Witness Name: **Heidi Hales**

Dated: **9 September 2026**

**THE SOUTHPORT INQUIRY**

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**WITNESS STATEMENT OF DR HEIDI HALES**

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I, Dr Heidi Hales, will say as follows: -

**Introductory Matters**

1. I am a consultant psychiatrist, dual trained in adolescent and forensic psychiatry. I am on the GMC specialist register for both Child and Adolescent and Forensic psychiatry. I currently work as a consultant CAMHS and adolescent forensic psychiatrist on NWAS (North Wales Adolescent Service General Adolescent Unit), Betsi Cadwaladr University Health Board. Prior to this post, I have worked as a consultant psychiatrist in Conwy CAMHS Team (Betsi Cadwaladr University Health Board), the North West London Forensic CAMHS Team (West London NHS Trust), at HMP Holloway (female prison, CNWL NHS Trust), HMYOI Feltham and Cookham Wood (adolescent male Young Offender Institutions, CNWL NHS Trust), St Andrews Adolescent Service (in a secure ward for female adolescents, St Andrews Healthcare) and the Wells unit (secure ward for male adolescents, West London NHS Trust). I am an Honorary Senior Research Fellow with Bangor University, Honorary Senior Lecturer with Cardiff University and Visiting Honorary Professor at the University of Bristol.

2. My PhD (Institute of Psychiatry, Kings College London, 2019) investigated the impact of suicide related behaviour on young people detained in Young Offender Institutions. Since then, my research has mainly been focussed on secure care for young people and the care needs of detained young people, in the UK and internationally; I was part of the team that completed the first scoping of the secure estate for young people in England and a census of young people detained in September 2016. I co-founded and co-chair GIRAF (Group of International Researchers in Adolescent Forensics), an online transdisciplinary international research community, which now has over 140 members representing 40 jurisdictions. I am part of an international research group considering risks associated with identifying as an INCEL; my particular interest is the pathways into joining these groups. I am a past chair of the Royal College of Psychiatry Adolescent Forensic Special Interest

Group (AFPSIG) and remain on the AFPSIG executive, and am the AFPSIG representative co-opted to the Royal College of Psychiatry Forensic Faculty. I have been a visiting expert for the European Committee for the Prevention of Torture inspection in 2024 and due to join another this year. I have prepared many expert court reports about adolescents and adults (male and female) for the criminal courts, regarding fitness to plead, psychiatric defences and disposal issues. I have also prepared reports on children and parents for the family courts.

**3.** This witness statement is made to assist the Southport Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 5 August 2025.

**4.** To note, I have not used the term 'Violence Fixated Individuals (VFI)' in my clinical or research practice. However, I am familiar with assessing children, young people and adults for whom there are concerns about the risk they pose to others. Part of these assessments includes identifying whether the risk to others is due to a specific ideology and/or other vulnerabilities including mental disorder, neurodevelopmental disorder (NDD), emotional health needs and/or impact of childhood trauma. I have used the terminology of risk, considering risk to self, risk of violence to others, risk of sexually harmful behaviour to others, risk of absconding, risk from others etc. In my opinion, whilst professionals could work together to formulate a term (such as VFI) and its definition, ideologies and identities of young people are currently changing at such a speed that definitions become outdated quickly. More important are *formulations* around risk behaviours; which consider the what, who, why, where and when of any risk behaviour, alongside a narrative of any escalation and trigger factors to enable us to consider the individual and their particular needs.

**The Mental Health Act 1983 and other legal powers**

**5.** A Mental Health Act assessment can be requested for people in the community where there are concerns about their mental health, such that their mental disorder places them at risk to their own health and safety, at risk of harm to self or of harm to others. In my experience the request is likely to arise after concerns have been raised with the community mental health team, or a person has presented to A&E, has become unwell in hospital, or has been detained by the police pursuant to Section 136 of The Mental Health Act. The Mental Health Act assessment is arranged by the local Mental Health Act office, requiring an in-person assessment by two doctors (one being Mental Health Act Section 12 approved) and an approved mental health professional (AMHP). If there are concerns

about the risk this person may pose to others, police can be asked to support the assessment.

**6.** The current threshold for detention under The Mental Health Act is that a person must be considered (1) to be suffering a mental disorder, (2) to be a risk to themselves, to their health and safety and/or to others, (3) to have risks that cannot be managed in the community and (4) do not consent to assessment or treatment in hospital. Detention under Section 2 enables admission for 28 days for assessment, and under Section 3 for 6 months for treatment. To be detained under Section 3, the 'treatability' clause must also be satisfied, such that treatment needs to be available. Much has been argued, legally, about what 'treatment' is. It is my understanding that this includes medication, therapy and nursing care, to improve the person's mental state and / or prevent deterioration. The 2025 amendments introduce the concept of 'appropriate treatment' for the person's disorder.

**7.** When considering a person's need for ongoing treatment, the current Mental Health Act (1983 as amended 2007) requires consideration of the nature and degree of the mental disorder. Thus, a person may have had treatment leading to improvement but still require further hospital admission to assess whether the improvement is sustained or to enable gradual 'testing' of community leave to assess compliance with treatment or whether risk behaviours return. The 2025 amendments include 'likelihood' such that the nature, degree and likelihood of harm need to be considered.

**8.** Currently, a person with autism or learning disability can be detained under the Mental Health Act 1983 as amended 2007, if this is associated with 'abnormally aggressive or seriously irresponsible behaviour'. However, it is my understanding that current practice, after the serious incidents at the Winterbourne hospital, is to try to avoid hospital admission for those with Neuro Developmental Disorder (NDD; for these purposes, autism or learning disability) because the hospital environment may cause a deterioration in their behaviour, leading to increased risk to themselves and others, such that they become too unsettled for discharge. This is understood as the fact of medical admission causing them iatrogenic harm. Furthermore, the serious incidents in Winterbourne hospital highlighted the vulnerability of this group of people to abuses from institutional carers. Current understanding of behavioural disturbance in those with NDD is that it can be managed with modifications to their environment, once the triggers have been analysed and understood. Therefore, a code of practice has developed to try to support this group of

people in the community with a specialist care package, which may include community mental health input. This does not mean that risk should not be assessed or managed, but that the multiagency team around the person should first consider whether a community package could support the person by reducing environmental triggers. In England, these multiagency discussions are held within Care (Education) and Treatment Reviews (CETR). Attempts are also made to pre-empt any crises, in England by having regular multiagency meetings to discuss the 'Dynamic Risk Register' of people with NDD at risk of placement breakdown and risk behaviours. Though CETRs and Dynamic Risk Register meetings do not happen in Wales, the principle of avoiding admission for those with NDD because of the potential harms caused, stands.

**9.** The 2025 amendments to The Mental Health Act in England and Wales specify that those with NDD (specifically here, Autism and Learning Disability) cannot be detained under civil sections (Part 2 of the Act, Section 2 for assessment and Section 3 for treatment) unless there is a co-occurring psychiatric disorder, but allows for those involved with the criminal justice system to be detained in hospital under Section within Part 3 of the Act as before. Furthermore, the amendments make the C(E)TR and Dynamic Risk Registers a statutory requirement in England. These changes legislate for current recommended practice within psychiatry but have raised concerns from those working in social care about care management for young people with these needs who are displaying risk behaviours.

**10.** Therefore, currently, a Mental Health Act assessment can be requested to facilitate assessment and discussion of need for Violent Fixated Individuals who have isolated themselves and disengaged from services. The 2025 amendments may prevent such assessments for those with NDD.

**11.** Risk needs to be assessed and managed. To note, it is important that, prior to requesting any formal Mental Health Act assessment, all efforts are explored to engage with the person and their carers in other assessments and interventions. This can be very difficult and takes time that services often do not have. Those who have disengaged from services often feel judged, misheard, stigmatised and misunderstood, and therefore trust needs to be earned by professionals seeking to engage them; this process is described in the literature about 'Epistemic Trust'. If the person and/ or their carers are unable / unwilling to come to clinics, then home visits may help with engagement. As it takes time to build up a therapeutic relationship, it may take many home visits over a protracted length of time to reassure the person and/or their carers that the professional is available, reliable and

there to support in the longer term. Furthermore, it is important to listen to and hear their narrative, in order to understand what their experience has been. The more a person and/or their carers feel heard, the more they are likely to engage with assessment, support and intervention. It is my opinion that this intervention is best provided by a multiagency team around the person, in which the team can consider the most appropriate team member to reach out to the person and/ or their carers, and the multiagency network then meet regularly to support the person offering face to face input.

**12.** In my opinion, the current legislative framework is sufficient to enable assessment for those with a mental disorder and risk behaviours who need mental health services to be the lead agency for managing their care and risk management plan. However, not all Violent Fixated Individuals have mental disorders as defined by the Mental Health Act, though they may have emotional, mental health and / or NeuroDevelopmental needs that would benefit from input from mental health services as part of a multiagency network. Their care is likely to be better supported through another lead agency, and those agencies have legislative frameworks in place that can support such assessment and intervention, including the Children Act and the criminal justice system. For example, if a young person is placed under a DOLs order, community mental health services can offer support to the network and ongoing community assessments and reviews in the young person's placement. Concerns have been raised about the availability of regulated placements for young people on DOLs orders. From my experience, most important to the young person's safe care, is the staff group around them. Therefore, it is my opinion that regulating the care staff and their training and support is the most important aspect of regulation of the care package.

**13.** I would be concerned about broadening legislation to enforce mental health assessment under this framework. It would inevitably lead to requests for mental health teams to be the lead agency in situations in which the risk mitigation would be more effectively lead by other agencies (eg when focussing on changes in the person's environment or community care rather than mental health treatment *per se)*. This would lead to mental health services becoming 'change preventers' as a result of other agencies relying on mental health interventions to monitor, manage and reduce the risk when difficulties with the person engaging may prevent this from being effective. What is needed is a multiagency approach, with each agency offering support and interventions within their system of care.

***Multiagency working and risk management with young people***

**14.** My clinical experience has included me supporting community CAMHS workers, social care and youth justice services to enable them to offer community or secure welfare or justice care to young people. Whilst there has at times been tension between services - with disagreements about funding and risk holding needing to be managed - when the teams have worked together, nominating a lead agency and meeting regularly, I have witnessed effective risk management plans that have kept the young person and others safe.

**15.** This form of care is expensive. Local Authorities require adequate resources to be able to provide regulated placements when needed, and other services need sufficient resources to support multiagency working. Often difficulties arise in planning care because of discussions around shared funding. It may be that creating regional multiagency teams to support young people who are considered to be High Risk / High Harm, with its own specific funding, would avoid these arguments. Such teams would need clearly defined exclusion and inclusion criteria and resources to care for those fulfilling the inclusion criteria.

**16.** Considering NDD is part of any mental health assessment. However, as most health services have now separated NDD clinics from CAMHS clinics, assessments are often not routinely offered within CAMHS; instead, referrals to NDD clinics are recommended if NDD is suspected. We know that referrals for NDD assessments have substantially increased in number since COVID and risk behaviours in a subgroup of those with NDD have also increased, particularly in respect of violence in the home. We have found this in our service evaluation of referrals to the North West London FCAMHS team (paper currently being prepared for journal submission). This is the paper which has been submitted and is HH/05 - **DHH000006** ).

**17.** I note the concerns raised in the phase 1 report that risks were reported to have been minimised due to suspected NDD. Whilst not all those with NDD are high risk, those who show risk behaviours with NDD need their risk to be understood within the context of their NDD rather than minimised. Those with NDD and risk behaviours have often also experienced childhood traumas. A neurodevelopmental profile and functional analysis of behaviour can help to understand the function of the risk behaviours within this context, in order to then inform an individualised risk management plan. In practice this means that where there is concern about risks, in this case risk to others, a formulation is made about

the what, who, where, when and why, considering the triggers and the function of the behaviour. This will include considering whether there is any NDD, trauma, mental disorder, personality disorder or any other factors contributing to the risks. Once a formulation has been completed, the multiagency team can work together to plan interventions to reduce that risk. This may include care plans focussed around reducing triggers associated with NDD (for example sensory sensitivities) alongside those associated with traumas or mental disorders. The aim is to develop a systematic framework to understand the risk, including precipitating, trigger and / or perpetuating factors within the person themselves, their family system, their work / school, and their wider community / environment.

**Risk assessment and management of VFIs**

**18.** There is currently no single validated risk assessment tool available to use with a young person who has no history of violence but is ruminating on violence. There are several risk assessment tools available to assess risk in individuals - some for adolescents and other for adults. I will focus on those available to assess young people. Risk assessments can be actuarial (counting positive answers to set questions); the difficulty with these is that they create static risk ratings because of the need to include historical and demographic items what do not change. Subjective clinician risk ratings are not helpful because they are - by their nature - subjective. Therefore, the preference has been for Structured Professional Judgements (SPJ), such at the SAVRY for young people and HCR-20 for adults. They highlight factors identified in research, that increase the level of risk. They aid a professional to formulate the risk of a young person and to identify areas in which support and intervention can be focussed. The SAVRY is the standard SPJ risk assessment tool to use with young people when assessing risk of violence (see - Pendlebury, G., Anderson, J., **Hales, H.,** Harding, D. & Lewis, A. (2023) Violent behaviour in adolescents: assessment and formulation using a structured risk assessment tool. *BJPsych Advances* - HH/01 - **DHH000002** ). There are also the START-AV (to facilitate consideration of changes of risk) and the SAPROF (to identify positive factors reducing risk) developed by the same team.

**19.** These tools have been developed to focus on risk in those with conduct disorder and antisocial behaviour, who have a history of violent behaviour that is gradually increasing. However, the difficulty in using them to assess risk in VFI, particularly those with NDD, is that they are not so helpful when assessing risk in someone who has no history of any

violent or offending behaviour. In these cases, the FARAS (Forensic Assessment of Risk in Autism Spectrum) can be a helpful adjunct to highlight other areas to consider.

**20.** It is important to recognise that the reliability of predicting risk increases the higher the prevalence of that form of risk-taking behaviour in the community. The risks associated with VFI's are high in harm but remain low in prevalence. As a consequence, using these tools may result in many young people being assessed to be high risk, despite the fact that the low level of prevalence shows us that few will actually develop high harm behaviour. Furthermore, for young people - many of whom are vulnerable - who are developing their identity and view of how they fit into the world, the way we (carers, services, people in authority) interact with them will itself impact upon their future risk. If we stigmatise and isolate them as a result of our concerns of their risk, we may inadvertently *increase* their risk. Therefore, it is essential that our response to risk rating needs to be carefully measured and the subsequent intervention to work towards rehabilitation and support, focussing on enabling the young person to find their positive place in society.

**21.** With those caveats in mind, where there is concern about risk, it is my practice to consider completing an SPJ focussing on the particular risk(s) of concern (violence, sexually harmful behaviour, fire setting etc). In my experience, good clinicians in local services can complete good assessments of young people, and reports from social care, CAMHS and Youth Justice teams contain much of the information that is needed to complete these assessments. Therefore, utilising these risk assessment tools within a multiagency professionals network is likely to be much more helpful than one service completing it alone and sending it to be filed away in a young person's notes. The multiagency discussions should lead to a multiagency SMART care plan / goal setting process in which the team around the young person considers who / which team is best placed to offer which interventions. Joint working across services is also very useful.

**22.** It is my opinion that the appropriate lead agency to manage the management plan should be a function of the predominant need identified from the young person's neurodevelopmental profile, functional analysis of behaviour and risk formulation – again noting that managing the risk of VFIs should be with the support of a multiagency network meeting regularly to review the risk and support plan.

**23.** I understand that there is consideration being given to whether a new risk assessment tool that can be used by all in the public sector can be developed. In my opinion, creating a risk assessment tool for all to use is likely to reduce the function, specificity and sensitivity of the tool: to be accessible to all professionals, it would have to avoid requiring particular expertise. Psychiatry and psychology bring an understanding of mental and emotional health difficulties and NDD into their risk assessment, including impact of trauma and attachment needs. Social care professionals are more aware of family dynamics, needs and local availability of support services whilst education consider the young person's cognitive abilities and youth justice know past history and risk of reoffending. Rather than developing a single tool for all, what is required is a tool that has elements for different disciplines to complete. This will support multiagency working and thinking. Most notably, often VFI do not hit threshold for any particular service but would benefit from all. If professional disciplines work in silos, there is a risk that VFI will be missed.

***Forensic CAMHS dual training***

**24.** Risk assessment tools, such at the SAVRY, have their own training modules that can be completed by all professionals. However, an understanding of and training in risk behaviours generally will enable the professional to understand the training and therefore to better utilise the risk assessment tool. Within psychiatry there is the option of forensic psychiatry training alongside Child and Adolescent training to provide a dual training in adolescent forensic. This was popular 20 years ago but availability has declined and there are few dual trained (forensic and CAMHS) psychiatrists working in forensic CAMHS. This is an area of debate amongst psychiatrists and there are differing opinions about how important this dual training is. The CAMHS faculty of the Royal College of Psychiatry reinforces that it is very important that professionals working with young people are specifically trained in CAMHS, to understand their developmental needs. I agree with this, and note that those trained in CAMHS are likely to have a greater understanding of neurodiversity than those trained in adult psychiatry. However, the forensic specialist training appears to be considered less essential, and knowledge and experience are otherwise developed through special interest sessions during Specialist training and whilst settling into a consultant post.

**25.** As someone who is dual trained, it is my opinion that my forensic psychiatry training has enabled me to be much more aware of risk assessment and risk management, and so my recommendation has always been to facilitate dual training. However, this takes time.

There are 2-3 dual training posts in England, which take 5 years to complete, instead of the usual 3 years for a single psychiatry speciality. Consequently, it is not currently popular with trainees because it takes them longer to become a consultant. It is also not popular with psychiatry specialist training programmes, because the psychiatry 'training numbers' in specialist training (ST4-6 grades) are allocated either to forensic psychiatry or CAMHS psychiatry and therefore when a specialist trainee is allocated a forensic 'training number' but needs to be placed in CAMHS for 2 years training, there is one less forensic trainee for the forensic training posts, and vice versa.

**26.** As our knowledge about the impact of isolation and trauma and NDD on the development of violence risk increases, our training will need to be refined to ensure that those working in adolescent forensic services are fully trained in this area. Peer mentoring and case based discussions amongst professionals are useful fora to develop thinking in this area. We also need clinical academics working alongside theoretical academics to transform theory into practice and to consider what works for whom.

***Working with VFI's***

**27.** When working with young people considered to be high risk, including those considered to be VFI, it is my opinion that multiagency working is essential. Following completion of risk formulations and identification of needs and areas in which intervention is required, a lead agency must always be identified and a lead worker named. The most appropriate lead agency will be a function of the agency and worker most experienced in that area of work. As there is a risk that other agencies may step down, it may be helpful to name secondary agencies that need to remain involved. FCAMHS does not, historically, case hold but has a role in supporting other agencies. If there was a drive for FCAMHS to become caseholders, this would require a review of their service specifications and resource allocation. CAMHS can be a lead agency for those where their risk is specific to a mental health disorder (such as depression, mania or psychosis). For those with NDD, the named agency will depend upon the needs identified as noted above. I note that Youth Justice services often have an important role but they often have time limited involvement due to the length of a community order; therefore, if they are to become lead agencies in such work, a preventative arm of youth justice will be needed. Similarly, whilst education also have an important role, when a child is excluded from school their input comes to an end which can impact upon care planning.

**28.** It is my experience that thresholds for acceptance for referral, intervention, risk assessment and placement are different across Boroughs and Counties. As all teams (CAMHS, FCAMHS, social care, Youth Justice) are now local or regional, this is unsurprising. Whilst there are guidelines, these are open to interpretation and, in my experience, decisions often depend upon local resources and local values. Some areas/teams are very risk averse and therefore complete risk assessments and risk management plans that are very restrictive, whereas others may be more concerned about criminalising a child. None of this is useful or helpful in preventing risk behaviours. Again, multiagency discussion and shared thinking can help ensure that care plans are well thought-through and balanced.

**29.** There are many local meetings to discuss young people at risk, including MASH, MAPPA, Child at Risk (of Exploitation) panels and the Dynamic Risk Register. In my opinion, where there are concerns that a child may be a VFI, they should be included in discussions in a Child at Risk Panel. This may be part of a MASH and/or MAPPA panel. However in my experience, the threshold for discussing individuals in a MASH or MAPPA panel are higher than that for a well-functioning Child at Risk panel and being able to discuss concerns about young people who are worrying but not yet a high risk enables preventative multiagency working to start earlier for the young person. I note that I have attended multiagency meeting with various ways of managing referrals and agendas. Those that I found most helpful had space to consider new referrals into the panel, for a longer period of time initially, and then time to review those who had previously been discussed each month to monitor their progress.

**30.** I recommend that resources are allocated to enable representatives from CAMHS or FCAMHS to join each of these multiagency meetings in every locality, alongside representatives of social care, youth justice, education, housing and appropriate local 3rd sector groups (notably, housing is often not included but environmental risk with regards to peer influences is often an important consideration). Input from all agencies and different professional disciplines is useful as we all look at risks and risk interventions with different perspectives. Psychiatrists can offer an understanding of the impact and treatment of mental disorder, personality disorder, neurodevelopmental disorder and traumatic experiences, support preparations of structured professional judgement risk assessments and develop risk mitigation care plans with the multidisciplinary, multiagency team.

**31.** When I was working in a London FCAMHS service (2018-2023), we allocated one team member to each Borough to join these meetings. In Boroughs where this and multiagency input was welcomed, my experience was that we could share concerns about risk at an early stage, and consider early intervention and prevention strategies. Where multiagency input is made statutory, thresholds for including a young person for discussion and level of input from each agency will need to be very clearly specified to prevent the local interpretation of guidelines that often currently happens. Furthermore, attending meetings does take time and removes time allocated to direct working; therefore this needs to be taken into account within central resource allocation for such work.

**32.** With regards to evidence-based interventions, there is currently a real lack of research outcomes nationally and internationally. Nationally, the Anna Freud centre lead on evaluations of various models of care and interventions. I have had good experience of working with the AMBIT model (designed and training given by the Anna Freud centre) to aid multiagency collaboration. I have also had positive experiences when I have worked with young people offered Multisystemic therapy; the early national evaluation by the Anna Freud found it to be less helpful but where the intervention is embedded there are more positive outcomes. I understand that MBT therapy is currently being evaluated within FCAMHS and will be interested to hear the outcomes. The Good Lives model, developed in Manchester, has been a good model for interventions in Sexually Harmful Behaviour and may be a useful tool for VFI as it avoids direct conflict about current actions and focusses instead on future hopes.

**33.** In my opinion, prevention is of central importance. Providing young people with opportunities to develop their skills in education and prosocial activities may distract them from negative fixations. Evaluations of the previous Sure START model showed this to have good preventative and early intervention outcomes. I would also encourage further consideration of the role of education, including the consideration of the harms of exclusion and the need for assessment and support plans to avoid exclusion where possible.

**34.** Developing further clinical academic posts in this area would enable integration of theoretical frameworks with interventions at a service and individual level. There are also studies of interventions in other countries though these are often difficult to translate into local services. GIRAF (Group of International Researchers in Adolescent Forensics – an international transdisciplinary online research community in this area) is developing studies to compare interventions across jurisdictions in naturalistic studies to identify what

works for whom. To enable this, we first need to compare systems and processes. This is underway. EFCAP (European Forensic Child and Adolescent Psychiatry, Psychology and other professionals) is also a useful group which holds a conference every other year to show case research in this area.

***Information sharing***

**35.** Multiagency working requires good information sharing. I note the comments about issues of consent to joint working and information sharing in the Phase 1 report. Professional opinion and practice about when information can be shared and when consent is needed varies. As examples, referrals to FCAMHS requires consent from the young person and their carer and information is shared with the GP, whereas referral to the Youth Justice Liaison and Diversion service does not need consent but information sharing with the GP is limited to where there are active concerns. In my experience, social care often offer support to young people who may be VFI at the Child in Need or CASP level rather than within a child protection framework, making them reliant upon engagement and consent. Counter Terrorism is the one area in which there is a statutory duty to share information.

**36.** Furthermore, I note the comments in the Phase 1 report raising concerns about the veracity of information given by parents /carers and withholding of consent. In my experience, parents and carers are often placed in an invidious position of being frightened of their child but wanting to enable them to get the best support possible, especially in accessing education. I have also heard many parents express how they have felt judged and stigmatised themselves, leading to them disengaging and mistrusting services. We therefore have to be aware that, whilst seeking information from parents / carers, it is important to note that they may minimise the risk behaviour

**37.** This, however, demonstrates the importance of working hard to engage parents / carers proactively and repeatedly reaching out to them: validating their experiences, fears and concerns without judgement. In my experience, when parents have felt heard, they become more engaged and are likely to be more truthful about the risk as a consequence.

**38.** Where there are concerns about risk, information sharing and multiagency working is essential, even if consent is withheld. We should always seek consent, but when working with young people and their families, must always be clear that information will be shared where there are concerns about risk.

## Improvements

**39.** I refer to the matters I have raised above, specifically in relation to multiagency working, training and clinical excellence, and future research.

## Other matters

**40.** The North West London FCAMHS team have published 3 academic papers describing:

40.1. The experiences of black and dual heritage young people referred to the service compared to their white peers (HH/02 - **DHH000003**)

40.2. The needs of those with ADHD who were referred to the service and considering missed opportunities for earlier intervention and support (HH/03 - **DHH000004**)

40.3. The needs of those with Autism who were referred to the service and considering missed opportunities for earlier intervention and support (HH/04 - **DHH000005**)

**41.** The North West London have also just submitted a fourth academic paper describing a service evaluation completed over 5.5 years (2018-2024) reviewing the referrals and activity of the service and how it has changed over the last 5 years (HH/05 - **DHH000006**)

**42.** I have also included in the exhibits list a systematic literature review we completed, reviewing papers that had been published which investigated the mental state of perpetrators of mass murder / homicide and suicide. This includes a subsection of perpetrators who completed mass shootings at schools, identifying some risk factors specific to this cohort of young people (HH/06 - **DHH000007**).

**43.** I would be happy to provide the Inquiry with some case studies on a confidential, redacted basis should this be seen to be helpful, with appropriate approvals.

## Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings many 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 in its truth.

**Exhibits**

| Exhibit Number | Inquiry Reference Number | Document Description |
|---|---|---|
| 1 | HH/01 - **DHH000002** | Published journal article – describing risk assessments in young people with risk of violent behaviour to others –<br><br>Pendlebury, G., Anderson, J., **Hales, H.,** Harding, D. & Lewis, A. (2023) Violent behaviour in adolescents: assessment and formulation using a structured risk assessment tool. *BJPsych Advances* https://doi.org/10.1192/bja.2023.13 |
| 2 | HH/02 - **DHH000003** | Published journal article – describing the different experiences of black and dual heritage young people referred to North West London FCAMHS compared to their white peers<br><br>Sandiford, M., Smith, J., Moran, D., **Hales, H.** (2024) Quantifying the Experiences of Black and Dual Heritage Young People in a Forensic CAMHS Service. BJPsych Bulletin. 1-9. Quantifying the experiences of Black and Dual Heritage young people in a forensic child and adolescent mental health service \| BJPsych Bulletin \| Cambridge Core |
| 3 | HH/03 - **DHH000004** | Published journal article – describing the needs of those with ADHD who were referred to North West London FCAMHS and considering missed opportunities for earlier intervention and support.<br><br>Ross-Michaelides, R., **Hales, H.,** Smith J, Sandiford, M., Sri, A. & Moran, D. (2024) Missed opportunities to prevent risk of offending in young people – a service evaluation from a central London FCAMHS service. The Journal of |

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| | | Forensic Psychiatry and Psychology, 1-19. https://doi.org/10.1080/14789949.2024.2387719 |
| 4 | HH/04 - **DHH000005** | Published journal article – describing the needs of those with Autism who were referred to North West London FCAMHS and considering the missed opportunities for earlier intervention and support<br><br>Sri, A., Smith, J., Sandiford, M., Moran, D., Ross-Michaelides, B., Benn, C., Curtis, E. & **Hales, H.** (2025) Lost opportunities for young people with ASC under early intervention: A service evaluation from a central London FCAMHS service. Research in Autism Spectrum Disorders. 124. Lost opportunities for young people with ASC under early intervention: A service evaluation from a central London Forensic CAMHS service - ScienceDirect |
| 5 | HH/05 - **DHH000006** | Submitted journal article describing the clinical activity of North West London FCAMHS from 2018 to 2024 and changes of use over the first 5 years.<br><br>**Hales, H.,** Shanmugam, A., Moran, D., Sandiford, M. & Smith, J. Use and changes of use of a Community FCAMHS services over 5 years; from inception, through Covid and beyond. *Submitted 09 09 2026 to BJPsych Bulletin* |
| 6 | HH/06 - **DHH000007** | Published systematic literature review article reviewing academic papers considering the mental state of people who perpetrate mass murder before killing themselves. In this, we reviewed some papers describing the mental health of perpetrators of mass shootings in schools, identifying specific risk factors.<br><br>Theodorou, A., Sinclair, H., Ali, S., Sukhwal, S., Bassett, C., & **Hales, H.** (2024). A systematic review of literature on homicide followed by suicide and mental state of perpetrators. |

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| | | Criminal Behaviour & Mental Health, 1–43. https://doi.org/10.1002/cbm.2322 |

Signed:__SIGNATURE__Dr Heidi J Hales_____

Dated:_09 09 2026_____