Witness Name: Jacqueline Totterdell

Exhibits: JT/01-JT/22

Dated: 14 August 2026

THE SOUTHPORT INQUIRY

WITNESS STATEMENT OF JACQUELINE TOTTERDELL

I, Jacqueline Totterdell, will say as follows: -

Introductory matters

1. I currently hold the position of the Director General of the Health, Care and Prevention Group within the Welsh Government and the Chief Executive of NHS Wales. In this role, I lead the Welsh Government's group responsible for health and social care policy, while also providing strategic leadership to the NHS in Wales.

2. I joined the Welsh Government and the NHS in Wales in 2025. Prior to joining the Welsh Government, I served as Group Chief Executive Officer of St George's, Epsom and St Helier University Hospitals and Health Group, one of the largest provider groups in England. During a career spanning more than four decades in the NHS, I have held a number of senior leadership positions, including Chief Executive of Southend University Hospital NHS Foundation Trust, Chief Executive of West Middlesex University Hospital NHS Trust, Chief Operating Officer at Barts Health NHS Trust, and Chief Operating Officer/Deputy Chief Executive at The Hillingdon Hospital NHS Trust. I have also held national and regional service improvement and performance management roles.

3. My professional background is rooted in healthcare leadership, operational improvement and large-scale service transformation. I hold a Master of Business Administration (MBA) from Durham University and a BSc (Hons) in Health Care Studies from the University of Huddersfield.

4. This witness statement is made to assist Phase 2 of Southport Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 7 July 2026.

Violence Fixated Individuals

5. The Phase 2 Terms of Reference for the Southport Inquiry define 'Violence Fixated Individual' ('VFI') as "individuals at risk of extreme violence, where ideology is not the primary driver" and seek to examine the adequacy of existing arrangements for identifying,

assessing and managing risks posed by such individuals, including the interaction between safeguarding systems, mental health services, social care, education, policing and other public protection agencies. The Inquiry also seeks to consider the role of online content and online environments in influencing and enabling violent behaviour.

6. Although the term "Violence Fixated Individual" does not currently have a defined status within Welsh legislation, Welsh NHS policy, or Welsh safeguarding frameworks, NHS organisations in Wales routinely provide services to individuals who may present with behaviours, needs or vulnerabilities that are potentially relevant to the Inquiry's consideration of VFIs. In addition to adults these may include children and young people exhibiting serious behavioural disturbance, violent ideation, aggression, complex trauma, neurodevelopmental difficulties, emerging personality difficulties, acute mental illness, or other factors associated with an increased risk of harm to themselves or others. Services may also encounter children and young people who have been adversely affected by harmful online content or whose mental health and wellbeing have been influenced by online environments.

7. As there is no developed or adopted a specific VFI framework, risk assessment process, policy or statutory guidance in Wales, this statement should therefore be read as observations based on existing adult and child safeguarding, health, social care and multi-agency arrangements in Wales rather than descriptions of a dedicated VFI system.

8. It is also important to note from the outset that matters potentially arising from Phase 2 of the Southport Inquiry relating to public order, policing, offensive weapons and violence prevention largely fall outside the legislative competence of the Senedd (Welsh Parliament) because they are reserved to the UK Parliament under the Government of Wales Act 2006. Wales operates a reserved powers model under section 108A and Schedule 7A of the Act, which reserves matters including the prevention and detection of crime, the maintenance of public order, policing, firearms, and knives (including knife blades, razor blades, axes and swords). As a result, the Senedd cannot legislate in these areas or establish a distinct legal framework governing these areas. Accordingly, while there are areas relating to prevention and detection of VFIs in which the NHS in Wales has duties and responsibilities these may sit in the reserved legislative framework.

9. Before I address the arrangements in Wales relevant to the identification of VFIs, it is important to set out the context of the organisational structure for the Welsh Government's Health Care and Prevention Group and that of the NHS in Wales, both of which fall within my responsibility and work closely together in the delivery of health services in Wales.

Welsh Government's Health Care and Prevention Group

10. Healthcare has been a devolved function since 1999, and the Welsh Ministers (served by the Welsh Government's Health Care and Prevention Group) are responsible under the NHS (Wales) Act 2006 for the promotion and provision of a comprehensive health service in Wales in accordance with the Act. The Welsh Ministers have a broad range of functions in relation to the NHS in Wales, this includes the power to direct local health boards, trusts and special health authorities ("NHS bodies") to exercise their respective functions in relation to the health service in Wales.

11. The Welsh Government, through the Cabinet Minister for Health and Care, is responsible for setting policy and standards to promote high quality, safe services based on population health need.

12. The Welsh Government (including the Welsh Ministers) are not responsible for operational decision making within the NHS in Wales. Operational decisions are made by the NHS bodies described above. Under the NHS (Wales) Act 2006 the Welsh Ministers give directions and make regulations with respect to the exercise by those NHS bodies of their functions. In addition to statutory instruments and directions, Welsh Ministers may issue guidance and instructions on a wide range of issues in the form of Welsh Health Circulars (previously referred to as Ministerial Letters).

13. NHS bodies have a legal duty to comply with any direction issued by the Welsh Ministers. Certain directions may be given by regulations or an instrument in writing[1]. It follows that a Welsh Health Circular containing instructions for compliance as to the exercise of health functions by the NHS in Wales (i.e. by way of direction) has the same legal standing as if the direction were made by regulations and should be treated as mandatory.

14. The Welsh Government's Health Care and Prevention Group may also issue information by way of Welsh Health Circular or other guidance to NHS bodies to support a key policy requirement or provide good practice guidance on a particular aspect of business. Such information or guidance (if not issued by way of direction) is non-mandatory but is expected to be followed unless there is a good reason. Furthermore, all chief executive officers of NHS bodies are issued an Accountable Officer letter on their appointment setting out their

[1] S.204(3)(c) of the 2006 Act specifies that certain directions (e.g. under s.12(1)(b) (exercise of functions by Health Boards), s.13 (transfer of exercise of functions or joint exercise) or s.19 (exercise of functions by NHS Trusts), may be given by regulations or an instrument in writing.

specific responsibilities as accountable officers for their organisations and their accountability to myself as Chief Executive of NHS Wales on those issues.

15. The Health Care and Prevention Group also includes the Social Services and Integration Directorate reflecting that in Wales we have an integrated health and social care system which the Cabinet Minister for Health and Social Care, supported by the Health Care and Prevention Group, oversees. The Social Services and Integration Directorate has primary responsibility for safeguarding policy in Wales but work closely with other health directorates in the Health Care and Prevention Group and as well as policy areas across the Welsh Government. The nature of the Welsh Government's oversight of social care is however fundamentally different to the healthcare system. In respect of health the Welsh Ministers are responsible for both the policy and ensuring the delivery of services by NHS bodies. In respect of social services and social care the Welsh Ministers are responsible for policy but not the delivery of services, which is a local authority responsibility. Further information regarding safeguarding policy in Wales and its relevance to VFIs is outlined below.

Director General, Health and Social Services and the Chief Executive of the NHS in Wales

16. The Director General of the Health Care and Prevention Group holds a combined role as Director General and a role referred to as the "Chief Executive NHS Wales".

17. While the role of Chief Executive NHS Wales is not a statutory role it is a significant and distinctive post located in the Welsh Government, bringing together the responsibilities of a Director General in the Welsh Government with the leadership and oversight of the NHS in Wales.

18. The Chief Executive NHS Wales role involves the leadership and oversight of appropriate planning, delivery and assurance across the NHS in Wales, working with all NHS organisations. The Chief Executive NHS Wales provides leadership and support to the seven Chief Executives of the Health Boards, the three NHS Trust Chief Executives, two Welsh Special Health Authority Chief Executives. The role acts as the health system leader for the NHS in Wales, overseeing those organisations responsible for more than 100,000 staff delivering NHS care and services across Wales.

19. The Chief Executive NHS Wales is accountable to the Cabinet Minister for Health and Care for the oversight and performance of the NHS in Wales, and responsible for providing policy advice and exercising strategic leadership and management of the NHS in Wales. As such, the role aligns closely with that of the Director General of the Health Care and Prevention

Group, as the senior civil servant in the Welsh Government's responsible for policy delivery in that area.

20. In this role I am supported by the Chief Medical Officer, two Deputy Chief Medical Officers, Chief Nursing Officer, Chief Pharmaceutical Officer, Chief Midwifery Officer, Chief Scientific Adviser for Health, Chief Allied Health Professional Officer, Chief Optometric Officer and Chief Dental Officer. All of these are members of the Health Care and Prevention Group and also provide professional leadership for the NHS in Wales.

21. Another benefit of the combined roles of the Chief Executive NHS Wales and Director General for the Health Care and Prevention Group is that it helps to enable integration of health and care in Wales. I am assisted in that aspect of my role by the Chief Social Care Officer for Wales who is the Welsh Government's senior professional adviser on social care and social work and also has responsibility for Welsh Government social care policy. The Chief Social Care Officer provides national leadership for the development and improvement of social care services across Wales and seeks to improve outcomes for children, adults and families by supporting preventative approaches and safeguarding vulnerable individuals. This includes fostering integration and collaboration across health, social care, local government, and the voluntary sector. Further information on the importance of social care and safeguarding arrangements is outlined below.

Areas within the Health Care and Prevention Group linked to work on VFIs

22. The Health Care and Prevention Group's role is to focus on supporting the Welsh Government to deliver its priorities, whilst also providing leadership to the NHS and local authority social services in Wales to ensure they can deliver the required changes in services and culture. These changes are set out in "A Healthier Wales", our plan for the future of health and social care, published in June 2018. A copy of this is exhibited as **JT/01-NHSW000024**

23. The group has the following overarching responsibilities:

    a. promoting, protecting and improving the health and well-being of everyone in Wales, and leading efforts to reduce inequalities in health;

    b. making available a comprehensive, safe, effective and sustainable National Health Service;

    c. ensuring that high quality social services are available and increasingly joined up with health care and other services; and

d. ensuring that through Cafcass Cymru, children are put first in family proceedings, their voices are heard and decisions made about them by courts are in their best interests.

24. An organogram of the structure of the group is exhibited as **JT/02-NHSW000033** Within the group the following policy areas relevant to the wider discussion on the identification of VFIs:

a. The Social Services and Integration Directorate, which is led by Albert Heaney, the Chief Social Care Officer. This directorate has responsibility for the policy in relation to the safeguarding children and young people;
b. The Primary Care, Mental Health and Early Years Directorate which is led by Alex Slade. This has responsibility for child and adolescent mental health services and mental health services in secure settings for children and young people; and
c. The Nursing, Experience and Safety Directorate, led by Sue Tranka, Chief Nursing Officer for Wales, provides professional leadership for nursing and midwifery, safety, NHS safeguarding and the health and wellbeing of children and young people, and women's health across the NHS in Wales. The Directorate works closely with the Primary Care and Mental Health Directorate, which holds primary responsibility for children's and young people's mental health policy and child and adolescence mental health services (CAMHS);
d. The NHS Delivery and Performance Directorate led by Nick Wood, Deputy Chief Executive NHS Wales. This directorate deals with NHS services in Wales including operational and strategic planning and responsibility for policy in relation to urgent and emergency care for children and young people.

25. In preparing this statement I have been supported by these Directorates. As noted above, through my dual role the Health Care and Prevention Group works closes with the NHS in Wales on all these areas. Before I explain the relationship the Health Care and Prevention group has with the NHS in Wales, I have outlined the structure of the NHS in Wales below.

The NHS in Wales

26. The organisational and governmental structure of the NHS in Wales is primarily set out in the NHS (Wales) Act 2006. The full legislative history of the devolution of health in Wales is outside the scope of this Inquiry and statement but the governance and structures of the NHS in Wales may be traced back to the National Health Service Act 1977. The NHS (Wales) Act 2006consolidated, in relation to Wales, the provisions of the National Health Service Act 1977 and associated legislation in order to set out in one statute the distinct structure of the Welsh NHS. In England, the National Health Service Act 2006 provides the

legislative structure for the NHS in England. There are many differences between the structures and governance of the NHS in England and Wales, especially with regards to the health service bodies in operation in Wales. For example, there are three principal kinds of NHS bodies under the NHS (Wales) Act 2006: local health boards, NHS trusts and special health authorities (collectively "the NHS bodies"). In England however there are also NHS Foundation Trusts and Integrated Care Boards among other bodies such as Public Health England and NHS England. I have set out below detail of how the three principal kinds of NHS bodies in Wales are organised and operate to deliver healthcare services in Wales.

Local Health Boards in Wales

27. In Wales healthcare services are primarily delivered by local health boards who are responsible for planning, securing and delivering all healthcare services for the benefit of their resident population in a specific geographical area. This includes primary, secondary, community, acute, mental health and specialised services.

28. There are currently seven local health boards in Wales[2]:

    a) Aneurin Bevan University Local Health Board (covering Newport, Torfaen, Monmouthshire, Caerphilly and Blaenau Gwent local authorities)

    b) Betsi Cadwaladr University Local Health Board (covering Flintshire, Denbighshire, Gwynedd, Wrexham, Conwy and Anglesey local authorities)

    c) Cardiff and Vale University Local Health Board (covering Cardiff and Vale of Glamorgan local authorities)

    d) Cwm Taf Morgannwg University Local Health Board (covering Bridgend, Merthyr Tydfil and Rhondda Cynon Taf local authorities)

    e) Hywel Dda University Local Health Board (covering Carmarthenshire, Pembrokeshire and Ceredigion local authorities)

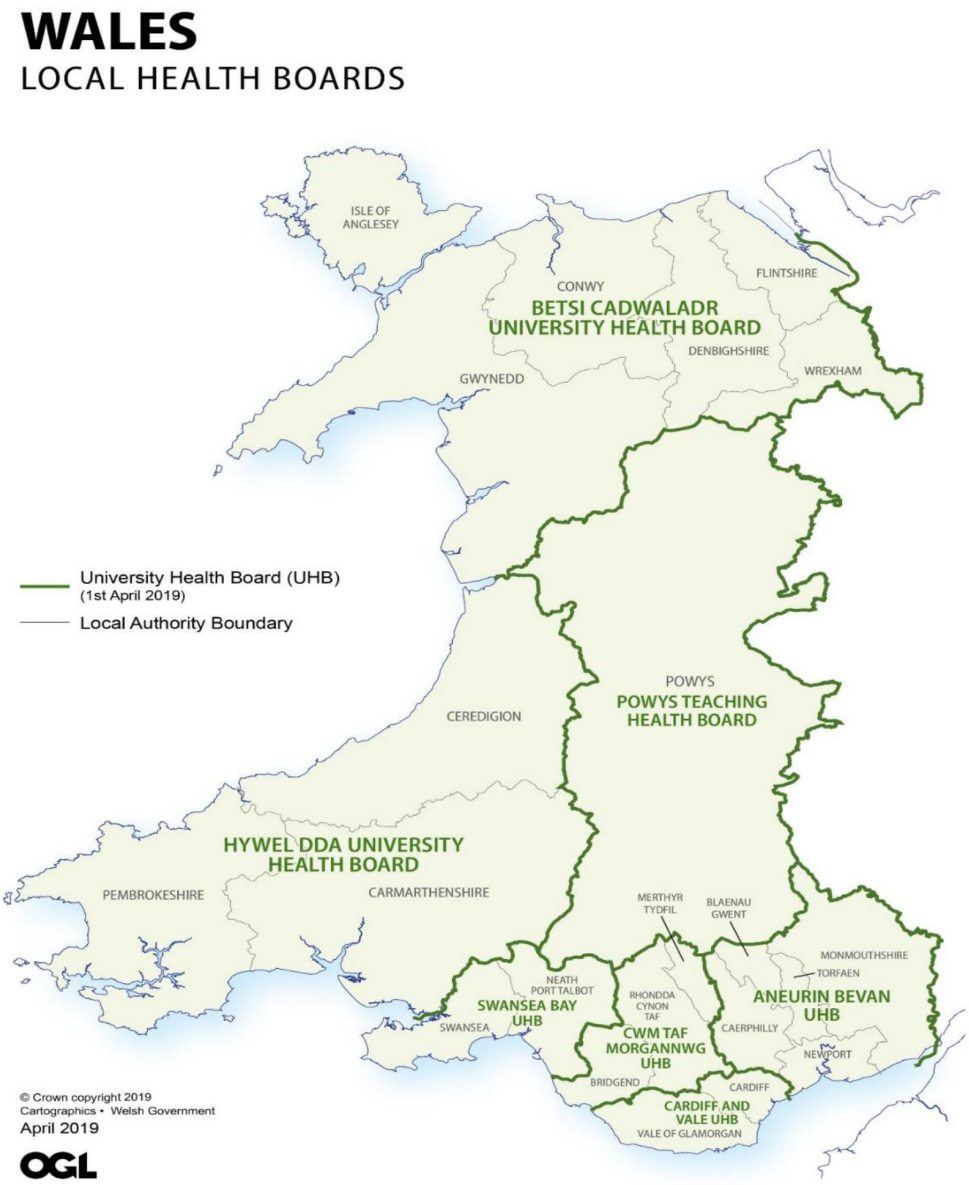
    f) Powys Teaching Local Health Board (covering Powys) (operating as Powys Teaching Health Board)

    g) Swansea Bay University Local Health Board (covering Neath Port Talbot and Swansea local authorities)

[2] The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009, No. 778 (W.66)

29. A map illustrating the geographical areas of each Local Health Board in Wales is set out below:

Figure 1: Map illustrating the geographical areas of each Local Health Board in Wales



30. The principal functions of local health boards are set out in the Local Health Boards (Directed Functions) (Wales) Regulations 2009 (S.I. 2009/1511), which are regulations made by the Welsh Ministers in exercise of their powers under section 12 of the NHS (Wales) Act 2006.

31. The Welsh Ministers delegate to local health boards functions under the NHS (Wales) Act 2006as well as under six other statutes[3]. These functions include the Welsh Ministers' general duty under section 1 of the NHS (Wales) Act 2006to continue to promote and provide comprehensive health service in Wales. The powers exercised by local health boards pursuant to such delegation (subject to certain exceptions) are in respect of those persons usually resident in the area for which the local health boards is established. In addition to those functions delegated by the Welsh Ministers, parts 4 to 7 of the NHS (Wales) Act 2006impose specific duties on local health boards in relation to the provision of medical, pharmacy, ophthalmology dental services.

32. The Regulations made in 2009 were made as part of a wider reorganisation of the NHS in Wales. Prior to the changes, which came into force on 1 October 2009, there were 22 local health boards in Wales, and the role of the local health boards in Wales was effectively limited to the commissioning of health services, while the Welsh NHS Trusts had the function of providing 'front-line' medical services in Wales. However, the 2009 changes introduced an integrated healthcare system in Wales, under which local health boards were made responsible for planning, securing and delivering all healthcare services for their resident population.

33. Local health boards are responsible for assessing the health needs of their populations and planning, commissioning and delivering integrated healthcare services across primary care, community health services, mental health services and hospital-based care within their geographical areas. Their remit includes responsibility for ensuring that services are coordinated around the needs of patients and delivered in partnership with other NHS bodies, local authorities, education services, social care providers, safeguarding partners and third-sector organisations.

34. In practice, local health boards are responsible for the delivery and integration of:

    a. Primary care services, including GP services, community pharmacy, dentistry and optometry;

    b. Community health services, including health visiting, school nursing, community paediatrics and community-based specialist services;

[3] See Schedule 1 of Local Health Boards (Directed Functions) (Wales) Regulations 2009/1511

c. Mental health services, including child and adolescent mental health services, crisis services, community mental health teams and specialist mental health provision; and

d. Secondary and tertiary care services, including acute hospital services, specialist inpatient care and access to specialised commissioned services. The seven health boards delegate the function of commissioning specialised services on a once for Wales basis to the NHS Wales Joint Commissioning Committee. This includes the commissioning of specialised services for mental health and vulnerable groups for children, young people and adults. Further information on the NHS Wales Joint Commissioning Committee is set out below.

35. Through these functions, local health boards play a central role in identifying vulnerable children and young people, assessing and responding to mental health and wellbeing needs, contributing to safeguarding arrangements, participating in multi-agency risk assessment and management processes, and ensuring continuity of care across different service settings.

36. The integrated nature of local health boards' responsibilities means they are often uniquely placed to bring together information and expertise from primary care, community services, mental health teams and hospital services in support of safeguarding, wellbeing and risk-management objectives. This is particularly relevant where children and young people present with complex needs requiring coordinated input from health, social care, education and other public services.

37. In the context of VFIs, which will be detailed further below, local health boards contribute through the identification, assessment and management of health, mental health and safeguarding concerns, whilst working alongside local authorities within established multi-agency arrangements. Their role is clinical, safeguarding and therapeutic in nature, rather than investigatory or law-enforcement focused.

NHS Trusts in Wales

38. As part of the reorganisation on 1 October 2009, seven Trusts which previously delivered hospital services were dissolved with the exception of the Welsh Ambulance Services NHS Trust and Velindre NHS Trust which continued in existence.

Public Health Wales

39. Public Health Wales NHS Trust was established on 1 October 2009 as a new unified Public Health organisation[4]. The functions of Public Health Wales are:

    a) Provide and manage public health, health protection, healthcare improvement, health advisory, child protection and microbiological laboratory services and services relating to the surveillance, prevention and control of communicable diseases;

    b) Develop and maintain arrangements for making information about matters related to the protection and improvement of health in Wales available to the public; to undertake and commission research into such matters and to contribute to the provision and development of training in such matters;

    c) Undertake the systematic collection, analysis and dissemination of information about the health of the people of Wales in particular including cancer incidence, mortality and survival; and prevalence of congenital anomalies; and

    d) Provide, manage, monitor, evaluate and conduct research into screening of health conditions and screening of health-related matters.

40. Public Health Wales plays a central role in violence prevention in Wales through its leadership of the public health approach to tackling violence and its partnership working across health, policing and criminal justice agencies. The National Safeguarding Service, which sits within Public Health Wales, provides national leadership, intelligence, learning and improvement support for safeguarding across the NHS in Wales. Its work supports the objectives of the Serious Violence Duty (detailed later in this statement) by strengthening multi-agency working, promoting a public health approach to prevention, sharing safeguarding intelligence and improving early identification of children and adults at risk of violence, exploitation and other forms of harm. The Serious Violence Duty Statutory Guidance as issued by the Home Office identifies Public Health Wales as a core partner within the Wales Violence Prevention Unit (VPU), a multi-agency collaboration that brings together policing, local government, health and third sector organisations to prevent violence through evidence-based, preventative interventions. A copy of this guidance is exhibited as **JT/03- NHSW000032** and notes that specific guidance is also included for authorities operating in Wales, which reflects the distinct Welsh legislative, policy and

[4] Public Health Wales National Health Service Trust (Establishment) Order 2009/2058

operational context. The guidance also highlights that Wales' distinctive approach to violence prevention is formalised through a Memorandum of Understanding between Public Health Wales, Policing in Wales and criminal justice partners. This agreement underpins collaborative working across devolved and non-devolved services and supports a trauma-informed, public health approach focused on prevention, reducing reoffending and addressing the root causes of violence. Further information on the Serious Violence Duty and the role of the Wales Violence Prevention Unit is provided later in this statement.

Welsh Ambulance Services

41. Welsh Ambulance Services NHS Trust was established pre-devolution on the 1 April 1998[5], with the management of NHS Direct Wales being transferred to Welsh Ambulance Services NHS Trust in April 2007. Welsh Ambulance Services NHS Trust, as the sole national provider of 999 Emergency Medical Services in Wales, provides the call handling, clinical assessment and advice functions of the NHS 111 Wales service; and provides a non-emergency patient transport service ("Non-Emergency Patient Transport Service").

42. As an NHS trust in Wales it has statutory duties relevant to the identification, assessment and management of VFIs, including the Serious Violence Duty and Prevent Duty outlined further below.

Velindre University NHS Trust

43. Velindre University NHS Trust was established on 1 April 1994[6] and at that time was a single speciality trust providing only cancer services. Over the years, the Trust has significantly evolved and expanded. The main function of Velindre University NHS Trust is to provide all-Wales and regional clinical health services to the NHS and the people of Wales. Velindre University NHS Trust consists of two clinical divisions: Velindre Cancer Centre and the Welsh Blood Service. The latter works with its UK counterparts both formally and informally to ensure the safety of the blood supply chain.

44. Velindre University NHS Trust also hosts NHS Wales Shared Services Partnership. Hosted organisations have their own Board or committee where more detailed discussions, review and approval of strategy and performance takes place. Velindre University NHS Trust is accountable for the statutory, legal and compliance framework. Further information about the NHS Wales Shared Services Partnership is provided below.

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[5] The Welsh Ambulance Services National Health Service Trust (Establishment) Order 1998. S.I. 1998/678
[6] Velindre National Health Service Trust (Establishment) Order 1993/2838 (as amended)

45. As an NHS trust in Wales it has statutory duties relevant to the identification, assessment and management of VFIs, including the Serious Violence Duty and Prevent Duty outlined further below.

Special Health Authorities in Wales

46. There are two Welsh Special Health Authorities: Health Education and Improvement Wales and Digital Health and Care Wales. There are also two joint special health authorities operating on an England and Wales basis: the NHS Business Services Authority and NHS Blood and Transplant.

47. NHS Business Services Authority and NHS Blood and Transplant are established jointly by the Secretary of State and the Welsh Ministers. As these are joint special health authorities the Welsh Ministers may direct the NHS Business Services Authority or NHS Blood and Transplant to exercise any of the functions of the Welsh Ministers relating to the health service in Wales which are specified directions made under the 2006 Act.

48. Special health authorities are not themselves a statutory safeguarding, Prevent or Serious Violence Duty partners. However, their roles are principally to enable local health boards and NHS Trust to fulfil their statutory duties and partnership responsibilities.

Health Education and Improvement Wales

49. Health Education and Improvement Wales was established in 2018[7] and its functions relate to the planning, commissioning and delivery of education and training for the Welsh health workforce. This was the first Welsh special health authority established by the Welsh Ministers.

50. The chair of Health Education and Improvement Wales is appointed by the Welsh Ministers as are up to 6 other members in addition to the chair. The chief executive is appointed by the non-officer members and the other officer members by the chief executive and non-officer members together.

51. Further information regarding the role of Health Education and Improvement Wales in relation to training of staff and practitioners in the NHS in Wales is set out later in this statement in the section headed 'Training'.

[7] Health Education and Improvement Wales (Establishment and Constitution) Order 2017/913

Digital Health and Care Wales

52. Digital Health and Care Wales was established in 2020[8] and became operational in 2021. Digital Health and Care Wales has such functions as the Welsh Ministers may direct in connection with the following areas:

    a) the provision, design, management, development and delivery of digital platforms, systems and services;

    b) the collection, analysis, use and dissemination of health service data;

    c) the provision of advice and guidance to the Welsh Ministers about improving digital platforms, systems and services;

    d) supporting bodies and persons identified in directions given by the Welsh Ministers to Digital Health and Care Wales in relation to matters relevant to digital platforms, systems and services;

    e) any other matter so as to secure the provision or promotion of services under the 2006 Act.

53. As the national provider of digital and data services for the NHS in Wales, Digital Health and Care Wales plays a key enabling role in supporting lawful, secure and effective multi-agency data sharing across safeguarding, Prevent and Serious Violence Duty partnerships, helping organisations access and share information necessary to assess risk, safeguard vulnerable individuals and prevent harm.

NHS Wales Shared Services Partnership

54. Velindre NHS Trust has the function of managing and providing shared services to the health service in Wales. The NHS Wales Shared Services Partnership is the operational name for the Shared Services Committee of Velindre NHS Trust. The NHS Wales Shared Services Partnership is a hosted organisation and is responsible for exercising Velindre NHS Trust's functions in relation to shared services, including the setting of policy and strategy and the management and provision of shared services to local health boards and NHS Trusts. The Committee has a Managing Director who is the designated Accountable Officer for Shared Services and through the Committee is accountable to the Welsh Ministers. The Committee produces its own Annual Governance statement.

[8] Digital Health and Care Wales (Establishment and Membership) Order 2020/1451

55. NHS Wales Shared Services Partnership functions include functions directed by the Welsh Ministers such as payroll services, procurement services, and legal services for NHS bodies in Wales. The NHS bodies have also collectively agreed to transfer services to NHS Wales Shared Services Partnership such as health courier services, laundry services, and student award schemes. The NHS Wales Shared Services Partnership delivers a wide range of high quality, professional, technical, and administrative services for and on behalf of the NHS in Wales also working with the wider public services, including the Welsh Government. This organisation is also sometimes referred to as "Shared Services".

NHS Wales Performance and Improvement

56. On 1 April 2023, the NHS Wales Executive was established, bringing together a number of pre-existing national NHS Wales functions, including the Delivery Unit, Finance Delivery Unit, Improvement Cymru and the Welsh Health Collaborative. On 1 June 2025, the organisation was renamed NHS Wales Performance and Improvement following recommendations made by the Ministerial Advisory Group on NHS performance and productivity in Wales. NHS Wales Performance and Improvement supports sustainable improvement in the quality, safety, performance and effectiveness of healthcare services across Wales and helps deliver improved outcomes for patients and communities.

57. NHS Wales Performance and Improvement is not a statutory decision-making body and the legislative framework governing organisations in the NHS in Wales remains unchanged. Welsh Ministers continue to set national priorities, objectives, targets and outcome measures for the NHS in Wales. NHS Wales Performance and Improvement supports the Welsh Government by providing performance oversight, assurance, improvement expertise and implementation support to NHS organisations in delivering those priorities and improving quality, safety, performance and patient outcomes. Responsibility for the commissioning and provision of healthcare services remains with local health boards, NHS trusts and other relevant NHS bodies. NHS Wales Performance and Improvement operates within the NHS in Wales and is accountable through arrangements established by the Welsh Government and the NHS in Wales leadership.

58. NHS Wales Performance and Improvement is hosted by Public Health Wales but operates as a national organisation with a distinct role in supporting performance improvement, delivery and assurance on behalf of the Welsh Government and the NHS in Wales.

The NHS Wales Joint Commissioning Committee

59. The NHS Wales Joint Commissioning Committee (NWJCC) is a joint committee of the seven local health boards in Wales and is hosted by Cwm Taf Morgannwg University Health Board. The committee is responsible for the planning, commissioning and securing of a range of services on an all-Wales basis on behalf of the local health boards, including specialised services and other nationally commissioned healthcare services. Its governance arrangements are set out in its Standing Orders, Standing Financial Instructions and other approved governance documents. The Committee has a designated Accountable Officer for Shared Services and through the Committee is accountable to the Welsh Ministers.

60. The NHS Wales Joint Commissioning Committee exercises functions on behalf of the seven local health boards in relation to the commissioning of services that are most effectively planned and secured at a national level. In undertaking this role, it supports consistent access to specialised and national services across Wales and works with health boards, NHS trusts and other stakeholders to plan and commission services in line with national priorities. The Committee commissions Tier 4 child and adolescent mental health services, providing specialised care for young people with complex mental health needs. This includes the Forensic Adolescent Consultation Service (FACS) for agencies concerned with the care and treatment of children and young people who, in the context of mental disorder(s) or significant adversity/trauma and related severe psychological difficulties, present a serious risk to others.

61. Local health boards remain responsible for meeting the healthcare needs of people resident within their respective areas. Although the NHS Wales Joint Commissioning Committee exercises commissioning functions on their behalf, accountability for the provision of healthcare services to local populations ultimately remains with the individual local health boards.

Relationship between Health Care and Prevention Group and the NHS in Wales

62. My experience since having taken up this role is that the combination of the NHS Wales Chief Executive and Director General for the Health Care and Prevention Group roles within a single individual provides an effective link between the NHS and the Welsh Government and supports a coherent approach to leadership, accountability and decision-making across Wales. This model has been maintained over a number of administrations and reflects the scale, structure and interconnected nature of the Welsh health service.

63. The NHS in Wales operates as a closely connected network of organisations, each of which retains its own statutory responsibilities. The directorates within the Health Care and

Prevention Group responsible for work in the area of the risks posed by VFIs set the policy and strategic direction, however, are not responsible for the delivery of services or for operation or clinical decision making. Policy and strategic leadership for Wales is therefore centralised however responsibility for local delivery and addressing local issues is that of individual health boards in Wales. However, the dual leadership arrangement supports a collective approach to issues that extend beyond the remit of any single health board or trust. It enables system-wide expectations to be established, facilitates collaboration across organisational boundaries and promotes consistency in the identification, assessment and management of matters that have an all-Wales dimension.

64. The arrangement also supports the timely sharing of intelligence and information from across the healthcare system and enables a comprehensive view of emerging issues to be brought together. This assists in achieving a coordinated and consistent approach across Wales, reducing the risk of variation in practice where matters affect multiple organisations or populations. It also provides an established mechanism through which intelligence, advice and proposed actions can be informed by the collective experience of NHS organisations and communicated effectively to Welsh Ministers.

65. Although the NHS in Wales is not constituted as a single corporate body, its governance arrangements and leadership structure support a system-wide approach to issues that cross organisational boundaries. Accordingly, where risks relating to a VFI span multiple health boards or Trusts, accountability for actions would remain with the relevant statutory bodies, but the Welsh NHS operating model enables information, oversight and decision-making to be coordinated on an all-Wales basis to ensure consistency of approach and effective management of risk. I will set this out further below in the section headed 'Identification of VFIs in Wales'.

Integration of Health and Social Care in Wales

66. Before concluding the overview of the Health Care and Prevention Group and the NHS in Wales, it is important to note that in Wales we have an integrated healthcare and social services system which the Cabinet Minister for Health and Social Care, supported by the Health Care and Prevention Group, oversees. This is important in respect of the identification, assessment and management of VFI much of which intersects with social services safeguarding systems. As noted above, the Social Services and Integration Directorate has primary responsibility for safeguarding policy in Wales but work closely with other health directorates in the Health Care and Prevention Group and as well as policy areas across the Welsh Government. The nature of the Welsh Government's oversight of

social care is however fundamentally different to the healthcare system. In respect of health the Welsh Ministers are responsible for both the policy and ensuring the delivery of services by NHS bodies. In respect of social services and social care the Welsh Ministers are responsible for policy but not the delivery of services, which is a local authority responsibility.

67. As noted above a clear benefit of the combined roles of the NHS Wales Chief Executive and Director General for the Health Care and Prevention Group is that it helps to enable integration of health and care in Wales. This is complemented by the legal framework set out in the Social Services and Well-being (Wales) Act 2014 ("the 2014 Act"), a key principle of which was the requirement for integrated and sustainable care and support services.

Safeguarding policy in Wales

68. The 2014 Act also establishes the safeguarding legislative framework in Wales which provides the principal mechanism through which concerns relating VFI are identified, assessed and managed, particularly where children and young people may be at risk of harm. The 2014 Act places safeguarding duties on a statutory footing and establishes a system for the protection of children at risk. Under Part 7 of the Act, relevant agencies are required to report concerns about children who may be at risk of abuse, neglect or other forms of harm, and local authorities must make enquiries where there is reasonable cause to suspect that a child is at risk.

69. The Welsh safeguarding system is inherently multi-agency. The 2014 Act establishes Regional Safeguarding Boards comprising local authorities, health bodies, police, probation and other relevant partners. These arrangements are designed to facilitate the sharing of information, coordinated risk assessment and joint decision-making across organisational boundaries. Where VFIs are identified, the safeguarding framework provides an established mechanism through which agencies can share intelligence, assess the nature and severity of risk, determine whether statutory intervention is required and coordinate protective action for children and others who may be affected.

70. The statutory framework is supported by the Part 7 Safeguarding Code of Practice, the *Working Together to Safeguard People* guidance which promotes a consistent approach to safeguarding practice across Wales. A copy of the Code of Practice is exhibited as **JT/04-NHSW000026** Although not directed specifically at VFIs, the principles underpinning the Welsh safeguarding system are highly relevant to behaviours associated with violence, extremism, fixation and other forms of concerning conduct, providing the framework through which such risks can be recognised, assessed and managed.

71. Effective information sharing is a particularly important feature of the Welsh safeguarding system. Guidance and procedures consistently emphasise the need for timely, lawful and proportionate sharing of information between safeguarding partners in order to identify emerging risks and protect children and adults from harm. A copy of the guidance *Information Sharing to Safeguard Children and Adults* is exhibited as **JT/05-** **NHSW000029** In the context of VFIs, this enables agencies to develop a fuller understanding of an individual's circumstances, monitor escalating concerns and implement coordinated safeguarding and risk management responses where necessary.

72. This integrated approach will be particularly important in relation to VFIs, whose circumstances and associated risks may extend beyond the boundaries of a single NHS organisation and may involve health services, social care services and safeguarding agencies simultaneously. While accountability for individual functions remains with the relevant statutory bodies, the Welsh model supports the sharing of intelligence, joint assessment of risk and coordinated decision-making across organisational boundaries. This helps to ensure that risks are identified and managed holistically, reflecting the often cross-cutting nature of such cases.

Primary external agencies and bodies working with the Health Care and Prevention Group on responding to the risk posed by VFIs.

73. In addition to the NHS bodies and organisations referred to earlier in this statement, there are also other bodies which are relevant to the operation of the NHS in Wales and who work with the Health Care and Prevention Group on responding to the risk posed by VFIs.

Regional Safeguarding Boards

74. As noted above, Regional Safeguarding Boards are the primary statutory multi-agency safeguarding partnerships in Wales and provide the principal framework through which NHS organisations, local authorities, policing and other partners work together to safeguard children and adults at risk. Local health boards and NHS Trusts are statutory members of these Boards and contribute clinical expertise, safeguarding information, risk assessment and professional leadership to regional safeguarding arrangements. Whilst Regional Safeguarding Boards do not manage individual cases directly, they oversee the policies, procedures and partnership arrangements that support the identification, assessment and management of complex safeguarding risks.

75. In the context of the Phase 2 Terms of Reference, Regional Safeguarding Boards represent a relevant Welsh partnership structure through which concerns relating to children and

young people presenting risks of serious harm, including those potentially analogous to the Inquiry's definition of VFI's, may be considered within a multi-agency safeguarding framework.

The National Independent Safeguarding Board

76. The National Independent Safeguarding Board (NISB) provides independent advice and assurance to Welsh Ministers on the effectiveness of safeguarding arrangements across Wales. The Board's role is strategic rather than operational and includes reviewing the adequacy and effectiveness of measures to protect children and adults at risk, promoting learning and improvement across the safeguarding system, and advising on policy, practice and emerging safeguarding issues. As noted above, NHS organisations in Wales are statutory safeguarding partners under the Social Services and Well-being (Wales) Act 2014 and participate in Regional Safeguarding Boards alongside local authorities, police and other relevant agencies. Through these arrangements, NHS organisations contribute to safeguarding activity, information sharing, risk assessment, child protection processes and multi-agency planning. The National Independent Safeguarding Board provides oversight and challenge at a national level, drawing on information and learning from Regional Safeguarding Boards and partner agencies, including NHS organisations in Wales , to support the continuous improvement of safeguarding practice and arrangements across Wales.

Wales Violence Prevention Unit

77. The Wales Violence Prevention Unit is a national multi-agency partnership established in 2019 through Home Office funding as part of the UK Government's violence reduction programme. Its purpose is to prevent violence before it occurs by adopting a public health approach, which seeks to understand the underlying causes of violence and address those causes through evidence-based interventions rather than relying solely on enforcement or criminal justice responses.

78. The Unit collaborates across multiple sectors, including policing, health, social care, education, youth services, criminal justice and local government. Rather than focusing exclusively on individual offenders, the Violence Prevention Unit examines the broader factors that contribute to violence, such as adverse childhood experiences (ACEs), trauma, social exclusion, substance misuse, poor mental health, deprivation and educational disengagement. It then supports partners across Wales to develop interventions that reduce those risks and strengthen protective factors within communities

79. The Unit has played an important role in supporting Welsh partners to prepare for and implement the "Serious Violence Duty", helping organisations develop violence prevention strategies and strategic needs assessments. Key partners include:

    a. Public Health Wales (which includes the National Safeguarding Service which provides national leadership, improvement support, learning and intelligence in relation to NHS safeguarding across Wales)

    b. South Wales Police

    c. South Wales Police and Crime Commissioner's Office

    d. His Majesty's Prison and Probation Service (HMPPS)

    e. Home Office

    f. Local authorities

    g. Health boards

    h. Youth justice services

    i. Third sector organisations

    j. Welsh Government

    k. Academic institutions,

80. The Violence Prevention Unit works with a wider network of partners including safeguarding services, education providers, community safety partnerships, criminal justice agencies, social services, youth work organisations and children's services across Wales.

81. The Wales Violence Prevention Unit works closely with the NHS in Wales and the NHS Violence Prevention Team (VPT), which was established in October 2019 is funded by the Violence Prevention Unit and operates in two emergency departments in South Wales. Each team comprises two nurses and a community-based caseworker. The VPT offers advice, support and guidance to patients who have experienced violence, with the aim of engaging with those injured whilst they are in hospital (at the point of crisis) and to prevent violence by encouraging patients to access support and services.

82. In practice, the Wales Violence Prevention Unit brings together the evidence, partnerships and public health methodologies that support a coordinated response to violence across

the country. While it does not manage individual VFI cases, much of the policy, evidence and prevention infrastructure that would underpin effective VFI identification and management is connected to or influenced by its work.

The Adverse Childhood Experiences (ACE) Hub Wales

83. The ACE Hub Wales supports organisations and communities across Wales to understand, prevent and respond to Adverse Childhood Experiences (ACEs) through the promotion of trauma-informed and evidence-based practice. The Hub was founded in 2017 and was set up to support Welsh society to help create a Trauma and ACE (TrACE) informed Wales and make Wales a leader in tackling, preventing and mitigating ACEs. ACE Hub Wales is funded by the Welsh Government and is hosted by Public Health Wales and is part of the World Health Organisation (WHO) Collaborating Centre on Investment for Health and Well-being. The Hub supports system-wide learning, workforce development and policy implementation, helping public services to identify and address the underlying causes of violence and vulnerability. Its work forms an important part of Wales' public health approach to violence prevention and early intervention.

Health Care and Prevention Group interaction with the wider Welsh Government in relation to VFIs

84. The focus of this statement is the Health Care and Prevention Group and the NHS in Wales however in relation to VFIs it is important to note that responsibility for work within the Welsh Government in this area is not contained solely within the Health Care and Prevention Group. Although responsibility for policing and criminal justice remains reserved, community safety in Wales operates through partnership arrangements. This includes the Criminal Justice Board for Wales which brings together partners from across the justice system in Wales to work collectively to prevent crime, anti-social behaviour, substance misuse and reoffending, and to improve community safety. The Welsh Government therefore exercises an important policy, coordination and funding role in relation to community safety initiatives relevant to VFI and safeguarding, whilst operational policing responsibilities remain reserved matters.

85. Community safety policy increasingly intersects with safeguarding policy in Wales. Although responsibility for policing remains reserved, the Welsh Government has utilised its devolved responsibilities in areas including social services, education, housing, health, violence against women, domestic abuse and sexual violence, community cohesion and modern slavery to support wider community safety objectives. The Policing Partnership Board for Wales is Chaired by the Deputy First Minister and Cabinet Minister for Social Justice and Equalities. This is the main strategic forum that brings together the Welsh Government, the

four Welsh Police and Crime Commissioners, the four Chief Constables, UK Government representatives, local government and other key public service partners to discuss issues affecting policing and community safety in Wales.

86. The Communities and Social Justice Directorate in the Welsh Government includes responsibility for the Cohesive Communities Division which has responsibility for the policy in relation to Violence Against Women, Domestic Violence and Sexual Violence; Migration and Nation of Sanctuary; Community Cohesion, Third Sector and Volunteering; and, Communities Policy. It also includes responsibility for the Community Safety Division which leads the liaison with community policing, and policy in relation to crime and justice and youth justice in so far as this intersects with devolved responsibilities.

87. In relation to VFIs the Welsh Government's Chief Officer, National Security and Resilience also has a significant role to play in the development of policy and work in respect of the identification, assessment and management of VFI's in Wales given their responsibility for the Welsh Government's functions and responsibilities in relation to National Security and Resilience, including the Welsh Government's crisis management functions. Whilst national security is a reserved matter, it is often delivered in a devolved area and the impacts and ramifications of any associated issues will be felt by the Welsh citizens.

88. The National Security Resilience team co-ordinates the Welsh Government's involvement in the UK Counter-Terrorism strategy (CONTEST) and provides representation on the CONTEST Cymru and associated Prevent Boards. Working closely with operational partners and stakeholders to ensure we understand the potential threats to Wales and support and enable mitigations against them. Further information on CONTEST is provided later in this statement from an NHS in Wales perspective.

Identification of VFIs in Wales

89. Wales does not operate a specific VFI framework. Instead, concerns are identified through existing safeguarding, mental health and multi-agency systems. These include safeguarding referrals, CAMHS (child and adolescent mental health services), forensic CAMHS, urgent and emergency mental health services, primary and community care, ambulance services, Prevent and Channel processes, as well as Regional Safeguarding Boards and wider public protection arrangements. Together, these systems provide opportunities to identify children and young people exhibiting concerning behaviours, escalating risk, violent ideation, significant mental health needs or vulnerabilities associated with serious harm

90. Practitioners are not currently trained to identify a recognised "VFI" category, rather, they are expected to identify vulnerability, risk and concerning behaviour through existing professional frameworks. These include safeguarding concerns, risk of harm to self or others, violent ideation, behavioural disturbance, trauma, neurodevelopmental conditions, exploitation, harmful online influences and significant changes in presentation. The challenge is that there is currently no agreed clinical or operational definition of a VFI, which makes consistent identification difficult across services and agencies. Existing systems can identify many of the factors associated with future risk, but are less explicit in recognising fixation, grievance and pathway-to-violence behaviours before serious harm occur.

91. Where concerns arise, practitioners are expected to act through existing safeguarding, mental health and multi-agency pathways. This may include referral to safeguarding services, CAMHS, forensic mental health services, crisis services, Prevent or Channel processes, information sharing with partner agencies, participation in child protection arrangements, and multi-agency risk management processes. The response is therefore based on assessed need and risk rather than a specific VFI pathway. The overarching aim is early intervention, information sharing, coordinated assessment and risk reduction before concerns escalate into significant harm.

92. Accordingly, for the purposes of this Rule 9 response, references to the identification and management of VFIs should be understood within the context of the Welsh Government and the NHS in Wales' existing responsibilities for safeguarding, mental health assessment and treatment, risk assessment and multi-agency risk management, rather than as a distinct operational category recognised within Welsh health policy or legislation.

93. It is also important to note that neither the NHS in Wales nor the Health Care and Prevention Group hold primary responsibility for monitoring online content, investigating criminal activity, or assessing national security threats. Rather, its role is to identify and respond to health, mental health and safeguarding needs; contribute clinical expertise to multi-agency risk assessment and management arrangements; and support children and young people whose presentation may indicate an increased risk of serious harm. Additionally, responsibilities also exist through England and Wales or UK wide reserved frameworks such as Prevent and Channel. Therefore, the NHS in Wales' contribution therefore sits within the wider safeguarding, mental health and public protection systems that the Southport Inquiry has been asked to examine.

Safeguarding children and young people

94. Part 7 of the Social Services and Well-being (Wales) Act 2014 establishes a statutory framework for safeguarding children in Wales through three principal mechanisms: a duty on relevant partners to report children at risk to the local authority, the establishment of Safeguarding Children Boards in designated areas across Wales, and multi-agency cooperation and information sharing arrangements. The duties apply to local authorities and their relevant partners, including police, health services, probation services and other specified bodies. Required actions include reporting suspected children at risk, establishing and participating in Safeguarding Children Boards, coordinating safeguarding activity, and complying with information requests. Multi-agency working is facilitated through mandatory cooperation arrangements and information sharing duties that apply across partner organisations.

95. Health professionals are often the first public service practitioners to identify concerns about:

    a. abuse and neglect;

    b. exploitation;

    c. self-harm;

    d. concerning behaviours;

    e. exposure to harmful online activity; and

    f. risks posed by, or to, children and young people.

96. In the context of VFIs, the NHS in Wales therefore contributes to the identification of escalating risk indicators through safeguarding referrals; information sharing; participation in multi-agency risk management arrangements; and child protection planning where a child presents a risk to themselves or others. These are not however framed in terms of VFI's but as part of the wider safeguarding and violence prevention initiatives.

97. With regards to the role of the Health Care and Prevention Group, this leads the Welsh Government policy in relation to safeguarding legislation, statutory guidance and oversight of safeguarding arrangements across Wales. This includes responsibility for the safeguarding framework within which NHS organisations in Wales operate.

Children and young people's mental health services

98. Local health boards commission and deliver Child and Adolescent Mental Health Services (CAMHS), including:

a. early intervention;

b. community CAMHS;

c. specialist CAMHS;

d. crisis support;

e. inpatient services; and

f. psychological and psychiatric assessment and treatment.

99. NHS Mental Health Services for under 18s in Wales are commissioned by local health boards in response to local needs. Service provision includes Local Primary Mental Health Support Services which are a requirement under the Mental Health (Wales) Measure 2010, specialist CAMHS, crisis services and Community Mental Health Teams.

100. Since 1 April 2024, the NHS Wales Joint Commissioning Committee is responsible for commissioning in-patient provision for CAMHS on behalf of the seven local health boards. Prior to that date the responsibility fell to the Welsh Specialised Services Committee. Two local health boards are commissioned by NHS Wales Joint Commissioning Committee to provide this service for Welsh residents: Cwm Taf Morgannwg University Health Board provides 15 beds for the South at Ty Llidiard and Betsi Cadwaldr University Health Board provides 12 beds at Abergele Hospital.

101. We only have low secure services in Wales. Young people requiring medium secure services are placed out of Wales. Very few young people require medium secure services and is only required when directed by the court or where a young person poses a serious risk to others. Only adults can be placed in high secure services.

102. In Wales, medium secure mental health in-patient services are commissioned on behalf of local health boards by the NHS Wales Joint Commissioning Committee, either from NHS England or from the independent sector via the NHS Wales National Collaborative Frameworks. The National Collaborative Frameworks (Hospitals and Care Homes) were developed to enable:

a. An approved directory of suitably qualified, financially viable providers to meet quality, service and cost criteria.

b. The establishment of bespoke care standards, standard contract terms/conditions, and a transparent pricing framework.

c. Consistent and sustainable high-quality service provision and improved patient/resident outcomes.

103. The National Collaborative Frameworks provide the mechanism for the commissioning of services supported by the NHS Wales Quality Assurance Improvement Service (QAIS). The Framework is a formal agreement and mechanism developed together by the National Collaborative Commissioning Unit and NHS Wales Shared Services Partnership (Procurement team). These services are provided once a patient is placed through the National Collaborative Framework processes and an individual patient placement agreement is generated, and therefore a contract enacted, between the commissioner (Local Health Board or the NHS Wales Joint Commissioning Committee) and provider.

104. CAMHS services routinely assess: risk to self; risk to others; aggression and violence; trauma; neurodevelopmental conditions; emotional dysregulation; and serious mental illness.

105. In relation to VFIs, CAMHS may encounter children and young people who: exhibit violent ideation; demonstrate obsessive interests in violence; have been influenced by harmful online content; display emerging patterns of fixation; or require specialised risk assessment and intervention.

106. The Health Care and Prevention Group has strategic policy responsibility for children's mental health policy, including:

a. implementation of the Mental Health and Wellbeing Strategy;

b. oversight of children's mental health reform programmes;

c. delivery of the NEST (Nurturing, Empowering, Safe and Trusted) Framework, including its 'No Wrong Door' principle; and

d. policy direction for CAMHS provision across Wales.

Forensic child and adolescent mental health services

107. Forensic child and adolescent mental health services are concerned with the provision of mental health services to children and young people, who present a risk of harm to others, and who also have mental health or neurodevelopmental needs.

108. The NHS Wales Joint Commissioning Committee Wales commissions a specialist Tier 4 Forensic Child and Adolescent Mental Health Service for Wales. A copy of the service specification used for commissioning of this service is exhibited as **JT/06- NHSW000041**

The service provides specialist forensic consultation and advice for and in relation to children and young people presenting with complex risk issues.

109. Of all of the NHS Services in Wales, forensic CAMHS is likely to have the closest operational relevance to the Inquiry's consideration of VFI identification and management because it provides expertise in:

    a. violence risk;

    b. complex presentations;

    c. behavioural threat assessment;

    d. youth offending; and

    e. risk management planning.

110. The Health Care and Prevention Group provides strategic oversight of specialised mental health policy and the commissioning framework under which these services operate, while operational commissioning is undertaken through NHS commissioning structures in Wales.

111. Further information on the Forensic CAMHS is provided later in the statement under the heading “Assessment and Management of Risk”.

Health services in secure settings for children and young people

112. The NHS in Wales provides and commissions health services for children and young people held within secure settings, including:

    a. Hillside Secure Children's Home;

    b. Parc Young Persons' Unit; and

    c. other secure welfare and justice environments.

113. Such services include:

    a. physical healthcare;

    b. mental healthcare;

    c. neurodevelopmental assessment;

    d. substance misuse assessment, treatment and support;

    e. safeguarding; and

    f. clinical risk management.

114. Children and young people accommodated within secure settings may present with complex and overlapping vulnerabilities and risks, including serious violence, violent ideation, fixation on previous attacks, concerning online behaviours (including exposure to harmful content and potential radicalisation indicators), grievance-based behaviours, emotional dysregulation, neurodevelopmental conditions, trauma, adverse childhood experiences, self-harm, suicide risk, exploitation and other factors that may contribute to an increased risk of serious harm to themselves or others.

115. The operation and management of secure custodial settings are largely matters reserved to the UK Government. However, healthcare services provided to children and young people within such settings are a devolved responsibility in Wales and are delivered or commissioned by the NHS in Wales.

Urgent and emergency mental health care for children and young people.

116. The NHS in Wales has developed a range of urgent and emergency mental health pathways, including:

    a. 111 Press 2 mental health access;

    b. specialist CAMHS crisis services;

    c. crisis assessment and treatment teams;

    d. inpatient CAMHS beds; and

    e. crisis hubs and sanctuaries for children and young people.

117. These services are responsible for responding to children and young people who present in crisis, including those experiencing:

    a. severe distress;

    b. psychosis;

    c. acute behavioural disturbance;

    d. serious self-harm risk; and

    e. risk of harm to others.

118. Such services may be involved where concerns emerge regarding: escalating violent thoughts; threats of serious violence; acute behavioural risk; deterioration in mental state associated with violent behaviour; or concerning online activity linked to mental health crises.

119. The Health Care and Prevention Group leads policy relating to urgent mental health care transformation, crisis pathways and children's mental health services, including reforms intended to provide earlier intervention and a "no wrong door" approach for children and young people.

120. From a Welsh perspective, the role of the NHS in Wales in relation to the Phase 2 Terms of Reference is likely to be characterised as:

    a. identification of children and young people with concerning behaviours, mental health needs or safeguarding risks;

    b. assessment of mental health, neurodevelopmental and violence-related risks;

    c. safeguarding and information sharing within statutory multi-agency arrangements;

    d. treatment and therapeutic intervention aimed at reducing risk;

    e. specialist forensic consultation regarding serious violence risk; and

    f. crisis intervention for children and young people presenting an immediate risk to themselves or others.

CONTEST

121. CONTEST is the UK Government's counter-terrorism strategy. Its overarching aim is to reduce the risk from terrorism to the UK, its citizens and interests overseas, so that people can live freely and with confidence. CONTEST is structured around four complementary workstreams, known as the "four Ps":

    a. Prevent, which aims to stop people becoming terrorists or supporting terrorism;

    b. Pursue, which aims to stop terrorist attacks;

    c. Protect, which aims to strengthen protection against terrorist attacks; and

    d. Prepare, which aims to minimise the impact of an attack should one occur.

122. In Wales, local health boards and NHS trusts have counter-terrorism strategy (CONTEST) Prevent leads and are part of multi-agency structures where these are in place. Prevent, including the Channel programme (see further below), forms the safeguarding and early intervention component of this wider counter-terrorism framework. As outlined below local health boards and NHS trusts have statutory responsibilities under the Prevent Duty and contribute to the identification, assessment and support of individuals who may be vulnerable to radicalisation.

Prevent

123. Prevent is a UK Government policy led by the Home Office. From an NHS in Wales perspective, Prevent is understood primarily as a safeguarding responsibility rather than a security or law enforcement function. Schedule 6 of the Counter-Terrorism and Security Act 2015 specifies the duty applies to an NHS trust established under section 18 of the National Health Service (Wales) Act 2006 and to a local health board established under section 11 of the National Health Service (Wales) Act 2006.Therefore NHS trust and local health boards in Wales are required to have due regard to the need to prevent people from being drawn into terrorism, as part of their wider duty to protect children, young people and adults at risk from harm. This is a reserved area and the UK Government has issued 'Prevent duty guidance: Guidance for specified authorities in England and Wales' to support the duty, a copy of which is exhibited as **JT/07 HOM000014**

124. The guidance is clear that role of health professionals is not to investigate individuals or determine whether someone poses a terrorist threat, but to recognise and respond to vulnerabilities that may increase susceptibility to radicalisation, in the same way that they would identify and respond to risks associated with exploitation, abuse, self-harm or neglect. Healthcare staff may become aware of concerns through clinical assessment, safeguarding activity or routine contact with patients and are expected to consider these alongside other health, social and environmental factors when assessing risk.

125. Where appropriate, concerns can be escalated through safeguarding procedures, information-sharing arrangements and multi-agency forums, including the Prevent referral and Channel processes. Within the NHS in Wales, Prevent is therefore delivered through existing safeguarding structures, partnership working and professional judgment, with an emphasis on early identification, proportionate intervention and supporting vulnerable individuals before risks escalate. The approach recognises that radicalisation is often linked to a complex combination of personal, social, psychological and environmental vulnerabilities and that effective prevention depends on coordinated action across health, social care, education, local authorities and policing partners.

Channel

126. Channel is the multi-agency safeguarding programme that sits within the Prevent framework and is designed to provide early support to individuals who may be vulnerable to being drawn into terrorism or radicalisation. It is not a criminal justice process and participation is generally voluntary. The purpose of Channel is to assess the nature and extent of an individual's vulnerability and, where appropriate, develop a tailored support package to reduce risk and build resilience. This support may include mental health services,

educational support, social care involvement, mentoring, family support or other interventions depending on the person's needs.

127. For NHS trust and local health boards in Wales, the Prevent Duty requires them to have due regard to the need to prevent people from being drawn into terrorism as part of their wider safeguarding responsibilities. In practice, NHS staff are expected to undertake appropriate Prevent training, recognise indicators of vulnerability to radicalisation, consider such concerns within clinical and safeguarding assessments, and know how to escalate concerns through local safeguarding and Prevent pathways. Where a referral is made and a Channel panel is established, NHS trusts and local health boards in Wales are under a duty under section 38 of the Counter-Terrorism and Security Act 2015 to, so far as appropriate and reasonably practicable, act in co-operation with the panel. This may in include contributing relevant health information, participate in risk assessment discussions, and support delivery of agreed interventions, subject to legal and professional requirements relating to confidentiality, information sharing and patient care.

128. Within Wales, Channel panels are typically chaired by the local authority and bring together partners from health, social care, education, policing and other relevant agencies. The NHS in Wales therefore has an important role in ensuring that health-related vulnerabilities, including mental health needs, neurodevelopmental conditions, trauma and other factors that may increase susceptibility to radicalisation, are properly considered within a multi-agency safeguarding response.

The Serious Violence Duty

129. The Police, Crime, Sentencing and Courts Act 2022 introduced a serious violence duty requiring specified authorities, including local health boards established under the NHS (Wales) Act 2006, to collaborate in preventing and reducing serious violence. Local health boards are designated as specified authorities under Schedule 1 to the Act and must therefore comply with the duty to collaborate and plan strategies for preventing and reducing serious violence in their local government areas. The Welsh Ministers have a specific consultative role in relation to guidance and regulations affecting devolved Welsh authorities, and serious violence strategies relating to areas in Wales must be submitted to the Welsh Ministers as well as the Secretary of State.

130. Guidance on the Serious Violence Duty Strategic Needs Assessment is issued by the Wales Violence Prevention Unit for public bodies in Wales. A copy of this guidance is exhibited as **JT/08-** **NHSW000039** From an NHS in Wales perspective, the Serious Violence Duty Strategic Needs Assessment Guidance emphasises the importance of health services,

Health Boards and Public Health Wales working with partners to identify, understand and prevent violence through a public health approach. The guidance promotes the use of health intelligence, including emergency department attendances, hospital admissions and wider population health data, alongside information from policing, education and community partners, to identify patterns of violence, vulnerable populations and underlying risk factors. The aim is to move beyond responding to violent incidents and instead use evidence to identify early indicators of harm, address the root causes of violence, and inform targeted prevention and early intervention activity that improves the health, wellbeing and safety of individuals and communities across Wales.

Statistical analysis relevant to VFIs collated by the NHS in Wales or Health Care and Prevention Group

131. Neither the Welsh Government's Health Care and Prevention Group nor the NHS in Wales routinely collect or report statistical information on VFI as a defined category. As outlined above this term is not currently embedded within Welsh health policy, safeguarding frameworks, mental health datasets or NHS performance reporting arrangements. Accordingly, no centrally-held statistical dataset has been identified that quantifies the number of VFIs known to NHS services in Wales.

132. The Welsh Government, Public Health Wales and other NHS bodies do, however, collect and analyse a range of information relating to safeguarding, children's mental health, forensic adolescent mental health services, violence-related health service contacts and wider violence prevention activity. Although these datasets may provide contextual information relevant to the Inquiry's consideration of VFIs, they are not designed to identify, categorise or count individuals meeting the Inquiry's definition of a VFI.

133. NHS data is included in the Wales Violence Prevention Portal which provides a national violence surveillance capability for Wales, bringing together police, ambulance and NHS data, including emergency department attendances and violence-related hospital admissions. The Portal enables partners to identify patterns, hotspots and emerging trends in violence through a shared evidence base, supporting Strategic Needs Assessments and informing targeted prevention activity. The Wales Violence Prevention Portal is managed by the Wales Violence Prevention Unit. From an NHS in Wales perspective, the Portal demonstrates the value of health data in identifying violence and vulnerability that may not otherwise be visible through criminal justice reporting alone, strengthening the public health approach to violence prevention.

134. In addition to the above sources of data, the Wales Safeguarding Repository also provides an important source of intelligence for violence prevention by bringing together Single

Unified Safeguarding Reviews, Domestic Homicide Reviews, Adult Practice Reviews, Child Practice Reviews and Mental Health Homicide Reviews. Collectively, these reviews offer rich qualitative evidence on the circumstances, vulnerabilities, risk factors and system interactions that precede serious harm and violence. The repository therefore supports violence prevention initiatives by enabling organisations to identify recurring themes, understand missed opportunities for intervention, strengthen multi-agency learning and inform evidence-based prevention strategies focused on reducing harm and improving outcomes for vulnerable individuals and communities. Guidance on how to access the repository is exhibited as **JT/09-NHSW000025**

Policies and guidance in Wales

135. In Wales, health and social care policy and guidance is developed by the Welsh Government or the NHS in Wales and is disseminated through a combination of legislation, ministerial policy statements, national strategies, statutory guidance, circulars, professional leadership communications and performance management arrangements. The system relies on a mixture of formal statutory mechanisms and established administrative channels to ensure that policy intent is communicated consistently across the NHS in Wales and local authorities.

136. Responsibility for promulgating policy generally sits with the Welsh Government's Health Care and Prevention Group. National policy positions, strategic priorities and operational requirements are published on GOV.WALES and are supported by a range of implementation documents including Welsh Health Circulars (WHCs), NHS Planning Frameworks, Quality Statements, National Clinical Framework requirements, and Ministerial Directions. Additionally, the Chief Professional Officers (as noted above) will also issue communications via letters to organisations in Wales and also have their own forums/networks within the NHS in Wales through which they disseminate information.

137. Where a policy requires formal implementation across the NHS in Wales, the Health Care and Prevention Group will commonly issue a Welsh Health Circular or similar national communication. These are distributed to Chairs, Chief Executives and accountable officers of NHS organisations in Wales and set out requirements, expectations, timescales and, where applicable, reporting arrangements. Depending on the subject matter, communications may also be issued by the Chief Medical Officer, Chief Nursing Officer, Chief Pharmaceutical Officer or other national professional leads. These provide authoritative professional guidance and often support the implementation of ministerial policy decisions and national clinical standards.

138. The Chief Executive of NHS Wales also plays a key role in translating Welsh Government policy into operational delivery requirements. Through the NHS Wales Planning Framework and associated accountability arrangements, health boards and trusts are required to demonstrate how national policy objectives will be incorporated into local plans, service delivery models and organisational priorities. The planning process provides an important mechanism for cascading policy intent throughout the NHS in Wales, linking ministerial priorities to organisational delivery plans and performance measures. The NHS Wales Planning Framework is issued under Ministerial Direction and is a statutory requirement under the NHS Wales (Finance) Act 2014.

139. At organisational level, local health board and NHS trust chief executives are responsible for ensuring implementation within their organisations. Policies and guidance are typically disseminated through executive management teams, clinical leadership structures, governance committees, directorates and operational management arrangements. Local policies, standard operating procedures and clinical pathways are often revised to reflect new national requirements. Compliance responsibilities are then delegated through organisational governance structures while remaining subject to board oversight and assurance processes.

140. For social care, Welsh Government policy is disseminated through a broadly similar but distinct set of arrangements. The Social Services and Well-being (Wales) Act 2014 provides the principal statutory framework and is supported by extensive regulations, statutory guidance and codes of practice issued by the Welsh Ministers. These documents are typically published on GOV.WALES and are communicated through the Chief Social Care Officer for Wales, Welsh Government social services policy teams and sector leadership networks.

141. The Association of Directors of Social Services Cymru (ADSS Cymru) plays an important role in supporting implementation of policy across local authority social services. While ADSS Cymru does not itself issue statutory guidance, it provides a key leadership and coordination function, facilitating communication between the Welsh Government and local authority directors, promoting consistency of interpretation and supporting implementation through professional networks and good practice forums.

142. Social Care Wales also has a significant implementation role. Although it is not a policy-making body, it supports the embedding of Welsh Government policy through professional standards, workforce guidance, learning resources, registration requirements and practice improvement activity. In many areas, Social Care Wales acts as a key conduit through which policy expectations are translated into frontline social work and social care practice.

143. Implementation of policy across both health and social care is subsequently monitored through a range of assurance mechanisms. Within the NHS in Wales, the Welsh Government maintains oversight through the NHS Wales Performance Framework, annual planning processes, accountability meetings and the Oversight and Escalation Framework. Health boards and trusts are required to provide evidence of delivery against national priorities and performance measures, and where concerns arise organisations may be subject to enhanced monitoring, targeted intervention or special measures.

144. In social care, implementation and compliance are monitored through local authority governance arrangements and through external regulatory oversight. Care Inspectorate Wales (CIW) assesses compliance with relevant legislation, regulations and statutory guidance in relation to care services, while Healthcare Inspectorate Wales (HIW) provides independent review and inspection of healthcare services. Audit Wales, the Welsh Government and Senedd scrutiny committees may also examine the extent to which policies are being effectively implemented and whether intended outcomes are being achieved. Learning arising from practice reviews, safeguarding reviews, serious incident investigations and other review processes may also inform assessments of policy effectiveness and identify areas where policy implementation, operational practice or inter-agency arrangements require strengthening.

145. Consequently, the Welsh system does not rely on a single dissemination route. Rather, policy and guidance are cascaded through a network of statutory publications, Welsh Government circulars, Chief Professional Officer communications, NHS executive leadership channels, local authority social care leadership structures, ADSS Cymru networks, Social Care Wales implementation support mechanisms and formal performance management arrangements. Compliance and effectiveness are then assessed through a combination of organisational accountability, performance reporting, inspection, regulation and independent scrutiny.

Policies relating to the identification, assessment or management of VFIs

146. The Health Care and Prevention Group has not identified any Welsh Government, or NHS in Wales policy or guidance that specifically addresses VFIs or establishes a dedicated framework for their identification, assessment or management. Nor has any Welsh health policy or guidance been identified that specifically addresses the role of harmful online content in influencing or enabling VFIs to prepare and carry out violent attacks.

147. Although no policy or guidance specifically addresses VFIs as a defined category, the following policies and guidance are considered the most relevant to the Inquiry's Phase 2 Terms of Reference, as they provide the Welsh framework for safeguarding, early

identification of risk, mental health intervention, violence prevention and multi-agency working

Working Together to Safeguard People and Wales Safeguarding Procedures

148. This is the principal safeguarding guidance framework in Wales and provides the policy and practice framework through which organisations work together to protect children and adults at risk. A copy of the guidance is exhibited as **JT/04-** **NHSW000026** It sets out expectations regarding early identification of concerns, information sharing, assessment of risk, multi-agency decision-making and safeguarding interventions. Whilst it does not refer specifically to VFIs, it establishes the arrangements through which concerns about children or young people presenting risks of harm to themselves or others would ordinarily be identified and managed.

National Strategy for Preventing and Responding to Child Sexual Abuse in Wales 2026-2036

149. The National Strategy for Preventing and Responding to Child Sexual Abuse in Wales 2026-2036, while not specifically directed at the identification or management of VFIs, is relevant to the wider safeguarding framework within which risks relating to children and young people are identified, assessed and managed. A copy of the strategy is exhibited as **JT/10-** **NHSW000027** The strategy promotes early identification of concerns, multi-agency information sharing, coordinated safeguarding responses, workforce development and trauma-informed practice across social care, health, education, policing and third-sector partners. The strategy therefore forms part of the wider policy landscape that may assist agencies in recognising, assessing and responding to concerning behaviours and vulnerabilities in children and young people, although it does not establish a specific framework for the management of VFIs.

NEST Framework

150. The NEST (Nurturing, Empowering, Safe and Trusted) Framework is the Welsh Government's whole-system framework for improving mental health and wellbeing support for babies, children, young people and their families. A copy of the guidance is exhibited as **JT/11-** **NHSW000037** It promotes a preventative, trauma-informed and person-centred approach, with an emphasis on ensuring children receive support at the earliest opportunity and do not fall between organisational boundaries. The framework advocates integrated working across health, education, social care and the third sector and is particularly relevant to the Inquiry's consideration of early identification and intervention.

Mental Health and Wellbeing Strategy 2025–2035

151. This strategy sets out the Welsh Government's long-term vision for promoting mental health and wellbeing across Wales. A copy of the guidance is exhibited as **JT/12-NHSW000036** Key themes include prevention, early intervention, timely access to support, trauma-informed practice and improved integration of services. The strategy seeks to ensure that individuals receive the right support at the right time through joined-up working across public services and provides the overarching strategic context for children's mental health services in Wales. This may be relevant where fixation is linked to severe mental illness, personality difficulties, trauma, social isolation or crisis presentations.

Mental Health Delivery Plan 2025-2028

152. The Mental Health Delivery Plan 2025–2028 sets out the Welsh Government's three-year programme for delivering the ambitions of the Mental Health and Wellbeing Strategy 2025–2035. A copy of the plan is exhibited as **JT/13-NHSW000035** Key priorities include improving prevention and early intervention, increasing access to community-based support, strengthening person-centred and trauma-informed care, reducing inequalities, and ensuring people receive the right support at the right time through a more connected and integrated mental health system. The plan outlines actions for Welsh Government, the NHS in Wales and partner organisations to improve outcomes across all age groups.

NHS Wales Strategic Programme for Mental Health

153. The NHS Wales Strategic Programme for Mental Health provides national leadership for the planning, improvement and transformation of mental health services across Wales. A copy of the programme information is exhibited as **JT/14-NHSW000040** Established in 2023, the programme aims to improve safety, quality and outcomes, reduce unwarranted variation in services, and promote parity between physical and mental health care. Through collaboration with the Welsh Government, local health boards and wider partners, the programme supports delivery of national mental health priorities and drives service improvement across the NHS in Wales. NHS Wales Strategic Programme for Mental Health covers all ages, including CAMHS. The structure of the Programme includes a Mental Health Inpatient Steering Group and an Open Access National Steering Group to support service transformation and improvement. Both Groups are informed by a children and young persons Advisory Panel, and the Programme has an emphasis on partnership working, early intervention and needs led care. This programme provides important context for pathways relating to high-risk individuals presenting to health services and where concerning behaviour emerges during adolescence.

Quality Statement for Mental Health (2026)

154. The Quality Statement for Mental Health (2026) sets out the Welsh Government's expectations for what high-quality, person-centred mental health services should look like across Wales. A copy of the statement is exhibited as **JT/15-NHSW000031** It provides a national framework for health boards, NHS organisations and partner agencies, underpinned by principles of equity, safety, effectiveness, person-centred care and timely access to support. The statement promotes a rights-based, trauma-informed approach to mental health care, with a strong emphasis on prevention, early intervention, recovery, co-production with people who have lived experience, and integrated working across health, social care and other sectors.

155. In relation to VFIs, the Quality Statement does not specifically refer to violence fixation, fixated persons, fixated threat assessment, or dedicated pathways for individuals who may pose a risk to the public. However, it contains a number of principles that are relevant to managing individuals who present risks to themselves or others. These include a requirement for services to take a proactive approach to safety and risk management, ensure appropriate information sharing across agencies, implement safeguarding measures, and escalate concerns where there is evidence of significant harm. The statement also recognises the needs of people involved with the justice system and those experiencing multiple disadvantage, and requires the mental health workforce to be trained in risk formulation, person-centred safety planning and de-escalation. Overall, the document adopts a broad, rights-based and trauma-informed approach to risk rather than establishing any specific policy or service model for VFIs.

Wales Without Violence: A Shared Framework for Preventing Violence among Children and Young People

156. The Wales Violence Prevention Unit has worked with a wider network of partners through the development of the Wales Without Violence Framework, involving safeguarding services, education providers, community safety partnerships, criminal justice agencies, social services, youth work organisations and children's services across Wales. A copy of the Framework is exhibited as **JT/16-NHSW000044** The Wales Without Violence Framework sets out nine evidence-based strategies designed to prevent violence among children and young people through a public health and whole-system approach. Rather than focusing solely on responding to incidents, the Framework seeks to reduce the underlying risk factors that can contribute to violent behaviour, including trauma, adverse childhood experiences (ACEs), social exclusion, poor mental health and exposure to violence.

Trauma-Informed Wales Framework

157. The Trauma-Informed Wales Framework provides a national approach to embedding trauma-informed practice across public services in Wales. A copy of the framework is exhibited as **JT/17-NHSW000042** The framework supports organisations to recognise and respond to the impact of trauma and adverse childhood experiences on individuals' health, wellbeing and behaviour. In a health service context, the framework is particularly relevant to violence prevention initiatives as it promotes earlier identification of vulnerability, improves responses to individuals affected by violence and abuse, and supports preventative, person-centred interventions that address the underlying causes of violence. The framework forms a key component of Wales' public health approach to violence prevention and is referenced within the Serious Violence Duty guidance as supporting the delivery of trauma-informed practice across Wales.

Youth Justice Blueprint for Wales

158. The Youth Justice Blueprint for Wales sets out a shared vision between Welsh Government, the Youth Justice Board and criminal justice partners for a distinct, child-centred approach to youth justice in Wales. A copy of the Blueprint is exhibited as **JT/18-NHSW000045** The Blueprint promotes a rights-based and trauma-informed model focused on prevention, early intervention, diversion from the criminal justice system and rehabilitation. It seeks to prevent children from entering the justice system wherever possible, minimise contact with formal justice processes, address the impact of adverse childhood experiences and support children to lead positive, healthy and crime-free lives. This blueprint sets out the links between adverse childhood experiences (ACEs), offending, violence, vulnerability and early intervention.

Youth Justice Prevention Framework

159. The Youth Justice Prevention Framework provides a national framework to support services in preventing children from becoming involved in offending behaviour. A copy of the framework is exhibited as **JT/19-NHSW000030** The framework promotes a coordinated, multi-agency approach involving education, health, social care and youth justice services, recognising the important role of early help and prevention in improving outcomes for children. It adopts a Child First approach, emphasising children's rights, wellbeing and development, and aims to ensure that children receive appropriate support at an early stage to reduce the risk of offending and future involvement in the criminal justice system.

Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) Strategy 2022–2026

160. The Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) Strategy 2022–2026 sets out the Welsh Government's national approach to preventing violence against women, domestic abuse and sexual violence, whilst improving protection, support and outcomes for victims and survivors. A copy of the strategy is exhibited as **JT/20-NHSW000043**. The strategy promotes a preventative, trauma-informed and whole-system approach, with a strong emphasis on early intervention, collaboration and tackling the underlying causes of violence. In a health service context, the strategy is relevant to violence prevention initiatives as it supports the identification of individuals at risk of harm, strengthens safeguarding responses and promotes partnership working across health, social care, policing and specialist support services. The strategy is also recognised within the Serious Violence Duty framework as an important component of Wales' wider approach to preventing and reducing violence

Online Safety and Digital Safeguarding Guidance

161. The regulation of internet services is the responsibility of the UK Government. In response to the evolving digital landscape and the risks associated to online safety, including findings from industry, such as the children's Media Lives research, the Digital Resilience team in the Education and Public Services Group was established in 2017. Following the recent Senedd elections the Group has been renamed the Learning, Communities and Culture Group which contains the Education Directorate. This is responsible for raising awareness and supporting digital resilience activities including online safety, cyber security and data protection with local authorities and schools in Wales. The Health Care and Prevention Group is therefore not responsible for online safety or digital safeguarding guidance.

162. Through the Education Directorate, the Welsh Government is responsible for the delivery of the national Hwb platform which is designed specifically for children and young people to use in an education context. Although, the Welsh Government guidance does not specifically address VFIs or the role of harmful online content in facilitating mass casualty attacks, existing safeguarding guidance recognises that children and young people may experience harm through online activity and digital environments. A copy of the guidance on inappropriate illegal and offensive content online is exhibited as **JT/21-NHSW000034**. The guidance supports information sharing, safeguarding assessment and multi-agency responses where online activity gives rise to concerns regarding abuse, exploitation, wellbeing or safety. The primary focus is safeguarding rather than threat assessment or counter-violence activity.

Challenges related to the national strategy, guidance, governance and accountability structures related to VFIs

163. A fundamental challenge in considering VFIs from both a policy and service-delivery perspective is the absence of a clearly defined and operationalised clinical or public-service "case definition". Whilst the Inquiry Terms of Reference define VFIs as individuals at risk of extreme violence where ideology is not the primary driver, considerable uncertainty remains as to the essential features required for an individual to be regarded as falling within such a category. It is unclear whether the presence of a single characteristic, such as violent ideation or fixation on previous attacks, would be sufficient, or whether multiple features would need to be present and, if so, in what combination, how many episodes over what period of time, how severe the consequences, or the wider circumstances. These might be just a few of the defined parameters that would be needed for prospective identification and risk assessment.

164. This lack of definitional clarity creates practical difficulties for services and for those setting policy and providing strategic guidance. Effective identification, assessment and management arrangements depend upon a clear understanding of who is being identified and for what purpose. Without an agreed definition, it is difficult to establish meaningful prevalence estimates, develop consistent referral criteria, determine thresholds for intervention or assess the effectiveness of any risk-management approaches. Most importantly, it limits the ability to identify predictive factors associated with future serious violence and therefore makes risk estimation inherently challenging. Risk assessment is nevertheless the cornerstone of prevention, and it would be good to create systemic focus on these features of violence as a potentially avoidable public health threat.

Training

165. In Wales, the education, training and continuing professional development of healthcare staff and practitioners is delivered through a coordinated national, regional and local model. At a national level, Health Education and Improvement Wales (also know as HEIW), the strategic workforce body for the NHS in Wales, leads the planning, commissioning and quality assurance of education and training programmes across the healthcare workforce, from undergraduate and postgraduate training through to post-registration professional development. Health Education and Improvement Wales works in partnership with universities, professional regulators, and NHS organisations in Wales to ensure that training provision aligns with workforce needs and national healthcare priorities.

166. At a regional and organisational level, local health boards and NHS trusts are responsible for implementing training programmes and supporting workforce development within their services. Education is delivered through a combination of formal courses, clinical placements, simulation-based learning, leadership programmes, mandatory training and specialty-specific professional development. Regional education teams, practice educators, clinical educators and workforce development leads work collaboratively to ensure staff have access to learning opportunities that support both service delivery and professional standards. Training is increasingly delivered through blended approaches, combining face-to-face teaching with digital learning platforms, including all-Wales resources that enable consistent access to education across the NHS in Wales.

167. At a local level, healthcare practitioners receive training within their workplaces through induction programmes, supervised practice, mentorship, multidisciplinary learning and continuing professional development activities. Local services are responsible for identifying workforce training needs and ensuring staff maintain the knowledge, skills and competencies required for safe and effective patient care. This integrated approach allows national priorities to be translated into locally relevant training programmes while maintaining consistency of standards across Wales and supporting a sustainable, skilled healthcare workforce.

168. As stated above, there is currently no specific all-Wales training programme focused on VFIs. Healthcare staff and practitioners in Wales instead receive training through a range of established programmes that support the identification, assessment and management of vulnerability, risk and safeguarding concerns. These include safeguarding children and adults training, Prevent training, mental health awareness, suicide and self-harm prevention, trauma-informed practice, Adverse Childhood Experiences (ACE) awareness, neurodevelopmental conditions, violence prevention, exploitation and contextual safeguarding, risk assessment, and information-sharing responsibilities.

169. The level of training undertaken is proportionate to an individual's role and responsibilities and is delivered through a combination of mandatory e-learning, classroom-based learning, simulation exercises, multidisciplinary training and continuing professional development activities. NHS organisations in Wales support staff to recognise indicators of vulnerability, understand safeguarding obligations, make appropriate referrals and work collaboratively with partner agencies to protect individuals at risk.

170. While these programmes collectively provide many of the core competencies that would be expected within a VFI framework, including recognising risk factors, engaging with

vulnerable individuals, responding to disclosures, and promoting person-centred, trauma-informed care, there is no specific VFI training framework in Wales.

171. Building on the learning from the Inquiry, consideration should be given to the development of training that supports staff and practitioners to recognise, assess and respond to the risks associated with VFIs. Any such training would need to reflect the multifactorial nature of vulnerability and incorporate learning from a range of related policy and practice areas, including safeguarding, mental health, domestic abuse, trauma-informed practice, exploitation, substance misuse and public protection. Training should equip practitioners with the skills and confidence to identify risk, understand the cumulative impact of vulnerability factors, engage effectively with individuals, and work collaboratively across agencies to support prevention, early intervention and appropriate safeguarding responses.

Information sharing

172. In Wales, NHS bodies can and do share information with external agencies where an individual presents a risk of serious violence, but the sharing must be lawful, necessary and proportionate.

The Serious Violence Duty

173. Since 31 January 2023, local health boards in Wales have been specified authorities under the Serious Violence Duty in the Police, Crime, Sentencing and Courts Act 2022. The duty requires health, police, local authorities, youth offending services, probation and other partners to work together to prevent and reduce serious violence, including by sharing information and intelligence where appropriate.

174. The statutory guidance emphasises that agencies should:

    a. collaborate through existing partnership structures;

    b. share relevant information and data;

    c. undertake joint assessments of serious violence;

    d. develop and implement multi-agency violence prevention strategies.

175. The sharing of information between organisations is generally justified by reference to one or more applicable legal frameworks, including the UK GDPR and Data Protection Act 2018, the Common Law Duty of Confidentiality, Article 8 of the Human Rights Act 1998, the Crime and Disorder Act 1998, safeguarding legislation and associated statutory guidance, and the Serious Violence Duty. Collectively, these frameworks establish the circumstances in which information may be shared lawfully, proportionately and for legitimate purposes such as

safeguarding individuals, preventing crime, protecting public safety and delivering effective public services.

176. I am not aware of any situations presenting particular problem in Wales where parents of young people withhold, withdraw or manipulate their consent to information sharing. That may be something dealt with at a local level but not requiring escalation to myself or the Health Care and Prevention Group. Health information may be shared without a patient's consent where there is a sufficiently strong public interest justification for disclosure. This includes circumstances involving the prevention or detection of serious crime, the prevention of serious harm to others, the safeguarding of children or adults at risk, and the management of significant risks to public safety. Accordingly, where a patient is assessed as presenting a credible risk of serious violence, NHS organisations may disclose relevant information to the police where such disclosure is necessary and proportionate to prevent or detect serious crime, avert an imminent risk of death or serious injury, protect potential victims, or support wider public protection arrangements. In such circumstances, the public interest in protecting individuals or the wider community may outweigh the individual's expectation of confidentiality, provided that any disclosure is limited to what is necessary for the purpose concerned.

177. In Wales, Youth Offending Teams/Youth Justice Services are specified partners under the Serious Violence Duty. NHS representatives commonly participate in multi-agency arrangements involving:

    a. young people involved in serious violence;

    b. exploitation and county lines concerns;

    c. repeat violent offending;

    d. violence prevention interventions.

    e. Information may be shared to facilitate risk assessment, case management and safeguarding responses.

178. Where there are safeguarding concerns, NHS organisations in Wales routinely share information through:

    a. Regional Safeguarding Boards;

    b. Multi-Agency Safeguarding Hubs (MASH);

    c. Child Protection Conferences;

    d. Adult Protection procedures;

e. Multi-Agency Risk Assessment Conferences (MARAC).

179. The general principle in Welsh safeguarding guidance is that fear of information sharing should not prevent appropriate protection of children or adults at risk. Information can be shared without consent where necessary to safeguard individuals from harm.

Multi-Agency Public Protection Arrangements (MAPPA)

180. Where the individual is a violent or sexual offender subject to MAPPA, NHS mental health and other relevant services may contribute information to:

a. risk assessments;

b. risk management plans;

c. public protection meetings.

181. This allows police, probation and health partners to manage the risk posed by high-risk offenders in the community.

182. A distinct Welsh feature is the strong public-health approach to violence prevention. Public Health Wales, policing bodies, criminal justice agencies and local authorities work through established partnership arrangements and memoranda of understanding to share intelligence and develop violence prevention responses. As noted above, the Wales Violence Prevention Unit has also produced guidance specifically for Welsh partners implementing the Serious Violence Duty.

Assessment and Management of Risk

183. The identification and assessment of risk presented by a VFI within NHS-funded services in Wales is undertaken within established clinical, safeguarding, risk management and public protection frameworks. There is no single Wales-wide VFI-specific risk assessment framework currently in operation. Rather, practitioners are expected to apply professional judgement and utilise the risk assessment processes, tools and guidance applicable to the individual's presenting circumstances, clinical condition, age, setting and identified risk factors. The nature and extent of the assessment will therefore vary depending upon the level of concern, the evidence available, the wider circumstances of the case, including any identified risks to others beyond the healthcare setting, and the purpose of the assessment.

184. The type of assessment undertaken following identification of a potential VFI is dependent upon the presenting risks and the service involved. Assessments may include standard clinical risk assessments, mental health risk assessments, safeguarding assessments, violence and aggression risk assessments, structured professional judgement tools,

specialist forensic assessments and, where appropriate, assessments relating to risks posed by children and young people. The threshold for assessment is determined by the nature and severity of the concerns identified, the potential risk of harm to the individual or others, and whether further intervention of multi-agency risk management is required.

185. The appropriateness of current thresholds is likely to be hindered by the absence of a defined and evidence-based understanding of the population that the term "Violence Fixated Individual" is intended to describe. Greater conceptual clarity, supported by an improved evidence base regarding prevalence, risk factors, trajectories and effective interventions, would assist services in developing proportionate, consistent and evidence-informed approaches to identification, assessment and management.

186. Risk assessment within NHS-funded services is not necessarily confined to risks arising within healthcare premises or during the delivery of healthcare services. Where information indicates that an individual may present a risk to identified persons, public officials, staff members or members of the public outside of the healthcare environment, practitioners may consider those wider risks as part of a holistic assessment. The extent to which wider community risks are considered will depend upon the circumstances of the case, the professional responsibilities of the practitioner and the availability of relevant information from partner agencies.

187. The assessment tools utilised across Wales vary according to the clinical setting and the nature of the risk being considered. There is currently no single all-Wales assessment tool designed specifically for VFI-related risk. Practitioners may utilise locally adopted violence and aggression risk assessment tools, mental health risk assessment frameworks, safeguarding assessments, structured professional judgement approaches and specialist forensic assessment tools where appropriate. Consequently, whilst common principles of risk assessment apply, the format and documentation of assessments may differ between services, health boards and clinical specialties.

188. Existing risk assessment frameworks within NHS-funded services were principally developed to assess clinical, safeguarding, self-harm, suicide, violence and aggression risks. As a result, they may identify many of the factors associated with VFI-related behaviour, including threats, escalating hostility, fixation upon individuals and concerning patterns of conduct. However, the extent to which current frameworks consistently identify fixation, grievance-driven behaviour, pathway-to-violence indicators and pre-attack behaviours may vary between settings and professional groups. This may be influenced by the information available to practitioners, access to specialist expertise, variation in professional experience, and the quality of information shared by partner agencies.

Consideration may therefore be required as to whether existing arrangements provide sufficient consistency in the identification and management of such risks, particularly where they arise outside traditional clinical or forensic contexts.

189. A number of factors may affect the effectiveness of risk assessment where VFI-related concerns arise. These include limitations in the information available to practitioners, difficulties obtaining collateral information from other agencies, variation in practitioner experience of fixation-related behaviours, resource pressures affecting access to specialist assessment, and challenges associated with assessing future behaviour in the absence of a diagnosed mental disorder. Assessments may also be affected where the individual concerned does not engage with services, where family members are unable or unwilling to contribute information, or where information-sharing arrangements between agencies do not provide a comprehensive view of risk.

190. Effective management of VFI-related risk may be enhanced through improved multi-agency information sharing, clearer escalation pathways, access to specialist advice, workforce training on fixation and targeted violence indicators, and the development of more consistent approaches to assessment across organisations. Consideration may also be given to strengthening the current links already in place between healthcare services, safeguarding arrangements, police services, public protection structures and other relevant agencies to ensure that emerging risks are identified and managed at the earliest opportunity.

191. NHS risk assessments are informed, where lawful and appropriate, by information received from partner agencies, including police services, local authorities (including social services), safeguarding bodies, education services and public protection arrangements. Information obtained through multi-agency discussions, safeguarding processes and established information-sharing mechanisms may contribute to NHS assessment and decision-making. However, there is currently no single cross-sector risk assessment methodology used universally across all settings, and different organisations may utilise different assessment tools and frameworks according to their statutory functions.

192. Consistency of approach is promoted through national policy, professional standards, safeguarding procedures, clinical guidance and established governance arrangements which I have outlined above. However, operational delivery may vary between health boards, trusts and specialist services because of differences in local pathways, service models, workforce expertise and case mix. Efforts to improve consistency generally focus on the development of shared guidance through co-production, training, information-sharing arrangements and multi-agency working practices.

193. Where risks extend beyond the boundaries of a single health board or NHS trust, management arrangements typically rely upon established inter-organisational governance mechanisms, information-sharing agreements, safeguarding processes and multi-agency public protection arrangements. In practice, organisations work collaboratively to ensure that relevant information is shared with those who have a legitimate need to know and that responsibility for risk management is clearly identified. The specific arrangements adopted will depend upon the nature of the risk, the agencies involved and the statutory or operational frameworks applicable to the case.

Autism Spectrum Disorder as an increased risk factor

194. In the Phase 1 Report, the Chair identified that AR's Autism Spectrum Disorder (also known as 'ASD') was not properly recognised as being, in his individual case, a factor which increased the level of risk which he posed to others. Similarly in Wales, risk assessment is not undertaken on the basis that Autism Spectrum Disorder or another neurodevelopmental condition is itself a risk factor for violence. Rather, practitioners are expected to assess whether neurodevelopmental conditions, mental disorders, trauma, communication difficulties, cognitive impairments, learning disability, Attention Deficit Hyperactivity Disorder (also known as ADHD), autism or other developmental vulnerabilities are relevant to understanding an individual's presentation, needs, behaviour and any associated risks. This reflects the understanding that the relationship between such conditions and violent behaviour is complex and cannot be reduced to simple 'cause and effect' assumptions. Care therefore needs to be taken to avoid stigmatising neurodevelopmental conditions or implying an inherent association with offending behaviour. Equally, practitioners recognise that individuals with autism, Attention Deficit Hyperactivity Disorder and related conditions may themselves be at increased risk of exploitation, abuse, victimisation or unmet safeguarding needs.

195. The current NHS Forensic Adolescent Consultation Service (FACS/FACTS) specification for Wales expressly recognises that children and young people who present a serious risk of harm to others frequently have mental health and neurodevelopmental needs, and that forensic CAMHS services are concerned with young people who present a risk of harm to others in the context of mental health or neurodevelopmental difficulties. A copy of the specification is exhibited as **JT/06-** **NHSW000041**

196. The NHS Forensic Adolescent Consultation Service is not commissioned as a routine autism or neurodevelopmental diagnostic service. However, as part of its specialist assessment of a young person's mental health, developmental history and risk presentation, the NHS Forensic Adolescent Consultation Service may identify evidence suggestive of

autism or another neurodevelopmental condition and may contribute to a broader formulation of need. Where a neurodevelopmental assessment is required, this would ordinarily be undertaken through the appropriate local neurodevelopmental assessment pathway rather than by the NHS Forensic Adolescent Consultation Service itself.

197. For referral to the NHS Forensic Adolescent Consultation Service the young person should be under the age of 18 years at the time of referral, and meet all of the following criteria:

    a. Receiving care from CAMHS with ongoing case management by CAMHS. Ideally the child should be receiving a service from a Tier 3 Forensic Child and Adolescent Mental Health Service.

    b. Have a mental disorder (including mental illness or neurodevelopmental disorder) and/or significant adversity/trauma with related severe psychological difficulties.

    c. Present a serious risk to others (this would often be encapsulated in a seriously violent index offence/alleged index offence or an index offence/alleged index offence threatening or inciting serious violence). Youth Justice involvement is not a prerequisite for a referral to be accepted as indicators of the presence of risk can manifest in other ways and criminal charges may not have been brought due to a range of reasons. Preventative intervention also requires that children and young people presenting a significant risk to others, who have not received any criminal convictions have access to the NHS Forensic Adolescent Consultation Service.

198. For young people presenting to the NHS Forensic Adolescent Consultation Service with a diagnosed /documented learning disability, individuals will be assessed on a case by case basis with respect to suitability for the clinical service.

199. Given the nature of the service, it is expected that most children and young people referred will be aged between 12 and 18 years old, however children aged 11 years or younger would be accepted in exceptional circumstances. Such referrals would be considered on a case by case basis.

200. Accordingly, where a VFI has Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder or another neurodevelopmental condition, practitioners would generally be expected to consider:

    a. the young person's social communication difficulties;

    b. rigidity of thinking and behaviour;

    c. sensory sensitivities;

d. emotional regulation difficulties;

e. co-occurring mental illness;

f. trauma history and adverse childhood experiences;

g. learning disability or cognitive impairment;

h. the extent to which these factors may influence understanding of risk, impulsivity, fixation, access to support, engagement with services and responsiveness to interventions.

201. The concerns noted in Phase 1 of the Southport Inquiry that Autism Spectrum Disorder was not properly recognised as increasing risk in AR's individual case is broadly consistent with the need for a formulation-based assessment that considers how a neurodevelopmental condition affects that specific individual's presentation, rather than treating Autism Spectrum Disorder or any other neurodevelopmental condition either as a standalone cause of violence or as irrelevant to risk.

202. It is my understanding that the NHS Forensic Adolescent Consultation Service is not commissioned as a diagnostic neurodevelopmental assessment service for autism or other neurodevelopmental disorders. Instead, it is described as a Tier 4 forensic CAMHS consultation and advice service providing specialist consultation, advice and case formulation in relation to children and young people who present a serious risk to others.

203. The service specification identifies the NHS Forensic Adolescent Consultation Service as a consultation-liaison forensic mental health service. It supports local CAMHS and other agencies in understanding and managing risk where there are mental health, neurodevelopmental and complex psychosocial factors. This specification is reviewed from time to time and the next review is due later this year, 2026.

204. The Welsh forensic CAMHS model expects practitioners working with high-risk children and young people to possess expertise in mental health and neurodevelopmental disorders. The service specification exhibited above recognises the high prevalence of mental health, learning disability and neurodevelopmental needs among young people presenting serious risk and requires access to specialist forensic CAMHS consultation.

205. In addition, the Welsh Government has established national neurodevelopmental pathways and training resources through Neurodivergence Wales, managed by the National Neurodivergence Team which support practitioners in recognising, assessing and responding to autism and related neurodevelopmental conditions. The Team's programme of training and awareness raising for professionals across health, social care and education

helps to supporting improved understanding of the needs of neurodivergent children, young people and adults.

206. In respect of training, we do not have an all-Wales training programme specifically entitled training on "assessment of risk posed by VFIs with Autism Spectrum Disorder or other neurodevelopmental conditions". However, specialist CAMHS and forensic CAMHS practitioners receive professional training and supervision relating to mental health and neurodevelopmental conditions; national neurodevelopmental training resources are available across Wales; neurodevelopmental considerations form part of specialist forensic consultation and risk formulation.

207. For children and young people, autism assessments are normally undertaken through local multidisciplinary neurodevelopmental services operating under the All-Wales Neurodevelopmental Referral Pathway. A copy is exhibited at **JT/22-NHSW000038**. Those services typically involve staff from:

    a. Health Boards (community paediatrics, CAMHS, speech and language therapy, psychology and psychiatry);

    b. local authority education services;

    c. schools and education professionals;

    d. local authority social services;

    e. allied health professionals such as occupational therapists and speech and language therapists, where appropriate.

208. For adults, Integrated Autism Services operate across Wales as partnerships between Health Boards and Local Authorities and provide, or contribute to, autism diagnostic assessments and post-diagnostic support.

209. Therefore, Autism Spectrum Disorder assessment in Wales is generally a multi-agency endeavour involving NHS services, local authorities, education services and specialist neurodevelopmental teams rather than the NHS Forensic Adolescent Consultation Service acting alone.

VFI risk assessments

210. There is currently no Welsh Government policy, framework, guidance or prescribed risk assessment process relating specifically to VFIs. Accordingly, NHS staff are not subject to any Wales-specific requirements regarding the completion, management, sharing or escalation of VFI risk assessments.

211. Where concerns arise regarding an individual's risk to themselves or others, practitioners would be expected to act in accordance with existing professional obligations, organisational safeguarding procedures, information governance requirements, relevant statutory duties, and established multi-agency arrangements. Decisions regarding information sharing and escalation would therefore be made on a case-by-case basis, taking account of the nature and severity of the risk identified, relevant safeguarding considerations, applicable legal gateways for information sharing, and any local multi-agency processes.

212. As there is no VFI-specific framework in Wales, there are no sections of Welsh Government guidance or policy that prescribe how completed VFI assessments should be managed, shared or escalated.

213. As Wales does not currently operate a specific VFI framework or risk assessment tool, the Health Care and Prevention Group has not adopted a position on whether a single shared tool should be developed. However, there may be potential benefits in a common approach that supports consistency, shared understanding of risk, and effective multi-agency working. Equally, any such approach would need to recognise the differing statutory responsibilities, professional obligations and operational contexts of participating organisations.

214. A shared approach could support consistency, communication and joint working across agencies. However, there may be challenges in developing a framework that is sufficiently flexible to accommodate the differing roles, responsibilities and legal duties of organisations involved in risk assessment and management.

215. NHS organisations in Wales form an important part of multi-agency risk management arrangements. Any shared approach would need to operate in accordance with existing legal, professional and confidentiality requirements applicable to healthcare settings.

216. There is currently no Wales-specific VFI framework that designates responsibility for the management of individuals identified through a VFI process. Consequently, there is no prescribed agency or individual who holds primary responsibility for VFI management within Wales.

217. Responsibility for managing risk would ordinarily depend on the circumstances of the individual case, the nature of the risk identified, and the statutory functions of the agencies involved. In practice, responsibility may be shared across multiple agencies through existing safeguarding, public protection, health, social care, education, or policing arrangements.

218. In principle, there may be benefits to identifying a lead professional or coordinating agency where multiple organisations are involved in risk management. Potential benefits could

include improved coordination, clearer accountability, reduced duplication and greater continuity of oversight.

219. However, in the absence of an established VFI framework, the Welsh Government has not adopted a formal position on whether a designated "duty holder" model would be appropriate.

220. A healthcare practitioner could potentially act as a lead professional in circumstances where health services are the principal agency involved and where this aligns with their professional responsibilities. However, there may be limitations where the identified risks extend beyond healthcare functions into areas such as public protection, policing or community safety particularly in light of the mix of devolved and reserved areas which would be relevant to such a role.

221. The appropriateness of a healthcare practitioner undertaking such a role would depend on the facts of the individual case, the practitioner's authority, expertise and seniority, and the governance arrangements supporting the role. No Wales-specific framework currently exists identifying any healthcare professional group as the designated lead for VFI management.

222. There is currently no Wales-specific VFI framework and no designated multi-agency structure established for the management of VFIs.

223. In principle, where risks relating to violence fixation have been identified, effective management would likely depend upon timely information sharing, clear accountability arrangements, coordinated intervention planning, and appropriate multi-agency oversight. The most appropriate structure would therefore need to facilitate these functions whilst avoiding unnecessary duplication of existing mechanisms.

224. A potential advantage of utilising existing multi-agency structures is that they are already established, understood by practitioners and supported by existing governance arrangements, information-sharing protocols and professional relationships. This may reduce the need for the creation of additional administrative processes and minimise complexity for frontline staff.

225. However, the suitability of any existing structure would depend on the nature of the risk presented and whether the agencies involved have the necessary expertise, powers and operational responsibilities to assess and manage violence-related concerns. There may be circumstances in which a clearly identified lead agency or coordinating professional would assist in ensuring oversight, continuity and accountability across multiple organisations.

226. The creation of an entirely new structure would require significant consideration of governance, legal powers, information-sharing arrangements, resourcing, training requirements and interaction with existing safeguarding, health and public protection frameworks.

227. As no VFI-specific arrangements currently exist in Wales, the Health Care and Prevention Group has not adopted a formal position on whether management should be undertaken through existing structures, a designated lead agency model, or a new bespoke mechanism.

228. In the absence of a specific VFI framework in Wales, I believe that effective risk management is most likely to be supported by clear roles and responsibilities, effective multi-agency working, practitioner confidence, and a shared understanding that risk management is often a collective responsibility rather than one that can be transferred entirely to another organisation.

229. A culture of appropriate risk ownership may be supported through:

    a. clearly defined governance and accountability arrangements;

    b. shared understanding of agency roles and responsibilities;

    c. high-quality multi-agency training and professional development;

    d. accessible guidance on decision-making, escalation and information sharing;

    e. opportunities for joint case discussions and multi-agency learning;

    f. leadership that promotes collaborative risk management and professional curiosity; and

    g. assurance processes that focus on effective management of risk rather than solely on referral activity.

230. Consideration should also be given to ensuring that practitioners have confidence that proportionate information sharing and intervention will be supported by their organisations when undertaken in accordance with legal and professional requirements.

231. It is recognised that some risks will require referral to another agency due to statutory responsibilities or specialist expertise. However, effective multi-agency practice is generally supported where agencies retain ownership of those aspects of risk that fall within their respective responsibilities, while working collaboratively with partner organisations to deliver coordinated management plans. In this context, referral should not necessarily be viewed as the transfer of responsibility, but rather as one component of a broader shared approach to risk management.

Interventions

232. The Health Care and Prevention Group has not undertaken any work in relation to interventions to reduce the risk posed by VFIs. As noted at the outset of this statement the term VFI does not currently have a defined status within Welsh legislation, Welsh NHS policy, or Welsh safeguarding frameworks. However, NHS organisations in Wales routinely provide services to children and young people who may present with behaviours, needs or vulnerabilities that are potentially relevant to the reduction in the risk of VFIs. Any work is therefore within the existing safeguarding, health, social care and multi-agency arrangements in Wales rather than specific to a reduction in risks posed by VFIs.

233. The Mental Health Act 1983, as amended by the Mental Health Act 2025, provides a framework for the compulsory assessment, detention and treatment of individuals suffering from a mental disorder where specified statutory criteria are met. The legislation is not, however, designed primarily as a public protection or violence prevention regime. Its powers are only available where there is a sufficient connection between the individual's presentation, the presence of a qualifying mental disorder, and the statutory criteria for compulsory intervention.

234. Accordingly, where a VFI is suffering from a mental disorder and satisfies the relevant detention criteria, the Mental Health Act 1983 may provide an effective mechanism for assessment, detention and treatment. However, where an individual presents a significant risk of violence but does not meet the statutory threshold for detention, refuses to engage with services, or presents risks that are attributable to factors other than mental disorder, the powers available under the Mental Health Act 1983 are considerably more limited.

235. The Mental Health Act 2025 strengthens certain detention criteria by introducing a focus on "serious harm" and requiring consideration of the nature, degree and likelihood of harm. However, these reforms do not alter the fundamental position that compulsory powers remain contingent on the existence of a qualifying mental disorder and satisfaction of the statutory criteria. They do not create a new power to intervene solely because an individual presents a risk of violence or is considered fixation-driven.

Children and young people who do not meet the detention threshold

236. Particular challenges arise where a child or young person presents a serious risk of violence but does not meet the criteria for detention under sections 2 or 3 of the Mental Health Act 1983.

237. I understand that there may be circumstances in which a child exhibits highly concerning behavioural and emotional difficulties, including behaviours creating a risk of serious harm

to themselves or others, but where those difficulties are assessed as arising from trauma, adverse childhood experiences or other complex social circumstances rather than a mental disorder for the purposes of the Mental Health Act 1983. In those circumstances, detention powers under the Act are unavailable.

238. Where Mental Health Act 1983 powers cannot be exercised, alternative legal mechanisms may be available. These include secure accommodation orders under section 25 of the Children Act 1989 for looked after children who are likely to abscond and thereby suffer significant harm or cause injury to themselves or others. The High Court's jurisdiction may also be invoked in certain circumstances to authorise restrictive arrangements in a child's best interests. For young people aged 16 and 17 who lack capacity to make decisions regarding their care and welfare, applications may additionally be made to the Court of Protection under the Mental Capacity Act 2005.

239. However, these frameworks are not direct substitutes for detention under the Mental Health Act 1983. This may indicate a broader gap in the statutory framework where children and young people present substantial violence-related risks but neither meet the threshold for detention under the Mental Health Act 1983 nor have access to suitably restrictive therapeutic placements.

Individuals who decline to engage with services or assessments

240. The Mental Health Act 1983 does not contain a general power to compel individuals to engage with mental health services or participate in assessments simply because concerns exist regarding future violence or fixation.

241. Where an individual does not meet the threshold for detention and remains in the community, participation in assessment and treatment is generally dependent upon voluntary engagement. Refusal to engage does not, of itself, create a power of compulsory intervention.

242. The principal exceptions arise through the emergency powers contained in sections 135 and 136 of the Mental Health Act 1983. Section 135 permits a magistrate to issue a warrant authorising police entry to premises and removal of an individual to a place of safety where there is reasonable cause to suspect that the person is suffering from mental disorder and is being ill-treated, neglected, kept otherwise than under proper control, or is unable to care for themselves. Section 136 allows police officers to remove an individual from a public place where the individual appears to be suffering from mental disorder and is in immediate need of care or control. Both provisions are intended to facilitate assessment and immediate intervention rather than ongoing management of risk.

243. The Mental Health Act 1983 also provides for guardianship in limited circumstances. Guardianship can impose requirements relating to residence, attendance and access by professionals but does not authorise compulsory treatment or deprivation of liberty. Similarly, Community Treatment Orders may support engagement and permit recall to hospital in appropriate cases but are only available for individuals who have already been detained for treatment and cannot be used to impose restrictions amounting to a deprivation of liberty.

244. As a result, where a VFI does not meet detention criteria and refuses to participate in assessment or treatment, there may be limited options available to mental health services beyond continued attempts at engagement, information-sharing and multi-agency risk management.

Other powers available to obtain welfare information or assessment

245. Outside compulsory detention powers, the NHS in Wales has relatively limited powers to obtain direct access to, or ongoing oversight of, an individual in the community.

246. Where a person is already receiving secondary mental health services, the Mental Health (Wales) Measure 2010 provides mechanisms for care coordination, care and treatment planning and multi-agency working. These arrangements may assist with monitoring risk and facilitating engagement but do not create powers of compulsory participation.

247. The Social Services and Well-being (Wales) Act 2014 also provides assessment and safeguarding powers. In some circumstances a local authority's duty to assess will continue despite an individual's refusal, particularly where the person lacks capacity or where abuse or neglect is suspected. However, these provisions do not create a general power to compel engagement or participation in assessment processes.

248. In practice, the management of individuals presenting serious violence concerns in the absence of Mental Health Act 1983 powers is likely to depend heavily on multi-agency arrangements involving health services, local authorities, police and other relevant partners. Information-sharing, safeguarding processes and wider public protection mechanisms may therefore become the primary means of managing risk.

Assessment of the existing legislative framework

249. The existing legislative framework appears broadly effective in circumstances where an individual's violence risk is clearly linked to a qualifying mental disorder and the statutory criteria for detention are satisfied. However, there is a potential gap where serious violence

concerns arise but the individual either does not meet detention criteria or refuses engagement with services.

250. This gap appears particularly apparent in three categories of case:

    a. children and young people whose risks arise primarily from trauma, adverse childhood experiences or behavioural difficulties rather than a detainable mental disorder;

    b. individuals who present significant violence-related concerns but do not satisfy MHA detention criteria; and

    c. individuals who decline assessment or treatment, resulting in limited opportunities for professionals to evaluate risk or provide intervention.

251. Whilst the Mental Health (Wales) Measure 2010 and the Social Services and Well-being (Wales) Act 2014 provide important mechanisms for care coordination, assessment and safeguarding, they do not create additional compulsory powers equivalent to detention under the Mental Health Act 1983.

252. Whether stronger powers are required is something that will need more detailed consideration and mapping, which I hope the work of the Southport Inquiry will assist with. However, if the objective is to enable compulsory assessment, monitoring or intervention in respect of VFIs who do not meet the Mental Health Act 1983 detention criteria, such powers would likely require specific statutory provision outside the existing mental health legislative framework. Any such proposal would need to be carefully balanced against individual rights under Articles 5 and 8 of the European Convention on Human Rights and supported by clear safeguards, thresholds and oversight mechanisms.

Effectiveness of current laws and systems

253. The Welsh statutory framework as outlined in this statement provides comprehensive mechanisms for protecting children who are at risk of being harmed. Under the Social Services and Wellbeing (Wales) Act 2014 the duty to report children at risk, the requirement for risk assessments in family proceedings, the establishment of Safeguarding Children Boards with prevention objectives, and the provision of preventative services all contribute to a system designed to safeguard vulnerable children. Multi-agency working is embedded throughout the framework, with cooperation required between local authorities, police, health boards, education providers, and other relevant partners.

254. However, when considering the specific question of whether the framework adequately supports the identification, assessment and management of children and young people who

may themselves present a serious risk of violence before harm occurs, several observations can be made.

a. First, the definition of children "at risk" in the 2014 Act refers to children who are experiencing or at risk of abuse, neglect or other kinds of harm. This formulation is focused on children as potential victims rather than potential perpetrators of harm.

b. Second, although preventative services must include purposes such as encouraging children not to commit criminal offences and reducing the need for criminal proceedings against children, the statutory provisions do not specifically address how children who may present a risk of serious violence are to be identified before any offending behaviour has occurred.

c. Third, the risk assessment provisions under section 16A of the Children Act 1989 apply when an officer is given cause to suspect that a child is at risk of harm, with the assessment being of the risk of harm being suffered by the child. This again reflects a focus on the child as potential victim rather than as potential source of risk to others.

255. The objectives of Safeguarding Children Boards as set out in statute do include both protecting children who are at risk and preventing children from becoming at risk. This preventative objective could encompass efforts to prevent children from developing behaviours that pose risks to others. Similarly, the broader preventative services framework, with its emphasis on not waiting until crisis point and on encouraging children not to commit criminal offences, provides a potential foundation for early intervention with children who may be at risk of violent behaviour. However, the statutory provisions do not establish specific mechanisms or criteria for identifying such children in advance of harmful conduct.

256. More broadly, the existing legislative and service framework in Wales has been developed principally around the identification and protection of children who are vulnerable, at risk of harm, or in need of care and support. Whilst elements of that framework may be utilised where a child or young person presents concerning behaviours or risks to others, there is no equivalent, clearly defined statutory or operational framework focused specifically on the identification, assessment and management of children who may present a serious risk of violence prior to the commission of an offence. Existing arrangements therefore rely on the ability of agencies to recognise risk through safeguarding, education, health, social care, youth offending or policing pathways and to respond through established multi-agency mechanisms.

257. A further consideration is that responsibility for the services most likely to identify early indicators of concern in children and young people, including health, mental health, social care, education and safeguarding, is largely devolved in Wales. By contrast, responsibility for policing, criminal justice, youth justice, counter-terrorism and wider public protection frameworks remains largely reserved to the UK Government. While there are established arrangements for partnership working and information sharing across these sectors, the division of responsibilities can create practical challenges where concerns do not fit neatly within either a welfare-based safeguarding response or a criminal justice/public protection response. This may be particularly relevant in circumstances where a child or young person displays behaviours suggestive of escalating risks of serious violence but has not committed a criminal offence, does not meet statutory thresholds for compulsory intervention, and does not present with a diagnosable mental disorder requiring specialist treatment.

258. In that respect, the Inquiry may wish to consider whether existing legislation, policy and operational arrangements across England and Wales provide sufficient clarity regarding the identification, assessment and management of children and young people who may present a risk of serious violence before harm occurs, and whether additional guidance, assessment frameworks, multi-agency pathways or information-sharing arrangements would assist public services in responding consistently and proportionately to such concerns.

259. With regards to the acquisition of dangerous but otherwise lawful items, health services are not generally responsible for monitoring the acquisition of lawful items. However, health and mental health professionals may identify indicators of escalating risk through clinical contact, including violent ideation, obsessive grievances, fixation on individuals or issues, deteriorating mental health, significant behavioural change, disclosures made in treatment settings, or information obtained through safeguarding processes. Where concerns arise, clinicians can make safeguarding referrals, contribute to multi-agency risk assessments and, where necessary and proportionate, share information with partner agencies to prevent serious harm.

260. Prevent and Channel processes may also provide a route for escalation where concerns relate to radicalisation or vulnerability to extremist influences. The Prevent duty guidance, exhibited above specifically identifies the need for specified authorities, including NHS organisations and local authorities, to work collaboratively to prevent individuals from being drawn into terrorism.

261. However, it is also important to recognise the limitations of existing systems. In many cases the challenge is not the absence of statutory powers but the fact that behaviours associated with developing risk may be individually lawful and spread across multiple agencies, sectors

or online environments. No single organisation may therefore have full visibility of the emerging picture. As a result, effective risk management often depends upon timely information sharing, professional judgment, multi-agency coordination and appropriate escalation rather than the creation of additional legal powers. This position is reflected in Prevent guidance and multi-agency safeguarding arrangements, both of which emphasise partnership working and the aggregation of information from multiple sources.

Improvements

262. In terms of improvements or recommendations that would be practicable and make an effective difference I think these would focus around how those at risk of fixating on violence are identified and managed compassionately, particularly in mental health settings. While there is an established evidence base concerning severe mental illness, including schizophrenia, bipolar disorder and psychotic disorders, this evidence does not support a simple association between mental illness and serious violence. Although some studies demonstrate elevated rates of violence perpetration within certain populations with severe mental illness, the majority of individuals with such disorders do not commit acts of violence and the relationship between mental illness and violence is at times overstated, contributing to stigma. Mental health illnesses already have an inherent stigma and working to move beyond that so people have the support they need is important. Emerging evidence suggests that risk may be greatest during periods of untreated or first-episode psychosis, potentially providing opportunities for early intervention and risk reduction. However, a VFI construct appears intended to capture a broader and more heterogeneous group than those with diagnosed severe mental illness alone, potentially incorporating individuals whose difficulties arise from multiple interacting factors, including trauma, neurodevelopmental conditions, personality development, social circumstances, online influences and broader behavioural difficulties.

263. From a children's services perspective, the challenges may be even greater. In practice, the issues most likely to come to the attention of schools, health services or safeguarding systems are behavioural concerns, threatening behaviour, interpersonal violence, emotional dysregulation or escalating difficulties in functioning. Services are generally responding to observable behaviours and safeguarding concerns rather than to an established VFI category. Furthermore, some children and young people may exhibit concerning behaviours primarily within the home environment, meaning concerns may only become visible through parental or carer reports. Others may be disengaged from education or have limited contact with universal services, potentially reducing opportunities for early identification. Family members may also be an important source of information regarding emerging concerns, behavioural change, fixation or escalating risk, and consideration should be given to the

support needs of the wider family unit when developing assessment and intervention plans. Some young people will have grown up in environments where domestic violence was experienced as a 'social norm', potentially leading them to normalise violence as a means of responding to frustration or resolving conflict. Others may be abused by being 'coached' into using violence through county lines, so called 'honour' based violence, sexual exploitation or modern slavery. These are all manifestations of abusive behaviour which safeguarding training continues to develop in order to equip statutory staff to identify and intervene.

264. At present, where concerns arise regarding significant behavioural disturbance, aggression, violent ideation or risks of harm to self or others, existing safeguarding, mental health and multi-agency arrangements provide mechanisms for assessment and intervention. However, these systems were not specifically designed around the concept of VFIs. As a result, the Inquiry may wish to consider whether there is sufficient consistency across agencies in recognising and responding to patterns of behaviour that fall below criminal thresholds but may nevertheless indicate escalating risks.

265. A further issue is whether the term "violence fixated" adequately describes the population of concern. The phrase may suggest violence pursued as an end in itself, which may be directed indiscriminately at strangers or communities, and might be obsessionally or ideologically driven. However, some recent incidents involving children and young people might be more accurately characterised as acts arising from interpersonal grievance, frustration, resentment, perceived injustice or emotional dysregulation, which are then acted upon in a planned manner without adequate restraint, empathy or appreciation of consequences. There is also the consideration of psychotic states where individuals are, at the time, out of touch with reality. This range of scenarios suggests that a focus solely on "fixation with violence" may risk overlooking wider developmental, psychological and social factors that contribute to serious acts of violence.

266. In this regard, there may be opportunities to strengthen prevention and early intervention approaches. Recent incidents involving young people and the wider increase in concern regarding knife crime suggest value in exploring how services can identify and respond earlier to patterns of interpersonal violence, aggression, grievance-based behaviour and escalating risk. Such an approach would align with existing safeguarding, public health and children's mental health frameworks in Wales, which emphasise prevention, early intervention and multi-agency working. It may also represent an area where the Inquiry could usefully consider whether existing systems are sufficiently equipped to recognise and respond to emerging violence-related risks before they escalate into serious harm.

267. Overall, the principal challenge is not necessarily the absence of safeguarding, mental health or risk-management systems, but rather the absence of a clearly articulated and evidence-based understanding of the population that the term "Violence Fixated Individual" is intended to describe. Greater conceptual clarity, supported by an improved evidence base regarding prevalence, risk factors, trajectories and effective interventions, would assist services in developing proportionate, consistent and evidence-informed approaches to identification, assessment and management. This would need to be underpinned with a research programme to review existing literature, create some expert consensus around a working definition and classification of violence (such as targeted at other people or indiscriminately at communities, evaluate severity, motives, repeated events, timescale, etc) and commission multidisciplinary empirical research to address questions such as reliable identification, risk assessment, effective prevention, early intervention, diversion, ongoing management and rehabilitation.

Other matters

268. The circumstances giving rise to the Southport Inquiry were of profound sadness and have had a devastating impact on the victims, their families, survivors and the wider community. The loss of young lives and the lasting harm caused by the events under investigation continue to resonate across public services and society more broadly. All those involved in the provision of public services share a common commitment to doing everything possible to prevent such tragedies from occurring.

269. The Inquiry's Phase 2 Terms of Reference raise important and complex questions concerning the identification, assessment and management of individuals who may present a risk of serious violence, the interaction between safeguarding, health, education, social care and public protection systems, and the influence of online environments on behaviour and risk. These are issues that cross organisational and professional boundaries and which cannot be addressed by any single agency acting alone.

270. The Inquiry provides an important opportunity to improve understanding of these emerging challenges, to strengthen the evidence base, and to identify whether existing arrangements are sufficient to recognise and respond to escalating risks at the earliest possible stage. It also provides an opportunity to reflect on how services can work together most effectively in support of prevention, early intervention and the safety and wellbeing of children and young people.

271. The Welsh Government is committed to learning from the Inquiry's findings and recommendations. Any opportunities to strengthen safeguarding, improve multi-agency working, enhance support for children and young people, and reduce the risk of future harm

would be welcomed. The Inquiry's work therefore represents an important contribution to the collective effort to better understand, prevent and respond to serious violence, while ensuring that vulnerable children and young people receive the support they need at the earliest opportunity.

Statement of Truth

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

Signed: **SIGNATURE**

Dated: 14th August 2026