

Witness Name: James Neale

Statement No: 1

Exhibits: JN/01 – JN/12

Dated: 13 August 2025

**THE SOUTHPORT INQUIRY**

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WITNESS STATEMENT OF

JAMES NEALE

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I, JAMES EDWARD NEALE, will say as follows:

**Introductory matters**

1. My name is James Edward Neale. I am currently a Temporary Chief Inspector within Local Policing for Lancashire Constabulary.
2. I make this statement in response to a Rule 9 request received from the Southport Public Inquiry ('**the Inquiry**') dated 22 July 2025. This is the first witness statement I have provided to the Inquiry. I also provided input to inform the preparation of the corporate witness statement made on behalf of Counter Terrorism Policing North West ('**CTPNW**') by DCS Sarah Kenwright ('**the CTPNW corporate statement**'), dated 30 June 2025.
3. If I may, I would like to take this opportunity to express my condolences to the victims, their families and those affected by the atrocious Southport attack.
4. This statement addresses the matters raised in the Rule 9 request pertaining to the Inquiry's Terms of Reference, insofar as they relate to my involvement in AR's case, my reflections on those events, and any improvements that have been made or could be made to working practices and procedures in this area.

*Preliminary matters*

5. I should say at the outset that over my career as a police officer, and in my role within CTPNW, I have dealt with a very broad-ranging, high volume caseload. For that reason, I hope the Inquiry will appreciate that I cannot recall with clarity the specific detail of each individual matter I worked on, particularly where they occurred a number of years ago. With regard to AR's case, I did not have a strong recollection of my work on that matter. With that in mind, with a view to being as helpful as possible to the Inquiry, I have refreshed my memory by reviewing the relevant documents from that time, and having done so, I do recall elements of this case and the actions that were carried out by me. Where I rely on those documents rather than my own direct memory, I try to make that as clear as possible.
6. I am aware that AR was referred to CTPNW Prevent on three separate occasions between December 2019 and April 2021. My involvement in AR's case was limited to his first referral, which was received by the Lancashire Fixed Intelligence Management Unit

('FIMU') on 10 December 2019, and referred to the Prevent team on 16 December 2019 [JN/01-CTPNW000154]. I was a Sergeant in the CTPNW Prevent team, seconded from Lancashire Constabulary, at that time. I authorised the closure of the case on 31 January 2020. This is when my involvement in this matter ended. I discuss this in more detail below.

7. I moved on from the Prevent team before the second referral was received. In this statement, where I refer to the 'Relevant Time', I am referring to the period 10 December 2019 to 31 January 2020, i.e. the period of my involvement.
8. I understand that a chronology of the key decisions that were made with regard to AR's first Prevent referral is set out within Section 4 of the CTPNW corporate witness statement, and so I do not repeat it in full here.
9. I have limited my use of technical policing language and abbreviations where possible, and have tried to explain those as appropriate.

*My background and relevant experience*

10. I joined the police in June 2003, and have 22 years' police service. I am currently a temporary Chief Inspector in Local Policing. My first role was in Response Policing, I then carried out a number of other policing roles including working in neighbourhood policing and as a Target Team officer. Having passed my Sergeants' exams I then undertook periods in temporary Sergeant roles – from September 2010 until August 2011 where I worked as a Response Sergeant, and April 2012 until December 2013 where I worked as a Neighbourhood Sergeant. I joined Counter Terrorism Policing in January 2014, joining as a Detective Constable in Ports. In this role I worked in a number of port environments carrying out examinations of persons traveling into or out of the country to ascertain if individuals were or had been involved in the commission, preparation or instigation of acts of terrorism. Between March 2015 and February 2017 I performed the role of temporary Sergeant at the ports where I supervised the teams carrying out the examinations. Between February 2017 and August 2017, I worked for a period as temporary Sergeant with the Prevent team, because the Sergeant whose full time role it was had been seconded elsewhere. I then returned to my Ports role. I moved back to Prevent as a temporary Sergeant on 3 April 2018, initially as temporary cover for a Sergeant's post,

before being promoted to substantive Sergeant in the post. I stayed in the Prevent Team until 31 July 2020.

11. In August 2020, I left Prevent on promotion to a role as a Force Incident Manager ('**FIM**'). I was an inspector working as a FIM until May 2023, when I became a Divisional Response Inspector working on an immediate response team within South Division of Lancashire Constabulary. In August 2024 I became a Temporary Chief Inspector within Neighbourhood Policing, Partnerships and Local Policing, within South Division, Lancashire Constabulary. I am still in that role now.

*Prevent and Channel*

12. While I will not in this statement go into detail outlining the functions of Prevent and Channel (and I am aware this has been done in the CTPNW corporate statement), it may assist to provide a brief outline to ensure my account is read in context.

13. Prevent is one strand of the counter-terror CONTEST strategy. In short:

- a) **Prevent** is designed to prevent people from entering into terrorism or supporting terrorism;
- b) **Pursue** aims to disrupt and investigate potential terror attacks;
- c) **Protect** is focused on enhancing security measures; and
- d) **Prepare** aims to mitigate the impact of any attacks that cannot be prevented.

14. Section 26 of the Counter-Terrorism Act 2015 ('**the 2015 Act**') introduced a duty on particular authorities, including the police, to have "due regard to the need to prevent people from being drawn into terrorism' when carrying out their functions. That is known as 'the Prevent duty'.

15. The police play a fundamental role in Prevent. There is a designated team for each specified area of England and Wales dealing with the initial referrals and how to handle them. This is designed, wherever possible, to enable early intervention where any individual is showing signs of the relevant vulnerabilities or risks.

16. Where an individual, school, organisation, member of the public, etc, is concerned about the behaviour or actions of any person and considers there is a Prevent-related risk, they

may make a referral to Prevent. The Prevent team in the relevant police force will consider that referral and make an assessment. They will also consider what support or intervention might be appropriate based on the information provided to them, and that will inform the next steps.

17. One option, if the relevant criteria is met, is to refer the individual to Channel. While there is no strict threshold for referral, the assessment comprises a vulnerability assessment, and consideration of the risk to that individual of radicalisation and their vulnerability to being drawn into terrorism. This is a multi-faceted assessment and each case must be considered on its own facts and merits.
18. Channel forms a significant part of the Prevent strategy. Section 36 of the 2015 Act sets out a duty on particular authorities to provide support for people vulnerable to being drawn into terrorism. This comprises 'the Channel duty'. Fulfilment of the Channel duty is, in practice, mainly actioned through the convening of Channel panels. These are multi-agency panels of authorities and organisations designed to consider the vulnerability of an individual to being drawn into terrorism and implementing interventions with that individual to steer them away from that path. Participation in Channel is voluntary.

#### *Dovetail*

19. In the course of this statement, I make reference to 'Dovetail'. When I refer to this, I mean Operation Dovetail, which was an initiative in place at the Relevant Time piloting moving 'ownership' of Channel from CT Police to local authorities, with a local authority Channel coordinator taking on functions previously dealt with by a member of the CT police. The functions of Channel itself remained the same but the processes were slightly different in that local authorities took more responsibility for the coordination of the programme under Dovetail. The relevant criteria for referral remained the same.

#### *CTPNW team structure*

20. Before I go on to outline my own role, it might be helpful if I provide some brief context for how the team was structured at the Relevant Time.

21. At the Relevant Time, I was a Sergeant in the Prevent team, alongside Sgt. Kathryn McIntyre. My supervisor was Detective Inspector Darren Mangan, and he was supervised by David Wells, who held the equivalent of Chief Inspector rank for the region at that time.
22. Between us, Sgt. McIntyre and I supervised eight Counter Terrorism Case Officers ('CTCOs') across Lancashire and Cumbria (comprising six CTCOs in Lancashire and two in Cumbria). We also had a member of civilian staff on the team, who carried out more of a support and engagement role. We generally tried to separate out the supervisory work with reference to geographical location, and I mainly supervised the caseload for Cumbria and north Lancashire.
23. Our team was mainly based in Lancashire. All of the Lancashire-based CTCOs worked from the same office. As mentioned above, two of our CTCOs were based in Cumbria – one in Barrow and one in Penrith. I travelled regularly to see those officers in person.

*My role*

24. I was in a supervisory role for the duration of my time in the Prevent team, and at the Relevant Time I had been working in counter terrorism for just under six years. The general duties of supervisors in the Prevent team involved general oversight of the Prevent caseload [JN/02 - {CTPHQ000116}], including but not limited to:
- a) allocating referrals received to CTCOs and ensuring that key actions and updates were recorded on the Prevent Case Management Tracker ('PCMT');
  - b) ensuring all referrals received had been submitted to the Fixed Intelligence Management Unit ('FIMU') for deconfliction and assessment prior to any CTCO work commencing;
  - c) supporting and managing CTCOs and their day-to-day work, including their timely completion of the Police Gateway Assessment ('PGA') and, where appropriate, the Dynamic Investigation Framework ('DIF');
  - d) bearing joint responsibility for CTCO decisions within Police Case Management ('PCM') and supervising CTCO decisions and their rationales;
  - e) assessing case suitability for closure, and where appropriate, signing off closures; and
  - f) supervising and quality checking all CTCO PCM work and making sure deadlines were met.

25. Locally, we also assisted in the implementation of Operation Dovetail, and represented the Constabulary on Channel panels.
26. The daily running of the department was primarily led by the Sergeants acting as Prevent supervisors. We would meet with our Detective Inspector on a weekly basis, or more often if there was a need to do so. At the weekly meeting we would discuss any issues with the team or other matters of administration. The Inspector would be available should there be any requirement to escalate a matter and if he was not in his office in our building I could make contact via phone. He was not, however, closely involved in terms of the handling of the day-to-day caseload.
27. In terms of the day-to-day supervision of cases, Sgt. McIntyre and I met with the CTCOs for a team meeting at the start of every shift. The meetings were an opportunity for us to see the CTCOs every day, and for the CTCOs to highlight any concerns and/or questions that had arisen from the referrals that they were handling. If they had any concerns or questions, these would be highlighted to us and, as supervisors, we would deal with those concerns. Most of the queries would relate to the relevant processes and workflows of the Prevent system and could be dealt with by referring to the relevant guidance. If I or Sgt. McIntyre could not deal with an issue raised ourselves, we could escalate the matter to the DI either in person or by phone, or could raise any issues relating to regional processes by contacting Dave Wells if necessary. We also had one-to-one meetings with the CTCOs, where required, as well as having continual conversations throughout the day or week in passing.
28. In general, I would take a more active role in the cases that were specific to my geographical area and Sgt. McIntyre would do the same. However, if Sgt. McIntyre was on leave or otherwise unavailable, I would pick up the supervision of her cases and she would do the same for me. Otherwise, I was always happy to pick up any questions that any of our CTCOs had.
29. I was quite involved in the caseload - the CTCOs in our team would copy Sgt. McIntyre and me into any emails that they sent regarding the referrals they were handling. There were two channels through which referrals were received. The first was directly through policing channels, where cases would come to the Prevent team through the FIMU. However, most cases came through referrals to the Prevent scheme, i.e. from schools, local agencies, members of the public etc. Cases would be sent to FIMU for their

assessment, and would then be sent to us to carry out the PGA. CTCOs, after carrying out their assessments, would add the information from the PGA to the PCMT. At the Relevant Time, our team was quite well staffed for the work that was coming into our team.

### *Training*

30. Throughout my time within CTPNW/Prevent, I attended a number of training courses. I have concentrated on the training I completed by the time of AR's first referral, relevant to my role as a Prevent Supervisor.
31. At the Relevant Time, I believe the force had only recently brought in the National Prevent Foundation Course, which was a weeklong national course. CTCOs and CTCO Supervisors were generally required to do this course. I know that I didn't attend this training at that time - we were prioritising the CTCOs that may have had to visit individuals as part of the referral process to ensure they went through the course first. I moved from this post before being allocated a place on that course. I don't think there was specific formal Prevent training for supervisors, but I do recall doing a lot of CPD/training more generally. There was training throughout the year for Prevent officers and staff so that people were up to date with current issues relating to Prevent functions. Professional Development Reviews also ensured that Prevent staff had up to date knowledge and dealt with any gaps in knowledge with all CTCOs and staff.
32. I have exhibited a copy of my Police Training Record which sets out the training I had completed prior to the Relevant Time [JN/03: CTPNW000043/TAB 7]. I have listed below the courses I completed which were most relevant to my CT roles, and the date of completion, as well as some detail on the course's duration and content:
- a. **Introduction to CT**, attended January 2014. This is the introduction to working with CTPNW and covered a general overview and the varying roles within CT policing.
  - b. **Insight**, completed 24 November 2014. This course covered the processes and progress of a counter terrorism investigation which is very different to the way a mainstream policing investigation is conducted.
  - c. **NCIA Core**, completed 20 October 2015. This covered the use of the secure CT computer system.

- d. **Lancashire Safeguarding Children's Board – Safeguarding Level 1 and 2:** completed June 2017. This covered mainstream multiagency safeguarding.
- e. **Terrorist legislation course:** completed 17 September 2018. This covered the key terrorism related legislation and its difference from mainstream police powers and legislation.
- f. **Prevent Gateway Assessment Dynamic Investigation Framework workshop:** attended May 2019. This covered the new DIF forms and how to complete them.
- g. **Bass – Behaviour detection:** completed June 2014. This is a ports course aimed at spotting suspicious behaviour in public spaces - it is not a Prevent course.
- h. **Schedule 7 Ports course:** completed December 2014, and then yearly reaccreditation.
- i. **NPPC:** completed July 2014. This course covered the powers and procedures involved in CT Policing at ports.

#### **Factual narrative of involvement**

##### *Supervision of PC Carmen Thompson during the first referral*

33. At the Relevant Time, Sgt. McIntyre was responsible for the general supervision of PC Carmen Thompson. I think Sgt. McIntyre must have been away towards the end of the first referral because it came to me to deal with, but I can't remember exactly. I first became aware of the case on 10 December 2019, when I received an email from PC Thompson [JN/04-[LANC000175].] where she asked whether we had received a new referral regarding AR and noted that "apparently it was referred Thursday" of the previous week. She noted that there had been issues with emails being received into the inbox and cited that as the potential reason for delay in receipt.

34. On 16 December 2019, I was copied into correspondence with PC Russ Davies and [redacted] Officer B along with Sgt McIntyre and PC Thompson. The correspondence noted that PC Davies and PC Thompson were due to have a meeting with a social worker, Anna Jameson (Children's Social Care Central Lancashire, Lancashire County Council) about this referral [JN/04-[LANC000175/48; 129-131; and, 138-141.]

*Entries on the PCMT*

35. General practice was to record key updates and/or actions in the PCMT. The entries that I made are limited to those shown in pages 15, 31 and 33 of JN/05{CTPNW000122}.
36. The only time that I might have made notes about a case that were not then transferred to the PCMT were when, from a security perspective, the information would not be suitable for the PCMT. For example, if the information was deemed to be of a classification not suitable for an open system such as the PCMT. In addition to the PCMT, given that the cases we were dealing with were highly sensitive, there was also a 'checked-out' notebook where people could record sensitive information if necessary. I am confident that no such additional notes were made in this case. I may have scribbled down brief notes in a daybook, but I am confident that I would have transferred everything onto the PCMT, as was normal practice at the time. From reviewing the previous entries made on the PCMT, I was comfortable that I had all the information that I needed to make an assessment.
37. I refer to page 15 of JN-05{CTPNW000122}, which shows an entry made by me on 17 December 2019 on the PCMT relating to AR's first referral. The entry details state that I authorised a change in allocation of the case from PC Russ Davies to PC Carmen Thompson. I accept that I made this entry, and would presume that this was done because of annual leave, or some other reason of capacity, to warrant changing the case allocation, though I have no direct memory of that.
38. I became more involved in the case when it was submitted for closure. This came after a visit by PC Christopher Lawrence and PC Thompson to AR's home, where they had met with AR and his father. By this point, I remember having an awareness of the case. Following the visit, PCs Lawrence and Thompson submitted the case for closure. Before I authorised closure, I felt it important to speak to PC Thompson and PC Lawrence to make sure I properly understood the case. I remember both officers held the strong opinion that AR was not suitable for referral to Channel.
39. I didn't make any notes of the conversations that I had with the officers. I knew that I would be heading immediately to my office to make an entry onto the PCMT, so I did not think it was necessary to make notes during the conversation. Also, as above, given the sensitivity, it was normal practice for everything to be recorded directly on the PCMT, and

minimal extra notes made of conversations outside of that. We routinely discussed cases, however, not all discussions were then recorded or reflected in the PCMT.

40. Following the meeting with PCs Thompson and Lawrence, I read through the previous entries and decisions on the PCMT. I was aware that there were two multi-agency meetings that had been held regarding AR, and that CTCOs had been present. I noted the FIMU assessment, which had stated that the case did not involve counter terrorism/domestic extremism ('CT/DE'). When I came to consider authorising the closure of the case, this was a persuasive factor.
41. I considered a number of factors when deciding whether to authorise the closure of the case: the meeting with AR and his father, in which CTCO officers reported AR showed no indication of CT/DE concerns; the multi-agency meetings (where it was made clear support was being provided by different agencies); and the views of CTCOs, PC Lawrence and PC Thompson. I assessed, from the information that I had, that AR had violent tendencies and had been violent, leading to his arrest in December 2019, shortly after the first referral was received. However, in my view that behaviour was criminal violence, being dealt with already by mainstream policing, and was not what would be considered 'counter terrorism' violence that would require intervention from CT channels. He had already been arrested and was being dealt with through those channels. I took the FIMU assessment as supporting evidence that the known behaviour was criminal rather than terrorist in nature.
42. The second part of my assessment was to consider whether AR was at risk of radicalisation or vulnerable to being drawn into terrorism. When I was considering the second part of that assessment, I considered the information from FIMU, and the opinions of PCs Lawrence and Thompson. PC Thompson had attended the multi-agency meeting and I was aware that AR was receiving support from other agencies, extra support from school, and was, for example, awaiting an ASD diagnosis. There has been some discussion as to whether AR had an ideology that would raise risks of being drawn into terrorism or radicalisation, including whether he had a fixation on mass casualty events or school shooting. It was the officers' view that the case did not meet the criteria for referral, and while he had an interest in current affairs and the news, it could not be said that he presented as having an obsession with school massacres. Both officers were satisfied that he was not suitable for Channel/Dovetail.

43. Having considered all this information in the round, and the previous assessments by the JAT and FIMU, I was minded to accept the conclusions of PCs Lawrence and Thompson. Accordingly, I authorised closure of the case [JN/05: CTPNW000122]. I don't recall discussing this case with Sergeant McIntyre.

44. I now refer to page 33 of JN/05: CTPNW000122 which shows an entry made by me on 31 January 2020. The entry states that I authorised closure of the case and provides the following rationale:

*"As detailed in the PCM the concerns relayed to Prevent have been explored and do appear to be linked to an Ideology or a vulnerability to radicalisation. There are vulnerabilities and needs which are being met by mainstream safeguarding and this case can be closed to Prevent."*

45. This reflects broadly the rationale for closure. The PCMT documents the process in order. I took into account all the due diligence that had been carried out by the CTCOs. If, at any point, I felt that there was important and relevant information that had not been recorded on the PCMT, I would have added this. If I had not agreed with the CTCO rationale, or if I felt I needed more information, I would not have authorised the closure.

#### *Interaction with FIMU*

46. Prevent Supervisors have limited interaction with the FIMU in the day-to-day handling of the caseload. As part of the Prevent Case Management Plan ('PCMP') assessment CTCOs are required to report any suspected vulnerabilities/concerns identified as part of the process to the FIMU. My role with regard to FIMU was to ensure that relevant information or intelligence was fed back to them so that it could be included in their assessments. The actual feedback was completed by the CTCOs in most cases, as it was in this case.

47. I can see that PC Thompson noted that *"the subject is extremely vulnerable and needs support from other agencies that are already in place"* and that she *"advised agencies to re refer to prevent should they have any more concerns in the future and also if any relevant information is found on his internet history from the school or from his devices."* She concludes that the information should be submitted to the FIMU for assessment [JN/0- /INQ00000000/29].

48. All of the details relating to the arrest and information gained through the multi-agency meetings that the CTCOs attended, required to be communicated back to the FIMU to reassess. It was recorded on the system by PC Thompson that this had been done, and I am confident it will have been. Information would have been sent either by conventional police IT or updated against an action on the National Common Intelligence Application ('NCIA') if such an action had been created. That was standard practice. That was also the channel through which the risk level of a case might be escalated – we would submit any new information to FIMU to let them make that assessment.
49. Once we received an assessment from the FIMU, we wouldn't generally go back to them asking them for further information. In this case, we did not identify any new information that suggested enhanced risk, or anything that they were not already aware of.
50. I don't remember having any direct engagement with FIMU in this case. FIMU assessed in this case that AR did not present a CT/DE risk. That assessment is not determinative - from time to time I would disagree with a FIMU assessment, and their view certainly did not mean that the case *had* to be closed. If I had had information to suggest that the case should not be closed, then we would have kept it open. This did not happen in this case.
51. FIMU assessments do have an impact on our case handling. They have access to information that informs their assessment and their assessment is persuasive, but the decision on closure is for supervisors to take with all of the available information. I would have never closed a case that was considered to be CT/DE relevant. The areas where the FIMU assessment was significant in this case were their assessment that the known violence was criminal not terrorist in nature; that there would be no CT investigative action undertaken; and that there was no perceived current CT risk.
52. I was reassured by the fact that the case had undergone FIMU assessment and mainstream policing checks, which had concluded that whilst some of AR's actions or statement could, in isolation, be considered CT/DE relevant, that on the whole, his behaviour was criminal, rather than terror-related. Those considerations are not necessarily reflected in the PCMT but I am satisfied they were taken into account.

*Discussions with JAT team*

53. I don't recall having any direct conversations with PC Phil Blundell, or anyone else in the JAT team in this case. That is not unusual – I would not generally have had discussions with JAT as part of my supervisory role.

*Vulnerability Support Hub*

54. As a supervisor, my interaction with the Vulnerability Support Hub (**VSH**) was limited. The CTCO, however, would, as part of carrying out their assessment, attempt to identify the subject's needs, vulnerabilities, and/or previous convictions, which may be relevant to the referral. The VSH could form part of that assessment. The VSH generally gave a clinical overview. They could also support the Channel panel. Where the CTCO identified any mental health concerns, or potential issues such as neurodivergence, or any other such vulnerability, the CTCO could make referrals themselves to the VSH for further support or onward referral to local agencies and/or organisations. Those considerations would form part of the overall assessment. I did not have any direct discussions or engagement with the VSH – I think those discussions about referrals would happen more at a peer-to-peer level.

55. In reference to the first referral, I can see that PC Thompson flagged that AR had "undiagnosed ASD and mental health issues and may also have special educational needs" [JN/05: [CTPNW000122]] and indicated that a referral to the VSH should be made by the Prevent Team. I do not know whether that referral was made. This would have remained as an outstanding action for the CTCO if the case had not been suitable for closure.

56. In this case, I do not consider that the input of the VSH would have changed my assessment. I'm aware that multi-agency meetings were held and that Child and Adolescent Mental Health Services (**CAMHS**) were engaged with AR. I was therefore comfortable that AR was getting the support that he needed for his potential Autism Spectrum Disorder (**ASD**) diagnosis via CAMHS. I believed that he was getting suitable support. Accordingly, I was content to close the case without further inquiry through these channels.

### *Supervision*

57. At the Relevant Time, I was supervised by DI Mangan. As set out above, the case handling was more Sergeant-led and as such I would not have regularly involved him in the detail of my caseload. If I had concerns about a particular case, though, I could raise these with my supervisor. If I did raise an issue with a particular case then the DI would consider any further action he thought could be taken, or his own rationale for closure. I could raise these cases either in person or electronically.

58. I recall that we had regional meetings to discuss general issues such as the implementation of new processes or initiatives to increase referrals or awareness of Prevent. However, I don't recall going through cases individually in those meetings. The DI would, however, carry out 'dip-sampling' of the team's casework to ensure that we were consistently at the right level in terms of closure/progression, and if they ever disagreed with a decision, they could or would intervene. I cannot recall any instances where any serious concerns were raised about either the standard of work or decisions being made. It would be more common for my supervisor to query why a case remained open rather than a closure decision. This would result in an agreement of any outstanding actions that were needed to progress the case to a decision. As a team, if we weren't comfortable that closure was the right decision, we wouldn't close a case.

59. I don't recall having any discussions with my own supervisor about this case.

### *Closure of the first referral*

60. I don't recall any specific questions that came to me about this case prior to the involvement that I have outlined above. I had a very limited role in this case, and I have outlined that in detail above at paragraphs 33 to 59. However, the key point from my perspective is that the decision to close was mine as a supervisor. As a general statement, how I dealt with a case would depend on what the key issues were, what the difficulties were, what the facts were, etc and I would assess on its merits.

61. I have given this a lot of thought, and have reflected a lot on my role in this case. If I ever thought a CTCO had made an error, had failed to check or investigate something, or that there was insufficient information, I could go back to them and ask for that work to be

carried out or to challenge their view. I could also have allocated another CTCO to the case, for example to speak to people involved in the case and reassess. I did not think that was necessary here.

62. I did not close cases until I was comfortable with the decision. In this case, two officers had been present at the visit at the home, and I was comfortable with the level of support outlined in the multi-agency meeting and knowing that both mainstream policing and a range of other organisations were engaged in AR's case. I was comfortable that while AR had a range of live issues to be dealt with, that these were not for CT policing to address. I spoke at length to both CTCOs and this was standard practice – I would want to understand their perspective on the case. If they had said they were uncomfortable with any part of the case or if they had concerns, or that their gut was telling them there was an issue to warrant referral, that would have been factored into my reasoning. In this case no such concerns were raised.

63. Aside from reviewing the PCMT, and meeting with PCs Thompson and Lawrence, I did not conduct any further checks, and as far as I'm aware, no further checks were required under the relevant guidance at the time.

64. Had I reason to believe that this case should not be closed, then I would have, upon review, made this clear. In this case, I did not have reason to believe that this case should remain open to the Prevent Team. Accordingly, I authorised closure of the case.

#### **Practical issues relevant to my involvement**

65. This section considers particular themes and issues arising from my involvement in AR's first referral, expanding on what is set out above.

#### *Joint Letter*

66. The Inquiry has referred me to the Joint Letter of 25 June 2019 ('**Joint Letter**') [JN/06-**CTPHQ000056**] from the Director of Prevent at the Home Office and the National Coordinator for Prevent. This did not constitute 'training' for the team, but rather was making clear expectations as to how issues relating to ideology might be construed or

applied in the context of Prevent. I do remember this message being communicated to the team and this was something that was very much on the team's radar. I recall that, as a team, we were very driven to stay on top of changes to guidance and protocol. As new information, guidance and/or protocols came out, we would familiarise ourselves with it.

67. I was very aware of the Joint Letter and its contents. In fact, it was something that we as a team really welcomed at the time. The guidance in the Joint Letter not only helped us with decision-making, but made clear that mixed or conflicting ideology could form the basis of a referral to Channel – that issue arose a lot. It also provided a basis to make an argument for referral in cases where an apparent fixation on mass casualties or similar was present. In cases, for example, where there was an interest in terrorism or terrorist-related activities but without a clear-cut ideology, that guidance was helpful for my decision making and for the team's assessments. Against that background, concepts such as the mass casualties or fixation/obsession with school shootings would have been an active consideration in this case – obsession with mass killings is something Prevent would be interested in. The assessment of AR was that he did not appear to have such an obsession or display other factors such as to constitute the ideology to justify a referral.

#### *Dynamic Investigative Framework*

68. The Dynamic Investigative Framework ('DIF') [JN/07 {CTPHQ000040}] was a document the CTCO would complete in making an assessment of Police-Led cases. The DIF covers a number of different indicators, and is designed to lead CTCOs through their reasoning in a case to make sure all relevant considerations are taken into account and checks are done.

69. PC Thompson, as supervised by DS McIntyre, completed the PGA on 23 December 2019 [JN/05 {CTPNW000122}] and the decision was noted on the PCMP. It was decided in the course of the PGA that the case would be police-led, meaning that the information gathering would stay with the Police Prevent team rather than being sent to the Dovetail team for information gathering. Accordingly, PC Thompson completed the PGA and then completed the DIF. One of the sections in the DIF against which a referral should be assessed relates to potential ideology/beliefs.

70. It was never the case that we thought AR's interest in mass killings was irrelevant to Prevent. In this case, it was not that the team failed to consider these points or that they didn't think any of this was relevant – it was taken into account. It is more that, having considered all of the information available and having made a visit to AR's home, it was not considered a suitable case for Channel, having explored the concerns raised in the referral. The conclusion reached after working through the concerns raised was that AR did not have an obsession or interest in mass killings. I used the DIF as part of my assessment of a case for closure to consider what the CTCO had taken into account and what the relevant factors were [JN/07-CTPHQ000040].

71. Sometimes the line between individuals showing an interest in something and those who had developed obsessions was unclear. Of course, some subjects would or could lie to officers. Often, however, if the case involved a young person, and they were not telling the truth or where they said very little, for example, we would be approached by their parents expressing concerns about their child's behaviour. That was really quite common. Other times, the parents might be very quick to say their child was not a terrorist or a criminal, but would report things they have said and done as matters of concern. As I understand it, at the home visit, AR said very little if anything on those subjects (mass casualties, school shooting, etc), though he expressed discontent and anger at other things in his life. In AR's case, the CTCOs spoke with his father who did not consider the school's concerns were representative, and who did not express any concern about obsessive behaviour. In other similar cases a lot of relevant information came from family members as they were the people who know the individuals the best and have the most access to them. This was often most apparent in fixation or obsession-based cases as such an interest is usually hard to hide from family members.

72. I do not consider that the team in this case missed a clearly present ideology that could have formed the basis of a referral. I believe that we noted the information on this and considered it. In terms of intent, and the FIMU assessment of that, there were indicators of violent intent and violent actions that were carried out, but those were considered to be criminal rather than terrorist violence, and that the surrounding intentions were criminal rather than terrorist. That is reflected in the FIMU assessment and reinforced by the fact mainstream policing were dealing with his criminal behaviours.

*JAT Assessment*

73. The JAT assessment was dated 13 December and was noted on the PCMT. The JAT assessment was made before the CTCOs visited AR's home, and prior to the CTCO assessment [JN/05: CTPNW000122].

74. I am referred to the section of the JAT assessment which states:

*"preference would be for continuance and recommend Dovetail team and Channel Panel are sighted with regards safe-guarding and AR vulnerabilities going forward"*  
[JN/08: CTPNW000146]

I am comfortable that I would have seen this document at the time. My view of this comment is that a given case is either suitable for Channel, or it is not. I would not have sighted Channel/Dovetail about vulnerabilities or safeguarding unless the case was being referred. At the point that I reviewed the case, I did not consider it was suitable for Channel or that it would have been adopted. AR had been assessed as not having relevant ideologies or to be developing any relevant ideologies or obsessions, and that his behaviour and actions were not CT/DE relevant. I did not consider that the necessary criteria were met for referral, with regard to vulnerability to being drawn into terrorism, or risk of radicalisation. As such I would not have considered it appropriate to sight Channel or the Dovetail team.

75. When I came to assess the case, the PCMT tracker had what I would have expected it to have on it in terms of level of information. This included the write-up of the visit.

*PCMT entries relating to JAT involvement*

76. The PCMT on 16 December recorded that this case had been "*returned from the JAT for a prevent referral to be inputted onto the pcm tracker and referral to channel/dovetail*" [JN/05: CTPNW000122]

77. For context, I should make clear that this assessment was made quite early in the process, prior to some of the CTCO assessment work that was being done. Looking at this now, I

did think that it was a fair assessment in terms of likelihood of referral to Channel/Dovetail at the time it was made, because there were matters of concern in the Prevent referral.

78. An earlier assessment by Sgt. McIntyre in the process indicated that the case was not suitable for escalation to Channel but that it should follow the Police-Led route [JN/05-CTPNW000122]. I wasn't part of that initial decision, but having reviewed the entries on the PCMT, I can confirm that I am comfortable with her decision to seek further information about the referral before coming to a conclusion.

79. I am also referred to an email from [Officer B] dated 17 December 2019 which stated:

*"JAT assessment for prevent visit to establish ideology and consideration for Channel/dovetail" [JN/09-LANC000175/150-152]*

80. I would have only been aware of this email if it was copied into the PCMT. This language in my view reflects that the Prevent visit would be designed to enable 'consideration' for Channel/Dovetail, which followed. I have no further comment to make on that point.

81. Overall, with regard to the JAT assessment, the information had changed by the time that I was assessing it, in that I had the benefit of understanding what had happened with regard to AR's arrest, the multi-agency meeting and the different agencies involved through that, and the visit the CTCOs made to AR's home. I was aware of the JAT assessment when making my decision and that was factored in. As set out above, I would not engage directly with JAT and had no direct contact with them in this case.

*Decision to progress case as Police-Led*

82. In terms of the detail of why AR's case was considered suitable to be handled as a Police-Led case, rather than submitted to the Channel Panel, I didn't make that decision and I don't remember being consulted in relation to it. I don't think it would have been necessary for me to be consulted in this case either, as it was not on the face of it contentious. In terms of the substance of that decision, beyond what I say above at paragraph 78, I don't think it would be helpful for me to speculate, having not been involved.

*CTCO visit with AR*

83. I have considered whether the visit, and further information gathering, could have been carried out following a referral to the Channel Co-ordinator.
84. Technically, the visit could have been conducted following a referral to the Channel Panel, exceptionally. We could have made that request, however, that would have been unusual. In fact, it would have potentially interfered with our ways of working with the Dovetail/Channel team in that it would blur the lines between the CTCO/Prevent role and the Channel role. At that stage, it was felt more information was required, which is why the visit took place.
85. Any decisions we made were to ensure that we had the best information to inform any potential referral to Channel. I don't think there was enough information to warrant us referring to the Channel Panel at that stage, which is why the visit was considered necessary. Had that visit raised concerns or provided information that met the threshold for referral, we would have referred it.

*PCMT entries relating to device searches*

86. I note PC Thompson's rationale for moving the referral to pending closure on 15 January 2020 [JN/05 **CTPNW000122**], which is included on the tracker, stating:

*"I have advised agencies to re refer to prevent should they have any more concerns in the future and also if any relevant information is found on his internet history from the school or from his devices."*

87. I have considered the fact that there were checks being done on AR's devices following his arrest, and potentially searches being done by the school on internet search history, and whether I should have or could have waited for the results of those.
88. I have also considered whether I would have expected further work to be done to resolve those matters before closing the case. Regarding the school internet history, my assumption at the time would have been that this information was not logged by the school, - they had not provided any internet history, and there was information on the PCMT

suggesting they could not access such information. In any event, the school were encouraged to re-refer in the event of any further concerns (and went on to do so in other contexts). No further information or concerns relating to the results of any further searches were provided to Prevent. I did not consider it proportionate to chase this any further.

89. In relation to how that would have impacted the progress of the referral, had the school found any further information, they were encouraged to submit a further referral, or request that the first referral be reopened in light of new information. I am comfortable that had further information surfaced from those searches, the referral would have been reopened. If the CTCO had received further contact either in person or electronically, we would have submitted any new information to FIMU for assessment.

90. Similarly, with regard to devices seized in December 2019 in the course of AR's arrest, I did not consider awaiting the results of these searches and/or checks before closure, because I was comfortable that all the initial concerns had been considered and addressed, and was satisfied that the case was not CT/DE. Had new or concerning information arisen from those searches, that information would have been communicated to the Prevent team, at which point the case would be re-opened or a new referral opened if appropriate.

91. I also considered this against the background of the various accounts given by AR about his browsing history and his intended use of a knife in the PCMT, along with the fact the CTCOs were comfortable he did not carry an obsession, and the fact his parents expressed no concerns. I considered this as part of my own assessment. I considered the possibility of disguised compliance and that AR could simply be telling us what we wanted to hear. His father's view had an impact on my view of that. My experience had been that parents would vocalise their concerns if they were worried about what their child was looking at on the internet. This was not the case in this referral. As such, I felt that overall it was proportionate to close.

#### *FIMU Assessment*

92. I have considered further FIMU's assessment that the first referral could be 'closed to Prevent'. I understand that there were two entries recorded on the PCMT which contained FIMU's assessment of the case in the context of closure:

- a. On 8 January 2020, PC Thompson recorded: *"FIMU have assessed that the case can now be closed to prevent there are no CT/DE concerns present at this stage; the relevant agencies are supporting the subject, all agencies aware that if any new concerns are identified they can refer to prevent."* [JN/05: CTPNW000122].
- b. On 15 January 2020, PC Thompson updated the case status from 'Police Led' to 'Pending Closure'. Within her rationale, she noted: *"...This information has been assessed by FIMU as suitable for closure at this stage."* [JN/05: CTPNW000122].
93. My understanding of the FIMU's wording *"closed to prevent"* [JN/05: CTPNW000122] meant that the information and intelligence received was not suitable for Prevent to keep the referral open in any capacity. I am aware that it is for the assigned Prevent CTCO to make the decision on case closure, which I, as a Supervisor, could either agree or disagree with. In this case, I agreed with PC Thompson's closure rationale for the reasons set out above. While this language from FIMU might look like a direction to us from them, that is not the case. There was no suggestion that because they recommend closure, that is necessarily what would happen.

*My assessment of AR's case*

94. I authorised a status change on 31 January 2020. In my rationale on the PCMT, I stated: *"As detailed in the PCM the concerns relayed to Prevent have been explored and do not appear to be linked to an Ideology or a vulnerability to radicalisation. There are vulnerabilities and needs which are being met by the mainstream safeguarding and this case can be closed to Prevent."* [JN/05: CTPNW000122].
95. I considered at the time and have reflected on whether I thought AR had a terrorist ideology. As part of my consideration, I have considered views AR expressed about the Manchester Arena terrorist attack, and his interest in that. I view that as a really concerning and stark comment. However, when the CTCOs went to visit AR, they talked to him and his father and understood that he was in a pupil referral unit at school with closer supervision, and those remarks were made in school. Those conversations and the context of those remarks led officers to believe that while these comments were concerning, in light of his vulnerabilities (including his ASD indicators) he did not hold a terrorist ideology or an interest in terrorism. I agreed with that for the reasons given above.

96. I have considered whether fascination with extreme violence or school/public mass casualty attacks can be considered an ideology and whether that could apply in this case. I have noted above that this could be considered an ideology to inform a referral to Channel, but I set out some particular thoughts relating to the facts of this case below to outline my rationale for concluding that this did not apply in this case.

*School massacre ideology on the PCMT / the Joint Letter*

- a. School massacre ideology was entered on the PCMT as 'ideology' for the first referral, and there were sections on ideology and intent in the DIF which referred to mass killings. In line with the Joint Letter guidance [JN/06: CTPHQ000056] this was the area of concern in terms of ideology that most closely aligned with the facts of this case, and this reflects that these matters were being actively considered by the Prevent team. On balance, we assessed that he did not have that fascination or obsession with mass casualties that we were aware of it and taking it into account, hence it being reflected in the PCMT.

*AR's comments and behaviours*

- b. The referral stated that AR had complained about being unable to look at guns on the internet in class, and made reference to a picture of a severed head in an art class [JN/05: CTPNW000122]. There was also reference to AR 'researching' school shootings in America. He also made various comments at school with reference to murder and violence. I was also aware he had assaulted a fellow pupil, had been arrested for a violent offence, and that he had brought knives to school. AR had also complained of being bullied.

97. I recall considering these matters. They were of course concerning. Some of the comments made in school should be set in context – for example, with regard to AR complaining about wanting to look at guns on the Internet. My understanding in that respect is that the class had been given images of the video game, Call of Duty, to colour in an art lesson. AR had questioned why they were permitted to see images from a violent video game, but he was not allowed to look at pictures of guns on the internet. Similarly, with regard to AR 'researching' school shootings, my understanding was that he had been

looking at news articles on the subject. This is a very different context to him researching or planning something similar. All of these points set out at paragraph 96.b. were worked through by the CTCOs during the home visit to AR and his father. These comments were definitely concerning, but ultimately they were all actively considered in making the assessment as to whether this case was CT/DE relevant. While it may have indicated violent tendencies, the CTCOs did not consider the case to be CT/DE relevant, in light of AR's vulnerabilities. I agreed with that assessment for the reasons set out above, not least because of the involvement of support agencies, and his behaviour being dealt with through the mainstream justice system.

98. I considered whether AR should be referred to Channel based on an unclear, mixed or unstable ideology, consistent with the reasoning set out in the Joint Letter [JN/06-CTPHQ000056], at the outset. If there had been information indicating a fixation or a mixed/unstable ideology, it may be that he would have been a candidate for referral, however at that early stage in the case handling, a decision was made that more information was required to inform conclusions on referral. I don't think it is helpful to speculate on the rationale for that initial assessment, given I was not involved, though, as referred to above, I was comfortable with the conclusion that more information was required.

99. I have considered whether I would have referred AR to Channel if all three referrals had consistently related to the same theme, for example right wing extremism or Islamist extremism. If he had done something that indicated right wing extremism or Islamist extremism ideology, and we had three clear examples of that, then a clear ideology might have been easier to spot. However, I would want to be as clear as I can that my decision not to refer to Channel wasn't because he did not have a defined ideology, or because I had not considered whether he had an unclear, unstable or mixed ideology. It was based on my overall assessment of the risks to being drawn into terrorism or the risk of radicalisation – and this assessment included my view that he did not appear to have had an obsession with mass killings. It is worth noting also that in this case, I was involved only in the first referral, and so there were no live issues of the impact of cumulative referrals or emerging themes from multiple referrals.

100. My supervisory role required me to balance my assessment of AR's ideology against the assessment of the other components of the PCMP, including his complex needs, levels

of engagement, grievance, intent, capabilities, escalations, triggers and warnings. The assessment of the CTCO was that while he didn't have an interest in mass killings, he was clearly vulnerable. He was in a pupil referral unit receiving additional support at school, and there were strong indications that he needed a diagnosis and support for ASD. He may have needed mainstream safeguarding support. Bullying was assessed as a vulnerability/grievance, but our assessment was that mainstream safeguarding could assist with this. Overall, in terms of complex needs, engagement, and grievances, these were observed by the CTCO officers, and he was not assessed by them or by me on the information I had as having a CT/DE vulnerability. In my view he was receiving a lot of support for these issues already without CT/DE intervention.

101. In terms of the capabilities, escalations, triggers, etc, they were recognised. They were, however, known to mainstream police and related to criminal behaviour rather than CT behaviour requiring CT/DE intervention. If the case was to be reviewed now, after all three referrals and knowledge of the incident as it happened, then it would be possible to read it through a CT lens or consider it to be CT relevant, but on the information available at the time, I assessed that these factors had been taken into account and did not warrant a Channel referral.

102. I have considered whether there were, at any stage, any reasonable grounds to suspect that AR was vulnerable to being drawn into terrorism. I will not speculate on the views of others dealing with this case in its earlier stages, because I didn't review it as a supervisor until it came to closure. I don't think we necessarily had enough evidence to get the case through to Channel at any stage, but when it came to me to consider, I had quite a lot of information to help me make that assessment and I did not think the criteria on vulnerability to being drawn into terrorism and risk of radicalisation were met.

#### *AR's pending ASD diagnosis*

103. I have considered my views on the effect of AR's ASD indicators on the risk that he presented. The consideration of ASD in the course of Prevent referrals is quite challenging and it features in a number of Prevent cases. I felt I always needed to be careful in this respect - I'm not an expert in autism. Sometimes the presence of or potential of ASD will increase the necessity of Prevent safeguarding, especially if it manifests in a fixation about an ideology. In this case, it was something that I considered and the CTCOs did explore

it. In particular, both the CTCOs and I explored whether he had any fixations and how that might interact with ASD traits. AR didn't present as having a fixation that you sometimes see in people with an ASD diagnosis. I didn't see it as something that increased the risk in his case. The fact that he was awaiting an urgent diagnosis reassured me that mainstream safeguarding was addressing one of the potential causes of his behaviour and the issues he was struggling with at the time.

104. Further, we were aware that he was already receiving support and that he had been flagged for additional support going forward which indicated the right assistance was being put in place through other channels.

#### *Case closure*

105. I have considered whether it would have assisted me to have received the charging decision in relation to the December violent assault, which involved possession of a knife and offensive weapon (hockey stick). I had the information that he had attended school with a weapon when closing the referral, and that he had been arrested for that, as well as the fact he had previously taken knives to school. I was aware that police were dealing with it, and that information had been fed back to FIMU. He had confessed and there was no doubt about what had happened. Accordingly, unless the charging rationale had any materially different information, then I don't think that the charging decision would have changed my decision to close the referral.

#### *CAMHS assessment*

106. I note the strategy meeting on the 6 January 2020, by which point AR had received his first CAMHS assessment. No mental health concerns were identified, but it had been noted that ASD was "apparent" and a diagnosis was required urgently. AR was due to attend a CAHMS appointment on 21 January 2020 [JN/05 CTPNW000122].

107. I did not consider awaiting the outcome of the CAHMS appointment prior to closing the referral. We had reached the point where we considered that AR did not have a relevant obsession/ideology. I was of the view that we could reassess and reconsider if new information was to come to light. For example, had he said something in that appointment that would have indicated that he had a relevant ideology, then that may have changed

the outcome of the assessment. However, it would have had to be something specific to the Prevent criteria and had such information arisen, I would expect that information to be communicated to Prevent as appropriate.

### **Involvement with other agencies**

108. In terms of my involvement with other agencies, I didn't actively contact or directly deal with other agencies as part of my assessment. I reviewed the information that I was presented with. However, my observation was that people appeared to be open and supportive of the process and the information sharing. That engagement with external bodies was more likely to be done by CTCOs in the course of their assessment.

109. It wasn't the case that I would have just expected other agencies to manage AR's risks – ultimately I took the view that the risks were not CT/DE and were not suitable for Channel. I did consider that he needed support, but that they were being dealt with through mainstream policing and other organisations. There were a number of different issues and risks evident. In terms of the criminal behaviour, he was going through the legal processes for that. Social services were carrying out an assessment. Additional needs assessments were going to be carried out for him. In my view, those assessments by appropriate bodies were going to address a lot of the vulnerabilities that we were concerned about.

### **Reflection on events**

110. On reflection, I have considered whether there are any things I or CTPNW could have done differently. In doing so I have considered the three external reviews that have been carried out. I have been shown the relevant recommendations arising from the Prevent Learning Review ('PLR') and the Dignate Review, and Lord Anderson's review.

### *General reflections*

111. Overall, my view is that at the Relevant Time, I was working within the criteria of the Prevent scheme and within the limitations of the processes in place. There are undoubtedly things that we could have done differently but this needs to be considered against the background of the guidance and the relevant frameworks at the time, and we would have been constrained by that. For example, Prevent itself as a team did not have

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powers to have a phone read, even when the phone was in the possession of the Police. We were to an extent limited to the investigative work we could do off our own bat. This is due to the clear separation between Prevent and Pursue and I knew from the FIMU assessment that there would be no investigative work being undertaken by the Pursue teams. The team was, however, in my view, well-resourced in terms of number of staff and training, and we tried to use the resources we had as well as we could.

112. If the fact the subject would go on to commit such an atrocious act four and a half years later had been known at the time the case would undoubtedly have been a priority for Prevent. I have detailed my thinking as to why I did not believe that he was suitable for Channel at the time base on the information available to me, but I have also considered the other routes and outcomes that could in theory have occurred. These include consideration of circumstances where a different decision had been taken and AR had been referred to Channel and he had been adopted by that programme, neither of which are a given.

113. In terms of addressing potential issues or difficulties arising in similar cases in the future, there are several challenges facing Prevent that would benefit from consideration more generally. The first area is around individuals being either dishonest or not being open, either during the PGA or in the event of a referral to Channel. Truthfulness is clearly a challenge in many areas and especially for Prevent as participation with the Channel panel is voluntary. If individuals agree to participate and are allocated an intervention provider but deny having views for the intervention provider to explore and challenge, the process is unlikely to work. It requires genuine engagement from the individual. Whilst these issues did not necessarily arise in this case, when I reflect on the programme more generally, I can foresee these issues arising and believe they merit consideration to develop the response in future cases.

114. In terms of guidance, I consider that the resources available were helpful. I do believe, even in hindsight, that I was making decisions based on the guidance in place at that time. The demarcation between criminal behaviour and terrorism-related behaviour has probably created issues in this case, in that while I consider AR's case fell outside of the Prevent guidance, it raises questions of how cases like that should be dealt with instead. The key issues arising here were being dealt with through other avenues which reinforced the idea that this was not a CT/DE case. The threshold for referral to Channel and to Prevent is low, but the criteria is very specific.

115. The incident at the school for which AR was arrested involved a violent armed attack with serious intent and it was known at the time that there were a number of people who he felt aggrieved about. This was assessed at the time as a criminal rather than a terrorist attack and this assessment was again confirmed by FIMU when it, along with all the other factors in the first referral, assessed that it was not a CT matter. This is the context in which the decision was made. There may be an argument that he only 'slightly' fell outside of the Channel thresholds, but I do not think this is a helpful way to categorise this - the case is either suitable for referral or it is not and this was my understanding of the guidance at the time.
116. I did find the Joint Letter [JN/06-CTPNW000134] very useful, and I have already explained why I did not consider this applied here.
117. There are so many different aspects to this referral that each member of the Prevent team came to the same view on. Unless we had different information that indicated that level of obsession or fixation, I think I would have come to the same conclusion. All the efforts the team made was all intended to do all the work necessary to get to the right outcome.
118. In terms of whether it would have been helpful in terms of the overall outcome to have referred this to Channel. It is hard to say. In my view, because based on the information I came to a clear decision that the relevant criteria had not been met, it is very unlikely that Channel would have accepted the referral, and from Dovetail I would have expected a section 36 closure had we tried to refer it. Again, if I thought the criteria was met or there was an argument to be made, I would have done it.
119. In terms of going forward, I am not familiar with the new guidance on fascination with violence. I gather the reviews have indicated that the case should have been referred to Channel. I do not think, in the absence of additional or new information, that I would have reached a different conclusion, and have set out in depth above why I consider the decision made to be reasonable.

*Reflections on the Prevent Learning Review, Dignate Review and Lord Anderson Review*

120. I have considered the three reviews that have been carried out, and overall would say that insofar as relevant to my role, I am comfortable broadly with the lessons identified and recommendations made.

*Reflections from the PLR*

121. I have considered the lessons arising from the PLR, and outline some thoughts in response insofar as relevant to my involvement. I note their recommendation that there should be a standardised 'product' to form the basis of information sharing by FIMUs to Prevent teams. I believe that this is an ongoing issue, and that a standardised format would be helpful to ensure consistency [JN/10-CTPHQ000055].

122. I note also their recommendation that CTCO policy should be reviewed to require all outstanding enquiries or information gathering to be completed prior to closure [JN/10-CTPHQ000055]. This makes sense in principle, but would need to be considered in the context of the powers the Prevent team have, and the limitations on the legal powers of supervisors at that time. Prevent does not have an investigative function, so would not be able to order phone searches, etc, if they were not already being done – I could request for this to be done only.

123. Regardless of my powers/abilities in my post at the Relevant Time, I agree that the guidance should be that the Prevent team completes or follows up on all live enquiries before closure – I think that is reasonable. However, that guidance needs to be clear in terms of whose responsibility it is to oversee and ensure completion of each enquiry to reflect the powers of relevant bodies – for example, if there is a want to access a phone or internet search history. Guidance on what constitutes 'reasonable enquiries' in the context of Prevent information gathering would be helpful, alongside advice for what to do should information from additional sources not be returned (or, for example, an OIC no longer needs information from a phone for their own investigations, but Prevent would want the phone to be read). We would also need to be careful about which responsibilities the Prevent team could properly take on and where the boundaries lie in terms of responsibility. It would also need to be clear that it would be inappropriate for anything that could be perceived as fishing to occur.

124. The PLR recommends that it should be considered whether referrals involving children and/or complex needs should be routinely referred to Channel (unless immediate closure is the chosen option, or the CT risks are deemed too high for Channel [JN/10-CTPHQ000055]). This is a valid point to consider, however, practically speaking, I suspect that this may create a significant issue in terms of volume. I would not necessarily disagree with this, but consideration would need to be given as to the practicalities of that, but also what that would mean in terms of application of the Channel criteria.

125. The PLR also recommends further training for supervisors to ensure that when closures are being signed off or assessments completed, that there is a record of all behavioural factors and motivations captured [JN/10-CTPHQ000055]. There was also a recommendation that assessments contain a consideration of 'Prevent relevancy' expressly. I am aware that the recently-introduced Prevent Assessment Framework may have made a difference in this respect, but overall this seems like a helpful recommendation that would assist supervisors. Any review in general of training and guidance would I'm sure be helpful – there probably were some misunderstandings about FIMU's work that guidance might assist with – but I would welcome any training designed to streamline matters and improve ways of working, including on matters such as vulnerabilities and their impact on case handling.

#### *Record-keeping*

126. In particular, I would like to address the general theme across all three reports that our record-keeping could have been better. While I do accept that not every consideration was recorded, the concerns that were flagged in the initial referral were all explored. Whilst AR was really vulnerable, I was confident that those vulnerabilities were being dealt with via mainstream policing. Had there been more to consider, or had the case been contentious, then the record-keeping would have likely been more detailed. The fact that my own rationale was so brief reflects my thoughts at the time that it was clear from the information in the PCM tracker that the case did not fit the criteria for Channel.

#### *Recommendation of JAT team*

127. The Lord Anderson review makes the following observation:

*“The JAT assessment, like that of FIMU, is not intended to be determinative of whether a referral to Prevent is made. It is noteworthy however that the JAT assessor recommended referral to Channel whereas the CTCO and the Supervisor, as will be seen, did not. The CTCO and Supervisor have responsibility for the final decision as to whether or not an individual is referred to Channel. The JAT document referred directly to AMR’s arrest and assault.” [JN/11-CTPNW000114]*

128. I have explained in detail above the interaction between the JAT assessment and my own recommendation, and do not have further comment to make.

*Dignate Review*

129. I note the reference made in the Dignate review [JN/12-CTPHQ000028] to the possibility that there was an overall reluctance to refer to Dovetail. I would disagree that there was a reluctance to pass it to Dovetail – if anything, I would say that the Prevent team would have been more inclined to make the best argument it could for referral. I can only speculate that the perceived reluctance of referring cases to Dovetail came from the data which showed that, proportionally, a lot of cases that came to Prevent were not referred to Dovetail. We always did our best to gather the relevant information to make an informed decision on whether to refer. We sought to refer those which we felt were suitable for and would be accepted to the Channel Panel, though from time to time we referred cases that the Channel Panel felt did not fit the criteria and were not then adopted. If we did not think the case met the threshold for the Channel Panel, we simply would not refer it. Our aim was to put together the strongest case for referral and consider that against the criteria.

130. It was also flagged in the Dignate Review [JN/12-CTPHQ000028] that there were a lack of open source checks. From our perspective in Prevent, FIMU had already completed some checks and, at that time, I don’t believe that we had open-source check trained officers. This is a specific skill set on how to use a particular system, and training on this subject was not something I believe CTCOs were expected to undertake for this role at the time. This is something that I would have welcomed in the team and would say would be helpful now. While I am not sure it would have affected the outcome in this case, I think in principle it would be helpful and good practice.

**Improvements**

131. I have reflected on any improvements that could be made in the Prevent team, or that have been made since these events and the incident last year. I should note that I haven't been involved in the case, or in Prevent/CT since I left the team in July 2020. As such, I am not aware of any improvements that have been made by CTPNW since then.
132. In terms of improvements that could be made going forward, I believe that CT/Prevent guidance could be strengthened to make it clearer which team should be dealing with the case and at what stage. For example, it might help to have more guidance on whether a case would be better dealt with by mainstream policing, as opposed to CT policing, or where the line is between CT and criminal behaviour in light of these types of cases where the ideology is less clear but there are violent tendencies.
133. I would also like to see more resources for Prevent officers to use where an individual is not engaging with the Prevent team. For example, it might be sensible for the Prevent team to be able to make Prevention Orders against individuals who are not engaging with support, especially where there is concern that further crimes might be committed or there are concerns about behaviour escalating.

**Other matters**

134. I do not have any further matters that I would like to draw to the Chairman's attention.

**Statement of Truth**

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

Signed: **Signature** \_\_\_\_\_

Dated: 13/08/2025