

IN THE MATTER OF THE SOUTHPORT INQUIRY
PHASE TWO

WRITTEN OPENING STATEMENT ON BEHALF OF NHS ENGLAND

Introduction

1. NHS England is the national body currently responsible for the strategic co-ordination of health care services in England, and oversight of local healthcare commissioners and providers. 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.
2. As Phase Two opens, NHS England's thoughts remain very much with the victims, Bebe King, Elsie Dot Stancombe, Alice da Silva Aguiar, their families and friends, as well as the many others who suffered dreadful injuries – both physical and psychological - on 29 July 2024. We welcome and endorse the Chair and Counsel's comments in their opening remarks that the victims are at the centre of this Inquiry, and that collectively we must do all we can to help prevent such a tragedy happening again.
3. NHS England has provided a corporate witness statement ("CWS") signed by Dr Nick Broughton, the National Priority Programme Director for Mental Health, Learning Disability and Neurodevelopmental Conditions and the Chief Executive of the Thames Valley Integrated Care Board.
4. Reflecting key parts of part 1 of the Terms of Reference for Phase Two, this opening statement is structured as follows:
 - a. NHS England's status against the Inquiry's recommendations (noting that the Government intends to abolish NHS England by April 2027, prior to the publication of the Phase Two report in May 2027);

- b. A discussion of points defining Violence Fixated Individuals/Violence Fixated Behaviours and the management of the risk posed by individuals with violence fixated behaviours, suggesting key areas for further exploration in Phase Two;
- c. Conclusions.

NHS England and the Inquiry's Phase Two Recommendations

- 5. As the Inquiry is aware, the Government intends to abolish NHS England by April 2027, subject to the passage of the Health Bill. Under the provisions of the Bill and subject to parliamentary process, it is currently planned that NHS England's functions relevant to this Inquiry will transfer to the Department for Health and Social Care ("DHSC"). Until this primary legislation is enacted, NHS England will continue to carry out its statutory functions, ensuring there is no break in service delivery or accountability.
- 6. Against this background and as the Inquiry is aware, NHS England has coordinated its consideration and response to the Inquiry's Phase One recommendations (especially numbers 8, 50, 52 and 54) alongside DHSC. On 15 September, DHSC and NHS England filed a joint response to the Inquiry's request for an update on the implementation of its Phase One recommendations, which set out key progress made against these.
- 7. In relation to Phase Two, it is understood that the aim is to deliver a final report in May 2027. As a result, and subject to the will of Parliament, it is suggested that Inquiry recommendations from Phase Two which might otherwise be directed at NHS England, based on the evidence given to the Inquiry, may require to be directed to the DHSC. That said, there would be careful consideration by the DHSC/Government of the bodies or structures best placed to respond to, and carry forward, all Inquiry recommendations, in any event.

Points for further exploration in Phase Two

- 8. NHS England suggests that some of the issues set out in its CWS can be further explored in evidence-gathering as part of Phase Two of the Inquiry. It notes that this has already begun in the seminars which have taken place. Noting that these have a clear place in the Inquiry's agenda already, NHS England considers that the following areas are amongst the topics meriting further consideration:

- a. Defining Violence Fixated Individuals/ Violence Fixated Behaviours;
- b. Assessing and managing the risk posed by individuals with violence fixated behaviours;
- c. Effective multi-agency working;
- d. Improving information sharing;
- e. Preventative/early identification measures; and
- f. Expanded training opportunities.

(a) Defining Violence Fixated Individuals/Violence Fixated Behaviours

9. NHS England notes that the Inquiry intends to explore the concept of a “violence fixated individual” (or "VFI"), as a step in the development of recommendations and policy designed to address the behaviours and significant risks presented by these individuals. The papers for the Inquiry’s first seminar, which invited views from experts in the field of Psychiatry, Philosophy and Psychology on VFIs, included a paper from Professor Cassam, discussing potential definitions. NHS England understands that assessments, services and potential interventions are centred on individuals. However, it may be helpful for the Inquiry to broaden its consideration to also focus on “violence fixated behaviours”, and the need for guidance on the management and treatment of such behaviours. This would ensure that the focus is on the response to presenting needs, with appropriate support prioritised over a requirement to attach diagnostic labels to individuals. NHS England has concerns that the creation of a discrete clinical, operational or diagnostic category of individuals or “violence fixated individuals” may have unintended consequences, as discussed below.
10. NHS England welcomes the discussion of the issue of language and definitions at the first seminar on 8 September 2026. The Inquiry is now well placed to grapple with the complexities of this issue, including: whether a definition is helpful and what the most helpful definition might be; the fact that there is no one clinical diagnosis that determines violence fixation and/or likelihood to commit extreme violence, and violence fixation itself does not constitute a clinical diagnosis; and the possibility of other definitions such as non-ideological violent extremism ("NIVE") and non-ideological extreme violence ("NIEV").

11. As set out in NHS England's CWS and discussed in the seminar, there is no single profile of a VFI. Rather, individuals exhibiting violence fixated behaviours represent a heterogeneous group and may present with a wide range of underlying needs and issues, including safeguarding concerns, mental health conditions, neurodevelopmental conditions, or none of these. Slide 5 of the presentation from Dr Aisling Martin (10 September 2026) set out the wide range of systems which may have had experience of an individual falling within the 'high risk, high harm, high vulnerability cohort', including social services, care settings and the youth justice system.
12. We note that this understanding is consistent with the Inquiry's Opening Statement for Phase Two, where CTI observed: *"...There is in fact no single definition of VFIs. Our Terms of Reference refer to individuals at risk of extreme violence, where ideology is not the primary driver. That is a helpful and practical steer for the Inquiry's work. However, it is not and does not purport to be a formal, recognised, cross Government, let alone cross public sector, definition of VFIs."* [Counsel to the Inquiry's Opening Statement, 8 July 2026, 107/25 – 108/7].
13. 'Violence Fixated Individual' and 'Violence Fixated Behaviour' are not clinical diagnoses (as clearly stated by Dr Irani in her presentation for the Inquiry's first Seminar: Slide 3). Identifying, assessing and managing such individuals may require consideration of a broad range of factors and, in some cases, a coordinated and multi-agency response across (e.g.) health, education, social services and safeguarding, and criminal justice agencies. A focus on the identification of the behaviours of concern, their causes or drivers, and the strategies available for their management or mitigation is a necessary precondition for enabling effective action in respect of a VFI.
14. An emphasis on violence fixated behaviours is consistent with NHS England's understanding of the origins of the concept within Counter Terrorism Policing and Prevent-related contexts. The concept appears to draw on work undertaken by forensic psychologists concerning the identification and assessment of "fixated" behaviours associated with an increased risk of serious violence, including among individuals influenced by traditional extremist ideologies. The focus of that work was on the nature and significance of the behaviours exhibited, rather than on the creation of a discrete clinical, operational or diagnostic category of individual.

15. There is a risk that if the label "VFI" (or similar) is used, it will or may be wrongly considered to be a diagnosis. It might inadvertently obscure underlying mental health, neurodevelopmental or other clinical needs, diverting attention from the assessment, treatment or other response that the individual may require. The “overshadowing” of needs as a result of a suspected or actual clinical diagnosis was evident in the case of AR, when a diagnosis of autistic spectrum disorder overshadowed multiple issues and heavily influenced the response of (for example) police agencies. There is also a risk that focusing on a defined cohort of VFIs, and designing a dedicated pathway or service around that definition could overlook individuals with other multiple needs who require sustained multi-agency attention, but who do not represent a perfect ‘fit’ with that specific definition. These factors point to the need for a focus on the behaviours requiring intervention and support, and the description of these behaviours.
16. Notwithstanding the concerns described above, NHS England's position is not that VFIs could never be defined as a category (whether or not that term is used, or alternatives such as NIVE or NIEV, or others). Rather, any attempt to develop a formal definition should be grounded in research and empirical evidence and accompanied by a clear framework for assessment, management and intervention. In the absence of such an evidence base and supporting framework, NHS England considers it more appropriate to focus on violence fixated behaviours than on VFIs as a discrete category of people; and upon a descriptive approach, rather than one based on definitions.
17. Regardless of the terminology used, Child and Adolescent Mental Health Services ("CAMHS") and Forensic Child and Adolescent Mental Health Services ("FCAMHS") professionals report that violence fixated behaviours are being observed among patients. This is clearly a growing issue that needs to be addressed both urgently and comprehensively.

(b) Assessing and managing the risk posed by individuals with violence fixated behaviours

18. The Government and NHS England have committed to reviewing whether further development and clearer national guidance is needed on the use of structured risk assessments for children and young people who present a risk of violence to others, in

response to the Inquiry's Phase One, recommendation 52 (see para 68 of the CWS for further details). Dr Irani notes in her presentation for the Inquiry's first Seminar (Slide 7) that the SAVRY tool is currently under review, and NHS England has discussed the limitations of such tools in its CWS [paras 72 – 75]. The key focus, it is suggested, must be on an individualised assessment, carried out by suitably trained staff and integrated into an effective multi-agency response. As Dr Irani noted, other risk assessment tools may be more appropriate, such as AREVA (Assessment of Risk for Extremist Violence in Adolescents, Borum et al 2026) which would assess risk and resilience across 5 domains – behaviour, mindset, social and relational context, individual factors, maturity of judgement.

19. NHS England has further noted in its statement [CWS para 92] that it is currently working with NIHR in relation to the identification of risk factors for those in contact with CYPMH services who pose a risk of violence. As part of this, NHS England has commissioned a review of the latest evidence on assessment and management of risk of harm to others by adults and children with mental disorders and neurodevelopmental conditions who present to CAMHS and general adult mental health services. This evidence synthesis is ongoing. Once the evidence is available, it is planned that guidance on assessment and management of risk of harm to others for CAMHS and general adult mental adult services will be developed. NHS England will, of course, update the Inquiry upon any material outcomes or key developments.

(c) Effective multi-agency working

20. Individuals exhibiting violence fixated behaviours do not constitute a discrete group, and may have a range of diagnoses, underlying needs, or no identified health needs at all. See (for example) the presentation of Dr Aisling Martin on the cohort presenting to the Vanguard service (Seminar, 10 September 2026): the vast majority of those presenting have neither suspected nor diagnosed clinical conditions.
21. Not all individuals exhibiting violence fixated behaviours will present to NHS services, nor will they all have needs that would require clinical intervention from NHS services. As a result, it is NHS England's view that violence fixated behaviour is best managed via a multi-agency approach to ensure that such behaviour is not missed in circumstances where an individual might not fall neatly within any definition of "Violence Fixated Individual". Dr Irani (in the seminar on 8 September 2026) also stressed the importance of multi-agency

working in addressing the risk of violence fixated individuals, to include, in particular: educational / vocational engagement, parental support, treatment of mental disorders (if applicable), external monitoring and internet safety. This was addressed in the same seminar by Dr Richard Taylor, advocating for a "big front door" approach (i.e. that definitions were not restrictive to the extent that they would exclude some individuals from the services to which they were presenting). The holistic 'no wrong door' approach must be embedded; this should also enable consideration of earlier, lower risks as well as working to reduce the potential stigma associated with more narrowly focussed services.

22. NHS England considers that the key to addressing violence fixated behaviours is not necessarily the absence of formal legal powers addressing this specific issue, but how existing powers, duties and sources of information are brought together within a coherent multi-agency framework. Clear arrangements for information sharing, joint assessment and collaborative decision-making are, in our current view, likely to be of the greatest practical significance. A robust multi-agency framework that balances flexibility with accountability is needed. Such a framework should be capable of responding to the diverse needs of this cohort whilst ensuring that individuals do not fall between existing service thresholds or referral pathways.
23. Given the position outlined above, NHS England considers that a multi-agency approach, with sufficient flexibility to respond to the circumstances and needs of the individual, would be preferable to identifying a lead agency in advance or by default. Instead, responsibility for coordinating the response could be determined on a case-by-case basis, according to the individual's presentation and risks. This would better reflect the heterogeneous nature of the cohort, recognising that some individuals may have mental health or neurodevelopmental needs whilst others may not. Thus, in some cases the lead agency should be health services, including FCAMHS, whereas in others the lead role may more appropriately sit with Prevent, Youth Justice services, education, social services or another agency.
24. NHS England is neutral as to whether this objective is achieved through the adaptation of existing frameworks or through the development of new statutory arrangements. However, irrespective of the longer-term approach adopted, NHS England considers that in the short to medium term, a Concordat between the relevant agencies could provide a practical mechanism for setting out how they should work together to assess risk, identify needs and

allocate responsibility for individual cases. The CWS sets out some examples of concordats which have worked in practice [para 83].

25. In that context, NHS England welcomes the emphasis placed on multi-agency working in both the Children's Wellbeing and Schools Act 2026 and the Inquiry's Phase One Report. In particular, NHS England supports the objectives underpinning Recommendations 39 (the Department for Education should update Working Together to Safeguard Children and the Children's Social Care National Framework) and 57 (nationwide reminder to all agencies), which are consistent with the need for effective coordination, information sharing and joint decision-making across agencies. This aligns to concerns about the wider complex needs of some children, and the ability to address such concerns and take earlier preventative steps.
26. In any model, there will likely be a need for national standard-setting and/or co-ordination. NHS England notes the evidence from MAPPA (for example) upon how its national Framework sets standards and supports shared learning; and the evidence from the Netherlands (presentation of Professor Sizoo) on the national standards and the element of independent case management in its Care and Safety Houses.

(d) Improving information sharing

27. NHS England is aware that information which should be shared is not always shared. In particular, information relevant to assessing the risk posed by an individual exhibiting violence fixated behaviour is likely to be held across multiple agencies, with no single organisation possessing a complete picture of the individual's circumstances or risk profile. For example, NHS England is aware that FCAMHS (a service which is reliant on and works collaboratively with community partners) has faced difficulty in both receiving information from and sharing information with other organisations. This is particularly the case where the child/young person's family state that they do not want information shared without their consent.
28. It is hoped that the work of the Inquiry will explore the reasons why information is not currently being shared (where appropriate to do so) within the current legislative framework. The CWS refers to initiatives which are seeking to address such issues, including the introduction of a single unique identifier for every child, together with the

Department for Education's consultation on new information sharing guidance; and the rollout of the Child Protection Information System.

29. NHS England welcomes consideration of whether the current legislative framework is sufficient but is not being properly used - in which case targeted guidance and/or training may be sufficient - or whether a more radical overhaul of the legislative scheme is needed. However, it notes that there will always need to be proper and effective safeguards for confidential information, not least as health agencies hold genuinely sensitive information, which patients, service users and members of the public rightly expect not to be shared without proper and lawful justification.
30. The Inquiry has already noted the additional, and significant, challenges posed by the limits on the interoperability of IT systems. As to this, and focussing upon reforms relating to the health and social care sector, NHS England is pursuing a range of initiatives aimed at improving NHS systems interoperability, including legislative, commercial and digital initiatives. In particular, details upon the progress towards the creation of the Single Patient Record (SPR) were included in the joint DHSC/NHS England update to the Inquiry provided on 15 September. This set out, relevantly, how NHS England and DHSC are developing a consistent and accessible view of relevant patient information for authorised health and care professionals across organisational and geographical boundaries. SPR will build on information already held in GP systems, Shared Care Records and other national and local health and care services, rather than replacing providers' own electronic patient records. SPR is being delivered in phases, with the first major capability planned to be available nationally in 2027. Information about the delivery of SPR, including the developing timeline for rollout, is published and regularly updated on NHS England's website.¹

(e) Preventative/early identification measures

31. NHS England's CWS sets out a number of initiatives/programmes designed to support children and young people's mental health needs and needs more broadly [paragraphs 130 – 145]. NHS England considers that exploration of these initiatives would help inform a

¹ <https://www.england.nhs.uk/digitaltechnology/the-single-patient-record/>

discussion about early identification or even possible prevention or attenuation of violence fixation behaviours in children and young people.

32. The measures include (for example) Mental Health Support Teams in schools and colleges [paragraphs 130 – 135], Young Futures Hubs [paragraph 136], Prevention Partnership Panels [paragraphs 137 – 139] and the “Framework for Integrated Care (Community)”, together with the Vanguard linked to that Framework [paragraphs 140 – 145]. All of these initiatives have significant multi-agency working which NHS England agrees should be the focus of consideration in Phase Two.
33. The model Vanguard, operating under the “Framework for Integrated Care (Community)”, are a specific intervention which the Inquiry heard about in the seminar of 10 September 2026, in a presentation by Dr Aisling Martin. The Framework is also explained in the CWS, and examples of the Framework in action have been disclosed to the Inquiry. This programme is demonstrating that vulnerable young people achieve better outcomes when services work together around the child and family, rather than through fragmented interventions, and when approaches are built on trauma-informed, relationship-based practice and sustained therapeutic relationships. Early evidence from the Vanguard shows that understanding the context of behaviour, strengthening daily relationships and providing integrated wraparound support can improve outcomes for children and families, particularly where needs are complex and entrenched.
34. Each individual Vanguard has commissioned their own independent evaluation, and a recent thematic evaluation of this work has supported the early evidence referred to above, alongside a national dataset. The Vanguard models vary across different areas, but all have the following elements: psychologically-informed, trauma-responsive practice; a shared understanding of need; multi-agency collaboration; multi-agency formulation including the development of the child’s story (‘my story’); participation and co-production. Across the different Vanguard, there was consistency of outcome in the following respects:
 - a. Improved engagement with services.
 - b. Improved relationships with trusted adults.
 - c. Greater educational engagement and stability.
 - d. Improvements in wellbeing and emotional functioning.
 - e. Reduced risk-taking and harmful behaviours.

- f. Reduced offending and behavioural difficulties.
- g. Increased opportunities for listening to the child's voice, encouraging participation and influence.

35. In the discussion on 10 September, Dr Martin noted the evidence that progress can be made in addressing need and risk in the absence of a mental health or clinical diagnosis. She further noted issues concerning:

- a. Organisational stress/trauma when organisations are confronted with complex and risky individuals. She noted that this can result in ‘scattergun’ or inappropriate referrals. It is apparent that anxiety on the part of professionals can result in risk-averse practice, but managing anxiety within systems enables thinking and effective decision-making. NHS England considers that this merits further consideration by the Inquiry, with thought being given to whether measures (such as embedding psychological support within any multi-agency framework, e.g. in the Vanguard model) can be taken to prevent or mitigate organisational stress/trauma to improve the assessment and management of these ‘high risk/high harm’ individuals. The thematic evaluation of the Vanguards suggests that there are benefits for staff: psychological consultation, supervision and reflective practice not only improved professional capability but also reduced isolation, increased confidence and helped practitioners feel better supported when working with complexity.
- b. The need for support to avoid polarised thinking: that is, individuals can be both ‘dangerous’ and ‘vulnerable’;
- c. The great value of established relationships within any system aspiring to integrated, multi-agency working (this was a point repeated by those addressing the experience of MAPPA and the more recent Violence Reduction programmes).

36. NHS England invites further reflection on these themes, the value of the “Framework for Integrated Care (Community)” and associated Vanguards, and the place of health services (including psychological support and approaches) even in the absence of mental health diagnoses in VFIs.

(f) Expanded training opportunities

37. As described in the CWS (paras 146-155), although training on violence and aggression is delivered across a range of healthcare settings, training relevant to the identification, assessment and management of violence fixated behaviours is primarily provided within services which are most likely to encounter these behaviours, such as FCAMHS. NHS England considers that, if a truly multi-agency and multidisciplinary approach is to be achieved, relevant training should extend beyond specialist services and be made available more widely across health and other public sector organisations. This should include ongoing supervision and reflective practice as standard.

Conclusions and next steps

38. We hope these observations have been of assistance to the Inquiry and all its Participants. The NHS England team looks forward to engaging with further evidence gathering in Phase Two of the Inquiry.

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