

Thursday, 4 June 2026

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2 (2.04 pm)
3 **MS LANGDALE:** Chair, may I call please the Minister for
4 Women's Health and Mental Health, Baroness Merron.
5 **THE CHAIR:** Yes.
6 **BARONESS GILLIAN MERRON (sworn)**
7 **Questioned by MS LANGDALE**
8 **MS LANGDALE:** Minister, you have prepared a statement dated
9 5 March 2026. Can you confirm the contents are true and
10 accurate as far as you're concerned.
11 **A.** I can.
12 **Q.** I understand you'd like to say something at the outset
13 of your evidence.
14 **A.** I would. Thank you very much.
15 I want first of all to address our bereaved
16 families, those who have been so deeply affected by
17 these events, and those who have survived, and I want to
18 express my heartfelt sympathies and to also say that
19 I want to express my gratitude but my absolute respect
20 for the way in which you have engaged with us, despite
21 what I can only describe, perhaps, as unimaginable pain.
22 So I thank you and deeply respect you for that.
23 And I would also like to say to the Chair how much
24 I welcome this Inquiry, and how I look forward to its
25 recommendations. They will be of great assistance to us

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1 Practice, as we seek to implement the Bill which, whilst
2 it's on the statute books, is not yet implemented.
3 So there's the scope, but there's also, I believe,
4 the commitment and intent.
5 **Q.** And the timing, the timing is -- (*overspeaking*) --
6 **A.** The timing is crucial.
7 **Q.** The Mental Health Act Code, of course, is really
8 important, isn't it, for practitioners --
9 **A.** (*The witness nodded*)
10 **Q.** -- and generally for guidance, but the statute
11 overrides, doesn't it, in circumstances of conflict
12 between the two, through the courts the statute itself
13 prevails. So it's important to get the test right in
14 the statute as well, isn't it, in the legislation?
15 **A.** I actually see them both as important and indeed there
16 are many other expects that are important. I believe
17 that the Inquiry heard evidence from Mr Alex Ruck Keene
18 to this very point that I was very interested to read
19 about, and he spoke to a point that I believe very much:
20 that it's so important to get legislation right, but
21 good legislation is only something that's as good as
22 what it does. And, therefore, it is never all in
23 statute, important though that is, but it is often the
24 case -- and indeed, this is the perfect case for me, the
25 Code of Practice -- it's absolutely key that the Code of

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1 in government and I am of course, I'm very ready to
2 continue to assist as much as I possibly can.
3 **THE CHAIR:** Thank you.
4 **MS LANGDALE:** What mechanism do you think you have in
5 government for ensuring any recommendations from this
6 Inquiry and others will be implemented? We know that's
7 an issue, isn't it, and indeed the Ritchie report made
8 recommendations around Assertive Outreach many years ago
9 and they've fallen by the wayside by the time we're
10 here.
11 So when you say the government is keen to hear the
12 recommendations and to work with them, what confidence
13 can we have that they would be implemented and how do
14 you see that happening?
15 **A.** Well, first of all, it was our government that agreed to
16 set up the Inquiry, having listened to families. So we
17 feel a great sense of ownership of the process. Of
18 course, it is up to the Inquiry to make its
19 recommendations. So that's the first thing.
20 I think that the other point that I would make is,
21 as Mr Vineall, our senior official, spoke to earlier
22 when questioned, the timetable does allow us very
23 much -- and I was keen as the Minister responsible for
24 overseeing the process -- does allow us to take full
25 account of recommendations as we develop the Code of

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1 Practice is got right because that is what gives effect
2 to it.
3 It also deals with a lot of the questions of
4 practice, it gives the guidance. A lot of this will be
5 about clinical judgement. That is a challenge and it's
6 our duty to assist clinicians.
7 **Q.** Can we have on screen, please, WITN0409001, page 36.
8 Before we go to the legislation and the like, it's just
9 paragraph 100, please, of your statement, Minister. And
10 you say:
11 "The Department recognises there were failures in
12 the provision of care to VC. ... particular[ly] the
13 lack of oversight of [his] mental health in the year
14 before the attacks ... unacceptably poor ... should not
15 have been allowed to happen. NHFT operates within
16 a broader, national framework and it is certainly not
17 the Department's position that [Nottinghamshire Health
18 Foundation Trust] is solely to blame for the failings in
19 VC's care."
20 Where would you widen that, then? Are you saying
21 that's the government or Department of Health's
22 responsibility too, the failings in his care?
23 **A.** Well, the matter of failings in the care of an
24 individual of course can sit in many places.
25 The intent of that paragraph is not to pass on

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1 responsibility but to take responsibility. And it is
2 the very reason that one of our first Acts in terms of
3 the King's Speech, where we set out, as of course you'll
4 be aware, our legislative programme, as soon as we came
5 into government, was to include the Mental Health Bill
6 which has now become the Mental Health Act, because we
7 recognise that this was an outdated framework.

8 The provisions of it remain sound, but what we have
9 done is modernise that framework on the basis of
10 experience. And I should say to your earlier point,
11 also some of the experiences of previous inquiries too,
12 and the experience of the events of this Inquiry, as we
13 have heard directly from those affected.

14 So there is that point, but there's also -- and
15 again Mr Vineall made this point -- about the way in
16 which responsibility sits, and when we came into
17 government, we took our time to look at the arrangement
18 of National Health Service England is the operational
19 arm, and the Department and the role of ministers, and
20 we concluded, and I really wish to say -- I do believe
21 it's the right thing, and that's why we have the Health
22 Bill now in Parliament as of Monday with its second
23 reading -- we concluded actually the structure for
24 accountability and delivery was not what it should be.

25 There's a whole range of other things and I'm sure

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1 Long Term Plan, also NHS Mental Health Implementation
2 Plan, 2019, the Community Mental Health Framework for
3 Adults and Older Adults, and page 46 we see the aims of
4 the framework.

5 2021, publication of "COVID-19 mental health and
6 wellbeing recovery action plan", and then the:

7 "Call for Evidence for the Mental Health and
8 Wellbeing Plan: Additionally, in ... 2022 ... seeking
9 the public's views on what the Department could do to
10 improve everybody's mental health and wellbeing and
11 prevent suicide."

12 Do you agree the primary moving focus was towards
13 mental illness -- from mental illness, rather, to mental
14 health and wellbeing?

15 **A.** It's difficult for me to comment in that I wasn't -- we
16 weren't in government at that time so obviously I can't
17 speak to the intention of the previous government.

18 **Q.** But the references include those very topics --

19 **A.** They are.

20 **Q.** -- don't they, suicide, wellbeing, and recovery and the
21 focus being on getting support for mental health at an
22 earlier stage.

23 **A.** Mm.

24 **Q.** Which I'm not criticising as a proposition, but the fact
25 is we don't see reference to potential harm, to public

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1 we'll come onto them, but they're my sort of main
2 points, and, you know, those bits of legislation on
3 their own won't solve this, but they do give us a basic
4 structure.

5 And perhaps the last point, if I could make, is
6 I certainly would want to note that when we came into
7 government, we found what Dr Lade Smith described as,
8 putting it mildly, fragmentation, but services that were
9 not anywhere where they should be. And it is our view,
10 and Lord Darzi, in his independent report has confirmed
11 this and we have enacted this through the 10-Year Plan
12 and other means, that actually we need quite a reform of
13 mental health services and that's why so recently, the
14 first day of the new Secretary of State, we published
15 the Call for Evidence and also confirmed there will be
16 a mental health strategy, which has been very warmly
17 received.

18 **Q.** Can we have a look, please, WITN0155001, page 45 and 46
19 alongside each other. We've heard, I'm sure you've
20 heard too, Minister, Mr Vineall's, the Senior
21 Official's, evidence to the Inquiry, and this is an
22 extract of his statement summarising, as you've just
23 referred to, the Call for Evidence.

24 If we have a look, please, at page 45 first,
25 WITN0155001, page 45, we see published in 2019 the NHS

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1 or public safety or concerns around that; would you
2 agree?

3 **A.** Yes, I would.

4 **Q.** Do you accept that shift appears to overlook risks to
5 public safety? Even if that was the (*unclear*) the
6 intention, it's not set out, is it, and it's not
7 inviting or calling evidence in relation to public
8 safety or risks to public safety?

9 **A.** It would only be fair and correct of me to say that for
10 any government, the first responsibility of government
11 is to public protection and safety of the nation,
12 whether that's through defence or whether it is in terms
13 of public protection in the environment in which we are
14 discussing, and so it does run as a thread throughout,
15 and in some ways, as I say, I'm reluctant to comment on
16 papers and plans that I wasn't part of, but I would --
17 I cannot believe we have any government that would not
18 take that view, that it actually runs seamlessly
19 throughout.

20 **Q.** In 2018, the National Confidential Inquiry ceased to
21 collect data on homicides, so continued in relation to
22 suicides but not homicides. It's the same point, isn't
23 it? It appears to reflect less interest in the risk to
24 public safety and homicides when you cease to collect
25 data? Because you're not collecting it, you're not

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1 monitoring it, you don't care to measure it, arguably.
 2 **A.** Again I'm in a bit of a difficult position about
 3 commenting about the intention behind that action.
 4 I can only speak from my own experience that actually,
 5 often, we do seek now to plug gaps on data because, as
 6 you correctly make the point, collecting data does
 7 inform. And I should say that all the work that I've
 8 done and sought to do has been very much evidence-based,
 9 so to have evidence data, it's part of evidence.
 10 **Q.** Since then, of course, that's been resurrected in
 11 relation to homicides, but if we're focusing on public
 12 safety it's important to know where attempted homicides
 13 and grievous bodily harm and actual bodily harm have
 14 occurred as arising from mental health, serious mental
 15 health illness.
 16 **A.** Mm.
 17 **Q.** So is there any reason not to expand that list of the
 18 Confidential Inquiry and the data it collects?
 19 **A.** I can't offer a particular reason, as in certainly
 20 there's not an objection to that, or would not be on my
 21 point.
 22 **Q.** It would be more helpful in really understanding the
 23 risks to public protection and public safety from those
 24 who are under mental health services and not adequately
 25 treated or where it's found that their mental health

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1 **A.** I'm not sure in what I'm about to say this is exactly
 2 what it is that you're driving at, but -- so please do
 3 correct me if I haven't got the point, but again,
 4 I remember Sir Simon Wessely in his evidence to this
 5 Inquiry made the point that, of all the clinicians --
 6 and he is one too -- but of all the clinicians he's
 7 spoken to, there is a far greater fear of making
 8 a mistake that could lead to the severe violence of
 9 which we are speaking, far greater fear of that than
 10 there is any fear about encroaching on territory which
 11 might stigmatise somebody, and I would certainly endorse
 12 that view too.
 13 **Q.** What's the evidence base for that? I mean, we're
 14 certainly not seeing it in the case the Chair's
 15 examining, but what's the evidence base for saying risk
 16 aversion is a relevant factor in not detaining people?
 17 **A.** I don't think I said risk aversion was --
 18 **Q.** Let's look at what Sir Simon's words are, if we go to
 19 his --
 20 **A.** Yes, thank you.
 21 **Q.** -- foreword. WITN0155008, page 7. It's under "Fear"
 22 you were citing this content, if we see it on the
 23 screen. "Fear", page 7, please, WITN0155008.
 24 **A.** Ah.
 25 **Q.** Do you see that paragraph there:

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1 contributes to the offence in some way.
 2 **A.** Mm (*The witness nodded*)
 3 **Q.** That's how you're going to know more about the
 4 associated link between violence and mental health,
 5 potentially.
 6 **A.** Indeed. But it is also why the basis of the Mental
 7 Health Act remains as it's always been, which is about
 8 to enable the detention and treatment of those who may
 9 be of harm to themselves or to others. And why I very
 10 much welcomed, and I know the Inquiry has heard from
 11 Sir Simon Wessely to this point, about the independent
 12 Inquiry which actually of course dates back to 2017 and
 13 was established by the then Prime Minister, Theresa May,
 14 to whom I feel most grateful.
 15 **Q.** The link between schizophrenia and violence offences is
 16 clearly established, isn't it? The Inquiry has heard
 17 evidence from Professor Fazel in particular, who's made
 18 it clear that 5-10% of all violent incidents in
 19 countries such as the UK refer to people with
 20 schizophrenia.
 21 **A.** I understand that was reported to the Inquiry, yes.
 22 **Q.** Do you think that an interest in avoiding stigma has
 23 created a reluctance to be open and grapple with the
 24 known risks of schizophrenia and those with mental
 25 health serious disorders such as schizophrenia?

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1 "Professionals are fearful unless they adopt
 2 a cautious, risk averse approach to their patients, they
 3 will find themselves being publicly shamed for those
 4 occasions when those same people cause serious harm to
 5 themselves or others."
 6 Do you see that?
 7 **A.** Yes, under the section on "Fear"?
 8 **Q.** Yes.
 9 **A.** I do think the important thing here is the point
 10 actually about fear. If I might go back to the Code of
 11 Practice, there is already a Code of Practice with the
 12 1983 Act, it hasn't been updated since 2015. This is
 13 the major piece of work we are now on, and it is -- and
 14 the work will be undertaken by properly working with
 15 clinicians who may -- you know, this report's fear --
 16 people often, in my experience, have fear because
 17 they're just not sure. And I understand that, and that
 18 is why we have to equip people to do the job.
 19 The Code of Practice will be designed with
 20 clinicians, with people with lived experience. It will
 21 engage those who work in the health services and those
 22 who have been affected. And in that regard, we will
 23 build -- and I think this, again, came out Mr Vineall's
 24 evidence this morning -- we will build -- and this isn't
 25 some woolly thing, but we will -- we intend not just to

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1 get it absolutely right by calling on all that
 2 experience, but also to build consensus.
 3 I think that what has been described here -- and
 4 I think it's a valid point so I thank you for drawing my
 5 attention to it -- actually speaks to the point here:
 6 the public may be fearful, patients may be fearful, and
 7 professionals may be fearful.
 8 We need to overcome that with clarity, guidance, and
 9 also we've been asked, particularly by the Royal College
 10 of Psychiatrists, with whom we work very closely, to
 11 include illustrations and examples and I'm very keen
 12 that we do that.
 13 I should also say that we will go out to
 14 consultation once we have drawn up the documents, so
 15 there is great opportunity to get this one right and to
 16 build that understanding and support around it, which,
 17 as this reports, may not be there currently.
 18 **Q.** This was obviously 2017/2018, this foreword. So my
 19 question is: what's the evidence base for that, that
 20 they are fearful, clinicians, unless they adopt
 21 a cautious risk-averse approach: from your perspective,
 22 it's the Review and Sir Simon Wessely telling you that?
 23 **A.** Yes, but it does say here about the various
 24 conversations that Sir Simon and also that independent
 25 review held, and I know they were extremely thorough in

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1 **Q.** Understood. Page 8, please, second paragraph. In the
 2 foreword:
 3 "... far greater risk of serious harm to self, but
 4 we cannot deny that there is also risk to others, even
 5 if usually overstated by public, politicians and media."
 6 This is 2018, as I've said, do you think the risk of
 7 serious harm to others from those who are mentally
 8 unwell is overstated by politicians?
 9 **A.** I believe we're talking about serious mental illness.
 10 **Q.** Yes.
 11 **A.** I'm --
 12 **Q.** And risk of serious harm.
 13 **A.** Yes. Well, there are circumstances, as we know only too
 14 well because of the events that this Inquiry is looking
 15 at, where that is indeed the case. But this suggests
 16 it's usually overstated by the public, politicians and
 17 media. I will only speak for myself and my government
 18 colleagues, we seek to be honest and transparent in how
 19 we assess the situation.
 20 But we do know there's a risk, and we are not shy to
 21 address it, and that is why we reformed the Mental
 22 Health Act and it got Royal Assent.
 23 **Q.** Can we go to page 17, please, this is the introduction
 24 and executive summary to this Review, and we see the
 25 three problems faced, and the top one:

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1 their work. Again, I wasn't -- we weren't in government
 2 at the time, so I wouldn't have had an intimate
 3 knowledge of this, but I know, from my dealings since
 4 with members of that independent Inquiry, how they
 5 conduct -- not Inquiry, forgive me -- independent
 6 review -- I know how they conducted themselves.
 7 **Q.** In terms of a consensus, it sounds, from the evidence we
 8 have heard, there was a wide range of views, including
 9 some psychiatrists, respected -- I'm not sure of their
 10 respectable body, I don't know how many Sir Simon was
 11 speaking of -- but respected psychiatrists who thought
 12 there shouldn't be detention against a person's will.
 13 So it doesn't seem likely you have consensus if you
 14 have people considering that detention shouldn't be
 15 a lawful option and you shouldn't be able to compel
 16 treatment for those who are dangerous to others because
 17 they don't wish to take it?
 18 **A.** Well, the view you've just expressed is certainly not
 19 one that I share, nor is it one within the 1983 Mental
 20 Health Act or the 2025 Act which, of course, amended the
 21 1983 one because it's absolutely clear that there are
 22 circumstances in which people may need to be detained,
 23 may need to be treated to protect -- to prevent harm to
 24 them or to others. I think that's absolutely crucial.
 25 So I wouldn't share the view that's just been put to me.

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1 "... complex balance between respecting a person's
 2 autonomy and the duty of a civilised State to protect
 3 the vulnerable."
 4 le, the patient, "the vulnerable".
 5 Again, no mention of "or to protect the public", is
 6 there? And it's not just semantics; if you don't keep
 7 reminding yourself of the importance of that, there's
 8 a danger it's overlooked, isn't there, in assessment?
 9 **A.** I do understand the point that's being made. The
 10 Independent Review, and I remember Sir Simon making this
 11 point, is that it isn't so much a problem with the
 12 legislation, but actually, how it is being applied, and
 13 how effective it was. That was the key thing in his
 14 thought, as far as I understand, and I think that that
 15 is true. I certainly would -- I mean there are huge
 16 complexities here. The Independent Review was extremely
 17 helpful in terms of leading to the draft Mental Health
 18 Bill, which the last government did prepare, but they
 19 took it no further on to the statute books. I think
 20 that was a missed opportunity. I'm very glad that we
 21 made that one of our very first acts, and getting it
 22 into the King's Speech, not just to be taken for
 23 granted, it was a commitment we had, but there's no
 24 given in terms of a legislative programme. Myself and
 25 the Secretary of State worked very hard to make sure it

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1 was there, and to make sure that it had the scrutiny it
2 deserved.

3 So I think, in that respect, we've -- we took great
4 account, but not just of the Independent Review, but
5 pre-legislative scrutiny. I should say that the Bill
6 was -- and the pre-legislative scrutiny, was held up as
7 some kind of high standard for other Bills to aspire to.
8 I certainly found it very helpful.

9 **Q.** Can we look at page 24, please, "The Use of Least
10 Restriction". Page 24, "Principle 2":

11 "The Mental Health Act enables people to be detained
12 and treated against their will. The Least Restriction
13 principle requires that the Act's powers are used in the
14 least restrictive way, and that less restrictive
15 alternatives must always be considered."

16 That should say "consistent with the management of
17 the level of risk", shouldn't it? The least restriction
18 principle is important, but it has to be consistent with
19 patient safety and public safety.

20 **A.** Yes, and again, I can only assume, because I wasn't
21 a member of the Inquiry, nor was I -- nor was our
22 government in place at that time, but I -- my guess, and
23 I can go no further than that, is that they would have
24 assumed that as a given. I take your point about
25 clarity. I have no problem with that.

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1 chamber, because I was taking the Bill through on this
2 very point, and the debate was such, and the feeling, in
3 the end, in the chamber, was that because there was some
4 lobby to actually change the Mental Capacity Act, but it
5 was accepted by the House that that was not desirable or
6 wise but that the two should work together.

7 So I do agree with that. And of course where
8 someone doesn't have capacity there is provision for
9 nominated persons, and again, from my point of view,
10 I think that's a very helpful point within the Act.

11 **Q.** Shall we have a look at page 86 I think deals with that.
12 "A new Nominated Person to replace the Nearest
13 Relative". And we see if we go above the "Family and
14 carer involvement", second paragraph there:

15 "People with experience of detention, their family
16 members, and mental health professionals gave a wide
17 range of examples of inappropriate people serving as
18 a patient's [Nearest Relative], or instances where
19 patients who had no [Nearest Relative] because the
20 default person was unsuitable".

21 So the question of a nominated person, you may or
22 may not get someone suitable, I suppose it might be
23 someone who only recently knows the patient for example,
24 which is less helpful to clinicians or others, but even
25 in circumstances where that such person is nominated,

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1 But I think the other thing I would say, because
2 it's more current to me, is that is why we made changes
3 in the draft Mental Health Bill before it went to
4 Parliament, not least because of the conversations that
5 we had with bereaved families.

6 **Q.** I'll come to that --

7 **A.** Indeed, thank you.

8 **Q.** -- and the amendment that was made or the tweaks that
9 were made.

10 If we go, please, to page 64, and we see "Mental
11 capacity and decision making in the Mental Health Act".

12 Alex Ruck Keene gave evidence to the Inquiry that
13 a statutory test to assess capacity may be beneficial,
14 that perhaps the presumption of capacity isn't it
15 working as it should, people presume it and don't
16 actually look for what's necessary to understand whether
17 someone really can weigh the benefits and disadvantages
18 of treatment or any other decisions that are pertinent
19 to their care.

20 Do you have any views or thoughts about that?

21 **A.** I think that's a good point to make, and I would say on
22 that, of course, we have the Mental Health Act. We also
23 have the Mental Capacity Act, and both of them have
24 codes of practice. It is crucial that they interact.
25 We had quite a lot of debate, certainly in the Lords

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1 there is still provision here for sharing information
2 with relatives and families, isn't there?

3 **A.** There is, and we need to remember, and again, this was
4 debated at great length in Parliament, it isn't the case
5 for everybody, and I know you're not suggesting this,
6 but it is not the case that everybody's nearest relative
7 or family member is a happy relationship that they have,
8 and indeed sometimes it can be a toxic relationship, and
9 therefore would not be appropriate.

10 So we got to a place in terms of the scrutiny of the
11 Bill that members of both houses were content that we
12 had protected against that point, and also the point you
13 make about nominated persons. I should also just
14 mention briefly at this point about advance choice
15 documents. When I've spoken to people with lived
16 experience they've welcomed the fact that an advance
17 choice document, it was possible to make their wishes
18 known should they become unable to express themselves.
19 It gave them a real sense of security.

20 And the point I haven't said throughout, and perhaps
21 should have said at the beginning, in all of this, as
22 was said earlier in the evidence and I'm sure has been
23 said in earlier times in the Inquiry, that actually the
24 best way to manage people's care and treatment
25 successfully, thereby protecting them and also the

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1 public where that is the case, is of course to have
 2 effective treatment that they participate in. And that
 3 is why the Act talks about getting it right.

4 **Q.** Can we look at, please, at page 112. This is reference
 5 to the new criteria for significant harm, and we see in
 6 the third paragraph:

7 "We believe the Act needs to be more explicit about
 8 how serious the harm has to be to justify detention
 9 and/or treatment, or how likely it is that the harm will
 10 occur. We are recommending that there must be
 11 a substantial likelihood of significant harm to the
 12 health, safety or welfare of the person, or the safety
 13 of any other person."

14 If we go to page 302, it sets out a proposed
 15 criteria for detention. We see there at (b), so 42b.

16 What do you say about that as a test as it was
 17 originally formulated?

18 **A.** If you'll allow me to, I'll just read that.

19 **Q.** Of course.

20 **A.** Thank you.

21 **Q.** Do you think that was raising the bar for detention and
 22 the consideration of a risk that a patient might pose to
 23 another?

24 **A.** Well, I think the difficulty -- and again, Mr Vineall
 25 said this this morning -- that's why we landed -- and

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1 "there is a significant risk of serious harm to the
 2 health or safety of the patient or of another person."

3 So it's the risk, rather than the causation or
 4 likelihood, it's risk. Do you see the merit in that
 5 considered view?

6 **A.** As I mentioned earlier, certainly we've worked very
 7 closely and I'm very grateful to the Royal College of
 8 Psychiatrists and we will indeed continue to work with
 9 the Royal College. I think it's actually a balance of
 10 factors that need to be taken into account, but perhaps
 11 the biggest thing I could say here is the statutory Code
 12 of Practice is exactly the place for unpicking -- no,
 13 not unpicking, no, that's entirely the wrong word.

14 **Q.** Refining?

15 **A.** Actually, no, I'm afraid I've led you down a road
 16 I should not have done. I'm going to withdraw that
 17 completely.

18 Actually giving interpretation, guidance, example,
 19 to what the primary legislation means, what factors need
 20 to be taken into account by a clinician when making
 21 a decision.

22 You know, I'm very struck by the point that there
 23 could be a low possibility of risk, but it's such
 24 a serious harm, that is grounds for detention and I do
 25 think it's important to emphasise that.

23

1 there was a lot of debate and consultation about it --
 2 we landed on serious harm and we also spoke -- we
 3 also -- the Act speaks to various points that need to be
 4 weighed up, because -- and my understanding on serious
 5 harm certainly is that Sir Simon was not -- how can
 6 I put it -- I don't wish to put words in his mouth, and
 7 I'm probably overstating it a little, I'll use the words
 8 "relaxed" about the words "serious harm". "Found them
 9 acceptable", there you are, that's a better way of
 10 putting it. Because I know that there are different
 11 opinions. I know that the independent review suggested
 12 one thing, Dr Lade Smith, for example, suggested
 13 another, but we landed in a place that we think will
 14 best do the job and Parliament debated that and agreed
 15 that was the case.

16 So there's been consultation and great scrutiny as
 17 well.

18 **Q.** If we have a look at Dr Lade Smith's WITN0320001,
 19 page 70, the Royal College's reservations about it, as
 20 the way it's currently expressed, and with a preference
 21 at page 70.

22 "... recommend[ing] ... detention criteria are
 23 amended to require the following:

24 "... patient is suffering from mental disorder of
 25 a nature or degree; and.

22

1 **Q.** Can we go back to the review, so WITN0155008, page 305,
 2 for Community Treatment Orders and the criteria, please.
 3 We see at page 305, paragraph 58:

4 "The onus should be on the [Responsible Clinician]
 5 to demonstrate ... a CTO is a reasonable and necessary
 6 requirement to maintain engagement with services and
 7 protect the safety of the patient and others. The
 8 evidence threshold should be raised for demonstrating
 9 that contact with services has previously declined, and
 10 that this led to significant decline in mental health."

11 And again, "this led to significant decline in
 12 mental health", it may lead to a significant decline and
 13 it may lead to serious risks to others if it's
 14 associated with a pattern of relapse and risk of
 15 violence to others, irrespective of the decline to the
 16 person.

17 So again, do you think this is setting a threshold
 18 that's too high or too precise for something as
 19 important as a Community Treatment Order in some cases?

20 **A.** Well, Community Treatment Orders are absolutely key.
 21 I know from my reading of this that the Independent
 22 Review was concerned about appropriate use of CTOs.
 23 I should say I recall very well in our chamber a lot of
 24 debate because some Peers felt that there shouldn't be
 25 CTOs, and some also felt that they should have a fixed

24

1 time limit. That was not my view; it was not the view
2 of the government, and so we have retained CTOs within
3 the Mental Health Act, and I should say actually I think
4 the mood in that chamber changed very much when one of
5 the Peers spoke of her daughter and the value of the CTO
6 in protecting her.

7 I was very struck by that. So I think the other
8 thing about the CTO is one of the other changes that
9 we've made from the draft Bill to where we ended up, was
10 to ensure that there was a community-based clinician who
11 would be part of the decision-making. I think
12 previously -- you know, that's the kind of improvement
13 that I believe the Review was looking for, because
14 otherwise it was all rather one-sided and therefore
15 couldn't do what it was meant to do, which you have
16 explained could be the case.

17 **Q.** In terms of one-sided, the Review began with the premise
18 that CTOs were overused, and again, the Royal College
19 urged more research around that.

20 **A.** Mm.

21 **Q.** Sir Simon gave evidence that he thought it was of
22 limited value, in fact, Professor Burns' trials, because
23 understandably he hadn't been able to include the most
24 severely unwell in those randomised samples which
25 therefore prevented them being randomised, as it were,

25

1 concerned that there shouldn't be detention if someone
2 didn't wish for that, and equally that Community
3 Treatment Orders were being overused.

4 **A.** *(The witness nodded)*

5 **Q.** So a different perspective, fundamentally different
6 background perspective from people round the table
7 looking at this issue.

8 **A.** That may be so but that isn't a view the government
9 shares.

10 **Q.** Thank you. That can come down.

11 We understand, and you referred to earlier, that you
12 met with the bereaved families on 6 August 2024
13 following the CQC Section 48 Review, and the families
14 expressed doubts about the reforms to the 1983 Act,
15 considering it would make it more difficult to detain.
16 And you said you'd hold their concerns when reviewing
17 the Act.

18 We know that when it was then reviewed, there was
19 some alteration, and we also know that you obtained
20 advice, didn't you? If we have WITN0155039, page 2.
21 This is 22 September 2024:

22 "... further advice around considerations for public
23 protection in relation to the draft mental health bill
24 due to be introduced ..."

25 And we see at the beginning:

27

1 and course we know that the data the Inquiry has
2 collected around in excess of 500 cases, how few, 92%,
3 had ever been prescribed or had a Community Treatment
4 Order. So in a cohort where it's a really significant
5 factor, they're absent.

6 So looking at whether they were overused, the data
7 was very poor, wasn't it, to state that as an assertion
8 of fact? Just because the numbers appeared to have gone
9 up, and just looking at raw data like that isn't
10 effective in terms of analysing the efficacy of them or
11 the need for them.

12 **A.** Well, we -- certainly I can speak for now -- there
13 isn't -- and I am aware you're not suggesting this, but
14 there isn't a target, there isn't a "This is the right
15 number, this is the wrong number", that doesn't exist.
16 What matters is that the individual patient is literally
17 looked at as the individual. Where a CTO can be
18 helpful, that is a good use of it. But I have to say,
19 you know, I think the thing for me is actually I think
20 we've improved the structure, because -- and practice --

21 **Q.** And the scrutiny, potentially of what --

22 **A.** Yes, indeed so.

23 **Q.** -- *(overspeaking)* -- but that works both ways, doesn't
24 it, because it's a bit like the detention point: it
25 sounds like at the time of the Review there were people

26

1 "Agree to remove 'how soon' from the revised
2 detention criteria, to ensure the new detention criteria
3 [...] not misinterpreted to exclude early intervention
4 under the [Mental Health Act] or to require that risks
5 must be imminent to detain someone."

6 Would you like to elaborate on that?

7 **A.** Yes, indeed, both the Secretary of State at the time and
8 myself did indeed agree that.

9 We were, as it suggests here, concerned, having
10 listened to the families, that if "how soon" had stayed
11 in, that the difficulty there, it suggests that risk,
12 considerable risk, was imminent. And as I said earlier,
13 that is not actually at all helpful, and what we did --
14 when we came into government, one of our first acts, and
15 I've spoken to officials about this, and they reminded
16 me about how direct the Secretary of State and I were
17 about it, we tasked them with reviewing the Draft Mental
18 Health Bill through the lens of public protection. We
19 wanted to do that because we knew how important that
20 was.

21 The families that we met absolutely focused us on
22 that and informed that further.

23 And it is from there that the changes that are
24 listed that we accepted, we believed, and believe, that,
25 one, they responded to the points that families had

28

1 raised with us, and that they were about improving
2 public protection. And certainly that is how it's been
3 received.

4 And I feel we were absolutely right to do that.

5 **Q.** If we go to page 4 of the same document at paragraph 9:

6 "The general feedback on the detention criteria
7 changes has been that they do not significantly change
8 or raise the bar, except for intentional changes for
9 people with a learning disability or autistic people
10 (see section below)."

11 Again, was that your understanding, and belief, that
12 it doesn't significantly change or raise the bar,
13 particularly having removed the "too soon" criteria?

14 **A.** Yes, because the concern was that it would be more
15 difficult to detain people.

16 **Q.** If we go over to page 5, please. We see at
17 paragraph 14:

18 "Sir Simon Wessely's Independent Review ...
19 recommended the [Mental Health Act] Code of Practice
20 should set out ... a section 2 shouldn't be used over
21 a section 3 detention if someone has been detained in
22 the last 12 months."

23 And indeed we've seen its overuse in the case the
24 Chair is examining.

25 And the suggestion here: "... we plan to take this
29

1 accountability ..."

2 And it's set out below:

3 "... further options to use the [Mental Health Act]
4 Code of Practice to strengthen required adherence to
5 guidance and procedure."

6 You set out there what can be considered, including
7 risk to discharge. What's the progress with that at the
8 moment?

9 **A.** Well, we did indeed ask officials to explore the points
10 made by Dr Kumar and the families, and we certainly
11 agreed with the intention of what was being said, and
12 understood totally the concerns.

13 The Bill had already been introduced into Parliament
14 and, like with any legislation, the potential
15 legislative change, we always look at what is the best
16 way to do this. In other words, we all know where we
17 want to get to, but how do we best get there?

18 And it was our view that the specific suggestions
19 which related to Section 117, as I recall, I hope I'm
20 right, were absolutely valid in intent, but it was and
21 is our view that actually those could be achieved
22 through other means that would be more effective
23 including the arrangements about discharge. On
24 discharge, we did already -- we have already -- we
25 straightaway actually, and I don't know if it's in this
31

1 forward in the revised Code of Practice."

2 Was there any concern, although the Review had begun
3 on the basis of there was an overuse of detention, that
4 this may be flagging up something of greater concern,
5 which was that clinicians were not prepared to use
6 Section 3 because they thought it was more onerous and
7 they were admitting people when they should be admitted
8 for treatment under Section 3? In other words, what did
9 that suggest about the use of the least restrictive
10 principle in a broader sense?

11 **A.** I think on least restrictive principle, I think what
12 I would say is that this isn't there to override "and
13 everything else". It is part of the consideration. But
14 where detention needs to take place it should take
15 place. And I emphasise that in view of the earlier
16 comments about that isn't the view of everybody, so
17 I would like the Inquiry to be quite clear where we
18 stand on it.

19 **Q.** Page 6, please, paragraph 18 at the top:

20 "You asked us to explore Dr Kumar's, and the
21 families', suggestions around improvements to the Bill.
22 ... mostly centred around improving the discharge
23 process, particularly with regard to assessing and
24 managing any ongoing risk posed by a patient, ensuring
25 better continuity of care, and greater clinical
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1 sub or another one, we did make the change from the
2 Draft Bill by saying that there needed to be a second
3 clinician involved in the discharge.

4 In other words, that there was greater rigour. So
5 I use that as just one example. So that, along with the
6 Personalised Care Framework, which will come forward,
7 with care and treatment plans, which have been described
8 as the cornerstone of the 2025 Act, and other aspects,
9 including the application and helpfulness, as it will
10 be, of the Code of Practice, we felt actually better
11 delivered. It would also have been very unusual to put
12 some of the changes on the face of the Bill, so it
13 was -- it wasn't avoiding the issue, it was actually
14 thinking: how could we do this better?

15 **Q.** Can we have, please, the bottom of page 7, top of
16 page 8, improving care and treatment for people with
17 severe mental illnesses.

18 We see at the top of page 8:

19 "You have agreed to put forward bids in the spending
20 review which seek to improve public and patient safety,
21 including through expanding assertive outreach provision
22 and new Community Mental Health Centres. However, as
23 agreed with strategic finance, given the tight fiscal
24 position, the size of additional investment being sought
25 for 2025/2026 ... will not allow for full national
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1 coverage."

2 Can you set out the position here?

3 **A.** I think again, as was described this morning by
4 Mr Vineall, we always have a process, we have an amount
5 of funding and decisions have to be made. I did want to
6 emphasise on Assertive Outreach that in our first month
7 of coming into government we did immediately task
8 officials, and it was sent out within a month of us
9 coming into office, guidance on Assertive Outreach. It
10 has moved us in the right direction. We have also
11 committed, through the 10-Year Plan, into 100% coverage
12 on Assertive Outreach, and we may -- you may, of course,
13 want to ask me more about that.

14 **Q.** Upper case, lower case? I mean, which are we talking
15 about? The model that works? The Assertive Outreach
16 uppercase, the fidelity model?

17 **A.** I don't mean the word "assertive", I mean the practice
18 called Assertive Outreach. But -- and we have seen
19 improvement. There is much more to do and we are
20 committed to that over a 10-year period. That was the
21 first point I wanted to make on Assertive Outreach.

22 On Community Mental Health Centres, I am very
23 pleased that we have a pilot of six new Community Mental
24 Health Centres. The evaluation is ongoing through our
25 implementation team, who look at real-time evidence, who

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1 provide Assertive Outreach is.

2 **Q.** Provided it's loyal to the model which is effective, did
3 you see it as being able to work alongside the community
4 neighbourhood centres? In other words, the case is that
5 they're not enabled or able to deal with within the
6 centres themselves --

7 **A.** Yes.

8 **Q.** -- either they can refer or flag up those that they are
9 losing to services and an Assertive Outreach Model.

10 **A.** Yes. Yes, is the answer.

11 **Q.** -- (*overspeaking*) --

12 **A.** -- answer to that. Assertive Outreach though can take
13 different forms, and -- but the fundamental is there,
14 those who are not coming -- who have -- who need
15 proactive going after, if you like.

16 I mean, I visited the Leeds Service and spoke to
17 both the Lead Consultant and the whole team. Quite
18 clearly there they expressed to me, and I was very taken
19 with this, the whole point of Assertive Outreach is you
20 don't just do it once and you don't give up, but
21 actually they work with people, perhaps for the whole of
22 somebody's life course.

23 That is how it is and I completely understand that.

24 **Q.** And indeed the Ritchie Report had made quite specific
25 recommendations for the operation of that.

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1 are constantly in contact with those working there, but
2 also those are using the services and those who have an
3 interest in the services.

4 We will shortly have the evidence that we need to
5 see where we go next. I myself have visited the one in
6 Birmingham, and I hope I'll get a chance to speak about
7 that, because it really is the model of how we provide
8 mental health services going forward, and tackle some of
9 the most difficult and challenging cases in respect of
10 severe mental illness.

11 **Q.** Why do you say that?

12 **A.** Why? Because they -- because of their whole approach,
13 what they told me in Birmingham, we are -- this is what
14 they said, they said they were rooted in the community,
15 they operate according to the community that they serve.
16 It is 24/7 open access, services are under one roof, and
17 they have assigned named workers to people. If they
18 disappear, they are not left.

19 They also talked to me, which I thought was quite
20 interesting, because there is, to use the expression
21 capital A, capital O Assertive Outreach service in
22 Birmingham that they work with closely, but they talked
23 to me about the possibility of them providing such
24 a service of some degree, which speaks to the point
25 about, depending on where you are, what the best way to

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1 **A.** (*The witness nodded*)

2 **Q.** For an identified class of patients and it included
3 ring-fencing of roles, and time, and limitations on
4 volume of work to allow for intensive oversight.

5 **A.** (*The witness nodded*)

6 **Q.** Going back again to the same patient, frequently on the
7 same day, in the middle of the night if necessary.

8 **A.** (*The witness nodded*)

9 **Q.** Recognising key risk factors for that patient. It's an
10 intensive model, isn't it?

11 **A.** It is, and that's what it takes, in some cases. And
12 I know there was a reference earlier to some people
13 saying, "Oh it's very expensive". That isn't the point.
14 The point is that is the service that is needed. And
15 not least in terms of public protection.

16 **Q.** And does that mean you'll need to obtain separate
17 funding for those teams? You may have a number of
18 Community Neighbourhood Centres in a city but you might
19 need one team that's set up, for example, to deal with
20 Assertive Outreach cases, a fully functioning Fidelity
21 Model team? Is that something that would require
22 separate funding?

23 **A.** Well, I think it is part of the whole package of mental
24 health services that are provided locally, and depending
25 which area we're in, and the most obvious difference is

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1 between a rural area and an urban area, but there are
2 many other variations, it really is up to -- and it is
3 correct that we empower and enable local health services
4 to make decisions about (a) what is needed, but (b) how
5 they provide it.

6 Similarly, Community Mental Health Centres will be
7 established in different ways. That's why the -- I'm so
8 enthusiastic about the pilots, because they will give us
9 evidence and a lead, and why we have made capital
10 funding available.

11 **Q.** Can we look at funding, please. WITN0409068, page 67.
12 If we go, please, to page 67 of the report.
13 Paragraph 170:

14 "As we have heard, sustainable funding is a key
15 enabler of the transformation of [the Community Mental
16 Health Service]. However, Lord Darzi's 2024 Independent
17 Investigation of the NHS concluded 'there is
18 a fundamental problem in the distribution of resources
19 between mental and physical health.' Despite mental
20 health accounting for over 20% of the total disease
21 burden, it receives less than 10% of the NHS
22 expenditure."

23 Given your role, I don't say I need to set out what
24 it says on page 68 and 69, which can be shown, public
25 record, but how do you say or consider this should be

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1 I would also say we have always sought to be
2 transparent on funding. It's quite right and proper
3 that we report to Parliament. It's worth saying that
4 mental health spend doesn't include everything, at all.
5 It doesn't include, as was spoken about this morning,
6 the improvements to the Health Service overall which
7 massively help mental health services, and I use just
8 one example: digital and technological transformation.
9 Investment into GPs, that is another area. It also
10 doesn't include medication, and so on. There's a whole
11 list of things it does not include.

12 So as we have dealt with the fundamentals, and
13 that's what Lord Darzi was saying, and it was us that
14 commissioned a long, hard look at this, in his
15 independent review. The fundamentals of the Health
16 Service, which he described as "broken but not beaten",
17 which gave us hope, the fundamentals needed fixing, and
18 that is what the 10-Year Plan is all about. Within that
19 there is absolutely no doubt that the key pillars and
20 other aspects will greatly improve mental health
21 services but that won't be within the mental health
22 spend.

23 **Q.** Understood about data, which affects all services,
24 doesn't it?

25 **A.** *(The witness nodded)*

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1 addressed, the difference, and the disparity between
2 mental health services' financial provision and physical
3 health services and the demands placed in the services
4 you are Minister for?

5 **A.** Mm. So I'm sure the Inquiry won't be surprised to know
6 how much I and Secretaries of State have interrogated
7 this very point.

8 My conclusion on it, if I could put it this way, is
9 that actually the whole point about funding is
10 a complexity. We did very clearly speak, and I was very
11 proud of this, in the first King's Speech, about the
12 need for parity on services between mental health and
13 physical health.

14 When we came into government, I can say that the
15 state of mental health services was lacking. It was, as
16 Dr Smith has said, fragmented. It was not built around
17 effectiveness and evidence-based, and the outcomes,
18 despite whatever funding mental health services had gone
19 were not what anyone would have expected.

20 So that's where we started. In terms of funding, as
21 the Inquiry heard earlier, there is actually
22 £140 million more this financial year than the previous
23 year. Because I know that the evidence that was
24 discussed here was the statement of Health Services
25 Journal by the then Secretary of State, Wes Streeting.

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1 **Q.** And the data transformation and sharing of information
2 is critical for patient safety generally.

3 **A.** Yes, it is.

4 **Q.** Can you have a look at this article, WITN0075014.

5 I don't know if you have seen this before.

6 Professor Fazel is one of the authors. It's:

7 "The economic impact of violence perpetration in
8 severe mental illness".

9 The human impact, of course, is so enormous, but if
10 you needed to look at the figures and data around
11 finances, page 2 sets out under:

12 "Outcomes.

13 "... estimated annual economic impact of violence
14 perpetrated by people with severe mental illness ..."

15 If ever there was a justification for the Assertive
16 Outreach Team funding, however expensive it was, this
17 outweighs it, doesn't it, by far, the cost?

18 **A.** There's no doubt in my mind about the economic impact.

19 I can assure the Inquiry of that. It isn't the only
20 impact --

21 **Q.** Of course.

22 **A.** -- but it is very -- and I'd want to emphasise the human
23 impact, which has a massive ripple effect but as well as
24 to those directly affected in the first instance.

25 So yes, absolutely, I would accept that. And to the

40

1 point on funding, that's also why, since the statement
2 was made to Parliament, that we have made available
3 £473 million for new developments, including the
4 Community Mental Health Centres, including Mental Crisis
5 Centres, including dealing with inappropriate
6 out-of-area placements. All of these things work
7 against good provision, and that is why that capital
8 funding is there.

9 So again -- I will use the word "unpick" -- I always
10 think it's important to unpick what the financial
11 situation is, and also to say, important though funding
12 is, there's been a very big emphasis on that when really
13 the emphasis has to be on outcomes. And we've always
14 said yes, investment, but with investment must come
15 reform of services and it is that latter point that we
16 are working to as well as resourcing.

17 **Q.** Thank you. The last document and question from me,
18 please, WITN0409071. Just in relation to the criteria
19 for detention, so again, a DHSC paper, this is in effect
20 a memorandum of the Bill's compatibility with the
21 European Convention on Human Rights. If we look at
22 page 12, please, the grounds for detention,
23 paragraph 43:

24 "The government considers ... these amendments will
25 raise the risk threshold for detention under the act ...

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1 detain people? I would say no.

2 **Q.** The Inquiry has heard a lot of evidence from clinicians
3 on the ground about what they understand the criteria to
4 mean and to represent. But you say, from your
5 perspective, it's not making it more difficult at the
6 moment, or it shouldn't? Or clinicians should be able
7 to make a judgement --

8 **A.** No, we need the right people detained at the right time,
9 in the right way. That is the whole focus of the Act.
10 I -- by the way, I do understand people's concerns and
11 fears. I do want to say that. And that is why they
12 will be working with us on the Code of Practice. It's
13 a statutory Code of Practice, and that is the place to
14 make all of this as clear as anybody could do, and to
15 enable people to do their jobs and to keep the public
16 safe and to keep patients safe.

17 **MS LANGDALE:** Thank you.

18 Chair, this may be a good time for the afternoon
19 break before Core Participant questions.

20 **THE CHAIR:** I think we'll come back at 3.25. Thank you.

21 (3.09 pm)

(A short break)

23 (3.24 pm)

24 **THE CHAIR:** Yes, Mr Moloney.

25 **Questioned by MR MOLONEY**

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1 and thus bolster compliance with Article 5."

2 Article 5 being, of course:

3 "Everyone has the right to liberty and security of
4 person."

5 Other than certain circumstances, including lawful
6 detention of those of unsound mind.

7 So this does reflect consideration that it will
8 raise the threshold for detention, doesn't mention at
9 all the Article 2 rights to life in relation to the risk
10 to others if people are killed. That doesn't appear in
11 this balance, but irrespective of that, it stated that
12 it will "raise the risk" and "bolster compliance with
13 article 5".

14 So it appears that, in some quarters at least, there
15 is a view that this is going to raise the risk for
16 threshold for detention under the Act, isn't there?

17 **A.** Yeah, I mean, I'm reading it now and thinking raising
18 the risk threshold, not raising the threshold.

19 **Q.** It sounds like a toleration of risk, "raising the risk",
20 "raising assessment of risk"; what do you --

21 **A.** I think probably to this point, the important thing for
22 me, as I said earlier, is that the Act does not raise
23 the threshold for detention, because I know there's been
24 a lot of discussion -- and rightly -- what does the
25 Mental Health Act do? Does it make it more difficult to

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1 **MR MOLONEY:** Baroness Merron, good afternoon.

2 **A.** Good afternoon.

3 **Q.** Ms Langdale has just asked you about the ECHR memo, and
4 in particular that that ECHR memo says at paragraph 43
5 on page 12 that:

6 "The government considers ... these amendments will
7 raise the risk threshold for detention under the act ...
8 and thus bolster compliance with article 5."

9 May I take you to an illustration of what I know is
10 the importance of this to you, and to a read-out of the
11 minutes of a meeting that you had with the families
12 which is document WITN0409003, and to page 1.

13 If we please go down just roughly in between where
14 the two hole punches would be, Baroness:

15 "In particular, BM noted that the Government have
16 been looking at clinical decision making around
17 detention and discharge, as two key areas for the
18 management of risk. In particular they have been
19 considering:

20 "Strengthening statutory discharge processes ..."

21 I'll come on to that in a moment, if I may:

22 "Strengthening clinical decision making ..."

23 And then at third bullet point:

24 "Amending the new detention criteria to ensure there
25 is no risk they are misinterpreted to mean that

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1 clinicians cannot intervene early in deciding to detain
2 someone who is at risk or harm to themselves or others."

3 So you were assuring the family at that point that
4 you wanted to make sure there was no barrier in law to
5 clinicians intervening early to detain someone who posed
6 a risk of harm to others.

7 Now there is perhaps an inconsistency with -- the
8 ECHR memo as identifying the risk threshold as going up
9 and it might cause confusion.

10 Will you make clear to all practitioners that that
11 ECHR memo is not to cause confusion and there isn't to
12 be a raising of the risk threshold for detention with
13 the new legislation?

14 **A.** I do think that's important, the points that you raise.
15 And certainly in our consultation and engagement that we
16 will have about -- and forgive me if it seems I'm
17 repeating myself, but it is actually a key point --
18 about the Code of Practice. That's exactly the kind of
19 thing that I am sure I would absolutely expect, and
20 indeed, if by some amazing reason nobody raised it, I'd
21 certainly raise it --

22 **Q.** Thank you, Baroness.

23 **A.** -- following the work of the Inquiry, so there is
24 absolutely clarity. I think on that third bullet
25 point --

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1 community/outreach Consultant. It was suggested that
2 a Section 117, covers this. The fact is that it does
3 not. Every patient who has been assessed as being
4 a threat to themselves or the public must have a formal
5 handover to the community consultants".

6 And Dr Kumar's concern was that if this is not in
7 statute it will not happen, and you've explained how you
8 responded to that, and may I take you to your response,
9 please, Baroness, which is at WITN0409021, and to page 2
10 of this document we see your email. There's a series of
11 emails before that, but if we see how you dealt with
12 this point, Baroness.

13 "As set out in my letter last week, I am writing to
14 come back on the specific point you made around
15 [section] 117 and statutory handovers to the community."

16 And as you say:

17 "As I set out in the letter, the Bill has now been
18 introduced to Parliament, which means it is no longer
19 simple for government to update, as we would need to
20 submit an amendment to the Bill and for this to be
21 passed by the House in the same way other amendments
22 would do".

23 And that's essentially as you described it to
24 Ms Langdale and you went on to say:

25 "However, as set out in my letter and in discussion,

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1 **Q.** Yes.

2 **A.** -- that is exactly why myself and the Secretary of State
3 early on said: yes, take out those words "how soon"
4 because it was exactly speaking to this point. We were
5 very concerned that a clinician could think that it had
6 to be imminent. That would not be where we want to
7 land.

8 **Q.** Now just my second and final point if I may, please.
9 You, in answer to questions from Ms Langdale, described
10 how it was that Dr Kumar raised issues with you around
11 discharge. And one of the issues that he raised was not
12 in relation to Section 117, but was about discharge from
13 consultant in hospital to consultant in the community.

14 May I take you, please, to the relevant email that
15 he sent to you --

16 **A.** Yes.

17 **Q.** -- just to put it in context, and that is WITN0409020,
18 and it's the second paragraph. The first paragraph he
19 expresses his gratitude to you, and the second
20 paragraph:

21 "Yesterday we discussed the hand over of a seriously
22 ill patient who may have been admitted under Section 3
23 for hospital treatment been released into the community.
24 I had suggested that it should be statutory for the
25 hospital Consultant to hand over to the

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1 we are looking to strengthen discharge under the MHA,
2 building on steps already taken with the publication of
3 statutory discharge guidance [as you said] which
4 emphasised the importance of join up and coordination
5 between the hospital and community."

6 And you go on to say that the Bill will be subject
7 to debate and scrutiny and your officials would happily
8 keep Dr Kumar informed of its progress.

9 So you'd acknowledge, Baroness Merron, I am sure,
10 that appropriate discharge is fundamental to securing
11 public safety.

12 **A.** It is.

13 **Q.** And will you monitor the effectiveness of the guidance
14 that you create in relation to that?

15 **A.** Yes, and it's important to say that, as with any new
16 legislation, it is kept under review, it is monitored
17 and so on and so forth, because it is never the end of
18 the story. In lots of ways it's the beginning of the
19 story and I certainly feel very strongly about that.

20 In terms of the Mental Health Act 2025, work
21 continues apace, as I mentioned earlier, to give effect,
22 to give clarity, to give example, to give guidance in
23 the way that we all want to see through that Code of
24 Practice and to build the consensus, so that people feel
25 a part of it, and apply themselves to it. But they will

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1 have contributed, through their experience, whoever they
2 are, and also the public will have the chance to be
3 consulted as well until we finally nail it down.

4 So I think that gives you some suggestion of our
5 approach.

6 **Q.** And your approach being that serious --

7 **A.** Yes.

8 **Q.** -- if guidance or wasn't working, then you wouldn't rule
9 out further statutory change?

10 **A.** Well, exactly. Well, I don't want processes that don't
11 work, let me put it that way.

12 **MR MOLONEY:** Thank you very much, Baroness.

13 **THE WITNESS:** Thank you.

14 **THE CHAIR:** Ms Cartwright.

15 **Questioned by MS CARTWRIGHT**

16 **MS CARTWRIGHT:** Good afternoon, Baroness Merron. I ask
17 questions on behalf of the survivors.

18 **A.** Good afternoon.

19 **Q.** You started your evidence this afternoon by saying:

20 "... our government ... agreed to set up [this]
21 Inquiry having listened to [the] families."

22 The Inquiry was announced on 12 February 2025, and
23 can I ask you then, we need to correct your evidence to
24 confirm that before the Inquiry was announced, there had
25 been no consultation, contact, or engagement with any of

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1 **A.** I have accepted that -- (*overspeaking*) --

2 **Q.** -- does it, Baroness?

3 **A.** I am accepting that, and I am apologising for that.

4 **Q.** And can I ask you, obviously the meetings that started
5 with the bereaved that you detail in your witness
6 statement started in the January of 2024, but bearing in
7 mind you had had the portfolio role in 2007 to 2008 as
8 Minister for the East Midlands and Parliamentary
9 Under-Secretary for Regional Affairs, at any point did
10 you give thought to the victims who were essentially
11 former individuals who you maintained the portfolio for:
12 these hard working residents of Nottingham whose lives
13 were changed forever on 13 June 2023?

14 **A.** Well, let me first of all acknowledge their lives were
15 changed forever. I should say that as Minister for the
16 East Midlands, the role actually related to economic
17 development, particularly, and promoting the region.
18 I've lived and worked in the East Midlands for most of
19 my life, so actually I feel very connected, and of
20 course I have spoken to the Members of Parliament
21 informally who represent Nottingham who have obviously
22 great worries and have sought to get their points across
23 too.

24 But I can only reiterate the apology. I am sure it
25 has caused great distress and, as I say, that is, if we

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1 the survivors, victims of VC's attempted murder, had
2 there?

3 **A.** Hmm. I interrogated on this point before coming to the
4 Inquiry, and I believe that the situation that you
5 outline is correct. What I would like to say is that
6 with the benefit of hindsight that wasn't the right way
7 to proceed, and the Secretary of State, when he did
8 receive contact from the survivors, did meet with the
9 survivors, but I actually -- I do take on board the
10 implied criticism and perhaps the actual criticism that
11 survivors were not included as they should have been.
12 Yes, I accept that and wish to apologise for that.

13 **Q.** Well, I'll come on briefly on the correspondence, but in
14 fact I think even after when they proactively contacted,
15 it was a further year before the Secretary of State
16 actually met with the survivors either, wasn't it?

17 **A.** I don't have to hand -- you may do --

18 **Q.** Well, we'll look at it.

19 **A.** Of course, thank you.

20 **Q.** What I'm going to suggest is it was a serious omission
21 because, as victims of this attack, they should have
22 been consulted prior to the Inquiry being announced, and
23 I think you've accepted that.

24 **A.** (*The witness nodded*)

25 **Q.** But it doesn't require hindsight --

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1 could possibly rerun it -- and we cannot, but if we
2 could, I'm sure -- I know we would do it differently.

3 **Q.** Then can I just be clear, because some evidence from
4 other people that had overlooked the survivors has
5 candidly accepted that they in fact forgot that there
6 were victims who had survived.

7 Can I just check that -- had you appreciated that
8 there were surviving victims? Particularly bearing in
9 mind you were having all these meetings from
10 January 2024, the correspondence, and at no point was
11 any of that then offered or shared with the survivors.

12 So had you appreciated that there were surviving
13 victims also when you were having these meetings from
14 January 2024 onwards?

15 **A.** I'm sure that everybody, every minister, every official,
16 was aware, but clearly not aware enough would be the
17 answer to your very valid point.

18 **Q.** Right. Can we then just please look at where you deal
19 with the correspondence from February of 2025. It's
20 your paragraph 77, please, of your witness statement,
21 page 31. Thank you. If we can move to paragraph 77.

22 So obviously you detail that:

23 "On 7 February ... the survivors' legal
24 representative contacted the Department to express full
25 support of a public inquiry and to request that they be

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1 included in any communications and invited to any future
 2 meetings pertaining to the Nottingham attacks."
 3 And if we could just look at that email
 4 correspondence, please, WITN0409033. Thank you. If we
 5 could go to page 5, please.
 6 Now we can see at the bottom of the page,
 7 7 February, that email from Greg Almond on behalf of the
 8 survivors, and over the page, please, we can see that
 9 details, the correspondence for Mr Streeting were
 10 essentially "strongly urge ... to consider supporting us
 11 in our call for the public enquiry to be held".
 12 "The survivors are Nottingham people, members of the
 13 local community and the lasting impact of these attacks
 14 continues to affect not only them but countless others
 15 across the city.
 16 "To date, much of the media coverage has
 17 understandably been focused on the deceased victims and
 18 their families, and we believe it is of equal importance
 19 for the voices and experiences of the survivors to be
 20 acknowledged and considered in legal details."
 21 And then details the life-changing conditions that
 22 those I represent were suffering from. Detailing it:
 23 "... it is imperative that [they] ... are included
 24 in any communications around the plans for the public
 25 enquiry ... invited to any meetings being held with the
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1 announced on 12 February, but essentially, it was
 2 announced in the media. They heard about it as they
 3 were travelling in the taxi to that meeting with the
 4 Prime Minister. But even before the public announcement
 5 nobody had engaged or spoken to those survivors, and
 6 would you agree that's highly regrettable?
 7 **A.** Yes, I would, and again, I can only give my apologies
 8 for that.
 9 **Q.** Again, the survivors attended when the Terms of
 10 Reference was announced in May, but again no substantive
 11 meetings on that day.
 12 But if we could then perhaps just summarise, I don't
 13 want to go through the meetings that you had thereafter,
 14 but you detail them in your witness statement along with
 15 correspondence, but this having been essentially the
 16 request to keep them in the loop, none of that then took
 17 place. So can you assist as to why, after essentially
 18 the solicitor proactively for these survivors saying,
 19 "Consult with us, keep us in the loop", that didn't take
 20 place?
 21 **A.** I accept that on behalf of the government and I can't
 22 answer as to why, in honesty, as to why that happened,
 23 but I do know that that wasn't as we would want it to be
 24 now, and you are right to shine a light on that and
 25 I will repeat my apology for handling, which was not
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1 families and government about this matter."
 2 And seeking support.
 3 And if we go over the page, please, again there's
 4 statement that was issued alongside this email was
 5 detailed there, which again reiterating the real need
 6 for consultation and engagement but also transparency
 7 with the surviving victims; would you agree?
 8 **A.** I'm sorry, can you just restate? You asked me would
 9 I agree. Would I agree with?
 10 **Q.** So really this is saying: please, when you're having
 11 meetings with the families, include us, not necessarily
 12 at the same time, but don't overlook us, we have valid
 13 issues that we need to raise and be consulted upon --
 14 **A.** Yes.
 15 **Q.** -- even more so as residents of Nottingham using these
 16 services also.
 17 **A.** Yes. Yes, I would agree.
 18 **Q.** So really flagging "Don't forget us."
 19 **A.** Yes.
 20 **Q.** "We need to be kept in the loop for all future ..."
 21 -- (*overspeaking*) -- "
 22 **A.** It is quite clear.
 23 **Q.** It is, and we know that essentially the bereaved and --
 24 sorry, the survivors, if we follow this chain through,
 25 they did then attend when the Public Inquiry was
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1 what had been requested, nor what it should have been.
 2 **Q.** Can we then go back, please, to your witness statement
 3 because we're now a year on from that initial contact in
 4 February 2025. We can go to paragraph 98, please, of
 5 your witness statement.
 6 Sorry, paragraph 98, please.
 7 I do apologise. I've not got the page reference.
 8 **THE CHAIR:** Thirty-five.
 9 **MS CARTWRIGHT:** Thank you.
 10 Paragraph 98, please, page 35. Thank you.
 11 So again we can see the reference there to 15
 12 January -- I DO apologise, 96 -- 15 January, Mr Almond
 13 again writing to the Secretary of State. Sorry, that
 14 should be -- that's his letter, but the meeting that
 15 then took place I referenced earlier was 5 February with
 16 the Secretary of State.
 17 But again can we just look at that correspondence
 18 that was sent in the January, just to again underline
 19 the significant omission of essentially keeping these
 20 survivors continually in the dark, WITN0409065, please.
 21 So this is now the letter that again underpins some
 22 of the significance of the lasting impact for both Wayne
 23 and Sharon. If we could go over the page, please, and
 24 again, this is in the context of a CQC Report that had
 25 been published that no pre-warning to the survivors had
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1 been given, and again, this letter needing to highlight
2 the need to liaise with and keep the survivors in the
3 loop.

4 Would you agree that it's highly regrettable that
5 once again, having asked to be kept in the loop, there
6 were further reports then being issued, where they find
7 out for the first time once those reports are being
8 published, and again, them flagging there that:

9 "They, along with all Nottinghamshire residents,
10 deserve to have confidence in the agencies and public
11 bodies operating in the city in which they live."

- 12 **A.** Yes, I do understand that, not just about the point that
13 you rightly make about using services in Nottingham, but
14 also the severe and long-lasting effect on the survivors
15 is considerable. And, as I have said and probably can't
16 say enough, that isn't, that wasn't the right thing to
17 do or not do in this case, and I apologise. But perhaps
18 I can also say, of course, and I know it doesn't repair
19 what I imagine is the distress this has caused to the
20 survivors, but of course I'm -- I would welcome, if they
21 wished, a meeting with the survivors and I'm sure also
22 the new Secretary of State would too.
- 23 **Q.** Thank you for that. But then can I ask, bearing in mind
24 we've heard some evidence about how other agencies have
25 engaged with them as victims, how is the government

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1 It's just really in the context of what you've said
2 earlier in your evidence about taking an evidenced
3 approach always to how you engage with matters, you
4 boldly stated in paragraph 29, in respect of changes to
5 the Mental Health Act:

6 "The fundamental powers and purpose of the 1983 Act,
7 which is to detain and treat people when they are so
8 unwell they become a risk to themselves or others, will
9 remain the same and will not be impacted by the
10 changes."

11 Would you accept, Baroness Merron, that you've
12 overstated the position there: the statutory test for
13 detention has been changed by the reforms, and you
14 yourself have admitted that still the work needs to be
15 done to finally nail down the Code of Practice. That's
16 an overstatement, isn't it, Baroness Merron?

- 17 **A.** No, I stand by what's in paragraph 29, not least of all
18 because that is a direct quote of what the fundamental
19 powers and purpose of the 1983 Act -- I'm not sure
20 whether to say "is" or "was", but "is", and which is
21 repeated for the 2025 Act.

22 So no, I don't accept that's an overstatement, and
23 I can't recall what words I used about the Code of
24 Practice but the statutory Code of Practice is
25 absolutely key to giving effect to this Act.

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1 going to do better for other victims of these terrible
2 atrocities to avoid the retraumatisation that's been
3 talked about by simply overlooking them, forgetting
4 them, not inviting them to the table so that they feel
5 like second-class victims? How is that going to be
6 addressed moving forward for victims of attacks or
7 other serious incidents?

- 8 **A.** I recognise very much the point you're making about
9 additional trauma caused by the process caused by the
10 approach, additional trauma to the trauma and severe
11 harm that's already been done, and that is not
12 acceptable.

13 We have a new Minister for Victims, and I will be
14 raising this following the Inquiry. I'm sure there will
15 be recommendations too, but I won't wait for that. But
16 I will, through our two departments, the Minister for
17 Victims is with the Ministry of Justice, I will
18 undertake to pick that up because, no, I'm sure none of
19 us want a repeat of this.

- 20 **Q.** Thank you. Then just two final topics, please. Can we
21 look, please, at your paragraph 29 of your witness
22 statement on page 14. I want to briefly deal with this
23 topic because I know you've been asked questions by my
24 learned friend Ms Langdale KC. Paragraph 29. Thank
25 you.

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1 It is not an afterthought, it is an integral part of
2 the process. I know that those involved, including
3 those with lived experience, are very keen to get this
4 right with us, and to buy into the process but also to
5 inform it, as I am sure the public also have a view,
6 I do hope, and I will ensure that the victims you
7 represent will have a clear opportunity -- as do -- as
8 will the bereaved families in this case -- to actually
9 give their views and concerns about the Code of Practice
10 because that will help us to get it right.

- 11 **Q.** I think it's more than that. I think all of the
12 evidence it seems that we've heard on the changes is,
13 it's actually going to require the Code of Practice to
14 make clear what these new statutory criteria is about
15 serious harm, nature, degree, and likelihood of harm
16 actually is going to mean on the ground for clinicians
17 applying that.

- 18 **A.** And what I would put back is that is absolutely usual.
19 It's already the case, the 1983 -- excuse me, the 1983
20 Act had a Code -- has a Code of Practice. That was
21 reviewed just over ten years ago so it hasn't been
22 reviewed in that time. So the process and situation is
23 already -- there is no change in that respect.

- 24 **Q.** Finally please, paragraph 64 on page 25.

25 Thank you.

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1 This is by reference to the statement of the
2 Secretary of State in August 2024 to discuss the CQC
3 Section 48 Review, and you detail that:

4 "At [that] ... meeting, the Secretary of State
5 reflected that the CQC had done a thorough job in
6 producing this report."

7 Obviously the Inquiry has now heard some frank
8 evidence and admissions from CQC about the inadequacies
9 of that report and information that it did not consider.
10 So can I just be clear: on what basis was there the view
11 that there had been a "thorough job" in producing the
12 report?

13 **A.** I'll do my best to suggest what I think that is saying:
14 that the CQC had indeed -- in fact it was the -- it was
15 under the last government and the then Secretary of
16 State, Victoria Atkins, in my view quite rightly asked
17 for a Section 48 Report from the CQC. She was quite
18 right to do that. And of course we received that.

19 I understand there have been criticisms of the CQC.
20 I can only say that at the time, on the advice given to
21 the Secretary of State, and in his reading of it, that
22 was his view.

23 **MS CARTWRIGHT:** Thank you Baroness Merron, and thank you for
24 the invitations to future meetings also.

25 **THE WITNESS:** Thank you.

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1 implementation of public Inquiry recommendations?

2 **A.** To the best of my knowledge, that decision hasn't yet
3 been taken.

4 **Q.** Okay.

5 **A.** If I'm incorrect, I will gladly write to clarify that
6 point.

7 **Q.** Moving on. Now, you may know that some organisations
8 like Inquest, that work in the area of coronial
9 inquests, are advocating for a national oversight
10 mechanism to ensure ongoing monitoring and
11 implementation and learning from inquests,
12 investigations, public inquiries and official reviews.

13 In her evidence to this Inquiry, Sarah Jones, MP
14 Minister for Policing, agreed that she would support
15 some form of mechanism for monitoring the implementation
16 of recommendations from other types of inquiries like
17 coronial inquests. So would you support some form of
18 oversight mechanism for the monitoring of implementation
19 of recommendations from public inquiries, inquests, and
20 other independent investigations?

21 **A.** I would.

22 **Q.** Thank you.

23 Moving on, then. Resourcing in the new ICB. So
24 this is the new structure that's coming. The Inquiry
25 has heard from Professor Lade Smith, who I'm sure you

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1 **THE CHAIR:** Yes, Ms Heaven.

2 **Questioned by MS HEAVEN**

3 **MS HEAVEN:** Good afternoon, Baroness.

4 **A.** Good afternoon.

5 **Q.** I wanted to ask you some questions on behalf of VC's
6 family.

7 First topic, please, implementation of Inquiry
8 recommendations.

9 As I'm sure you'll know the House of Lords Statutory
10 Inquiry Committee recommended in September 2024 the
11 establishment of a Parliamentary committee to oversee
12 the implementation of Public Inquiries and obviously
13 we've heard about the changes that were made in the
14 Cabinet Office.

15 Sir Robert Behrens, in his capacity as former
16 Parliamentary and Health Service Ombudsman, has told
17 this Inquiry that he would endorse a Parliamentary
18 committee as he doesn't: "think the Cabinet Office is
19 the place where you seek an independent view about the
20 implementation of recommendations. There needs to be
21 a Parliamentary device to question reluctant ministers
22 about these issues."

23 So is the government intending to introduce a motion
24 in the House of Commons or House of Lords to create such
25 a Parliamentary Select Committee to oversee the

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1 know, and she raised the concern that at present there's
2 a lack of dedicated mental health specialists in Senior
3 Leadership positions across these new ICB structures
4 that have just been created and, quotes, in her words,
5 a lack of senior people:

6 "... who understands about mental health ...
7 understands ... population need, understands the
8 evidence, understands the importance of this being
9 clinically driven, and understands that care needs to be
10 delivered in a way that people will actually access the
11 service."

12 And she tells the Inquiry that if this doesn't
13 happen, nothing's going to change. She has referenced
14 one person in post in a pan-ICB body called the OPIC,
15 and that's in the Midlands area.

16 So is the government committed to ensuring that
17 there are dedicated mental health specialists at senior
18 leadership level in each of these ICB structures?

19 **A.** I can understand why Dr Smith raises the points that she
20 does that you have reflected before the Inquiry, and
21 I do think that ensuring that we have the right people
22 round the table, but also the right voices, is
23 absolutely key.

24 I would need to look at this more closely about how
25 we achieve what it is that Dr Smith is asking for,

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1 because I think what she's asking for, I completely get,
2 under the previous Bill -- sorry, forgive me --
3 Act which was under the last government, I can remember
4 discussions about ensuring there was a mental health
5 representative on Integrated Care Boards and that was
6 agreed in Parliament.

7 I will certainly undertake to look at that, and what
8 the evidence is and the process about how we ensure that
9 indeed practitioners have their voice. But I can
10 certainly say -- forgive me for going back to the Code
11 of Practice -- but our design of that will absolutely be
12 with practitioners as well as those with lived
13 experience, as well as those who work in the service and
14 those who have been affected, and indeed anyone else.
15 I should add stakeholders because, of course, the
16 voluntary community and faith sector is absolutely key
17 in this, and one of our major partners as we deliver
18 mental health services.

19 **Q.** I think the issue she was raising was about staffing,
20 but let me move on --

21 **A.** Of course.

22 **Q.** -- to another resource and staffing issue. This is
23 evidence from Ms O'Brien, Head of the Royal College of
24 Nursing. She told the Inquiry the current system is
25 unsafe due to nursing workforce shortages, overall

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1 because, in her words, the lack of information sharing
2 increases risk.

3 She told the Inquiry that the government has failed
4 to make these changes. So can you just assist the
5 Inquiry: what is the government doing about the
6 interoperability of digital records?

7 **A.** Well, it's absolutely important, as Dr Smith says, and
8 that is why, in the Health Bill, which had its second
9 reading in the Commons on Monday, there are two aspects.
10 We've mostly focused here today, in today's hearing, on
11 the abolition of the -- of NHS England, but actually
12 there's another very key point and that's about the
13 single electronic patient record.

14 I totally agree about the need to make sure that all
15 systems talk to each other, but most importantly that
16 information transfers to the right people in a safe and
17 secure way for the reasons that we've heard here.

18 **Q.** Can I stop you there; there is a difference though,
19 isn't there, between a single patient record, which is
20 a product, and interoperability, so digital systems
21 talking? There's a difference there, isn't there,
22 and --

23 **A.** Well, there is at the moment --

24 **Q.** -- and that's not being addressed by the single patient
25 record, is it?

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1 patient care is impacted by workforce shortages in
2 a survey of 399 community mental health nurses 51% said
3 they had a daily worry about the safety of patients due
4 to these shortages and the "vast majority" said they
5 were unable keep their patients safe.

6 Is the government committed to rectifying nursing
7 workforce shortages?

8 **A.** Well, the nursing workforce is absolutely key. That is
9 why -- and Mr Vineall mentioned this, this morning -- we
10 are committed to 8,500 more mental health staff and have
11 delivered that three years early. In addition, and it's
12 key to this point, we, in the coming months, will be
13 publishing the 10 Year Workforce Plan to accompany the
14 10 Year Health Plan. Clearly, that will look at a whole
15 range of staff, and of course nurses are absolutely key.

16 I recognise their concerns and we want to meet them.

17 I think I would say, as I mentioned some time ago, the
18 situation in which we inherited -- and it does take time
19 to train people, but we need the right staff in the
20 right place, and of course that does include nurses.

21 **Q.** Moving on to the final topic. This is the
22 interoperability of digital records, another concern
23 raised by Professor Lade Smith. She said that the
24 College has been repeatedly asking the government to
25 support the interoperability of digital patient records

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1 **A.** Well, I believe it will be, but that is the whole point
2 of the single patient record, as you describe: that the
3 right systems can, if you like, connect with each other.
4 That's exactly what it's there for.

5 **Q.** So your understanding in evidence to the Inquiry is that
6 the government changes are going to allow separate
7 digital software platforms being used within the NHS to
8 talk to each other?

9 **A.** That can talk to each other. You know, I completely
10 agree that having systems in different places that don't
11 talk to each other, we should be focusing on the
12 patient, and their information should be there. It's
13 not -- it is about patient safety and it is about public
14 safety, but it is also about the patient shouldn't be
15 the responsible one for repeating the information -- or
16 their carer indeed, repeating the information time and
17 time again, it's one of the greatest complaints,
18 rightly, that we get.

19 **MS HEAVEN:** Thank you.

20 Thank you, Chair.

21 **THE CHAIR:** Yes, thank you.

22 Any other questions?

23 **MR ROSSER:** (*Off microphone*) No questions, thank you.

24 **Questioned by THE CHAIR**

25 **THE CHAIR:** Yes, I just wanted to ask about obviously

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1 Ms Cartwright, on behalf of the survivors, has raised
2 the question of those who do survive these attacks by
3 mental health patients. Obviously the National
4 Confidential Inquiry stopped collecting any data on
5 homicides by mental health patients, and I think you
6 said you supported the inclusion in there of, for
7 example, attempted homicide, because it's often a very
8 fine line, isn't it, a matter of chance? And it would
9 give a much better picture and data as to what was
10 actually happening; do you agree?
11 **A.** Yes, I do agree. How might I put it? To use the words
12 that we've had before, that it's too high a threshold to
13 say homicide is the only measure.
14 **THE CHAIR:** Yes. I don't have any further questions.
15 **THE WITNESS:** Thank you.
16 **THE CHAIR:** So we'll finish there and we'll start again
17 tomorrow, for the last time, at 10.00. Thank you.
18 **(4.02 pm)**
19 **(The hearing adjourned until 10.00 am the following day)**
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