
**OPENING STATEMENT TO THE NOTTINGHAM INQUIRY
ON BEHALF OF NHS ENGLAND**

Introduction

1. This is the Opening Statement of NHS England to the Nottingham Public Inquiry. NHS England is the national body responsible, in England, for arranging for the strategic provision and co-ordination of health care services in England, and oversight of local commissioners and providers of those health care services.¹ It also provides leadership and operational guidance to NHS organisations in England. It works closely with the Department for Health and Social Care (DHSC); DHSC is responsible for its oversight, as well as the setting of strategic direction and oversight for the NHS and the securing of resources for it. More details of the role of NHS England are set out below.

2. At the outset of the hearings in this Inquiry, NHS England wishes to extend its deepest sympathies to the family and friends of Grace O'Malley-Kumar, Barney Webber and Ian Coates, and to Wayne Birkett, Marcin Gawronski, Sharon Miller and their families. Dr. Jessica Sokolov acknowledged in an NHS England press release on 5 February 2025 that *"It's clear the system got it wrong, including the NHS, and the consequences of when this happens can be devastating... This is not acceptable, and I unreservedly apologise to the families of victims on behalf of the NHS and the organisations involved in delivering care to Valdo Calocane before this incident took place."* NHS England has read with care the statements that have been provided by those so tragically affected by the events of 13 June 2023. The need, so clearly expressed, for answers, for transparency and accountability, is understood. NHS England is committed to helping this Inquiry answer the questions raised about these events, about their causes and what has happened since, to understand and learn from these matters. This will include scrutiny and candid assessment to learn from mental health-related homicides.

¹ See in particular s1H of the National Health Service Act 2006.

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3. NHS England's participation in the Inquiry will be aimed at furthering understanding, learning lessons and achieving improvements, to the best of its ability.
 4. At present, NHS England has provided a large volume of general disclosure, as well as responding to several witness statement requests from the Inquiry. It has filed: (1) a Corporate Witness Statement (CWS) signed by Dale Bywater dated 8 December 2025,² as well as further statements from (2) Dr. Jessica Sokolov, Medical Director for NHS England Midlands Region;³ (3) Dr. Adrian James, National Medical Director for Mental Health and Neurodiversity;⁴ and (4) Professor Tim Kendall, National Clinical Lead for New Models of Mental Health in England.⁵ The contents of those statements reflect the issues which NHS England has, to date, been asked to address.

Outline of Contents

5. This written Opening covers the following matters:
 - a. The structure, role and remit of NHS England in the NHS in England;
 - b. NHS England's role in policy, guidance and oversight of mental health services, including some observations on the development of mental health systems that may be of interest to this Inquiry;
 - c. NHS England's involvement in the oversight of Nottinghamshire Healthcare NHS Foundation Trust (NHFT);
 - d. Patient safety and patient safety investigations, including independent mental health homicide investigations;
 - e. NHS England's role in relation to the events of 13 June 2023, including:
 - i. The commissioning of the Theemis Report;

² [WITN0310001]

³ [WITN0364001], dated 19 December 2025.

⁴ [WITN0365001], dated 19 January 2026.

⁵ [WITN0076001], dated 11 November 2025.

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- ii. Principles relating to report publication; and
 - iii. Learning from the Theemis report and other investigations of the events of 13 June 2023, and the implementation of recommendations.

NHS England – role and remit

6. The CWS of NHS England⁶ (and also that of William Vineall on behalf of the DHSC)⁷ set out, in some detail, the role and remit of NHS England and its place in the NHS ecosystem. We do not repeat the contents of either statement; but we hope it is helpful to set out in this Opening, in more summary form, the role and responsibilities of NHS England, tailored to the focus of the Inquiry.
7. We have described the system as it exists at present in our CWS and below. The Inquiry will of course be aware that on 13 March 2025, the Secretary of State for Health and Social Care (the Secretary of State) announced the abolition of NHS England, with its central functions to be assumed by the DHSC. Legislation is planned to legally transfer NHS England's functions into the DHSC from April 2027. In the meantime, NHS England is working closely with the DHSC and there is now, for example, a single integrated management structure.⁸ However, in legal terms, the framework of responsibilities and accountabilities established by – in particular – the National Health Service Act 2006 (the 2006 Act) remains in place. NHS England's role as a Core Participant in the Inquiry reflects that current reality and its legal responsibilities.
8. Returning to the broader position of the NHS, it is important to recognise that the NHS in England is not one organisation. It is an ecosystem of commissioners, regulators and service providers each with their own distinct role. It includes important groups of independent contractors, such as General Practitioners.
9. At the highest level, the Secretary of State is responsible for continuing “the promotion in England of a comprehensive health service”; acting to secure

⁶ [WITN0310001]

⁷ [WITN0155001]

⁸ [WITN0155001] at paras 31, 105.

resources for the NHS and setting the strategic direction and priorities. The Secretary of State is accountable to Parliament for the operation of the bodies that make up the NHS.⁹

10. NHS England shares the duty to “continue the promotion in England of a comprehensive health service”,¹⁰ a duty which extends to seeking to improve both physical and mental health, with the Secretary of State. NHS England discharges its duty by, in particular, the co-ordination of the provision of healthcare services in England and the oversight of local commissioners (Integrated Care Boards or ICBs) and providers (Trusts and others) of those health care services. In so far as is of key relevance to this Inquiry, NHS England’s role includes:¹¹
 - a. Implementing national policy and strategy and determining NHS priorities, subject to the annual mandate provided by the Secretary of State. The mandate sets out objectives that NHS England should seek to achieve in the exercise of its functions¹² and is a mechanism by which the Secretary of State sets NHS England’s strategic direction;
 - b. Ensuring accountability and enabling improvement by: defining accountability structures, setting standards for performance, supporting challenged organisations and, when required, instigating regulatory intervention and recovery support;
 - c. Mobilising expert networks by: bringing together expert knowledge to support service improvement, supporting the delivery of improved outcomes and providing (for example) benchmarks for services by drawing on the help and expertise of clinicians. See, for example, the role of Professor Kendall (National Clinical Lead for New Models of Mental Health in England), programmes such as Getting It Right First (GIRFT) and the document

⁹ See 2006 Act, which sets out the central statutory duties and responsibilities of the Secretary of State and NHS England, including at section 1(3) (ministerial responsibility) and section 1H (NHS England and its general functions) in particular.

¹⁰ Section 1H(2) 2006 Act.

¹¹ The full list is at paragraph 28 of the NHS England CWS. The current Operating framework for NHS England is at [NHSE0000378].

¹² See section 13A 2006 Act.

'Guidance to Integrated Care Boards on Intensive and Assertive Community Mental Health Care' which was developed with the support of an expert advisory group.

11. NHS England is not:
 - a. a core political or governmental decision-making body;
 - b. responsible for setting national health or public health policy;
 - c. responsible for commissioning the majority of services, with ICBs commissioning most services locally;
 - d. a provider of patient services; or
 - e. an inspector of clinical services (the Care Quality Commission (CQC) undertakes this role).

12. NHS England has a limited role in disseminating clinical information and recommending best clinical practice, this being primarily the role of other bodies. The National Institute for Health and Care Excellence (NICE) is responsible for issuing guidance on the diagnosis, treatment and management of diseases and other conditions. In addition, the professions' Royal Colleges, regulatory bodies such as the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC), and many professional societies publish clinical and professional guidance for use across the system. Providers are then required to ensure that their services meet relevant legislation and guidelines.

NHS England – role in policy, guidance and oversight of mental health services

13. In line with its role as set out above, in respect of mental health services, NHS England:
 - a. Publishes mental health service strategy documents and implementation documents. The strategy is driven by government policy and the annual mandate from the Secretary of State;

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- b. Publishes guidance documents in specific areas to do with the implementation of mental health services, in line with the strategy;
 - c. Directly commissions some specialised mental health services, including secure psychiatric hospitals. As none of these services were used by VC prior to 13 June 2023, they are not directly addressed in this Opening Statement.¹³

Guidance documents - Mental Health strategy

- 14. As part of its role in leading and overseeing national policy for the commissioning and delivery of all NHS services across England, NHS England publishes overarching policy and guidance documents that are relevant to all NHS services across England, as well as service models and other support that local providers and commissioners can use.
- 15. NHS England's mental health strategy has been set out in a series of key publications, whose purpose and scope were set out in the CWS; see for example the 'Five Year Forward View for Mental Health' [NHSE0000002] (2016) together with its implementation plan [NHSE0000003]; the NHS Long Term Plan [NHSE0000014], [NHSE0000013] (2019); and the Community Mental Health Framework [NHSE0000015] (2019). There has been a consistent ambition to improve community mental health services, including the strengthening of Early Intervention in Psychosis services and the provision of more integrated services for people with mental health needs in the community. There has also been a focus on securing adequate financing for mental health services, with plans for additional funding and staffing. Reviews, such as that of adult crisis and acute mental health services (including of Early Intervention in Psychosis services) in "The Mental Health Adult Crisis and Acute Care Report" (April 2021) [NHSE0000223] have sought to identify progress, challenges, and improvement priorities.

¹³ Save insofar as concerns about Rampton Hospital formed part of the reasons for the heightened oversight of NHFT – this issue has been briefly summarised in this Opening Statement.

Early Intervention in Psychosis services

16. NICE defines Early Intervention in Psychosis services as “*care for adults with a first episode of psychosis during the first 3 years of psychotic illness. However, this may be extended if the person has not made a stable recovery from psychosis or schizophrenia*” [NHSE0000538]. Access to and waiting time standards have been in place since April 2016. Early Intervention in Psychosis services are multidisciplinary community services intended to provide the full range of pharmacological, psychological, social, occupational and educational interventions for people with psychosis.
17. NHS England published guidance on implementing the Early Intervention in Psychosis access and waiting time standards in 2016 [NHSE0000315] and February 2023 [NHSE000032].

Assertive Outreach

18. Assertive Outreach Teams (AOTs) are part of secondary mental health services and are usually attached to the community mental health team. They work with people who are 18 to 65 years old with particularly complex needs and who need more intensive treatment and engagement.
19. Assertive Outreach Teams were first introduced by the National Service Framework for Mental Health in 1999, and the NHS Plan in 2000 set out to deliver 220 assertive outreach teams by 2003 (this target was met). This framework was never ‘decommissioned’.
20. However, NHS funding challenges from 2010 and questions about the efficacy of Assertive Outreach Teams through research led to some commissioners disinvesting in these services, at a time where there was no national policy framework for mental health. A few areas, however, retained them (including the NHFT), until 2019 when a new model was implemented,¹⁴ and there is current variation nationwide as to whether areas have a dedicated team, a dedicated

¹⁴ See [WITN0223001] para 75, which explains that there was dedicated AOT provision until 2019. During 2019, NHFT implemented a revised operating model by amalgamating its AOT team into its Local Mental Health Team “in line with national policy direction at the time”.

function within their community mental health services (including Early Intervention in Psychosis teams and forensic outreach teams), or no Assertive Outreach function.

21. Providers have always been expected to follow the applicable NICE guidelines relating to intensive case management for people with psychosis or schizophrenia who are likely to disengage from treatment or services. NICE guidelines do not stipulate a specific team format required to deliver intensive case management.
22. Dr. Adrian James (National Medical Director for Mental Health and Neurodiversity) has stressed the importance of sustained engagement: *“To avoid a recurring cycle of crisis intervention, it is essential that patients with severe mental illness receive assertive outreach to ensure sustained engagement with services including recovery and rehabilitation services. Early intervention and assertive outreach typically lead to better outcomes. Where the full care pathway is unavailable, pressure is placed on inpatient capacity, potentially resulting in inappropriate out of area placements. This increases the likelihood of further admissions that might otherwise have been preventable, although it must be acknowledged that readmission may still be necessary in certain cases.”* ([WITN0365001], para 19).
23. NHS England has been working to strengthen intensive and assertive outreach functions. In particular:
 - a. The 2024/25 NHS Planning Guidance required all ICBs to: *“review their community services by Q2 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge...”*. “This was in response to the initial findings of the CQC’s special review into mental health care at NHFT, published in March 2024”¹⁵ (see paragraph 37 below).

¹⁵ [WITN0223001] para 76.

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- b. In July 2024, NHS England published 'Guidance to Integrated Care Boards on Intensive and Assertive Community Mental Health Care' as a result of the events in Nottingham [NHSE0000527] [NHSE0000046] (having set up a working group to design this). The guidance was intended, among other things, to support ICB reviews of these services; reviews were requested to be completed by the end of September 2024. The Guidance notes that although ICBs were not required to commission AOTs, they were required to have in place the dedicated core elements of intensive and assertive community care to meet the needs of persons with severe mental illness (CWS paras 323, 324).
- c. All 42 ICBs have provided the returns requested;¹⁶ that for the Midlands Region (i.e., covering NHFT) can be found at [NHSE0000462].
24. Further details of the wider national response to learning from the events of 13 June 2023 is set out at paragraph 58 below (and in the CWS).

NHS England's involvement in the oversight of Nottinghamshire Healthcare NHS Foundation Trust

Overview

25. NHS England has statutory accountability for oversight of both ICBs and providers of NHS services, including Foundation Trusts. As set out above, NHS England does not oversee or inspect clinical services, but it considers the work of the CQC as part of its own oversight role.
26. NHFT, the former provider of healthcare services to VC, has a degree of autonomy as a Foundation Trust, but it must have regard to guidance published by NHS England.
27. NHFT is required to report against a number of metrics as set out in the Foundation Trust Annual Reporting Manual (see [NHSE0000425] for an example). This includes reporting on performance, quality and the applicable oversight framework (which must include details of any breach, or suspected

¹⁶ See [NHSE0002354] and [NHSE0002353].

breach, of licence conditions where these have been notified by NHS England and any action(s) taken to remedy). NHFT is required to publish its annual reports online.

Oversight framework

28. The primary way that NHS England seeks assurance about how Trusts are performing is through its Oversight Framework.
29. For the purpose of the Inquiry, the key version is the NHS oversight metrics for 2022/2023. Trusts were placed into one of four categories or “segments” according to their performance against the various metrics which made up the Framework.
30. At the time of the attacks in June 2023, NHFT was in Segment 3, which means that it had *“Significant support needs against one or more of the five national oversight themes and [was] in actual or suspected breach of the NHS Provider Licence”*. However, the key drivers for NHFT entering segment 3 were the CQC ratings for the Rampton Hospital (high secure services) and the Seacole Ward at the Wells Road Centre (low secure inpatient services) [NHSE0000383], both of which are commissioned by NHS England's Specialised Commissioning Team, but neither of these services provided care to VC. At this point, NHFT's CQC rating overall was 'Requires Improvement' and 'Requires Improvement' for 'Well-led'.
31. At the end of June 2023, following further assessments, it was agreed that NHFT should remain in segment 3 [NHSE0000530] [NHSE0000529].
32. On 22 February 2024, a paper was presented to the Midlands Regional Support Group outlining the reasons why NHFT required mandated intensive support i.e., placing NHFT in segment 4 of the NHS Oversight Framework and, as a result, in the Recovery Support Programme (RSP) [NHSE0000426]. The considerations for a move to segment 4 related to the breadth of challenges and the care quality, safety, and performance concerns across a range of services provided by the NHFT. Whilst one of the strands of concerns related to the ongoing investigations

relating to the care and treatment of VC (reports from the Trust and the NHSE-commissioned report were both awaited), the remaining matters were as follows:

- a) the provision of high secure services (Rampton Hospital) and re-licensing of this hospital;
 - b) offender health service provision (i.e., healthcare services in prisons);
 - c) staff suspensions due to serious misconduct;
 - d) concerns around certain medium secure services; and
 - e) concerns regarding the financial position of NHFT.
33. Details of the support put in place by NHS England at this point are set out in the CWS, paras 500 – 509.

Licence conditions

34. In addition to the Oversight Framework, Trusts are required to hold a licence. The licence sets out the conditions that providers of healthcare services must meet. The applicable Provider Licence conditions for the NHFT until April 2023 have been shared with the Inquiry [NHSE0000311]. The NHS Provider Licence Standard Conditions applied after that date [NHSE0000389].
35. NHS England has a range of enforcement powers. Enforcement options against Trusts include imposing undertakings for breach of licence conditions, additional governance licence conditions and revocation of the licence.
36. The management of NHFT's licence conditions is discussed at paras 510 - 511 of the CWS.

Other Reviews

37. The Inquiry will be aware that on 29 January 2024, the Secretary of State requested a 'special review' of the services provided by NHFT, to be provided by the CQC.¹⁷ This is not further addressed in this Opening, but the CWS at para

¹⁷ [CQCM0014708] explains that the Review was split into three strands: (1) a review of the care VC received; (2) an assessment on patient safety and quality of care provided by NHFT, and (3) an

563 explains how the CQC's recommendations from the Review that were directed to NHS England have been addressed.¹⁸

38. NHS England's National Recovery Support team conducted an independent well-led developmental review of NHFT between March and October 2024 [NHSE0000463], providing "an objective review around leadership, governance and culture" as part of the Trust's improvement journey. The review made 8 recommendations which were summarised into 3 major themes. The 3 themes were:
- a) A focus on improving dialogue and expediting actions around risk and patient safety between frontline clinical teams and senior management (including Care Groups and Executive Directors), based on a common approach to a culture of safety for Trust services.
 - b) Encouraging staff to 'speak up' about and report concerns about patient safety and experience and prioritising clear responses describing the Trust position and proposed action.
 - c) Supporting further development and practicalities of a 'clinically led and engaged organisation', for example via work on medical leadership and Allied Health Professionals engagement.
39. NHFT accepted the findings and recommendations and set out how they would integrate these with the core improvement programmes [NHSE0000466]. Updates on progress are provided to the Improvement Oversight and Assurance Group [NHSE0000493].
40. NHS England asked NHFT to conduct a review of homicides and attempted homicides by patients. NHFT identified cases involving five patients in total since 2022 – two incidents resulting in homicides (including that involving VC), two attempted homicides, and one complex case (which was neither a homicide nor

assessment of progress made at Rampton Hospital. Strands 2 and 3 were published on 26 March 2024, Strand 1 was "pushed back following a request from the victims' families to allow a more thorough review" and was published on 13 August 2024.

¹⁸ A Table of the Recommendations made is at [CQCM0014708]. NHS England's progress against recommendations is at [NHSE0002879].

an attempted homicide). The report from the review (dated 15 May 2024) is exhibited at [NHSE0000933]. The Trust set out its learning and actions taken, including highlighting delays in carrying out reviews and investigations as a result of police directions concerning access to patient records or speaking to staff. It explained that it had put in place more robust procedures to mitigate delays of this kind in the future.¹⁹

Patient Safety, including Independent Mental Homicide Investigations.

41. The topic of patient safety is addressed in the CWS, Section 3 (page 108 onwards). It explains, first, how NHS England collects information about “what goes wrong in the health service and uses that information to provide advice and guidance” (para 352). The work is led by the National Patient Safety Team. Between 2013-2023, the principal policy setting out how the NHS should identify and manage certain patient safety incidents and other defined 'serious incidents' was the Serious Incident Framework (SIF).²⁰ This set out, amongst other things, a standard operating model for investigating homicide by those in receipt of mental health care (para 1.5.4 and Appendix 1). The SIF has been updated and replaced by the Patient Safety Incident Response Framework (PSIRF) with effect from Autumn 2023, with full compliance required from April 2024; it was thus the SIF that guided the NHFT’s response to the events of 13 June 2023.
42. The key organisational accountability for serious incident management under the SIF was from the provider in which the incident took place to the relevant commissioner of care: thus implementation and oversight of the SIF was provided by ICBs and their statutory predecessors.
43. Trusts were advised to directly inform their ICBs and relevant NHS England regional team of any mental health homicide. This is defined as a homicide committed by a person who has been in receipt of mental health care within the last 6 months, although it should be noted that this was not a strict cut-off - it may have been appropriate to declare a serious incident for a homicide by a person discharged from mental healthcare more than 6 months previously, depending

¹⁹ [NHFT0011548].

²⁰ [NHSE0000058].

on circumstances.²¹ Reporting enables the NHS England regional team to consider whether an independent investigation is needed. Whilst most patient safety incidents will be directly investigated by the provider organisations, both ICBs and NHS England may commission an independent investigation if the circumstances require it.

Trust-level investigation of mental health related homicides

44. The SIF included a standardised approach that Trusts were advised to take in relation to mental health homicides. In brief, this advised Trusts to:
- a. report the incident and conduct an initial review, producing a report within 72 hours; and
 - b. then conduct an internal investigation, producing a more detailed report within 60 days (also known as a Level 2 report or Serious Incident Investigation report).
45. The Inquiry and its Core Participants will be aware that, pursuant to this guidance, NHFT carried out an internal (Level 2) serious incident investigation (CWS, paras 535 – 537). A draft internal investigation report was received from NHFT on 13 February 2024 [NHSE0002318], with the final report being available on 15 March 2024 [NHFT0000451].

Independent mental health homicide investigations

46. Paragraphs 375-386 of the CWS explain the process by which NHS England has commissioned, since 1 April 2013, independent homicide investigations where there has been a homicide by an individual who was in recent receipt of care and treatment for a mental health disorder – whether subject to a care programme approach or under the care of specialist mental health services within the last 6 months (see paragraph 43 above on this cut-off). The commissioning process is conducted by the relevant Regional Team – in this case, the NHS Midlands Regional Investigation Team, in conjunction with the relevant Regional Independent Investigations Review Group. In addition, the National Patient

²¹ SIF, Appendix 1 p47 and footnote 49.

Safety Independent Investigations Team was established in 2022 as part of the national patient safety team in NHS England, to support consistency of approach and encourage learning.

47. Paras 383-384 of the CWS explain that:

"[383] The purpose of an independent patient safety investigation ("IPSI") is to generate insight to inform safety improvement through investigation and exploration of the care, treatment and healthcare systems and processes for one or more patients at any level of the healthcare system. They support the NHS to identify areas for improvement to reduce the possibility of a reoccurrence of similar events.

[384]. IPSIs do not inquire into how a person died - this is the role of the Coroner. They also do not assign blame or liability in relation to any incident which has occurred, or consider fitness to practice (which is the role of the relevant professional regulators (e.g., the GMC and the NMC)). In cases of breach of regulations, the CQC may consider prosecution (as referred to in paragraph 118 above), but this is entirely separate to the IPSI process. Similarly, the criminal justice system would respond to concerns about criminality, and internal human resource systems at an organisational level would consider any breaches of employment terms and conditions (e.g., disciplinary processes)." (see too para 385, 386).

The Theemis Report

48. In this case, an independent mental health homicide investigation was commissioned by NHS England in February 2024 under the Independent Investigations Procurement Framework (see CWS para 421-424 for details). The process by which Theemis Consulting Limited was selected is set out at CWS paragraphs 539-544; this addresses matters such as the alternative providers, the previous experience of its proposed investigators and the role of Oliver Shanley as a specialist adviser.

49. A copy of the Report is available at [NHSE0000298].

Publication of Independent Mental Health Homicide Investigation Reports

50. The final part of the independent mental health homicide investigation process involves the publication of the IPSI report on the NHS England website, along with links to any action plans. The process is to facilitate the purpose of the investigation, which is learning to prevent recurrence.
51. The history of the approach to the publication of IPSI reports is discussed in the CWS at paragraphs 387 onwards. Practice has reflected: (i) the statement in the SIF on the publication of reports (CWS paras 392 - 393), which assumed publication in an anonymised form; (ii) the more recent guidance in PSIRF (CWS para 394) which requires – in cases where a patient, the family of a deceased patient or another affected person does not consent to publication – that rights to privacy be considered and weighed, and suggested that “*Where risks to individuals [i.e. of breaches of their privacy rights] outweigh the wider public interest, other approaches can be considered, such as publishing a summary report of the investigation and/or thematic work, or system improvement plans relating to similar incident types/issues*”; and (iii) the legal advice on publication commissioned by NHS England in 2020 and 2023, which expressed the view that the publication practice of IPSIs, and specifically those relating to mental health homicide, did not conform with data protection law.
52. This legal advice was taken to the Independent Investigations Committee in November 2023, which noted that the advice was “*conclusive and advised action be taken to fully anonymise reports and take an alternative approach to publication.*” [NHSE0002312].
53. However, there were continued concerns expressed regarding alternative approaches, and whether the public interest in full publication had been sufficiently considered. As a result:

“402.in January 2024 further advice was provided which considered the extent to which a substantial public interest would establish a lawful basis to publish reports containing identifiable information concerning the patient who carried out the homicide. The advice outlined that this would need to be determined on a case by-case basis, but the starting presumption must

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- always be in favour of nondisclosure, before considering whether there are specific factors to support displacing that presumption" [NHSE0002317].*
54. It was against this background that the Theemis Report was received, and in January 2025, was shared in full with the families (with the consent of VC, CWS para 551); but it was proposed, by NHS England, to publish a summary version only. It is apparent that this caused distress to the families of the victims, not least as it created uncertainty about the rights of those family members to talk publicly about what they had seen. By 5 February 2025, and after representations and feedback from stakeholders such as the families and the DHSC, the decision was taken to publish the report in full (CWS para 553).
55. We note that Mr Hendy, commenting on these events, has stated that this change of position *"suggested to me that the legal advice was not as robust or definitive as NHS England claimed it to be"* (para 67). NHS England has supplied copies of the legal advice received by it with regards to the development of the policy in this area, which can be scrutinised by the Inquiry.
56. There has been further work done since these events by NHS England on an internal publication policy for NHS England-commissioned patient safety incident investigations (see paragraph 409 of the CWS). This policy, which is intended to support regional teams, has recently been approved and has been disclosed to the Inquiry. The policy, which became operational from 1 February 2026, now provides that the *"default position is that all patient safety incident investigation reports commissioned or undertaken by NHS England should be published."* Reports should be written on the basis that they will be published in full. However, *"There is no one size fits all approach to publishing information related to patient safety incident investigations. The information which can be published will need to be considered on a case-by-case basis."* The information to be included should *"include sufficient information and analysis from the investigation process for the reader to understand those events and as a result take action to improve patient safety"*. As a result, *"Any inclusion of confidential and personal data relating to healthcare must be considered through that lens: is it necessary to include it to understand the work system and provide insight about how to improve it?"* Drafted on this basis, legal compliance should be achieved, but if confidential

and personal information is to be included without an individual's consent, legal advice must be sought.

57. NHS England acknowledges the points made by some Core Participants about the traumatic effect on victims' families when access to information that they seek in order to understand the circumstances of their loved ones' death is restricted and limited, including as a result of the stance taken by the perpetrator. However, it notes that the reasons for restricting full publication or managing it on a case-by-case basis relate to data protection law, rather than a lack of candour on NHS England's part. As NHS England states in the CWS (para 554):

NHS England considers that the tensions or competing privacy interests which were debated in the policy advice and the papers of [its PPWG]... have not been resolved. Legislation or further action may be required to resolve them, or to set clearer guidelines for public bodies such as itself or successor bodies in the future.

58. We further note that this issue is also linked to concerns about family and public access to the Level 2 Report from the NHFT. The complexities of access to the former are evidenced by the legal advice on this topic disclosed by the Trust [NHFT0004713]; this advised a case by case consideration (and documentation) of the extent of disclosure needed to satisfy the obligation (from SIF guidance), to ensure that the families are satisfied that lessons identified will prevent the incident recurring and to explain the conclusions and recommendations reached.

The naming of clinicians and those involved in VC's care

59. NHS England is further aware of the disappointment of many of the family members who received a copy of the Theemis report, and who consider that it should have named the individual clinicians who were involved in VC's care. The present position is that, as set out above, NHS England has recently finalised and implemented its "*policy on the publication of NHS England-commissioned patient safety incident investigations*", following its review of this topic. This confirms that it is not "*normally considered appropriate to name staff members or provide information by which they can be identified*" in reports, as patient safety incident investigations "*are not conducted to assign blame or liability to*

individuals, and they proceed from the assumption that the events in question relate to issues with work systems and are not the fault of individuals.” However, if concerns about an individual’s conduct or fitness to practise are raised during a patient safety incident investigation, the NHS England “Being Fair” tool should be used to determine if referrals to other bodies, including professional regulators, should be made.

Learning from the Theemis Report and other Mental Health Homicide Investigations

60. Ensuring effective learning, and action based on that learning, is one of the significant challenges arising from IPSIs, and from patient safety incidents in the NHS more generally.
61. The NHFT and ICB joint action plan that resulted from the Theemis Report is available online and exhibited at [NHSE0002333]. The Theemis recommendations for NHFT are part of the overall improvement work for the Trust; oversight is provided by the Improvement Oversight Assurance Group (IOAG), formed jointly with the ICB and which has the wider purpose of overseeing, relevantly, the improvement work at the NHFT.²²
62. This Opening Statement has already described, briefly, the reviews required of ICBs under the 2024/25 NHS Planning Guidance (see para 23 above). We have also described how in July 2024, NHS England published 'Guidance to Integrated Care Boards on Intensive and Assertive Community Mental Health Care' [NHSE0000527] [NHSE0000046], with reviews by ICBs to be completed by 30 September 2024.
63. The publication of the Theemis Report on 5 February 2025 was accompanied by a letter from NHS England's National Director for Mental Health, Learning Disabilities and Autism, and the Medical Director for Mental Health and Neurodiversity outlining next steps and requirements of Trust and ICB boards

²² The Improvement Oversight Assurance Group (IOAG) exists to bring together appropriate interested parties (multi-stakeholder) from across the local and wider health and social care system in strategic oversight of the NHFT Quality improvement programme. It was set up, in relation to the NHFT, when this moved into NOF 4.

[NHSE0000048]. Trusts and ICBs were asked to review the local action plans previously prepared to ensure that they addressed the issues in the Theemis report, paying particular attention to:

- a. Personalised assessment of risk across community and inpatient teams.
- b. Joint discharge planning arrangements between the person, their family, the inpatient and community team (and other involved agencies).
- c. Multi-agency working and information sharing.
- d. Working closely with families.
- e. Eliminating Out of Area Placements in line with ICB 3-year plans.

Updated action plans were to be discussed in both trust and ICB public board meetings no later than 30 June 2025.

64. There is further evidence in respect of NHS England's actions in implementing recommendations addressed to it at CWS paras 557-563, in particular. This addresses, first, the Theemis Report's National Recommendations, where the first 2 areas for improvement and associated recommendations were addressed to NHS England, including recommendations:

- a. For national leaders, including those with lived experience, to come together and debate how the needs of those similar to VC are being met; the Report outlined key areas for debate.
- b. For NHS England to consider how mental health and social care understand the concept of risk, with a view to understanding systems and guidance in this area.
- c. To reconsider how national data can be collected which accurately assists with the identification and the likelihood of risks of particular outcomes.²³

65. Paragraphs 560-561 of the CWS summarise the actions taken to implement these recommendations, including – in respect of the third – the recommissioning

²³ See [NHSE0000298_0025, 26] – these recommendations are also summarised at CWS para 559.

of the work of the National Confidential Inquiry into Suicide and Homicide (NCISH). Paragraph 563 explains the actions taken to implement the CQC's recommendations addressed to NHS England in its s48 report (a rapid review of the NHFT commissioned by the Secretary of State for Health and Social Care following the events of June 2023).²⁴

66. In terms of the wider learning from mental health homicide investigations more generally, the CWS explains that:
- a. IPSIs are supplied to the providers concerned. Copies of many have been published on the NHS England website, or a summary in lieu if the full report has not been published.
 - b. A new learning and improvement focused group has been established within NHS England: the Mental Health Patient Safety Improvement Group (MHPSIG). The MHPSIG was established in response to a request from NHS England's former Chief Executive Officer following the events in Nottingham to ensure that NHS England had a stronger structure for what it does, with insight generated from IPSI reports and other sources which are informative about the safety of mental health services. The first meeting took place in January 2025; meetings are chaired by the National Medical Director for Mental Health and Neurodiversity [NHSE0000488].
67. The significant challenges in learning from events was highlighted by the DHSC's review of patient safety across the health and care landscape [NHSE0000528] (the Dash report); this recommended the revamping and revitalization of the National Quality Board (the NQB), which is currently underway.

Further Learning and Reflections

68. The statements filed by NHS England contain a number of reflections about learning and potential improvement in services, and the reduction of risk, at their close.

²⁴ See paras 119, 120 of the CWS for a brief explanation of the CQC's powers.

69. Dr. Adrian James (National Medical Director for Mental Health and Neurodiversity) touches upon a number of themes, including, for example, the need for effective involvement of patients' families and carers in mental health care (see paras 16 -17).²⁵ Dr. Jessica Sokolov (Medical Director for NHS England Midlands Region) has also reflected in her witness statement:

One of the key areas for future work should be around family and carer involvement and engagement. This is not straightforward, as not all patients will want their involvement, be well enough to decline it, or even have families for support. However, it is clear that the people who knew VC best raised concerns about him on numerous occasions, and while Nottinghamshire Healthcare NHS Foundation Trust have done a lot of work on improving family and carer engagement, it may be this is an area for concerted focus across the NHS as a whole.

70. Another theme is the need for effective and sustained community services and intervention, including assertive outreach (addressed in some detail above). Other developments of potential relevance are:

- a. The work on piloting 24/7 Neighbourhood Mental Health Centres, aimed at tackling problems of (i) overdependence on institutional or hospital response to mental health conditions and needs, and (ii) the fragmented community response to such needs, including the issues raised by the fact that service users are often discharged from services if they fail to engage with them. See the witness statement of Professor Tim Kendall, which outlines the work being done; and
- b. The Personalised Care Framework²⁶ and Modern Service Framework for Severe Mental Illness (CWS paragraphs 349-351).

71. Dr. Jessica Sokolov has further reflected that:

²⁵ One of the findings of the Theemis report was that "The voice of VC's family was not effectively considered to support the dynamic evaluation of risk" [NHSE0000298_0013, _0139, also _150, _154, _155 – and others].

²⁶ [NHSE0002879_27].

Having a shared understanding of risk, across inpatient and outpatient teams within health settings, but also across health and housing, for instance, and having the ability to update this when events in individual settings occur, is extremely important in identifying patterns of behaviour or identifying deterioration and might be worth exploring as an area for improvement.

72. There is ongoing thought and learning about how investigative recommendations are both most effectively formulated and disseminated. As Dr. James observes:

While NHS England, through the Mental Health Patient Safety Improvement Group, now provides a forum for collating such learning, it remains necessary to ensure that investigative recommendations are formulated in a manner which enables them to be implemented and/or makes clear where it will require investment or significant policy change. We need to ensure that recommendations are themed, prioritised and disseminated to the parts of the system where change is necessary (e.g., commissioning, service provision, clinical intervention) and is received into a learning and continuously improving culture.²⁷

73. Finally, NHS England notes that a further issue revealed in the reports commissioned is that of resources, and the quality of care delivered when services are stretched. A number of these challenges were linked to the Covid-19 pandemic; the care delivered to VC, and his contacts with mental health services, took place during the pandemic, including during periods of heightened alert. Covid-19 affected staffing levels, as well as requiring protocols that limited face-to-face contact with patients and, to some extent, normalised withdrawal and self-isolation by patients.²⁸ Thus the pandemic impacted on service quality and measures to improve this, including as the NHS recovers from the pandemic. More generally, the Theemis report made observations on the links between resources, particularly in the community, and therapeutic risk-taking:

²⁷ [WITN0365001] para 20.

²⁸ [NHSE0000298_0163].

The care delivered to VC should be considered within the context of high demand on services, this includes limited inpatient beds, limited capacity and high demand for Crisis team support and an EIP [Early Intervention in Psychosis] team with high caseloads and policy expectation which outweighed available resources.

The ability of the service to proactively support people in the community primarily relies upon high levels of resources and actions to support engagement in the least restrictive way and through a positive risk-taking approach...²⁹.

74. NHS England has sought to significantly increase resources to mental health services, including by support for measures such as the Mental Health Investment Standard. It must now consider not only how to enable the system to provide appropriate care in 'normal' times, with the resources available to the NHS, but also prepare the service for delivering care during any future pandemic.
75. These are only preliminary observations, made in advance of the Inquiry's oral hearings. NHS England is committed to making further contributions and also to learning from the evidence and observations of all participants.

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19 February 2026

²⁹ [NHSE0000298_0162].