THE UNINVESTIGATED THRESHOLD

NG163, CQC oversight and Operation Talla in Covid-era care-home and community deaths

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Executive proposition

This paper asks potentially two narrow but fundamental questions.

(1) *Were reports concerning deaths in elderly care homes or elsewhere in the community rejected, or prevented from being recorded as crimes, because they arose within the Covid context and were handled under Operation Talla?*

(2) *If so, how is that approach reconciled with the official frameworks requiring early police engagement, regulatory liaison, preservation of evidence and individual assessment whenever avoidable harm or suspected criminality may have contributed to death?*

The documents considered do not prove that NG163 caused unlawful deaths. Nor do they presently prove that Operation Talla was applied to any identified care-home death.

They establish something different but important:

- NG163 authorised potent symptom-control medicines in community settings;
- CQC regulated care homes and had enforcement responsibilities for unsafe care;
- police retained responsibility for homicide, wilful neglect and ill-treatment;
- and successive national instruments required those bodies to communicate and investigate where the relevant threshold was reached.

Separate documentary material concerning Operation Talla indicates that some Covid-related allegations were subject to rejection or '*not record*' handling.

Whether death allegations were included is therefore a question of fact requiring disclosure, not assumption.

The constitutional difficulty

A real pandemic could change clinical pressures, available resources and the evidential context. It could not lawfully convert every death associated with Covid into a natural death, remove the coroner's jurisdiction, displace the CQC's statutory functions, or extinguish the police obligation to assess credible information suggesting criminality.

Emergency guidance was guidance for individual clinical judgment - not a categorical immunity from scrutiny.

> *Suspicion is not proof. But reasonable suspicion is the beginning of an investigation, not the conclusion of one.*

The proper course protects everyone:

- residents and families from overlooked harm;

- clinicians and carers from accusation unsupported by evidence;
- and institutions from the corrosive consequence of unanswered questions.

Non-recording risks protecting none of them, because it removes the evidential process capable of distinguishing compassionate care, error, regulatory breach and crime.

Scope

The focus is England, because the CQC's jurisdiction is English.

The analysis concerns elderly care homes and other community deaths where NG163 may have influenced symptom management or end-of-life care.

It uses the 2006 NHS–ACPO–HSE protocol and guidance; the 2018 Williams Review; the 2019 CQC–NPCC memorandum; the 2024 multi-agency memorandum; and 2025 police practice advice as a continuous official record.

Later documents are not applied retrospectively as law. They are used to illuminate enduring investigative principles and the institutional response to previously identified weaknesses.

1. NG163: what it authorisednand what it did not

NICE published NG163 on 3 April 2020 as a rapid guideline for managing Covid-19 symptoms in the community, including at the end of life.

It was updated in October 2020 and later incorporated into the consolidated guideline NG191.

Its practical field included private homes, residential and nursing homes and other community settings in which frail older people might deteriorate quickly without hospital admission.

Medicines and clinical purpose

NG163 addressed cough, fever, breathlessness, anxiety, delirium, agitation and end-of-life symptoms.

It contemplated anticipatory prescribing and the use of medicines familiar to palliative care, including opioids and benzodiazepines.

Such medicines can be clinically necessary and humane. Morphine may relieve pain and refractory breathlessness; midazolam may relieve severe anxiety or agitation.

Their presence in a medication chart is not, of itself, evidence of unlawful killing and their proper use should not be inhibited merely through fear of respiratory depression.

The safeguard lies in the clinical predicates. The resident must be assessed individually; reversible causes and the possibility of recovery must be considered; prognosis and treatment-escalation decisions must be reasoned; dose, route, timing and cumulative effect must be appropriate; renal and other vulnerabilities must be addressed; and consent, capacity and best-interests law must be observed.

Administration must be recorded and monitored.

The question is never simply whether a listed medicine was permitted. It is whether its use in this person, at this time, for this purpose, was clinically and legally justified.

Contemporaneous professional concern

In May 2020, palliative-care specialists publicly welcomed rapid symptom guidance but warned that uncritical use could create unintended risk.

They identified uncertainty in prognosticating Covid-19, limited evidence for detailed dosing in this new disease, renal impairment, drug interactions, the experience required for proportionate sedation, and the danger of treating a potentially reversible acute illness as an irreversible dying phase.

These concerns did not establish wrongdoing. They demonstrated why clinical records, monitoring and specialist judgment mattered.

The later NG191 history records removal of a recommendation to consider a benzodiazepine for anxiety or agitation and removal of specific end-of-life medicines recommendations because established NICE end-of-life guidelines covered the subject.

Revision does not retrospectively prove that earlier treatment was improper. It does, however, defeat any suggestion that the original rapid guidance was an evidential endpoint beyond examination.

The forensic questions in an individual death

Where concern is credible, the relevant material includes prescriptions; anticipatory-medication authorisations; medicine administration records; stock and disposal logs;

containers and packaging; syringe-driver or infusion data; observations of respiration and consciousness; renal function and comorbidities; clinical consultations; decisions not to admit or escalate; DNACPR documentation; capacity and best-interests records; communications with relatives; staffing and training records; and the body itself, including toxicological samples.

Without timely preservation, later review may be reduced to competing recollections after the most probative evidence has disappeared

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> *NG163 could authorise symptom relief. It could not authorise the abandonment of diagnosis, individual judgment, documentation, monitoring or investigation.*

2. CQC: receipt of notifications was not the end of oversight

CQC was the independent regulator of health and adult social care in England. Care and nursing homes fell expressly within its remit.

Its statutory objective was to protect and promote the health, safety and welfare of people using services. It registered, monitored, assessed, inspected and regulated providers and could use civil or criminal enforcement powers.

Relevant standards and enforcement

The 2019 CQC-NPCC memorandum records CQC's lead inspection and enforcement responsibility, from 1 April 2015, where a registered person's breach of a prosecutable regulatory standard caused avoidable harm or exposed a service user to significant risk.

Relevant standards included Regulation 12, safe care and treatment; Regulation 13, safeguarding from abuse and improper treatment; and Regulation 14, nutrition and hydration. A single serious incident could suffice.

CQC could investigate provider and registered-manager responsibility, but could not investigate or prosecute murder, manslaughter, wilful neglect or ill-treatment.

Those boundaries demanded liaison with police rather than institutional isolation.

Care-home providers notified deaths to CQCnand CQC data contributed to national mortality reporting.

The regulatory question is therefore not how many notifications were received. It is how they were analysed. Were unexpected patterns identified by provider, prescriber, medicine, locality or decision pathway? Were family concerns

linked to notifications? Did CQC request medication records, inspect governance, examine safe treatment and safeguarding, or refer possible individual criminality to police?

Inspection during emergency conditions

Pandemic restrictions altered ordinary oversight and constrained physical access.

That may explain why regulatory methods changed; it does not answer whether intelligence, notifications and complaints were assessed adequately.

The Regulators' Pioneer Fund material shows CQC participating during 2021 - 2022 in a government-funded project encouraging innovation in GP practices and regulatory recognition of innovative responses to health inequality.

That project was not about NG163, care homes or medicines and does not establish external direction of CQC's enforcement. Its limited relevance is institutional: CQC was operating not only as an enforcer but also as a supporter of provider innovation during a period of exceptional regulatory flexibility.

The question this raises is whether encouragement of innovation remained matched by rigorous protection of fundamental standards.

The Williams benchmark

The 2018 Williams Review recommended a thorough local investigation of all unexpected deaths in NHS and independent healthcare settings, with CQC considering the effectiveness of those investigations through inspection.

Where suspected healthcare manslaughter reached CPS, CQC should be informed and consider a parallel provider investigation into systemic and human factors.

Families should receive transparency, accurate explanation, involvement and support.

Accordingly, adequate oversight would leave an auditable trail: notification, risk assessment, intelligence linkage, inspection or investigative decision, reasons, referrals, evidence requests, engagement with families and outcome.

The absence of enforcement would not itself establish failure; the absence of a demonstrable assessment might.

> *The CQC question is not: 'Were deaths counted?' It is: 'Were risks recognised, connected, examined and where necessary, referred?'*

3. An established pathway from concern to investigation

2006: early contact and preservation

The February 2006 NHS-ACPO-HSE memorandum concerned unexpected death or serious harm.

It required informed decisions, coordinated investigations, support for families, links with coroners and prompt criminal investigation where necessary.

The accompanying November 2006 NHS guidance said early contact with police or HSE was best practice when a serious incident might require their attention.

Police could become involved following a family complaint or coronial referral; the need might emerge only after an internal or MHRA investigation.

The guidance's medication-related case study is instructive.

A patient was found dead with a syringe attached to an intravenous line and an empty medicine bottle nearby. Staff did not declare homicide; they recognised unusual circumstances. They preserved lines, bottles, packaging, disposable items, clinical notes and the room, then contacted police.

The lesson is procedural: preserve first, allow competent investigation to decide later.

2019: CQC and police in care homes

The 2019 CQC-NPCC memorandum expressly included care and nursing homes.

For incidents involving avoidable harm or significant risk, it required early engagement, decisions on investigative primacy, joint and separate lines of enquiry, experts, forensic

coordination, witness and suspect strategies, parallel examination of individual and organisational failure, regular reviews and family liaison.

It stated that normally there should be no legal barrier to relevant information sharing.

It also expressly invoked the Criminal Procedure and Investigations Act 1996: CQC and police should retain and record relevant material generated in their respective or joint investigations and ensure necessary revelation and disclosure.

If a report never became an investigation, those preservation and disclosure disciplines might never attach in practice.

2024: reasonable suspicion and an active convenor

The signed 2024 multi-agency memorandum, developed from the 2006 protocol and Williams Review, applies prospectively where there is reasonable suspicion that individual criminal activity led or significantly contributed to death or life-changing harm.

The party first identifying the suspicion must convene, chair and minute an Incident Co-ordination Group.

Evidence must be secured; a lead agreed; families supported; and parallel learning, regulatory and criminal responses coordinated.

CQC should be informed, invited to meetings and supplied with minutes even if it does not attend.

Its latest inspection reports and previously notified deaths should inform whether wider system or provider-level failure requires examination.

Routine entry into a patient-safety system or MHRA Yellow Card does not itself convene the group. Someone must recognise and communicate reasonable suspicion.

2025: the cost of a flawed gateway decision

Home Office police practice advice states that if the initial police decision that a death is not suspicious is flawed, no forensic examination may occur and a potential homicide may be missed.

It requires records of treatment and drugs, prescription and non-prescription medicines found at the scene, medical records and appropriate toxicology.

It also requires consideration of similar historic or recent incidents.

> *Across the official chronology, the operational verbs remain constant: recognise, refer, preserve, coordinate, investigate, record and review.*

4. Operation Talla: the gateway question

Operation Talla was the nationally coordinated policing response to Covid-19.

The material available to this investigation indicates that Covid-related allegations were, in at least some contexts, governed by rejection or *'not record'* arrangements and routed toward intelligence functions rather than ordinary crime recording.

Material concerning Police Scotland in January 2022 refers to reports associated with vaccination allegations and attempts to serve papers, logging to intelligence structures, and Operation Talla being informed.

Other material described *'guidance to not record'* as a success.

The precise provenance, territorial scope, start date, categories and implementation of that approach remain matters requiring full primary disclosure.

What is established and what is not

It is established from the supplied official healthcare documents that suspicious or potentially avoidable healthcare deaths required individual assessment and inter-agency coordination.

It is also established from the wider Talla material identified by this investigation that non-recording practices existed in relation to some Covid-linked reporting.

It is not established on the present evidence that a named care-home death report in England was rejected under Talla, or that the January 2022 material governed earlier deaths in 2020 or 2021.

This paper therefore advances no finding of that kind.

The unresolved issue is nonetheless fundamental.

- Was *'Covid-related'* treated as a subject category capable of determining the recording outcome before the content of an allegation was assessed?
- Did the category include allegations concerning care-home medication, non-escalation, DNACPR decisions, wilful neglect, gross negligence, suspicious certification or other community deaths?
- Were such reports referred to local crime registrars, coroners, CQC or specialist investigators, or only logged as intelligence?

Why intelligence is not an equivalent pathway

Intelligence may reveal threats, networks or patterns and can properly supplement investigation.

It does not necessarily secure a scene, preserve a body, obtain medication and clinical records, commission forensic pathology or tailored toxicology, interview witnesses under an investigative strategy, determine offences, engage a coroner, create CPIA schedules, or communicate with a bereaved family as victim liaison.

For an identifiable death, intelligence-only handling may therefore be materially different from crime recording and investigation.

The timing problem

The first wave produced exceptional care-home mortality in 2020;

NG163 was issued in April 2020.

The clearest supplied non-recording documents arise later.

A proper inquiry must therefore not assume one continuous policy. It must obtain every relevant Talla instruction, decision log, briefing, national and force-level message from the beginning of the operation, together with version histories and implementation dates.

It must distinguish vaccination-report policy from death-report policy, Scotland from England, and national advice from local application.

The counterfactual test

For each report, investigators should ask:

stripped of the words ‘Covid’, ‘pandemic’ and ‘vaccine’, would the alleged facts ordinarily have prompted police attendance, coronial referral, safeguarding action, crime recording, contact with CQC, preservation of medication evidence or a suspicious-death assessment?

If yes, then the record should explain lawfully and evidentially why the pandemic context changed that response.

> *A subject label cannot safely substitute for an offence-and-evidence assessment.*

5. Can non-recording be reconciled with the official agreements?

A lawful reconciliation may be possible in an individual case.

Police are not required to record every complaint as a crime regardless of content. Some reports may disclose no identifiable victim, no cognisable offence, no jurisdictional basis, no evidence beyond speculation, or facts conclusively establishing a natural death.

National coordination may also prevent duplicative demands and manage genuinely abusive reporting.

The Williams Review itself sought to avoid inappropriate healthcare-manslaughter investigations and reserve criminal sanction for truly exceptionally bad conduct.

What reconciliation would require

Reconciliation requires proof of an individual, competent threshold assessment - not merely reliance upon a Covid category.

The decision record should identify the allegation, deceased person, potential offence, available evidence, applicable crime-recording rules, coronial status, safeguarding considerations, CQC interest, reasons for non-recording, decision-maker, supervision and review route.

Where medicine or clinical care is implicated, the assessor should have access to suitable expertise or seek it.

Where the facts could indicate wider system failure, CQC liaison should be considered.

Where reasonable suspicion arises, the coordinated pathway should be activated.

Five points of apparent conflict

First, the official frameworks require early communication; rejection may terminate communication.

Second, they require evidence preservation; non-recording may allow medicines, records, samples and bodies to be lost.

Third, they allocate complementary roles; categorical screening may permit police to decide a regulatory or clinical question without CQC or expert input.

Fourth, they require documented coordination and family involvement; an intelligence log may supply neither.

Fifth, they recognise that suspicion can emerge progressively; immediate rejection may prevent the factual development through which suspicion could be confirmed or dispelled.

The CQC-police dependency

The failure risk is reciprocal.

If police assumed that CQC would manage provider safety while CQC assumed that police would address individual criminality, an allegation could fall between jurisdictions.

The 2019 memorandum was designed to prevent precisely that fragmentation.

A non-recording direction could be reconciled with it only if another demonstrably adequate pathway preserved evidence, assigned responsibility, shared information, examined regulatory and criminal possibilities, and recorded the reasons and outcome.

CPIA and the pre-investigation gap

The 2019 memorandum requires retention and recording of relevant material during investigations under CPIA principles.

But the decisive vulnerability occurs earlier: if the matter is never recognised as an investigation, material may not enter an investigative record at all.

That makes the gateway decision itself a vital auditable record.

The absence of crime recording cannot be allowed to become the mechanism by which the evidence necessary to test the recording decision disappears.

No presumption either way

The correct standard is symmetrical.

Police should not assume criminality because relatives are distressed or because morphine or midazolam was administered. Nor should they assume natural death because Covid appeared on a certificate, NG163 existed or many similar deaths occurred.

Each conclusion must follow the evidence.

> *A policy is reconcilable with the framework only if it preserves the framework's substance: individual assessment, competent allocation, evidence security and accountable reasons.*

6. The evidential examination now required

The issue can be answered through records.

A focused, independent examination should reconstruct both policy and cases, then compare what should have happened with what did happen.

A. Reconstruct the Talla policy

Obtain from NPCC, NPoCC and every relevant English force all Gold, Silver and Bronze decisions; policy and legal advice; crime-recording instructions; allegation taxonomies; briefing notes; emails; meeting minutes; intelligence-routing instructions; audit material; reviews; and communications with government, CQC, DHSC, NHS England, coroners and CPS.

Record creation dates, version histories, recipients and withdrawal dates. Identify whether *'not record'* meant no crime, no incident, intelligence only, duplication control or another defined outcome.

B. Identify the affected report population

Search call logs, online reports, incident systems, crime systems, intelligence databases, professional-standards records and correspondence for allegations involving care homes, community palliative care, end-of-life pathways, anticipatory medicines, morphine, midazolam, syringe drivers, DNACPR, non-admission, wilful neglect, gross negligence and suspicious or unexpected death.

Include reports rejected before formal logging and preserve audit metadata showing deletion, reclassification or transfer.

C. Match police reports to CQC and coronial records

For each identifiable death, compare police records with the provider's CQC death notification, complaint and safeguarding material, inspection history, CQC risk assessment, enforcement decision, coronial referral and medical-examiner documentation.

Determine whether either institution informed the other and whether previous deaths at the provider were considered.

A common identifier and chronology are essential.

D. Reconstruct the clinical evidence

Obtain the complete care record and original audit trail: prescriptions; MAR charts; stock, receipt, transfer and destruction logs; syringe-driver data; observations; GP and community-nursing contacts; escalation decisions; hospital advice; DNACPR and treatment-escalation plans; capacity and best-interests documents; family communications; staffing and training; and local NG163 implementation guidance.

Where lawful and scientifically meaningful, seek independent geriatric, palliative-care, pharmacological, forensic-pathology and toxicology review.

E. Test decisions, not outcomes alone

The review should ask whether the decision was reasonable on information available at the time, what further information should have been obtained and whether later evidence required reconsideration.

It should not infer misconduct merely because a resident died, or validate a decision just because prosecution would now be impossible.

Lost evidence caused by delay is itself a finding about process.

F. Publish an accountable result

Report aggregate numbers of death-related allegations received, rejected, recorded, intelligence-logged, referred to CQC or coroners, investigated and reviewed.

Publish the governing policies and legal rationale subject only to necessary redaction.

Provide families with case-specific explanations and a route to independent reconsideration. Where systemic defects emerge, preserve material for coronial, regulatory, disciplinary or criminal action.

> *The first question is empirical: how many death-related reports entered Talla handling, and what became of each one?*

7. Findings, questions and conclusion

Provisional findings

1. NG163 created an urgent community symptom-management framework involving medicines capable of relieving profound distress but also requiring careful diagnosis, dosing, monitoring and documentation. Its existence neither proves nor excludes improper treatment.

2. CQC possessed express regulatory responsibility for care homes, safe care, safeguarding and avoidable harm. Police possessed responsibility for serious individual criminality. Their remits overlapped by design and were joined through information-sharing and investigation arrangements.

3. From 2006 onward, official documents consistently required early referral, evidence preservation, coordinated responsibility, family engagement and consideration of both individual and systemic causes. The 2019 memorandum applied those principles expressly to CQC-regulated care homes. The 2024 and 2025 documents reaffirm the same forensic logic after the pandemic.

4. A mistaken gateway decision can be irreversible. If a death is treated as natural or non-suspicious without adequate assessment, there may be no forensic post-mortem, tailored toxicology or preservation of medication evidence; cremation may end the possibility of later proof.

5. The present material raises, but does not answer, whether Operation Talla rejection or non-recording arrangements reached care-home and other community-death allegations. That question is capable of proof through policy, system and case records and should now be answered.

Questions requiring institutional answers

NPCC and forces should state whether any Talla instruction governed death-related reports; the dates, wording, territorial reach and legal basis; how many reports were affected; whether offence-based assessment preceded categorisation; what information went to CQC or coroners; and what review has tested for missed suspicious deaths.

CQC should state whether it was informed of Talla's rejection or non-recording arrangements; whether it assessed their effect on its own intelligence and enforcement; how it analysed care-home death notifications and medicine-related concerns; how many referrals it made to police; what responses it received; and whether patterns across providers were examined.

Government and coronial bodies should explain what assurance existed that emergency guidance did not displace ordinary suspicious-death safeguards and whether families were given an effective route to raise medication or treatment concerns when police recording was refused.

Conclusion

The question is not whether every Covid-era care-home or community death was suspicious. Plainly, it was not. Nor is the question whether palliative medicines such as morphine or midazolam are inherently sinister. They are not.

The question is whether the ordinary mechanisms by which an exceptional death is distinguished from the tragic mass of natural deaths remained operational when the circumstances carried a Covid label or involved treatment administered under NG163.

The Dimmock case demonstrates why that distinction matters.

As reported by Jacqui Deevoy, Derek “Del” Dimmock was admitted to Royal Trinity Hospice in June 2020 suffering from severe gout pain and died the following day after being assessed as approaching the end of life and receiving midazolam, alfentanil and oxycodone.

His family disputes that he was dying when admitted.

Deevoy reports that Professor Sam Ahmedzai subsequently gave evidence at the inquest expressing the opinion that Mr Dimmock’s death resulted from iatrogenic acute intoxication with those medicines, together with uncontrolled gout and acute renal failure aggravated by enforced dehydration.

Concerns have also been raised about his clinical assessment, hydration, dose escalation, the certified cause of death and the reported destruction of a controlled-drugs record after the family had submitted a written complaint.

Those matters must remain subject to the coronial process and should not be presented as finally adjudicated facts.

Their relevance here is procedural and profound: they illustrate the type of disputed medication-associated death for which preserved records, expert evidence, CQC oversight, coronial scrutiny and an accessible police pathway may be indispensable.

If elements of Operation Talla guidance and procedures did not apply to reports of this nature, disclosure should establish that clearly. If they did, then policing must demonstrate how rejection or non-recording preserved the substance of the 2006, 2019 and related frameworks: individual assessment, CQC liaison, coronial access, evidence security, expert scrutiny and accountable decision-making.

If those safeguards were not preserved, the issue is not merely one of historical administration. It is the possibility that potentially suspicious deaths, or deaths presenting circumstances that would ordinarily have required police attention, were never permitted to become investigations.

The Dimmock case also demonstrates why delayed scrutiny cannot fully replace contemporaneous investigation.

Medication records may be incomplete or destroyed; witnesses' memories may fade; bodies may have been cremated; toxicological opportunities may have been lost; and institutional decisions may become increasingly difficult to reconstruct.

An inquest held years later may expose serious questions, but it cannot necessarily recover evidence that should have been secured at the time of death.

Public confidence does not require a predetermined finding of wrongdoing. It requires proof that the system was willing and able to look. That obligation applies equally to policing, the CQC, healthcare providers and every institution entrusted with distinguishing compassionate end-of-life care from avoidable harm, professional failure or criminal conduct.

This paper therefore calls for a defined, independent and auditable examination of Operation Talla's treatment of care-home and community-death allegations, conducted across police, CQC, coronial and healthcare-provider records, with affected families able to submit cases and evidence.

The examination should include cases such as that of Derek Dimmock, not to presume their outcome, but to determine whether the established investigative safeguards were activated when concerns first arose - and, if they were not, why not.

You can read more about the Dimmock case in Jacqui's article, published in May 2026 at:

https://jacquideevoy.substack.com/p/revealing-the-man-behind-the-story

My Personal View - Upon the Basis of My Current Knowledge of the Dimmock Case

On the basis of what is presently known to me, I consider that the circumstances surrounding the death of Derek Dimmock ought to have resulted in prompt police involvement.

That does not mean that criminality should have been presumed. It means that the speed of his deterioration, the disputed assessment that he was dying, the administration and escalation of powerful end-of-life medicines, the questions surrounding hydration and the subsequent concerns raised by his family were collectively sufficient to warrant police notification, preservation of the relevant medication and clinical records, and a properly documented assessment conducted in liaison with the coroner and the Care Quality Commission.

From a policing perspective, the proper course ought therefore to have been to secure the available evidence and determine, through appropriate clinical, pharmacological and where necessary, toxicological expertise, whether the death was natural, resulted from legitimate and proportionate palliative care, involved avoidable harm, or disclosed grounds for criminal investigation.

I do not presently claim to determine which of those conclusions is correct. My concern is whether the established investigative pathway was ever permitted to operate and in particular, whether any Operation Talla rejection or non-recording approach prevented the circumstances of Derek

Dimmock's death from receiving the police attention which, outside the Covid context, they could reasonably have been expected to attract.

Principal documentary sources

- NICE, NG163 (3 April 2020; updated 13 October 2020) and consolidated NG191;
- DH/NHS–ACPO–HSE, Investigating patient safety incidents involving unexpected death or serious untoward harm (February 2006) and Guidelines for the NHS (November 2006);
- Williams Review, Gross negligence manslaughter in healthcare (June 2018);
- CQC–NPCC, MoU on avoidable harm in health and social care (October 2019 copy supplied);
- DHSC multi-agency MoU, Investigating healthcare incidents where suspected criminal activity may have contributed to death or serious life-changing harm (17 December 2024);
- Home Office, Police Practice Advice: The Medical Investigation of Suspected Homicide, version 3 (2025);
- ONS care-sector mortality reporting;
- BEIS/Kantar Public, Evaluation of the Regulators' Pioneer Fund Second Round (January 2023);
- and Operation Talla material identified in the associated investigation.

NOTE:

Later instruments are used as comparative guidance, not retrospectively imposed duties.