IN THE MATTER OF THE SOUTHPORT INQUIRY

PHASE ONE

WRITTEN CLOSING STATEMENT ON BEHALF OF NHS ENGLAND

Introduction

1. NHS England is the national body responsible for the strategic co-ordination of healthcare services in England, and oversight of local commissioners and providers of those healthcare services. It also provides leadership and operational guidance to NHS organisations in England. It is not a provider of NHS services and nor is it the employer of the staff who deliver healthcare services. Focussing on the healthcare services under examination in this Inquiry, it was the commissioner of two of the services which had contact with AR in December 2019 and early 2020: the Community Forensic Child and Adolescent Mental Health Services ("FCAMHS") and the Criminal Justice Liaison and Diversion team ("CJL&D").

2. Members of the NHS England team have been present, remotely or in person, throughout Phase 1 of the Inquiry, from the opening and impact evidence on 8 and 9 July 2025, through to the last day of evidence on 6 November 2025.

3. NHS England wishes to recognise, at the outset of these submissions, the power of the impact evidence heard by this Inquiry and the extraordinary courage of the families who gave evidence. The Chair rightly stated that nobody who was in the room when that evidence was given will ever forget it. NHS England understands the imperative of keeping Bebe King, Elsie Dot Stancombe and Alice da Silva Aguiar and those others who suffered dreadful injuries on 29 July 2024, together with their families, carers and friends, at the heart of this Inquiry and at the heart of those institutions which must scrutinise their actions and understand lessons for the future. The call for answers rather than sympathy, and straight talking and accountability, was heard and understood. We have sought to reflect that approach in these submissions, and we also commit to it in Phase 2 of the Inquiry.

4. We acknowledge at the outset of these submissions that, focussing on the healthcare sector, the evidence shows clear missed opportunities within the NHS in its response to the risks posed by AR, together with collective inadequacies in interagency working across multiple sectors. We have explored those issues further below. NHS England will strive to examine its own responsibilities and actions to ensure that learning from these dreadful events and from this Inquiry is used to improve services and to reduce the risk of future failings.

Structure of these Closing Submissions

5. Below, we have addressed:
    a. The role of NHS England in commissioning NHS services, including FCAMHS and the Criminal Justice Liaison and Diversion team;
    b. The Emergency Response to Events on 29 July 2024;
    c. The involvement of NHS England-commissioned Services;
    d. Structured Risk Assessments and the SAVRY;
    e. Clarity about which agency was co-ordinating action and acting as the lead agency;
    f. AR's interactions with NHS services more broadly;
    g. Further considerations for Phase 2, conclusions and next steps.

The role of NHS England and NHS England commissioned services

7. In response to the Inquiry's first Rule 9 request, NHS England submitted the First Witness Statement of Michael Gregory on 4 July 2025; this was a corporate witness statement on behalf of the organisation as a whole ("CWS"). The CWS set out how the NHS operates in England. It 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."[1]

8. NHS England's primary responsibility is the co-ordination of the provision of healthcare services in England, certain direct commissioning (addressed, as relevant, in more detail below) and oversight of local commissioners and providers of those healthcare services.[2] "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)".[3]

9. Section 2 of the CWS outlined relevant Mental Health, Learning Disability and Autism commissioning arrangements and objectives for children and young people ("CYP"). The detail is not repeated here, but it is worth reiterating that during the Relevant Period, Clinical Commissioning Groups ("CCGs") (and then Integrated Care Boards or "ICBs") were responsible for commissioning a range of children's services covering both physical and mental health. This included CAMHS[4] services in the community (also known as Tier 1 – 3 services). NHS England had no direct commissioning responsibility for the CAMHS services involved with AR during the Relevant Period.

10. The CWS further explained that during the Relevant Period, Specialised Mental Health Services for Children and Young People ("Tier 4 services") were directly commissioned by NHS England through its Specialised Commissioning Team, including FCAMHS. "Commissioning" means 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

[1] [NHS000349] paragraph 22.
[2] **[NHS000024] and [NHS000349], paragraph 27**.
[3] [NHS000349] (CWS), paragraph 34.
[4] Now known as CYPMHS but we have used the term CAMHS in this written statement as this was used during the hearings.

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.

11. The nature of AR's contact with FCAMHS and CJL&D and the adequacy or otherwise of the commissioned services is considered in more detail below. NHS England first became aware of AR's referral to these services, which took place in late 2019, from disclosure given during the course of this Inquiry. In response, NHS England sent a letter dated 16 October 2025 to the Inquiry setting out the position and offering to seek any further information or evidence required.

12. An overview of the services is briefly set out here.

Community Forensic Child and Adolescent Mental Health Services

13. Community FCAMHS is a Tier 4 service commissioned by NHS England for CYP up to the age of 18. It delivers mental health consultation, advice, assessment and limited intervention for high-risk young people with complex needs living within the catchment[5] who meet the following criteria:[6]

    a. Under 18 years old at the time of referral (no lower age threshold for access to the service although most referrals will be for 10–18-year-olds);
    b. Presenting with serious conduct and emotional issues, neuropsychological difficulties or serious mental health problems and/or neurodevelopmental conditions (including learning disability or autism) with/without learning difficulties, where there are legitimate concerns about the existence of such conditions;

    c. Usually involved in dangerous, high-risk behaviours whether they are in contact with the youth justice system or not. This will include young people who present a high risk to others through such behaviours as fire setting, physical assault and sexual offending.

[5] The catchment for each service should be 'regional' in the sense that it covers a population and or geographical area for a total population of about 2.5 million.
[6] Taken from the 2024 Service Specification, [GMMH000011]

14. The referral criteria are deliberately broad, covering all CYP up to their 18th birthday about whom there are questions regarding mental health or neurodevelopmental needs, including learning disability and autism, who present high-risk of harm towards others and about who there is major family or professional concern.

15. The agencies which can refer a CYP to FCAMHS include:
    a. health and social care agencies (the majority of referrals are made from CAMHS);
    b. education (schools, pupil referral units etc);
    c. police and the youth justice system;
    d. the Prevent programme;
    e. social workers.

16. In addition to the above, FCAMHS seeks to make itself accessible to any professional who wishes to make initial contact regarding the child or young person's mental health. FCAMHS is not a case holding service, and the responsibility for risk management and care planning remains with the referrer throughout the process unless otherwise agreed (for example, where issues identified during an initial contact identify the need for alternative case holding responsibility). As a result, FCAMHS relies on other agencies identifying high-risk cases for referral and, if necessary, re-referral into the service.

17. Although the referring agency usually remains the case holder of the young person, direct assessment will be offered in high-risk cases, where there is a need for specialist opinion to ensure that CYP presenting high risk of harm to others are managed.

18. The service specifications for FCAMHS applicable in 2019 (the 2017 Service Specification)[7] and as updated in 2024 (the 2024 Service Specification)[8] have been disclosed. NHS England is responsible for commissioning FCAMHS services, setting the service specification and providing funding. In this case, the Greater Manchester Mental Health Trust ("GMMHT") was commissioned to operate the service in the North West.

[7] [NHS000570].
[8] See copy at [GMMH000011].

19. On 21 October 2025, the Inquiry heard evidence from John Hicklin who worked for the GMMHT at the relevant time and from Amanda-Jayne Brown (the current Head of Operations for the CAMHS division, which included FCAMHS, of GMMHT).

Criminal Justice Liaison and Diversion services

20. Criminal Justice Liaison and Diversion services aim to provide early intervention for vulnerable people as they come to the attention of the criminal justice system. It is an all-age service available to all points of intervention in both youth and criminal justice pathways. CJL&D services are commissioned by NHS England.

21. CJL&D aims to facilitate a multi-agency response to address health and social care needs and offending behaviour. This includes securing and supporting referrals into mainstream health and social care services. The CJL&D Standard Service Specification which was in place in 2019 has been provided to the Inquiry.[9]

22. CJL&D is intended to be a short-term measure service which screens those referred to it (by criminal justice agencies) to identify and then assess the level of need, risk and urgency. It may then refer a person to other agencies for treatment or further support.

The Emergency Response to Events on 29 July 2024

23. In response to the events of 29 July 2024, NHS England activated its regional Emergency Preparedness, Resilience and Response ("EPRR") structures. NHS England did not stand up its national EPRR incident response, as, on the day itself, this was a locally contained emergency, which was best managed on a local basis (in line with the principle of subsidiarity). NHS England's national EPRR team did provide some limited assistance to the hospitals that received and treated the victims of AR's attack, in light of the matters which led to the charges brought against AR under Section 1 of the Biological Weapons Act 1974.

24. NHS England conducted an "Internal EPRR Debrief and After Action Review for the Southport Incident and Public Disorder" and the "North West Regional Health System Debrief and After Action Review for Southport Incident and Public Disorder" to reflect on the response to the incident, identify any issues to be addressed and lessons to be learned.[10]

[9] [NHS000572].
[10] [NHS000533] and [NHS000560].

25. NHS England's National Director for NHS Resilience also commissioned a review from the Cheshire and Mersey Major Trauma Network and the Northwest Children's Major Trauma Network, to assess the clinical response to the incident. The review considered, in detail, the clinical response and management of patients, and also highlighted elements of the EPRR processes which had a direct impact on that clinical management.[11] NHS England will of course assist the Inquiry with any exploration of these reviews and follow-up, in Phase 2 of the Inquiry.

26. NHS England notes that on 24 September 2024, Daniel Ainsworth, Director of Operations, North West Ambulance Service ("NWAS") gave oral evidence to the Inquiry that NWAS was unable to release its call handlers to engage in training exercises. He suggested that it had not been possible to fulfil recommendation 196 from the Manchester Arena Inquiry (Monitored Recommendation 20) that NWAS should ensure non-specialist ambulance personnel are involved in multi-agency exercising, as a result of lack of additional funding from NHS England (having asked NHS England's Urgent Emergency Care Team and not received a response).

27. NHS England has not been asked to provide evidence on this issue. However, it may be relevant to note at this stage that a detailed update was sent out by NHS England on 1 August 2025, outlining progress by NHS England, the NHS Emergency Resilience Capabilities Unit (ECU), and all ambulance trusts supporting several recommendations from the Manchester Arena Inquiry. Details of progress set out included information on the additional investment secured. The letter further stated:

> "NHS England recognises that there are areas for improved compliance within the broad themes of training, exercising and commander competencies. The [Clinical Response to Major Incidents ("CRMI")] programme has both a training and exercising sub-group within the structure in recognition of the essential need to deliver in this area.
>
> NHS England also supports increased investment for training and exercising, and we will work with the Department of Health and Social Care

[11] [NHS000074].

to do so in future spending review rounds. This position does not however prejudice in any way the ongoing legal and contractual duties placed upon ambulance trusts to train and exercise for emergencies and major incidents, or for commissioners to support trusts in their capacities as category one responders under the Civil Contingencies Act.

These programmes [i.e., CRMI and a further Strategic review of the interoperable capabilities programme] are likely to be significant and once these programmes of work have been completed, there will be a further self-assessment exercise to understand next steps and funding requirements. Until this assessment has taken place, it would not be appropriate for NHS England to consider funding requests in these areas."

29. NHS England will be happy to provide further information and evidence regarding implementation of the Manchester Arena Inquiry recommendations, as relevant to the Inquiry.

The involvement of NHS England-commissioned Services

30. The Inquiry has prepared a detailed timeline of events and explored evidence, which includes a comprehensive review of AR's interactions with NHS England-commissioned services FCAMHS and CJL&D.[12]

31. Stephanie Hallaron (CJL&D) acted in accordance with the service specifications of the CJL&D[13] when making the necessary referrals to FCAMHS and CAMHS on 13 December 2019. It was clearly her view that the incident on 11 December 2019 was concerning and warranted a multi-agency response and the involvement of FCAMHS. AR was closed to the CJL&D team on 8 March 2020 because Ms Hallaron considered that at that stage his involvement with the criminal justice system had been completed and all appropriate referrals had been made and actioned.[14]

[12] [ILT000034]
[13] [NHS000572]
[14] CTI 29 October 2025 241/20 – 242/8 and [MERC000026] (statement of Ms Hallaron), paragraph 70.

32. The Inquiry has heard evidence critical of the contribution made by FCAMHS to the management of AR's risk following the referral to its service by Ms Hallaron on 13 December 2019, most notably from Ms Amanda-Jayne Brown of the Greater Manchester Mental Health Trust and the Inquiry's expert Dr Irani, consultant child and adolescent forensic psychiatrist. The criticisms of FCAMHS may be summarised as follows:

a. The service failed to offer sufficient guidance and support to the other agencies involved, and specifically to lead them in ensuring that a proper forensic assessment of the risk posed by AR was carried out.

b. It was wrong to suggest that the lack of an autism diagnosis meant that it was not possible to contribute further to the understanding of risk.[15] Rather, as Dr Irani put it in oral evidence, "*we are encouraged and have been encouraged for a while to look at young people with a neurodivergent lens. So you make adaptations and you work through with that lens with most young people, at least we do in my service...*"[16] So, a working diagnosis or 'autism lens' would have been helpful to consider, together with co-occurring conditions such as ADHD.

c. FCAMHS should have led a structured forensic risk assessment (such as the SAVRY, one such model) at the end of December 2019 / beginning of 2020. The expertise to undertake the assessment lay with FCAMHS (even though it would have involved gathering information from other agencies).[17]

d. According to Ms Amanda-Jayne Brown, a further professionals' meeting should have been called to ensure that there was a safe discharge, as there were key players missing from the 4 March 2020 meeting and it was not clear who was going to take on the roles and responsibilities outlined in FCAMHS' recommendations.[18] She stated in evidence that the closure decision was

[15] Molyneux 20 October 2025 30/15-19; Ramasubramanian 20 October 2025 106/12
[16] Dr Irani 22 October 27/1 and 27/20 - 28/4; also Report at paragraph 3.1.3.3
[17] Dr Irani, 22 October 2025 22/7 – 21
[18] Brown 21 October 2025 184/18 - 23

understandable at the time, rather than being a poor professional decision, but now there would have been a different approach.[19]

e. In addition (and this is relevant to both FCAMHS and CJL&D), the letters from FCAMHS dated 11 February and 9 March 2020 were initially only sent to Ms Hallaron and not sufficiently widely circulated. In May 2020, copies of the letters were requested by CAMHS. Although the letters were then received, they were not successfully scanned into the electronic patient records and were therefore not visible / accessible to CAMHS clinicians.[20] The 'loss' of the letter and of its recommendations contributed to a measure of false reassurance on the part of services, according to Dr Irani.[21]

f. Following discharge from FCAMHS in March 2020, there was no further referral to, or contact with NHS England-commissioned services. In particular, (i) despite the (implicit) suggestion that FCAMHS might be able to contribute further to risk assessment once the diagnostic process for ASD had been completed, there was no re-referral in May 2021; and (ii) there was no further referral when incidents of concern (see the list at paragraph 50 below) happened at a later date.

33. NHS England does not seek to comment on the substance of those criticisms, or to persuade the Inquiry that it should not accept them – these are matters for the Inquiry. Instead, we comment below on the evidence heard from the perspective of a national commissioner.

Structured Risk Assessments and the SAVRY

34. The Inquiry has explored in evidence, with Dr Irani, the nature of a SAVRY (Structured Assessment of Violence Risk in Youth) – it is a resource-intensive tool which requires wide input from a number of teams and takes a number of weeks, if not months, to complete.[22] Acknowledging that the expertise to co-ordinate and complete such an assessment lies with

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[19] Brown 21 October 2025 185/17 – 25

[20] Killen 20 October 2025 184/5 – 186/9. The Joint Statement from Dr Imran and Ms Brown notes [GMMH000015_0012] that "… the clinical record for AR does not reveal whether letters detailing the consultation were sent to all professionals involved in the consultation process. A consultation template has been in place since August 2023, which now mandates this."

[21] Irani, 22 October 2025 29/3 - 8.

[22] Irani, 22 October 2025, 20/15 - 21/19

FCAMHS (rather than, say, CAMHS), it is apparent that it will always be matter for FCAMHS practitioners, in collaboration with the multiple agencies likely to be engaged in any referral, to decide whether the threshold for such an exercise has been passed. Stating this is not to challenge the evidence that it should have been carried out in AR's case, in early 2020; but for services as a whole, it is important to bear in mind that:

a. There are a number of potential outcomes from a referral to FCAMHS, differing in the levels of engagement offered.[23]

b. A SAVRY (or other risk assessment) is a resource intensive process and will not be appropriate in every case.

c. Ms Brown noted that at the material time FCAMHS was not commissioned or funded to carry out autism assessments itself. She noted that this had since changed, with further funding from NHS England in 2022: the local FCAMHS service "*now has the capability to offer an autism assessment to young people where an excessive delay in completing this assessment may increase the risk of a young person entering the criminal justice system or their admission to a secure setting.*"[24] Nationally, the 2024 FCAMHS specification requires that providers should consider, at a minimum, "*how their assessment process supports effective identification of additional vulnerabilities*", which includes neurodiverse needs such as ASD and ADHD. There is a requirement for all services to "*identify and assess a range of disabilities*" including autism and ADHD.[25]

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[23] See the 2017 Service Specification for details, but to summarise: These include (a) not accepting the referral; (b) accepting the referral for either brief advice (including signposting/facilitation of access to more appropriate services); or (c) a more detailed formal consultation with referrer/local network regarding young person's presentation. These discussions take place on the basis that the outreach service has not had direct clinical input with the young person in question and that advice/recommendations are provided in line with general management principles. At the end of the formal consultation a course of action will be agreed between referrer and community forensic CAMHS secure outreach clinician, summarised in a letter to the referrer. Options include (i) closing the case with no further current input; (ii) referrer and outreach service clinician agreeing the initial formulation and local plan of action and that direct input is not immediately required; but the secure outreach team is to keep case open and seek a progress update before closing or becoming directly involved; or (iii) the Outreach team agreeing to become directly clinically involved, usually in conjunction with the referrer. See also the Joint Witness Statement of Dr Imran and Ms Brown [GMMH000015] at paras 2-6.

[24] [GMMH000015] at paras 17, 30.

[25] [GMMH000011] p12 – 13, p14.

35. The merits of a risk assessment at the time would have included the development not only the understanding of risk but of defined interventions and agreed management strategies.[26] However, the limitations of such risk assessments (see below) should still be born in mind. In addition, the effectiveness of such analysis still depends on effective use and follow-up. Difficulties in (for example) getting accurate information from the family home to inform and update the assessment, or securing engagement from, or getting 'eyes on' a young person who does not wish to be seen, may remain key issues.

36. The Inquiry may wish to note, including looking forward to Phase 2, that even now there is not a good, evidence-based tool for assessing risk in young people who present with violent ideation or intense interests in the macabre. This is still a relatively new area and services such as FCAMHS are learning and developing their approaches in conjunction with partnership agencies (such as Prevent). NHS England will wish to consider, with clinical experts, whether there is a need for further development and guidance, including on the thresholds for use.

37. NHS England will also consider whether changes would be needed to staffing and resources if, for example the expectation was that FCAMHS would carry out more SAVRY/other risk assessments.

38. In terms of autism assessments by FCAMHS, it may not be appropriate for all FCAMHS to offer autism assessments routinely; partnership with local services is expected. It is important that FCAMHS should work with local children's neurodevelopmental services to help appropriately expedite assessments for some CYP for whom there are concerns regarding criminal behaviour and high risk. This may not be possible in all services currently; it would be an area of work to develop clinical prioritisation pathways and has implications for training and skills across such pathways. This will be considered through a review of the FCAMHS specifications to standardise practice and consider training needs.

Clarity about which agency was co-ordinating action and acting as the lead agency

39. Criticisms made of the outcome of the referral to FCAMHS included criticism of the clarity as who the lead agency was to be. There was also a lack of clarity as to what actions had been recommended or were to be taken.

[26] Dr Irani, 22 October 2025 23/8 – 24/18.

40. The FCAMHS service specification (both the one in place in 2019 and the current 2024 version) is clear that the referring agency retains overall responsibility for the case:

    a. 2017 specification: - Referrers to retain overall clinical responsibility for the young people that they refer and assume a case coordination role irrespective of level of outreach team involvement. Referral services to identify a case coordinator who remains in contact throughout period of involvement.

    b. 2024 specification: - FCAMHS is not a case-holding service – responsibility remains with referrer unless otherwise agreed.

41. A lead agency other than the referrer may need to be designated when CJL&D refers a case to FCAMHS and other services. The CJL&D model is that of a short-measure service which refers to agencies but does not 'hold' the referral.

42. It appears that Mr Hicklin (FCAMHS) was operating on the basis that Stephanie Hallaron (CJL&D) was the lead professional for AR's case, as she was the referrer and his letters were sent to her on that basis so that she could distribute them to other agencies.[27] That said, John Hicklin gave evidence to the Inquiry that Anna Croll of the Youth Offending Team ("YOT") would be taking over as the lead professional.[28]

43. Stephanie Hallaron's witness statement detailed that her brief note of the 4 March 2020 meeting recorded that social care would be closing to the family; there was no evidence of mental health issues so CAMHS/FCAMHS would also close; and that AR's education was the main priority, which was currently being addressed by an EHCP referral and ASD assessment. YOT was to continue to manage AR's risk in terms of offending. AR was closed to the CJL&D team on 8 March 2020 because Ms Hallaron considered that at that stage his involvement with the criminal justice system had been completed and all appropriate referrals had been made and actioned.[29]

44. It also appears from the evidence that there is some enduring confusion about which agency maintains the lead responsibility in terms of carrying out risk assessments. CAMHS clinicians indicated that in their view a SAVRY or structured risk assessment would be done

[27] Hicklin 21 October 2025 129/20 – 131/5
[28] Hicklin 21 October 2020 136/12-24
[29] [MERC000026] at p16 and para 70; also summarised by CTI 29 October 2025 241/20 – 242/8

by FCAMHS,[30] but John Hicklin's evidence was that it was not the role of FCAMHS to complete a formal risk assessment but to contribute to the understanding of risk with the professionals that are working directly with the young person.[31] We have already commented on the issue of undertaking a SAVRY or other structured risk assessment above, although we note that, whatever the general expectations might be, in the case of AR, CAMHS staff could not have reasonably considered that a forensic risk assessment was being undertaken by FCAMHS in early 2020, and specifically after receipt of the FCAMHS discharge letter of 9 March 2020 in May 2020.

45. The evidence of Dr Killen (clinical psychologist at Alder Hey CAMHS) was that it would be helpful to have more clarity with regards to responsibilities for risk assessment, including in relation to commissioning oversight of this.[32] NHS England notes that Ms Brown has been asked to provide the Inquiry with a written update on her understanding of responsibilities on this issue.[33] NHS England will consider the extent to which further clarification and delineation is required, and further evidence can also be provided by NHS England during Phase 2 in respect of the national service specifications if required. It would be important to bear in mind that:

    a. Not all referrals to FCAMHS will lead to the conclusion that a forensic risk assessment is required – it is clearly contemplated by the specification that advice and support may be the appropriate outcome;

    b. If an assessment is carried out, it may be completed by FCAMHS, but the process will always need close liaison and co-operation with local agencies, who will be responsible for providing the inputs into the assessment;

    c. Once completed, the issue becomes who will be responsible for maintaining and updating any risk assessments and holding the lead responsibility for ensuring that agreed actions are implemented. FCAMHS services are not, in general, structured to carry out such a function.

[30] Ramasubramanian 21 October 2025 148/14 – 149/12, Killen 21 October 2025 192/12 – 193/25
[31] Hicklin 21 October 2025 105/6-9
[32] Killen 20 October 2025 192/18-23
[33] Brown 21 October 2025 179/18 – 180/14

46. Clarity around roles and expectations would thus appear to be key in all of this. Ms Brown gave evidence of the need to ensure that discharge letters adopted a SMART approach, with specific recommendations, clearly allocating responsibilities.

47. It may also be prudent to consider whether complex / high risk case discharges should be brought to an allocation meeting or complex case discussion to agree whether discharge is indicated or agreed. In addition, consideration might be given to the role of the discharge letter in clearly detailing the rationale for discharge and a clear option to re-refer to FCAMHS if indicated.

AR's interactions with NHS services more broadly

48. AR's history and interactions with NHS England-commissioned services may be seen in the broader context of his history and interactions with the NHS and beyond that with social care, education and in the family home. This part of the Closing Statement focuses on his interactions with the wider NHS only, i.e., beyond NHS England-commissioned services.

49. We note the following acknowledgments of missed opportunities that were made in evidence, together with information about how the situation has changed/would be dealt with differently now:

    a. The recording system within Alder Hey CAMHS for keeping track of the risk information should have been better at the material time; there should have been a system whereby key historical information was more visible.[34] This led to lack of awareness that AR posed a risk to others. This has now been improved so that information on risk is more immediately visible on the electronic patient record (EPR) at Alder Hey.[35] When a CAMHS practitioner now opens a young person's record, the document and date of the most recent care and risk plan come up, as does a systematic risk form and the current view and key CAMHS data.[36]

[34] Molyneux 20 October 2025 22/5-14; Ramasubramanian 20 October 2025 119/9-16; Killen 20 October 2025 161/10-12.
[35] Molyneux 20 October 2025 94/2-10.
[36] Killen 20 October 2025 204/7-11

b. CAMHS risk assessments (which should have been done every 3 months) were carried out on 11 October 2019, 15 October 2019, 8 January 2020, 22 February 2024 and 23 July 2024 only.[37] The risk management tool completed "*was neither filled out comprehensively enough or regularly enough*".[38] The risk assessments carried out by CAMHS were inadequate and did not properly assess the risk AR posed to others (even based on the information which was available to CAMHS in the EPR), or inform clinical decision-making.[39]

c. There were delays in AR being assessed for autism which cannot be explained by the Covid-19 pandemic.[40] Although Dr Irani did not necessarily think the delay was critical, as most services, e.g. education, should be working towards an 'autism-informed lens', still a diagnosis was important to contribute to AR and his family's understanding and in securing SEND support, for example.[41] There have been two material changes in respect of autism assessments since 2019/2020: the local FCAMHS (within GMMHT) can now assess for autism where considered appropriate[42] and where there is a concern about criminal behaviour the assessment process can be prioritised;[43]

d. There were multiple delays in pursuing an ADHD assessment for AR[44] (although Dr Irani's evidence was that his risk to others was not linked to impulsivity so this failure may not have been a strong factor in what went wrong);[45] that said, NHS England comments that it would still be appropriate to consider the possible cumulative effect of multiple conditions (ASD, ADHD) and their impact on functioning and risks;

e. It is evident that poor record keeping processes meant that a rereferral of AR back to FCAMHS after his autism diagnosis did not take place; the autism service would have done this if it had known of the FCAMHS recommendation

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[37] Ramasubramanian 20 October 2025 146/1-13
[38] Killen 20 October 2025, 170/5-10
[39] Dr Irani, 22 October 2025, 9/18 – 14/11.
[40] Boggan 21 October 2025 22/8-25, 23/1-14
[41] Dr Irani 22 October 2025 54/6-8
[42] Brown 21 October 2025 172/3 - 14
[43] Boggan 21 October 2025 82/13-25 - 83/1-21
[44] Boggan 21 October 2025 78/20-22
[45] Irani 22 October 2025 56/9-22

in the 9 March 2020 letter.[46] This issue was the subject of extensive questioning from the Chair culminating in a request for updates on whether there had been real change.[47]

50. NHS England further acknowledges the evidence heard, suggesting the following:

a. That rather than AR needing more CAMHS intervention, CAMHS involvement should have ended sooner than it did as AR was not engaging with CAMHS and their involvement tended to mean that he was not dealt with within the criminal justice system and masked the fact that the risk he posed to others was unassessed. [48] NHS England notes, however, that the involvement of CAMHS and the CJS should not be seen as mutually exclusive - agencies should continue efforts to engage proactively.

b. There were multiple missed opportunities to re-refer to FCAMHS after discharge in March 2020, including:

   i. following the ASD diagnosis in February 2021;

   ii. two further PREVENT referrals in February 2021 and April 2021;

   iii. incidents in November 2021 of violent and volatile behaviour at home;

   iv. the incident in March 2022 when AR was found on a bus having gone missing from home. He was found by the police in possession of a knife. He said that he wanted to stab someone in the hope that his TikTok account would be closed down, and had made poison for the same reason.[49]

c. There are few barriers to referring to FCAMHS and it is not readily understandable why AR was not rereferred. One significant missed opportunity appears to be in respect of the March 2022 bus incident, when the police chose

[46] Boggan 21 October 2025 86/2-6
[47] Boggan 21 October 2025 91/13 – 96/15
[48] Irani 22 October 2025 76/6 – 78/3
[49] Inquiry Master Chronology (Version 1) at p30 [ILT000034]

not to deal with AR under the criminal justice system due to what they described as 'severe autism.'[50]

d. There needs to be learning within the criminal justice system and in particular amongst police officers that a diagnosis of autism does not mean that a child or young person should not be held responsible for their actions, within the framework of the criminal justice system.

51. NHS England notes the evidence that where a child or young person is refusing to engage with mental health services and / or where there is no diagnosed mental health condition, there is currently no adequate mechanism for those services to get 'eyes on' the child. In a situation like AR's where there is no recognised mental illness (e.g. severe depression or psychosis) which would generally regarded as potentially treatable in a psychiatric hospital (as opposed to a long-term neurodevelopmental condition such as autism), the use of a mental health act assessment to assess whether or not there is a need to admit to hospital, represents only an imperfect potential solution.

52. In AR's case, the clinicians involved did not consider that would have been appropriate. He was not considered to have a serious mental illness (e.g. psychosis) that would have warranted the use of the Mental Health Act (MHA). In her report, Dr Irani was critical of the decision to discharge AR from CAMHS in April 2024, and suggested instead that the "*historic risks and the deterioration in his presentation"* should have prompted a mental health act assessment.[51] Dr Irani accepted in evidence, however, that the decision not to carry out such an assessment was a reasonable exercise of professional judgment and that perhaps, in fact, there is a legislative gap – "*I think there is potentially a gap in the legislation to allow us to see and assess young people better in the community*"[52] and "*I think you need some legislative framework that allows for clinicians or other statute bodies to be able to clap eyes on a young person in a similar situation."*[53]

53. This is a topic that the Inquiry may wish to consider further in Phase 2. At this stage, NHS England notes that:

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[50] Irani p20 para 3.2.1.3 [DRI000001].
[51] Expert report, para 3.3.4.3 [DRI000001]
[52] Irani 22 October 2025 49/1-3
[53] Irani 22 October 2025 50/1-3

a. The provisions of the Mental Health Bill, currently being considered in Parliament, are relevant as they seek to introduce measures preventing people from being detained under section 3 of that Act (admission for treatment) on the basis of autism or learning disability alone;[54] that said, the topic needs to be considered holistically, with reference to potential interventions such as Care (Education) and Treatment Reviews, which are appropriate for CYPs who have been admitted to a mental health setting or who are at risk of such admission.[55]

b. When considering powers to get 'eyes on' a young person, it is true that s135 of the MHA allows an application to the Magistrates' Court for a warrant allowing police to enter premises; but it requires 'reasonable cause to suspect that a person believed to be suffering from mental disorder either (a) has been, or is being, ill-treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice, or (b) being unable to care for himself, is living alone in any such place.'

Further considerations for Phase 2

54. There are many issues on which the Inquiry is already well-sighted on. For example, it seems likely that the Inquiry will wish to consider further the current lack of multi-agency levers to monitor and address online harms, and the challenge that all services face (across healthcare, education and social care) when dealing with online harms and violent fixated individuals.[56]

55. Focussing first more specifically on the contribution of the healthcare sector and NHS England-commissioned mental health services in particular, NHS England has set out below some of the issues which, as a commissioner, it considers require further thought, in case these observations are of assistance for the Inquiry's future agenda. These include whether:

    a. the referral categories for FCAMHS require further scrutiny and potential change, given the issue of violent fixated individuals.

[54] The proposals would not affect those who received a criminal disposal under Part 3 of the Act (e.g. s37 MHA).
[55] **[NHS000349] paras 80 - 81.**
[56] **See for example the evidence of ACC Winstanley, 8 October 2025, 100 - 101.**

b. a working group should be established to agree on baseline standards for violent fixated individuals including thresholds for Structured Professional Judgment assessment.

c. further stakeholder engagement should be encouraged to ensure all services are aware of FCAMHS and refer in; however, the definition of FCAMHS interventions as per the service specification should be reiterated.

d. the future might be the development of a hub and spoke model to ensure local provision for FCAMHS assessment and intervention together with consideration of training needs and / or minimum standards.

56. Counsel to the Inquiry explored with several witnesses the issue of a potential gap in services, noted in the statement of Amanda-Jayne Brown, current Head of Operations for the CAMHS division, GMMHT. Her evidence was of a: *"a gap in service offer for children and young people who display high-risk and high-harm behaviours, in the absence of a mental health disorder, who would benefit from a structured psychological intervention."*[57]

57. NHS England agrees that some children and young people may require highly specialised psychological support, falling outside of the remit of mental health services, and that funding/resources for these services are limited.[58] Clinical experience suggests that a multi-agency approach, with a lead agency, is needed for this multi-faceted problem.[59]

58. In Phase 2, the Inquiry may wish to consider issues such as (i) the need for a multi-agency framework to require the identification of a lead agency and the drawing up a comprehensive formulation that identifies all the needs and risks, and the proposed interventions; (ii) whether there is a case for legislation that might mandate providing or accepting support; and (iii) the nature of post-diagnosis interventions, recognising that evidence on 'what works' is still emerging and that the support needed is not from

[57] [GMMH000015] para 34.
[58] **[NHS000349], para 174(a).**
[59] **[NHS000349], para 174(b).**

health services alone. Issues may include the role of FCAMHS in the formulation of multi-agency plans.

59. NHS England's autism programme has published a "National framework and operational guidance for autism assessment services" (April 2023) and "Meeting the needs of autistic adults in mental health services" (December 2023).[60] Both these documents set out the requirements for commissioners and providers to provide equal and equitable access for all autistic people seeking access for an autism assessment or seeking care and support through mental health services.

60. In addition, the government's 10 Year Plan for the NHS includes some key commitments for mental health which could play an important part in addressing these issues. The Inquiry may wish to reflect on how measures in the 10 Year Plan can help deliver service improvements and contribute to the wider policy aims to address gaps in services for violent and fixated individuals as part of Phase 2. For example, the 10 Year Plan commitments include the recruitment of 8,500 additional mental health professionals to reduce waiting times for both children and adults, expansion of mental health support teams in schools and colleges, embedding mental health support in new Neighbourhood Care Models, ensuring integrated support close to home and investment to develop more dedicated mental health emergency departments. The government's National Youth Strategy also sets out plans to support young people in all aspects of their lives including support for mental health, wellbeing and the ability to develop positive social connections.

Conclusions and next steps

61. We hope these observations have been of assistance to the Inquiry and all its Participants.

Eleanor Grey KC
Anna Bicarregui
24 November 2025

[60] **[NHS000349], para 129.**