Wednesday, 4 November 2026

(10.00 am)

SIR ADRIAN FULFORD: Do remain standing for a moment so you can take the oath.

MS SUZY POWELL (affirmed)

SIR ADRIAN FULFORD: Thank you very much. Please have a seat. Yes, Mr Jamieson.

Questions by MR JAMIESON

MR JAMIESON: Thank you, sir, good morning. Please may we have your full name.

A. Suzy Powell.

Q. And in terms of title, what would you prefer? Ms, Mrs?

A. Mrs is fine.

Q. Mrs Powell, you provided us with a statement for which we are grateful. Please may we have it on the screen, DHSC000068. There is your name at the top and the date, 19 August 2026, if we went all the way to page 26 DHSC000068_0026, please, we would see that you have signed it, we have redacted it, there is a statement of truth. Is it your statement?

A. Yes.

Q. Is it true and accurate to the best of your knowledge and belief?

A. Yes.

Q. Thank you. Please may we go back to page 1

DHSC000068_0001 and just deal with introductions. If we went down over the page onto page 2 DHSC000068_0002 and to paragraph 3 at the top. You tell us that you are the Director for Emergency Preparedness and Health Protection. You set out the role of your directorate and does that include, at the end of the paragraph, advising -- planning for and advising ministers on critical issues and how to mitigate them, a number of sorts, including mass casualty attacks?

A. Correct.

Q. Does "mitigating mass casualty attacks" include preventing them?

A. That would be the Home Office lead doing their prevention but our job would be making sure that we are set up across the NHS and other services in health to deal with mass casualty attacks.

Q. What you haven't told us is, I think, how long you have been in the DHSC, how long you have been in that role?

A. I started that role in November 2024.

Q. Okay, and how long have you been in the civil service?

A. I joined the civil service in 2009. Since then I have done various things in patient safety, EU exits and special educational needs policy in the Department for Education.

Q. Thank you, and in common with other Government

witnesses, have you drawn on the expertise of those who work with you to produce this statement?

A. Yes, absolutely. I'm sort of a corporate witness and there is quite a broad amount of stuff in here.

Q. If we came down the page just there to paragraph 4, you have set out the role and the remits of the DHSC, the Department of Health & Social Care.

You are responsible for the health and social care in England?

A. Correct.

Q. But not Wales?

A. Not Wales.

Q. Which, I think we have heard from other witnesses, that it is an element of devolved policy making and responsibility for Wales, is that correct?

A. Correct, yes.

Q. You set out there, at paragraph 4, that its functions including securing NHS resources within Government. Does that mean negotiating with the Treasury?

A. Yes.

Q. "... supporting Ministers in setting strategic health and social care policy, representing health and adult social care interests across government, and maintaining accountability to Parliament ..."

You also exercise "oversight of NHS bodies at

strategic level through its relationship with NHS England".

We are going to hear from Dr Broughton from NHS England this afternoon. You help us to understand the current difference between the two at your paragraph 5, where you say this. You have set out your strategic and policy responsibilities at paragraph 4:

"By contrast, NHSE has day-to-day responsibility for the NHS in England ... responsible for commissioning and operational oversight of NHS services ... overseeing ... trusts and ... foundation trusts."

You tell us that the NHS, it is widely known, is comprised of a large number of organisations operating in a variety of circumstances.

You say that:

"NHSE therefore holds primary responsibility for the operational delivery, implementation and assurance of NHS services across the system in England."

So is that how we should think of it, that the Department, strategic policy, cross-government responsibility for health and social care; NHS England, operational delivery of the NHS?

A. Absolutely, yes.

Q. I think it is, again widely known, that there is a proposal, a policy, that the NHS England function will

be taken in-house by the DHSC. Is there a timescale by which that is proposed to occur?

A. So it is all in the passage of the NHS Modernisation Bill which is currently in Parliament. The ambition or plan is for that to be through in this session of Parliament, ie by spring 2027.

Q. In short summary, what will be the effect of that bill or that law, if passed as currently drafted?

A. The effect of the law will be to abolish NHS England and its functions would have to be subsumed into a structure that is -- the policy intends to be more accountable to ministers. The actual detail of how that's going to be work is yet to be determined and is being done in the background and actually our Secretary of State is going to be in front of the Health Select Committee today possibly explaining some of that, so we can make sure we can give you the transcript of that, which might be helpful to the Inquiry, to understand more of that policy intent as of now.

Q. Yes, thank you. I think we will take you up on that. But the broad intent is that the operational delivery of the NHS will be brought back to the DHSC. Thank you. Just to round out this section, may we just look at paragraph 7, which is just over the page DHSC000068_0003 at the top.

Because you tell us there that one of the things that the Department does is it:

"... serves ministers and provides strategic advice and policy support in relevant areas, including mental health, patient safety, neurodevelopmental and learning disability policy ..."

So again, that is across Government that you provide that support and advice in relation to those topic areas, which are relevant to our terms of reference and what I will ask you about as we go.

A. (Witness nods).

Q. Between paragraphs 8 and 10, you tell us a little about the DHSC's involvement in Prevent. I'm not going to read all of that out but again, in short summary, can you tell us what the Department's involvement in Prevent is?

A. Yes, so Home Office is the lead Government department for Prevent but clearly, health care plays a very large role in the actual delivery of Prevent and the intersection with different sectors of the health sector. So we make sure that we are well entrenched in all of the Prevent sort of governance the Home Office owns. So I sit on various Prevent boards with the Home Office and we have our own internal structure which brings together actors across health and social care, to

make sure we are clear across the healthcare system about what our duties are under Prevent and how those are being actioned across the system and that includes NHS England.

Q. So the Chair has heard some evidence again about the Prevent duty. That's something that applies in healthcare settings?

A. Absolutely.

Q. Okay. I think that will do for my purposes for introductions. Thank you.

My first substantive topic that I need to talk to you about is definitions. At various places in your statement, you have told us about how the DHSC and its officials participated in the development of some of the definitions that the Inquiry has heard about. But you haven't actually given us your evaluation of those definitions and so I would like to ask you about that now.

The first definition that was developed and used in policy discussions during 2025 and indeed in this Inquiry's terms of reference, is that of "VFI", either a violence-fixated or a violence-fascinated individual. Is that a helpful definition? Is it something that health care professionals can work with?

A. So our view is that any definition that helps coalesce

different sources around understanding this cohort is helpful, whether that definition is "NIEV" or "NIVE", as is in the interim guidance that has gone out from the Home Office. That is the overarching view. I would say that from a Departmental point of view, the things we think are important for any definition, are that it recognises that from a healthcare point of view, this cohort is heterogeneous. They appear in very different ways and to different services across health and care, which are also quite varied. We would want to ensure that any definition focuses on behaviours and risk, rather than fixating on an actual diagnosis, because that brings its own risks within health and care.

We would also want to ensure that any definition keeps pace with what is a very rapidly evolving position in terms of the evidence that we have out in the system, the evidence that we hear from this Inquiry and the more we learn about this cohort. Ultimately, the risk prevention is the sort of tantamount thing for us in any definition, but like I say, it is very helpful that there are definitions out there because it does enable people to coalesce around something.

Q. The almost universal message from people who work on the frontline of delivery services, whether that is in healthcare, whether that's in children's social care,

whether it's in justice, is that some sort of working definition is necessary so there can be policy, so there can be guidance, so there can be training.

A. Exactly.

Q. You ascribe to that. In terms of the factors that a definition should have, all important thinking -- thank you -- I don't think you actually evaluated VFIs, as to whether or not it met those. One of the criticisms that that definition has had before from other witnesses is that violence fixation is perhaps a risk factor for the sort of harm that we are seeking to try to prevent, rather than an all-encompassing definition of the individuals who might perpetrate it. Is that a criticism that you would -- or an observation that you would also adopt, or do you have a different point of view?

A. I think, if you took it from the perspective of somebody working on the frontline in health, the risk would be the element that they would be focusing on. So the behaviours and the risks. So, I'm not sure I would necessarily ascribe to that view. I think it is helpful to have it spelt out what some of the behaviours that we should be looking out for and some of the risks attributed to it are.

Q. Because, if we are trying to intervene at an early stage

with somebody with a developing picture of risk, some of the early things to look for might be a sense of isolation, a sense of grievance, a lack of supporting factors. I could give a longer list but those sorts of things. Violence fascination or fixation may be a direction towards which they are travelling but not somewhere where they have arrived yet?

A. Yes, absolutely -- and this may have come through in Phase 1 and certainly in some of the conversations we have been having -- it's the journey between becoming interested in violence and becoming fixated to actually committing an act, it is very unknown at the moment, what that pathway is. It is one of the things that's not known much about this cohort at the moment.

Q. All right. Anything else that you want to say about VFI before I move on?

A. No that's all, thank you.

Q. So, "NIEV" you have mentioned; non-ideological extreme violence. May we have a very familiar document on the screen. HOM001011. Here is the interim guidance that you mentioned shortly -- a moment ago.

A. Yes.

Q. Did the DHSC participate in the development of this guidance?

A. Yes.

Q. So may we look at page 2 HOM001011_0002 at the bottom, the definition. Crop in on paragraph 6. Thank you very much.

Here is the working definition of "NIEV", which tells us on its face it is not statutory, no, it is not legal, no, but not designed to be operational either, ie not designed for employment by frontline professionals:

"The use or threat of extreme violence, not driven by a clear ideological purpose, which is communicative in nature and intended to shock, intimidate or outrage the public or a section of the public."

So not terrorism. It has that but, again, three common criticisms of this: it describes a threat or a type of violence, not a person; it requires intent, which is difficult to determine and can necessarily only be determined after something has happened; and, indeed, communicative in nature, the further detail which sits under this definition is that the communicative nature of an attack can be explicit or implicit in nature and again, an implicit communicative nature of an attack very difficult to work out. People can disagree about that afterwards. So those are the general criticisms of it that we have heard.

Do you accept those criticisms?

A. So, again, I think it is helpful that a definition has

been worked up and I would go back to the points I made earlier, which I think basically apply to any definition. As long as they are not sort of stopping those in health and care or not causing a distraction to those in health and care who are seeing these individuals on a day-to-day basis from being able to work through what their behaviours are, what the, potentially, diagnosis is and what interventions are necessary, that's what is important to us.

SIR ADRIAN FULFORD: I don't want to be difficult, Mrs Powell, but it might be said that that answer leaves you sitting very firmly on the fence. It would be useful to have your point of view, if you have one, as to whether this is a good, bad or indifferent definition --

A. Yes.

SIR ADRIAN FULFORD: -- and if there are problems with it, what you think those problems might be.

A. Yes, and I think I would probably say good to have something. I would also say it is early days when this has actually been out in the system. We sent it out to our safeguarding leads pretty much straightaway but it has been three or four weeks since it has been out there. I think the key to this would be working through rapidly what the feedback is from health and care

workers on the frontline as to how useful it actually is and whether it is problematic.

SIR ADRIAN FULFORD: Well, I'm not going to press it but that really doesn't answer the question. But I understand what you are saying is that you don't have a view at the moment.

A. Yes.

SIR ADRIAN FULFORD: You want to see what happens with this. I'm sorry to interrupt you, Mr Jamieson.

MR JAMIESON: No, sir.

SIR ADRIAN FULFORD: Isn't that in itself going to be difficult? To reach a point where one has got sufficient feedback from individuals applying this in the field, that is going to stretch over probably a significant period of time and if this is an unhelpful definition, simply looking at the definition, then that's not going to be a very satisfactory state of affairs, is it? Do you have any response to that?

A. I think we can make sure that we work as rapidly and as comprehensively as we can in the boundaries of the Inquiry --

SIR ADRIAN FULFORD: Thank you.

A. -- to have a more comprehensive answer.

SIR ADRIAN FULFORD: All right.

MR JAMIESON: Is that feedback currently being sought?

A. It is out there. It has been out to 8,000 --

Q. Sorry, I know the guidance has been released but have you said: please tell us what you think, here is a survey, here is a way of capturing your feedback?

A. I would have to check and I'd have to come back to you on that one.

Q. All right. Just a thought in terms of what you were -- your general response: definitions are helpful, they give our practitioners something to work to, things that are distracting from the core risk aren't helpful. Potentially focusing healthcare professionals on unpicking questions of intent, in terms of ideology, in terms of whether an ultimate attack would be communicative and intended to shock, would distract them or may distract them from core factors of risk, such as grievance, becoming fascinated with violence, becoming isolated from society; is that a potential risk with this definition?

A. Potentially. That's a question we can ask.

Q. The Inquiry has received a third definition from Professor Cassam, "non-ideological violent extremist". I think, rather than going through all the detail of that, I will just say, do you have any particular response, good, bad or indifferent, to that definition, anything particular to say about it?

A. I think, again, it is good to have a definition that we can then work with.

Q. All right. I will move to the second of my substantive topics which is safeguarding and social care. Please may we have page 3 DHSC000068_0003 and paragraph 11 on the screen. Thank you.

So, just at the very bottom you say:

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

Over the page DHSC000068_0004:

"... (principally the Care Act 2014 in respect of adult social care and that bodies working in local safeguarding partnerships are discharging their responsibilities under the Children Act 2004). DHSC, working closely with NHSE, therefore has a role in ensuring that safeguarding responsibilities are effectively implemented and assured across the health ..."

That is the language, I think, of strategic oversight:

"... across the health and adult social care system. The statutory safeguarding assurance for NHS providers is contained ..."

In the guidance which you set out there, DHSC000061, which I am going to come to very quickly.

But just in simple terms, your Secretary of State is the Secretary of State for Health and Social Care --

A. Yes.

Q. -- which relates to adult social care particularly, in this circumstance?

A. Yes.

Q. Whereas children's safeguarding, the lead agency responsible -- the lead ministry responsibility for that, I should say, is the Department for Education?

A. Correct.

Q. But there is some overlap and you are telling us about that in is this section?

A. Yes, absolutely.

Q. So it is not quite as clean cut as that but we should understand that DHSC is principally responsible for adult safeguarding, DfE is responsible, principally, for children's safeguarding?

A. Yes, in terms of owning the legislative frameworks.

Q. Yes, thank you. May we just look at that piece of statutory guidance, DHSC000061: so overarching guidance on "Safeguarding, children and young people and adults at risk in the NHS".

So guidance particularly at that context, as of

course it would be for your evidence, but why this document is helpful is you said, in answer to my question a moment ago, responsibility for legislative frameworks, this document provides a useful look at the legislative frameworks for each adult and children's social care because they are different, aren't they, in England?

A. Yes.

Q. We have heard in other evidence that in Wales they have a common statute but in England it is different. If we went on please to page 2 DHSC000061_0002, just in the middle and then towards the bottom. This document sets out legislation, statutory and recommended guidance, which is applicable for all ages, so children and adults and there are some very familiar pieces of legislation here: European Convention, Mental Health Act, Human Rights Act and so on.

If we go over the page to page 3 DHSC000061_0003, we will see -- and just crop down to the bottom half of the page, thank you.

For adults, a shorter list but the principal statute is the Care Act 2014, isn't it?

A. Correct.

Q. And the regulations that sit underneath that?

A. Yes, and the statutory guidance.

Q. And the statutory guidance, yes, thank you. Whereas for children, the principal pieces of legislation are there at the second bullet, the Children Act 1989 and the Children Act 2004 and then all of those other pieces of legislation and statutory guidance that come with it.

So, it is set out there in that way to help us to understand it. If we just looked at the bottom of this page, at the bottom of page 3. Again, what this tells us, at the very bottom paragraph, is that in respect of children:

"Local authorities have a general duty ... to safeguard and promote the welfare of children within their area who are in need."

And that is a responsibility across the board?

A. Correct.

Q. For adults it is different, we don't have a piece of statutory guidance to put up but if we just went over the page to page 4, we have a little of the duty about adults but does it come essentially to this, that under the Care Act 2014, whether or not an individual adult will be eligible for support is governed by the snappily titled "Care and Support (Eligibility Criteria) Regulations 2014"? And essentially, to meet eligibility, the adult must have a need that arises from, or is related to, a physical or mental impairment

or illness; that physical or mental impairment or illness must be serious enough that it means that they can't themselves achieve one of a number of particular outcomes that are specified, things like managing and looking after their own nutrition, their own personal care, being safe. Those sorts of outcomes.

And the impact on their achieving those outcomes must be significant enough that it will make a significant impact on their wellbeing.

A. Yes.

Q. So, can we agree that those are more restrictive criteria than for children, where there is the general duty for all of those who are in need, is that a fair summary of the different positions?

A. I think -- I'm not sure I would use the language "restrictive", but I would say they are different frameworks.

Q. Yes.

A. The adult social care covers more people than children's but the criteria, I would agree, are more narrowly defined in adult's social care.

Q. I think "narrowly defined" will do enough. If you don't want to use the word "restrictive", I think "narrowly defined" will do for my purposes.

A. Yes.

Q. Thank you. That document can come down and we can go back to the statement just at page 4 DHSC000068_0004, I think it is, paragraph 11 and 12.

So, the other difference, there you tell us:

"Child safeguarding is [inherently] a multi-agency function, led across government by the DfE."

You say that:

"The DfE works closely with [the] DHSC and [the Home Office] to design policy, legislation and statutory/non-statutory guidance ..."

But it is designed to be, it is inherently multi-agency?

A. Yes.

Q. Whereas adult social care is principally single agency; other partners, other experts can be brought in but it is principally delivered by local authorities?

A. Yes, local authorities but then there will be people that access adult social care outside the boundaries of the state system. But that's probably not particularly relevant to this conversation.

Q. Yes.

A. Just on the children's social care point of view, our involvement is by virtue of the joint and equal principle in the children's social care framework which brings in police, education and health services together

at a local level and that's why we are so closely involved at national level as well.

Q. Yes. I have acknowledged already, I know it is not your department's core responsibility, I'm just trying to get an understanding of the differences of the regime, the difference of the criteria and the difference of the arrangements. It is not a single continuum between children and adults; they are different regimes that meet different needs?

A. Correct.

Q. Actually, it is not my purpose to say that that's generally wrong, I am sure it isn't. But the cohort that we are concerned with are adolescent and they span the 18-year-old cliff edge, cut-off, whatever you call it, between children and adults and so we are looking, with some focus, on the difference of support that is available for those who are under 18 and for those who are over 18.

And I am taking from what you have said so far, guarded and careful and important as it is to acknowledge the different needs of adults who require social care and the different agency that they have in their own choices, but there is a significant difference in terms of the support that is offered pre-18 to post-18.

A. Yes, and I think -- and I know we will come onto this, but one of the things that we would be thinking about is how you don't see that as a sort of a binary construct between children's into adults and actually, what are the other services outside those slightly more narrowly defined criteria of adult and social care? What else can you bring in, in a multi-agency way, to make sure that those transitions are not as bumpy as we clearly know that they are at the moment in some cases.

Q. Any concrete suggestions or proposals to make in that regard?

A. So, I mean, there are a couple of things and we know that transitions, for this cohort and all sorts of cohorts, are challenging between children's and adult services. We see that across the board. So --

Q. There's a lot of evidence of all sorts of negative outcomes at exactly this point in all sorts of circumstances?

A. Yes, absolutely. We, already as a department, are looking at the statutory guidance that sits behind the Care Act as part of the work for the Casey Commission. I do think there is space in that work, that will be taking place over the coming months, to think about how do we, without sort of -- you don't have to name a particular VFI or use a particular definition, but how

do you make sure that it is clear to those working in adult social care that the transition work is important, you need to do it early, so you don't have people falling over a cliff. The multi-agency work is important, how you share information, and getting that I think more clear in the guidance is something we can take away. I think you also know that the adult social care legislation looks very much at sort of harm and risk to an individual, the individual rather than the harm and risk that they may pose to others.

Q. Yes.

A. Now, while we wouldn't be supporting sort of changing the legislation, so it broadens that out, there could be some work that we could do to be signposting a bit more in the guidance that sits behind the Care Act, what a practitioner in social care could potentially do if they are presented with somebody who pose as risk to others. And again, it would be very much going down the multi-agency working but that's something we could look at. And there is some work afoot on how to improve the training for the adult social care workforce more generally on multi-agency working, and where to signpost into different services for transitions.

Q. But just thinking about those two proposals, so -- or those particular proposals -- statutory guidance --

re-writing the statutory guidance and providing some signposting; they don't alter the fundamentals of the statute, which, as you rightly acknowledge, is designed to prevent or protect individuals from risk of harm that they themselves might suffer.

If I'm thinking about a particular example of a 17-year-old who has no diagnosable physical or mental health condition, but has a number of vulnerabilities that are relevant to our risk cohort, you know, isolated, some sense of grievance, perhaps some early instances of violence that have resulted in non-criminal disposals, who is receiving some sort of non-statutory youth-focused intervention, perhaps sport, perhaps a youth club, perhaps something of that nature, perhaps some mentorship, when they become an adult, if we take away ideas of transition and perhaps some interim provision for a short period of time, as that person crosses 18, under the Care Act, the evaluation that social workers are required to perform is prescribed by the statutory guidance. Does that individual meet the criteria for assistance? He is not going to.

A. Correct.

Q. And so essentially, that will fall away, once the transition period is finished.

A. Yes. And I think this comes back to people that are

doing those assessments being aware of what other pathways or avenues there are that are outside the more narrowly described actual adult social care pathways. Ultimately --

Q. So to signpost that person to somewhere else?

A. Yes, because ultimately, as you say, the services that are available in adult social care are probably not going to benefit somebody with those characteristics because adult social care is going to be looking at: do you need help in the home?

Q. Do you need somebody come in and help you get up in the morning; that's what they are thinking about?

A. It is very functional. So, therefore, I think our view is the trick is in making sure that rather than that practitioner seeing it through that narrower lens, they can see more broadly into: who else could I speak to, who else do I need to signpost this particular individual to, because there is a risk that they could fall between a crack between two services.

Q. Yes. One of the witnesses that the Inquiry heard from earlier was Mr Mark Norris of the Local Government Association, he said the same thing, effectively in a different way, which is those that are involved in youth safeguarding, children's safeguarding, deal with a broad cohort of individuals, of all sorts of risks and

vulnerabilities and strengths, whereas those who are involved in making assessments for adult care and needs, as you say, consider quite a narrow set of criteria and they judge individuals against those narrow set of criteria, essentially to decide whether or not funding will be extended to them, either directly or through the provision of a service.

And he told the Chair that, essentially, those adult social care professionals would be far less likely to encounter somebody who was displaying the risk factors for VFI and NIEV, on an average working practice, than a youth practitioner would. Would you agree with that analysis?

A. Yes, I think so. I mean, Mr Norris will see this on a day-to-day basis, but that feels like a very sensible judgement to me.

Q. All right. Sir, I'm going to move on from this topic, unless you had any particular questions on it at this moment?

SIR ADRIAN FULFORD: Not at the moment.

MR JAMIESON: May I come back to your statement and the role that DHSC has played in the development of Government policy in this area, which is one of the topics that you tell us about in your statement. I'm not going to go through every paragraph but I will pick out key

landmarks.

May we look at paragraph 17 first, which I believe is on page 5 DHSC000068_0005 at the bottom. So:

"Early [policy] work included the formation of [the VFI] Analytical Group that first met [in] February 2025. [And] DHSC was part of this group ..."

That's when the description "VFIs" was discussed. If we just looked at that guidance briefly, HOM000266. And we just looked at (2)/(3), we could see there that right at the start -- again, I'm not going to read it all but just to emphasise a point that you have made in your statement, the need for a name and definition of this cohort was there right at the start and indeed, number (3) describes that, on how we define these individuals "being the most important question". That's been recognised since February 2025, that we need a definition for this cohort, from which all other policy work can flow?

A. Yes.

Q. Back to the statement, please, at paragraph 18. Page 5 DHSC000068_0005 at the bottom. So:

"At the same time, [Home Office] sought to establish a central team ... that would lead on and 'propel' policy [response] ..."

Your Secretary of State was asked to provide

a secondee and one couldn't be found, is that right?

A. Correct.

Q. Can you explain how one secondee could not be found for such an important team?

A. So, capacity issues within the Department, but I think --

Q. Not one official within the entire DHSC?

A. That was the judgement that was made at the time. That's not to say that we didn't do the work with the Home Office department; the facts speak for themselves.

Q. I know you did things, yes, but you were asked for a secondee and one could not be found. That's the long and the short of it?

A. Correct.

Q. I will resist any comment. There was also a literature review that was performed, which is DHSC000032. May we also see that briefly. Here was the evidence summary produced by officials in your department, essentially trying to understand what the scientific learning was about the interrelation between autism, mental health and the risk of violence and homicide.

This was put together from a variety -- if we just went down to the bottom of page 1, we would see that a number of different studies were footnoted throughout it. But there was one particular -- or two studies from

one professor that was not looked at and may we just look at that now. ILT000177.

This is the work -- what we understand to be the leading work of Professor Al-Attar, in this circumstance. This is one of his papers:

"Autism spectrum disorders and terrorism: how different features of autism can contextualise vulnerability and resilience."

Which is on all fours with the topic that the literature review was considering.

If we just went onto the next page ILT000177_0002, we would see the abstract there in the middle, which is very familiar to this Inquiry and indeed has been commended by a number of experts:

"... no empirical evidence to link autism and terrorism, in the general population."

Which is really important to say; people shouldn't consider that the fact that somebody is autistic is a risk of extremism. But relevant to the understanding of the risk, contextual, especially in individuals:

"Caution is encouraged against drawing conclusions of causality ... [but] highly individualised formulations that take into account the heterogeneity of autism and how [its functionality] is expressed, as well as the complexity, is strongly advocated."

Push and pull factors, how they interrelate with risk, really important to look at.

Professor Al-Attar's research paper was not in the DHSC's literature review, is there a reason?

A. So, you are right, I can't see it in the references. I would quite like to take away the question of whether it was looked at and then not referenced or whether it wasn't looked at all and we can come back to you on that. I agree, it's a very helpful paper, and a lot of the conclusions in this are similar to those that were drawn in the literature review. Possibly with the exception of, sort of like, the push and pull factors.

Q. Well, that's the point, isn't it? Because we can't draw a line, we are not drawing a line between autism, neurodiversity and terrorism risk; we are not. But if there is -- if an individual has ASD, has neurodiversity and has other risk factors, we need to be thinking about how their neurodiversity interacts with those risk factors; we should not be ignoring it, we should not be treating it as irrelevant. That's potentially the important difference that Professor Al-Attar is drawing to our attention?

A. Yes, and I think what I would say is that -- and I know it is in the bundle -- but the guidance we put out recently on radicalisation, sort of guidance for those

working in mental health, you will see that does talk about push and pull factors and that does contextualise it more broadly. But I will take away the question about whether it was in the lit review.

Q. Yes, that is a fair thing to say. Really at the moment I'm asking about -- we are back in 2025 and I'm trying to understand whether or not that thinking was present.

Thank you. Please may we go back to the statement then, page 6 DHSC000068_0006, paragraph 21. So we are winding the clock on a little. We have gone past February 2025. Now we are in March 2025 and the NSC meeting which, again, the Inquiry has heard a deal about. The DHSC attended that meeting and were given some actions arising out of it and again, I would just like to look at those actions, if I may.

Can we have on the screen CAB000053, it should be the NSC meeting record. There it is. Sir, we have looked at it lots of times but if we just went to page 2 CAB000053_0002 and action 4, we will see that, just further down, one of the actions allocated to DHSC and others was:

"[Accelerating] a national roll-out plan for Prevention Partnerships and wider complementary work to identify and support minors showing signs of vulnerability towards extreme violence."

Can we just roll down the page a little to see number 6:

"Local services should prioritise the VFI cohort ([being] individuals who do not meet Channel thresholds, but do represent a clear risk of violence to others) across the national security, social care, health, education, youth justice and ..."

Other environments:

"Any resourcing and financial implications of delivering this should be considering at the Spending ..."

And it would say "review". If we just went back up, we can see that amongst others -- so, prioritisation of the cohort, amongst existing services allocated to DHSC and others.

If we go back onto page 3 CAB000053_0003, we can see:

"Prioritise adapting health services in 11 priority local areas to accept VFI referrals for access to mental health and other services, with a view to expanding further ..."

I think that is a reference to Vanguard?

A. Yes, it is.

Q. But prioritisation should be given to accepting VFI referrals for access to mental health and other services

with a view to expanding further. So the creation of a route through those Vanguards for VFIs, to get priority access to mental health and other services, was the action. If we went down to the bottom of this page, just to complete our analysis. Number 7, also allocated to the DHSC:

"Scope further, more ambitious options which go beyond those in Action 6 for how long social services can prioritise and support VFIs."

And 8:

"Scope a national prevention gateway and case management service ..."

Or, as it has come to be called, the big front door. Again, allocated to DHSC as well as others. So those were the actions that that senior committee allocated to the DHSC.

If we go back to your statement, page 7 DHSC000068_0007, paragraph 23, so you have helpfully set them out there in (a) (b) (c) (d) in short summary but you say, at 23:

"Following the ... meeting, the Department took forward two actions to address the concerns raised ... working closely with the central [Home Office] team as they developed these actions and reported their progress into the joint HO/CO senior team ..."

We will just look at what those actions were. So the first one is at paragraph 24. I think, as I develop this detail, I will observe to you that two is not four in terms of actions and I will come back to why some of the actions were not taken forward when we have looked at the detail of this.

You set out there, at 24 and 25, essentially Counter Terrorism Police asked you to help them to track a cohort of people that CTP had identified as VFIs, or at least potential VFIs, who had been referred to mental health services. So people that they were worried about?

A. Yes.

Q. Who may pose VFI-type risks, who they could say had been referred to mental health services. They had been -- they had gone into Prevent but they hadn't been taken forward because they didn't exhibit any clear ideology, despite the risk of violent behaviour. So, CTP -- tell me if this is right -- indicated: there is a cohort of people that we are worried about, they present a risk of violence but they haven't been adopted by Channel because there's no ideology, there is no vulnerability to terrorism, but they have been referred to some sort of mental health provision and we want to have an eye on them to see what's happening with that cohort. Is that

what they asked you to do?

A. Yes.

Q. And what you say at paragraph 25, is that:

"DHSC could not directly support CTP with this work because the Department does not have access to patient-level data."

A. Correct.

Q. You:

"... worked closely with NHSE to develop a process by which CTP could work with local trusts, allowing CTP to follow-up on individuals identified as VFIs. That process was set out in an email from NHSE that was shared with the Department on 25 April 2025 ..."

So let's have a look at that, DHSC000039. So, we don't need to look at the addressees. If we can crop in on the first bold underneath. Thank you.

So this is some advice that NHSE, I think, were providing back to Department of Health & Social Care?

A. That is right.

Q. So the first question is:

"... what information [do] we need from the Home Office/CTP to help us identify [who these] people ... [are]."

It says:

"NHSE and DHSC should not be in receipt of patient

identifiable information, however, in order to confirm the circumstances of all 400 referrals, local providers will need patient identifiable data. Therefore, we need to build a process whereby such information can be shared directly between the Local Authority [and] Prevent with [the] relevant providers of [mental health] services locally."

So there needs to be a way for those to interact:

"This process will also need to be able to aggregate the data so a summary of outcomes can be provided ...

"The information which each ... Prevent partnership [or local authority] needs to provide is:

"NHS number ... [date of birth] ...

"What needs were ... identified ...

"[The] reason the referral to Prevent.

"If the VFI is under 18 ..."

A number of particulars of information. Over 18, some different particulars of information. If we scroll down, just to the next bold one there DHSC000039_0002:

How in turn we will support. So once CTP give us the information we need, how are we going to support them:

"The relevant provider of [mental health] services will then need to respond with the following information ..."

And essentially provide it back to Counter Terrorism Police, Prevent, Channel, whoever it might be.

So an email setting out a process that could be followed locally?

A. Yes.

Q. Right. What happened?

A. So this set of answers was sent back over to Counter Terrorism Police, who then took it forward, to better understand where a set of individuals -- and I can't remember the number off the top of my head, but I think it was about 800 people.

Q. 400 was referred to here.

A. 400, whereabouts they were in the system. So then that took that away and part of this was -- and again, I would have to double-check this -- but it was quite significantly retrospective. Some of it was: what is happening in an existing cohort and some of it was looking back to actually understand: what are the pathways that people take if you fall out of the Channel process?

Q. So if we just went back to your statement though and back to paragraph 23 on page 7 DHSC000068_0007 -- sorry paragraphs 24 and 25. Thank you.

So you asked NHSE to design the process, they came back to you with that email, you sent it to CTP. But

that's where your statement stops in the story of what happened with this issue. Was there any assurance or feedback or supervision that the DHSC took thereafter, to see whether or not this was happening on a local level?

A. I would have to check.

Q. Because --

SIR ADRIAN FULFORD: Amongst the recommendations was that there was a need to build a process in order to capture the information that could then be of use. Now, that was a clear proposal. What happened to that proposal?

A. So my understanding is that the processes outlined in the email that went back to CTP, that was used to design a process where they could actually work that through.

SIR ADRIAN FULFORD: So that has been implemented?

A. I would want to take that away and double-check.

SIR ADRIAN FULFORD: Well, it would be useful to know whether those in this cohort are being captured with that information then being available, so that it can help inform decisions that are going to be taken in relation to those who constitute the cohort.

A. Yes, absolutely.

SIR ADRIAN FULFORD: You will come back with that?

A. Absolutely.

SIR ADRIAN FULFORD: Thank you.

MR JAMIESON: Because, as you say, there are really two parts to this work, one is: well, we have got this existing cohort of people that we are worried about, we don't know where they are in the system, we don't know what's happened with them, we had better find out pretty quick. But there's also the ongoing issue of, people who aren't accepted by Prevent, what are their pathways? Are they being picked up by the right service? Are they being mitigated?

So it is both a retrospective and current risk management process but also a future one, so I think it is both aspects of that we need to know. Sir, we have received some information from CTP about some of the work that they did in this area and we have looked at that already, but really what I'm asking about is about the DHSC's strategic assurance of this issue --

A. Yes.

Q. -- which is what the Department does.

A. Yes.

Q. And what happened with this story after April and May 2025, because that's where the statement stops?

A. Yes, that's fine.

Q. Thank you. The second action is there, at paragraph 26:

"... the Department has worked with NHSE to consider how best to offer tailored support to people identified

as VFIs who were referred to mental health services by Prevent. DHSC identified the ... Vanguards ..."

Which is what was there in the NHSE meeting:

"... as an option for delivering on this goal and worked with NHSE (and clinical experts) to develop a proposal to expand these Vanguards ..."

In the spending review.

Skipping to the end, there was no funding to expand Vanguards in the spending review.

A. Correct. At the point of the NSC meeting, there would have been -- because they were put into the spending review process, but ultimately -- and we will see this when we get to the meetings later in June -- by that point, we kind of new that the settlement would not come of Vanguards. But at this point in time, in March 2025 that was very much a live discussion and consideration about what should be in our spending review bid that they were putting together.

Q. I'm going to come back to the spending just in a moment because the families have some specific questions about that that I will ask you.

A. Okay.

Q. But if we just put to one side whether or not the Vanguard was going to be expanded from its current coverage to national coverage, that was actually only

half of the task. The task was: how are the VFI individuals going to be prioritised for access to mental health and other services by the Vanguards; what is the process? Was a process ever developed by which that could happen within the Vanguards?

A. So the fundamental principle -- so the fundamental principle of Vanguards is that they do pick up individuals with quite complicated needs. They won't be specified as VFIs but you could see that the Venn diagram is pretty much like that and make sure that those children or young people who are not quite hitting statutory boundaries, but are at risk of falling out of waiting lists and various other things, are put into a specialist pathway and are scooped up by the system. So that's the fundamental principle of the Vanguard. Whether they talk about VFIs or not is another matter.

Q. One of the things the Inquiry heard right at the starts we had a very helpful and informative seminar presentation from the NHS Vanguard in Gateshead which told us about the importance of looking at the entirety of a child's story, about -- rather than just having off-the-shelf interventions and designing -- picking up all sorts of areas of vulnerability and strength, designing interventions that met those dealing -- it's a buzzword that I hate, but -- holistically with

individuals.

A. Yes.

Q. Understood; that's what they are for. But the NSC said: go and design a specific process that prioritises VFIs amongst Vanguards. I think your answer is: well, Vanguards look at a child globally and the Venn diagram will overlap and they'll pick them up. Does that mean there was no specific process for VFIs?

A. I think we would have equated the action from the NSC to be: look at the funding of Vanguards.

Q. All right. Well, I'm going to resist putting it back up again but I think, as I read it, there were two aspects of it: prioritisation; and expansion across the country. But if that is how you interpreted it, that is the evidence to give.

On the question of funding, could we just roll on so we have got the top of the next page DHSC000068_0008, because paragraph 26 ... is there. Thank you. You say:

"While further expansion of Vanguards did not receive specific funding within the current Spending Review period, there are currently 11 Vanguard sites in England covering around 19% of the country. The Medium-Term Planning Framework gives ICBs greater autonomy to decide how funding is spent, balanced with the need for national accountability ... National

funding of Vanguards may be reviewed in future spending rounds."

So the victims and survivors asked some specific questions about that, which I will do now. Firstly, they draw attention to the fact that you say the 11 Vanguard sites cover 19 per cent of the country. Dr Broughton for NHSE thinks it is 26 per cent of the country. Do you know why there's that difference?

A. No, but it is 26, is what I have had in my briefing.

Q. So 19 there is wrong; it should be 26?

A. Let me take it away.

Q. Okay. Perhaps not at the very top of your list but yes, it would be very useful to know it. Perhaps more significantly, what does "may be reviewed" in future spending rounds mean? What is the next opportunity to bid for additional funding and will the Department do so?

A. So the next spending review is going to be in 2027. We are not sure on the timing of that yet. But I imagine it will be the second half of the year. We would absolutely be taking a view -- and we can come back to sort of different actions we are taking on mental health but we are putting out a mental health strategy at the back end of this year. We would absolutely be thinking about what to include in any bidding process and we

would absolutely be thinking about whether Vanguard should be included in that. So it will be a live question in the spending review deliberations.

Q. What's the general evaluation of their effectiveness? There has been a review?

A. So there has been evaluations of all of them, and I think eight have been published. Two of the things that I pulled out the evaluations is (1) they reduce risk-taking behaviour and (2) is that they reduce offending. And there are lots of other sort of bits of detail in there which again we can provide to you but those are the two that really struck me as most relevant for this cohort.

Q. Do you have a sense of how high up your list of priorities funding for those is going to be?

A. I think that --

Q. You are going to tell me that is for ministers?

A. I'm going to tell you it's for ministers. I mean, I can give you my personal opinion and I could give you the opinion of ministers. My opinion is that these feel like a very useful and timely use of kind of people in the system who are very expert across CAMHS and Forensic CAMHS for this particular cohort, but we have to make decisions about funding in the round against a whole host of priorities, across mental health and across

other critical areas in the NHS, and that's what will play out over the course of this year.

Q. Thank you. We will note, at paragraph 27, that there was a follow-up meeting from the NSC that your director general of primary care attended and you have given us the minute for that. I think in the interests of time I will just note that. Thank you, we have that evidence.

Paragraph 28, you tell us about -- and again, something that you have mentioned I think in our discussions this morning -- about an update to some guidance in relation to staff working in mental health trusts on the management of radicalisation risk.

Now, the document that you appended to your statement, DHSC000058, that was the 2017 version?

A. Yes.

Q. But in fact, the new guidance since your statement has now been published, hasn't it?

A. Correct.

Q. So we, the Inquiry team, have obtained that. We can put that up. ILT000366. Is it guidance that sits online and so there are a number of different parts to it?

A. Yes, so there's the central piece -- it is all on gov.uk -- there is this central piece and then there are bits underneath it that are aimed at particular staff

groups.

Q. So this is the general piece of guidance but there is a piece of guidance that's aimed at the designated lead for Prevent, there is a bit that's aimed at individual members of staff, other pieces. But this will do for our purposes. So here it is. It is the management of the risk of radicalisation in mental health services. It was published very recently, 19 October 2026.

If we just scroll down to page 2 ILT000366_0002, we see that an introduction to Prevent is provided for those who come to this guidance. We would note that the objectives of Prevent are to:

"Tackle the ideological causes of terrorism;

"Intervene early to support people who may be susceptible to radicalisation;

"Enable people who have already been engaged in terrorism to disengage ...

"Radicalisation is the process of a person legitimatising support for, or use of, terrorist violence."

Which is all accurate but focuses on ideological terrorist violence. If we look, however, at the bottom of page 4 ILT000366_0004, which is where we pick up "When you should consider making a referral", so the general guidance, it's particularised in the other

documents that we have talked about. But this is what mental health professionals are being told:

"When you should consider making a referral.

"One rule always applies: if there is a risk of immediate harm to the person, yourself or others, contact 999 without delay."

So simple and clear: call the police if there is an immediate risk. It doesn't say "call the police" but presumably that is the emergency service that you are being directed to.

If we go over the page to 5 ILT000366_0005, we have this:

"You should be aware that there is no set criteria to determine when to make a referral. Radicalisation can take many different forms, and anyone, regardless of background, can be susceptible. A referral should be made if there is a concern that a person may be at risk of becoming a terrorist or supporting terrorism.

"Each person should be considered on a case-by-case basis using ... professional judgement ... it is far better to receive [presumably, make] a referral that turns out not to be of concern than for someone who genuinely needs support to be missed."

So, be precautionary:

"You should be aware of signs that is someone may be

susceptible to radicalisation. Susceptibility to radicalisation often develops through the interaction of multiple influences ..."

And they are set out:

"You should not regard a referral as being unfair to your patients or a breach of confidentiality.

"When assessing ... consider the Notice, check, share ... framework."

I think if we roll down, we will see that:

"Notice ...

"There are many things that could be potential warning signs or reasons to be concerned ...

"... change in behaviour ... spending time with groups who may be involved in concerning behaviour."

Then this second bullet, which I think is the first factor of relevance to the cohort that we are concerned with:

"Increased online activity, such as engagement with extremist or hateful content ..."

Which is probably classic terrorism:

"... or material promoting or glorifying violence.

"Changes in how they think, such as new thoughts that seem threatening or worrying."

"Check" is the next thing:

"... gather information available to you and discuss

your Prevent lead."

Then, if we go over the page ILT000366_0006:

"Share ...

Once you have got the information, share it, precautionary principle.

This is the new guidance that has been produced and promulgated to the staff working in mental healthcare, yes?

A. Sorry?

Q. This document is the new guidance, that we have been going through. This is the 2026 guidance?

A. Yes, 2026.

Q. And is it designed to take account of non-ideological extreme violence, or the risk thereof? Is it designed to warn members of staff to be alert to that?

A. So I think -- and I can't see it on this particular part of the document, but I'm -- we do refer to the fact that you don't have to -- there doesn't have to be an ideology present to make a referral to Prevent and I think that is quite far up and high up and prominent in the document.

Q. Okay. Shall we go back up and look again?

A. Yes, I think so. Sorry, I can't remember where --

Q. Shall we go to page 1 ILT000366_0001. Scroll down to page 2 ILT000366_0002. So it is a description of

Prevent, its role and the package of support. I drew your attention to the first three bullets. Over the page, to page 2. Your role. You should know what to do in circumstances where you might become concerned that someone is at risk of becoming radicalised. Making yourself familiar with the basic principles. Assessing each situation. Keeping up to date with training. Knowing who your Prevent lead is.

If we turn over the page ILT000366_0003. It is directed to Prevent leads, and then when you should consider making a referral, we have gone through. We can roll on. Page 5 ILT000366_0005. Notice, check share. We have looked at that.

We can look at page 6 ILT000366_0006, for completeness. Then there is the particular guidance in relation to taking account of mental health conditions and neurodivergence. So I have not gone through all of it and I have drawn your attention, in particular, to that bullet that referred to online activity and interest, glorification of extreme violence, in and of itself, not linked to any ideology. But this is the principal document. You think there is other guidance underneath it?

A. So there is the old 2024 guidance which again, I think we are going to have to look at, which is specifically

about Prevent. This was the update for 2017, for 2026, and it brings in some of the things that have moved on since then. So the criteria you have mentioned, the three at the top, including the online one, that's taken directly from the Home Office sort of broader guidance that we have sort of pulled across to make sure it is up to date because the 2017, for those warning signs was -- it wasn't reflective of those warning signs.

Q. All right. But this document that we are looking at, this is the principal guidance that has been distributed?

A. Yes.

Q. All right. Well, I will move on for that. May we just go back to your statement then, thank you. Page 9 DHSC000068_0009, paragraph 32. We are now at June 2025 and the permanent secretary for DHSC, who was then Professor Chris Whitty, went to the cross-government meeting of Permanent Secretaries that we have looked at before. The Home Office prepared two papers. Let's just have a look at the outcome from that.

DHSC000024. So this was the briefing that Sir Chris was provided. Just at the bottom of the first page please, there is the discussion of the definition and what the Department -- the definition of "VFI". What the DHSC was saying at that stage, was:

"Agreeing this definition is a useful first step. However, it is our view that we need to break this down further in terms of biopsychosocial/clinical drivers to help us identify and flag VFIs. We understand that [the Home office] and ... (CTP) have conducted analyses of the cohorts of concern ..."

But certainly that was what was being said about definitions at that stage. "VFI" was useful but it needed to be broken down further to identify the risk factors that would help practitioners identify the individuals of concern?

A. Yes.

Q. Do you know if anything was done in relation to that, in terms of developing the definition?

A. I don't know but we can take it away.

Q. All right. And then over the page, please, onto page 2 DHSC000024_0002, certainly -- so this is picking up those actions that the NSC had set. So:

"Home Office and CTP have identified a cohort in their system of around 1,000 people who were referred to Prevent ... who they consider meet the definition ...

"DHSC and NHSE have proposed a process by which we can identify what happened to any members of this cohort who were referred to mental health services ..."

Which is the email that we looked at earlier.

The process was:

"... a necessary first step to understanding where and why members of this cohort may not be being appropriately prioritised. We have been clear that this needs be a local process ...

"However, as yet no information has been shared about this cohort ..."

So the process wasn't working as at June of 2025 and you are going to come back to us as to whether matters have developed since?

A. Yes.

Q. All right. What about that final paragraph:

"Once we have this information, we could offer to write to ICBs ..."

So ICBs are local commissioning bodies, aren't they? They decide which services are going to be funded and commissioned:

"... we could offer to write to ICBs to ask them to ensure that VFIs are being appropriately prioritised. Currently, where a person is referred to mental health services from Prevent with a diagnosable mental illness and that person pose as risk of harm to others, that person should be prioritised for treatment."

Do you know if that action was taken forward, writing to the ICBs?

A. I don't think so.

Q. No, I haven't seen any evidence --

A. I haven't seen any evidence.

Q. Do you know why that wasn't taken forward?

A. I think the answer probably lies in what I am going to come back to you on, in what actually happens in relation to the previous paragraphs.

Q. If you don't know which ICBs have got these individuals, you don't know which ones to write to, I suppose, unless you are going to write to all of them?

A. I imagine, the ambition would be to write to all ICBs, that tends to be what we do. And I imagine, although I don't know, it might have been directed at the statutory safeguarding leads at ICBs.

Q. Okay. Thank you. That can come down, may we just go back to the statement. Page 10 DHSC000068_0010, paragraph 36. The next event I want to pick up, so we are now at the end of 2025:

"... 17 December 2025, Baroness Merron ..."

Who I think is one of the ministers in your department?

A. Yes, at the time, she was the Minister for Mental Health.

Q. Thank you:

"... visited the Counter [Terrorism] Operations

Centre to discuss complex issues they were coming across in their Pursue casework, including cases with complex needs such as mental health and neurodiversity. This was a result of the Security Minister offering a briefing and opportunity to discuss ..."

If we looked at paragraph 38, there was an exchange of letters, wasn't there, following on from that visit? I just want to look at those letters. So the one that CTP sent to the Baroness, was DHSC000092. Just so we understand the context, the Security Minister has spoken to the Mental Health Minister and given her a briefing, after which, she goes to the operations centre, has a meeting and arriving out of that, there's this exchange of letters. If we just look at the top half of the page, we can see, January 2026 this is sent. There are some paragraphs thanking her for coming and providing the context.

If we just scroll down. Acknowledging the critical requirement for a whole system approach and addressing the particular challenges; that is a sharp increase in individuals with complex vulnerabilities. There is some detail of how things work in Pursue. There are some details of the objectives of Prevent. What it says is this:

"The objectives of Prevent are to tackle the

ideological causes of terrorism, intervene early to support people susceptible to radicalisation and enable people who have already engaged in terrorism to disengage ..."

We are already familiar with that. There has been:

"A sharp rise in referrals that fall below the terrorism threshold [which] has created unsustainable strain on the system -- compounded by the lack of any system to which CT partners can confidently 'hand off' casework, and public safety risk, where it does not meet CT thresholds."

So, Prevent are saying -- CT police are saying: we have had all these referrals that Prevent -- sorry, that present a public safety risk, but they don't meet our criteria for adoption; they are not terrorist vulnerability cases and at the moment, we don't have confidence of where we can hand them off to:

"We greatly appreciate your acknowledgement of these ... pressures ... and agreed that the health service's ability to identify vulnerabilities early, reducing the risk of radicalisation before CT system involvement becomes necessarily, remains essential."

So mental health services are good at getting involved early before risks become acute, dealing with areas of particular vulnerability.

Then they make a number of asks which are there in terms of next steps DHSC000092_0002:

"We were pleased to agree that DHSC will identify a dedicated point of contact ... to develop and enable health interventions, and scope the prospect of seconding staff to and from ... CT ... Together ... will work to [find] 'quick wins' that could have an immediate impact ..."

So, point of contact, secondments. Second bullet:

"We fully welcome and appreciate your offer to include these challenges within the demand and supply side reviews of the mental health services to explore opportunities for early intervention in incidents where neurodiversity, learning difficulties and mental health are assessed to impact risk."

So, you have offered to put these factors into your wider consideration of mental health services:

"Home Office agreed to convene quarterly forums ...

"... DHSC would look for solutions to resolve the unsustainable funding position of the CCS ...."

And we had Dr Taylor from the CCS come and give evidence:

"... which to date has been solely financed by CTP."

Brackets: give us some money to fund this. So those are the asks. In terms of what the Baroness said back,

please may we have DHSC000091. 24 March, so a couple of months later. Again, some thank yous and acknowledgement of the increasing demand, a remark that that's not only on mental health services, not only with counter-terrorism, but generally. Yes, a whole system approach is necessary. Thank you for the next steps:

"I would like to offer a brief clarification on funding following our discussion. To ensure everyone has the right access to care and support, DHSC is committed to building a NHS that's not only fit for now, but also for the future."

All parts of Government need to do that. Challenging spending review. We welcome existing possible options and how this might be taken forward. Does that mean: no, we are not giving you any money for CCS?

A. I would have thought so.

Q. Yes:

"... demand and supply side ... was mentioned in your letter ... I would like to share some additional information on this topic. The Secretary of State for Health and Social Care launched the independent review into mental health conditions ... and autism ... in December 2025."

We will look at some of that in a minute:

"It will look at prevalence and need, drivers of changing trends ..."

Sets that out:

"Thank you again for your ongoing partnership. I look forward to continuing to work together on these critical challenges."

Over the page. That's it.

Does that mean none of the asks were agreed to?

A. No. So the secondees, that is happening. There are two that are now going to be working with the CTP. So that has happened.

Q. Excellent, and when did that happen?

A. The dates -- they were interviewed before the summer and they are currently going through -- as you can imagine, there are quite complicated security clearances -- was the position a few weeks ago.

Q. Okay. So not yet, but in train?

A. Yes. So that has happened. You have touched on the demand and supply side review. That's fine. We will come onto that, but that's moved on quite a lot since then and, as we will come to, does look at both kind of early intervention and looks at the sort of sharper specialist end of things.

Do you mind flicking back and showing me what the other actions were?

Q. Certainly. DHSC000092, please. It is the second page DHSC000092_0002 of the bulleted list. So dedicated point of contact?

A. Yes. I think that refers to setting up basically a small --

Q. (Overspeaking) to make the secondments work?

A. Yes, a small team within the Department that can make that work. And that happened, that sort of -- mainly the mental health part of the Department, but partly in the national security part as well, given the security interlink.

Q. Yes. Explore these challenges within the Fonagy Review?

A. Yes.

Q. Quarterly forums, give us some money for CCS?

A. Correct. So I think I can say with some confidence that the last one didn't happen because I don't think we have funded CCS, for all the reasons that were outlined in Baroness' letter. As I say, the Home Office agreed to convene quarterly forums. I think the thing that moved on from this is that the Home Office now convenes the ministers every six months as well.

Q. Yes, and we have heard about the taskforce that now exists and didn't at the time of this letter. All right. I think you got a copy of this letter, I can see at the bottom of the page.

Thank you. All right, that can come down. Sir, I'm just going to round out this topic, if I may, and then suggest that we take our break.

SIR ADRIAN FULFORD: Yes, certainly.

MR JAMIESON: So we are on page 10 DHSC000068_0010, paragraph 36. I just want to complete the chronology of your involvement.

A. Yes, of course.

Q. Or the important bits to pick out in the chronology. If we just looked at paragraph 39, which is at the bottom of this page. I have some questions from the family.

Which tells us about the cross-government VFI working group that was set up in January 2026 and the leadership and membership. Then over the page, please DHSC000068_0011, at (b):

"All departments [were] to develop plans to increase capacity in interventions where demand is clearly growing from the VFI cohort, to help supply meet demand, while recognising the resource-constrained environment. This should be informed by [the Home Office] analysis on the efficacy of interventions."

And the family question is -- or the victims/survivors' question is: has that plan been written? What does it propose? What does it cost?

A. So, I will take those in turn. Part of this would have

been about Vanguards but I will probably answer the question more in the round. What this would be, from our point of view, is our response to the development of Fonagy and the response to Fonagy. So this would be our mental health strategy that is due to be coming out in the next couple of weeks, which looks at -- while again, I don't know if that specifically refers in name to VFIs, but it certainly talks about the challenges in the system and will be looking at both how you intervene early to stop people's needs escalating and then how do you improve the performance and capacity of the specialist end of the spectrum where you will be seeing sort of VFIs as their risk is increasing. So that's what we would say our plan is to addressing this point (b).

Q. So it is going to come in the response to the Fonagy Review?

A. Yes.

Q. So you can't say what it is going to cost and you can't say what it is going to contain?

A. And I think it goes back to the other question from the families about when the spending review is happening, that's when this will be pulled together. It is in our sort of mental health bundle of activity for the spending review, later in 2027.

Q. So that's the critical time period for actually getting things to change(?).

A. (Witness nods).

Q. Okay. And the follow-up question is this -- again, from the victims and survivors: will the Department with NHS England -- or can the Department, in the light of that timescale, put costed options for interventions for this cohort, with access criteria, staffing, waiting times and evaluations, before the Inquiry before it closes its evidence? The date the families have given is 9 November, but I think I can extend that to the end of the year. Are you going to respond to Fonagy in that period of time?

A. So the public commitment is to take the mental health strategy out before Christmas and I think there is also -- and this is slightly tangential, but a public commitment to respond to the Milburn Review as well. While that looks at a different issue, because it is looking at NEETs, some of the substrate in the mental health area is similar. So there will be both those things out before Christmas.

Q. Okay, and are they going to deal specifically with interventions that are necessary, effective for our cohort, however it is defined?

A. So I think it is all still currently not even gone

through ministers yet.

Q. Okay, but the answer we -- I'm sorry, you finish.

A. No, no. Carry on.

Q. I was going to say but whatever is coming, is going to come before Christmas --

A. Yes.

Q. -- so we will be able to see the answer to my question in what comes?

A. Yes, and it will be, as I say, looking at both early intervention and is looking at specialist support and the issues within that and the performance issues and there will be things in the strategy that look at that specific area as well and you can see how that is a link across into VFIs.

MR JAMIESON: Thank you. Sir, would that be a convenient moment?

SIR ADRIAN FULFORD: It would. Quarter of an hour?

MR JAMIESON: Yes, thank you.

SIR ADRIAN FULFORD: We will sit again at 11.45 am. Thank you very much.

(11.30 am)

(A short break)

(11.46 am)

SIR ADRIAN FULFORD: Yes, Mr Jamieson.

MR JAMIESON: Thank you, sir. Please may we have the

statement back on the screen, page 13 DHSC000068_0013, paragraph 46.

So, just before we broke, we were going through the highlights of DHSC's role in policy development back over the last 18 months or so. Now we are onto the current work being undertaken. You tell us at paragraph 46, essentially that you have some membership of the NIEV Taskforce, is that right?

A. Correct.

Q. And at 47:

"As part of the ... Taskforce Governance, the Early Intervention Working Group ... was established in June 2026, bringing together cross-government policy and operational leads to ..."

Fulfil that piece of work on the early intervention side of it. May we just look at -- well, I tell you what, let's flick over the page DHSC000068_0014 to paragraph 48, just so we can see the terms of reference of that group, what it is supposed to be doing:

"(e) Provide clear recommendations to the Advisory Board on priority policy, and operational issues relating to early intervention."

The document that you have us that was referenced in the earlier paragraph, DHSC000037, please.

That's the read-out, it was a meeting in June 2026.

We don't need to go through it all because those discussion points map some of what's in your statement but if we just go to the bottom of the page, we will see that it says:

"Actions."

Then over onto the next page DHSC000037_0002, what those actions are, which include: confirming who is going to be on the team; feedback on the terms of reference; develop the working definition of NIEV. Well, we know that's fulfilled:

"Gather feedback on key policy questions;

"Circulate high-level EIWG workplan."

Could I fairly characterise those as all pretty early actions to achieve in the work of this group; confirming representation and providing feedback on the terms of reference?

A. Yes.

Q. Then, if I look down to "Next steps":

"The next working group will take place in July ..."

"The first Advisory Board is expected in July ..."

And what it says. So this is the document you gave us with your August statement. Did the board meet in July? Is there any progress? Is there any further work on this, on the early intervention working group that you can tell us about?

A. Yes. So I don't know whether a meeting happened in July, we can check that, but just in terms of what's happened since then, so you are absolutely right to pick out that the sort of the main piece of work that this group pulled together over that period was the definition work. As you said, that's now out there in the open, so that's the main thing. From our point of view, I think there were two other things that are not explicitly mentioned, but they're work has been taken alongside this governance structure; one is the information sharing piece of work, which was --

Q. I will come to that --

A. -- asking departments to put in the barriers for information sharing, which we fulfilled. The second thing has been work between ourselves and Home Office on improving the representation of data in Prevent data on mental health and neurodisability.

Q. Yes. Neither of those are interventions though. What's happened with the development of interventions for this cohort? Is there any progress, from this working group, that you can tell us about?

A. I don't know where the Home Office got to in terms of putting together --

Q. Have you provided a submission to them as to: well, we think these interventions work, we think those don't,

these are the ones that we need to be looking at for this cohort. Has that been fed into this working group?

A. I don't know.

Q. Okay. Would you please provide an update to us --

A. Yes, of course.

Q. -- in writing in relation to that. I will pick up the two points that you mentioned. May we go back to the statement please, page 14 DHSC000068_0014, paragraph 49. This is the commission that you got in relation to information management, which you were just telling me about. So, as well as your membership of that working group:

"The Department is also currently working with the NSS on a cross-government short term project to support the ... Taskforce, focusing on information management ... An initial work plan has been set out and the NSS aim to conclude this work by September 2026 with a view of producing findings that the [Home Office] can take forward ..."

Has that been concluded?

A. I don't know but we can check with the Home Office where they have got to.

Q. Okay. Let's just look at that document, CAB000039 which was the initial work plan. So, it is a Home Office work plan, which I acknowledge, in fairness, it sets out the

relevant Phase 1 Inquiry recommendations that the learned Chair made. And then, if we went down to the bottom, just so I can see those bullets:

"... the overall work plan of the ... Taskforce makes clear, we need to:

"Improve information sharing between agencies at the local level;

"This should be supported by ensuring local IT systems can provide a full understanding of an individual's risk at-a-glance (including warning markers."

Role for NSS is set out. It says, in bold: buy-in will be required from all departments. If we go over the page CAB000039_0002.

Here are the deliverables, key next steps and the like. So this was the work plan. But we don't know if it's been completed?

A. So I know that the top one has been completed, in relation to identifying key barriers to data sharing because we have sent this information over and identified the main areas from a health perspective, so that's is definitely done. Second one --

Q. We will look at that momentarily.

A. Yes.

Q. Sorry, please do go on.

A. No, no that's fine.

Q. Are there any other of these -- I think we will ask -- it was due to be completed in September. It is November. I think we would ask an update as to whether or not that has happened?

A. Yes, sure. We can check with the Home Office.

Q. Thank you. The key barriers to information, the document that you mentioned, DHSC000033 please.

I think this is the document that you were just referring to?

A. Correct.

Q. I will resist a question about why there is a LPP redaction in it. But if we came down the page, you identified some technical problems. You identified some cultural problems. More risk averse organisations or staff will be more reluctant to share information if they are not absolutely clear on legality:

"Challenges around confidence that staff can share information/Staff unsure if they can/should share in particular circumstances -- Royal Colleges and regulators have published professional practice [guidance on information] sharing."

Just over the page DHSC000033_0002. You identify particular transition points at which there are difficulties in sharing information. One of those is

between children's social care and adult social care. You are nodding. For the transcript, you have to say "yes"?

A. Yes.

Q. No, it is not your fault, I should have made it clear.

And you identify that there are cultural and legislative barriers. We have talked about legislative differences, I won't go through that again. But the different culture of those organisations, you set out here, and the data capability barriers which I think is a heading for different computer systems that capture different types of information and don't necessarily work together?

A. Correct.

Q. And then capacity barriers:

"Local systems require sufficient workforce capacity ..."

And that is a significant challenge across health, social care and education. So you have identified those. So for this wider commission that the Home Office has given, you have identified some of the particular problems in information sharing within your area of competence and the one that you are particularly identifying here is between adults and children's social care?

A. Yes, and I think in this bill also it is also about data sharing within the health and family, so to speak, but also outwith the health and family and into education and law enforcement.

Q. Yes. If it is difficult, even to share information between social care for adults and social care for children, it is going to be even more difficult to share it outside, with those cultural factors, towards agencies that have an entirely different area of operation?

A. Yes, absolutely and I think there are a few things sort of since this has been put through that have happened that I think could be helpful, all related to the DfE legislation around information sharing. (a) the guidance and that being out in the system and being clear on this cultural points about nervousness about confidentiality. I think again, that is a helpful movement since this has been put through.

Q. We did ask the DfE and the related witnesses about those legislative changes, so, if you will excuse we, I won't do that with you. But, I think what I will observe and what I will ask you to confirm is that, in other areas of the Inquiry's investigation we have heard about those cultural factors that can prevent information sharing, even when the powers are clearly there and what your

return to the Home Office commission tells us is that those are similarly operative within the health and care family, to borrow your phrase?

A. Correct.

Q. Thank you. Please may we go back to the statement for the final point under this heading. Page 15 DHSC000068_0015, paragraph 52. So, you tell us, in May 2026, the then Security Minister wrote to departmental ministers, including your Baroness Merron on the need to establish a new CT ministerial board:

"... asks for interventions, adopting a 'whole sector' approach. [And] The Director for CT noted at the meeting on 10 June 2026 ..."

Which might be considered a pretty neat encapsulation:

"... that there is a requirement to '[put] a wrapper of broader disruption and divergence around those in need.' Actions included ..."

For the various departments to work together:

"... to identify all available levers and interventions that may be suitable for managing [those] risks for individuals with complex needs within CT investigative casework ..."

If the director for CT has identified the problem, we need this wrapper of broader disruption and

divergence, what are the proposals that DHSC -- what are the levers that you have identified that can meet that problem?

A. Yes, so just first of all, background -- and you might know this already -- but this particular discussion is around the sort of what we think about as the top of the triangle of those with mental health and neurodivergent issues and the sort of -- the terrorist sort of sector, rather than the NIEV or VFI cohort that sits alongside or underneath. So that's --

Q. The learning is likely to be --

A. Exactly. But for us, as you say, the sort of like the drivers and the push and pull in the system are the same, regardless of whether you go down the ideological route or the non-ideological route. But just so we are clear what the discussion was at this particular meeting. Again, this comes back to the work that we have been doing with CTP and Home Office, in trying to get secondees over so we can work on the casework and understand sort of what's sitting behind that and what's going on behind it.

So it's the operational work that is ongoing behind the scenes, particularly with CTP. And then I would come back to, sort of like, there is the much bigger question, which is sort of the capacity in the system

and the ability for the mental health system and neurodivergent system to actually have the capacity to deal with sort of some of issues that they are seeing, which is a separate issue but something that is seen quite frequently, in this -- in these discussions -- it is not just about how services work together, it is the capacity of services to actually deal with the increased numbers in both cohorts.

Q. Okay. So the secondees, which we picked up on when we talked about Baroness Merron's letter to the CTP before and the wider system response to need, mental healthcare, and neurodiversity treatments, which I will come to momentarily. Just before I do, we can see, just there, that you have also told us in your statement about some work that the Department has done to improve Prevent data on mental health and neurodevelopmental conditions. I'm not going to read those out. We have them there. We are grateful for them. Sir, for your reference, it is paragraphs 53 to 57.

SIR ADRIAN FULFORD: Thank you very much.

MR JAMIESON: I'm not going to spend time on that now. But I am going to come straight back to that point that you have just made about the general barriers to mental health treatment in society at large.

Could we look please at page 18 DHSC000068_0018,

paragraph 68. So this is where you set that out and you note, to focus that wider society issue on our terms of reference:

"As noted in the Phase 1 Report, AR experienced delays in accessing mental health support and ASD and ADHD assessments, reflecting wider pressures on services."

Those were factors in his case but they are not particular to him; those are pressures in society at large and require a system response?

A. Yes.

Q. You tell us there, at paragraph 69, about an important report from Lord Darzi in 2024, where he looked at the global state of the NHS in general, didn't he?

A. He did.

Q. Again, I'm not going to call it up, it is a very long and detailed report. Sir, you have the reference. But in simple terms, did he note that there was essentially increased demand on the National Health Service, that the population was spending less time in good health and that was one of the things that increased that systematic demand and then, in particular, there was an increasing demand for mental health services?

A. Yes.

Q. Are those some of the conclusions that he gave?

Obviously, I don't do justice to his report in that short summary, but those are some of the problems that he noted?

A. Yes.

Q. If we went to paragraph 72, which is just over the page DHSC000068_0019. You tell us about some of the strategic work, the broad system work, that the Department is doing in this space. The reference there, DHSC000042, that was the commission of a report that the Department put out and you also, at the time of your statement, gave us the interim report, which is there at 73, but since you wrote your statement, we now have Professor Fonagy's final report, don't we?

A. Correct, yes.

Q. We will just look at that very briefly. Sir, I know you have seen this before but it is perhaps worth repeating. ILT000365.

So this is the final report on the "Independent review into the prevalence and support for mental health conditions, ADHD and autism", which is known more generally by the name of its Chair, the Fonagy report. You and I have talked about it a couple of times in passing during your evidence. Published in October 2026 and you have told us that we can expect the response to this from the Government before Christmas?

A. Correct.

Q. May we just look very briefly at some of the executive summary. Again, I will not do it justice. This is as 600-page report and we are going to look at one or two pages.

May we look just at page 5 ILT000365_0005. So here is the executive summary, where Professor Fonagy and his team set out some of the systemic problems in the first three paragraphs, and then at 4, he says this:

"... (ADHD) and autism are neurodevelopmental conditions, strongly genetically influenced and present from early life, influencing attention, communication, behaviour, learning and how people experience the world. With the right adjustments many people live full lives; some face substantial difficulties and lifelong high support needs. Traits related to these conditions, including inattention, social difficulties and emotional regulation, occur to varying degrees across the population, but having some of these traits, or identifying as neurodivergent, is not the same as having a diagnosable neurodevelopmental condition. Diagnosis depends not simply on early developmental presence of traits, but on their severity, persistence and impact on functioning."

So he is telling us about the difference between

recognising those traits and having a formal diagnosis. Then at 5, he says this:

"Recognition of ADHD and autism has risen dramatically, leading to hundreds of thousands of people awaiting diagnostic assessment and many others struggling to access support. Many people also continue to face barriers to timely treatment, [including] the refusing that difficulties escalate and become more severe."

I think you can see our interest in this, as we look at these paragraphs. 6:

"Continuing as we are is not sustainable: not for the people waiting weeks, months or years, becoming more distressed because help is locked behind waiting for a diagnosis; not for those with the most severe needs who cannot access specialist care; and not for a society paying the human and economic price of failing to support people to participate in family, community, education and working life."

I won't continue to read it all out, but he says, essentially, the opportunity -- rather than simply carrying on as we are and managing that rising demand, we have to build a better system. His key conclusion, or key recommendation is there at paragraphs 8 and 9. We have to stop focusing on diagnosis and we need to

move to a system where "needs-led plus diagnosis":

"The heated debate about whether there is too much diagnosis or too little risks reinforcing the centrality of diagnosis rather than need and timely access to support and treatment. The government must address two failures at the same time: people wait far too long for support, diagnosis and treatment, and diagnosis has become the primary gateway to support that could and should be available earlier. These failures sit looked insufficient capacity for people with the most severe, enduring and complex needs."

That's his key conclusion, isn't it? That support needs to be available earlier, pre-diagnosis, to meet needs, to intervene early?

A. Yes, absolutely, and my three sort of real key takeaways from Fonagy are: it is not just about the money, it is about system redesign, although money is obviously important. Absolutely, think about needs not diagnosis and intervene early. The only thing I potentially would add is he does also focus on the need for dealing with the specialist end of the system as well. So that's my kind of encapsulation of what to take from it.

Q. Yes, and I think the plea that I make, or the question that I ask, more properly, is that, obviously, responding to this, if this is to be implemented, is

going to be a very large, very substantial system redesign. Will you ensure that, amongst that system redesign -- and as you have just said recommendation that some of this cohort have got particular specialist need and need particular focus -- that account is taken of those who may fit into the cohort that AR did, whether you call them "VFIs", or "NIEVs" or whatever it might be? If we are going to provide care and support pre-diagnosis, that needs to be available to those who present a risk or a vulnerability to extreme violence of a non-ideological sort. Do you see that? Do you see how that needs to be included?

A. I do see how that needs to be included and as I said before, we are sort of working through ministers at the moment. (1) I don't know whether the strategy itself, when it is published, will reference particular cohorts. It will certainly reference the need to look at the performance of the specialist end of the system, as well as investing in early diagnosis -- sorry, not early diagnosis. Complete opposite. Early identification of need.

Q. Early identification of need. Because it is not easy -- it is not hard to see how that could pay real dividends?

A. I completely agree.

Q. All right. Thank you. Please may we go back to the

statement and to page 20 DHSC000068_0020, paragraph 76.

A related question. So you were, there, dealing with the interim report in the paragraphs above. I have not asked you about that because now we have got the final report and we have looked at it.

But you say that one of the ways that "the Government is seeking to reduce barriers to access to services" is to increase funding and there has been an increase of funding in this area; 140 million in real terms, from the previous funding award. You tell us that this funding "will help the Government accelerate the rollout of Mental Health Support Teams", which you set out at paragraph 77, but please can you give the Chair a brief summary of what they are and what they are designed to do?

A. Yes, absolutely, and this actually is germane to the conversation about the last spending review because this is what was --

Q. This is where the money went?

A. This is where the money went, basically. So you have your 161 billion here which is keeping existing services going and then mental health support teams was on top. So mental health support teams, they have been in existence for a while. They cover about 60 per cent of the schools, 60 per cent of pupils at the moment, and

the ambition is to have them to 100 per cent by the end of Parliament. Basically, they are teams of frontline workers including mental health workers that are based in schools and that's primary and secondary schools, across the country, with the aim of providing drop-in support for sort of children in need, but also providing specific interventions for those whose needs are slightly higher up.

So this is by no means an intervention that is specialist, but it bridges that early support and slightly more interventionist sort of part of the sort of support spectrum that you would have for children with mental health issues, emergent and existing.

Q. And a question that comes from the victim and survivors group is: do those teams have a pathway? Are they directed to focus upon and intervene with young people who pose a risk of harm to others, or who may pose a risk of harm to others, rather than to themselves?

A. So my hunch is yes, but I would want to check that explicitly just so I'm not giving you the wrong information.

Q. Yes, please. I think a sort of comprehensive and answer and understanding -- I'm speaking for the Chair -- but I think we would like a proper explanation of that, thank you.

Then, at 78, you tell to us about Young Future Hubs, which has also been funded. Those are not in schools, they are open-access, community-based, but they are also designed to provide mental health support for children and young people, I think?

A. Correct. Yes.

Q. It is the same question, if I may, for those: do they have a pathway? Are they designed to identify, assess, manage, individuals who may pose a risk of harm to others rather than to self?

A. So, shall I cover both young futures and early support, if that's okay?

Q. Yes, please.

A. So we have put them together in the same paragraph for a reason, is that they are very much at the open-access, support end of the spectrum, which we feel is incredibly important for young people. Young Future Hubs, specifically, it is a DCMS-led initiative that we are feeding into from the mental health point of view and they are looking specifically at knife crime and mental health. They are a work in progress. So, I think there are a few earlier adopters and there is now another 26 local authorities identified they are going to have them, but they are very, very early days. But the aim of those is that they sort of provide sort of drop-in

support for children who are struggling, with a particular focus on knife crime.

How they are run -- and I think this comes back to your question about sort of what the referral routes are -- the guidance, having read it recently, it feels very much that it is for local determination, how it operates. So I think that's what I say about Young Future Hubs. Early Support Hubs, in a sort of similar way, they have been a little bit more longstanding, provider a similar open access, they are very specifically about mental health. Again, they are not universal at all, they are in different patches of the country. I will take away the question about referrals and what they cover.

Q. Yes, because one of the attractions, on the face of what you say at paragraph 78, is those Early Support Hubs. Patchy, local, as you say, I accept all of that, but they don't have a 18 cut off; they are 11 to 25?

A. They are, and that recognises the fact that the SEND statutory system goes up to 25. So I would imagine that the 25 is in reference to that, rather than a blanket coverall for 25, but again, we can take that away and check.

Q. Please. Thank you. I'm going to move to my next topic. If we can go over the page just to check we have nothing

that we have missed about those. I don't think -- you tell us about the additional funding, the additional support hubs which will expand the service but it is still going to be -- it is not going to be national coverage at this stage?

A. Correct.

Q. The next topic that I want to ask you about is about the recent changes to the Mental Health Act. Was that legislation that was brought forth by your department?

A. It was.

Q. So, please may we just have -- I just want to put this in context for you, before I ask you these questions.

A. Of course.

Q. Because it is a bit nuanced but it has some real relevance to the facts of our case. So please may we have on the screen the Phase 1 report, volume 2, which is CHAIR000002. So this is the learned Chair's report and please may we go to page 315 CHAIR000002_0315 of the pdf, at the bottom. You can see the title "Mental Health Act assessments: gap in assessment powers".

I have taken you to this rather than just giving you a summary so you can see it.

A. Of course.

Q. In effect, some of the facts of AR's case, Dr Irani was the expert who -- psychiatrist who assisted the Inquiry

at Phase 1 and some of what she said was that, he was particularly concerning because he had not been seen for a long time by a mental health professional or indeed any other professional. He was essentially locked away in his own room, refusing to meet with professional visitors. However, the challenge was that any assessment -- and that means assessment under the Mental Health Act, in context:

"... of AR at this stage would have been that there was a lack of evidence that he was suffering from a recognised mental illness (such as severe depression or psychosis) which was potentially treatable in a psychiatric hospital."

You will recognise those as gateway criteria for the Mental Health Act assessment, which is what the learned Chair says here:

"On that basis there was no Mental Health Act power to assess AR."

Just over the page CHAIR000002_0316, please:

"Accordingly, Dr Irani accepted that the decision not to carry out a Mental Health Act assessment was a reasonable exercise of professional judgement. As NHS England have observed in their closing statement [at Phase 1], the use of a Mental Health Act assessment in such a situation [would have] only [been] an imperfect

solution [anyway]. In reality, such an assessment may have required a somewhat artificial justification, relying upon the responsibility that AR may have been psychotic when isolating himself ... even though no clinician had considered that was the case, or [indeed] raised it as a possibility ... Indeed, even then, on examination, psychosis was ruled out. As both Dr Irani and NHS England acknowledge, this gives rise to a wider and difficult question as to whether there is a gap in the legislation. There is a risk of a cohort of cases (of which AR was arguably one) where mental health clinicians cannot assess a child or young person in the community despite the fact that they have completely self isolated at home, are not attending education, have mixed neurodivergence and anxiety conditions (or similar) with marked risks of violence, and are not meeting the current thresholds for a Mental Health Act assessment. The issues to which this gives rise are complex and beyond the scope of the Inquiry's Phase 1. I therefore make the following recommendations for the matters to be covered in Phase 2.

"Phase 2 should consider whether further legislative change is required to allow mental health clinicians to assess children and young people who are isolated from professional support and may pose a risk of violence,

particularly where powers under the Mental Health Act 1983, as mended ... do not permit assessment or detention."

A lot of context, but you can see, that's the problem. The recent changes to the Mental Health Act that the department has made, in that 2025 Act, they don't meet that problem, do they? Let me see if I can summarise them for you and you tell me if this is accurate.

In simple terms, the change that has been made -- there are two principal powers that we are concerned with. One is detention for assessment --

A. Correct, yes.

Q. -- and one is detention for treatment. After the changes, it is still possible to detain somebody who has Autism Spectrum Disorder for the purposes of assessment?

A. Correct.

Q. But it is not possible to detain them for the purposes of treatment?

A. Correct. Based on the fact, that you can't treat --

Q. It is not a treatable condition. As we saw in Professor Fonagy's report, it is a lifelong, genetically influenced condition, which may present areas of vulnerability that require support but it is not treatable in the sense of an illness. So that is the

change?

A. Yes.

Q. But, I suppose, it could be observed, in general, that means that the circumstances in which somebody who has Autism Spectrum Disorder may be detained pursuant to the Mental Health Act are fewer since that Act has been passed than before? It used to be for assessment and treatment, now it is just assessment?

A. It will be when it is commenced. Yes.

Q. When it's commenced. It is going through currently?

A. Yes and again, that's based on the fact that what's the utility in detaining somebody under the Mental Health Act for mental health treatment if they haven't got a treatable mental health condition, as opposed to a neurodevelopmental condition.

Q. The Inquiry is in receipt of a statement from Professor Dave of the Royal College of Psychiatrists. I can pop that up on the screen if you would like to see it, or have you had a chance to see it already?

A. I have had a chance to see it but it would be helpful to have it on screen, if it is not too disruptive.

Q. Not at all. RCP000001, please. So this is the statement of Professor Dave. He is the President of the Royal College of Psychiatrists. If we went onto page 11 RCP000001_0011. Just at the bottom, so under the

heading "Legislative treatment of Learning Disability and Autism."

He says:

"There are circumstances where detention for assessment can be on the basis of autism ... under the MHA, in its current form and after amendment ... if the statutory criteria are met."

This is what I have just been taking you through, the difference between assessment and treatment. But what he says is this, that essentially, the College sought to intervene during the passage of the bill and asked for an amendment and the amendment was, essentially -- so, it is there at 55 RCP000001_0012, that there should be "provision by which detention can be continued after ... 28 days", which is the maximum for assessment, isn't it?

A. Correct.

Q. That is the maximum period of time that somebody can be detained under section 2, which is the assessment provision:

"... for people with learning disabilities or autistic people in tightly defined exceptional circumstances."

Which would include being pre-authorised by a Tribunal. Time to be determined by the Tribunal and

subject to regular review.

So the Royal College were asking for a safety valve, effectively, to expand that 28 days subject to strict restrictions. That was not taken forward?

A. No, it wasn't.

Q. Why?

A. Ministers made the call to make no revision to the Bill and as the Bill made its way through Parliament, it didn't lose any votes on the issue and therefore it went into statute.

Q. Well, we can pick that up with Professor Dave but that is the situation as things currently stand and so --

A. Yes.

Q. -- the problem that the Chair identified, of there being -- if we have an individual, who is clearly risky, but the nature of their presentation is such that the Mental Health Act criteria are not clearly applied, there cannot be any forcible intervention, there is, as yet, no -- or there is a gap, in the sense that there can be no way of assessing that person, seeing what risk of harm that they pose to others? Is there a proposal to meet that gap? Has thought been given to it? What's the process within the Department?

A. Can I take the assessment and the treatment slightly separately, if that's okay, just in answer to your

question, to split them up?
Q. Yes.
A. In terms of the powers under the Act for assessment, sort of now, and in the future, there doesn't have to be a confirmed diagnosis of a mental health disorder for a clinician to do an assessment. In fact, that sort of comes through, I think, quite clearly in what Dr Irani has said in Phase 1 and is also helpfully very clear in the Royal College of Psychiatrists' statement, where sort of as a clinician, it makes a clear statement that actually sometimes the purpose of an assessment is to understand whether somebody does hit the criteria for detention and for treatment and it's perfectly logical that sometimes they won't, but it is within --
Q. Sometimes they will, sometimes they won't.
A. Yes, but it is within their gift to do an assessment even if there's not an obvious or diagnosed mental health condition there and that's the situation now and in the future. So taking that assessment. I will come back to that. But then in terms of treatment -- we sort of come back to the original point that detaining somebody for treatment, you should have a recognised mental health condition that can be treated, otherwise you are not in the right place.

But coming back to assessment and your question

about what the gap is, given that it is possible for a clinician, depending on their judgement, to detain someone for assessment, albeit only for 28 days, I think our position in the Department would be, it is not a gap in the legislation itself that needs to be fixed with the primary legislative route, but we would equally agree, say that there is space understanding how you apply the law in a way it is reasonably understood and in the clinical world and we would also come back to the capacity question. And I think it is sort of clear to us that both of those issues are at play in this specific case but probably more broadly in these very difficult judgements that clinicians may have to make.

So I think our position would be the legislation sort of passed but obviously a lot of it has not commenced and we won't commence the autism-related in section 3, until we know there is enough community support out there, so you don't have people falling between the cracks. So that's a future thing. But in terms of the kind of what we think we have got space to do, the code of practice for the Mental Health Act has clearly got to be completely revisited, given that legislation is changing. That process is just starting and will be consulted on over the summer next year. So there is absolutely space for that consultation, for the

code of practice, to reflect on the learnings from this Inquiry and other Inquiries, to see how we can use that code of practice to get a better understanding out there in the system on how to apply the Mental Health Act in these very difficult situations.

So that's one area, and then, just coming back to the capacity area. Clearly, clinicians make assessments on risk to others and to people's selves all the time and will always prioritise those people who are most risky. However, that is within the boundaries of a very, very strained system. So coming back to all the thinking around mental health strategy and the outcomes of Fonagy, that's another area where we think there is space rather than it being a primary legislative fix.
Q. Okay. I will come back on a couple of the aspects of that, if I may.
A. Of course.
Q. So, the new Act is requiring new statutory guidance and a new code of practice, of course?
A. Yes.
Q. You say, helpfully, that that -- the development of that guidance will include this issue that I have identified for you. Was that already within the thinking? Was that already within the process of the development of that guidance, before we had this interchange? Or is

this the first time it has been thought about?
A. I don't know. I mean, I can ask.
Q. All right. Just in terms of thinking about assessment for the minute.
A. Yes.
Q. Dr Irani explained you, and rightly say, difficult circumstance, but the good of an assessment in that circumstance, as you say, not all detentions for assessment will lead to treatment -- and perhaps at that stage AR had a treatable condition, perhaps he didn't, on preponderance -- but the good of it is that a detailed understanding of the risk that that individual poses can be gained and even if compulsory Mental Health Acts, detention for treatment, cannot follow, risk mitigations of other sorts can be put in place by other agencies?
A. Absolutely.
Q. And in his particular case, a search of his bedroom, an understanding of what was going on, a removal of items, all of those sorts of things. So an assessment can have those benefits, even if it doesn't lead to treatment. But just thinking about those professionals who have to make those difficult decisions, essentially, what Dr Irani was saying was: he could have done that, but I'm not criticising the professionals who didn't --

A. No.
Q. -- because in reality, it would have been a little artificial. Really if the assessment had been undertaken, it would be for those goods that I have just identified or others like them. It is not really for what the statute is for, which is assessment as to whether or not there is a condition of a nature and severity that warrants compulsory inpatient treatment, right?

In removing the possibility of treatment for autism and other neurodevelopmental conditions from the Act, whatever good reasons that is -- and I'm not suggesting that they weren't good reasons -- but mightn't an unintended consequence of that be that a professional is less likely to detain somebody in those circumstances, similar to AR, for assessment? They know that the principal concern may or may not be ASD or something neurodevelopmental, there certainly can't be treatment for that anyway, compulsorily; does that mean an assessment is likely to be less likely in those circumstances? It is quite a convoluted way of putting it, but I hope you understand?
A. No, I understand your point. So I am not a clinician working on the frontline, obviously but --
Q. No, but you can see how that --

A. No, I can imagine -- and I can imagine a lot of this came through in the passage of the Bill itself, which was heavily scrutinised, as you can imagine, both in the passage of the legislation, but also pre-legislative scrutiny and also came from an independent review of the legislation a few years previous to that.

The point I made around the code of practice -- well, there are two points actually -- the third point I make around the code of practice, I think, applies to the section 3 provisions as well as sort of general assessments. So that is absolutely something we can think about. And as before, there are many parts of this legislation that are not commenced and won't be commenced until we have got clarity on these kind of questions about how it is actually going to land, out there in the real world.
Q. Yes, and so those factors that we have been talking about, they may be particularly important matters to evaluate for you and your department?
A. Absolutely.
Q. Both in terms of those commencement provisions and indeed, the guidance that you ultimately issue?
A. Yes.
Q. And you will take those on board, no doubt?
A. Yes.

Q. Thank you. The final topic, please may we go back to the statement page 24 DHSC000068_0024, paragraph 93. You have -- we have dealt with those issues just there -- so, you have dealt with the issue of the suitability of current laws, here, in particular, in relation to modern online threats and you tell us about the upcoming social media ban and how that's been led by DCMS and indeed, sir, for your note, you kindly give us a discussion of that and related issues between paragraphs 93 and 98. The upcoming social media ban and in short, you recommend a precautionary approach to policy in this area because the harms are unknown.

Thank you. We have those paragraphs, so I'm not going to ask you any more about them. What I will ask you about though is about whether the Department has any proposals, or evaluation of other's proposals, generally in this area, as to how the risk of harm from VFIs can be mitigated and managed? And the most convenient way of looking at that is very quickly to go to Jonathan Emmett's statement, which is HOM000964 at page 124 HOM000964_0124. Again, I hope you have had a chance to look at this before I'm putting it to you.

Can you see, just at the bottom of the page, please, I'm not going to go through it all now, but the pros and cons of potential changes to existing arrangements or

the development of new mechanisms. A number of proposals are evaluated. Expanding MAPPA, category 3 is there. If we go over the page HOM000964_0125, please.

Putting the PDP, Potentially Dangerous Person, scheme on a statutory footing; putting MASH on a statutory footing; expanding Prevent to include serious violence risk more broadly, so broadening it from ideological terrorism; expanding young offender teams, or youth justice services to cover wider serious violence risk management.

One which might be particularly relevant to your department: expanding Vanguard which are currently largely health-led, to support individuals with complex needs linked to risk of future violence; expanding Young Futures Panels, which we understand are different to Young Futures Hubs, which you told us about in your evidence before.

Over the page HOM000964_0126: expand particular Prevent thresholds; create local or regional multi-agency hubs; and then the big proposal, there at the bottom, the big front door, a single violence prevention gateway to which all referrals could go and be triaged to appropriate places.

Does the Department have a view on those proposals?
A. So, I think it is incredibly helpful that Mr Emmett sort

of laid these out in this way in this statement and also helpful how he's outlined sort of the next steps on this and the cross-government work that's going to have to happen on the back of this initial assessment and the outcomes of the Inquiry.

I think there is a couple of things that I would sort of add to it. Some of it we have touched on earlier. But on Vanguards, in particular, I think he is absolutely right to sort of hone in on the fact that these are very much health led. As we talked about earlier, their genesis has been very much from the mental health sphere and while the evaluation is that they are successful -- and we wouldn't have put them forward for additional spending review funding if they were not successful -- they are very much health led and while we know that the prevalence of mental health and neurodevelopmental needs in this particular cohort is high, it doesn't capture --

Q. It is not exclusive?

A. It is not exclusive. So there is a risk and there is with all of these proposals, and that is the sort of central dilemma, isn't it? Because the cohort is so varied, how do you find something that covers everyone? So that would be the one thing I would add on Vanguards, and the fact that it is patchy.

Q. So that's what we should understand by Vanguards, that although they are holistic, although they consider all areas of a young person's vulnerability and strength, they are principally directed towards mental health or neurodiversity needs, which -- you have used the Venn diagram description already -- or capture a proportion of our cohort, but not all of our cohort?

A. Exactly. They are very much multi-agency and they do bring in sort of Youth Offending Teams, sort of police, education, they do bring that in. They are convened by the health services --

Q. So a positive in their column, whilst they are health led -- and health is aimed at improving people's health, not public protection -- but they can bring in public protection focused agencies into their multi-agency consideration?

A. Yes.

Q. We shouldn't think they are just health and they can't manage risk; they can bring that in?

A. Absolutely.

Q. But you are drawing our attention to the focus of those panels?

A. Yes and again, as we touched on earlier, the sort of variability in how they operate and how the referrals into them work. So some of the Vanguards, anybody can

refer into a Vanguard and there are others which are designed in a slightly different way and then there is the obvious point around the fact that they are only present in 26 per cent of the country. So, I would add that into it.

And on the young futures side of things, I take your point that the panels might be slightly different to the hubs. I must admit I put it as being hubs. But again, sort of seeing those alongside other sort of hub models that exist out there is probably a useful thing to do. There are a lot of hubs aiming at slightly different things and there is I think something about that as well that's -- I would add into this table.

Q. So the final recommendation -- or the final consideration and you can see the bullet points there: Address system fragmentation. Sweep the board, rationalise. Single structure or single gateway referral certainly. Concerned about violence of individuals, one place to refer to, with triage to either ideological, Prevent, other, violence or health management structures thereafter. Can you see the advantages in that?

A. I can. I think sort of the big front door concept is an interesting one and we would definitely agree with sort of Lord Anderson's contention, that the current way

that different frameworks work is confusing.

Q. Confusing --

A. And I think I would say that the things that -- there will be some people out there in the system, certainly in health and maybe elsewhere, that would see -- do see MASH as a front door, albeit that in this case, it definitely didn't work and may not in others, but see that as a potential sort of route in.

Taking that aside, and this helpful analysis from the Home Office, again, sort of coming back to just the things that we care about in any framework, would be, going back to the point that you are identifying -- you are looking at behaviours and you are looking at risk and you are identifying the right interventions for people that are flowing through, whatever it may be, that you are -- from a health perspective, our workforce is sort of semi-unusual, in as much as it is very varied, from Forensic CAMHS, to CAMHS, to learning disability, to school nurses, to GPs, to make sure that whatever is designed just brings in the right fragments of the health and care system and workforce --

Q. At the right stage?

A. Exactly, and they can offer the right kind of advice because often you will see calls for a health lead in a particular area but it is not always obvious to see

what part of the system they need to be coming from. So I think that is just one thing from our perspective.

And this is a very obvious point but it is back to the whole thresholds argument. Anything that's designed -- if there is a threshold set, what happens if people fall out of it and how do you signpost in? I think this comes to the bullet points on the right-hand side here. But I think ultimately, our aims with any system or framework would be (a) reducing risk, identifying risk early and making sure that there is the right people in the room to do that.

But also that, whatever is designed, is flexibly designed, basically because the knowledge of this cohort is moving at such pace. If you are designing something specifically for this cohort, our knowledge of it and the evidence -- as we have seen from other witnesses -- is changing at such a rate that you design something that can kind of move with that.

Q. So, something tightly defined, tightly focused, another structure on this cohort would risk not keeping up with evidence, missing important potentially risky individuals?

A. Yes.

MR JAMIESON: Yes, thank you.

Sir, those are all of my questions. I'm looking to

my left. No questions from the victims and survivors. Sir, do you have any questions?

SIR ADRIAN FULFORD: Just a couple of things, Mr Jamieson. Thank you.

Questions by SIR ADRIAN FULFORD

SIR ADRIAN FULFORD: When Mr Jamieson was asking you about the cliff edge, the point when somebody passes the age --

A. Yes.

SIR ADRIAN FULFORD: -- you, I think, made it clear that you, or the Department, would not support changes to the legislation but instead would look to other pathways, signposting, training and guidance. Training and guidance, in one sense, they are sort of clear as concepts. I'm interested in what you have in mind, specifically and practically, in terms of signposting and pathways? They can be quite vague, those expressions.

A. Yes. No, I can comment to that, and I think what you saying is a fair summary of the position. Obviously, we are always open to changing the law but the question is: but to what end? And I think, in this case, changing the Care Act risks pushing people into a system that is not designed or set up for this particular cohort, as we have described.

In terms of more specificity about what I mean about guidance and training, those are still in development, so there is space to influence those. The factors that I know have been specifically picked up for attention in both the guidance for the Act and for the training for the next year are around how do you -- in a transition conversation, or process of transition, how do you make sure you are bringing the right people into the conversation? How do you make sure that these barriers to information sharing, that we have spoken about, which are sometimes systemic but sometimes cultural, how do you overcome those?

Those are sort of the specifics. But as I say, that is all currently in development. So there is space to (a) come back to you with where that's got to, but also where this is space for influencing what could be included.

SIR ADRIAN FULFORD: Thank you. I'm going to press slightly because my real concern here is in relation to the signposting and pathways part of this. So to whom would they be signposted? Where does the pathway lead? So you have someone who has -- to use the expression -- fallen off the edge of the cliff. If one isn't going to say there is some kind of statutory obligation to pick up this cohort, but instead, they have got to be

signposted, I'm curious to know as to whether there is actually anything under the current system that realistically can be done to pick them up?

A. Yes. I don't know the answer to that question but we can certainly come back with a list.

SIR ADRIAN FULFORD: Could you? Because I think, certainly as things are at the moment, as it seems to me, it is pretty fundamental. One can say, with the best of intentions, that one can give the practitioners on the ground training and guidance, but if actually there are no solid options in relation to people in that category, it doesn't matter how much training that you have provided, or guidance that you have given, there needs to be some mechanism and the cohort is reckoned -- I mean, it is very difficult to come up with a figure -- to be relatively small. But there does need to be something definite that can be done once they have been identified. Can you get those in your department to think about that?

A. Yes, absolutely.

SIR ADRIAN FULFORD: And come back with something --

A. Sensible?

SIR ADRIAN FULFORD: Solid. Thank you. That's very kind.

My other question is this, and it is linked really, when you talk about this not being primarily

a legislative issue, and instead one must look at risk mitigations, so it is a kind of variant of the question that I have just asked you, I just in relation to this want to go back to the potential critical role of sharing information and what I have in mind is, those who -- it looks as though they do have a serious violence fascination which they may act on, whatever the definition is; they have gone into Prevent; they haven't been taken on; they have fallen outside; yet mental health services are in possession of information in relation to that individual, and the question I ask you is whether you would agree that it is critical that those who later are hopefully going to be providing assistance to the individual will know all of that history; they will know all about what's happened in relation to the referral to Prevent, but they will also know that there have been mental health assessments in relation to that individual along the way. Would you agree with that?

A. Yes.

SIR ADRIAN FULFORD: All right. Thank you. I'm very grateful to you. A lot of work has been put into the statement and you have clearly done a lot of preparation for your evidence and it has been very helpful. Thank you very much.

A. Thank you.

MR JAMIESON: Thank you, sir. For good and understandable logistical reasons, Mr Moss is keen to make a start with the next witness, if that is acceptable to you, sir?

SIR ADRIAN FULFORD: It certainly is. *(Pause)*.

Could you remain standing and take the oath please.

DR NICHOLAS BROUGHTON (sworn)

SIR ADRIAN FULFORD: Thank you very much. Please take a seat.

Yes, Mr Moss.

Questions by MR MOSS

MR MOSS: Thank you, sir. Doctor, just start by giving us your full name, if you would?

A. Dr Nicholas Owen Broughton.

Q. If we could have on screen, please, NHS000602. This is your witness statement and if we go to page 34 NHS000602_0034, we will see that it is a statement that you signed on 31 July of this year. Can you just confirm that the statement is true to the best of your knowledge and belief?

A. I can.

Q. Thank you. If we just look at page 2 NHS000602_0002, paragraph 5, please, just to set the very basics. We see that you are providing a corporate witness statement on behalf of NHS England and taking it very shortly, you

set out, fully and quite properly, that it is a corporate statement, in the sense that it goes beyond your personal knowledge. You have had assistance, both by external solicitors but more importantly, by others within NHS England, where matters are outside your personal knowledge; is that correct?

A. That is correct.

Q. Before I turn to your own professional background and role, I think there's something that you wanted to say?

A. If I may, yes. And may I begin from the outset by saying that my thoughts today are very much with the families of Alice, Bebe and Elsie, as well as all the other victims of the tragic events of 29 July 2024.

Q. Thank you. If we just keep on page 2 on our screens and scroll up, please, to paragraph 4. You won't need the reminder but just tell us a little bit about your professional background, first of all?

A. I'm a fully registered medical practitioner. I'm a forensic psychiatrist by background and a fellow of the Royal College of Psychiatrists. But since 2015, I have occupied a variety of senior leadership roles in the NHS, including being Chief Executive of three mental health trusts and more recently, Chief Executive of an integrated care board and I'm now, in addition to that role, the National Priority Programme Director for

Mental Health, Learning Disability and Neurodevelopmental Conditions in NHS England.

Q. Thank you. So if we go back to the first page NHS000602_0001 -- we are looking at your clinical qualification there, but if we go back to the first page of your statement, if we look at paragraph 2, I think that's where you set out your role within NHS England. National Priority Programme Director for Mental Health, Learning Disability and Neurodevelopmental Conditions, which is a joint role between NHS England and DHSC; is that right?

A. That's correct.

Q. And then your other roles -- you have mentioned them a moment ago, but paragraph 3 -- Chief Executive of Thames Valley Integrated Care Board. Can I just understand, in relation to that, it may not matter, but how do you split your time, percentage-wise?

A. Up until three weeks ago, I split my time down the middle, half time in the ICB role and half time in the national role. More recently, the secondment to the national role has increased in terms of my time commitment. So I now spend four days a week in the national role.

Q. Thank you. I want to, turn just briefly to deal in overview, with the role of NHS England and doctor, if we

look, please, at page 35 NHS000602_0035 of your statement, we see that you provided a helpful annex on the NHS in England setting out considerable detail. I obviously don't need to go through it all. You say, in paragraph 3, that:

"... the NHS in England is not one organisation. It is an ecosystem of commissioners, regulators and service providers, each with their own distinct role."

You then explain that:

"The publicly funded health service (excluding public health) in England comprises primary care, secondary care, tertiary care, mental health and community health."

Then in paragraph 4, you give the current position in terms of NHS England's position within the machinery of Government. So it is an executive non-departmental public body, sponsored by DHSC, an arm's-length body, and you set out at paragraph 5 that what that entails. Then in paragraph 6, as was touched on with our last witness, subject to the Health Bill going through Parliament, NHS England to be abolished as of, I think, the intention is spring next year.

Thank you. If we look, please, at page 37 NHS000602_0037, paragraph 14, again, I just want to set the high level context for this:

"ICBs [integrated care boards] were given responsibilities relating to the commissioning of mental health services unless NHS England had a duty to arrange provision."

So I think for the majority of, if I can call it standard NHS provision in a local area, that will be commissioned by the integrated care board, is that right?

A. That is correct.

Q. And the responsibility for monitoring -- obviously, there are independent inspections -- but the responsibility for those sits with the individual ICBs?

A. That is correct.

Q. Thank you. If we look on the same page, further down, paragraph 17, there are some exceptions to that arrangement relative to this Inquiry and these came up with AR and as the Inquiry understands it, within the services that are directly commissioned by NHS England, as opposed to commissioned by ICBs, are the Forensic CAMHS service and the Criminal Justice Liaison and Diversion Service, is that right?

A. That is right, yes.

Q. Thank you. If we go back then to page 6 NHS000602_0006, paragraph 28, against that broad background, is it right that the policy responsibility within NHS England falls

within the national priority programme, for which you are the lead?

A. That is correct.

Q. So, although the arrangements were quite complicated, within NHS England as opposed to DHSC, you have the policy lead for the VFI type of cohort?

A. That is right, yes.

Q. Thank you. I want to explore briefly with you please the extent to which NHS England has had a role in the outputs from the cross-government work. Could we look, first of all, at page 19 NHS000602_0019 of your statement, at paragraph 90 towards the bottom of the page.

You explain there -- and we bear in mind the date of your statement as mid-summer -- but you say that:

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

You then say, in paragraph 91:

"For example, NHS England (together with DHSC) is involved in ..."

What we understand to be the early intervention working group, which is a subgroup of the NIEV Taskforce, is that right?

A. That is my understanding, yes.

Q. Yes. Other than in that area, in broad terms, has NHS England had any role in actually producing deliverable outputs from the cross-government work?

A. NHS England has been involved in work in relation to risk assessment, which I think falls under another recommendation from Phase 1. But in terms of the cross-government work, it is as set out in my statement.

Q. Thank you. So we will come to the area of risk assessment in particular. But otherwise, would this be right? That the NHS England has had a seat at the table, as it were, in those discussions and has been contributing but in terms of firm outputs that we can say: right, that is an output from that work, that's not principally been NHS England?

A. That is correct, yes.

Q. Thank you. If we go over the page NHS000602_0020, you note that NHS England is currently working with "NIHR", I think the National Institute for Health and care Research?

A. That is correct.
Q. All right. We will try to avoid the acronyms as much as we can. To identify "risk factors for those in contact with [children and young person's mental health services] who pose a risk of violence".
Just pausing there. Is that as a result of Southport and the VFI cohort risk, or is that a wider piece of work that would have been taking place anyway?
A. It is as a consequence of Southport, yes.
Q. Thank you. You say that that's not designed to specifically address the effectiveness of interventions. What is that work looking at?
A. We have commissioned the National Institute of Health Research to undertake a review of literature and the evidence in relation to the use of various risk assessments in children and young people's mental health services. This work is ongoing, and I'm reliably informed that we should receive the output of it in December this year.
Q. All right. So we should come back to that when I ask you questions about risk assessments because that's part of that stream of work; is that right?
A. That is correct.
Q. Thank you. Looking at Government work more broadly, if we turn, on the same page, to paragraph 94, you say

that:
"NHS England further considers that existing whole system approaches, such as the Government's strategy for tackling Violence Against Women and Girls, may provide a useful model for the development of a coordinated cross-government response."
Can you be a little bit more specific about that? What is it, in the cross-government approach to VAWG, that NHS England considers could or should be adopted for dealing with the VFI cohort?
A. NHS England is aware that the cohort is complicated. It is not a homogeneous group but made up of individuals with a wide variety of needs, not all of which fall under the umbrella of health and, therefore in order to address the needs of this group, and prevent events such as those in July 2024 from happening, it is essential that there is a suitably joined-up, coordinated multi-agency approach that will encompass the work of various Government departments and that, in essence, is the premise behind highlighting the strategy for Violence Against Women and Girls as a model which could be replicated, to ensure suitable response in relation to people who display violent-fixated behaviours.
Q. Thank you. Could I press you just a little bit. I mean, you say that there needs to be suitably

joined-up, coordinated multi-agency approach that will encompass the work of various Government departments. I don't mean to denigrate that as an aim because it is obviously important but it is quite high level and general. Is there anything more specific, in terms of how Government has started to have success in targeting Violence Against Women and Girls, that is more specific and more directly a read-across that we should be aware of, or is it just that high level?
A. It is just that high level, I'm afraid.
Q. Thank you. Just finally, I think, before we break and just to round off on the NHS England's role, if we look at page 6 NHS000602_0006, paragraph 23, you deal there, in the body of your statement -- we touched on it earlier in the annex -- about the planned abolition of NHS England. Can I ask, in relation to that, when you say in paragraph 24, that the majority of NHS England's functions are expected to transfer into the DHSC, what will happen to, specifically, your role and the work that NHS England is doing on the VFI cohort?
A. So my role spans both NHS England and the Department. The priority programme team already includes people from both NHS England and the Department. So I think -- well, we anticipate that the work will relatively seamlessly transition to the new departmental

arrangements. We see clarification today, from the Secretary of State, that the 1 April remains the target date for the transition arrangements to come into place, subject to the passage of the Bill and that within the new department, there will be two leadership teams; one which will focus on operational delivery and will be led by the NHS England Chief Executive and the other will be leading the Department and will be led by the Permanent Secretary.
So I think that gives us a direction of travel and I anticipate that the priority programme that I'm currently leading will continue to report into the chief executive of NHS England.
Q. So that will be on that side of the house?
A. Yes.
Q. On the operational delivery side?
A. In relation to implementing any actions required on the back of the Southport Inquiry and indeed, to ensure the effective management by health services of people who display violent-fixated behaviours.
Q. One of the questions raised by the victims and survivors team is: who will be responsible for recommendations 52 and 56 -- which we will come onto -- and what measures are in place to ensure that those tasks don't lapse in the complex transition? Can you give us the assurance

that that will sit with you as you transfer, or at least somebody in your role going forwards, that there is a clear handover or retention of those responsibilities; they are not in any way going to be reduced?

A. That is my understanding. Now, I can't definitively guarantee that because we are still working through the detail of the transition. However, what I can say is that there is a very robust arrangement in place to ensure that such matters are incorporated in the new operating model. There is a joint executive team that has been up and running for quite some time to oversee this work, so I'm confident that the work will continue and as I said, I think it is likely it will continue to fall under the remit of the national priority programme director, which currently is myself.

Q. Thank you. Through your legal team, will you please keep of learned Chair advised, coming up towards the spring of next year, with the report's publication in mind, of what the arrangements for that are going to be as they are firmed up?

A. We will indeed, yes.

MR MOSS: Thank you. Sir, I'm going to turn to definitions, guidance and training, but that might be a convenient moment to take 45 minutes for lunch, if that's convenient to you, sir?

SIR ADRIAN FULFORD: Certainly. We will sit again at 1.50 pm.

(1.09 pm)

(The short adjournment)

(1.50 pm)

SIR ADRIAN FULFORD: Yes, Mr Moss.

MR MOSS: Thank you, sir. Dr Broughton, may we turn then to definitions, guidance and training. I start with definitions. Page 4 NHS000602_0004 of your statement please, paragraph 14.

I want to start just by drawing out some of the key points. So you start, in your statement, by making the observation that:

"There is no single profile of a violence fixated individual ... Rather, individuals exhibiting violence fixated behaviours represent a heterogeneous group and may present with a wide range of underlying needs and issues ..."

You then suggest that that is consistent with our opening statement, which I won't recite. Then in paragraph 16, you say that:

"NHS England further considers that an emphasis on violence fixated behaviours is consistent with its understanding of the origins of the concept within [CTP] and Prevent related context. The concept appears to

draw on work undertaken by forensic psychologists concerning the identification and assessment of 'fixated' behaviours associated an increased risk of serious ..."

If you just scroll down'...

"... violence, including among individuals influenced by traditional extremist ideologies. The focus of that work was on the nature and significance of the behaviours."

Then over the page NHS000602_0005, you also draw out a slightly different point, the:

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

And in paragraph 19, you round it off, by saying:

"Notwithstanding the concerns described above, NHS England's position is not that VFIs could never be defined as a category. Rather, any attempt to develop a formal definition should be grounded in research and empirical evidence and accompanied by a clear framework for assessment ..."

And so on. So, against that background, what is NHS England's ultimate position on this, in terms of whether

a definition is appropriate or useful?

A. I think a definition is potentially useful, not least in terms of ensuring consistent communication between different agencies and a consistent understanding of individuals' needs between different agencies. The position of NHS England though is that any definition should be grounded in empirical evidence and the latest research and that is why we have set out the position regarding violence-fixated individuals as we have done. The concept is not grounded in research and empirical evidence and it is my understanding that the position of NHS England reflects that of the Royal College of Psychiatrists.

Q. All right. So if we look at page 14 NHS000602_0014, paragraph 67 of your statement, in the helpful summary at the end, you say that:

"... whilst a rigid definition of VFIs may be neither feasible nor desirable, there is a need for a shared multi-agency understanding ..."

You say that:

"The point at which behaviours are regarded as 'extreme' may vary between agencies ..."

You suggest that:

"... a descriptive framework focused on violence fixated behaviours would be preferable to a formal

definition of violence fixated individuals."

Now, that seems to be getting quite close towards saying that there shouldn't be some form of short-form definition. You need more, something like a psychiatrist's descriptive framework, several paragraphs long, perhaps. Is that NHS England's position?

A. It is, yes, but obviously this position will change as the evidence grows in this field and we are very aware that the concept is an emerging one. As I highlighted, I'm a forensic psychiatrist by background. When I was in practice and indeed training, this concept was not one that we recognised. Indeed, in preparation for giving evidence today, I looked back in some of the textbooks I used and there was no mention of "violence-fixated behaviour" or "violence-fixated individuals" in those textbooks, which I think reinforces the argument that this is a new and emerging area and it is important that we respond to it but also respond in a way that is led by the evidence and the research.

Q. Thank you. Can I put some of the counter-arguments to that, that other witnesses have spoken about the need that if you are going to provide a multi-agency process and have a service provision that is targeting at

intervention for this cohort, you need to have a definition in order to understand your target cohort. You need a definition because you are going to have to have some sort of thresholds and, importantly, others have mentioned the fact that if you don't have a definition, you will not have anything to guide and correlate data on the effectiveness of interventions, for example. You have to sort of say: well, we have tried these interventions against this cohort who match this definition and it either worked or didn't work and without that, there is going to be an absence of national clarity and data in this area. Do you recognise those factors?

A. I recognise those concerns, but I believe the approach that we have set out in relation to focusing on violence-fixated behaviours rather than defining violence-fixated individuals is a sensible way forward.

Q. It might be suggested that a problem with that approach is that in some respects action has already been slowed up by the lack of a definition and if what is being said is: well, we are not yet in a position to give a psychiatrist type of descriptive framework, it's got to be led by further research, are we going to be pushing back both the definition but also the work that needs to follow from the definition? What do we do in

the interim?

A. Well, I suppose, in the interim it is about ensuring that individuals who are at risk receive the support that they need and that support is provided by the appropriate agencies. I don't think that the lack of definition is a barrier to that happening because I believe that the assessment as to whether someone is at risk of extreme violence is not dependent on there being a definition for "violence-fixated behaviour" or "violence-fixated individuals".

Q. No, but a number of witnesses from various organisations and indeed Government departments have said: in the absence, for example, of a definition we don't yet have a pathway; in the absence of a definition we are not monitoring data on this cohort.

A. Well, we do have services and I would suggest potential pathways for this cohort, which are based on the services that are available for young people who have complex needs, who are vulnerable, and are at high risk of violent behaviours of one kind or another. I'm thinking, in particular, of Forensic CAMHS services and also the Vanguard programme, the integrated community framework.

Q. So we will come onto some of those when we look at pathways and case management options. But, in a sense,

the Government has pressed on, if we can look at HOM001011, please. You will know that this is the interim Government guidance, published by the Home Office, which does give a working definition, at page 2 HOM001011_0002, paragraph 6. All familiar with it by now.

So, a working definition, non-statutory, not legal or operational in nature, but:

"The use or threat of extreme violence, not driven by a clear or ideological purpose, which is communicative in nature and intended to shock, intimidate or outrage the public or a section of the public."

Can I check first of all that prior to the evidence proposal with references that was provided for you to assist you with giving evidence, had you seen this definition before that?

A. I had not, no.

Q. Now that you have seen it, what is your view of this definition?

A. Well, I think it is helpful to have this, but I do have concerns regarding the definition as it stands and in particular whether it would exclude certain individuals who are at risk of extreme violence, particularly the "intended to shock" element of the definition.

Q. Thank you. The Home Office, when pressed upon this both by myself and by the learned Chair, were keen to say: one needs to understand that this is the final act of extreme violence, which we are concerned with, and so the cohort of those who are at risk of falling into carrying out this sort of act, and "intention to shock, intimidate or outrage the public" should be read with that in mind. Does your concern remain as to how clear this would be in terms of excluding people or how clear this would be for practitioners? Do you remain concerned about this definition?

A. Yes, I do and in anticipation of giving evidence today, I liaised with the National Clinical Advisor for forensic mental health services, who happens to be a consultant who looks after young people who are at high risk. One of her concerns in relation to this was that she has a number of patients at the moment who she considers are at risk of extreme violence, who would be excluded by this definition as it stands because of the "intended to shock, intimidate or outrage" component.

Q. Unless there is a reason not to, could you just give the name?

A. Dr Mayura Deshpande.

Q. Thank you. Professor Cassam in our seminars suggested an alternative of "non-ideological violent extremist"

and we have been exploring the concept of whether the cohort could be defined as those vulnerable to being drawn into non-ideological violent extremism. Do you have a view on that?

A. Professor Cassam's proposal obviously relates to individuals rather than the behaviour, as such.

Q. Yes.

A. I think the concerns we have in relation to that is that the cohort is heterogeneous and there are individuals who are at risk of this extreme violence who have a wide variety of underlying difficulties; some of which may fall under the remit of health, others will not. And that, I think, is the primary concern we have in relation to the proposal from Professor Cassam.

Q. Would that be met by having Professor Cassam's definition, or something like it, perhaps the "vulnerable to being drawn into" part added, but then having the explanatory descriptive framework sitting behind that?

A. Yes, I think that is a possibility, and the way we see things, this is a really helpful step forward, it is helpful having these proposed definitions, but they require further refinement and, indeed, we need to take into account, the emerging evidence base whilst doing that.

Q. I am going to put you on the spot because it might be thought that just in terms of the cohort for Prevent, you have a statutory-based short form: those vulnerable to being drawn into terrorism. In order to understand the cohort about which we are speaking and will be targeting interventions, targeting a pathway, it might be thought that having some short form definition is useful. If not the Home Office's current version, and if not Professor Cassam's, what would be better?

A. I don't have a better proposal today. But I think what NHS England is keen to do is to reflect, not least on this discourse but also on the outcome of the Inquiry, and then make an informed decision regarding what any definition should look like.

Q. May I gently encourage -- although, of course, Government decisions must follow after the Inquiry, in terms of definition and any recommendations by the learned Chair -- may I gently encourage as much further thought linked to any further submission, whether it is in closing submissions or further statement or correspondence, giving such assistance as you can on that because if, with its links into Forensic CAMHS, NHS England is able to come up with an alternative that you consider would work, particularly for that short form, then before the Inquiry reports, it would be helpful so

that it can be taken into account?

A. Understood.

Q. Thank you. If we go back please to your statement. When you say at page 5 NHS000602_0005, paragraph 19, that there is that need for the definition to be "grounded in research" and I think you are, there, referring to the descriptive framework as a psychiatrist may think of it, what work is currently ongoing, so far as you are aware, to address that?

A. I'm aware that the Government pulled together an expert group in relation to this field and there is, as I understand it, work that individual academics are progressing. But I haven't got any granular detail beyond that, I'm afraid.

Q. Because in some senses, that work may have led to the NIEV definition that we saw in Mr Emmett's statement and the interim guidance from the Government. So, again, I think the Inquiry would be keen to understand, at that more granular level, what work is going on, when it will report. Because if it really is to be the case that the definition ought to await that, one needs to know what work and to what timescales.

But you wouldn't, in broad terms, be against the best short form formulation that can be arrived at, together with the best current understanding of a more

descriptive framework, but recognising that that descriptive framework will be subject to amendment, as the research improves our knowledge?

A. That's correct and I think we need to be pragmatic in this space, things will evolve over time, but we do appreciate and accept the benefit of having definitions, not least to ensure that people don't fall between various services and don't get the support they require.

Q. Thank you. If I may turn then to guidance and if we can look together, doctor, please at page 7 NHS000602_0007, paragraph 32 of your statement you say that:

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

The Inquiry is aware of the generic guidance -- and I don't use that in a pejorative sense -- NG10, "Violence and aggression: short-term management in mental health, health and community settings" from NICE -- but that is quite generic advice on how to try to predict and deescalate aggression, particularly in care settings.

The Inquiry is not aware of any guidance from NICE specifically in relation to the violence fixation or violence fascination type risks, do you agree?

A. I do, yes. I'm not aware either.

Q. And this may be my inaccurate layperson's understanding, but would it be right that in the absence of empirical evidence about what interventions work best for this cohort, that in some respects, it would be quite early for NICE type guidance because the layperson's understanding of NICE is that generally, it is when it's got good, hard-edged, research-based recommendations for treatment that takes into account the costs and cost benefits and has a good platform of evidence to assist on the best forms of treatment and we don't seem to be there yet on VFIs, however they are defined?

A. Yes, I would agree.

Q. So, if we can just have briefly on screen, please, NHS000598, just to identify the guidance rather than to go through it. This is the Care Act statutory guidance.

I'm really not going to go through this to prove a negative but I think you have been alerted to the fact that we wish to raise this document with you and I think you would agree that, while this has a good deal of detail on adults who may be subject to neglect or abuse, financial abuse, matters of that kind, there's nothing in here on violence fixation risks in adults, is there, in this guidance?

A. That is my understanding, yes.

Q. Thank you. If we can look at page 7 NHS000602_0007, paragraph 35 of your statement. Looking elsewhere for guidance, you very helpfully draw the Inquiry's attention to the very recent NHS England mental health personalised care framework, "to support improved care for people of all ages needing secondary mental healthcare". And you say, to give context:

"[Whilst] violence fixated behaviour is not, in itself, a mental disorder, the Framework may be relevant where a child or young person exhibiting such behaviours comes into contact with mental health services."

You say that it:

"... sets out a clear, consistent national approach to how services plan, coordinate and deliver care ..."

If we can just look together at a little bit of the detail of that, please. So if we could have NHS000599.

If we just go to page 2 NHS000599_0002. We see, in the introduction, a good explanation of what this is about. So:

"The mental health personalised care framework sets out the approach and related principles and actions for delivering personalised care ... for adults and older people with ..."

And then note the words:

"... severe mental health problems (summarised in

the appendix)."

Should we understand it that this is the new guidance and policy on what previously would have been CPA, Care Programme Approach?

A. Yes, in essence, that is correct.

Q. Thank you. Is there any -- you say "in essence, that is correct", is there any rider you want to give to that?

A. No, it is an evolution of the Care Programme Approach which was the model that underpinned the delivery of mental healthcare from the early 1990s onwards.

Q. All right. So in a working understanding, for the more severe end of psychiatric patients?

A. Well, for everyone in contact with NHS mental health services.

Q. Thank you. The reference to for delivering personalised care "for adults and older people with severe mental health problems", so presumably means some sort of threshold in relation to that?

A. Yes, but the expectation would be the vast majority of patients under the care of the mental health services, delivered by the NHS, would have a personalised care plan.

Q. Thank you. And then I think if we look at page 9 NHS000599_0009, again, I want to try to deal with quite a detailed document as briefly as I may without

unfairness. We see "Core principle 1: Everyone has a care and support plan that reflects their needs at [the] time."

Then you start to go into subheadings, "Personalised care and support plans". So we get a feel for how it is organised as a document.

Then if we look at page 36 NHS000599_0036, in particular, for the learned Chair's note, without going through them all, helpfully there is an appendix that gives all of the core principles in bold and the subheadings, I think, below that. So everyone has a care and support plan that reflects their needs at that time, was the core principle 1 that I went to in the key actions below that. Have we understood correctly how it is framed?

A. Yes, indeed, you have.

Q. Thank you. Sir, I'm not going to read it all out but perhaps, I could just give a moment for the first page and then over to the next page NHS000599_0037.

(Pause).

Then over again NHS000599_0038. *(Pause)*.

SIR ADRIAN FULFORD: Yes.

MR MOSS: We see the date of this, very recently, 17 July. There's then annex A, which is NHS000600. For a VFI who was under mental health services, this is the sort of

care planning that there should be and if we look at page 3 NHS000600_0003, I think we see, in diagrammatic form, "Principles of Safety Management". So the aspects to think about the principles on the left, the process of safety management and planning and the output 3, "Comprehensive assessment, formulation and management across all types of risk" and clearly, "risk to others" is being clearly flagged up as one of the risks, alongside "risk to self" and "risk from others".

And "iatrogenic harm" meaning harm arising from the treatment itself?

A. Exactly.

Q. Thank you, and if we look at page 15 NHS000600_0015, we get detail of "Safety management and planning" and one sees, for example, the reference for:

"Serious case reviews often find that poor multi-agency working is a reason that care, treatment, safeguarding and public protection arrangements have forgot kept the person and the public safe. Where someone poses a risk to others or has acted on that risk, it is critical for mental health services to work in partnership with other agencies, including the police, community forensic services, probation and prison community mental health teams, and multi-agency risk meetings ... should be regularly held."

It then gives the:

"Multi-agency public protection arrangements (MAPPAs) ..."

Guidance, which are available:

"Good management of safety requires all parties and agencies to have proportionate necessary information. These include, where appropriate, the person, their family, carers and support network, as well as professional staff and the agencies listed above."

Would you agree, looking at that on its face, that there are pros and cons to this? First of all, there is good guidance, it might be thought, on the principles of the importance of information sharing when there is risk to others, would you agree?

A. I would, yes.

Q. But when one looks at the type of guidance that could be given, so multi-agency risk meetings, MAPPA and the like, there is nothing specific in relation to the arrangements for the VFI type of cohort at the moment in this guidance?

A. I would agree.

Q. Thank you. If we go to Annex B, again, taking it as briefly as I can in what's quite dense material, NHS000601, please.

We see that this is the "Mental health personalised

care framework: the modern care programme approach ... considerations for children and young people."

Why this is of note is if we turn to page 4 NHS000601_0004, we see that there is a section on "Safety management and safeguarding", "Assessing online use". So:

"Children and young people are increasingly active online.

"Clinicians need to be competent in responding to changes in societal factors that can impact on risk ... They need to understand how the use of digital cultures and technologies, the internet and social media can impact on children and young people's safety, both positively and negatively, and what reasonable measures they can take to educate the child or young person and their support network about relevant risks ..."

It then goes on to say:

"Young people's digital lives should be considered in their mental health assessment, with practitioners recognising both the potential helpfulness ..."

And that is a reference to:

"... (social connection, combating loneliness) and harm of online spaces (for example, those covering suicide and self-harm ..."

Then, just note the words because I don't want to

skate over them:

"... hate and violence ..."

So that is referenced:

"... sexual risks, gambling, eating and weight loss, some of which may be illegal). Local child protection and safeguarding policies should be followed where there are concerns that the child or young person, or another person, may be at risk of harm."

There is a reference to:

"To aid the assessment and formulation, practitioners should consider the young person's vulnerabilities ... and protective factors and why they engage with the digital material they do, as well as their digital skills ... May wish to explore the use of ... (AI) and chatbots for mental health and wellbeing purposes.

"Information on a child or young person's online use should be included in their safety management plan and reasonable measures taken to educate them and their support network about relevant risks."

Then:

"Further information and advice can be found."

If we go over the page NHS000601_0005, we see all of those links are principally about vulnerabilities. So, the first one is: young people, adults facing online

harms and professionals working with children; Samaritans; the NSPCC; and Childline.

If we go back to the previous page NHS000601_0004. I didn't want to, as I say, suggest that there's nothing in here on extreme violence, gore and hateful material, because there is that reference to "hate and violence". But, bearing in mind how recent this guidance is, do you not think that there is still a tendency for the emphasis to be on the risks to the child, or to adult, with not very much attention being paid to the risk to others and to the extreme violence and gore risks and issues of fascination with violence?

A. I think it is important, from the outset, to highlight that this is a generic approach that will apply to all mental health services and as you touched on, the issue of assessing risk in mental health settings is a complex one, not least because risk manifests itself in many different forms. Obviously we have touched on the risk of violence to others, risk of self-neglect, risk of self-harm, risks associated with treatment, et cetera. And the risks of violence to others comes in many different manifestations as well, so sexual violence, risks of fire setting, risks of physical violence, et cetera.

And the premise underpinning the personalised care

framework is that where there are significant concerns of that nature, then, referrals should be made to appropriate services, not least forensic mental health services, where there would be a more specialised approach and a more nuanced approach in relation to risk assessment and indeed risk management.

But, again, as we have touched on, the area of fixated violent behaviour is an emerging one and I do think it would be appropriate for the personalised care framework and the two annexes we have been through, to be reviewed in light of the Inquiry and not least the evidence I'm giving today.

The timeline again, it is also important, because it took many months to finalise the personalised care framework and I think that work began probably at least two years ago, if not longer. And as you will be aware, the process that we need to follow to get to the point where guidance such as this -- which obviously is for national services -- can be published, is somewhat time consuming. And I think that was unfortunate and perhaps was one reason why the Inquiry's initial findings perhaps weren't factored into the guidance in a way that we would have liked.

Q. So, of course, one must allow for the fact that this is generic guidance because if you have two pages on VFI

cohort, you would have to have five pages on something else and three pages on something else. So one is not expecting a lot in this, but it might be thought, when one looks at the date of this and how recent it is, even allowing for what you say about these are two years in the drafting and this is a major publication, it may be thought to be really quite concerning that the VFI cohort doesn't seem to be reflected at all in this guidance. Even a line saying: practitioners should be aware of the concerning and emerging threat of extreme violence linked to internet violence, internal gore, Com networks; this is a complex, emerging area but your assessment should take account of it. I mean, one paragraph might not be thought to be controversial or difficult but it just doesn't feature.

A. Well, I think, it does feature but not as strongly as you have just outlined. So, the reference to "hate and violence" for example, we have already touched on, I think, is how it is covered. But I accept that it could be strengthened and that is why I think it would be appropriate for the guidance to be reviewed.

Q. Thank you. So far as training is concerned, page 31 NHS000602_0031, paragraph 146 please of your statement. I just want to try to get to the granular level reality of this. You start by saying:

"Although training on violence and aggression is delivered across a range of healthcare settings, training relevant to the identification, assessment and management of violence fixated behaviours is primarily provided within services where such presentations are most likely to be encountered, including [in] FCAMHS."

Then, if we go over, please NHS000602_0032, against that background, to page 32, you explain that:

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

Is that right?

A. That's correct, yes.

Q. You say that:

"... the FCAMHS network deliveries a programme of online and face-to-face training covering violence fixated behaviours, the formulation and assessment of complex cases and threats, the role of online influences, and approaches to risk assessment."

Do you know what that training covers, beyond that

high level?

A. I'm afraid, I don't, no.

Q. It may be we can pick that up with our witness tomorrow. Thank you.

You say in paragraph 150, I think on the previous page NHS000602_0031, that:

"As part of the NHS Prevent Training and Competencies Framework, all staff working in health and social care settings ... must complete training on preventing radicalisation."

That, of course, is right and we are familiar with that as the Prevent duty but that presumably is in relation to when to make referrals, what to look out for in, broadly speaking, the realms of ideological terrorism?

A. That is correct.

Q. And should we understand that there has not been, for the NHS, any -- my words -- bolt-on to that training to deal with the allied issues of VFIs?

A. That is correct. But there lies a possibility, I would suggest.

Q. And so, other than the expectation that we looked at a moment ago, that there would be specialist training for FCAMHS practitioners, should we understand that there is no training given more generally to the NHS

work staff, including to mental health staff outside of FCAMHS?

A. In relation --

Q. In relation to the VFI risks and the VFI cohort?

A. That is correct and again, the principle being that it is about identifying individuals at potential risk of significant violence and then referring those individuals to appropriate services, so FCAMHS or adult forensic services.

Q. But even in relation to that first stage -- because I understand of course what you are saying, that that would become a FCAMHS issue, that is the right body to refer it to -- staff who are going to make that referral need some assistance, it might be thought, some training and education in what to look for, what behaviours to look for, awareness of things like Com networks, the ubiquity of gore material on the internet, those sorts of matters, in order to be best placed to make the referrals, just like they have Prevent training in relation to ideological terrorism? Isn't there a striking gap in that area?

A. I think there is a gap but I would highlight that, in terms of the wider training we provide to staff in relation to other offending behaviours, that is pretty limited but it is about creating a culture whereby

clinicians are curious and if there are issues of concern, they are escalated and dealt with through line management supervision and then, where appropriate, referrals made to more specialist services.

Q. Is there any current plan within NHS England, either directly or through the most appropriate other body, whether it is royal colleges or whatever, to roll out training in this area for the frontline healthcare staff?

A. I'm not aware of there being a plan.

Q. Do you think there should be a plan?

A. I think consideration needs to be given as to what training is required and there is a piece of work, as I understand, looking at mandatory training in its entirety, across the NHS, and looking at what that mandatory training programme should include. And it is not a straightforward area. For example, there is an ongoing discussion regarding the merits of suicide prevention training, being mandated for all staff working in mental health services.

Q. Yes.

A. And that's not currently mandated and I would suggest there is a compelling case for it to be mandated, given the suicide risk associated with mental ill-health. But one of the reasons why it has not been mandated to date

is because of the resource implications, not least in terms of how much time colleagues then spend in training. So, it is, as always in these situations, a question of striking the right balance, but we certainly need to have a discussion as to whether the training should be expanded to include something that focuses on violence-fixated behaviours.

Q. Thank you. Do you know if a question has been put, to those doing that work on mandatory training, as to whether anything does need to be included in relation to violent extremism, so that it is at least on the table of considerations?

A. I'm not aware that that has been posed as yet, no.

Q. Does that mean you don't know one way or the other, or you don't think it has been put to them?

A. I don't know one way or the other, but my guess is it has not been asked of them yet.

Q. Is that something you can check up on --

A. We certainly can, yes.

Q. -- and confirm? I think in general terms, when one looks across the piece, subject to any indication to the contrary from the learned Chair, at training and guidance, it would be helpful for the Inquiry to be updated as to NHS England's -- and in due course, DHSE's -- intentions here as to whether further training

or further guidance is intended to be issued.

A. Understood.

Q. Thank you. Could we turn, then, to risk assessment and prevalence. Doctor, if we may look together, please, at paragraph 20, page 5 NHS000602_0005. You say there that:

"Regardless of the terminology used ... ('CAMHS') and ... ('FCAMHS') professionals report that violence fixated behaviours are increasingly being observed among patients and are becoming a growing consideration in clinical assessment, risk formulation and risk management."

Now, that may play into the need for guidance and training, given that observation. But what do you understand to be the reason for the increase being observed? Is that a question of greater awareness, post-Southport, post-Adolescence, or is that thought to be a substantive change in prevalence?

A. So, my understanding is that it is multi-factorial. In part, it is a consequence of greater awareness, not least as a consequence of this Inquiry. But there also seems to be an increase in prevalence, which, it would appear at least in part, is driven by the expansion of the online world, if I can use that phrase.

Q. Thank you. Can you help us in any more terms, other

than the areas on which I have asked you about, on what the national priority programme is intending to do in response to that report of increase?

A. Well, in simple terms, to take stock, not least again from the output of the Inquiry and the work of the Inquiry to date; to look at the evidence base as it emerges, to work closely with colleagues, particularly in the Royal College of Psychiatrists and in academia; to review our approach to training; as I have indicated earlier I think it is appropriate to review the personalised care framework as well.

And there is work in train, in relation to risk assessment, which we may well touch on, which was initiated on the back of Phase 1 of the Inquiry. I think, as well, there is a piece of work in relation to some of the existing services that have been established, some of which are in pilot form and consideration needs to be given to the need to expand both the scale of those services and indeed the scope of those services.

Q. All right. So lets pick up on some of those aspects. If we could have NHS000574, this is NHS England's closing submissions. If we could have page 12 NHS000574_0012, paragraph 36. You cite this in your own statement, but you say that:

"... even now there is not a good, evidence-based tool for assessing risk in young people who present with violent ideation or intense interests in the macabre. This is still a relatively new area and services such as FCAMHS are learning and developing their approaches in conjunction with partnership agencies ..."

Now, just following through the chronology. If we can then have on screen CHAIR000002 at page 312 CHAIR000002_0312. Following those closing submissions and analysis of the evidence, you are aware, page 312, of recommendation 52.

So:

"Nationally, [DHSC] and NHS England should review:

"Whether there is a need for further development and guidance including on the thresholds for when complex structured risk assessments (such as [SAVRY]) are required for children and young people who present a risk of violence to others. A balance may need to be struck between sufficient provision of guidance to assist as to when the more complex type of structured risk assessment may be justified and retaining the case-specific judgements by professionals that are inevitably required.

"2. Whether national guidance is required to ensure clarity about who is responsible for conducting complex

structured risk assessments (where they are appropriate) for children and young people who present a risk of violence to others. Consideration should also be given to the roles of children and young people's mental health services and wider children's services in conducting or referring for appropriate risk assessments."

So, I think you said earlier that -- going back to your statement please, at page 20 NHS000602_0020, paragraph 92 -- I think you said that that work, that you referenced there in paragraph 92, is in response to that recommendation; did I understand you correctly?

A. Yes, the commission of the National Institute of Health Research to undertake a review of the literature and evidence in relation to the use of risk assessments in children and young people's mental health services is ongoing, yes.

Q. Thank you. Just give, again, if you would, the update in terms of expectations for that?

A. I have been informed that we should receive the output, the report, in December.

Q. Thank you, and I think, from the response that's been given, the target for an action arising out of this is 31 March, is that right?

A. That is correct.

Q. Are you able to say what the emerging picture is in relation to that, from the work that has been done to date? I appreciate it is still a work in progress.

A. It is still a work in progress, so I haven't received a draft of the report. But in addition to that there is an aligned piece of work that's being led by the clinical network for forensic CAMHS services, who have been working with our national clinical directors to develop a consensus statement regarding the use of structured professional judgements in Forensic CAMHS services, particularly with reference to the use of the SAVRY risk assessment tool, the Structured Assessment for Violent Risk in Youth.

Q. Thank you, and when is the return date for that?

A. I have seen a draft document. My understanding, again, is that this should be finalised this side of Christmas.

Q. Thank you. Again, what's the emerging picture on that?

A. I think the emerging picture is that the tool should be used to assess interpersonal violence and should not be used to assess areas where it is not validated. That would include violent-fixated behaviour, but the statement reinforces the importance of such tools being part of the overall approach to assessing risk and adjunct to the overall clinical assessment, which should be based on obtaining as detailed a history as possible

regarding the young person, including detailed collateral history.

The other thing to say reinforces the importance of the tool being carried out by people who are suitably trained in its use.

Q. Thank you. Although it is not yet complete and not yet validated, the AREVA tool, the Assessment of Risk of Extreme Violence in Adolescence, is being developed and some of our seminar speakers, quite a few of them, referred to that as being a potentially helpful piece of work. I assume that the work that is being looked at by NHS England is including the potential for AREVA, once validated to, as it were, fill the gap?

A. Yes. My understanding is that the NIHR work will look at AREVA and any other tools that are in development.

Q. Thank you. On SAVRY, you have touched on it. If we look at page 15 NHS000602_0015 of your statement. You gave some cautionary words about it. Taking it briefly, paragraph 70: it is not designed to quantify risk. Paragraph 72:

"Each assessment is reliant on a large amount of information, which takes a significant amount of time ... (some weeks, if not months)."

Just pausing there. That's something that was stressed in the NHS England's closing submissions. So

the reference for that is NHS000574, page 10 at paragraph 34. We don't need to flag it up because it is similar to the doctor's statement.

SIR ADRIAN FULFORD: Thank you.

Q. Paragraph 73 -- and this, I think, is what you were touching on a moment ago -- that SAVRY is primarily designed for "young people with a history of anti-social behaviour and offending in contact with the criminal justice system". I think you might add "interpersonal violence" rather than "violence fascination", as I have understood your evidence; is that right?

A. That is correct.

Q. Over the page NHS000602_0016, 74. A general warning, "tools should not be applied in an overly rigid way" and 75, not appropriate "to rely on SAVRY alone". Now, I'm not seeking to criticise those cautions and caveats, but are you familiar with the evidence of the Inquiry's expert cadre, in particular, Dr Richard Church, dual-qualified psychiatrist, who, in a nutshell, said that he was struck by how the SAVRY risk headings correlated very well with what the expert group had seen in the case studies? So he thought that it was a very good guide, in general terms, to the sort of issues that needed to be explored.

A. I'm aware that's his opinion, yes.

Q. Do you differ from it?
A. So I'm not an expert, despite my professional background, in the use of these tools in children and young people, so I will be guided by the experts in this field and the content of the draft consensus statement, as I have already alluded to. But, the structure of a tool like the SAVRY, I think, is helpful because it does cover a wide range of risk factors. I think the SAVRY cool covers 24 separate risk factors, historic, contextual, clinical, together with some protective factors.

And, in essence, that is what good risk assessment is all about. It is about taking a comprehensive assessment. So the framework itself, I think, would be beneficial but it is a fairly standard framework to those we use in assessing risk.

Q. Thank you. I can bring it up on screen if you like but we have given you notice of it, so I suspect you have been able to read it. One aspect that Dr Church said about in his evidence -- sir, for your note, it is page 155, line 7 on the 7 October -- but he spoke that there had been a trend over the last decade or so towards our structured professional judgements used in mental health to become longer and longer documents.

Later on, at page 156, he said, in essence, that if

you have a professionals meeting with individuals who hold good knowledge of the young person, then the information is all there and he said, in effect, you can add to something like the SAVRY later on and give full detail but you can, in an early meeting -- my words -- get the essence of the key factors quite quickly.

So he seemed to be pushing back slightly against the evidence and the emphasis that NHS England had given to the fact that SAVRY is very complicated, very time-consuming and he was effectively saying it wasn't always so?

A. I certainly recognise the fact that the SAVRY tool and indeed other tools such as the HCR-20, do seem to have become more laborious to complete and I think that's something that we need to look at. Certainly, when these tools were initially rolled out, they were completed in a relatively timely fashion. So the fact they appear to take some teams weeks, if not longer, to complete the assessment is a cause for concern.

Again, I think that points to the importance of pieces of work such as the consensus statement and the review by NIHR of risk assessments in children and young people's services and I think on the back of that, there is a need for some guidance from NHS England in relation to their utilisation.

Q. So, will the outputs of the work that is in hand, including by NIHR, specifically address that the trend that, I think it is fair to say that Dr Church saw as being an adverse trend of over complexity, overly long use of the structured judgement. Not perhaps saying that you shouldn't keep working on it, but that the early readouts from it could come at a professionals meeting early on. Is that going to be covered in the work streams that you have been speaking about?
A. That would be my expectation. I think it is important to highlight that risk assessment is a dynamic process. So it doesn't just stop once a tool is completed and it is right and proper that the risk assessment should be updated, particularly when things change. But it shouldn't take, as I understand it, weeks if not months, to complete a risk assessment.
Q. Thank you. Dr Broughton if you don't mind me observing, that the answer "that would be my expectation" is a careful one. Do you, in fact, know whether they are covering that?
A. I don't know, no. But my expectation is about the outputs and then what we do with the final report and the consensus statement.
Q. Again, subject to the learned Chair's intervention, do you think that that is -- bearing in mind in particular

Dr Church's concern and the issues that I'm exploring with you, do you think there would be merit in making sure that these work streams that are going to be reporting by the end of the year, are cited on this aspect?
A. I do.
Q. Thank you. Can we turn, next please, to neurodivergence and mental health in risk assessments.

Michael Gregory, who gave NHS England's statement for Phase 1, spoke about the issue of autism in children's mental health remaining a significant area of challenge, which requires better cross-agency working and potentially similar guidance to that which applies to adults with autism.

Before we look specifically at the impacts of neurodivergence in the VFI cohort, in terms of general progress being made by the Government, by DHSC and by NHS England in this area, presumably, Professor Fonagy's report and the expected response to it is the major headline piece on the overall challenges of, in particular, autism?
A. It is, and as you will be aware, Professor Fonagy, in his report, has highlighted that we need to fundamentally transform how neurodevelopmental disorders such as autism are assessed. And need to move towards

a far more needs-based approach, an approach that takes into account the fact that young people often have multiple conditions and that autism often occurs alongside mental health problems, such as depression and anxiety.

Q. Thank you. That was explored with Mrs Powell and I won't -- our previous witness -- explore it further with you. But what I did want to pick up, please, is page 12 NHS000602_0012, paragraph 59 of your statement, because it is an important but familiar refrain. You say:

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

Now, the Inquiry has seen a lot of evidence that sits behind that, including Professor Al-Attar's publications and the work done in the Prevent sphere as to why there is such an over-representation of those with neurodivergent conditions, particularly autism, in the Prevent cohort, which, taking it very shortly, is broadly consistent with what you say, but a lot of detail sitting behind it.

How do mental health practitioners, particularly those at the front line, come to have that understanding, that it perhaps is not causative, but needs to be looked at as a significant textural factor that needs individual assessment where they are dealing with risk of extreme violence?

A. So the relationship between violent behaviour and mental disorder is complicated and will vary significantly, based on the individual concerned.

But the principle that underpins our practice is that the assessment of an individual who is at risk of behaving violently, or indeed has behaved violently, should be comprehensive and take into account consideration of their full clinical history, including whether they have a neurodevelopmental disorder, whether they have a mental illness, whether they have physical health problems, whether they have substance misuse problems, alcohol problems, cognitive impairments of one kind or another.

So that is how we approach this matter, taking a very detailed history, considering the whole person, their entire health needs and then it is a question of working out the relationship between the mental health difficulties that an individual may have and their offending behaviour.

And there may be a very straightforward relationship, so, in the case of someone who is suffering from a psychotic illness, the violent behaviour might be driven by their psychotic symptoms, or the relationship may be far more complicated.

Q. One understands that, but it may be thought not to be an answer to the question. What I'm seeking to understand is, given the emphasis on the complexity of the interplay between neurodevelopmental conditions and violence fixation -- what I mean by that not a relationship of direct causation, but nor is it irrelevant -- requires detailed individual assessment. But the risk at the other end -- there is a risk of oversimplification and stigmatisation, autism causing extreme violence, completely wrong -- but the risk at the other end is to excuse violent behaviour on the basis that the child or young person is autistic or has another neurodevelopmental condition. And taking that approach may be to overlook the risk to others and not to be taking action on the risk to others.

And sitting between that is what seems to be the emerging truer picture, of complexity in this. So those with autism may be more likely to suffer from social isolation; may be more likely to have senses of grievance that may be connected with that; may be more

likely to be bullied, may be more likely to be perceived that they are being bullied. They may have greater vulnerability to bad actors on the internet. But their interest in -- narrow-focus, intense interests could lead to harmful interests online as well. And the sense in which autism can be inherited may mean that there are complex relational issues with their parents and how behaviours may not be picked up by parents and addressed in the same way as for those who are neurotypical.

So, a lot of complexity in relation to that and the question I'm really getting at is: where do we see, at the moment, guidance to frontline practitioners that sets that out, saying: you need to be aware of this if you are dealing with extreme violence, or the risk of extreme violence, or those fascinated with gore?

A. So, as far as I'm aware, there is no specific guidance in relation to autism and the risk of violence-fixated behaviour. But the point I was endeavouring to make is that the expectation, particularly in forensic practice, is that there would be due consideration of the role that autism, or indeed any other neurodevelopmental condition, may have in an individual's offending and risk of offending; taking into consideration the points you have made, that it may be protective or it may be something that actually increases the likelihood of

risky, violent behaviour, because of some of the reasons you have set out.

SIR ADRIAN FULFORD: But that's not written down anywhere?

A. But it is part and parcel of how forensic practitioners operate.

MR MOSS: But two challenges to that, doctor. The first is: what about before that stage? Because if the risk is of violence-related behaviour being "excused" on the grounds of autism, that is a trap that frontline, non-forensic mental health practitioners could fall into in a multi-agency environment. And it may be said that happened with AR. So, it is not an answer to that, to say that is sort of part and parcel of what forensic specialists look at because you are talking about the specialist stage; I'm asking about mental health nurses and psychiatrists.

A. So I'm not aware that there is a generic problem with mental health practitioners excusing violent behaviour because someone is autistic. Now, there may be an issue with other professional groups and I would suggest that extends beyond autism to mental illness, but in the world of mental health practice, we would encourage and expect that holistic view of the individual and certainly would not just discount violent behaviour, or indeed a risk of violent behaviour, because someone has

a diagnosis of an autistic spectrum disorder.

Q. The other challenge to your answer, in terms of: we would expect forensic professionals to be aware of that, is to look at the realities of what happened in AR's case, which is that he was open to FCAMHS at an early stage but, in broad terms, their response was to say: well, here is preliminary input but until you have a diagnosis, we can't assist further.

A. Well, I'm somewhat surprised by that. And I'm aware that one of the challenges for the service, when the referral was made, was that there was a lack of resource, capacity to undertake autism assessments. The team now has the necessary capacity to undertake such assessments. But the expectation that I would have is that the assessment of any individual referred to a service such as forensic CAMHS would be holistic and that a diagnosis of autism would not be a barrier to being assessed by such a service.

Q. Thank you. Part of the purpose of guidance in this area may be to serve to assist those who are less experienced and less specialist and does this exchange cause you to have pause for thought about whether, while best practice would be taking this into account already, there may be a role for further guidance to ensure that best practice is met?

A. Indeed there may, and, again, I think it reinforces the fact that the concept of violence-fixated behaviour is an emerging, developing one and we need to take that into consideration, along with the fact that we know that there are more and more young people presenting to services who are displaying such behaviour. And the guidance needs to respond accordingly to that.

Q. And one can think, within living memory, of lots of risks and conditions, some of them purely health, that emerged, that are new risks where you don't know all the answers initially but you, nevertheless, have to give guidance as to best understanding, potentially before there is that fully formed understanding; would you not agree?

A. Yes, and obviously it is a judgement call as to when one issues such guidance. You know, when we have reached that tipping point where we know enough, to issue something that is value adding.

Q. Yes, but the delays in waiting for too long --

A. Indeed.

Q. -- when one thinks about Southport, are so evident that they don't need to be articulated; would you agree?

A. I would agree.

Q. Thank you. Another aspect, in terms of risk and assessing risk, was conduct disorder, which I think you

will be aware of that Dr Irani in Phase 1 was of the opinion that AR should have been diagnosed with conduct disorder and that was a misdiagnosis.

Our expert cadre of witnesses, particularly Dr Church, found that in the case studies he thought that was the case also. Not necessarily in every case but he thought that there was a problem with conduct disorder being missed. So could we, just on this occasion, look up his evidence on that. It is the 7 October transcript. I think if you go to pdf page 33, that should take you to page 132 in the internal pagination.

So you will see, if you look with me, doctor, if you would, at the right-hand side of the page, I ask:

"... what information is opened up by a diagnosis of conduct disorder ..."

And he said:

"... it is a huge topic, very significant in CAMHS because my belief is that there is a cultural -- I think it has been present for many, many years -- a cultural -- quite embedded culture against diagnosing conduct disorder. It is a diagnostic category that has been included in the [ICD] by the [WHO] with many top professionals from around the world contributing and yet, it is a diagnostic category that's not used in our

CAMHS teams, by and large.

"It appears to be a very active avoidance of that -- of the usage of that diagnosis. It is not unusual at all that it has not been used in the cases we have looked at. Sometimes 'oppositional defiant disorder' is used and that is that's very closely related to conduct disorder. But, the importance of making a diagnosis of conduct disorder is that -- well, first of all, in a CAMHS caseload, it gives commissioners an indication of the need in that patch. So if a commissioning body asks: what's the rate of conduct disorder in your caseload? It is quite helpful to say: well, half of them, because actually then that naturally leads to a sort of plan for interventions and there is NICE guidance on what works for conduct disorder. There are all sorts of obstacles to delivering effective treatments for conduct disorder but the other benefit actually is that it is a very descriptive category, the benefit is that it can communicate a young person's presentation to other professionals in a more accurate way and that means that the young person's needs are more likely to be met in a multi-agency sort of context because it is a form of effective communication between professionals."

Without turning it up, we remind ourselves, sir,

page 97 for your note, of the same transcript, that he said: what we have heard is a few CAMHS services, perhaps more than a few, identify conduct disorder as an exclusion criteria for their services.

SIR ADRIAN FULFORD: Thank you.

MR MOSS: Now are Dr Church's, and indeed Dr Irani's, concerns about the under-diagnosis of conduct disorder and a cultural reluctance within CAMHS, to diagnose conduct disorder, something that you recognise?

A. I do.

Q. What's being done about it?

A. Well, firstly, conduct disorder is relatively common. I think I'm right in saying the prevalence is thought to be around 5 per cent of children. Secondly, there is a concern regarding the stigma associated with labelling a young person as having conduct disorder. But we are aware that there are evidence-based treatments for conduct disorder, including family interventions, which are effective and I'm hoping, in relation to that particular intervention, it is something that will be included in the forthcoming mental health strategy that the Government is developing.

But, there's also work in train in relation to the role of mental health support teams in schools, which is something we may touch on later. Currently, 60 per cent

of children are in schools where there is a mental health support team and we should have universal coverage in place by 2029 and we are looking at expanding and enhancing the role of mental health support teams so they are able to assess and support children with conduct disorder.

Q. So have those teams been given guidance on the importance of stopping the cultural reluctance to diagnose conduct disorder?

A. There hasn't been guidance issued, as far as I'm aware, regarding the cultural element to this.

Q. Why not?

A. Because -- well, I can't answer that. I wasn't aware this was such a problem up until very recently.

Q. All right. So --

A. I was aware there was an issue about conduct disorder and the need to deploy more effective treatment for it. I wasn't aware there was an issue in terms of the culture of certain CAMHS services seeing it as a diagnosis of exclusion.

Q. Thank you. The concern, in the context of AR, but heightened by the fact that the expert cadre looked at six case studies and say, within these case studies, conduct disorder failed to be diagnosed when it should have been as well, is that it seems to have

a read-across to the VFI cohort and have NICE-approved interventions, which won't be deliberately planned for, for young people, if they are not diagnosed in the first place.

So it may be thought that, against that risk, the concept that, welcome though it is, that there's real investment in mental health practitioners going into school, and there's going to be a mental health strategy, those don't seem to be direct responses to the under-diagnosis of conduct disorder and the cultural problems. So would you agree that there needs to be fresh action in that area that's not currently planned for?

A. I'm not sure I would agree with that. I think the expansion of the mental health support teams is a very significant step.

Q. I haven't sought to undermine that. But it is not an answer to the under-diagnosis of conduct disorder if they are not trained and given guidance about it. I don't see the correlation. Of course -- it is helpful to have mental health practitioners more on the ground in schools, of course, because they will be seeing more young people and dealing with the need --

A. I don't also accept that people aren't trained in relation to conduct disorder. So I think CAMHS

practitioners are trained in relation to conduct disorder. I think one of the issues at play here is the demand for CAMHS services. And the Inquiry will be aware that we have seen a very significant increase in referrals to CAMHS services, which I think is reflected in Peter Fonagy's review that we have touched on earlier.

And what we want to address, through the mental health strategy, is how we can support young people earlier and, therefore, ensure that those young people who require specialist CAMHS interventions, whether it be for conduct disorder or any other particular mental disorder, are able to access those services. So I think the diagnostic challenge that you have described in relation to conduct disorder is as much a reflection of capacity constraints as it is about culture.

Q. Thank you. If there is any material that shows that arising out of, either the Inquiry's Phase 1 report or the admittedly very recent expert cadre evidence, but also much more widely any learning in NHS England on the under-diagnosis of conduct disorder, if there's any documents going to what is positively done to try to deal with that problem, whether it is cultural or some other reason, could you alert the Inquiry to those documents?

A. I will, indeed.

Q. Thank you very much. Allied to that, I hope you have been made aware, through the evidence proposal, of the expert cadre also having a concern about foetal alcohol spectrum disorder. Taking it very briefly. We don't need to bring up the transcript, but you have been put on notice, I think, of the evidence about concerns that the cadre had about an absence of professional curiosity about foetal alcohol spectrum disorder. Sir, that is 122, line 19; a high rate of co-occurrence between FASD and neurodevelopmental conditions, 122, line 4; but the fact that the support that is required is different from ASD and ADHD, that is page 121, line 10; and also that FASD is preventable, in the sense that it is preventable through abstinence of alcohol in pregnancy.

So really, the cadre were raising the concern about the impact of this on young people who suffer from it, the need for different treatment and also its under-recognition. Again, first of all, is that something that you recognise and agree with?

A. I certainly wasn't aware that there is an under-recognition of foetal alcohol syndrome. And I suppose, I would question the validity of making assumptions about that on the basis of analysing six cases.

Q. Understood, and that must be right, but it does beg the question as to whether there has been any wider analysis undertaken with a bigger cohort or whether there is work in relation to this because what the cadre were seeking to draw out is that the lack of recognition of FASD in some of the case studies, meant that the interventions, where there were interventions, were not correctly targeting that and to some extent, may have been obscured by the fact that there were co-concurrent neurodevelopmental conditions and they were talking about it, in broad terms, in a background of it also leading to relational problems and a sense of grievance and a sense of social isolation because the behavioural problems associated with it simply weren't being recognised for what they were -- my layperson's summary.

Is there any work on that area -- you are quite right to place the challenge to the Inquiry, it is quite a lot to draw from six case studies -- but is there work ongoing in NHS England or allied bodies looking at that, do you know?

A. I'm certainly not aware of any work ongoing in NHS England looking specifically at foetal alcohol syndrome.

Q. Thank you. Again, if there's anything in that area that you wish to check, it would be useful for the Inquiry to know because it is an area of concern following the

expert cadre's evidence.

If we go back to your statement, please, and look at page 13 NHS000602_0013, paragraph 65. I think finally in this area, I just wanted to look at a different aspect of this, of when children reach their majority and the cliff edge problem and you, yourself, say:

"... we highlight that while referrals will only be accepted up to a [child or young person's] 18th birthday, those approaching their 18th birthday on referral are likely to reach a time-limited service from FCAMHS. The focus of such interventions will typically be on ensuring a robust transition plan to adult services ..."

What do you say about the challenge that -- the difficulty with that is that the adult services are less and they are also very differently organised, so there is a risk of a sudden drop-off in support when children with these sort of support needs turn 18?

A. Well, firstly, FCAMHS is not typically a case-holding service. So it is a service that would provide consultation, advice, assessment and very rarely limited interventions. So it will be supporting the generic CAMHS service to manage the young person.

But I do accept that the transition from child and adolescent services to adult services is far from

straightforward, not least because the models of how the services operate are somewhat different and that is something that we have known for quite some time and is one of the reasons why we want to move towards a service model that covers all of adolescents and as you will be aware, the human brain continues to develop until someone is in their mid-20s.

Q. Yes, 25, I think I was given, as the --

A. Exactly. So that's why we are looking at developing a 0-25 year old service, which will go some way to addressing this cliff edge, as you describe it.

Q. Thank you. If we can just look at LGA000032. So Mr Norris on behalf of the Local Government Association. It is page 42 LGA000032_0042, please. Paragraph 128.

So was putting it a bit higher really:

"... the waiting list for CAMHS and other agencies is so long that this may not be appropriate or effective in serious cases."

That is the referring people to CAMHS in the first place:

"Furthermore, in some cases local CAMHS teams reject referrals for autism unless the child has a co-existing, severe mental health condition ..."

Then they refer to the paper from the Association of Directors of Children's Services, "A healthcare system

that work for all". There, they are pointing out the specific challenges for young people aged 16-18. Even at age 16:

"... many young people are deemed too old for support from CAMHS but too young for support from adult mental health services ..."

Again, is that a challenge you recognise? It is coming from a senior national representative organisation.

A. Well, I am not aware of young people being rejected from CAMHS because they are too old if they are 16, and it would be helpful, if there is evidence to support this, for me to have sight of that and I will address it in my capacity as national priority programme director.

Q. Thank you. So, the reference for that -- and your legal representatives will have access to it -- is that ADCS report, which has the Inquiry reference LGA000023. That's where he has derived that from.

A. I will have to have a look at that.

Q. Thank you.

A. And I assume there are examples in that report of cases where this has actually happened because obviously the danger of a statement such as this is based on anecdote which is not supported by the evidence.

Q. Thank you. Is there positive evidence from NHS England

of the success rate for continuity of care for those aged 16 to 18, putting it the other way round?

A. I don't think so, no. But, I suppose we would be able to pull together evidence demonstrating the number of young people whose cases are transferred to their local adult service.

Q. Yes. I suppose the risk is, anecdotal or otherwise, that if this picture is happening, so the 16-year-old who is not being captured because the waiting list, for example, may mean that they have been referred at 16 but they won't be caught, that they fall between the gap completely and, by definition, they wouldn't be transferred to an adult care case?

A. Yes, obviously if they are not accepted by the CAMHS service, then they are not going to be transferred from the CAMHS service to the adult service. But the point I was making is that I was not aware that there was a systemic problem with young people who are 16 being turned away from CAMHS because they are considered to be too old. Not least, because the specification for CAMHS is very clear; it is a service for children up to the age of 18.

MR MOSS: Up to 18. I follow, thank you.

Can I turn to my next topic then, please, which is information sharing.

But, sir, I note the time. We've been going for just short of an hour and a half, so I wonder if that is an appropriate moment?

SIR ADRIAN FULFORD: It certainly is. We will sit again at 3.30 pm.

(3.19 pm)

(A short break)

(3.30 pm)

SIR ADRIAN FULFORD: Yes, Mr Moss.

MR MOSS: Thank you, sir.

Dr Broughton, may we proceed with your next topic, information sharing. If we can start with page 21 NHS000602_0021 of your statement and paragraph 100.

You set out there, candidly, the observation that:

"NHS England is aware that information which should be shared is not always shared ... [and] it is important to understand the underlying reason why ..."

That may not be happening. Then in paragraph 101, you cite that, for FCAMHS, it is:

"... a service which is reliant on and works collaboratively with community partners, [but] has faced difficulty in both receiving information from and sharing information with other organisations."

Can you just tell us in a nutshell what you understand to be the cause of that?

A. I think it is multi-factorial. I think there is a challenge when it comes to inter-agency working and different cultures within organisations. There is a challenge in relation to information systems and the fact that they don't necessarily communicate effectively. There's also a challenge in relation to concerns regarding protecting patient confidentiality and perhaps a lack of knowledge regarding the Caldicott Principles and the fact that, whilst protecting patient confidentiality is important, at times it is as important, if not more important, to share information.

Q. Yes. Why -- in a situation in which all health organisations are meant to have trained Caldicott Guardians, for example, why are these problems so persistent?

A. That is a very good question because it is something that staff across the NHS are trained in regularly and the Caldicott Principles have been embedded into practice now for many years. I don't know.

Q. So when you say, in paragraph 102 -- and you will understand that it is not a criticism of you, doctor, but a challenge to the nature of the problem -- you say:

"If the conclusion is that information ought properly to have been shared by health bodies, or that the relevance information was held by other

organisations and not shared with health bodies (when it should have been), under existing legal and policy frameworks, then targeted guidance or training may be required in supporting future decision making."

It may be thought, first of all, that's quite conditional and it may also be thought that it is more of the same. And you will forgive me putting it in that way, but the challenge, I suppose, may be this: has not the time come when, as happens with MAPPA, that there should be a clear statutory obligation to co-operate and, therefore, to share information, so that practitioners know that they have both a duty and a protection, when they are sharing information, that is relevant specifically to the risk posed to others?

A. Well, my understanding is that practitioners should know that already.

Q. Yes. But if, with guidance, they have not taken that on board, the prescription -- if you will forgive me putting it to you, as a doctor -- of further guidance may be thought not to be likely to cure the illness?

A. I accept that.

Q. There are a number of examples one could take of this, but if we look, please, together at DHSC000061, this is the guidance on safeguarding accountability and assurance.

So if we could just have the top third of the page highlighted. So:

"Safeguarding children, young people and adults at risk in the NHS."

If you just note the dates, if you would, that it was published in June 2024 but we are now on the fifth edition. Against that background, if we look, please, to page 9 DHSC000061_0009 at the bottom of the page, we will see a section 8, which deals with "Information sharing" and starts with the principles that you are referring to, so:

"Robust information-sharing is at the heart of safe and effective safeguarding practice.

"... covered by legislation ..."

But then it says this:

"Practitioners must have due regard to the relevant data protection principles which allow them to share personal information."

So there is an emphasis there on legislation allowing to share information. And then GDPR and DPA:

"... place greater significance on organisations being transparent and accountable in their use of data and help organisations share information in a fair, proportionate and lawful way."

I don't want to overlook that because, in general

terms, that is about: under the GDPR, you have a policy about how you will share information, you tell people about that and so on.

But if one goes over the page DHSC000061_0010, we then see:

"All organisations handling personal data need to have comprehensive and proportionate arrangements for collecting, storing, and sharing information. The GDPR ... and [DPA] ... do not prevent or limit the sharing of information for the purposes of keeping babies, including those on an unborn child protection plan, children, young people and adults safe.

"Personal data may need to be shared to protect an individual from neglect or physical, mental or emotional harm, or to protect the wellbeing of a child under 18, or an adult defined as being 'at risk' ... Sharing information to protect and promote the welfare of an unborn child must also be considered within health and in the multi-agency safeguarding processes set out in Working Together, 2023."

Now, I don't for one moment, Dr Broughton, want to be taken to be suggesting that those provisions are anything other than very important and indeed essential when one thinks about cases of harm to babies and children inflicted by abusive adults and so on.

But one sees nothing here about an emphasis on sharing information where there is a risk to others.
A. I accept that.
Q. And, again, if we may just go back to the front page DHSC000061_0001. The concern that the outside observer may have is, here again, we have a very recent publication which does not seem to be taking account of the mounting concern that a problem area is a failure of sharing information, where children are a risk to the public because they are at risk of being extremely violent.
A. And I think, in part, the explanation for this is this obviously, the safeguarding, accountability and assurance framework, which is very much focused on safeguarding children and vulnerable adults and preventing neglect and victimisation and harm to those individuals. So, it is rather focused on that element, rather than preventing harm -- from individuals perpetrating harm on others.
Q. Yes. But of course, the difficulty with that is that not all but many of the cohort, of which AR is an example, will be open to children's social care and to CAMHS for safeguarding concerns as well.
A. Indeed, yes.
Q. And I will be corrected if I'm wrong, but other than the

Prevent guidance, which is in relation to ideological terrorism, principally, I do not think we have been made aware of explicit NHS guidance that gives granular detail in relation to the sharing of information where the risk is to others; do you follow?
A. I do, and obviously, you know, the principle of the Tarasoff liability would apply in this space but I'm not aware what guidance NHS England has that covers the point you have made.
Q. Thank you. We have been looking at the Children's Wellbeing and Schools Act 2026 and the reforms there. Can I ask you in relation to that, first of all, the reform to have a single, unique identifier for children in that context, will that have a read-across to healthcare and the sharing of information?
A. That is my understanding.
Q. Can you explain to us how that is expected to be of benefit?
A. To hopefully facilitate information sharing and ensure that there is no confusion regarding the child that is being discussed because we will use -- or the process we will use, the NHS number. I think it is addressing challenges that have been encountered previously, where the children's name has been used and obviously names --
Q. With differences in the name?

A. Exactly, and that's led to a breakdown in communication or indeed the communication of incorrect information.
Q. Now, health is a statutory partner for these purposes and if we look at ILT000362, we have been looking at the very recent statutory guidance. So September 2026.
"information sharing duty". If we go, again it is well-worn territory now, I'm afraid, but if we go to page 20 ILT000362_0020, middle of the page:
"Sharing information where a child poses a risk to others."
We have been looking at the fact that the guidance starts with saying:
"The information sharing duty extends to information about any other individual connected to a child, provided it is relevant to a child's safety and welfare -- therefore, it includes sharing information about a child who potentially poses a risk to another child."
So it starts off with a focus of what may be thought as the typical familial situation, where siblings may be a risk to each other, or potentially a school pupil may be a risk to other pupils. Then it says:
"Information should not be withhold solely because the child, as the information subject, is not at risk themselves but instead potentially poses a risk to the

safety and welfare of others."
So, there, the "others" appears to be wider. But then, in the next paragraph, it goes back to saying:
"Often, children who display harmful behaviour toward other children are unmet support needs ..."
So it might be thought that if this statutory guidance was intended to bring clarity to the situation in which there is an information-sharing duty where a child poses a risk to others, it is singularly unclear about whether that is restricted to a child's risk to other children, or to a child's risk to adults, specific adults, or a child's risk to the public as a whole. Would you agree?
A. I would.
Q. Did NHS England have input into this guidance and if so, do you know how the lack of clarity got through the editing process?
A. I'm afraid, I don't know the answer to that question.
Q. Thank you. Could we look back in your statement, please, at page 24 NHS000602_0024 and it is paragraph 114.
So the "Child Protection Information System" and you helpfully give an outline to this, that:
"NHS England is currently facilitating the NHS system wide rollout of the ... ('CP-IS') ..."

And, as I have understood from paragraph 116, this is something that sits at the higher end of social care intervention, so in relation to children who are under an interim care order, a full care order, a voluntary care order, or a section 47 child protection plan.

So it wouldn't cover cases of early help. Against that background, to what extent will this be of real assistance for the child and adolescent VFI cohort? Can you help, in terms of information sharing?

A. Well, if the child concerned was either looked after or had a child protection plan and they presented to unplanned health services, so their local Emergency Department, their local authority would be immediately alerted to the fact that they had presented to the NHS and would also have access to the last 25 appointments with the NHS that that young person had had. So the idea of this system is that it will help address safeguarding concerns.

So quite what impact it would have, in terms of managing the risk of violence-fixated behaviour, I think is uncertain but it is one way that we are trying to ensure better communication between local authority services and NHS services. And the expectation is that it will be rolled out to planned services by the end of this calendar year.

Q. Thank you. So, would it be fair, you think, to say that the principal target of this is about better information sharing about the risk to the child? One can envisage situations in which, coincidentally, it might help with information sharing but it is not principally driving at the risk the child poses to others?

A. That is correct. The primary driver is about reducing risk to the child.

Q. Thank you. Of some note, though, in the broader context, is that it is a system that seems to be linking up NHS IT systems with local authority IT systems. Is that fair?

A. That is fair, yes.

Q. And shows that some technical solutions are possible. How long has this been in the making?

A. I don't know, I'm afraid. I can take that away and get an answer for you.

Q. It may be -- forgive me because I'm making a long shopping list -- that if there were a note available, on the essence of what's been involved in making the two systems talk to one another, that's obviously, in broad terms, an area of interest to the Inquiry and I will leave it there in terms of questions to you.

Thank you.

Let's turn then to our next topic, of the frameworks

for managing VFIs. If we look at page 33 NHS000602_0033, paragraph 157, again, this is part of the useful "Improvements" section at the end of your statement. You say that:

"NHS England considers that the key to addressing violence-fixated behaviours is the establishment of a robust multi-agency framework that balances flexibility with accountability. Such a framework should be capable of responding to the diverse needs of this cohort [while] ensuring that individuals do not fall between existing service thresholds or referral pathways. Rather than requiring a single agency to take responsibility by default, the lead agency should be determined according to the individual's presentation and needs, reflecting the fact that some individuals may have mental health or neurodevelopmental needs [while] others may not."

Then, if we may also look, please, at page 19 NHS000602_0019, paragraph 86. You say that:

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

That do exist.

So, can we move from the high-level principle to the

granular detail of what may need to change. Can I ask about the screening stage, first of all. So, who may receive referrals for assessment in the case of those fascinated with violence or where there's a concern about that.

Now, at present, while some referrals in that area may fall to Youth Offending Teams, some may first present to CAMHS. What the Inquiry has heard is that, in essence, the current process is really they will be caught up in the increase in referrals to Prevent. So, there will be a large number of Prevent referrals where there's concern about fascination with extreme violence and mass casualty attacks.

If we look at CCE000001. This is Dame Rachel de Souza, the children commissioners' report, "Children referred to the Prevent programme". If we look at page 26 CCE000001_0026, she was -- if we have the diagram highlighted, she was, in this report, drawing attention to the problem of referrals to Prevent that bounce back to the original referrer.

So, health, as an organisation, making referrals is outnumbered by education, police and local authority. But if you look at the "health" column, 140 referrals were made to Prevent, where Prevent or Channel ended up not accepting the case and referring it to another

agency.

And if you see, the colour code for "health" at the bottom, you see that, I don't know exactly what the percentage is, but it looks like possibly around half ended up being bounced back to health. So either Prevent or Channel saying: we are referring this back to you, for onward care.

Do you recognise that as a problem, in terms of health organisations referring to Prevent but getting the referrals coming back to them?

A. I do, yes.

Q. Thank you. In broad terms -- and this may be a difficult question because it will obviously be dependent on individual facts -- but what would you expect the health organisation then to do with those referrals? Is it then potentially FCAMHS or a care plan? Do you know what the pathway normally would be?

A. My expectation would be that if there was seen to be a need for a referral to Prevent, the concerns would be such that the next port of call would be Forensic CAMHS.

Q. Thank you. So, a number of reports have been issued -- that can come down from the screen, thank you -- in which reform to this is suggested by way of having a big front door; I am sure you are aware of that as a suggestion. So, a process to take the first referral

away from Prevent and a different process, looking at both referrals that will traditionally go to Prevent, so concerns about vulnerability to being drawn into radicalisation, in the sense of ideological terrorism but also of violent extremism that is not connected to ideology.

Does NHS England have a view on that suggestion, the big front door, and whether it is a desirable development?

A. I think our opinion is that it is something that we are keen to explore, that it would be desirable and we are concerned about what happens to those young people who are referred to Prevent but not deemed to meet the criteria for further Prevent intervention.

Q. So, is there -- it doesn't need to be characterised as a criticism of Prevent, but is there agreement in NHS England that the current framework does not serve those young people well in the context of a large number of referrals to Prevent, relatively few of whom are taken on and the bounce-back problem?

A. There is, yes.

Q. Thank you. The big front door concept has different variations and some suggest that it should take the public protection cases, so current Prevent cases and concerns about non-ideological violent extremism, but

not safeguarding cases, as would currently be dealt with typically by a MASH, at least for children. Another variation is you should have a very big front door that takes all referrals for concern, whether they are in relation to safeguarding concerns, the risk to the child or to the adult, but also in relation to the public protection type cases.

Does NHS England have a view about which type of front door, or the width of the front door?

A. It doesn't, no.

Q. And not the only, but the leading contender to carry out that role has been suggested to be MASH, but with a recognition that it would need up-scaling. So up-scaling, in the first place, because not all MASH currently are designed to deal with adults; many, as we understand it, only deal with children. And there would need to be additional skills brought to bear because while an effective MASH would have police involvement currently, it is unlikely to have any Counter Terrorism Policing involvement but if they were looking at Prevent-type referrals, they would need to have that.

Does the -- does NHS England have a view on the most appropriate body to carry out the process of the screening and triage of the big front door?

A. It doesn't, but I think we consider that it makes sense

to look at building on existing platforms and existing examples of multi-agency working, rather than creating something brand new.

Q. Thank you. Can I put it another way, other than an up-scaling and an up-skilling and an up-resourcing of MASH, does NHS England have any better working concept of who could do it, other than an up-scaled MASH?

A. The other possibility would be to look at the Vanguard programme and up-scaling that. However, that is something that only covers 26 per cent of the geography, as things stand.

Q. We will come onto that as a pathway, but in terms of a body who would initially take referrals for children and adults for safeguarding potentially and for public protection risk, the Vanguard may be thought to be a useful potential for the pathway later on. But could they really act as the screening and triage, first referral, port of call?

A. Potentially.

Q. That would require a massive increase in Vanguard, wouldn't it? Because they would need to --

A. And that was the point I was making, the fact that it is still in a pilot stage. But the model appears effective and certainly, they have a pretty wide front door in terms of the percentage of referrals that are accepted,

which I think stands about 89 per cent.
Q. But -- it may be me, and if it is please say so -- but one might struggle to see how even an up-scaled Vanguard, as a front door exercise, could take the traditional safeguarding referrals for children?
A. I would accept that and certainly, the MASH arrangement is far better established.
Q. Thank you. Then, when one thinks about the pathway thereafter, so if you take it for the moment as read, in the sense that it is currently a matter of statutory duty, that Prevent would still take a cohort of those referred, because they would be taking those who were vulnerable to being drawn into terrorism, I want the focus to be on the cohort who fall outside of that, either because they are non-ideological and they are not vulnerable to being drawn into ideological terrorism, or because they fall short of the thresholds in other ways for Prevent.
I want to explore what the best multi-agency pathway for that would be. If we look over the page in your statement, please. So if we go to page 34 NHS000602_0034, paragraph 158.
What you say about that is:
"NHS England is neutral as to whether this objective is achieved through the adaptation of existing

frameworks or through the development of new statutory arrangements."
Now, I don't overlook for a moment, doctor, that in your statement you have given helpful information about Young Futures Hubs and NHS England involvement in them. Sir, for your note, paragraph 136; on Prevention Partnership Panels, paragraph 138; and perhaps we will come back to Vanguards, on which you give details at paragraph 140 to 145. So I'm not suggesting for a moment that your statement hasn't traversed existing groups.
But, ultimately, where your statement on behalf of NHS England seems to land is, you are neutral as to who takes this on. Is there a view as to which are the better contenders, whether existing multi-agency frameworks or whether it needs to be a new multi-agency framework? But if it is existing ones, which ones?
A. I think one of the challenges we have here is that there are a number of interventions in train, many of which are in the process of being evaluated and the approach that we are keen to follow is one that's based on the best evidence. So we commit to something that we have evaluated robustly and we know is effective and uses the resources available as effectively as possible. And as my statement has indicated, there's a lot of moving

parts in this space at the moment and that's why paragraph 158 is phrased in the way it has been.
Q. While all of that is right, ultimately, one can't leave the matter in abeyance and of course this Inquiry will be looking at it, but for example, what is -- could we just have on screen the beginning of your passages on the Vanguards. So, page 29 NHS000602_0029, paragraphs 142.
So without going through all of this, is Vanguard, you have mentioned it earlier on, a realistic contender for being the pathway that could case manage the NIEV/NIVE/VFI cohort who are not taken on by Prevent?
A. I believe it is, yes.
Q. So, they're, at the moment, dealing with complex children and young people. The cohort would include adults. Is that realistic that Vanguard could be up-scaled to also deal with the case of adults?
A. I think that would be far more problematic. So I think it is a realistic prospect to manage the under-18 cohort, but its focus is very much on the complex needs and vulnerabilities of children rather than adults.
Q. Obviously, Mrs Powell was asked about this, but one would need to expand the 26 per cent coverage, which you address in your statement and which Mrs Powell indicated was the correct figure rather than her figure, to have

coverage across England and Wales, yes?
A. Yes.
Q. Has NHS England given consideration to this problem, that, as was explored in our seminars, the Vanguard programme takes a child's story approach, looking at what -- not: what is wrong with this child, but: what has happened with this child approach?
A. Exactly.
Q. I'm taking it very simplistically but that was a key message that was delivered. We were told by a previous witness that, of course, that multi-agency approach does include criminal justice partners where necessary but if Vanguard was to be used as the pathway for VFI/NIVE/NIEV type cases, there may be a need for quite significant police and potentially, in appropriate cases, Counter Terrorism Police involvement. Is that going too much against the grain of what Vanguard is trying to achieve in being health-led, building trusting relationships and not perhaps being associated so much with overt criminal justice intervention?
A. I think it would be, yes. So, as I have said earlier, the Vanguard programme is very much focused on vulnerable children and managing the risks associated with vulnerable children, hence the focus on being trauma-responsive and psychologically informed.

Q. And I'm not for a moment suggesting that the multi-agency process to deal with the VFI/NIVE/NIEV cohort should be anything other than trauma-informed and I'm not suggesting, for a moment, that it shouldn't be thinking about the unmet health and other needs, but it would need to have that criminal justice involvement and the need to take, for example, tough decisions about disruptive interventions, so arrests, search, in appropriate cases. Does that cause you to reflect on whether Vanguard really is the solution, when one thinks about the need to cater for adults and to deal with those sorts of risks?

A. As I said earlier, I think it could be a solution for the under-18 cohort but I don't think it is a solution for the adult cohort.

Q. And bearing in mind that the 18-25 category -- and one bears in mind what you have said previously and our expert cadre emphasised this as well -- that they are not fully neurologically developed, but they are part of the risk cohort, as indeed, in some cases, would be older adults. There is a risk, isn't there, if one adopts the solution for the VFI pathway that is child-centred, that you are going to then create a multiplicity of systems and you also create, if not a cliff edge risk between the two, you get to the stage:

well, we have been dealing with this child so far under Vanguard, but now they are going to turn 18, we need to move them into the adult VFI pathways. Is that desirable?

A. There is indeed a risk and I think the challenge here is I think, it is unrealistic to have an all-age service to manage this group. And we need to remember that children aren't mini adults, they have very different needs to adults. So, that is a layer of complexity that we will have to try and navigate and I'm afraid, I haven't got the answer as to how we are going to do that.

Q. All right. Isn't it the other way round, though? When you say it is unrealistic to have an all-age service to manage this group, isn't it that actually you want to have a service that consistently can manage the cases, including those who are 16, 17, 18 but then going into adulthood, precisely because they are then young adults but not fully neurologically developed? You would want to have a system that caters for all of that group, rather than having two separate systems with a cliff edge, if not a significant step between the two?

A. Well, continuity clearly is important and we need continuity, whether that be between 17 and 18, or 25 and 26. But I think the idea of having a single service

that is able to effective support and manage the risks associated with very young children potentially and, you know, middle-aged adults is unrealistic.

Q. Thank you. Insofar as they edge towards a potential solution, our expert cadre spoke about adapting something similar to what is happening in Brighton, where there is a high-risk adolescents group and that team within social care, as we understand it, is able to call on multi-agency meetings that have good buy-in from, and regular attendance, and it is co-hosted by children's social care -- sorry, it is hosted by children's social care but co-chaired by children's social care and police, but with heavy health involvement and appropriate other attendees, including youth justice services and so on. That sort of a multi-agency process.

The two things that they emphasised is that they struggle in Brighton to then have the continuity into adult care and they also felt that there would need to be more emphasis on capacity to deal with online harms and online risks and internet and better skills in understanding but also in the interventions in that area. But they were pointing to that sort of a multi-agency process. So, drawing on existing processes, but using that sort of approach. Does that

seem, to you, to have benefit?

A. It does, and as I said earlier, I think the idea of building on existing models that are effective seems sensible. And what you described in Brighton sounds similar to the proposed expansion of the Vanguard programme that's being funded this year with an additional £8 million to address that high harm, high risk, high vulnerability cohort of children.

Q. And might that approach -- you must say if you disagree -- if it drew on the learning from Vanguard, and the Vanguard type approach, perhaps be more realistic, in that if you are looking at children's social care, or children's social services and policing being the co-chairs, those organisations are in place throughout England and Wales in every local authority area, as a starting point?

A. Yes.

Q. Thank you. In terms of the teams that could be brought to bear as part of that sort of multi-agency response, just in terms of FCAMHS, if we can look at page 26 NHS000602_0026 of your statement, and paragraphs 127 to 129. So we start with 127, you say:

"[It] does not usually provide direct interventions to the child or young person, its ... nevertheless ... important ..."

And we heard about this in Phase 1 in terms of, other than some exceptions, it would be giving advice to other agencies with their interventions rather than interventions given by FCAMHS directly.

So you explain that in paragraph 127. If one goes over the page NHS000602_0027, please:

"Through this role, FCAMHS can contribute to the planning and delivery of interventions for [children and young persons] exhibiting violence fixated behaviours, even [when the] interventions are implemented by other[s] ... [But], given the indirect nature of this role, no research has been conducted specifically in relation to FCAMHS interventions for individuals exhibits violence fixated behaviours."

So, the victims and survivors teams have asked a number of questions, I think, arising principally out of that. So when you say, as you have elsewhere in your statement, that there is no dedicated pathway at the moment, and no corresponding national training programme focused on this area, they are keen to know if that is going to change and what FCAMHS can specifically offer to the VFI cohort? Can you help with that?

A. I think the training and indeed, the specification for FCAMHS needs to be reviewed in light of the Inquiry and, as I have indicated, colleagues working in FCAMHS are

reporting that they are seeing an increasing number of young people who display violent-fixated behaviours and we need to ensure that the service adapts to that increasing demand. And this is where I think the work that's in train in relation to reviewing risk assessments is key, because that will help inform what skills and resources will be required in these services.

The other thing to say is I think there is some variation in how FCAMHS services operate across the country and variation in terms of the make-up of the FCAMHS teams across the country, some of which don't have a child and adolescent forensic psychiatrist in the team and that is something that we need to address.

Q. Thank you. One possibility would be this, would it not, there could be an exception made to the general principle that FCAMHS isn't case-holding and doesn't, for the most part, give direct interventions. You could make an exception for that for the VFI cohort. There would obviously have to be thresholds in relation to that, but if one looks at the number of Prevent referrals as a proxy for this risk group, the numbers are not huge and do you think that there might be benefit in looking at that, that FCAMHS might become case-holders or at least more directly involved in a multi-agency way?

A. I think there is benefit in looking at that. One of the obvious challenges is that there are only 13 FCAMHS teams in operation across England. So it would follow that they each cover a large geography. They are relatively small teams in terms of manpower. So, we need to look at the practicalities of managing cases and being responsible for cases, particularly in terms of what happens out of hours, if there were a crisis.

That's not an insurmountable challenge but it does highlight that there are some significant practical considerations in relation to moving towards a case holding model of practice, even if we are talking about a relatively small number of cases.

Q. But if one is looking at what, for example, within MAPPA, might be level 2 and level 3 type cases, so not perhaps a single agency lead but the higher end of the spectrum, the Inquiry has been exploring whether the multi-agency process might be potentially better at a regional level anyway and that has some resonance with Counter Terrorism Policing units which are regional. So it could marry up potentially, at least in that sphere, would you agree?

A. I would agree.

Q. Thank you. In terms of -- you have mentioned there, when we were looking at the potential pathways, talking

about the fact that rather than a single lead agency pre-defined, that there might need to be different agencies in different cases. Shall we look at that again? It is page 33 NHS000602_0033, paragraph 157.

So rather than requiring a single agency to take responsibility. Now, in fairness to you, doctor, that will have arisen out of a question that was asked to NHS England in the Rule 9 request, about concepts whether there should be a lead agency.

We have been exploring two schools of thought on this. One is that you should have a lead agency identified. And I hasten to add, it wouldn't always be the same agency because it would be case dependent. But within the management system, for the VFI cohort, there should be a process by which one agency is always selected to be in the lead. The advantage being that you have clear responsibility sitting with an organisation who's accountable.

The second school of thought, which was pressed quite hard by our expert cadre, is that that is problematic because as soon as you say that an identified single agency is in the lead, other agencies, who should in fact be taking actions within their own sphere of competence and responsibility, will drop off and will tend to say: ah, but CAMHS is in the

lead, or FCAMHS is in the lead on this case.

And that what is better is to make sure that the multi-agency process is clearly identified and is in the lead. So in the Brighton model they would say that ultimately those co-chairs of the process hold the responsibility and you would have the governance arrangements above them to ensure quality of delivery but actually, the lead responsibility should sit with the chairs of a multi-agency process rather than artificially saying: this agency has the lead responsibility.

Does NHS England or you, with your personal and professional experience, have a view on those two schools of thought as it might apply to the VFI cohort and managing them?

A. Well, firstly, the key requirement is that we have robust multi-agency working. Personally, I think it makes sense to identify a lead agency, so there is clarity regarding who is responsible and I do not see that as something that would undermine the effectiveness of multi-agency working and lead to other agencies not doing what was required of them within the agreed multi-agency framework.

Q. Thank you. I need to turn, now please, to the Mental Health Act and Mental Health Act powers. Could we have

on the screen please CHAIR000002 and page 315 CHAIR000002_0315. I won't read all of this out because you will be familiar with it. But you will see, at paragraph 364 please, at the bottom of the page, the Phase 1 findings in relation to what happened with AR and the lack of a Mental Health Act assessment and Dr Irani's view, which was, in essence, that she felt that a Mental Health Act assessment could have been called for in AR's case but she recognised that a body of practitioners would not have seen that as a conventional approach.

If we go over the page, please CHAIR000002_0316, without going through it all, that led to recommendation 56, that:

"Phase 2 [of this Inquiry] should consider whether further legislative change is required to allow mental health clinicians to assess children and young people who are isolated from professional support and may pose a risk of violence, particularly where powers under the Mental Health Act ... as amended by the Mental Health Act 2025, do not permit assessment or detention."

So that's the area that we are looking at. If we can go back to your statement please, page 9 NHS000602_0009. Bottom of the page. So 45, you set out the way in which the Mental Health Act introduces

"additional definitions" and in 46, you set out the consequence of those. And that effectively is that, if I can take autism as the example, autism on its own would no longer be sufficient as a grounds for section 3. There would have to be a psychiatric disorder that was a comorbidity with the autism, in order to justify detention under section 3, although it would still apply for assessment in relation to section 2 powers.

Now, first of all, would you agree, in general terms, that notwithstanding the important reasons that have led to that change, in a sense, that only gives greater emphasis to the concern and the potential gap that Dr Irani was alluding to in her evidence in Phase 1 of the Inquiry?

A. I would, but I would highlight that under the amended Act, that a young person with autism, who is at risk of violence can still be detained under the provisions of section 2 of the Mental Health Act for a period of assessment.

Q. Yes. But that would need to be where there was the grounds to consider that they were suffering from a mental disorder, in addition, of a nature and severity that might require treatment?

A. Yes, and obviously the principle of the Mental Health

Act is that patients aren't detained in hospital unless they are suffering from a mental disorder and that's a very important one because there is a danger that the Mental Health Act potentially could be used to warehouse people who are at risk of violence and we need to remember that it is about treating people in hospital, not detaining people in a prison.

Q. Thank you. And so, in relation to that, if we could look at paragraph 53 NHS000602_0011 of your statement, you say:

"The position described above has led to concerns regarding the impact of the ... 2025 [Act] reforms once they come into force ... the removal of section 3 detention powers in relation to individuals whose sole diagnosis is autism or a learning disability may further reduce the options available to clinicians and other agencies in certain crisis situations."

Then you say this:

"Where an individual presents significant risks to themselves or others but does not have a co-existing psychiatric disorder, the effectiveness of the amended framework will be dependent upon the availability of appropriate community-based support, care and safeguarding arrangements."

Now, being blunt about it, is what you are saying

there, that there would not be a Mental Health Act intervention available at all in those cases and it is really over to other agencies, to children's social care, potentially to the police or other agencies, to manage the risk in those situations; the Mental Health Act powers are not going to assist?

A. Well, the power that can assist is section 2.

Q. Yes, but if we can -- perhaps it is helpful to look at it in AR's specific case. Taking it in short order. I don't know if you listened to my learned friend, Mr Jamieson, summarising this for Mrs Powell, our previous witness. But effectively, what you had there was an original concern as to whether AR may have been suffering from psychosis in his earlier arrest and detention, but assessment soon showed at the time of his original arrest and detention for his first serious offending that that was not the case.

And thereafter, a series of mental health workers, including psychiatrists who dealt with him, didn't detect any serious mental health disorder. There was some concerns about anxiety of different forms and talking therapies, but the real problem was that, other than medication seeking, he gradually, over time, withdrew from those services, was non-compliant. And when mental health practitioners sought to engage with

him, he refused to come out of his room and refused to be seen and there came a time when he would refuse to go to appointments as well.

At that time, he wasn't attending school. So education professionals didn't have eyes on him either. But had they been properly assessed at the time, there was a series of concerns beyond the original conviction and the threats around that, that he wanted to kill people, the knife on the bus and so on -- I'm sure you are aware, in broad terms, of the pattern that emerged -- that would have led to the view that he remained a significant risk to others.

Now, what is to be done in that situation? Because Dr Irani's interpretation involves a certain amount of artificiality in some ways, even for section 2, because probably the mental health practitioners would not have thought that there was a need to assess, for the purposes of potential treatment, with a concern that he was suffering from a serious mental health disorder.

There may be some suspicion about psychosis, we should check again, but that's why she accepted that many psychiatrists in that situation wouldn't have gone down a Mental Health Act route at all and she did say that flags a concern.

So, in that situation, how do mental health

practitioners get into a face-to-face assessment with the child, in that situation, where they pose risk?

A. So when there are good grounds that the child is suffering from a mental disorder, which is potentially of a nature or degree to warrant treatment and detention, then it is appropriate to initiate a Mental Health Act assessment with a view to detention under section 2. And I would suggest it is important not to pre-judge the outcome of that assessment, not least because there are benefits of carrying out the assessment, particularly in terms of arranging a multidisciplinary assessment and then thinking about what alternative to treatment in hospital may be appropriate.

Now, if it is a question of actually getting eyes on the child to carry out that assessment, then -- and the child is in their home address -- consideration, I would suggest, needs to be given to the merits of a section 135 order and for that to happen, the police would need to seek a warrant from the Magistrates' Court.

Q. Does it follow, from the first part of your answer, that part of the solution here, if you are saying there isn't a gap in the legislation, there don't need to be further powers, is that psychiatrists need potentially to be

more robust in the use of section 2 powers in this type of case?

A. Obviously, psychiatry is not an exact science and I wasn't involved in this case, so I'm looking at things with the benefit of hindsight.

Q. Yes, of course.

A. And to what extent the professionals involved in the case were aware of the potential risk of violence, I'm not sure. But clearly, as is always the case, we learn from experience, we learn from case law and I am sure that there will be reflections on the use of section 2 of the Mental Health Act on the back of this Inquiry and the recommendations of this Inquiry.

I also think that the changes to the Mental Health Act will mean that there will be a review in thinking as to how section 2 can be used, not least because of what happens if you detain someone with a diagnosis of autism, for example, and then they cannot be detained under the provisions of section 3. So what happens then to ensure their support in the community? What arrangements need to be in place?

Q. And what's the answer to that, in terms of where that leads?

A. It will depend on the individual needs of the patient concerned.

Q. All right. But what one senses, from the way that your statement is structured -- and you must tell me if this inference is wrong -- is that there does not appear to be a current appetite, so far as NHS England is concerned, to extend Mental Health Act powers to give a novel power in the area of helping mental health staff to get eyes on, in circumstances that may not comfortably be currently covered by section 2?

A. That is correct. So our approach is that we need to use the Act as it stands, as effectively and as pragmatically as possible.

MR MOSS: Thank you. Sir, I'm just looking at my notes, but I think the questions I would have asked about intervention, I think I've covered -- and the doctor has covered in his earlier answer. So, doctor, I'm grateful, those are my questions.

I'm going to look to Ms Temkin to my left. I do not think they have any questions. Sir, do you have any questions?

SIR ADRIAN FULFORD: I don't, thank you. Thank you very much indeed, Dr Broughton. That's been incredibly helpful. I'm very grateful to you.

MR MOSS: We are 10.00 am tomorrow, sir.

SIR ADRIAN FULFORD: Thank you all very much. I will sit again at 10.00 am tomorrow morning.

MR MOSS: Thank you, sir.

(4.31 pm)

(The Inquiry adjourned until 10.00 am the following day)

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