Witness Name: Michael Gregory

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SOUTHPORT INQUIRY

FIRST WITNESS STATEMENT OF MICHAEL GREGORY

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I, Dr Michael Gregory, of NHS England, Wellington House, 133-135 Waterloo Road, London, SE1 8UG will say as follows:

NHS England would like to emphasise that our thoughts remain focused on the families of those affected by Axel Rudakubana's crimes. NHS England acknowledges the pain and anguish they have suffered and which they continue to suffer.

Corporate witness statement

1. I trained as a doctor between 1984-1989 at Liverpool University and gained my Bachelor of Medicine, Bachelor of Surgery (MB ChB) in 1989. I gained a Diploma of the Royal College of Obstetricians and Gynaecologists in 1992. In 1994, I gained a Diploma of Child Health and qualified as a member of the Royal College of General Practitioners. In 2004, I received a Diploma in Medical Jurisprudence and in 2009 was awarded a Fellowship of the Faculty of Forensic & Legal Medicine of the Royal College of Physicians. In 2010, I achieved the Post Graduate Certificate in Leadership for Quality Improvement.

2. As a General Practitioner, I was a partner in practice in Altrincham, Cheshire for twenty-four years before joining NHS England in 2016.

3. During my time as a GP, I had undertaken different roles outside the practice. In 2010, I became the Medical Director of Trafford Community Services Provider and worked with the Nuffield Trust to support early thinking about integration.

4. The introduction of Clinical Commissioning Groups (**"CCGs"**) provided the opportunity to move to a new post of clinical director for strategy and policy. I was the clinical lead for the development of the Trafford Care Co-ordination Centre which started operation in January 2016.

5. I took up the role of Clinical Director, Specialised Commissioning North on 12 July 2016. I was responsible for clinical oversight of the commissioning of specialised services for the North of England. I also contributed to national policy development, national Individual Funding Requests panels and programmes of care work. In the North region I was part of the regional medical directorate and was involved in regional assurance and strategy work.

6. In 2018, NHS England and NHS Improvement entered into joint working arrangements (but did not formally merge at this point), and the regional teams changed from four to seven teams. I was appointed to the role of the Regional

Medical Director for Commissioning NHS England and Improvement North West Region which covered primary and specialised commissioning, health and justice commissioning, immunisation and screening.

7. In July 2022, I was appointed as the Regional Medical Director for NHS England North West Region, which is my current role. As the regional medical director, I am responsible for the regional medical directorate team and am a member of the Regional Executive Team. I have direct line management of six people, one of whom is the current Regional Medical Director of Commissioning. At the time of the events that took place in Southport on 29 July 2024, I was interim Regional Director for the NHS England North West Region.

8. This corporate witness statement was drafted on my behalf, and with my oversight and input, by external solicitors acting for NHS England in respect of the Inquiry. The rule 9 request received on 30 May 2025 (the "**Rule 9 Request**") to NHS England goes beyond matters which are within my own personal knowledge. As such, this statement is the product of drafting after communications between those external solicitors and a number of senior individuals in writing, by telephone and by video conference. I do not, therefore, have personal knowledge of all the matters of fact addressed within this statement and have not been able to personally review each document exhibited. However, given the process here described, I can confirm that all the facts set out in this statement are true to the best of my knowledge and belief.

9. During the period referred to in the Inquiry Terms of Reference (i.e. 2019 up to and including 29 July 2024 ("**the Relevant Period**")), NHS England merged with:

    a. NHS Improvement on 1 July 2022;[1]

    b. NHS Digital on 1 February 2023;[2] and

    c. Health Education England ("**HEE**") on 1 April 2023.[3]

10. This statement refers to the legacy organisations above as is necessary to respond to the Rule 9 Request.

[1] On 1 April 2016, the Trust Development Authority and Monitor were brought together to create "NHS Improvement".
[2] The statutory functions of NHS Digital were transferred to NHS England on 1 February 2023 pursuant to the Health and Social Care Information Centre (Transfer of Functions, Abolition and Transitional Provisions) Regulations 2023.
[3] The statutory functions of HEE were transferred to NHS England on 1 April 2023 pursuant to the Health Education England (Transfer of Functions, Abolition and Transitional Provisions) Regulations 2023.

11. As this statement includes evidence from a breadth of sources, combined to represent the evidence and voice of NHS England, references throughout to 'NHS England' and 'we' represent the voice of the organisation. I have referred to all individuals (including myself) in the third person and by job title where possible.

12. This corporate statement has been produced with input from a number of colleagues across NHS England and following a targeted review of documents collated to date. In the time available it has not been possible to review every potentially relevant document, and it is highly likely that relevant documents exist that have not been reviewed. This statement is accurate to the best of our knowledge, but we cannot exclude the possibility that it will require updating as further evidence emerges through our ongoing process of internal investigation and document review. NHS England will of course notify the Inquiry as soon as practicable if information comes to light that would have been included in this statement if it was available before the deadline for its production.

13. Within this witness statement, we refer to documents which are exhibited to support a particular point being made. These documents are exhibited as [MG1/XXX][XXX].

Approach to the Rule 9 Request

14. NHS England welcomes the chance to assist the Inquiry to understand and examine the key issues it has identified as in scope for the Inquiry (and in subsequent engagements with the Inquiry team).

15. I understand that the purpose of this document is to provide a corporate statement on behalf of NHS England to assist the Chair of the Inquiry in exploring a range of matters as set out in the Rule 9 Request.

16. A list of key individuals and decision-making structures is set out at Annex 1, and a chronology of key actions has been provided separately to the Inquiry.

17. This statement comprises of 5 sections:

    a. Section 1: the NHS in England;

    b. Section 2: an overview of commissioning arrangements for mental health, learning disability and autism services for children and young people;

    c. Section 3: relevant policies and procedures pertinent to the scope of the Inquiry;

d. Section 4: incident response; and

e. Section 5: lessons learned.

18. In this statement I have referred to NHS England, the Department of Health and Social Care ("**DHSC**") and the Secretary of State for Health and Social Care ("**SSHSC**") in accordance with how they are structured today, but such references include all predecessor organisations and roles as the context may require.

19. NHS Trusts and NHS Foundation Trusts are referred to collectively as "**Trusts**" in this statement unless otherwise stated.

20. In this statement, references to workforce or healthcare staff within the NHS should be interpreted as broadly as possible. However, where issues pertain to a particular profession or job role, or to a function of the NHS such as primary care, we have included more specific detail.

21. I have, at the Inquiry's request, provided a broad overview of the arrangements in England concerning children's and young people mental health services (**"CYPMH"**). It is also necessary to do so as it provides broader context to the services that Axel Rudakubana actually engaged with or received. To be clear, however, the focus should be on care and treatment of autism with violent characteristics, care of people with highly functional autism and access to highly specialised psychological support services, and not broader CYPMH services. As such, any wider reference to CYPMH services within this statement should be seen in that context and not as a comment on the type of care that Axel Rudakubana received.

SECTION 1: THE NHS IN ENGLAND

22. In accordance with the framework established by Parliament, the NHS in England is not one organisation. It is an ecosystem of commissioners, regulators and service providers, each with their own distinct role. The publicly funded health service (excluding public health) in England comprises primary care, secondary care, tertiary care, mental health and community health. These are explained further in section 2 below (as relevant to the scope of the Inquiry) but essentially NHS England is one part of the NHS, alongside local commissioners (which are now Integrated Care Boards (**"ICBs"**) but were previously CCGs)), providers and so on that comprise the whole NHS system.

23. Many bodies hold contracts with the NHS and are part of the publicly funded health service, such as GP practices, independent hospitals, community rehabilitation providers, but not all will be NHS bodies. For the most part, the term 'NHS' is used as an umbrella term to mean all those performing their services pursuant to NHS funding and contracts.

NHS England overview

24. NHS England is an Executive Non-Departmental Public Body ("**NDPB**") sponsored by the DHSC. It is referred to as an Arm's Length Body ("**ALB**") as it is a public body established with a degree of autonomy from the SSHSC. It was established on 1 October 2012 and is operationally distinct from the DHSC.

25. Statutory ALBs (such as NHS England) do not set strategic national health and/or public health policy but have a key role in implementing and advising on it. The Government, via the DHSC, will seek input from NHS England on how to improve existing policies or address new challenges. NHS England may engage other people and organisations across the healthcare sector, including service users before providing its advice. The Government is then responsible for selecting from the policy options and ensuring any policy selected is appropriately financed.

26. NHS England is responsible for determining how to operationalise those policies to ensure effective delivery and evaluating their impact. This is reported to Government, via the DHSC.

27. NHS England's primary responsibility is the co-ordination of the provision of health care services in England, certain commissioning and oversight of local

commissioners and providers of those health care services. To achieve this NHS England's role includes **[MG1/001][NHS000024]**:

a. setting direction by: developing and setting national policy and strategy; managing the relationship between the NHS in England and Government; determining NHS priorities (subject to the mandate),[4] providing thought leadership and subject matter expertise for national priorities (paragraph 30 below);

b. allocating resources by: leading on national workforce innovation; being responsible for financial stewardship of the NHS;

c. ensuring accountability and enabling improvement by: defining accountability structures; setting standards for performance, deploying resources to supported challenged organisations (where required); instigating regulatory intervention when required and running a recovery support programme (see paragraphs 64 to 75 below);

d. mobilising expert networks by: bringing together expert knowledge to support service improvement; supporting delivery of improved outcomes and proving benchmarks for services; managing relationships across national and professional bodies; enabling and supporting the development of systems;

e. delivering centralised services, collecting data sets, and setting minimum standards (for example, in cyber security and privacy) and promoting interoperability;

f. managing the NHS England medicines procurement and supply chain through the NHS England Medicines Value and Access Directorate, which aims to (amongst other things) deliver efficiencies for the NHS in the procurement of medicines and ensure an efficient and effective supply chain for medicines to the patient; and

g. Managing performance concerns for medical, dental and optometry practitioners, maintaining the performers list, managing appraisal and revalidation, the Responsible Officer functions and the Controlled Drugs

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[4] Before the start of each financial year, SSHSC issues an annual 'mandate' for NHS England setting out its objectives which NHS England must seek to achieve and its budget, which sets limits on the use of capital and revenue resources (in effect, this sets NHS England's financial allocation) (section 13A of the National Health Service Act 2006)

Accountable Officer.

28. NHS England:

a. is governed by its Board, which is comprised of a Chair, a Chief Executive Officer (Mental Health, Learning Disability and Autism is part of the CEO's portfolio), and a number of executive and non-executive directors. The Board provides strategic leadership and accountability to Government, Parliament and the public, and is supported by a number of committees; and

b. operates by way of a national team and a number of regional teams. From 2019, there have been seven regional teams: East of England, London, Midlands, North East and Yorkshire, North West, South East and South West.

29. Regional teams are managed by regional directors who, at the time of the incident reported to the NHS England Chief Operating Officer. They now report to the NHS England Chief Executive Officer. Regional teams are responsible for overseeing the performance of all NHS organisations in their region in relation to quality, finance and operational performance.

30. In accordance with the NHS England Operating Framework **[MG1/001][NHS000024]** in place during the Relevant Period, regions:[5]

a. act as the main voice to integrated care systems (**"ICSs"**) and the primary interaction between NHS England and the wider NHS system;

b. translate national strategy and policy to fit local circumstances, ensuring local health inequalities and priorities are addressed;

c. agree 'local strategic priorities' with individual ICSs;

d. provide oversight to ICBs and agree oversight arrangements for place-based systems and organisations;

e. develop leadership within ICBs and providers;

f. within national frameworks, determine the 'how' of delivery to achieve outcomes and expectations to reflect local populations, workforce, service structures and digital capabilities;

[55] Since the end of the Relevant Period, in January 2025, a new operating model has been adopted.

g. develop mechanisms for systematically collating and sharing good practice and lessons learnt;

h. manage regional level relationships including, regional government; and

i. provide support to integrated care systems to enable delivery.

31. The NHS England Regional Team relevant to the Southport Inquiry's investigations is NHS England's regional office referred to as NHS North West, which directly commissions specialised services, and oversees providers and local commissioners across Cheshire and Merseyside, Greater Manchester, and Lancashire and South Cumbria.

32. In discharging its statutory functions, NHS England works closely with a number of other partners in the 'health family' at national and regional level, including HEE and NHS Digital (during the Relevant Period and pre-merger), the Care Quality Commission (**"the CQC"**) and the National Institute for Health and Care Excellence (**"NICE"**), to ensure services are safe, effective and clinically and financially sustainable. For example:

    a. NHS England and the CQC entered into a partnership agreement in 2013 which sets out the commitment between both bodies to work together; and

    b. the National Quality Board, which has members from NHS England, the Care Quality Commission, the UK Health Security Agency, NICE, the Office for Health Improvement and Disparities, the Department of Health and Social Care, Healthwatch England, the National Guardians Office and the Health Services Safety Investigations Body, provides advice, recommendations and endorsement on matters relating to quality, and acts as a collective to influence, drive and ensure system alignment of quality programmes and initiatives. It is jointly chaired by NHS England's National Medical Director, and CQC's Medical Director.

33. NHS England also works with other agencies outside of the health family, such as the police and local authorities.

34. NHS England is not:

    a. a core political or governmental decision-making body;

    b. responsible for setting national health or public health policy;

c. a provider of patient services; or

d. an inspector of clinical services (the CQC undertake this role).

35. On 13 March 2025, the Prime Minister announced the integration of NHS England into the DHSC. Further details were set out by the SSHSC in a statement to Parliament on the same day. Since 1 April 2025, a Transition CEO of NHS England has been heading the transformation team to implement these reforms.

36. NHS England can only be abolished by an Act of Parliament with provision made for the transfer of all its commissioning and regulatory functions (this cannot be achieved through regulations, see section 103(3) Health and Care Act 2022 ("**2022 Act**")).

Clinical Advisers

37. Decision-making in NHS England has always relied on the input of National Clinical Directors ("**NCD**") who are supported by a number of National Specialty Advisers ("**NSA**"), who sit alongside formal governance structures. NCDs and NSAs relevant to the Inquiry's investigation are detailed in Annex 1.

38. In addition, 'Getting It Right First Time' clinical leads provide advice and leadership to help identify unwarranted clinical variation within their specialty, at national, local, and provider level. They also provide advice on identifying and implementing best practice standards.

Clinical Commissioning Groups

39. CCGs were established on 1 April 2013 following the Health and Social Care Act 2012. CCGs were responsible for planning and commissioning healthcare services within their local areas and were clinically led statutory NHS bodies.

40. CCGs worked with NHS England regional teams to ensure joined up care. They were replaced by ICBs on 1 July 2022.

Integrated care systems

41. As stated above, the NHS is an ecosystem, and that means it is at its best when it is working in an integrated way to provide joined-up care for patients.

42. The NHS in England is now organised across a number of ICSs. These built on earlier initiatives by NHS England to increase collaboration (as opposed to

competition) between local NHS organisations so that population care could be better planned, joined up and more efficient.

43. In January 2019, NHS England and NHS Improvement published the NHS Long Term Plan **[MG1/002][NHS000012]**, which set out the ambition for all parts of the country to become part of an ICS by April 2021, within the legal framework that applied at the time. NHS England and NHS Improvement also recommended changes to legislation to remove barriers to integrated care.

44. While the policy which led to the 2022 Act was being developed, ICSs continued to operate and develop collaborative ways of working. Patients needed support that was joined up across local authorities, NHS and voluntary organisations, based on a common understanding of the risks and issues faced by different people. It required openness in data sharing, collaboration commitment in the interests of patients and communities, and agile collective decision-making, all of which were features of the 'system working' approach of ICSs.

45. The 2022 Act put ICSs on a statutory footing by establishing two new statutory bodies:

    a. ICBs: new statutory bodies that bring together commissioners and providers of healthcare services into a single organisation, and which will take over the functions of CCGs as regards the planning and delivery of healthcare services in order to meet local health needs; and

    b. Integrated Care Partnerships: statutory committees bringing together representatives from the ICB, local authorities within their areas, and other partners (including NHS providers, public health, social care, housing services, etc), responsible for developing an integrated care strategy setting out how the wider needs of the local population will be met.

46. The move towards integrated care has also led to a move towards providers working more closely together, in partnership, to deliver more efficient and sustainable services. These partnerships are known as Provider Collaboratives and are collections of providers of commissioned services to the NHS. They feature a lead Trust, which acts as the commissioned provider, a number of other Trusts and, potentially, further providers, such as third sector organisations or other independent providers who collaborate with the lead under partnership arrangements. The intention is that working at scale in this way enables providers to come together to

improve quality of care by standardising clinical practice to tackle variations in access and outcomes across different sites, to increase sustainability through better use of a limited workforce, and to consolidate corporate services for greater efficiency.

47. Collaboratives also focus on reducing the use of out of area placements for young people, as these can delay their recovery. The successful functioning of Provider Collaboratives is seen as an important contribution to improving services including children's mental health, learning disability and autism services. The lead provider's role involves understanding their local population and empowering local clinicians and 'Experts by Experience' to design improved pathways of care. The lead provider will sub-contract to other providers, manage contracts, assure the quality of services and lead the necessary reporting regionally and nationally to NHS England.

48. Provider Collaboratives were a key constituent of the NHS Mental Health Implementation Plan **[MG1/003][NHS000011]** and all Trusts providing acute and mental health services, including specialist trusts, were expected to be part of one or more Provider Collaboratives by April 2022 **[MG1/004][NHS000016].** Community trusts, ambulance trusts and non-NHS providers (e.g., independent and third sector) were expected to be part of Provider Collaboratives where this would benefit patients and makes sense for the providers and systems involved.

Types of NHS services

49. There are four broad categories of services, which denote the typical way in which a patient can experience the health system from first point of contact. These services are intended to act as an integrated system:

    a. Primary care, which includes general medical practice (GP). Almost all primary care providers are independent businesses operating in accordance with contracts commissioned by NHS commissioners;

    b. Secondary care, which includes urgent and emergency care ("**UEC**") including 999, ambulance services, hospital emergency departments, and some mental health services. Secondary care is predominantly provided by public sector organisations such as Trusts but can also be provided by independent sector organisations under contract to the NHS;

    c. Tertiary care, which is highly specialist care provided to patients who are referred from primary or secondary care services. Tertiary care includes secure forensic mental health services. Whilst tertiary care is predominantly provided by public sector organisations, independent sector organisations

also provide this under contract to the NHS. Very specialist care is sometimes described as 'quaternary care', which is considered an extension of tertiary care; and

d. Community care, which includes community mental health services. Community care is provided by a range of independent and public sector organisations. Commissioning of community care is a mixture of local authority and NHS commissioning.

Incident response in the NHS

50. NHS England is a Category 1 Responder pursuant to the Civil Contingencies Act 2004 ("**CCA 2004**") and its subsidiary regulations, the Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005 (the "**2005 Regulations**"). The CCA 2004 requires Category 1 Responders to assess, plan and advise, which includes a requirement to undertake a number of tasks, specified in section 2(1) of CCA 2004.

51. NHS England, as a Category 1 Responder, has certain duties of co-operation under the 2005 Regulations. This includes co-operation with other general Category 1 Responders in connection with the performance of their duties and co-operation with relevant general Category 2 Responders (listed in Part 3 of Schedule 1 to CCA 2004, and which included CCGs until July 2022) in so far as such co-operation relates to or facilitates the performance of the relevant general Category 1 Responder's duties.

52. There is a reciprocal duty on relevant Category 2 Responders to co-operate with relevant Category 1 Responders, as well as a duty for Category 2 Responders to co-operate with each other. Under the CCA 2004 and 2005 Regulations, responders have a duty to share information with partner organisations.

53. Since 1 July 2022, ICBs have been Category 1 Responders.

54. In England, NHS England is responsible for setting a risk-based Emergency Preparedness, Resilience and Response ("**EPRR**") strategy for the NHS, ensuring there is a comprehensive NHS EPRR system, and leading the mobilisation of the NHS in the event of an emergency, working with partners where a joint response is needed.

55. In relation to EPRR, NHS England works with a range of national partners, including the devolved administrations and other Government departments and public bodies, as well as regional and local partners.

56. NHS England has had an EPRR team in place since 1 October 2012. The EPRR function is organised on a national and regional basis, to reflect the fact that planning, preparation and response can need different levels of co-ordination. The national EPRR team was part of the NHS England Chief Operating Officer's directorate at the time of the incident. The team is now part of the Urgent and Emergency Care and Operations directorate.

57. NHS England maintains an EPRR Framework (**[MG1/005][NHS000028]**), together with a number of specific incident plans as well as a generic overarching 'Incident Response Plan' (**[MG1/006][NHS000025]**), not only to discharge its obligations under civil contingencies legislation but also because NHS England has a duty under NHS legislation to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. The types of incidents that NHS England must prepare for includes casualty and mass casualty, hazardous materials (HAZMAT) and chemical, biological, radiological and nuclear (CBRN), adverse weather, business continuity and infectious diseases and pandemic.

58. Under the EPRR Framework, NHS incidents are categorised as:

    a. business continuity: an incident where an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities etc;

    b. critical: any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions. A critical incident is principally an internal escalation response to increased system pressures/disruption to services; and

    c. major: any occurrence that presents a serious threat to the health of the community, or causes such numbers or types of casualties, as to require special arrangements to be implemented. A major incident may involve a single agency response, although it is more likely to require a multi-agency response, which may be in the form of multiagency support to a lead responder. The decision to declare a major incident will always be made in a

specific local and operational context. There are no precise universal thresholds or triggers.

59. In addition to the categories above, incidents are also classified by their type e.g. “rapid onset” (a serious transport accident, explosion, or series of smaller incidents), “rising tide” (a developing infectious disease epidemic, or a capacity/staffing crisis or industrial action), or "mass casualty" (an incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services ability to manage). A non-exhaustive list of classifications is set out in the EPRR Framework.

60. Within the NHS, incidents are also described in terms of the level of response and coordination required, which may change as the incident evolves. These levels are specific to the NHS in England and are not interchangeable with other organisations' incident response levels. They must be used by all organisations across the NHS when referring to incidents. The EPRR Framework describes how escalation and de-escalation decisions are made, and the box below details, at a high level, each incident level which in turn informs how the NHS will respond:

Level 1	An incident that can be responded to and managed by an NHS-funded organisation within its respective business as usual capabilities and business continuity plans
Level 2	An incident that requires the response of a number of NHS-funded organisations within an ICS and NHS coordination by the ICB in liaison with the relevant NHS England region
Level 3	An incident that requires a number of NHS-funded organisations within an NHS England region to respond. NHS England to coordinate the NHS response in collaboration with the ICB. Support **may** be provided by the NHS England Incident Management Team (National).
Level 4	An incident that requires NHS England national command and control to lead the NHS response. NHS England Incident Management Team (National) to coordinate the NHS response at the strategic level. NHS England (Region) to coordinate the NHS response, in collaboration with the ICB, at the tactical level.

61. Separately to managing incidents, as part of preparedness, NHS England takes part in exercises funded by the DHSC and commissioned the UK Health Security Agency to test existing plans. The theme is linked to the National Risk Assessment[6] (e.g., terrorism, pandemic influenza etc.). Separate to this exercising is also carried out on a regional basis and at a Trust level.

[6] This is a classified assessment of the most significant threats and hazards that the UK could face over the following 5 years, and is led by the CCS within the Cabinet Office.

62. In August 2024, NHS England wrote to Trusts and ICBs around exercise themes to assist the NHS in being fully prepared for incidents (**[MG1/007][NHS000092]**).

63. Formal assurance of local, regional and national emergency preparedness takes place annually. The assurance process helps to identify areas requiring further attention as well as building upon good practice that can be shared.

Provider and commissioner oversight

64. NHS England has statutory accountability for oversight of both ICBs and providers of NHS services.[7]

65. Prior to 2019, there had been several types of oversight frameworks to monitor the performance of Trusts and CCGs.

66. When NHS England and NHS Improvement came together in 2019, alongside the move to system working through (non-statutory) ICSs, the existing frameworks were replaced by the NHS Oversight Framework which applied to both CCGs and Trusts. This was later replaced by the NHS System Oversight Framework until the end of June 2022.

67. In June 2022, the new NHS Oversight Framework was published in readiness for the re-organisation of the NHS **[MG1/008][NHS000019]**.

68. Currently, NHS England seeks assurance through the Oversight Framework and the associated oversight metrics (the current version of which is the NHS oversight metrics for 2022/23). The metrics are used to indicate potential issues and prompt further investigation. The metrics align with the five national themes of the Oversight Framework:

    a. Quality of care, access and outcomes;

    b. Preventing ill health and reducing inequalities;

    c. People;

    d. Finance and use of resources; and

    e. Leadership and capability.

[7] Persons providing primary medical services (GPs) or primary dental services only are currently outside the licensing and enforcement regime described in the NHS Enforcement Guidance.

69. The metrics (aligned with these themes) are reviewed, and organisations are put into segments according to their performance against the metrics.

70. There are four segments, with Trusts in segment one having no specific support needs and those in segment four requiring mandated intensive support. Importantly, the CQC's view on the organisation is considered as part of the framework, with a rating of 'Requires improvement overall' triggering segment three.

71. NHS England is updating how it assesses performance, with the consultation on the NHS Performance Assessment Framework having closed on 30 May 2025.

Enforcement

72. Providers of NHS funded care are required to hold a licence[8] unless they are exempt, this includes Trusts[9] and independent sector providers, which provide services to the NHS under contract.

73. The NHS provider licence is used to regulate providers of NHS services and was regulated by NHS Improvement until it merged with NHS England. The licence sets out the conditions that providers of healthcare services, for the purposes of the NHS in England, must meet to help ensure that the health sector works for the benefit of patients **[MG1/009][NHS000027]**.

74. NHS England has a wide range of enforcement powers, which are detailed in the NHS Enforcement Guidance **[MG1/010][NHS000029]**. Enforcement options against ICBs and providers include:

    a. the power to direct ICBs when NHS England is satisfied that an ICB is failing, or at risk of failing to discharge its functions;

    b. imposing undertakings for breach of licence conditions (see below);

    c. directions for NHS Trusts;

    d. additional governance licence conditions for NHS Foundation Trusts; and

    e. revocation of licence.

75. In exercising its enforcement powers, NHS England, where appropriate, will discharge its duties in collaboration with ICBs, asking the ICB to oversee and seek to

[8] Foundation Trusts have always been required to hold a licence and this was extended to include NHS Trusts from April 2023.
[9] The governance structure of Trusts is determined by statute.

resolve local issues before escalation. Where NHS England intervenes directly with individual providers, this will happen with the awareness of the relevant ICB.

SECTION 2: MENTAL HEALTH, LEARNING DISABILITY AND AUTISM COMMISSIONING ARRANGEMENTS AND OBJECTIVES FOR CHILDREN AND YOUNG PEOPLE

76. The majority of NHS services are commissioned locally by ICBs. In such instances, ICBs are the responsible commissioner and NHS England's role is centred around oversight (as detailed in Section 1 above), and setting national policy, which is then implemented by local commissioners and providers.

77. For a small number of services, as detailed below, NHS England is the responsible commissioner.

78. "Commissioning" is the continual process of planning, agreeing and monitoring that services are delivered. For example, where NHS England commissions a service, it develops and issues a service specification, which forms part of a contract between NHS England and the relevant provider. Under this contract, the provider agrees to deliver the service in accordance with the service specification, in return for payment by NHS England.

Learning Disability support, neurodevelopmental services and autism services

79. During the Relevant Period, CCGs (and then ICBs) were responsible for commissioning a range of children's services covering both physical and mental health. This included a range of community services and commissioner duties set out in Part 3 of the Children and Families Act 2014 (Children and young people in England with special educational needs or disabilities) and the SEND Code of Practice (2015). To support children and young people with SEND, including looked after children or leaving care, local authorities and CCGs were required commission services jointly (this is now an ICB duty).

80. Care (Education) and Treatment Reviews (C(E)TRs) are part of NHS England's commitment to transforming services for children and young people with a learning disability and/or autism **[MG1/011][NHS000017]**. C(E)TRs are for people who have been admitted to a mental health setting or for people who are at risk of admission. They are undertaken by the commissioners to ensure that CYP are only admitted to hospital when absolutely necessary and for the minimum amount of time possible.

81. A C(E)TR is carried out by an independent panel of people, including an expert by experience, which will either be an autistic person, a person with a learning disability

or a family carer with lived experience of services. The panel also includes a clinical expert who is qualified to work in healthcare and the commissioner.

82. For completeness, it is important to note that other services which autistic children and young people may encounter are commissioned by non-NHS bodies. For example, the commissioning of public health services for children is undertaken by local authorities, and includes school nursing services, health visiting and family nurse partnership services. These health services have an integral role in safeguarding children and young people.

CYP mental health services

83. CYP mental health services ("**CYPMHS**") are commissioned by a number of different commissioning bodies, depending on the nature of the service. NHS England has a statutory role to arrange a number of mental health services and, through its Mental Health team (each of NHS England's regional teams has a mental health lead) supports the commissioning of NHS community services, via ICBs, providing guidance, support and direction as appropriate.

84. Commissioning responsibilities are set out in the National Health Service Act 2006 ("**2006 Act**") and in regulations made by the SSHSC under the 2006 Act, namely the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (the "**Standing Rules**").

85. ICBs were given responsibilities relating to the commissioning of mental health services unless NHS England had a duty to arrange provision.

86. NHS England is required (pursuant to the Standing Rules and Sections 3B and 6E of the 2006 Act) to arrange for the provision of services for rare and very rare conditions ("**Specialised services**"). These include certain specific mental health services for children and young people such as:

    a. medium secure in-patient services;

    b. child and adolescent mental health in-patient services; and

    c. mental health services for deaf children and adolescents.

87. Traditionally CYPMHS has been described by way of "tiers", with tier 4 being in-patient services, and tiers 1-3 community-based services. Terminology is now focussed on whether the service is "in-patient" or "community" to focus the needs of

the young person themselves and the whole care pathway, rather specification-driven categories.

88. We set out below an overview of arrangements for tier 4 CYMPHS. However, it should be noted that NHS England's understanding is that Axel Rudakubana was not assessed as requiring and did not receive tier 4 services prior to 29 July 2024.

89. During the Relevant Period, Specialised CYPMHS services (traditionally 'tier 4') were commissioned by NHS England through its Specialised Commissioning Team:

   a. Specialist inpatient autism spectrum disorder services;

   b. Tier 4 CYPMHS;

   c. Tier 4 CYPMHS Psychiatric Intensive Care Units (or "PICU");

   d. Tier 4 Child and Adolescent Low Secure Inpatient Service;

   e. Tier 4 CYPMHS Adolescent Medium Secure; and

   f. Tier 4 CYPMHS General Adolescent Services including specialist eating disorder services.

90. NHS England's Specialised Commissioning Team also commissions community forensic CYPMHS (including Secure Outreach) (tier 4).

91. Community CYPMHS services (then traditionally tiers 1-3) encompass:

   a. specialist community multidisciplinary CYPMHS teams (including community mental health clinics and child psychiatry outpatient services) (tier 3);

   b. targeted services, including youth offending teams, primary mental health workers, educational psychologists and school and voluntary/third-sector providers (tier 2); and

   c. universal services such as early years services and primary care (tier 1).

92. NHS England's Specialised Commissioning team coordinates a Clinical Reference Group ("**CRG**") for CYPMHS, covering secure and non-secure services, and services for children with learning disabilities, autism, and eating disorders. The CRG provides expert clinical leadership and support to services and during the Relevant Period was chaired by NHS England's National Specialty Adviser for Children and Young People's Mental Health. Membership of the group includes multiple clinicians from across the NHS, and patient and public voice representatives. The CRG's focus is on measuring and improving quality of care and value-for-money, reducing unwarranted

service variation, effective commissioning of services, and developing new clinical models.

Providers of mental health and learning disability and autism services

93. Providers of the different groups of care range from public sector organisations e.g., NHS Trusts (established by orders of the SSHSC) and NHS Foundation Trusts (public benefit corporations), to independent providers including charitable and other not-for-profit providers, and independent contractors (e.g., GP practices) including some for-profit organisations.

94. Trusts can operate multiple hospital and community sites.

95. All providers of NHS funded care (whether they are public or independent sector providers) employ and manage their workforce; there is not a centrally employed 'NHS workforce'.

96. Providers of NHS services i.e., those that provide direct care to patients at an organisational and clinician level, are regulated by multiple regulators depending on their structure and the services being delivered. This includes:

    a. the CQC, the independent regulator for the quality and safety of care who oversees and inspects organisations that provide health and social care services;

    b. NHS England (see above); and

    c. for clinicians themselves, the relevant healthcare professional bodies, such as the General Medical Council and the Nursing and Midwifery Council.

97. Ambulance Services are commissioned from 'ambulance trusts' by ICBs. Each of the ten ambulance trusts covers a wide geographical footprint and supports the ambulance needs of individuals present in their region. In addition, they provide support and assistance to neighbouring regions and cross border assistance with the devolved nations by way of mutual aid in accordance with agreed protocols.

98. Specific service contracts are mandated for use by commissioners including:

    a. the NHS Standard Contract (consisting of particulars, general conditions and service conditions), which:

i. exists in order that commissioners and providers operate to one clear and consistent set of rules which everyone understands, giving a level playing field for all types of providers. The service conditions are drafted so that some apply to all services (such as EPRR at condition 30 and safeguarding at condition 32), whilst others will apply to specific services e.g., Mental Health and Learning Disability Services;

ii. is mandated by NHS England for use by commissioners (NHS England and ICBs) for all contracts for NHS funded healthcare services (including acute, ambulance, patient transport, continuing healthcare services, community-based, high-secure, mental health and learning disability services); and

iii. has been the responsibility of NHS England since 2013.

[MG1/012][NHS000030][MG1/013][NHS000031] [MG1/014][NHS000032]

b. specific contracts for different primary care services e.g., GP services.

99. Providers are accountable to commissioners through their contracts for the services commissioned. It is the responsibility of the provider to ensure that services are carried out in accordance with specifications, allocated budgets and appropriate clinical guidance. Providers also make their own decisions on staffing, purchasing and stock levels, maintenance etc.

100. The day-to-day management of patients is the responsibility of the relevant provider. For example, in hospitals clinicians use their professional judgement and appropriate clinical guidelines to determine the treatment that a patient should be offered and receive. This judgement includes the patient's suitability for treatment options (assuming those are NHS-funded and commissioned services/treatments) as well as whether or not a patient should be admitted.

101. Patients, provided they have legal capacity, may refuse treatment, or have a preference for one treatment option over another that is presented to them. Section 1 of the Mental Capacity Act 2005 states that a person must be assumed to have capacity unless it is established that they lack capacity. Young people aged 16 and 17 years are presumed to have sufficient capacity to decide on their own medical treatment, unless there is significant evidence to suggest otherwise. Children under the age of 16 years can consent if they are Gillick competent.

102. Both admission and discharge decisions are ultimately the decisions of individual clinicians who are best placed to assess all relevant factors.

SECTION 3: POLICIES AND PROCEDURES

103. This section of the statement provides information regarding NHS England's policies and procedures in place during the Relevant Period and within the scope of the Inquiry's Terms of Reference.

104. The ICB and the local providers will hold relevant local policies as commissioner of services received by Axel Rudakubana.

105. However, as part of its role in leading and overseeing national policy for the commissioning and delivery of all NHS services across England, which includes driving service improvement and ensuring high quality care, NHS England publishes overarching policy and guidance documents that are of relevance to all NHS services nationally, as well as service models and other support that local providers and commissioners can use. This includes areas such as CYP Mental Health Services and Learning Disability and Autism Services.

106. It is standard practice for the NHS to plan ahead. NHS England considers requests for advice and guidance from the NHS system (as defined and explained in section 1 above). Often guidance is developed in collaboration with providers and other key stakeholders.

107. Most of the guidance and policy produced by NHS England is typically available through its public website. NHS England often directs guidance and policies to the relevant audience, for example ICBs and providers, through system letters. This is done in conjunction with NHS England's national and regional operations centres. Where appropriate, guidance will be sent direct to the CEOs and/or chairs of the relevant NHS body. It may also be cascaded to specific roles within the NHS (for example, chief finance officers, medical directors, chief nurses, chief people officers, etc.), depending on the subject matter.

108. Guidance and policies will usually be cascaded to the relevant audience on the day they are published on the NHS website. However, some guidance may be shared via bulletins instead, for example, in the weekly healthcare leaders bulletin or the mental health, learning disability and autism bulletin.

Overarching mental health policy and the NHS Long Term Plan

109. NHS England is responsible for overseeing national mental health policy and its mental health strategy is set out in a series of key publications as explained further in

this section. Although some of these documents predate the Relevant Period, they are included to aid wider understanding of the relevant national policy context.

The Five Year Forward View

110. The 'Five Year Forward View' (October 2014) was published jointly by NHS England and other national NHS bodies with a vision to transform the NHS by 2020. This was focused on addressing three identified gaps:

   a. The health and wellbeing gap: the need to reduce demand on the NHS by shifting focus towards prevention and addressing health inequalities;

   b. The care and quality gap: to harness technology and innovation to reduce variations in the quality of care, including in relation to safety and outcomes in care; and

   c. The funding and efficiency gap: to ensure that additional funding for the NHS is used to improve efficiencies, transform services and achieve financial sustainability.

111. Following this, in 2016, NHS England published the 'Five Year Forward View for Mental Health' **[MG1/015][NHS000005] [MG1/016][NHS000008]** together with its implementation plan ('Implementing the Five Year Forward View for Mental Health' **[MG1/017][NHS000006]**) for developing mental health services for all ages, following recommendations made in an independent report of the Mental Health Taskforce commissioned by NHS England. This set out a roadmap to deliver key national-level objectives, including in respect of children and young people's mental health. The document was directed at commissioners and providers to support and influence the development and implementation of local plans. It set out NHS England's support offer to implement the plan, and delivery was underpinned by an additional £1 billion in funding for mental health.

The NHS Long Term Plan

112. In 2019, the NHS Long Term Plan **[MG1/002][NHS000012]** was published, which set out an ambitious plan to transform mental health services and build on progress from the Five Year Forward View for Mental Health.

113. The NHS Long Term Plan made a renewed commitment that mental health services would grow faster than the overall budget, with a ringfenced investment worth at least £2.3 billion a year by 2023/24. It also committed to growing CYP mental health services faster than both the overall NHS funding and total mental health spend.

NHS Mental Health Implementation Plan 2019/20 – 2023/24

114. The NHS Mental Health Implementation Plan 2019/20 – 2023/24 **[MG1/003][NHS000011]** focused on implementing the commitments of the Five Year Forward View for Mental Health and the Long Term Plan, setting out planning and delivery requirements over 5 years.

115. The policy aim was to provide more integrated services for people with mental health needs in the community. This involved new care models with better coordination between the range of different NHS mental and physical health services and other services (for example, social care) that an individual may need.

116. In respect of Children and Young People's mental health, one of the key goals set out for delivery by 2021/22 was for CYP mental health plans to align with those for children and young people with learning disability, autism, special educational needs and disability, children and young people's services, and health and justice.

Children and Young People's Mental Health Services

117. CYPMHS refers to NHS services that assess and treat young people with emotional, behavioural or mental health difficulties. This section refers primarily to CYPMHS and less to the traditional description of Child and Adolescent Mental Health Services ("**CAMHS**"). The former has been replacing the latter in use in the health service and references in discussions and documents now mainly – but not exclusively – use CYP terminology. The two terms describe the same group of services.

118. As above, NHS England's direct role in commissioning of CYPMHS is limited to certain specialised services. However, NHS England does provide guidance to local commissioners and providers in respect of Tier 2 and Tier 3 (community) of CYPMHS services.

119. Services specifications for local CYPMHS services are set by the relevant commissioner, however, NHS England does publish a (non-mandatory) Model Specification for Child and Adolescent Mental Health Services: Targeted and

Specialist levels (Tiers 2/3) **[MG1/018][NHS000010]**. The aim of this specification is to support CYPMHS commissioners in commissioning these services for their local population, working in conjunction with provider organisations.

120. NHS England also publishes a wide range of guidance documents, tools and other information for commissioners and providers **[MG1/019][NHS000093]**. These are published alongside additional resources from external organisations to support the delivery of accessible, evidence-based, outcome-focused services in collaboration with children, young people and their families.

121. Other organisations that provide resources for the design and delivery of CYPMHS services include:

    a. the Royal College of Psychiatrists (RCPsych); and

    b. NICE, which publishes a number of evidenced-based Pathways and quality standards for children and young people's mental health to guide decisions by practitioners, providers, commissioners and others, as well as other tools and resources to help put these into practice.

122. NHS England is committed to providing support and guidance to systems to ensure a joined-up approach between the many different services associated with CYPMHS **[MG1/020][NHS000094]**. By way of example, this includes a framework for systems that support such patients in acute paediatric settings **[MG1/021][NHS000095]**.

123. Further information about policy for Learning Disability & Autism services is outlined below, but for young people there is an important service overlap with CYPMHS. This is because children and young people with autism can experience challenges such as anxiety, and difficulties managing emotions, which may impact their mental health. Autistic CYP may have complex overall needs and are typically at higher risk of developing mental health concerns. CYPMHS teams are well-placed to provide specialist, and tailored, support to meet the needs of autistic CYP.

Learning Disability and Autism Services

124. NHS England oversees national policy in respect of Learning Disability and Autism Services. NHS England's current Learning Disability and Autism Programme is focused on making health and care services better so that more people with a

learning disability, autism, or both can live in the community, with the right support, and close to home.

125. NHS England publishes a range of learning disability improvement standards for Trusts **[MG1/022][NHS000096]**.

126. Since 2015, NHS England has developed the Transforming Care Programme as a national plan for developing community services and inpatient facilities close to home for people with a learning disability and autistic people, including those with a mental health condition. This was outlined in Building The Right Support (**[MG1/023][NHS000002]**), which was developed with the help of people with lived experience. This was published alongside the National Service Model outlining what good services for people with learning disabilities and/or autism should look like **[MG1/024][NHS000003]**, and accompanied by supplementary information on the service model to support commissioners in implementation **[MG1/025][NHS000004]**.

127. Further guidance was published:

   a. to support implementation of the Transforming Care Model Service Specifications in January 2017 (**[MG1/026][NHS000007]**); and

   b. on Developing support and services for children and young people with a learning disability, autism or both in September 2017 **[MG1/027][NHS000009]**.

128. Following the structural changes to the NHS drive to improve integration and partnership working across health and local government as a result of the 2022 Act, NHS England worked with the Local Government Association and Association of Directors of Adult Social Services to develop and publish a set of guiding principles in 2023 for integrated care systems **[MG1/028][NHS000099]**. These set out how partners in local systems can work together to improve the lives and outcomes of people with a learning disability and autistic people.

129. In respect of autism assessments, NHS England developed a national framework to deliver improved outcomes in all-age autism assessment pathways, published in April 2023 (updated November 2023) **[MG1/029 [NHS000086]**. Operational guidance for ICBs sits alongside the framework and sets out the principles underpinning the planning, design and delivery of this pathway **[MG1/030][NHS000087]**.

130. In terms of other key NHS England policy and guidance in this area:

a. NHS England has published guidance and a code of practice on Dynamic Support Registers and Care (Education) and Treatment Reviews **[MG1/031][NHS000026] and [MG1/032][NHS000098]**. The Dynamic Support Register requires local health commissioners to work with local partners to develop and maintain a register of all people with a learning disability and autistic people who are (or may become) at risk of admission to a mental health hospital without specific and timely dynamic support. These processes are used to provide coordinated support to people with complex needs in a timely way with a view to minimising the need for such admissions on Dynamic Support Registers and Care (Education) and Treatment Reviews.

b. NHS England has a programme on Learning from lives and deaths of people with learning disability and autistic people (LeDeR). The latest LeDeR policy was published in March 2021 and introduced the inclusion of autism into the programme for the first time from late 2021 **[MG1/033][NHS000015]**. LeDeR is a service improvement programme aiming to improve care, reduce health inequalities and prevent premature mortality of people with a learning disability and autistic people by reviewing information about the health and social care support people received. LeDeR is a national programme, although it is delivered locally at ICB and ICS level.

Workforce, training and education

131. Since NHS England's merger with HEE, it has national responsibility for supporting the development and planning of health workforces and education and training programmes. This work covers more than 100 programmes from planning and commissioning through to recruiting and developing healthcare staff in a range of healthcare and community settings and includes programmes in respect of autism and mental health (including CYPMHS). There is a workstream dedicated to developing new ways of working in mental health.

132. In respect of CYPMHS, in 2022 HEE commissioned mental health training for the wider children's workforce in three pilot areas; the report was published in 2023 **[MG/053][NHS000342]**. It has also:

a. commissioned benchmarking studies (**[MG/054][NHS000340]**);

b. developed a competence framework for CYPMHS;

c. developed a strategic framework for CYPMHS inpatient workforce development **[MG/055]**[NHS000341]; and

d. developed a training course for key training programmes to expand and develop the CYPMHS workforce.

133. In respect of the autism workstream, in 2019 HEE published a core capabilities framework for supporting autistic people and/or people with a learning disability (**[MG/056]**[NHS000339]). This is used to describe the skills, knowledge and behaviours which people bring to their work and are used to support development and planning of the workforce and inform the design and delivery of education and training programmes.

Safeguarding and Prevent

Safeguarding

134. Safeguarding means protecting a citizen's health, wellbeing and human rights, enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality healthcare. Safeguarding children, young people and adults is a collective responsibility.

135. All staff, whether they work in a hospital, a care home, in general practice, or in providing community care, and whether they are employed by a public sector, private sector or not-for-profit organisation, have a responsibility to safeguard children and adults at risk of abuse or neglect in the NHS. Appropriate safeguarding must be in place across all vulnerable patient and service user groups.

136. During the Relevant Period, Section 11 of the Children Act 2004 required various bodies, including NHS England and CCGs/ICBs to make arrangements to ensure that:

a. their functions are discharged having regard to the need to safeguard and promote the welfare of children; and

b. any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need.

137. In discharging their duties under Section 11, the bodies must have regard to guidance given by the Secretary of State for Education, namely the Working Together Guidance. Chapter 4 of the current version of the Working Together

Guidance, published in December 2023, describes the role of different bodies as relevant to safeguarding.

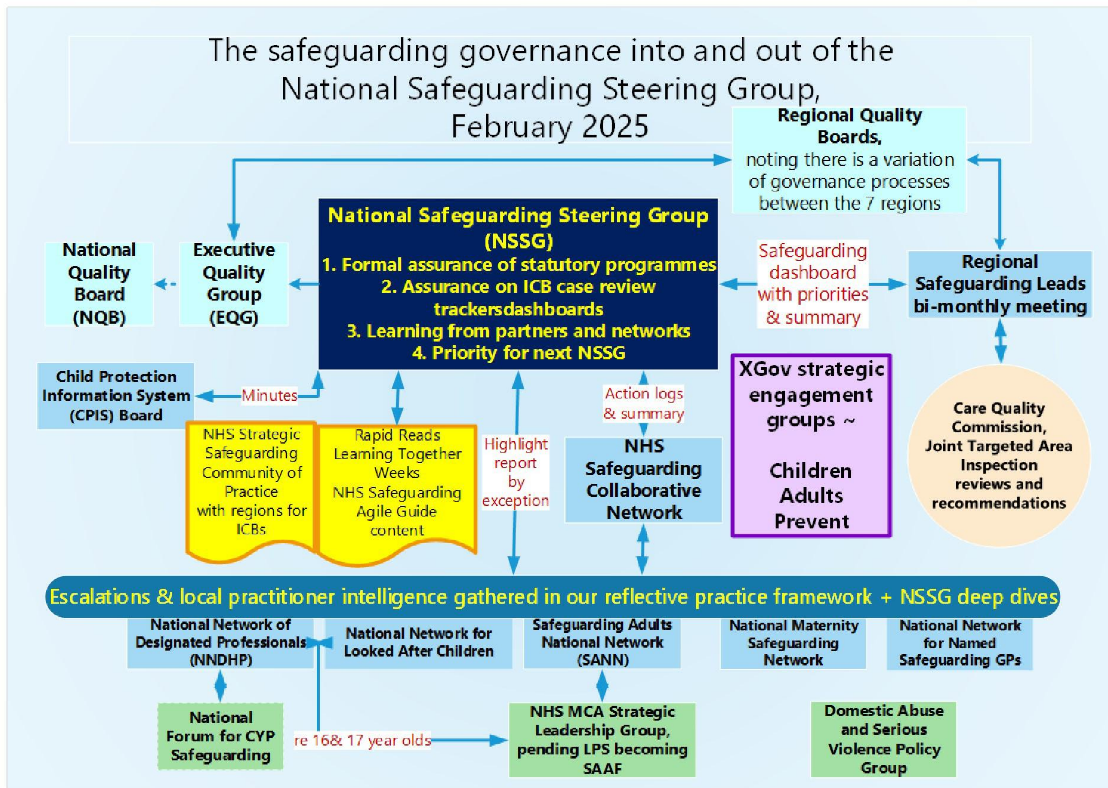
138. Local arrangements are also required under Section 16E of the Children Act 2004, and local authorities, the police and ICBs (CCGs prior to 1 July 2022) establish Multi Agency Safeguarding Arrangements for their local child population, together with other relevant agencies as they deem appropriate. The partners are required to work together to safeguard children and promote the welfare of all children in their area, and to monitor and ensure the effectiveness of those arrangements. They are equally accountable for the arrangements put in place.

139. NHS England oversees assurance of ICBs in their commissioning role. This involves formal assurance reviews carried out quarterly, in line with the published framework and technical guidance.

140. There is a distinction between providers' responsibilities to provide safe and high-quality care, and commissioners' responsibilities to assure themselves of the safety and effectiveness of the services they have commissioned. ICBs are responsible for the safeguarding element of services that they commission. As commissioners of local health services, ICBs are required to assure themselves that organisations from which they commission have effective safeguarding arrangements in place.

141. Trusts must also have regard to the Working Together Guidance. Responsibilities for safeguarding form part of the organisations' statutory functions, and each Trust's board is responsible for effectively discharging those statutory functions.

142. In terms of NHS England's governance structures for fulfilling its statutory safeguarding responsibilities, the Chief Nursing Officer in NHS England has ultimate accountability as the executive lead to ensure the effective discharge of NHS England statutory safeguarding responsibilities. There are a number of forums through which oversight is sought, as outlined below:



143. These groups, together with NHS England's regional groups support assurance to the NHS England Board.

144. Each NHS England Region provides an annual safeguarding assurance report to the National Safeguarding Steering Group, which allows identification of common issues, emerging trends and learning to be identified from across the health system.

145. The National Safeguarding Steering Group plays a key role in bringing together regional safeguarding reports, assuring the system overall, and identifying and disseminating common issues, emerging trends and learning. The National Safeguarding Steering Group is a permanent structure, chaired by the Deputy Chief Nursing Officer for England for Professional and System Leadership. Its work is supported by a number of working groups, national networks and implementation groups. These vary, reflecting safeguarding priorities, new legislation and specific projects.

146. In addition, NHS England promotes best practice through:

a. making available the NHS Safeguarding App as a resource for healthcare professionals, carers and the public;

b. ensuring that ICBs appoint senior executives at Board level who have responsibility for safeguarding; and

c. the national Safeguarding Accountability and Assurance Framework (**[MG1/034][NHS000100]**), which sets out the safeguarding roles and responsibilities of all individuals and organisations related to their statutory requirements and appropriate accountabilities for the safeguarding of children, young people and adults at risk of harm or abuse. Overall, it is intended to provide the minimum standards that all those working in NHS funded care settings should work to, but it is not intended to constrain the development of other effective local safeguarding practice and arrangements (e.g., those developed by local safeguarding partners).

Prevent

147. Whilst not directly relevant to the NHS services that Axel Rudakubana received, the following information about Prevent may be helpful for the Inquiry by way of a general overview of how safeguarding aligns with the Government's counter-terrorism strategy.

148. Prevent is part of the Government's counter-terrorism strategy and aims to reduce the threat from terrorism in the UK; it is a key component of NHS England's safeguarding arrangements. Prevent extends to supporting the rehabilitation and disengagement of those already involved in terrorism.

149. The Prevent duty applies more broadly than healthcare, but in 2024 the DHSC published focused guidance for the healthcare context: Prevent Duty: guidance for healthcare professionals (**[MG1/035][NHS000101]**). This covers Prevent awareness and training for all professionals who provide services to NHS patients, radicalisation risk indicators and process for raising a concern / referral. Regional NHS England safeguarding teams are available to provide support or advice to practitioners locally.

150. Counter-terrorism and Prevent require effective joint working across multiple sectors and organisations and particularly with the police. Disclosure of information about patients to the police by health and care organisations can be a complex issue with

potential legal implications, and the NHS England Transformation Directorate has published guidance titled Sharing Information with the Police (**[MG1/036][NHS000102]**) to support professionals and organisations in navigating these issues.

Covid-19 Policies

151. The Relevant Period included the duration of the Covid-19 pandemic, which is recognised to have had a major impact on the delivery of healthcare nationally. This included changes to the manner in which services were traditionally delivered, i.e. from face-to-face to remote (where clinically appropriate).

152. The use of technology during the pandemic was necessary to enable the NHS to maintain care in a way that would not have otherwise been possible.

153. NHS England published a number of guidance documents to assist with the adoption of remote consultations and remote working in secondary care **[MG1/037][NHS000008]**, which included specific advice for remote consultations with children and young people.

154. NHS England also published a specialty guide on 27 March 2020 **[MG1/038][NHS000013]** to mitigate against inappropriate use, including in relation to children and young people. This offered practical guidance to clinicians and managers, including the following principles:

    a. remote consultations are suitable for patients who do not need a physical examination or test, and can communicate by phone or video (with a preference for video if there is benefit in seeing the patient or their surroundings);

    b. a clinical risk assessment should take place in all cases in order to stratify services and individual patients, with remote consultation only taking place where there is a low risk of impact to patient safety and outcome;

    c. considerations for children and young people:

        i. communication with children and young people - be mindful that in a video consultation children and young people may feel less able to communicate effectively with clinicians and defer to parents;

ii. safeguarding - assess whether virtual consultation is appropriate in context of safeguarding and make alternative arrangements if there are any concerns.

155. Of further and particular potential relevance to the Inquiry are the following:

a. Mental Health, learning disabilities and autism: Guidance (**[MG1/039][NHS000104]**). This publication brings together a series of documents, guidance and letters to help those working with patients with mental health, learning disabilities and autism during the pandemic, including:

i. Getting NHS help when you need it during the coronavirus outbreak - information for patients about how to access NHS services, including an easy read version **[MG1/040][NHS000014].**

ii. Legal guidance for services supporting people of all ages during the coronavirus pandemic (**[MG1/041][NHS000103]**) concerning the use of the Mental Health Act 1983 and other systems supporting the legal rights of people receiving mental health, learning disability and autism services during the pandemic.

iii. Patient carer and family engagement and communication during the coronavirus pandemic (**[MG1/042][NHS000106]**), which included advice for both commissioners and providers and for patients and families.

b. Managing capacity and demand within inpatient and community mental health, learning disabilities and autism services for all ages (**[MG1/043][NHS000105]**), which was produced by the national NHS England mental health, learning disability and autism and specialised commissioning Covid-19 response cell (part of NHS England's pandemic response structure). It provided information and guidance for providers and their clinical and non-clinical teams in planning for how best to manage their service capacity & contingency plans for resource-constrained scenarios.

Patient safety

156. In the context of NHS England's role in fulfilling its statutory patient safety duties under section 13R of the 2006 Act (Information on safety of services provided by the health service), NHS England collects information about what goes wrong in the health service and uses that information to provide advance and guidance "for the purposes of maintain and improving the safety of the services provided by the health service".

157. Delivering these functions as well as a wider duty to improve quality pursuant to section 13E of the 2006 Act (which by definition includes patient safety) requires NHS England to operate the National Patient Safety Team. This was formerly part of NHS Improvement (2016-2022) while before that it was part of NHS England (2012-2016). The National Patient Safety Team rejoined NHS England on 1 July 2022.

158. The NHS Patient Safety Strategy (**[MG1/044][NHS000108]**) which was published in 2019 (then updated in 2021 and 2023), set a vision for the NHS to improve patient safety continuously. However, the Strategy did not (and, in its current iteration, does not) seek to direct the whole of the NHS. Elements of the NHS, such as workforce and financial planning, clinical training/education and guidance and estates and facilities maintenance, remain subject to each provider's own strategic leadership and implementation and to wider support and guidance provided by other parts of NHS England and beyond.

159. Between 2013 and 2023, the principal policy setting out expectations for how the NHS should identify and manage certain patient safety incidents and other defined 'serious incidents' was the Serious Incident Framework (first published 2013 and refreshed in 2015) (**[MG1/045][NHS000107]**).

160. In 2022, a new approach to incident management was announced when NHS England published the Patient Safety Incident Response Framework ("**PSIRF**") (**[MG1/046][NHS000085]**). PSIRF replaced the 2015 Serious Incident Framework and is one of the key initiatives under the Patient Safety Strategy.

161. PSIRF has four key aims:

   a. compassionate engagement and involvement of those affected by patient safety incidents;

   b. application of a range of system-based approaches to learning from patient safety incidents;

c. considered and proportionate responses to patient safety incidents; and

d. supportive oversight focused on strengthening response system functioning and improvement.

162. After a preparation phase between 2022 and 2023, organisations were asked to transition to PSIRF during Autumn 2023 **[MG1/047][NHS000021]**. Subsequent to that, compliance with the PSIRF was made a contractual requirement under the NHS Standard Contract from April 2024 (see service condition 33), and as such is mandatory for all services provided under that contract. All Trusts are now working under PSIRF.

163. Implementation of PSIRF is overseen by ICBs. ICBs have a responsibility to establish and maintain structures to support a co-ordinated approach to oversight of patient safety incident response in all the services within their system **[MG1/048][NHS000023]**. ICBs do not oversee the response to every single incident nor do they sign off every patient safety incident investigation report as commissioners did while working under the Serious Incident Framework. Instead ICBs are required to establish systems and processes to ensure that the providers that they commission services from have effective patient safety incident response systems and processes.

164. When an incident occurs, Trusts and other providers are encouraged to record the details of the incident on their local risk management system which is required to be connected to the Learn From Patient Safety Events Service ("**LFPSE**") if services are being delivered under the NHS Standard Contract. All Trusts have such a local risk management system. For services not delivered under the NHS Standard Contract and for providers without a local risk management system connected to LFPSE (e.g. in primary care), there is also a LFPSE web portal that can be used to record incidents. LFPSE is the mechanism by which NHS England collects information about what goes wrong in NHS services.

165. Patient safety incident recording in the NHS is largely voluntary. A subset of patient safety incidents, principally those incidents thought to have directly caused death or severe harm, must be notified to the CQC. Trusts can notify the CQC about such incidents by recording them on a LFPSE-compatible local risk management system or via the LFPSE web portal. NHS England then provides a full set of the data collected via LFPSE to the CQC. The purpose of NHS England collating patient safety incidents is to support learning and improvement.

166. ICBs and NHS England may also directly commission patient safety incident investigations in certain circumstances. This includes where a provider does not have the capability, skills, knowledge or objectivity to deliver an effective patient safety incident investigation itself, or where it is identified that an incident spans multiple health systems and so it makes more sense for an organisation with a wider remit to commission the investigation, thus enabling collaboration across providers, pathways and/or local health systems at a broader level.

167. Organisations are expected to use a wide range of qualitative and quantitative data sources, including incident records, stakeholder views and existing data collections, to develop a thorough understanding of their patient safety incident profile, and then use this with their stakeholders to create a Patient Safety Incident Response Plan. This plan then guides how the organisation responds to and learns from incidents. NHS England publishes a template Incident Response Plan (**[MG1/049][NHS000022]**) as part of the core materials to support with PSIRF. It also publishes a guide to Engaging and involving patients, families and staff following a patient safety incident (**[MG1/050][NHS000020]**).

SECTION FOUR: INCIDENT RESPONSE

168. NHS England did not play a direct role in any of the events forming part of the Inquiry's Terms of Reference prior to 29 July 2024.

169. In response to the incident, NHS England stood up its regional incident response EPRR structures. NHS England did not stand up its national EPRR incident response, as it was a locally contained incident which was best managed on a local basis (in line with the principle of subsidiarity).[10]

170. NHS England's direct role, therefore, came after the end of the Relevant Period. However, to assist the Inquiry's broader understanding, a chronology has been provided to the Inquiry separately detailing the actions taken by NHS England.

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[10] NHS England's national EPRR team did provide some limited assistance to the Trusts that received and treated the victims of the incident, in light of the matters which led to the charges brought against Axel Rudakubana under Section 1 of the Biological Weapons Act 1974.

SECTION FIVE: LESSONS LEARNED

171. As explained, NHS England had no direct involvement in Axel Rudakubana's care and holds no records in relation to the care he received. NHS England's involvement was limited to incident response and the records it holds are primarily linked to that response specifically. Further, and again as set out above, although autism technically forms part of CYMPHS, autism is not a mental health issue per se; accordingly, the incident was not a trigger for a wider review or critique of CYMPHS.

172. For the avoidance of doubt NHS England does not seek to diminish the impact of the incident which has had a catastrophic impact on the lives of many. Further, it does not seek to diminish the importance of the opportunity to learn from the incident more broadly (to which we return below) but rather to contextualise the direct learning that NHS England itself has been able to progress. I would also briefly note that a Local Safeguarding Practice review was started in January 2025 but then paused in light of the Inquiry.

173. With that context in mind NHS England's National Director for NHS Resilience commissioned a review from the Cheshire and Mersey Major Trauma Network and the Northwest Children's Major Trauma Network.[11] The purpose of this review was to assess the clinical response to the incident **[MG/057]** NHS000343**]**. The review considered each individual patient's treatment and was completed in December 2024 **[MG1/051][** **NHS000074**], although we anticipate this is most likely to be relevant to Phase 2 of the Inquiry.

174. NHS England would also take the opportunity to make the following observations, to assist the Inquiry in its consideration of potential recommendations. I note that many of these issues are likely to be more relevant to Phase 2 of the Inquiry than Phase 1, and so offer these observations in summary form only at this stage and would welcome the opportunity to expand on them further in due course:

    a. It would appear that many of the issues that Axel Rudakubana faced were more societal in nature and so beyond the scope of what NHS England/the NHS can meaningfully influence or affect. NHS England understands that he was regularly accessing troubling, toxic content online, made all the more easier through the ready accessibility of such material (including through smartphones). This has a significant impact on the mental wellbeing of

[11] This review is within the remit of the trauma networks who typically review care to improve future outcomes.

people, including children and young people, and some of these individuals may require highly specialised psychological support (i.e., not mental health services) and funding/resources for these services are limited;

b. Those societal challenges probably require a governmental and multi-agency, coordinated response in order to meet them. The NHS is just one, highly specific part, of that response as it provides a very specific set of services. Roles and responsibilities of different agencies are therefore fundamental to understanding individual organisational accountability – it is likely that no one single organisation is accountable for a whole person and therefore it requires a whole system approach including (but not necessarily limited to) the police, schools, local authorities and the NHS. This requires multi-agency coordination and appropriate information sharing – unduly focusing on the role of the NHS would miss the opportunity to ensure that people do not slip between the cracks;

c. NHS England does recognise the importance of NHS services in the context of that multi-agency responsibility and would note that mental health services have been historically underfunded (compared with 'physical' health) and a number of major policies have been launched in an attempt to tackle this problem (for example the Five Year Forward View, the Long Term Plan and so on) **[MG1/052] [NHS000001]**. Similarly, psychological support for individuals such as Axel Rudakubana is highly specialised and needs significant funding to ensure it is comprehensively available and effective; and

d. Finally, the issue of autism in children's mental health remains a significant area of challenge which requires better cross-agency working and potentially similar guidance to that which applies to adults with autism.

Statement of Truth

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

Signed: Signature

Dated: 04 July 2025

ANNEX 1

Key Individuals

This Annex 1 sets out a brief summary of key individuals within NHS England relevant to the Inquiry's investigations.

National	
Chief Executive Officer	The Chief Executive Officer ("CEO") of NHS England leads the NHS's work nationally to improve health and ensure high quality care for all. The CEO is jointly accountable to the Board of NHS England, the Department of Health and Social Care, and to Parliament. Mental health is within the current CEO's portfolio. During the Relevant Period, this role was held by Amanda Pritchard. The Transitional CEO since 1 April 2025 is Sir James Mackey.
Chief Operating Officer	During the Relevant Period, the Chief Operating Officer ("COO") (Dr. Dame Emily Lawson) was responsible for operational delivery of the NHS in England including performance standards across all systems. This includes oversight of EPRR incidents, ensuring that appropriate plans are in place to support the delivery and recovery of NHS services. They are also responsible for the Delivery of National programmes for urgent and emergency care ("UEC"), cancer, mental health and learning disabilities. EPRR is now the responsibility of the Urgent and Emergency Care Director (Sarah-Jane Marsh)
Chief Finance Officer	The Chief Financial Officer ("CFO") is responsible for strategic financial management of NHS England's resources. They oversee the development and administration of financial policy levers and lead financial and corporate performance management. During the Relevant Period this role was held by Julian Kelly.
Chief Nursing Officer	The Chief Nursing Officer ("CNO") for England (Duncan Burton) is employed by NHS England to provide expert clinical and workforce advice to the Board and is formally the Chief Nursing

	Officer providing advice to the Government and the Department of Health and Social Care. The role also provides professional leadership for all Nurses and Midwives in England (with the exception of public health nursing). The NHS England CYP Transformation programme is part of the CNO portfolio, and the CNO is also the national director with responsibility for safeguarding
National Medical Director	The National Medical Director ("NMD") (Professor Sir Stephen Powis) is the most senior doctor in the NHS in England and provides clinical governance across the health system. The NMD is responsible for patient safety.
Director of Mental Health, Learning Disability and Autism Quality	Director of Mental Health, Learning Disability and Autism Quality (Claire Murdoch), is responsible for overseeing mental health services commissioned by the NHS and implementing quality improvement.
National Director for Primary Care, Community Services and Strategy	Throughout the Relevant Period, the National Director for Primary Care, Community Services and Strategy (Dr. Amanda Doyle) has the strategic responsibility for primary care and community services.
National Director of Patient Safety	The National Director for Patient Safety (Dr. Aiden Fowler) oversees patient safety policies nationally.
National Director for NHS Resilience	The National Director for NHS Resilience (Dr. Mike Prentice) oversees NHS England's Emergency Preparedness Resilience and Response function
North West Region	
Regional Director	Michael Gregory was the Regional Director on an interim basis during the time of the incident. This role has been held by Louise Shepherd since November 2024.

Medical Director	Michael Gregory
Chief Nursing Officer	James McClean
Director of Commissioning	Linda Charles-Ozuzu
Deputy Director of EPRR	Phil Storr
Head of EPRR	Jo Butler
Interim Chief Operating Officer	Sam James Commenced role on 5 August 2024. Prior to this was Director of Performance. Is an executive lead in the region for EPRR in accordance with NHS England's Scheme of Delegation.
Regional Head of Strategic Communications	Robin Scott
On Call Tactical Commander	Sue McGorry
On Call Strategic Commander	Chris Cutts

National Clinical Directors and National Speciality Advisers

National clinical director for children and young people's mental health	Professor Prathiba Chitsabesan
National clinical director for children and young people	Professor Simon Kenny
National clinical director for learning disabilities and autism	Dr. Ken Courtenay

National medical director for mental health and neurodiversity	Dr. Adrian James
National specialty advisers for autism	Dr. Amy Dissanayake Dr. Justine Robinson Dr. Christopher Matthew Ince
National specialty adviser for children and young people	Dr. Matthew Clark