IN THE MATTER OF THE INQUIRIES ACT 2005

BEFORE HHJ TAYLOR

THE NOTTINGHAM INQUIRY

CLOSING SUBMISSIONS ON BEHALF OF

THE DEPARTMENT OF HEALTH AND SOCIAL CARE

---

1. The Department of Health and Social Care (the Department) starts these closing submissions in the same way that it began its opening submissions, by commending those who worked to ensure that this Inquiry has taken place and expressing our heartfelt sympathies to them.

2. The Department stands ready to consider recommendations which are made by the Inquiry and to provide any further assistance that the Inquiry requires to formulate any such recommendations. The Department has listened intently to the evidence and will learn from that evidence and the report that will follow.[1]

3. This written closing sets out the Department's position on some of the key areas and themes which have developed as part of the Inquiry. The Department will also set out those areas where it committed in oral evidence to provide a response or take action. These submissions will deal with the following areas:

    a. Mental Health Strategy;

    b. Resourcing and investment in the mental health sector;

    c. The introduction of the Mental Health Act 2025, including amendments to the detention criteria;

    d. Community Treatment Orders;

    e. The Code of Practice and forthcoming amendments;

[1] William Vineall – 4 June 2026 – AM 1/15 – INQT0000109

f. The Department's contact with bereaved families and surviving victims;

g. The Department's knowledge of VC's care and associated concerns;

h. Risk assessments and Personalised Care Framework;

i. Assertive Outreach;

j. Community-based mental health centres;

k. Policing response to people in mental health crisis;

l. Prevention of Future Deaths reports; and

m. Actions that the Department has undertaken to the Inquiry to carry out.

Mental Health Strategy

4. The Department recognises that whilst there has been significant investment in mental health services over the past ten years, demand has risen and outpaced the services available. The Department further recognises there are problems with continuity of care in mental health services and there is not always sufficient capacity in the system for staff to provide the quality of care that they would wish. Early intervention is key to avoid crisis care and the Department knows that this does not always happen. Delayed discharge from mental health hospitals, sometimes caused by a lack of social care and housing support when people need it, can put further pressure on bed capacity. The Department is taking steps to make the system less fragmented, but it knows that change will take time.

5. The Department recognises the importance of sustaining the necessary capacity and resilience in the system to keep both patients and the public safe. The Department has sought to ensure this through the introduction of the 10 Year Health Plan.[2] The 10 Year Health Plan seeks to reform the NHS through three radical shifts:

   a. hospital to community;

   b. analogue to digital; and

   c. sickness to prevention.

6. We are developing a new cross-government Mental Health Strategy for England, to be published as the next stage of reform under the 10 Year Health Plan. The Strategy is being

[2] DHSC0000096

informed by a 'Call for Evidence', which closed on 10 July 2026, seeking views on how best to deliver the three shifts set out above. The Department will also work closely with experts to ensure the Strategy is shaped by their views and experience. The findings and recommendations of the Independent Review into Prevalence and Support for Mental Health, ADHD and Autism[3] will also inform the Strategy, and it will be aligned with the Mental Health Act 2025 and the Modern Service Frameworks for Children and Young People and Severe Mental Illness. In particular, the Modern Service Framework for Severe Mental Illness will set out a long-term vision for high-quality, equitable care, including the co-produced outcome goal that, by 2035, people with severe mental illness will live longer, healthier and more fulfilling lives through high-quality, integrated and equitable care.[4] It will establish a roadmap for delivery and support consistent implementation across the health and care system.

Resourcing and investment in the mental health sector

7. The Inquiry heard evidence regarding the available resources for the health and social care sector both in Nottingham and in England as a whole, with a particular focus on provision for mental health. Mr Vineall explained that "*Departments have a fixed amount of money and need to make decisions in the round about how they're going to use those resources*".[5] Funding for mental health, like all other aspects of health and social care, is allocated according to the choices made by each Government drawing on finite resources and is subject to Parliamentary scrutiny. Resourcing always involves trade-offs between different areas and differing emphasis depending upon the democratic mandate given to the executive.

8. The Department recognises there is a "*need for parity on services between mental health and physical health*".[6] That is the basis for the investment identified in these submissions and the evidence both of Baroness Merron[7] and William Vineall.[8] For 2026/7, NHS mental health spending is forecast to increase to a record £16.1bn; a real-terms increase of around £140m from the previous year.[9] Integrated Care Boards will be required to meet

[3] DHSC0000666
[4] DHSC0000667
[5] William Vineall – 4 June 2026 – AM – 12/4 – 12/6 – INQT0000109
[6] Baroness Merron – 4 June 2026 – PM – 38/12 – INQT0000110
[7] Baroness Merron – 4 June 2026 – PM – 35/5 to 37/6 – INQT0000110
[8] William Vineall – 4 June 2026 – AM – 13/6 – 14/1 – INQT0000109
[9] William Vineall – 4 June 2026 – AM – 10/13 – INQT0000109

the Mental Health Investment Standard by protecting mental health spending in real terms.

9. In respect of capital funding, the Department has made available £473 million over 4 years and is encouraging the system to invest in new models of mental health delivery, including community based mental health centres, building on findings from the six pilot schemes discussed in the Department's written and oral evidence, and other capital projects such as mental health emergency departments. It is also to be used to eliminate out-of-area placements. The Government has recently announced plans for up to 155 new mental health facilities across England, comprising 100 further new community-based mental health centres and 55 dedicated mental health emergency departments. These facilities will help people to access support earlier and bring together mental health, social care and wider support services, in order to try and deliver more joined-up, preventative and community-based care[10]. This is a significant investment into creating new models and ways to improve the delivery of mental health services. Dr Adrian James, for example, made reference in oral evidence to the capital funding that is already available,[11] as did Mr Vineall.[12]

10. Additionally, there is further indirect spending on mental health. As part of the Department's 10 Year Health Plan to undertake the three radical shifts described above, there is significant additional investment into other core areas. This includes NHS technological and digital transformation such as the introduction of the single patient record, strengthening general practice and establishing Neighbourhood Health Centres. These improvements, while not counted in pure mental health service spend, will deliver important benefits for mental health services and patients.

11. The last Spending Review was published on 11 June 2025 and set multi-year budgets. The Department will keep funding under review alongside the next Spending Review.

[10] DHSC0000664
[11] Dr Adrian James – 21 May 2026 – PM – 45/20 – INQT0000094
[12] William Vineall – 4 June 2026 – AM – 84/2 – INQT0000109

The introduction of the Mental Health Act 2025, including amendments to the detention criteria

12. The Mental Health Act 2025 received Royal Assent on 18 December 2025 and as set out in the witness statement of the Department,[13] the legislative changes as enacted were the result of careful analysis, extensive consultation, and parliamentary debate over a very lengthy period. As further set out in the witness statement of the Department,[14] the changes are designed to achieve the following:

    a. Improving patient safeguarding and reducing unnecessary restriction;

    b. Strengthening the focus on therapeutic benefit;

    c. Improving patient choice and autonomy;

    d. Limiting the detention of people with a learning disability and autistic people; and

    e. Improving advance planning, patient and family involvement and join up across the system.

13. The previous Government under Theresa May recognised that the Mental Health Act 1983 was an outdated piece of legislation that had fallen out of step with modern attitudes to mental health. This led to Prime Minister Theresa May commissioning Sir Simon Wessely to undertake an independent review of the Act which was published in 2018. Whilst not explicitly set out in the terms of reference for that review, Sir Simon Wessely set out in his evidence to this Inquiry that public safety was "*in the room*",[15] and it also "*appeared in the central theme of what we did*."[16] As Sir Simon went on to clarify in oral evidence to this Inquiry, giving patients more involvement in their treatment increases compliance; benefits to the patient and public safety "*are not in any way incompatible*."[17]

14. The 2025 reforms do not change the core powers and purpose of the Mental Health Act 1983, which is fundamentally to detain and treat people when they are so unwell that they become a risk to themselves or others, as has been identified by the expert to the Inquiry,

[13] WITN0155001_038
[14] WITN0155001_070 onwards
[15] Professor Sir Simon Wessely - 2 June 2026 – PM – 65/25 – INQT0000106
[16] Professor Sir Simon Wessely - 2 June 2026 – PM – 14/10 – 11 – INQT0000106
[17] Professor Sir Simon Wessely - 2 June 2026 – PM – 15/1 – 2 – INQT0000106

Alex Ruck Keene KC,[18] as well as Dr Adrian James of NHS England,[19] Dr. Shubulade Smith of the Royal College of Psychiatrists,[20] and the Department.[21]

15. The Department has submitted that the amended legislation strikes the appropriate balance between public safety and autonomy. The amended legislation was, as confirmed by Baroness Merron, the result of "*a lot of debate and consultation*".[22] The need to balance autonomy and protection formed the very basis of Professor Sir Simon Wessely's review; it is this balance that lies at the heart of why we have such powers of the state.[23] These powers may be used to determine that someone must be admitted to hospital and be compelled to receive treatment, even if individuals who are to be detained have capacity over consent. As identified continuously in case law,[24] practitioners have such powers in order to make the community safe, and to treat the person, but this must be balanced and proportionate to the circumstances.[25]

16. The Department would refer the Inquiry to Dr Adrian James's evidence in which he stated that he does not believe that the legislative changes will "*put more people at risk in the community*" and that there are "*aspects within it that will make people safer*".[26] The Department would further observe that there were alternative approaches that were considered but not adopted which would have placed a far greater focus on autonomy than the legislation as amended, for example, as set out in Professor Sir Simon Wessely's statement at Paragraph 69:

"What we proposed was a carefully calibrated process in which we would see more of patient choices being considered, but subject to certain restrictions. For example, we rejected the idea that patients could simply refuse all treatment (as happens I think in Ontario, if the patient has capacity, under the Health Care Consent Act (HCCA)) since this would lead to prolonged incarceration on the grounds of unmitigated risk. Likewise,

---

[18] Alex Ruck Keene KC – 16 April 2026 – AM – 48/17 – INQT0000053
[19] Dr Adrian James – 21 May 2026 – PM – 119/22 – INQT0000094
[20] Dr Shubulade Smith – 1 June 2026 – AM – 86 to 88 – INQT0000103
[21] WITN0409001 _0002 – Paragraph 6
[22] Baroness Merron – 4 June 2026 – PM – 22/1 – INQT0000110
[23] Professor Sir Simon Wessely - 2 June 2026 – PM – 16/20 – 17/5 – INQT0000106
[24] RLIT0000077 - AM v SLAM NHS Foundation Trust [2013] UKUT 365 (AAC) - MHA 1983 have to be applied on the basis that for detention in hospital to be 'warranted' it has to be 'necessary' in the sense that the objective set out in the relevant statutory test cannot be achieved by less restrictive measures;
RLIT0000078 - MS v North East London Foundation Trust [2013] UKUT 92 (AAC) – "has to be applied in a context that requires detention to be strictly justified."
[25] WITN0322001_0005
[26] Dr Adrian James – 21 May 2026 – PM – 119/22 – 119/24 – INQT0000094

an advance directive would not be considered if it was contrary to accepted medical evidence (e.g., "I will only accept homeopathic treatment"), or impossible to carry out (e.g., "I wish to be treated only by this consultant/the Queen" etc etc). Likewise, we agreed that no professional could be forced to administer a treatment or process that they did not think was safe or effective. This would be a red line. We did not want to create a climate that would mean professionals going against their own judgements." [27]

17. The grounds of detention under Sections 2 and 3 were amended to include the following:

    a. serious harm may be caused to the health or safety of the patient or of another person unless the patient is so detained; and

    b. given the nature, degree and likelihood of the harm, the patient ought to be so detained.

Detention criteria

18. We acknowledge that the two areas of legislative reform of most likely interest to the Inquiry are changes to the detention criteria and Community Treatment Orders. The approach taken by the Department on detention criteria broadly adopted the recommendations set out by Professor Simon Wessely in the Independent Review:

    "We believe the Act needs to be more explicit about how serious the harm has to be to justify detention and/or treatment."[28]

19. Sir Simon Wessely conducted his review in 2017 with the benefit of input from various stakeholders including the Royal College of Psychiatrists. He gave his position in respect of the detention criteria in oral evidence when asked if the threshold had been increased:

    "I think my view is that they have clarified the threshold to detention, and it's in a way that permits people to continue to do what they should do, which is make good clinical judgements for the protection of the public and for the treatment of the person. I think it's helpful."[29]

20. Professor Sir Simon Wessely also explained that, in his view, there is little difference in practice between the term "*substantial likelihood of significant harm*" (as recommended

[27] WITN0322001_0028
[28] WITN0322001_0036
[29] Professor Sir Simon Wessely – 2 June 2026 – PM – 68/1 – INQT0000106

by the Independent Review) and the new criteria[30] that "*serious harm may be caused… given the nature degree and likelihood of the harm*"[31] The Professor was asked about the alternative proposals put forward by the Royal College of Psychiatrists[32] and indicated *that "I think I agree with the Act as it currently is*".[33]

21. The Department would further highlight the comments made by Alex Ruck Keene KC in his evidence when considering the changes to the detention criteria:

"I should, though, make clear that the Bill does not propose any radical changes to practice — what it is, in essence, doing is placing on a statutory footing what is already meant to be good clinical practice." [34]

22. As set out in the witness statement of the Department, and confirmed by Mr Vineall in oral evidence:

"The planned reforms will not change the fundamental powers and purpose of the Mental Health Act, which is to detain and treat people when they are so unwell they become a risk to themselves or others." [35]

23. It is submitted that the 2025 Act's Explanatory Notes provide further explanation at Paragraph 77:

"The purpose of these changes is to provide greater clarity as to the level of risk of harm that a person must present in order to be detained. Firstly, the "serious harm" test sets out the severity of the harm a patient must pose in order to fulfil the criteria for detention under section 2 of the 1983 Act. The Act does not define serious harm; further guidance will be provided in the Code of Practice. Secondly, the "nature, degree and likelihood" test introduces a new requirement that the clinician must consider the likelihood that this harm will occur, when deciding to admit the individual under section 2. "Likelihood" should be considered holistically alongside the nature and degree of harm. It does not require the decision maker to conclude that it is more likely than not harm will occur." [36]

---

[30] Professor Sir Simon Wessely – 2 June 2026 – PM – 47/23 – 49/16 – INQT0000106
[31] Mental Health Act 2025 s.5 (amending the Mental Health Act 1984 ss. 2 and 3)
[32] WITN0320001_70
[33] Professor Sir Simon Wessely – 2 June 2026 – PM – 52/20 – INQT0000106
[34] WITN0288001_0077
[35] WITN0155001_92; William Vineall – 4 June 2026 – 62/1 – 62/16 – INQT0000109
[36] DHSC0000665

Community Treatment Orders (CTOs)

24. CTOs were introduced following the Ritchie report[37] because of the "*strong view that they aided public protection*"[38] and that CTOs "*were a useful tool to clinicians to have because you could recall people and if necessary, subsequently require medication to be taken*".[39]

25. The effectiveness of CTOs is fundamentally difficult to measure, as is clear from the evidence put before the Inquiry.[40] Professor Sir Simon Wessely gave consideration to CTOs during his review. He explained that the reason he determined that they ought to be retained was because of first-hand evidence that he witnessed.[41] Professor Sir Simon went on to state that abolishing CTOs would disadvantage people that he had seen. This is shown further by the evidence that the Inquiry has heard, for example, Dr Dissanayaka stated that CTOs *"if you target the right cohort, then I think they can be incredibly effective*".[42]

26. This was echoed by Baroness Merron during her oral evidence; in particular the value that CTOs can have in protecting patients and wider society.[43]

27. The Department submits that CTOs are an important tool to appropriately balance public protection and patient autonomy, with further steps being taken in the Mental Health Act 2025 to ensure their proper use. The amended legislation introduces a requirement that where the responsible clinician is not the community clinician, the community clinician must state in writing that they agree that the relevant criteria are met in order to make a CTO. The community clinician must also be consulted on other decisions, including the renewal of a CTO, the recall of the patient to hospital, the revocation of a CTO, and discharge from the CTO. Requiring the community clinician to agree to the CTO aims to ensure continuity of care for patients and ensure clear handover of responsibility between inpatient and community teams. The reforms in the 2025 Act aim to strike a balance, recognising that some people are kept on a CTO for far too long, without a good reason

[37] DHSC0000160
[38] William Vineall – 4 June 2026 – AM – 20/5 – 6 – INQT0000109
[39] William Vineall – 4 June 2026 – AM – 20/7 – 9 – INQT0000109
[40] For Example - WITN0155008_262 – 264
[41] Professor Sir Simon Wessely – 2 June 2026 – PM – 53/16 – INQT0000106
[42] Dr Dissanayaka – 15 April 2026 – AM – 123 / 4 – 7 – INQT0000051
[43] Baroness Merron – 4 June 2026 – PM – 24/20 – INQT0000110

for the restrictions placed on them (for example if there is no previous evidence of non-compliance with treatment when in the community).[44]

28. Under the new legislation, clinicians will still have the power to place patients onto a CTO upon discharge if they think there are valid clinical reasons for doing so. The fact that their use will need to be considered by a community team (who may well have prior knowledge of the patient) before discharge will help alert that community team to the need for adequate support and safeguards and a better safety net for those who require them. The fact that a CTO was not used with VC does not suggest the need for further legislative change; as the evidence from the clinicians demonstrated, the significant failure was *not* putting a CTO in place under a misplaced view by some clinicians that VC was concordant with his medication.[45]

Code of Practice and forthcoming amendments

29. If the Inquiry considers that the detention criteria require explanation to avoid an interpretation that:

    a. there must be some kind of test or threshold of balance of probabilities in respect of harm; or

    b. that the likelihood test is unclear,

    then the best and most appropriate place to provide such clarification would be within the Code of Practice.

30. The 2025 Act (similarly to the 1983 Act) provides that clinicians and all working in the mental health system must have regard to the Code of Practice. It is a legal requirement of the Act. That means much more than simply looking at it; clinicians must follow it, deviating from it only if there is an exceptional reason, as it has been laid before Parliament and provides significant guidance and description. In **Regina v. Ashworth Hospital Authority (now Mersey Care National Health Service Trust) (Appellants) ex parte Munjaz (FC) (Respondent) [2005] UKHL 58**,[46] the House of Lords ruled that the Code of Practice is not legally binding in every single instance. Hospitals "*must have regard to it*", but they are permitted to depart from its guidance if they have "*good reason*"

[44] WITN0155038
[45] Dr Burri – 28 April 2026 – PM – 40/23 – 25 and 41/1 – INQT0000066; Dr Lloyd – 6 May 2026 – AM – 108/20 – 25 – INQT0000073
[46] RLIT0000079

to do so. The House of Lords continued to state that "*Statutory guidance of this kind is less than a direction*". But it is more than something to which those to whom it is addressed must "*have regard to*". The Code of Practice provides the appropriate opportunity to give a clearer explanation and real-life scenarios and parameters to the meaning of a serious risk of harm.[47]

31. The planned date for publication of the revised Code of Practice and, concurrently, enactment of the first part of the reforms, is in 2028/2029.[48] This will be the result of the input of various stakeholders and people with lived experience. In addition to engaging widely during the drafting of the revised Code of Practice, the Department has committed to then launching a public consultation on the draft Code. We envisage this taking place in early summer 2027, which should allow learning from the recommendations of the Inquiry to be included. Following this, the Department will need to make revisions to take on board consultation feedback and ensure the existing workforce is trained on the revised Code ahead of publication and Phase 1 reforms coming into force in 2028/29.

32. The Department agrees with Alex Ruck Keene KC that the appropriate means for explaining legislation is within this Code; he stated the "*Code of Practice can't make the law, but can explain it*". The revised Code of Practice will be in place before the commencement of the amended legislation, including the amended detention criteria.

33. As Mr Vineall confirmed, the timing of the drafting of the Code of Practice allows for the Department to take on board recommendations made by the Inquiry. Baroness Merron said:

"...and I was keen as the Minister responsible for overseeing the process -- does allow us to take full account of recommendations as we develop the Code of Practice, as we seek to implement the Bill which, whilst it's on the statute books, is not yet implemented." [49]

34. The Department has already begun consulting on an informal basis with key bodies such as the Royal College of Psychiatrists. As Dr Shubulade Smith confirmed in evidence:

[47] WITN0155001_39 / Paragraph 121
[48] William Vineall – 4 June 2026 – AM – 88/21 – 23 – INQT0000109
[49] Baroness Merron – 4 June 2026 – PM – 2/23 to 3/2 – INQT0000110

"And right now the Department of Health and Social Care are working with various stakeholders to develop the Code of Practice around the new, you know, the new amendments to the Mental Health Act." [50]

35. Baroness Merron confirmed in her written evidence that this approach will be taken at Paragraphs 27:

"More detail on the definition of serious harm will be provided in the Code of Practice, which will be developed in consultation with a wide range of stakeholders, including people with lived experience and their families and carers, staff and professional groups commissioners, providers, and the voluntary sector."[51]

The Department's contact with bereaved families and surviving victims

36. The Department wishes to express its deep regret that earlier contact did not take place with the surviving victims and their families. Baroness Merron accepted that this was a failing and apologised for it.[52] The Secretary of State was able to meet with survivors and representatives on 5 February 2026.

37. The Department has sought to reflect the views of the bereaved families in developing the legislation following meetings with them. The Department welcomed the views of the families during a meeting in August 2024.[53] Following on from this, and alongside this, a submission was prepared which led to amendments to the legislation to better strengthen public protection. [54]

38. The Department also met with the bereaved families, including on the following dates:

    a. 29 January 2024;

    b. 6 August 2024;

    c. 4 November 2024;

    d. 12 February 2025;

    e. 9 June 2025; and

[50] Dr Shubulade Smith – 1 June 2026 – AM – 59/3 – 6 – INQT0000103
[51] WITN0409001_13
[52] Baroness Merron – 4 June 2026 – PM – 49/19 – INQT0000110
[53] NHSE0001541
[54] WITN0409001_0028

f. 8 December 2025.

39. The Department also considered the observations made by Dr Kumar in respect of Section 117 after-care provided in email following the meeting on 4 November 2024.[55] Dr Kumar's proposal was that there be a statutory requirement for the hospital Consultant to hand over to the community/outreach Consultant at the point of discharge. This was best illustrated by Baroness Merron's evidence that the observations were "*absolutely valid in intent, but it was and is our view that actually those could be achieved through other means that would be more effective including the arrangements about discharge*".[56] The Department's view is that these changes will be considered as part of the work to revise the Mental Health Act Code of Practice.

40. Further, NHS England has published a new Personalised Care Framework, which intendeds to address many of the concerns raised. This will underscore the importance of proactive, continuous and responsive care, including patients receiving community support having a named care professional.[57] Further support in this area will result from care and treatment plans which are the "*cornerstone of the 2025 Act*".[58]

The Department's knowledge of VC's care and associated concerns

41. The Department has significant concerns about the shortcomings in respect of the care provided to VC. The Department agrees that urgent work is required in a number of areas including, for example, the need for record keeping in all multi-disciplinary team meetings and much improved record keeping generally by all mental health services (failings have been observed in inpatient and community care provided to VC, as well as the failure to transfer records from independent hospitals to the Trust).

42. The Department would observe that the following are some (but not the only) failings which the Inquiry will wish to address:

    a. The decisions taken to discharge VC from the Early Intervention in Psychosis service to primary care, without telling his family and for the reason of non-engagement. A person should not be discharged from services in the position that

[55] WITN0409020_0001
[56] Baroness Merron – 4 June 2026 – PM – 31/20 – 31/23 – INQT0000110
[57] William Vineall – 4 June 2026 – AM – 93 / 5 – INQT0000109
[58] Baroness Merron – 4 June 2026 – PM – 32/8 – INQT0000110

VC was in in September 2022 (not taking his medication, being mentally very unwell as a result of that);

b. That some clinicians seemed to take the view that section 2 of the Mental Health Act 1983 should be used rather than section 3 on the basis that it was the "least restrictive" option. Where a patient has already been detained under section 3 of the Mental Health Act 1983, and where there is no new diagnosis in place for which assessment is needed, section 3 would be more appropriate, this also permits a CTO to be put in place;

c. The failure to engage with VC and provide assertive and proactive steps to seek to encourage and/or enforce (where appropriate) the taking of anti-psychotic medication;

d. The lack of joined up care between inpatient and outpatient/community services;

e. The inadequacy of staffing; and

f. The lack of active community care services.

43. In January 2024, the Department announced the undertaking of a review under section 48 of the Health and Social Care Act 2008 into Nottinghamshire Healthcare NHS. The Department agrees with the conclusions of this review which found the following failings in respect of VC's care:

a. Inconsistent approaches to risk assessment;

b. Poor care planning and engagement; and

c. The decision to discharge VC back to his GP in September 2022, which failed to adequately consider or mitigate the risks of relapse. [59]

44. In February 2024, NHS England placed the Trust in the highest level of oversight and assurance in the NHS Oversight Framework, where it remains to this day, and has entered the Recovery Support Programme for mandated support and heightened regulatory oversight. The Recovery Support Programme replaced what was previously known as "*Special Measures*". It allows organisations to receive support (for example, financially and through the provision of additional resource) for a time-limited period with exit

[59] CQCM0016517

criteria agreed that will demonstrate sustainable improvement and recovery.[60] Between May 2024 and August 2025, the Care Quality Commission (CQC) has carried out a programme of 39 inspections at Nottinghamshire Healthcare NHS Foundation Trust.[61] The CQC as the regulator of health and social care services is best placed to provide advice to the Trust and to the Department in the reports that it publishes as to what further steps need to be taken.[62]

45. On 31 July 2024, following on from delivery of the report, the Department met with NHS England and CQC to discuss how they and the Nottinghamshire Healthcare NHS Foundation Trust are progressing the recommendations and how they will work together to make swift, sustained improvements to mental health services. On 13 August 2024, the Secretary of State responded to the findings of CQC report and announced a series of measures. This included actions by NHS England ensuring that every provider of mental health services has clear policies and practices in place to treat patients with serious mental illness, issuing guidance to trusts reiterating instructions not to discharge patients with serious mental health issues if they do not attend appointments, and establishing an expert advisory group to oversee the development of core standards for safe care in community mental health services, as well as specific actions the local trust has taken, such as putting a new crisis telephone system in place.

46. Following on from this, the Secretary of State asked for regular updates from NHS England (which, as described in the witness evidence of the Department,[63] has day to day operational responsibility for the workings of Trusts). Updates from NHS England were received on the following dates:

    a. 23 October 2024;

    b. 4 December 2024;

    c. 7 August 2025;

    d. 12 December 2025; and

    e. 24 June 2026.

---

[60] NHSE0001397; Dr Sokolov – 3 June 2026 – AM - 59/20 to 62/9 – INQT0000107
[61] WITN0409076
[62] WITN0155001 _0021
[63] WITN0155001 _0002

47. Mr Vineall confirmed in oral evidence that the Department would continue to assure itself as to the improvement of the Trust using the oversight mechanism that it has through continued reports from the CQC and NHS England. The Department sought an update from NHS England on the implementation of the recommendations made in the CQC s48 report and in the Theemis-led Independent Homicide Review prior to Mr Vineall and Baroness Merron's evidence session on 4 June 2026. The Department received the update on 24 June 2026 which indicated that 37 of the 39 recommendations made in the CQC s48 report are now complete from the Trust and/or others. All recommendations made in the Independent Homicide Review are complete.

Risk assessments and the Personalised Care Framework

48. The most recent national guidance on risk management in mental health services was published by the Department of Health in 2009.

49. Notwithstanding the period of time since the national guidance was introduced, it is considered to be "*good guidance*"[64] and sets out quite carefully the fact that it is extremely important that clinicians satisfy themselves, through their various clinical processes, of the risk to an individual and of that risk to others.[65]

50. As already mentioned, the Personalised Care Framework (PCF), published by NHS England on 17 July 2026, provides updated national guidance on the minimum standards expected of mental health services, including in the management of risk, setting out how secondary mental health services must effectively assess, plan and manage people's care in collaboration with all relevant teams. This sets out "*the basics*" of how practitioners should deal with cases like VC.[66]

51. The PCF sets out minimum standards of care to address variation in quality of services that patients receive following implementation of Community Mental Health Framework.

Assertive Outreach

52. Assertive and intensive outreach care supports individuals with severe mental illness who may struggle to engage with services due to complex needs or their illness, meaning they lack insight into their illness. We recognise that effective assertive outreach is an

[64] William Vineall – 4 June 2026 – AM – 25/19 – INQT0000109
[65] William Vineall – 4 June 2026 – AM – 25/19 – INQT0000109
[66] William Vineall – 4 June 2026 – AM – 93/4 – INQT0000109; Baroness Merron – 4 June 2026 – PM 32/6 – INQT0000110

important component of managing risk, that is why the 10 Year Health Plan set an ambition to reach 100% national coverage of assertive models of care by the end of 2035. This is a long-term commitment that looks beyond the current Spending Review and there is currently no specific funding from central government earmarked for Assertive Outreach for 2026-2029. However, local areas could choose to spend their mental health funding – which is increasing in real terms – on these services within this period.

53. Dr Dissanayaka and his service have plainly been very successful in implementing their Assertive Outreach service, achieving a very high standard of care and reducing the need for hospital admissions. But this does not mean that the implementation of the full Assertive Outreach model as operates in Leeds will work for each and every location, let alone each and every patient.[67] In an urban area like Nottingham, with a denser population, higher levels of socioeconomic inequality and various other factors leading to increased poor mental ill health and higher rates of serious mental illness, it would seem apparent that a full Assertive Outreach service is needed.

54. However, Dr Adrian James observed that such a model should be used where useful, but there will be areas where this is impractical such as in rural areas. As such, there is a need for flexibility.[68] Dr James confirmed that "*it is for the local commissioning groups, so the ICB* [(Integrated Care Board)]*, to commission the services that meet the needs of their population, so they would need to – so we're highlighting a need that we were concerned – in fact we had evidence – that it was being missed*".[69]

55. The Department's position is that the appropriate course is that each Integrated Care Board (ICB) is responsible for putting in place the required care systems. Mr Vineall explained the nature of the guidance provided by NHS England on assertive outreach[70] and the effect of such guidance during his evidence:

"ICBs report into NHS England and, working [with] NHS Trusts, have to decide what is the best service for their local community based on that community's needs. And the guidance here from NHS England is setting up two options, but not the third option of not having it at all." [71]

---

[67] William Vineall – 4 June 2026 – AM – 43/15 – INQT0000109
[68] Dr Adrian James – 21 May 2026 – PM 38/1 – 38/23 – INQT0000094
[69] Dr Adrian James – 21 May 2026 – PM 40/21 – 41/2 – INQT0000094
[70] DHSC0000101_021
[71] William Vineall – 4 June 2026 – AM – 45/11 – 16 – INQT0000109

56. This approach allows for resources to be properly allocated and efficacy of systems to be monitored. It is submitted that this is in line with much of the evidence given by Dr Dissanayaka, during which he noted that it is "*difficult to separate violence risk management from good clinical care*".[72]

57. In 2024, the Department agreed with NHS England that NHS England should immediately review all community mental health services and commission a review of the evidence to support the development of a model of assertive outreach. Following a requirement in the 2024/25 NHS Priorities and Operational Planning guidance for all ICBs to "*review their community services.....to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge*",[73] in July 2024 (updated February 2025) NHS England issued accompanying guidance to ICBs on intensive and assertive community mental health care to support ICBs in this review. The guidance sets out that while ICBs are not required to commission assertive outreach teams, meeting the needs of all individuals with a severe mental illness requires dedicated resource for intensive and assertive community care. It is down to ICBs to prioritise and invest in assertive outreach. The PCF, published on 17 July 2026, echoes NHS England's 2024 guidance on assertive outreach by making clear the basics of what all services responsible for the care of people with serious mental illness should do to assess, plan and manage people's care in collaboration with all relevant teams, including how they should assess safety and risks of harm to others. Crucially, the PCF also underlines the importance of reassessing and communicating risks when people are moving between services and it makes clear that no one should ever be discharged for disengaging with services.

Community Based Mental Health Centres

58. For people with serious mental illness, the 10 Year Health Plan commits to transforming mental health services into 24/7 neighbourhood models. In the immediate term, this is backed by capital funding over 4 years.

59. Dr James discussed the establishment of these centres during oral evidence and set out the approach to them, noting the need for pilots to assess their effectiveness, and that they

[72] Dr Dissanayaka – 15 April 2026 – AM – 60/17 – INQT0000051
[73] DHSC0000098_ 0025

"*need a proper evaluation*".[74] Baroness Merron stated that she was "*enthusiastic about the pilots, because they will give us evidence and a lead, and why we have made capital funding available*".[75] Health and Social Care Secretary of State, Yvette Cooper, said that "*Too many people are only getting mental health support when they each crisis point, after struggling for far too long to get the help they need*".[76] She explained that the announcement on 6 August 2026, of the new mental health facilities across England is "*how we will turn the tide on mental ill health – preventing more people from reaching crisis, cutting waits for care and building an NHS that is fit for the future*".[77]

60. The aim is that these services have the following benefits:

    a. Open 24/7 with no referral needed;

    b. Patient centred: designed to improve continuity of care;

    c. Community based: located in the middle of the community to reduce stigma and improves access;

    d. Multi-disciplinary teams: including NHS staff, those from the voluntary sector and in reach support from wider services including social care, housing and employment; and

    e. No more passing of patients in between different community mental health teams.

61. In its opening submissions, the Department set out the aims of the NHS Long Term Workforce Plan and the efforts to address staffing shortages in mental health services.[78] The Department acknowledges that this alone does not solve the workforce shortages and the problems with workforce retention. There is high turnover in mental health services, and this has a compromising effect on the quality of care. The Department has sought to take steps to improve working conditions for those within health and social care. This has included the recruitment of thousands of new mental health staff, of which half are mental health nurses.[79]

---

[74] Dr Adrian James – 21 May 2026 – PM – 46/13 – INQT0000094
[75] Baroness Merron – 4 June 2026 – PM – 37/8 – 10 – INQT0000110
[76] DHSC0000664
[77] DHSC0000664
[78] NHFT0017698
[79] William Vineall – 4 June 2026 – AM –12/11 – INQT0000109

Policing response to people in mental health crisis

62. Right Care Right Person (RCRP) provides a framework for assisting police with decision-making about when they should be involved in responding to reported incidents involving people with mental health needs. It is a police-led approach designed to ensure that people of all ages, who have health and/or social care needs, are responded to by the right person, with the right skills, training, and experience to best meet their needs.

63. The National Partnership Agreement (NPA) is a strategic document that sets out key principles of the RCRP approach and its application to mental health-related incidents. It was signed by the following bodies during the previous Government under Prime Minister Rishi Sunak:

    a. Department of Health and Social Care;

    b. Home Office;

    c. NHS England;

    d. National Police Chiefs' Council (NPCC);

    e. Association of Police and Crime Commissioners (APCC); and

    f. College of Policing.

64. The Home Office is responsible for the provision of healthcare workers in custody suites or as part of triage teams. The Department concurs with the views expressed during this Inquiry that any such workers should have adequate training in assessing the capacity of those who are mentally unwell and an ability to assess someone's mental ill health and mental state. The Department agrees with the evidence of Alex Ruck Keene KC on this point.

Prevention of Future Death (PFD) reports

65. The Department acknowledges the importance of PFD reports and the value that they can bring in respect of developing policy. [80]

66. The dedicated PFD Oversight Team acts as the main point of contact with coroners, handling incoming and outgoing PFD correspondence. Since 2024, each response to a PFD report is now led by the relevant policy team(s), ensuring specific concerns raised

[80] WITN0155001 _0067

by coroners are addressed. As part of this process, the Department collaborates closely with other Departments and regulators to help formulate its responses and to make them aware of the issues raised.

67. Responses are reviewed and signed off by the relevant Senior Civil Servant (SCS) before being submitted for Ministerial approval. This ensures that policy teams are more clearly accountable for the quality and content of responses to PFD reports and better able to incorporate learning from individual PFD reports into their ongoing policy work and ensure actions committed to in the response, are implemented. Quarterly statistics on compliance rates and number of commitments the Department has made in responses PFD reports and its implementation, are shared with the Department's Executive Committee and Ministers to ensure the Department is meeting its statutory obligation and keeping track of actions. The Department also meets with the Ministry of Justice, the Chief Coroner's Office and other Government departments as part of a cross government group, to share learning on PFD reports and apply a consistent approach to handling PFD reports where appropriate.

68. It was put to Mr Vineall that there ought to be monitoring of PFD reports outside of those addressed directly to the Department. The coroners regulations states that it is the responsibility of the recipients of PFD reports to implement the actions they have committed to in their responses. The Department would submit that the current approach is the appropriate one as it allows coroners to make targeted referrals to departments where such reports require that department's attention. It also ensures that each organisation to whom the PFD report is addressed is responsible for implementing the actions, rather than raising short-comings relating to individual ICBs or Trusts. But the Department will keep this issue under review.

Actions that the Department has undertaken to the Inquiry to carry out

69. As Baroness Merron confirmed in evidence, considerations regarding Dr Kumar's views on the need for statutory requirements for a hand-over upon the point of commencement of section 117 aftercare were ongoing during the progress of the Mental Health Bill. As Mr Vineall indicated, the Department is committed to reviewing the ICB structures and how section 117 arrangements are being discharged in these new structures. This will be supported by the implementation of the PCF, which will establish clear expectations around care and continuity of support following discharge, helping to address concerns

about coordination and handover between services for individuals receiving section 117 aftercare.[81]

70. Mr Vineall was asked questions on behalf of the University of Nottingham regarding the potential need for a consensus statement in respect of information-sharing. The Department recognises the value of the position taken by the University.[82] The Department recognises that information sharing can be a key tool in both public protection but also carrying out risk assessments.[83] As Mr Vineall confirmed in oral evidence, the Department is considering whether or not bespoke guidance on information-sharing and public protection, including university information sharing, would be useful such like that in place in respect of suicide as also suggested by Alex Ruck Keene KC.[84] Baroness Merron agreed to consider whether there are sufficient mental health specialists in leadership positions within ICBs. This is ultimately an area of responsibility of the individual ICB. The Department will consider whether guidance would assist in ensuring practitioners' voices are heard at board level. The Department is considering how best to develop this area and what data to obtain and analyse.

71. The Department will take steps to consider how best to approach oversight of PFD reports, in particular ensuring that these are monitored where they relate to individual ICBs. The Department has undertaken work already in respect of oversight of PFDs but will continue to review the position.

72. Furthermore, the Department will consider whether data-collection by the National Confidential Inquiry into Suicide should be expanded, for instance to also cover serious harm caused by mentally ill patients.

73. As Mr Vineall stated, the Department intends to liaise with the Ministry of Justice to consider the impact of the Supreme Court's judgment regarding the definition of deprivation of liberty in respect of conditional discharge. Section 35 of the Mental Health Act 2025 amends section 42 of the 1983 Act, creating a power that allows the Tribunal or the Secretary of State for Justice to place conditions that amount to a deprivation of liberty on a patient as part of a conditional discharge. The Department will ensure that terms are

[81] DHSC0000668
[82] UNIN0001807_17
[83] Dr Farnham – 31 March 2026 – 66/25 to 68/14 – INQT0000046
[84] DHSC0000108

consistently understood, noting that there have been references by other departments to "*supervised discharge*", but that term does not appear in the Act.

74. Finally, the new NHS Modernisation Bill will improve patient safety and experience through a new Single Patient Record, enabling joined-up, proactive care and empowering patients in their care.

Conclusion

75. The Department finishes these submissions by expressing its deepest sympathies to all those impacted by the events which led to this Inquiry, and in particular to those who lost family members or who were injured. It hopes that the changes it has and is seeking to make will make a positive difference to the quality and provision of mental health services. It recognises that whilst change for the future is positive, it cannot remove the failings of the past.