CLOSING SUBMISSIONS TO THE NOTTINGHAM INQUIRY

ON BEHALF OF NHS ENGLAND

Introduction

1. This is the Closing Statement of NHS England to the Nottingham Public Inquiry (the "**Inquiry**").

2. At the outset of these submissions, NHS England reiterates its sincere and unreserved apology to all those affected by the serious failings in the care provided to VC.[1]

3. NHS England further recognises that an apology alone is insufficient. NHS England is committed to learning from the events at the heart of this Inquiry, including improving how it engages with families in circumstances of profound trauma, and to supporting the Inquiry in ensuring that its findings lead to tangible and enduring improvements.

4. NHS England's position is that the single most important measure for reducing the risk of harm is ensuring that people experiencing psychosis receive timely, effective and evidence-based treatment. The evidence before the Inquiry has demonstrated the importance of early access to appropriate assessment, intervention and continuing care, and NHS England remains committed to supporting improvements in the quality, consistency and accessibility of those services.

5. NHS England has engaged fully with the Inquiry and carefully considered the evidence as it relates to NHS England's responsibilities, including its role in multi-agency working. The Inquiry heard oral evidence from three NHS England

[1] [WITN0310001_0006]; [WITN0364001_0002]; [WITN0365001_0002]; [SUBS0000011_0001]; [Anna Bicarregui, 24 February 2026, 21/9 to 22/2] [INQT0000003]; [Dr Jessica Sokolov, 3 June 2026, 97/15-19] [INQT0000107]

witnesses: (1) Dr Adrian James, National Medical Director for Mental Health and Neurodiversity on 21 May 2026;[2] (2) Professor Tim Kendall, National Clinical Lead for New Models of Mental Health in England on 29 May 2026[3] and (3) Dr Jessica Sokolov, Medical Director for NHS England Midlands Region[4] on 3 June 2026.[5] Their oral evidence to the Inquiry is referenced in detail in this Closing statement. The Closing statement also refers to evidence in the corporate witness statement provided to the Inquiry, signed by Dale Bywater ("**CWS**")[6] and additional documents provided by NHS England to the Inquiry.

6. NHS England has provided rolling batch disclosure to the Inquiry as requested with regular updated material being provided. These updates included papers and action trackers from NHS England's Improvement Oversight and Assurance Group ("**IOAG**") that was overseeing and monitoring the progress of the Nottinghamshire Healthcare NHS Foundation Trust ("**NHFT**") against recommendations made by the Care Quality Commission ("**CQC**") and the Theemis Report to ensure that the Inquiry was kept up-to-date with the progress and areas which still required further work.

7. These submissions address a number of specific topics or points of challenge or disagreement. A comprehensive overview of the evidence would be impossible, and probably unhelpful. We have focussed on NHS England's contribution or actions in the Relevant Period. However, at many times these submissions consider wider perspectives relating to the performance of the NHS and its many components. NHS England appreciates that all written and oral evidence will be carefully considered by the Inquiry.

Outline of Contents

8. This written Closing covers the following matters:

---

[2] [INQT0000094]
[3] [INQT0000102]
[4] The Regional Medical Directorate leads for the Midlands on Mental Health, Learning Disability and Autism, Primary Care Transformation, Long Term Condition management, and Prevention. [WITN0364001_003]
[5] [INQT0000107]
[6] [WITN0310001]

a. The structure, role and remit of NHS England in the NHS in England

    i. Overview;

    ii. The role of NHS England;

    iii. Enforcement and oversight;

    iv. Nottinghamshire Healthcare NHS Foundation Trust;

    v. Information Sharing Arrangements and Policies.

b. The Mental Health Landscape in England:

    i. Development and change in the last 30 years;

    ii. Policy framework;

    iii. Resilience and challenges.

c. Models of care:

    i. Assertive outreach/Assertive Outreach Teams;

    ii. 24/7 Neighbourhood Mental Health Centres.

d. Improving safety

    i. The Patient Safety Incident Response;

    ii. Mental Health Homicides and Independent Patient Safety Investigations;

    iii. Purpose of NHS England commissioned independent patient safety incident reports;

    iv. Publication of Independent Mental Health Homicide Investigation Reports;

    v. Learning from previous mental health homicides;

vi. The work of the National Confidential Inquiry into Suicide and Homicide.

e. Steps taken by NHS England post 13 June 2023

i. The Mental Health Personalised Care Framework;

ii. Unauthorised access to patient data;

iii. Response to the Theemis Report;

iv. NHS England's progress implementing the recommendations of the Theemis Report and the CQC section 48 report.

f. Engagement with families;

g. Conclusion.

The structure, role and remit of NHS England in the NHS in England

General overview

9. We refer the Inquiry to the CWS and Opening Statement of NHS England,[7] and also the Corporate Witness Statement of William Vineall on behalf of the Department for Health and Social Care (the "**DHSC**"), for a full explanation of the role and remit of NHS England.[8] Oral evidence has also been provided by NHS England witnesses on its role at a national (Dr James) and regional (Dr Sokolov) level. These submissions summarise the core responsibilities of NHS England insofar as they are relevant to this Inquiry.

10. In accordance with the framework established by Parliament, the NHS in England is not a single organisation but a system comprising a number of distinct bodies with different roles, including commissioners, regulators and service providers. NHS England is one part of that system, alongside local commissioners (now Integrated Care Boards ("**ICBs**")) and NHS service providers.[9] It has held that

[7] [SUBS0000011]
[8] [WITN0310001_0011 to 0018 paragraphs 23 to 40]; [WITN0155001_0001 to 0018 paragraphs 3 to 56] (First Witness Statement of William Vineall)
[9] [WITN0310001_0011 paragraphs 23 and 24]

position since 2013 and during the events scrutinised by the Inquiry. On the anticipated assumptions of its responsibilities by the DHSC, please see the Conclusion at paragraph 197 below.

11. As the Inquiry has heard, NHS England is the body responsible for the strategic co-ordination of health care services in England, arranging the provision of certain specialised health care services, and the oversight of local commissioners and providers of health care services.[10] It also provides leadership and operational guidance to NHS organisations in England. It works closely with the DHSC, which is responsible for its oversight as well as for setting the strategic direction and resourcing of the NHS in England.

12. In England, there are 36 ICBs,[11] 205 NHS Trusts and NHS Foundation Trusts (together "**NHS Trusts**"),[12] 6,624 GP surgeries[13] and 50,572 GPs. In the Midlands region alone, there are 11 ICBs,[14] 40 NHS Trusts,[15] 1,268 GP surgeries[16] and 9,615 GPs. Within the NHS Nottingham and Nottinghamshire ICB area[17] there are 5 NHS Trusts and 1,000 GPs, covering a population of approximately 1.2 million people.[18] Direct oversight by NHS England at a national level or even by individual NHS England regions of so many providers would be unfeasible and unsafe (as well as threatening to overshadow valuable local expertise and innovation). It is for that reason that oversight within the NHS is multilayered and staged.

13. The oversight and assurance process begins with each NHS Trust, with each being responsible and accountable for the provision of services within its area via its Board Leadership, supported by Trust internal governance arrangements

---

[10] See in particular s1H of the National Health Service Act 2006
[11] At the time of these Closing submissions, a number of ICBs are operating under "clustering arrangements". Under these arrangements, ICBs work together through shared leadership and combined teams, but they remain separate legal entities.
[12] This number can change over time due to NHS mergers and acquisitions.
[13] This number will vary over time.
[14] There are five clusters in the Midlands - the Nottingham and Nottinghamshire ICB is working in a cluster with Derby and Derbyshire ICB and Lincolnshire ICB.
[15] [WITN0310001_0014]
[16] This number will vary over time, and does not include prisons.
[17] [WITN0223001_0010] (First Witness Statement of Amanda Sullivan)
[18] [WITN0223001_0006 paragraph 17]

designed to provide assurance as to the quality and safety of those services.[19] NHS Trusts are subject to oversight within the NHS system, with ICBs overseeing the quality and suitability of services provided to their local populations as commissioners, and NHS England then exercising system-wide oversight of both NHS Trusts and ICBs through its oversight framework.

14. Separately, it is the CQC's role to register, monitor and inspect registered providers to assess whether they are delivering safe and high-quality care, and to take enforcement action where standards fall short.

15. The NHS England Oversight Framework draws on information from NHS Trusts, ICBs and the CQC to understand the performance and risks of individual providers and, where appropriate, determine whether support or intervention is required. NHS England's oversight of NHFT both before and after 13 June 2023 is covered in detail below. However, that oversight and assurance must be understood in the context of the size and complexity of the NHS if NHS England's role is to be properly assessed.

The role of NHS England

16. NHS England was established as an Executive Non-Departmental Public Body sponsored by the DHSC on 1 October 2012, and became fully operational on 1 April 2013. The Secretary of State for Health and Social Care ("**SSHSC**") has an overarching duty to promote a comprehensive health service in England and has responsibility to Parliament for the health service as a whole. Within that framework, NHS England is accountable to the SSHSC, including through the mandate issued under section 13A of the National Health Service Act 2006 (the "**2006 Act**") which sets out the objectives NHS England should seek to achieve in the exercise of its functions.[20]

17. NHS England's primary responsibilities are the co-ordination of the provision of health care services in England, the exercise of certain commissioning functions,

---

[19] [WITN0310001_0048 paragraph 146]. Regarding Nottinghamshire Healthcare NHS Foundation Trust, see [WITN0310001_0146 to 0147 paragraphs 480 to 486]; [WITN0133001_0010 to 0041 paragraphs 34 to 137]

[20] [WITN0310001_0011 to 0012 paragraphs 25 to 28a]

and oversight of local commissioners and providers. Pursuant to section 1H of the 2006 Act, NHS England is under a general duty to exercise its functions so as to secure that services are provided for the purposes of the NHS in England. This is a national-level responsibility, requiring NHS England to ensure that an effective system is in place for the planning and commissioning of health services. In exercising its functions, NHS England is subject to statutory duties, including duties to promote quality, reduce inequalities and act efficiently.[21]

18. By contrast, ICBs are local statutory bodies responsible for commissioning and arranging the delivery of the majority of NHS services within their geographic areas. Pursuant to section 3(1) of the 2006 Act, ICBs must arrange for the provision of such services as they consider appropriate to meet the reasonable requirements of their local population.

19. NHS England operates through a national structure, supported by seven regional teams. For the purposes of this Inquiry, the relevant regional team is NHS England's regional office referred to as 'NHS Midlands' in this statement.

20. NHS England's regional teams are responsible for overseeing the performance of NHS organisations within their regions in relation to quality, finance and operational performance. However, this is an oversight function only. Operational management of NHS Trusts remains the responsibility of their respective Boards, which are accountable for their day-to-day running and performance.[22]

21. Further detail on the role of regions within NHS England's Operating Framework is set out at paragraph 33 of the CWS.[23] NHS England's oversight role is addressed in further detail from paragraph 29 below.

22. NHS England does not set strategic health policy or determine financial allocations across the NHS system; those functions sit with the DHSC.

---

[21] See in particular sections 13C to 13G of the 2006 Act
[22] [WITN0310001_0048 paragraph 146]; [WITN0133001_0010 to 0041 paragraphs 34 to 137]
[23] [WITN0310001_0015]

23. Further details of NHS England's role in relevant policy and guidance documents during the Relevant Period are set out at section 2 of the CWS.

24. NHS England has a limited role in the dissemination of detailed clinical guidance and the determination of best clinical practice, these functions primarily sitting with other bodies. In particular, the National Institute for Health and Care Excellence ("**NICE**") is responsible for issuing evidence-based clinical guidelines and recommendations on the diagnosis, treatment and management of diseases and other conditions (including schizophrenia).[24] Written evidence from Professor Jonathan Benger CBE has been provided to the Inquiry setting out the guidance provided by NICE during the Relevant Period[25]. He further confirmed that updates to guidance are *"prepared by NICE based on surveillance activity identifying matters such as new evidence of national strategies."*[26]

25. In addition, Royal Colleges, professional societies and regulatory bodies, such as the General Medical Council ("**GMC**") and the Nursing and Midwifery Council ("**NMC**"), publish clinical and professional guidance for use across the system.

26. Professional regulation, including the setting of standards of conduct and the investigation and determination of disciplinary matters, falls within the remit of statutory regulators such as the GMC and the NMC. NHS England is not a professional regulator and has no direct role in disciplinary proceedings against individual clinicians.

27. NHS England does not inspect clinical services or monitor the quality of care provided – this is the responsibility of the CQC. The CQC inspects NHS Trusts and other independent sector providers, and exercises civil and criminal enforcement powers under the Health and Social Care Act 2008. As Chris Dzikiti (Interim Chief Inspector of Mental Health and Executive Director for Operations at the CQC) explains in his First Witness Statement, "*enforcement is one of the core components of the operating model that CQC uses to achieve our purpose*

---

[24] [WITN0310001_0018 paragraphs 37 and 38]
[25] [WITN0111001_0009 to 0010] (First Witness Statement of Professor Jonathan Benger CBE)
[26] [WITN0111001_0007 paragraph 25]

and perform our role".[27] The CQC's enforcement powers extend well beyond simply raising concerns. They include the imposition or removal of conditions of registration, suspension or cancellation of registration, as well as criminal enforcement actions such as cautions, fixed penalty notices and prosecution (for example, if a provider has breached its obligation to provide safe care and treatment under regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).[28] These powers enable the CQC to take direct regulatory action where concerns are identified and to hold both providers and certain individuals who work for providers to account.[29]

28. The respective roles of the CQC and NHS England therefore reflect their statutory functions and expertise. However, and as recognised by Chris Dzikiti, there is close working and information sharing between the organisations.[30]

Enforcement and oversight

29. NHS England exercises oversight of ICBs and providers through a range of regulatory and enforcement mechanisms, primarily via the NHS provider licence regime. Under section 106 of the Health and Social Care Act 2012, NHS England may take enforcement action where a licence condition has been breached.[31] In line with its Enforcement Guidance,[32] NHS England can accept undertakings from providers and impose licence conditions or compliance requirements where it is satisfied that a provider is failing or is at risk of failing to comply with its obligations. In exercising these powers, NHS England will, where appropriate, work through ICBs in the first instance, seeking resolution locally before escalation. Where NHS England intervenes directly with providers, it does so with the relevant ICB's awareness.

---

[27] [WITN0091001_0048 paragraph 134] (First Witness Statement of Chris Dzikiti)
[28] The CQC can prosecute for a breach of regulation 12 or a breach of part of that regulation if a failure to meet the regulation results in avoidable harm to a person using the service or if a person using the service is exposed to significant risk of harm. They do not have to serve a warning notice before prosecution
[29] [Chris Dzikiti, 3 June 2026, 37/9-24] [INQT0000108]
[30] [Chris Dzikiti, 3 June 2026, 37/25 to 38/10, 59/20-23] [INQT0000108]
[31] [WITN0310001_0036 to 0037 paragraphs 109 to 113]
[32] [NHSE0000416]

30. The Oversight Frameworks in place during the Relevant Period are summarised at paragraphs 97 to 105 of the CWS.[33] Under the Oversight Framework in place from 2022, organisations were assigned to segments according to their performance. There were 4 segments, with organisations in segment 1 having no specific support needs and organisations in segment 4 requiring mandated intensive support. ICBs and NHS Trusts allocated to segment 4 would enter the Recovery Support Programme (the "**RSP**").

31. The RSP was NHS England's intensive support and oversight regime for the most challenged organisations. In the case of NHFT, this included the appointment of an Improvement Director to work closely with NHFT in driving recovery and improvement.

Nottinghamshire Healthcare NHS Foundation Trust

32. Section 5 of the CWS (as well as NHS England's opening submissions) provide detail of NHS England's involvement in the oversight of NHFT.[34] This was also addressed in Dr Sokolov's oral evidence.[35]

33. Formal enhanced surveillance of NHFT commenced in August 2019, and from 2021 onwards NHFT was consistently placed in segment 3. The key drivers for NHFT entering segment 3 in 2021 were the CQC ratings for the Rampton Hospital (high secure services) and the Seacole Ward at the Wells Road Centre[36] (neither of which provided care to VC).

34. In February 2024, NHFT was placed in segment 4 due to quality, safety and financial concerns across a range of service provisions. A paper was presented to the NHS Midlands Regional Support Group outlining the reasons for mandated intensive support.[37] The key considerations (which were set out in the February 2024 paper)[38] included the provision of high secure services and re-licensing, offender health service provision, staff suspensions due to serious misconduct,

---

[33] [WITN0310001_0032 to 0035]
[34] [WITN0310001_0146 to 0157]; [SUBS0000011_0009 to 0011]
[35] [Dr Jessica Sokolov, 3 June 2026, 41/25-42/3; 61/14-73/24; 79/3-89/8] [INQT0000107]
[36] [NHSE0000383]
[37] [NHSE0000426]
[38] [NHSE0000426]

the investigation relating to the care and treatment of VC, concerns around certain medium secure services and concerns regarding NHFT's financial position. As explained by Dr Sokolov in her evidence, the decision to place NHFT in the enhanced support regime was not due to one single issue, but rather the cumulative impact of a number of concerns; concerns which had increased in the second half of 2023.[39]

35. Details of the support put in place by NHS England are set out at paragraphs 500 to 509 of the CWS.[40] This includes NHFT entering the RSP at the end of February 2024 and the appointment of an embedded Improvement Director who has visibility of NHFT's performance and improvement activity, including on matters such as improvements to risk assessment processes.[41] The Improvement Director does not undertake inspections of services - that function remains the responsibility of the CQC.[42]

36. Although RSP ceased as a programme at the end of March 2026, NHFT remains subject to enhanced regional oversight, including the support from the embedded Improvement Director as described above.[43] That oversight will continue for as long as it is considered necessary, and there is currently no identified exit date. NHS England recognises that NHFT remains a challenged organisation and is committed to maintaining appropriate oversight until there is sustained improvement.[44] The continuation of enhanced scrutiny and support will not be affected by NHS England's transition into the DHSC.[45]

Information Sharing Arrangements and Policies

37. NHS England accepts the overarching principle that information sharing across public bodies is a key part of risk management and, more broadly, is important to provide good care for individuals being treated for mental health disorders. However, the extent to which that overarching principle requires development in

[39] [Dr Jessica Sokolov, 3 June 2026, 79/21 to 81/9, 84/20 – 86/8, 88/4-6] [INQT0000107]
[40] [WITN0310001_0151 to 0154]
[41] [Dr Jessica Sokolov, 3 June 2026, 73/10-24] [INQT0000107]
[42] [Dr Jessica Sokolov, 3 June 2026, 71/1-6] [INQT0000107]
[43] [Dr Jessica Sokolov, 3 June 2026, 65/3-8] [INQT0000107]
[44] [Dr Jessica Sokolov, 3 June 2026, 65/18-25] [INQT0000107]
[45] [Dr Jessica Sokolov, 3 June 2026, 77/17-78/6] [INQT0000107]

further or additional national guidance is a nuanced and difficult issue, as reflected in the evidence provided to the Inquiry.

38. NHS England was asked to provide further evidence to the Inquiry about information sharing, including securing information from third parties, and did so in the form of a third witness statement from Dr James.[46] That set out references to the guidance available nationally, including the DHSC's Public Interest Guidance,[47] guidance issued by the professional regulators, and the more granular guidance issued by NHS England on topics such as sharing information with the police.[48] The statement noted that introducing additional national guidance without a careful joint developmental approach would risk creating competing information-sharing frameworks across the system, potentially leading to inconsistency rather than greater clarity.

39. Dr James was asked to comment on the specific of issue of whether a nationally mandated pro forma had been issued by NHS England for NHS providers to use when requesting information about a person from non-NHS organisations such as the police. He explained that this was not in existence and set out the reasons why NHS England has not developed such a form, including the responsibility of each organisation to develop processes that reflect its legal obligations when sharing information it holds.

40. This issue of information sharing and NHS England developing or endorsing a pro forma for NHS services to request information from other bodies was also explored in oral evidence with Dr James.[49] He explained that he was aware that there were other local versions of the information sharing form that had been provided to the Inquiry by Dr Dissanayaka and which was used in Leeds (notably Dr James was aware of such a form in his own NHS Trust and in the South London and Maudsley NHS Foundation Trust).[50] We note that Rob Griffin, Temporary Deputy Chief Constable of Nottinghamshire Police has recently confirmed there was an information sharing agreement in place between NHFT

[46] [WITN0365006]
[47] [NUHT0000028]
[48] [NHSE0000544]
[49] [Dr Adrian James, 21 May 2026, 67/11–79/12] [INQT0000094]
[50] [Dr Adrian James, 21 May 2026, 72/18–74/3] [INQT0000094]

and the police force throughout the period from 2020 – 2023, which remains in effect.[51]

The Mental Health Landscape in England

Development and change in the last 30 years

41. Since the death of GRO-D in 1992 and the publication of the Ritchie Report into the Care and Treatment of Christopher Clunis in 1994,[52] mental health services have undergone profound change. The system that exists today is larger and more complex than the one considered by the Ritchie Inquiry. Care that was once predominantly delivered in institutional settings[53] is now delivered overwhelmingly in the community, reflecting successive policy decisions, advances in treatment, greater recognition of mental illness and the rights of patients, and efforts to provide care in less restrictive environments. Responsibilities for the provision of services have shifted, in particular from 2012 when responsibilities for the provision of addiction and substance abuse services shifted to local authorities as part of their public health functions.[54]

42. This transformation has been accompanied by substantial growth in demand. Mental health services now support people with a wider range of needs, greater clinical complexity, and often with co-existing social, physical health and substance misuse issues. Services are expected not only to provide treatment, but also to manage safeguarding concerns and risk across multiple settings and organisations.

43. Against that background, direct comparisons between the risks managed by mental health services in the early 1990s and those managed today are not straightforward. However, the Inquiry may be concerned to examine the evidence of trends in mental health homicides over these years, or to ask whether the expansion of community-based treatment has been accompanied by an increase in the prevalence of mental health homicides. Since this will be a matter for the

[51] [WITN0074003_0013 to 0016 paragraphs 61-64]
[52] [DHSC0000160]
[53] [NHSE0003209]
[54] Health and Social Care Act 2012.

consideration of the Inquiry and its experts, detailed analysis is not presented by NHS England.

44. However, review of data from the National Confidential Inquiry into Suicide and Homicide ("**NCISH**") and associated material[55] appears to suggest that the overall prevalence of mental health homicides has not increased over the 30+ years since 1992, despite the trends in mental health needs and delivery referred to above. The data also suggests a continuing need to ensure the effective provision of services to people with severe mental illness, particularly schizophrenia and other psychotic disorders, and to address associated physical health and social vulnerabilities. Links between substance misuse and other comorbidities are highlighted, including the need for more targeted intervention and prevention (including public-health work) in relation to substance abuse. The data is not suitable to enable conclusions about specific models of intervention or mental health.

Policy framework

45. The Inquiry has heard evidence that there is an established system of legislation, policy, clinical guidance (including NICE guidelines) and service models intended to support people experiencing severe mental illness, including patients with psychotic disorders such as schizophrenia. In particular, NHS England's evidence has addressed the legislative and policy framework for mental health services, including the Mental Health Act 1983, the Mental Capacity Act 2005, the Five Year Forward View for Mental Health, the NHS Long Term Plan, the Community Mental Health Framework, and the commissioning and delivery of Early Intervention in Psychosis services, crisis services, and community mental health teams. A detailed account of the mental health policy landscape is set out in Section 2 of the CWS[56] and need not be repeated in these submissions, save where relevant to the issues under consideration.

46. Throughout the Relevant Period, NHS England remained committed to improving mental health provision as a whole. Where targeted programmes were

[55] [WITN0069003]; [WITN0075013]; [WITN0069005]; [WITN0069011]
[56] [WITN0310001_0061 to 0108 paragraphs 204-351]

introduced, these were designed to provide additional support in areas of identified need, such as perinatal mental health services, or where the potential benefit and impact were greatest, such as 24/7 crisis lines and mental health support in schools. Alongside these initiatives, NHS England continued to support the development of more integrated models of care for people with mental health needs, recognising the importance of timely intervention and coordinated support across services. These targeted programmes therefore complemented, rather than displaced, broader efforts to improve mental health services. Throughout, considerations of patient welfare and public safety remained central to decision-making.

47. In relation to psychosis, NHS England consistently supported investment in services designed to deliver effective, evidence-based treatment for people experiencing psychosis, including those with schizophrenia. This has included sustained investment in Early Intervention in Psychosis services, supported by national access and waiting time standards and ongoing audit to drive improvements in quality and outcomes, as well as investment in core community mental health services through the Community Mental Health Framework, particularly in strengthening rehabilitation services, which are predominantly aimed at people with psychosis.

48. Against that background, NHS England's position is that the evidence suggests that public safety has always been an integral part of national mental health policy and guidance. It demonstrates the need for continued focus on the effective implementation of established standards and good practice, particularly in areas relating to risk identification, care coordination and the management of patients with complex needs.

49. The Inquiry may want to consider recommending that NICE undertakes a review and update of its guidelines on psychosis and schizophrenia. In particular, consideration could be given to whether updated guidance should address:

    a. the promotion and maintenance of continuity of care in community mental health services, including approaches to reducing fragmentation, minimising

unnecessary handovers between services, and preventing individuals with psychosis from becoming disengaged from care;

b. the assessment, management and engagement of individuals who disengage from services, including those in stable accommodation and those who are homeless, itinerant or otherwise living in unstable accommodation;

c. the assessment and management in the community of individuals with psychosis who have a history of violence, including consideration of risk assessment, risk management and engagement strategies; and

d. the circumstances in which discharge from mental health services is, and is not, clinically appropriate, including factors relevant to discharge planning, continuity of care and ongoing risk management.

50. In addition, we note that the Inquiry has heard evidence regarding the need for further clinical training, including upon issues related to the management of patients with challenging presentations or issues such as risk assessment.[57] NHS England would invite the Inquiry to consider a recommendation that NHS England should work with the relevant Royal Colleges and the NMC to develop further clinical training with a specific focus on meeting the needs of, and managing the risks associated with, higher risk patients.

Resilience and challenges

51. The Inquiry has heard evidence about the significant challenges facing mental health services. Demand for mental health services has increased significantly in recent years, with rising acuity and complexity of need, meaning patients are often more unwell by the time they access care, particularly following long waits.[58]More broadly, the Inquiry has been provided with evidence that these pressures have been recognised nationally for some time and have been the subject of sustained policy attention. As explained at paragraphs 246 to 251 of

[57] [Emma Robinson, 5 May 2026, 2/14-3/10] [INQT0000071]; [Sharon Heath, 5 May 2026, 108/11-14] [INQT0000071]; [Christopher Hart, 29 May 2026, 65/6-66/5] [INQT0000102]
[58] See for example [CQCM0029115]

the CWS,[59] the Mental Health Investment Standard was introduced by NHS England in 2016/17 and requires local commissioners to increase their spending on mental health services by at least the same proportion as the increase in their overall programme allocation.

52. Despite this, the Inquiry has heard evidence that mental health services continued to face substantial resource and workforce pressures throughout the Relevant Period. CTI highlighted that "*Lord Darzi's 2024 Independent Investigation of the NHS concluded 'there is a fundamental problem in the distribution of resources between mental and physical health.' Despite mental health accounting for over 20% of the total disease burden, it receives less than 10% of the NHS expenditure.*"[60] Dr Shubulade Smith, President of the Royal College of Psychiatrists, described the impact of funding constraints and workforce shortages on mental health NHS Trusts, explaining that "*nearly every single Mental Health Trust is required to deliver the same care, if not more care but on less budget*", with NHS Trusts continually seeking "*cost improvement savings*" in order to meet increasing demand on limited resources.[61] The Inquiry has also heard evidence from NHFT witnesses regarding capacity pressures affecting service provision.[62] These challenges arose in the context of finite NHS resources and included the additional pressures associated with the Covid-19 pandemic, which took place during the Relevant Period.[63]

53. There is nevertheless evidence before the Inquiry that NHS staff routinely adapt to resource and capacity pressures in order to continue delivering care. As one witness observed, *"we did manage: we made the best of what we could, which is how a lot of the NHS works."*[64] NHS England acknowledges the dedication of NHS staff members who continue to exhibit such behaviours on a daily basis. Dr Sokolov's evidence included an illustration of the pressures that are regularly

---

[59] [WITN0310001_0073 to 0074]
[60] [Baroness Merron, 4 June 2026, 37/11-39/22] [INQT0000110]
[61] [Dr Shubulade Smith, 1 June 2026, 85/13-20] [INQT0000103]
[62] [SUBS0000013_0020 to 0021 paragraphs 89-92]. See also, for example, [Dr Vidayah Adamson, 2 June 2026, 5/24-8/9] [INQT0000105]; [Dr Tuhina Lloyd, 6 May 2026, 75/15-18] [INQT0000074]
[63] [Rachel Langdale KC, 23 February 2026, 236/14-23] [INQT0000001] [SUBS0000013_0019 paragraph 82]
[64] [WITN0460001_0015 paragraph 61] (First Witness Statement of Kelly Simpson)

faced by NHS providers and commissioners in seeking to make the most appropriate use of finite resources. She acknowledged that NHS England had not recently been able to secure additional funding for Assertive Outreach Teams ("**AOTs**") teams, but that in the Midlands it had been possible to establish 6 dedicated AOTs, yet "*.. without an expansion of the resource, that means that's being funded through something else being reduced.*"[65]

54. One manifestation of the wider capacity pressures outlined above has been the continuing challenge of ensuring sufficient inpatient and community mental health capacity, including reducing reliance on out-of-area placements ("**OAPs**"). Capacity constraints within mental health services, including pressures on inpatient beds, crisis services and community provision, have also been recognised nationally. The Five Year Forward View for Mental Health (2016) and the NHS Long Term Plan (2019) both identified the need to reduce and ultimately eliminate inappropriate OAPs. Dr James' first witness statement to this Inquiry sets out how the NHS has worked for a decade to reduce inappropriate placements, but acknowledges that additional measures are still needed.[66]

55. Against that background, the Inquiry has heard evidence suggesting that pressures on mental health capacity, and in particular a decrease in psychiatric beds, correlates with an increase in the prison population.[67] It is submitted that the fact that an individual with mental illness comes into contact with criminal justice agencies does not, in itself, demonstrate a failure of mental health services or a lack of available capacity.

56. NHS England further respectfully submits that caution is required before drawing broad conclusions about the consequences of capacity changes. The vast majority of interactions between mental health services and patients are managed safely and effectively. While there have been significant changes in the configuration of mental health services over time, including a reduction in inpatient bed numbers,[68] NHS England has already referred, at paragraph 43

---

[65] [Dr Jessica Sokolov, 3 June 2026, 75/6-16] [INQT0000107]
[66] [WITN0365001_0008 paragraph 15]
[67] [Julian Hendy, 28 May 2026, 44/16-22] [INQT0000100]
[68] NHS England has provided the Inquiry with statistics on the average number of available beds since the late 1980s.

above, to the apparent absence of evidence suggesting that this has been associated with an increase in homicides committed by people in contact with mental health services. This illustrates the importance of exercising caution before inferring a causal relationship between changes in inpatient capacity and adverse outcomes, whether in the criminal justice system or elsewhere.

57. NHS England reiterates its view that the single most important measure for reducing the risk of harm is ensuring that people experiencing psychosis receive timely, effective and evidence-based treatment. Effective treatment improves outcomes for patients and is fundamental to risk management, as individuals whose symptoms are appropriately recognised, monitored and treated are generally at lower risk of harm to themselves and to others. Accordingly, NHS England's focus continues to be on strengthening the delivery of high-quality evidenced-based treatment and care, recognising that effective clinical intervention is the foundation upon which patient safety depends.

58. More generally, access to timely, high-quality and well-run services, together with the consistent delivery of evidence-based care, is critical to the safety and effectiveness of mental health services. Sustainable improvement therefore depends upon ensuring that all elements of the pathway are sufficiently resourced, coordinated and able to operate effectively together.[69]

Models of Care

Assertive outreach/Assertive Outreach Teams

59. The Inquiry has heard detailed evidence concerning assertive outreach, including the principles underpinning it, the role of AOTs, and ways in which assertive and intensive treatment is delivered within community mental health services across England.

[69] [WITN0310001_0074]; [William Vineall, 4 June 2026, 11/12-12/1; 18/14-19] [INQT0000109]; [Baroness Merron, 4 June 2026, 37/11-39/22] [INQT0000110]; [Dr Adrian James, 21 May 2026, 89/6-17] [INQT0000094]

60. The introduction of, and changes to, AOTs is set out at paragraphs 318 to 319 of the CWS[70] and is not repeated here.

61. One of the challenges highlighted by this Inquiry is how national policy objectives are maintained over time once they have been delivered. AOTs provide an example of this challenge. The Inquiry has heard that national policy, implemented through the National Service Framework, led to the establishment of AOTs across the country in order to deliver assertive case management in line with NICE guidance. The Inquiry has also heard that there was subsequently no national policy change requiring AOTs to be discontinued, and the relevant NICE guidance continued to recommend consideration of "intensive case management" for patients with psychosis or schizophrenia who were likely to disengage from treatment or services.[71] Many local systems moved away from the AOT model over time, however, the guidance stated that *"all teams providing for people with psychosis or schizophrenia should offer a comprehensive range of interventions consistent with this guidance"*.[72]

62. Assertive outreach is now delivered through a range of service models. In some areas, it is provided by a dedicated AOT, while elsewhere it is delivered through community mental health services with a function or capability focused on assertive and intensive engagement. Mental health services must provide the level of engagement, flexibility and intensity of support required by patients.[73]

63. The Inquiry has received evidence regarding the 'high-fidelity' Assertive Outreach Model.[74] In his evidence, Dr James highlighted the challenges associated with requiring services to operate exclusively in accordance with the high-fidelity model, particularly given its significant workforce and resource demands against a backdrop of constrained NHS resources. He explained that much of the evidence base for the assertive outreach model derives from urban settings and

---

[70] [WITN0310001_0097]
[71] [NHSE0000539_0023 paragraph 1.5.1.2]. See also the recommendations on early intervention teams.
[72] [NHSE0000539_0007 paragraph 1.1.3.1]; [Dr Adrian James, 21 May 2026, 88/1-13] [INQT0000094]
[73] [Dr Adrian James, 21 May 2026, 38/17-39/14] [INQT0000094]
[74] [WITN0412001_0003 to 0005 paragraphs 6 and 13] (First Witness Statement of Dr Nuwan Dissanayaka)

cautioned against assuming that effective assertive outreach cannot be provided in other settings simply because the high-fidelity model is not feasible. In particular, he noted that in rural areas it may be impractical to establish dedicated AOTs in every locality,[75] but possible to deliver assertive and intensive treatment through existing community teams. He highlighted the importance of flexibility in how assertive outreach functions are delivered.

64. Reflecting the need to ensure effective provision while acknowledging resource constraints, NHS England has been working to strengthen intensive and assertive outreach functions. The 2024/25 NHS Planning Guidance required all ICBs to review their community mental health services to ensure effective provision for people with severe mental illness who require intensive community treatment and follow-up but whose engagement presents challenges.[76] These reviews examined existing arrangements across NHS Trusts within each ICB's area, including whether dedicated AOTs were in place, and identified any gaps in provision to inform subsequent guidance.

65. In July 2024, NHS England published 'Guidance to integrated care boards on intensive and assertive community mental health care'[77]. The guidance sets out features of intensive and assertive community care, which is designed to meet the needs of individuals who (non-exhaustively and in summary) are presenting with psychosis (with or without a diagnosis), may not respond to or want to engage with 'routine' monitoring, support and treatment, are vulnerable to relapse and/or deterioration, have multiple social needs, present with co-occurring problems, or have a negative perception of mental health services.

66. In line with the broader shift within the NHS away from centrally prescribed models of care and towards greater local autonomy in the design and delivery of services, Dr James explained that ICBs remain responsible for determining how services should be configured and delivered within the resources available to them and in a way that meets local need.[78] In all cases, regardless of the model

[75] [Dr Adrian James, 21 May 2026, 37/15-39/14; 41/7-12] [INQT0000094]
[76] [DHSC0000098_0025]
[77] [NHSE0000046]
[78] [Dr Adrian James, 21 May 2026, 50/13-23] [INQT0000094]

adopted, providers are (and have always been) expected to deliver care in accordance with the relevant NICE guidance on intensive case management for people with psychosis and schizophrenia.[79] NICE guidelines do not stipulate a specific team format required to deliver intensive case management. NHS England notes that its guidance on intensive and assertive community mental health care was developed with the support of an expert advisory group, which included representatives of the Royal College of Psychiatrists as well as a wide range of experts and assertive outreach clinicians, including Dr Dissanayaka and Dr Shubulade Smith, both of whom gave evidence to the Inquiry. See Annex A of the guidance for the full membership of the Group.[80]

67. Dedicated resource made up of staff skilled in working with this patient group is critical. Recognising this, NHS England required systems to review their current provisions in line with the national guidance, and asked systems to set out their resource gap.[81] NHS England used the information provided by ICBs, together with national modelling, to support bids for additional funding through two separate spending reviews.[82] However, neither bid secured the additional investment required.[83]

24/7 Neighbourhood Mental Health Centres

68. The Inquiry has also examined the wider transformation of adult community and crisis mental health services through the development of the 24/7 Neighbourhood Mental Health Centre ("**NMHC**") model. The pilot phase has recently concluded and an independent evaluation is awaited, following which national implementation guidance will be developed as appropriate. The pilot programme was founded on the principles that NMHCs should be open to all individuals with mental health needs, that continuity of care should be strengthened through the redesign of core Community Mental Health and Crisis Teams within the NMHC model, and that assertive engagement should be available for those who require

---

[79] [NHSE0000539]; [NHSE0000538]
[80] [NHSE0000046_0035]
[81] [NHSE0000046_0033 and 0035]; [DHSC0000098_0025]
[82] [WITN0155039_0009 paragraph 31]
[83] [William Vineall, 4 June 2026, 82/19-83/7; 115/11-22] [INQT0000109]; [NHSE0003188]; [NHSE0003189]

it. The Inquiry has heard that some pilot sites have explored how assertive and intensive interventions can be delivered within the NMHC model, consistent with the NHS England guidance referred to above.

69. NHS England considers that improvements to, and the ongoing maintenance of, core community and crisis services are required alongside assertive outreach, as each depends on the other to be effective and sustainable. [84]

70. NHS England has addressed the NMHC programme in these submissions because the Inquiry sought evidence about this wider programme of service transformation. However, NHS England does not suggest that the programme should be regarded as a complete answer to the issues considered by the Inquiry, nor as a substitute for assertive and intensive treatment for those who require it. Nevertheless, several features of the programme, including its focus on continuity of care, engagement and therapeutic relationships, are relevant to the matters examined by the Inquiry. The NMHC programme should therefore be viewed as one element of a wider programme of service improvement, alongside the ongoing need to strengthen and adequately resource services providing intensive and assertive interventions.

71. The Inquiry heard evidence from Professor Kendall regarding these features of the NMHC programme. He described the programme as part of a broader transformation of community mental health care.[85] Professor Kendall explained that the programme was developed in response to longstanding challenges within mental health services, including fragmentation of care, difficulties navigating multiple pathways and thresholds, poor continuity of care, delayed access to treatment and insufficient integration between mental health services, physical health services, social care and the voluntary sector. The programme seeks to provide a more accessible and locally-based model of care, organised around the needs of patients rather than the structure of individual services.[86]

---

[84] [Dr Shubulade Smith, 1 June 2026, 103/8-104/23] [INQT0000103]; [Dr Nuwan Dissayanaka, 15 April 2026, 119/1-14] [INQT0000051]
[85] [WITN0076001_0011 to 0019] (First Witness Statement of Professor Timothy Kendall)
[86] [WITN0076001_0011 to 0017 paragraphs 41-49, 57-58]

72. The Inquiry heard that the intended model is based upon neighbourhood centres providing open and accessible support within local communities, bringing together a range of services within a single setting and operating on a "no wrong door" basis. The aim is that individuals experiencing severe mental illness should be better able to access support without being required to navigate multiple referral pathways or service boundaries. Professor Kendall's evidence was that continuity of care, persistent engagement and the development of therapeutic relationships are central features of the model.[87] Consistently with those objectives, the "no wrong door" ethos of the NMHC model does not remove the need for proactive outreach. As Professor Kendall explained, some patients require services to "go to the person" rather than relying on the individual to engage with services independently.[88] The outreach and assertive engagement function therefore remains an important component of the model and has, in some NMHCs, been strengthened.

73. Professor Kendall further explained that the programme was developed, in part, in response to concerns regarding the care of individuals living with severe mental illness, including psychotic illness, and the difficulties which arise when patients become disconnected from services.[89] A key theme of his evidence was that continuity of care is not merely desirable, but is itself an important component of safe and effective care. He linked sustained engagement with improved treatment adherence, earlier identification of deterioration, better risk assessment and reduced likelihood of crises requiring more intensive intervention.

74. NHS England submits that it is important to consider this evidence within the wider context of the challenges facing contemporary community mental health services. The circumstances examined by the Inquiry arose within a complex landscape characterised by increasing demand for services, workforce pressures,[90] varying local models of provision[91] and the inherent difficulties of supporting individuals whose illnesses may affect insight, engagement and

[87] [WITN0076001_0021, Annex 1]
[88] [Professor Timothy Kendall, 29 May 2026, 20/6-14] [INQT0000102]
[89] [WITN0076001_0008 to 0018 paragraphs 28-30, 43, 61]
[90] [Dr Shubulade Smith, 1 June 2026, 73/18-74/6; 83/8-9] [INQT0000103]
[91] [Dr Adrian James, 21 May 2026, 20/6-8] [INQT0000094]

willingness to accept treatment.[92] The Inquiry has also heard evidence throughout these proceedings regarding the interaction between health services, social circumstances, family support, housing, criminal justice agencies and wider societal factors. The issues raised by VC's case cannot therefore be viewed solely through the lens of any single service model or intervention.

75. NHS England's responsibility extends beyond the circumstances of any individual case and requires consideration of how services can safely and effectively meet the needs of the wider population. Whilst the Inquiry has properly examined the care and treatment provided to VC, questions relating to service design necessarily require consideration of a much broader cohort of individuals with severe mental illness, including those who actively seek treatment, those who engage intermittently with services and those who may lack insight into their illness or repeatedly disengage from care.

76. Both Professor Kendall and Dr James recognised the importance of improving engagement with services, strengthening continuity of care and reducing fragmentation across mental health provision. Both described neighbourhood-based services as seeking to create a more accessible and attractive model of care, capable of bringing together different forms of support around the needs of patients.[93] At the same time, the evidence highlights the continuing importance of improving care for people who require assertive outreach. These objectives are not mutually exclusive and should, in NHS England's view, be pursued together.

77. The Inquiry also heard evidence from Dr James regarding the practical considerations associated with implementation and long-term service design. CTI referred Dr James to emerging NHS England plans which contemplated improving assertive outreach care and treatment to achieve national coverage over the coming decade. Dr James explained that NHS England was actively reviewing the relationship between NMHCs and assertive outreach services and

[92] [Dr Benjamin Lomas, 28 April 2026, 3/14-22; 5/3-8; 7/3-12] [INQT0000065]
[93] For example, [Professor Tim Kendall, 29 May 2026, 9/15-10/5] [INQT0000102]; [Dr Adrian James, 21 May 2026, 18/15-19/5] [INQT0000094]

cautioned against assuming that neighbourhood models had already been shown to provide a complete alternative to specialist outreach provision.[94]

78. Dr James' evidence was that neighbourhood services were being tested in order to understand the extent to which they could successfully provide outreach functions and sustain engagement with individuals who might otherwise become disconnected from services. Whilst he noted encouraging early indications regarding engagement, he repeatedly stressed the need for robust evaluation before conclusions could be reached regarding wider implementation or system redesign.[95]

79. Importantly, Dr James identified a cohort of patients who may present particular challenges for any community-based model, namely those who do not recognise that they are unwell, do not voluntarily seek treatment or repeatedly disengage from services. His evidence was that NHS England did not yet know the extent to which neighbourhood models alone would be sufficient for such individuals and that it may be necessary for dedicated Assertive Outreach services to sit alongside neighbourhood provision rather than be subsumed within it.[96]

80. Finally, the Inquiry heard evidence that the future development and expansion of neighbourhood mental health centres would depend upon both evaluation and funding considerations. Dr James accepted that there is no guaranteed long-term revenue stream for universal expansion and that NHS England must understand whether the model delivers measurable benefits, including any reduction in demand for other services, before decisions regarding future rollout can properly be taken.[97]

81. The evaluation of the neighbourhood programme will not be completed until October 2026, following a three-month extension to ensure a sufficiently robust evidence base. NHS England submits that caution should therefore be exercised before drawing definitive conclusions regarding effectiveness, optimal operating

---

[94] [Dr Adrian James, 21 May 2026, 43/15-44/18; 46/8] [INQT0000094]
[95] [Dr Adrian James, 21 May 2026, 44/2-11; 45/11-47/17] [INQT0000094]
[96] [Dr Adrian James, 21 May 2026, 44/12-18] [INQT0000094]
[97] [Dr Adrian James, 21 May 2026, 49/3-50/23] [INQT0000094]

models or the future relationship between neighbourhood services and assertive outreach provision before that work has concluded.

82. As a matter of general observation, NHS England notes that managing complex and long-standing risks, such as those that relate to the care of people with severe mental illness in community settings whose engagement by multiple services is variable or challenging, is complex. Delivering significant improvement on these issues requires fundamental and long-term consideration of service design, workforce, resourcing, estates, clinical pathways, medicines management, engagement of patients, their families and carers, and wider determinants of healthcare and wellbeing, including the criminal justice system. However, NHS England is continually seeking to improve its data and response to such challenges, including by the operation of patient safety systems - to which this Closing now turns.

Improving Safety

Patient Safety Incident Response

83. Patient safety is addressed in the CWS, Section 3.[98] NHS England operates well-established mechanisms for identifying, responding to and learning from risks to patient safety.

84. At the outset, we refer to NHS England's statutory duty under section 13R of the 2006 Act, which imposes a duty on NHS England to collect information relating to the safety of services provided within the health service. The discharge of this duty also contributes to NHS England's wider duty to "secure continuous improvement in the quality of services" under section 13E of the 2006 Act, which encompasses patient safety.

85. In practice, NHS England fulfils its obligation under section 13R through the collection of a range of patient safety data via the Learn from Patient Safety Events (the "**LFPSE**") service.[99] This service was introduced in a phased

[98] [WITN0310001_0108 to 0135]
[99] The LFPSE works by interacting with local risk management systems and collating a defined subset of information from them. LFPSE is therefore a 'secondary use' service

approach from 2021. The LFPSE service replaced the National Reporting and Learning System (the "**NRLS**"),[100] enabling the ongoing collection and analysis of patient safety event information from across the health service, while improving the efficiency and quality of patient safety event information collection, and enabling a wider range of users to access and analyse patient safety information more effectively.

86. It has been suggested that NHS Trusts are no longer able to compare data relating to causal factors of patient safety incidents through the LFPSE service, and that such comparison was possible under the previous system.[101] However, the NRLS did not provide direct access to patient safety event information for any providers, commissioners or regional teams (although we note that providers have always been able to access and interrogate their own patient safety event information as they are the primary collectors and users of that information). Collated data was only available outside of the national patient safety team via nationally curated data publications. Functionality that will enable providers to directly access appropriately anonymised patient safety event information from across the health service and enable providers' identification and comparison of themes and trends from patient safety events is currently being developed and will be available through the LFPSE in due course.

87. The NHS Patient Safety Strategy (last updated in 2023)[102] provides the overarching framework for the NHS's approach to improving safety. The frameworks and approaches to learning described below form part of the implementation of that strategy.

88. Until 2023, the NHS's response to serious incidents was governed by the Serious Incident Framework.[103] The Patient Safety Incident Response Framework ("**PSIRF**"),[104] was published in 2022 and NHS Trusts began transitioning to it during 2023. Although implementation took place on a phased basis, with

---

[100] The NRLS had become increasingly defective, costly to maintain and complex to interrogate
[101] [WITN0133001_0047 paragraph 158] (First Corporate Witness Statement of Nottinghamshire Healthcare NHS Foundation Trust)
[102] [NHSE0000502]
[103] [NHSE0000058]
[104] [NHSE0000054]; [NHSE0000038]

different NHS Trusts transitioning at different times, PSIRF became a contractual requirement for organisations operating under the NHS Standard Contract in 2024.[105] NHFT transitioned to PSIRF in 2024. Accordingly, the Serious Incident Framework provided the framework for NHFT's response to the attacks in June 2023.

89. Evidence to this Inquiry has highlighted the benefits of the approach now embodied in PSIRF. The DHSC have commented on the importance of the system-based approach to learning promoted by PSIRF, rather than a focus on 'root cause' and individual accountability where other processes exist for that purpose:[106]

"The PSIRF promotes a range of system-based approaches for learning from patient safety incidents, rather than methods that assume simplistic, linear identification of a single cause. The focus is on identifying system-based learning, not causes and individual accountability where other processes exist for that purpose (e.g. Human Resources, coronial investigation, police investigation)."

90. NHFT have similarly endorsed PSIRF:

"*PSIRF has fundamentally shifted how the NHS responds to patient safety incidents for learning and improvement. It advocates a coordinated and data driven approach to patient safety incident response that prioritises compassionate engagement with those affected and embeds patient safety incident responses within the wider improvement system. It supports the introduction of a range of system-based approaches to learning, with considered and proportionate responses to patient safety incidents and thematic reviews being undertaken to develop safety improvement plans".*[107] In her second statement to the Inquiry, Diane Hull also said; *"PSIRF has enabled the Trust to consider why incidents happen and how the learning should be understood, I*

[105] [NHSE0000392_0050], "SC33 Patient Safety"
[106] [WITN0155001_0080 paragraph 236]
[107] [WITN0133001_0204 paragraph 517]

ensure that learning is shared across all Care Groups, and we do not lose sight of the families who have been affected".[108]

91. Implementation of PSIRF is overseen by ICBs. ICBs have a responsibility to establish and maintain structures to support a coordinated approach to oversight of patient safety incident response. Under PSIRF, providers are also expected to create and implement a Patient Safety Incident Response Plan (see the CWS, paragraphs 365 to 366) to foster learning and improvement.

92. In August 2022, NHS England issued a suite of guidance documents, available online, for ICBs and providers to support implementation of the PSIRF. This includes an 'Oversight Roles and Responsibilities Specification' which sets out the guiding principles of the oversight approach and organisational responsibilities under PSIRF.[109] This guidance addresses both the statutory Duty of Candour and the wider moral obligation to be open and transparent:

"regardless of whether an independent PSII is required, the organisation identifying the incident is expected to be open with those affected, explaining what has happened, listening to any questions and/or concerns, and explaining what will happen next. Any immediate risks to the patient(s) or others and actions that may be required to mitigate those risk must be considered. The requirement to comply with Duty of Candour regulations is unchanged: that is, all providers must inform the patient/family/carers of any notifiable patient safety incident and follow all the requirements of the Duty of Candour".

93. It is highlighted in particular that: *"In cases of mental health related homicide, this will be both the patient and their family, and the victim's family. While legal obligations associated with Duty of Candour apply to those in receipt of care, the moral obligation to be open, honest, supportive, and inclusive must be upheld for all affected".*[110]

94. The documents also include specific guidance (also published in August 2022) on 'Engaging and involving patients, families and staff following a patient safety

---

[108] [WITN0133041_0039 paragraph 142] (Second Witness Statement of Diane Hull)
[109] [NHSE0000028_0032]
[110] [NHSE0000028_0032]

incident'.[111] The guidance emphasises that meaningful learning and improvement following a patient safety incident can only be achieved through compassionate engagement with those affected and that organisations should prioritise openness, listening, and involvement throughout any learning response.

95. The Inquiry has heard evidence that there is no guidance for NHS organisations on discharging the duty of candour when patient safety incidents involve criminal proceedings, multiple victims and families.[112] NHS England respectfully submits that, in the context of mental health-related homicides, the PSIRF guidance described above (and available at the material time) provides relevant guidance on these issues, including the expectation that organisations engage openly with both the patient and their family, and the victim's family, and uphold the moral obligation to be open, honest, supportive and inclusive towards all those affected. However, NHS England considers that questions concerning compliance with the statutory and professional duty of candour are more appropriately addressed by the CQC and the relevant professional regulators respectively, given their expertise and regulatory responsibilities.

96. The introduction of PSIRF represents a significant and positive development in the NHS's approach to patient safety. PSIRF adopts a more learning-focused approach, placing greater emphasis on compassionate engagement with patients, families and staff; systems-based learning and improvement; and proportionate responses to patient safety incidents. NHS England continues to learn from the implementation of PSIRF and to refine the framework accordingly. This commitment to ongoing iteration reflects the recognition that patient safety systems must continually evolve in light of emerging evidence and experience, while maintaining supportive oversight to help providers embed PSIRF's principles effectively.

97. NHS England notes that evidence presented to this Inquiry suggested that its National Director of Patient Safety had stated that "investigations are burdensome". For completeness, the article to which that evidence referred has

---

[111] [NHSE0000026]
[112] [SUBS0000013_0026 paragraph 117]

been provided to the Inquiry.[113] Read in context, the article makes clear that the National Director of Patient Safety was advocating for a more proactive approach to preventing patient harm rather than only seeking to learn after harm has occurred, a position that is consistent with NHS England's patient safety strategy and the evidence it has provided to this Inquiry. The article also observed that investigations can be burdensome for NHS Trusts, given the significant time, resource and operational commitments they often entail. That observation was not made to discourage investigation or accountability, but rather in the context of emphasising the importance of earlier intervention, learning and improvement, to prevent patient harm and systemic failures from occurring in the first place.

98. Additionally, the Mental Health Patient Safety Improvement Group has been established as a new learning and improvement focused group to ensure that insights generated from Independent Patient Safety Investigation ("**IPSI**") reports, together with other information concerning the safety of mental health services, are translated into learning and improvement.[114]

Mental Health Homicides and Independent Patient Safety Investigations

99. IPSIs are commissioned, when appropriate, by NHS England. Homicides that are committed by patients being treated for mental illness are one category of case for which the commissioning of such reports may be required (see the account in the CWS at paragraphs 375 to 386 for the commissioning criteria for independent reports more generally).[115]

100. Most homicides are not committed by people with mental illness. NCISH data confirms that, in England, of 4,967 homicides in the general population between 2012 and 2022, 508 (around 10%) represent homicides committed by patients in recent contact (within 12 months of the offence) with mental health services.[116] It

[113] [NHSE0003023]
[114] [Dr Adrian James, 21 May 2026, 96/24-97/5] [INQT0000094]; [WITN0365001_0010 paragraph 23]
[115] [WITN0310001_0114 to 0118]
[116] [NHSE0000483_0022 to 0023]

is estimated that less than 6% of homicides are committed by people with schizophrenia.[117]

101. The causes of homicide are complex and multifactorial, both among those with a history of mental illness and within the wider population. Where an individual who commits homicide has a history of mental illness, the relationship between that illness and the offence may vary considerably; in some cases, the illness may have directly contributed to the homicide, while in others it may be incidental. Mental illness is relatively common, and the existence of a mental health condition does not, without more, establish a causal connection with the offence. Even where mental illness is implicated, it may be only one of a number of contributing factors. By contrast, in a smaller number of cases involving severe mental illnesses, such as schizophrenia, symptoms associated with an acute psychotic episode or crisis may significantly affect behaviour. In those circumstances, individuals may act in ways that are wholly uncharacteristic and which, upon recovery, they may themselves find shocking and distressing.

102. Ultimately, establishing whether a homicide was attributable to mental disorder is a fact-specific question, often determined through clinical and legal evidence (e.g., psychiatric assessments and findings in criminal proceedings).

103. For NHS investigation purposes, a mental health homicide is generally understood to be *"a homicide / suspected homicide where the individual had contact with a specialist mental health provider in the preceding 12 months and it appears that poor or deteriorating mental health may have influenced behaviour and/or been a significant contributing factor to the homicide; this includes diagnosed, undiagnosed and short-term mental health conditions."*[118] "Contact" includes any form of assessment, intervention, or meaningful clinical engagement. This is not, however, a rigid or exhaustive threshold. Circumstances may arise in which it is appropriate to classify and investigate a homicide committed by an individual who was discharged from services beyond this limit as a patient safety incident.

---

[117] [WITN0076001_0011 paragraph 39]
[118] [NHSE0003005_0002]

104. NHS England recognises the concerns that have been raised regarding both the categorisation and counting of these incidents. This includes questions about which incidents should be classified as mental health homicides and whether other serious violent incidents involving mental health service users should also be captured. In particular, concerns have also been expressed about the methodology used to count incidents. For example, where a single incident results in multiple deaths, it has been suggested that each death should be recorded as a separate incident, rather than the event being counted as a single incident, to ensure that the data more accurately reflects the scale and impact of the harm caused.[119]

105. NHS England acknowledges the importance of ensuring that the methodology used accurately reflects the nature and impact of such incidents. NHS England's position is that NCISH data provides the authoritative measure of the number of mental health homicides.

Purpose of NHS England commissioned independent patient safety incident reports

106. NHS England regional teams are responsible for considering whether it is necessary to commission an IPSI into patient safety incidents escalated to them by providers and ICBs in their area. The decision to commission an IPSI in this case is detailed at paragraphs 535 to 539 of the CWS.[120]

107. As set out in the CWS,[121] IPSIs are commissioned to generate insight to inform safety improvements, thereby enabling the NHS to identify areas for development and reduce the likelihood of similar events recurring. It is well established that patient safety incidents are rarely attributable to the acts or omissions of a single individual; rather, they typically reflect risks inherent within the wider system.[122]

108. IPSIs cannot operate beyond the limits of NHS England's statutory remit, and do not:[123]

---

[119] [WITN0258001_0010 to 0011 paragraphs 44-47] (First Witness Statement of Julian Hendy)
[120] [WITN0310001_0160 to 0161]
[121] [WITN0310001_0117 paragraphs 383-384]
[122] [WITN0310001_0118 paragraphs 385-386]
[123] [WITN0310001_0117 paragraph 384]

a. inquire into how a person died - this is the role of the Coroner;

b. assign blame or liability in relation to any incident which has occurred;

c. consider fitness to practice – this is the role of the relevant professional regulators (e.g., the GMC and the NMC), although:

    i. referrals may be made to professional regulators as a result of a learning response where concerns have been raised; and

    ii. internal human resource systems at an organisational level would consider any breaches of employment terms and conditions (e.g., disciplinary processes)

d. result in any criminal action:

    i. the CQC may consider prosecution; and

    ii. the criminal justice system would respond to concerns about criminality

e. name those involved in the care and treatment of a patient - wider processes may involve the naming of the individual publicly (e.g., regulatory action such as suspension or removal from professional registers), but this is outside the scope of any IPSI.

109. In the context of this Inquiry, NHS England acknowledges the bereaved families' disappointment that the Theemis Report did not assign blame or directly hold individuals to account. NHS England does note, however, that the scope and purpose of IPSIs was clearly explained to the families:

a. in the letter confirming the commissioning of an IPSI (28 February 2024): *The main purpose of an Independent Investigation is to ensure that mental health care-related homicides are investigated in such a way that lessons can be learned effectively. This is done to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of health services in the future. The aim is to identify risk and opportunities to improve patient and public safety and to make*

recommendations for organisational and system learning. The investigation will be carried out separately from any police, legal or coroner's proceedings. The findings from the investigation will be published and the NHS will act on any recommendations made by the investigation;[124]

b. in response to further questions from the bereaved families (16 July 2025), where NHS England wrote to the families and confirmed: *NHS England may commission an independent investigation into serious incidents that have occurred. Incidents include suicides, mental health homicides and domestic homicides as well as near misses. The purpose in all cases is to prevent recurrence through learning. Independent investigations do not inquire into how a person died; this is the role of the Coroner. They also do not assign blame or liability in relation to any incident which has occurred, determine liability, or consider fitness to practice (and documents are not collected or analysed for these purposes). The latter function is the role of the relevant professional regulators (e.g., the GMC and the NMC). In cases of breach of regulations (e.g., Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) the CQC may take action, which may include prosecutions. Similarly, the criminal justice system would respond to concerns about criminality, and internal human resource systems at an organisational level would consider any breaches of employment terms and conditions (e.g., through disciplinary processes). Patient safety incidents can be signs of underlying systemic issues that require wider system-level action. There are established protocols for referrals to appropriate agencies in circumstances where a learning response raises concerns about an individual's conduct or fitness to practise.*[125]

c. in emails, for example in July 2024, where NHS England explained that: *…The focus of the Independent Investigation is the care and treatment Valdo received from his first contact with specialist services up till the day of the homicides. As I have previously mentioned the purpose of an Independent Investigation is to ensure that mental health care-related*

[124] See for example: [NHSE0000429]; [NHSE0000430]; [NHSE0000433]
[125] See for example: [WITN0409046]

homicides are investigated in such a way that lessons can be learned effectively. This is done to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of health services in the future. The aim is to identify risk and opportunities to improve patient and public safety and to make recommendations for organisational and system learning…[126]

110. Dr Sokolov also explained in her evidence that system risk and individual accountability are distinct concepts and should be considered separately, consistent with established practice in other high-risk industries:

".. there is a significant amount of evidence drawn from high-risk industries such as aviation and healthcare and others, that we do need to look at the system separate from individual accountability. There are processes that manage individual accountability, either professional regulatory processes, or employer disciplinary processes, but in order to reduce the risk of recurrence of an incident, what we want to understand is the broader context. And so an investigation like this would not be focused on individuals but would be focused on culture, policy, accepted practice, and opportunities that should have been taken that weren't."[127]

Publication of Independent Mental Health Homicide Investigation Reports and disclosure of confidential information in the overriding public interest

111. It is well established that confidential information relating to a patient should not be disclosed without the patient's consent unless there is an overriding public interest sufficient to outweigh the public interest in maintaining patient confidentiality and confidence in the provision of a confidential health service. Any disclosure must be necessary, proportionate and no more extensive than is reasonably required to achieve the relevant public interest objective.[128]

112. In the context of investigations, the public interest in transparency and accountability will not, by itself, automatically override the common law duty of

---

[126] [NHSE0000762_0002]
[127] [Dr Jessica Sokolov, 3 June 2026, 47/24-48/12] [INQT0000107]
[128] [NUHT0000028]

confidentiality. NHS England (or the authors of reports) must balance the public interest in disclosure against the public interest in preserving confidentiality and Article 8 rights under the Human Rights Act 1998 of affected individuals, including the patient and their family. The key factors in deciding whether or not to share confidential information are necessity and proportionality.

113. That assessment includes consideration of whether the public interest can be met through less intrusive means, such as anonymisation, redaction or publication of a summary. However, anonymisation is not always effective; individuals may remain identifiable in practice, or anonymisation may undermine the purpose of the disclosure.

114. In the context of an IPSI, disclosure may serve a genuine public benefit where it promotes patient safety, supports organisational learning, protects the public from harm, maintains confidence in the healthcare system, or facilitates informed debate on matters of public importance.

115. Commonly, the public interest can be adequately served through disclosure of the substance of an investigation's findings, conclusions, recommendations and learning, thereby promoting transparency, accountability and patient safety.

116. Consistent with those principles, NHS England's internal publication policy, discussed further below, requires report authors to consider these competing interests during the drafting process. The objective is to produce a single report capable of publication, rather than separate full and summary versions, while protecting confidentiality, privacy and safeguarding interests. In particular, report authors should consider whether the inclusion of confidential patient information or personal data is necessary and proportionate to achieve the purpose of the report.[129]

117. IPSI reports are usually published on the NHS England website, together with links to any action plans. Publication advances the principles of openness and

[129] [NHSE0002938_0003 paragraphs 9 and 10]

transparency. The history of the approach to the publication of IPSI reports is discussed in the CWS and is therefore not repeated here.[130]

Current NHS England Publication Policy

118. Since the publication of the Theemis Report (which is addressed in more detail below), NHS England has agreed an internal policy for use in respect of IPSIs commissioned by NHS England (it does not apply to Trust-level investigations).[131]

119. The policy provides that the *"default position is that all patient safety incident investigation reports commissioned or undertaken by NHS England should be published.*" Reports commissioned from 1 February 2026 should be written on the basis that they will be published in full.

120. The tension between the desire to be open and transparent with IPSIs and the requirement to comply with applicable data protection legislation and confidentiality obligations still exists. As noted above, it is now the responsibility of the author of an NHS England commissioned IPSI report to prepare a single report which is suitable for publication wherever possible, without redaction, save where there might be safeguarding risks. Reports must be written so that the sharing of any personal data and confidential information remains lawful.

121. The policy also reiterates the expectations of PSIRF[132] in respect of the moral obligation to be open and honest with all affected, even where the duty of candour does not apply:

> *"when a patient safety incident investigation (PSII)… is undertaken, organisations should meaningfully involve those affected where they wish to be involved."* It also states *"all providers must inform the patient/family/carers of any notifiable patient safety incident and follow all the requirements of the Duty of Candour. In cases of mental health-related homicide, this will be both the patient and their family, and the victim's family. While legal obligations*

[130] [WITN0310001_0118 to 0125 paragraphs 387 to 409]
[131] [NHSE0002938]
[132] PSIRF supporting guidance "Oversight roles and responsibilities specification" published in 2022 confirms the same obligations as to the duty of candour and moral obligations [NHSE0000028_0032]

associated with Duty of Candour apply to those in receipt of care, the moral obligation to be open, honest, supportive, and inclusive must be upheld for all affected."[133]

122. The policy further considers the impact on other third parties, including the family of the patient involved in a homicide:

"They may also have family members who are not only impacted by the events themselves but who could face significant personal consequences due to their association with the patient. This must not be exacerbated by the sharing of personal healthcare information. These same concerns may similarly also apply to members of staff and third parties who have worked with the patient."[134]

123. NHS England appreciates there is a tension between the rights of patients who have committed acts of extreme violence and third parties associated with the patient, and the desire for survivors and families of victims to have their questions fully answered. NHS England submits that there is not a straightforward answer, as Dr Sokolov explained:

"Confidentiality exists for many reasons. We need our patients to feel confident to share information with us that they wouldn't share with anybody else. We need our clinicians to feel confident in documenting what is shared with them, and if there is an understanding, particularly in a sector like mental health, if there is an understanding that some of that may end up in the public domain, it may change behaviour. And I don't say that is right or wrong, but the reality is scrutiny does tend to change behaviour. And we need to have open and trusting therapeutic relationships with our patients."[135]

124. NHS England further submits that, in respect of these tensions, *"[l]egislation or further action may be required to resolve them, or to set clearer guidelines for public bodies such as itself or successor bodies in the future"*.[136] However, any

---

[133] [NHSE0002938_0007]
[134] [NHSE0002938_0010]
[135] [Dr Jessica Sokolov, 3 June 2026, 107/14-108/1] [INQT0000107]
[136] [WITN0310001_0164 paragraph 554]

such step must be approached with caution and carefully balanced against the potential for unintended consequences.

125. In relation to patients, a safe and effective mental health system depends upon patients trusting clinicians and having confidence that highly sensitive personal information will be treated confidentially. That trust is fundamental to encouraging individuals to disclose thoughts, feelings and intentions that they may find difficult or distressing to discuss, including thoughts relating to violence, self-harm or other serious risks, so that clinicians can assess those risks and take appropriate action. There is a real risk that individuals with actual or potential mental health conditions, particularly those from groups with existing mistrust of such services, may be deterred from seeking care altogether. There is a further risk that, even where help is sought or concerns are raised by families or friends, individuals may not be fully candid with clinicians if they believe their medical records could be made public (even if in practice that risk would be remote for the vast majority of patients).

Learning from previous mental health homicides.

126. Ensuring that effective learning is derived from patient safety incidents and translated into meaningful improvement remains one of the most significant challenges arising from IPSIs and patient safety incidents more generally across the NHS. National frameworks, standards, guidance and reporting mechanisms play an important role in supporting learning and identifying opportunities for improvement. However, achieving lasting change requires more than the identification of lessons. It depends upon those lessons being translated into sustained improvements in clinical practice, service delivery, organisational culture and patient outcomes, requiring coordinated and often ongoing action at provider, system and national level.

127. During the course of the Inquiry, it has been suggested that the NHS does not learn from previous incidents and that the same lessons continue to be repeated.[137] NHS England respectfully submits that this is an overly simplistic characterisation of a much more complex challenge. While there are cases where

[137] [David Webber, 25 March 2026, 29/14-21] [INQT0000039]

improvements could and should have been implemented more effectively or more quickly, often the issues identified by investigations, such as suboptimal care and discharge planning, family engagement, information sharing and governance, are complex, system-wide issues that do not lend themselves to simple or immediate solutions, still less ones that will be implemented consistently at all times by every staff member.

128. Addressing these issues is made more difficult by the considerable resource and operational pressures under which the health and care system operates, often with little spare capacity to implement further changes while continuing to meet increasing demand for frontline care. The challenge, at a local level, was articulated by NHFT during its opening submissions, which stated that demand had "*increased with local mental health team caseloads rising from 8,619 in July 2022 to more than 10,000*" as of the end of February 2026.[138]

129. It is submitted that, whilst the repeated identification of these concerns is an important consideration, so too is the question of whether the system has sought to respond to such issues through informed and sustained efforts to improve care. In relation to this, it is submitted that the evidence demonstrates that NHS England has responded appropriately to issues identified through investigations and other sources of insight, including through the development and implementation of major national programmes and frameworks aimed at addressing these challenges.

130. It must also be recognised that some incidents arise from issues within a particular local system or provider, while others expose risks or weaknesses that require NHS-wide action. A key part of effective learning is determining where responsibility for improvement properly lies and ensuring that lessons are implemented at the appropriate level. In addition, where recommendations are directed at a national level, their implications may extend beyond patient safety and mental health policy to encompass broader considerations, including information governance and data protection. This can make implementation more

[138] [Jason Beer KC, 24 February 2026, 6/19-21] [INQT0000003]

complex, as different legal, regulatory and operational frameworks may be engaged and responsibility for action sit across multiple organisations.

131. The Inquiry Legal Team has produced a report 'Mental Health Related Homicides – The Inquiry Legal Team Review' (the "**ILT Review**").[139] As part of the Inquiry's work, NHS England was requested to provide investigation reports relating to incidents identified through the public questionnaire issued by the Inquiry in May 2025. NHS England provided reports relating to 41 separate incidents identified through the questionnaire process and subsequently disclosed a further 147 reports in response to a disclosure request from the Inquiry. These materials were among the sources considered by the ILT in undertaking its thematic analysis.

132. The themes identified by the ILT, including communication and information-sharing failures, shortcomings in engagement with families and carers, deficiencies in risk assessment and care planning, and concerns regarding the effectiveness of post-incident investigations, are serious and longstanding challenges within the healthcare system.

133. The PSIRF and associated guidance on openness, learning and engagement with patients and families demonstrate that NHS England recognises the need to strengthen the systems through which patient safety events are investigated and addressed, and has sought to do so. NHS England has also established other mechanisms to support learning and improvement. This includes the Mental Health Patient Safety Improvement Group, which seeks to improve the use of insight and learning from investigations, and the National Patient Safety Independent Investigations Team, which aims to improve the consistency and coordination of investigations into patient safety incidents while reducing inappropriate variation in the approach to these investigations.

134. NHS England does not suggest that improvements to reporting systems or investigative frameworks alone are sufficient to eliminate the risks identified in the ILT Review. Such frameworks are intended to support learning and improvement, but patient safety outcomes ultimately depend upon the extent to which lessons

[139] [INQY0000033]

are translated into changes in clinical practice, service delivery, leadership, governance and organisational culture at local level.

135. NHS England's role is to provide oversight, standards, guidance and support, while responsibility for implementing and embedding improvements lies with provider organisations and system partners, with NHS England acting as an enabler and source of support. Alongside providers and system partners, individual clinicians are responsible for delivering safe and effective care, including through the application of professional skill and judgement in the care of individual patients. The effectiveness of any patient safety framework therefore depends upon action at multiple levels, from national leadership and organisational governance through to frontline clinical practice.

The National Confidential Inquiry into Suicide and Homicide

136. The Inquiry has heard evidence about NCISH, particularly in relation to its role in the collection of data on homicide committed by individuals under the care of mental health services.

137. NHS England commissions (via the Health Quality Improvement Partnership) NCISH to develop research from national data collections and comparisons regarding suicides and mental health homicides. NHS England recognises the importance of data in identification and prediction of risk and learning.

138. As explained at paragraph 268 of the CWS, the programme of work was changed in 2018 following funding reallocations. However, NCISH continued to report the number of homicides by people in contact with mental health services.[140] The decision was made following careful review by the Independent Advisory Group, membership of which includes, amongst others, programme funders and individuals with subject expertise.[141] As explained by Professor Louis Appleby in his witness statement to the Inquiry:

"This decision was based on their assessment of priorities in the context of a reduction in funding, a competing priority being the extension of our studies of

[140] [WITN0310001_0080]
[141] [NHSE0002959]

suicide by mental health patients to groups of concern within the general population. Informal discussions also referenced: the growing maturity of NHS serious incident investigations in cases of patient homicide; concerns that regular publication of our homicide findings may inadvertently perpetuate stigma towards people with mental illness; and that the core learning from our homicide findings had by now been sufficiently achieved. Data collection did not cease entirely in 2018. We continued to record the number of homicides committed by individuals in contact with mental health services".[142]

139. The full programme of work in relation to homicides has since been recommissioned. The aim of recommissioning this element of NCISH's work is to achieve:

"*comprehensive data collection on homicide by people under the recent care of mental health services*", reinstating the research that ended in 2018 and adding to the previous methodology: "*in response to current concerns, proposed new elements include: (1) closer working with the families of both victim and perpetrator, (2) earlier data collection, reducing delays inherent in the justice system, (3) enhanced focus on patients with psychosis, and (4) a rolling programme of priorities, reflecting recent cases*".[143]

140. NCISH is also a member of the Mental Health Patient Safety Improvement Group, which will enhance visibility of NCISH's work and support system learning and improvement.[144]

Steps taken by NHS England post 13 June 2023

141. The steps taken by NHS England following the Nottingham attacks have rightly been considered in detail by the Inquiry.

142. NHS England has not waited for the final findings of every review, investigation or the Inquiry before taking steps to improve services where emerging learning has identified areas requiring action. The evidence before the Inquiry

---

[142] [WITN0069001_0003 paragraphs 10-12] (Witness Statement of Professor Sir Louis Appleby)
[143] [NHSE0000467_0001]
[144] [NHSE0002960_0002]; [NHSE0002982]

demonstrates that NHS England has, where appropriate, sought to act on emerging concerns and to communicate expectations to the wider system without delay. One example is the national correspondence from NHS England's former National Director for Mental Health, Learning Disabilities and Autism (Claire Murdoch) and Medical Director for Mental Health and Neurodiversity (Dr James) relating to intensive and assertive treatment, issued in July 2024.[145] This reflects a proactive approach to patient safety and improvement, recognising that opportunities to strengthen care should be taken when identified rather than deferred pending the conclusion of all review processes. This letter also reminded providers that a patient's failure to attend appointments must never be used as a reason to discharge them.

Mental Health Personalised Care Framework

143. NHS England has developed the Mental Health Personalised Care Framework ("**MHPCF**"), as highlighted by Dr James in his evidence,[146] which supersedes previous guidance in the Care Programme Approach and Community Mental Health Framework[147]. The MHPCF, published on 17 July 2026,[148] establishes a clear and consistent national framework for the planning, coordination and delivery of care for people of all ages receiving secondary mental health services.

144. The MHPCF is built around four fundamental requirements:

    a. every person must have a personalised care and support plan;

    b. every person must have a clearly identified professional responsible for that plan;

    c. care must be reviewed regularly and whenever circumstances change; and

    d. outcomes must be routinely measured and acted upon.

---

[145] [DHSC0000163]
[146] [Dr Adrian James, 21 May 2026, 55/5-56/6; 61/11-18; 99/12-17] [INQT0000094]
[147] See [WITN0310001_0074 to 0075 paragraphs 252-253; 0095 paragraphs 313-316]
[148] [NHSE0003019]; [NHSE0003020]; [NHSE0002989]; [NHSE0002992]; [NHSE0003021]

145. Those requirements will be supported by national guidance on safety planning and risk management.

146. Importantly, the MHPCF directly highlights a number of the concerns that have arisen in connection with the Nottingham attacks.[149] It:

    a. makes clear that disengagement from services should not, of itself, lead to discharge from care;

    b. includes a requirement that where a patient needs intensive and assertive treatment (e.g., where disengagement with services has occurred, where there is complexity and risk of violence), they should have a named consultant psychiatrist in the community;

    c. strengthens expectations around multi-agency care planning and information sharing;

    d. reinforces the importance of involving families and carers in care planning and decision-making; and

    e. connects the importance of overall effective care and treatment to the management of risk.

147. The MHPCF supports a shift in the approach to safety assessment and management. Rather than seeking simply to predict future risk, it requires services to understand and address the factors that drive harm. It moves away from considering individual risks in isolation and instead adopts a whole-person approach, encompassing risks to self, risks to others, safeguarding concerns and treatment-related harms. It replaces static, one-off assessments with a model of continuous review and adaptation, and it recognises that effective safety planning is best achieved through active partnership with patients, families and support networks, wherever possible.

148. NHS England acknowledges that the MHPCF reflects the core principles of the Care Programme Approach. This is because the fundamental elements of good

---

[149] [William Vineall, 4 June 2026, 93/3-9] [INQT0000109]; [Baroness Merron, 4 June 2026, 32/1-11] [INQT0000110]

care have not changed. However, consistent implementation of these principles across the country has not always been achieved. The MHPCF is designed to address these implementation challenges, whilst reaffirming the importance of delivering these core elements of care in practice. In doing so, NHS England considers the MHPCF to be a significant step forward in strengthening the quality, consistency and safety of mental health care, embedding lessons learned from past failures and promoting more proactive, personalised and effective care for people with severe mental illness. On 29 June 2026, NHS England offered to engage directly with the survivors and the bereaved families ahead of publication of the MHPCF.[150]

149. In addition to the MHPCF:

    a. in May 2026, the government issued a call for evidence to inform their plans to publish a mental health strategy. NHS England is working closely with the DHSC on the content of that strategy; and

    b. NHS England and the DHSC are developing a Modern Service Framework for Severe Mental Illness as part of the government's 10 Year Health Plan. Its core ambition is that by 2035, people with severe mental illness will live longer, healthier, and more fulfilling lives through integrated, equitable care.[151]

Unauthorised access to patient data

150. In this Inquiry, evidence has been heard of serious data breaches affecting the victims and survivors, highlighting the real and profound impact that such breaches can have when information should have been protected.[152]

151. Unauthorised access to patient records is not a trivial matter. It represents a fundamental breach of patient confidentiality, professional standards and the trust placed in NHS staff. It is conduct capable of causing significant distress to

---

[150] [NHSE0003026]; [NHSE0003028]; [NHSE0003029]; [NHSE0003031]; [NHSE0003036]
[151] [SUBS0000011_0022]; [WITN0310001_0105 paragraph 346]
[152] See for example: [Emma Webber, 25 March 2026, 88/16-20; 108/24-109/11] [INQT0000039]; [Dr Sinead O'Malley Kumar, 25 March 2026 66/25-67/9] [INQT0000040]; [Dr Sanjoy Kumar, 25 March 2026, 67/16-22] [INQT0000040]; [Lee Coates, 24 March 2026, 93/11-16] [INQT0000038]; [James Coates, 24 March 2026, 88/9-15] [INQT0000038]

patients and their families, undermining public confidence in the NHS and compromising confidence in the security of confidential patient information.

152. In response to recent incidents of inappropriate access to patient records across NHS organisations, NHS England's Chief Executive wrote to all NHS Trusts and Regional Directors regarding the prevention of unlawful access to patient data on 8 July 2026.[153] NHS Trusts were expressly directed to strengthen prevention, monitoring and staff education arrangements. It is submitted that the message from NHS England could not have been clearer: *"There can be no place in the NHS for those who misuse patient information."*

153. At the same time, NHS England launched its national campaign, "*Don't let curiosity kill your career*". The campaign is designed to raise awareness of the legal, professional and personal consequences of accessing patient records without a legitimate reason.[154]

154. These measures form part of a coordinated national initiative to tackle the unlawful viewing of patient records and to reinforce the fundamental importance of patient confidentiality. NHS England expressly states that accessing patient information out of curiosity, for personal reasons, or for any purpose unconnected with an individual's professional duties is not a harmless lapse of judgment, it is unlawful conduct.

155. The accompanying guidance emphasises that all health and care staff owe both a professional and legal duty to access records only where there is a legitimate work-related reason for doing so. Staff are reminded that such conduct may constitute offences under the Data Protection Act 2018 and the Computer Misuse Act 1990 and may lead to disciplinary action, dismissal, referral to professional regulators, investigation by the Information Commissioner's Office and the police, and, where appropriate, criminal prosecution.[155]

156. These developments provide important context to the standards expected of NHS staff and the importance attached by NHS England to the protection of

---

[153] [NHSE0003039]
[154] [NHSE0003035]; [NHSE0003041]
[155] [NHSE0003037]; [NHSE0003038]; [NHSE0003040]

confidential patient information. They demonstrate that unauthorised access to patient records is regarded as a serious matter, with potential professional, disciplinary and legal consequences.

Response to the Theemis Investigation

157. Following publication of the Theemis Report, NHS England took a number of actions to respond to its findings and recommendations. Those actions are relevant to the Inquiry's consideration of how learning arising from serious incidents is identified, disseminated and implemented across the mental health system.

158. Alongside the publication of the Theemis Report into the Nottingham attacks, Claire Murdoch and Dr James wrote to all ICBs and mental health trusts requiring them to review and, where necessary, strengthen their existing action plans in light of the report's findings.[156] The letter recognised the devastating impact of the events and accepted the national recommendations arising from the review in full.

159. NHS England directed systems to focus on personalised risk assessment across community and inpatient teams, effective discharge planning, multi-agency working and information sharing, engagement with families, and the elimination of inappropriate out-of-area placements. NHS Trusts and ICBs were required to review their arrangements, update their action plans, and consider those plans in public board meetings (to ensure maximum transparency), with progress subject to ongoing oversight and reporting.

160. The letter demonstrates NHS England's immediate and proactive response to the findings of the Theemis Report. On the day of publication, NHS England accepted the report's national recommendations in full and also required NHS Trusts and ICBs across England to review their services, strengthen local action plans where necessary and implement improvements in response to the lessons identified. The response illustrates NHS England's wider approach of translating learning from serious incidents into action at both national and local level.

---

[156] [NHSE0000893]

161. Following this, NHS England's former Chief Executive addressed the findings of the Theemis Report during a meeting of the NHS England Board on 6 February 2025:[157]

I did want to start by talking about the report published yesterday by the Midlands Team into the care and treatment of Valdo Calocane by Nottinghamshire Healthcare NHS Foundation Trust. The first thing to say is that my thoughts, our thoughts, continue to be with the families and loved ones of Ian Coates, Grace O'Malley-Kumar, and Barnaby Webber who have all suffered just heartbreaking and immeasurable personal loss.

The report confirms that the system including the NHS, failed Valdo Calocane and therefore failed Ian, Grace and Barnaby, and I want to add my full apology to the families for the unacceptable failings by the NHS in this case.

The report helpfully sets out a number of recommendations for the Trust, the ICB and for NHS England, which we will be taking forward in addition to the actions that have already been taken forward over the last 18 months to improve how those services work.

But as ever, we are clear that where there's learning for one system, there will be learning for others. So, we've written to the whole NHS to urge colleagues to read the report and develop their own action plans with their local partners including the police, to better manage risk for patients with severe mental illness. Again, that's on top of actions we've already taken at an NHS-wide level, particularly on how services manage patients who disengage with care.

Lastly, it's worth saying that we heard the concerns shared by families about the approach to publishing this report, and I apologise for any upset this caused. When you're talking about people's medical care, there are complex legal and confidentiality issues to navigate, especially in sharing more widely than with the families. So, what this case reinforces is the need for us to work with the DHSC and partners to agree how future independent mental health homicide

[157] [WITN0310001_0171 paragraph 567(d)]

reports should be published to ensure that we comply with our legal obligations whilst also being transparent and supportive with affected parties.[158]

Progress on Theemis and CQC recommendations

162. Both the Theemis and CQC Section 48 reports addressed recommendations to NHS England and NHFT. The recommendations relating to NHFT form part of the broader improvement work and oversight undertaken by the IOAG. All actions from the Theemis Report and the Section 48 have been completed by NHS England and NHFT.[159]

163. The recommendations directed to NHS England in both reports (see paragraph 559 of the CWS)[160] have been completed, and are now in the ongoing monitoring phase. NHS England has:

    a. developed the national guidance for intensive and assertive community mental health care, and following its implementation, has continued to monitor delivery and progress against action plans;

    b. developed new guidance, the MHPCF, to support improved care for all people needing secondary mental health care; and

    c. Recommissioned NCISH.

164. Dr James was referred in his evidence to the guidance provided by NHS England to ICBs on intensive and assertive community mental health care dated 26 July 2024, updated on 13 February 2025, referred to above. The first version was published after the CQC section 48 recommendations had been published but before the Theemis recommendations had been produced. The second version of the guidance took account of the Theemis recommendations. Dr James had recently started in post at the time the guidance was initially published and was

---

[158] [NHSE0003033_0009 to 0010]
[159] It was suggested by CTI that NHS England had not disclosed an improvement plan since the plan dated July 2025 [Dr Jessica Sokolov 3 June 2026, 66/20-25] [INQT0000107]. However, NHS England can confirm it has disclosed updated material on a rolling basis as agreed with the Inquiry, including on 19 May 2026, which included plans confirming completion of all actions.
[160] [WITN0310001_0165 to 0166]

not personally involved in its development or subsequent revision. As noted above, Dr Dissanayaka advised on the guidance as part of the national expert advisory group. [161]

165. It was suggested to Dr James by CTI that the wrong version of the NICE guidance had been included in the guidance. This was not accepted by Dr James who explained that the same principles applied[162] and that the alternative guidance that CTI referred to was applicable to short term management of violence in in-patient settings, rather than a longer-term assessment of risk to others. This is borne out by the text of the intensive and assertive outreach guidance. The NICE guidance is only cited as a reference point for what a 'good risk assessment'[163] should include, making clear that services should: (i) avoid using risk assessment tools as a predictor of risk, (ii) assessments should focus on the person's needs and how to support their immediate and long-term psychological and physical safety, and (iii) professionals should undertake a risk assessment as part of every psychosocial assessment.[164]

Engagement with families

166. The Inquiry has heard much about engagement between affected families, survivors and state bodies, including engagement with NHS England. NHS England's engagement with the families and survivors affected by the events of 13 June 2023 centred around:

    a. the Theemis investigation between February 2024 and February 2025;[165]

    b. a number of follow-up questions from the families in relation to the care and treatment of VC and the response of multiple state bodies between June 2025 and September 2025.

167. The evidence before the Inquiry has highlighted both the steps taken by NHS England to engage with the families and the concerns raised regarding that

[161] [NHSE0000046_0035]
[162] [Dr Adrian James, 21 May 2026, 53/20– 54/4; 58/13-16] [INQT0000094]
[163] [NHSE0000046_0009 to 0010]
[164] [NHSE0000046_0010]
[165] [NHNB0018966]

engagement. In that regard, Dr Sokolov acknowledged that *"...one of the things that we need to consider, going forward, is how we do manage to engage with families. Because it's not the responsibility of the bereaved or the affected to make this work, and we failed to do this in the way that we wanted to."*[166]

168. Nothing related to the history of engagement set out below is intended to detract from that acceptance.

Addressing concerns about the Theemis Report

169. When setting out above its acceptance of the Theemis recommendations and the actions taken to implement them, NHS England has been conscious that the report itself, and the experience of its authors, have attracted questions and criticisms, particularly in the context of engagement with the families affected by this tragedy. We have accordingly addressed this topic below.

170. Material concerns as to the conduct of the Theemis investigation have been raised both in advance of, and in the course of, the Inquiry. These were also escalated to the SSHSC and, in particular, discussed in a meeting on 8 December 2025 between some of the bereaved families and the SSHSC.[167] This includes whether Theemis had the requisite experience, and whether the report adequately addressed the concerns of the affected families. NHS England respectfully submits that it acted transparently throughout the process, providing all relevant information in advance of publication, including the investigation's purpose and terms of reference, together with details of the investigating team. NHS England also made clear, almost a year before publication, that only a summary of the report would be made publicly available.

171. Taking these matters in turn, NHS England has a Framework Agreement for the Provision of Independent Investigation Services. Consistent with standard practice, NHS Midlands commissioned Theemis through this Framework,[168] following evaluation of all three providers on the framework. NHS England also confirmed that Professor Oliver Shanley was to be appointed as an external

---

[166] [Dr Jessica Sokolov, 3 June 2026, 97/15-19] [INQT0000107]
[167] [WITN0409059]
[168] [WITN0310001_0130 to 0131 paragraphs 421-424; 0160 to 0161 paragraphs 535-540]

advisor to the investigation; having recently chaired the Independent Review of Greater Manchester Mental Health NHS Foundation Trust, he would provide both additional support in relation to family liaison[169] and "check and challenge" to the process.[170]

172. NHS England submits that those involved in the Theemis Investigation had the requisite experience to carry out the investigation and produce the report into the care and treatment of VC. As stated by Dr Sokolov, notwithstanding the fact that Theemis as a company was relativity new, the investigation team (who were also responsible for the ultimate report) *"had been involved in mental health homicides before, they'd been involved in Patterson and the David Fuller Inquiry and Mid Staffs and Baby P*".[171] The biographies for the Theemis team were shared with the bereaved families on 9 May 2024 following a meeting with Theemis,[172] and are further confirmed in the statement of Amber Sargent.[173]

173. As set out in the CWS, NHS England met with the families about the terms of reference and subsequently produced an amended version to take into account the feedback provided prior to commencement of the investigation.[174]

174. As part of this engagement the families had questions as to whether certain matters would be covered. A question was raised in respect of whether VC's care during the period from arrest through to sentencing would be covered by the reviews being commissioned. Whilst this was not within the remit of the Theemis Investigation, the Head of Independent Investigations for NHS Midlands ("**Head of Independent Investigations**") sought confirmation from the CQC as to whether the Section 48 Report would cover this, but the CQC confirmed it would not, as neither the police nor HM Prison Service is a healthcare provider. The position was confirmed to the bereaved families.[175] NHS England was later asked

---

[169] [Dr Jessica Sokolov, 3 June 2026, 96/17-25] [INQT0000107]
[170] [NHSE0000684_0001]
[171] [Dr Jessica Sokolov, 3 June 2026, 98/7-13] [INQT0000107]; [WITN0310001_0162 paragraph 542c]
[172] [NHSE0000697]; [NHSE0000680]
[173] [WITN0392001_0008-0012] (First Witness Statement of Amber Sargent)
[174] [WITN0310001_0163, paragraph 549]
[175] [NHSE0000701]; [NHSE0000713]

whether the care of those at the scene of the attacks or subsequently in hospital would be covered, to which NHS England explained it would not be:

> *"The investigation that is commissioned will not include the treatment you daughter received at the scene. The focus of the Independent Investigation is the care and treatment Valdo received from his first contact with specialist services up till the day of the homicides… I am sorry but I will not be able to look at the treatment your daughter received."*[176]

175. As set out at paragraphs 107 to 108 of this Closing, NHS England's IPSI's have a specific remit and, following completion, it is for the relevant system together with NHS England to ensure that the relevant organisation acts on any findings and recommendations. The Head of Independent Investigations confirmed this to the families in April 2024, whilst also confirming that a *"summary report focusing on the learning/outcomes/recommendations from the investigation will be made public"*.[177]

176. NHS England acknowledges that the families had concerns as to whether they would be provided with a draft of the Theemis Report, particularly in light of their experiences of investigations by other organisations, which, we understand, were presented as a fait accompli. Those concerns were articulated to NHS England by the families' legal representatives in November 2024, including concerns that they might not be permitted to review the full report, alongside an offer from the families to provide NHS England with a non-disclosure undertaking:

> *"The families need to fully understand the circumstances that led to the deaths of their loved ones. Any non-disclosure will significantly hinder their grieving process.*
>
> *We would be grateful if your organisation could confirm its position regarding this.*

[176] [NHSE0000762_0002]
[177] [NHSE0000684_0001]

We are happy to provide any undertaking you deem necessary to assure non-disclosure of the report." [178]

177. NHS England sought VC's consent (which was subsequently provided) for the full report to be shared with the affected families, given the clear need for further details to be shared with them. A meeting at which the full report was discussed with bereaved families and their legal team took place in January 2025.[179]

178. Following concerns being expressed about publication of a summary only, the Theemis Report was ultimately published in full on 5 February 2025, as explained in the CWS.[180]

179. As set out by Dr Sokolov, NHS England recognises the families' concern that non-publication of the full report might have hampered public debate. However, as she also explained, "*we felt the summary report did include the information that would enable that public debate. It did include identification of the findings and failings and it did include the actions that were needed*", thereby enabling that necessary conversation to take place.[181]

180. Alongside the publication of the Theemis Report, Dr Sokolov and Claire Murdoch were clear there had been unacceptable failings:

> *"It's clear the system got it wrong, including the NHS, and the consequences of when this happens can be devastating. "This is not acceptable, and I unreservedly apologise to the families of victims on behalf of the NHS and the organisations involved in delivering care to Valdo Calocane before this incident took place."*
>
> *… "It is clear there were failings in the care provided to Valdo Calocane which is why the trust responsible was placed in our highest oversight and support*

[178] [NHSE0000833_0002]
[179] [WITN0310001_0163, paragraphs 550(b)].
[180] [WITN0310001_0163 to 0164 paragraphs 550-553], and a copy is available at [NHNB0018966]
[181] [Dr Jessica Sokolov, 3 June 2026, 56/21-57/1] [INQT0000107]

programme which has seen them overhaul their risk assessment processes…" [182]

181. NHS England acknowledges that the bereaved families do not accept the Theemis Report, with one of the primary reasons being that it does not identify individual clinicians or attribute personal accountability. However, it is submitted that the Theemis Report fully discharges the requirements set out in the terms of reference. The absence of individual attribution reflects established and appropriate practice, whereby issues of personal conduct are addressed outside the scope of such reports through separate, well-defined processes. These include referral to the relevant professional regulatory bodies, as well as internal HR procedures where appropriate, both of which are specifically designed to ensure that any concerns are investigated and determined through an independent and impartial process. The naming of individuals in reports may also:

    a. impact future patient safety investigations as individuals need to be confident that there is a culture which enables them to speak up. Sir Robert Behrens CBE, former Parliamentary and Health Service Ombudsman, explained that working in the NHS is often highly demanding and stressful, citing staff survey and National Audit Office data indicating significant levels of work-related stress and attrition. He also referred to evidence of bullying, staff feeling undervalued, and clinicians facing disciplinary action after raising patient safety concerns. Such factors may undermine openness and candour and discourage staff from speaking up. Supporting staff wellbeing, creating psychologically safe working environments[183] and ensuring that concerns can be raised without fear of adverse consequences are therefore important foundations for a culture of candour and patient safety; and[184]

---

[182] [NHSE0003022_0002]
[183] This includes ensuring that staff can speak-up about concerns, mistakes, risks or poor practice, ask questions and challenge decisions, admit errors without fear of blame, and raise concerns without fear of retaliation, disciplinary action, damage to their career, or being treated unfairly.
[184] [Sir Robert Behrens CBE, 3 June 2026, 8/17-10/19] [INQT0000107]

b. expose them to risks to their personal safety, as well as to adverse and potentially prejudicial public comment, before all relevant facts and circumstances are fully understood though such a process.

Wider Engagement with Affected Families

182. Engagement via correspondence and a number of meetings was undertaken both directly with affected families and indirectly through their advocate from Hundred Families, as well as via their legal representatives.[185]

183. The Head of Independent Investigations acted as the primary point of contact between the families, their advocate, their legal representatives, as well as the police and NHFT.

184. NHS England was aware of concerns regarding a lack of engagement between the families and the NHS by the families' advocate owing to the ongoing police investigation. In particular, NHS England questioned the basis on which NHFT was being prevented from communicating with the victims' families by the police.[186]

185. NHS England was also copied into correspondence involving the police in which NHFT expressed the view that it was imperative for it to make contact with families in order to be open and transparent.[187] NHFT were given permission to commence their investigation by the police in November 2023,[188] but this meant that the families became understandably frustrated with the delay in receiving the internal NHFT investigation,[189] with over a year passing since the attacks before NHFT were in a position to share the report,[190] originally as a summary and later the full version.

---

[185] Although opportunities for meetings were made available to the survivors, those offers were not taken up in every case.
[186] [NHSE0000585]
[187] [NHSE0000586]; [NHSE0000590]; [NHSE0000593]; [NHSE0000596]
[188] [NHSE0000715]
[189] [NHSE0000728]
[190] [NHSE0000762]

186. NHS England notes that there has been some discussion as to whether, and to what extent, it met with the bereaved families.

187. In this regard, NHS England records that its representatives met with the families on a number of occasions. Dr James attended three meetings with the families on 6 August, 4 September and 4 November 2024.[191] These were in addition to meetings arranged by the Head of Independent Investigations in relation to the Theemis Investigation, and frequent email correspondence. The Inquiry has been provided with the correspondence between NHS England and the families.

188. However, NHS England recognises that its decision not to meet with the families in late 2025/early 2026, following several letters between it and Dr Kumar on behalf of the bereaved families, has been met with frustration. This was not its intention. Rather, the position reflected a number of concerns, including that the Inquiry had commenced at that stage and evidence was in the process of being disclosed:[192]

> "*NHS England is providing a comprehensive statement and significant disclosure to the Inquiry, including any information we hold that may be relevant to your questions. We are confident that the Inquiry will cover the areas set out in your letter and do not wish to take any steps that could affect the Chair's ability to conduct proceedings fairly, transparently and in line with due process*."

189. NHS England was concerned that a meeting at that stage would not have been able to provide full answers to all of the questions raised (as NHS England does not have access to all information held by the NHS in England). In particular, NHS England observes that, in the correspondence received, the majority of the questions raised were not matters in respect of which it held complete information to enable a full and appropriate response. Where information was held, there was concern that providing partial responses without full context could be misleading. NHS England also understood the disappointment that it's decision would lead to:

---

[191] [NHSE0001541]; [WITN0409002]; [WITN0409003]
[192] [WITN0409050]

"We understand your wish to meet, but given the above, our view is that the Inquiry will provide much more comprehensive answers than we can offer by correspondence or in person. We therefore do not think it appropriate to meet outside the Inquiry.

We are sorry for any disappointment that this may cause, but we would want to reassure you that NHS England is engaging fully and transparently with the Inquiry and is absolutely committed to learning and making changes as required."[193]

190. By that stage, the Inquiry process had commenced. It was therefore considered appropriate to avoid any impact on the integrity of that process, including by providing material outside the Inquiry which was properly a matter for consideration within it. It was also recognised that a number of the matters raised were already addressed within material disclosed to Core Participants, including the affected families.[194]

191. It is, however, important to recognise that NHS England had provided responses where it could provide a full response. This included details as to the nature and remit of IPSIs, the procurement of the Theemis investigation, confirmation that the composition of the Theemis team was as presented to families during the investigation process, and that information regarding the company was publicly available via Companies House. NHS England further explained its understanding that Theemis was being voluntarily wound down for reasons unconnected with the IPSI.[195]

192. Further, NHS England sought to facilitate responses to the bereaved families from where it did not hold the information. For example, the Head of Independent Investigations wrote to Theemis, the CQC and NHFT to facilitate the provision of responses to the bereaved families.[196]

---

[193] [WITN0409050_0002]
[194] [WITN0409043]; [WITN0409073]; [WITN0409044]; [WITN0409045]; [WITN0409046]; [WITN0409047]; [WITN0409048]; [WITN0409049]; [WITN0409050]; [WITN0409051]; [WITN0409054]; [WITN0409055]
[195] [WITN0409046_0003]
[196] See for example: [NHSE0000819] [NHSE0000701] [NHSE0000713] [NHSE0000762]

193. Overall, NHS England sought throughout its correspondence to be open and transparent with the affected families in relation to what it could answer and what the Theemis Investigation and resulting report would deliver. It is clear, however, that there remained fundamental differences in expectations.

194. NHS England submits that, since the attacks, its intention has always been to ensure that accurate and full information on these issues was provided to affected families, in order to avoid such conflicts or disappointments. For example, on 31 July 2024, a meeting took place between the SSHSC, Baroness Merron, the DHSC, NHS England and the CQC to discuss the Section 48 Review, attended by Dr Emily Lawson (former Chief Operating Officer), Claire Murdoch, Dr James and Dr Sokolov.[197] During that meeting, Dr James and Dr Lawson highlighted the importance of openness and transparency in relation to the scope of any Inquiry, including what it would, and would not, have the power to undertake, with a view to supporting clarity and a shared understanding.

195. NHS England accepts that, whilst efforts were made to engage fully and clearly, the engagement did not meet the needs of the families. NHS England recognises that it did not get this right and is genuinely sorry for that failure. NHS England does, however, submit that the evidence of its actions demonstrates a proactive and genuine commitment to transparency, and does not support any finding of a lack of candour, dishonesty,[198] or deliberate obfuscation on the part of those acting on its behalf.

196. NHS England will continue to reflect on the experience gained from these events, particularly in the context of a trauma-informed approach to engagement with families during the IPSI process and beyond. In this regard, the Victims' Commissioner emphasised that: "*you are dealing with people who are processing grief and trauma and so there is lots of evidence to demonstrate, to show, families can't take in information and can misunderstand information, through no fault of their own. It is because they are processing their grief and trauma and that impacts their memory and recall.*"[199]

---

[197] [WITN0155035]
[198] [WITN0409053_0002]
[199] [Claire Waxman OBE, 5 June 2026, 31/1-7] [INQT0000111]

Conclusion

197. The Inquiry is aware that, on 13 March 2025, the SSHSC announced the government's intention to integrate NHS England into the DHSC and, through legislation, to transfer NHS England's functions to a restructured DHSC. The Health Bill, introduced to Parliament in May 2026, remains subject to the parliamentary process. In the meantime, NHS England and DHSC are working together to support the transition to the future operating model, including through joint programme arrangements and, in some cases, shared leadership responsibilities.[200]

198. Notwithstanding those transition arrangements, the current statutory framework remains in force, unless and until Parliament determines otherwise. NHS England continues to exist as a separate legal entity, retains its statutory functions and responsibilities, and remains accountable through its own Board and governance arrangements. The fact that some future functions are intended to transfer to DHSC does not alter NHS England's current legal responsibilities. NHS England's role as a Core Participant in the Inquiry reflects that present legal position.

199. NHS England hopes that these observations have been helpful and looks forward to the Inquiry's Report.

[200] [WITN0155001_0011 paragraph 31; 0033 paragraph 105]