Witness Name: Rachael Treharne
Statement No: 1
Exhibits: RT/01 – RT/12
Dated: 21 August 2025

**THE SOUTHPORT INQUIRY**

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**WITNESS STATEMENT OF**

**RACHAEL TREHARNE**

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I, RACHAEL JUDITH TREHARNE, will say as follows:

## Introductory matters

1. My name is Rachael Judith Treharne. I am a retired police officer.

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 a small amount of 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 8 August 2025.

3. First, I would want to convey my sincere condolences to anyone affected by the Southport attack and its aftermath, and in particular the victims of this attack and their families.

4. This statement addresses the matters raised in the Rule 9 request, which relate broadly to my involvement in AR's case, my reflections on the handling of this case and my role in it, and any improvements that have been or could be made in this general area of work.

*Preliminary matters*

5. I should say at the outset that I have extremely limited recollection of the specifics of this case, to the extent that until the Inquiry contacted me, I had no direct memory of having had involvement in these referrals. These events took place a number of years ago, and my policing career required me to deal with a very high volume of cases across a wide range of subjects and disciplines. For that reason, I hope the Inquiry will understand that I cannot remember the details of every individual matter I was involved in, particularly where they occurred some time ago. With that in mind, in order to assist the Inquiry insofar as I can, I have reviewed the relevant documents from that time and have considered those alongside my memory of the way in which the team operated and the way cases were handled at the time. Where I rely on those documents rather than my own direct memory, I try to set that out expressly.

6. I know that AR was the subject of three separate referrals to CTPNW Prevent between December 2019 and April 2021. I was involved in the decision making only with regard to the second and third referrals. The second referral was sent to the Prevent team on 1 February 2021. I authorised changing the status of the case to 'closed' on 17 February 2021. The third referral was sent to the Prevent team on 22 April 2021, and I agreed on 7

May the case could be closed, subsequently authorising the status of the case to be changed to 'closed' on 10 May 2021. That was the last of my involvement in AR's case. I expand on this at paragraphs 31-56 below where I discuss in more detail my role in these events. Throughout this statement, when I refer to 'the relevant time', I am referring to the period from 1 February 2021 to 10 May 2021 (i.e. the period of my involvement).

7. I understand that chronologies of the key decisions relating to AR's second and third Prevent referrals are set out within section 5 and 6 of the CTPNW corporate statement, and so I do not repeat those in full here.

8. I have limited my use of technical policing language and abbreviations where possible, and, where it is necessary to use them, I have tried to explain these.

*My background and relevant experience*

9. I joined the police force in 1992 in Cleveland. I worked predominantly as a uniformed police officer until I took a career break from 2002 through to 2005. At this point, I returned to Cleveland Police and became a Detective in the Child Abuse Investigation Unit. In March 2008, I sat and passed both the Sergeants' exam and the National Investigators' Examination. In 2010 I completed the Initial Crime Investigators Development Programme, and in 2012 I completed a UCPD Leadership and Management Development course. I worked as a Sergeant in temporary roles within vulnerability, child protection and domestic violence units until 2014, when I left Cleveland Police and transferred to Cumbria Police. I worked as a uniformed officer briefly before working in the Criminal Investigation Department and Public Protection Unit.

10. In November 2018, I began working in Prevent as a Counter Terrorism Case Officer ('**CTCO**'). In 2020, I moved out of Counter Terrorism Policing and worked in the Safeguarding Hub as a temporary Detective Sergeant. Also that year, I passed the promotion board and was promoted into the post of Detective Sergeant within the Prevent team, acting as a Prevent Supervisor from January 2021. At the relevant time, I was seconded out from Cumbria Constabulary to Lancashire as part of CTPNW, which continued until I left Prevent in 2022.

11. After leaving Prevent, I went back to Cumbria Police, initially into the Uplift Recruitment Team, and then I moved into the Positive Action team. On 30 April 2025, I retired from the police force, with thirty years' service.

*Prevent and Channel*

12. While I will not in this statement go into detail outlining the functions of Prevent and Channel (and I have been informed that 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** aims to prevent people from entering into terrorism or supporting terrorism;

    b) **Pursue** focuses on disrupting and investigating potential terror attacks;

    c) **Protect** focuses on enhancing security measures; and

    d) **Prepare** aims to mitigate the impact of any attacks that cannot be prevented.

14. The 'Prevent duty' was introduced in legislation in 2015. Section 16 of the Counter Terrorism Act 2015 ('**the 2015 Act**') placed 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.

15. The police are heavily involved in the Prevent strand highlighted above. Each specified area of England and Wales has a designated team that deal with initial referrals for that geographical area. Referrals can be made by any person (including, but not limited to, schools, organisations, and members of the public) who is concerned about the behaviours and actions of another person and considers there may be a Prevent-related risk. The Prevent strand of CONTEST is designed to facilitate early intervention with support for individuals showing signs of relevant vulnerabilities or risks. The Prevent team receiving the referral will review it and make an assessment, based on the information provided, and also from information the team itself gathers. The outcome of this assessment will inform next steps, including consideration of what support the individual has in place or might benefit from.

16. The assessment is multi-faceted and comprises a vulnerability assessment and consideration of the risk to that individual of radicalisation and their vulnerability to being drawn into terrorism. Each case is determined on its own facts and merits, and though there is no strict criteria for referral, one possible outcome is to refer the individual to Channel.

17. Section 36 of the 2015 Act sets out a duty on particular authorities to provide support for people vulnerable to being drawn into terrorism, known as 'the Channel duty'. Channel forms a significant part of the Prevent strategy. Participation in Channel is voluntary and if

the case is adopted, usually would involve the convening of a Channel panel, which would help to discharge the Channel duty. These panels are constituted of multiple agencies that consider the vulnerability of an individual to being drawn into terrorism with the aim of implementing interventions to steer the individual away from that.

18. In the course of this statement, I make reference to 'Dovetail'. Operation Dovetail was a pilot programme in place at the relevant time. The initiative aimed to move 'ownership' of Channel from Counter Terrorism Police to local authorities. Each local authority had Channel coordinator that took on functions previously dealt with by the Counter Terrorism Police team. The functions and relevant criteria for referral remained the same, but the processes were slightly different as local authorities took on more responsibility for coordination.

*CTPNW team structure*

19. Before I set out the detail of my own role as a supervisor in the Prevent team, it might be helpful for me to provide some background information as to how the Prevent team was structured at the relevant time.

20. At the relevant time, I was a Detective Sergeant in the Prevent team, alongside Sgt. Kathryn McIntyre. From memory, the Prevent team at that time was made up of between eight and ten Counter Terrorism Case Officers ('**CTCOs**'), subject to staffing fluctuations, with Sgt. McIntyre and I acting as Prevent Supervisors, sharing the management of the team of CTCOs. We were overseen by Detective Inspector Darren Mangan. The team dealt with Prevent referrals from Cumbria and Lancashire. Supervisors and staff in Lancashire were co-located in the same office, with the Inspector also on site in a separate office space. The officers working from Cumbria were based within Cumbria. The team worked across Cumbria and Lancashire. We split the management of the team by geographical location, but both Sgt. McIntyre and I were happy to answer questions from CTCOs on their caseload and would cover each other's work when the other was on leave or otherwise unavailable.

*My role*

21. At the relevant time, I was a Sergeant within CTPNW, acting as a supervisor in the Lancashire Prevent team. I formally managed half of the CTCOs in the team, including two in Cumbria, but Sgt. McIntyre and I worked very closely together across the whole team. My role as a Prevent Supervisor mainly involved supporting and managing CTCOs day to

day; taking joint responsibility for CTCO decisions within Police Case Management; and supervising and quality assuring all CTCO Prevent Case Management ('**PCM**') and ensuring its timely completion. When I started this role in January 2021, it was during the Covid-19 period and there were therefore additional logistical and welfare-related issues to deal with. At the time the team was busy, dealing with a relatively high volume of cases, but was quite well resourced.

22. In terms of supervising the PCM process, my main responsibilities were to:

    a) ensure that all received referrals were allocated and that regular updates on all PCM actions or decisions are recorded on the Prevent Case Management Tracker ('**PCMT**');

    b) supervise the completion of Dynamic Investigation Frameworks ('**DIFs**') completed for Police Gateway Assessments ('**PGAs**'), seeking to ensure they were completed within 5 working days of receipt from the Fixed Intelligence Management Unit ('**FIMU**');

    c) ensure any referrals received by CTCOs directly from partners or members of the public were submitted to the FIMU for de-confliction and "PURSUE Assessment" prior to any CTP-Prevent work commencing;

    d) supervise Gateway Decisions and the rationale applied in each such decision;

    e) assess any given case's suitability for closure and take appropriate action to close it; and

    f) ensure the wellbeing of CTCOs and the team generally.

23. Each morning, Sgt. McIntyre and I held a meeting with the CTCOs to discuss what everyone was working on, plans for the day, and key priorities. This was held in the office, but with an online option to ensure inclusion of team members based in Cumbria, and any other team members working remotely on that day to ensure appropriate social distancing. This was an opportunity for issues to be raised and discussed. I tried to split my time between the Cumbria and Lancashire offices to ensure I could spend time with team members in both locations. During the Covid-19 pandemic, we implemented a rota system for office attendance to ensure safe working distances. The daily meeting also allowed the supervisors to check in on the welfare of the team, and this became particularly important during the pandemic as the team worked remotely more often than before.

24. Prevent referrals came to the team through a team inbox. The cases were usually allocated to CTCOs based on geographical area as we had two CTCOs servicing each area that fell within our team's remit. This allocation process was subject to workload and capacity

concerns, as some areas received more referrals than others. We were conscious to ensure the workload was balanced, and to do what we could as supervisors to create a harmonious team. The allocation of supervisors to cases operated in a similar vein. Efforts were made to split the supervision of the cases in terms of geographic location – I broadly took responsibility for Cumbria and North Lancashire, whereas Sgt. McIntyre would cover cases coming in from other parts of Lancashire. We did, as mentioned above, cover each other's work where necessary and worked closely together. As a general statement, I worked closely with the CTCOs, discussing the detail of their caseloads.

25. At the time of the second and third referrals, I was managed by DI Darren Mangan. I met with him regularly in person, though would not escalate the substance of individual cases often. Where I did, this was more likely to be Police-Led cases or particularly contentious cases. Usually, I would escalate broader issues such as staff welfare, issues relating to interactions with Channel, or anything I was particularly uncertain about. The day-to-day running of the team and oversight of individual case handling was largely done by us as Prevent supervisors.

26. While I do not remember the specific detail and dates, from memory, I initially had technical issues obtaining access to data systems that were quite fundamental to my role, including the team's shared inbox. As I was employed by Cumbria Constabulary, and on secondment to CTPNW, I had equipment from Cumbria, from which Lancashire systems could not be accessed and which was not compatible with the Lancashire office systems. As such, for a period of time, other staff members with access would check the inbox and would produce extracts and printouts of relevant information for my consideration, which was cumbersome and time consuming. This issue persisted for some time. In the course of preparing this statement, I have had confirmation that I was given account permissions to access the necessary Lancashire systems on 27 January 2021, so a number of weeks after I started in post. It was also noted alongside those permissions that there were additional steps that needed to be taken before I could access the Prevent hard drive. I do not know on what date those further accesses were granted and the relevant ICT team in Lancashire could not provide this information. While I had permissions from 27 January 2021, from memory it took some further time to obtain access to the full range of systems required in my role, including the team inbox. I did after a time receive a Lancashire laptop and successfully logged in, and so would work off a laptop for each area, accessing the Lancashire laptop to monitor the team inbox.

*Training*

27. Throughout my time within CTPNW and Prevent, I attended a number of training courses. In this statement I have concentrated on the training I completed by the time of AR's second and third referral, relevant to my role as a Prevent Supervisor.

28. There was a strong culture of learning in the team, in part because the subject matter and the nature of the work was constantly evolving. The team was open to learning lessons, and we were constantly looking at how to make ways of working better. Generally, there was a positive approach to training and development.

29. CTCOs and Prevent Supervisors were required, amongst other things, to complete the National Prevent Foundation Course which was a week-long national course. I completed this in April 2019 during my time as a CTCO. There was also 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 for all CTCOs and staff in the team.

30. I have exhibited a copy of my Police Training Record which sets out the training I had completed at the relevant time **[RT/01 –** **CTPNW000355**. 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 duration and content:

    a) **Introduction to CT:** attended on 1 October 2018. This is the introduction to working with CTPNW and CT policing generally.

    b) **NCIA Core:** attended on 7 November 2018. The NCIA is a database used by UK police forces in CT investigations, this training covered the use of this system.

    c) **Insight:** attended on 23 September 2019. The training covered the processes and progress of counter terrorism investigation.

    d) **Covert Open Source Internet Investigation:** attended on 19 March 2019. This course covered how to conduct open-source checks of social media.

    e) **National Prevent Foundation Course:** attended on 1 April 2019.

    f) **Vulnerability Assistance Framework:** attended October 2021. This training covered how to complete the VAF documentation.

g) **Prevent Case Management:** attended 11 May 2022. The training was an interactive session that covered practical guidance on processes for case management.

h) **Prevent Case Management, Hydra**: attended June 2022. Involvement in AR's case

31. I should reiterate that I have very little direct recollection of this case but having reviewed the papers I can confirm my involvement as follows.

*Supervision of PC Carmen Thompson during the second and third referral*

32. At the relevant time, I supervised PC (now DS) Thompson, who was allocated all three referrals in relation to AR. This was a standard practice in the team, whereby if there were repeat referrals (which were not uncommon), best efforts were made to ensure continuity so that the same officer would be allocated to cases involving the same subject. A repeat referral would only in practice be allocated to a different CTCO if the original officer was on leave when the repeat referral came in, or if the officer in question was no longer in post. At the time the second referral was submitted, I had only recently joined as Prevent Supervisor (in January 2021) and therefore had supervised PC Thompson for about one month.

33. While I cannot recall the specifics of my interactions with PC Thompson in this case, I can confirm that generally, I worked very closely and collaboratively with her, and indeed with the CTCOs more generally. PC Thompson and I discussed cases regularly, talking through the information available, what she thought about the cases she was dealing with, and what we thought should be done. In the team generally, officers were not working in isolation and would get advice from each other. There were a number of experienced people in the team, and we did our best to foster a culture of support. While I cannot remember the specifics or have records of each individual discussion I had in this case, general practice was to speak directly to CTCOs about their cases often. I was aware of the officers' ongoing caseload and would review cases within the team regularly to ensure they were on track.

34. My role was to consider the CTCO assessment of a given case and consider whether I was satisfied with or agreed with the CTCO's view on next steps for the case. I would take a view on whether a case should be escalated, or whether onward referrals should be made, or whether the case should be closed. In this case, I was considering, in both the second and third referrals, the CTCO's recommendation to close.

***Second referral***

35. I first became aware of the second referral on 4 February 2021. FIMU sent the referral to the team inbox on 1 February 2021, Sgt. McIntyre sent it to me on 4 February 2021 **[RT/02 – CTPNW000356]**. The second referral came from Jan Lewis, the Designated Safeguarding Lead at Acorns School, who had also submitted the first referral. The second referral related to social media posts made by AR about Colonel Gaddafi.

36. On 4 February 2021, I assigned the case to PC Thompson, as she had background knowledge of the case, having completed the first referral. I confirmed to Sgt. McIntyre on 8 February 2021 that PC Thompson had been assigned the case due to her knowledge of the individual **[RT/02 – CTPNW000356]**, having dealt with the first referral in December 2019. On 17 February 2021, I authorised closure of the case.

37. I should make clear that there were cases where I pushed back on the CTCO's recommendation, to either ask for more information to be gathered, to challenge a recommendation, or to disagree with it. Similarly, I have dealt with cases where I have gone against the general assessment made by FIMU and/or the CTCO recommendation. It would in theory also be possible to escalate a case to the DI for consideration if it was particularly difficult or contentious. It was not the case that supervisors simply signed off the recommendation without probing. In this case, however, based on the information available, I agreed with the CTCO recommendations both times.

*Access to systems*

38. As noted above at paragraph 26, when I started my role as Prevent Supervisor, I initially had issues accessing data systems. I made enquiries to get access to the systems that I needed, but early in my post, I did not have access to the Lancashire systems, including the team inbox, from my Cumbria laptop. This was a source of real frustration for me in that it really hampered my ability to carry out my role without relying on colleagues to provide me with information. This resulted in some practical issues which I explain below insofar as I consider it may have affected the handling of this referral.

*CTCO assessment*

39. PC Thompson conducted the PGA, made her assessment and logged this on the PCMT. PC Thompson's recommendation was that the case was considered 'Standard Priority' and the recommended route at the time was 'Closure'. The PCMT noted her rationale as follows **[RT/03 – CTPNW000124]**:

*"The subject has previously been referred to Prevent and was closed due to there being no evidence of CT/DE [Domestic Extremism] concerns. PC 5905 has checked police systems and there are no updates to report since the last referral was closed. The school has been contacted and they do not have any additional concerns other than the information reported from his previous school*

*This […] referral does not highlight any new concerns and can be closed to prevent, the school are aware re refer if there are any concerns in the future."*

40. Once PC Thompson concluded her initial assessment, I can see that I conducted a supervisor review of the case file. In this case, having read the documents from the relevant time, I did not have reason to believe that this case should remain open to the Prevent team. Accordingly, I authorised closure of the case.

*Entries on the PCMT*

41. I was still relatively new to the post at this time, though I had previously been a CTCO in 2018. I was still getting to grips with the amount of detail and information that was required in the PCMT as a supervisor. The Counter Terrorism Case Officer Guide ('**CTCO Guide**') stipulates that all updates and/or actions are to be recorded in the PCMT **[RT/04 – CTPHQ000059]**. In relation to the second referral, PC Thompson created the PCMT entry on 8 February 2021, and the supervisor review I conducted was included in the DIF form PC Thompson completed as part of her PGA. This was then uploaded to the PCMT by PC Thompson on 15 February 2021. My comments were as follows **[RT/03 – CTPNW000358]**:

*"I have reviewed this case and note there is a lack of information in all areas. I am satisfied that the OIC [Officer in Charge] has made sufficient enquiries with the original referrer and linked in with FIMU. The concerns in this case were around posts online which were not deemed CT/DE relevant. There does not appear to be any further safeguarding that is currently required. I am unable to see any previous referral into Prevent on the PCMT, although as that has been closed and this case does not contain any CT/DE concerns then I am satisfied this can be closed immediately."*

42. On 17 February 2021, Sgt. McIntyre changed the case status to 'closed' and used the above comment for the rationale on my behalf. I cannot recall specifically why I did not log these comments myself, though as noted above at paragraph 26, I was having issues accessing the PCMT from my laptop at the time, which may explain that.

43. It is also clear from the information in the PCMT that the substance of the previous referral had been set out in the course of PC Thompson's assessment of the second referral. I

have considered why the supervisor comments I made indicate that I had not seen the first referral. Given that the substance of the first referral is contained in the PCMT, I can only suggest that this language in my comment reflects my frustration at my inability to access firsthand the systems, and requiring others to provide me with access or copies of information. It is clear from the PCMT and the accompanying emails that I was aware of the first referral, and consider that this would also have been taken into account. I discuss record-keeping further below at paragraph 121.

***Third Referral***

44. By the time of the third referral, I had access to the systems and could view and log comments on the PCMT. Again, I have no direct recollection of my handling of this case but have reviewed the relevant documents.

45. I can see that on 22 April 2021, Jan Lewis submitted a third referral regarding online content viewed during class time and a subsequent conversation with his teacher regarding the London Bridge attack, the IRA, and the Israel-Palestine conflict. On the same day, FIMU submitted the third referral (and the FIMU assessment) to the Prevent team inbox **[RT/05 – CTPNW000358 ]**. PC Thompson was allocated the third referral, given her previous involvement, and created the PCMT entry on 26 April 2021.

46. On 29 April 2021, PC Thompson completed the PGA and sent it to me to consider her recommendation to close the case. I reviewed this and the PCMT was updated on 7 May 2021 with the completed DIF/PGA form. I authorised closure of the case.

47. PC Thompson recommended closure on the following basis: *"There are no CT/DE concerns at this stage. He is currently waiting for an EHCP [Education, Health and Care Plan] and is awaiting a specialist educational placement which I believe will help and support him through his ongoing education"* **[RT/06 – CTPNW000125 ]**.

48. My comments were as follows **[RT/06 – CTPNW000125 ]**:

> *"The subject displays an interest in a recent London bomb and researched news articles as a result. Following a conversation with Teaching staff there is context provided which shows an interest in history and current affairs. Conversation included knowledge of troubles in Israel/Palestine, IRA/London attacks. There are no extreme views or concerns of a CT/DE rhetoric. The subject displays critical thinking skills demonstrating he has considered different viewpoints and information. I note the previous concerns raised which have been sufficiently addressed and does not change the outcome of this assessment. Subject appears to have sufficient support in place,*

*and I do not feel the subject is at risk of radicalisation currently from the information provided. As such, I agree this case should close immediately. Agencies already involved can raise any issues should they arise. Referrer has been contacted and offered advice and support and is aware of reporting any future concerns. Agreed closure."*

49. The case was closed as "Non-CT Concern Referred On" and notes onward referral to school. This reflects contact with the school, who were providing additional support for AR, and advice provided to the school on further referrals, encouraging continued engagement should any additional concerns arise. I considered that close supervision by teachers through specialist educational provision would provide suitable support. Multiple agencies were involved, and I considered they could raise specific issues if anything arose in future that was Prevent-relevant. My supervisor comments note that there were no extreme views or concerns of a CT/DE rhetoric, and that there was sufficient support in place. I can see that I did not consider AR to be at risk of radicalisation from the information provided. If I had thought otherwise, I would have referred the case to Channel/Dovetail. This decision would have taken into account the previous referrals as they are mentioned in the PGA. Accordingly, I authorised closure of the case.

*Entries on the PCMT*

50. As above, I had access to the systems by the time of the third referral. The entries I made are at pages 13 and 19 of **[RT/06 – CTPNW000125]**. PC Thompson would email me DIF/PGA forms via email and I would input my supervisor review comment in these forms. They were then uploaded to the PGA by PC Thompson. I also uploaded an entry as 'Supervisor Tasking/Review', which was a brief reflection of the longer PGA comments. In both the second and third referral, this PGA comment was then duplicated and used as the status change rationale when closing the file. With regard to the duplication of comments, I acknowledge that this would not be best practice and ideally when closing a case a new narrative should be provided. I note that the Prevent Learning Review ('**PLR**') conducted in 2025 makes a recommendation that each new PCMT entry should be unique and not duplicated (recommendation 7) **[RT/07 – CTPHQ000055]**. I accept and agree with this recommendation. I have further considered my supervisor review comments in relation to the third referral while preparing this statement. While there is more information than in the second referral, I still acknowledge that more detail could have been provided.

*Supervision*

51. I do not recall any contemporaneous conversations I had with my supervisor, DI Mangan, regarding the second or third referral, and that would align with normal practice given the nature of this case.

*Cross-working between CTPNW Prevent and FIMU*

52. The Prevent team was separate to the FIMU. We worked in different parts of the office, though we had regular interaction. When I first started working with Prevent, I was not entirely clear on FIMU's role and how their work sat alongside the Prevent team's work. I felt there was some confusion about the separation of roles and responsibilities, after observing how the processes worked in dealing with a Prevent referral. In particular, I felt the FIMU team were directing the Prevent team in terms of case handling, and I had questions about that, which I raised with DI Mangan at the time. I recall being asked to provide some training about Prevent to FIMU at one point. I do not recall the specifics of that, but I remember thinking at the start there might be some duplication between the teams and I took exception to the idea of FIMU being seen to direct my team.

53. Generally, however, we had a good working relationship with FIMU. I would have spoken to FIMU directly if I had questions about a referral, including about de-confliction or information to be passed to partners when decisions were being made. Sometimes I would double check points FIMU raised to ensure I understood them. I recall that over time I felt the delineation between the two teams was clearer, but as a Supervisor from the outset I was very aware that decisions on whether to refer to Channel were for me to make.

54. When I became Prevent Supervisor, I was keen to better the working relationships and understand the different roles. I also asked FIMU to assist me with understanding the systems they used to better inform my overall knowledge of the processes in place. Despite my initial concerns about the role separation, both FIMU and Prevent worked well together and I was able to have constructive and frank discussions with my supervisor and with FIMU regarding my concerns, which I found to be helpful.

55. In this case, I may have had direct discussions with FIMU but I cannot remember. I would tend to approach them directly if I had any questions but there is nothing in the documentation to indicate that was the case here.

*Discussions with JAT team*

56. I do not recall having any direct conversations with 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.

**Practical issues relevant to my involvement**

57. This section expands on a number of themes and issues relating to my involvement in AR's second and third referrals, where I consider it might be helpful to the Inquiry.

*Joint Letter*

58. The Inquiry has referred me to the Joint Letter of 25 June 2019 ('**Joint Letter**') **[RT/08 – CTPHQ000134]** from the Director of Prevent at the Home Office and the National Coordinator for Prevent. I do not recall whether I specifically received or viewed a copy of this letter. At that time, I was a CTCO in the Prevent team. However, when I was Prevent Supervisor, I was aware of the substance of the letter and specifically, about mixed or unclear ideology/school shooting or mass casualty ideology, and that it could in principle form the basis of referrals to Channel. This was something that was definitely brought to our attention, and I relied on mixed or unclear ideology/mass casualty interest multiple times to form the basis of a referral to Channel.

59. The question of whether an ideology was present in any given case was regularly discussed. The concept of mixed or unclear ideology set out in the Joint Letter was less well understood in that it was an emerging and new area, but this was progressing at the time and was a focus of the team. When we met with DI Mangan key themes such as these were discussed.

60. I would also note that we were regularly pushing for cases to be adopted by Channel. Our assessments were aimed towards pulling together the best case for consideration by Channel. On that basis, while I cannot remember my specific thought processes in this case, I can confirm that I had an awareness of this potential avenue for analysis of ideology, and that it was one factor that I routinely took into account.

*Dynamic Investigation Framework*

61. The DIF was a CT policing tool designed to help CTCOs screen, triage and risk manage Prevent cases **[RT/09 – CTPHQ000040]**. The CTCO Guide states that it is used at the Gateway Assessment stage, as it was here **[RT/04 – CTPHQ000059]**. The DIF is used to

risk assess whether there are any particular leanings evident in how the subject is presenting that point to risks of radicalisation, and was intended to guide officers in their assessment.

62. PC Thompson utilised the DIF form to conduct the PGA for the second and third referrals. The substance of the DIF form was then uploaded to reflect the outcomes of the PGA in the PCMT. I was aware of this process and considered the DIF to be a useful tool to aid decision making at the PGA stage. I note that the DIF indicates ideology is 'non-evident' in both cases, and that in my view reflects our views that the substance of these referrals did not indicate a relevant ideology formed part of this case.

***Second referral***

*Spelling error in AR's name*

63. I am aware that there was a spelling discrepancy between the first and second referrals. I do not consider that this would have had an impact on the handling of the referral, as the two cases had been linked when the referral came in. This is clear from all correspondence at the time which refers to the previous referral. Small errors like this did occur from time to time, and usually I would have changed this in the system to reflect the correct spelling. I do not recall why that did not occur in this case. However, it made no material difference to the way the team conducted the case. It was allocated to PC Thompson due to her involvement in the previous referral, and she went on to also deal with the third referral, which indicates the error did not have a bearing on allocation or handling.

*FIMU Assessment*

64. I have considered further FIMU's assessment that the new referral should not be escalated to Prevent as it did not meet the threshold for adoption to Channel. PC Thompson recorded the FIMU assessment in the PCMT **[RT/03 – CTPNW000124]**. Specifically, the assessment notes:

> *"I do not believe this new intelligence is worthy of a new Prevent referral as I do not assess it would meet the thresholds for adoption at Channel and the content does not suggest he holds any extremist ideology but rather an opposing opinion on Gaddafi's Libyan regime, questioning the US and EU motivation for removing him"*

65. The documents indicate that I was aware of the FIMU assessment at the time of my supervisor review. As previously noted, this referral occurred shortly after I began this role as Prevent Supervisor. I do not recall the specifics, but I consider it likely I would have

viewed this as persuasive when conducting my assessment, particularly given I was new in post. I am also aware, however, of how conscious I was at the time of any suggestion of FIMU directing or being seen to direct the Prevent team, and how keen I was to ensure proper delineation and assertion of our team's role and my role. I was very aware that it was not for FIMU to decide whether the referral met the thresholds for adoption at Channel. So while FIMU assessments, given the information they have access to, are persuasive, I was aware that the decision was for me to make as the Supervisor, and this assessment was just one factor to be taken into account.

*Issues other than ideology*

66. I have reflected on what consideration, if any, was given to the issues other than ideology. I do not recall the specifics of the case and therefore cannot comment with any authority on this matter, and I do not consider it would be helpful to speculate.

*Complex needs and grievances*

67. I note the sections of the PGA that were marked as *"Non evident at this stage.",* including matters such as grievances, complex needs, capabilities. My supervisory role required me to review the work done by CTCOs to investigate these issues and how they reached their conclusions. As mentioned above, I discussed cases regularly with CTCOs and would expect conversations will have been had in this regard in these cases, however I cannot recall the specifics of this case and would not be comfortable speculating beyond noting that if PC Thompson had considered that her information gathering had raised issues relating to any of these headings, she would have recorded it for consideration.

68. In my supervisor review comment from the time I noted *"I am unable to see any previous referral into Prevent on the PCMT…".* I have considered whether it would have assisted to see the first referral. In my email of 8 February 2021 to Sgt. McIntyre, I noted that the case was allocated to PC Thompson because of her previous experience with this subject, having completed the first referral. Further, my email allocating the case to PC Thompson **[RT/02 -** **CTPNW000356** noted *"I know you are aware of him"*, which also points to my having knowledge and awareness of PC Thompson's prior involvement. It is clear, therefore, that I knew of the first referral and would have discussed this with PC Thompson in the context of the second. In any event, the substance of the first referral is noted on the PCMT to be taken into account as context for assessing the second. My comments here should be taken in the context of the access issues I was having at the time, and are not an indication that I had no awareness of the first referral.

*Closure of second referral*

69. In my supervisor review comment, I note that there was a *"...lack of information in all areas."* I go on to note that that the concerns raised in this case were around a post online that were not deemed to be CT/DE relevant. As such, I authorised the closure of the case.

70. I cannot recall what materials I consulted when making the decision to close the second referral, and have no further information I can provide on this matter. I can go only by what is recorded in the PCMT. Generally I would review the PCMT entries, speak with the CTCO officer involved and review the materials they had compiled and used to reach their recommendation.

71. I have considered whether further steps could have been taken to gather information, or whether the case should have been referred to Channel/Dovetail for information gathering. This was always a consideration when conducting a supervisor review, though I acknowledge that the specific considerations in this case were not documented well or reflected fully in the PCMT. I cannot recall what was specifically considered in this case.

72. In terms of additional information gathering, one thing we did do reasonably regularly was to go back to the party making the referral if we considered that more information was required or if we thought they might be able to clarify or expand on anything said in the referral form. Our team was also very conscious to encourage referrers to keep the channel of communication open and to re-refer in the event of any further concerns. We would encourage a cautious approach where people felt able to refer to Prevent if they had any worries in the CT/DE vein. I note that PC Thompson did seek further information from Jan Lewis, who made the referral into FIMU, regarding any other concerns Acorns School may have had beyond the information about the social media posts reported by AR's previous school **[RT/10 – CTPNW000363]**. The response from Jan Lewis was that there were no further concerns.

73. The CTCO Guide notes that the PGA is a screening and triage, and not a comprehensive risk assessment **[RT/04 – CTPHQ000059]**. For contentious cases I would have looked at intelligence and crime reports. There were avenues to pursue for further information, however, the PGA stage is for initial triage only - thorough investigation and formal 'information gathering' did not occur at this stage in accordance with the CTCO guide.

74. In terms of onward referral to Dovetail/Channel, generally, if there was an area requiring clarification, I would refer it back to the CTCO rather than to Dovetail or Channel for 'information gathering' as we were conscious to avoid duplication of work, and it was for

us to put together a sufficient assessment to make a decision on referral. We either would refer the case to Channel/Dovetail on the basis the criteria were deemed to have been met, or we would not on the basis that we did not think the relevant indicators were there to warrant referral. For the case to reach the 'information gathering' stage, there was a threshold that needed to be reached regarding CT/DE concerns or vulnerability to radicalisation.

*AR's social media and internet presence*

75. I am asked what steps were taken to consider AR's social media and to outline any further steps taken beyond FIMU's initial investigations to understand his social media activity. I cannot recall specifically what was completed in this case. The Prevent team could do our own open-source checks and that could be a consideration when assessing a case. FIMU had already conducted checks in line with their investigative functions, however, and that had not brought up additional social media materials. The Prevent team would not have expected to duplicate work already completed during the FIMU assessment unless there was a specific reason.

*My assessment of the information available*

76. I have considered whether obtaining access to AR's internet search history from his school would have assisted in conducting the assessment and have reflected on why these measures were not pursued. This may have been helpful but given my limited recollection any comment on this matter would be speculative. Accessing internet search history was not routinely done in the course of conducting PGAs. It is not clear to me whether the school would even have the capacity to capture that information. I would also note that had any information arisen which was of concern to the school, a further referral could and should be made.

77. I have considered whether it might have assisted to speak directly to the pupil who reported the concerns and had access to AR's Instagram account, or to AR's parents. As noted above, the CTCO Guide states that the PGA is a triage and not a comprehensive risk assessment. The CTCO guide also provides guidance on contact with external parties **[RT/04 – CTPHQ000059]**. It notes CTCOs should always endeavour to contact the initial referrer and as above, PC Thompson did so when she emailed Jan Lewis. The CTCO also notes that visits to subjects or partners *"…**should not** be necessary in order to complete the PGA phase"* (original emphasis). The CTCO Guide includes a 'strong word of caution'

on early visits by Counter Terrorism Police and the risk of deterring subjects from engagement.

78. With that in mind, I consider that Prevent visiting the pupil who reported the concerns would not have been appropriate from a safeguarding perspective or proportionate in the circumstances. First, this was a child who had confided in their school, and the reported behaviour was referred through the proper channels to Prevent, which opened a dialogue between Prevent and the referrer. The social media username is visible from the information provided, and so could be searched for through open-source research. I do not consider that sending counter terrorism officers to visit the child in question would have been fair, proper, or proportionate.

79. Further, at this time, the UK was in the third national lockdown due to the Covid-19 pandemic. We were not visiting regularly at the time due to this, and so it is likely there would have needed to be an exceptional circumstance to warrant visiting AR's parents. In this case, the material in question did not indicate a CT/DE concern and so again I would not have considered it proportionate to ask for this course of action to be carried out. It may have been helpful to understand their viewpoint, but I do not think this would have been appropriate in the circumstances.

80. I have also considered whether I ought to have tried to access results that may have come from the download of AR's devices following his arrest for assault in 2019. I am uncertain if it would have assisted in assessing the current concern which related to the social media posts, and again, given the limited nature of the information underpinning the second referral, and the lack of CT/DE concerns, I would not have considered it appropriate to proactively ask for this additional information. Further, it is important that note that following that seizure, had something concerning arisen from those searches, I would have expected that information to be passed to the Prevent team accordingly, particularly given there was contact with the Community Safety Team at the time.

*Ability to access previous Prevent referral*

81. As stated in paragraph 68 with hindsight, my comments regarding being unable to see any previous referral on the PCMT should not be taken as indicating a lack of *awareness* of the first referral but rather the system access issues I was encountering at the time. PC Thompson included a description of the initial referral in her PGA comment and though I cannot specifically recall the details, I am confident I would have seen these **[RT/03 – CTPNW000124**. Further, as indicated in my emails to Sgt. McIntyre at the time, I was aware

of PC Thompson's history with the case **[RT/02 – CTPNW000356]**. In hindsight, the record-keeping on this file should have been more thorough, however, I believe I would have discussed the first referral with PC Thompson when reviewing the second.

82. I do not have recollections on the specifics of the decision making, but I made the decision to close based on the information I had. I worked closely with PC Thompson and am confident I would have discussed the PGA/DIF assessment and her decision making with her. I do not consider that reviewing the first referral on the system would have made a difference to the decision to close the case. Where the PCMT notes 'no CT/DE concerns' this, from memory, in practice to me would mean that there is no evident vulnerability to being drawn into terrorism or a risk of radicalisation. As I have already noted, I am confident I was aware of the content and nature of the first referral and I would not have overlooked this. I assessed the information available with regard to the second referral and concluded there were no CT/DE concerns. I consider I had sufficient information to make the decision to close.

*Safeguarding*

83. In my supervisor review comment I noted that no further safeguarding appeared to be required. I cannot recall the specific decision making related to this but on reflection, in the circumstances, I did not consider it proportionate or necessary to refer for further safeguarding at that time on the basis that there were some protective factors in place at school. I would have spoken with PC Thompson about her assessment and information gathered, and any decision making arising from those conversations should have been reflected in the PCMT.

*Post-closure review*

84. I am asked by the Inquiry why a post-closure review was undertaken in this case. I cannot recall specifically why this occurred and cannot provide any further information on this point. In practice, some CTCOs requested extra checks from time to time, not necessarily due to new concerns or evidence, and I cannot speculate here. The obligation to conduct 6 and 12-month reviews only related to Police-Led cases, but it was viewed as a positive measure if reviews were undertaken on other cases, as additional due diligence.

***Third referral***

*Spelling of AR's name*

85. As mentioned above, there was a spelling discrepancy in AR's surname across all three referrals. Again, I do not consider this had any impact on the handling of the third referral. On 22 April 2021, FIMU referred the case to the Prevent team inbox and the covering email from Tim Aspinall noted the two case file numbers of the previous referrals **[RT/05 – CTPNW000358]**. The referrals had clearly been linked, and the same CTCO was allocated to the third referral. The FIMU assessment with pre-existing case numbers was uploaded into the PCMT and was visible when reviewing the case **[RT/06 – CTPNW000125]**.

*My assessment: PGA*

86. I cannot recall specifically what materials I reviewed when conducting the supervisor review of the third referral, over and above the information in the PGA and PCMT. There are sources I could refer to and did from time to time refer to, for example looking at linked cases to refresh my memory, information held on the NCIA, but I would not expect the latter to have been relevant here, and as set out above, I had an awareness of the previous referrals.

87. The PGA listed *"Non evident at this stage"* on the DIF form for grievances, engagement, ideology, capabilities, intent and opportunity. I cannot recall my specific decision making from the time, but I consider that I would have agreed with this assessment. I recall discussing the case with PC Thompson and consider I would have been aware of what steps were taken to investigate these issues. I cannot recall the specifics of the conversations, and I have not recorded all these interactions. This was not outside of standard practice – it would not be practicable or proportionate to note all such internal interactions, given the volume of conversations but also given the sensitivity of the nature of the work we were doing. Extraneous paper notes of such discussions outside of what was recorded in the PCMT would not have been common. I have discussed my record-keeping above at paragraph 50. As I became more experienced in the role of Prevent Supervisor, I completed more detailed record-keeping. The PGA reflected the views of the previous referrals and I had sight of all relevant details from these referrals at the point of decision making.

88. My entry on the PCMT as 'Supervisor Tasking/Review' concluded that there were *"…no CT/DE concerns currently"* **[RT/06 – CTPNW000125]**. This reflected my view that based on

the information available there were no CT/DE concerns. In hindsight, I should have recorded expressly the language denoting that I was not concerned about the risk of radicalisation/vulnerability of being drawn into terrorism. This is the language used by Channel and reflects the criteria against which the available material would have been measured. As set out above, my understanding on the use of terminology developed with experience in the role.

89. When considering the risk of radicalisation, the CTCO supervisor must balance the assessment of CT/DE concerns alongside the other factors listed in the PGA (grievances, engagement, intent, etc). This is done by considering all factors in the round and ensuring each factor is accounted for and was not given more weight than any other. As noted above in paragraph 73, the PGA is a triage and screening stage, and the information available may be incomplete. Despite this, an assessment is made considering the factors and information there is available. I cannot recall the specific assessment undertaken in this case, but reflecting on the contemporaneous documents, I am comfortable with the assessment made at the time that there was no CT/DE concern and AR was being supported appropriately by other agencies.

90. When assessing whether a subject had sufficient support in place and considering safeguarding requirements, my general practice was to speak to the CTCO dealing with the case to understand what was in place. This usually included whether social services were involved, whether additional needs were being met at school, if any other agencies were involved and speaking to the referrers ahead of closure to ensure it was the appropriate course of action. Further, reporting the action taken back to referrers often encouraged them to report any new information or concerns. I cannot recall specifically who I spoke to in this case, but the PGA notes that the school were contacted and support would be provided by way of the EHCP plan.

91. I have been asked by the Inquiry if I considered the possibility of disguised compliance. This was certainly an issue that had arisen in other cases so was something the Prevent Team were aware of. It is also a consideration across the board in policing so I believe would have been considered, however, I cannot recall whether I specifically considered it in this case. Schools could, and were encouraged to, refer matters back to Prevent if further issues arose.

92. I am aware that some of the reviews have made reference to the adequacy of open-source checks, and I cannot remember whether I considered asking for any further open-source checks to be done. That would likely have been done at the FIMU stage if it were to be

done, but given the limits on my recollection, I do not think it would be helpful to speculate further.

*Channel and Information Gathering: multiple referrals*

93. I have also reflected on the significance of the fact that there were repeat referrals in this case, and whether that had an impact on my decision making. Given my limited recollection, I cannot be specific about this, but the fact there had been more than one referral would have been a consideration in itself. It was not uncommon for this to happen, but it is important to note that repeat referrals can arise for a variety of reasons – sometimes for example, multiple referrals are submitted at different times which reflect the same incidents. Similarly, organisations, upon a first referral being dealt with, are actively encouraged to re-refer should any further concerns arise. This cautious approach is helpful, but means that it remains important to assess each referral carefully against the Channel criteria, given the range of behaviours that can and have previously triggered referrals to Prevent. With that in mind, given my role is to give consideration to the application of the relevant criteria consistently, alongside the substance of the referrals and the nature of the particular information forming the basis of the referrals, I would have taken into account the fact there were repeat concerns. If I had thought, taking this all in the round, that the relevant criteria had been met for referral, I would have referred it.

94. I would also note that soon after I left the Prevent team in 2022, an addendum policy regarding multiple referrals was implemented (titled 'Multiple Referrals: Risks, Supervision and Accountability in PCM') **[RT/11 – CTPHQ000035 ]**. This policy states that for referrals where there has been a referral on a previous occasion, serious consideration must be given to historical referrals for the same subject. Further, the Prevent Inspector must be made aware of the repeat referral before a PGA decision is made, and that previous referrals should be considered *"reasonable suspicion"* for the purposes of escalating to the 'information gathering' or PLP stage. This is particularly the case where previous referrals have not progressed past the PGA stage. In such cases, if the CTCO and supervisor determined the case should be closed and not escalated, the rationale must be fully explained in the closure rationale combined with the Prevent Inspector's endorsement. In practice, this meant that from January 2023 when the addendum was published, repeated referrals either needed to be escalated or closed with agreement from the Prevent Inspector in post. This policy was updated further on 31 March 2025. I discuss the question of referral to Channel more generally from paragraph 98 below.

***Overall***

*Ideology*

95. With regard to ideology, I was not under the impression that a definitive terrorist ideology needed to be proved before a case could be referred. That is quite clearly not the criteria to be applied.

96. In this particular case, I would have considered whether there was a terrorist ideology present as part and parcel of making the supervisor decision. I cannot remember the detail of my thought process at the time but based on the information in the PCMT and the overall outcome of my assessment, I did not think the material provided indicated that AR had such an ideology. I noted, for example with reference to the second and third referrals, AR's apparent interest in the London Bridge attack, political matters relating to MI5 and the IRA, and comments made on social media about Colonel Gaddafi. I am aware that the school had provided context for the searches relating to an interest in history and current affairs. He was displaying critical thinking skills looking at different viewpoints and information and challenging views, and I can see that I had taken into account previous concerns raised. Noting that definitive terrorist ideology is not part of the relevant criteria, I still did not consider such an ideology to be a feature of this case, which is consistent with the overall decision not to refer.

97. In terms of fascination with extreme violence/mass casualties, I have set out above my recollections and thoughts relating to the Joint Letter. This was an active consideration in my assessments in light of that, and I was aware this was a live issue that could have a bearing on my assessment of ideology. As mentioned above, this was an issue that was on the radar within the team and would have been factored into my considerations.

98. I have been asked to consider whether AR should have been referred to Channel based on an unclear, mixed or unstable ideology. While I cannot remember the detail of my thought process at the time, this matter, and in particular the fact that these factors could form the basis of a referral, was well known to me. Taking the relevant information before me into account, I did not consider that referral was appropriate. I was aware that it was in theory possible to refer based on unclear, mixed or unstable ideology – but I did not think it was appropriate to do so here, otherwise I would have.

99. I have also thought about whether I would have referred AR to Channel had the three referrals consistently referred to the same theme, for example right wing terrorism, or Islamist extremism. This ultimately would require the underlying facts to be completely

different, however I cannot definitively say that this would have resulted in a referral. What I can say is that I would have assessed the available information relating to each referral, and the cumulative effect of the material forming the basis of the referrals and considered them against the relevant criteria to decide whether a referral would be appropriate. Where three referrals consistently relate to a clearly identifiable theme, there might be a more obvious susceptibility to the individual being drawn into terrorism or a clearer risk of radicalisation. But all of the information would need to be assessed on its merits. It may be harder to make the argument for adopting to Channel where a case involves a mixed ideology rather than a very clear-cut set of views, but if I considered that a given case met the criteria, I would refer it.

100. In terms of how I balanced AR's potential ideology (or the question of ideology) against other components of the PGA (including such things as complex needs, grievances, and triggers), I have no direct memory of how I carried that out in this case. In general however, all factors presented to me as a supervisor were always taken into account and considered in the round. I was always very conscious of the need to consider cases holistically, and would have done that here as in every case.

101. Overall, I did not consider there were grounds to suspect that AR was vulnerable to being drawn into terrorism – if I had thought so in light of the second or the third referral, I would have referred the case to Dovetail/Channel.

*AR's ASD diagnosis*

102. Given my limited recollection of this case, I cannot comment with authority on AR's ASD diagnosis and the effect of that on my views of the risk he presented. I was aware autism assessments had been done or were being done. I would have been aware of the impact this can have on things such as fixations. All I can say is that if the second or third referrals had given rise in themselves to particular concerns relating to AR's ASD indicators and the risk he presented, I would have referred to the Vulnerability Support Hub, who I found to be excellent, or at least consulted them.

*Involvement with other agencies*

103. In terms of my contact with other agencies in this case, I do not have a direct memory of this, but having revisited the relevant documents I do not think I would have had any interaction with any other organisations. That was not unusual in my supervisory role. Generally speaking, when I was supervising CTCO case handling, I would have had

contact with the FIMU, if appropriate or necessary, but if any interaction with external bodies was required to inform a CTCO assessment, that would have been done by the CTCO rather than the supervisor. I cannot remember the specifics, but as a general statement I do not think it would be fair to suggest that the Prevent team, or I, would have taken the view or assumed that other bodies would take responsibility for managing AR's risks. I would have been focused on my duties and my role. Any other organisation or agency – schools, social services, CAMHS, etc – are all subject to the Prevent duty with their own responsibilities to discharge. In this case it is clear that other bodies were involved and that he was or had been receiving support in different aspects of his life, but I made my own assessment in each case I supervised.

**Reflection on events**

104. Having looked at this case in the round, including with the benefit of hindsight, I have considered whether there are things I or CTPNW could have done differently when dealing with AR's referrals. In doing so I have had drawn to my attention the external reviews that have been completed since the attack took place and have been shown the relevant recommendations from the PLR, the Dignate Review, and Lord Anderson's review.

*General reflections*

105. I have thought a lot about whether I could have done things differently, or whether we as an organisation could have done more. Having considered the papers from the relevant time in detail, it is clear to me that I could have written up my notes into the PCMT in more detail to make clear everything I had done. The PCMT does not reflect the work that will have been done and the time that will have been spent assessing this, including, for example, the engagement with CTCOs that routinely happened in these cases. What is written there is simply not reflective of the process, the steps followed, and the way that I worked. Part of documenting this is to provide an aide memoire and a clear indication of rationale, and I, and others, would benefit from seeing that.

106. I have been directed to spelling mistakes in AR's name across different referrals and have addressed that in detail above, but of course on reflection I could or should have picked up on that. For the reasons given above, I do not consider that this would have affected the handling of the case, because the referrals were clearly linked.

107. Given the magnitude of what AR went on to do, it is difficult to look at the process objectively and it is hard to know what to say. Having revisited all of this in the course of preparing this statement, in terms of the decision to close itself, I did the best I could with

the knowledge I had at the time and the information available. If this case were to be considered by Prevent now, the 'multiple referrals' policy discussed above at paragraph 94 would mean the case would be escalated to the 'information gathering' stage, or closed with review and approval of the Prevent Inspector in post. That is not, however, to say that the outcome would be different – it is not clear it would have been adopted or that AR would have voluntarily participated, for example. But now the processes have changed such that referral would happen. That means that the fact of multiple referrals itself is now given more significance. That does not, however, mean, that the substantive assessment of the particular information in question would necessarily be different because the criteria for referral remains the same as it was at the relevant time.

108. In terms of CTPNW, I have thought a lot about what could be done differently either with the information available at the time or with the information we have now. As a general statement, the team, its work and its approach to the work were evolving all the time, and we were, in my view, always looking for how to improve ways of working and how to do things differently. It was an emerging practice area then and it continues to evolve and change. I have been away from the team for some time, but when I was in Prevent we were always looking for how to be better because there was a strong desire to get the best result for the end users. In the period I was working in that team, as a unit we were taking into account lessons learned as we went, and from memory, there was a regular review or consideration of processes and how effective they were. If a training need was identified, efforts were made to address that. Even the computer system was being changed if I remember correctly to try and make processes work more smoothly. I am aware that policies, and Dovetail itself, has changed since I was in Prevent, but I cannot comment on the detail of that.

*Referral*

109. I have considered whether there was a general reluctance to refer to Dovetail at the time, and I really do not think there was. If a case needed to be referred, then it was. The assessments were made on the merits of the case, based on the information we had.

110. It has been repeatedly suggested to me that I did not see the previous referral and I have considered whether I should have ensured that I could see it before authorising the closure of the second referral. I have set out above as much as I can on this matter, but would reiterate here that it is clear from the PCMT that the substance of the first referral is on record there, and summarised within the body of the information provided by the CTCO

in the course of the second referral **[RT/03 – CTPNW000124]**. With that in mind, I am confident I had access to the relevant facts. I am also confident I would have had several discussions with PC Thompson at the time, on which I have already commented.

111. I have considered, on reflection, whether it would have been beneficial to refer AR to the Channel coordinator for information gathering and to allow a Channel panel to discuss the case, either following the second or the third referral. First, I should say that even if I had opted to refer the case, there is no guarantee that a Channel panel would have been convened. It is not a given, based on the information available, that the case would have been adopted. I cannot speculate about that, but it cannot be taken as guaranteed. Secondly, and more importantly, I cannot say much more than to reiterate that at the time, based on the information available, I did not think that the case was suitable for Channel. As mentioned above at paragraph 94, the fact of multiple referrals would now be treated differently, but it is difficult to say whether the situation would have benefited in practical terms from Channel intervention. It may have, but equally, it may have been exited from Channel or may not have been taken up. I do not think that it would assist the Inquiry for me to speculate.

*Guidance/training*

112. In terms of the guidance, training and resources available to me at the relevant time, insofar as relates to my involvement in this case, in hindsight I could have benefited from more of an induction at the very beginning of my role as a supervisor. I started the job and found my way, but I think if there had been more training at the outset, that would have been really helpful. What might have assisted, for example, would have been a tailored supervisor course or specific guidance on processes/procedures that dealt specifically with very practical matters, including for example expectations on the detail to include on PCMT, or accessing particular systems. It would also have been helpful to have training on how my role interacted with, or sat alongside, the FIMU team.

113. I was very keen to learn and when I started, I asked colleagues regularly for guidance or a steer where appropriate while I was learning. With hindsight, for example, when I look at my entries on the PCMT, I consider them to be inadequate in terms of the level of detail. I know that by the time I left that role my entries would have more adequately reflected the detail of what I had done. With that in mind, targeted training at the very outset on those expectations and procedure would have been helpful. Though my previous experience as a CTCO stood me in good stead because I understood the context for the work and had

that background, I still think more of an induction would have helped me and would assist new supervisors now. Generally, if I identified training requirements, I was permitted to do it, and there was, as I set out above, a training programme that I undertook. But on reflection, more on those particular subjects would have been welcome.

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

114. I have considered the three reviews that have been undertaken to date, and set out some thoughts in response to the recommendations contained in those reports that are most relevant to my role in the Prevent team.

*Reflections from the PLR*

115. I have turned my mind to the outcomes of the PLR, and the recommendations it makes, and have considered those recommendations most relevant to my role at the relevant time **[RT/07 – CTPNW000055]**.

116. The PLR recommends that there ought to be a standardised format for information sharing between FIMU and Prevent officers. I have set out above that there were, in my view, some ambiguities between the Prevent team role and the FIMU role, and a standard form of communicating setting out the key points to be covered would be helpful to avoid that and keep things consistent. It might also assist with discouraging people from including opinions on next steps, which I think would also be helpful.

117. I note also that the PLR recommends that relevant CTCO guidance and policy should be reviewed/amended to include a requirement for any live or outstanding enquiries or information gathering to be completed before the case can be closed. I think this would be helpful to make the position as clear as possible and no question about whether queries have been followed up.

118. The PLR recommends that it should be considered whether policy and/or guidance should be developed to the effect referrals involving children and/or complex needs should be routinely referred to Channel (subject to certain caveats). As I understand it, this would mean that in a case such as AR's referral would happen almost automatically. This is worth considering and could in theory be useful, but this could lead to a significantly higher volume of cases being referred for further assessment by the Channel panel. It would ensure a base level of assurance for multi-agency and involvement and increased scrutiny for this kind of case and would in effect be a safeguarding measure. I can see both pros and cons of that approach, but if it was being considered, it would be essential to resource

the programme properly to deal with that increased volume of cases. There are practical issues that would need to be worked through properly.

119. The PLR also recommends a review of existing training for supervisors with a view to strengthening the review process, such that when cases are being closed by supervisors, it is clearly on record that any behavioural factors and motivations have been noted and taken into account. It also suggested that assessments include express consideration of 'Prevent relevancy'. I am not sure if the Prevent Assessment Framework might deal with some of these points, but either way I think this would be helpful. If there were to be a training update, it would need to be consistently rolled out to new supervisors and should include general training on form-filling and appropriate record-keeping. This would be beneficial but would also need to be timely so that new supervisors have that message at the outset.

120. There is a further, more general, recommendation that Prevent staff training should be reviewed and, where necessary, updated, with regular training refreshers scheduled. Overall, any training in my view would be helpful, particularly where it can give new members of staff more context for their work. I would have found training on the FIMU role and how the FIMU remit fits together with the Prevent team/CTCO remit useful when I first started. I found that quite difficult to grasp at the beginning, and training on those practical matters would help get people up to speed quickly. So again, this would be useful but only if it is delivered timeously.

*Record-keeping*

121. I do note a number of general themes across all three reports that our record-keeping could have been better. On reflection, and having gone through all the relevant trackers, etc, in the course of preparation for participating in the inquiry, I am struck by how brief my own notes were on the PCMT, particularly when recording my rationale for decisions. While, for the reasons given above at paragraph 87, not every conversation or development was recorded, I do still consider that I should have recorded more in this case. I can confidently say that these entries came very early in my role as a supervisor, and by the time I left the post, my record-keeping would have improved significantly. In this case, I do not think in any way this would have impacted the outcome and I do not consider that I would have reached a different decision. I can see that I did not consider the case to be contentious at the time, which may explain the relative lack of explanation, and I am confident the relevant information was taken into account, but I would expect a

fuller rationale to be reflected on the PCMT as a matter of record-keeping. I would expect to see more, for example, on safeguarding, other support available at the time, and more on my reasoning.

*Dignate Review*

122. I have considered Learning Observation 7 from the Dignate review, which outlines concerns relating to FIMU assessments 'guiding' Prevent cases, and quotes excerpts from the FIMU assessments for each of the three referrals **[RT/12 – CTPHQ000028]**. It notes that only the Prevent team should be making assessments relating to decisions within the Prevent remit. I have addressed this in detail above. I acknowledge that this reflects my experience to an extent, in terms of the delineation between the roles of Prevent and FIMU. Seeing those interventions was not always helpful, because it created potential confusion. I would maintain, however, that I as a supervisor, remained clear that it was my role to make an assessment of the merits of the case against the Channel criteria, based on the information available. Any additional training with regard to the delineation of roles, however, in my view would continue to be helpful to people starting roles within FIMU and Prevent even now.

123. I have considered Learning Observation 8, which relates to the Vulnerability Support Hub. While the observations in the Dignate Review relate primarily to the first referral, I would note that it was always an active consideration in any case as to whether a referral to the Hub would be appropriate or beneficial **[RT/12 – CTPHQ000028]**. I would regularly speak to that team, and was very aware they were there, and what their role was. I worked closely with them, and found them to be extremely helpful. I did not consider, in the context of the second and third referrals, that it was proportionate to make a referral in this case.

124. I note a number of additional matters raised in the Dignate review relevant to the second and third referrals, including, for example, learning observations relating to multiple referrals, data entry and consideration of the full case history. I consider that I have dealt with those points throughout the statement above, and have provided my views where appropriate. I do not consider that I can provide any additional helpful commentary in that regard.

**Improvements**

125. In terms of improvements that have been made by CTPNW since these events (and by that I mean since the handling of the second and third referrals, as well as the attack

itself), there is a limit to what I can say. I left the Prevent team in 2022 – I am aware that work is being done but I do not know the specifics. I have mentioned above that there is now a multiple referrals policy in place, and that a triage system is in place, but other than that, I could not comment with any authority on internal processes. In terms of improvements that could now be made, without a clear sense of the current working environment, it is hard to say.

**Other matters**

126. 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:** 21/8/25