Forensic Faculty Newsletter

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RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Contents

Chair's Message

News from the Faculty Chair

by

Dr Sandeep Mathews

Chair of the Forensic Psychiatry Faculty

I am writing this as the Faculty is preparing to assemble in Edinburgh for our annual faculty conference. The programme put together by Dr Mary Davoren and colleagues look exciting, and I look forward to three days of learning and also meeting colleagues from all over.

The faculty executive met in October 2024 and February 2025. The main thrust of our deliberations was about refining the faculty strategy for the coming years. The key areas we would be focussing on are on improving skills in assessment and care planning, engaging patients and carers in the formulation of care plans, enhancing the experience of trainees and SAS doctors in the specialty, improving the use of digital resources and technology, improving the academic focus of the specialty and improving the service provision in our prison and secure hospital estates.

As you are all aware, the state of our prisons and issues in our secure hospitals remain a huge concern. The plight of mentally disordered prisoners awaiting transfer to hospitals is heart breaking. Whilst secure hospitals suffer with continued challenges in staffing, flow through the system and modern therapeutic environments. There is a widespread sense of despair and despondency amongst our senior Consultant colleagues. This may not be apparent at present, but if this prevails, the ability of the specialty to attract talented and bright young resident doctors who are the future consultants would be at risk.

With this and various other challenges in mind, the Forensic Faculty is embarking on a challenging and arduous task. We have had more than thirty years of existence as a faculty. I think it is time to take stock and reflect on where we are as a psychiatric specialty. What have been our achievements, what are our failings, what could we have done better for our patients, what is being done better in other countries for this patient group and where do we go as a specialty in perhaps the next thirty years. How can we as a group of experienced and well paid professionals who have a holistic overview of services lead the future development of services for our patients who are the amongst the most marginalised and neglected.

This initially came out of a challenge posed to us by colleagues from NHS England who asked us- How do we define a Forensic patient or who do we call as a patient of Forensic Psychiatric services? While most of us have a vague idea of our patient group, as patients who pose a risk of harm to others, there is no unified agreed definition of patients who use our services. Whilst a varied and amorphous definition is useful, this causes problems for service planners and people who prepare service specifications. This question set a few of us to brainstorm and we felt we had to seek answers to the questions posed in the paragraph above.

We are planning to set up a group of academics and senior clinicians to think these questions through. The aim is to review academic literature, synthesise knowledge from other jurisdictions and countries, collate views from practising clinicians, service users and carers and prepare a broad based report on the state of Forensic Psychiatry and potential future directions for development. As you know some of the things we keep on doing are the same things we used to do many years back. The world and the knowledge base has advanced (I hope) and we should be open to thinking about achieving the same objectives in novel and different ways. If we as Forensic Psychiatrists do not lead this, we will be forced to follow what others might impose on us!

So my plea to my colleagues is to help with this work. You will be approached for your views by ways of surveys, participation in focus groups and the like. Please do take an active part in shaping the future of our specialty. The views of all of us are important and the more views we can gather, the better.

In other news, the faculty has worked with the NHS England Health and Justice team to outline

a trajectory of the journey of a mentally disordered offender through the criminal justice system and identify the points where they could be diverted. The Health and Justice commissioners would look at these pathways and aim to enhance liaison and diversion at the earliest, taking a preventive approach, thus reducing the number of mentally unwell people coming into prisons. I await these developments with hope and anticipation. We have also worked with the Times justice and crime commission, where our President Dr Lade Smith is a commissioner.

Wishing everyone a great spring and summer 2025!

Yours sincerely,

Sandeep Mathews

Legal Update

By Dr Richard Latham, Consultant Forensic Psychiatrist, South London and Maudsley NHS Trust

Tempting as it is, to focus on the latest criminal sentencing remarks on autism and culpability, or developmental disorders and diminished responsibility, most of what we do, is treat people in hospitals. The three cases below are linked by being about the decisions we make in our day jobs. Two of the cases are from the Upper Tribunal and one from The Parole Board. The case details are of less interest than the analysis and reasoning which provides an insight into a legally driven way of making complex decisions that inevitably, for us, involves consideration of the intersection of clinical, legal and ethical. My apologies for failing (again) to provide a representation of cases from all four nations.

When the team is not willing to treat someone

JB v- Elysium Healthcare and SSJ (HM) [2025] UKUT 009 (AAC)

JB was detained under the Mental Health Act, after transfer from prison. He said he had PTSD, his treating team diagnosed schizophrenia. The First Tier Tribunal (FTT) considered his application for discharge, which was opposed by his responsible clinician. The FTT upheld his detention and accepted evidence about the medical and psychological treatment that would be available. JB had conversations with his responsible clinician immediately following the hearing. JB recorded these conversations, which he said showed that the evidence given at the hearing – about the intention to continue psychological treatment – had misled the panel. JB's new responsible clinician later confirmed that there was no intention to restart psychological treatment. The Upper Tribunal accepted that the FTT had been misled, and that psychological therapy was not available, if the hospital were not willing to provide it. The original decision was set aside and the case remitted for a new panel to hear the appeal again.

When the Tribunal discharges but the Parole Board disagrees

D [2023] PBRA 98

D was serving a life sentence for murder. The victim was his partner who suffered approximately 39 stab wounds. Her ex-husband's name was written in blood next to the body. He was psychotic at the time, but this was attributed to amphetamine use and he was convicted of murder. He had three hospital transfers as a sentenced prisoner and the diagnoses of delusional disorder, borderline and paranoid personality disorder were made. The FTT found that had he been detained under section 37/41 he would have been entitled to conditional discharge and that he should remain in hospital until his Parole review. He had married his first partner since being sentenced and had not disclosed that she had changed address. His leave was suspended, and he was remitted to prison. The Parole Board subsequently heard his case and did not direct release or recommend transfer to open conditions. D applied for reconsideration. One of the considerations was whether the decision was irrational, in part because of the conflict with the decision of the Tribunal. The application for reconsideration was refused.

When a victim makes representations to the Tribunal

AM v Greater Manchester Mental Health NHS Foundation Trust [2024] UKUT 438 (AAC)

AM was conditionally discharged and applied to the FTT seeking changes in conditions. This was specifically about exclusion zones in relation to the victim of the original offence. The application for variation in the conditions was 8 years after the offence. The application was associated with a work opportunity which would necessitate entering the exclusion zone. The victim made some representations which they requested were not disclosed to AM. The issues

were considered in the Upper Tribunal (UT). Disclosure was considered according to the likelihood of serious harm and proportionality, both of which were not adequately addressed by the FTT. The UT then addressed whether this non-disclosure had made a material difference to the outcome or fairness of the hearing. Ultimately, the judge concluded that if it could have made a difference then it was material. The judge also made clear that what is disclosed is different in terms of different people and different harms. Ultimately, the decision about the exclusion zone was not addressed but it was noted that taking up work was a relevant matter that could be considered when amending exclusion zones.

Richard Latham

March 2025

Knives and Preventable Harm: Recent Developments

By Professor John Crichton, Consultant Forensic Psychiatrist

Over the past six months, the Safer Knives Group, a small team of experts from law, trauma surgery, forensic science, and psychiatry, has intensified its advocacy for a simple but effective crime prevention measure: safer kitchen knife design. Our work has gained momentum, with significant media coverage and growing political engagement, as policymakers begin to recognise that public health approaches to knife crime must extend beyond enforcement and punishment.

The issue is stark. According to Home Office statistics, in England and Wales, over 50% of homicides involving sharp instruments are committed using kitchen knives (Office for National Statistics, 2023). This is not just an issue of organised crime or gang violence—it extends to impulsive acts of violence in domestic settings, self-harm, and suicides. Studies show that it is the sharp, pointed tip of a kitchen knife that causes the most life-threatening penetrating injuries. Removing the tip does not prevent a knife from being used in violence, but it significantly reduces its lethality (Nichols-Drew et al 2020).

A Model from Suicide Prevention

The parallels with suicide prevention strategies are striking. The most significant reduction in UK suicide rates followed an unintended consequence of a policy change: the switch from coal gas to low-toxicity natural gas in domestic supply (Clarke & Mayhew, 1988). Similarly, in Scotland, a concerted effort to reduce public knife carrying among young men led to a 69% fall in offensive weapon charges and a 50% drop in sharp instrument homicides (Crichton 2017). These successes are built on a principle well understood in forensic psychiatry: reducing access to lethal means saves lives.

A Growing Consensus on Safer Knife Design

The past few months have seen increasing political and media attention on knife design. In December 2024, we met with Dame Diana Johnson, Minister for Policing, Fire and Crime Prevention, to discuss our proposals, and we have continued to engage with policymakers.

In January 2025, Idris Elba made headlines by calling for a rethink of kitchen knife design alongside his BBC documentary Our Knife Crime Crisis (BBC, 2025). This was followed by a data-driven analysis in The Sunday Times, supporting the arguments (Calver, 2025). These interventions help to shift public perception—far from being a radical idea, safer knife designs are already available.

Viners' Assure range and other blunt-tipped knife designs have been successfully introduced, with some UK retailers beginning to stock only safer knives. Several police forces have also started quietly distributing safer kitchen knives to families where risk factors for violence are present. However, without wider systemic change, the default kitchen knife remains a potentially lethal weapon.

A Public Health Approach to Knife Crime

We advocate a multi-pronged strategy that encourages manufacturers, retailers, and policymakers to take responsibility. Key recommendations include:

· Phasing out pointed-tip kitchen knives as the industry standard, replacing them with rounded-tip alternatives.

· Introducing a pricing differential, with pointed knives subject to an additional levy to discourage their purchase.

· Stopping the sale of single kitchen knives, as these are more likely to be used impulsively. Retailers could limit sales to tamper-proof sets stored securely behind counters.

· A national scheme to modify existing knives, where supermarkets, police stations, or high-street key cutters offer a service to grind down knife tips in exchange for small incentives.

Next Steps and Future Engagement

We are working to engage major UK retailers, having already opened discussions with Timpson and the British Home Enhancement Trade Association (BHETA).

In forensic settings, these interventions have relevance not only for violence prevention but also for self-harm reduction. As forensic psychiatrists, we are all too familiar with the crossover between impulsive violence, mental health, and weapon availability. By incorporating safer knife design into violence prevention strategies, we have an opportunity to take a pragmatic, evidence-based step toward reducing preventable harm. We should also bear in mind situational risk management in our discharge planning. There is no need for a patient with a history of knife use to have pointed knives at home when there are safer alternatives.

For those interested in supporting or contributing to this initiative, please feel free to get in touch.

Safer Knives Group

The Safer Knives Group is a multidisciplinary team of experts advocating for practical measures to reduce knife-related injuries and fatalities. Our members bring expertise from law, trauma surgery, forensic science, forensic psychiatry, and public policy:

· His Honour Nic Madge – Former circuit judge, who presided over numerous serious knife crime trials and has written extensively on knife law and sentencing reform.

· Duncan Bew – Consultant major trauma surgeon at King's College Hospital, with first-hand experience of treating life-threatening injuries caused by knives.

· Leisa Nichols-Drew – Chartered forensic practitioner and Associate Professor of Forensic Biology at De Montfort University, specialising in the forensic investigation of knife-related injuries.

· Andy Slaughter MP – Chair of the Justice Select Committee in the UK Parliament, a long-time advocate for reform to reduce knife crime.

· Professor John Crichton – Consultant forensic psychiatrist, past chair of the Royal College of Psychiatrists in Scotland, with a longstanding research interest in homicide reduction.

References and Media Links

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5. Nichols-Drew L, et al. (2020). On a knife edge: A preliminary investigation of clothing damage using rounded-tip knives, Science & Justice, 60 pp 495-503,

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Obituary – Malcolm Faulk

Malcolm Faulk, fondly remembered by many as one of the pioneers in the post-Butler Report development of the specialist forensic mental health medium security hospital units, died on 13th December 2024.

Malcolm was born in 1936. He qualified in medicine at University College Hospital London in 1962. He followed this with further general medical training and an MRCP, before psychiatric training at the Maudsley Hospital 1966-1972.

In 1972, he was appointed to design and run the first Wessex Regional Secure Psychiatric Hospital Unit and clinical service for those patients with mental disorder said to be too difficult or dangerous to be managed in the increasingly liberal and open general psychiatric hospitals, but not requiring a high security hospital. The 'Interim Wessex Unit' was opened in 1977, with an accompanying community service. A larger unit was opened in 1983. The service successfully integrated with general psychiatric services, the special hospitals, courts, prisons, probation and psychiatric community services. Malcolm's resultant knowledge and experiences were incorporated in his textbook: *Basic Forensic Psychiatry* (1988).

Malcolm retired from the NHS in 1992 but remained a welcome and familiar figure at the RCPsych Forensic Psychiatry Faculty national conferences until the pandemic. He was appointed a Medical Member of HM Inspectorate of Prisons (1992-1996) and was a medical member of the Mental Health Review Tribunal 1975-2008.

Malcolm was married to Barbara Heller in 1959, who died in 1999; they had two children Harriet and Matthew, who survive him. His second wife, Chantal, an artist, also survives him. Malcolm loved music, from baroque to jazz and he played guitar, banjo and mouth organ. He was also a fine photographer and a rather successful fisherman. He continued to write until quite recently when his rather long battle with illness finally took most of his strength. He will be missed.

Mark your diary

Gaming the Mind are having their first conference, examining the intersection between mental health and videogames.

Talks will range from discussions on depictions of mental health in games, problematic gaming behaviour, and video game psychoanalysis.

Where: The Royal College of Psychiatrists London headquarters.

When: Monday 29.09.2025.

Who: Dr Henrietta Bowden Jones, Dr Stephen Kaar, Former Judge Victoria McCloud, Dr David Zendle, Dr Leon Xiao, Prof Paul Fletcher, Dr Andrew Howe, Chella Ramanan, and many more.

Please check gamingthemind.org for more information very soon.

Disclaimer: details may change.

Contributions Welcome

Thank you to the contributors of this edition.

We would welcome contributions for the next e-newsletter by Friday 29th August 2025.

If you would like to reach out to someone on the committee please do not hesitate to contact:

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The newsletter is a means to keep you informed and updated on relevant topics and the Faculty of Forensic psychiatry's work.

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