**NRCPD Response to the Regulation 28 Report regarding Imogen Nunn**

**Introduction**

The National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD) acknowledges receipt of the Regulation 28 Report issued by HM Coroner and wishes to express its sincere condolences to the family and friends of Imogen Nunn.

We are deeply saddened by the circumstances that have led to this report and recognise the significance of Imogen's life and advocacy. From the accounts shared publicly, and through her own presence online, it is evident that Imogen was a powerful advocate not only for her own rights but also for the rights and visibility of other Deaf young people, including those within the LGBTQ+ community. We honour her memory and the continuing advocacy of her family and loved ones.

NRCPD accepts the Coroner's matter of concern, specifically regarding the lack of availability of British Sign Language (BSL) interpreters to support Deaf patients experiencing mental health difficulties in the community, particularly during times of crisis.

We agree that this issue has serious implications for the safety, dignity, and wellbeing of Deaf individuals.

In preparing this response, NRCPD has taken time to seek input from our registrants, reflect on the regulatory responsibilities we hold, and consider how NRCPD can contribute meaningfully to the wider effort to address the systemic challenges raised in this case.

This document offers a contextual overview of the national landscape surrounding interpreter provision in mental health care, followed by specific ways in which NRCPD will seek to support improvements in response to the matter of concern.

We are committed to working collaboratively with Public Bodies, service providers, Deaf-led organisations and our Registrants to reduce the risk of recurrence and ensure that Deaf individuals in crisis receive safe, accessible, and timely care.

**Actions Undertaken by NRCPD in Response to the Regulation 28 Report**

Following receipt of the Regulation 28 Report issued by HM Coroner, NRCPD undertook a series of actions to understand the systemic and practical issues contributing to the matter of concern: namely, the lack of availability of qualified British Sign Language (BSL) interpreters to support Deaf individuals in mental health crisis situations.

We began by seeking to understand the current professional landscape from the perspective of those working directly within it. A survey was distributed to all NRCPD

Registrants, receiving over 450 responses. Respondents provided detailed feedback about the structural and practical barriers they experience when engaging with healthcare interpreting, particularly within mental health services and crisis settings. This feedback has been instrumental in shaping our understanding of where interventions may be most effective.

In addition to direct engagement with our Registrants, NRCPD consulted with key stakeholder organisations, including professional associations such as the Association of Sign Language Interpreters (ASLI) and Visual Language Professionals (VLP), as well as Deaf-led and representative bodies including the British Deaf Association (BDA) and members of the BSL Advisory Board.

We also drew upon evidence and data published in recent research and sector reports, notably *Sick of It* (SignHealth, 2014)and *Still Ignored* (SignHealth and RNID, 2025), which continue to evidence longstanding issues in access to communication within healthcare settings.

As the largest national register and voluntary regulator, we also reflected critically on our own role in relation to the confidence and preparedness of Registrants who accept bookings within complex, high-risk domains such as mental health.

We asked ourselves whether NRCPD is providing sufficient information, guidance, or frameworks to support interpreters in making informed and ethical decisions in accordance with the NRCPD Code of Conduct. Mental health interpreting can involve high levels of emotional, ethical, and linguistic complexity. It is imperative that interpreters are adequately prepared, both in terms of specialist knowledge and access to information before accepting such assignments.

**Contextualising the Coroner's Concerns: A National Perspective on Systemic Barriers to Healthcare for Deaf Individuals**

The tragic and preventable death of Imogen underscores systemic challenges in the provision of accessible healthcare for Deaf individuals. The issues identified by HM Coroner are not isolated incidents but reflect longstanding, documented challenges within the National Health Service (NHS) and broader healthcare systems across the UK.

**Persistent Health Inequalities and Communication Barriers**

In 2014, SignHealth's *Sick of It* report revealed that Deaf people experience significant health disparities, including higher rates of obesity, hypertension, and diabetes, compared to the general population. These disparities are attributed to inadequate access to healthcare information, misdiagnoses, and poor treatment stemming from communication barriers. The report estimated that misdiagnosis and poor treatment of Deaf patients cost the NHS approximately £30 million annually.

A decade later, the *Still Ignored* report (RNID & SignHealth 2025) indicates minimal progress. The study found despite clear legal obligations under the Equality Act and the Accessible Information Standard, 70% of Deaf individuals and those with hearing loss have never been asked about their communication needs when accessing NHS care, despite the legal requirements of the Accessible Information Standard (AIS). This has resulted in the frequent absence of qualified, registered communication professionals, particularly British Sign Language (BSL) interpreters, during medical consultations and emergency health situations.

Furthermore, only 24% of NHS staff reported always being able to meet the communication needs of Deaf patients, with barriers including lack of training (34%), time constraints (32%), and inadequate IT systems (30%) .

These failures are not new and are not rare. They represent a structural problem that remains largely unresolved despite over a decade of clear evidence.

National, representative organisations like the British Deaf Association (BDA) have now embedded these concerns into their long-term strategic planning. The BDA's strategic vision sets out a comprehensive response, including:

- Support for NHS bodies—particularly Integrated Care Boards (ICBs)—to implement national recommendations for accessible communication, including those resulting from NHS England's review of BSL interpreting.
- The promotion of real-time, digital interpreting solutions like those offered during the pandemic, to avoid unnecessary delays in urgent care.
- A call for the NHS to take responsibility for training interpreters in highly specialist domains such as mental health, where need is high and risk is significant.
- Clearer progression pathways for BSL/English interpreters and recognition of specialist skills within regulated frameworks.

NRCPD wholeheartedly supports these strategic aims and note that they reflect a consensus across the Deaf community: that the failure to provide appropriate communication in healthcare is not just a practical inconvenience it is a breach of human rights and a threat to life.

**Barriers Created by Interpreter Procurement Models**

In many regions, interpreting services are procured via multi-provider frameworks where several agencies hold contracts simultaneously. While intended to ensure flexibility and value for money, these frameworks often result in a fragmented and inconsistent approach to service provision. Interpreters frequently report a lack of clarity about which agency is coordinating a given booking, who holds clinical responsibility, or what information, if any, will be provided in advance of the assignment.

This uncertainty can significantly impact interpreter confidence, particularly when the assignment involves crisis care or mental health assessment. As the only individual in the room fluent in both BSL and English and culturally aware of both Deaf and hearing contexts, the interpreter plays a critical, delegated role in facilitating effective communication. Without access to adequate background information about the patient, clinical concerns, and setting, interpreters are unable to assess the ethical or practical viability of the assignment. This creates risk for the patient, the clinical team, and the interpreter themselves.

Compounding this is a wider lack of consistent guidance available to NHS staff and other public sector commissioners on how to procure BSL interpreting services effectively. The absence of standardised information about working conditions, ethical requirements, and terms of engagement for interpreters leads to additional uncertainty, both for those booking the services and those delivering them.

**NRCPD's Ongoing Role and Contribution to Systemic Reform**

In light of these findings, NRCPD recognises its responsibility to contribute to the development of sector-wide improvements.

In accordance with the British Sign Language (BSL) Act 2022, the Department for Culture, Media and Sport has established the BSL Advisory Board, which is now tasked with developing statutory guidance. As the UK's largest voluntary register of communication professionals working with Deaf and Deafblind people, NRCPD considers it incumbent upon us to contribute actively to this work.

We will work directly with the BSL Advisory Board to ensure that the statutory guidance being developed is informed by professional standards and is practically implementable. This includes advocating for greater awareness among commissioners and NHS bodies about the professional requirements of BSL interpreters, and how these can be embedded at the contract level.

Areas of focus will include minimum notice periods, access to preparatory information, booking transparency, and appropriate remuneration for high-risk or specialist settings.

**The Procurement Act 2023: A Catalyst for Reforming Language Service Provision in Health and Care Settings**

The Procurement Act (2023) provides a unique opportunity to reform how interpreting and language services are commissioned, particularly for British Sign Language (BSL) users and other Deaf and deafblind people whose access to care is intrinsically dependent on these language services.

**Current Challenges in Language Service Procurement**

As outlined in earlier sections of this report, the current procurement structures for BSL interpreting are often fragmented and, at times, inconsistent. This has led to widespread uncertainty among interpreters regarding terms and conditions, access to preparatory information, and their role in risk-sensitive or urgent contexts.

Furthermore, language access is frequently treated as an ancillary rather than essential function. This results in reactive, last-minute bookings that lack continuity, clinical integration, or respect to patient-centred principles of care. As the only professionals able to navigate both BSL and English with cultural fluency, interpreters must be resourced to carry out their responsibilities ethically and effectively. Current commissioning models often prevent this.

**Embedding Interpreters into the "Team Around the Patient" Model**

During the preparation of this response, NRCPD consulted with a range of practitioners and stakeholders, including interpreters working in community and mental health contexts. In doing so, we were made aware of agencies operating a person-centred approach to language provision, where Registered Sign Language Interpreters (RSLIs) are included in service planning with a focus on continuity and clear communication pathways. RSLIs working within this model reported a more structured and supportive working environment, with improved access to information and clearer expectations about their role. While not representative of all current practice, this example demonstrates how embedding Sign Language Interpreter provision more closely within care teams can support both professional confidence and service consistency.

Building on this evidence and the goals of the Procurement Act, NRCPD has looked to multi-agency safeguarding frameworks like Team Around the Child (DfES, 2003), this

model re-frames interpreting not as an external booking but as an embedded function within the care pathway.

Originally developed under the *Every Child Matters* policy agenda (DfES, 2003) and formalised in response to the Laming Report (2003), TAC/TAF established the need for multi-agency collaboration, early intervention, shared responsibility, and coordinated planning, particularly where there is complexity or vulnerability. These models have been widely endorsed across education, social care, and early help services and serve as a proven foundation for ensuring joined-up support around individuals with multiple or specialised needs.

In the context of mental health and community care, this model does not suggest that interpreters are contributors to clinical decision-making or care planning content. Rather, it recognises interpreter provision as a central communication function, integral to the infrastructure of inclusive care. When a Deaf or deafblind individual identifies that their language preference is BSL and, as such, require BSL interpretation, Intralingual interpretation or any other language service, the interpreter or interpreting team must be embedded from the earliest stages of care planning. This includes ensuring Sign Language Interpreter access is in place for all planning, review, and multidisciplinary meetings, and that continuity is maintained throughout the patient's engagement with services.

The model supports and operationalises the principles of Person-Centred Care, a framework enshrined in the *NHS Five Year Forward View* (2014), *NHS Long Term Plan* (2019), and supported by NICE guidelines on service user experience in adult mental health (CG136). These principles emphasise the right of individuals to be seen, heard, and involved in decisions about their care in ways that are accessible and respectful of their communication preferences, cultural identity, and lived experience. For Deaf and deafblind individuals, such involvement is only meaningful if interpreting support is familiar, consistent, and planned, not arranged reactively or delivered by unfamiliar professionals at the last minute.

This approach also reflects and supports the Accessible Information Standard (AIS), The AIS requires all health and adult social care services to identify, record, flag, share, and meet individuals' communication and information needs. Embedding interpreting provision as part of the structural design of a patient's care pathway, rather than as an add-on, ensures that AIS is implemented not just technically, but meaningfully, throughout a person's contact with services.

In practical terms, this model requires that interpreter provision is confirmed as part of initial care planning. A consistent team of Registered Sign Language Interpreters should be identified, by the contracted agency, wherever possible, and their availability should be factored into scheduling decisions. Where a Deaf patient is attending a planning

meeting, the RSLI or interpreting agency should be included in the logistics of setting the meeting date.

For patients using remote or hybrid services, remote interpreting services (VRI/VRS) must be built into contingency and routine access plans.

For emergency and out-of-hours situations, interpreter continuity may not always be possible. However, where a language service need is known, care plans and crisis protocols should include communication contingency planning; pre-identified access routes to qualified, registered sign language interpreters (including remote interpreting providers) who can respond quickly and safely within the clinical governance requirements of the setting. This prevents dangerous delays, promotes continuity of communication, and ensures that critical interactions such as Mental Health Act assessments, safeguarding interventions, or urgent care reviews are not conducted without accessible language provision.

To embed this model into practice, NHS commissioners and procurement leads must require interpreting agencies to adopt a continuity-based framework. This includes demonstrating systems for assigning dedicated interpreter teams to long-term care cases, contributing to meeting scheduling logistics (without clinical involvement), and confirming interpreter availability at the planning stage.

It also requires that only Registered Professionals are used, ensuring that practitioners are subject to a code of conduct, complaints procedures, and continued professional development requirements.

**Expanding Access Through Remote Interpreting Provision (VRI/VRS)**
Remote interpreting services (VRI/VRS) are a vital component of a modern, responsive approach to language access for Deaf people, particularly in situations where immediate support is needed and an in-person interpreter cannot be secured.

While **remote interpreting is not a substitute for face-to-face interpreting** in complex or ongoing care scenarios, such as mental health assessments or therapeutic interventions, it plays a crucial role in ensuring that Deaf individuals are not left without language support in urgent, unplanned, or short-notice interactions.

The success of BSL Health Access, a 24/7 Video Relay Service launched during the COVID-19 pandemic, provides clear evidence of the value of such provision. Funded by SignHealth and delivered in partnership with InterpreterNow, the service supported over 25,000 health-related conversations in its first year, primarily with GP appointments.

Deaf users frequently reported a significant increase in their ability to manage their own health independently and in real time. One service user described the experience as "empowering" and highlighted the contrast between instant access to remote interpreting services and the previous delays caused by having to wait days or even weeks for an in-person interpreter to be booked, even in urgent situations.

Despite its proven value and a recommendation in a Rapid Review that the service be maintained, BSL Health Access was discontinued due to a lack of long-term funding. Its closure represents a step backwards in equitable access and highlights the fragility of ad hoc or charity-funded solutions to what is ultimately a statutory responsibility.

As part of a wider language access strategy, remote interpreting services should be embedded within commissioning frameworks, service-level agreements, and care planning pathways. This includes ensuring that access to qualified, registered sign language interpreters, whether in person or via remote interpreting provision, is designed into services rather than added reactively.

**Opportunities Under the Procurement Act 2023**

The Procurement Act introduces principles that directly support a more strategic and ethical approach to commissioning language access services, including:

- **Public Benefit**: This includes the advancement of equality and social value through public procurement decisions.
- **Value for Money**: Not only measured by financial cost, but also through improved outcomes and effectiveness, relevant in ensuring that care is genuinely accessible.
- **Transparency and Accountability**: Enabling clearer standards for the quality and consistency of contracted interpreting services.
- **Supplier Engagement**: Encouraging co-design and greater flexibility in contract specifications to meet diverse user needs.

These provisions provide a policy foundation upon which NHS commissioners and Integrated Care Boards (ICBs) can develop bespoke commissioning models for BSL services that centre the person and safeguard continuity.

For example, new contracts could require providers to deliver:

- Tailored language service provision, focused on the language preferences identified by the Deaf person, themselves

- Dedicated interpreter teams for ongoing care (including mental health cases),
- Evidence of meeting Accessible Information Standard (AIS) requirements,
- Transparent scheduling protocols that involve interpreters in planning,
- Digital and remote access services such as Video Relay Service (VRS) for crisis or out-of-hours care,

**NRCPD's Role in Supporting Procurement Reform**

NRCPD recognises our role in supporting a shift towards person-centred, ethically commissioned interpreting services.

We commit to:

- Supporting NHS England and ICBs in designing new procurement frameworks aligned with the Procurement Act 2023,
- Providing detailed guidance on quality assurance and ethical conditions for BSL interpreter provision,
- Contributing to the development of statutory guidance under the BSL Act

These actions will support the long-term integration of interpreting into care models—not as a reactive cost, but as an ethical and clinical necessity. The failings that prompted this Regulation 28 report demand a systemic, sustained, and standards-based response. We believe the Procurement Act 2023 presents a critical opportunity to deliver it.

**NRCPD's Commitment to Addressing Systemic Barriers**

NRCPD asserts that the use of qualified, registered communication professionals is not optional but is essential to safe, equitable, and dignified care.

We are committed to playing an active role in addressing the systemic barriers that contributed to the circumstances of Imogen's death.

In response to the Coroner's concerns, and in alignment with the national picture outlined above, NRCPD will:

- **Continue to uphold and enforce rigorous registration standards** that include safeguarding awareness, professional ethics, and mandatory CPD for all registrants.

- **Work collaboratively with health and social care providers** to promote understanding of the importance of using NRCPD-registered professionals.
- **Support national Deaf organisations and sector partners** in advocating for system-wide changes, including service models that make real-time language service provision a practical reality.
- **Work in collaboration with Deaf communities** in the development of training, policies, and guidance, ensuring their insight and experience meaningfully inform our approach.
- **Improve public-facing information and engagement**, so Deaf people and their families can understand their rights and how to check whether a professional is registered.
- **Engage in policy-level discussions** to support the development of specialist pathways and recognition for interpreters working in high-risk domains such as mental health, domestic violence, and end-of-life care.

This is not a challenge NRCPD can meet alone. But we are committed to playing our part, informed by evidence, guided by our registrants, and accountable to the Deaf and Deafblind communities we exist to protect.

**Supporting Interpreter Readiness in Mental Health Settings**

NRCPD recognises its regulatory responsibility to ensure that all of our registrants, including Registered Sign Language Interpreters and Registered Sign Language Intralingual Interpreters, are appropriately supported to make informed, ethical decisions when accepting bookings, particularly in high-risk, complex contexts such as mental health settings.

Amongst our registrant population are highly skilled, motivated, and values-led practitioners who demonstrate a clear commitment to ethical practice and to delivering safe, high-quality services. NRCPD expects all interpreters on our register to operate in accordance with our Code of Conduct, which includes duties to work within one's competence, to ensure effective communication, and to act in the best interests of the people they work with.

Despite the professionalism of our registrants, the evidence gathered from our recent survey and engagement with professional associations (ASLI, VLP), community feedback, and independent research reveals a range of challenges faced by interpreters in undertaking work within mental health contexts. These include a lack of structured preparation, inconsistent access to appropriate training, limited opportunities to observe

or work alongside experienced peers, and variability in the information provided by agencies and public bodies about the nature and complexity of assignments.

Studies such as Hetherington (2012) and Dean & Pollard (2013) highlight that interpreters working in mental health contexts report higher emotional demands, greater ethical complexity, and increased risks of vicarious trauma. They also note the challenge of interpreting for service users in acute distress while navigating the needs and expectations of multidisciplinary professionals unfamiliar with interpreting processes. A review by Bontempo & Malcolm (2012) stresses that interpreters in healthcare may be underprepared for clinical environments, particularly without specialised training.

The feedback from our Registrants supports best practice recommendations from professional bodies such as ASLI and international counterparts like the Registry of Interpreters for the Deaf (RID, USA), which advocate that interpreters should not work in mental health or similarly complex environments until they have acquired at least three years of post-qualification experience (RID, 2007).

However, Registrants have told us that what constitutes relevant experience during that three-year period is not clearly defined by NRCPD. As a result, while more experienced Registered Sign Language Interpreters are generally confident in taking on this work, other qualified interpreters, even after completing three years of experience, may be hesitant to accept assignments in complex settings. This, in turn, affects the pipeline and risks reducing the number of registered sign language interpreters willing or prepared to work in areas such as mental health.

This gap in clarity and support needs to be addressed by NRCPD to ensure that, during those first three years, both Registered Sign Language Interpreters and Intralingual Interpreters acquire the core competencies necessary to work in complex settings.

Doing so will better enable them to undertake this work effectively and ethically, with the appropriate supportive structures in place, such as professional membership and professional supervision, to sustain their practice over the long term.

NRCPD acknowledges its responsibility to define these core competencies and to provide Registrants with clear guidance on how they can be acquired, establishing a transparent and supportive pathway from qualification to safe, ethical practice in complex settings.

Specifically, NRCPD commits to:

- **Commissioning a programme of work led by expert mental health practitioners and experienced interpreters** to develop detailed, practical guidance on what constitutes readiness for mental health interpreting.

- **Producing clear guidance for registrants, agencies, and service commissioners** that defines the types of experience and training that support safe practice in complex or high-risk interpreting contexts.
- **Exploring the feasibility of structured pathways to specialisation** in mental health, similar to RID's Alternative Pathway Programme for healthcare interpreting, which includes supervised practice, mentorship, and formal assessment.
- **Working collaboratively with NHS England, Integrated Care Boards, and training providers** to co-develop endorsed training and CPD opportunities aligned with regulatory standards and workforce needs.
- **Consulting with Deaf community-led organisations and Deaf individuals** to ensure that guidance and training incorporate the lived experience of Deaf people who use mental health services.

These actions are intended not only to increase the number of interpreters who are confident and competent to work in mental health settings but also to ensure that those already undertaking this work are better supported through robust guidance and recognised training frameworks.

Ultimately, this approach forms part of a broader strategy to enhance interpreter access and quality within health and social care, ensuring linguistic inclusion and safeguarding remain central to care for Deaf and deafblind people.

**Deaf People as Primary Rights Holders and Experts in their Care**

NRCPD acknowledges that while this response to the Regulation 28 report has necessarily focused on professional regulation, interpreter standards, and systemic recommendations, it is essential to recognise the individuality and agency of Deaf people when considering language services provision.

In particular, we acknowledge the importance of positioning Deaf individuals not simply as stakeholders, but as agents and primary rights holders and experts in their own care.

Too often, discussions about access and safety are centred on professionals, commissioners, or services, rather than on the lived experience, autonomy, and leadership of Deaf people themselves. In the context of Imogen's death, this imbalance is especially significant.

Imogen was an articulate advocate for her language rights and, the Regulation 28 report suggests that she made clear requests for BSL interpretation, which were not consistently upheld. Although Imogen was able to lipread, in all of her public posts, she was clear that her language preference was BSL. Therefore, her ability to lipread should not have been taken as a substitute for her requested professional language service provision, BSL interpretation. Lipreading is cognitively demanding, especially during moments of acute mental distress. It requires the Deaf BSL user to interpret and complete incomplete information, often in their second language, at significant cost to their energy and, at times, wellbeing.

The capacity to "code-switch", to move between different language modes such as BSL, lipreading and, at other times, requiring intralingual interpretation is not a sign of inconsistency but rather a reflection of a Deaf individuals' deep understanding of their own language access needs in different settings. It is therefore imperative that public services, including healthcare, respect and respond to these self-identified needs without making assumptions based on surface-level assessments of language ability.

Flexibility in provision, led by the Deaf person's expressed preference, must be central to safe and effective communication access.

NRCPD further acknowledges the need for deeper co-production with Deaf communities in shaping policy, guidance, and regulatory improvements. This includes actively involving Deaf advisors, Deaf professionals, and those with lived experience of the systems we seek to influence.

The rights of Deaf people, as outlined in the UN Convention on the Rights of Persons with Disabilities, particularly Articles 9 (Accessibility) and 25 (Health), must underpin both the language and substance of our work. Accessible care must not only include qualified

registered language professionals, but also reflect Deaf culture, identity, and the right to be understood on one's own terms.

NRCPD is committed to using its platform and regulatory responsibilities to elevate these principles, and to advocate for them within national policy, commissioning frameworks, and professional standards.

**Conclusion and Summary of Actions**

NRCPD acknowledges the matter of concern raised in this Regulation 28 Report and accepts its seriousness. We recognise that the lack of timely and appropriate interpreting provision for Deaf individuals in mental health crisis can have grave consequences and must be addressed as a matter of urgency

In response to the concerns raised by HM Coroner, NRCPD commits to a programme of meaningful and collaborative action aimed at improving the safety, accessibility, and quality of interpreting provision for Deaf individuals in mental health and community care settings.

We will commit to:

- **Support the development of person-centred, linguistically inclusive procurement models** by working with commissioners, interpreting agencies, and statutory bodies to ensure interpreting provision is embedded from the outset of care planning.
- **Advocate for clear national guidance, aligned with the Accessible Information Standard and the BSL Act 2022**, on the commissioning and delivery of interpreting services, including terms and working conditions that enable interpreters to work safely and effectively.
- **Contribute to the development of statutory guidance under the BSL Act,** ensuring that the requirements for high-quality, regulated interpreting provision are reflected in service specifications and contracts.
- **Promote models in which interpreter provision is recognised as a core communication function** and not a peripheral support service, particularly where language access is essential to care and safeguarding.
- **Commission expert Deaf and practitioner-led work to define interpreter readiness for mental health and other complex contexts** and to produce guidance on safe practice, experience requirements, and routes to specialisation.

- **Collaborate with NHS England and training providers to develop endorsed, specialist training pathways** that support interpreter confidence and competence in complex settings.
- **Engage with Deaf-led organisations, professional associations, and our own registrants** to ensure that all actions taken are informed by lived experience, ethical standards, and professional realities.
- **Champion Deaf-led principles** across national policy, commissioning, and professional standards through its regulatory role.

NRCPD recognises that improving access to interpreters in mental health settings requires both systemic and professional-level change. We are committed to playing a central role in that change through regulation, guidance, and partnership, so that Deaf people can receive the care they need, in the language they use, with safety, dignity, and equity.

We extend our condolences once again to Imogen's family and loved ones. In responding to this matter of concern, we aim to honour her advocacy and contribute to the systemic changes needed to safeguard others.

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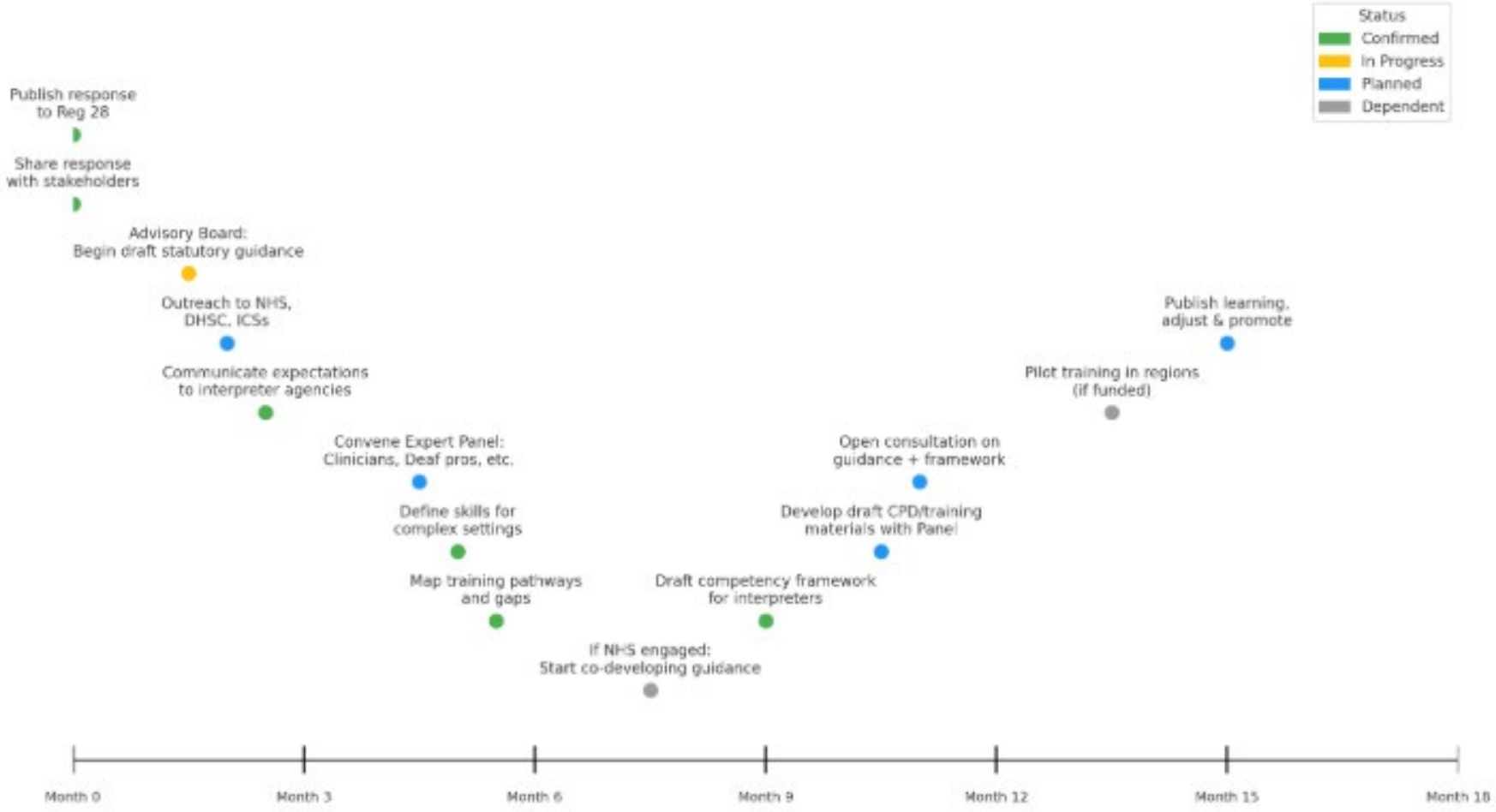
Chief Executive Officer

NRCPD

**Timetable of Actions**



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