Marjorie Wallace
Statement No: WITN0458001
Dated: 26 May 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF Marjorie Wallace

I, Marjorie Wallace, will say as follows: -

INTRODUCTION

1. I am the chief executive of mental health charity, SANE, which I founded in 1986.

2. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 7 May 2026 (the "**Request**").

BACKGROUND

3. I have been asked to set out the work and expertise of SANE and recommendations for preventing similar attacks in future.

Career and role

1. I am the founder and chief executive of the national mental health charity SANE. I have worked as an investigative journalist, author, and broadcaster. I worked on *The Frost Programme* with David Frost and at the BBC as a reporter and film director for news and current affairs programme *Nationwide.* Harold Evans, editor of *The Sunday Times*, recruited me into the Insight Team to work on the Thalidomide scandal.

2. I am an Honorary Fellow of the Royal College of Psychiatrists, a Fellow of University College London, an Honorary Doctor of Science at City University London, and Emeritus Guardian Fellow at Nuffield College, University of Oxford. I am an honorary member of the World Psychiatric Association and an Honorary Fellow of the Department of Psychiatry, University of Oxford.

3. In 1986, I wrote a series of campaigning articles in *The Times* about schizophrenia and other severe mental illness. The articles were published under the title *The Forgotten Illness*. They focused on misconceptions about mental illness, the anguish and neglect of sufferers and families, and the under-resourcing of the community care policy.

4. The response to the articles was one of the largest *The Times* had received on a home news subject. As a result of the scale of the public response, with backing of News International I founded SANE in 1987. The charity initially focused on the most severe mental illnesses but later expanded its remit to all mental health.

5. In 1992, we launched SANEline, which at the time was the UK's first national specialist out-of-hours mental health helpline. Two years later I helped to raise over £6 million to fund a dedicated research facility and in 2003 The Prince of Wales International Centre for SANE Research opened in Oxford. King Charles III, then Prince of Wales, was the charity's first patron. I was made MBE in 1994 and appointed CBE in 2008.

About SANE

6. SANE aims to raise awareness and understanding of all mental health conditions; fight to improve frontline mental health services for individuals and carers; provide support, information and guidance through its helpline, SANEline, and other services.

7. SANE also promotes and hosts research into causes, treatments and therapies at the Prince of Wales International Centre for SANE Research in Oxford.

8. SANEline is open every day of the year and provides emotional support, guidance and information to anyone affected by mental ill-health, people in crisis, those with enduring and relapsing conditions and those who care for them. Trained volunteers offer listening, understanding, up-to-date information and support to callers in need and distress.

9. The Call Back service is for anyone struggling who can call and leave a message, providing their name and phone number, and they will be called back. Through Textcare, SANE provides personalised, targeted messages to people at times agreed with them when they feel most lonely and vulnerable, such as on an anniversary or a bereavement, Christmas and other holidays, or when alone in the evenings or at weekends. People can also seek help from our Email Support service, a dedicated email address where individualised replies are sent within 24 hours.

10. The charity operates schemes to encourage people affected by mental illness to fulfil their creative potential. Chief among these is the SANE Creative Awards Scheme which aims to improve the quality of life for people with mental health problems, their families and carers, by encouraging them to fulfil their creative potential. It provides grants to individuals to cover the cost of materials, specific projects and courses, or towards relief cover for carers. The Charles Bracken Award is a specific award which recognises exceptional talent in communicating the relationship between creative endeavour and mental illness. SANE works in

partnership on the scheme with the Open College of the Arts, which is part of the Open University.

Service access

11. Patients may find it difficult to access services or find crisis support. All too many struggle to access high quality, therapeutic inpatient care in their locality when they need it. Those who are able to access this care are likely to have to be acutely ill before they qualify to be admitted.

12. Those who need to be admitted to inpatient care can face considerable delays in A&E departments while they wait for an available bed - often longer than for any other condition - or may be cared for in inappropriate environments, such as a ward in an acute hospital.

13. They may also find themselves shunted around the country for an out of area placement in order to access treatment in crisis. This leaves them uprooted from family and community, can undermine their recovery and puts great pressure on them and their relatives. If they are placed under the care of crisis resolution or other community teams, they can be at greater risk than inpatients of taking take their own lives.

14. Under sections 135 and 136 of the Mental Health Act patients may be admitted to a health-based place of safety for up to 24 hours. But there is evidence from the Care Quality Commission of this time limit being breached because of delays in accessing an inpatient bed.

In-patient mental health care

15. SANE has warned about a shortage of mental health beds for many years. Far too many individuals in crisis are being turned away because no local beds are available or being deprived of their liberty under the Mental Health Act as the only way to receive treatment.

16. The number of psychiatric beds in England has almost halved since 2000 when there were 34,214, with the current total today standing at just over 18,000. Bed occupancy has remained consistently above the recommended levels to the point at which quality of care is at risk of being compromised.

17. In-patient health care can be at times be fragmented. Staff often get moved around between wards to cover absences and gaps in staffing. This can have a significant impact on staff morale, to the point that some leave.

18. It also affects the continuity of care that people receive and impacts on the therapeutic relationship between staff and patients. It makes everything more stressful and disorientating than it need be for people who may already be stressed and disoriented, and it does not give time for trust to develop between patients and staff.

19. Lack of continuity of care can lead to inefficiency and errors as responsibility is handed over from one team to the next. These issues can be exacerbated further by poor record-keeping, inadequate communication between teams and a lack of consistent clinical supervision for staff.

20. The shortage of beds and the performance indicators that measure success by the number of hours that a patient is kept out of hospital make it even harder to provide a safety net when a person feels unsafe in the community or presents a risk to themselves or others.

Community mental health care

21. The increase in recent years in the use of the Mental Health Act to detain people is in part a consequence of overstretched, fragmented and under-resourced community-based mental health teams, which cannot provide the longer-term, consistent connection between individuals and care workers who the majority of those who contact us say they rely upon the most.

22. Where patients are not admitted to inpatient care or have been discharged too early, community teams may have to care for people with critical, unstable conditions. This strains already overburdened services and staff, who may have to rely on telephone assessments or visits.

23. There is a small but significant minority of people for whom care in the community is not working. They are typically young men, who may not comply with medication and only engage with services irregularly, if at all. In some cases, they may abuse illegal drugs or alcohol.

24. In our opinion, more must be done to provide adequate numbers of safe places for the care and treatment of mentally ill people in the community. The lack of supervised accommodation within the community has led to people remaining longer in hospital.

25. A failure to provide appropriate community-based facilities and a lack of continuity of care, especially for patients with complex needs, has been identified as a factor in a significant number of suicides and homicides

26. As currently organised, care in the community is letting down people with serious and enduring mental illness. The "jigsaw" of teams, including GPs and social workers that are supposed to support and treat people in the community, only really work with those patients who are willing to engage with services.

27. Disengagement from mental health services is a recognised and significant risk factor for both suicide and homicide. Non-attendance at appointments and loss of contact with services are frequently cited in inquiries into homicides by mentally ill people.

28. Mental health trusts have varying approaches to managing patient disengagement, which can create unsafe patient care.

29. We believe there should be better strategies to deal with disengagement, relying on rigorous assessments rather than patient choice.

30. Measures known to improve engagement, but which we hear are not always implemented include immediate follow-up where services contact patients who miss appointments to determine the reason; removing barriers by making services more convenient, such as providing transport; or using digital tools as well as more effective peer support services.

31. Close communication between community teams is essential. As far as practically possible, consistency of support should be provided through patients being seen by the same doctor, nurse or mental health professional.

32. Seeing the same psychiatrist, doctor, nurse or other mental health professional is valued as most important, not only by patients, but also by families and carers. This reflects SANE's own evidence from running our helpline for 34 years and other regular contact with patients, families and carers.

Information sharing and involvement of families

33. Information is frequently not shared within mental health services or more importantly with families. There is an unacceptable failure to listen to the concerns and warnings of relatives and carers of patients, who are a risk to themselves or others, and to respect them as a resource and not as an inconvenience or a nuisance.

34. There can be too narrow, rigid and varied an interpretation of confidentiality by professional staff. Families can be left feeling isolated and kept out in the cold, given limited or conflicting responses to their queries and, of the many cases we know, excluded from critical decisions.

35. They struggle without being given diagnoses, information, advice or support until the illness of their family member reaches crisis point, by which time it may

be too late. The impact of this is devastating to the families of victims who have to live with the heartbreak of their loss. It also affects relatives of the perpetrators who may carry a burden of guilt for the actions of their family member who suffers from a severe mental illness for which the family is not to blame.

36. Relatives' concerns should be reflected in care planning and risk assessments; tackling these matters is critical to preventing further tragedies. It should be mandatory for concerns expressed by families to be recorded and in the majority of cases acted upon and included in risk assessments and care plans.

37. When a patient stops taking medication this 'red flag' should be noted and steps taken to intervene. This along with disengagement from services can be a precursor to suicide or homicide.

38. Families should be supported so they can help encourage patients to engage with services and comply with their treatment. Professional staff should contact families so that information and concerns can be shared fully across all care teams. If a patient does not at a moment in time consent to their involvement, the family should still be listened to and considered as part of the care planning process. Families or carers will always find it more comfortable to meet and discuss options with a health professional face-to-face.

39. Care plans often depend on communication between psychiatric services and other agencies such as the police and councils, but this can all too easily be partial or fragmented. Breakdown in communication is a key factor leading to a homicide.

Patient discharge

40. All healthcare organisations across the system should work together to ensure effective discharge planning to give the best outcomes for patients leaving hospital, with families and carers fully involved. There should be regular communication about discharge between hospital teams and community

services, with information shared effectively across teams.

41. The safety of mental health patients is being put at risk when they leave inpatient services prematurely, leading to a revolving door of care and discharge. It remains the case that, for the overwhelming majority of people with severe and enduring mental illness being treated in the community, the default option when in crisis is to present at their local Accident and Emergency department.

42. For those unable to get to A&E, it is likely that it will be the police, rather than specialist services, which are available to respond. Across the country around one third of all police callouts are mental health-related, with that figure reaching as much as 40 per cent in London in recent years.

43. Close to half of SANEline callers tell us that that they had been discharged from A&E with a promise of a call or visit from their community mental health team within a defined time limit, but on many occasions this simply did not happen, leaving them feeling let down, even more alone and with nowhere to turn.

Conclusion

44. The government agenda is *prevention* and yet in too many cases patients and families have been let down by fragmented mental health and other services, which do not have sufficient resources to provide care and treatment for acutely ill individuals and protect their families and the public.

45. Pressure on psychiatric beds and inadequate numbers of trained and experienced mental health staff mean that overstretched teams tell us they are unable to provide safe care in either hospital or the community.

46. Numerous reports have identified inadequate numbers of trained and experienced professionals as contributing to failures in the treatment and care of people with severe mental illness, too often resulting in preventable tragedies.

47. There should be improved training for the mental health workforce in the care of

complex, high-risk patients with a history of violence. However, this is compromised by increases in newly qualified staff, existing vacancies among clinical staff, and reliance on bank staff, which have led to a change in the skill mix and experience of the workforce.

48. Under these pressures we fear that the mental health system is in danger of buckling further and could become less able to provide a network of care that protects patients and leaves families and the public at risk.

Statement of Truth

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: GRO-B

Dated: 26.05.26