Thursday, 4 June 2026

(2.04 pm)

MS LANGDALE: Chair, may I call please the Minister for Women's Health and Mental Health, Baroness Merron.

THE CHAIR: Yes.

BARONESS GILLIAN MERRON (sworn)

Questioned by MS LANGDALE

MS LANGDALE: Minister, you have prepared a statement dated 5 March 2026. Can you confirm the contents are true and accurate as far as you're concerned.

A. I can.

Q. I understand you'd like to say something at the outset of your evidence.

A. I would. Thank you very much.

I want first of all to address our bereaved families, those who have been so deeply affected by these events, and those who have survived, and I want to express my heartfelt sympathies and to also say that I want to express my gratitude but my absolute respect for the way in which you have engaged with us, despite what I can only describe, perhaps, as unimaginable pain. So I thank you and deeply respect you for that.

And I would also like to say to the Chair how much I welcome this Inquiry, and how I look forward to its recommendations. They will be of great assistance to us

in government and I am of course, I'm very ready to continue to assist as much as I possibly can.

THE CHAIR: Thank you.

MS LANGDALE: What mechanism do you think you have in government for ensuring any recommendations from this Inquiry and others will be implemented? We know that's an issue, isn't it, and indeed the Ritchie report made recommendations around Assertive Outreach many years ago and they've fallen by the wayside by the time we're here.

So when you say the government is keen to hear the recommendations and to work with them, what confidence can we have that they would be implemented and how do you see that happening?

A. Well, first of all, it was our government that agreed to set up the Inquiry, having listened to families. So we feel a great sense of ownership of the process. Of course, it is up to the Inquiry to make its recommendations. So that's the first thing.

I think that the other point that I would make is, as Mr Vineall, our senior official, spoke to earlier when questioned, the timetable does allow us very much -- and I was keen as the Minister responsible for overseeing the process -- does allow us to take full account of recommendations as we develop the Code of

Practice, as we seek to implement the Bill which, whilst it's on the statute books, is not yet implemented.

So there's the scope, but there's also, I believe, the commitment and intent.

Q. And the timing, the timing is -- *(overspeaking)* --

A. The timing is crucial.

Q. The Mental Health Act Code, of course, is really important, isn't it, for practitioners --

A. *(The witness nodded)*

Q. -- and generally for guidance, but the statute overrides, doesn't it, in circumstances of conflict between the two, through the courts the statute itself prevails. So it's important to get the test right in the statute as well, isn't it, in the legislation?

A. I actually see them both as important and indeed there are many other expects that are important. I believe that the Inquiry heard evidence from Mr Alex Ruck Keene to this very point that I was very interested to read about, and he spoke to a point that I believe very much: that it's so important to get legislation right, but good legislation is only something that's as good as what it does. And, therefore, it is never all in statute, important though that is, but it is often the case -- and indeed, this is the perfect case for me, the Code of Practice -- it's absolutely key that the Code of

Practice is got right because that is what gives effect to it.

It also deals with a lot of the questions of practice, it gives the guidance. A lot of this will be about clinical judgement. That is a challenge and it's our duty to assist clinicians.

Q. Can we have on screen, please, WITN0409001, page 36. Before we go to the legislation and the like, it's just paragraph 100, please, of your statement, Minister. And you say:

"The Department recognises there were failures in the provision of care to VC. ... particular[ly] the lack of oversight of [his] mental health in the year before the attacks ... unacceptably poor ... should not have been allowed to happen. NHFT operates within a broader, national framework and it is certainly not the Department's position that [Nottinghamshire Health Foundation Trust] is solely to blame for the failings in VC's care."

Where would you widen that, then? Are you saying that's the government or Department of Health's responsibility too, the failings in his care?

A. Well, the matter of failings in the care of an individual of course can sit in many places.

The intent of that paragraph is not to pass on

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. But the references include those very topics --

A. They are.

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

A. Mm.

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

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

A. Yes, I would.

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

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

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

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

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

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

"Professionals are fearful unless they adopt a cautious, risk averse approach to their patients, they will find themselves being publicly shamed for those occasions when those same people cause serious harm to themselves or others."

Do you see that?
A. Yes, under the section on "Fear"?
Q. Yes.
A. I do think the important thing here is the point actually about fear. If I might go back to the Code of Practice, there is already a Code of Practice with the 1983 Act, it hasn't been updated since 2015. This is the major piece of work we are now on, and it is -- and the work will be undertaken by properly working with clinicians who may -- you know, this report's fear -- people often, in my experience, have fear because they're just not sure. And I understand that, and that is why we have to equip people to do the job.

The Code of Practice will be designed with clinicians, with people with lived experience. It will engage those who work in the health services and those who have been affected. And in that regard, we will build -- and I think this, again, came out Mr Vineall's evidence this morning -- we will build -- and this isn't some woolly thing, but we will -- we intend not just to

get it absolutely right by calling on all that experience, but also to build consensus.

I think that what has been described here -- and I think it's a valid point so I thank you for drawing my attention to it -- actually speaks to the point here: the public may be fearful, patients may be fearful, and professionals may be fearful.

We need to overcome that with clarity, guidance, and also we've been asked, particularly by the Royal College of Psychiatrists, with whom we work very closely, to include illustrations and examples and I'm very keen that we do that.

I should also say that we will go out to consultation once we have drawn up the documents, so there is great opportunity to get this one right and to build that understanding and support around it, which, as this reports, may not be there currently.

Q. This was obviously 2017/2018, this foreword. So my question is: what's the evidence base for that, that they are fearful, clinicians, unless they adopt a cautious risk-averse approach: from your perspective, it's the Review and Sir Simon Wessely telling you that?

A. Yes, but it does say here about the various conversations that Sir Simon and also that independent review held, and I know they were extremely thorough in

their work. Again, I wasn't -- we weren't in government at the time, so I wouldn't have had an intimate knowledge of this, but I know, from my dealings since with members of that independent Inquiry, how they conduct -- not Inquiry, forgive me -- independent review -- I know how they conducted themselves.

Q. In terms of a consensus, it sounds, from the evidence we have heard, there was a wide range of views, including some psychiatrists, respected -- I'm not sure of their respectable body, I don't know how many Sir Simon was speaking of -- but respected psychiatrists who thought there shouldn't be detention against a person's will.

So it doesn't seem likely you have consensus if you have people considering that detention shouldn't be a lawful option and you shouldn't be able to compel treatment for those who are dangerous to others because they don't wish to take it?

A. Well, the view you've just expressed is certainly not one that I share, nor is it one within the 1983 Mental Health Act or the 2025 Act which, of course, amended the 1983 one because it's absolutely clear that there are circumstances in which people may need to be detained, may need to be treated to protect -- to prevent harm to them or to others. I think that's absolutely crucial. So I wouldn't share the view that's just been put to me.

Q. Understood. Page 8, please, second paragraph. In the foreword:

"... far greater risk of serious harm to self, but we cannot deny that there is also risk to others, even if usually overstated by public, politicians and media."

This is 2018, as I've said, do you think the risk of serious harm to others from those who are mentally unwell is overstated by politicians?

A. I believe we're talking about serious mental illness.

Q. Yes.

A. I'm --

Q. And risk of serious harm.

A. Yes. Well, there are circumstances, as we know only too well because of the events that this Inquiry is looking at, where that is indeed the case. But this suggests it's usually overstated by the public, politicians and media. I will only speak for myself and my government colleagues, we seek to be honest and transparent in how we assess the situation.

But we do know there's a risk, and we are not shy to address it, and that is why we reformed the Mental Health Act and it got Royal Assent.

Q. Can we go to page 17, please, this is the introduction and executive summary to this Review, and we see the three problems faced, and the top one:

"... complex balance between respecting a person's autonomy and the duty of a civilised State to protect the vulnerable."

Ie, the patient, "the vulnerable".

Again, no mention of "or to protect the public", is there? And it's not just semantics; if you don't keep reminding yourself of the importance of that, there's a danger it's overlooked, isn't there, in assessment?

A. I do understand the point that's being made. The Independent Review, and I remember Sir Simon making this point, is that it isn't so much a problem with the legislation, but actually, how it is being applied, and how effective it was. That was the key thing in his thought, as far as I understand, and I think that that is true. I certainly would -- I mean there are huge complexities here. The Independent Review was extremely helpful in terms of leading to the draft Mental Health Bill, which the last government did prepare, but they took it no further on to the statute books. I think that was a missed opportunity. I'm very glad that we made that one of our very first acts, and getting it into the King's Speech, not just to be taken for granted, it was a commitment we had, but there's no given in terms of a legislative programme. Myself and the Secretary of State worked very hard to make sure it

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

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

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

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

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

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

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

Q. I'll come to that --

A. Indeed, thank you.

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

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

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

Do you have any views or thoughts about that?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Of course.

A. Thank you.

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

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

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

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

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

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

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

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

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

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

Q. Refining?

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

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

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

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

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

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

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

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

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

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

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

A. Mm.

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

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

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

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

Q. And the scrutiny, potentially of what --

A. Yes, indeed so.

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

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

A. *(The witness nodded)*

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

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

Q. Thank you. That can come down.

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

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

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

And we see at the beginning:

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

Would you like to elaborate on that?

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

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

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

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

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

And I feel we were absolutely right to do that.

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

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

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

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

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

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

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

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

forward in the revised Code of Practice."

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

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

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

"You asked us to explore Dr Kumar's, and the families', suggestions around improvements to the Bill. ... mostly centred around improving the discharge process, particularly with regard to assessing and managing any ongoing risk posed by a patient, ensuring better continuity of care, and greater clinical

accountability ..."

And it's set out below:

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

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

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

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

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

sub or another one, we did make the change from the Draft Bill by saying that there needed to be a second clinician involved in the discharge.

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

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

We see at the top of page 8:

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

coverage."

Can you set out the position here?

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

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

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

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

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

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

Q. Why do you say that?

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

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

provide Assertive Outreach is.

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

A. Yes.

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

A. Yes. Yes, is the answer.

Q. -- *(overspeaking)* --

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

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

That is how it is and I completely understand that.

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

A. *(The witness nodded)*

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

A. *(The witness nodded)*

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

A. *(The witness nodded)*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. *(The witness nodded)*

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

A. Yes, it is.

Q. Can you have a look at this article, WITN0075014. I don't know if you have seen this before. Professor Fazel is one of the authors. It's:

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

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

"Outcomes.

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

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

A. There's no doubt in my mind about the economic impact. I can assure the Inquiry of that. It isn't the only impact --

Q. Of course.

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

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

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

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

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

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

and thus bolster compliance with Article 5."

Article 5 being, of course:

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

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

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

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

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

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

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

detain people? I would say no.

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

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

MS LANGDALE: Thank you.

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

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

(3.09 pm)

(A short break)

(3.24 pm)

THE CHAIR: Yes, Mr Moloney.

Questioned by MR MOLONEY

MR MOLONEY: Baroness Merron, good afternoon.

A. Good afternoon.

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

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

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

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

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

"Strengthening statutory discharge processes ..."

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

"Strengthening clinical decision making ..."

And then at third bullet point:

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

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

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

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

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

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

Q. Thank you, Baroness.

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

Q. Yes.

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

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

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

A. Yes.

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

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

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

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

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

And as you say:

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

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

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

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

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

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

A. It is.

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

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

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

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

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

Q. And your approach being that serious --

A. Yes.

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

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

MR MOLONEY: Thank you very much, Baroness.

THE WITNESS: Thank you.

THE CHAIR: Ms Cartwright.

Questioned by MS CARTWRIGHT

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

A. Good afternoon.

Q. You started your evidence this afternoon by saying:

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

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

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

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

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

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

Q. Well, we'll look at it.

A. Of course, thank you.

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

A. *(The witness nodded)*

Q. But it doesn't require hindsight --

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

Q. -- does it, Baroness?

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

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

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

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

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

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

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

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

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

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

So obviously you detail that:

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

included in any communications and invited to any future meetings pertaining to the Nottingham attacks."

And if we could just look at that email correspondence, please, WITN0409033. Thank you. If we could go to page 5, please.

Now we can see at the bottom of the page, 7 February, that email from Greg Almond on behalf of the survivors, and over the page, please, we can see that details, the correspondence for Mr Streeting were essentially "strongly urge ... to consider supporting us in our call for the public enquiry to be held".

"The survivors are Nottingham people, members of the local community and the lasting impact of these attacks continues to affect not only them but countless others across the city.

"To date, much of the media coverage has understandably been focused on the deceased victims and their families, and we believe it is of equal importance for the voices and experiences of the survivors to be acknowledged and considered in legal details."

And then details the life-changing conditions that those I represent were suffering from. Detailing it:

"... it is imperative that [they] ... are included in any communications around the plans for the public enquiry ... invited to any meetings being held with the

families and government about this matter."

And seeking support.

And if we go over the page, please, again there's statement that was issued alongside this email was detailed there, which again reiterating the real need for consultation and engagement but also transparency with the surviving victims; would you agree?

A. I'm sorry, can you just restate? You asked me would I agree. Would I agree with?

Q. So really this is saying: please, when you're having meetings with the families, include us, not necessarily at the same time, but don't overlook us, we have valid issues that we need to raise and be consulted upon --

A. Yes.

Q. -- even more so as residents of Nottingham using these services also.

A. Yes. Yes, I would agree.

Q. So really flagging "Don't forget us."

A. Yes.

Q. "We need to be kept in the loop for all future ..." -- *(overspeaking)* -- "

A. It is quite clear.

Q. It is, and we know that essentially the bereaved and -- sorry, the survivors, if we follow this chain through, they did then attend when the Public Inquiry was

announced on 12 February, but essentially, it was announced in the media. They heard about it as they were travelling in the taxi to that meeting with the Prime Minister. But even before the public announcement nobody had engaged or spoken to those survivors, and would you agree that's highly regrettable?

A. Yes, I would, and again, I can only give my apologies for that.

Q. Again, the survivors attended when the Terms of Reference was announced in May, but again no substantive meetings on that day.

But if we could then perhaps just summarise, I don't want to go through the meetings that you had thereafter, but you detail them in your witness statement along with correspondence, but this having been essentially the request to keep them in the loop, none of that then took place. So can you assist as to why, after essentially the solicitor proactively for these survivors saying, "Consult with us, keep us in the loop", that didn't take place?

A. I accept that on behalf of the government and I can't answer as to why, in honesty, as to why that happened, but I do know that that wasn't as we would want it to be now, and you are right to shine a light on that and I will repeat my apology for handling, which was not

what had been requested, nor what it should have been.

Q. Can we then go back, please, to your witness statement because we're now a year on from that initial contact in February 2025. We can go to paragraph 98, please, of your witness statement.

Sorry, paragraph 98, please.

I do apologise. I've not got the page reference.

THE CHAIR: Thirty-five.

MS CARTWRIGHT: Thank you.

Paragraph 98, please, page 35. Thank you.

So again we can see the reference there to 15 January -- I DO apologise, 96 -- 15 January, Mr Almond again writing to the Secretary of State. Sorry, that should be -- that's his letter, but the meeting that then took place I referenced earlier was 5 February with the Secretary of State.

But again can we just look at that correspondence that was sent in the January, just to again underline the significant omission of essentially keeping these survivors continually in the dark, WITN0409065, please.

So this is now the letter that again underpins some of the significance of the lasting impact for both Wayne and Sharon. If we could go over the page, please, and again, this is in the context of a CQC Report that had been published that no pre-warning to the survivors had

been given, and again, this letter needing to highlight the need to liaise with and keep the survivors in the loop.

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

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

A. Yes, I do understand that, not just about the point that you rightly make about using services in Nottingham, but also the severe and long-lasting effect on the survivors is considerable. And, as I have said and probably can't say enough, that isn't, that wasn't the right thing to do or not do in this case, and I apologise. But perhaps I can also say, of course, and I know it doesn't repair what I imagine is the distress this has caused to the survivors, but of course I'm -- I would welcome, if they wished, a meeting with the survivors and I'm sure also the new Secretary of State would too.

Q. Thank you for that. But then can I ask, bearing in mind we've heard some evidence about how other agencies have engaged with them as victims, how is the government

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

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

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

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

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

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

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

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

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

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

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

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

Q. Finally please, paragraph 64 on page 25.

Thank you.

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

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

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

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

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

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

THE WITNESS: Thank you.

THE CHAIR: Yes, Ms Heaven.

Questioned by MS HEAVEN

MS HEAVEN: Good afternoon, Baroness.

A. Good afternoon.

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

First topic, please, implementation of Inquiry recommendations.

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

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

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

implementation of public Inquiry recommendations?

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

Q. Okay.

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

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

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

A. I would.

Q. Thank you.

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

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

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

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

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

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

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

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

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

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

A. Of course.

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

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

Is the government committed to rectifying nursing workforce shortages?

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

I recognise their concerns and we want to meet them. I think I would say, as I mentioned some time ago, the situation in which we inherited -- and it does take time to train people, but we need the right staff in the right place, and of course that does include nurses.

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

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

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

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

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

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

A. Well, there is at the moment --

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

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

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

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

MS HEAVEN: Thank you.

Thank you, Chair.

THE CHAIR: Yes, thank you.

Any other questions?

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

Questioned by THE CHAIR

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

Ms Cartwright, on behalf of the survivors, has raised the question of those who do survive these attacks by mental health patients. Obviously the National Confidential Inquiry stopped collecting any data on homicides by mental health patients, and I think you said you supported the inclusion in there of, for example, attempted homicide, because it's often a very fine line, isn't it, a matter of chance? And it would give a much better picture and data as to what was actually happening; do you agree?

A. Yes, I do agree. How might I put it? To use the words that we've had before, that it's too high a threshold to say homicide is the only measure.

THE CHAIR: Yes. I don't have any further questions.

THE WITNESS: Thank you.

THE CHAIR: So we'll finish there and we'll start again tomorrow, for the last time, at 10.00. Thank you.

(4.02 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X