WITN0388003**], medium secure units were also developed. Low security units and community forensic services have since been established.

18. Currently, forensic psychiatric services can broadly be organised into two categories:

    a. Secure forensic psychiatry offering treatment that is delivered in high, medium, or low-secure units (i.e. mental health hospitals meeting specific security standards) to patients detained under the Mental Health Act 1983 ("**MHA**"); and
    b. Community forensic psychiatry, i.e. mental healthcare which is delivered in community settings.

19. This distinction is important because it affects both the process by which a patient may be referred to forensic psychiatry services, and the degree to which forensic clinicians will become involved in the patient's overall care.

**Secure forensic services**

<u>Overview and patient profile</u>

20. Secure care services are commissioned by NHSE ("**NHSE**") as they involve specialised, small volume, high quality care provision. Secure services provide treatment for adults aged 18 and over with mental disorders. These include mental illness, personality disorder, and neurodevelopmental disorders. All patients in secure services are detained under the MHA. Their risk of harm to others and risk of escape from hospital cannot be managed safely within other mental health settings. Patients in secure services typically have complex chronic mental disorders which are linked to offending or seriously harmful behaviour.

21. NHSE publishes service specifications for low **[NHSE0000022]**, medium **[NHSE0000023]**, and high **[NHSE0000020]** secure mental health units. As NHSE's service specifications explain, the three different levels of security across secure adult inpatient services provide a range of physical, procedural and relational security measures that ensure effective treatment and care while providing for the safety of the patient and others, including other patients, staff, and the general public **[NHSE0000020, paragraph 2.1.5; NHSE0000023, paragraph 2.1.5; NHSE0000022, paragraph 2.1.5]**

22. The three different types of secure unit can be summarised as follows:

    a. High secure services provide care and treatment to those adults who present a **grave** risk of harm to others and who cannot be managed in lower levels of security, and who must not be able to escape from hospital;
    b. Medium secure services provide care and treatment to those adults who present a **serious** risk of harm to others, and whose escape from hospital must be prevented;
    c. Low secure services provide care and treatment to patients who present a **significant** risk of harm to others and whose escape from hospital must be impeded.

23. As NHSE's specifications explain, high secure services are provided in hospitals whose physical security arrangements are equivalent to a Category B prison. They can, however, also treat individuals who, in a prison setting, would be in a Category A environment [**NHSE0000020, paragraph 1.3.6**]. All high secure patients will be detained under the MHA, and the decision to admit will be based on a comprehensive psychiatric assessment and risk assessment. Many, but not all, patients admitted to high secure services will have been charged with or convicted of a violent criminal offence.

24. As the specifications explain, the core objectives of high secure care are as follows [**NHSE0000020, paragraph 2.1.9**]:

    a. To assess and assertively treat mental disorder;
    b. To provide a safe and therapeutic environment;
    c. To protect others by reducing the likelihood of current and future interpersonal violence;
    d. To maintain dignity through individualised and compassionate care; and
    e. To improve health and wellbeing (including physical, mental and spiritual).

25. Medium secure services provide care and treatment to a variety of patients. The predominant need for medium secure management is related to the patient's assessed risk of harm to others in the context of mental disorder. Patients in medium secure services will usually have been stepped down from high secure services, been transferred up the security gradient from low secure services, or be admitted from prison.

26. NHSE describes low secure services as generally treating two distinct groups of patients, as follows.

a. Those requiring forensic low secure admission after being transferred directly from prison or court, or who have been charged with an offence whilst in the community or another hospital inpatient setting; and
b. Those requiring forensic low secure rehabilitation and who will generally have been transferred from medium secure inpatient services, have been convicted of a serious offence, and who are subject to a hospital order (often with restrictions), or have been transferred from prison.

27. In my experience, however, the profile of patients that I have seen in clinical practice is more varied than this, and can be better described in paragraphs 34 and 36.

28. The core objectives of low and medium secure services are set out in NHSE's service specifications as follows **[NHSE0000023, paragraph 4.1.4; NHSE0000022, paragraph 4.1.4]:**

a. Assess, formulate and treat mental disorders including neurodevelopmental disorders such as learning disability and autism;
b. Reduce the risk of harm to self and others;
c. Provide individualised care that meets needs of and includes the patient and family and carers in decision-making;
d. Provide a time-limited intervention that supports recovery and enables a safe transition though the care pathway;
e. Provide all patients with a full multi-disciplinary assessment including assessment of risk and formulation resulting in a care plan developed in collaboration with them and reflective of their wishes and aspirations;
f. Achieve delivery of efficient and seamless transfers of patients between care settings;
g. Use the Care Programme Approach to underpin service delivery;

h. Proactively manage violence and aggression;
i. Provide a range of meaningful activities and therapeutic programmes;
j. Deliver care within a therapeutic regime that places primary importance on behavioural approaches, de-escalation and psychopharmacological treatment of mental illness and agitated behaviour in the context of mental disorder.

29. In all three types of secure unit, patients may be admitted despite not having any criminal charges present. This will occur if there is evidence of a significant, serious or grave risk to others in the context of mental disorder, generally due to a pattern of assaults and escalating threats **[NHSE0000020, Appendix 1, paragraph 2.4; NHSE0000023, Appendix 1, paragraph 3.2.1; NHSE0000022, Appendix 1, paragraph 3.2.1]**. In my experience, whether or not a patient without criminal charges would be admitted would depend upon the level of secure unit. Whilst I do not work in high secure care, I am aware that the 'grave and immediate danger' test applied to patients before they can be admitted to a high secure unit is a very high bar to meet. To admit a patient to a high secure unit without evidence of serious criminal charges would be unusual. Overall it would be unusual for a patient to be admitted directly into a secure unit without having had any contact with the criminal justice system.

30. The pathway through and out of any secure unit will be identified early in any patient's admission. The broad aim of treatment is to assess and treat mental disorder, reduce a patient's risk of harm, support recovery and rehabilitation, and therefore transition the patient into a lower security setting.

31. A key principle underpinning the provision of secure services is that the patient must be managed in the least restrictive environment possible in order to facilitate their safe recovery. 'Least restrictive' refers to the therapeutic use of the minimum levels of physical, procedural, and relational measures necessary to provide a safe and recovery focused environment.

32. High secure services are commissioned nationally, while medium and low secure services have regional level commissioning oversight through NHS-Led Provider Collaboratives ("**PCs**"). These are groups of providers of specialised mental health, learning disability, and autism services who have agreed to work together to improve the care pathway for their given population. The PC for the East Midlands is IMPACT, which comprises nine partner organisations. The lead provider for the PC is NHFT.

33. NHFT is a large provider of secure forensic services. It provides high secure care at Rampton Hospital, one of the three high secure hospitals (along with Broadmoor and Ashworth) in England and Wales. Rampton Hospital is the sole provider of high secure care for women, deaf men, and men with a learning disability. NHFT has two medium secure services, Arnold Lodge and Wathwood Hospital. It has a low secure service, Wells Road Centre, a community forensic service, and a community forensic intellectual and developmental disability service. Further detail on these services is provided in NHFT's corporate witness statement to the Inquiry.

Referrals to secure forensic units

34. Referrals to secure forensic units are typically made from other secure hospitals, from prisons, or through the courts. Low, and occasionally medium, secure units will also receive referrals from non-forensic inpatient mental health services, including for patients already detained in psychiatric intensive care units ("**PICUs**"), locked rehabilitation wards, and acute wards. Some low secure services may admit patients directly from the community, but it would be very unusual for a patient's first referral to a secure forensic unit to come directly from the community.

35. NHSE's service specifications explain that the recognised pathways into high secure care are as a step up from medium secure care, admission directly from

the criminal justice system (including transfers from prison) or, more rarely, as a step up from other services.

36. Recognised pathways into medium secure services are as a step-down from high secure care, admission directly from prison, or as a step-up from low secure or non-secure settings. NHSE's service specifications also refer to direct community admissions, patients who are recalled (i.e. section 37/41 patients liable to be recalled under conditional discharge), or patients subject to a Community Treatment Order ("**CTO**"). In my experience, however, these patients would more likely be admitted to PICU in the first instance or (rarely) to low secure units. This process is set out further in the IMPACT standard operating procedure, which is described later **[WITN0388004, in section 7 and Appendix F]**.

37. Recognised pathways into low secure services include stepping down from high/medium secure care; admission directly from the community; admission from acute adult inpatient services; and admissions from secure child and adolescent mental health services ("**CAMHS**") as part of the patient's transition to adult services **[NHSE0000022, paragraph 2.1.7]**.

38. Patients will be admitted to secure services where an access assessment supports admission. In medium and low secure services, the access assessment will be requested from a secure care provider by the PC. This follows a satisfactory initial screening of the information provided about the case by the PC, which will decide whether to progress the referral. My experience is that in taking a decision on whether to refer a patient for assessment, the IMPACT case manager may take advice from clinicians working at the secure unit in question. It is my understanding that they may also discuss potential referrals with senior case managers at IMPACT or with the IMPACT Clinical Director.

39. IMPACT has its own standard operating procedure ("**SOP**") for managing referrals, assessments, and admissions to low and medium secure adult inpatient services within the East Midlands [**WITN0388004**]. The criteria set out in the SOP for referring a patient to secure services are reflective of the NHSE inclusion criteria for patients in low and medium secure units.

Admission to Secure Units

40. A patient will be admitted to a secure unit following an access assessment which recommends this outcome. Access assessments are conducted by a consultant forensic psychiatrist. In high secure units, the admission decision will be taken by the High Secure Hospital Admissions Panel, considering the consultant psychiatrist's written report. The NHSE service specification states that "*the referring clinician must seek an opinion from the patient's catchment area medium secure access assessment service before submitting a referral to a high secure service*" [**NHSE0000020: Appendix 1, paragraph 5.3.7**].

41. The access assessment is a specialist clinical assessment and formulation of the mental health and risk management needs of an individual. The purpose of access assessments is to:

    a. Determine whether admission to secure care is necessary and consider alternatives;
    b. Identify the appropriate level of security, if admission is required;
    c. Articulate treatment needs; and
    d. Inform clinical decisions regarding the readiness or need for patients to move within the secure care pathway.

42. NHSE's service specifications provide that the access assessment service must focus on four key questions:

    (1) How clinically urgent is the admission?
    (2) Is there a need for admission to secure inpatient services?
    (3) What level of security does the patient require?
    (4) What are the patient's initial assessment/treatment needs?

43. The assessment process will involve reviewing the patient's clinical records, their offending history, and other appropriate documentation (e.g. CPA reports, reports for the First Tier Mental Health Tribunal, risk assessments, and professional reports). The psychiatrist will conduct a clinical interview with the patient, nursing staff, and referrer as appropriate.

44. On reviewing this information, the assessor will use their clinical expertise to form an opinion on the patient's diagnoses, risk assessment, and treatment needs. They may recommend that the patient be admitted to secure care and, if so, at what level of security. The decision whether to admit a patient is not an exact science, and it involves evaluative judgment on the part of the consultant. It is therefore difficult to provide a list of factors that will be determinative of whether a patient will or will not be admitted to a secure unit. The factors at play will vary on a case-by-case basis. A consultant may decline to admit a patient to secure care if they do not feel that admission is appropriate. One reason for this could be that the clinician considers that the patient's mental disorder and risk levels can be appropriately managed in a less restrictive setting. The decision made, and feedback given, will depend on the individual circumstances of the referral. The assessor will be guided by the least restrictive and proportionality principles. If the referrer disagrees with this conclusion, then they can pursue the Appeals Panel process where the referral is for high secure care [**NHSE0000022: Appendix 1, paragraph 5.3.14**] or the Dispute Resolution process [**WITN0388004, section 12, page 15**].

45. In deciding whether to accept a referral to a secure forensic unit, a threshold will need to be met. For example, it may be agreed with the IMPACT case manager that before an access assessment takes place, the assessor will contact the referrer to discuss the patient further, seek additional information, or make preliminary clinical recommendations. The assessment may then proceed. It may however be put on hold pending an update once the clinical recommendations have been implemented, or the referral may be closed with clear guidance as to when a re-referral could be made. In my experience, in the male mental illness low secure pathway most referrals will result in a clinical assessment.

46. On completion of the access assessment, the assessor will produce a written report which will be submitted to IMPACT. The report will explain whether the patient will be admitted and, if not, will provide specific clinical recommendations about the patient's ongoing treatment and care.

Care Pathways and Treatment

47. If an assessor recommends that the patient be admitted to secure care, a multidisciplinary team ("**MDT**") will begin assessing the patient's needs. The scope of the MDT will depend on the individual patient, but it will likely involve a named nurse, an occupational therapist, a psychologist, and a social worker. It may also include a speech and language therapist, particularly if there are communication needs identified, or where the patient has learning disability or autism. A consultant forensic psychiatrist, acting as the patient's Responsible Clinician under the MHA, will typically act as the patient's care coordinator.

48. Service delivery in secure units is underpinned by Multidisciplinary Team ("**MDT**") working and the Care Programme Approach ("**CPA**"). A patient's MDT will meet at MDT meetings and CPA meetings. MDT meetings will take place regularly. The exact frequency will depend on the procedure of the individual

hospital, but generally I would expect MDT meetings to take place weekly or fortnightly.

49. The first CPA meeting, which is a medium-term treatment planning meeting, should take place within three months of admission, and then every six months thereafter. At these meetings, the MDT will triangulate their observations of the patient thus far from ongoing assessments and set out and review the patient's treatment plans and care pathway. In my experience, there are also clinical formulation and risk assessment meetings, during which a formulation of the patient's risks of violence, in terms of type and nature, are discussed. During these meetings we will also review associated structured professional judgement tools (such as HCR-20 v3 **[WITN0388005]**, which is discussed in more detail below).

50. All patients within secure units will be treated and managed according to a 'care pathway'. The care pathway is planned in consultation with the patient, their family, and their carer(s) (where appropriate). The care pathway describes the patient's anticipated transition into, through, and out of secure care. The overarching aim of the care pathway is for patients to safely transition within forensic services to units with lower levels of security (e.g. from high to medium or low secure services, or from low secure services to the community), or to be returned to prison.

51. The indicators and criteria which are used for assessing progression and transition through the pathway are set out in NHSE's service specifications. They include the nature and degree of the patient's mental disorder and its relationship to risk; the patient's level of risk to others; and the patient's level of care and supervision management. Throughout the treatment and care pathway of a forensic patient, clinicians will regularly review evidence of any risk reduction on the part of the patient. Clinicians will seek to support the patient in becoming more autonomous in managing their disorder and risks, albeit within the context of robust clinical management.

52. All patients in secure care are detained under the MHA, some under part 2 and others under part 3 (under provisions known as the 'forensic sections'). First-tier Tribunal (Mental Health) and Associate Hospital Managers' hearings seek to test whether detention in hospital, and in the current security level, is necessary and proportionate. Some members of the MDT (Responsible Clinician, nurse, and social worker) will give written and oral evidence to those hearings to justify their rationale for detaining the patient in the secure setting.

53. Appropriate medical treatment must be available to the patient. Care and Treatment Reviews ("**CTRs**") are another mechanism by which the care pathway is tested for patients who are part of what used to be called the Transforming Care cohort. These are patients who have learning disabilities and/or autism in mental health hospital care.

54. Where patients are subject to the Ministry of Justice ("**MoJ**") jurisdiction, they are restricted under the MHA, and there is a dialogue with the MoJ as to the patient's risk, response to treatment, and any access levels outside the hospital environment. Further reference is made to this later.

55. The types of treatment offered to a patient will depend on their history and presentation. Treatment may include types of treatment that are available to patients in non-forensic mental health inpatient services. However, forensic services can also offer specialist treatment programmes, delivered individually or in groups, that address offending and risk behaviours. These types of programmes will normally not be available through non-forensic mental health inpatient services. I have set out further information on the treatment of patients in forensic units below.

56. Patients will generally remain in secure forensic units for longer periods of time than patients detained in other types of psychiatric hospital. For example,

NHSE's service specification for high secure forensic units indicates that patient lengths of stay are typically between five and six years **[NHSE0000020, paragraph 2.1.10]**. In my experience consultants working in secure care have a defined caseload of patients who they will work with over a period of months or even years. This knowledge and understanding of the patient forms part of the relational security provided in secure care.

Assessment in secure units

57. The clinical model for secure care services is underpinned by the assessment and management of mental disorder and associated risk behaviours. The reason for this is that patients in secure forensic units will generally have a history of violent offending and/or interaction with the criminal justice system. They will therefore present with a high risk of harm to others. The aim of forensic psychiatry is to treat patients and reduce those risks, and patients will regularly be assessed by their MDT members accordingly. The QNFMHS, at the Royal College of Psychiatrists, sets standards for how care should be provided in medium and low secure units **[WITN0388009]**.

58. As well as carrying out risk assessments, forensic psychiatrists may also provide other specific types of assessment such as assessments of a patient's fitness to plead or stand trial, or psychiatric evidence in relation to special defences. They may also advise on case disposal under part 3 of the MHA. They may do this for inpatients under their care, or for other patients who they have been instructed to assess by courts or solicitors.

Discharge / transition

59. As indicated above, the key aim of treatment in a secure forensic unit is to transition a patient to a lower security setting when it is clinically safe to do so. This may include a community-based placement if appropriate.

60. NHSE envisaged having Forensic Outreach and Liaison Services ("**FOLS**"), which could have represented an important and efficient component of the safe pathway from medium and low secure care into the community [**NHSE0000020 and NHSE0000023, paragraphs 2.2.1 and 2.2.2**]. A FOLS service manages and facilitates the transition of high-risk patients with mental disorders through secure services into the community. These are not however universally present across England, and I am unaware of how many FOLS services there are. NHFT has never been commissioned to provide a FOLS service. Nonetheless, there is some similarity between FOLS services and how community forensic services operate in practice within Nottingham (see later).

**Community Forensic Services**

61. As indicated in paragraph 5, I have no recent direct experience of current working practices in community forensic services. I have therefore liaised with the Trust's solicitor, the community services operational manager of LSCF at NHFT, and an experienced consultant psychiatrist working clinically in the community forensic service in order to gain an understanding of how NHFT's community forensic services currently operate in practice.

62. Community forensic mental health services in the UK have developed in an ad-hoc manner. Historically they have tended to have different service specifications and operational referral criteria, shaped by clinicians and commissioners based on local needs.

63. Community forensic mental health services are commissioned at a local level. In Nottinghamshire this is via the Integrated Care Board ("**ICB**"). There is not a nationally applicable NHSE service specification for community forensic mental health services, so the manner in which they are provided can vary between different Trust areas. The core purpose of many community forensic services,

however, is the safe and timely transition of mentally disordered offenders from secure care into the community.

64. Within NHFT, community forensic mental health services are delivered by the Nottinghamshire Community Forensic Team ("**CFT**"). The CFT is a city and county wide service providing mental health services for adults of all ages across Nottingham City, Nottinghamshire County, and Bassetlaw. It operates from two bases, Westminster House (to support patients in Nottingham City) and Heatherdene (for patients in the County). The team provides assessment, care and management to individuals over 18 years old with a mental disorder related to significant risk of harm of others. The service aims to support patients to live as independently as possible in line with risk reduction strategies.

65. Patients will sometimes be accepted to the CFT without criminal charges or convictions. NHFT's Procedure No. FO/C/55 gives the example of a patient for whom there is "*clear evidence of an emerging danger to others in the context of the patient's mental disorder, or if there is a pattern of assaults and escalating threats*" [**WITN0388006: Appendix 1, paragraph 1.4**].

66. The CFT will be involved in providing through-care to patients who are likely to be discharged from secure units, as is explained in NHFT's Procedure No. FOC/47 (Management of Throughcare Patients by the Nottinghamshire Low Secure and Community Forensic Service) [**WITN0388007**]. Where patients are stepping down from secure units to be case-managed by CFT there will usually be an engagement phase with the patient whilst in secure care. CPA transfer to the CFT to the CFT will occur when the patient is discharged from hospital. The CFT will case-manage the patient until such time as it is clinically appropriate for them to transfer to an alternative service (such as a Local Mental Health Team, "**LMHT**"), where the receiving service is in support of this, or in rare circumstances to the patient's GP. Some patients may require longer-term case management, depending on their risk profile and legal status (such as patients liable to recall under Section 37/41 MHA). Where CFT patients require crisis

support, or need admission to hospital, they can access NHFT's non-forensic Crisis Resolution and Home Treatment ("**CRHT**") or mental health inpatient beds.

67. The CFT offers four different levels of intervention/support:

    (1) **Advice only** – this is where the CFT reviews the case and gives advice to the referrer/team, usually without seeing the patient.
    (2) **Assessment** – the CFT assesses the patient including formulation, advice, and recommendations. This could be a joint assessment with the referrer.
    (3) **Joint working** – working alongside the referring team, with the referring team holding care coordination / case management.
    (4) **Full case management** – case transferred to the community forensic team.

68. Patients are not therefore always 'admitted' to community forensic mental health services in the sense of the CFT fully taking over their care (i.e. Level 4). Rather, a forensic psychiatrist (or psychiatrist with significant forensic experience) and other clinicians in the service may provide a less intensive level of input to a community patient's care, such as through participation in existing MDTs (i.e. Levels 1-3).

69. The CFT receives referrals from LMHTs, GP practices, Probation Services, and Secondary Mental Health teams in the prison services. The service does not accept self-referrals. Patients referred to the CFT will need to fulfil all the following criteria [**WITN0388006, paragraph 1.1; NHFT 0001578, paragraph 3.4**]:

    a. They will have an identifiable mental disorder.
    b. They will present with a significant probability of serious harm in that the individual's behaviour has or could lead to life threatening injury or irreversible harm to others. Patients typically have a history of

GBH, fire setting, stalking, and/or sexual violence, with a suspected link between the mental disorder and significant risk of serious harm.

c. There should be a suspected link between the mental disorder and significant risk of serious harm.

d. Specialist forensic management is required. The specialist work undertaken may include providing education and therapy on issues such as impulse control, problem solving and building healthy structures and routines. Specialist work may involve directing the individual to a relevant inpatient or criminal justice service.

e. Patients should have the potential to benefit from the treatment/assessment provided through active engagement with the team. Where this is not the case the referring agency will be contacted, and a plan will be shared in regard to future management or discharge.

70. Referrals to the service are considered on their individual merits by clinicians with expertise working within the CFT. Where a patient does not meet the threshold for clinical assessment, joint working or case management (levels 2-4 at paragraph 67 above), level 1 advice may be provided. Where the referral does not meet the forensic threshold the team will make a written recommendation to the referrer which may be followed up by consultation with the referrer [**NHFT0001578, section 3.5**].

71. It is my understanding that in 2024 the case consultation offer was re-worked so that NHFT now has a specific consultation service, which has been advertised to potential referrers such as Adult Mental Health ("**AMH**") and probation services. This was done to enhance and strengthen the process by which referring bodies can consult with the CFT to discuss whether a referral to forensic services should be made, and to receive Level 1 advice and signposting. Referrals can be made directly to the consultation service, which is made up of dedicated CFT clinicians. From the data reviewed, there has been a substantial increase in the number of these consultations in 2025.

72. Where a patient does have an assessment by the CFT (Level 2), this will consist of a clinical interview and a review of the patient's clinical records, offending history, and other appropriate documentation. The assessment will be overseen by a consultant forensic psychiatrist (or consultant psychiatrist with significant forensic experience). The outcome of the assessment will depend on the individual circumstances of the case. It could include the assessor providing recommendations on care and treatment, for example that a patient be prescribed particular or different psychotropic medications (including route of administration); recommending consideration of MHA or Mental Capacity Act 2005 ("**MCA**") mechanisms to aid adherence with treatment and supervision; or recommending the involvement of other agencies (such as adult safeguarding or MAPPA eligibility).

73. Community forensic clinicians may also offer a professionals' meeting following assessment to discuss the patient's clinical presentation and needs. They may offer to co-work with the patient and the clinical team around some risk-related areas of treatment need, where clinical responsibility remains with the referring team (Level 3). They may offer to transfer clinical and CPA responsibility to the CFT (Level 4).

74. As with secure services, the core objectives of the CFT are to manage the risk of harm by individuals while supporting recovery and promoting safe management in the community. The CFT holds weekly MDTs to review patient care. Meetings are consultant led and are rotated on a weekly basis with a different consultant caseload each week. There is also time allocated for additional patients to be presented where complexity and risks have increased. Members of the MDT will contribute to making plans around meeting patient needs, managing risk, planning interventions, and safeguarding.

75. If the CFT considers that a community patient's risk of harm to others has reduced then they will complete a written referral to the appropriate LMHT identifying why the patient no longer meets the community forensic risk criteria but continues to require secondary care, more appropriately delivered by the LMHT.

76. Previously, a Specialist Community Forensic Team ("**SCFT"**) called the Assertive Transitions Service ("**ATS**") also operated across the East Midlands PC region. This service was developed following an NHSE-driven initiative in 2018 to pilot SCFTs across 17 sites **[WITN0388008]**. The purpose of SCFTs was to reduce the length of patients' stay in secure units where appropriate community forensic services were in place. The ATS worked alongside secure care providers, community mental health services (including the NHFT community forensic team), housing providers, and other third sector services. However, the ATS has since been decommissioned by IMPACT during 2025.

**Assessments undertaken by forensic psychiatry services**

77. I have been asked to set out the types of assessments undertaken by forensic psychiatry, and to explain which (if any) are unique to forensic psychiatry. I have also been asked whether forensic psychiatry has a particular expertise in assessing the risk of violence posed by mental health patients.

78. As I have outlined above, patients in secure units will first be assessed during the access assessment. The access assessment will set out the consultant's view on the patient's diagnosis and appropriate treatment, and will include a risk assessment. The outcome of this assessment will shape the patient's care pathway and progression through secure services. Similarly, Level 2 community forensics patients will be assessed by the CFT. Throughout the treatment and care of a forensic patient, via the mechanisms described in paragraph 47 above clinicians will review evidence of any risk reduction on the part of the patient to update their assessment of patients' risk, diagnosis, and treatment.

79. As also outlined above forensic psychiatrists in secure units will be involved in assessments concerning a patient's interactions with the criminal justice system, e.g. through fitness to plead/stand trial assessments and advice on psychiatric disposals for offenders.

80. In terms of forensic psychiatry's particular expertise, clinicians working in forensic psychiatry exclusively treat patients with a history of violence and/or associated risk behaviours. The clinical model for all forensic services, and associated clinical decisions within these services, is underpinned by the assessment and management of behaviours which present significant risks towards others. This could support the assertion that forensic psychiatrists do have a particular expertise in assessing and considering patients' risks of violence. However, 'expertise' would imply that there is evidence to support better longer-term outcomes for patients who have been treated in secure forensic psychiatric care compared to non-forensic services. Studies have considered patient outcomes in terms of violent offending reconviction rates, hospital readmission rates, and mortality. I have exhibited two of these studies at **WITN0388010** and **WITN0388011**. Academic forensic psychiatrists would be better able to fully summarise the evidence-base underlying these studies and their findings.

81. I have been asked to comment on violence risk assessment tools, with specific reference to the Historical Clinical Risk Management-20 ("**HCR-20**"). In doing so I will set out the different approaches to violence risk assessment and management. HCR-20 is currently in its third version, and I understand it was last published in 2013. It is a comprehensive set of professional guidelines for the assessment and management of violence risk. The authors of the HCR-20 report its applicability internationally in custodial, forensic, and general psychiatric settings. The following is taken from the HCR20v3 User Guide (2013 edition) [**WITN0388005, page 7 paragraph 5**]:

> *"Approaches to making decisions about violence risk assessment and management may be divided into two types based on how information is weighted and combined to reach a final decision, and regardless of the information that is considered or how it was collected. The first approach is discretionary decision making, also referred to as clinical, intuitive, and informal, subjective, and impressionistic. The hallmark of discretionary decision making is that the evaluator exercises substantial professional judgment in the decision making process, including which information to consider and how to gather it, as well as how to weight and combine it. The second approach is non-discretionary decision making, also referred to as actuarial, statistical, mechanical and algorithmic. The hallmark of this approach is that evaluators make an ultimate decision according to fixed and explicit rules that are developed a priori. It is often the case that the non-discretionary approach uses mathematical formulas, derived from empirical research and optimised for specific settings and populations and outcomes, to determine which information to consider, how to gather it, and how to weight and combine it."*

82. Structured professional judgment ("**SPJ**") or structured clinical judgment is a form of discretionary decision making. HCR-20 is an example of such a tool. The User Guide goes on to note the following in relation to SPJ [**WITN0388005, page 8 paragraph 4**].

> *"Here, decision making is assisted by guidelines that have been developed to reflect the "state of the discipline" with respect to scientific knowledge and professional practice. Such guidelines – also referred to as clinical guidelines, consensus guidelines, or clinical practice parameters – are quite common in medicine, although used less frequently in psychiatric, psychological, or correctional assessment. SPJ procedures are evidence-based according to broad and narrow definitions. First, the guidelines are directly informed, guided, and structured by the scientific and professional literature. Second, there is a substantial and growing body of scientific evidence supporting the view that decisions about violence risk made using SPJ guidelines are both reliable and valid, as we will review later."*

83. In clinical practice, the HCR-20 tool involves the evaluation of the presence of key violence risk factors, and their relevance to the patient at hand. HCR-20

requires clinicians to examine 20 items. These include ten historical variables (H), which are intended to index a core set of important violence risk factors that have arisen in the patient's past. These look at the patient's history of problems such as violence, other anti-social behaviour, relationships, substance use, mental and personality disorders and antisocial behaviours. It has five dynamic clinical factors (C), which are intended to be able to capture relatively short-term changes. These include the patient's insight, violent ideation or intent, and symptoms of major mental disorder. This dynamic risk focus reflects emphasis on ensuring that risk factors that are highly relevant to intervention and management are included. There are also five dynamic risk management factors (R) which focus on the patient's goals, and future plans. These can include professional services and plans, personal support, and treatment or supervision response. The presence and relevance of each risk factor is evaluated. This process involves using an HCR-20 assessment template, on which the clinician will record whether each factor is present (either 'yes', 'possibly', 'no' or 'omit'), and the relevance to the patient (rating the factor as either 'high', 'medium', 'low', or 'omit').

84. The guidelines contain information to help evaluators construct meaningful formulations of a patient's risk of violence, future risk scenarios, appropriate risk management plans, and formative communication of risk. The HCR-20 manual guides evaluators through seven steps: (1) gathering case information; (2) coding the presence of the 20 risk factors and their sub-items; (3) judging the relevance of these risk factors with respect to the development of future risk management strategies; (4) risk formulation (i.e. integrating separate risk factors into a conceptually meaningful framework that explains a patient's violence); (5) planning risk scenarios; (6) recommending risk management strategies; and (7) documenting conclusory opinions (summary risk ratings in terms of low, moderate or high).

85. In my inpatient clinical practice, MDT members will meet before the patient's first CPA meeting to contribute their observations, rate each of the HCR-20 items,

and agree the initial HCR-20 clinical formulation for the patient. The HCR-20 rating will be updated at subsequent CPA meetings, or more often if there is step-change in risk or where a significant change in environment is anticipated (such as planning for Section 17 community leave).

86. Clinicians receive training about the use of HCR-20. The tool is used in all NHFT secure forensic services and the CFT. HCR-20 interlinks with SPJ tools such as those that exist for sexual violence or spousal violence. There is a section of the HCR-20 assessment form which requires the clinician to provide a clinical formulation of the patient's violence. In my experience, a commonly used tool for assessing a patient's clinical formulation of violence is the '5Ps' psychological formulation model[1] (presenting, predisposing, precipitating, perpetuating, and protective). The patient's treatment plan and the sequencing of the patient's treatment may take account of Risk-Need-Responsivity ("**RNR**") principles.[2]

87. The HCR-20 assessment process helps clinicians to create future scenarios for a patient where relevant to the current circumstances of the patient's care. For example, clinicians may assess whether a patient poses a risk of assaulting others on the ward, or a risk of assault in a community setting if the team were planning to consider Section 17 community leave. These future risk scenarios can be modelled in a manner similar to past behaviours, as an escalation in the nature of the patient's behaviours, or as another twist in behaviours. Scenario planning is informed by a patient's past clinical and risk history, weighed against the patient's treatment response in some areas. The patient's HCR-20 risk factors are used to guide this process.

[1] This model provides a structure in which to consider mental health needs, in terms of biological, psychological and social contributory factors.

[2] The User Guide refers to 'risk' as follows: "*higher risk cases should receive higher intensity management*". Need is referred to as follows: "*management efforts should target dynamic risk factors, also called criminogenic needs*". Responsivity refers to delivering treatment "*in a manner that is responsive to the learning styles of those receiving them*" [**WITN0388005, pp.58-59**].

88. Once scenarios have been compiled for a patient, case management plans can be developed. These plans will consider risk management measures such as monitoring, treatment, supervision, and victim safety planning. For example, if the MDT were considering Section 17 escorted leave for a patient with a stalking history, they may review the patient's mental state regularly to establish whether they were showing evidence of fixation upon the victim. Antipsychotic medication and an appropriate psychological intervention may have achieved a change in dynamic risk associated with the patient's behaviour. The MDT may inform the victim liaison officer of the type of leave being introduced, and develop a safety plan with the police in case the patient were to abscond from leave. If the patient were subject to the jurisdiction of the MoJ then these plans will likely have been submitted to the MoJ for consideration and challenge. The final conclusory part of the HCR-20 has subheadings of case prioritisation, risk of serious harm, and risk of imminent violence. Practitioners will seek "*to document summary judgments in a clear, simple manner that facilitates appropriate action*" **[WITN0388005, pp.61-63]**.

89. As I have explained, HCR-20 provides a structure in which clinicians and the patient can consider risk factors that may contribute to the patient's risk of violence. It is difficult to provide an exhaustive list of examples of where risk can be mitigated by treatment interventions, but one example would be the prescription of appropriate psychotropic medication for acute psychotic symptoms linked with interpersonal violence. Another example would be psychological interventions, which are too extensive to list here. Psychological interventions may include a psychoeducation approach, which can be used to equip patients with information about their mental disorder and its links with risk. Information can be provided to patients about the impacts of substance misuse on their mental disorder and risk, before considering strategies to manage high risk situations where they will seek to use substances. Psychological therapies may be offered such as cognitive behavioural therapy, cognitive analytical therapy, dialectical behavioural therapy, schema therapy, compassion focused therapy or eye movement desensitisation and reprocessing therapy. Structured

offending programmes or related interventions may be offered, focused on anger, violence, sexual offending or fire-setting behaviours.

90. A recent systematic review paper, published in 2023, noted that "*current violence risk assessment tools in forensic mental health have mixed evidence of predictive performance*" **[WITN0388002, p.780]**. In the discussion section, the authors note "*instruments that facilitate formulation as part of the risk assessment procedure might aid clinicians in creating effective risk management plans that are sensitive to risk erosion, actively mitigate risk, and avert violence*" **[WITN0388002, p.787]**. I interpret this to mean that current best clinical practice in forensic mental health is that the HCR-20 tool is used alongside clinical judgment to assess risk and make informed risk-related clinical decisions.

**Treatment of forensic psychiatry patients**

Secure units

91. The treatment available to secure forensic psychiatry patients may include nursing, medical, psychological, occupational, and social interventions. These are described below but are not exhaustive.

92. Treatment is delivered and sequenced during the patient's care pathway, as described in paragraph 86. For example, when a patient's mental health has sufficiently stabilised following appropriate response to psychotropic medication, they may be more likely to be able to participate effectively in psychological interventions. These interventions require a degree of motivation, concentration, and ability to retain information to be effective.

93. As a more holistic picture of a patient's needs, and the context in which risk to others may occur, becomes evident the MDT will consider making decisions

around graded access levels within the hospital (i.e. allowing the patient to access different areas in the hospital). Appropriate steps will be taken to mitigate the patient's risks. As this dynamic process continues, and when it is considered clinically safe to do so, the use of therapeutic Section 17 leave (under the MHA), initially escorted and then unescorted, will occur. Section 17 leave does not usually occur in high secure settings. Where patients are restricted, obtaining leave would involve making an application for permission with supporting detailed information to the MoJ. Decisions involving Section 17 leave will be underpinned by consideration of HCR-20 and will be carefully considered.

94. Nursing care provided to patients can include:

    a. Building a therapeutic relationship with a patient;
    b. Therapeutic observation of patient;
    c. Administering medications;
    d. Providing psychological interventions that they are competent to offer (such as supporting the patient to develop coping strategies to manage distress);
    e. Providing a consistent therapeutic ward environment in which patients can feel psychologically contained.

95. Medical care can include:

    a. Making decisions about the prescription of psychotropic medication;
    b. Consent to treatment provisions under the MHA;
    c. Making diagnoses and considering prognoses;
    d. Having an overview of the physical healthcare needs of the patient;
    e. Leading the MDT and acting as care coordinator during the inpatient journey.

96. Psychological care can include:

a. Providing specialist psychological and psychotherapeutic interventions to support the patient to manage their mental health;
b. Providing programmes for mental health education, substance misuse and specific offending needs (such as anger control, violent offending, sexual offending or fire-setting);
c. Assisting the MDT in terms of clinical formulation, and the use of specialist risk assessment tools (such as for violence, stalking and spousal violence, fire-setting and sexual offending).

97. Occupational care involvement can include:

a. Assessing the patient's level of occupational functioning;
b. Providing for patient's rehabilitative needs, in terms of activities of daily living skills, education and work skills.

98. Social care involvement can include:

a. Understanding the social and family network for the patient;
b. Providing a link role with other risk management agencies, such as MAPPA and probation;
c. Family interventions.

99. Speech and language involvement can include:

a. Communication assessment and provision of guidelines;
b. Dysphagia assessment (difficulty swallowing) and recommendations.

100. As illustrated throughout, secure forensic psychiatric services involve the provision of coordinated, patient specific care to a cohort of patients who present risks to others. They are configured and commissioned to deliver a forensic care

pathway, often over an extended length of stay in hospital, in a manner appropriate to the patient's needs and risk profile.

101. When considering the question of which treatments are unique to forensic psychiatry, it is difficult to answer this straightforwardly. Forensic services have a particular risk-related function, and should have access to treatment interventions which are targeted accordingly. The ethos of the MDT and clinicians working in forensic services will be aligned with this. In terms of specific unique types of treatment, offence-related programmes are likely to be unique to forensic psychiatric services relative to non-forensic settings. It is unlikely that such interventions would usually be made available in non-forensic settings, other than perhaps in locked rehabilitation hospital care.

102. My experience is in forensic psychiatry, but I expect that it would be possible to provide some of the other types of treatment described above to a patient in a non-forensic hospital setting, where a need has been identified and appropriate expertise has been sourced. An example in my own recent practice was that a communication assessment and guideline were obtained for a patient, which helped the MDT to have a dialogue with the patient about risk concerns. I can see no reason why this would not be possible in a non-forensic setting. I expect that it is also possible to provide psychological assessment and interventions in non-forensic settings, which may assist the MDT in addressing a patient's needs and developing an appropriate care pathway. Given that my experience is in forensic psychiatry, I am unable to comment on the extent to which this is done in practice.

<u>Community forensic services</u>

103. As indicated above, I do not have current direct experience working in the Nottingham CFT. However, the CFT Operational Policy sets out the model of structured supervision and treatment provided for case-managed patients

under the care of the team (i.e. Level 4 patients) **[NHFT0001578, sections 3.7 to 4.1]**.

104. In addition to a care coordination role, nursing interventions may include psychosocial interventions with the patient. These could include relapse prevention, oversight of medication compliance and effectiveness, social problem solving, and supporting the patient to understand the function of risk management strategies. Further psychological interventions may also be available, depending on patient need.

105. Treatment offered under Level 3 would usually be targeted towards specific forensic needs. An example may be working with clinicians from the referring service to conduct a stalking risk tool, which may help guide treatment and risk management of the patient.

## FACTORS RELEVANT TO VC

106. I have been asked questions of relevance to VC's case, in particular the circumstances in which EIP patients may be referred to forensic psychiatric services.

107. As with all patients, and in line with NHSE's service specifications, it is not necessary for any patient (including EIP patients) to have either (i) an extensive offending history and/or (ii) criminal offence charges linked to their mental health condition prior to them being referred to, or a referral being accepted by, a secure forensic unit. Patients may in theory be referred and admitted to a secure forensic unit even if they do not have a history of contact with the criminal justice system. They may, for example, not have been prosecuted despite evidence of incidents of risk to others on account of their mental health needs. From my own experience, patients may present with a repeated pattern of assaults towards healthcare staff or other patients, or an escalation in the severity of assaults, and a referral may be made on the basis

that the patient's risk cannot be safely managed on an ongoing basis in a PICU environment. This may be despite the use of restrictive practices such as seclusion or rapid tranquilization. However, as I have outlined above, a patient referred without the presence of (i) or (ii) would not be commonly assessed and admitted to a secure forensic unit.

108. The position is similar when it comes to the CFT. While it is theoretically possible for a patient in the community to have input from the CFT even if they have never been detained under the MHA and do not have an extensive offending history/charges, this would be unusual. Ordinarily, patients treated by the CFT will have had some contact with the criminal justice system.

109. If an EIP patient were referred to either secure forensic services or the CFT, their referral would be assessed in the same way as any other referral. It is difficult to provide a list of circumstances where a referral will necessarily be accepted or refused, because the outcome of an access or admission assessment will depend on the individual patient's presentation and the clinical judgment of the assessor. For secure services, the key question will be whether the patient's admission to a secure unit is necessary and proportionate, and the assessor will seek to explore less restrictive alternatives. In terms of the CFT, access will depend on whether the patient meets the five referral criteria.

110. I have been asked what potential treatment and/or advice could be provided by forensic psychiatry where an EIP patient is assessed as posing a risk to others, and referral has been accepted by forensic psychiatry. As I have sought to explain above, the process by which forensic services may become involved in a patient's care and/or provide advice is not limited to circumstances in which their referral is 'accepted'. The provision of advice and/or treatment by forensic services will depend on the referral circumstances.

111. If a patient is accepted for admission to secure care, then a forensic inpatient care pathway will commence. If a patient is not admitted, then advice

might be given to the referrer. Due consideration will be given to NICE guidance [**NHSE0000539** and **NHFT0004025**] in the context of the assessment of clinical risks, including the patient's insight into the need for treatment.

112. As I have explained, where a referral is made to the CFT there are options for forensic clinicians to become involved in a patient's care even if the case is not fully transferred to the CFT (i.e. through Level 1-3 support). CFT may therefore become involved in an EIP patient's care in an advisory or joint working capacity, even where they have not fully taken over the care of the patient.

**<u>Statement of Truth</u>**

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: 10th February 2026

**Index to First Witness Statement of Mark Henry Taylor**

| No. | Inquiry URN | Description |
|---|---|---|
| 1. | NHSE0000020 | Service Specification – Adult High Secure Services |
| 2. | NHSE0000023 | Service Specification – Adult Medium Secure Services including Access Assessment Service and Forensic Outreach and Liaison Services (FOLS) |
| 3. | NHSE0000022 | Service Specifications – Adult low secure services including access assessment service and forensic outreach and liaison services |
| 4. | NHSE0000539 | NICE clinical guideline – Psychosis and Schizophrenia in adults: prevention and management |
| 5. | NHFT0004025 | NICE guideline – Violence and aggression: short-term management in mental health, health and community settings |
| 6. | WITN0388002 | Lancet Psychiatry 2023 - Violence risk assessment instruments in forensic psychiatric populations: a systematic review and meta-analysis |
| 7. | NHFT0001578 | Community Forensic Team (CFT) Operational Policy |
| 8. | WITN0388003 | Report of the Committee on Mentally Abnormal Offenders – October 1975 |
| 9. | WITN0388004 | East Midlands Adult Secure Provider Collaborative Standard Operating Procedure |
| 10. | WITN0388005 | HCR-20 Assessing Risk for Violence |
| 11. | WITN0388006 | Procedure – Referral, acceptance, and discharges into and from community teams |
| 12. | WITN0388007 | Procedure – Management of throughcare patients by the Nottinghamshire Low Secure and Community Forensic Service |
| 13. | WITN0388008 | Mental Health Secure Care Programme |
| 14. | WITN0388009 | Standards for Forensic Mental Health Services – Sixth Edition |
| 15. | WITN0388010 | The Journal of Forensic Psychiatry & Psychology – Long-term outcomes discharge from medium secure care: still a cause for concern? |
| 16. | WITN0388011 | The British Journal of Psychiatry – Patient outcomes following discharge from secure psychiatric hospitals: systematic review and meta-analysis |
| 17. | WITN0388012 | Email from Dr Mark Taylor to Louisa Hagan re: Clinical information exchange – high profile case – 16 June 2023 |
| 18. | WITN0388013 | Email from Dr Mark Taylor to Fiona Lamb and others re: Incident Follow up 13 June 2023 |
| 19. | WITN0388014 | Email from Dr Mark Taylor to Adele Fox and others re: Confidential Meeting 16 June 2023 |
| 20. | WITN0388015 | Email from Dr Mark Taylor to Jacky Chapman and others re: Serious incident in Nottingham 13 June 2023 |
| 21. | WITN0388016 | Email from Louisa Hagan to Dr Mark Taylor and others re: Up-date 14 June 2023 |

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|---|---|---|
| 22. | WITN0388017 | Email from Andrew Horton to Dr Mark Taylor and others re: Referral of a Nottingham man |
| 23. | WITN0388018 | Letter from Dr Mark Taylor to Mr Horton and Ms Kemp |
| 24. | WITN0388020 | Email from John Wallace to Dr Mark Taylor re: Urgent Consideration – 14 August 2023 |