Witness name: Suzy Powell

Statement No.: 1

Exhibits: SP/01-SP/54

Dated: 19 August 2026

THE SOUTHPORT INQUIRY

FIRST WITNESS STATEMENT OF SUZY POWELL

I, Suzy Powell, Director, Emergency Preparedness and Health Protection, at the Department of Health and Social Care, 39 Victoria St, Westminster, London SW1H 0EU, will say as follows.

Introduction

1. I make this statement on behalf of the Department of Health and Social Care ('the Department' or 'DHSC') in response to a letter from the Southport Inquiry dated 7 July 2026. The Department is keen to ensure that evidence is provided by the correct body, and has, at the Inquiry's invitation, reviewed the Rule 9 request to NHS England and considered matters raised that fall within the Department's remit. As this corporate statement is made on behalf of the Department, it necessarily covers matters that are not within my personal knowledge or recollection. This statement has therefore been prepared with the assistance of DHSC colleagues and legal advisors. I am authorised to make this statement on behalf of the Department.

2. I would like to take the opportunity to extend the Department's deepest sympathy to all the families and friends of Alice, Bebe and Elsie, and to recognise the unimaginable pain and loss suffered by the bereaved. I also want to recognise the significant trauma suffered by the survivors and their families, the effects of which they continue to deal with.

3. I am the Director for Emergency Preparedness and Health Protection. My directorate supports the protection of people's health, including by ensuring we are prepared for incidents and emergencies. We plan for and advise ministers on critical issues and how to mitigate them, including pandemics; chemical, biological, radiological and nuclear threats; and environmental hazards and other threats, including mass casualty attacks. We also lead the response function for any incidents, acting rapidly when they occur to protect people's health.

The role and remit of the Department

4. DHSC, acting on behalf of the Secretary of State for Health and Social Care ('Secretary of State'), has a role in the governance, policy direction and legislative framework of health and social care in England. Its functions include securing NHS resources within government, supporting Ministers in setting strategic health and social care policy, representing health and adult social care interests across government, and maintaining accountability to Parliament for the operation of the health and care system. The Department also exercises oversight of NHS bodies at a strategic level through its relationship with NHS England ('NHSE'), including through ongoing dialogue, collaboration and performance frameworks.

5. By contrast, NHSE has day-to-day responsibility for the NHS in England. NHSE is responsible for commissioning and operational oversight of NHS services and for overseeing NHS trusts and NHS foundation trusts. The NHS is comprised of a large number of organisations operating across public, voluntary and commercial sectors, including independent contractors such as GPs. NHSE therefore holds primary responsibility for the operational delivery, implementation and assurance of NHS services across the system in England.

6. In the context of matters relevant to the Inquiry, it is important to distinguish between DHSC's policy and strategic role and NHSE's operational functions. DHSC does not identify, assess, manage or monitor individuals who present a risk of serious violence or radicalisation. It also does not hold operational responsibility for services involved in reducing violent or counter-terrorism risk. Those functions sit with operational agencies and service providers, including Counter Terror Police.

7. The Department serves ministers and provides strategic advice and policy support to ministers in relevant areas, including mental health, patient safety, neurodevelopmental and learning disability policy, safeguarding, and the relationship between health services and the Prevent programme. The Department also works across government, including with the Home Office ('HO') and Department for Education ('DfE'), on policy development, legislation and cross-governmental guidance relating to these subjects.

8. In relation to Prevent, the Department is responsible for cross-government engagement, healthcare sector representation, guidance to the sector and for the formulation of health-focused policy jointly with HO. By contrast, NHSE is responsible for operational implementation within the NHS, including training, assurance and oversight of compliance with the Prevent duty across NHS trusts and NHS foundation trusts in England. Staff working within NHS organisations have responsibilities to identify, refer and, where appropriate, manage concerns relating to radicalisation risk in partnership with police and other agencies **[SP/01 - DHSC000057 and SP/02 - DHSC000046]**.

9. DHSC has an internal Prevent governance board called the Prevent Partnership Group. This board is jointly chaired by the Deputy Director for National Security and Operational Response for the Department, and the NHSE Deputy Director for NHS Safeguarding, and brings together DHSC, NHSE Regional Safeguarding Leads and other partners such as Counter Terror Policing ('CTP') to discuss and drive forward Prevent priorities in health. CTP is funded by the Government to deliver the law enforcement elements of its CONTEST Counter Terrorism Strategy. CTP delivers this as a collaboration of the 43 police forces of England and Wales, alongside the police services of Scotland and Northern Ireland.

10. DHSC also attends several cross-government Prevent governance boards. This includes HO's Prevent System Board to discuss cross-government Prevent operational and system priorities, the CONTEST Board to discuss Prevent within the wider context of cross-government counter terrorism priorities, and the Counter Terrorism Ministerial Board to discuss Prevent within the context of wider strategic ministerial priorities.

11. In relation to safeguarding, the Secretary of State has oversight responsibilities for NHS bodies in meeting their obligations under relevant safeguarding legislation

(principally the Care Act 2014 in respect of adult social care and that bodies working in local safeguarding partnerships are discharging their responsibilities under the Children Act 2004). DHSC, working closely with NHSE, therefore has a role in ensuring that safeguarding responsibilities are effectively implemented and assured across the health and adult social care system. The statutory safeguarding assurance for NHS providers is contained within the NHS England Safeguarding children, young people and adults at risk in the NHS and Integrated Care Boards ('ICBs') statutory safeguarding protocols **[SP/03 – DHSC000061]**. NHS providers and ICBs offer statutory safeguarding reports which have oversight by the NHSE regional safeguarding function. The assurance reports feed into the National Safeguarding Steering Group which reports to the Director General Chief Nursing Officer and the NHSE Executive Quality Group.

12. Child safeguarding is a multi-agency function, led across government by the DfE. The DfE works closely with DHSC and HO to design policy, legislation and statutory/non-statutory guidance on multi-agency child safeguarding, as the departments with oversight of the three statutory child safeguarding partners – local authorities ('LA'), ICBs and Police – with joint and equal legal responsibility for multi-agency safeguarding arrangements in each LA area. Child safeguarding partners are required to have regard to any guidance given by the Secretary of State for Education ('SSE'), which emanates principally through 'Working Together to Safeguard Children 2026' **[SP/04 - DHSC000065]** and other associated guidance for those multi-agency bodies.

13. As part of the Department's strategic oversight of NHS England, the Secretary of State provides NHSE with an annual mandate. It also has a statutory responsibility to keep under review how effectively various bodies exercise their functions in relation to the health service in England. Section 13U of the National Health Service Act 2006 ('NHS Act 2006') requires the Secretary of State to consider NHSE's annual report on performance and assess how well they have met the objectives set out in their mandate, their business plan and other duties under the NHS Act 2006 (as amended). Section 13Z2 of the same Act allowed the Secretary of State to intervene where NHSE were failing in the exercise of their functions. The Health Care Act 2022 replaced Section 13Z2 with Section 13ZC which gives the Secretary of State a broader power to issue directions to NHSE, other than in cases of significant failure, subject to the exceptions specified at Section 13ZD, which include a direction in relation to: the appointment or employment of a person; a decision about the services to be provided

to a particular individual in connection with their illness; or the provision of a drug, medicine or treatment in the absence of NICE guidance or recommendation.

14. The Secretary of State retains ministerial responsibility to Parliament for the provision of the health service in England and has a number of general duties which are set out in Part 1 of the NHS Act 2006. Unless the scope is explicitly limited, the duties apply to every action undertaken in relation to the NHS and public health (but not adult social care).

15. The Equality Act 2010 places a responsibility on public authorities to have due regard to the need to eliminate discrimination and promote equality of opportunity. Age is a protected characteristic under the Equality Act 2010. The Secretary of State is required to demonstrate that the needs of children were taken into account when making policy decisions.

Cross-government response to Violent Fixated Individuals

16. Following the conclusion of AR's criminal proceedings and in light of the emerging risk of extreme violence caused by lone actors with no clear ideology, the Cabinet Office ('CO') identified an urgent requirement for a cross-government approach addressing the response to non-ideological extreme violence. CO, working closely with HO, took leadership of early cross-government work in early 2025 regarding Violent Fixated Individuals ('VFIs'), with an initial focus placed on defining and establishing the risk posed **[SP/05 – DHSC000070]**.

17. Early work included the formation of a Violent Fixated Individuals Analytical Group that first met on 13 February 2025. DHSC was part of this group, during which the use of the term/description "violently fixated individuals" ('VFI') was discussed, with a clear emphasis on defining VFIs. It was understood that, to identify the most effective interventions for VFIs, it was vital to assess and understand the threat they posed **[SP/06 - HOM000266]**.

18. At the same time, HO sought to establish a central team, based in HO, that would lead on and 'propel' policy responses based on the initial assessment work led by the Analytical Group. Sir Matthew Rycroft, Permanent Secretary at the HO, wrote to DHSC's Permanent Secretary on 10 February 2025 seeking a secondee from DHSC

to sit in that team and 'reach back to' experts in their departments and agencies to support the delivery of these policy responses. Due to capacity constraints, DHSC were unable to identify a secondee, but the DHSC team worked closely with the central HO team to progress the initial policy work, contributing policy views as well as bringing in operational and clinical expertise from the NHS and NHSE to contribute to the effort, where appropriate. This included working closely with the central team, and the national clinical advisor for Children and Young People's Mental Health Services ('CYPMHS'), formerly known as CAMHS.

19. Immediately following the verdict, in February 2025, the T1D* in the CO led work to define and identify the cohort of VFIs. This work drew on evidence provided by DHSC based on a literature review of the evidence relating to mental health, neurodiversity and violence **[SP/07 - DHSC000032]**

20. DHSC and NHSE officials attended a challenge session led by T1D* in early March 2025, where the definition of VFIs was discussed including the clinical meaning behind the new term. This work resulted in a paper, finalised on 27 March 2025. DHSC and NHSE were part of the iterative drafting process and provided feedback as the paper developed **[SP/08 – DHSC000021]**. The paper set out the importance of the complex role neurodiversity plays in contextualising vulnerability and risk, and highlighted mental illness as a possible 'co-occurring factor' that needs to be considered when designing interventions. It also recommended that HO, working with relevant departments and agencies, should improve data linking to enable a more complete picture of VFI threats **[SP/09 – CAB000023]**. The paper was discussed with DHSC in a HO-led virtual policy workshop on VFIs on 21 May 2025, focusing on developing the VFI definition and potential interventions for the VFI cohort.

21. In addition to the paper referred to above, cross-government work on VFIs culminated in a National Security Council ('NSC meeting), on 25 March 2025, focusing on T2A/T2B T2A/T2B and the risk of violence posed by VFIs. This meeting served as a key trigger point for the current cross-government programme of work on VFIs.

22. DHSC, working with other government departments and CTP, was identified as one of the responsible departments for the following actions:

a. The acceleration of a national roll-out plan for Prevention Partnerships and wider complementary work to identify and support minors showing signs of vulnerability towards extreme violence;
b. The prioritisation of VFIs by local services across the national security, social care, health, education, youth justice and law enforcement systems;
c. The further scoping of more ambitious options for how social services can prioritise and support VFIs; and
d. Scoping a national prevention gateway and case management service for the management of VFIs and vulnerable individuals more broadly **[SP/10 – CAB000053]**.

23. Following the NSC meeting, the Department took forward two actions to address the concerns raised. DHSC officials worked closely with the central HO team as they developed these actions and reported their progress into the joint HO / CO senior team that led on the response to these actions.

24. Firstly, DHSC worked with HO and CTP to assist with tracking a cohort of people that CTP had identified as VFIs, and who had been referred to mental health services. This cohort had been referred to Prevent but had not been taken forward by Channel because they did not exhibit any clear ideology, despite the risk of violent behaviour.

25. DHSC could not directly support CTP with this work because the Department does not have access to patient-level data. However, DHSC worked closely with NHSE to develop a process by which CTP could work with local trusts, allowing CTP to follow-up on individuals identified as VFIs. That process was set out in an email from NHSE that was shared with the Department on 25 April 2025 and sent onto Home Office and CTP on 28 April and again on 2 May 2025 **[SP/11 - DHSC000039]**.

26. Secondly, the Department has worked with NHSE to consider how best to offer tailored support to people identified as VFIs who were referred to mental health services by Prevent. DHSC identified the Framework for Integrated Care Vanguards, working with Forensic CAMHS services, as an option for delivering on this goal and worked with NHSE (and clinical experts) to develop a proposal to expand these Vanguards through the 2025 Spending Review. The Framework for Integrated Care is an evidence-supported approach to identifying and working with children and young people who present with complex needs in multiple domains and who are at risk of or have a

'Deprivation of Liberty' under the Children Act 1989. It is a set of evidence-informed guiding principles and practices and integrates relevant services around the child or young person, developing a psychologically informed formulation of their needs and a plan to address them. While further expansion of Vanguards did not receive specific funding within the current Spending Review period, there are currently 11 Vanguard sites in England covering around 19% of the country. The Medium-Term Planning Framework gives ICBs greater autonomy to decide how funding is spent, balanced with the need for national accountability to deliver transformation of services. National funding of Vanguards may be reviewed in future spending rounds.

27. Jonathan Marron, as Director General of Primary Care and Prevention, attended an official level follow up from the NSC meeting to discuss these next steps from the NSC meeting on 1 April 2025. DHSC followed up from that meeting by providing initial lessons learned from the attacks **[SP/12 - DHSC000059]**.

28. In April 2025, following discussions with HO and CTP on the trends in casework of people with mental ill health and neurodiversity being potentially radicalised to terrorism, DHSC and NHSE agreed to update guidance from 2017 for clinical leaders and staff working in mental health trusts on managing radicalisation risk **[SP/13 - DHSC000058]**.

29. DHSC contracted RAND Europe, an independent not-for-profit policy research organisation, to review and revise existing guidance. The Department worked closely with RAND Europe throughout the process to ensure that revisions to the guidance were evidence-based, including extensive consultation with key stakeholders. The revised guidance will outline the responsibilities of those working in mental health services to manage the risk of radicalisation, explain how to determine when a referral may be appropriate, including specific considerations for people with mental health conditions and those who may be neurodivergent, and describe the referral process and the role of staff throughout the wider Prevent pathway.

30. The revised guidance is expected to be published in Autumn 2026, pending legal and ministerial approvals.

31. In May 2025, HO shared a paper with relevant departments setting out strategic issues undermining an adequate response to non-ideological extreme violence, and key objectives for cross-government activity on this issue. The paper described an 'expert

* Cabinet Office Body

consensus' that 'neurodivergence is not a risk factor for violence in the general population, but that in the VFI population it appears to have raised prevalence.' The paper raised questions for departments to consider, arising from each objective, with DHSC and NHSE policy and clinical leads providing input **[SP/14 - HOM000345].**

32. On 9 June 2025, in his capacity as interim Permanent Secretary for DHSC, Professor Chris Whitty attended a cross-government meeting of Permanent Secretaries to discuss the challenges faced by the VFI work and next steps **[SP/15 - DHSC000024]**. HO prepared two papers in preparation for this meeting. The first, about measures to manage the risk from VFIs and the second, addressing the high ambition response to the VFI challenge. The T1D* also provided a paper addressing the analysis update and next steps.

33. In addition to the work that followed the NSC meeting referred to above, the Home Secretary (The Rt Hon. Yvette Cooper MP) asked HO officials to conduct a review into mental health and neurodiversity and the relationship with radicalisation to terrorism. The review included a mapping exercise/literature review which found no causal link between mental ill-health or neurodivergence and radicalisation risk. However, the review found that these factors can contextualise vulnerability and risk needs to be assessed on an individual basis, and support plans should be tailored to the individual. The review also found that it is important that practitioners have the skills and confidence to support people with mental ill-health or who are neurodivergent, including being able to provide tailored, considered interactions, and that there needs to be a strengthened evidence base to understand "what works" when providing interventions for this cohort **[SP/16 - DHSC000071); SP/17 - DHSC000050 and SP/18 - DHSC000056]**.

34. From December 2025 HO held working group meetings with a number of departments involved in the review to discuss the findings and consider where government partners could deliver against these to improve management of T2A/T2B in individuals with mental ill-health or neurodiversity.

35. DHSC hosted a number of meetings with HO and NHSE to discuss steps taken, including the mental health and radicalisation guidance development as below, as well as initial conversations with NHS partners on neurodiversity assessments as pathways

to T2A/T2B management. The Mental Health and Neurodiversity working group was paused from May 2026 due to HO resourcing changes.

36. On 17 December 2025, Baroness Merron visited the Counter Terror Operations Centre to discuss complex issues they were coming across in their Pursue casework, including cases with complex needs such as mental health and neurodiversity. This was a result of the Security Minister offering a briefing and opportunity to discuss the challenge of mental health in counter-terrorism casework and build upon the delivery of actions from the March 2025 National Security Council.

37. Pursue is a strand of the UK Government's CONTEST (counter-terrorism) Strategy. The aim of Pursue is to stop terrorist attacks happening in this country or against UK interests overseas by detecting, investigating and disrupting terrorist activity. Pursue focuses on counter terrorist threats that are typically ideologically driven and is designed to reduce the threat.

38. CTP sent a letter to Baroness Merron following the visit **[SP/19 – DHSC000092]**. Baroness Merron sent a response on 10 March 2026, committing to work with CTP and partners in this area of work **[SP/20 – DHSC000091]**. There has been ministerial engagement between DHSC and HO on the importance of health considerations within certain CT work. DHSC and CTP have identified opportunities to strengthen collaboration, with a particular focus on improving shared knowledge and relationships across teams, including:

    a. CTP and partners to collate existing evidence and research in train and will work with DHSC to offer briefings to aid DHSC conversations with departmental and NHS colleagues. DHSC teams provided briefings to CTP staff on mental health and neurodevelopmental conditions; and
    b. DHSC to share the findings of the Independent Review into mental health conditions, ADHD, and autism, which is due to be published this Autumn.

39. In January 2026, CO set up a Cross Government VFI Working Group, which included DHSC, led by the National Security Secretariat ('NSS'). The Group set out a 2026 work plan, which included the following deliverables in which some level of involvement from DHSC was anticipated:

a. HO analysts to develop a report on the efficacy of interventions, based on evidence from CTP and CTOC as well as international comparators;
b. All departments to develop plans to increase capacity in interventions where demand is clearly growing from the VFI cohort, to help supply meet demand, while recognising the resource-constrained environment. This should be informed by HO analysis on the efficacy of interventions;
c. NSS, working with relevant departments, should hold workshops with relevant Local Authorities ('LA') and service providers from those LAs to understand how issues are manifesting and test proposals to address this;
d. Informed by the work above, NSS to produce joint advice which can go to all departmental Ministers, setting out the work needed to deliver prioritisation successfully - but with the wider objective of underpinning a broader strategy to manage risk from VFIs; and
e. NSS/HO to draft a joint letter from Ministers which can go to local services with (i) clearly articulated objectives and (ii) how we think prioritisation can work.

40. The work plan was shared with DHSC Special Advisers ('SpAds') who requested a note setting out cross-government VFI work and the working level positions of DHSC teams. It provided an opportunity to bring together the outputs from across the workplan and give SpAds the chance to provide direction and feedback on the work area, where needed. SpAds are political appointees hired to support ministers and are usually media advisers or policy experts recruited for their expertise in a particular field. The Code of Conduct for Special Advisers defines the role of SpAds, which includes giving assistance on any aspect of departmental business, and providing advice (including expert advice). DHSC provided a note to the SpAds and DHSC Secretary of State Private Office on 25 February 2026, as they requested an update on the Department's work following their conversations with No.10 on work being undertaken by Ministry of Justice on VFIs who do not meet the Prevent criteria and, consequently, are referred back to mental health services **[SP/21 - DHSC000090]**. A further update note was provided to SpAds in May **2026**, due to a new ministerial team. The note covered work on VFIs, Southport Inquiry Phase 1 and broader cross government work on Prevent **[SP/22 - DHSC000064]**.

41. The DHSC Mental Health team brought in NHSE operational and clinical expertise as the working group progressed with work, including discussions around mental health and neurodevelopmental conditions and to identify if there is a link to

violence/radicalisation. This included reviewing relevant briefing materials, such as the note to SpAds referenced above, supporting CO VFI policy development, and attending CO VFI workshops to provide specialist clinical perspectives on mental health and neurodevelopmental conditions. The group included: Sunil Lad – the National Clinical Director for Health and Justice and Prathiba Chitsabesan – the National Clinical Director for Children and Young People. In preparation for a series of workshops on understanding how VFIs are managed in local areas, the Cross Government VFI Working Group in CO shared a list of questions with Departments to gather feedback from service providers, including mental health services. The DHSC Mental Health Policy Team consulted with the Royal College of Psychiatrists on the list of questions to bring in their expertise on this work area and provide a response to the questions **[SP/23 - DHSC000034]**.

42. On 31 March 2026, a VFI workshop organised by CO was held in Birmingham, bringing together various relevant sectors and agencies. DHSC invited NHSE experts to attend, given the clinical and operational focus of the workshop. The workshops involved in excess of six hours of in-depth discussion with the following themes emerging:

    a. It would be useful to have national guidance on the definition of VFIs and the aggravating risk factors that are common across cases;
    b. A key issue for VFIs is that they sometimes do not meet the threshold for intervention in a single sector e.g., social care, education, CAMHS etc;
    c. Parental consent is an issue with intervention;
    d. The online environment is a key catalyst and driver for VFIs;
    e. The need for defensible decision-making (in the context of later review by an Inquiry or as part of litigation) can make practitioners risk averse; and
    f. Mixed feelings regarding the need for a Lord Anderson's Prevention Gateway style model, despite general agreement that it was desirable to have a single system, for ensuring oversight of children across all services **[SP/24 - CAB000048]**.

43. Ahead of the publication of Phase 1 of this Inquiry, the NSS, a unit within CO that coordinates security and intelligence issues of strategic importance across government provided advice, shared advice with DHSC Ministers which summarised key findings from the Cross Government VFI Working Group and put forward recommended next steps across different areas **[SP/25 - DHSC000022]**. HO was

tasked with the setup of a new team on Non-Ideological Extreme Violence established to drive forward progress on VFI policy and to lead the Southport Inquiry response. CO provided the following definition of VFIs in their advice; however, no cross-government agreement has been reached:

> *A violent fixated individual (VFI) has been defined by CO as someone with a "fascination with and an intent to commit extreme violence, where ideology is not the main driver". VFIs will not meet the threshold for referral to Prevent channels as they will not exhibit behaviours that indicate a pathway towards terrorism. There is therefore a gap in identifying and managing the risk of these individuals to others.*

44. DHSC and NHSE have highlighted that VFI is not a clinical diagnosis and that individuals captured by the cohort may present a wide range of symptoms, vulnerabilities and underlying needs.

45. On 27 April 2026, Baroness Merron considered and agreed with the advice and recommendations provided by CO, noting that VFIs are a very serious issue with clear links to a number of public inquiries. Baroness Merron also noted that DHSC should include VFIs when considering matters such as Assertive Outreach and made it plain that the Department needed to be doing everything possible to address the issue of VFIs **[SP/26 - DHSC000060]**.

Current work on VFIs

46. In April 2026, HO established the Non-Ideological Extreme Violence ('NIEV') Team/Taskforce, with the Prevent Delivery Unit to lead policy development on NIEV and VFIs, coordinate the Government response to the Southport Inquiry, and establish governance at senior and ministerial level. DHSC is a member of that taskforce.

47. As part of the NIEV Taskforce Governance, the Early Intervention Working Group ('EIWG') was established in June 2026, bringing together cross-government policy and operational leads to coordinate and develop the early interventions work strand. The working group had a particular focus on measures to support individuals at risk of involvement in non-ideological extreme violence, including VFIs **[SP/27 - DHSC000037]**.

48. DHSC is a member of this working group, and there is DHSC Senior Civil Servant membership (at Director level) to the Strategy Delivery Board under the Taskforce. The working group's terms of reference include the following objectives:

    a. Ensure cross-government and operational partner input into the development of policy options for intervening early with individuals at risk of NIEV;
    b. Identify, commission, oversee and evaluate pilot approaches to identifying and supporting individuals at risk, including consideration of how these interact with existing early intervention and safeguarding arrangements;
    c. Develop, test and issue interim guidance for practitioners on NIEV;
    d. Support Advisory Board oversight of the early interventions work strand by providing updates, identifying risks and issues, and escalating matters requiring senior direction or agreement;
    e. Provide clear recommendations to the Advisory Board on priority policy and operational issues relating to early intervention;
    f. Coordinate any resulting policy advice to Ministers, including joint advice where appropriate; and
    g. Support engagement with Phase 2 of the Southport Inquiry, where relevant to the early interventions work strand **[SP/28 - HOM000466]**.

49. The Department is also currently working with the NSS on a cross-government short term project to support the NIEV Taskforce, focusing on information management and sharing between agencies, which was a key conclusion from Phase One of the Southport Inquiry. An initial workplan has been set out and the NSS aim to conclude this work by September 2026 with a view of producing findings that HO can take forward **[SP/29 - CAB000039]**.

50. The Department has responded to NSS's first commission which was to set out barriers to information sharing and management and will continue to work closely with NSS on the project **[SP/30 - DHSC000033]**.

CT Ministerial Board

51. On 7 May 2026, the then Security Minister, Dan Jarvis MP wrote to departmental Ministers, including to Baroness Merron, on the need to establish a new CT Ministerial Board **[SP/31 - DHSC000047]**.

52. The CT Ministerial Board focuses on T2A/T2B, and it asks for interventions, adopting a 'whole sector' approach. The Director for CT noted at the meeting on 10 June 2026 that there is a requirement to "*[put] a wrapper of broader disruption and divergence around those in need*." Actions included DHSC, DfE, Ministry of Housing, Communities and Local Government and the Department for Work and Pensions working together to identify all available levers and interventions that may be suitable for managing risks for individuals with complex needs within CT investigative casework. **[SP/32 - DHSC000072]**

Work to improve Prevent data on mental health and neurodevelopmental conditions

53. DHSC's Mental Health team have been working with HO and NHSE to address issues around how mental health, learning disability and neurodevelopmental conditions are being recorded in Prevent statistics. Over Summer 2026, the Mental Health team have been working to understand the methodology used by HO, querying a number of issues including the difference between 'confirmed' versus 'suspected' diagnoses, whether diagnoses are clinically verified, and flagged concerns around how data was potentially being used in VFI analysis with ongoing concerns around methodology.

54. HO has reported that two thirds of those identified as VFIs were suspected or diagnosed as having 'mental ill health'. However, DHSC/NHSE believe that figures reported represent an overestimate due to variations in definitions, for instance not distinguishing between mental illness and autism, and the inclusion of 'suspected' conditions as opposed to solely clinical decisions. DHSC/NHSE and HO have been exploring these issues since November 2025.

55. DHSC and HO have worked together to make some changes to the latest publication of Prevent statistics, published on 6 August 2026 **[SP/33 - DHSC000044]**. A key change was updating the definition for each mental health and neurodiversity condition to better align with NHS standards.

56. As noted in the publication, these findings describe associations within the data rather than causal relationships. Data on mental health and neurodiversity conditions in the publication does not indicate that being neurodiverse or having a particular mental health condition increases or decreases the likelihood of progressing through the Prevent or Channel process. Therefore, patterns in findings should be interpreted with caution.

57. DHSC is continuing to work with HO and CTP to improve the recording of these conditions, especially the recorded category of 'Other', so there is a more comprehensive breakdown of mental health and neurodiversity conditions in future releases.

The Department's role in child safeguarding

58. The Children Act 1989, the Children Act 2004 and the Children and Social Work Act 2017 do not place statutory duties directly on DHSC Ministers. Responsibility for children's policy and legislation falls to the SSE and DfE Ministers. Where the legislation refers to a Secretary of State (without specifying which), it denotes any Secretary of State (sch.1 Interpretation Act 1978). It is a matter of machinery of government, not law, which Secretary of State will exercise a given power and in this instance, the power is exercised by the Secretary of State for Education.

59. By and large, the duties in the Acts are placed on LAs and these duties can only be discharged with the full cooperation of other partners, many of whom have individual duties when carrying out their functions under section 11 of the Children Act 2004. Relevant to health, those partner organisations include NHSE, ICBs, NHS trusts and NHS foundation trusts (and Special Health Authorities by order under s.11(1)(d) – although currently no SpHAs are designated under that section).

60. There is a duty on NHSE, integrated care boards, NHS trusts and NHS foundation trusts (and SpHAs, if relevant) in section 11(2) to make arrangements for ensuring 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.*

61. These health bodies are also under a duty to have regard to guidance given for these purposes by SSE.

62. Section 10 of the Children Act 2004 places LAs under a duty to make arrangements to promote cooperation between itself and organisations and agencies to improve the wellbeing of local children, including their physical and mental health. Those other agencies have an express duty to co-operate with the LA. This section applies to NHSE and integrated care boards, and it also contains a duty to have regard to relevant guidance by SSE.

63. Policies set by the Secretary of State must be consistent with the safeguarding duties applicable to the bodies which directly provide services to children. In addition to the co-operation duties mentioned above, an example of a specific duty would be section 47 of the Children Act 1989 which places a duty on NHSE, ICBs, Special Health Authority, NHS Trusts and NHS Foundation Trusts, where it is reasonable to do so in the circumstances, to assist a LA with conducting enquiries to enable the LA to decide whether to take child safeguarding action.

64. NHSE is responsible for ensuring that the health commissioning system, as a whole, is working effectively to safeguard and promote the welfare of children. Integrated care boards are one of the statutory safeguarding partners and the major commissioners of local health services.

65. Certain references in the Children Act 1989 (as amended by the Health and Social Care Act 2012) apply to the Secretary of State where they are exercising public health functions under the 2006 Act and to arrangements made by NHSE or an ICB by virtue of section 7A of the 2006 Act. Where the Secretary of State or NHS commissioning bodies make arrangements for accommodation of a child for longer than 3 months, a "looked after child" for the purposes of section 24, the child qualifies for advice and assistance under Part III of the Children Act 1989. Under section 80 of the Children Act 1989, SSE may require inspection and provision of information regarding accommodation for children arranged by the Secretary of State or NHS commissioning bodies.

New multi-agency child protection teams

66. Once fully established and operational across England, multi-agency child protection teams ('MACPTs') will bring together experts across agencies, including new social worker Lead Child Protection Practitioner roles, health, police, and education professionals, to protect children. The Children's Wellbeing and Schools Act 2026 creates a new duty for safeguarding partners, LAs, police and integrated care boards to establish MACPTs to support LAs to discharge child protection duties under section 47 of the Children Act 1989. Local safeguarding partners are expected to be establishing the teams during 2026-27, and DfE intends to commence the duty during 2027 **[SP/34 - DHSC000031]**. LAs continue to be responsible for undertaking child protection enquiries and deciding what action should be taken to protect a child, supported by MACPTs. The Children's Wellbeing and Schools Act 2026 requires membership of a MACPT to include a social worker, a police representative, a healthcare professional and person with education experience. Safeguarding partners must commit dedicated resources for these roles. The Act also allows the Secretary of State to use regulations to further proscribe the:

    a. functions of MACPTs;
    b. qualification and skills requirements for MACPT member; and
    c. relevant agencies that safeguarding partners can approach to facilitate the operation of MACPTs.

67. DfE published a policy statement during the passage of the Children's Wellbeing and Schools Bill explaining MACPTs, and how DfE intended to use the regulation making power. DHSC and NHSE are working closely with DfE to specify what requirements for ICBs and health professionals in MACPTs will be included in the regulations that DfE intend to lay during 2027 **[SP/35 - DHSC000045 and SP/36 - DHSC000053]**.

Barriers to access, referral or sustained engagement with mental health treatment

68. As noted in the Phase 1 Report, AR experienced delays in accessing mental health support and ASD and ADHD assessments, reflecting wider pressures on services. DHSC recognises that long waiting times for mental health services and neurodevelopmental assessments are a significant challenge.

69. This was highlighted by Lord Darzi's Independent Investigation of the NHS in England (2024) **[SP/37 - DHSC000048]**. Lord Darzi highlighted that long waits have become

normalised for mental health services. By April 2024, around one million people were waiting for mental health services. There were 345,000 referrals where people were waiting more than a year for first contact with mental health services. Nationally, the report showed demand for assessments and support for autism and ADHD has grown significantly in recent years and that people are experiencing severe delays for accessing such services. 270,701 people were waiting for an autism assessment in mental health services in March 2026, a 14% increase on the previous year and more than a fourfold increase since 2021.

70. Work to reduce the treatment gap and expand access to support for mental illness and neurodevelopmental conditions could help reduce the risk of violence in individual cases. This is separate to considerations under Paragraph 56 on Prevent referrals and links to mental health conditions and autism.

71. Information on the Department's work to improve access to services and reduce waiting times can be found in the sections below.

72. On a broader and more strategic level, the Department has launched an independent review into the prevalence of, and support for, mental health conditions, ADHD and autism to better understand rising demand for assessment and support **[SP/38 - DHSC000042]**. The review is examining changes in prevalence, diagnosis, referrals and need for support, alongside how current support systems operate in practice, including the extent to which diagnosis has become the main gateway to support and how earlier intervention could be provided within and beyond the NHS.

73. The interim report **[SP/39 - DHSC000043]**, published in March 2026, summarises the evidence reviewed to date, the impact of rising demand, and the key questions for the next phase. This includes evidence suggesting that current patterns of increasing demand for assessment and support for autism and ADHD are shaped by multiple interacting factors, including but not limited to improved identification of previously unmet need, changes in help-seeking behaviour, systems in which diagnosis functions as a route to support, and broader changes in public and professional understanding. The evidence indicates that many who would benefit from support may still be missed, and that inequalities in access to diagnosis and support remain insufficiently understood.

74. The interim report does not make recommendations. The recommendations in the final report, due this Autumn, will inform future policy development on how the health system and wider public services can respond more effectively to rising demand; improve care; reduce waiting times; and ensure people receive the right support at the right time.

75. The review's findings will feed into a new cross-government mental health strategy for England, covering all ages, which will be published later this year. The mental health needs of autistic people and people with ADHD will be reflected within the mental health strategy. Since autistic people and people with ADHD face a much higher risk of developing a mental health condition, there is a clear need for integrated and equitable access to mental health services and support, including appropriate adjustments to how services are designed and delivered.

Mental health funding and waiting times

76. Mental health funding is one of the ways the Government is seeking to reduce barriers to access to services. For 2026–27, NHS mental health spending across children's and adult healthcare is forecast to increase to a record £16.1bn. This is an increase of around £140m in real terms compared with the previous year. This funding will help the Government accelerate the rollout of Mental Health Support Teams in schools and colleges to reach full national coverage by 2029 **[SP/40 - DHSC000040]**.

77. Mental health support teams (MHSTs) are an existing government programme for children and young people funded by DHSC and delivered by NHSE. Practically, they are NHS-funded groups working within schools and colleges to provide early intervention, low-intensity mental health support, and support for whole-school approaches for children and young people. As of March 2026, 60% of pupils (approximately 5.8m children and young people) in schools and learners in further education in England are covered by an NHS-funded Mental Health Support Team (MHST), rising from 52% in March 2025.

78. The Government has also invested in open-access community-based mental health support for children and young people delivered through Hubs, with a commitment to opening fifty Young Future Hubs in the next four years, with eight early adopters now operational. Early support hubs are community-based services that provide drop-in mental health support for young people aged 11 to 25 with a range of issues, helpful

to prevent more severe mental illness without the need for a referral or doctor's appointment. The Government has provided over £20m of top-up funding for 24 Early Support Hubs, that together will enable over 30,000 additional mental health interventions to be delivered for children and young people close to their home. **[SP/41 DHSC000066 and SP/42 DHSC000038]**

79. For adults, the Government is seeking to transform mental health community services in line with the 10-Year Plan, delivering neighbourhood health services through community-based mental health centres, with six pilot sites already established across England. The Government is making £473 million of capital funding available nationally to improve mental health, learning disability and autism services. This includes an expansion of community mental health support, with £343 million allocated to establish 100 community-based mental health centres and 59 mental health emergency departments across England. These centres intend to improve continuity of care, drive down waits, improve access to the right support, and reduce inpatient admissions. The wider capital programme will also support action to eliminate inappropriate out-of-area placements and locked rehabilitation placements and expand crisis accommodation for people with a learning disability or autistic people where capital infrastructure is the primary constraint on improving capacity and patient care.

Funding and assessment wait times for neurodevelopmental conditions

80. ICBs remain responsible for commissioning and funding services for those with autism and other conditions, and services for those with learning disabilities.

81. It is the responsibility of ICBs to also make appropriate provision to meet the health and care needs of their local population, including providing timely access to autism and ADHD assessments. ICBs are expected to fund autism and ADHD services from their general funding allocations. The NHS Medium-Term Planning Framework, published 24 October 2025, was explicit that ICBs and providers are expected to optimise existing resources over the next three years to reduce long waits for autism and ADHD assessments and improve the quality of assessments by implementing existing and new guidance, as published **[SP/43 - DHSC000049]**.

82. DHSC is aware that NHSE is supporting local systems by issuing operational guidance on ADHD services and autism assessment pathways, sharing learning from areas trialling innovative service models, and publishing data to help ICBs monitor demand, waiting times and service performance **[SP/44 - DHSC000026]**.

83. There is currently a national strategy for autistic children, young people and adults (2021-2026) **[SP/45 - DHSC000063]**. DHSC have committed to develop and publish a revised cross-government autism strategy, as required under the Autism Act 2009. The Department are currently exploring the possibility of extending the scope to include ADHD. Statistics show that around 40% of autistic people also have ADHD and around 21% of people with an ADHD diagnosis are autistic **[SP/46 - DHSC000041 and SP/47 - DHSC000018]**. DHSC will also be seeking the views of stakeholders on extending the scope to include ADHD.

84. The current strategy will remain in effect until a revised strategy is published. While DHSC have not yet begun development of the strategy due to awaiting the final report of the Independent Review into the Prevalence and Support for Mental Health Conditions, ADHD and Autism, along with other relevant incoming evidence, reviews and reports, it is likely any revised version will ensure an updated focus on children and young people as well as adults, and include a focus on improving access to timely support, subject to Ministerial views.

85. The Government's consultation on Special Educational Needs and Disabilities ('SEND') reform closed on 18 May 2026 and DfE are now reviewing the responses alongside feedback from engagement events before setting out next steps **[SP/48 - DHSC000062]**. The NHS Medium-Term Planning Framework included a clear expectation that ICBs and providers fulfil their statutory SEND duties and support the government's SEND reforms.

The Mental Health Act 1983 and assessment and intervention for children and young people

86. The Mental Health Act is not a general mechanism for preventative detention and applies only where statutory criteria are met. The main purpose of the Mental Health Act 1983, as and when reformed, is to allow compulsory action to be taken, where necessary, to make sure that people with mental disorders get the care and treatment

they need for their own health or safety, or for the protection of other people. It sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients. Article 5 of the European Convention on Human Rights ("ECHR") provides that detention for those of unsound mind or mental health conditions can only take place in accordance with a procedure known to law. Safeguards ensure that any such deprivation of liberty is not arbitrary and complies with the law (including Article 5 of the ECHR as set out in the Human Rights Act 1998). The Department is confident the Act, as and when reformed, is compliant with our international obligations.

87. The Mental Health Act 2025 modernises the 1983 Act to bring it more in line with modern attitudes to mental health, whilst ensuring these essential powers remain available to clinicians.

88. The revised criteria for detention in the Mental Health Act 2025, once commenced, will clarify that there must be a risk of serious harm to the patient or another person in order to justify detention, and that there must be a reasonable prospect that the patient will benefit from treatment. A "reasonable prospect" is one where there is a reasonable possibility that a patient will derive some benefit from the treatment. This does not require the decision maker to conclude that it is more likely than not that the patient will benefit from the treatment. Benefitting from the treatment includes stopping or reducing symptoms such as aggression or danger to others due to a person's mental disorder.

89. The purpose of these changes to the criteria is to provide greater clarity to the level of risk of harm, to themselves or another person, that a person must present, in order to be detained, underlining that the purpose of the Mental Health Act is to prevent such harm, and to make sure that decision makers are required to consistently consider the risk of serious harm as part of the assessment process.

90. The Act's current Code of Practice **[SP/49 - DHSC000051]** acknowledges that, for people with a learning disability and autistic people, evidence-based good practice is that most needs can be best met by suitable community provision, rather than in hospital. The Mental Health Act 2025 clarifies that neither learning disability or autism, as they are lifelong conditions rather than a treatable illness, are to be considered mental disorders that justify compulsory treatment in hospital beyond the current 28-

day assessment period. This means that, when the changes to the criteria in the 2025 Act are commenced, it will only be possible to detain someone with a learning disability or an autistic person for up to 28 days under the Act, unless they are found to have a co-occurring mental disorder that requires hospital treatment. The changes to the detention criteria for people with a learning disability and autistic people will only be commenced when strong community support is in place. This will ensure people receive safe and appropriate care in the community and that changes to the detention criteria can be implemented safely.

91. The 2025 Act introduces new statutory measures to improve support for people with a learning disability and autistic people **[SP/50 - DHSC000029 SP/51 - DHSC000028; SP/52 - DHSC000030]**. Once commenced these will include a requirement on ICBs to establish and maintain a register of people with a learning disability and autistic people in the community who may be at risk of a future admission under Part 2 of the Mental Health Act. ICBs and LAs will be required to have regard to information obtained by virtue of this register when exercising their existing commissioning and market functions under the NHS Act 2006 and Care Act 2014 respectively and seek to meet the needs of people with a learning disability and autistic people in the community.

92. Upon commencement of the relevant sections, whenever a person with a learning disability or an autistic person does need to be detained for treatment of a mental health condition, the Act will require that they have a Care (Education) and Treatment review within 28 days, or 14 days for children and young people, to ensure they are receiving the right care and treatment, and barriers to discharge are being addressed and overcome **[SP/53 - DHSC000035]**.

Whether statutory powers sufficiently address modern online threats

93. The Government will ban social media companies from offering their services to those under the age of 16. This will be an 'Australia Plus' model, and will include platforms like Snapchat, TikTok, YouTube, Instagram, Facebook and X. The Department for Culture, Media and Sports ('DCMS') is leading the Government's action to ban social media for those under 16 **[SP/54 - DHSC000054]**. It was previously led by Department for Science, Innovation and Technology ('DSIT'), which was recently dissolved.

94. The ban will restrict under 16s from accessing harmful functions, including livestreaming and stranger communications. These restrictions will apply to a wider range of online services, including on gaming sites.

95. So-called AI 'romantic companion' chatbots, designed to simulate sexual relationships or roleplay with users, will be required to enforce a minimum age of 18.

96. The Government will require highly effective age assurance – meaning age checks will be tougher than those in place in Australia. It is not intended for messaging services like WhatsApp and Signal to be included in the social media ban, and there will be a narrowly defined list of exemptions, including for music streaming platforms and educational services. The Government will lay regulations this year and are aiming for them to be in effect in Spring 2027.

97. The Government has committed to work with regulators and across government to address services that provide dangerous, misleading or unverified mental health advice. This will consider all options, including banning chatbots that pose a serious threat to children.

98. DHSC views online harms as a public health and safeguarding issue and consider they should be treated as such. The known risks of online harms to the health and wellbeing of individuals include exposure to harmful online content such as distressing content around suicide, self-harm or eating disorders, and health misinformation and exposure to harmful online experiences such as cyberbullying and exploitation. There may be harm at a population level from excessive amounts of time spent online, reducing time available to engage in important activities for health and development such as sleep and physical activity. Therefore, DHSC's position is that early, preventative action to reduce exposure to online harms is necessary. The Department is following a precautionary principle – an approach to policymaking when there is scientific uncertainty about the nature and extent of a risk of harm to health, but good reason to expect, and some evidence for, reduction in the risk of harm from reasonable action compared to taking no action.

99. The Government has engaged with counterparts in Australia on the health harms of social media, and through joint DHSC/DSIT/DfE collaboration with external researchers to advance the evidence base on social media and public health.

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 in its truth.

Signed: **SIGNATURE**

Dated: 19 August 2026