Witness Name: Baroness Merron

Statement No: WITN0409

Exhibits: BM1/1-105

Dated: 05 March 2026

NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF BARONESS MERRON

Introduction

1. I make this statement in response to two Rule 9 requests from the Nottingham Inquiry, dated 12 and 14 January 2026.

2. I wish to start my statement by expressing my heartfelt sympathy for the families of Grace O'Malley-Kumar, Barnaby Webber and Ian Coates; as well as for those surviving victims, Sharon Miller, Wayne Birkett and Marcin Gawronski following the horrific events on 13 June 2023. As set out in more detail below, between us, the Secretary of State and I have met with the bereaved families on six occasions since July 2024; on some of those occasions we were both in attendance. This engagement is ongoing, as is that with the survivors of the attacks, with a further meeting with the Secretary of State taking place last week (5 February 2026). I have therefore heard first-hand of the families' incomparable loss and pain, and I admire their determination to drive improvement to the mental health system and ensure such dreadful attacks are never repeated.

3. I have been in post since July 2024, and some of the questions I have been asked pre-date my time in office. Where I have been asked to answer questions which relate to a

previous government, I would refer the Inquiry to the documents provided and to the corporate witness statement of William Vineall, Director, NHS Quality, Safety and Investigations, as I am unable to comment upon the policies of previous governments – and convention identifies that I should not see, apart from exceptional circumstances, documents of previous ministers if the political party leading the Government has changed. I have sought to set out in this witness statement the steps we have taken as a Government since July 2024.

4. In answering the specific questions, which focus largely on legislative reform and measures taken by the Government in response to the terrible attacks by VC in 2023, I will focus on events and decisions that relate to my tenure as Parliamentary Under-Secretary of State at the Department of Health and Social Care ('the Department' or 'DHSC'). This includes the passage of the Mental Health Bill through Parliament and the ongoing programme to implement the subsequent reforms, including substantial revisions to the Mental Health Act Code of Practice. Our actions have also drawn on the learning derived from the Care Quality Commission ('CQC') special review into services provided by Nottinghamshire Healthcare NHS Foundation Trust ('NHFT'), the final section of which was published in August 2024 **[BM1/01 - WITN0155030 and BM1/02 - WITN0155033]**.

5. The Inquiry also has the benefit of Sir Simon Wessely's Independent Review of the Mental Health Act 1983 ('the Independent Review') **[BM1/03 - WITN0155008]** which provides context and rationale behind the legislative reforms, the work on which had been in motion for many years prior to my appointment.

6. I feel it important to first address an issue that I believe is central to many of the questions that this Inquiry has asked: whether the forthcoming reforms to mental health legislation, as set out in more detail below, will hinder or enhance our ability to keep people safe. I am aware that concerns have been raised that public protection will be diluted or watered down. I do not agree that this is the case. The reforms do not change the fundamental powers and purpose of the Mental Health Act 1983, which is to detain and treat people when they are so unwell that they become a risk to themselves or others. The reforms are designed to drive better, more personalised care of those with the most severe mental health conditions, and to give them greater choice and control over their treatment, whilst maintaining the ability to compel treatment where necessary for patient and public safety.

Patient and public safety remains a paramount consideration, and I do not believe it is a trade-off; if we seek to improve outcomes for people subject to detention, to drive better care, we have a greater chance to keep people safe.

7. I refer the Inquiry to an extract from Sir Simon Wessely's foreword to the Final Report of his Independent Review at page 7 **[BM1/03 - WITN0155008]**, which I believe illustrates the driving force behind the reforms; that when such infringements on liberty and autonomy are deemed necessary, we are ensuring that people are treated with dignity:

> *...I heard compelling narratives that for some detention left them worse, not better off. Of course, all interventions, and being detained under the Mental Health Act (MHA) is an intervention, have side effects. The treatment that only does good, and never harm, doesn't exist. But we can only help reduce these outcomes if we accept, they happen. I often heard from those who told me, looking back, that they realise that compulsory treatment was necessary, even lifesaving, but then went on to say, "why did it need to be given in the way it was?". And it was that last comment which has given rise to the majority of our recommendations.*

Background

8. I was elected as the Labour Member of Parliament for Lincoln in 1997 and served for thirteen years until 2010. During this period, I was appointed to serve the following Ministerial roles:

    a. Minister of State for Public Health (9 June 2009 to 6 May 2010)

    b. Parliamentary Under-Secretary of State for Foreign and Commonwealth Affairs (5 October 2008 - 9 June 2009)

    c. Parliamentary Under-Secretary of State for International Development (24 January 2008 - 5 October 2008)

    d. Minister for the East Midlands (28 June 2007 - 25 January 2008)

    e. Parliamentary Secretary for the Cabinet Office (28 June 2007 to 25 January 2008)

    f. Parliamentary Under-Secretary of State for Transport (5 May 2006 - 28 June 2007)

g. Lord Commissioner, HM Treasury (28 October 2004 - 5 May 2006)

h. Assistant Whip, HM Treasury (1 January 2002 - 28 October 2004)

9. Following my departure from the House of Commons, having lost my seat in 2010, I continued to work in senior public and community roles, most notably as Chief Executive of the Board of Deputies of British Jews. I later entered the House of Lords as a life peer in 2021 and have since served on the Labour front bench, both in opposition and government, where I now hold ministerial responsibility for women's health and mental health.

10. I was appointed Parliamentary Under-Secretary of State at the Department on 9 July 2024 and hold responsibilities for women's health and mental health. As the Government Minister responsible for the DHSC in the Lords, I answer questions put by members of the House of Lords on all issues relating to health and social care and am responsible for piloting legislation relating to health and social care through the Lords stages. Whilst I therefore have ministerial responsibility for the areas set out above, I have additional responsibilities in Parliament. I am the sole Minister in the Lords with the health brief and my duties and responsibilities are wide. I therefore was responsible for ensuring that the Mental Health Act 2025 passed its stages of scrutiny by the House of Lords as well as having overall responsibility for its provisions in my role as Ministerial lead for mental health.

11. As the Parliamentary Under-Secretary of State for Women's Health and Mental Health, I am responsible for a wide range of areas. This includes the following key areas:

a. Mental health;

b. Women's health;

c. Maternity;

d. Gender identity services; and

e. The UK COVID-19 Inquiry.

Mental Health Act 2025

Forthcoming reforms

12. The Mental Health Act 2025 ('the 2025 Act') amends and alters the Mental Health Act 1983 ('the 1983 Act'). These legislative changes have been discussed since 2017, when the then Prime Minister Theresa May commissioned Professor Sir Simon Wessely to undertake his Independent Review **[BM1/03 - WITN0155008]** which identified the need to make changes to the legislation and to the culture of mental health care in England. The 2025 Act delivers reforms to address many of the issues identified by the review and its recommendations form the basis of much of the legislative reforms within the 2025 Act. I note here that whilst the review reported in 2018, it took until 2024 for a reforming Bill to be introduced into Parliament. It was confirmed in the Labour Party manifesto that the party would modernise legislation to give patients greater choice, autonomy, enhanced rights and support, and ensure everyone is treated with dignity and respect throughout treatment. Mental health stakeholders had long been calling for such legislation to be brought forward and warmly welcomed the Bill which was introduced early in the new Government's first session of Parliament on 6 November 2024.

13. The 2025 Act seeks to improve the experience of patients within the mental health system. The more that their needs are met and treatment is begun with them, the more likely they are to remain concordant with medication and recover as much as possible from mental health crises. The overarching legislative changes which have been made to meet this goal are set out in the following paragraphs.

14. The 2025 Act will place a statutory duty on the Secretary of State to include four new guiding principles in the statement of principles set out in the updated Code of Practice. The wording of the new principles: choice and autonomy; least restriction; therapeutic benefit; and the person as an individual, is as recommended at page 297 of the Independent Review **[BM1/03 - WITN0155008]**. Practitioners will be under a statutory duty to take account of the principles when making decisions under the Act including decisions around detention, care and treatment, and discharge. The principles of the Act reflect those which were identified by the Independent Review as requiring development. Drafting the revised Code of Practice is the first priority following Royal Assent, and the

Department will engage carefully as part of this. Engagement will begin in early 2026 with formal consultation on the draft Code expected in early 2027.

15. The 2025 Act will introduce statutory 'Care and Treatment Plans' for patients detained under the 2025 Act (and for those subject to a Community Treatment Order ('CTO') or guardianship), excluding those under short-term sections (specifically, sections 5(2) or (4), 135 or 136 or directions for detention in a place of safety under section 35(4), 36(3), 37(4), 38(4) or 45A(5), which are a matter of a couple of days). The 2025 Act sets out how the plan should be prepared, reviewed and monitored. It also includes a power for the Department to set out in regulations the required contents of the plan. These changes are to ensure that patients have a clear and up-to-date plan in place outlining what treatment and support they need to progress towards recovery and a safe and effective discharge, on which the relevant people (including, for example, the patient, family members and their carer) have been consulted. I consider that this provides a mechanism by which treatment and support can be set out more clearly and fully than may have previously been the case in some situations and that it will also strengthen planning for discharge.

16. The 2025 Act will remove police stations as a designated 'place of safety' by repealing section 136A. The aim of this is to ensure that those who are detained receive medical treatment rather than being criminalised or placed in police custody which may not be appropriate for their needs. It is not anticipated that this will lead to any change in the application of policing or charging decisions.

17. The 2025 Act seeks to strengthen decision-making and ensure patient and public protection by:

    a. Strengthening and clarifying the criteria for detention. The new criteria under section 5 of the 2025 Act amends sections 2, 3 and 5 of the 1983 Act, as well as the criteria for renewal of detention under section 20. The new wording makes clear that people may be detained if they pose a risk of 'serious harm' to themselves and/or others and that there is a 'reasonable prospect' that they will benefit from the proposed treatment. Consideration must therefore be given to whether there is a chance that treatment would have some therapeutic benefit for that patient, even if the benefit is simply to alleviate symptoms and even if

the chances are less than certain. To assist with application of this new requirement, section 8 of the 2025 Act provides a definition of 'appropriate medical treatment'. That is, treatment which '...has a reasonable prospect of alleviating, or preventing the worsening of, the disorder or one or more of its symptoms or manifestations, and is appropriate in the person's case.' The updated criteria largely reflect guidance already set out at chapter 23 of the current Code of Practice **[BM1/04 - DHSC0000007]**. Putting this in primary legislation provides clarity so that any risks to the public and patient are consistently considered as part of the assessment and application process. We are not seeking to raise the bar to reduce detentions. However, we do want to ensure that people are only detained when appropriate, pursuant to section 8 of the 2025 Act.

b. Strengthening clinical decision making across the detention pathway and allowing for greater scrutiny of decisions. As part of the statutory Care and Treatment Plans, there will need to be, among other things, a record of the reasons for the patient's detention, reasons for the use of compulsory treatment, and record of the outcomes which the assessment and/or provision of care and treatment is designed to achieve. There will also need to be a personalised safety management plan, detailing an assessment of the person's risk to self and/or others and how this will be managed and a plan for their discharge, where relevant and appropriate. The decisions recorded in a person's care and treatment plan should serve as an audit trail of key decisions. As mentioned above, the contents of the Care and Treatment Plans will be specified in secondary legislation and further developed in statutory guidance under the Code of Practice.

c. Providing for greater scrutiny of the decision to discharge. The Responsible Clinician – who is the person charged with a particular patient's care under the Act and, in particular, deciding if they meet the conditions for discharge – will be required to consult with another person who has been professionally concerned with the patient's medical treatment, before they can discharge an individual. This may be a community or hospital-based clinician who has previously cared for the person.

d. Reforming the use of CTOs to reflect the revised detention criteria, to increase oversight and scrutiny of decision-making, and to create new powers to allow the Nominated Person to object when appropriate (see below).

18. The 2025 Act seeks to improve patient choice and autonomy by:

a. Providing an opportunity for individuals to set out who should be involved in their care (a 'Nominated Person') if they experience mental health crisis. This move from the former, more narrow role of a 'nearest relative' under the 1983 Act is designed to recognise the fact that family, friends or peers can all play a valuable role in a person's care and that they may be able to provide critical personal insight and support at a time when this is most needed. These policies also seek to avoid family, friends or carers being excluded from the picture when a person becomes unwell and may disengage from those relationships or from mental health services. More widely, the 2025 Act places greater emphasis on clinicians engaging with family and carers, including when making treatment and care planning decisions, to ensure that the right people are appropriately recognised as an important part of the patient's continued support network. Family and friend involvement in the care of those with serious mental illness can make successful outcomes more likely as there will be a supportive network and framework to assist those who are unwell and to act as an early warning signal when someone's health may deteriorate. The role of the Nominated Person is specified clearly in legislation as having specific statutory rights and powers. This is distinct from the role of family members more widely and does not cut across this. Family members who are not the Nominated Person should also be involved in the patient's care and clinicians have a duty to consult with anyone with an interest in the patient's welfare, not solely the Nominated Person.

b. Improving Mental Health Tribunal oversight of a patient's detention by increasing the frequency that detention must be renewed and increasing the frequency of access to the Mental Health Tribunal to mirror the reduction in initial detention periods.

c. Introducing new safeguards around the use of compulsory medication. Under the amendments to section 58, if a patient has capacity and is refusing treatment, or if the treatment conflicts with an Advance Choice Document, medication can only be administered if there is a "compelling reason". These aim to encourage clinicians to take steps to identify medication that they consider viable but that the patient also finds agreeable and is therefore more likely to adhere to. This is to help ensure that compulsory treatment is only used when necessary and appropriate.

d. Introducing a new clinical 'checklist'. The patient's Responsible Clinician will have to follow this when making decisions about a patient's care and treatment. This seeks to put the patient at the heart of clinical decision making. Specifically, the checklist requires that the clinician supports the patient to engage in decisions about their treatment. This could include nursing, psychological interventions, specialist care, and medication. Clinicians must also consider the patient's wishes, feelings, beliefs and values, consult with those close to the patient, for example their nominated person or carer, and avoid making decisions solely based on external factors such as the patient's age or condition. Where the patient is too unwell and lacks capacity or competence to make decisions concerning their treatment, the checklist requires the clinician to consider any wishes, feelings, views and beliefs that they think the patient might have had if they had capacity. They might establish this by consulting with those close to the individual or looking at their Advance Choice Document. The checklist represents best practice, but sadly it does not represent current *standard* practice. The Independent Review identified multiple incidents of patients feeling disempowered and unsupported to share their wishes and feelings and unfairly ignored when they do **[BM1/03 - WITN0155008]**. This can undermine the patient's sense of self-worth, their recovery, and their trust in mental health services. This checklist is somewhat akin to the best interests checklist under the Mental Capacity Act 2005, which has come to be widely recognised and highly regarded by practitioners. We consider that the clinical checklist under the 2025 Act is fundamental to delivering the guiding principle of patient choice and autonomy.

e. Introducing a statutory duty for NHS England and Integrated Care Boards ('ICBs') to 'make arrangements' to provide information and support that allows people to create Advance Choice Documents. The 2025 Act also specifies how these duties should be discharged by commissioners, including how information should be provided, and where information and support should be targeted to maximise the benefits of this policy. The intention is that this document can then be used by mental health professionals to inform decision-making on admission, care and treatment if the individual later loses the requisite capacity or competence to make decisions at the time. Under the statutory reforms, clinicians will have a duty to consider the wishes, preferences, beliefs and values set out by a person in their Advance Choice Document, as part of the clinical checklist. The 2025 Act also introduces stronger safeguards where the individual has an advance decision to refuse medication or electroconvulsive therapy. It should be noted that clinicians are not bound to follow the contents of a person's advance choice document. It is of course legitimate for a person's wishes not to followed where, for example, the treatment the patient prefers is not clinically appropriate or where the patient's request cannot practically be achieved. In these circumstances, the clinician should explain the reasons for not taking forward the patient's request and, if applicable, discuss alternative options with the patient or those close to them. The purpose of our policy on Advance Choice Documents is to help ensure that individuals can have some say over their care and treatment, even when they are very unwell and may lack capacity to make decisions at the time. Our expectation is that Advance Choice Documents will particularly help address the significant racial disparities under the Act. This is based on evidence that they may be most effective among service users of black ethnicity, compared to those of other ethnic backgrounds. These reforms were recommended by both the Independent Review **[BM1/03 - WITN0155008]** and the pre-legislative scrutiny committee.

f. Expanding access to Independent Mental Health Advocates to include voluntary patients as well as those detained under the 2025 Act. Independent Mental Health Advocates were introduced via the Mental Health Act 2007 (implemented 2008/2009) to provide specialist, statutory, and independent support for patients detained under the 1983 Act. The role is designed to provide assistance to those

who are detained and to explain concepts, such as the rights provided under the 1983 Act, to those who have been detained. Some patients with serious mental illness do not have relatives or friends and the role of the Independent Mental Health Advocate is vital in advocating on the patient's account and providing an independent voice to secure good and appropriate treatment options. As a result of the 2025 Act, for detained patients, access will be on an opt out basis. Rather than the onus being on the patient to ask for an advocate, advocates will visit patients to offer their services and patients can decline if they do not want to take this up.

19. The 2025 Act will limit the detention of people with a learning disability and autistic people (without a qualifying co-occurring psychiatric disorder) by:

    a. Removing the power to detain people with a learning disability or autistic people under Part II, section 3 of the 2025 Act, unless they have a co-occurring psychiatric disorder that warrants hospital treatment. A psychiatric disorder is defined as a mental disorder other than a learning disability or autism. Detention under Part II, section 2 will still be possible for a maximum of 28 days for assessment to determine whether the person has needs for hospital treatment for a psychiatric disorder. This change will not apply to Part III, which applies to people in the criminal justice system. The Ministry of Justice is responsible for making decisions about this aspect of the legislation. It will still be possible to detain someone with a learning disability or an autistic person in hospital under Part III, so that suspects, offenders and defendants who are autistic or have a learning disability are able to access the specialist support they need.

    b. Placing Care (Education) and Treatment Reviews on a statutory footing. These reviews are for people who have been admitted to a mental health hospital or for people who are at risk of admission and are undertaken by commissioners to ensure that people are only admitted to hospital when absolutely necessary and for the minimum amount of time possible. An NHS commissioning body must take steps to ensure reviews are held when a patient with a learning disability or an autistic patient is detained in hospital. Certain bodies will also have a new duty to have regard to the review recommendations.

c. Creating a duty on ICBs to establish and maintain a register of people with a learning disability and autistic people who are at risk of detention. Both ICBs and local authorities will then be required to have regard to any information obtained for, or contained in, the register or shared under the provisions and seek to ensure the needs of these people can be met without detaining them.

Impact of the reforms:

20. An Impact Assessment ('IA') was published when the Bill was introduced to Parliament **[BM1/05 - WITN0155028]**. It provides an economic assessment of the costs and benefits of the reforms contained within the Bill over a 20-year appraisal period, during which implementation will take place in phases, with the IA assuming that policies will start from mid-2025/26 following Royal Assent. The IA remains the current best assessment of the economic impact of the 2025 Act.

21. Prior to the Bill being introduced to Parliament, the Department also published a memorandum of the Bill's compatibility with the European Convention on Human Rights **[BM1/06 - WITN0409071]**.

22. The Department also gave due consideration to the equality impact of planned legislative reforms prior to the Bill's introduction to ensure compliance with the Secretary of State's duties in relation to the Public Sector Equality Duty, the Family Test and duties under the NHS Act 2006 **[BM1/07 - DHSC0000514]**.

23. In addition, the Department reviewed the Bill and the planned reforms to ensure that the 2025 Act has the necessary powers to enable clinicians to keep patients and the public safe in the light of the events of June 2023.

24. Further changes were made to strengthen the Bill as a result of this review, including removing proposed amendments. An earlier draft of the Bill proposed adding a requirement for clinicians making decisions about detention to consider 'how soon' harm may occur. Following concerns raised by clinicians that the term risked being misinterpreted, the proposed wording was removed.

25. The 2025 Act also introduces the requirement for consultation with another mental health professional as part of the discharge process and the Department is committed to

specifying in regulations that the new statutory Care and Treatment Plans should include a safety management plan for the patient, to keep themselves and others safe. In practice, this will entail an assessment of the risks the individual poses to themselves and/or others and interventions for managing those risks, where relevant. This element may sometimes be missing from a person's plan and so by making it a requirement in the secondary legislation, the Department seeks to ensure that it is always included.

26. The vast majority of people with mental illnesses, including severe mental illness, present no risk to themselves or others and treatment can ordinarily be provided without compulsion. However, there are some people whose illness, when acutely unwell, make them a risk to themselves, and sometimes to other people. Mental health legislation is there for when someone reaches this point, and where detention and compulsory treatment is necessary to mitigate this risk. The 1983 Act and 2025 Act have the necessary powers to enable clinicians to manage high risk patients and their risk to the public. It is not the intention of the Department, nor do I think it likely, that the amendments to the legislation made by the 2025 Act will alter this position.

Planned reforms: 'serious harm'

27. More detail on the definition of serious harm will be provided in the Code of Practice, which will be developed in consultation with a wide range of stakeholders, including people with lived experience and their families and carers, staff and professional groups, commissioners, providers, and the voluntary sector. The aim of the Code is to provide guidance for clinicians, but not to be overly prescriptive: clinicians need to use their clinical judgement, experience and training to make informed decisions about when or if it is appropriate to detain someone. There will be further training on the reformed Code of Practice as part of the re-drafting process. As per section 118 (3), there is a statutory obligation that before preparing the Code or making any alteration in it, the Secretary of State shall consult such bodies as appear to him to be concerned.

28. The definition of 'harm' will include serious physical or psychological injury, as well as a threat to the life of the patient or others. The current Code of Practice already clarifies that examples of harms include psychological as well as physical harm, at paragraph 14.10 for example, which sets out factors to consider when deciding *'whether detention is necessary for the protection of other people'*, it tells clinicians to take into account:

'harm to other people including psychological as well as physical harm' **[BM1/04 – DHSC0000007]**. The Department will continue to consult clinicians and other stakeholders across the sector, including people with lived experience and their families and carers, on further examples when updating the Code of Practice.

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

30. The revised detention criteria will not hinder a clinician's ability to detain someone where it is necessary to protect either themselves or others. Introducing the threshold of 'risk of serious harm' to the detention criteria will require clinicians (and subsequently the Mental Health Tribunal) to consider risk as part of the assessment or tribunal process. Formalising this requirement will ensure that risk to the public or the patient is a key element of a clinician's assessment. This will ensure that any risks to the public and patient are consistently considered as part of the assessment process and will also protect patients from lengthy detentions when these risks are unlikely to occur.

31. In addition, subject to consultation, it is proposed that the revised Code of Practice will encourage mental health professionals to consider using detention under section 3 of the 1983 Act rather than under section 2 where a patient is known to services and has been detained within the last 12 months. Detention under section 3 provides the ability for clinicians to put the patient on a CTO upon discharge which provides greater scope for supervision and risk management and the ultimate safeguard of immediate recall where necessary.

Planned reforms: addressing concerns

32. Following the findings from the CQC's section 48 report in respect of the actions of NHFT **[BM1/01 - WITN0155030]**, policy officials within the Department engaged with a number of key stakeholders in summer 2024 to consider the wording of the detention criteria to ensure that the Mental Health Bill would not inadvertently act as a disincentive to detain those in need of treatment. Ministers were determined this question should be resolved before the Bill was entered into Parliament.

33. DHSC officials met with the bereaved families expressly to discuss the Mental Health Bill on two occasions. The first, on 4 September 2024, was attended by DHSC officials and the families only **[BM1/08 - WITN0409002]**, and the second, on 4 November 2024, I also attended **[BM1/09 - WITN0409003]**. The Mental Health Bill was also discussed at other departmental meetings with the families, but alongside other issues. I discuss these meetings in further detail below at paragraphs [67], [69] and [70].

Detention Criteria

34. Ahead of the Mental Health Bill's introduction, the Department reviewed the new detention criteria in the Bill to consider its impact upon the detention of those who are a risk to themselves and others. This review included engagement with stakeholders in July and August 2024 **[BM1/10 - WITN0155041]**. This included: national clinical leads in NHSE, psychiatrists, social care workers, policy representatives from the CQC and NHSE, and members from the voluntary sector. Following this review, the Department removed the phrase 'how soon [the harm may occur]' from the draft detention criteria **[BM1/11 - WITN0155039]**. It was thought that the wording could be misinterpreted to suggest that harms must be imminent to justify detention, or place an impossible expectation on clinicians to predict when something might happen. It is important to ensure clinicians are not dissuaded from making beneficial early interventions, so the wording was removed.

35. At paragraph 14.10 of the current Code of Practice, in determining whether detention is necessary, clinicians are asked to consider 'the nature of the risk to other people arising from the patient's mental disorder, the likelihood that harm will result and the severity of any potential harm' [emphasis added], and, at 14.9, to take into account a number of other factors, such as the potential benefits of treatment to the patient **[BM1/04 - DHSC0000007]**. The new criteria formalises these considerations, putting this more holistic approach to risk assessment into a clear and consistent legal footing to enable clinicians to determine when detention is appropriate.

36. The new detention criteria, with the exception of changes in relation to people with a learning disability and autistic people, are not intended to seek to reduce the number of people detained. As a broader policy, the Department is seeking to ensure more people are cared for in the community so that earlier intervention may reduce the risk of crisis

and need for detention, which may well have the effect of a reduction in the number or length of detentions. However, the Department does not think it is appropriate to utilise legislation to drive down detention in an arbitrary way that could interfere with clinical decision making and create a risk that people do not receive the help that they need.

Community Treatment Orders ("CTO")

37. The reforms to CTOs under section 17A are designed to address longstanding issues, notably people being subject to a CTO for an inappropriate length of time and their disproportionate use on Black or Black British people which I understand was part of the reason why the previous government commissioned the Independent Review of the Mental Health Act. CTOs are, when used appropriately, an important safeguard, and it is important that those who benefit from them can still be discharged from hospital with the safeguard of being potentially recalled for further medical treatment, if necessary. The reforms seek to ensure that CTOs can only be used where there is a strong justification (i.e., a risk of serious harm) and a genuine likelihood of therapeutic benefit for the patient. These proposed changes to CTO criteria provide clarity and focus attention on patients who pose a risk of serious harm. This comes from the Independent Review which found that CTOs were often used by clinicians as a way for patients to get access to services that may otherwise be in short supply – which was not the purpose they were designed for **[BM1/03 - WITN0155008]**.

Compulsory Medication

38. The Act maintains the power to give compulsory medication to patients when detained in hospital, as the Government recognises that for some people this is the only means for recovery. However, to improve patient choice and autonomy and address the power imbalance between the patient and clinician, greater safeguards have been introduced to ensure compulsory treatment is only used when necessary and appropriate. Under the reforms, there will need to be a compelling reason (i.e. there is no clinically viable alternative or none that that is more agreeable to the patient) or it must be urgent (according to statutory criteria) before a clinician can administer compulsory medication in the face of a decision to refuse (whether made in advance or at the time). The reforms also limit the circumstances under which urgent medication and urgent and compulsory electroconvulsive therapy can be administered.

These changes should mitigate the use of compulsory treatment without any attempt by the clinician to find a clinically viable alternative that better meets the patient's wishes or needs. This is crucial to ensuring the patient's trust in mental health staff, their engagement with mental health services, and adherence to treatment.

Updated Code of Practice

39. The Code of Practice provides statutory guidance to registered medical practitioners, approved clinicians, managers and staff of providers, and approved mental health professionals on how they should carry out functions under the Mental Health Act in practice. It is statutory guidance for registered medical practitioners and other professionals in relation to the medical treatment of patients suffering from mental disorder. Lord Bingham described in the case of R (Mumjaz) v Mersey Care Trust [2005] UKHL 58, at [21]:

> *It is in my view plain that the code does not have the binding effect which a statutory provision or a statutory instrument would have. It is what it purports to be, guidance and not instruction. But the matters relied on by Mr Munjaz show that the guidance should be given great weight. It is not instruction, but it is much more than mere advice which an addressee is free to follow or not as it chooses. It is guidance which any hospital should consider with great care, and from which it should depart only if it has cogent reasons for doing so. Where, which is not this case, the guidance addresses a matter covered by s 118(2), any departure would call for even stronger reasons. In reviewing any challenge to a departure from the code, the court should scrutinise the reasons given by the hospital for departure with the intensity which the importance and sensitivity of the subject matter requires.*[1]

40. Section 118 (2D) of the 1983 Act sets out that specified persons must have regard to the Code of Practice when carrying out specific functions under the Act. This includes

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[1] (R (Mumjaz) v Mersey Care Trust [2004] QV 395, para 21.

registered medical practitioners, approved clinicians, managers and staff of hospitals, independent hospitals and care homes, and approved mental health professionals in relation to the admission of patients to hospitals, to guardianship and to community patients under this Act. It also includes members of other professions in relation to the medical treatment of patients suffering from a mental disorder. The revised Act extends the application of the Code of Practice to:

a. Nominated Persons in relation to their functions;

b. health or care professionals in respect of their function to witness the appointment of a Nominated Person by a patient;

c. Independent Mental Health Advocates appointed under arrangements made under section 130A or 130E – i.e. those for detained or voluntary patients;

d. the regulatory authority (CQC in England and Health Inspectorate in Wales) in relation to its functions under Part 4; and

e. NHS England, ICBs and Local Health Boards (in Wales) in relation to functions under specified functions.

41. There is a statutory duty for the Secretary of State to prepare and, from time to time, revise the Code of Practice pursuant to Section 118 of the 1983 Act. Where legislative reforms are introduced, changes must also be made to ensure the Code of Practice reflects updates to the legislation. The Code of Practice was already in need of updating prior to the commencement of the reforms in the 2025 Act. The Code was last updated in 2015 and makes reference to outdated guidance and practices. It will therefore be updated to bring it into alignment with current policy and practice whilst also producing guidance that addresses the legislative changes.

42. The Department has committed to extensive engagement in developing the revised Code, including with people with lived experience and their families and carers, staff and professional groups, commissioners, providers and others to do this. In addition, a draft of the revised Code of Practice will be subject to public consultation to ensure that all relevant stakeholders are given an opportunity to have input into the drafting of the document.

43. Alongside the development of the Code, the Department will oversee the drafting and introduction of the relevant secondary legislation. It is estimated to take at least a year to develop the revised Code for consultation. Following public consultation, the existing workforce needs to be trained on the new Code, this is also estimated to take around a year. The final Code will then be laid before Parliament, in line with the negative procedure, before coming into effect. This process is intended to align with the commencement of the first major reforms which are expected to commence in 2028/2029, to ensure that the enacted Code stays consistent with current legislation.

Other work and planned reforms

44. There have been a number of reforms to seek to improved community and inpatient mental health services over recent years, but there is still a way to go. Demand for mental health support continues to rise and people are waiting too long to get the right community support they need when they need it.

45. The 10 Year Health Plan **[BM1/12 - DHSC0000096]** sets out the Department's vision for a Neighbourhood Health Service as one way to try and lessen this gap and to deliver high quality community services for mental health. Neighbourhood Mental Health Centres are already being piloted in six locations. These are locations are: Tower Hamlets (London): Run by East London NHS Foundation Trust (first to open); Whitehaven (Cumbria): Run by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust; Acomb (York): Run by York Mental Health Partnership; Heeley (Sheffield): Run by Sheffield Health and Social Care NHS Foundation Trust; East of Birmingham: Run by Birmingham and Solihull Mental Health NHS Foundation Trust; Lewisham (London): Run by South London and Maudsley NHS Foundation Trust. These pilots aim to provide open access care for anyone with a severe mental illness 24 hours a day, seven days a week.

46. The Government will make available capital funding of £473 million over four years to invest in new models, including 24/7 neighbourhood care models, building on findings from the six pilots, and other capital projects such as Mental Health Emergency Departments and eliminating out-of-area placements. This capital investment sits within a total circa £5 billion being provided over four years to deliver more care in communities and meet the performance improvement targets government set through the Medium Term Planning Framework.

47. Through 24/7 Neighbourhood Mental Health Centres, people with severe mental illnesses and their families can receive care and treatment when they need it, in their community, 24 hours a day. The centres are a reorganisation of mental health services into one place to restore continuity of care and move away from the more siloed system with hand-offs between teams. It is hoped that this will also have a positive effect on access and waiting times. Neighbourhood Mental Health Centres seek to go further in delivering continuity of care, by bringing community mental health services together with Crisis, Home Resolution and Treatment Teams. These are NHS mental health services providing 24/7, urgent, community-based care as an alternative to hospital admission. Comprised of nurses, psychiatrists, and social workers, they offer intensive, short-term support (typically 2 weeks) to stabilise acute crises at home, including medication management and therapy. The services and Crisis, Home Resolution and Treatment Teams are brought together in one physical place, including providing beds in the community for patients during times of acute distress or crisis. This aims to reduce the need for hospital admission and treat more people close to where they live. Bringing these centres into the heart of communities would mean that people with severe mental illnesses do not need to present in A&E departments but instead can get the support they need in a more appropriate and calm environment with immediate access to specialist clinicians and a multi-disciplinary team to provide treatment. People with serious mental illness can walk in without an appointment if they need mental health support, such as psychological therapies, medication and other interventions while also having access to expertise that can help with other wider issues that may be impacting their wellbeing and recovery including employment, housing, or volunteering.

48. Neighbourhood Mental Health Centres are organised and set up with primary care services - such as the GP, dentist, optometrists and community pharmacies, as well as voluntary, charitable, faith and social enterprise services. Similar community-based mental health centres have been in operation in a number of locations internationally, such as Lille, France and Trieste, Italy. Although these models and any measurable outcomes will be specific to their location and therefore cannot be transferred wholesale, there are indications of positive impact in their locality. An external evaluation of the impact of the pilot Neighbourhood Mental Health Centres has been procured from Centre for Mental Health, IPSOS Mori and University College London. The final report is due in June 2026. The Department will seek to use this evaluation alongside discussions with

those using the services and providing them to see how effective this new model has been, particularly on patient experience, access and potential reductions in pressure on existing services, and economic impact. Based on this evaluation, an assessment will be made on future roll out to other areas. The pilots will report by summer 2026.

49. The Department has also committed to improving assertive outreach care and treatment to ensure 100% national coverage in the next decade. Assertive care involves proactively reaching out and offering sustained, personalised support. It means that highly skilled care managers and other personnel – such as specialist social workers – will work closely with a small set of individuals who have severe and enduring mental ill health and have previously found it difficult or who have refused treatment. They find them wherever they are and provide them with therapy and support. There is evidence that this approach can have a positive impact on patients, including improving outcomes and reducing hospitalisation **[BM1/13 - DHSC0000505; BM1/14 - DHSC0000125; BM1/15 - DHSC0000126; BM1/16 - DHSC0000127; BM1/17 - DHSC0000128]**. It is especially effective for individuals experiencing psychosis, who may have encountered barriers to care.

50. NHS England has also sought to strengthen local oversight and action to support people with severe mental illness who pose a risk of harm to others when unwell to ensure they are properly supported and can access appropriate care to avoid relapses in their mental health. These are largely set out in a letter from NHSE from 30 September 2024 **[BM1/ - 18 - DHSC0000094].**

51. As part of the 2024/25 NHS Priorities and Operational Planning Guidance, published on 27 March 2024 **[BM1/19 - DHSC0000098]**, NHSE required all ICBs to complete a review of their community mental health services by Q2 2024/25. All 42 ICBs have now completed these reviews, identifying examples of good practice as well as areas requiring further development to improve local services.

52. NHS England also published guidance on intensive and assertive community mental health care in July 2024 (updated February 2025) **[BM1/20 - DHSC0000101]** to support ICB reviews of practice and the development of improvement plans, with the expectation that action plans would be presented at local public boards to ensure accountability.

53. Substantial progress has been achieved in building more robust crisis care pathways across all ages to ensure that people in mental health crisis have access to timely and appropriate support. This includes the introduction of the NHS 111 'select mental health' option in August 2024 and hundreds of alternative crisis services, including crisis cafes, sanctuaries and crisis houses which provide a supportive environment outside of traditional clinical settings. Work is underway with all ICBs to roll out crisis text services across England by Spring 2026. NHS England has successfully completed the delivery phase of the Mental Health Response Vehicles programme, with 88 vehicles now built and handed over to local systems. The Department has also committed up to £120 million to bring the total number of mental health emergency departments to 85, reducing pressure on busy A&E services and ensuring people have the support they need when they need it.

54. The Department is taking steps to ensure consistency in the quality of care provided by community mental health teams. NHS England will publish new guidance, the Personalised Care Framework, which will outline the core principles of care that all people using NHS commissioned community mental health, crisis and inpatient services should receive. The draft guidance has already been shared with systems to facilitate early adoption. The new guidance sets out the critical function of a 'named worker' as having responsibility for building a trusted relationship with the person, as well as supporting delivery of the care and support plan including co-ordinating professionals, services and agencies needed to realise it. Named workers are part of a multi-disciplinary team which has overall responsibility for the care and treatment of people within the service.

55. The introduction of a Modern Service Framework for severe mental illness will also support consistent, high quality, and high value care. Modern Service Frameworks will define an aspirational, long-term outcome goal, identify the best evidenced interventions that would support progress towards this goal, set standards on how those interventions should be used and identify areas where innovation is needed to drive progress. This is part of wider programme following the 10 Year Health Plan to improve outcomes, reduce unwarranted variation, and align provider payments with provision of high-quality care.

Communication with the bereaved families and the survivors

56. In the following section I have set out communication with the families of those who died in the attacks as well as those with the survivors of the attacks up to the date of drafting (allowing some time for clearance and finalising the draft). Communication with the families and survivors is ongoing and should the Inquiry require updated correspondence and/or minutes from meetings, I would be happy to provide these at a later date.

57. The account I provide below contains summaries taken from Department attendance notes and correspondence. Although I have attempted to present these as neutrally as possible, they reflect the Department's own account; approval or agreement by the families and survivors should not be inferred. I apologise in advance if any of their views have been misrepresented in any way. That is not my intention. I also wish to echo the Secretary of State's apology to the survivors of the attacks for not meeting with them sooner. The survivors have expressed that they have struggled to have their experiences heard. While significant attention has been given to the bereaved families, it is equally important that the survivors of the attacks receive appropriate support and public interest. Both the Secretary of State and I will work to address this to ensure that none of those affected by the horrific events on 13 June 2023 feel excluded.

Pre-July 2024 General Election

58. First contact between the bereaved families and the Department took place on 28 January 2024 when Emma Webber wrote to the Department to request a meeting with the Lord Chancellor, the Prime Minister, the Attorney General and the Health Secretary. This request was made in the context of VC's recent sentencing. As the bereaved families were already due to meet with the Prime Minister on 29 January 2024, the then Health Secretary Victoria Atkins agreed to also meet with the families on the same day. In addition to the Health Secretary, this meeting was attended by the Prime Minister and the Home Secretary **[BM1/21 - WITN0409004]**. No readout for this meeting has been found despite our searches against departmental records. The Home Office and No.10 are best placed to provide this readout, if it exists.

59. Following this meeting, the Department contacted the bereaved families on 31 January 2024 to facilitate a meeting with the CQC in light of the recent announcement of the section 48 review into NHFT **[BM1/22 - WITN0409005 and BM1/23 - WITN0409069]**.

60. On 2 February 2024, the Department contacted the families again, this time to facilitate a meeting between them and His Majesty's Crown Prosecution Service Inspectorate ('HMCPSI') given the Attorney General's announcement of HMCPSI's review **[BM1/24 - WITN0409006]**. On 9 February 2024, the Department passed on the families' concerns about the narrow scope of HMCPSI review to the Attorney General's office as the families had not had contact from the Attorney General's office **[BM1/25 - WITN0409007]**.

61. On 22 March 2024, Dr Kumar included the Health Secretary in his correspondence to the Minister for Victims and Safeguarding, Laura Farris MP **[BM1/26 - WITN0409008 and BM1/27 - WITN0312007]**. His correspondence was in relation to the inappropriate use of WhatsApp by officers of the Nottinghamshire Police Force. Minister Farris's Private Office replied on 22 March 2024 and reassured Dr Kumar that Minister Farris was monitoring developments and intended to meet with Dr Kumar again after Easter **[BM1/28 - WITN0409009]**.

62. On 25 March 2024, the Department shared the Terms of Reference for the CQC section 48 review into NHFT with the bereaved families **[BM1/29 - WITN0409010 and BM1/30 - CQCM0011937]**.

Post-July 2024 (under this Government)

63. First written contact between the bereaved families and the Department under the current Government took place on 19 July 2024 when the new Secretary of State Wes Streeting reached out to the families to offer them a meeting ahead of the publication of CQC's section 48 report into the care received by VC at NHFT **[BM1/31 - WITN0409011]**. To note, while this was the first written communication with the families under the new Government, the Secretary of State had a telephone call with Dr Sanjoy Kumar on 18 July 2024 to discuss reforms to the Mental Health Act 1983. As part of this call, Dr Kumar also raised the CQC section 48 review and shared that he wanted the review's findings to be laid in front of the Secretary of State first **[BM1/32 - WITN0409012]**. Following exchanges with the families, the meeting on the CQC section 48 report was agreed for 6 August 2024. In advance of the meeting, the families, via their solicitor, shared their concerns about the care received by VC and expressed the need to see the full report ahead of their meeting with the Secretary of State **[BM1/33 - WITN0409013]**.

64. The meeting on 6 August 2024, which both the Secretary of State and I attended, was set up to discuss the CQC section 48 review into NHFT with the bereaved families. At the meeting, the Secretary of State reflected that CQC had done a thorough job in producing this report. He also emphasised that he did not want to see these levels of failings repeated in the future and that he was keen for information not to be withheld to favour openness and transparency. DHSC officials confirmed that the CQC section 48 report would be made available to the families in full **[BM1/34 - NHSE0001541]**. Although the meeting was to discuss the CQC section 48 report, the families also raised several other concerns including:

a. The Trust's report. The families reported that they were given a high-level summary only of the Trust's report and shared that they had not had any involvement in its terms of reference. The families were disappointed with the report and expressed that they had little confidence in it. More broadly, the families said they felt this way about all ongoing investigations which they felt were too siloed and consequently reiterated their call for a statutory judge-led inquiry. The families also shared that there was a lack of accountability at a Trust-level and that relevant clinicians needed to be named.

b. The Mental Health Bill. The families emphasised that both patient safety and public protection needed to be considered and that the former should not come at the detriment of the latter. They expressed doubts that reforms to the 1983 Act would help improve patient engagement and raised concerns that once reformed, the Act would make it more difficult to detain individuals. The Secretary of State said that striking the right balance when reforming the Act was key and I echoed his point. I let the families know that I would hold their concerns in mind when reviewing reforms to the Act. Both the Secretary of State and I told the families that we were keen to engage with them further on the Mental Health Bill.

c. Evidence in Court. The families criticised the expert evidence provided by Dr Blackwood in Court. They said the outcome of manslaughter had left them feeling devoid of justice.

d. BBC Panorama Documentary. The families flagged that they had not been involved in the forthcoming BBC Panorama Documentary and that they were uncomfortable with this. The Secretary of State was concerned by this and committed to exploring this matter further **[BM1/34 - NHSE0001541]**.

65. Following the meeting, on 7 August 2024, the Department contacted the bereaved families to offer to pass on their questions about reviews conducted within the NHS to senior NHS England officials **[BM1/35 - WITN0409014]**.

66. On 12 August 2024, the Department gave the families advance sight of the press notice that it would be releasing on the Secretary of State's response to the CQC section 48 review **[BM1/36 - WITN0409015]**. Shortly after this, the Department was once again in touch with the families, this time to share a message on behalf of the Secretary of State who confirmed having spoken with the BBC Director General to voice his strong concerns that the families had not been adequately consulted in the making of the BBC Panorama documentary on the Nottingham attacks and to share his apologies that his intervention had not led to any changes or improvements **[BM1/37 - WITN0409016]**.

67. DHSC officials met with the bereaved families on 4 September 2024 to have a first meeting on the Mental Health Bill **[BM1/08 - WITN0409002]**. This meeting was offered to the families following the meeting on 6 August 2024 where some of the families had expressed wanting to provide their views on the Bill **[BM1/38 - WITN0409017]**. In advance of the meeting, on 2 September 2024, a three-page note was sent to the families, setting out some high-level background to the Independent Review of the Mental Health Act and summarising key reforms and what changes these would bring in comparison to existing legislation **[BM1/39 - WITN0409018 and BM1/40 - WITN0409019]**. As part of this meeting, officials provided the families with some background on the Bill and heard the families' views and concerns. These were as follows:

a. A strong patient-focus. The families reflected that the Bill seemed to focus excessively on patients and that other people who may be at risk needed to be considered. The families questioned where the right to liberty stops and where public safety comes in. They acknowledged that the Bill is understandably patient-centred but thought that the pendulum should not swing too far the other

way, promoting too much autonomy and least restriction. The families were particularly worried about proposed reforms to the 'nearest relative', perceiving it as involving patient families less and giving more autonomy to patients. Finally, the families were also of the opinion that the Bill focuses very little on victims and that this is a big omission of the Bill.

b. Compulsory risk assessments. The families shared that risk assessments are crucial and should be made statutory as part of the Bill, particularly as part of discharge. They also raised the importance of having a single clinician's name against any given risk assessment to ensure clinicians are held responsible.

c. Continuity of care. The families voiced that mental health patients should have a single responsible clinician to ensure continuity of care and drew parallels with physical healthcare. They expressed concern that crucial information can be lost through handovers and that having a responsible clinician throughout the course of one's mental health patient journey was essential to avoid this. This is a reform the families wanted to see included in the Bill.

d. Racial disparities. The families were worried that the Bill was trying to reduce detentions of individuals from black and ethnic minority communities simply to address a disparity rather than understand the driver of mental health problems is within this group.

e. Multi-agency checks. According to the families, if an individual is coming off a section or is being discharged into the community, it should be mandatory for a Police Liaison Officer (PLO) to conduct checks to see if there are any outstanding issues with the police, including outstanding warrants. The families also expressed that whenever a section is challenged and a panel convened, it should be mandatory for the PLO to provide input **[BM1/08 - WITN0409002]**.

68. DHSC officials considered how the above points could be incorporated into the Bill after the meeting. Officials also took the meeting as an opportunity to reassure the families that the Bill had been developed following extensive consultation and that there would be further opportunities for input into both the Bill and the Code of Practice. Officials provided further reassurance on some of the aforementioned points raised by the families, for instance, by emphasising that the aim of the Bill is not to arbitrarily reduce detentions

under the Mental Health Act, in general or for specific communities, nor to lessen the involvement of the families of those detained under the Act. Over their concerns that the Act did not touch upon victims and potential victims, officials acknowledged that the Act does not address victims or, rather, potential victims explicitly but this is a reflection of the very purpose of mental health legislation; that is to detain and treat people when they are so unwell that they become a risk to themselves or others. Legislation exists that engages victims of crime, such as the Victims and Prisoners Act 2024, which was shared with the families. Finally, officials committed to providing the families with further information after the meeting on how the Bill factors in public protection.

69. On 4 November 2024, Alex Davies-Jones MP, Parliamentary Under-Secretary of State for Victims and Tackling Violence Against Women and Girls and the Ministerial Single Point of Contact for the bereaved families, and I met with the bereaved families to share with them the steps the Department was taking to strengthen public protection measures ahead of the introduction of the Mental Health Bill to Parliament. I reassured the families that the Department had taken into consideration the points they had raised around public protection over the summer. Specifically, that officials had been looking at clinical decision-making around detention and discharge, two key areas for risk management, with a particular focus on:

    a. Strengthening statutory discharge processes to include a personalised risk assessment of the risks a patient may pose and to have a Responsible Clinician accountable for the discharged plan, but with other clinicians' involvement, improving the process through adding more voices but having a single line of accountability. The Government will build on this further in secondary legislation and statutory guidance.

    b. Strengthening clinical decision making across the detention pathway and allowing for a greater scrutiny of decisions.

    c. Amending the new detention criteria to ensure these cannot be misinterpreted to mean that clinicians cannot intervene early in deciding to detain someone who is at risk of harm to themselves and/or to others **[BM1/09 - WITN0409003]**.

70. In addition to the above, officials provided the families with more detailed information on the focal points of the Bill, making clear that the aim of the Bill is on setting national,

statutory expectations about what should happen, guiding clinicians to following these expectations and increasing accountability. Officials emphasised that these reforms had been discussed with the General Medical Council and CQC who had both reflected that having this clarity at a national level would make it easier for them to take action against individual clinicians and Trusts where errors occur. Officials also confirmed that the Department would pick up cross-agency working as part of Bill work and to work to consider whether Section 117 meetings should have mandatory attendance for. Finally, at this meeting, I offered to keep the families informed on the progress of the Bill and on any amendments **[BM1/09 - WITN0409003]**.

71. I received correspondence from Dr Kumar the next day, 5 November 2024, emphasising that inpatient to community clinician handovers should be made statutory as this is not currently covered by section 117 **[BM1/41 - WITN0409020]**. In response to this, DHSC officials drafted a letter from me informing the families that changes to section 117 could not be made at this time due to the Bill already having been introduced to Parliament and setting out plans to strengthen discharge guidance, including strengthening the coordination between inpatient settings and the community. I also highlighted proposed changes to CTOs which directly link to this point. Specifically, these would ensure the clinician responsible for a patient in the community would need to agree to the use of a CTO before discharge to the community, ensuring a smooth handover between hospital and community care and therefore allowing better supervised treatment in the community to keep the patient and others safe. In addition to this, I highlighted other wider ongoing work to improve discharge and continuity of care and assured them that these are priority areas **[BM1/42 - WITN0409021]**. Searches of Departmental records indicate that the letter was never sent to the families. I am unable to comment with certainty on why this occurred but apologise for this oversight and reiterate my commitment to open communication with the families. I have spoken with officials to reiterate the importance of any such communication being sent out promptly in future.

72. At the meeting on 4 November 2024, the families had also raised their concerns about the NHS England-commissioned independent investigation into the care and treatment received by VC. The families were discontent with communications received from NHS England's Head of Independent Investigations on the issue and, following this meeting, Emma Webber shared the correspondence in question **[BM1/43 - WITN0409022;**

BM1/44 - WITN0409023; BM1/45 - WITN0409024]. A letter was drafted explaining that I had asked my officials to speak to NHS England about the Independent Investigation reports. NHS England had advised that they intended to first share a complete independent report with the families. They confirmed that a public report would also be published but that this may differ from the report the families received due to requirements related to publication standards and data protection **[BM1/46 - WITN0409025]**. Regrettably, searches of Departmental records indicate that this letter was also erroneously not sent. I am unable to explain why this occurred but once again, apologise for this oversight (and, as above, I have spoken to officials about this).

73. On 6 November 2024, I wrote to the bereaved families separately to inform them of the formal introduction of the Mental Health Bill to the House of Lords. This marked the start of the Bill's parliamentary scrutiny process. I also shared with them the Bill itself, a summary of the reforms and their implication for public protection and the Bill's Explanatory Notes. To avoid duplication, I exhibit the email and attachments which were sent to the Webber family, noting that they are identical to those sent to the Coates and O'Malley-Kumar families. **[BM1/47 - WITN0409026; BM1/48 - WITN0409027; BM1/49 - WITN0409070; BM1/50 - WITN0409075; BM1/51 - DHSC0000150]**. In response to my update, I received further views on the Bill from the families and a request that they continue to be kept informed of key developments **[BM1/52 - WITN0409028]**. A further update was given by DHSC officials on 16 May 2025 after the Bill's transfer to the House of Commons, having completed its passage through the House of Lords. A supporting document detailing the changes made to the Bill during the House of Lords passage accompanied this update **[BM1/53 - WITN0409029 and BM1/54 - WITN0409030]**.

74. On 20 November 2024, the Secretary of State and I attended a meeting with a member of the public to hear her concerns about her son who suffers from several severe mental illnesses, and the risks she felt he posed to others. She believed there were parallels between her son and VC and invited Emma Webber to attend the meeting with the Secretary of State, to which he agreed.

75. On 20 December 2024, the Secretary of State received a letter from Dr Sanjoy Kumar raising concerns about failings in relation to the attacks, including that no clinician had yet been held accountable for any failures in VC's care. Dr Kumar also challenged the

quality of the expert evidence provided by Dr Blackwood in court and called for a judge-led statutory inquiry into the attacks **[BM1/55 - WITN0409031]**.

76. On 30 January 2025, Emma Webber, on behalf of all the bereaved families, wrote to the Secretary of State, me and other relevant Government Ministers to express their disappointment with the response to the attacks from a number of agencies and their reviews, which they felt were inadequate and poorly-handled, and to renew their request for a judge-led statutory inquiry **[BM1/56 - WITN0409032]**.

77. On 7 February 2025, the survivors' legal representative contacted the Department to express full support of a public inquiry and to request that they be included in any communications and invited to any future meetings pertaining to the Nottingham attacks **[BM1/57 - WITN0409033]**.

78. On 12 February 2025, the Secretary of State met with the bereaved families, alongside other Government Ministers, including the Prime Minister, to announce a judge-led statutory Inquiry into the Nottingham attacks to begin *'within weeks'* of the meeting **[BM1/58 - WITN0409034]**.

79. On 19 March 2025, Dr Sanjoy Kumar wrote to the Secretary of State on behalf of all the bereaved families in relation to the Theemis-led Independent Homicide Report ('IHR') commissioned on 19 March 2025. In his correspondence, Dr Kumar expressed the families' discontent with the report, notably because it did not name any clinicians. On this basis, Dr Kumar requested a meeting with the Secretary of State **[BM1/59 - WITN0409035]**.

80. On 24 March 2025, Dr Kumar wrote another email to the Secretary of State to inform him that the families also wanted to discuss the investigation into the data breach that took place at Nottingham University Hospitals NHS Trust ('NUH') **[BM1/60 - WITN0409036]**.

81. On 28 March 2025, Emma Webber wrote to the Lord Chancellor and copied in my office to share her distress at having learnt through the media that individuals had accessed footage of VC's attacks without having the authorisation to do **[BM1/61 - WITN0409037]**. Shortly after her email to me, Emma Webber wrote to the Secretary of State to bring this data breach to his attention as well **[BM1/62 - WITN0409038]**.

82. Further correspondence from the families between end of March 2025 and end of May 2025 were focused on securing a date and agreeing logistics for a meeting with the Secretary of State. Following from this, a meeting was agreed for 9 June 2025 between the bereaved families, the Secretary of State and me.

83. As set out above at paragraph [73], DHSC officials wrote to the families on 16 May 2025 to provide an update on the progress of the Mental Health Bill, which transferred to the House of Commons on 24 April 2025 after completing its passage through the House of Lords. A summary of changes that the Bill underwent during its Lords passage was also sent to the families **[BM1/53 - WITN0409029 and BM1/54 - WITN0409030]**.

84. On 28 May 2025, Dr Kumar wrote to the Secretary of State to share his correspondence with Ifti Majid, Chief Executive Office of NHFT, in which Dr Kumar detailed his frustrations with the Independent Homicide Review conducted by Theemis and raised a number of questions on its content **[BM1/63 - WITN0409039; BM1/64 - NHSE0000782; BM1/65 - NHSE0000852; BM1/66 - NHSE0002076]**. Dr Kumar subsequently shared Ifti Majid's response to his letter with the Secretary of State on 5 June 2025 **[BM1/67 - WITN0409072 and BM1/68 - NHFT0017601]**.

85. Both the Secretary of State and I attended the meeting with the bereaved families on 9 June 2025. At the meeting, the families expressed their full support for the Inquiry but stressed the importance of addressing systemic and individual-level failings without waiting for the Inquiry to conclude. The families still had a number of concerns on accountability and felt that many of their questions remained unanswered, particularly around the names of the clinicians involved in VC's care. The Secretary of State was sympathetic to the points raised by the families but also shared the potential risks associated with naming clinicians and acknowledged the tension between these two approaches. He also recognised that there were cultural issues around openness, transparency and accountability in the NHS. The Secretary of State also pointed to the upcoming 10 Year Health Plan and shared that patients harmed by the NHS were at the forefront of his thinking on this. He committed to share key headlines from the 10 Year Health Plan with the families prior to its publication and said that he was looking to the CQC to ensure more effective inspections. The families reiterated the need for meaningful learning and questioned why more tragedies from the past had not led to lasting change **[BM1/69 - WITN0409040]**.

86. On 26 June 2025, ahead of the publication of the NHS 10 Year Health Plan, which is set out in more detail below, officials wrote to the bereaved families to enquire whether they would welcome a meeting to talk through key points included in the Plan. The families accepted this meeting which went ahead on 2 July 2025. Officials followed up with the families after the meeting to share the 10 Year Health Plan with them alongside a written summary of the Plan and key points on Neighbourhood Mental Health **[BM1/70 - WITN0409041]**.

87. On 16 September 2025, Dr Sanjoy Kumar, on behalf of all the bereaved families, wrote to the Secretary of State **[BM1/71 - WITN0409042]** to request a meeting with him after his questions to NHS England on the Independent Homicide Review were only partially answered by NHS England **[BM1/72 - WITN0409043; BM1/73 - WITN0409073; BM1/74 - WITN0409044; BM1/75 - WITN0409045; BM1/76 - WITN0409046; BM1/77 - WITN0409047; BM1/78 - WITN0409048; BM1/79 - WITN0409049; BM1/80 - WITN0409050; BM1/81 - WITN0409051]**. In his correspondence, Dr Kumar also expressed wanting to discuss the data breach investigation at NUH **[BM1/71 - WITN0409042]**. Following correspondence between the Department and the bereaved families, this meeting was arranged for 8 December 2025.

88. On 19 September 2025 Dr Sanjoy Kumar wrote to CQC and the Secretary of State in relation to the Independent Homicide Review and asked CQC to review and investigate actions of the NHS England Mental Health Directorate and their failure to answer the questions posed by the families **[BM1/82 - WITN0409052 and BM1/83 - WITN0409053]**.

89. Correspondence between Dr Sanjoy Kumar and NHS England in relation to the questions the families had about the Independent Homicide Review continued between September and December 2025. The Secretary of State was copied into this correspondence **[BM1/84 - WITN0409054; BM1/85 - WITN0409055; BM1/86 - WITN0409056; BM1/87 - WITN0409057]**.

90. On 2 December 2025 Dr Sanjoy Kumar wrote to Professor Oliver Shanley OBE in relation to his involvement as an external advisor to the Independent Investigation review panel, as well as the commissioning of Theemis in the first instance. The Secretary of State was copied into this correspondence **[BM1/88 - WITN0409058 and BM1/89 - NHSE0000680]**.

91. On 8 December 2025 the Secretary of State and DHSC officials, including William Vineall, met with the O'Malley-Kumar and Webber families. At the meeting, the bereaved families called for greater transparency and described repeated difficulties in obtaining answers on the Theemis-led Independent Homicide Review as well as other organisations. They had questions about the events preceding the homicides as well as various data breaches. They described having to chase multiple organisations for answers **[BM1/90 - WITN0409059]**.

92. The families raised concerns about having to wait for the Inquiry to conclude before receiving answers to their questions as mental health homicides continue to happen, including those not subject to a public inquiry. They also sought active oversight of violent schizophrenic patients, arguing that in such cases, a Responsible Clinician should always be appointed and their care arrangements should be reviewed by consultants and psychiatrists **[BM1/90 - WITN0409059]**.

93. The families then renewed their call for 'real accountability' and described a culture of obfuscation and over-redaction in reports. They felt blanket GDPR obligations and principles of least restriction should be overridden in the interest of the public who also want truth and transparency. The Secretary of State noted the importance of not prejudicing the Inquiry but empathised with the families, having also received heavily redacted information. He committed to exploring this issue and reverting to the families in the new year **[BM1/90 - WITN0409059]**.

94. On 12 December 2025, Dr Sinead O'Malley and Dr Sanjoy Kumar wrote to the Secretary of State outlining the actions they sought the Secretary of State to take in relation to the questions posed about the Theemis-led report. They also sought an executive order to be directed to all regional mental health directors within NHSE to ensure all people with paranoid schizophrenia with a history of violence have a responsible/named consultant and that they be reviewed at least once a year in relation to medication compliance and symptom control **[BM1/91 - WITN0409060 and BM1/92 - WITN0409061]**.

95. On 13 January 2026, Dr Sanjoy Kumar wrote to the Secretary of State after a CQC inspection into NHFT rated Leadership at the Trust as 'Requires Improvement'. In his correspondence, Dr Kumar listed some of the key findings from the CQC report and called for emergency measures against the Trust Board as a result of these. He also

urged the Secretary of State to intervene immediately in NHFT **[BM1/93 - WITN0409062; BM1/94 - WITN0409076; BM1/95 - CQCM0029106]**. This is something the Webber family also requested **[BM1/96 - WITN0409063]**.

96. On 15 January 2026, Greg Almond, a solicitor representing Wayne Birkett and Sharon Miller, two of the survivors of the Nottingham attacks, wrote to the Secretary of State to request a meeting with him as soon as possible in light of the CQC report which they found deeply concerning. The survivors also expressed their belief that intervention from the Department with regards to NHFT was now necessary **[BM1/97 - WITN0409064 and BM1/98 - WITN0409065]**.

97. Following the above correspondence from the bereaved families and the survivors, DHSC officials, working with NHS England, sent the Secretary of State and me advice on action that can be taken by the Department to hold NHFT to account and drive improvement. The Secretary of State also agreed to the bereaved families and survivors' request for a meeting.

98. On 5 February 2026, the Secretary of State met with the survivors and their representatives as planned. At the meeting, he apologised for not meeting sooner and acknowledged their concerns. He said that he would ensure families were kept informed about report publications. He agreed that progress at the Trust since the CQC reports was unacceptable and said he was not personally satisfied with the pace of improvement. He explained that the Trust was under the highest level of scrutiny under the National Oversight Framework, upon which regular updates were being sought. A new Chair and CEO were also being brought in, and he was planning on meeting them. He added that the Department was looking more broadly at how to supervise people at risk - balancing autonomy with public safety **[BM1/99 - WITN0409066].**

Actions taken in response to the attacks

99. I have been asked to set out any actions the Department has taken in response to the attacks committed by VC on 13 June 2023. In responding to this question, I have set out below both direct actions taken by the Department (and the Secretary of State), such as the commissioning of CQC to carry out a rapid review of NHFT, and the measures that followed by NHFT and NHSE in response.

100. The Department recognises that there were failures in the provision of care to VC. In particular, the lack of oversight of VC's mental health in the year before the attacks was unacceptably poor and should not have been allowed to happen. NHFT operates within a broader, national framework and it is certainly not the Department's position that NHFT is solely to blame for the failings in VC's care. While I have set out the ways in which challenges within the broader system will be addressed through legislative reform and other measures, there does, of course need to be oversight of how NHFT implements the improvements to its services that are evidently required in the reports that have been produced since 2023.

101. Firstly, I wish to make clear that NHFT is a Foundation Trust which means that neither the Department nor the Secretary of State has the power to intervene in how it delivers its services. Under the current statutory framework, such action is the responsibility of NHS England and also the CQC. Foundation Trusts operate under a licence which allows NHS England to intervene where a Foundation Trust is failing to operate sufficiently well. The Department has, however, continued to commission and consider the recommendations from reviews as set out below and monitor any subsequent action taken.

102. On 29 January 2024, the former Secretary of State commissioned the CQC to carry out a rapid review of NHFT under section 48 of the Health and Social Care Act 2008. The CQC explored a rapid review of the available evidence related to the care of VC, an assessment of patient safety and quality of care provided by NHFT, and an assessment of progress made at Rampton Hospital since the most recent CQC inspection activity. Part 1 of the CQC's review was published on 26 March 2024 **[BM1/01 - WITN0155030]** and part 2, which related to the care of VC, was published on 13 August 2024 **[BM1/02 - WITN0155033]**. The report was highly critical of the Trust, stating that 'the gaps and challenges we have identified at NHFT are longstanding issues at the trust which need to be addressed' and that despite 'some evidence of improvement, we continue to have concerns about the quality and safety of patients at NHFT.' Following publication of part 2, the Secretary of State responded to the findings and provided an update on the series of measures that had already been undertaken since the publication of part 1. This included national measures undertaken by the NHS such as:

a. ensuring every provider of mental health services has clear policies and practices in place to treat patients with serious mental illness;

b. issuing guidance to trusts reiterating instructions not to discharge patients with serious mental health issues if they do not attend appointments; and

c. establishing an expert advisory group to oversee the development of core standards for safe care in community mental health services, as well as specific actions the local trust has taken, such as putting a new crisis telephone system in place.

103. In February 2024, NHFT was placed on the highest level of oversight and assurance in the NHS Oversight Framework, where it remains to this day, and has entered the Recovery Support Programme for mandated support and heightened regulatory oversight. It is therefore subject to rigorous assurance processes led by NHS England to ensure that the concerns raised by the CQC will be addressed. The CQC will determine any further enforcement action.

104. The Department has also sought assurances directly from NHSE. This included a meeting with CQC and NHSE on 31 July 2024 to discuss how they and the NHFT are progressing the CQC's recommendations **[BM1/100 - WITN0155035]**. Updates were provided in October 2024, December 2024, August 2025, and, most recently, December 2025. The Department has also been frequently monitoring the recommendations from the Independent Homicide Review into the treatment of VC in the months leading up to the events of 13 June 2023 **[BM1/101 - WITN0409074; BM1/102 - WITN0409067; BM1/103 - DHSC0000477; BM1/104 - NHSE0002879]**.

105. As set out above, in his meeting with the survivors of the attacks, the Secretary of State acknowledged that progress at the Trust since the CQC report has been disappointing. To address this, both the Secretary of State and I have requested regular updates on implementing recommendations from prior CQC reports and are planning to meet the new leadership team including a newly appointed Chair, Tom Cahill (January 2026). Recruitment is now live for a new Chief Executive, and replacements for other executive posts are underway.

106. The CQC's Well Led report (published 14 January 2026) **[BM1/95 - CQCM0029106]** rated the Trust as 'Requires Improvement' and identified important gaps with work to be done on culture, leadership, on staff engagement, and on longer term strategy development. The Trust are developing the action plan in response and once this has been submitted to CQC on 12 February 2026, it will be shared and tracked through the existing Oversight Group

107. Notwithstanding our disappointment with the pace of change, CQC recognises the Trust continues to make progress particularly in relation to the quality and safety of the services they visited. All recommendations are expected to be completed and taken through the externally chaired Evidence and Assurance Group by the end of March 2026.

108. There are also a number of other policy proposals which are being implemented or in train which I consider may improve the quality of care and therefore will hopefully make the events of June 2023 less likely to happen.

109. Assertive outreach is a further example of this. The Department has published guidance to systems on the requirements for intensive and assertive models of care, which can play a critical role in managing risk. The 10 Year Health Plan commits to 100% coverage of assertive models of care by the end of the decade.

110. The Department and NHS England are currently undertaking a supply side review of mental health services which is intended to identify unwarranted variation in service models and explore how to improve access, productivity, and quality of NHS services. It is being supported by engagement with a range of experts, including people with lived experience and system providers. Findings will be used to set out clear proposals for the future of mental health, autism and ADHD services. This should help with some of the capacity and resource gaps in the system as well as inefficiencies.

111. In light of VC's attacks, the Department reviewed the Mental Health Bill, adding improvements to the policy focusing on discharge and detention criteria as previously set out in the earlier section of this statement.

112. As previously mentioned, while not a direct response to the attacks, the Department has also introduced a Modern Service Framework for severe mental illness to support consistent, high quality, and high value care.

113. Lastly, and although not an action taken in response to the attacks, on 13 March 2025, the Prime Minister announced that NHSE will be integrated into a restructured Department of Health and Social Care. One aim of this is to provide better oversight and transparency which I believe will help address some of the issues raised above, particularly those related to lines of accountability. I summarise the purpose of such reforms below, and how the new structure seeks to foster an environment of clear, open leadership.

114. In line with the 10 Year Health Plan, the Programme's aim is to form a new single, more efficient and leaner organisation. Specifically, the intention is to build a future Department that:

a. Provides clear leadership for public health, healthcare and adult social care;

b. Fosters collective responsibility for shared objectives rather than competing priorities or silos;

c. Empowers local systems with clear and streamlined priorities and accountabilities;

d. Eliminates duplication and maximises value for money;

e. Operates with greater efficiency and focus, with clarity on what the centre should and should not do; and

f. Empowers leaders to lead whilst treating all staff with dignity, honesty and respect.

115. Following the Prime Minister's announcement, a joint DHSC-NHSE Transformation Programme was established with dual reporting lines to the DHSC Permanent Secretary (Samantha Jones) and the Chief Executive of NHSE (Sir James Mackey).

116. Since 3 November 2025, the Department and NHSE have established a single integrated senior management structure as a precursor to the Department and NHSE merger. These pragmatic transitional arrangements will support our move towards a formal merger which is anticipated in early 2027, subject to the passage of legislation. Ahead of that point, NHSE and DHSC will continue to be legally responsible for all of their

current respective statutory functions. The Department will publish an impact assessment as part of its work on the primary legislation.

117. The Department will provide the Inquiry with further updates on the merger of DHSC and NHSE, including what impact the changes will have on national mental health policy and delivery, as the plans develop.

Recommendations

118. I am asked to set out the recommendations that ought to be made by the Chair of the Inquiry. As a Department, we have already taken substantial steps, which I have set out above, to drive lasting improvements to a mental health system in sore need of reform. Work on this continues. Many of the failings in VC's care at trust level, as well as the current challenges in community mental health services I am aware of across the country, which are evident from the investigations and reports as set out above. The recent report by the Health and Social Care Select Committee, to which I gave evidence, found that too many people with severe and enduring mental illness are continuing to fall through the gaps, that waits are unacceptably long and that, too often, support is only available when people reach crisis point **[BM1/105 - WITN0409068]**. I exhibit this simply to identify that these are the conclusions reached by the Committee and assuming that the facts are not in dispute.

119. At this stage, however, before all evidence has been heard and tested before the Inquiry, I would not seek to pre-empt the findings or recommendations of the Chair or attempt to offer any remedy that goes further than the actions already being taken by the Department working with NHS England, in acknowledge of these challenges. I will of course be listening to the evidence carefully and continue to reflect upon the proposals above and how these stand up in light of any new evidence heard. During the course of the Inquiry, if the Department can learn further from these awful events and can identify further measures to better address identified failings and further reduce the risk of such attacks happening again, it will do so.

Statement of Truth

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

Signed:

GRO-B

Name: Baroness Gillian Merron

Date: 05 March 2026

IN THE MATTER OF THE INQUIRIES ACT 2005

AND IN THE MATTER OF THE INQUIRY RULES 2006

UK NOTTINGHAM INQUIRY

Index to First Witness Statement of Baroness Merron

Number	URN	Document Description	Control Number	Para Number
1	WITN0155030	Report dated 26 March 2024, compiled by CQC Re: Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust		4, 32, 102
2	WITN0155033	Report dated 13/08/2024, compiled by CQC, Re: Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust: Part 2		4, 102
3	WITN0155008	Report, dated December 2018, compiled by DHSC, Re: Modernising the Mental Health Act - Independent Review - Increasing choice, reducing compulsion		5, 7, 12, 14, 18d, 18e, 37
4	DHSC0000007	Policy Document, Re: Mental Health Act 1983: Code of Practice, Department of Health	NOT00000472	17a, 28, 35
5	WITN0155028	Report dated 05/11/2024, compiled by Department for Health and Social Care Re: Mental Health Bill, Impact Assessment		20
6	WITN0409071	Mental Health Bill memorandum on European Convention on Human Rights (ECHR).pdf	NOT00000561	21

Number	URN	Document Description	Control Number	Para Number
7	DHSC0000514	Policy document, Re: Mental Health Bill. November 2024. Equality Analysis, Family Test and Secretary of State for Health and Social Care's duties under the NHS Act 2006	NOT00000571	22
8	WITN0409002	Notes - Nottingham families meeting with DHSC officials MH Bill 04.09.2024.docx	NOT00000555	33, 67, 67e
9	WITN0409003	Readout Meeting with Nottingham families to discuss the Mental Health Bill 04.11.24.docx	NOT00000497	33, 69c, 70
10	WITN0155041	Notes, Re: Stakeholders, Org, Background, Scheduling		34
11	WITN0155039	Memo from Esther Horner to SoS and Baroness Merron, Re: Public Protection and Mental Health Act Reform		34
12	DHSC0000096	Policy document, Re: Fit for the future: 10 Year Health Plan for England - executive summary (accessible version), by DHSC and Prime Minister's Office 10 Downing Street		45
13	DHSC0000505	Processes of disengagement and engagement in assertive outreach patients: qualitative study, British Journal article of Psychiatry		49
14	DHSC0000125	Report dated 01/03/2012 compiled by Raymond Tempier, Llyod Balbuena and others RE: Does assertive community outreach improve social support? Results from the Lambeth Study of early episode psychosis		49
15	DHSC0000126	Report dated 06/01/2017 compiled by Cochrane Schizophrenia Group. RE: Intensive case management for severe mental illness		49
16	DHSC0000127	Research Article dated 16/09/2015 compiled by BMC Health Services Research RE: Fifteen-month follow up of an assertive community treatment program for chronic patients with mental illness		49
17	DHSC0000128	Publication dated 01//03/2007 compiled by American journal of Psychiatry RE: The effectiveness of assertive community treatment for homeless populations with severe mental illness: a meta analysis		49
18	DHSC0000094	Guidance, Re: Mental Health, Learning Disability and Autism Inpatient Quality Transformation programme, by NHSE		50
19	DHSC0000098	2024-25 priorities and operational planning guidance v1.1.pdf	NOT00000483	51

Number	URN	Document Description	Control Number	Para Number
20	DHSC0000101	Guidance, Re: Guidance to integrated care boards on intensive and assertive community mental health care, by NHS England	NOT00000562	52
21	WITN0409004	RE: Nottingham attacks - urgent	NOT00000473	58
22	WITN0409005	Re: Nottingham attacks - urgent	NOT00000474	59
23	WITN0409069	Email exchange dated 02.02.2024 between SofS PO and Christopher Dzikiti.	NOT00000475	59
24	WITN0409006	RE: Nottingham attacks - urgent	NOT00000476	60
25	WITN0409007	RE: Nottingham attacks - urgent	NOT00000477	60
26	WITN0409008	Fw: Letter from CC Meynell ? Nottingham Attacks	NOT00000478	61
27	WITN0312007	Letter from Kate Meynell [NGPF] to Dr Sanjoy Kumar, Re: Answers to questions raised	NOT00000479	61
28	WITN0409009	RE: Letter from CC Meynell ? Nottingham Attacks	NOT00000480	61
29	WITN0409010	Terms of Reference, CQC Review into Nottinghamshire Healthcare NHS Trust	NOT00000481	62
30	CQCM0011937	Policy Document, Re: Draft Review into Nottinghamshire Healthcare NHS Foundation Trust: Terms of Reference (Unknown Author)	NOT00000482	62
31	WITN0409011	Invitation to meet with the DHSC Secretary of State	NOT00000484	63
32	WITN0409012	Re: Invitation to meet with the DHSC Secretary of State	NOT00000485	63
33	WITN0409013	Re: Invitation to meet with the DHSC Secretary of State	NOT00000486	63
34	NHSE0001541	Minutes of Meeting re: CQC s48 Review - Nottingham Families Meeting held on 06/08/2024, dated	NOT00000490	64, 64d
35	WITN0409014	RE: Invitation to meet with the DHSC Secretary of State	NOT00000487	65
36	WITN0409015	RE: Invitation to meet with the DHSC Secretary of State	NOT00000488	66
37	WITN0409016	RE: Invitation to meet with the DHSC Secretary of State	NOT00000489	66
38	WITN0409017	RE: Invitation to meet with the DHSC Secretary of State	NOT00000491	67
39	WITN0409018	RE: Invitation to meet with the DHSC Secretary of State	NOT00000492	67
40	WITN0409019	020924_Summary of bill reforms.pdf	NOT00000493	67
41	WITN0409020	Ammendments to Mental Health Bill	NOT00000498	71
42	WITN0409021	RE: FOR CLEARANCE: Response to Dr Kumar proposal	NOT00000504	71
43	WITN0409022	Fw: VC Investigation (1 of 3)	NOT00000494	72

Number	URN	Document Description	Control Number	Para Number
44	WITN0409023	Fw: NHS investigation 2 of 3	NOT00000495	72
45	WITN0409024	Fw: NHS England Report 3 of 3	NOT00000496	72
46	WITN0409025	Draft Letter Notts Families Nov 24.docx	NOT00000505	72
47	WITN0409026	The Mental Health Bill	NOT00000499	73
48	WITN0409027	Letter to Mr & Mrs Webber 061124.pdf	NOT00000500	73
49	WITN0409070	202411096 Public protection follow up info note.pdf	NOT00000501	73
50	WITN0409075	Mental Health Bill (6 November 2024).pdf	NOT00000502	73
51	DHSC0000150	Guidance, Re: Explanatory Notes to the Mental Health Bill, House of Commons	NOT00000503	73
52	WITN0409028	Re: The Mental Health Bill	NOT00000506	73
53	WITN0409029	Update on the Mental Health Bill Email dated 16.05.2025 between Caroline Allnutt and the bereaved families	NOT00000515	73, 83
54	WITN0409030	Changes to the Mental Health Bill during Lords passage.docx	NOT00000516	73, 83
55	WITN0409031	Re: new and additional failures - Dr Sanjoy Kumar	NOT00000507	75
56	WITN0409032	RE: Meeting request - Nottingham Attack	NOT00000508	76
57	WITN0409033	RE: Public Inquiry into the Nottingham Attacks - on behalf of the surviving victims	NOT00000509	77
58	WITN0409034	Readouts: Nottingham family meeting & pre-meeting	NOT00000510	78
59	WITN0409035	RE: Nottingham attacks families do not accept NHSE homicide report	NOT00000511	79
60	WITN0409036	Re: Invitation to meet with the DHSC Secretary of State	NOT00000512	80
61	WITN0409037	URGENT- Court staff dismissal over footage	NOT00000513	81
62	WITN0409038	RE: URGENT- Court staff dismissal over footage	NOT00000514	81
63	WITN0409039	Fw: Nottinghamshire Healthcare NHS Foundation Trust level 2 Comprehensive Investigation Report	NOT00000517	84
64	NHSE0000782	Outstanding Questions regarding NHS Conduct Submitted on behalf of the Webber, O'Malley-Kumar and Coates Families UNDATED	NOT00000518	84

Number	URN	Document Description	Control Number	Para Number
65	NHSE0000852	Notes of ANSWERS TO FAMILY QUESTIONS CONCERNING VALDO CALOCANE (VC) (TO BE READ IN CONJUNCTION WITH THE DOCUMENT SUBMITTED BY THE FAMILIES' LEGAL ADVISER AND THE COVERING LETTER SENT IN RESPONSE TO THESE QUESTIONS))	NOT00000519	84
66	NHSE0002076	Letter from Dr Sanjoy Kumar to Ifti Majid [NHNB], re: Learning about recent media reports from Nottingham	NOT00000520	84
67	WITN0409072	Response to Ifti Majid letter from 2.06.2025	NOT00000521	84
68	NHFT0017601	Letter from Ifti Majid {NHFT] to Dr Sanjoy Kumar and Sinead Kumar. Re: Missed opportunities in the care of VC	NOT00000522	84
69	WITN0409040	Readout - Nottingham mental health families, 09.06.25.docx	NOT00000523	85
70	WITN0409041	Re: NHS Ten Year Plan Email chain dated 03.07.2025 between Emma Webber and Caroline Allnutt	NOT00000526	86
71	WITN0409042	Urgent call for meeting with Secretary of State	NOT00000535	87
72	WITN0409043	Nottingham attacks - Theemis Consulting Ltd NHSE report - serious concerns from families of victims	NOT00000524	87
73	WITN0409073	Letter to Clare Murdoch and Jessica Sokolov June 2025.docx	NOT00000525	87
74	WITN0409044	RE: Nottingham attacks - Theemis Consulting Ltd NHSE report - serious concerns from families of victims	NOT00000527	87
75	WITN0409045	Response to letter (This is just an email stating letter is enclosed and not the letter)	NOT00000528	87
76	WITN0409046	Response to S Kumar July 2025 FINAL.pdf	NOT00000529	87
77	WITN0409047	Re: Response to letter	NOT00000530	87
78	WITN0409048	Reply to Dr Jessica Sokolov Aug 2025.docx	NOT00000531	87
79	WITN0409049	Response to Dr. Kumar Re: September 2025 letter: Nottingham attacks - Theemis Consulting Ltd NHSE report - serious concerns from families of victims	NOT00000532	87
80	WITN0409050	Response to Dr Kumar September 2025.pdf	NOT00000533	87

Number	URN	Document Description	Control Number	Para Number
81	WITN0409051	Re: Response to Dr. Kumar Re: September 2025 letter: Nottingham attacks - Theemis Consulting Ltd NHSE report - serious concerns from families of victims	NOT00000534	87
82	WITN0409052	RE: Failings - NHSE and Theemis independent homicide report	NOT00000539	88
83	WITN0409053	Chrostopher Diziki 2.0.docx	NOT00000538	88
84	WITN0409054	RE: Response to Dr. Kumar Re: September 2025 letter: Nottingham attacks - Theemis Consulting Ltd NHSE report - serious concerns from families of victims	NOT00000536	89
85	WITN0409055	Response to Dr Kumar 19 Sept 2025.pdf	NOT00000537	89
86	WITN0409056	DVLA and Notts healthcare trust	NOT00000540	89
87	WITN0409057	Ifti Majid DVLA questions.docx	NOT00000541	89
88	WITN0409058	Re: Theemis Consulting report	NOT00000545	90
89	NHSE0000680	Report compiled by Theemis RE: Investigation Team Biographies undated	NOT00000543	90
90	WITN0409059	Nottingham families - readout, 08.12.2025.docx	NOT00000547	91, 92, 93
91	WITN0409060	RE: Urgent call for meeting with Secretary of State	NOT00000548	94
92	WITN0409061	Rt Hon Wes Streeting MP letter 12122025.docx	NOT00000546	94
93	WITN0409062	Re: Publication of inspection report: Nottinghamshire Healthcare NHS Foundation Trust	NOT00000549	95
94	WITN0409076	20260114 Nottinghamshire Healthcare well-led press release.pdf	NOT00000550	95
95	CQCM0029106	Report dated 01/09/2025, compiled by CQCM, Re: NHFT Trust Level Assessment of Well-led	NOT00000551	95 and 106
96	WITN0409063	Re: Publication of inspection report: Nottinghamshire Healthcare NHS Foundation Trust	NOT00000552	95
97	WITN0409064	URGENT - LETTER TO WES STREETING MP - ROTHERA BRAY - URGENT MEETING REQUEST	NOT00000553	96
98	WITN0409065	Letter to Wes Streeting MP.pdf	NOT00000554	96
99	WITN0409066	Readout - Secretary of State meeting with Wayne Birkett 05.02.2026.docx	NOT00000559	98
100	WITN0155035	Minute of Meeting, Re: Meeting with CQC and NHSE - Nottingham s48 Review, dated 31/07/24	NOT00000425	104

Number	URN	Document Description	Control Number	Para Number
101	WITN0409074	Notts update briefing for SofS FINAL_October 2024.docx	NOT00000558	104
102	WITN0409067	Nottingham Table of CQC s48 Recommendations November 24 update Final.docx	NOT00000557	104
103	DHSC0000477	Recommendations from Nottingham Investigations July 2025.docx	NOT00000556	104
104	NHSE0002879	Recommendations from Nottingham Investigations December 25.docx	NOT00000544	104
105	WITN0409068	Health and Social Care Committee - Community Mental Health Services Fourth Report of Session 2024-25.pdf	NOT00000542	118