

Tuesday, 2 June 2026

1  
 2 (2.04 pm)  
 3 **THE CHAIR:** Yes, Ms Woodward.  
 4 **Questioned by MS WOODWARD**  
 5 **MS WOODWARD:** Good afternoon, Mr Rees. I ask questions on  
 6 behalf of the bereaved families.  
 7 You've given evidence today that the NMC's role is  
 8 to assure yourselves of the quality of the education and  
 9 training of nurses and establish the standards they have  
 10 to meet.  
 11 **A.** Yes.  
 12 **Q.** We've looked at the standards of proficiency, but one of  
 13 the other ways those Standards are set is through the  
 14 NMC Code; is that right?  
 15 **A.** Yes.  
 16 **Q.** If we could bring that Code up, it's NUHT0000058. If we  
 17 can go to page 3 please. We can see at the very top in  
 18 the introduction of that Code it says:  
 19 "The Code contains the professional standards that  
 20 registered nurses, midwives and nursing associates must  
 21 uphold."  
 22 **A.** Yes.  
 23 **Q.** It's one Code for all nurses, isn't it, regardless of  
 24 specialism?  
 25 **A.** Yes.

1

1 for some time and would have been well known to nurses  
 2 at that point?  
 3 **A.** Yes.  
 4 **Q.** If we could then just briefly go through some of the  
 5 Standards that that Code sets out. If we could go to  
 6 page 6 first of all, please. We can see there this is  
 7 a section on prioritising people and at 1.2 it says:  
 8 "Make sure you deliver the fundamentals of care  
 9 effectively."  
 10 Would that include the fundamentals of mental health  
 11 care for nurses?  
 12 **A.** Yes.  
 13 **Q.** That would be things like care planning, risk  
 14 assessments?  
 15 **A.** Yes.  
 16 **Q.** Therapeutic relationships?  
 17 **A.** Yes.  
 18 **Q.** Then if we go through, please, to page 7, can you see at  
 19 the bottom it's looking at people's physical, social and  
 20 psychological needs.  
 21 **A.** *(The witness nodded).*  
 22 **Q.** We can see at 3.1 it says meeting the changing needs of  
 23 individuals. Would this include things like responding  
 24 to changes in behaviour of an individual?  
 25 **A.** Yes.

3

1 **Q.** We heard from Ms O'Brien earlier today that the Code  
 2 contains very broad principles.  
 3 **A.** *(The witness nodded).*  
 4 **Q.** But these are also the fundamental principles of  
 5 nursing; would you agree with that?  
 6 **A.** Yes.  
 7 **Q.** The Code is integrated into the university education of  
 8 nurses?  
 9 **A.** Yes.  
 10 **Q.** It's central to the revalidation process as a focus for  
 11 professional reflection for nurses throughout their  
 12 career; is that correct?  
 13 **A.** That is correct.  
 14 **Q.** The Code was last updated substantively in 2015 with  
 15 some minor updates in 2018?  
 16 **A.** It was last updated in 2015, substantively. We're going  
 17 through a process now of updating the Code again and we  
 18 will be consulting in the autumn of this year on that  
 19 and then we will be producing a new Code in the autumn  
 20 of 2027, and I think certainly, you know, some of the  
 21 lessons that we've learnt from this Inquiry will help  
 22 with the sharpening up of some of the Standards in the  
 23 Code.  
 24 **Q.** But in terms of the relevant period that this Inquiry is  
 25 looking at, the Code had been in place in this version

2

1 **Q.** Changes in their engagement with services?  
 2 **A.** Yes.  
 3 **Q.** Then if we could please go to page 9, we can see there  
 4 this is about people's right to privacy and  
 5 confidentiality.  
 6 **A.** Yes.  
 7 **Q.** It sets out the right to confidentiality but also, at  
 8 paragraph 5.4, it makes clear there's a requirement to:  
 9 "Share necessary information with other health and  
 10 care professionals and agencies only when the interests  
 11 of patient safety and public protection override the  
 12 need for confidentiality."  
 13 **A.** Yes.  
 14 **Q.** So it does envisage circumstances, in broad terms, but  
 15 where confidentiality can be overborne?  
 16 **A.** Absolutely, and elsewhere we talk about professionals  
 17 using their Duty of Candour to share information where  
 18 there's a risk to patient safety or public protection.  
 19 **Q.** If we could then, please, go over to page 10. We can  
 20 see here it's about practising effectively, in line with  
 21 the best available evidence. And at 6.2 it says:  
 22 "Maintain the knowledge and skills you need for safe  
 23 and effective practice."  
 24 This would include, for example, undertaking  
 25 mandatory training?

4

1 A. Yes.

2 Q. Continuing with CPD for nurses?

3 A. Yes.

4 Q. Then if we could please turn to page 13. We can see  
5 here a whole section on keeping clear and accurate  
6 records relevant to your practice. And would you agree,  
7 Mr Rees, that this is an extremely important part of the  
8 nursing role?

9 A. Absolutely.

10 Q. Then, finally, please, if we could turn to page 17.  
11 This section is about:  
12 "Act[ing] without delay if you believe that there is  
13 a risk to patient safety or public protection."  
14 There are a number of circumstances set out there  
15 where individual nurses have a professional duty to  
16 raise concerns; is that right?

17 A. That is correct.

18 Q. That includes a professional duty to raise concerns if  
19 they think that they cannot undertake their role in  
20 accordance with this Code?

21 A. Yes.

22 Q. There's obviously other standards in here, but if an  
23 individual nurse fails to uphold the Standards set out  
24 in this Code, the NMC can take action through the  
25 fitness to practise process?

5

1 professionals; would you agree?

2 A. It is seen as being key.

3 Q. So just so we're clear, I mean, I think everyone is  
4 clear about what candour is broadly, but essentially the  
5 guidance makes clear, would you agree, that it's the  
6 professional responsibility for honesty in healthcare  
7 practitioners, particularly when things go wrong?

8 A. Yes.

9 Q. The need to make an apology?

10 A. Yes.

11 Q. But in addition to contribute to the culture of candour,  
12 being open and honest with organisations to ensure  
13 a culture of learning and to contribute to reporting  
14 adverse incidents that lead to harm as well as near  
15 misses; would you agree?

16 A. Yes, yes.

17 Q. And then just finally more broadly, in the umbrella of  
18 candour, I've no doubt that the NMC are aware of the  
19 Public Office Accountability Bill that's currently been  
20 reissued on 14 May this year in the carry-over motion.  
21 Could you perhaps, just broadly speaking, assist  
22 with what the NMC are doing to keep an eye on that Bill  
23 and also the significant implication that's going to  
24 have if the statutory Duty of Candour with criminality  
25 comes in?

7

1 A. That's correct, yes.

2 Q. That can be in relation to any of these Standards or all  
3 of them?

4 A. Yes, and it's looking at issues around competence,  
5 conduct, health, where there's been a criminal  
6 conviction or caution, or where someone doesn't have  
7 a good enough command of English.

8 **MS WOODWARD:** Thank you very much. Those are my questions.

9 **THE CHAIR:** Thank you.  
10 Ms Cartwright.

11 **Questioned by MS CARTWRIGHT**

12 **MS CARTWRIGHT:** Good afternoon, Mr Rees. I ask questions on  
13 behalf of the survivors.  
14 Can I just briefly touch on the issue of candour  
15 that you specifically addressed with Ms Woodward in  
16 answering her questions about the Code. It's right, as  
17 well as the reference to candour in the Code itself,  
18 it's right, isn't it, that in June of 2015 the NMC and  
19 the GMC issued joint guidance on the Duty of Candour and  
20 the professional requirements for all health and social  
21 care professionals?

22 A. Yes.

23 Q. I think it's right, isn't it, as well that that guidance  
24 was refreshed in December of 2024. So it's important,  
25 it's an important additional obligation on healthcare

6

1 A. If that is the case, as I say, we are updating our Code  
2 at the moment. There will be a new version that will be  
3 published next autumn so that will give us an  
4 opportunity to reflect that change, because obviously  
5 that would be something we would want to follow on in  
6 the Code. We're also updating our revalidation process  
7 again, so any major development like that we could look  
8 at reflecting in the updated revalidation process.

9 **MS CARTWRIGHT:** Thank you very much, Mr Rees.

10 **THE CHAIR:** Thank you.  
11 Thank you, Mr Rees. That's all the questions we  
12 have for you.

13 **THE WITNESS:** Thank you very much.  
14 **(The witness withdrew)**

15 **THE CHAIR:** Yes. So I think we'll deal with the next  
16 witness straight away but we may just have a short  
17 break. I'll stay in the room. Thank you.

18 **MS LANGDALE:** Chair, may I call Sir Simon Wessely, please.  
19 **PROFESSOR SIR SIMON WESSELY (sworn)**  
20 **Questioned by MS LANGDALE**

21 **MS LANGDALE:** Sir Simon, you have prepared a statement dated  
22 4 December 2025. Can you confirm the contents are true  
23 and accurate as far as you're concerned?

24 A. I can.

25 Q. Can you tell us about your background, please.

8

1 A. Okay.

2 Q. Professional background.

3 A. Well, I'm a Consultant Psychiatrist, I'm an academic.

4 My discipline is epidemiology, the study of large

5 populations, among other things, and I started my career

6 with an interest in forensic psychiatry for a period of

7 time but changed, and so for most of my career I've been

8 doing general hospital psychiatry at King's College

9 Hospital. I've been at various roles in King's College

10 London, that's my employer, the University, and during

11 that period I've had quite a lot of different roles.

12 The longest running is a long-standing commitment to our

13 armed forces.

14 Q. Pausing there, actually Sir Simon can we have on the

15 screen please WITN0322001, pages 2 and 3. This your

16 background as well, for those who want to follow it in

17 writing.

18 So you were saying in terms of working extensively

19 on the health of the military?

20 A. Yes. I set up a -- thank you. I set up a now --

21 I think it is world leading centre on military health

22 research, which has been a main preoccupation of mine

23 for a long time. I also set up, directed a health

24 protection unit on emergency response -- extremely

25 active during Covid as you'd imagine, and I've gone

9

1 Street, because it was the Prime Minister who had wanted

2 this review. I'm sure she didn't write this, and --

3 Q. Did you have any input into what was written?

4 A. No.

5 Q. No. So you were presented with them in this form --

6 (*overspeaking*)~--

7 A. Presented with them, and then added, which took up in

8 the end perhaps half of our time, was the requirement to

9 look at learning disabilities in autism, which I did

10 push back on actually, because I didn't want to do that.

11 I thought it would be separate but was overruled. And

12 then also added, from the Law Commission I think, was to

13 look at issues around the Mental Capacity Act and the

14 Mental Health Act, which had not been in the original

15 Terms of Reference, so, as often happens, it got more

16 complicated.

17 Q. The protection of the public was not a key focus of the

18 Review, was it? It's not specifically referred to,

19 public safety or public protection in the Terms of

20 Reference.

21 A. No.

22 Q. You tell us in your statement, this was something never

23 far from your mind. But it would have been better,

24 wouldn't it, to be consulted about the Terms of

25 Reference and to have it in the Terms of Reference, if

11

1 again with some various things.

2 I've had some awards in my time which I list there.

3 I spent a time as Dean of the Institute of Psychiatry

4 quite recently, and I'm also a one of the very few

5 psychiatrists who is a Fellow of the Royal Society and

6 have received -- well you can see -- various honours

7 during my time. Do you want me to go on?

8 Q. You say at paragraph 7:

9 "I have ... had a long-term interest in how ..."

10 A. Oh yes.

11 Q. "... ordinary people deal with traumatic events and

12 disasters and how they respond to adversity."

13 A. Yes.

14 Q. Can we look, please, at paragraph 8, so pages 4 and 5.

15 They are the Terms of Reference. You were asked in

16 October 2017 by the Secretary of State for Health on

17 behalf of the Prime Minister to lead an independent

18 review, the Review of Health Act 1983, and we see the

19 Terms of Reference set out. They can be enlarged.

20 They're in italics, it's only the parts in italics.

21 Who set the Terms of Reference?

22 A. Well, they actually were changed as well, not just

23 enlarged. They did change. Others were added as time

24 went by.

25 So added to that -- well, they were set by Downing

10

1 it was something that wasn't far from your mind?

2 A. Well, it depends what you mean by -- "far from my mind"

3 meant that I knew that this was not the purpose of the

4 Review. The purpose of the Review was driven by really

5 very major events that were happening across the world

6 in the way we were addressing mental disorder, and which

7 were having an impact in the UK, and also the need to

8 modernise the way that we were managing people with

9 mental disorder.

10 By never -- always in my mind was, because of the

11 fact I'd done by doctoral thesis on crime and

12 schizophrenia and had spent time, admittedly a very long

13 time ago, in forensic psychiatry, I was always aware of

14 those issues and anyone who was in the Review with me

15 will remember that I regularly hectored them in a way

16 and said that: whatever we do, if there is any

17 perception or truth in that we would have endangered

18 public safety the Review will just be ignored. I think

19 I used the word "we'd be finished" and that --

20 Q. Justifiably, if you -- (*overspeaking*) --

21 A. Sure, well I didn't want it to happen.

22 Q. Yes.

23 A. Yes. But that was not the purpose of the Review. There

24 had been plenty of other reviews, as you obviously know,

25 that had been entirely focused on that. This time there

12

1 were other big issues happening that we were expected to  
2 give opinions on, but I knew that that was always in the  
3 background and I had a kind of glib thing saying "How is  
4 this going to play? You've got to remember what this is  
5 going to look like when we finish," and I was mindful of  
6 that from day one to the last day, absolutely.

7 **Q.** And is it possible to look at big issues separately?  
8 Because they are all big issues, aren't they? What the  
9 Review had, public protection, safety?

10 **A.** Yeah, as I say, those are kind of the sea you're  
11 swimming in, I suppose. But as I say, clearly the  
12 purpose of the Review is set out in the Terms of  
13 Reference and that was what we were being expected to  
14 answer, and I think we did. But it was not expected at  
15 that time. The main driver was not, as you've correctly  
16 said, issues of public safety but that doesn't mean that  
17 they've gone away.

18 **Q.** Let's have a look at page 11, please, of your statement,  
19 and you set out:

20 "Landscape of the Review and its goals

21 "[...]"

22 "Our aims sought to achieve the following".

23 On page 11, there are ten bullet points, we can  
24 enlarge those.

25 **A.** Yes.

13

1 society in general. They're not in any way  
2 incompatible.

3 **Q.** If we can have paragraph 22, page 11, so the paragraph  
4 below that list, please, you say in terms:

5 "... broad set of goals, of which one was public  
6 safety."

7 **A.** Oh yeah, yeah.

8 **Q.** This is where you say this:

9 "... was always something myself and the Review Team  
10 and all the groups working on the Review considered all  
11 the time. Issues around public safety were never far  
12 from my mind ... I made sure that was the case for the  
13 rest of the Review team."

14 Pausing there, how did you make sure that was the  
15 case for the rest of the Review Team?

16 **A.** By repeating it virtually every day.

17 **Q.** How did you do that?

18 **A.** Well, just say, "let's think about what does this mean?  
19 Let's not forget what, you know, if there could be  
20 untoward consequences". Yeah, I mean, anyone who was on  
21 the Review -- and you've already talked to a few of  
22 them -- will definitely remember that.

23 **Q.** Mr Hendy told us he contributed to one of the focus  
24 groups around mental health tribunals and their secrecy  
25 about how you don't know the decision making of

15

1 **Q.** Page 11, ten bullet points and we see the penultimate  
2 one:

3 "Reduced harm and improved safety for all."

4 So this is the reference that touches upon public  
5 protection and safety from those who are mentally  
6 unwell.

7 How did that focus in the aim, given it doesn't  
8 appear in the Terms of Reference, how did that appear  
9 within aims here, as it were?

10 **A.** How did that appear? It appeared in the central theme  
11 of what we did was the issue -- I mean, I think the most  
12 significant change we made was around Advance Care  
13 Directives. And that -- central to that is the general  
14 theme of that is that the more people are involved in  
15 decisions about their treatment, whether or not they are  
16 detained or not, even if they are detained under the  
17 Mental Health Act, if they can be involved in those kind  
18 of decisions, they are more likely to comply, more  
19 likely to cooperate, as it were, more likely to turn up  
20 afterwards and more likely to continue to comply with  
21 medication, more likely to get better, and one effect of  
22 that is obviously increasing -- decreasing the risk of  
23 adverse events of relapse, violence, et cetera.

24 So if you can achieve those aims, the benefits will  
25 be to the patient. They will also be to the public and

14

1 tribunals. That's not expressly within your terms of  
2 review, but do you have a view on that, as it happens?

3 **A.** Sorry, say that again.

4 **Q.** The mental health tribunals, the decision making, isn't  
5 transparent. It's not easy for the public to have  
6 access to Mental Health Tribunal decision making?

7 **A.** Well, that's an issue for tribunals, I mean --

8 **Q.** Sure. I just wondered if you had a view about that.

9 It's not for your Review, I'm just asking what you think  
10 about that?

11 **A.** I don't really have a view on that, no. I think that's  
12 beyond my competence, for a start.

13 **Q.** What competence do you think you need to form a view  
14 about that? Is that a lawyer's competence or something  
15 else?

16 **A.** I would have thought so, yeah.

17 **Q.** The report, in terms, doesn't discuss the interplay  
18 between public safety, patient autonomy and detention,  
19 does it?

20 **A.** I'm pretty sure that my introduction does to it. I talk  
21 about there's always a tension between autonomy, which  
22 is something that most people regard pretty highly, that  
23 the idea that you can, you know, you're in charge of  
24 your own life and your own destiny. And then, when that  
25 gets overridden, in circumstances where we deliberately

16

1 reduce your autonomy by detaining you, and that these  
2 are -- they're always in tension. That's why we have  
3 a Mental Health Act, really, to balance out these two  
4 incompatible -- they're not incompatible, but they're  
5 acting in different directions.

6 **Q.** Maybe?

7 **A.** Oh.

8 **Q.** Do you think sometimes it's the same? The patient  
9 should be saved from themselves, for example, if they  
10 are sufficiently ill to commit a criminal act?

11 **A.** Oh, I see what you mean. No, I obviously think, and  
12 I think I write, one of the reasons you're  
13 a psychiatrist and do these things is because you think  
14 it is beneficial in the end that you do override  
15 autonomy that is justifiable.

16 At that time, and still, there is a very large body  
17 of people who do not think that, who think you cannot  
18 overwrite autonomy, as long as you have capacity.

19 **Q.** Did you have many on your Review Team who thought that?

20 **A.** Yes.

21 **Q.** Any voices that expressed that?

22 **A.** -- (*overspeaking*) --

23 **Q.** -- that you should not be detained in any circumstances?

24 **A.** I mean, there were certainly people who were sympathetic  
25 to that view, absolutely.

17

1 clever to believe something that is pretty stupid. And  
2 I just thought there's no way we're going to do that and  
3 other people have felt that as well. But if you look at  
4 the pages in the Lancet, there's a lot of people who  
5 really think that's the way forward.

6 And the one thing we did, in fact in, I think,  
7 sitting here now, thinking about it, maybe even the best  
8 thing we did was to say: not only are we not going to do  
9 that, we were the first people in -- or, you know,  
10 a reasonably privileged position -- to say: we're not  
11 even going to work towards it because it's draft. And  
12 that took me a paragraph to write, and you can see  
13 that's me because I write in the first person, and do  
14 that twice to make clear that is not -- that's not on  
15 the table.

16 It's still baffling as to why -- it still is,  
17 actually. It still is.

18 The next bit of that is something that -- this is  
19 what quite a few people did believe, and do, which is  
20 you should change the whole of the Mental Health Act  
21 from being risk-based, which is what it is, it's  
22 a risk-based Act, to being capacity-based. And I think  
23 you've had Alex Ruck Keene who has worked with us every  
24 day, a brilliant guy, and I'm sure you've had that  
25 explained in much more --

19

1 **Q.** Are you?

2 **A.** Am I?

3 **Q.** Yes.

4 **A.** It's fairly obvious that I'm not. Yes, I'm not --  
5 sympathetic, that's unfair. It's held by many people  
6 who I respect and admire but don't agree with it.

7 **Q.** Do you regard it as an extreme or an outlier view or  
8 within a respectable body of opinion?

9 **A.** It depends -- okay, it depends on what you're looking  
10 at. At the time there was a great deal of noise from  
11 something called the Convention on the Rights of Persons  
12 with Disabilities, which was a UN Convention which we  
13 have signed up to, "we" being the UK. Don't ask me why,  
14 but we had. And if we then enacted it, and we were  
15 under pressure to enact it -- there'd actually been  
16 a case against us a couple of years previously -- and we  
17 were under pressure to do that, that would have meant  
18 a complete -- there would be no Mental Health Act and no  
19 Mental Capacity Act. It's absolutely clear on that.  
20 There's no room for equivocation.

21 And the government's view was: well, we're working  
22 towards that, in the fullness of time, a lot of kind of  
23 "Yes, Minister", speak. I thought it was ridiculous.  
24 I still do. And I think there's a George Orwell quote,  
25 isn't there, of something like you have to be very

18

1 **Q.** We have -- (*overspeaking*) --

2 **A.** Yes, I thought you might have done. Yep. But in the  
3 simple way, is that if you have a capacity-based  
4 attack -- "attack"? Act -- then if you have capacity,  
5 you will retain your autonomy and the right to make  
6 decisions and that, actually, that can't really be  
7 overruled. And that -- now that had a lot of supporters  
8 and indeed, in the report you'll see that I quote  
9 Baroness Hale, Lady Hale as she was, the head of the  
10 Supreme Court at the time, who had addressed our  
11 conference, including some little digs at me, but there  
12 you go, and she made it very clear that she was  
13 a supporter. And this is a very influential person, and  
14 plenty of other people were.

15 Now the danger of that is that you will end up --  
16 there are two dangers. It's not a ludicrous position  
17 like the CRPD, it is a, you know, we take it seriously  
18 and we devote 40 pages to it, as to why we don't  
19 actually want to do it, or at least what are the tests?

20 So like Gordon Brown, you know, in joining the euro,  
21 there are five tests that must be fulfilled before we  
22 can think about it.

23 But the other key decision was -- this was always  
24 kind of a moment that certainly Alex and I remember very  
25 well, was Alex was explaining what could happen -- and

20

1 this is the Canada legislation in Ontario where they do  
 2 have that. And then the problem you get is that  
 3 about -- we don't know exactly how many people are  
 4 detained under the Mental Health Act who still have  
 5 capacity. Okay? We should know, but it's not recorded.  
 6 One of the things we've asked for is it's just -- you  
 7 can't complete a section without saying what the  
 8 capacity test --  
 9 **Q.** Not many assessments of capacity are recorded either, or  
 10 even undertaken by the example we're looking at.  
 11 **A.** I'm sorry?  
 12 **Q.** How many assessments of capacity are actually undertaken  
 13 in respect of treatment --  
 14 **A.** Well, we don't know.  
 15 **Q.** -- is a different issue-- (*overspeaking*) --  
 16 **A.** We don't know, but in future we will know for the  
 17 purposes of the Mental Health Act, because you won't be  
 18 able to complete the form --  
 19 **Q.** Without doing it.  
 20 **A.** -- (*overspeaking*) -- unless you write that. So that's  
 21 a recommendation I'm sure, I'm sure it must have been  
 22 adopted. But we think it's somewhere around 85% will  
 23 not have capacity. That still leaves quite a few who  
 24 do.  
 25 Now in Canada, you can refuse, okay? You can -- and

21

1 "I think ... there is not a day when we were not  
 2 considering this [that's public protection]. From the  
 3 first to the last ..."  
 4 **A.** Okay, yeah.  
 5 **Q.** "... and the ... press conferences/launches. I thought  
 6 constantly about public protection. It was also a  
 7 recurrent topic in the briefings I gave to politicians  
 8 as parts of the Review ... [you] met with members of  
 9 Parliament, from both Houses and all parties ...[and  
 10 you] do recall broad requests for reassurances about  
 11 public protection ... including ... from the Secretary  
 12 of State for Health at the time ..."  
 13 So that was the Right Honourable Jeremy Hunt MP,  
 14 was it?  
 15 **A.** No, it was actually Matt Hancock by then. But doesn't  
 16 matter.  
 17 **Q.** Okay, so what did he ask for?  
 18 **A.** Well, it was -- okay, it was a private conversation, but  
 19 anyway. He said --  
 20 **Q.** Sorry, you've referred to it. If you feel uncomfortable  
 21 not --  
 22 **A.** Yes, I know. You're right, okay --  
 23 **Q.** -- (*overspeaking*) -- but you've referred to the fact  
 24 that it was raised.  
 25 **A.** Fine. That he'd had someone saying -- he had

23

1 then -- well, you can refuse here but that's the  
 2 difference being in Canada that has to be then honoured.  
 3 You can't do anything. And I just said, that's just --  
 4 "We're not going to do that". This is to Alex and the  
 5 others, I said, "We're not going to do that, that's  
 6 just -- we are not going to do that."  
 7 So that was a decision, we're not going to do that,  
 8 and that the key thing there is no right to refuse  
 9 treatment in the Mental Health Act, okay? That's an  
 10 absolute. There is no right to refuse treatment. So  
 11 that's really important.  
 12 Now -- and actually could we do one other thing,  
 13 whilst we're at it, could we look at that passage there  
 14 and if I -- just look at those five tests and let's look  
 15 at the last --  
 16 **Q.** Let's look at that later. I don't want to do that now.  
 17 Let's move on to --  
 18 **A.** Okay, but can I park that for later on?  
 19 **Q.** Yes, park it, and I think you've answered the last  
 20 question. Let's have instead, please, page 27 on the  
 21 screen, "Final report: conclusions and recommendations".  
 22 And this is where you say again at paragraph 68, the  
 23 bottom of page 27.  
 24 **A.** Okay.  
 25 **Q.** Again you say:

22

1 a particular style of speaking -- that "Are you sure  
 2 this doesn't mean that there will be lots of people ..."  
 3 I don't know, I can't remember what it was, but it  
 4 was some phrase to the extent that "Are we going to be  
 5 overrun by" whatever -- I can't remember the exact  
 6 words, but it was something -- it wasn't his view. He  
 7 said one of his backbenchers had come along and said  
 8 this in a somewhat -- I think he called him slightly  
 9 antediluvian, he didn't say who it was. And I said no,  
 10 that's not going to happen, the Mental Health Act is  
 11 still strong, will be strong, in fact I think it will be  
 12 stronger.  
 13 **Q.** Right, so he was worried that the principles of  
 14 detention would be eroded or erased in some way?  
 15 **A.** He didn't know what the --  
 16 **Q.** Where you were going?  
 17 **A.** He didn't know where we were going, but I told him we  
 18 weren't going in that way.  
 19 **Q.** Understood. If we can go to page 19, please, of your  
 20 statement, paragraph 42 "Risk", you refer here to:  
 21 "... the risks of violence by those with mental  
 22 illness."  
 23 You say here:  
 24 "It is now accepted there is a small but significant  
 25 increase in the risk of serious violence by those with

24

1 SMI that the risk to self is in an order of magnitude  
2 greater than the risk to public and that this is  
3 strongly increased by the concurrent substance misuse.  
4 This is an enormous topic with a great deal of  
5 literature and other information. I am not ... placed  
6 to discuss or describe these issues in detail."

7 Do you think the Review would have benefited from  
8 engaging either an expert in this field or  
9 a comprehensive analysis of the information that was out  
10 there? So, for example, for the purposes of the  
11 Inquiry, the Inquiry legal team has undertaken analysis  
12 of 528 attacks involving 570 people between the early  
13 1990s and 2023, including matters relating to diagnosis.

14 In 92% of the cases the patient had never been  
15 subject to a CTO. That kind of material around the  
16 Community Treatment Orders.

17 **A.** I haven't seen that analysis, actually.

18 **Q.** No, it's only just been completed, but also  
19 Professor Appleby told the Inquiry and the whole history  
20 of collecting that homicide data only three cases had  
21 ever involved persons prescribed CTO. That might have  
22 been useful for you around that kind of analysis around  
23 Community Treatment Orders.

24 **A.** Well, Professor Appleby was advised of the Review and so  
25 was Professor Fazel and when you asked me -- someone

25

1 **A.** Yeah, but what I'm saying there is yes, we've accepted  
2 that it can be rescinded but not totally rescinded.  
3 That even though you have been detained against your  
4 will and treated against your will, does not mean that  
5 you still don't have, if it's possible, some say in how  
6 you should be treated and not -- by the way, that's just  
7 not it all. I mean, one of the people on the review had  
8 a long running thing about every morning she was given  
9 tea and she wanted coffee, and she said, "Why did that  
10 happen?" I don't know. You know, I don't know. So  
11 that's a restriction on her autonomy.

12 Now, you'd say well that's trivial, but if you're in  
13 hospital for three years, it's not trivial. So that's  
14 what we're referring to. We've taken the decision to  
15 restrict your autonomy. I've said I agree with it,  
16 otherwise, you know, I wouldn't be here, but what had  
17 happened in the past? Let me use an example, okay.

18 Let's say, in someone in this room, okay, takes an  
19 antidepressant and it's not working, and they come back  
20 to the doctor and they say, "I don't like this is  
21 antidepressant because of what's happened. I've lost  
22 libido" okay, "and I want another one, a different one."

23 What would happen if your GP said, "No, I'm giving  
24 you the same and you're going to take it." You really  
25 wouldn't be very happy with that and if you could, you

27

1 asked me: can you name any people who you think would be  
2 helpful for the Review. Those were the two I mentioned  
3 because I hold them in incredibly high esteem. So we  
4 did have the benefit of both of them.

5 **Q.** But not all of those cases and what they represented  
6 or --

7 **A.** Well, we didn't -- I actually generally don't know what  
8 analysis you're referring to, but we had the benefit of  
9 the two, I consider, world authorities on this.

10 **Q.** Yes. Can we go to your foreword, please. WITN0155008,  
11 page 5. "Why do we have Mental Health Acts?" And you  
12 set out the tension you alluded to earlier, the second  
13 paragraph.

14 **A.** Okay.

15 **Q.** "Allowing everyone to make the decisions that affect  
16 their life and accept the consequences of those  
17 decisions is a key aspect of respecting the unique value  
18 and character of each human person and in recent years  
19 it's become clearer that there is no reason why that  
20 should be rescinded simply because an individual is  
21 unwell."

22 I think you've already set out, as far as you're  
23 concerned, it can be rescinded, depending on the  
24 circumstances and detention is both lawful and  
25 appropriate?

26

1 wouldn't take it.

2 It's no different if you're detained under the  
3 Mental Health Act. If we can avoid that situation, then  
4 you're going to be more likely to comply. It's not  
5 difficult. It's not rocket science, and --

6 **Q.** Let's look at page 7, please, under "Fear" you set out  
7 here:

8 "The public are often fearful of mental illness and  
9 the consequences they have been led to believe flow from  
10 it, specifically the danger posed by people living with  
11 mental illness."

12 Do you think that's still the case, that the public  
13 are simply fearful of mental illness? It's much more  
14 widely understood, isn't it? More people, it's stated,  
15 experience mental health difficulties than ever; is that  
16 fair to say it's --

17 **A.** There's certainly been a major change in that area.

18 **Q.** There has been a major change?

19 **A.** There has been, particularly in the younger generation  
20 who are nothing like my generation when I started  
21 psychiatry. It's been almost a revolution and I'm  
22 currently Vice Chair of a massive review looking at this  
23 and what the consequences have been, which are not  
24 always entirely desirable.

25 But when it -- but it's not -- what's the word I'm

28

1 looking for -- the change is not as fixed in stone as  
2 you might think and we know that measures of stigma in  
3 the population have now started to go up again. So  
4 they've changed there.

5 So and I've long written that some of this is a bit  
6 skin deep, that, actually, underneath there are still --  
7 there is still quite a lot of stigma around and also  
8 some of it is quite deserved. I mean, we can't avoid  
9 that. Some of it is accurate.

10 **Q.** Do you think some of the messaging from psychiatrists  
11 and psychiatry generally, for example Professor Lade  
12 Smith told us yesterday that psychosis can be treated  
13 and early treatment matters. We've heard that  
14 consistently across psychiatrists in this Inquiry.

15 Do you think that's a key message that's explained  
16 sufficiently? You've talked about stigma as though that  
17 prevents getting help, but is the message that it can be  
18 treated --

19 **A.** Well, yes.

20 **Q.** -- sufficiently developed?

21 **A.** I spent early this morning reading one of  
22 Professor Fazel's latest papers, I thought was very good  
23 and shows that treatment of psychosis reduces violence  
24 in data that's completely, as far as I could see, close  
25 to perfect.

29

1 a cautious, risk averse approach to their patients they  
2 will find themselves being publicly shamed for those  
3 occasions when those same people cause serious harm to  
4 themselves or others."

5 Clearly the case we're examining does not  
6 demonstrate such a risk-averse approach, but what was  
7 the basis for you saying that there is that fear of  
8 a risk-averse approach?

9 **A.** Because it's one of the main explanations for why the  
10 numbers of detention have been steadily rising in many  
11 countries around the world, not just us, although ours  
12 was the fastest. And that -- I mean risk aversion is  
13 almost kind of the -- one of the most important things  
14 in our age, isn't it? It's not just in this, but it  
15 happens here, it affects so many decisions by  
16 institutions, by individuals. It's a reason why people  
17 don't share data when I think they should. They're  
18 averse to the consequences and they often have  
19 over-exaggerated view as to what the consequences would  
20 be.

21 Risk aversion in this context --

22 **Q.** How do we overcome that, then, for psychiatrists? That  
23 they don't share information, you don't think it's just  
24 about legal confidence; it's fear of consequences as  
25 well?

31

1 **Q.** And treatment is required?

2 **A.** When?

3 **Q.** Treatment is required to treat it?

4 **A.** Well, yes. I mean -- well, actually not always --

5 **Q.** It seems obvious --

6 **A.** -- sometimes you get better -- in the course of time  
7 you get better of your own accord. But --

8 **Q.** There it might conflict, mightn't it, with the concept  
9 of patient autonomy and being able to choose medication?  
10 The two are at direct odds, aren't they?

11 **A.** You go back to what I'm saying, that there is no right  
12 to refuse treatment, but you ought to be able to have  
13 some say in which treatment if you get. If you've tried  
14 one treatment before and it made you put on weight,  
15 people should have a think about that, but in the end it  
16 is clear that in the end you can override that with  
17 safeguards, which I think is reasonable, and in the end,  
18 there is no right to refuse treatment. And -- I mean  
19 you can say "I want to be treated with homeopathy" if  
20 you want, you could go ahead with it actually, it  
21 doesn't really matter, but you need to be treated --

22 **Q.** In addition to.

23 **A.** Yes. In addition with treatments that work.

24 **Q.** And we see here you say:

25 "Professionals are fearful that unless they adopt

30

1 **A.** Oh yeah, I mean written on that. People have an  
2 exaggerated fear of how it can go wrong. Instead, they  
3 should have an exaggerated fear of what happens when you  
4 don't share. And I've said this several times: not  
5 sharing data loses lives. And if you explain to people,  
6 this is our students now: if you do it properly and  
7 properly, as it always is, like doing a section of the  
8 Act: you write down what you're going to do; you say why  
9 you think it's the right thing to do; you take advice,  
10 and actually I've often said to people you can actually  
11 ring up these people, the regulators. They're not  
12 monsters. They're completely normal people who are  
13 trying to help you, like the GMC, things like that. But  
14 people don't.

15 **Q.** Is that about guidance or culture, training?

16 **A.** It's certainly about guidance. It's a little bit about  
17 culture. And the training that people get is actually  
18 often subtly risk averse as well, because institutional  
19 training is designed to protect the institution.

20 **Q.** And what about their understanding of patient  
21 confidentiality, thinking they can't share because of  
22 their patient which feeds into patient autonomy,  
23 arguably?

24 **A.** Yeah, fine, I'm happy to talk about that, because I feel  
25 quite strongly about it. Yeah. Again, teaching a paper

32

1 on confidentiality. There are a number of ways in which  
 2 you can legally share information, and it's exactly the  
 3 advice I've given: if you do it in the way I've said,  
 4 I've never heard of anybody getting adverse  
 5 consequences, I've literally never heard of it and nor  
 6 has Alex.

7 **Q.** Is that between police, probation, prisons, NHS --  
 8 **A.** I'm talking about doctors because I know them best  
 9 -- (*overspeaking*) -- their staff.

10 **Q.** So doctors sharing with other doctors?  
 11 **A.** No, no, no.

12 **Q.** Which agencies do you mean when you say you've  
 13 experienced it when it's no consequences?  
 14 **A.** I'm sorry?

15 **Q.** Which agencies are you talking about psychiatrists  
 16 sharing information?  
 17 **A.** Whoever they feel needs to know. If they really feel  
 18 they need to know it could be family. I've shared with  
 19 the police, broken confidentiality, not done it very  
 20 often, twice in my career, but I did it, and there were  
 21 no consequences at all. The guy got arrested, which he  
 22 should have done. So yeah, I mean it's -- well -- fine,  
 23 we're getting away from this but I don't mind.

24 I think I've also written on the Germanwings  
 25 disaster where 200 people lost their lives because of

33

1 **A.** I'm quite happy to talk about that because --  
 2 **Q.** What would you say then the risk for schizophrenia and  
 3 -- (*overspeaking*) --  
 4 **A.** Well, if I go through, if I go through the work I did  
 5 which was the first -- okay, I'll start at the  
 6 beginning.

7 When I started my career it was assumed that there  
 8 was no risk of violence in people with mental disorder.  
 9 That was a straightforward view that was repeated and  
 10 that was the standard consensus. I've then practised,  
 11 started training in epidemiology, as I've said, and then  
 12 I had to do a thesis, a doctorate, and I chose to do  
 13 that subject, and in the end I found that consensus was  
 14 wrong, that actually there was an increased risk.

15 Now there are lots of different ways of projected  
 16 risk, by the way. There's no one way of doing it. But  
 17 however you looked at it, it was increased in people  
 18 with schizophrenia, significantly so. And then I showed  
 19 that the main predictors were substance misuse and  
 20 previous history of violence, and that's been replicated  
 21 dozens -- I mean that's just not in dispute -- dozens  
 22 and dozens of times. So that's what I would say.  
 23 Academics love talking about their own work, don't they?  
 24 So that's what I --  
 25 **Q.** And you have.

35

1 a failure to share medical in-confidence information,  
 2 and that led to one of the worst airline disasters and  
 3 it was due to not knowing about the psychiatric history  
 4 of the pilot. I was part of a group that looked at  
 5 that. It doesn't matter, but yeah.

6 **Q.** Page 8, please, second paragraph. You refer to your  
 7 doctoral thesis, you mentioned it earlier, into crime  
 8 and schizophrenia.  
 9 **A.** Haha, yes.

10 **Q.** And you say:  
 11 "There is a far greater risk of serious harm to  
 12 self, but we cannot deny there is also a risk to others,  
 13 even if usually overstated by public, politicians and  
 14 the media."  
 15 Do you consider there has been an exaggeration of  
 16 the risk of violent offending by those with mental  
 17 health disorders?  
 18 **A.** Mm, I think at times I have. There's also the opposite,  
 19 of course, of under-stating the risk. My view is that  
 20 the best thing to do is to simply state the risk. So,  
 21 but yeah, I mean in general, people --  
 22 **Q.** How would you state the risk? Leave that to  
 23 Professor Fazel or would you --  
 24 **A.** Well, I did my thesis on it.  
 25 **Q.** Yes, so --

34

1 **A.** Yes, I have.  
 2 **Q.** Page 10, please.  
 3 **A.** I should, by the way, add I think Dr Fazel's most recent  
 4 work is close to brilliant and is better than mine.  
 5 That's the Swedish work, I think it's really brilliant.  
 6 It shows quite a big risk, actually.  
 7 **Q.** It does. Paragraph 4:  
 8 "... we cannot act on our own."  
 9 And if we go halfway --  
 10 **A.** Ah, here we are.  
 11 **Q.** -- (*overspeaking*) -- you say:  
 12 "[And] Any probability judgement must be wrong  
 13 sometimes, and that should not automatically mean that  
 14 this is a fault, let alone negligence."  
 15 "Any probability/judgement must be wrong".  
 16 In terms of what we're talking about, the risk of  
 17 people with schizophrenia committing violent offences  
 18 and homicides, that's not a risk that can be tolerated  
 19 by society, is it? It's got to be managed effectively.  
 20 We can't tolerate it.  
 21 **A.** Well, no, I mean no one is in favour -- well, yeah,  
 22 you're right. You can't -- but it's what you do about  
 23 it. How you do it. And in the end, you're going to  
 24 make risk judgements. You are. And the nature of risk  
 25 means that sometimes those judgements will be wrong.

36

1 They can't always be right.

2 **Q.** But the starting point can't be there's a probability it  
3 will be wrong sometimes, that's just the nature of  
4 assessing risk. It's not how you do it in the airline  
5 industry. You wouldn't say to a pilot: "Sometimes you  
6 might get a risk wrong when you're landing the plane."  
7 The fact is you can't tolerate that kind of risk. You  
8 have got to manage the risk effectively, haven't you?  
9 **A.** You have to manage risk effectively. Yeah, you --  
10 **Q.** So this shouldn't be seen to appear as though you say:  
11 it doesn't mean it's a fault, sometimes it must be  
12 wrong, you might get this wrong.  
13 **A.** I'm not sure where you're going on this. I mean, it  
14 is -- you cannot predict the future accurately. Okay?  
15 And planes still crash, by the way but, but you know,  
16 they do. Look, I've just mentioned Germanwings. They  
17 didn't predict that.  
18 So you can't -- you do the best you can to exclude  
19 it, using all the information that you can get, and  
20 obviously the more information you have, the better your  
21 judgement will be. And then you have to take  
22 a decision, which is a binary decision: are you going to  
23 detain someone or not? And it would be based on a lot  
24 of factors.  
25 And the area I would think, that I would point out

37

1 together.

2 **A.** Okay.

3 **Q.** You'd agree, the least restriction principle requires  
4 consideration of the risk of harm to self and also to  
5 others. You've said that --  
6 **A.** Yes.  
7 **Q.** -- throughout so far.  
8 **A.** Correct.  
9 **Q.** Do you think this could have been made clearer within  
10 the Review, discussing least restriction, people were  
11 reading it, people were interested in it, that least  
12 restrictive practice must be consistent with the  
13 management of the level of risk?  
14 **A.** Well, what we're saying about least restriction is that  
15 you don't start by thinking: what's the least  
16 restrictive thing I can do, and then justify it. It's  
17 entirely the other way round. You start with: what am  
18 I trying to achieve in this encounter with -- usually  
19 it's a crisis, a disturbed person -- and you decide what  
20 it is you want to achieve.  
21 Now once you've decided that, you then, yes, you  
22 have a duty to think about: well, what's the least  
23 restrictive way I can go about doing this, compatible  
24 with the goals that I have set? Which is as you've just  
25 said. And that will differ, and that comes up, and

39

1 is, that talking to psychiatrists as I do, the thing  
2 that -- I've noticed creeping a little bit is the idea  
3 that we take the prevention of suicide more importantly  
4 than we do the prevention of homicide.  
5 **Q.** You certainly have more guidance around it, don't you?  
6 **A.** Yeah, that's true but --  
7 **Q.** So what does that suggest to those who  
8 -- (*overspeaking*) --  
9 **A.** Can I finish what I was going to say? Is that there's  
10 absolutely no doubt at all that risk to others is the  
11 prominent thing in the mind of every single doctor who  
12 does an assessment under the Mental Health Act. It's  
13 just, I'm speaking to Louis Appleby just to check that  
14 I'm right, and he said, "Of course, of course, because  
15 the consequences are so devastating for everybody."  
16 So it's not true to say that doctors are not aware  
17 of that. You're right about guidance. I take that  
18 point, and that there's been more of a political and  
19 emphasis on suicide prevention in recent years. Yes, I  
20 take that point. That's true. But it's not true to say  
21 that that's not in the mind of every doctor from most  
22 junior to the most senior. It absolutely is.  
23 **Q.** Could we have a look, please, at pages 24 and 25. This  
24 is the report, "Principle 2: ... Use of Least  
25 Restriction". 24 and 25 could be on the screen

38

1 where it falls down, as we definitely draw attention to,  
2 is this issue of Section 2 and Section 3.  
3 And so the least restrictive option, if you're  
4 thinking of an assessment, all things being equal, it  
5 would be the shorter section, okay? Because you're  
6 thinking of an assessment. That's fine.  
7 But if you aren't, if you're thinking of treatment,  
8 it's entirely the other way round: the least restrictive  
9 option to achieve what you want to do, which is now  
10 treating a patient --  
11 **Q.** Section --  
12 **A.** -- is obviously Section 3. But it wasn't happening,  
13 because social workers, my son is a social worker and  
14 I'm a massive admirer of them, but not on this instance,  
15 were somehow believing just about what is shorter.  
16 **Q.** Yes, and the Section 3 was more restrictive?  
17 **A.** It's as restrictive.  
18 **Q.** No, the perception is that it's more restrictive,  
19 therefore an overuse of section 2 --  
20 **A.** Sorry, yes -- (*overspeaking*) -- it depends on what  
21 you're wanting to do and if you want to treat someone,  
22 it's obviously more restrictive to put them onto a 2  
23 because they're going to have to be moved up anyway, so  
24 you've actually prolonged the agony. And that was --  
25 you can see that that's one of our recommendations --

40

1 Q. Yes.

2 A. -- that you can only do it once in a period of time.

3 And I'm slightly sad that it's not statutory. It's

4 going to be in the Code of Practice, and I wasn't --

5 obviously I'm not consulted on that, but I'd prefer that

6 it was statutory, but, you know.

7 Q. Can we have page 29 on the screen, please. "Community

8 Treatment Orders."

9 A. Mm-hm.

10 Q. Reference here to considerations. Page 29. I'll wait

11 until it's on the screen.

12 A. Mm, yes.

13 Q. Third paragraph:

14 "... we think CTOs are significantly overused."

15 You've explained in your statement that you have

16 limited confidence in the results of the data from

17 Professor Burns' trial on this topic; is that correct?

18 A. I suppose --

19 Q. -- (*overspeaking*) -- the most unwell patients were

20 excluded, weren't they --

21 A. Yes, I suppose.

22 Q. -- (*overspeaking*) -- from the randomisation?

23 A. I'm not saying I didn't have confidence in the results,

24 it was a brilliant trial and he did very well to do it,

25 but it's not generalisable and I can't see there's any

41

1 overlooked, that they were much more likely to be used

2 if you were a black Afro Caribbean, and it was difficult

3 to explain that through normal demographics or the

4 normal things and that had been known for years, by the

5 way. It wasn't we who found that --

6 Q. In terms of race --

7 A. In fact, the Prime Minister knew it, everybody knew it.

8 Q. In terms of race and the detention criteria, your Review

9 is not suggesting that race is a factor in the

10 consideration of the detention criteria, they are to be

11 applied equally, aren't they, whoever is being

12 considered?

13 A. I mean, you would be absolutely -- if you did something

14 like that, if you did say, "I'm -- I was going to

15 section someone, but I'm not going to now because I've

16 noted that they're black Afro-Caribbean", you would be

17 completely out of order. I mean, you'd be in serious --

18 that would be a really seriously dramatically risky

19 thing to do and completely ridiculous.

20 Q. And nothing suggested like that at all in this?

21 A. Of course not, no.

22 Q. Can we look at page 64, please, where capacity and

23 decision making in the Mental Health Act is considered.

24 Alex Ruck Keene gave evidence to the Inquiry that

25 a statutory test to assess capacity may be advisable,

43

1 way that he could have done it actually, so --

2 Q. So it's limited, isn't it --

3 A. Yes.

4 Q. -- to --

5 A. -- well, the word -- (*overspeaking*) -- the word we use

6 is not generalisable. You can't apply it to the more

7 severe cases.

8 Q. That doesn't -- you've explained that in your statement,

9 but we don't see that here, we think there's an

10 assertion:

11 "... we think ... [they] are significantly overused.

12 [And] ... want to see a dramatic reduction in the number

13 of CTOs ..."

14 In the evidence we've compiled across a number of

15 cases and indeed your colleague Professor Appleby saying

16 there are only three cases, we've seen the reverse:

17 they're significantly underused in that cohort. So --

18 A. I genuinely wasn't aware of that data. As you say,

19 I still haven't seen it-- (*overspeaking*) --

20 Q. It would have been useful presumably before being --

21 (*overspeaking*) --

22 A. Yes, it might have been, but the overused bit is that

23 they were rising steadily, more so than other bits of

24 the Act, without any realisation precisely why that was.

25 And of course, we could not overlook, and we haven't

42

1 that the presumption is not working in practice.

2 What do you think about that? You don't need to

3 specifically look at this. I just want people to see

4 where you've considered it, but do you think that

5 a statutory test to assess capacity would be useful, or

6 you don't have a view on that?

7 A. I think it would be very difficult. The -- you know, as

8 you know, you have to test it for one specific thing.

9 You're not testing for a general, it's not a general

10 propensity.

11 I think it should be recorded, definitely. It

12 should be recorded. A statutory test, I don't know.

13 I do think it should be recorded and because without

14 data, you're flying blind.

15 Q. Page 67, please. "Proposed Principles", set out:

16 "Principle of choice and autonomy."

17 Second one:

18 "... Least Restrictive principle requires that the

19 Acts/powers are used in the least restrictive way, and

20 that less restrictive alternatives must always be

21 considered."

22 A. Mm-hm.

23 Q. From your evidence, you'd have no difficulty with the

24 insertion there "consistent with the management of the

25 level of risk"?

44

1 A. Of course, yeah. And consistent with having  
2 alternatives. The biggest reason they're not used is  
3 because most services don't have them.

4 Q. Page 86, please, "Family and carer involvement". The  
5 recommendation, of course, was made to the uses of  
6 nominated persons now. So if we just look underneath  
7 "Family and carer involvement", second paragraph:  
8 "People with experience of detention, their family  
9 members, and mental health professionals gave a wide  
10 range of examples of inappropriate people serving as  
11 a patient's [nominated person or nearest relative], or  
12 instances where patients had no NR because the default  
13 person was unsuitable".

14 What do you say about that? You must have been  
15 given many examples of a person nominated that would be  
16 unsuitable, both for the patient and presumably for the  
17 clinician, if both don't work. What was the evidence of  
18 getting around that, how it can --

19 A. Well, it was people saying exactly that. But the other  
20 reason was that the list of people that you could do,  
21 you know, starting -- I can't remember if it already  
22 was, but always you would put father first before  
23 mother, always it would put son before daughter. It was  
24 very, very Victorian and it was time to update that.  
25 And that was really what was really driving that. It

45

1 for' or 'justified in the interests of the patient's  
2 health or safety or for the protection of others'."

3 You thought -- the Review thought this sets the bar  
4 too low.

5 If we go over to page 112, the second paragraph:  
6 "... new detention criteria ... needs to be more  
7 explicit about how serious the harm has to be to justify  
8 detention and/or treatment, or how likely it is that the  
9 harm will occur. We are recommending there must be  
10 a substantial likelihood of significant harm to the  
11 health, safety, or welfare of the person ..."

12 That makes it harder, doesn't it, in the assessment  
13 of risk. You need to be clearer about the risk of that  
14 patient. Much clearer.

15 A. I'm not seeing that page, actually, but it doesn't  
16 matter, I --

17 Q. Sorry, page 112, can you see -- perhaps if we --

18 A. I'm not seeing it --

19 Q. Perhaps if we just have 112, second paragraph  
20 highlighted.

21 A. Anyway, I mean, I know what you're talking about.

22 Q. Mm-hm.

23 A. Yeah. The problem with the previous criteria was they  
24 were actually really very vague. It wasn't, you know,  
25 and I heard Lade Smith saying yesterday she thought the

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1 just looked so, you know, antediluvian from a --

2 Q. So you would you, just as you might get an inappropriate  
3 family member, you might get someone under this system  
4 that's the same --

5 A. You might indeed. And I was acutely aware of that risk  
6 and certainly some carers told me that during the thing:  
7 that they were fairly convinced that their -- whoever it  
8 was -- member of the family with serious illness,  
9 wouldn't choose them, and would choose someone else and  
10 that would be, you know, not in their best interests.

11 Q. It might be someone who has known them for a long time,  
12 their history, their background.

13 A. Yes, they might be unsuitable, and I accepted that that  
14 is definitely a risk. It was a risk before, by the way,  
15 and would be a risk now and then of course you would  
16 have to institute measures to get that changed, which is  
17 possible, okay. But I was aware that there'd be some  
18 families in which, you know, an inappropriate decision  
19 would be taken by the patient, yes. I wasn't not aware  
20 of that.

21 Q. Paragraph -- sorry, page 111 and 112, "The new criteria  
22 for significant harm". At the time, of course, of the  
23 Review the current legislation set out at the bottom  
24 there:  
25 "... a person can be detained where it is 'necessary

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1 new criteria were confusing. I think it's almost the  
2 opposite way round: I think they're clearer than the old  
3 one, which could almost just -- in theory, you could  
4 almost justify anything.

5 Now, the key point is, in theory; in practice, of  
6 course, we've been running that Act for a long time and,  
7 to be honest, the words: you are detained for serious  
8 reasons; you're not detained for trivial reasons. You  
9 could be but you're not. It's run for serious reasons.

10 Now we put in the word "substantial", it's been  
11 changed to "serious". I'm perfectly fine with that.  
12 I think they mean pretty much the same. I don't think  
13 they're really that different. And anyway, the choice  
14 of exact words, if you're a doctor, administering the  
15 Mental Health Act in acute situation, is actually not as  
16 influential as, for example, Alex Ruck Keene thinks it  
17 is, because that's not how it works, that's not how  
18 a detention works. You do the clinical bit first and  
19 you come to the decision you're going to come to, based  
20 on a lot of things that you assess very quickly. That's  
21 how all of medicine works. It's how general practice  
22 works; it's how A&E works. Doctors come to the decision  
23 fast and then they spend time justifying it.

24 But you -- if there's a police van outside the A&E,  
25 the chances of you detaining soar. If you see that

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1 there is a history of violence, they're even higher. If  
2 the patient lacks insight, you can -- if you've got the  
3 records, lacks insight, by now, you're probably going to  
4 detain. You're already at that criteria. And so that  
5 happens very quickly. And then, what you do, and  
6 actually this is what you should do, you then make sure  
7 you, as you write it out, that you're in keeping with  
8 what you need to do in order to carry out the detention.

9 The clinical decision first, then the legal  
10 protection, the legal, you know -- explain yourself.  
11 Alex says: you do the clinical decision but what we ask  
12 you as a lawyer to do is explain why you've done it.  
13 Okay? And that's what he taught me and then other  
14 lawyers have told me if it was the other way round, that  
15 you start with the law, you're going to make terrible  
16 mistakes.

17 **Q.** People are going to look, though, aren't they?  
18 Clinicians are going to look at what the Act says, what  
19 the admission criteria are.

20 If we go to WITN0288007, page 3. This is prepared  
21 by Alex Ruck Keene to just set out clearly what the  
22 amendment is.

23 **A.** Yeah. And being honest with you, he and I don't really  
24 agree on this. And this is Alex in his witness  
25 statement, I've heard him say this before, he admits

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1 the patient or of another person unless the patient is  
2 detained."

3 **MS LANGDALE:** And before it was "in the interests of his own  
4 health or safety or with a view to the protection of  
5 other persons". Much broader than "serious harm may be  
6 caused to the health or safety of the patient or ...  
7 another."

8 **A.** Yes, too broad. I've said that was too broad.

9 **Q.** Well, do you --

10 **A.** What we've done is clarify, I think. But the truth is  
11 that nobody actually took it to be too broad. In the  
12 way it was being used, people already had a heuristic of  
13 that: this has got to be serious.

14 Now how do you define "serious"? Well, I don't  
15 know. The Code of Practice will have a go, but serious  
16 is what serious is.

17 **Q.** You had been suggesting, or the Review, "substantial  
18 likelihood of significant harm."

19 **A.** Mm-hm.

20 **Q.** We're left here with "serious harm may be caused". Can  
21 I ask you to have a look at WITN0320001, page 70. The  
22 Royal College of Psychiatrists' position, page 70,  
23 recommending the detention criteria should be amended:

24 "there is a significant risk ..."

25 Do you see, at (b):

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1 that he's -- Alex's view, he said, "I talk lawyer,  
2 I can't speak doctor; and you talk doctor and you can't  
3 speak lawyer and that's how it should be."

4 **Q.** It's not really good for-- (*overspeaking*) --

5 **A.** Now if, for example, we're put in that criteria, it must  
6 be beyond reasonable doubt, the legal criteria. That  
7 would be completely bonkers. That really would have  
8 a massive effect.

9 **Q.** Look at the screen, please. We see at (b):

10 "serious harm may be caused to the health or safety  
11 of the patient or of another person."

12 There is a causal connection there, isn't there,  
13 between the patient --

14 **A.** "may be caused", yes.

15 **Q.** Before it was --

16 **A.** Sorry.

17 **Q.** I don't know what's happened there. If we go, please,  
18 to -- there we are at the top.

19 **A.** Anyway --

20 **Q.** "Admission for assessment". We need to go further  
21 down --

22 **THE CHAIR:** Further down.

23 **MS LANGDALE:** -- please, the bottom half of the page.

24 **THE CHAIR:** Yes.

25 **A.** "serious harm may be caused to the health or safety of

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1 "... significant risk of serious harm to the health  
2 or safety ..."

3 So not as predicted, "serious harm may be caused",  
4 but "significant risk". That puts it on to the  
5 clinician in the same way as you say, well they'll be  
6 making a clinical judgement anyway, but they're required  
7 to think about risk as well, significant risk.

8 **A.** It's a risk-based Act. Of course they're thinking about  
9 risk.

10 **Q.** So you would agree with that? That's a sensible  
11 criteria --

12 **A.** Well --

13 **Q.** You'd have no difficulty with that?

14 **A.** No, I agree with the criteria that it's in the new Act.

15 I mean obviously we didn't see this. This was written  
16 well after we'd finished. This the RC Psych's view.

17 Obviously I've been President of the RC Psych, but that  
18 doesn't mean I have to agree with it.

19 **Q.** No, I'm just asking you --

20 **A.** I think I agree with the Act as it currently is.

21 **Q.** Rather than the "significant risk" which makes it less  
22 causative but emphasises risk assessment. But you'd say  
23 that's what psychiatrists should be doing anyway, risk  
24 assessment.

25 **A.** Yes. I mean that is what psychiatrists should be doing

52

1 anyway. And there's-- and the key thing is there,  
2 "serious harm". I really think sometimes that people  
3 detain the people they think they need to detain.  
4 **Q.** If we look at page 61 of Professor Lade Smith's  
5 statement, paragraph 191. In terms, the bottom  
6 paragraph:

7 "The Royal College of Psychiatrists is aware of the  
8 concerns about the effectiveness of CTOs and encourages  
9 more research. ... particularly like to see more  
10 research into why [they] don't lead to lower admissions  
11 ... how effective [they] are at reducing the risks  
12 involved [et cetera] ..."

13 Would you agree with that: that it's not as simple  
14 as saying they're overused or underused in some cohorts?  
15 It's not sufficiently understood at the moment.

16 **A.** Well, the reason why I decided that we should keep them,  
17 funnily enough, wasn't the trial or the evidence. It  
18 was actually going to see a residential set-up in  
19 East London that was run by social workers, that was  
20 designed to look after people who had come out of medium  
21 secure high security, and this was a kind of halfway  
22 house.

23 Every single one of them was detained in some shape  
24 or form, and the social workers called them all  
25 "customers", which I found mildly amusing because

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1 the contributors -- to the -- referring to "The economic  
2 impact of violence perpetration in severe mental illness  
3 ..." And we see, I think it's page 2, the estimated  
4 annual economic impact, leaving aside the human impact,  
5 which is enormous, clearly.

6 When you -- had you seen this article before we  
7 referred you to it today, the costs?

8 **A.** I haven't seen it before, but it doesn't matter. Go on.

9 **Q.** And we see description at page 2, "Interpretation":

10 "The economic impact of violence perpetrated by  
11 individuals with severe mental illness is potentially  
12 important. Preventing violence, especially through  
13 services for individuals with comorbid substance misuse,  
14 and reducing recidivism might lead to cost savings at  
15 a governmental and individual level, in addition to the  
16 clinical and societal benefits."

17 Has this -- and we see at page 11, we can see the  
18 amounts, the annual cost to society, discussion,  
19 page 11.

20 **A.** Mm-hm.

21 **Q.** Estimate, "annual cost to society of ...2.5 billion."

22 We've been hearing, and indeed you've referred in  
23 your statement to the "Cinderella of services", mental  
24 health. Has this argument or data ever been used to  
25 compel greater funding for those with severe mental

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1 they're not customers. But the social workers on this  
2 group of people were absolutely a hundred per cent  
3 certain, without a CTO, they would all be back in  
4 Broadmoor or medium security very quickly. And  
5 actually, that's what made me change my mind. Because  
6 at the start I was probably in the group that thought  
7 maybe, you know, they don't seem to work from the  
8 evidence, although the evidence is not perfect, but  
9 there's a huge push to abolish them. I can't tell you  
10 how strong that push was.

11 And it was going to see that particular -- I can't  
12 remember its name but it's East London and it stuck in  
13 my mind that we would by, if we removed them completely,  
14 which was I think the view of the majority of the  
15 Inquiry, of -- sorry, the --

16 **Q.** The Review --

17 **A.** Sorry I'm seeing "Inquiry" on the screen, sorry -- of  
18 the Review, that I, you know, that would do harm. And  
19 also I'd have Louis shouting at me which wouldn't have  
20 helped very much.

21 But anyway, that took the decision and that's the  
22 decision I stuck to.

23 **Q.** Can we have, please -- that can come off the screen --  
24 finally from me: WITN0075014. And this is an article  
25 that you've seen earlier -- professor Fazel is one of

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1 illness to look at this in this way?

2 **A.** I've genuinely no idea. I mean articles like this are  
3 always being used to do that. I hadn't seen this one  
4 before. Well, the first thing was, even if it didn't  
5 save a penny, we should still be doing it, okay?

6 **Q.** Definitely.

7 **A.** The second thing is, my experience of these things is  
8 even if they do save money, we never see it. That's it.

9 **MS LANGDALE:** Chair, those are my questions. I wonder if  
10 this is a time for an afternoon break.

11 **THE CHAIR:** Yes, let's just take the afternoon break and  
12 come back at 3.30. Thank you.

13 (3.13 pm)

(A short break)

15 (3.30 pm)

16 **THE CHAIR:** Yes, Ms Cartwright? No? Mr Straw?

**Questioned by MR STRAW**

18 **MR STRAW:** Sir Simon, I represent VC's family.

19 I'd like to ask you first about CTOs, please. Could  
20 we have on screen the report, please, WITN0155008. This  
21 is your 2018 report again.

22 Could you turn, please, to page 262 of that report.  
23 So this comes from the appendices to the report, so  
24 information obtained by others for the purpose of the  
25 report. There's a section here about compulsory

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1 community treatment, there.

2 **A.** Mm-hm.

3 **Q.** Could you turn then forward, please, to 264. The

4 "Results" section. The second paragraph down there it

5 says "Analysis of available data" from one of the group

6 comparison studies, I think:

7 "... n=21 pre-post comparison studies found large

8 effect sizes for ..."

9 And then at the end of that sentence:

10 "... increase in community service use and increase

11 in treatment adherence."

12 Was it your understanding that that indicated there

13 was an improvement in increase in treatment adherence

14 for that part of it?

15 **A.** That's what it says, sure, but it's a question of why,

16 and the pre- and post-comparison isn't it a very strong

17 research method. Could be lots and lots of reasons. It

18 could be for the fact that they'd been treated in

19 hospital, so --

20 **Q.** Okay, thank you. And then the paragraph -- sort of

21 similar:

22 "Analysis of data from n=20 two-group comparison

23 studies ..."

24 Dot, dot, dot. And then towards the end:

25 "... a large but non-significant effect for

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1 **Q.** Might be, okay. Can we take a more specific example.

2 So someone who is considered to be at high risk if

3 they're not being medicated, who's made clear they're

4 not going to take medication voluntarily, where the

5 Community Team doesn't have the resources to watch them

6 actually take the pills, take the oral medication and

7 make sure they are taking it voluntarily.

8 For someone in that sort of category, a Community

9 Treatment Order could be a benefit, couldn't it?

10 **A.** I think I'm not actually the right person to answer that

11 question. So far you've been asking me research-based

12 questions which I do understand, but I'm not a community

13 psychiatrist, I never have been, and I've never done

14 a CTO. So you need to ask people who actually do this

15 for a living.

16 **Q.** Then just one more question about this evidence about

17 CTOs. We've heard that there are -- that there was --

18 there were concerns that CTOs weren't effective in

19 preventing or reducing bed numbers, so they're not

20 effective at preventing people going back into hospital

21 into inpatient beds.

22 Leaving that aside, so whether or not they reduced

23 bed time, is there evidence as to whether or not they're

24 effective in terms of public protection, so protecting

25 the public from the patient and protecting the patient

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1 increased treatment adherence ..."

2 Again, does that help, does that indicate there was

3 a positive impact on adherence in that study?

4 **A.** No, I'm afraid it doesn't, for the same reason, plus it

5 does say non-significant, so it could have occurred by

6 chance alone.

7 **Q.** Over the page please, this is from the discussion

8 section that you can see at the bottom of that page and

9 then it runs over to the next page. It says at the top:

10 "Evidence from pre-post-and two group studies

11 suggest that CCT does act as a mechanism for patients to

12 receive more treatment and support from community mental

13 health services."

14 But it then goes on to discuss the limitations of

15 the study.

16 Would it be correct that, to summarise this as

17 follows: that there were real limitations in this

18 data --

19 **A.** Mm-hm.

20 **Q.** -- but it did at least support there being a positive

21 impact of Community Treatment Orders, here they're CCTs,

22 in terms of treatment adherence?

23 **A.** There might be a positive impact. It doesn't say

24 that -- it doesn't prove that there is; it says that

25 there might be.

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1 from themselves?

2 **A.** Well, my answer is I don't know. You'd have to use that

3 as an outcome. I'm not sure that studies did do that

4 and you'd also have to follow people up for quite a long

5 time and I think one of the general criticisms of the

6 literature was that they all had fairly short

7 follow-ups. So I don't know is the answer to that, but

8 you'd need quite a big study to show that.

9 **Q.** Okay.

10 **A.** Again that's speaking -- I've written a book on

11 randomised trials, so I do know about that, but I'm not

12 suggesting I'm an expert in how CTOs are supposed to

13 work.

14 **Q.** Thank you for clarifying that. Then the only other

15 thing I'd like to ask you about, please, is could you

16 put up on screen, please, the witness statement, so

17 that's WITN0322001, page 25, and at the bottom of the

18 page paragraph 61:

19 "I am asked whether we found evidence that

20 professionals avoided restrictive practices for patients

21 from African and Caribbean communities due to

22 concerns/publicity about disproportionate overuse."

23 Paragraph 62, second sentence, you say:

24 "I do not recall the issue surfacing during the

25 various consultations that we undertook."

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1 Is that to say that you didn't see any evidence of  
2 that happening?  
3 **A.** I don't know that we specifically looked for it  
4 happening, but no one said that it had. Later on, later  
5 on long after the Inquiry finished, I was aware that  
6 some people had, but during the Inquiry I wasn't aware  
7 that that was an issue, no.  
8 **Q.** Towards the bottom of that paragraph, 62, over the next  
9 page, please, it said, you say here:  
10 "The direction ..."  
11 It's two lines up:  
12 "... the direction of travel was in the other  
13 direction."  
14 Do you see that there?  
15 **A.** I'm not actually sure what I meant by that. I'm sorry,  
16 what was the other -- (*reads sotto voce*)  
17 Even if was occurring in individual cases, this is  
18 what, the rate was still going up? I'm actually  
19 baffled -- I've baffled myself there. I'm not sure what  
20 I meant.  
21 **Q.** Was that simply referring back to the evidence that  
22 CTOs, restrictive practices, are used in  
23 a disproportionate way against people of  
24 African-Caribbean heritage?  
25 **A.** They're more likely -- oh, yes. It would act in the

61

1 dealt with that cohort of people who were in the east  
2 end, I think you said, halfway house --  
3 **A.** Mm-hm.  
4 **THE CHAIR:** -- and were discharged from Broadmoor or  
5 somewhere and you said that they needed CTOs, obviously  
6 they had a history of violence or something of that kind  
7 before they were discharged. Does that argument not  
8 equally apply to those who weren't in Broadmoor, didn't  
9 have a conviction, but did have a history of violence?  
10 **A.** The argument being?  
11 **THE CHAIR:** Being that a CTO is something which keeps them  
12 in -- out of another detention.  
13 **A.** Yes. I mean, I didn't know -- I wasn't given their  
14 clinical histories, it wouldn't be appropriate. But  
15 I can definitely infer that they've been in Broadmoor  
16 and medium secure units, that that would be the case.  
17 And of course most people who offend and have  
18 schizophrenia will not go to those establishments.  
19 **THE CHAIR:** No.  
20 **A.** They'll be treated in general situation. So yeah,  
21 I mean, it's an anecdote, but I've told you the truth  
22 that actually it did in the end make me decide I don't  
23 think we're at the position of saying we should abolish  
24 CTOs because I just thought -- I would disadvantage  
25 these people that I come to see. And it is an anecdote

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1 other direction, yes. Sorry.  
2 **Q.** Then coming back to what you said just now about a  
3 couple of examples after the Inquiry finished --  
4 (*overspeaking*) --  
5 **A.** It could have been clearer. Sorry, go  
6 on-- (*overspeaking*) --  
7 **Q.** Sorry, coming back to what you said just now about a  
8 couple of examples you came across after the Inquiry  
9 finished --  
10 **A.** Mm, yes.  
11 **Q.** -- were they cases in which people were trying to avoid  
12 discrimination against African-Caribbean communities,  
13 people saying, "I'm concerned about that evidence, I'm  
14 going to try to avoid it myself."  
15 **A.** The social workers, who -- the customers, the ones --  
16 yeah? No, it didn't come up in the conversation at all.  
17 What came up was these were people who needed a CTO to  
18 stay in the community. That's the only issue that was  
19 discussed.  
20 **Q.** Yeah.  
21 **A.** Yeah.  
22 **MR STRAW:** Okay, thank you very much. Those are all my  
23 questions.

**Questioned by THE CHAIR**

25 **THE CHAIR:** Perhaps I can just pick up that point. You've

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1 and, you know, I'm an academic, you're not supposed to  
2 listen to anecdotes, but sometimes you do.  
3 **THE CHAIR:** Well, it might be compelling, mightn't it?  
4 **A.** I'm sorry?  
5 **THE CHAIR:** It might be compelling.  
6 **A.** Sometimes they are, yes, that's true.  
7 **THE CHAIR:** Just dealing with the issue of the test under  
8 the new Section 2 and Section 3 and in particular the  
9 relationship of "serious harm may be caused to the  
10 health or safety". That that doesn't cause you any  
11 problems, does it? Causation is one of the most  
12 contested concepts in both civil and criminal law.  
13 **A.** I think it's going to be interpreted as: is there a risk  
14 of serious harm? That's what people are going to  
15 interpret it as. I'm not sure that the word "cause"  
16 changes very much. No. I don't know how you'd know, to  
17 be honest.  
18 **THE CHAIR:** Wouldn't it be better to have the risk in there  
19 as part of the test?  
20 **A.** Fine. I'm not -- I'm not -- yes. I mean, it's  
21 a risk-based Act. Everything is about risk. It's not  
22 about causation; it's about risk. That's what it's all  
23 about.  
24 **THE CHAIR:** Yes.  
25 **A.** Yeah, I mean, if you're saying that might be badly

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1 worded, I'm perfectly happy to accept that.

2 **THE CHAIR:** Thank you.

3 Right, no further questions. So thank you, we'll

4 stop there for today and start again tomorrow.

5 Oh, sorry, I understand there are some questions on

6 your behalf.

7 **THE WITNESS:** Actually am I allowed --

8 **THE CHAIR:** No, I'm just going to -- I didn't realise that

9 there were going to be some questions asked on your

10 behalf.

11 **THE WITNESS:** And there is one point I would like to make

12 that we interrupted.

13 **THE CHAIR:** No doubt your counsel will let you make it.

14 **Questioned by MR ROSSER**

15 **MR ROSSER:** There won't be many.

16 Sir Simon, as you know, I ask questions on behalf of

17 the Department of Health and Social Care.

18 You were asked at an early stage in your evidence

19 about the Terms of Reference.

20 **A.** Mm-hm.

21 **Q.** If public safety had been part of those Terms of

22 Reference, are you able to say whether that would in

23 fact have had any impact on your review?

24 **A.** I mean, I think we'd have done what we did. I mean, as

25 I say, public safety was in the room, whether it was in

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1 vulnerable in every sense of the word, that's the nice

2 part of human nature. And they can't always go

3 together.

4 **Q.** If we can move down slightly, please, to your discussion

5 in the Review on the "no simple solution", so it's the

6 same page just slightly further down, and your starting

7 point that you took was to agree that there is no simple

8 solution to the autonomy of -- to the issue, rather, of

9 autonomy versus protection.

10 **A.** Well, yes, we wouldn't have had a review if there was

11 a simple solution.

12 **Q.** Finally then, please, if I could take us to WITN0288007

13 This is the Keeling Schedule, which is the unofficial

14 update produced by Alex Ruck Keene.

15 **A.** Ah, yes.

16 **Q.** The Chair asked you a moment ago about some of the

17 changes to the legislation. If we can go to page 2,

18 please. Slightly further down. Perhaps over the page.

19 Apologies. Here we are, and into the section that deals

20 with "Admission for assessment".

21 You were taken to the amendment to subsection (2).

22 Do the amendments to the legislation, being the

23 inclusion of "serious harm", and the reference to

24 "likelihood of harm", in your view increase the

25 threshold for detention?

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1 the TORs or not. I think that's the best answer I can

2 give. It was there anyway. It was not front and centre

3 of the, at that moment in time, in, whenever it was,

4 2017/2018, what was the big issues going around mental

5 health and what were the threats, and the questions that

6 needed really addressing.

7 **Q.** Perhaps with that point in mind, if we can go, please,

8 to WITN0155008, page 17, which is your review.

9 We have here a summary first of all of your foreword

10 which discusses:

11 "The complex balance between respecting a person's

12 autonomy and the duty of a civilised State to protect

13 the vulnerable."

14 Was that something that was at the forefront of the

15 Review?

16 **A.** Yes, that's what I'd learnt from Sir Mark Hadley about

17 the balance and why -- basically why we have laws and

18 why we have judges is to -- this balance of incompatible

19 rights and incompatible bits of ECHR and all that kind

20 of thing, and that's the problem that we faced, that you

21 have competing things.

22 On the one hand, as I said, we all agree that we

23 don't want to live in a totalitarian state and people

24 should be able to do what they want, even if it's a bad

25 idea; but on the other hand we also want to protect the

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1 **A.** I think my view is that they have clarified the

2 threshold to detention, and it's in a way that permits

3 people to continue to do what they should do, which is

4 make good clinical judgements for the protection of the

5 public and for the treatment of the person. I think

6 it's helpful.

7 **MR ROSSER:** Thank you, Sir Simon. Thank you, Chair.

8 **THE CHAIR:** Thank you.

9 **Further questioned by MS LANGDALE**

10 **MS LANGDALE:** Chair, there was one other matter that you

11 wanted to raise, Sir Simon.

12 **A.** Yes, there was. It's to expand on the issue -- we'd got

13 to the person who could, in our legislation, who could

14 have been in our legislation, who has got capacity and

15 has refused treatment. And in Canada, that would be the

16 end of the matter. There's nothing you can do. And

17 what I was going to on to say was that actually is an

18 intolerable situation, because first of all that person

19 will be left still suffering when he could be treated

20 and in the end, because there is no treatment, he would

21 end up being discharged sooner or later because Mental

22 Health Acts all around the world are not preventative

23 detention. And that would be a second tragedy. And we

24 were determined for that not to happen, and then, in the

25 same argument, I did want you to go on to look at the

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1 tests for why we were sceptical about a fusion Act,  
 2 that's on 277 of the -- of our report, and I would just  
 3 quite like to look at that for one second --  
 4 **Q.** I don't need to do that, Sir Simon. I don't know if you  
 5 do, Chair.  
 6 **THE CHAIR:** I don't think so. Actually, we're not  
 7 considering that part of the Act.  
 8 **A.** What we were considering, it's on 277, and what we were  
 9 considering is what would happen to public safety in the  
 10 event of a switch to a capacity-based Act on best  
 11 interests, okay, which is very much on the cards. As  
 12 I said, lots of very, you know, distinguished people  
 13 were in favour and still are. So -- no, that's not it.  
 14 It's ... this is not -- I don't know what that is.  
 15 It's back onto the main --  
 16 **THE CHAIR:** I have the point that you're making and I'll  
 17 have a look at it.  
 18 **A.** I'm sorry?  
 19 **THE CHAIR:** I have the point you're making and I think we  
 20 did get some evidence from Mr Ruck Keene about it.  
 21 **A.** Well, I can explain what it is. The point is that we  
 22 said that protecting the public is not the purpose of  
 23 mental capacity, and it would not be possible, and  
 24 indeed the only way you would protect the public in  
 25 a best interests Act, which is what's been proposed, is

1 that you would have to say it is in the best interests  
 2 of the person so detained that they don't go out and  
 3 kill someone. Now, that is the only way you could do  
 4 it.  
 5 **MS LANGDALE:** Is there anything wrong with that?  
 6 **A.** Yes, it's awful. Don't you think it's awful?  
 7 **Q.** You're giving the evidence. What do you say about that?  
 8 **A.** Well, we reject it and we say that clearly is utterly  
 9 insufficient on grounds of how the public would respond,  
 10 and what it would do to public safety.  
 11 And so that's the point I was making, and it's in --  
 12 to show, it's really to show (a) that that's one of the  
 13 reasons why we don't want to go down that route, and  
 14 second, as I said, public safety is always in the room.  
 15 So it's there, and, you know -- anyway, as I say,  
 16 I've made the point, it's ludicrous.  
 17 **THE CHAIR:** It's what Mr Ruck Keene described as Orwellian.  
 18 **THE WITNESS:** Haha, yes. Haha, indeed.  
 19 **THE CHAIR:** Yes, thank's you.  
 20 All right, well we will now stop there and start  
 21 again tomorrow. Thank you.  
 22 **(3.49 pm)**  
 23 **(The hearing adjourned until 10.00 am the following day)**  
 24  
 25

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<hr/>				
	<p><b>M</b></p> <p><b>made [9]</b> 14/12 15/12 20/12 30/14 39/9 45/5 54/5 59/3 70/16</p> <p><b>magnitude [1]</b> 25/1</p> <p><b>main [5]</b> 9/22 13/15 31/9 35/19 69/15</p> <p><b>Maintain [1]</b> 4/22</p> <p><b>major [4]</b> 8/7 12/5 28/17 28/18</p> <p><b>majority [1]</b> 54/14</p> <p><b>make [14]</b> 3/8 7/9 15/14 19/14 20/5 26/15 36/24 49/6 49/15 59/7 63/22 65/11 65/13 68/4</p> <p><b>makes [4]</b> 4/8 7/5 47/12 52/21</p> <p><b>making [8]</b> 15/25 16/4 16/6 43/23 52/6 69/16 69/19 70/11</p> <p><b>manage [2]</b> 37/8 37/9</p> <p><b>managed [1]</b> 36/19</p> <p><b>management [2]</b> 39/13 44/24</p> <p><b>managing [1]</b> 12/8</p> <p><b>mandatory [1]</b> 4/25</p> <p><b>many [9]</b> 17/19 18/5 21/3 21/9 21/12 31/10 31/15 45/15 65/15</p> <p><b>Mark [1]</b> 66/16</p> <p><b>massive [3]</b> 28/22 40/14 50/8</p> <p><b>material [1]</b> 25/15</p> <p><b>Matt [1]</b> 23/15</p> <p><b>Matt Hancock [1]</b> 23/15</p> <p><b>matter [7]</b> 23/16 30/21 34/5 47/16 55/8 68/10 68/16</p> <p><b>matters [2]</b> 25/13 29/13</p> <p><b>may [11]</b> 7/20 8/16 8/18 43/25 50/10 50/14 50/25 51/5</p>			<p><b>N</b></p> <p><b>name [2]</b> 26/1 54/12</p> <p><b>nature [3]</b> 36/24 37/3 67/2</p> <p><b>near [1]</b> 7/14</p> <p><b>nearest [1]</b> 45/11</p> <p><b>necessary [1]</b> 4/9</p> <p><b>need [15]</b> 4/12 4/22 7/9 12/7 16/13 30/21 33/18 44/2 47/13 49/8 50/20 53/3 59/14 60/8 69/4</p> <p><b>needed [3]</b> 62/17 63/5 66/6</p> <p><b>needs [4]</b> 3/20 3/22 33/17 47/6</p> <p><b>negligence [1]</b> 36/14</p> <p><b>never [9]</b> 11/22 12/10 15/11 25/14 33/4 33/5 56/8 59/13 59/13</p> <p><b>new [7]</b> 2/19 8/2 46/21 47/6 48/1 52/14 64/8</p> <p><b>next [5]</b> 8/3 8/15 19/18 58/9 61/8</p> <p><b>NHS [1]</b> 33/7</p> <p><b>nice [1]</b> 67/1</p> <p><b>NMC [5]</b> 1/14 5/24 6/18 7/18 7/22</p> <p><b>NMC's [1]</b> 1/7</p> <p><b>no [52]</b> 7/18 11/4 11/5 11/21 16/11 17/11 18/18 18/18</p>

<p><b>N</b></p> <p><b>no...</b> [44] 18/20 19/22/8 22/10 23/15 24/9 25/18 26/19 27/23 28/2 30/11 30/18 33/11 33/11 33/11 33/13 33/21 35/8 35/16 36/21 36/21 38/10 40/18 43/21 44/23 45/12 52/13 52/14 52/19 56/2 56/16 58/4 61/4 61/7 62/16 63/19 64/16 65/3 65/8 65/13 67/5 67/7 68/20 69/13</p> <p><b>nobody</b> [1] 51/11</p> <p><b>nodded</b> [2] 2/3 3/21</p> <p><b>noise</b> [1] 18/10</p> <p><b>nominated</b> [3] 45/6 45/11 45/15</p> <p><b>non</b> [2] 57/25 58/5</p> <p><b>non-significant</b> [2] 57/25 58/5</p> <p><b>nor</b> [1] 33/5</p> <p><b>normal</b> [3] 32/12 43/3 43/4</p> <p><b>not</b> [125]</p> <p><b>noted</b> [1] 43/16</p> <p><b>nothing</b> [3] 28/20 43/20 68/16</p> <p><b>noticed</b> [1] 38/2</p> <p><b>now</b> [27] 2/17 9/20 19/7 20/7 20/15 21/25 22/12 22/16 24/24 27/12 29/3 32/6 35/15 39/21 40/9 43/15 45/6 46/15 48/5 48/10 49/3 50/5 51/14 62/2 62/7 70/3 70/20</p> <p><b>NR</b> [1] 45/12</p> <p><b>NUHT0000058</b> [1] 1/16</p> <p><b>number</b> [4] 5/14 33/1 42/12 42/14</p> 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68/19</p> <p><b>whenever [1]</b> 66/3</p> <p><b>where [19]</b> 4/15 4/17 5/15 6/5 6/6 15/8 16/25 21/1 22/22 24/16 24/17 33/25 37/13 40/1 43/22 44/4 45/12 46/25 59/4</p> <p><b>whether [6]</b> 14/15 59/22 59/23 60/19 65/22 65/25</p> <p><b>which [41]</b> 9/22 10/2 11/7 11/9 11/14 12/6 15/5 16/21 18/12 18/12 19/19 19/21</p>	<p>28/23 30/13 30/17 32/22 33/1 33/12 33/15 33/21 35/5 37/22 39/24 40/9 46/16 46/18 48/3 52/21 53/25 54/14 54/19 55/5 59/12 62/11 63/11 66/8 66/10 67/13 68/3 69/11 69/25</p> <p><b>whilst [1]</b> 22/13</p> <p><b>who [36]</b> 9/16 10/5 10/21 11/1 12/14 14/5 15/20 17/17 17/17 17/19 17/24 18/6 19/4 19/23 20/10 21/4 21/23 24/9 26/1 28/20 32/12 38/7 38/11 43/5 46/11 53/20 59/2 59/14 62/15 62/17 63/1 63/8 63/17 68/13 68/13 68/14</p> <p><b>who's [1]</b> 59/3</p> <p><b>whoever [3]</b> 33/17 43/11 46/7</p> <p><b>whole [3]</b> 5/5 19/20 25/19</p> <p><b>why [20]</b> 17/2 18/13 19/16 20/18 26/11 26/19 27/9 31/9 31/16 32/8 42/24 49/12 53/10 53/16 57/15 66/17 66/17 66/18 69/1 70/13</p> <p><b>wide [1]</b> 45/9</p> <p><b>widely [1]</b> 28/14</p> <p><b>will [31]</b> 2/18 2/19 2/21 8/2 8/2 8/3 12/15 12/18 14/24 14/25 15/22 20/5 20/15 21/16 21/22 24/2 24/11 24/11 27/4 27/4 31/2 36/25 37/3 37/21 39/25 47/9 51/15 63/18 65/13 68/19 70/20</p> <p><b>withdrew [1]</b> 8/14</p> <p><b>within [4]</b> 14/9 16/1 18/8 39/9</p> <p><b>without [6]</b> 5/12 21/7 21/19 42/24 44/13 54/3</p> <p><b>WITN0075014 [1]</b> 54/24</p> <p><b>WITN0155008 [3]</b> 26/10 56/20 66/8</p> <p><b>WITN0288007 [2]</b> 49/20 67/12</p> <p><b>WITN0320001 [1]</b> 51/21</p> <p><b>WITN0322001 [2]</b> 9/15 60/17</p> <p><b>witness [6]</b> 2/3 3/21 8/14 8/16 49/24 60/16</p> <p><b>won't [2]</b> 21/17 65/15</p> <p><b>wonder [1]</b> 56/9</p>	<p><b>wondered [1]</b> 16/8</p> <p><b>Woodward [4]</b> 1/3 1/4 6/15 71/3</p> <p><b>word [7]</b> 12/19 28/25 42/5 42/5 48/10 64/15 67/1</p> <p><b>worded [1]</b> 65/1</p> <p><b>words [3]</b> 24/6 48/7 48/14</p> <p><b>work [9]</b> 19/11 30/23 35/4 35/23 36/4 36/5 45/17 54/7 60/13</p> <p><b>worked [1]</b> 19/23</p> <p><b>worker [1]</b> 40/13</p> <p><b>workers [5]</b> 40/13 53/19 53/24 54/1 62/15</p> <p><b>working [5]</b> 9/18 15/10 18/21 27/19 44/1</p> <p><b>works [5]</b> 48/17 48/18 48/21 48/22 48/22</p> <p><b>world [5]</b> 9/21 12/5 26/9 31/11 68/22</p> <p><b>worried [1]</b> 24/13</p> <p><b>worst [1]</b> 34/2</p> <p><b>would [69]</b> 2/5 3/1 3/10 3/13 3/23 4/24 5/6 7/1 7/5 7/15 8/5 8/5 11/11 11/23 12/17 16/16 18/17 18/18 24/14 25/7 26/1 27/23 31/19 34/22 34/23 35/2 35/22 37/23 37/25 37/25 40/5 42/20 43/13 43/16 43/18 44/5 44/7 45/15 45/22 45/23 46/2 46/9 46/10 46/15 46/15 46/19 50/7 50/7 52/10 53/13 54/3 54/13 54/18 58/16 61/25 63/16 63/24 65/11 65/22 68/15 68/20 68/23 69/2 69/9 69/23 69/24 70/1 70/9 70/10</p> <p><b>wouldn't [10]</b> 11/24 27/16 27/25 28/1 37/5 46/9 54/19 63/14 64/18 67/10</p> <p><b>write [7]</b> 11/2 17/12 19/12 19/13 21/20 32/8 49/7</p> <p><b>writing [1]</b> 9/17</p> <p><b>written [6]</b> 11/3 29/5 32/1 33/24 52/15 60/10</p> <p><b>wrong [11]</b> 7/7 32/2 35/14 36/12 36/15 36/25 37/3 37/6 37/12 37/12 70/5</p>	<p>27/1 32/1 32/24 32/25 33/22 34/5 34/21 36/21 37/9 38/6 45/1 47/23 49/23 62/16 62/20 62/21 63/20 64/25</p> <p><b>year [2]</b> 2/18 7/20</p> <p><b>years [5]</b> 18/16 26/18 27/13 38/19 43/4</p> <p><b>Yep [1]</b> 20/2</p> <p><b>yes [79]</b></p> <p><b>yesterday [2]</b> 29/12 47/25</p> <p><b>you [309]</b></p> <p><b>you say [1]</b> 34/10</p> <p><b>you'd [11]</b> 9/25 27/12 39/3 43/17 44/23 52/13 52/22 60/2 60/4 60/8 64/16</p> <p><b>you'll [1]</b> 20/8</p> <p><b>you're [38]</b> 8/23 13/10 16/23 17/12 18/9 23/22 26/8 26/22 27/12 27/24 28/2 28/4 32/8 36/22 36/23 37/6 37/13 38/17 40/3 40/5 40/7 40/21 44/9 44/14 47/21 48/8 48/9 48/14 48/19 49/3 49/4 49/7 49/15 64/1 64/25 69/16 69/19 70/7</p> <p><b>you've [26]</b> 1/7 13/4 13/15 15/21 19/23 19/24 22/19 23/20 23/23 26/22 29/16 30/13 33/12 39/5 39/21 39/24 40/24 41/15 42/8 44/4 49/2 49/12 54/25 55/22 59/11 62/25</p> <p><b>younger [1]</b> 28/19</p> <p><b>your [41]</b> 5/6 8/25 9/15 11/22 11/23 12/1 13/18 16/1 16/9 16/24 16/24 17/1 17/19 20/5 24/19 26/10 27/3 27/4 27/15 27/23 30/7 34/6 37/20 41/15 42/8 42/15 43/8 44/23 55/23 56/21 57/12 65/6 65/9 65/13 65/18 65/23 66/8 66/9 67/4 67/6 67/24</p> <p><b>yourself [1]</b> 49/10</p> <p><b>yourselves [1]</b> 1/8</p>	<p><b>Y</b></p> <p><b>yeah [24]</b> 13/10 15/7 15/7 15/20 16/16 23/4</p>
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