Witness Name: Dr Nick Broughton

Statement No: 1

Exhibits: [NB1/01]-[NB1/30]

Dated: 31 July 2026

SOUTHPORT INQUIRY

FIRST WITNESS STATEMENT OF DR NICK BROUGHTON

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

1. As the Inquiry turns its attention to Phase 2, NHS England would like to reiterate and emphasise that our thoughts remain focused on the families of those affected by AR's crimes and the need to address the issues that the tragic events of July 2024 have brought to light. NHS England acknowledges the pain and anguish they have suffered and which they continue to suffer.

Corporate witness statement

2. In February 2026, I was appointed as the National Priority Programme Director for Mental Health, Learning Disability and Neurodevelopmental Conditions which is a joint role between NHS England and the Department for Health and Social Care ("**DHSC**"). The role combines two separate programmes that were previously led by two separate National Directors for mental health and learning disability and autism.

3. I am also the Chief Executive of Thames Valley Integrated Care Board. Prior to this, I served as Chief Executive of Oxford Health NHS Foundation Trust, having previously held Chief Executive positions at both Southern Health NHS Foundation Trust and Somerset Partnership NHS Foundation Trust.

4. I am a forensic psychiatrist by background and a Fellow of the Royal College of Psychiatrists ("**RCPsych**"). Most of my clinical career was spent working across a range of settings in west London, including adult prisons, a young offender institution and secure psychiatric hospitals. I served as Medical Director of West London Mental Health NHS Trust for six years, during which time I also held the role of Clinical Director for NHS London's mental health programme and sat on the board of Imperial College Health Partners.

5. This corporate witness statement was drafted on my behalf, and with my oversight and input, by external solicitors acting for NHS England in respect of the Inquiry. The rule 9 request received on Friday 26 June 2026 (the "**Rule 9 Request**") to NHS England goes beyond matters which are within my own personal knowledge. As such, this statement is the product of drafting after communications between those external solicitors and a number of senior individuals (including NHS England programme leads) in writing, by telephone and by video conference. I do not, therefore, have personal knowledge of all the matters of fact addressed within this statement and have not been able to personally review each document exhibited. However, given the process here described, I can confirm that all the facts set out in this statement are true to the best of my knowledge and belief.

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

7. This corporate statement has been produced with input from a number of colleagues across NHS England and following a targeted review of documents collated to date. In the time available it has not been possible to review every potentially relevant document. This statement is therefore based on the information identified through the review undertaken to date and is accurate to the best of our knowledge. We remain committed to supporting the Inquiry and to ensuring that it has access to all information relevant to Phase 2. As part of our ongoing internal investigation and document review process, we will continue to assess material as it becomes available and, where appropriate, provide any further relevant information to the Inquiry. NHS England will notify the Inquiry as soon as practicable if information comes to light that would have been included in this statement if it was available before the deadline for its production.

8. Within this witness statement, we refer to documents which are exhibited in relation to a particular point being made. These documents are exhibited as [**NB1/XX**][**XXX**].

Approach to the Rule 9 Request

9. NHS England welcomes the chance to assist the Inquiry to understand and examine the key issues it has identified as in scope for Phase 2 of the Inquiry. We share the Government's view, as set out in its response to Phase 1, that the scope for Phase 2 is unusual in looking forward rather than backward. We will work with the Government and alongside the inquiry to help strengthen understanding of the evolving threat of extreme violence and the effectiveness of different interventions from a healthcare perspective.

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

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

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

SECTION 1: INTRODUCTION

13. This section provides an overview of the concept of violence fixated behaviours and their relevance to risk assessment and multi agency working. It considers the characteristics that may be associated with such behaviours, the range of presentations that may be encountered, and the challenges involved in identifying, assessing and managing individuals who exhibit them.

14. There is no single profile of a violence fixated individual ("**VFI**"). Rather, individuals exhibiting violence fixated behaviours represent a heterogeneous group and may present with a wide range of underlying needs and issues, including mental health conditions, neurodevelopmental conditions, safeguarding concerns, or none of these.

15. This understanding is consistent with the Inquiry's Opening Statement for Phase 2, delivered on 8 July 2026, in which it was observed that:

> *"...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**]

16. NHS England's current view is that it may be more appropriate to focus on violence fixated behaviours, rather than violence fixated individuals. Violence fixated behaviour is not, in itself, a clinical diagnosis and, as a result, such individuals may or may not meet the criteria for involvement by NHS services. Accordingly, identifying, assessing and managing such individuals may require consideration of a broad range of factors and, in some cases, coordinated responses across health, safeguarding and criminal justice agencies.

17. NHS England further considers that an emphasis on violence fixated behaviours is consistent with its 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.

18. There is a further risk that the label "VFI" may inadvertently obscure underlying mental health, neurodevelopmental or other clinical needs, thereby diverting attention from the assessment, treatment and support that the individual may require.

19. Notwithstanding the concerns described above, NHS England's position is not that VFIs could never be defined as a category. 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.

20. 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 increasingly being observed among patients and are becoming a growing consideration in clinical assessment, risk formulation and risk management.

21. Given AR's age at the time of the attacks, this statement primarily focusses on children and young people ("**CYP**") who are under 18 years old, rather than the broader group of people who are under 25 years old. Community FCAMHS is for CYP who are under 18 years' old at the time of the referral. There is no lower age threshold for access to the service, although most referrals relate to individuals aged 10 to 18.

SECTION 2: NHS ENGLAND'S ROLE IN RESPECT OF VIOLENCE FIXATED BEHAVIOURS

Structure of NHS England

22. Annex 1 provides background information relevant to Phase 2 of the Inquiry. It summarises the structure of the NHS in England, NHS England's statutory functions and commissioning responsibilities, the services and programmes most relevant to the issues considered in this statement, including children and young people's mental health services, FCAMHS and, and the safeguarding framework within which NHS England, Integrated Care Boards ("**ICBs**") and NHS providers operate.

23. As the Inquiry is aware, the Government intends to abolish NHS England by April 2027, subject to the passage of the NHS Modernisation Bill. Until the necessary primary legislation is enacted, NHS England will continue to carry out its statutory functions, ensuring there is no break in service delivery or accountability.

24. The majority of NHS England's functions, including programmes relevant to the Inquiry's areas of interest, are expected to transfer into DHSC. Some, though not all, NHS England staff are expected to transfer alongside those functions. Many of these functions, including those relevant to the Inquiry's areas of interest, were undertaken by DHSC before the establishment of NHS England in 2013.

25. Work is underway to develop the future operating model and to plan for the orderly transfer of functions, responsibilities and staff. The Joint Executive Team across NHS England and DHSC is working collaboratively to review current functions and future operating arrangements, ensuring that the integrated organisation has the skills, capability and capacity required to discharge its responsibilities effectively. While it is too early to determine the precise organisational structure and staffing arrangements that will result, planning is being undertaken to support a smooth transition and continuity of delivery.

Responsibility for violence fixated behaviours within NHS England

26. NHS England has been asked by the Inquiry to identify specific groups or sections within NHS England which are responsible for work in the area of risks posed by individuals exhibiting violence fixated behaviours.

27. As individuals exhibiting violence fixated behaviours do not constitute a discrete clinical group, and may have a range of diagnoses, underlying needs, or no identified health needs at all, there will not be a default need for health service involvement in each case.

28. Policy responsibility within NHS England for risks associated with violence fixated behaviour where there is an underlying health need (mental health, learning disability or neurodivergence), falls within the National Priority Programme for Mental Health, Learning Disability and Neurodevelopmental Conditions, which I lead as the National Director for Mental Health, Learning Disability and Autism.

29. Further, the Inquiry has asked NHS England to identify the principal agencies and bodies with which it works in responding to risks associated with individuals exhibiting violence fixated behaviours.

30. NHS England works closely with a range of public bodies and strategic partners through both its routine activities and programme areas of particular relevance to the Inquiry, including mental health, learning disability and neurodevelopmental conditions, health and justice, and safeguarding.

31. In the context of violence fixation, these include DHSC, the Cabinet Office, Home Office, Ministry of Justice, Department for Education, Youth Justice Board, His Majesty's Prison and Probation Service (including Youth Custody Services), the Secure Accommodation Network, and professional and clinical bodies such as the Royal College of Psychiatrists.

Policies and Guidance

32. The National Institute for Health and Care Excellence ("**NICE**") is primarily responsible for setting guidance on the diagnosis, treatment and management of diseases and other conditions.

33. Professional bodies such as the Royal Colleges also have a role in developing clinical guidance and supporting training (see for example: RCPsych 2016 report on assessing and managing risk to others [**NB1/01**] **NHS000576**

34. However, as part of its role in leading and overseeing national policy for the commissioning and delivery of all NHS services across England, which includes driving service improvement and ensuring high quality care, NHS England publishes overarching policy and guidance documents that are of relevance to all NHS services nationally.

35. For example, on 17 July 2026, NHS England published the Mental Health Personalised Care Framework ("**MHPCF**") to support improved care for people of all ages needing secondary mental health care. While violence fixated behaviour is not, in itself, a mental disorder, the Framework may be relevant where a child or young person exhibiting such behaviours comes into contact with mental health services. The MHPCF sets out a clear, consistent national approach to how services plan, coordinate and deliver care [**NB1/02**] **NHS000599**, [**NB1/03**] **NHS000600**, [**NB1/04**] **NHS000601**.

36. The MHPCF focuses on the foundations of good care and aims to improve the quality of care for all people accessing secondary mental health care. It sets out the expectations on services around the assessment, planning and management of safety and risk, including where there is a risk of harm to others or history of violence.

37. For staff working in secondary mental health services, the MHPCF provides clarity on the core elements of care for people needing their help. For people seeking support, it describes what they should expect as standard from services.

38. The approach set out in the MHPCF centres on four key established principles:

    a. everyone has a personalised care and support plan;

    b. everyone has a person within the services responsible for their plan;

    c. plans are reviewed regularly and when things change; and

    d. outcomes are measured and responded to.

39. Published alongside the MHPCF is detailed guidance on safety planning and risk management within mental health services, as well as guidance on delivering the Framework within CYP mental health services.

SECTION 3: LEGAL LANDSCAPE

40. This section considers the extent to which the current legal and operational framework enables the identification, assessment and management of individuals exhibiting violence fixated behaviours. It examines the role and limitations of the Mental Health Act 1983 ("**MHA 1983**"), including the forthcoming reforms introduced by the Mental Health Act 2025 ("**MHA 2025**"), and considers the wider statutory and multi-agency arrangements through which risk may be identified, monitored and managed where mental health legislation does not apply.

Managing individuals exhibiting violence fixated behaviour under the Mental Health Act 1983

41. The MHA 1983 is the primary legislation that covers the assessment and treatment of people with a mental health disorder. The MHA 1983 is being reformed by MHA 2025. The reforms will be brought into force gradually through a phased implementation programme.

42. The MHA 1983 allows for the detention of individuals in certain circumstances including:

    a. section 2, which permits detention for assessment. The detention period is up to 28 days beginning with the day on which the individual is admitted. Persons detained pursuant to section 2 may be subject to compulsory

treatment, for example, if they refuse treatment but the medical team believes it is necessary; and

b. section 3, which is concerned with admission for treatment. The period of detention permitted under section 3 is six months, after which it may be extended initially for a further six months and thereafter for further periods of one year at a time.

43. Under the current provisions of the MHA 1983, prior to the coming into force of the MHA 2025 amendments, a person may be detained under section 2 or section 3 where they have a mental disorder and satisfy the applicable statutory criteria for detention. The MHA 1983 defines "mental disorder" as any disorder or disability of the mind. For present purposes, this term includes clinically recognised conditions such as schizophrenia, bipolar disorder, anxiety and depression, as well as personality disorders, eating disorders, autistic spectrum disorders and learning disabilities. In relation to learning disability, however, the MHA 1983 contains specific provisions limiting detention on that basis alone unless it is associated with abnormally aggressive or seriously irresponsible conduct.

44. Violence fixated behaviours are not, in themselves, a mental disorder within the meaning of the MHA 1983 and therefore do not, without evidence of any underlying mental disorder within the meaning of the MHA 1983, provide a basis for detention under the Act.

45. The MHA 2025 introduces additional definitions into section 1 of the MHA 1983, including:

> *"autism" means a lifelong developmental disorder of the mind that affects how people perceive, communicate and interact with others;*
>
> *"learning disability" means a state of arrested or incomplete development of the mind which includes significant impairment of intelligence;*
>
> …
>
> *"psychiatric disorder" means mental disorder other than autism or learning disability*.

46. A significant consequence of these amendments, once they come into force, is that section 3 of the MHA 1983 will no longer apply to a person that has a sole diagnosis of learning disability or autism and no psychiatric disorder. Section 2, however,

remains broader and will continue to permit admission for assessment where a person is suffering from a mental disorder (i.e. psychiatric disorders, autism and/or a learning disability).

47. The MHA 1983 may apply where violent or fixated behaviour is attributable to a mental disorder and the relevant statutory criteria for detention are met. However, the MHA 1983 does not permit the detention or compulsory treatment of a child or young person solely because they are considered to present a serious risk of violence. Where such an individual is not suffering from a mental disorder that meets the statutory criteria and declines to engage with services or participate in assessment, the MHA 1983 provides no power to compel that engagement or to authorise detention.

48. It should also be recognised that access to NHS services is determined by an individual's assessed clinical needs and whether those needs fall within the remit of the relevant service. Individuals who exhibit violence fixated behaviours, but who do not have a mental disorder, neurodevelopmental condition, or other co-existing health need that would ordinarily warrant NHS involvement, would not typically be managed by NHS services on the basis of violence fixated behaviours alone.

49. The practical limitations of the current framework have previously been recognised by NHS England. As set out at paragraph 51 of NHS England's Phase 1 Closing Statement [**NB1/05**] **NHS000588**:

> *"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 be 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."*

50. This observation illustrates a practical limitation of the current legal and clinical framework in circumstances where an individual presents significant concerns but does not have a mental disorder that would justify intervention under the MHA 1983.

51. In addition, the amendments described above do not affect the continued operation of the Part III provisions of the MHA 1983, which will continue to apply to individuals within the criminal justice system, including those serving custodial sentences who require transfer to hospital.

52. Criminal justice powers generally depend upon the commission of a criminal offence, or the existence of sufficient evidence of criminal conduct. Consequently, there may be circumstances in which an individual exhibiting violence fixated behaviours neither satisfies the criteria for intervention under mental health legislation nor presents evidence of criminal conduct sufficient to justify criminal justice intervention. In such cases, opportunities for preventive action or early intervention may be limited under current legislation.

53. The position described above has led to concerns regarding the impact of the MHA 2025 reforms once they come into force. In particular, the removal of section 3 detention powers in relation to individuals whose sole diagnosis is autism or a learning disability may further reduce the options available to clinicians and other agencies in certain crisis situations. Where an individual presents significant risks to themselves or others but does not have a co-existing psychiatric disorder, the effectiveness of the amended framework will be dependent upon the availability of appropriate community-based support, care and safeguarding arrangements.

SECTION 4: IDENTIFICATION AND ASSESSMENT OF VIOLENCE FIXATED BEHAVIOURS

54. The effectiveness of any legal or operational framework ultimately depends on the timely identification of relevant risks. Before considering how agencies should respond to individuals exhibiting violence fixated behaviours, it is therefore necessary to consider the extent to which such individuals can be identified as a distinct cohort and the role, if any, of the concept of a "VFI" within that process. NHS England's position is set out below.

Identification of VFI

55. The Terms of Reference for Phase 2 describes 'VFIs' as "*individuals at risk of extreme violence, where ideology is not the primary driver*". Counsel to the Inquiry, Nicholas Moss KC, explained in his opening remarks in the Phase 2 Preliminary Hearing that this was "*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".

56. Not all individuals exhibiting violence fixated behaviours will present to NHS services, nor will they have needs that would require presentation to 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 neatly fall within any definition of "Violence Fixated Individual".

57. While NHS England does not have an agreed definition of "Violence Fixated Individual" for the reasons explained above, it is aware that a number of healthcare services, including a number of services directly commissioned by NHS England (FCAMHS, CYP Secure Estate healthcare, and Liaison & Diversion Services) are all services with which individuals exhibiting violence fixated behaviour may engage. More broadly, CAMHS may also come across individuals exhibiting what would be considered violence fixated behaviours, often at a formative stage before violence is committed (for example those fixated on violent content online).

Identifying violence fixated behaviour in neurodiverse individuals

58. In the Phase 1 Report, the Chair identified that AR's diagnosis of autistic spectrum disorder ("**ASD**") was not properly recognised as being, in his individual case, a factor which increased the level of risk which he posed to others.

59. More generally, an individual's neurodivergence and other comorbidities such as any mental health condition, may or may not be relevant to their risk profile and the early intervention approach required to support that person. These should be considered as contextual, and not determinative, factors of a person's risk.

60. The FCAMHS referral criteria are deliberately broad and cover 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 whom there is major family or professional concern*" **[NB1/06][GMMH000011].**

61. NHS England FCAMHS service specification provides that:

"*all services will*

- *Identify and assess a range of disabilities (including Autism, ADHD, learning disability, speech and language difficulty and acquired brain injury).*
- *Make reasonable adjustments to clinical interventions and physical spaces to ensure all young people can access support equitably.*
- *Ensure their workforce planning supports accessible and appropriate interventions that meet individual needs.*
- *Develop a skills matrix for staff working within forensic mental health services to ensure appropriate training and development opportunities are available to support children and young people with additional needs. Training will include Oliver McGowen training, CQC requirements and QNIC standards".*

62. CYP are often referred for autism and/or ADHD assessment via a referral from their school, health visitor, GP or another healthcare professional. Autism and ADHD assessments are undertaken by NHS providers (whether NHS bodies or NHS services provided by independent providers) and are not directly commissioned by NHS England.

63. Demand for autism assessments has grown significantly in recent years, resulting in severe delays for CYP and adults seeking access to assessment services. Because CYP and adults access ASD assessment through various different routes, there is no national "average" period of time taken for an ASD assessment to be completed.

64. In response to these challenges, NHS England published a national framework and operational guidance for autism assessment services in April 2023, with the aim of supporting more consistent and effective delivery of assessment pathways [**NB1/07**][**NHS000087**]. However, ultimately, integrated care boards are responsible for ensuring appropriate provision is in place to meet the health and care needs of their local populations.

65. For completeness, we highlight that while referrals will only be accepted up to a CYP's 18th birthday, those approaching their 18th birthday on referral are likely to receive a time-limited service from FCAMHS. The focus of such interventions will typically be on ensuring a robust transition plan to adult services (where appropriate).

Identifying and managing risks arising from violence fixated behaviour

66. Different agencies, both within and outside health settings, will often use different risk assessment methodologies. These are not limited to formal structured tools, but may

also include safeguarding assessments, operational assessments and professional judgement informed by the agency's particular remit and expertise.

67. NHS England considers that, whilst a rigid definition of VFIs may be neither feasible nor desirable, there is a need for a shared multi-agency understanding of what is meant by fixation on extreme violence. The point at which behaviours are regarded as "extreme" may vary between agencies according to their respective roles, experience and operational context. NHS England therefore considers that a descriptive framework focused on violence fixated behaviours would be preferable to a formal definition of violence fixated individuals. This would avoid creating what might become a quasi-diagnostic category and would better reflect the heterogeneous nature of the group concerned. Any such framework should be informed by robust empirical research, including evidence derived from the UK context, and supported by clear multi-agency arrangements for assessing and managing risk whilst ensuring that appropriate support is provided to children, young people and their families.

68. The assessment of risk is a vital part of managing violence fixated behaviour, and the Government and NHS England have committed as follows to reviewing the use of structured risk assessments in response to Phase 1 Recommendation 52:

> *The Department of Health and Social Care (DHSC) and NHS England are the lead organisations and expect to complete this recommendation by 31 March 2027.*
>
> *Progress and next steps:*
>
> - *DHSC and NHS England will review 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.*
> - *The review will:*
>   - *Consider the current evidence regarding the use of structured risk assessment tools for relevant children and young people.*
>   - *Based on this evidence, decide whether further guidance is needed in the use and thresholds for structured risk assessment for these children and young people.*

- *The role of children and young people's mental health services in conducting or referring for appropriate risk assessments.*
- *Learning from Greater Manchester Mental Health NHS Foundation Trust's work under recommendation 51 will feed into the national review.*

69. NHS England's position in this regard was summarised in its Phase 1 Closing Submissions as follows:

> *"…there is not currently a good, evidence-based tool for assessing risk in young people who present with violent ideation of intense interests in the macabre."*

Structured Assessment of Violence Risk in Youth

70. There are no validated risk assessment tools designed specifically for individuals exhibiting violence fixated behaviour in the UK. Though the Structured Assessment of Violence Risk in Youth ("**SAVRY**") is a structured risk assessment of violence risks in adolescents – it is not designed to "quantify" risk. Therefore, although it may be useful in the cohort that are, for example, already known to FCAMHS services – it cannot be relied on as a predictive tool for those yet to demonstrate violence.

71. As part of Phase 1, the Inquiry examined whether a structured clinical risk assessment such as the SAVRY ought to have been carried out to assess ARs risk.

72. Structured risk assessment tools, including the SAVRY, are used in clinical practice by trained specialist forensic practitioners working withing multi-disciplinary teams. Each assessment is reliant on a large amount of information which takes a significant amount of time to collate (some weeks, if not months).

73. However, existing tools have limitations, particularly as they may not have been designed and validated for all children and young people who may present a risk of violence to others; these tools have been primarily developed for young people with a history of antisocial behaviour and offending in contact with the criminal justice system. They may also fail to capture the full complexity of presentation, including neurodiversity and other contextual factors. Accordingly, there should be careful consideration of the use of non-validated risk assessment tools for a wider population delivered by non-specialist professionals. Such tools may have low predictive validity, thereby increasing the probability of under or over estimating risk of violence (false

negatives and false positives). This may also lead to the inefficient use of already constrained CYPMH NHS resources.

74. From a clinical perspective, such tools should not be applied in an overly rigid way. Professional judgement and context remain essential. A principles-based and contextual approach is therefore preferable to mandating the use of a single structured tool, enabling clinicians and services to assess risk in light of individual circumstances and needs.

75. In light of these limitations, NHS England does not consider it appropriate to rely on SAVRY alone to identify the risks posed by individuals exhibiting violence fixated behaviour who are being seen by FCAMHS.

76. Instead, FCAMHS clinicians consider that an individualised assessment, focused on understanding the factors driving a person's behaviour together with the relevant risk and protective factors, is likely to be of greater utility than a standardised "one-size-fits-all" tool. Such an approach enables clinicians to contextualise risk rather than seek to predict it in isolation. It also supports the formulation of appropriate interventions and facilitates coordinated responses across health, social care, education and other agencies.

77. Once risk has been identified, NHS England's position is that the primary focus should be on ensuring effective multi-agency working in relation to individuals exhibiting violence fixated behaviours, supported by a shared understanding of what constitutes fixation on extreme violence and a common approach to intervention and risk mitigation. The risks presented by any individual are likely to fluctuate over time and according to their circumstances, stressors and exposure to disinhibiting factors and may be manifested across a range of settings including the home, education, social care, criminal justice and healthcare. The key challenge is therefore to ensure a coordinated multi-agency response, underpinned by a robust principles-based framework capable of supporting children and young people exhibiting violence fixated behaviours and preventing escalation over time.

SECTION 5: MULTI-AGENCY ASSESSMENT AND MANAGEMENT

78. There is no single, unified legislative framework that places a general legal duty on agencies collectively to identify, monitor and manage the risk posed by individuals exhibiting violence fixated behaviours. This is, at least in part, a reflection of the heterogeneous nature of the population concerned, as not all such individuals will

have health needs, fall within the scope of criminal justice arrangements, or otherwise be known to services.

79. Notwithstanding the absence of a unified framework, a range of statutory powers and multi-agency arrangements exist to support information sharing, risk management and intervention in particular circumstances. For example:

    a. Multi-Agency Public Protection Arrangements ("**MAPPA**") provide a framework for the assessment and management of certain offenders and other individuals who present a risk of serious harm. However, such arrangements operate within defined statutory criteria and do not provide a universal mechanism for the identification and management of all individuals exhibiting violence-fixated behaviours;

    b. the Prevent Duty facilitates coordinated action in cases involving concerns about radicalisation or terrorism related harm; and

    c. the child protection framework under the Children Act 1989 provides robust mechanisms for assessing and responding to significant safeguarding concerns.

80. In addition, concerns relating to online harms, fixation on violence, or the acquisition of potentially dangerous, albeit lawful, items may in some circumstances give rise to safeguarding concerns under the Children Act 1989. Where there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, section 47 of that Act provides a mechanism for enquiries to be undertaken and, where necessary, for the development of a Child Protection Plan. This may provide a safeguarding route for assessing and managing risks in circumstances that do not fall within, or may not be adequately addressed through, counter-terrorism or criminal justice pathways.

81. Despite the availability of safeguarding powers, significant practical challenges can arise in monitoring and managing online activity. Protection or safety plans often rely on parents and carers to implement and maintain restrictions, notwithstanding that they may have limited technological knowledge or confidence in doing so. Young people frequently possess a sophisticated understanding of online platforms and technologies, making effective monitoring difficult for both families and professionals. Furthermore, even where restrictions are imposed, they may be circumvented or online content may be accessed through alternative devices, networks or locations.

82. Whilst these arrangements provide important mechanisms for intervention and risk management, consideration could also be given to the development of non-statutory multi-agency arrangements, such as a concordat. A concordat is a non-statutory agreement between relevant organisations that sets out how they will coordinate their activities, share information and work together in relation to a particular issue. Unlike legislation, a concordat does not create new legal powers or duties but can provide a framework for consistent multi-agency working and accountability.

83. Examples of this approach have previously been developed in other contexts:

    a. the Mental Health Crisis Care Concordat was established to improve partnership working between local agencies involved in supporting people experiencing a mental health crisis [**NB1/08**] **NHS000575**; and

    b. the Concordat on Children in Custody was introduced to address longstanding difficulties arising from poor inter-agency coordination and misunderstandings regarding responsibilities between police forces and local authorities [**NB1/09**] **NHS000577**

84. Both provided frameworks to clarify roles, support information sharing and strengthen collaborative working across agencies. Such models may provide a useful precedent when considering how agencies could work more effectively together to identify, assess and manage risks of violence, even in the absence of a specific statutory duty to do so.

85. The key issue is, in NHS England's view, not necessarily the absence of legal powers, but how existing powers, duties and sources of information are brought together within a coherent multi-agency framework. A particular benefit of this approach would be to facilitate partnership working in the assessment and management of risk between health practitioners, Counter Terrorism Policing and other agencies. Health services may hold valuable information relating to mental health, neurodevelopmental conditions and safeguarding concerns that can assist in understanding the nature, severity and trajectory of violence risk. Clear arrangements for information sharing, joint assessment and collaborative decision-making are, in our current view, likely to be of greater practical significance than the creation of additional statutory powers.

Multi-agency risk assessment

86. We understand from clinical colleagues that a difficulty currently experienced on the ground where there is multi-agency working – is knowing how best to utilise multi-agency resource.

87. In his opening statement for Phase 2, Counsel to the Inquiry set out an argument around developing a multi agency safeguarding model in which Prevent operates as part of wider response to individuals exhibiting violent fixated behaviour.

88. This was framed by Counsel as a "big front door" approach, centred on Multi-Agency Safeguarding Hubs to provide a single point of referral and triage, enabling agencies to share expertise and assess risk collectively. This would strengthen Prevent's safeguarding function by ensuring that individuals whose vulnerabilities are linked to radicalisation are identified and supported appropriately, while those presenting other forms of violence risk are routed to alternative interventions.

89. Counsel was also clear that such a model for effective prevention would depend on robust multi-agency and multi-disciplinary working, coordinated decision-making and the use of established local safeguarding arrangements to deliver timely and proportionate support tailored to the needs of the individual.

90. In recent months, NHS England has been involved in discussions with the Home Office and the Cabinet Office (as the Government departments that have predominantly led the policy response to VFIs). This has included NHS England's attendance at meetings and events with a wide range of Government organisations, statutory partners and public service leads to discuss potential policy solutions and multi-agency approaches to addressing violence fixated behaviours **[NB1/10]** **DHSC000090**.

91. For example, NHS England (together with DHSC) is involved in a cross Government Early Intervention Working Group, which has been established as part of the Whitehall Taskforce announced by the Home Secretary in the Government's response to Phase 1 of the Inquiry. The working group has been established to bring together cross-Government policy and operational leads to coordinate and develop early interventions, with a particular focus on measures to support individuals at risk of involvement in non-ideological extreme violence, including violence-fixated individuals.

92. NHS England is also 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, however this is not designed to specifically address the effectiveness of interventions for this cohort. 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 general child and adolescent mental health services 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 general child and adolescent mental health services and general adult mental adult services will be developed.

93. Drawing on this work, NHS England considers that any future strategy should adopt a cross-government and multi-agency approach, bringing together relevant departments and partners to ensure a coordinated response. It should be informed by relevant evidence and research so as to promote the proportionate and effective use of resources. Such strategy should also identify and mitigate potential unintended consequences. In particular, care should be taken to avoid stigmatising individuals with mental health or neurodevelopmental conditions. It should also ensure that a focus on violence fixated behaviours does not inadvertently overshadow, or divert attention from, an underlying mental disorder or other clinical need requiring assessment, treatment support.

94. NHS England further considers that existing whole-system approaches, such as the Government's strategy for tackling Violence against Women and Girls, may provide a useful model for the development of a coordinated cross-government response.

95. NHS England agrees that the model outlined by Counsel to the Inquiry, centred on robust multi-agency working, coordinated decision-making and the effective use of local safeguarding arrangements, is broadly consistent with these principles. Phase 2 provides a valuable opportunity to explore the practical operation of such a model further, and NHS England would welcome the opportunity to contribute to those discussions through the proposed seminars and other evidential processes.

Information sharing

96. National and local policies encourage a culture of information sharing within legal boundaries. NHS organisations and local authorities are expected to have robust

protocols in place, including multi-agency safeguarding agreements and information sharing agreements.

97. Each organisation (NHS and non-NHS) that holds information about an individual is responsible for handling and sharing that information in line with applicable data protection law. Accordingly, they will establish and operate their own forms, processes, and local procedures for handling such information, including determining how information is shared and how requests for information are managed.

98. The Caldicott Principles, first established in 1997 and updated in subsequent reviews, provide ethical guidance for handling personal information in health and social care settings, with a core principle that "the duty to share information can be as important as the duty to protect patient confidentiality." Every NHS organisation is required to appoint a Caldicott Guardian, who provides advice on information governance and information sharing.

99. The Children Act 2004 and the Care Act 2014 impose specific duties on health and social care professionals to share information where it is necessary to protect children or adults at risk of harm. The statutory guidance 'Working Together to Safeguard Children' [**NB1/11**] **NHS000592** and 'Care and Support Statutory Guidance' [**NB1/12**] **NHS000598** reinforce these obligations, highlighting that confidentiality should not be a barrier to sharing information when it relates to safeguarding concerns.

100. NHS England is aware that information which should be shared is not always shared. In such circumstances it is important to understand the underlying reason why information is not currently being shared (where appropriate to do so) within the current legislative framework.

101. We understand that FCAMHS, as 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 in circumstances where the CYP's family state that they do not want information about their child to be shared without their consent. This can result in either a gap in the information, or can lead to lengthy discussions with the provider's Caldicott Guardian, legal teams and/or safeguarding colleagues.

102. If the conclusion is that information ought properly to have been shared by health bodies, or that the relevant information was held by other organisations and not

shared with health bodies (when it should have been), under existing legal and policy frameworks, then targeted guidance or training may be required in supporting future decision making.

103. Effective multi-agency working may also be hindered by limitations in the interoperability of IT systems, which can create practical barriers to the timely and effective sharing of information between relevant agencies. Interoperability remains a significant challenge, as information recorded within one system may not be readily accessible or readily understood within another without manual intervention. This increases the risk of miscommunication, duplication of effort, or important information being overlooked. Furthermore, the need to maintain robust cybersecurity protections and ensure compliance with data protection requirements can add complexity and delay to the development and implementation of more integrated information-sharing solutions.

104. Addressing issues relating to data sharing will also require ongoing investment in staff training, clear guidance, robust multi-agency agreements, and modern technology. Improving confidence and consistency in information sharing is essential for delivering effective safeguarding outcomes.

Sharing risk assessments

105. Generally, risk assessments would be shared with agencies that are actively involved in supporting the individual and managing identified risks in line with their organisational information governance processes. They would ordinarily also be shared with the family of the CYP, unless there were concerns that doing so could increase risk, for example because the assessment contained information not known to all parties or raised safeguarding concerns. Where a child or young person is approaching the age of 18, relevant information may also be shared with adult mental health or social care services to support transition planning, risk management and continuity of care.

106. In some circumstances, it may be more appropriate to provide a summary of the key findings and recommendations rather than the full assessment. This can assist schools, families and other partner agencies in understanding and responding to identified risks, while avoiding the unnecessary disclosure of confidential information that is not required for safeguarding or risk management purposes.

107. The sharing of risk assessments and related information is considered on a case-by-case basis and is guided by established information sharing principles (see below), including the need to ensure that information is shared on a proportionate and need to know basis.

Practical impact relating to risks posed by individuals exhibiting violence fixated behaviour

108. Notwithstanding the legal and policy framework described above, practical challenges remain. 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.

109. Within FCAMHS, for example, there have been instances where the Prevent programme could not share intervention provider data with FCAMHS, despite the fact that having access to that data would facilitate FCAMHS' assessment of risk. Similarly, there have been instances where one provider of social care has not been able to access information from social care in a child's previous area.

110. The 10-Year Health Plan committed to working with the Department for Education to implement a single unique identifier for every child, to enable proactive, preventative and joined-up care across different public services. NHS England considers that introducing this unique identifier will be critical to ensuring that individuals exhibiting violence fixated behaviour are identified and the risks managed appropriately **[NB1/13]** **NHS000583**.

111. NHS England notes that the Department for Education's consultation on new information sharing guidance, which closed on 14 July 2026, is relevant in this context. As identified in the Government's response to the Inquiry's Phase 1 Report, the Children's Wellbeing and Schools Act 2026 introduces a new information sharing duty (which applies to NHS England, Trusts and safeguarding partners) and provides for the introduction of a single unique identifier for children.

112. The new duty, which is expected to come into force in September 2026, makes it clear that information must be shared where it is relevant to safeguarding and promoting the welfare of children, providing a clear legal requirement for safeguarding partners to act decisively and collaboratively.

113. NHS England considers that introducing this unique identifier will be critical to ensuring that individuals exhibiting violence fixated behaviour are identified and the risks managed appropriately.

Child Protection Information System

114. NHS England is currently facilitating the NHS system wide rollout of the Child Protection Information System ("**CP-IS**") by December 2026.

115. The CP-IS service helps health and social care workers share information securely to better protect children and young people who are known to social care because they are:

    a. looked after; or

    b. have a child protection plan.

116. This includes:

    a. an Interim Care Order under Section 28 of the Children Act 1989;

    b. a Full Care order under Section 31 of the Children Act 1989;

    c. a Voluntary Care Order under Section 20 of the Children Act 1989, where they can be accommodated with the consent of those with parental responsibility;

    d. a child protection plan under Section 47 of the Children Act 1989, including unborn child protection plans.

117. CP-IS links IT systems across health and social care in England to help organisations share information securely. As it covers 100% of local authorities in England, it is the only national register of social care status, and the only system to provide information when a child is out of area.

118. It is currently available to over 1,200 unscheduled health care sites (this refers to NHS care that could not have been expected or planned before someone contacted a healthcare provider, such as ambulance and emergency services). NHS England is also working to add scheduled care settings (or planned care) such as school nursing and health visiting services.

119. Benefits of CP-IS include:

a. early intervention, which taking action to prevent or reduce future harm happening to CYP;

b. improved safety and care; and

c. increased workforce efficiency and effectiveness.

SECTION 6: INTERVENTIONS AND TRAINING

120. The heterogeneity of this group makes it difficult to identify a single intervention that will be effective in all cases. NHS England's view is that the most effective approach to intervention, and treatment more broadly, is likely to be a tailored multi-agency plan that responds to the individual needs and circumstances of the child or young person. Such an approach should also seek to identify and address wider risk factors, including bullying, social isolation, social exclusion (including school exclusion), and exposure and vulnerability to online harms. The examples set out below illustrate a number of existing interventions that may be relevant to children and young people exhibiting violence fixated behaviours.

CAMHS

121. CAMHS assess and treat a range of mental health and neurodevelopmental problems, including depression, anxiety, ADHD; and autism (among others). Doing so effectively often requires multiple services to collaborate, including children's social care, acute hospitals and paediatric services, education, police and other emergency services, the voluntary, community and social enterprise sector.

122. CAMHS do assess risk (risk to self, from others and to others). Risk assessments are undertaken using an agreed organisational/trust framework which is often semi-structured considering a range of risk and protective factors for that individual. Practitioners are expected to develop a formulation including risk formulation that brings together an understanding of mental health and/or neurodevelopmental needs and risks for that individual which will inform the care plan.

123. Assessment of risk should consider risk of harm to self, risk of harm from others, risk of harm to others and iatrogenic harm (i.e. harm inadvertently caused by the process of treatment). Practitioners may vary in their confidence in assessing different types of risk and understanding the contributory role of mental health or neurodevelopmental needs for individuals. In assessing risk, it is important to consider multi-informant sources of information (i.e. from parents, carers and other

agencies particularly schools/education services as well as the CYP) alongside the role of protective factors in developing a shared formulation. Key information regarding current and historic risk information should be readily visible to treating clinicians in a summarised form and where appropriate with suitable warning flags. Where information comes in from other agencies that is relevant to the risk of violence to others, there are robust systems to ensure the material is uploaded to or available on their own electronic patient records.

124. Where CYP present with significant risk to others, local FCAMHS should be involved to provide consultation, guidance to the network and where indicated, an assessment of the young person. FCAMHS involvement should provide a detailed formulation, contextualising risk with understanding of an individual's mental health and/or neurodivergent needs, experiences and wider social systems to inform development of the care plan and appropriate safeguards.

125. Local child protection and safeguarding policies should be followed to address concerns identified about the CYP or another person who may be at risk of harm.

126. To aid with the assessment and formulation, practitioners should consider vulnerabilities (including school and social exclusion) as well as protective factors, context and content of the digital material engaged with as well as the digital skills of the young person. Online content may be illegal and/or harmful and cover topics such as suicide/self-harm, hate and violence, sexual risks, gambling, eating and weight loss. Information should be incorporated into the care and safety plan for the CYP and reasonable measures taken to educate the CYP and their support network about relevant risks. Local child protection and safeguarding policies followed to address concerns identified about the CYP or another person who may be at risk of harm.

FCAMHS

127. Although FCAMHS does not usually provide direct interventions to the child or young person, its role in cases involving violence fixated behaviours is nevertheless an important part of the overall intervention. FCAMHS primarily supports frontline agencies by assisting with the assessment and formulation of risk, identifying underlying needs, advising on appropriate interventions, and supporting risk management planning. Risk management guidance may address both external controls and interventions aimed at reducing the underlying drivers of risk.

128. Through this role, FCAMHS can contribute to the planning and delivery of interventions for CYP exhibiting violence fixated behaviours, even where those interventions are implemented by other services. However, given the indirect nature of this role, no research has been conducted specifically in relation to FCAMHS interventions for individuals exhibiting violence fixated behaviours.

129. Where FCAMHS (or CAMHS) consider there to be need for further intervention, NHS England commissions Tier 4 Services, including:

    a. Specialist inpatient autism spectrum disorder services;

    b. Tier 4 CYPMHS Low Secure Inpatient Services; and

    c. Tier 4 CYPMHS Adolescent Medium Secure Services.

Mental Health Support Teams (MHSTs) in Schools and colleges

130. MHSTs in schools and colleges are designed to provide early mental health support to children and young people experiencing mild to moderate mental health difficulties. As of spring 2026, over 700 MHSTs were operational, covering approximately 60% of pupils and learners across around 11,800 schools and colleges. The Government has committed to full roll out of MHSTs by 2029 [**NB1/14**] **NHS000595**.

131. Supervised by NHS CYP mental health staff, MHSTs support children and young people from ages 5-18 through three core functions:

    a. delivering evidence based early interventions for children and young people experiencing common mental health difficulties;

    b. supporting schools and colleges to develop a whole-school or college approach to mental health and wellbeing; and

    c. acting as a link between education settings and wider health, safeguarding, and specialist services to help ensure children and young people access the right support at the right time.

132. While MHSTs are not specifically targeted at individuals exhibiting violence fixated behaviour, the preventative and early intervention function may contribute to identifying and responding to factors that can increase vulnerability or indicate emerging concerns. This may include supporting children and young people experiencing trauma, social isolation, emotional dysregulation, neurodevelopmental difficulties, behavioural concerns or other mental health needs.

133. Specific interventions provided by MHSTs include:

a. cognitive behavioural therapy in a school or college setting for adolescents at risk of depression and for young children and adolescents showing signs of anxiety;

b. family-based behaviour change, a behavioural or psychosocial intervention which can be successfully delivered by teachers and other non-clinical staff to help reduce child conduct problems; and

c. group-based intervention that encourages participants to critically evaluate and challenge the 'thin ideal', which can be effective in reducing eating disorder symptoms and body image concerns.

134. MHSTs work closely with other services such as local authority troubled families teams, social services and community sector organisations. Where concerns arise, MHSTs can help schools and colleges identify issues early, support appropriate escalation pathways and facilitate access to specialist services where further assessment or intervention is required.

135. Evidence from evaluations of MHSTs so far has demonstrated positive impacts on access to support, early intervention, partnership working and strengthening links between education and mental health services. As the programme continues to expand, MHSTs provide an important platform for promoting wellbeing, identifying emerging needs earlier and supporting children and young people before difficulties escalate. A full evaluation is expected in Spring 2027.

Young Futures Hubs

136. Young Futures Hubs were first announced in July 2025 as part of the Government's ambition to provide community-focused services for young people at risk of violence and experiencing mental health challenges. The Hubs are intended to bring a range of support services together under one roof, including providing activities, volunteering opportunities, mental health support, and employment support, with the overarching principle that there is 'no wrong door' for CYP seeking help. There are eight early adopter sites of this model, including a North West site in Manchester. On 15 July 2026, the Prime Minister set out plans to open 50 hubs over the next four years. **[NB1/15]** **NHS000596**

Expansion of existing frameworks

137. Because the referral criteria to FCAMHS are deliberately broad, over time, this has meant an increasing demand and referral rates which in turn lead to longer wait times.

138. Case escalation and management processes for individuals exhibiting violence fixated behaviours could be improved through the use of existing frameworks. This includes Prevention Partnership Panels, introduced in 2025, which are multi-agency initiatives designed to identify and support children and young people at risk of involvement in crime or anti-social behaviour, aiming to prevent escalation into serious violence. The panels include input from violence reduction units.

139. A challenge of intervention frameworks which operate on an individual level, such as Prevent, is that they are largely dependent on the individual's consent and engagement once they attain adulthood. Unlike safeguarding interventions under the Children Act, which provide statutory mechanisms for protecting children, equivalent welfare-based powers are generally not available in relation to adults.

Vanguards and the Framework for Integrated Care (Community)

140. The Framework for Integrated Care (Community) (**"the Framework"**) was originally developed to improve health and wellbeing outcomes and a reduction of health inequalities amongst a small but complex cohort of children and young people whose needs are difficult to meet within statutory services [**NB1/16**] **NHS000579**].

141. The Framework builds on evidence from NHS England's Health & Justice Children and Young People Mental Health Transformation workstream, which was part of the £1.4bn investment into mental health, social care and education delivered through Future in Mind. A further £7 million was later secured specifically towards the Framework (also known as the "Vanguard Programme", which was then known as the High Risk, High Harm programme) [**NB1/17**] **NHS000578**].

142. The Framework is the translation of the original Framework for Integrated Care (SECURE STAIRS) which was deployed in the children and young people secure estate. The Framework is delivered across a proportion of England through areas known as "vanguards" – which operate across integrated care systems / provider collaborative footprints. There is £13 million available to fund the Vanguard sites

which cover 26% of England, divided by c. £1.5 million per integrated care system or provider collaborative. The funding split varies differently depending on the population size in the area where the vanguard is situated. These sites are pilots and there is not currently funding for a full national rollout [**NB1/18**] **NHS000580** [**NB1/19**] **NHS000593**. A summary of the pilot programmes is available here [**NB1/20**] **NHS000586** Good practice is regularly shared by NHS England's Health and Justice team at national conferences [**NB1/21**] **NHS000594**.

143. The ways in which each area deploy the principles of the Framework varies, depending on the specific needs of their local cohort. Evaluation Reports and Annual Review Reports for a selection of the Vanguards in England are exhibited to this statement: [**NB1/22**] **NHS000582** (Lincolnshire), [**NB1/23**] **NHS000585** (Humber & North Yorkshire) [**NB1/24**] **NHS000587** (South East), [**NB1/25**] **NHS000589** (East of England), [**NB1/26**] **NHS000590** (London), Bristol, North Somerset & South Gloucestershire [**NB1/27**] **NHS000584** Gateshead [**NB1/28**] **NHS000581** and Sefton and Mersey [**NB1/29**] **NHS000597**.

144. The Framework aims to improve safeguarding, safety and outcomes by focusing not only on children and young people, but also on the cultures, systems and adult behaviours shaping their daily experiences. Traditional diagnosis or behaviour-led interventions, delivered in isolation, risk fragmenting care and reinforcing crisis-driven practice. The Framework shifts the focus from “what is wrong with the child?” to a shared understanding of “what has happened” – for the child, the adults around them, and the system itself. The Framework therefore emphasises trauma-responsive cultures, where systems may contain, reflect and respond thoughtfully, rather than reactively.

145. The Framework is not a prescribed model, instead it is a framework for practice, culture and organisational change, aligning health, custody, education, care and community partners around a shared, psychologically informed understanding (known by clinicians as "formulation"). The focus is twofold: creating stable, relational and developmentally attuned environments where everyday interactions are the primary intervention and aligning agencies to prioritise and sequence interventions by developmental need, readiness and context rather than behavioural labels or diagnosis alone. Multi-agency, co-produced formulations (“My Story”) are central, integrating perspectives into a shared narrative of the child’s experience and enabling more consistent responses across the system. These psychologically

informed formulations consider both the child's experiences and the system's responses, including where change is needed.

Training

146. 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 where such presentations are most likely to be encountered, including FCAMHS.

147. Effective practice does, however, require more than the delivery of training alone. It is essential that practitioners are able to identify and escalate any gaps in knowledge or capability and have access to regular supervision from more senior colleagues, including safeguarding leads, to support assessment, formulation and safety planning. Access to consultation from specialist services and practitioners can also facilitate shared multi-agency formulation, care coordination and risk management.

148. NHS England does not monitor the effectiveness of training in relation to managing VFIs. This reflects NHS England's current approach of focusing on violence fixated behaviours rather than VFIs as a distinct cohort and, accordingly, the absence of data collection arrangements for such individuals as a separate group.

149. Whilst this section describes current training provision, 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 would support the early identification of violence fixated behaviours and facilitate timely intervention before concerns escalate to the point that Health and Justice involvement becomes necessary. Such training should be informed by an understanding of psychosocial child development, together with the factors that promote risk and resilience.

NHS Prevent Training and Competencies Framework

150. As part of the NHS Prevent Training and Competencies Framework, all staff working in health and social care settings across the UK must complete training on preventing radicalisation. While that is unlikely to capture all individuals exhibiting violence fixated behaviour, we consider that this may provide a model for identifying and addressing violence fixated behaviour to allow early intervention.

FCAMHS

151. FCAMHS training is designed to develop practitioners' skills in assessing and formulating appropriate interventions for the patient groups typically seen in FCAMHS. As there is currently no dedicated pathway or research-backed intervention which specifically addresses individuals exhibiting violence fixated behaviours, there is no corresponding national training programme focused solely on this area.

152. However, the FCAMHS network delivers a programme of online and face-to-face training covering violence fixated behaviours, the formulation and assessment of complex cases and threats, the role of online influences, and approaches to risk assessment. The training also includes the use of the FARAH [1] and FARAS [2] frameworks, risk assessment approaches, and considers developmental factors that may influence, contextualise or contribute to the presentation of risk-related behaviours.

153. Since May 2024, clinicians working in FCAMHS have received training from a range of specialist practitioners and organisations on:

    a. Autism

    b. Developments in extremist use of social media

    c. Online extremism

    d. Harmful sexual behaviour

    e. Assessment of Risk for Extremist Violence

    f. Young people who present with fixated ideations and ideologies

    g. Assessing and formulating complex risk cases

    h. Radicalisation Masterclass

    i. Developments in counter terrorism

Framework for Integrated Care (Community) Vanguards training

[1] Framework for the Assessment of Risk and Protection in Offenders with Attention Deficit Hyperactivity Disorder.
[2] Framework for the Assessment of Risk and Protection in Offenders on the Autistic Spectrum

154. As part of the Framework for Integrated Care (Community) Vanguard programme, training has been delivered across a range of agencies within participating systems, including schools, the police, the fire and rescue service, social care and health services. The training has focused on improving understanding of trauma and attachment in children and young people.

155. By way of general observation (rather than specifically in relation to VFIs), experience from the Vanguard programme has highlighted the importance of consultation, supervision and reflective practice both during and following training. Many Vanguards have established multi-agency communities of practice to support ongoing learning and the sharing of effective approaches. Experience suggests that training is unlikely to be effective if delivered as a one-off (or "tick box") exercise. Developing a trauma-informed understanding of a child's behaviour and circumstances requires ongoing dialogue, reflection and support. Accordingly, where training is recommended, it should be complemented by appropriate arrangements for consultation, supervision and reflective practice.

SECTION 7: IMPROVEMENTS

156. It has been well documented and previously discussed that the response required for children who may (and may not) fit into these definitions requires a multiagency approach and not a single diagnosis or label-led pathway. The Framework for Integrated Care (Community) Vanguards 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. Evidence from the Vanguards shows that understanding behaviour in context, strengthening daily relationships and providing integrated wraparound support can improve outcomes for children, families and practitioners, particularly where needs are complex and entrenched.

157. NHS England considers that the key to addressing violence-fixated behaviours is the establishment of a robust multi-agency framework that balances flexibility with accountability. 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. Rather than requiring a single agency to take responsibility by default, the lead agency should be determined according to the individual's presentation and needs, reflecting the fact that some individuals may have mental health or neurodevelopmental needs whilst others may not.

158. 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.

159. 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 1 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.

160. 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. 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.

161. NHS England reiterates its commitment to supporting the Inquiry, and will strive to examine its own responsibilities and actions to ensure that learning from the dreadful events of 29 July 2024 and from this Inquiry is used to improve services and to reduce the risk of future failings.

Statement of Truth

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

Signed: **SIGNATURE**

Name Dr Nick Broughton

Date 31 July 2026

ANNEX 1 – THE NHS IN ENGLAND

1. The first corporate witness statement of Dr Michael Gregory was prepared in response to the Inquiry's Rule 9 Request for Phase 1. It addressed mental health, learning disability and autism commissioning arrangements, together with the relevant objectives for children and young people.

2. Some of the key sections of the witness statement of Dr Gregory that describe the responsibilities of NHS England in connection with services and policies falling within the scope of Phase 2 of the Inquiry have been replicated in the section below, for ease of reference.

3. As the Inquiry is aware, the NHS in England is not one organisation. It is an ecosystem of commissioners, regulators and service providers, each with their own distinct role. The publicly funded health service (excluding public health) in England comprises primary care, secondary care, tertiary care, mental health and community health.

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

5. Statutory ALBs (such as NHS England) do not set strategic national health and/or public health policy but have a key role in implementing and advising on it. The Government, via DHSC, will seek input from NHS England on how to improve existing policies or address new challenges.

6. The Inquiry will be aware that the Health Bill 2026, as currently drafted, will abolish NHS England and transfer a number of its functions into DHSC or the wider system.

NHS England's responsibilities for services and policies within the scope of Phase 2 of the Inquiry

7. The majority of NHS services are commissioned locally by Integrated Care Boards ("**ICBs**"). In such instances, ICBs are the responsible commissioner and NHS England's role is centred around oversight, and setting national policy, which is then implemented by local commissioners and providers.

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

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

Learning Disability support, neurodevelopmental services and autism services

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

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

CYP mental health services

12. CYP mental health services ("**CYPMHS**") are commissioned by a number of different commissioning bodies, depending on the nature of the service. NHS England has a statutory role to arrange a number of mental health services and, through its Mental Health team (each of NHS England's regional teams has a mental health lead) supports the commissioning of NHS community services, via ICBs, providing guidance, support and direction as appropriate. Though CYPMHS is now the preferred term, the services are often referred to by their previous name and acronym – child and adolescent mental health services ("**CAMHS**").

13. Commissioning responsibilities are set out in the National Health Service Act 2006 ("**2006 Act**") and in regulations made by the SSHSC under the 2006 Act, namely the

National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (the "**Standing Rules**").

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

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

    a. medium secure in-patient services;

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

    c. mental health services for deaf children and adolescents.

16. Traditionally CYPMHS has been described by way of "tiers", with tier 4 being in-patient services, and tiers 1-3 community-based services. Terminology is now focussed on whether the service is "in-patient" or "community" to focus the needs of the young person themselves and the whole care pathway, rather specification-driven categories.

17. We set out below an overview of arrangements for tier 4 CYMPHS. NHS England learned during Phase 1 that in December 2019 – March 2020, AR came into contact with two of its commissioned services – FCAMHS and the Criminal Justice Liaison and Diversion Service.

18. As the commissioner of those services, NHS England does not maintain access to individual patient records, and it was not involved in the decisions made by those services in relation to AR. NHS England's functions in this regard is to make commissioning arrangement for the delivery of health, it does not directly provide health services.

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

    a. Specialist inpatient autism spectrum disorder services;

    b. Tier 4 CYPMHS;

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

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

e. Tier 4 CYPMHS Adolescent Medium Secure; and

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

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

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

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

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

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

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

FCAMHS

23. Forensic Children and Adolescent Mental Health Services ("**FCAMHS**") is a tier 4 service commissioned 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 who meet the following criteria:

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 to 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.

24. 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.

25. The agencies which can refer a CYP to FCAMHS include:

    a. health and social care agencies (the majority of referrals are made from CYPMHS),

    b. education (schools, pupil referral units etc),

    c. police and the youth justice system,

    d. prevent programme,

    e. social workers; and

    f. the CYP themselves, a parent or carer.

26. 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.

27. 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.

28. Although the referring agency 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.

29. We have previously disclosed the service specifications for FCAMHS as applicable in 2019 (the 2017 Service Specification) and as applicable in 2024 (the 2024 Service Specification) which providers fuller detail of the service model.

Criminal Justice Liaison & Diversion

30. Liaison and Diversion ("**L&D**") 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. L&D services are commissioned by NHS England.

31. L&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.

Safeguarding

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

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

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

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

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

35. In discharging their duties under Section 11, the bodies must have regard to guidance given by the Secretary of State for Education, namely the Working Together Guidance. Chapter 4 of the current version of the Working Together Guidance, published in December 2023, describes the role of different bodies as relevant to safeguarding.

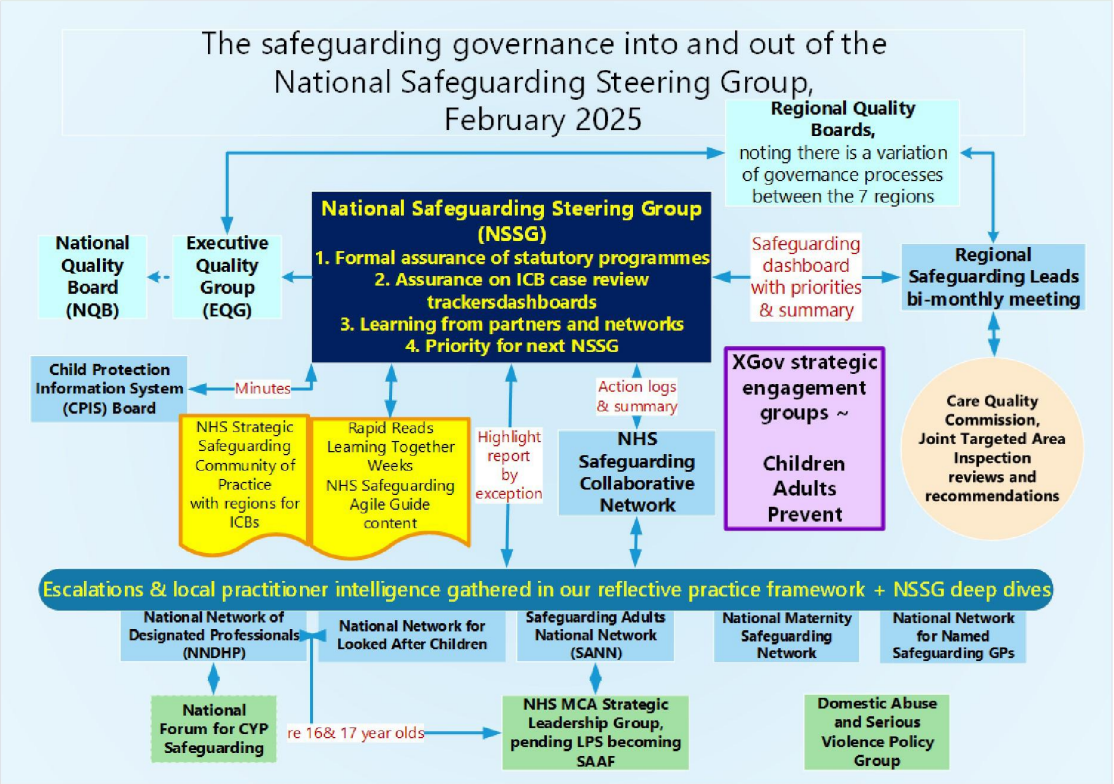
36. Local arrangements are also required under Section 16E of the Children Act 2004, and local authorities, the police and ICBs (CCGs prior to 1 July 2022) establish Multi Agency Safeguarding Arrangements for their local child population, together with other relevant agencies as they deem appropriate.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

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

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

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

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



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

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

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

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

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

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

c. the national Safeguarding Accountability and Assurance Framework ([**NB1/30**][**NHS000100**]), which sets out the safeguarding roles and responsibilities of all individuals and organisations related to their statutory requirements and appropriate accountabilities for the safeguarding of children, young people and adults at risk of harm or abuse. Overall, it is intended to provide the minimum standards that all those working in NHS funded care settings should work to, but it is not intended to constrain the development of other effective local safeguarding practice and arrangements (e.g., those developed by local safeguarding partners).

ANNEX 3 – INDEX OF EXHIBITS

Exhibit Reference	Unique Reference Number	Description
NB1/01	**NHS000576**	Royal College of Psychiatrists – Report on Assessing and Managing Risk to Others (2016)
NB1/02	**NHS000599**	Mental Health Personalised Care Framework, NHS England, 17 July 2026
NB1/03	**NHS000600**	Annex A to the Mental Health Personalised Care Framework
NB1/04	**NHS000601**	Annex B to the Mental Health Personalised Care Framework
NB1/05	**NHS000588**	NHS England's Closing Statement – Phase 1 Southport Inquiry
NB1/06	GMMH000011	FCAMHS Service Specification 2024
NB1/07	NHS000087	Operational Guidance to Deliver Improved Outcomes in all-age assessment pathways – Guidance for Integrated Care Boards, NHS England, updated 22 July 2026
NB1/08	**NHS000575**	Mental Health Crisis Care Concordat, 18 February 2014
NB1/09	**NHS000577**	Concordat on Children in Custody, updated 16 January 2020
NB1/10	**DHSC000090**	Briefing Note to Special Advisors on Violence Fixated Individuals, Mental Health, Autism and ADHD (undated)
NB1/11	**NHS000592**	Working Together to Safeguard Children, updated 18 March 2026
NB1/12	**NHS000598**	Care and Support Statutory Guidance, updated 22 July 2025
NB1/13	**NHS000583**	10 Year Health Plan
NB1/14	**NHS000595**	Youth Matters: Your National Youth Strategy, 10 December 2025

NB1/15	**NHS000596**	Guidance on Young Future Hubs, updated 8 April 2026
NB1/16	**NHS000579**	Framework for Integrated Care (Community) v3.3
NB1/17	**NHS000578**	Bid for Expansion and Acceleration of the Framework for Integrated Care for the Community and Children & Young People Secure Estate for children requiring the Complex Needs Pathway (undated)
NB1/18	**NHS000580**	Framework for Integrated Care (Community) – Supporting evidence for continued roll out across all ICBs in England (2023)
NB1/19	**NHS000593**	NHS England Health and Justice, Project Management Tracker (including Vanguards)
NB1/20	**NHS000586**	Summary of Vanguard Sites
NB1/21	**NHS000594**	Presentation by the Head of Health & Justice Children's Programme on the Framework for Integrated Care (Community)
NB1/22	**NHS000582**	Vanguard Evaluation Report – Lincolnshire
NB1/23	**NHS000585**	Vanguard Evaluation Report – Humber and North Yorkshire
NB1/24	**NHS000587**	Vanguard Evaluation Report – South East
NB1/25	**NHS000589**	Vanguard Evaluation Report – East of England
NB1/26	**NHS000590**	Vanguard Evaluation Report – London
NB1/27	**NHS000584**	Vanguard Evaluation Report – Bristol, North Somerset & South Gloucestershire
NB1/28	**NHS000581**	Vanguard Evaluation Report – Gateshead

NB1/29	**NHS000597**	Vanguard Evaluation Report – Sefton and Mersey
NB1/30	NHS000100	National Safeguarding Accountability and Assurance Framework