The Southport Inquiry

Phase Two

Expert Cadre Report

22 September 2026

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The Southport Inquiry

Phase Two

Managing the Risk from Violence-Fixated Individuals

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Expert Report: Anna Gianfrancesco, Dr. Monica Lloyd, Elizabeth Swan

1. Foreword

1.1. On 29 July 2024, three young girls were murdered in a knife attack at a children's dance club in Southport. Ten others were injured and sixteen survived the attack but live with psychological injuries. Following the conviction of the perpetrator, the Home Secretary established the Southport Inquiry on 7 April 2025 to examine what happened and identify learning to minimise the risk of a future tragedy.

1.2. This report has been prepared to assist the Inquiry in its Phase 2 examination of the arrangements in England and Wales for identifying, assessing and managing the risk from violence-fixated individuals, and to identify learning that may help reduce the risk of similar violence in the future.

1.3. The purpose of our work starts with those affected. We remember the three girls who were murdered, those who were injured, and their families and loved ones. We recognise the profound and enduring consequences of what happened in Southport and have kept their experiences at the centre of our approach. We recognise too the impact on the wider Southport community. We acknowledge the members of the public and professionals who responded to the attack and its immediate aftermath, and the services and professionals who continue to provide care and support to victims, their families and the wider community.

1.4. We also extend our thoughts to those affected by the events examined in the six case studies, first and foremost the victims and their families. We recognise that revisiting these events may resurface painful experiences for those seeking to heal and rebuild their lives. We are mindful of the impact on the families of the young people involved, and on the professionals whose work we examine. We have sought to treat all those involved with sensitivity and to review professional decision-making rigorously and fairly, while avoiding applying the benefit of hindsight.

2. Executive summary

2.1. The emergence of young people fixated on violence is a relatively new phenomenon that is referred to in the UK as Non-Ideological Extreme Violence (NIEV). These terms have evolved to describe those, mainly young people, who have failed to find their place in society and chosen violence as an outlet for their self-hate, anger, depression, frustration, alienation and hopelessness.

2.2. As an expert group we have explored in depth the trajectories of six cases referred to us by the Inquiry legal team to inform our response. This has in itself been a challenging exercise that has required us to explore in depth the dysfunctional aspects of their childhood histories and immersion in online dark material, that in many cases ended in attacks that caused unimaginable harm to victims and their families and have life-long consequences for the perpetrators.

2.3. We are aware of cases where individuals were prevented from carrying out attacks by others. However, these crimes are difficult to detect when they are carried out online by young misanthropists isolated in their bedrooms where they have access to a digital world where they are free to self-radicalise. All were male, reflecting the predominance of males in juvenile homicide. The case studies included both children under 18 and young adults.

2.4. The young peoples' motivations in the six cases varied, but they involved seeking attention, identity, revenge and significance through violence, notoriety and infamy. Two went on rampages with shotguns, another killed two women as part of a satanic pact to kill and the fourth killed a twelve-year-old boy, all of them tragedies. None of the six wanted to advance a political cause, but they shared a sense of grievance with those who had carried out extremist violence, and several had accessed extremist material online, both Islamist and Far Right that reinforced their drive to seek renown through violence. They had retreated from lives they could not manage, and rather than continuing to search for success and status they sought to gain recognition and self-worth through violence.

2.5. We have explored the backgrounds of these six cases to understand their trajectories and identify where opportunities for intervention were missed or mismanaged.

2.6. There was no single characteristic pathway or assessment that could reliably identify a child at risk of engagement in extreme violence. Across cases, their grievances came from the accumulation and intersection of vulnerabilities and adversity over time. These included neurodivergence, mental-health difficulties, adverse child experiences, bullying and social exclusion that contributed to their self-hate, loneliness, isolation and loss of a sense of belonging, with online spaces as their only source of connection. There was no single 'red flag', but a cumulative and intersecting picture of needs, vulnerabilities and changing circumstances, together with a failure on the part of professionals to consider intersectionality: how neurodivergence, adversity, trauma, race, gender and identity interacted to shape how these young people saw themselves. Assessments were made independently by different agencies and services that did not know them and their familial background or have the relevant expertise and professional curiosity to look further and deeper.

2.7. Across several cases there was a concerning inverse pattern: as needs and concerns accumulated and intersected, input from specialist services reduced or fell away, leaving

families and education providers to manage their increasingly complex needs without specialist support. These young people required more rather than less help because of the challenges they posed. Ironically, their increased withdrawal and isolation in the home, in the absence of protective factors and parental awareness of their online activities, took place when and where it was least likely to be seen. In reality, even with better informed practice it would have been difficult to predict their offences, given the low prevalence of such offences and when it was their first offence.

2.8. Our focus should therefore be on understanding and recognising how an accumulation of unmet needs, in the absence of protective factors results in risk to the young person and the public. Currently there is no single definitive profile of violence fixated juveniles, or methodology for detecting the threat that they pose.

3. Methodology

3.1. Scope and approach

3.1.1. Phase Two of the Southport Inquiry considers the wider public services and systems relevant to the identification, assessment and management of concerns and risks associated with violence fixation. As part of this work, the Chair provided six case studies of young people in England and Wales, drawn from a range of local authorities and service areas. The analysis takes account of differences in local structures, terminology, thresholds and professional responsibilities between these two jurisdictions.

3.1.2. In accordance with the Chair's instructions, analysis of the case studies is principally thematic and forward-looking rather than a retrospective examination of six individual case studies. The cases are used to identify recurring themes, systemic issues, cross-cutting patterns and the learning that is relevant to understanding and identifying violence fixation, its assessment and management.

3.1.3. In relation to professional practice and judgement, the report was informed by access to documentation that concerned the trajectories of each of the case studies, though it did not include any direct face-to-face contact. The exercise was carried out at pace to meet the deadlines set by the Home Secretary, given the growing concern associated with young people engaging in non-ideological extreme violence.

3.2. The expert cadre

3.2.1. The Expert Cadre was formed to provide independent expert opinion to Phase Two of the Inquiry. It comprises five experts whose professional backgrounds span education, children's social care and multi-agency safeguarding and oversight, child and adolescent mental health services (CAMHS), forensic psychiatry and psychology, policing, Prevent and counter-terrorism. Members of the Cadre have attended meetings together and exchanged views in the course of their work for the Inquiry.

3.2.2. Dr Monica Lloyd is a forensic psychologist specialising in terrorism and risk assessment. Her expertise includes violence, fixation and the identification, assessment and management of associated risk.

3.2.3. Anna Gianfrancesco is a former Director of Social Care and Family Services and Director of Commissioning and Community, she was also a Channel Chair. She provides expertise in safeguarding, children's services and multi-agency working, including the assessment and management of concerns that involve high risk young people.

3.2.4. Elizabeth Swan is an education and safeguarding expert and former headteacher, DSL and SENCo in mainstream and specialist SEMH schools. She provides expertise in safeguarding in education and other frontline settings, including the identification of concerns and how education professionals recognise, respond to and escalate them.

3.2.5. Neil Basu is a former senior national counter-terrorism policing lead. He provides expertise in policing, decision-making, escalation and disruption measures.

3.2.6. Dr Richard Church is a consultant forensic psychiatrist specialising in high-risk children and young people with complex mental health needs.

3.3. The report

3.3.1. This report has been prepared by Dr Monica Lloyd, Anna Gianfrancesco and Elizabeth Swan. We have discussed relevant aspects of policing and Prevent with Neil Basu and matters relating to forensic psychiatry with Dr Richard Church.

3.3.2. We were instructed by the Chair to identify recurring themes related to violence fixation from the case studies. We have undertaken a detailed and systematic examination of the material disclosed by the Inquiry, extending to many thousands of pages, to identify relevant evidence, patterns and issues across the cases. Our analysis has been informed by the relevant legislation, statutory and non-statutory guidance, regulatory and professional frameworks, research evidence and our respective professional expertise and experience.

3.3.3. As co-authors, we have worked in close collaboration throughout, jointly developing and reviewing the report, testing our interpretation of the evidence through discussion and agreeing its findings and recommendations. This multidisciplinary approach has enabled us to consider issues crossing professional and organisational boundaries, including how identification, assessment, information sharing, escalation and intervention depend upon effective coordination between services.

3.3.4. Individual cases are referred to where necessary to support wider thematic findings and systemic lessons. Each author has remained within their area of professional expertise and experience, and any material differences of professional opinion are identified.

3.4. Material reviewed

3.4.1. We have considered the material disclosed by the Inquiry relevant to the six case studies and our instructions. This extends to many thousands of pages and includes:

3.4.2. Multi-agency chronologies and reviews, including child safeguarding practice reviews, rapid reviews and domestic homicide reviews.

3.4.3. Children's social care and local authority records, including safeguarding, family circumstances, statutory intervention, early help, education and SEND/ALN.

3.4.4. Health and mental health records, including physical and mental health, neurodevelopment, referrals, assessment, treatment and support.

3.4.5. Education records, including safeguarding, attendance, behaviour, suspension and exclusion, special education needs/additional learning needs (SEND/ALN), pastoral support and alternative provision.

3.4.6. Policing, criminal justice and youth justice material, including police records and relevant Crown Prosecution Service material.

3.4.7. Prevent and Channel material, including referrals, assessments and multi-agency processes.

3.4.8. Other evidence provided by the Inquiry relevant to the young person's family and social circumstances, behaviour and presentation, vulnerabilities, online activity and contact with services.

3.5. The case studies

3.5.1. The Inquiry selected six case studies that monitored their progress from birth to the index offence. This provided a wide evidence base for tracking the trajectories that have provided the evidence base from which the cadre identified wider themes, patterns and learning. They are not treated as separate investigations.

3.5.2. Case Study A concerns a convicted young offender who, in several respects, fits the Inquiry's description of a violence-fixated individual. This case is subject to an anonymity order, and we therefore provide no further identifying details.

3.5.3. Case Study B also concerns a convicted young offender who, in several respects, fits the Inquiry's description of a violence-fixated individual. This case is subject to an anonymity order, and we provide no further identifying details.

3.5.4. Case Study C concerns a young person convicted of three murders, possession of a firearm and of a bladed article. Available information records a fixation with mass shootings, viewing extreme material, reconnaissance, forgery of a firearms certificate, obtaining a shotgun, and planning an attack in his former primary school. He was sentenced to custody for life with a minimum term of 49 years.

3.5.5. Case Study D concerns a young person who murdered two women at random using a knife he bought online. Before the murders, he had been accepted by Channel after accessing far-right material on a school computer. He was sentenced to custody for life with two concurrent minimum terms of 35 years.

3.5.6. Case Study E concerns a young person who carried out a series of violent assaults on elderly strangers in a park, including an attempt to drown one victim. He later fatally stabbed a 12-year-old child in a random knife attack. He was sentenced to detention for life with a minimum term of 13 years.

3.5.7. Case Study F concerns an individual who used a licensed shotgun to kill his mother before shooting six members of the public in the street, four of whom were killed. He shot himself and died at the scene.

3.6. Limitations

3.6.1. The report is subject to limitations. The number of case studies is limited; the report has been prepared without direct contact with the individuals themselves; and we have not had access to all the potentially disclosable evidence for each case. Our conclusions cannot therefore be read as an expert report into any individual case that is conclusive in terms of medical or neurodevelopmental diagnoses, or that expresses opinions that concern potential criminal or civil liability.

3.6.2. The nature, purpose, detail and completeness of the available material differs between the case studies. Some records were made at the time of key events, while others are later chronologies, summaries or reviews. We take these differences into account when determining the weight that can reasonably be placed on the evidence.

3.6.3. We have sought to avoid hindsight. Information that appears significant when a case is reconstructed later may not have been known or available to professionals or a service at the time. Later chronologies and reviews can also bring together information that was originally held by different professionals or services. Where the evidence allows, we therefore distinguish between what was known or available at the time and what became apparent only later, and we do not assume that individual professionals or agencies knew of information that appeared in a later account.

3.6.4. Where an action, discussion or piece of information is not recorded in the material available to us, we do not assume, without supporting evidence, that it did not occur or was not known.

3.7. Legislative, policy and professional framework

3.7.1. Our analysis takes account of the legislation, statutory guidance, statutory codes and relevant professional and non-statutory guidance applicable within our respective areas of expertise. We have considered differences between the legal and policy frameworks in England and Wales where relevant.

3.7.2. The principal areas considered are safeguarding and multi-agency working; children's social care and family support; education; SEND/ALN; mental health and neurodevelopment; policing, criminal justice and youth justice; Prevent and Channel; online safety; relationships and harmful sexual behaviour; and privacy, human rights and information sharing.

3.7.3. We distinguish between legal and statutory requirements and non-statutory guidance or professional resources when considering what was required and what represented expected or recommended professional practice.

3.7.4. A detailed schedule of the principal legislation, statutory guidance, codes and other guidance relied upon in preparing this report is provided at Appendix 1.

3.8. Thematic analysis

3.8.1. We have considered the six case studies collectively to identify recurring themes, cross-cutting patterns and systemic issues relevant to violence fixation and the identification, assessment and management of associated concerns.

3.8.2. Our analysis examines how concerns developed, persisted and escalated over time; what relevant professionals and services knew or could reasonably have known at the time; how information was recorded, shared and assessed; and how services responded through support, referral, intervention, escalation and multi-agency working. This includes relevant aspects of the young person's development, needs and circumstances, including education, mental health, neurodevelopmental needs, family and peer relationships, online activity and behaviour.

3.8.3. We do not treat any single diagnosis, vulnerability, interest or behaviour as predictive of serious violence. Rather, our analysis considers the accumulation and interaction of relevant concerns and, where information was held by different professionals or services, whether bringing that information together would have materially changed the picture available at the time.

3.9. Anonymity and confidentiality

3.9.1. The purpose of this report is to provide thematic analysis across the six case studies, rather than to conduct or publish a separate review of each individual case. We have therefore included case-specific information only where it is necessary to evidence or explain a wider thematic finding.

3.9.2. Anonymity orders apply in relation to two of the case studies, requiring particular care to avoid jigsaw identification through the publication of individual details which, whether alone or in combination with other information in the public domain, could enable those individuals to be identified. More generally, we do not consider the use of a cipher alone to provide sufficient protection against identification. We have therefore adopted a consistent protective approach across the case studies, limiting case-specific information where its inclusion is not necessary to the thematic analysis or could create an avoidable risk of identification or further notoriety.

3.9.3. The material reviewed contains highly sensitive information concerning not only the young people who committed the offences, but victims, family members, professionals and other individuals. Publication of such information has the potential to cause further harm, including through identification or unwanted exposure to distressing or potentially retraumatising material. Our approach is to preserve the substance of the evidence, our analysis and our professional opinions while limiting details that are not necessary to the thematic purpose of the report and that may create an avoidable risk of identification or harm. This does not limit our scrutiny of the evidence or obscure the findings relevant to the Inquiry, but reflects our respective professional obligations concerning confidentiality, the handling of sensitive information and informed consent.

3.10. Recommendations

3.10.1. Our recommendations for the Inquiry focus principally on systemic learning and improvements to current and future practice and avoid attributing fault to individual professionals or agencies.

3.10.2. Where a case provides evidence of a missed opportunity, gap or limitation, we use it principally to identify the wider thematic or systemic lesson that can reasonably be drawn from it.

3.10.3. The report reflects the collective opinion of the cadre. Recommendations requiring specific professional expertise are informed by the relevant expert or experts, while issues crossing professional boundaries are considered collectively.

3.10.4. Each expert's opinion remains limited to matters within their professional expertise. Any material difference of professional opinion is identified.

3.11. Terminology

3.11.1. We use terminology appropriate to England and Wales and to the professional context concerned. Where systems use different terms, we use the term appropriate to the jurisdiction and context.

3.11.2. We use violence fixation in the sense adopted by the Inquiry. The term is not a clinical diagnosis and does not, by itself, mean that an individual will commit an act of violence.

3.11.3. A glossary of the principal terms and abbreviations used by the Expert Cadre is provided at Appendix 2.

4. Overview of relevant agencies and systems

4.1. As with AR, the young people in the case studies had contact with a range of services, including Children's Social Care, Prevent, the police and CAMHS mental health services. Several had substantial involvement with Children's Social Care over many years in the context of domestic violence and, in some cases, parental substance misuse and poor mental health. Most of the young people have now reached adulthood, but the material available to us mostly concerned their childhood up to the age of 18. There has therefore been little involvement with adult services for any of the cases, including adult mental health services.

4.2. The young people had contact with their local CAMHS (Child and Adolescent Mental Health services) and/or paediatric services. Several received a diagnosis of Autistic Spectrum Disorder (ASD) prior to the offence as well as support for their mental health.

4.3. The nature and extent of support received by the young people and their families varied significantly. Repeated referral to CAMHS was common across the cohort, although there were also instances in which young people did not agree to engage with CAMHS. Several had identified special educational needs and disabilities (SEND), and statutory plans to meet those needs that included Statements of SEN or Education, Health and Care (EHC) Plans that were common across the cohort. Specialist educational provision catering for social, emotional and mental health (SEMH) needs also featured in the case studies.

4.4. Several young people were referred to Prevent; some progressed into Channel and received intervention from an Intervention Provider (IP). There were also instances of agencies having hypothetical discussions with Prevent about young people that did not result in a referral, where the concerns identified were not considered sufficient to warrant further involvement in Prevent.

4.5. Evidence records differing levels and types of contact with the police across the cohort. This included young people who had not previously been known to the police, those known to be victims of domestic violence or other crime, and those known in relation to their prior offending that had not resulted in convictions. There was no corresponding involvement with the Youth Offending Service in relation to that offending.

5. Themes emerging from the case studies

5.1. Risk pathways for violence-fixated individuals

5.1.1. The young people were within the age span associated with neuroimmaturity at the time of the relevant offending. Neuroimmaturity describes the developmental period during which the upper brain continues to acquire the learning and capacities needed to regulate the sensation-seeking that is associated with puberty. The extent to which this develops is influenced by positive developmental opportunities and experiences, which were few in number for the case studies.

5.1.2. Significant family adversity and instability were prevalent across the cohort, often beginning in infancy or early childhood. This included exposure to domestic violence, experiences of violence within the family and safeguarding concerns. Parental separation and disrupted or inconsistent parental care were common features, including absent, intermittent or disrupted relationships with biological parents. The case studies also included periods of temporary removal from parental care because of their addiction and mental health difficulties. In some circumstances, extended family members stepped in to provide care or support.

5.2. Neurodevelopmental conditions

5.2.1. The case studies included diagnoses of autism spectrum disorder (ASD), made at different stages of development and, in some instances, after the index crime. There were also co-occurring neurodevelopmental diagnoses, including attention deficit hyperactivity disorder (ADHD) and conduct disorder.

5.2.2. Although there was no recorded diagnosis of foetal alcohol spectrum disorder (FASD), the case study material included evidence of maternal substance and alcohol misuse during pregnancy in a number of cases. This is not equivalent to a diagnosis, although "possible FASD" was identified by a psychiatrist in one case. Where there is evidence of maternal alcohol use during pregnancy, this forms an important part of the young person's developmental history. Possible foetal alcohol spectrum disorder (FASD) is often not confirmed by specialist professionals and is thereby often overlooked, but because of its overlap with other neurodevelopmental conditions, there is a risk of diagnostic overshadowing, with difficulties attributable to FASD interpreted through the lens of

neurodivergence. Identifying the young person's full pattern of neurodevelopmental and functional needs is important for a statutory SEND assessment and a suitably individualised plan of educational, health and care support, with adaptations and interventions matched to these needs.

5.2.3. Although FASD overlaps with ASD and ADHD it is a developmental syndrome in its own right that affects the central nervous system and manifests in intellectual disability, learning disorders and behavioural and emotional dysregulation. Where FASD is diagnosed both social and emotional development are slow and the children are placed in schools for those with special educational needs. Those with this syndrome can display early aggression and inappropriate sexual behaviour, which was the case in some of the cases who were placed in SEN schools. Awareness of this syndrome is important for parents and teachers, who need to understand their needs and challenges and provide appropriate support.

5.2.4. Across the case studies, young people were identified as neurodivergent at different stages of their development. Neurodivergence does not cause misconduct, but as neurodivergent children grow, they need understanding and support to adjust to the neurotypical world, which can present additional difficulties when parents themselves are also neurodivergent. Both ASD and ADHD are lifelong conditions that are considered to be heritable.[1] ASD is associated with difficulties in social interaction, communication and emotional regulation, while ADHD includes attention deficits, hyperactivity and impulsivity, as well as emotional dysregulation. These overlapping features can make diagnosis and treatment complex.

5.2.5. Awareness of neurodiversity is relatively recent, such that it is unlikely that the parents of the children we reviewed were aware of their own potential neurodivergence. Where parents are themselves neurodivergent, they are likely to view their child's impulsivity, attention deficits, sensory avoidance and emotional reactivity as normal, when it can be interpreted by teachers as disobedience. If this is not understood, made explicit and managed between the school and the home, those with neurodevelopmental conditions, or FASD, can come to believe they are lazy, naughty or not good enough, which in turn can lead to shame, anxiety, depression, emotional overwhelm and defensive aggression.

5.2.6. Without an understanding of their needs the parents can themselves feel shamed and overwhelmed by the demands of parenthood that can lead to anger and domestic violence. Neither does neurodivergence fade with age. Without the necessary understanding and support they need, neurodivergent and FASD children can grow into young adults who mask their emotions, burn out, and react with aggression and violence. In these circumstances, several of the young people we reviewed retreated into a safe place where online dialogue was easier than real life relationships and where they found the sensory reward they sought, turning their backs on their parents, teachers, guardians and siblings.

5.3. Mental health and support

5.3.1. There was a clear pattern of young people being referred to mental-health services, and in more than half of the cases there was evidence of deliberate self-harm or suicidality. These

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1 Gidziela, A., Ahmadzadeh, Y.I., Michelini, G. et al. A meta-analysis of genetic effects associated with neurodevelopmental disorders and co-occurring conditions. Nat Hum Behav 7, 642-656 (2023). https://doi.org/10.1038/s41562-023-01530-y **(ILT000347)**

young people therefore had substantial and, in some cases, increasing mental-health and therapeutic needs. All suffered with low mood and anxiety, though few were clinically diagnosed because of their young age and neurodivergence, and because mental health professionals are careful not to apply adult diagnoses to young people when they are not fully mature.

5.3.2. In some cases, the focus was on the young person's behaviour or diagnosis, without consideration of other jeopardies that affected their mental health, such as family trauma, stress, disrupted routines, educational failures and social isolation. Mental health should be understood in the context of the young person's daily functioning and environment. When the demands placed on them exceed their capacity to cope, mental-health difficulties become more prominent. Loss of structure and changes in established routines are likely to be particularly significant for autistic young people and for those with other neurodevelopmental needs, and crucial for a holistic assessment.

5.3.3. In the majority of cases the response from mental-health services was poor, though there were also some examples of significant CAMHS involvement. Their pathways are primarily designed for diagnosable mental-health conditions, which do not include trauma-related therapeutic needs. As a result, young people experiencing trauma alongside neurodevelopmental needs, self-harm, suicidal thoughts and other mental-health concerns, rarely receive the level of support necessary to meet the full range of their needs.

5.3.4. Contact with CAMHS was variable, inconsistent and sometimes difficult to access. There was little feedback from them to the referring source, and Education providers found it hard to unlock their support when this was requested. CAMHS remit and therefore their focus was on the child's needs, and they rarely commented on potential risk to others. There were, however, references in CAMHS documentation to concerns about the mental health of their parents, that included evidence of some being sectioned under the Mental Health Act, which would have constituted a significant jeopardy for their children.

5.3.5. Mental-health involvement was therefore very variable. The loss of structure and routine due to suspension or permanent exclusion from school is identified as a significant contributor to the isolation experienced by young people. Both them and their families sought for sustained support following their assessment or referral.

5.3.6. For VFIs, mental-health difficulties should not be treated as an explanation for their violent behaviour or considered independently from other jeopardies that are relevant to risk. When mental-health concerns occur alongside concerns about violence, schools are well positioned to contribute important information about the young person's presentation, current functioning and changes over time. The loss of structure and routine during periods of educational disruption due to suspension, permanent exclusion or lack of suitable provision is a significant contributory factor to the sense of isolation experienced by the young people in these case studies.

5.3.7. There needs to be an emphasis on support at the earliest point, such that those with multiple and complex needs havetime to engage and build trust with a professional before they participate in a formal assessment. In one case, the young person was reluctant to engage in an ASD assessment but was willing to talk to someone, butthis was not provided.

Access to early help should not depend solely on a young person's willingness or ability to complete a particular diagnostic assessment.

5.3.8. A full mental health assessment should consider both safeguarding and the potential risk of harm to others and include an understanding of the multiple jeopardies and complex needs that their family context might contain.

> **Recommendation**: The Inquiry should explore whether clearer arrangements are required for the assessment and coordination of support where mental health, SEND, trauma and safeguarding needs overlap and there are emerging or escalating concerns about harm to self or others. This should include ensuring that mental-health assessment and treatment are accessible to neurodivergent young people, that relevant agencies jointly review the young person's needs and risks where necessary, and that responsibility for coordinating support and escalating concerns is clearly identified.
>
> **Recommendation**: The Inquiry should explore whether a clear therapeutic pathway is required for children and young people with significant trauma-related needs who do not meet the criteria for specialist mental-health services, particularly where these are accompanied by self-harm, suicidality or escalating behavioural concerns.

5.4. Childhood trauma and adversity

5.4.1. Developmental and behavioural difficulties were apparent from very early childhood for several young people and developed in the context of longstanding trauma and adversity. Although there is evidence that progress was made at different points with support from a range of services, this was not sustained. The case material records increasing difficulties with emotional and behavioural regulation over time, with incidents of violence and aggression escalating in seriousness and extending from peers and family members to professionals and members of the public. Alongside increasing risk to others, there were significant concerns about risk to self, including deliberate self-harm and suicidality. The case studies demonstrate how developmental vulnerability and trauma manifested in increasing behavioural dysregulation, in which risk of harm to self and risk of harm to others co-exist.

5.4.2. The Domestic Abuse Commissioner's review of babies', children's and young people's experiences of domestic abuse summarises the evidence of both the immediate distress and longer-term effects associated with children's exposure to domestic abuse:

5.4.3. "Alongside the distress experienced while abuse is occurring (such as increased levels of fear, inhibition, isolation, loss, anxiety and depression) is the likelihood of longer-term trauma that affects physical and mental health, development, behaviour and emotional wellbeing. Negative psychological impacts of coercive control that children are likely to experience include a lack of security and safety, a reluctance to trust others and limited

opportunities to choose, feel free and develop a sense of independence." (Domestic Abuse Commissioner, 2025)[2]

5.4.4. The young people's family and caregiving histories record longstanding concerns relevant to parental capacity and the safety and stability of the home environment. This included domestic abuse, neglect, emotional and physical abuse, parental offending and periods of imprisonment, parental absence and inconsistent care. There are instances in which protective restrictions such as restraining orders were imposed but parental relationships were re-established. Changes and recurring concerns within family relationships and their circumstances are integral to the continuing monitoring of a child's safety, development and support needs. Where a child has SEND or emerging developmental and behavioural difficulties, this is particularly significant because their vulnerabilities increase their need for safe, stable, predictable and containing care, making the capacity of parents and caregivers to provide consistent care, boundaries and support an important part of understanding and assessing those needs over time.

5.4.5. The disclosed materials provide evidence that different services recorded relevant information at different stages of the young people's development, including direct observations of concerning interactions within the family. However, the material reviewed does not demonstrate that, before the index incidents, this information was brought together to develop a complete picture of the child's lived experience and caregiving environment. In some cases, this was compounded by instances in which the significance of longstanding and accumulating concerns was overlooked or minimised.

5.4.6. In some of the case studies, we consider that the history, persistence and accumulation of concerns warranted earlier consideration of protective intervention, including whether removal from the parental home was necessary. Developmental and behavioural difficulties evident from very early childhood increased the young people's need for a safe, stable and consistent caregiving environment and made parental and caregiver capacity particularly relevant both to the assessment of their protective needs and to understanding and responding to their developmental and support needs.

5.5. The role of families

5.5.1. The Domestic Abuse Act 2021 recognises children as victims where they see, hear or experience the effects of domestic abuse, an approach reflected in KCSIE 2026[3], which also recognises the potentially harmful impact of domestic abuse on children. This is relevant when considering the role of parents and wider family members as protective influences: family networks can be an important source of support and protection, but this must be balanced against the need to identify and respond to harm occurring within the family.

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2 Victims in their own right? Babies, children and young people's experiences of domestic abuse. April 2025, Domestic Abuse Commissioner for England and Wales **(ILT000353)**

3 Department for Education. (2026). Keeping children safe in education 2026: Statutory guidance for schools and colleges (DFE000263)

5.5.2. In one case, active parental involvement was reported as protective, but it is unclear from the material reviewed whether professionals considered whether changes in the young person's behaviour in that parent's presence were "due to fear and/or coercive control by his father".

5.5.3. Across several of the case studies, members of the wider family took significant responsibility for supporting and caring for the young people, including siblings, aunts and uncles, and grandparents. This reflects the increasing emphasis within children's social care on identifying and involving family networks where it is safe and in the child's best interests (Working Together, DfE, 2026[4]). The Families First Partnership reforms reinforce this approach through Family Help, family group decision-making and family network support, including to help children remain safely within their family networks[5].

5.5.4. In New Zealand radicalised young people are treated as a welfare concern for the whole extended family, and they take a lead role in providing support as 'partners in practice' with the professionals[6]. In this model, following an initial shared discussion with the social worker, psychologist and family together, the professionals withdraw for an hour during which the family develop their own plan to protect their family member and take responsibility for its management, with support from professionals.

5.5.5. In England and Wales, family group decision-making (FGDM), including family group conferences (FGCs), are used within children's social care to involve wider family networks and help prevent entry into care. In England, FGDM forms part of the Families First Partnership reforms, while in Wales Family Group Meetings form part of the Early Intervention and Prevention Framework[7]. The case studies raise the question of whether opportunities to use these approaches preventatively were sufficiently considered and whether current resources and structures provide opportunities to enable this to happen.

5.6. The route to violent fixation

5.6.1. There are no specific indicators to identify a young person at risk of becoming a VFI. There are instead inherited jeopardies such as neurodivergence and FASD that without parental support can lead to frustration and anger with their failure to achieve and, over time, affect their self-efficacy and sense of worth. Risk is assessed from the identified risk factors and from failures of protection.

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4 Department for Education. (2026b). Working together to safeguard children 2026: A guide to multi-agency working to help, support and protect children (NHS000592).
5 Department for Education. (2026). Families First Partnership programme guide: Delivery expectations for statutory safeguarding partners in England: Year 2 (2026 to 2027) (ILT000346)
6 The Family Network Meeting approach draws on principles associated with Family Group Conferencing, which originated in New Zealand. Research into the New Zealand model examined the involvement of the wider family and social network in decision-making and planning with children and young people. See Maxwell, G. M., & Morris, A. (1993). Families, victims and culture: Youth justice in New Zealand. Social Policy Agency & Institute of Criminology, Victoria University of Wellington; Morris, A., & Maxwell, G. (1998). Restorative justice in New Zealand: Family group conferences as a case study. Western Criminology Review, 1(1), 1–17. (ILT000349)
7 Welsh Government. (2026). Early intervention and prevention framework to support babies, children, young people and families in Wales (ILT000354)

5.6.2. The toxic trio of domestic violence, substance misuse and mental health problems in the home creates long-term trauma in children, which in most of the case studies reduced their parents' ability to keep their children safe and comfort them.

5.6.3. It is also likely that the parents themselves are carrying their own long-term trauma that reduces their capacity to console and support their children. In several cases the parents were of mixed race which in itself may have created a racism jeopardy, and in one there was evidence of the impact of war trauma on the parents who came to the UK as refugees and that manifested in the father's violence and the parents' subsequent divorce. The irony is that the physical absence and/or intermittent absence of a violent parent puts a strain on the family but also reduces the risk of violence in the home, though it does not provide long-term security.

5.6.4. Neurodivergence is not a risk factor in itself but becomes an issue if the necessary supports are not in place to help neurodivergent young people manage the challenges they face and regulate their emotions and behaviour, all of which contribute to self-hate, self-harm, poor mental health and a burgeoning sense of grievance.

5.6.5. Also relevant is the role of the internet that reliably provides comfort and connection to autistic individuals and allows them to build social relationships, learn new things and follow their interests, but it also carries the jeopardy of attracting those drawn to violence for whom this can be addictive. However, such jeopardies are shared by many young people who do not progress to violent fixation, so risk assessment needs to include failures of protection as much as risk factors.

5.6.6. From the material available to us, the trajectory of all these young people included early signs of aggression towards adults and peers, and conduct issues, and in the cases with statutory SEND plans this included sexualised behaviour and damage to property, which escalated over time and resulted in suspensions and exclusions from school. At different points all these young people failed to thrive and eventually withdrew into an online world where they were in control and social skills were not required.

5.6.7. For some young people who were not in education, employment or training (NEET) (Department for Education [DfE], 2024[8]), online activity appeared to provide a significant source of stimulation and engagement, including through gaming, social media and intensive online searching. Several cases became fascinated with the perpetrators of mass attacks that they were separately plotting to match. There is evidence in the case studies of young people drawn to the occult and Satanism, others to Inceldom and some who were drawn to extremist violence that included the Far Right, ISIS and Al Qaeda.

> **Recommendation**: The Inquiry should consider recommending that the current ERG-R common assessment framework, developed by the Ministry of Justice for the assessment and management of terrorist offenders, is adapted to include the risk factors that correspond with the jeopardies identified here, together with protective factors that have the potential to prevent juveniles from completing a violent fixation pathway.

5.7. The role of ideology

8 Department for Education. (2024). Participation of young people: Education, employment and training: Statutory guidance for local authorities. UK Government. (ILT000358)

5.7.1. Ideology is associated with terrorism where it acts as a belief system that frames personal experiences of alienation, identity issues and grievance that justify violence against a political enemy. It requires identification with a political cause that is framed cognitively as a shared ideology. Violent fixation is also driven by alienation, grievance and a lack of identity, meaning and belonging, but also by embodied memories of childhood trauma, neurodiversity and poor mental health that are connected to embedded emotional and behavioural neural pathways. A violent fixation is not cognitively framed but emotionally framed, and VFIs are driven not by ideology but by a fixation with violence that is embraced as a solution to their despair when they can see no other future for themselves.

5.7.2. In several cases there was evidence that they had searched online for information on bomb making and knives from Islamist and Far Right sources, but this did not include ideology. AR came to the attention of Prevent and was charged for possessing material that could be useful to a terrorist, though his search history was more consistent with VFI motivation. The evidence revealed increased searches into how to cause serious harm which should raise the question of whether the individual has moved beyond interest towards an intent to harm.

5.7.3. An earlier assessment of low risk or a decision that a threshold was not met may have been consistent with the information available at the time but should be reassessed if new information appears. A significant change in online activity, relationships or behaviour may require reconsideration, re-referral or escalation. Such assessments are the preserve of Prevent and the Counter Terrorism (CT) police, whereas the responsibility of frontline professionals is to recognise concerning material and refer it to the relevant services. Prevent statistics for the year ending in March 2025 indicate that over half (56%) of the young people referred to Channel had no adherence to an identified ideology. There is therefore a sizeable pool of young people who are attracted to extremist violence with a range of different motivations, of which some will include violent fixation.

5.7.4. The incel (involuntary celibate) community is characterised by misogynistic beliefs about women and a fatalistic outlook on society. Incels claim to be 'misogynistic non-violent ideological terrorists' and are responsible for several mass attacks globally and recognised as an emerging terror threat. Both Canada and the United States have formally recognised incel-related violent extremism within their respective frameworks for addressing violent extremism. England and Wales have not gone as far in formally characterising incel-related violence as a form of violent extremism, although the Home Office now expressly identifies "InCel extremism" as a category of concern within Prevent.

5.7.5. An independent 2024 government study found that the mental health of incels was typically very poor, with a high number reporting that they suffered from depression and suicidal ideation. They also reported a high degree of victimhood, anger and misogynistic attitudes, and around a third passed the cut-off for a medical referral in an ASD questionnaire[8]. These jeopardies are mirrored in our six case studies, some of whom shared an interest in incel-related material online, one of whom was on an escalating trajectory of increasing violence

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9 Whittaker, J., Costello, W., & Thomas, A. G. (2024). Predicting harm among incels: The roles of mental health, ideological belief and social networking. Journal of Sexual Aggression, 30(1), 97-112 (MOJ000002)

with little insight into his behaviour. Across the case studies, incel-related interests formed part of a broader pattern of online activity that also included violence, weapons-related and masculinity-related content.

5.7.6. It is evident that some of our cases and those in the broader incel groups carry multiple shared grievances, of which their involuntary celibacy is but one, but the influence of the growing manosphere offers the possibility of this being framed as a misogyny-motivated ideological terrorist movement, which confers a degree of power and status on those who seek this.

5.8. Parental oversight and digital literacy

5.8.1. Families across the case studies experienced difficulties understanding or monitoring aspects of the young people's online activity. Some parents recognised the concerns and attempted to respond by removing devices or restricting access. These measures were not always sufficient, particularly where internet access remained available through other devices, accounts or locations.

5.8.2. Placing responsibility for serious violence on parents is not a sufficient protection. Parents cannot be expected to undertake specialist digital monitoring or replicate the investigative powers of the police. Some were actively trying to manage behaviour which they found difficult to understand or control. Where parents are expected to restrict or monitor digital access, they need practical support to understand what is required and how the young person is accessing the internet. This would require knowledge of the devices and accounts being used, parental controls, access through other people or locations, and applications or technical features that reduced their visibility. The purpose was not surveillance for its own sake, but a means of ensuring that an agreed safeguarding measure was capable of implementation and review.

5.8.3. Disclosed records provided little evidence that parents were given structured support to understand the platforms, communities or content involved, or that the effectiveness of agreed controls was under review. Where the concern exceeded what could reasonably be managed through parental oversight or single-agency arrangements, the question becomes one of wider safeguarding coordination, where existing adolescent-risk arrangements may provide a mechanism for coordinating high levels of risk for the young person or others.

> **Recommendation**: The Inquiry should explore whether there is sufficient practical digital-safety support to families where significant online concerns have been identified, including support adapted to the young person's communication and neurodevelopmental needs and review of whether agreed measures are workable and effective.

5.8.4. Social media and internet activity were concerning issues across the cases, although its content, extent and significance differed between them. There was evidence of extensive gaming and social media use, but also the accessing of violent, sexual, misogynistic and extremist material. There was also contact with extremist groups and online communities, repeated searches and posts about harming others and the viewing of extreme material. In many cases their online activity provided evidence of preparation and intent to harm,

such as researching how to obtain weapons or other resources, while concealing their online activity or identity.

5.8.5. Across the case studies, online relationships formed an important part of their social lives and were the only option for those who were not at school. They were not without social contact, but their relationships were not visible to their parents or professionals, which effectively excluded them. Broad descriptions such as "gaming", "internet use" or "inappropriate content" do not clarify what a young person is doing online and what, if any, safeguarding response is required. Disturbing violent or extremist material was present in most cases but not detected by their parents. The digital world has changed rapidly within a generation from social media, messaging and gaming to streaming, online forums and new technologies that are part of young people's everyday lives.

6. The multi-agency response

6.1. Multi-agency safeguarding arrangements (MASAs)

6.1.1. Phase 1 of the Inquiry found that existing risk-management systems did not identify the risk associated with AR's increasing violent fixation, pointing to a wider system failure. It also found that child-protection processes are designed principally to respond to harm experienced by children, but do not consistently recognise or manage the violent risk a young person may pose to others. This raises wider questions about current risk-management systems, interventions, professional accountability and multi-agency working.

6.1.2. In considering the management of violent fixation, the cadre has examined current risk-management systems, interventions, professional accountability and multi-agency working.

6.1.3. Multi-Agency Safeguarding Arrangements (MASAs), established pursuant to the Children and Social Work Act 2017[9], provide the local mechanism to ensure that children and young people are protected from harm through coordinated action and processes. They provide clear and agreed thresholds, pathways and multi-agency safeguarding procedures alongside escalation processes. Their purpose is not only to coordinate practice, but to enable local areas to learn from inquiries, practice reviews and inspections, identify gaps and set system priorities. Alongside this, each area must also have multi-agency arrangements for adult safeguarding.

6.1.4. The three statutory partners, Integrated Care Boards, Police and Local Authorities, are responsible for setting priorities, ensuring the wider system is delivering them and working to the local safeguarding protocols.

6.1.5. Given the focus of the multi-agency safeguarding arrangements is the risk of harm to the child, they did not consistently bring together concerns about children who may pose a risk of violence to others. While local areas have systems and processes for child protection, Prevent, Multi-Agency Public Protection Arrangements (MAPPA) and exploitation, there is

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10 Multi-Agency Safeguarding Arrangements (MASAs), established under the Children and Social Work Act 2017 (Children and Social Work Act 2017, ss. 16E-16G) (CSPRP000024)

no consistently used route for drawing the whole picture together when concerns cross those boundaries and move into risk to others.

6.1.6. The case evidence shows how multi-agency practice can improve over time when arrangements are used to drive learning. In older cases, professionals repeatedly minimised domestic violence, gave greater weight to the male voice, failed to recognise the impact on the child and did not escalate concerns to child protection; even where concerns were appropriately escalated, the evidence included significant delay before a child protection conference took place, without education attendance or a report being provided.

6.1.7. While partnership learning has driven improvements in practice in relation to domestic abuse, it must now drive improvements in practice in relation to Violent Fixated Individuals and serious violence-related concerns. Each MASA annual report should identify how it is addressing extra-familial harms, including learning from the Southport Inquiry, as part of its reporting on multi-agency priorities, learning, impact and improvement (DfE, 2026, paras. 112-113[10]). This should include how the partnership will develop professional understanding of VFIs, strengthen information sharing, and ensure that serious violence-related concerns are not managed in isolation by individual agencies.

6.1.8. Recommendation: The Inquiry should consider recommending that each Multi-Agency Safeguarding Arrangement publishes within its plan how it will take forward the learning from the Southport Inquiry.

6.2. MASA and education

6.2.1. Multi-agency safeguarding partnerships need to ensure that Education is central to the safeguarding response. Schools and colleges had the most sustained day-to-day contact with the young people in most of the case studies and could therefore hold information about changes in their presentation and functioning that was not visible to other agencies. Education's contribution to Multi-Agency Safeguarding Arrangements is consequently important in ensuring that this longitudinal knowledge forms part of the wider assessment of a child's needs and risk.

6.2.2. The case studies demonstrate the significance of this contribution. Education frequently identified concerns and made referrals to CAMHS, Prevent and children's social care, sometimes continuing to raise concerns despite limited or unsuccessful responses from other agencies. In several cases, the school or college was the only agency to have sustained involvement with the young person, giving it a perspective that other agencies may not have had. The issue for multi-agency arrangements is not whether Education makes referrals, but whether the information it holds is brought together with that held by other agencies to inform subsequent assessment and decision-making.

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[11] Department for Education. (2026). Working together to safeguard children 2026: A guide to multi-agency working to help, support and protect children (NHS000592)

6.2.3. These findings are consistent with concerns identified nationally. The Independent Review of Children's Social Care (MacAlister, 2022[11]) concluded that, in too many areas, the contribution and voice of Education was missing from safeguarding partnership arrangements and recommended that schools become a statutory safeguarding partner. The national review following the murders of Arthur Labinjo-Hughes and Star Hobson similarly emphasised the pivotal role of education settings in identifying concerns, recognising escalation and sharing information with safeguarding partners[12].

6.2.4. The Children's Wellbeing and Schools Act 2026 responds to these concerns by providing for a strengthened role for Education within Multi-Agency Safeguarding Arrangements. Once the relevant provisions are commenced, education and childcare agencies will be included automatically as relevant agencies, with their views represented in operational and strategic priorities. The reforms do not, however, make Education a statutory safeguarding partner; responsibility and accountability remain with the local authority, Integrated Care Board and police.

6.2.5. Working Together to Safeguard Children 2026 (NHS000592) describes education providers as having a "pivotal role" and provides for Education's contribution to be represented at the highest level of decision-making, including strategic discussions. The practical issue is therefore whether Education's knowledge of an individual child is consistently brought into multi-agency assessment and whether relevant information is shared back to Education.

> **Recommendation**: The Inquiry should consider recommending that the Government review whether education should become a statutory safeguarding partner within Multi-Agency Safeguarding Arrangements.

6.3. Organisational ownership of VFIs

6.3.1. Phase 1 of the Inquiry identified a central issue: no single-agency or multi-agency structure held clear responsibility for managing the risk posed by a young person who may harm others. Current safeguarding and child-protection legislation focuses on promoting welfare, reducing risk to the child and responding where a child is suffering, or is likely to suffer, significant harm. It does not assign clear responsibility where the child is also the potential source of harm to others.

6.3.2. Within education, schools and colleges have statutory duties to safeguard and promote children's welfare and must have regard to Keeping Children Safe in Education (KCSIE). KCSIE 2026[13] gives greater prominence to circumstances in which a child's behaviour may present a risk to others, while recognising that the child may have safeguarding and support needs of their own. It identifies early signs of abusive, violent or harmful behaviour as potentially requiring additional support and serious violence and radicalisation as forms of

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12 MacAlister, J. (2022). The independent review of children's social care: Final report. Department for Education (DFE000204)
13 Child Safeguarding Practice Review Panel. (2022). Child protection in England: National review into the murders of Arthur Labinjo-Hughes and Star Hobson. Department for Education (CSPRP000048)
14 Department for Education. (2026). Keeping children safe in education 2026: Statutory guidance for schools and colleges. Department for Education (DFE000263)

extra-familial harm (paras. 18, 21). Where information indicates a risk to others and/or the individual pupil, including previous concerns involving a knife or weapon, schools are expected to assess the risk and put in place a safety and support plan (para. 152). Relevant information about serious violence, harmful behaviours or existing Channel support should also be shared promptly when a child or young person moves to a new school.

6.3.3. Although this statutory guidance makes clear that safeguarding includes responding to risks a child may pose to others, it does not resolve the wider question of responsibility for assessing and managing those risks where concerns involve more than one agency.

6.3.4. The wider legislative and multi-agency safeguarding frameworks do not resolve this question. The Children Act 1989, the Children Act 2004, the Children's Wellbeing and Schools Act 2026 and Working Together to Safeguard Children 2026 (NHS000592) all create important duties to safeguard and promote the welfare of children. Although they encompass wider safeguarding concerns, including extra-familial harm, exploitation and serious violence, they do not establish a clear overarching framework for the assessment and management of children who may themselves pose a serious risk of harm to others, particularly where concerns do not fall clearly within established safeguarding or other statutory pathways. This can leave uncertainty about professional and agency ownership, thresholds for escalation, responsibility for bringing together information about developing risk, and the mechanism through which that risk should be assessed and managed.

> **Recommendation**: The Inquiry should consider recommending that the Government reviews and consults on the legislative gap to clarify the lead process for managing violent fixated individuals.

6.3.5. Across the case studies, there is evidence of referrals made to other agencies or pathways, including Prevent, social work and CAMHS. Professionals then appeared either to treat the case as having been handed over or to await the outcome of the referral before taking any further action. This creates particular concern where professionals are managing serious risks such as violent fixation.

6.3.6. To strengthen multi-agency working in these circumstances, systems and structures need to focus not only on a single "lead practitioner" or "lead agency", but on identifying the lead process. In child safeguarding, this may be the child protection process. For terrorism-related concerns, a referral may be made through Prevent, with Channel providing a multi-agency process for assessing and supporting individuals where the relevant threshold is met. However, one process does not exclude the other, and each element of the plan should be owned by the relevant agency.

6.3.7. Effective multi-agency working should enable professionals to work together with overlapping plans, ensuring that all risks are addressed and that each professional understands their role within the risk-management plan. Referral should not become a means of transferring risk or closing a case prematurely.

6.4. School safeguarding arrangements

6.4.1. KCSIE 2026 provides a framework for schools to identify, record and respond to safeguarding concerns. The designated safeguarding lead (DSL) supports staff to carry

out their safeguarding duties and liaises closely with other services. DSLs are expected to liaise with relevant staff, including SENCOs and mental-health leads, so that "children's needs are considered holistically". The guidance emphasises the "critical importance of recording, holding, using and sharing information effectively" (KCSIE 2026, Annex B). Written records should be detailed, accurate and secure and include all concerns, discussions and decisions made, the rationale for those decisions, and whether referrals were or were not made to another agency (DfE, KCSIE, 2026).

6.4.2. Within the case studies the effectiveness of these arrangements depended first on concerns being recognised and acted upon within the school. There were instances where significant decline in academic attainment, attendance, behaviour or functioning did not lead to further assessment, support or referral. This was particularly apparent where young people were quiet and less likely to draw attention to themselves. Schools' and colleges' regular contact with young people places them in an important position to identify these changes and contribute to the developing safeguarding picture, consistent with Working Together 2026, which highlights the "pivotal role" of Education in safeguarding.

6.4.3. In the context of VFIs, violence-related concerns should be considered alongside the young person's wider needs and circumstances. SEND, neurodevelopmental and mental-health needs are important to understanding their presentation and identifying appropriate support and intervention, but should not obscure potential risk to others or the need for escalation. KCSIE 2026 identifies serious violence as a safeguarding concern and emphasises the importance of early identification and intervention.

6.4.4. Across the case studies, recording of safeguarding concerns was inconsistent. Electronic systems provided a structure for logging and tracking concerns, but records were sometimes incomplete and did not always capture ad hoc or hypothetical conversations with agencies. Case study material identifies instances of contact with Prevent, CAMHS and children's social care about young people which informs decision-making but is not recorded at the material time. Gaps in recording safeguarding concerns may have occurred where staff lacked time or access to safeguarding systems, including professionals working closely with vulnerable children who were not always resourced to record their concerns. Effective arrangements therefore require appropriate resourcing, clear recording expectations, training, monitoring and DSL oversight, consistent with Working Together 2026.

6.4.5. The school's safeguarding role does not end when a referral is made. KCSIE 2026 requires concerns to remain under review: where a child's situation is not improving or is deteriorating, further referral or escalation should be considered, and referrals should be followed up. Schools should therefore continue to share new information and respond to changing or accumulating concerns rather than assume that responsibility has transferred to another agency. This is particularly important where violence-related concerns are continuing or escalating.

6.4.6. The case studies provide some examples of professionals attempting to re-refer young people for support, including to CAMHS. However, these attempts were hindered by a lack of information or understanding about how concerns should be progressed or escalated when support was not forthcoming. There were more examples where further referral or

escalation did not occur despite deterioration or increasing concern. This included enquiries about local authority support to reduce the risk of a young person becoming NEET that were not progressed until crisis point, and a case where the breakdown of a college placement did not prompt further referral.

6.5. Assessment, planning and review of special educational needs

6.5.1. Across the case studies, there were significant changes in the young people's wellbeing, behaviour and functioning which should have prompted consideration of whether their needs remained adequately understood and whether existing support and provision remained appropriate. This was particularly important where difficulties persisted despite intervention, behaviour escalated, placements became unstable or presentation changed substantially during adolescence. In an education context, the cause of such changes does not need to be established before considering whether further assessment, support or referral is required.

6.5.2. The SEND Code of Practice[14] establishes a graduated approach of assess, plan, do and review. Earlier decisions and actions should be revisited and refined as understanding of the pupil's needs develops, drawing where necessary on more detailed approaches and greater specialist expertise. Assessment should draw on information from the pupil, parents, school and relevant professionals rather than relying on a diagnosis or assessment made at one point in the child's development. This is particularly important where a young person's presentation changes substantially over time.

6.5.3. Children with SEND or certain health conditions may face additional safeguarding challenges, including assumptions that indicators of possible abuse relate to their condition, being disproportionately affected by behaviours such as bullying without outwardly showing signs, and communication barriers and difficulties in managing or reporting those challenges. In such cases, additional pastoral support and extra support for communication should be considered (DfE, KCSIE 2026, paras. 249-251). This is particularly relevant to the case studies, where difficulties with communication, social interaction and emotional regulation were evident to differing degrees, but evidence of additional support was limited and, in most cases, emerged only at or around points of crisis.

6.5.4. Assessment and support did not keep pace with significant changes in needs, circumstances or functioning across the case studies. Earlier understandings of need were not revisited as the young person's presentation changed, and specialist assessment or input was sometimes delayed or not completed. In some cases, professionals questioned whether changes reflected autism, mental ill-health or other factors without any evidence of coordinated reassessment as practioners' concerns continued. This highlights the

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15 Department for Education, & Department of Health. (2015). Special educational needs and disability code of practice: 0 to 25 years: Statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities. Department for Education. **(ASCL000012)**

importance of regularly reviewing a young person's needs as they develop into adolescence.

6.5.5. In one case, staff identified a marked change in the young person's presentation as he moved into post-16 education, recording "red flags", increasing disengagement and concerns for his wellbeing. Education staff questioned whether his presentation reflected autism, mental illness or drug use and described occasions when he became mute when stressed. Support documented by the school included TAC meetings, SENCo involvement, mentoring, and a referral to MASH. However, the evidence does not evidence a coordinated reassessment as concerns continued or after the MASH referral was declined. The young person's refusal to participate in assessment created a practical limitation but did not remove the need to continue reviewing the information available and the support that could be offered.

6.5.6. Communication barriers may present as an additional safeguarding challenge for some children with SEND presenting a need for appropriate communication support. Where there is evidence of such support in the case studies, this relied principally on the discretionary effort or lived experience of individual practitioners, rather than established and consistent mechanisms to aid communication.

6.5.7. Changes in a young person's behaviour or functioning can be important indicators of changing need or increasing risk, particularly where there is self-harm, suicidal ideation, violence, offending or disruption to education. These factors are not evidence of violent fixation in themselves but may contribute to a wider picture of concern when considered alongside violence-related behaviour and other information known to professionals. This is consistent with KCSIE 2026, which emphasises the importance of recognising indicators of harm and identifies serious violence as a safeguarding concern (KCSIE, 2026, paras. 47, 52).

6.5.8. Among young people with statutory SEN plans (i.e. Statements of SEN and Education, Health and Care (EHC) Plans), behavioural difficulties were longstanding and, at points, severe. Incidents record verbal and physical aggression towards peers and professionals, harmful sexual behaviour, absconding and damage to property. These resulted in restraint or other restrictive interventions, off-site direction, suspensions and permanent exclusion, with a number of young people at different stages at risk of permanent exclusion. However, there is limited evidence that escalating behaviour and repeated incidents prompted a coordinated response to understand what was driving the behaviour and whether existing support remained effective. This is illustrated by a Rapid Case Review which identified 19 suspensions in the months preceding a proposed permanent exclusion and questioned whether these had triggered appropriate multi-agency intervention to address the behaviour and its underlying causes.

6.5.9. Behaviour should not be viewed solely as misconduct or attributed to neurodevelopmental or mental-health needs without considering whether that adequately explains the young person's presentation or whether separate violence-related risk is being overlooked. Across the case studies, professional assessments did not always reach the same conclusions about the relationship between neurodevelopmental needs, behaviour, fixation and risk, and earlier explanations for behaviour were not always revisited as presentation changed.

Guidance for schools recognises that behaviour may indicate additional or unidentified SEND, disability or mental-health needs and that specialist expertise may be required, while the SEND Code provides for greater specialist involvement where progress remains limited despite appropriate support and intervention (DfE, 2024; DfE & DoH, 2015).

6.5.10. Repeated use of restraint or other restrictive intervention can provide important information about a young person's needs and the effectiveness of existing support. Physical restraint was recorded in several case studies, but the disclosed evidence did not consistently demonstrate how incidents informed subsequent review. This is particularly important for children with SEND, mental-health needs or other vulnerabilities. KCSIE 2026 and the DfE's updated guidance on restrictive interventions emphasise prevention and de-escalation, the recording of significant incidents, and the use of patterns of intervention to inform practice. Where restraint occurs repeatedly alongside escalating behaviour, exclusion or placement instability, the combined pattern should prompt a wider reassessment of the young person's needs, the factors driving their behaviour, and whether existing support and risk management remain appropriate.

6.5.11. The statutory EHC framework provides a separate mechanism for responding where a young person's needs change significantly. EHC Plans must be reviewed at least annually, and reassessment may be appropriate where needs have changed and the existing assessment is no longer sufficient (DfE & DoH, 2015, paras. 9.166, 9.186 -9.192). Despite significant changes in functioning, behaviour, mental health, engagement with education or circumstances, the disclosed records provide no evidence that a review or reassessment of EHC needs was considered or requested for any of the young people. In multiple cases, statutory planning continued to rely substantially on assessments and descriptions of need developed in early childhood, without updated assessment reflecting subsequent changes in needs and functioning.

6.5.12. Schools repeatedly sought CAMHS support in some cases without receiving the help they were seeking, while there is limited evidence of substantive involvement by local authority SEND services in helping schools to review or secure suitable provision as needs and behaviour became increasingly complex. Schools were consequently at times left managing needs that were difficult to meet within their existing provision, relying heavily on individual professionals rather than a sufficiently supported and sustainable package of support. This is relevant to the statutory framework for EHC needs assessment: the local authority must consider the action already taken by the school and the child's progress, while the SEND Code also recognises the relevance of whether the provision required can reasonably be provided from the resources normally available to mainstream settings (Children and Families Act 2014, s. 36; DfE & DoH, 2015). Where existing provision is insufficient, this framework provides a route for considering whether further assessment and specialist provision are required.

6.5.13. The need for coordinated specialist input is consistent with Working Together to Safeguard Children 2026 (NHS000592), which states that strong multi-agency and multidisciplinary working is vital to identifying and responding to children's needs. Multi-agency safeguarding arrangements should support effective information sharing, correct identification and understanding of the likelihood of harm, and coordinated services that meet the child's needs.

6.5.14. The Government's current SEND reform proposals[15] provide an opportunity to strengthen this process. The proposed Individual Support Plan (ISP) would be standardised across settings, developed with parents and young people, and record barriers to learning, provision, reasonable adjustments and intended outcomes. It is intended to be a "living product", updated as needs and provision change and reviewed at least annually. For young people with an EHC Plan, the ISP would set out individually tailored day-to-day provision and progress towards outcomes, while the EHC Plan would guarantee entitlement to the relevant Specialist Provision Package (DfE, 2026). This could help ensure that significant changes in need and functioning are reflected in provision but would depend on those changes prompting meaningful reassessment and access to appropriate specialist support. The proposed nature of the ISP is relevant to the case studies, where significant changes in presentation were not always reflected in updated assessment, provision or specialist input.

6.5.15. For VFIs, SEND processes provide an existing means of reviewing whether needs remain adequately understood and provision remains appropriate as presentation changes. They do not assess risk of serious violence and should operate alongside, rather than substitute for, safeguarding and specialist assessment and management of risk to others. Similarly, a change of educational placement does not itself address changes in need or risk and should not replace consideration of whether further assessment, specialist provision or intervention is required.

> **Recommendation**: The Inquiry should consider recommending that the SEND reforms provide timely additional resources and specialist multi-agency support where increasing complexity of need or behaviour exceeds a school's existing capacity, including where there are associated concerns about risk to others.

7. Risk management, intervention and support

7.1. Social work and multi-agency child protection teams

7.1.1. As identified above, children's social work does not automatically work with young people who pose a risk of harm to others, outside of the established safeguarding categories of sexual, physical, emotional abuse and neglect, thought different models across the country may enable more flexibility. Although models of delivery vary between areas, thresholds and practice to identify and respond to harm should be the same. Across the case studies, the cadre saw differing levels and interventions within the social work practice.

7.1.2. In a number of cases, the nature and accumulation of child protection concerns raised questions about whether stronger protective intervention, including in some cases removal from parental care, had been considered at an earlier stage. Full case records were not available, and it was not the Cadre's role to undertake a full case review or, with the benefit of hindsight, to reach conclusions about decisions made at the time. The cases nevertheless highlight the importance of considering early protection and cumulative harm,

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[16] Department for Education. (2026). Special educational needs and disabilities (SEND) reform: Government consultation. Department for Education (OFST000007)

and the potential long-term impact on children and young people who continue to come to the attention of social care throughout their childhood.

7.1.3. There was evidence of robust social work intervention, appropriate risk management, and escalation to Prevent, police and CAMHS. In some cases, the young person's risk to others was considered through Prevent referrals and information-sharing with police. However, no professional identified any young person as presenting a lone actor risk and, even with hindsight, there was no clear evidence across the cases to indicate lone actor intent.

7.1.4. Although child protection requires a multi-agency response, social work often operates as a stand-alone service, working alongside education, police and health rather than as part of a fully integrated system. The Children's Wellbeing and Schools Act seeks to develop Multi-Agency Child Protection Teams, bringing together social work, education, health and police to improve joint working and promote consistency in responses to child protection concerns where children are at risk of significant harm.

7.1.5. While a mandate to multi agency working is very welcome it is essential that it has the flexibility to allow areas to work in the way that best suits their model of social work and multi-agency partnership. Currently the intention is for the regulations to require MACPT's to deliver the following functions:

- convene strategy meetings
- lead section 47 enquiries
- convene child protection conferences and forums
- oversee the development and delivery of child protection plans
- keep child protection plans under review
- provide case consultation for practitioners who need MACPT expertise
- maintain an understanding of patterns of significant harm in the local area and agency responses.

7.1.6. However, in the year leading up to the offence only one of the young people in the case studies would have met the threshold for the MACPTs and this was not in relation to his rising levels of violence. The issue is that contextual harm involving adolescents often requires a response that differs from standard child-protection processes. Conferences and child-protection plans may be inappropriate where the harm occurs outside the home if the family is already working with professionals. The risk may require a flexible coordinated adolescent safeguarding social work response rather than a conventional intra-familial child-protection response.

7.1.7. In one case, escalating behaviour and repeated episodes where the young person was missing from home, a section 47 assessment had been started a month prior to the offence and he would have met the criteria for a MACPT. In the other cases, the full risks were either not known, the family was already working with social care, and/or the case did not meet the significant-harm threshold. However, in all these cases a specialist multi-disciplinary adolescent response would have been beneficial.

7.1.8. While a MACPT would benefit some children and young people, it is likely that this model will not fit adolescents. These case studies point to the fact that experienced, skilled and multi-agency workers (with good multi agency engagement and information sharing) are needed at the earliest point to identify and address harmful trajectories. While this early identification is the aim of Family Help Teams under Families First, multi-agency working is only mandated within the MACPT and child protection.

7.1.9. Local areas need flexibility to design adolescent safeguarding models that can respond to risk to self, risk from others and risk posed to others. The regulations and guidance on MACPT's should avoid a single model that works only for conventional child-protection cases. Local areas need to be able to align MACPT, Family Help, exploitation, adolescent-risk and serious-violence arrangements so that children experiencing harm outside the home, or posing risk to others, are not left outside coordinated safeguarding structures.

7.1.10. Where MACPTs and Family First interventions may benefit and help divert children coming young people with violent fixations is in the earlier intervention and multi-agency response to abuse, harm and neglect. As has been highlighted earlier in the report the majority of young people in the case studies had experienced, domestic violence, parental substance misuse, mental health and in a minority of cases it was unclear why the young person had not been removed from their parents, as a small child, given the continuously high risks and abuse they experienced. MACPT will pull together the multi-agency response and ensure robust plans are acted upon, reducing the risk for drift, delay and inaction.

7.1.11. The development of the MACPT and the rise in VFI and harms outside the family give an opportunity for consideration to be given to National standards/guidance on safeguarding processes for adolescents. Building on the work of Professor Carlene Firmin [16] and, using the learning from Contextual Safeguarding alongside the developed guidance and tools already developed in relation to counter terrorism. We defer to policing and counter-terrorism experts on how that existing practice might appropriately inform a wider safeguarding framework.

> **Recommendation**: The Inquiry should consider recommending the development of national standards and safeguarding processes for adolescents experiencing harm outside the home and/or presenting a risk of harm to others, recognising that current child protection processes may not meet their needs.

7.1.12. Across the case studies, there were a lack of records of Youth Offending Service involvement before the index offences. Although there were instances of arrest, cautions or suspected offending which may have provided opportunities for earlier youth justice assessment, diversion or intervention, there was no evidence of previous convictions or appearances before a court. Keeping children out of the criminal justice system where appropriate remains important, and prevention and diversion should not be displaced by unnecessary criminalisation. However, youth justice involvement can also provide

17 Firmin, C. (2020). Contextual safeguarding and child protection: Rewriting the rules. Routledge.

opportunities for assessment, intervention and safeguarding and, in some circumstances, additional structure or restrictions around a young person. The case studies therefore raise a wider question about whether opportunities for appropriate youth justice involvement were sufficiently considered where offending or escalating violence had already brought a young person into contact with the police.

7.2. Exploitation

7.2.1. The vulnerabilities identified across the six case studies are not specific predictors of VFI. Many children experience domestic violence, parental mental ill-health, substance misuse, neglect, neurodiversity, school exclusion, racism, isolation, interest in violence without becoming violent. The relevance of these features lies in how they accumulate, change and interact with online activity, exploitation risk and unmet need.

7.2.2. These common features are also found in young people at risk of exploitation, Barnardo's Centre of Expertise on Child Sexual Abuse (2021) found that some young people may be more vulnerable to risk of exploitation:

7.2.3. "those who have experienced prior abuse, are homeless, are misusing alcohol and drugs, have a disability, are in care, are out of education, have run away/gone missing from home or care, or are involved with a gang."[17]

7.2.4. Alongside the factors highlighted by Barnardo's, young people at risk of exploitation will often also experience isolation, a desire to be included, not feeling a sense of belonging, loss/bereavement, (Home Office 2023).[18]

7.2.5. These characteristics have also been seen in the young people in these case studies. While safeguarding frameworks recognise in some contexts that a child who causes harm may also require support, existing exploitation processes are usually designed around harm caused by others to the young person. They are less developed for young people who may be drawn into harmful online spaces, intensify violent or sexualised interests, or present a risk to themselves and others without a clear external exploiter. This review uses the term self-exploitation cautiously to describe situations where online life may reinforce harmful identity, status-seeking, belonging or fixation.

7.3. Self-exploitation

7.3.1. In a number of the cases, professionals sometimes linked the young person's interests in violence, guns or Satan to neurodiversity without sufficient evidence, or exploration and challenged. It was not considered that such an interest could lead to violence or that an assessment should be undertaken to identify where the views persisted, intensified, connected to online communities or sit alongside other vulnerabilities.

7.3.2. Kaplan's article on self-exploitation[19] explains that, in today's digital, social-media-driven world, people can exploit themselves rather than being exploited by an external authority.

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https://www.barnardos.org.uk/get-support/support-for-parents-and-carers/child-abuse-and-harm/child-sexual-abuse-and-exploitation/what-experts-know-about-csa-cse

18 Barnardo's 2021, What the experts know about child sexual abuse and exploitation

19 Criminal exploitation of children and vulnerable adults: county lines (ILT000348)

20 Kaplan, İ. (2025). Self-exploitation, transparency, and control: Byung-Chul Han's perspective on social media. (ILT000350)

He identifies that social media creates a society in which individuals constantly try to be seen, recognised and improve themselves. While this may feel like freedom, it can become a form of self-imposed control, where people push themselves to gain approval and validation. This self-exploitation can lead to burnout, depression, anxiety, narcissism and feelings of emptiness.

7.3.3. Across all of the case studies, there is evidence of how repeated engagement with social media reinforced harmful patterns of thinking, alongside the pursuit of approval, identity and notoriety. In a number of cases, this appears to have contributed to a desire to replicate well-known mass murderers; in the case of C, this developed into an expressed desire to become a renowned mass murderer.

7.4. Multi agency child exploitation meetings (MACE)

7.4.1. MACE meetings already provide a forum for regular information sharing and action planning where young people are at risk of exploitation. The issue is whether that model could be extended to adolescents who present high risk of harm to themselves or others, including those who are self-radicalising online or whose online life is intensifying violent or harmful interests.

7.4.2. The case evidence suggests that the potential relevance of such a forum varied according to what was known about the young person at the time. In some circumstances, escalating behaviour and multi-agency involvement may have provided a basis for referral, while in others the risks were either not known or were not sufficiently developed to meet the threshold for a high-risk adolescent forum. This reinforces the need for proportionate thresholds and clear routes for consultation, as well as formal referral.

7.4.3. The issue with risk management of high-risk adolescents is not which agency holds the risk, but how agencies work together where no single statutory pathway fits. A MACE-style adolescent risk forum would not make the any agency the sole risk holder or replace child protection, SEND, mental-health, Prevent or MAPPA processes. It would provide an additional mechanism for agreeing risk, coordinating actions, checking delivery and escalating where concerns remain unresolved.

7.4.4. Where a multi-agency forum agrees the level of risk, it should produce a shared plan that sits alongside individual agency plans. The plan should identify the concern, the actions required, who is responsible, how progress will be reviewed and what will trigger escalation. This would help ensure that risk to others is addressed without displacing existing statutory duties.

7.4.5. This process would not prevent a young person from being considered under MAPPA where the threshold is met. It would instead provide a lower-level, earlier multi-agency platform for adolescents whose risks are serious enough to require coordinated oversight but do not fit existing public-protection or child-protection routes.

7.4.6. Brighton and Hove's Adolescent Vulnerability and Risk Meeting provides an example of this type of approach. Young people at risk of exploitation or harm to others are considered by a multi-agency panel, enabling agencies to develop a rounded understanding of risk to and from the young person and to align their plans.

Recommendation: The Inquiry should consider whether Local Authorities should extend their multi agency adolescent risk meetings to include those who pose a risk of harm to others.

7.5. Adolescent teams

7.5.1. The issue for delivery is how local areas provide skilled, sustained support for adolescents with complex risks that cut across exploitation, serious violence, online harm, SEND, mental health and youth justice. Specialist adolescent services, such as those developed in Brighton and Blackpool, offer one model for working with high-risk adolescents, including those who may pose a risk to others. These teams work alongside their Youth Offending Teams (YOTs), as well as having professionals from the police, young person substance misuse services, education support and mental health services embedded within them. This supports multi-agency working with the highest-risk young people.

7.5.2. The case evidence suggests that a number of the cases most clearly would have benefitted from a specialist adolescent response, while other cases may have benefited from consultation as risks emerged. The value of these teams is therefore not limited to direct case holding; they can also provide advice and consultation when risks are developing but thresholds are uncertain.

7.5.3. An emerging challenge is how specialist adolescent services align with MACPTs, Family Help and child-protection arrangements. Some young people experiencing harm outside the home, or posing risk to others, may not need a child-protection plan where the family is already working with services. Others may need child-protection processes to bring the family and agencies together. Local areas therefore need flexibility to design adolescent services that complement, rather than duplicate or compete with, MACPT's.

Recommendation: The Inquiry should explore whether local authorities should extend multi-agency adolescent risk meetings to include young people who pose a risk of harm to others.

Recommendation: The Inquiry should consider recommending that within the Family First Framework, and as MACPT's are, developed, local areas are given the flexibility to develop their own model to meet the needs complex, high risk adolescents in order to support the development of multi-agency and multidisciplinary specialist adolescent services.

7.5.4. The case studies raise the issue of whether existing public-protection arrangements could have provided a risk management framework around the young people. MAPPA (Multi Agency Public Protection Arrangements, Criminal Justice Act 2003[20]) brings together police, probation and prison services to protect the public from serious harm by sexual, violent and other dangerous offenders. Although MAPPA can include young people, it is primarily designed around offenders who meet specific eligibility criteria and is more commonly associated with adult public-protection arrangements.

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21 Ministry Of Justice: Multi-agency public protection arrangements (MAPPA): Guidance Updated 2024 (MOJ000019)

7.5.5. There is no evidence in the case studies that young people were managed through MAPPA and there is no indication that MAPPA was considered at the relevant time. This appears to have been because none of them had convictions or cautions that suggested serious public-protection risk, and because professionals did not have sufficient information about violent fixation, preparation or intent to trigger consideration of MAPPA.

7.5.6. There is often a misunderstanding and an assumption that to access MAPPA a person must have committed a high-risk offence, however this is only the case in MAPPA categories 1 and 2. MAPPA category 3 requires:

7.5.7. a conviction for any offence (current or historic, within the UK or abroad); or

7.5.8. received a formal caution (adult or young person) or reprimand/warning (young person) for any offence; or / and

7.5.9. the offence for which they received the disposal indicates that the person may be capable of causing serious harm to the public.

7.5.10. To be registered as Category 3 and have a multi-agency approach to manage the risks they present, the current risks do not have to relate directly to the offence they were convicted or received a caution for.

7.5.11. MAPPA can therefore apply more broadly than is sometimes assumed, including where a person has a previous conviction, caution or warning and their current presentation indicates a risk of serious harm. Some of the young people had previous contact with the criminal justice system which could potentially have provided a route to consideration of MAPPA if the nature and extent of their subsequent risk had been known. However, police contact or previous offending does not in itself demonstrate that a serious public-protection risk was identifiable. Across the case studies, the information known to professionals before the index offences did not provide a clear indication of the serious violence that subsequently occurred.

7.5.12. This distinction is important when considering the cases with the benefit of hindsight. In some instances, information about alleged offending or other behaviour which might now appear relevant to an assessment of risk was not known to police or other professionals until after the index offence. Such information could not have informed contemporaneous assessment or consideration of MAPPA. The case studies illustrate both the potential breadth of MAPPA and its practical limitation, that an available public-protection framework can only be engaged where the relevant risk is identifiable from information known at the time.

7.5.13. Other young people had received cautions, but none had convictions. One had completed an out-of-court disposal but was not displaying known indicators of serious public-protection risk at the time. Another was showing escalating aggression towards police and care staff, but, based on the information then available, it is likely that a MAPPA referral would not have met the threshold. Even with the benefit of hindsight, it is therefore doubtful that these cases would have been managed through MAPPA at the relevant time. The learning is not that MAPPA should have been used in these cases, but that guidance could provide greater clarity about when MAPPA may be relevant to individuals with a violent

fixation, particularly where a young person has a previous caution or other disposal alongside emerging evidence of capability, intent or risk of serious harm to the public.

Recommendation: The Inquiry should consider recommending that guidance is provided to MAPPA in relation to VFI and NIEV

7.6. Prevent

7.6.1. Prevent and Channel are addressed in a separate report to the Inquiry, which focuses on issues relating to policing and counterterrorism. They are considered briefly here as a specialist multi-agency process through which concerns may be assessed and, where appropriate, intervention provided. Their relevance here is how that process interacts with wider safeguarding and risk-management arrangements.

7.6.2. Prevent provides a safeguarding framework for concerns that a person may be susceptible to radicalisation into terrorism. Where appropriate, individuals referred to Prevent may receive multi-agency support through Channel.

7.6.3. A significant number of the young people were referred to Prevent before their index offence, some more than once, and most subsequently entered Channel and received an intervention. In one case, however, Prevent did not accept the referral because the young person's interest in violence was understood as linked to neurodiversity rather than as posing a wider risk. In another case, concerns about a continuing fixation with weapons resulted in a Prevent referral which was not progressed because there was no identified intent to cause harm or evidence that others were seeking to exploit the young person's vulnerabilities. In another case, services paused action following the Prevent referral.

7.6.4. These examples highlight the importance of services continuing to act within their own responsibilities while another process is underway. Professionals should continue to engage with the young person and, within their role, explore relevant views and beliefs so that this information can contribute to multi-agency assessment. While neurodivergence may be relevant to understanding a young person's presentation, it should not reduce the significance of concerns or prevent further professional exploration where those concerns persist or change.

7.6.5. Where young people were referred to Channel, the records do not make clear whether any agency continued to monitor and respond to concerns once Channel involvement ended, or where the young person was not adopted into the process. This creates a risk that concerns may lose visibility at the point when continued oversight and coordination remain necessary.

7.6.6. The Prevent duty forms part of schools' wider safeguarding responsibilities, with the designated safeguarding lead having a key role where concerns arise about susceptibility to radicalisation. Education professionals may therefore contribute information about the young person's behaviour, relationships, circumstances and changes over time, alongside information held by other agencies.

7.6.7. For VFIs, it is important to recognise the limits of this pathway. Prevent is specifically concerned with susceptibility to radicalisation into terrorism. A Prevent referral should not be treated as addressing wider concerns about violence, fixation or risk to others where those concerns extend beyond that remit. Nor should referral to Prevent displace action that a school or other service would otherwise take within its own responsibilities. The Prevent duty guidance[21] states that where other support mechanisms are simultaneously required or being considered, these should proceed unless there is a good reason not to do so.

7.7. Mental health support

7.7.1. The mental-health needs and vulnerabilities identified across the case studies are considered earlier in this report. From a multi-agency perspective, there was a clear pattern of referral to CAMHS and other mental-health services, but the response was variable. There were examples of significant CAMHS involvement, alongside repeated referrals, difficulties accessing services and young people and families seeking help without sustained support following assessment or referral. In some cases, concerns included suicidal ideation, self-harm, significant isolation or deteriorating functioning, yet the young person did not meet the threshold for specialist mental-health intervention or their therapeutic needs did not fit clearly within existing pathways.

7.7.2. The case studies highlight the need for clarity about the role of CAMHS where there are significant concerns about a young person's mental health or safety, and clear routes for escalation where a referral does not meet the threshold for intervention. A decision that CAMHS criteria are not met should not leave a gap in assessment or support, particularly where concerns about suicidality, self-harm, isolation or deteriorating functioning persist or escalate. Where mental health, SEND, trauma, safeguarding and risk to self or others overlap, there should be a clear process for bringing together relevant agencies, identifying what support is required and who will provide it, and escalating concerns where the young person's needs or risks increase.

7.8. Delivery of special educational needs provision

7.8.1. Identification of SEND and the existence of an EHC Plan or Statement of SEN do not establish that the provision identified was secured, delivered or effective. Across the case studies there was evidence of intervention, including Thrive, Sensory Circuits, Zones of Regulation, Speech and Language Therapy, mentoring and offers of specialist or therapeutic support. However, the disclosed records do not consistently establish what provision was delivered, for how long or with what effect.

7.8.2. In some cases, young people were without suitable educational provision for extended periods: months or years. Where an EHC Plan remained in force, loss of a school placement

22 Home Office. (2023). Prevent duty guidance: Guidance for specified authorities in England and Wales. HM Government (CTPHQ000012)

did not remove the local authority's responsibility to secure the special educational provision. The disclosed records provide limited evidence of how that provision was secured during periods when young people were unable to access their usual placement.

7.8.3. The records were unclear in most cases about whether planned intervention was delivered and whether it achieved its intended purpose. Some statutory plans described provision broadly without consistently specifying its frequency, duration or level of specialist input. There was limited evidence of systematic tracking of whether Section F provision had been delivered and whether it was effective.

7.8.4. The distinction between identification, referral and delivery is important. A need may be identified and an appropriate referral made, but intervention may subsequently be delayed or unavailable. Conversely, absence of intervention should not be attributed to service capacity where the records instead indicate that a need was not recognised, an appropriate referral was not made, or an outstanding response was not followed up.

7.8.5. The case-study material included examples where multiple services were involved, but the disclosed records do not establish that all planned or recommended intervention was delivered. In one case, the part of the EHC Plan setting out the special educational provision the young person should receive (Section F) substantially carried forward provision developed much earlier in their education, despite significant subsequent changes in needs, behaviour and educational circumstances. Special educational needs provision was not consistently quantified and there was limited evidence that its delivery and effectiveness were systematically tracked. Following the breakdown of an educational placement, the disclosed records also provide limited evidence of how continuity of this provision was secured. There were also examples of recommended therapeutic intervention and planned mental-health assessment which the records reviewed do not establish took place.

7.8.6. For VFIs, the existence of a statutory plan, referral or identified intervention should not be treated as evidence that support was received. Understanding a young person's trajectory requires consideration of what intervention was actually delivered, whether the young person was able to access it and whether it was effective.

7.9. Transitions and continuity of support

7.9.1. Transitions and disruption to education affected young people across the case studies through changes of school or placement, suspension and permanent exclusion, prolonged absence and movement out of education. For some neurodivergent young people, these changes occurred alongside existing difficulties managing transitions or changes in routine. Loss or reduction of education could simultaneously remove structure, relationships, opportunities for social engagement and regular professional oversight at a time when needs or concerns were increasing.

7.9.2. Disrupted education is associated with a higher likelihood of involvement in serious violence (KCSIE, 2026, para. 52). Consequently, children who have experienced multiple suspensions, are on part-time timetables or are at risk of permanent exclusion likely benefit

from additional support (KCSIE, 2026, para. 18). This reinforces the importance of considering changes in educational engagement as part of the wider developing picture and responding with appropriate support. Phase 1 of the Inquiry identified the importance for AR of the "routine and structure of an appropriate education placement", alongside his social isolation and need for opportunities for social engagement (DfE, KCSIE 2026, paras. 18, 52). This theme is echoed across the case studies.

7.9.3. The case studies demonstrate the importance of responding when a young person's educational circumstances change. In one case, a referral made when the young person was considered at risk of becoming NEET was not accepted because he remained in education, but the disclosed evidence identifies no further referral when he subsequently became NEET. An earlier decision based on circumstances at one point should not determine the response when participation or level of need subsequently changes.

7.9.4. The case studies provide examples where significant existing needs made planned transition particularly important, but uncertainty about the next placement prevented transition work from beginning. In one case, difficulties managing even "micro-transitions" within the school day had already been identified, while dysregulated behaviour frequently occurred at the start of the school day. As a later educational transition approached, professionals expressly identified the "level of transition that will be needed", but uncertainty about the next placement prevented this work from beginning. Subsequent planning identified alternative placements and the need for a transition plan, but the existing specialist placement ended and the young person's education was significantly disrupted.

Recommendation: The Inquiry should explore whether local authorities require greater support and capacity to meet existing responsibilities for maintaining professional oversight during significant disruption to education, including maintaining or restoring meaningful education and ensuring clear transfer of responsibility between professionals, settings or services.

7.9.5. Transition to adult services

7.9.6. Transition from children to adult services presents a challenge. Eligibility, services and support may change at 18 while SEND, mental-health or other needs and concerns about risk to others continue. Transfer should not be assumed because involvement with a children's service has ended. For young people receiving multi-agency intervention, transition planning should establish whether the young person will transfer to a different service, if so, who has accepted responsibility, what information has transferred, what intervention will continue and who has oversight of any unresolved need or risk.

7.9.7. The transition into adulthood creates a particular risk of disconnection from support. Young people will still be developing emotionally, cognitively and socially into their early twenties, while adult services often expect a higher level of independence, self-referral and sustained engagement than young people are used to. This can be especially difficult for young people with neurodevelopmental, communication, mental-health or trauma-related needs.

7.9.8. For young people with an EHC Plan who remain in education or training, support can continue up to age 25 where the plan is still required. Transition at 18 does not therefore necessarily end statutory SEND responsibilities. In the case studies, however, the relevant

young people had left education by the time they were 18 and became Not in Education, Employment or Training (NEET). This reduced opportunities for professionals to observe changes in functioning, hear concerns, identify emerging risk and maintain protective relationships. Although one young adult later gained employment and was working at the time of the offence, much of his social contact remained online. Despite family members seeking mental-health support for him, he did not wish to engage.

7.9.9. Adult social care and adult mental-health services generally require the young adult to agree to support and work primarily with them rather than their family. Where a young adult does not engage, it can be more difficult to maintain support and coordinate a response to continuing needs, vulnerabilities or risks.

Recommendation: The Inquiry should consider recommending the development of guidance to support local authorities and mental-health providers in developing transitional safeguarding models for young people moving into adulthood, particularly where neurodevelopmental, mental-health, trauma, safeguarding or serious violence-related concerns remain unresolved.

7.9.10. Transition to new local authorities

7.9.11. Movement between local authority areas can create gaps in records, disrupt referrals and waiting-list pathways, and fragment family and developmental histories. Similar challenges arise where children live in one authority but attend school or receive health, social care or specialist provision in another. This was evident across the case studies, including where families moved between areas and where different services were provided across local authority boundaries. We did not always see joined-up working: agencies were not consistently aware of other services involved, relevant information was not always connected, and onward referrals were not always directed to the appropriate agency. Cross-boundary arrangements also created challenges around provision and funding.

7.9.12. These difficulties can have significant consequences for safeguarding and continuity of support. When the multi-agency histories are considered together, information relating to neglect, abuse, domestic violence, parental police involvement, education, health and specialist services was sometimes dispersed across agencies and areas, making it more difficult to develop a complete picture of the child and family. Effective systems require proactive communication, timely transfer of records and clarity about which agency takes responsibility for coordinating and following through concerns, referrals and provision. Greater consistency across areas would reduce gaps in information and delays in children receiving the right support at the right time.

8. Professional practice

8.1. This section considers how professionals across agencies understood and responded to the information available to them, informed by relevant findings from Phase 1 of the Southport Inquiry. It focuses on professional reasoning, considering whether professionals brought relevant information together, tested assumptions and explanations, followed concerns through when circumstances changed, exercised professional challenge and understood the young person's communications and voice.

8.2. These issues were particularly important where violence-related concerns occurred alongside neurodevelopmental, mental-health, safeguarding, educational or other needs. The professional-practice question is not whether those needs themselves indicated a risk of violence, but whether they were considered alongside violence-related concerns without either obscuring the other.

8.3. Phase 1 of the Inquiry identified failures in information sharing and management and instances of risk being passed between agencies. This thematic analysis considers the professional practice required to maintain a developing understanding of the young person across agency and service boundaries.

8.4. The systemic gap in organisational ownership is considered earlier in this report. At professional level, the case studies highlight the importance of practitioners maintaining responsibility for their own actions and contributions when other services or processes became involved.

8.5. Across the case studies, the extent of multi-agency involvement before the index incidents did not result in a coordinated understanding or response. In one case, 32 organisations were involved with the family, 19 of which had significant involvement with the young person; a subsequent Rapid Case Review found that key agencies were not engaged in the Child in Need plan and that important information was not considered. Elsewhere, information about possible SEND, mental health, trauma, behavioural change and disengagement was held across education, CAMHS, social care and other services without evidence that these concerns were consistently brought together. In another case, information about a young person's needs and functioning, including a longstanding fixation with firearms, was held by different services over time without evidence that the developing picture was collectively reviewed.

8.6. There is evidence of a pattern of multiple referrals and re-referrals throughout the material. This includes requests for support that did not result in the intervention sought, referrals that did not progress or were lost, and recommendations where the disclosed evidence did not establish whether they were acted upon.

8.7. Referral to another service does not remove the need for professional follow-through. Where a referral was declined, lost, did not progress or resulted only in advice, the continuing concern needed to be reconsidered and further action, re-referral or escalation considered where appropriate. Informal discussion about whether another service might accept a referral is not equivalent to making a referral, recording the decision-making or obtaining an assessment.

8.8. In some instances, the involvement of another service or specialist process also appeared to affect the response elsewhere. This included a professional awaiting the outcome of a Prevent referral before determining what they should do, and discussion of possible referral to Prevent which did not progress.

8.9. These examples highlight the importance of services continuing to act within their own responsibilities while another referral, assessment or process is underway. Professional follow-through is distinct from which agency or process holds overall responsibility. Practitioners need to establish what has happened to actions they initiate, respond where

anticipated action does not occur, and contribute relevant information to the wider multi-agency response.

8.10. Recording and information sharing

8.10.1. Working Together to Safeguard Children 2026 (NHS000592) sets out expectations for multi-agency working, with the central principle being that safeguarding is a shared responsibility, recognising that no one agency can meet all a child's needs. The wider principles include the sharing and analysis of information across services, joint assessment, decision making, planning and review, alongside an expectation for timely and coordinated action and clear roles and accountability. It also sets out principles for agencies' record keeping, which include keeping clear and accurate records, recording the rationale for decisions, sharing information appropriately and in a timely way, maintaining records that evidence impact and ensuring records support the child's journey.

8.10.2. KCSIE 2026 provides specific expectations for education. It requires concerns, discussions and decisions, and the reasons for those decisions, to be recorded in writing. It also emphasises the importance of early information sharing for effective identification, assessment and allocation of appropriate services.

8.10.3. Across the case studies, it was at times difficult to understand decisions and actions, establish outcomes or see a clear chronology of the young person's needs and circumstances, the support provided and its impact. Establishing that chronology at times required information to be drawn together from numerous records held across different agencies. There are examples of substantial gaps in records, proposed referrals or interventions described as being "considered" without evidence of subsequent action or outcome, and terms such as "monitor" and "exhaust" being used without consistently identifying responsibility, what was to be monitored or the outcome. A continuing history can make concerns, changes in behaviour and engagement, previous referrals and unresolved needs more visible to those making decisions.

8.10.4. Relevant information needed to be recorded, retained and made available to inform subsequent assessment and decision-making. Records should identify the concern, information available at the time, professional reasoning, decisions and action, including responsibility and timescales for follow-up. Relevant information exchanged through informal professional contact should also be recorded. Where the decision is to "monitor", the record should identify what is being monitored, by whom and what would trigger further action. Where a concern is assessed as low risk, below threshold or requiring no further action, the basis for that decision should be clear. This enables subsequent professionals to understand the earlier decision and reconsider it where circumstances change.

8.10.5. Recording is not just about the young person's and family's behaviours and actions, but also about multi-agency involvement, plans and agreements. There was evidence of agencies not knowing, or not clearly recording, what other agencies were involved with a young person. In one case, an agency repeatedly referred a young person to the wrong CAMHS service over a number of years, despite correspondence within its records identifying the responsible health service.

8.10.6. Relevant information may therefore be recorded but, if it is not readily accessible to practitioners, may not inform subsequent action.

8.10.7. These findings are relevant to current reforms intended to improve information sharing across services. The Children's Wellbeing and Schools Act 2026 introduces strengthened information-sharing duties and provision for a consistent child identifier across different systems[22]. This provides an opportunity to consider how these reforms could support a more accessible view of multi-agency involvement with a child. Such an approach could build on existing models of proactive information sharing, including Operation Encompass[23]and complement the development of digital records proposed within the SEND reforms[24].

8.10.8. The quality and completeness of recording varied across the case studies. Some records lacked basic information about when an incident occurred or was recorded, who made the record and their professional role. Others did not record the information considered, reasons for decisions or resulting action. This sometimes limited the expert cadre's ability to establish from the records what professionals knew at the time and how concerns were understood or addressed. An absence from the records does not establish that something did not happen; however, professional activity or reasoning that is not recorded may not be available to inform subsequent practice.

8.10.9. In one case, school staff identified a marked change in the young person's behaviour and presentation, including concerns about engagement and wellbeing, but there is limited recording of those concerns on the school safeguarding system despite evidence of wider professional concern. A referral was made concerning the extreme change in behaviour and requesting mental-health support but was declined, with referral to CAMHS advised. The young person left school the following week. He had previously been unable to receive support from a local authority employability service because he was not yet NEET; when his circumstances subsequently changed, no further referral by the school was identified.

8.10.10. In another case, a Rapid Case Review found that key agencies were not engaged in the Child in Need plan, important information was not considered and there were occasions when police should have referred information to children's social care but did not. Earlier social-care records included information about exposure to domestic abuse, but this was not consistently reflected in the information subsequently available. This illustrates the distinction between information existing somewhere within the professional network and that information being available to, considered by and influencing those making subsequent decisions.

8.10.11. Records of significant incidents should enable subsequent professionals to understand what occurred, the response and whether the incident altered the existing assessment or plan.

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[23] Children's Wellbeing and Schools Act 2026, s.4
[24] Domestic Abuse Act 2021, s. 49A; Victims and Prisoners Act 2024, s. 20; Home Office, 2025.
[25] Department for Education. (2026). Special educational needs and disabilities (SEND) reform: Putting children and young people first - Government consultation. (OFST000007)

8.10.12. Professional assumptions about consent also affected information sharing and access to support. In one case, the young person's age and perceived autonomy influenced decisions about referral and information sharing, including an approach in which students were regarded as "young adults" who were "making a choice to be in college". CAMHS involvement did not progress because the young person did not consent to an ASD assessment, despite continuing concerns about his presentation and his agreement to talk to someone. Practitioners need to understand when consent is required and when safeguarding information can be shared without it, so that assumptions about age or autonomy do not prevent appropriate action.

8.10.13. These recording and information-sharing issues are particularly relevant where there are concerns about serious violence. Information about changes in behaviour or functioning, mental health, weapons, online activity or other concerns may be held by different services. Information considered in isolation may contribute to a different understanding of need or risk when considered alongside earlier concerns, previous referrals or changes over time.

8.10.14. Similar issues are identified in wider safeguarding evidence. The Child Safeguarding Practice Review Panel Annual Report 23-24 found that lack of coordination or handover between services featured in 81% of the 330 serious incident notifications considered, including failures in information sharing, inconsistent record keeping, role confusion, delayed responses and fragmented services. This does not establish what occurred in any individual case but indicates that these are recognised systemic safeguarding issues.

Recommendation: The Inquiry should explore how greater professional accountability can be achieved for recording and information sharing, including recording professional reasoning, decisions and agreed actions, following up referrals and actions, and ensuring that relevant safeguarding information is appropriately shared.

Recommendation: The Inquiry should consider how a 'single child view' could build on current reforms to enable authorised practitioners to identify other agencies involved with a child and access relevant information about their involvement, plans and responsibilities [Children's Wellbeing and Schools Act 2026, s. 4].

8.11. Recognising change in the assessment of risk

8.11.1. Significant change is relevant to professional practice because it may alter the significance of information already known. A previous assessment or explanation may have been reasonable on the information available at the time but require reconsideration where behaviour, functioning, relationships, mental health, online activity or engagement subsequently changes. The issue is not whether change predicts violence, but whether professionals recognise when the developing picture no longer supports an earlier understanding or decision.

8.11.2. This is particularly important where change occurs alongside existing concerns about violence, weapons, threats, fixation or other harm. Violent interests may persist or intensify, threats or plans may become more specific, or new information about weapons or online activity may emerge. Professionals should consider whether this changes the significance

of information already known and whether further enquiry, assessment, information sharing or referral is required.

8.11.3. The nature and extent of violence-related information available to professionals differed significantly between the case studies. In one case, professionals were aware of a marked deterioration in the young person's behaviour, engagement and wellbeing, but the disclosed records provide limited evidence that they knew the extent of the violence-related interests subsequently identified. In another, professionals knew about extensive and escalating violent behaviour, including assaults, criminal damage and an incident involving a bladed item, although other information about the nature and extent of the young person's concerns became available only after the index incident. In other cases, the nature or extent of concerning interests and behaviour similarly became apparent only after the index incident. Professional practice must therefore be assessed against the information reasonably available at the relevant time rather than knowledge acquired subsequently.

8.11.4. Wider needs or circumstances should not themselves be interpreted as indicators that a young person will become violent. SEND, trauma, poor mental health, withdrawal, exclusion from education and concerning interests or internet use are not, individually or collectively, evidence of future violence. Equally, their presence should not prevent professionals from recognising and exploring a distinct violence-related concern where one arises.

8.11.5. Practitioners should recognise and record relevant concerns but are not expected to undertake specialist violence-risk assessment unless they have the appropriate expertise. Where further assessment is required, concerns should be referred through the appropriate pathway to professionals with relevant specialist expertise. Specialist assessment should consider risk to others alongside risk to the young person: mental ill-health, self-harm, suicidality and vulnerability may coexist with concerns about harm to others, and consideration of one should not obscure the other.

8.12. Professional curiosity and analysis

8.12.1. Professional curiosity requires professionals to test whether the explanation they have for a concern remains adequate in light of the information available. Individual observations may appear capable of explanation in isolation but acquire different significance when considered alongside other information or as circumstances change. Professionals therefore needed to identify patterns, test assumptions and seek further information where an existing explanation did not adequately account for the developing picture. Where violence-related behaviour or interests were present, neurodivergence, mental ill-health, trauma or adversity should neither be assumed to explain them nor treated as evidence that the young person was dangerous.

8.12.2. The case studies show that this did not happen consistently. Significant behaviour or new information was sometimes recorded or responded to without sufficient exploration of its meaning or significance. Where behaviour had become familiar, particularly within specialist provision, there was also a risk that deterioration or escalation was normalised

rather than prompting further enquiry. Professional curiosity was particularly important where an explanation materially affected whether a concern was explored further, referred, assessed as low risk or closed.

8.12.3. In a number of cases there is evidence of over-reliance on autism spectrum disorder as an explanation for concerning interests or behaviour, including a professional observation describing a young person's longstanding fixation with weapons as his "special interest from an autistic point of view". Autism and other neurodevelopmental needs may be important in understanding a young person's communication, behaviour, interests and support needs, but should not provide a default explanation for violent fixation or other concerning behaviour. Professional curiosity requires practitioners to test and revisit such explanations as new information emerges, rather than allowing an earlier understanding to become fixed. The issue is not whether autism may be relevant to understanding an interest or fixation, but whether that explanation remains sufficient as further information about weapons, behaviour, isolation or other changes in the young person's circumstances emerges.

8.12.4. Professional curiosity was required in response to concerning online communications. These may include statements, messages, posts or other communications about violence, weapons, harming others or intentions to cause harm. The forensic literature uses the term "leakage" where a person intentionally or unintentionally communicates thoughts, feelings, fantasies, attitudes or intentions that may indicate possible violence (Meloy & O'Toole, 2011[25]). Such communication does not establish violent intent or dangerousness. Its significance depends on its content, context and relationship to other information known about the young person. Where sufficiently concerning, it may therefore require further exploration rather than being interpreted from the communication alone. This is consistent with KCSIE 2026, which requires the DSL, where there are concerns about a child carrying or using a weapon or expressing an intention to do so, to assess risk to the pupil and others, taking account of wider information and concerns.

8.12.5. Professional curiosity means considering whether an explanation adequately accounts for a concern and, if not, identifying what further information is needed. This may require discussion with the young person, family or other professionals, checking information or history, considering information held in other settings or seeking specialist advice. Where an explanation materially affects assessment, referral, the level of concern or case closure, professionals should ensure that it is sufficiently supported by the information available.

8.12.6. An interest in violence, weapons or violent offenders can have different meanings for different young people. Where sufficiently concerning, professionals should explore its individual meaning and relevant context. This may include identity, relationships and belonging, experiences of victimisation or vulnerability, moral development, sense of agency or control, and online relationships or influences. The context of any associated beliefs may also be relevant. These are possible lines of enquiry rather than explanations

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26 Meloy, J. R., & O'Toole, M. E. (2011). The concept of leakage in threat assessment. Behavioral Sciences & the Law, 29(4), 513-527. **(ILT000352)**

to be assumed or imposed. In particular, it should not be assumed that an interest in violence provides a young person with a sense of safety, identity or control; these are possible meanings to be explored where relevant to the individual.

8.12.7. The records included some exploration of violent interests and associated beliefs, but less evidence in some cases that explanations were tested against the wider information available. For example, one young person's interests in guns, extremist groups and Satanism were explored, but his interest in Satanism was subsequently assessed as low risk after he said that an online contact was his cousin. The disclosed records do not establish that this was checked before the case was closed. The issue is not whether the explanation was incorrect, but whether it was sufficiently checked before the level of concern was reduced.

8.12.8. There is some evidence of effective professional curiosity in the case studies. Further questioning in one case elicited additional information about concerns which lead to an intervention. This demonstrates that further enquiry can materially alter professional understanding where the information initially available does not provide a sufficient account of the concern.

8.12.9. Reviews identified the consequences of insufficient professional curiosity, such as a lack of professional curiosity about the reasons for the young person's behaviour, alongside weaknesses in assessing his parents' ability to meet his needs and understanding the family history. This analysis was relevant to understanding the presentation in the context of accumulating concerns. It does not follow that further enquiry would necessarily have identified or prevented the subsequent violence; the issue is whether professionals had sufficiently explored the information needed to understand needs, behaviour and developing circumstances.

8.12.10. The wider safeguarding evidence identifies similar concerns. The Child Safeguarding Practice Review Panel Annual Report 2023-24 found a lack of professional curiosity or failure to ask further questions in 66% of the 330 serious incident notifications it considered. This does not establish what occurred in any individual case but indicates that weaknesses in professional curiosity are a recognised systemic safeguarding issue.

8.12.11. Professional curiosity should therefore continue where significant concerns remain unresolved. It should be renewed where new information calls an earlier explanation into question or alters the significance of what was previously known. This does not require professionals to assume the worst or to undertake specialist assessment outside their expertise. It requires them to recognise when the available explanation is insufficient, identify what further information or expertise is needed and ensure that material assumptions are adequately tested before they determine the professional response.

8.13. Referrals and reviews

8.13.1. Professional activity and referral in the case studies were more consistently evidenced than review of whether intervention had occurred or resolved the concern. There was substantial educational support, referral to specialist services and, in some cases,

extensive multi-agency involvement. However, support was sometimes delayed or unavailable, referrals were declined or closed, and some young people did not engage with the intervention offered. The records were less consistently clear about whether agreed intervention occurred, whether it was effective and how the professional response changed when difficulties continued.

8.13.2. Referral should be understood as part of a continuing process rather than an end point. Professionals needed to establish the outcome of actions they initiated and consider what that outcome meant for the concern that prompted them. Where anticipated assessment or support did not occur or did not address the concern, further action within the professional's role needed to be considered, including a different intervention, further referral or escalation. This is consistent with KCSIE 2026, which requires follow-up where information about the response to a referral is not forthcoming and consideration of escalation where the child's situation does not appear to be improving.

8.13.3. Informal consultation could also affect whether concerns progressed to formal assessment. In one case, concerns about a young person's isolation and continuing preoccupation with weapons led to discussion of a possible referral to Prevent, but a referral was not progressed because there was reportedly no evidence that the young person was talking to people who could take advantage of him. Informal professional advice may appropriately inform a decision about referral, but it is not equivalent to a formal referral or assessment. Where serious concerns remain, professionals should be clear about what has and has not been assessed and the basis on which no further action is being taken.

8.13.4. Review needed to establish whether intervention was delivered as intended, whether the young person was able to engage and whether it was effective. Across the case studies, there were examples of specialist assessment or intervention being delayed, not progressed or ending while concerns remained, and of further action being considered or monitoring continuing without a clear recorded outcome. Where this occurred, professionals needed to understand why and adapt the response accordingly. This included considering whether support was unavailable, a service threshold was not met, an intervention was not delivered, or the young person was unable or unwilling to engage.

8.13.5. A young person's refusal or disengagement from a particular intervention did not automatically indicate that support was no longer required. Professionals needed to consider whether communication needs, accessibility, the relationship with the professional, the setting or form of intervention, or the young person's understanding of its purpose affected their ability or willingness to participate. This could require adaptation of the intervention or a different route to support rather than repeated offers in the same form. In one case, the school recognised significant changes in the young person's presentation and sought further assessment and support, but the response became focused on obtaining a neurodevelopmental assessment, which the young person refused. A subsequent referral seeking mental-health support was declined. The issue was therefore not whether referrals had been made, but whether the response was sufficiently adapted when the routes being pursued did not provide the assessment or support sought.

8.13.6. These issues are particularly relevant to VFIs where concerns about serious violence, weapons, threats or harm to others persist or develop. Professionals should not assume that an earlier referral, assessment or threshold decision continues to address the concern where materially different information subsequently emerges. Equally, an unsuccessful intervention does not itself indicate increased violence risk. The professional task is to establish whether the concern remains, whether its significance has changed and what further assessment or response is required.

8.13.7. Where monitoring was the agreed response, it needed a defined purpose, responsibility and point for review. Monitoring should identify what changes or additional information would prompt further action and should not substitute for assessment or intervention where concerns continue or increase.

8.14. Professional challenge and escalation

8.14.1. Professional challenge has a distinct role where a professional considers that another agency's response has not adequately addressed the substance of a concern, an anticipated assessment or intervention has not occurred, or agreed action has not been followed through. Working Together to Safeguard Children 2026 (NHS000592) includes constructive challenge within its expectations for effective multi-agency working, while KCSIE 2026 provides for escalation where a child's situation does not appear to be improving following referral. Professional challenge therefore goes beyond making or repeating a referral: it requires professionals to question whether the response received adequately addresses the information or concern they have raised.

8.14.2. Education professionals may be particularly well placed to identify when further challenge is required because of their sustained contact with a young person and knowledge of changes over time. They should not seek to override specialist assessment, but where their concerns remain unresolved, they can seek clarification about the basis for a decision, provide additional or updated information, consult senior or specialist colleagues and use established escalation arrangements. Where another service has reached a different professional judgement, the issue is not whether Education's view should prevail, but whether material differences in professional understanding have been recognised, explored and, where necessary, escalated.

8.14.3. There was also evidence of professional challenge resulting in further action, including evidence of social worker escalating concerns to their line manager, following which a safety plan was agreed. Further examples include CAMHS practitioners challenging the need for re-referral or escalation and local authority careers services highlighting the need for intervention from Prevent. This demonstrates the importance of escalation where the response at one level has not adequately addressed the concern.

8.14.4. Professional challenge is particularly relevant to VFIs where information indicates possible serious violence, threats, weapons or risk of harm to others and the professional considers that the response received has not addressed the nature or significance of that concern. It does not require professionals to make specialist risk judgements outside their expertise or assume that another professional's assessment is wrong. It requires them to make unresolved concerns explicit, identify the information on which those concerns are based

and use appropriate challenge or escalation arrangements where they consider that the response does not adequately address them.

8.15. Hearing the young person

8.15.1. Hearing the young person's voice requires professionals to understand how the individual young person communicates and to adapt professional engagement where necessary. This is particularly important where speech, language and communication, neurodevelopmental or sensory needs affect the young person's ability to understand questions, process information, express themselves or participate in assessment and intervention. The SEND statutory framework reflects this principle by requiring children and young people to have the information and support necessary to express their views and participate in decision-making.

8.15.2. Across the case studies, young people communicated difficulties, fears, violent interests or a need for help in different ways and to different people. These communications did not always take the form of a direct request for professional intervention. They included conversations with trusted adults, approaches to services, behaviour and changes in presentation, and communications with others online. In one case, professionals had identified communication and sensory needs and recorded concern that he was trying to process or disclose experiences that he found difficult to communicate.

8.15.3. Another of the cases illustrates why a young person's communications may need to be considered across different settings and relationships rather than solely through what they say during a particular formal assessment. Communication and neurodevelopmental needs identified more fully after an index incident should not be applied retrospectively to determine what an earlier presentation meant.

8.15.4. A young person's presentation during a particular professional encounter may not therefore provide a complete account of what they are experiencing or trying to communicate. Communication needs may affect whether they understand what is being asked, how quickly they process information, whether they can organise and express their thoughts, and whether they are able to communicate when distressed. For some young people, masking[26] may also mean that distress, difficulties or support needs are less apparent in particular settings or interactions. Such communications may provide relevant information when considered alongside the wider picture.

8.15.5. Professionals should identify and respond to communication needs as part of assessment and intervention. This may require reasonable adjustments to the timing, setting, language or format of communication; additional processing time; alternative means of communication; involvement of a trusted adult; or support from professionals with relevant communication expertise. The appropriate adjustment will depend on the individual young person. The purpose is not only to obtain their views, but to ensure that the method of

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27 Masking is the conscious or unconscious suppression or concealment of neurodivergent traits or behaviours in order to conform to social expectations.

professional engagement does not itself prevent them from communicating information relevant to their needs, wellbeing or possible risk.

8.15.6. The importance of this was evident where a young person with a stammer and delayed processing became mute when stressed and was observed "sat in the office in the dark swaying… become mute because he was stressed". He had told a teacher with whom he had an established relationship that he was willing to talk to someone. The teacher had spent considerable time building his trust, made referrals for further support and asked to be present during an assessment. The young person was subsequently asked to attend the assessment by a professional relatively unknown to him, without the trusted teacher being informed or present, and did not participate. His non-participation did not therefore establish that he was unwilling to receive help more generally. The example demonstrates how communication difficulties, professional relationships and the arrangements for assessment can affect a young person's ability or willingness to participate.

8.15.7. Communication may also occur through behaviour or changes in presentation, particularly where a young person has difficulty identifying, organising or expressing what is happening to them. Withdrawal, refusal, disengagement, aggression, dysregulation or self-harm do not have a single meaning and should not automatically be interpreted as communication of a particular need. However, severe emotional dysregulation, aggression and difficulties with engagement occurred in the case studies alongside identified neurodevelopmental and mental-health needs; in one case, a subsequent review identified a lack of professional curiosity about the reasons for the behaviour. In another, longstanding behavioural difficulties occurred alongside autism and identified speech, language, communication and sensory needs. These examples do not establish what particular behaviours meant but demonstrate why communication needs and the individual ways in which a young person expresses distress or difficulty should form part of professional understanding.

8.15.8. A young person's refusal, limited communication or inability to participate in a particular assessment should not automatically be interpreted as refusal of help or absence of need. Professionals should consider whether the young person understood the purpose of the intervention, whether their communication needs had been identified and accommodated, and whether a different professional, trusted relationship, setting, format or other reasonable adjustment might enable participation. This is particularly important where the concern remains unresolved and the young person's communication difficulties may themselves limit access to assessment or support.

8.15.9. These principles are particularly relevant where a young person communicates thoughts, interests or intentions relating to serious violence. Hearing the young person's voice does not mean accepting what they say as a complete assessment of either their needs or risk. Professionals should seek to understand what the communication means for that individual, the context in which it occurred and whether communication needs affect what is communicated, how it is expressed or how it may be interpreted. Equally, communication difficulties should not lead professionals to minimise a serious violence-related communication. It should be considered alongside other relevant information without

assuming either that it establishes violent intent or that neurodevelopmental or communication needs explain it.

Recommendation: The Inquiry should explore whether mechanisms exist to ensure children and young people, including those with communication needs, are adequately heard and understood when serious violence-related concerns arise.

9. The digital environment

9.1. The digital environment formed a significant part of the downward trajectories of several of the young people. Its significance was not only the amount of time they spent online or their exposure to harmful material. Across the case studies, digital activity provided information about violent interests, relationships and influences, communications concerning suicide or harm to others and, in some cases, activity potentially relevant to intent or preparation for serious violence. For some young people, its significance increased as education, routine, face-to-face relationships or other sources of activity and belonging fell away.

9.2. Digital activity varied considerably. The evidence included gaming and social-media use; violent, sexual, harmful, misogynistic or extremist material; online relationships and communities; communications concerning suicide or harm to others; and searches or other activity potentially relevant to serious violence. In one case, later digital examination identified material concerning mass shootings, creation or modification of violent games, abusive sexual material and research relevant to obtaining a firearm and forging a firearms licence.

9.3. Another young person undertook online research and contact concerning extremist organisations, racial ideology, Satanism and the occult. Some of this evidence became available only after the index incident and should not retrospectively be treated as information available to professionals at the time.

9.4. These examples demonstrate that information relevant to a young person's interests, relationships, vulnerabilities and developing concerns may exist within their digital life without being apparent from their presentation to professionals or family members. The significance of digital activity depended upon what the young person was doing online, with whom, what it meant for them, whether it was changing and how it related to the wider information available.

9.5. Understanding digital activity

9.5.1. KCSIE 2026 categorises online-safety risks into four areas: content, contact, conduct and commerce. This provides a useful framework for distinguishing different forms of digital activity rather than treating "internet use", "gaming" or "inappropriate content" as a single concern. The case-study evidence was particularly relevant to content, contact and conduct; there was less evidence relating to commerce.

9.5.2. Content included violent material, pornography and harmful or illegal sexual material, extremist content and misogynistic or incel-related material. Across the cases there was

evidence relating to mass shootings, firearms and other serious violence, ISIS, Nazi symbols, racial ideology, Satanism and occult interests. Such material did not itself establish violent intent. Its relevance depended upon its nature, persistence and context, whether it had been encountered or deliberately sought, and its relationship to other information about the young person. Algorithms and recommendation systems may also affect what material a young person encounters online.

9.5.3. Extremist, ideological and sexual material required individual assessment. Online research and contact relating to right-wing organisations occurred in one case alongside racial and occult interests, while elsewhere violent or extremist interests included ISIS and Nazi material. These interests did not represent a coherent ideology. Sexual material also formed part of the digital picture in several cases and, where harmful sexual behaviour or other relevant concerns were already known, could provide additional information relevant to assessment.

9.5.4. Contact concerned the relationships and interactions young people experienced online. Online relationships may be significant relationships for the young person and can provide sources of identity, influence or belonging that are not readily visible to parents or professionals.

9.5.5. The significance of online relationships may also need to be understood in the context of the young person's neurodevelopmental, communication and mental-health needs. Where a young person is socially isolated, has difficulty forming or maintaining relationships, or has experienced disruption to education, routine or other sources of identity and belonging, online relationships and communities may assume greater importance in their lives. This does not make those relationships inherently harmful, nor should neurodevelopmental or mental-health needs be treated as evidence of dangerousness or used to explain away concerning online contact. Rather, professionals need to understand what particular relationships or communities mean to the young person, the influence they may have, and how they relate to the young person's wider functioning, relationships, vulnerabilities and developing behaviour.

9.5.6. Across the case studies, young people interacted with online communities and individuals associated with concerning interests and communicated information to online contacts that was not necessarily being shared with adults. KCSIE 2026 also recognises that contact risk can arise through interaction with generative AI applications that simulate interaction with other users, reflecting the changing nature of digital relationships and influences.

9.5.7. Conduct concerned the young person's own online behaviour. The case studies included extensive violence-related searches, research potentially relevant to obtaining a firearm, creation or modification of violent games, communications about suicide, killing another person or intended violence. In one instance, messages concerning an intention to jump in front of a train resulted in police involvement; later communications included statements about killing others. Elsewhere, online contacts received communications concerning intended violence and another internet user independently reported concerns to police.

9.5.8. These communications were particularly important because they could disclose information that was not being communicated directly to family members or professionals. They did not themselves establish an intention to act, but sufficiently concerning communications required assessment alongside the wider information available. Encountering content, deliberately searching for it, communicating about violence and taking practical steps towards an intended act are different forms of activity and should not be treated as equivalent.

9.5.9. Commerce was relevant in the case studies, in particular where online retailers or marketplaces were used to obtain, or attempt to obtain, weapons and other potentially dangerous items. The Phase 1 Southport Inquiry report identified AR's use of online retailers to purchase knives and machetes, as well as other items capable of use as weapons and materials and equipment used in his attempts to manufacture ricin. Some purchases were made using false names or identities. Such activity is materially different from viewing or searching for violent content because it may provide evidence of movement from interest or research towards acquisition or practical preparation. Its significance will depend on the nature of the item, the circumstances of the purchase or attempted purchase and the wider information known about the young person. Where concerns about serious violence already exist, patterns of online purchasing or attempted purchasing may therefore be important to the assessment of developing risk.

9.6. Visibility

9.6.1. Parents and professionals did not necessarily have visibility of the young person's digital life. The case studies included password-protected devices which a parent could not access, VPN use and activity across multiple platforms and devices. Private or disappearing communications could create further limits on what was observable. These technologies have legitimate uses and their presence should not itself be interpreted as evidence of concealment or harmful intent. There is also an important distinction between a facility being available and how it is actually used.

9.6.2. Reduced visibility becomes relevant where significant concerns are already present and an assessment or safety plan depends upon adults understanding or monitoring online activity. Professionals need to be clear about what is known, what remains unknown and whether the available information is sufficient for the purpose of the assessment or plan.

9.6.3. Digital environments also change rapidly. Safeguarding cannot depend upon individual parents, teachers, social workers or other practitioners having specialist technical knowledge. Relevant professionals do, however, need to be able to recognise significant digital concerns, describe them with sufficient precision and know when specialist advice or assessment is required.

Recommendation: The Inquiry should explore whether multi-agency professionals have sufficient digital expertise to undertaken and support assessment of serious violence-related concerns.

9.7. Education and online safeguarding

9.7.1. Schools identified significant online concerns in several cases. These included violent or extremist interests, harmful material identified through school IT systems which contributed to a Prevent referral, and an instance in which a young person accessed pornography on a professional's computer in school. These concerns arose alongside other information about the young people's needs, behaviour and circumstances. Their significance extended beyond breaches of acceptable-use or IT policies and required consideration within the wider safeguarding picture.

9.7.2. Filtering and monitoring are integral to a school or college's online safety measures, but only one component of that response. Filtering may prevent access to some harmful material and monitoring may identify activity of concern, but neither determines what that activity means for an individual young person. Where school systems identify material relevant to possible serious violence, the issue is not just whether access should be blocked, but whether the information requires safeguarding assessment, recording, escalation, referral or sharing.

9.7.3. This approach is underpinned by KCSIE 2026 (para 164-173) and the associated DfE filtering and monitoring standards. Schools and colleges are expected to have appropriate filtering and monitoring arrangements, understand their limitations and review their effectiveness. The current standards require consideration of the particular risk profile of pupils, including SEND, how technology is accessed, and changes such as remote access, personal devices and generative AI. They also emphasise the respective safeguarding and technical responsibilities of the DSL, senior leaders and IT support, and the need to act upon concerns identified through monitoring.

9.7.4. Recommending that the Government builds on current information-sharing reforms to develop a 'single child view', enabling authorised practitioners to identify other agencies involved with a child and access relevant information about their involvement, plans and responsibilities.

9.7.5. The significance for the case studies is that the digital environment extended well beyond school-managed networks. Relevant activity occurred through personal devices, gaming, social media and other platforms, sometimes at times when the young person had reduced engagement with education and greater time online. Remote education, mobile phones and other personal smart devices similarly create routes to digital content, contacts and conduct that may not be visible through school-network controls. Generative AI adds further complexity because content and interaction may be dynamic and personalised. Current DfE standards[27] specifically require schools to consider how and where generative AI is used and whether filtering and monitoring systems can address AI-generated content.

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28 Department for Education (2026), Meeting digital and technology standards in schools and colleges: Filtering and monitoring standards for schools and colleges, updated 2026 **(DFE000239)**

9.7.6. The professional response needs to extend beyond technical controls. Online-safety and relationships education may form part of prevention, but its effectiveness needs to be considered in relation to the individual young person. In one case, sex education was recorded as part of the school's curriculum at different stages of education but sat alongside longstanding concerns about the individual's harmful sexual behaviour, later online sexual activity, autism and communication needs. The relevant question was not only whether teaching had been delivered, but whether the support provided adequately addressed the young person's individual needs.

9.8. Digital information

9.8.1. Significant digital information can be held by different people and organisations without being brought together with the wider information about the young person. Education might hold information generated through school systems; parents might observe activity at home or be unable to access devices; peers and online contacts might receive communications not made to adults; police might receive reports or subsequently obtain material from devices; Prevent might hold information about ideological concerns; while health and children's social care held information about needs, functioning and family circumstances.

9.8.2. The case studies illustrate this fragmentation. A peer of one of the young people became concerned when they suddenly stopped responding through Snapchat. In another case, online reports of suicidality resulted in police intervention. Elsewhere online contacts received communications concerning intended violence.

9.8.3. The significance of this information depended on how it related to what other professionals knew. The issue was not only whether digital information was shared. Relevant information needed to reach those undertaking assessment and be considered alongside what education, health, social care, police, Prevent and other services already knew. A young person appearing settled at school or during an appointment did not mean that concerns identified elsewhere were no longer relevant. Where different agencies held important digital and other information, this needed to be brought together and reviewed so that decisions were based on the wider picture.

Recommendation: The Inquiry should explore whether multi-agency arrangements ensure significant digital information informs assessment of serious violence-related concerns.

9.9. Online safety planning

9.9.1. Where serious concerns had been identified, generic instructions to "monitor internet use" or remove a particular device could be insufficient if they did not reflect how the young person accessed and used the digital environment. A safety plan needed to be proportionate to the identified concern and sufficiently specific about its purpose, actions, responsibilities and review.

9.9.2. Later evidence from criminal proceedings illustrates the complexity of restricting digital access once serious risk has been established. Restrictions imposed through criminal

orders should not be treated as measures that parents, schools or safeguarding agencies could necessarily have imposed beforehand, as some depended upon legal powers and enforcement mechanisms unavailable to them. Effective digital safety planning requires an accurate understanding of the young person's actual routes to devices, platforms and internet access.

9.9.3. Where agreed controls could not be maintained, this should not automatically be interpreted as evidence of escalating violence risk. It should, however, prompt review of whether the safety plan remained capable of addressing the concern and whether further safeguarding or specialist input was required.

9.9.4. The case studies contained evidence of parental restrictions, school safeguarding responses, monitoring, police involvement and Prevent referrals. None removed the need for ongoing assessment. A Prevent, police or other specialist referral addressed matters within the remit and information available to that service; it did not resolve other safeguarding, SEND, health, social-care or educational concerns. Similarly, blocking content or restricting a device might reduce one route of access without addressing concerning relationships, communications or underlying needs. Digital interventions therefore needed to be reviewed against subsequent information and alongside the wider professional response.

Recommendation: The Inquiry should explore whether serious digital safeguarding concerns require proportionate multi-agency safety planning with clear responsibility and review.

9.10. Post-incident review and learning

9.10.1. A distinct systemic issue arises where significant digital evidence becomes available only after a review following serious harm has been completed. Device examination and wider police investigation may take substantially longer than an initial safeguarding or rapid review. An early review cannot reasonably consider evidence that was not then available, but later digital evidence may materially alter understanding of the young person's trajectory and the information or opportunities available to professionals before the VFI.

9.10.2. This occurred in the case studies. Later digital examination in one case identified material concerning mass shootings, creation or modification of violent games, sexual material and firearms-related research. Other post-incident digital evidence provided additional information about violent or ideological interests, online relationships and communications. This evidence should not retrospectively be treated as information professionals knew or should have known. The relevant question is whether, once available, it materially changes the understanding upon which professional and systemic learning was based.

9.10.3. Post-VFI learning arrangements therefore need a mechanism for determining whether significant later digital evidence requires existing findings to be supplemented or reconsidered.

Recommendation: The Inquiry should explore whether post-VFI review arrangements provide a mechanism for significant later digital evidence to inform or reopen learning.

10. Summary of recommendations

10.1. The Inquiry should consider the following recommendations:

10.2. Exploring whether clearer arrangements are required for the assessment and coordination of support where mental health, SEND, trauma and safeguarding needs overlap and there are emerging or escalating concerns about harm to self or others, including accessible mental-health assessment and treatment for neurodivergent young people, joint review where necessary, and clear responsibility for coordinating support and escalating concerns.

10.3. Exploring whether a clear therapeutic pathway is required for children and young people with significant trauma-related needs who do not meet the criteria for specialist mental-health services, particularly where these are accompanied by self-harm, suicidality or escalating behavioural concerns.

10.4. Recommending that the current ERG-R common assessment framework, developed by the Ministry of Justice for the assessment and management of terrorist offenders, is adapted to include the risk factors that correspond with the jeopardies identified here, together with protective factors that have the potential to prevent juveniles from completing a violent fixation pathway.

10.5. Exploring whether there is sufficient practical digital-safety support for families where significant online concerns have been identified, including support adapted to the young person's communication and neurodevelopmental needs and review of whether agreed measures are workable and effective.

10.6. Recommending that each Multi-Agency Safeguarding Arrangement publishes within its plan how it will take forward the learning from the Southport Inquiry.

10.7. Recommending that the Government reviews whether education should become a statutory safeguarding partner within Multi-Agency Safeguarding Arrangements.

10.8. Recommending that the Government reviews and consults on the legislative gap to clarify the lead process for managing violent fixated individuals.

10.9. Recommending that the SEND reforms provide timely additional resources and specialist multi-agency support where increasing complexity of need or behaviour exceeds a school's existing capacity, including where there are associated concerns about risk to others.

10.10. Recommending the development of national standards and safeguarding processes for adolescents experiencing harm outside the home and/or presenting a risk of harm to others, recognising that current child protection processes may not meet their needs.

10.11. Exploring whether local authorities should extend multi-agency adolescent risk meetings to include young people who pose a risk of harm to others.

10.12. Recommending that within the Family First Framework, and as MACPT's are development local areas are given the flexibility to develop their own model to meet the needs complex, high risk adolescents in order to support the development of multi-agency and multidisciplinary specialist adolescent services.

10.13. Recommending that guidance is provided to MAPPA in relation to VFI and NIEV.

10.14. Exploring whether local authorities require greater support and capacity to meet existing responsibilities for maintaining professional oversight during significant disruption to

education, including maintaining or restoring meaningful education and ensuring clear transfer of responsibility between professionals, settings or services.

10.15. Recommending the development of guidance to support local authorities and mental-health providers in developing transitional safeguarding models for young people moving into adulthood, particularly where neurodevelopmental, mental-health, trauma, safeguarding or serious violence-related concerns remain unresolved.

10.16. Exploring how greater professional accountability can be achieved for recording and information sharing, including recording professional reasoning, decisions and agreed actions, following up referrals and actions, and ensuring that relevant safeguarding information is appropriately shared.

10.17. Exploring whether children and young people, including those with communication needs, are adequately heard and understood when serious violence-related concerns arise.

10.18. Exploring whether multi-agency professionals have sufficient digital expertise to undertake and support assessment of serious violence-related concerns.

10.19. Exploring whether multi-agency arrangements ensure significant digital information informs assessment of serious violence-related concerns.

10.20. Exploring whether serious digital safeguarding concerns require proportionate multi-agency safety planning with clear responsibility and review.

10.21. Exploring whether post-VFI review arrangements provide a mechanism for significant later digital evidence to inform or reopen learning.

The Southport Inquiry

Phase Two

Statement of Truth

Expert: Anna Gianfrancesco

Report: Expert Report

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

I understand that proceedings for contempt of court 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 in its truth.

Signed Signature

_____

Name: _____Anna Gianfrancesco_____

Dated: _____23.09.26_____

The Southport Inquiry

Phase Two

Statement of Truth

Expert: Dr Monica Lloyd

Report: Expert Report

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

I understand that proceedings for contempt of court 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 in its truth.

Signature

Signed:

Name: Dr. Monica Lloyd

Dated: 22/09/2026

The Southport Inquiry

Phase Two

Statement of Truth

Expert: Elizabeth Swan

Report: Expert Report

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

I understand that proceedings for contempt of court 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 in its truth.

Signed: Signature

Name: Elizabeth Swan

Dated: 22 September 2026

11. Appendices

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Appendix 2: Terminology

VFI: Violence-Fixated Individual Used in this report to describe an individual presenting with a significant and enduring preoccupation or fixation with extreme violence. Drawing on the terminology used by the Southport Inquiry, this may include a fixation on extreme violence that is not attributable to a clear or stable ideology. The term does not constitute a diagnosis, and an interest in violence or violent material does not, by itself, establish that an individual is violence-fixated or presents a risk of serious violence.

ADHD: Attention Deficit Hyperactivity Disorder A neurodevelopmental condition affecting attention and/or activity and impulse regulation.

AP: Alternative Provision Education arranged for children and young people who, because of exclusion, illness or other reasons, would not otherwise receive suitable education.

ASD: Autism Spectrum Disorder The diagnostic terminology used in many of the records reviewed. The report otherwise generally uses autism or autistic young person where appropriate.

CAMHS: Child and Adolescent Mental Health Services Specialist NHS services providing assessment and treatment for children and young people with mental-health difficulties. Service names and structures vary locally.

Channel
The voluntary, multi-agency programme through which support may be provided to individuals considered susceptible to being drawn into terrorism. It forms part of Prevent.

CIN: Child in Need A child assessed as being in need within the meaning of section 17 of the Children Act 1989. A CIN Plan is used to coordinate support for an individual child and family following such an assessment.

CP: Child Protection Used in the report in relation to safeguarding action where there are concerns that a child is suffering, or is likely to suffer, significant harm. A Child Protection Plan (CPP) records the multi-agency plan for protecting a child following a child protection conference.

Contextual safeguarding An approach to safeguarding which recognises that children and young people may experience harm in contexts beyond their family or home, including peer groups, schools, neighbourhoods and digital environments.

CSC: Children's Social Care Local authority services responsible for functions relating to children in need, child protection and other statutory social-care responsibilities.

DSL: Designated Safeguarding Lead The senior member of staff within a school or college with lead responsibility for safeguarding and child protection.

Early Help Support provided to a child and family when needs or difficulties are identified that may require coordinated help but do not necessarily require statutory intervention. Terminology and arrangements have varied over time and between local areas.

EHCNA / EHC needs assessment: Education, Health and Care Needs Assessment The statutory assessment undertaken by a local authority to determine whether it is necessary to issue an Education, Health and Care Plan.

EHC Plan / EHCP: Education, Health and Care Plan A statutory plan for a child or young person with special educational needs whose needs require provision to be made through an EHC Plan. The report generally uses EHC Plan.

FASD: Foetal Alcohol Spectrum Disorder A diagnostic term describing a range of lifelong effects associated with prenatal alcohol exposure. Evidence of prenatal alcohol exposure is not, by itself, evidence of FASD.

Family Help The terminology used in Working Together to Safeguard Children 2026 for multi-agency support for children and families who require help additional to universal services.

HSB: Harmful Sexual Behaviour Developmentally inappropriate sexual behaviour displayed by children or young people which may be harmful or abusive towards themselves or others.

IEP: Individual Education Plan A plan historically used in schools to record a pupil's identified special educational needs, intended outcomes, provision or interventions and arrangements for review. IEPs are not required under the current SEND statutory framework, although the term appears in historical case records.

Incel: Involuntary celibate A term originating as a description of people who consider themselves unable to form desired sexual or romantic relationships. It has also become associated with online communities and, in some contexts, an ideology or worldview involving grievance about sex, relationships and gender, including misogynistic beliefs. Use of the term or engagement with incel-related material does not, by itself, indicate violent intent.

ISP: Individual Support Plan The standardised support plan proposed in the Government's 2026 SEND reform consultation. It is not part of the current statutory SEND framework.

Jeopardy
Used in this report to describe circumstances, experiences or influences that may increase a young person's vulnerability to adverse outcomes or contribute to a developing pathway of concern. A jeopardy is not, by itself, an indicator or predictor of serious violence.

KCSIE: Keeping Children Safe in Education Statutory safeguarding guidance issued by the Department for Education for schools and colleges. References to the current framework in this report are to Keeping Children Safe in Education 2026 unless otherwise stated.

LA: Local Authority The local government body exercising statutory functions relevant to Education, SEND, children's social care and safeguarding.

LSP: Lead Safeguarding Partner A senior representative of one of the three statutory safeguarding partner organisations: the local authority, integrated care board and chief officer of police.

MAPPA: Multi-Agency Public Protection Arrangements Statutory arrangements through which specified criminal justice and other agencies assess and manage certain offenders who present a risk of serious harm.

MASA: Multi-Agency Safeguarding Arrangements The local arrangements through which the three statutory safeguarding partners, the local authority, integrated care board and police, work together, and with relevant agencies, to safeguard and promote the welfare of children.

MASH: Multi-Agency Safeguarding Hub A local multi-agency arrangement for receiving, sharing and considering safeguarding information and determining or coordinating appropriate responses. Structures and terminology vary between local areas.

NIEV: Non-Ideological Extreme Violence

NEET: Not in Education, Employment or Training A term used for young people who are not participating in education, employment or training.

Neurodevelopmental condition A pervasive and lifelong condition affecting neurological development and functioning, including autism and ADHD.

Neurodivergence / neurodivergent Terms used to describe neurological development or functioning that differs from what is regarded as typical (terms attributed to Kassiane Asasumasu). In this report, neurodivergent is used in relation to an individual or group of individuals.

Neurodiversity The variation in neurological development and functioning across the human population. It describes diversity at a population level rather than a diagnosis or an individual characteristic (term attributed to Judy Singer).

OCD: Obsessive-Compulsive Disorder A mental-health condition characterised by recurrent intrusive thoughts, images or urges (obsessions) and/or repetitive behaviours or mental acts (compulsions).

ODD: Oppositional Defiant Disorder A diagnostic term for a pattern of persistent angry or irritable mood, argumentative or defiant behaviour and/or vindictiveness.

Off-site direction An arrangement through which a pupil may be required to attend another education setting temporarily for the purpose of improving behaviour.

Prevent / Prevent duty Prevent is part of the UK counter-terrorism strategy concerned with preventing people from becoming terrorists or supporting terrorism. The Prevent duty, under the Counter-Terrorism and Security Act 2015, requires specified authorities, in exercising their functions, to have due regard to the need to prevent people from being drawn into terrorism.

PRU: Pupil Referral Unit A type of Alternative Provision maintained by a local authority for pupils who may otherwise not receive suitable education.

Reasonable adjustments Changes required under equality legislation to avoid a disabled person being placed at a substantial disadvantage. The report also refers more generally to adapting professional communication and engagement to meet an individual young person's needs where appropriate.

Restrictive intervention An intervention that restricts a child or young person's movement or liberty. The term encompasses a range of practices, including restraint and segregation.

Restraint A form of restrictive intervention involving the use of force or restriction of movement. Where the report refers to "restraint or other restrictive interventions", restraint is included within the broader category of restrictive intervention.

RONI: Risk of NEET Indicator A locally used assessment or screening approach intended to identify young people at risk of becoming NEET. It is not a nationally standardised statutory assessment.

SALT / SaLT: Speech and Language Therapy Assessment and intervention relating to speech, language and communication and, where relevant, eating, drinking and swallowing needs.

SEMH: Social, Emotional and Mental Health needs One of the four broad areas of special educational need identified in the SEND Code of Practice.

SEN: Special Educational Needs A child or young person has SEN where they have a learning difficulty or disability which calls for special educational provision to be made for them.

SENCo / SENDCo: Special Educational Needs Coordinator The member of staff with designated responsibility for coordinating SEND provision within an education setting. Terminology has varied over time and between records.

SEND: Special Educational Needs and Disabilities The collective term used in the report when discussing special educational needs and disability. It encompasses a broad range of needs and is not itself a diagnosis.

SLCN: Speech, Language and Communication Needs Difficulties relating to speech, understanding or using language, social communication or other aspects of communication.

Suspension Temporary exclusion of a pupil from school for a specified period. Current Department for Education guidance uses suspension; older records may use fixed-term exclusion or fixed-period exclusion.

TAF / TAC: Team Around the Family / Team Around the Child Multi-agency approaches through which professionals working with a child or young person and their family coordinate assessment, support and agreed actions, commonly within Early Help arrangements. Terminology and arrangements vary between local areas and over time.

Violent misogyny Used in this report to describe misogynistic beliefs, communications or conduct in which hostility towards women or girls is associated with, advocates, threatens or legitimises violence. Misogynistic views do not, by themselves, establish violent intent; their significance depends on their nature, context and relationship to other information about the individual.

Working Together Working Together to Safeguard Children, the statutory guidance governing multi-agency working to help, support and protect children. References to the current framework in this report are to the 2026 guidance unless otherwise stated.

YOS / YOT: Youth Offending Service / Youth Offending Team Local multi-agency services working with children and young people involved in, or at risk of involvement in, the youth justice system. Youth Offending Team is the statutory terminology, although Youth Offending Service and other local service names are also used.

The Southport Inquiry

Phase Two

Expert Report 2

Author:

Dr. Richard Church, Consultant Psychiatrist

11 September 2026

Expert Report: Dr. Richard Church

1. Introduction

1.1. The tragic events that unfolded at a children's dance club in Southport on 29/07/2024 were of a brutality that shook the nation. The perpetrator AR murdered three children, injured another 10 people, and left at least another 16 individuals with serious psychological trauma. The Home Secretary announced a statutory inquiry on 07/04/2025, and the Southport Inquiry Phase 1 report was published on 13/04/2026.

1.2. As part of Phase 2 of the Inquiry, I have been instructed to review six case studies, referred to by letters A to F, and to provide an expert opinion in relation to a number of pertinent questions.

1.3. I have engaged in multiple meetings and discussions with the following other experts instructed by the Inquiry:

1.4. Neil Basu – former senior national counter-terrorism policing lead, providing expertise on policing decision-making, escalation, and disruption measures.

1.5. Dr Monica Lloyd – forensic psychologist specialising in terrorism and risk assessment, focusing on how violence fixation is identified and managed.

1.6. Anna Gianfrancesco – former Director of Children's Services and Channel Chair, bringing extensive safeguarding and multi-agency expertise.

1.7. Elizabeth Swan – former headteacher and safeguarding expert, with strong experience in identifying risks in education and frontline settings.

1.8. I extend my deepest sympathy and condolences to the families and loved ones of those bereaved and harmed by the Southport atrocity, and to those bereaved and harmed in the other cases I have reviewed. I have approached this task with a deep-rooted determination to do everything possible to help prevent the reoccurrence of such events.

1.9. Author

1.9.1. I am a medical doctor on the Specialist Register of the General Medical Council UK (GMC 6040373) with a Certificate of Completion of Training (CCT) in Child and Adolescent Psychiatry (2009) and Forensic Psychiatry (2012). I am approved by the Secretary of State under sections 12(2) and 12(2A) of the Mental Health Act 1983, as amended by the Mental Health Act 2007, in England and Wales. My professional qualifications include Bachelor of Medicine and Surgery degrees from the University of Cambridge (2002), Membership of the Royal College of Psychiatrists (2006), Diploma in Child Health from the Royal College of Paediatrics and Child Health (2007), Associateship of King's College London (2009). I was elected to Fellowship of the Royal College of Psychiatrists in 2020.

1.9.2. I have worked as a psychiatrist in a broad range of settings including at the Maudsley Hospital, the Bethlem Royal Hospital, HMYOI Feltham, HMYOI Cookham Wood, Broadmoor High Secure Hospital, Three Bridges Medium Secure Unit, The Orchard Women's Enhanced Medium Secure Service, Westminster Forensic Community Service, Lambeth CAMHS, Lambeth Youth Offending Service, National & Specialist Neurodevelopmental CAMHS, King's College Hospital, and the National & Specialist Adolescent Forensic Psychiatry service. I worked at South London and Maudsley NHS Foundation Trust for 11 years, five of those as a Consultant Psychiatrist and four years as a Lead Clinician. Since 2017 I have been employed full time at Cygnet Hospital Woking as a Medical Director and a Consultant Forensic Psychiatrist on a Female Low Secure Unit. In February 2024 I was appointed to the role of Regional Medical Director for South East England at Cygnet Health Care.

1.9.3. I have provided services as a psychiatric expert witness since 2008. I have extensive experience of assessment and management of individuals with complex needs who present high risks to themselves and others in prison, secure psychiatric hospital and in community settings. I am particularly experienced in the clinical assessment and management of mental and behavioural disorders in children, young people and adults who come into conflict with the law.

1.9.4. I serve as Chair of the Adolescent Forensic Psychiatry Special Interest Group at the Royal College of Psychiatrists in the UK, and I am a Board member of the European Association for Forensic Child and Adolescent Psychiatry, Psychology and other involved Professions (EFCAP). I have been an Honorary Clinical Senior Lecturer at the Institute of Psychiatry, Psychology and Neuroscience, King's College London, where I continue to be active as a clinical teacher and lecturer in the field of psychiatry, offending behaviour and mental health.

2. Limitations

2.1. I defer to the other experts in areas including education, social care, policing, counter terrorism and online technology. Any observations or recommendations that I make regarding these or other areas outside psychiatry should be understood to be limited to the extent that they interface with psychiatry and delivery of mental health services.

2.2. In this report I have identified themes from my reading of case study materials and from my discussions with the other experts. I do not claim to hold comprehensive knowledge of these case studies.

3. Summary of identified problems and recommendations

3.1. 'Critical' items are indicated with a red filled box in the number column.

3.1.1. **Online safety**

	3.1.2. Problem: The nature of online activity of young people was invisible to parents and professionals.	**3.1.3.** Recommendation: The Inquiry should explore mechanisms by which technology can enable visibility and supervision of the online activity of children and vulnerable adults.
	3.1.4. Problem: Extreme materials, extreme communities and individuals with extreme views were easily found online.	**3.1.5.** Recommendation: The Inquiry should explore mechanisms by which extreme and harmful online material, including extreme online communities, might be made inaccessible to children and vulnerable adults.
3.1.6. Information sharing		
	3.1.7. Problem: Significant risk information obtained and stored by one team or agency was very often not available to other agencies.	**3.1.8.** Recommendation: The Inquiry should consider the scope for development of a shared, multiagency child risk information system, including risk events, risk assessments, agency involvement, and historical safeguarding / child protection matters. This would enable more rapid and accurate urgency triaging, risk assessment, diagnosis/formulation and intervention in any agency where young people present.
	3.1.9. Problem: There were unacceptable delays, threshold obstacles and incomplete information sharing in referrals between agencies.	**3.1.10.** Recommendation: The Inquiry may wish to consider the benefits of co-location of agencies/representatives in multiagency high-risk adolescent

		teams (with Children's Social Care, Education, Youth Justice, CAMHS, Police, Counter Terrorism / Prevent) for rapid/immediate communication, triage and consultation.
3.1.11. Assessment, diagnosis and formulation		
	3.1.12. Problem: The voice of the young person with ASD was repeatedly not heard or taken seriously, and significance of sustained low mood withdrawal/isolation, self-harm, gender/identity concerns, and ongoing abuse was overlooked.	**3.1.13.** Recommendation: The Inquiry should explore mechanisms to encourage agencies to take distress and help-seeking behaviours particularly seriously in individuals with ASD, who may present with less visible difficulties and be less likely to express their needs.
	3.1.14. Problem: The lack of a diagnosis of Conduct Disorder contributed to an incomplete appreciation and communication of needs.	**3.1.15.** Recommendation: The Inquiry should consider recommending better implementation of the diagnostic category of Conduct-dissocial Disorder and specifiers in ICD-11, commonly referred to as Conduct Disorder, to help guide appropriate intervention, management and commissioning of services.
	3.1.16. Problem: Assessment is often difficult in the community due to poor engagement, limited access to the young person, lack of consent or parental objection.	**3.1.17.** Recommendation: The Inquiry should explore mechanisms for the empowerment of agencies to overcome obstacles and press forward with assessments when there are concerns about risk of serious harm. If assessment is not

		possible in the community, opportunities for assessment in more controlled environments should be considered (e.g. in alternative settings, hospital, potentially under the Mental Health Act or Children Act). For example, it is a criminal offence to obstruct a Mental Health Act assessment.
3.1.18. Risk assessment		
	3.1.19. Problem: Each agency has its own risk assessments with a lack of comprehensive, multi-agency summative risk assessment or formulation.	**3.1.20.** Recommendation: The Inquiry should consider recommending establishment of a shared multi-agency risk assessment/formulation.
	3.1.21. Problem: For those who present elevated risks of harm to others, there was little use of specific risk assessments for violence.	**3.1.22.** Recommendation: The Inquiry should consider recommending the implementation of a shared multi-agency risk assessment of harm to others (e.g. such as the SAVRY).
	3.1.23. Problem: For young people identified as VFIs, there is no specific risk assessment to guide assessment and intervention.	**3.1.24.** Recommendation: The Inquiry should consider development and implementation of a specialist risk assessment tool for VFIs (e.g. a modified version of the ERG-R).
3.1.25. Intervention and risk management		
	3.1.26. Problem: Following diagnoses of ASD, young people and families received little onward ASD-related support.	**3.1.27.** Recommendation: The Inquiry should consider recommending access to ongoing ASD-related support after diagnosis (e.g. behavioural analysis, social skills,

		coping skills, sensory profile analysis, consideration of co-morbidities and implications for school and learning including EHCPs).
	3.1.28. Problem: Interventions for Conduct Disorder are absent or delivered in a manner that is piecemeal, lacking a coherent pathway or integration with other agencies.	**3.1.29.** Recommendation: The Inquiry should consider recommendations to ensure access to an integrated and coordinated multi-agency therapeutic pathway for young people with Conduct Disorder.
	3.1.30. Problem: The cases indicate a lack of expertise in the delivery of therapeutic interventions for young people presenting antisocial behaviour, negative attitudes and mood disturbance.	**3.1.31.** Recommendation: The Inquiry should consider recommending increased availability of specialist therapeutic intervention for individuals presenting antisocial interests and behaviours, violence fixation, and likely history of psychological trauma. This could take the form of enabling access to forensic mental health training for practitioners, including in the development of skills and the emotional resilience required for the identification of serious risk to others.
	3.1.32. Problem: Cases generally display a lack of a coordinated multi-agency approach to managing VFIs.	**3.1.33.** Recommendation: The Inquiry should consider mechanisms to ensure that young people presenting high risks to others receive a coordinated, integrated, multi-agency risk management

		plan with involvement of key agencies.
3.1.34. **Leadership in a complex multiagency setting**		
	3.1.35. Problem: Responsibility and leadership in a multi-agency setting is often not clear, with instances of discharges to a marked lack of ongoing care and oversight (E).	3.1.36. Recommendation: The Inquiry should consider recommending that all young people who present risks of serious harm to others must be held within a formal framework to ensure clear ongoing case responsibility and overall leadership.

4. The relevant policies, roles, bodies and multi-agency systems applicable to the way in which forensic psychiatrists handle VFIs

4.1. The term 'Violence Fixated Individual' or VFI is relatively new, lacks a formal definition, and does not feature in medical diagnostic systems. Despite this, it is a term that is immediately understandable, is accessible to a broad audience, and has a degree of face validity. Adult forensic psychiatrists tend to have clinical roles caring for mentally disordered offenders in secure psychiatric hospitals, prisons and in the community, as well as consultation to other mental health teams – and may encounter VFIs in any of these settings.

4.2. From a forensic psychiatry perspective, the management of VFIs will vary according to the specific characteristics of that individual, with additional potential variation in clinical practice arising from local arrangements. Whilst the intensity, breadth and persistence of fixation on violence will contribute to a risk assessment, the psychiatrist is equally or more interested in what is driving the fixation. For example, violence fixation may emerge in the context of severe mental illness such as psychosis, as part of an obsessive-compulsive disorder, as an intense, restricted interests in an autism spectrum disorder, as part of a depressive, resentful presentation in the context of a grievance, or as an interest held by an individual with a significant primary dissocial presentation. The risk of harm to others associated with a violence fixation will be largely determined by what drives the fixation.

4.3. The forensic psychiatrist, registered with and regulated by the General Medical Council (GMC), usually operates within healthcare organisations regulated and inspected by the Care Quality Commission, in a rich multiagency environment which can include: family or carers, other mental health teams in the NHS, independent sector or third sector, NHS commissioning teams, Primary Care (GPs), Secondary Care (outpatient medical clinics), Prisons, the Ministry of Justice Mental Health Casework Section, Courts including the Mental

Health Tribunal, legal representatives, Local Authority Social Work and Housing teams, Safeguarding and Child Protection teams, Police including Counter Terrorism and Prevent, Probation and Youth Offending Services, and Education. There are also a range of specialist services. For example, in cases where an individual is fixated on the Royal Family or a senior politician, a specialist team called the Fixated Threat Assessment Centre (FTAC), may become involved.

4.4. Multiagency planning and risk management frameworks include Care Programme Approach (CPA) meetings led by mental health, Child Protection meetings, Multiagency Public Protection Arrangements (MAPPA), Multi-Agency Risk Assessment Conference (MARAC), Care Education and Treatment Reviews (CETR) in children or Care and Treatment Reviews (CTR) in adults (frameworks for individuals with autism or a learning disability who are at risk of admission to a mental health hospital, or are already inpatients), and Education, Health and Care Plans (EHCP) for those with special educational needs who are under 25 years old.

4.5. Each agency and organisation will have risk management policies, but each will have a particular focus according to their function. Police and Counter Terrorism agencies have a natural focus on public protection; Child Protection teams hold the welfare of the child as paramount; most general mental health services will naturally be more focussed on the common risks of self-harm and suicide in their patient population, whilst forensic mental health teams will be more accustomed to assessing and managing risks that the individual poses to others, as well as to themselves.

4.6. In short, forensic psychiatrists may encounter VFIs across a wide range of settings with a range of different agencies and professionals involved, and a number of possible frameworks for multiagency management.

4.7. The practice of psychiatry is underpinned by descriptive psychopathology (signs and symptoms of mental illness) and accurate diagnosis to guide treatment. For completion, in Appendix 1 of this report I have included ICD-11 (International Classification of Disease, 11th Revision, by the World Health Organisation) diagnostic criteria for Conduct-dissocial Disorder (commonly referred to as conduct disorder) and for Autism Spectrum Disorder (ASD), for their relevance to the case studies and VFIs.

5. Violence-fixated individuals and risk pathways

What features, such as behaviours, circumstances and trajectories, are apparent across the case studies that may be relevant to understanding the risk posed by violence-fixated individuals?

5.1. In the case studies provided, a number of early life features stand out. A high number have a diagnosis or traits of an autism spectrum disorder (ASD), which is one of the reasons for being selected. The cases also feature exposure to domestic violence or other forms of abuse, parental separation or instability, and development along a conduct disordered trajectory, with some exhibiting behavioural problems in early childhood.

5.2. I also note that many of the individuals in the case studies became immersed in an online world of extreme content, encompassing severe violence, death, serial killers, historical mass killings including school shootings, pornography including the most serious child pornography, misogynistic and incel groups, antisemitism, white supremacy, illegal guides to making various weapons, explosives and poisons, and much more. Online engagement encompasses viewing and sharing extreme images and videos, but also participation in extreme online communities and chatrooms – all of this online, too readily accessible to the young people.

5.3. A further common feature is that the nature and extent of the young person's immersion in a toxic online world was often not known to parents or professionals, and remained private, constantly accessible, with potential for access across a number of devices. The online activity was usually not monitored or supervised effectively, or at all.

5.4. In many cases, social withdrawal and isolation, including not attending school, increased the young person's opportunity for virtually unlimited engagement and immersion in an extreme online environment, whilst reducing exposure to the potentially moderating influence of more pro-social peers.

5.5. When antisocial behaviours were identified or escalated in severity, I note cases where victims, including family and professionals, did not press charges, did not seek help despite significant sustained violence and abuse, and ongoing safeguarding concerns around the young person, were not resolved. Overlooking serious criminal behaviours is a form of overlooking the young person's needs. A lack of assertive action appears to have been driven by a wish to support the troubled young person, by fear of retaliation, or by fear of escalating aggression or violence to others. In these and other ways, there was often a lack of appropriate recognition of, and response to, antisocial behaviour and individual needs, which appears to have reinforced development along increasingly concerning, conduct disordered trajectories. A diagnosis of Conduct Disorder was rarely made.

5.6. Whilst alcohol and substances, including prescription medication, misuse feature in the cases, they do not appear to be a significant or primary driver of index events.

5.7. A strong pattern in the case studies is the emergence of individuals acting alone, not in a partnership or group, nor in a gang. These VFIs characteristically undertake lone, solitary violent or other antisocial acts, often driven by internal factors, with potentially devastating consequences.

To what extent do the case studies suggest identifiable patterns in: fixation, grievance, fascination with previous attacks, weapons interest, concerning online behaviour, leakage, planning, rehearsal, escalation or social withdrawal?

5.8. The cases feature interests across a variety of extreme topics, with a range of intensity and persistence. In some cases, the extent of fixation on weapons, violence and killings remained concealed until after a fatal incident had taken place. Some cases had a particular interest

in emulating a school shooter, but this interest was unknown to others until after their arrest. In other cases the fixation was well known to carers and professionals.

5.9. There is evidence of strongly held resentment and grievances in many cases, including those who identified with incel and misogynistic ideologies online, who often had low self-esteem, low self-image, and felt somewhat defeated and disadvantaged in life.

5.10. In the context of resentment or anger, some displayed a dark grandiosity in seeking notoriety to exceed that of past perpetrators of multiple killings. Such grandiosity can lead to preparatory acts and boastful comments that may increase discoverability prior to the offence, sometimes referred to as leakage, especially to those closest to the individual. Sadly such leakage, in some cases, appears to have failed to prevent the tragedies and possibly led to victimisation of the recipients of the information.

5.11. Some cases have evidence of very meticulous planning to the extent of having pre-recorded social media messages ready for posting after the planned killings. Others had more impulsive patterns, such as reactive assaults on teachers, professionals and vulnerable members of the public.

5.12. Alongside violent thoughts and behaviours, it is also clear that these VFIs also presented episodes of significant low mood, anxiety, self-harm, suicidality, social difficulties, identity and gender issues, functional neurological disorder and high levels of distress. In some cases this appears to have fuelled further isolation and withdrawal from the world, antagonism to it, into the arms of toxic online communities.

5.13. Interestingly, some cases appear to seek and to be open to receiving help at certain points. Others were much more resistant to offers of help.

What indicators, should prompt further assessment, escalation, intervention, information sharing or multi-agency coordination?

5.14. It is not just indicators of criminal activity that should raise concerns, but any risk event, including evidence of sustained, intense interest in violence, weapons, extreme ideology, or extreme pornography. Depending on the nature of the concern, it should be assessed, escalated, shared or acted on appropriately.

5.15. In terms of mental health, any significant changes such as social withdrawal, isolation, school refusal, excessive time online, low mood, anxiety or irritability should raise concerns, especially in the context of ASD. It is the internalising conditions (e.g. depressive and anxiety disorders) that are most easily overlooked. The cases include examples of able students who present significant changes in mood and behaviour, with further concerns expressed by family. Some cases decline help or assessment saying they are fine, despite it being clear that something very significant had changed; there was scope for more assertive action.

5.16. In summary, it is impossible to provide an exhaustive list of possible indicators that should raise concerns, but any instances of law-breaking, risk of harm to themselves or others, and any signs of ill-health in a young person should prompt further action as required.

Are there particular risk factors, protective factors, vulnerabilities or contextual features identifiable from these case studies that are commonly misunderstood, under-weighted or difficult for agencies to assess?

5.17. The Structured Assessment of Violence Risk in Youth (SAVRY, see Appendix 2) is a structured professional judgement risk assessment that can be completed by experienced professionals. It helps to identify indicators of risk of harm to others, as well as protective factors.

5.18. It is striking to me that the risk factors and features contained in the case studies are extremely well represented in the items of the SAVRY, which I paste below for convenience:

5.19. Historical Risk Factors	**5.20.** 1: History of Violence 2: History of Non-Violent Offending 3: Early Initiation of Violence 4: Past Supervision/Intervention Failures 5: History of Self-Harm or Suicide Attempts 6: Exposure to Violence in the Home 7: Childhood History of Maltreatment 8: Parental/Caregiver Criminality 9: Early Caregiver Disruption 10: Poor School Achievement
5.21. Social/Contextual Risk Factors	**5.22.** 11: Peer Delinquency 12: Peer Rejection 13: Stress and Poor Coping 14: Poor Parental Management 15: Lack of Personal/Social Support 16: Community Disorganization
5.23. Individual Risk Factors	**5.24.** 17: Negative Attitudes 18: Risk Taking/Impulsivity 19: Substance Use Difficulties 20: Anger Management Problems 21: Low Empathy/Remorse 22: Attention Deficit/Hyperactivity Difficulties 23: Poor Compliance 24: Low Interest/Commitment to School

5.25. Protective Factors	**5.26.** P1: Prosocial Involvement P2: Strong Social Support P3: Strong Attachments and Bonds P4: Positive Attitude Towards Intervention and Authority P5: Strong Commitment to School P6: Resilient Personality Traits

5.27. This illustrates that it is not just isolated risk factors, but the combination of multiple risk factors that can be the most effective indicator of particular risk.

5.28. Under-recognised or generally under-weighted factors include recognition of self harm and suicidality as indicators of risk of violence (this is included in the SAVRY).

5.29. Low empathy is often challenging for professionals to evaluate, but can be a highly significant, permissive factor in relation to violence.

5.30. An inherent feature of many of the highest risks is that that are somehow covert, hidden or hard to evaluate. Forensic, safeguarding and law enforcement professionals are likely to be well tuned to denial, minimisation of seriousness, minimisation of responsibility and obstruction to assessments, and recognise their significance.

5.31. A common concern, in my experience, is that less experienced practitioners may take denial and minimisation of seriousness at face value and fail to recognise actual, significant risks.

5.32. It may sound somewhat convoluted, but when this is identified, there is scope to include this in a risk assessment – i.e. 'This individual presents significant risks to others that may be underestimated due to their presentation, including denial and minimisation of significant past violence'.

5.33. The emotional resilience required to identify and manage serious violence and other antisocial behaviour should not be underestimated, and is an area where staff are likely to benefit from training, support and supervision.

5.34. This challenge also illustrates the benefits of multi-agency work, as each professional views risk through their own lens, and can pick up on risk factors missed by others. It is the availability of comprehensive, multi-agency information that underpins any effective risk assessment.

5.35. The research literature points us towards other potential indicators that might be overlooked, such as those described in the article 'The Role of Warning Behaviors in Threat Assessment: An Exploration and Suggested Typology' by Meloy et al 2012 (ILT000173). This includes "last resort thinking", which is displayed in some cases but not always identified. Such research can help guide more specific risk assessments for VFIs.

6. Identification, assessment, management and intervention

How effective are current arrangements for identifying, assessing and managing the risk posed by individuals who may be drawn into extreme violence?

6.1. Current arrangements appear to work well for identifying and managing risk in certain situations. When a threshold for assertive intervention is crossed and the appropriate agencies are engaged, there can be effective risk management. I am aware of cases where it may be considered that tragedy was averted.

6.2. Some cases indicated a high standard of multi-agency work and documentation. I am also aware of cases which used assertive Mental Health Act provision to enable a thorough assessment.

6.3. Regrettably, there are cases in which risk was simply not identified and individuals managed to sustain extreme online interests, obtain weapons, and deliver tragic consequences.

6.4. Perhaps equally or more concerning are cases in which high risk was identified, but somehow not managed, with very high risks being identified even in the days prior to a significant adverse event.

6.5. In both scenarios, current arrangements are clearly found to be lacking, for various different reasons.

6.6. It appears that much is lost in the incomplete communication, or inherent miscommunication, that results from referrals from one agency to another. Indicators of particular risk that may have been observed in one agency were not consistently communicated to another agency that may have identified it as a red flag worthy of further exploration. Until recently, VFIs did not even have an easy pathway to Police or Prevent attention.

6.7. Much has changed with the new Prevent Case Management Tracker (PCMT) and new categories of "InCel extremism" and "fascination with extreme violence or mass casualty attacks (where no other ideology)", which enables Prevent to be involved in such cases.

Did any risk assessment tools that were used adequately capture the risk?

6.8. Across the case studies there were minimal instances of risk assessments that captured, formulated and communicated risk adequately prior to arrest for the index offence. Each agency has its own risk assessment, with some being in the form of very limited "tick box" exercises. There are no multiagency incident logs in risk assessments or risk formulations prior to the index offences.

6.9. I am a strong advocate of the SAVRY, which was historically undertaken in a concise manner that provided very effective assessment and communication of risk (see Appendix 2), and naturally led to a management plan. This structured professional judgement can be completed by an experienced practitioner from a range of disciplines, typically psychology or psychiatry, ideally in consultation with other professionals familiar with the young person.

6.10. I believe there is much to be gained from a general multi-agency risk assessment, and alongside that a more specific multi-agency risk assessment for harm to others such as the SAVRY.

6.11. For those identified as having a fixation on violence, there is scope for a specialist risk assessment tool specifically for VFIs (e.g. a modified version of the Extremism Risk Guidance – Revised (ERG-R, as described by other experts) to help guide intervention.

Were there variations in the training and capability of professionals to assess fixation, pre-attack behaviours, and complex vulnerabilities?

6.12. This is difficult to assess from the materials available. As stated in a previous paragraph, the skills held by practitioners in forensic, safeguarding and law enforcement agencies are not necessarily shared by the wider workforce serving young people. Each agency and discipline brings its strengths, training and capabilities to bear on the assessment of young people. There is certainly scope to build up workforce skills for addressing the needs of the high-risk group of young people, in terms of interventions for ASD, conduct disorder, and a history of psychological trauma.

Were psychological, behavioural, therapeutic, or social interventions available and accessible? What barriers were there to interventions? How effective were they at reducing the risk of the Case Studies? Where interventions were successful, could they be used more widely?

6.13. I am aware of cases that featured a measure of success regarding intervention, in that some adverse outcomes appear to have been prevented. However, often it appears that it has been assertive police action alongside other agencies that delivered this outcome, rather than therapeutic interventions.

6.14. In terms of child and adolescent mental health service (CAMHS) interventions for ASD and Conduct Disorder, I note that some cases had therapeutic sessions with an experienced practitioner, but nonetheless progressed to an adverse outcome. Some received interventions of the sort described in National Institute of Health and Care Excellent (NICE) guidance for conduct disorder prior to grave adverse events, which were not averted.

6.15. The challenge of this quite mixed group of case studies is that prior to their offence, they often seem to have fallen between the cracks of more assertive service responses – they were not detainable under the Mental Health Act, were not seen to have broken the law, were not deemed eligible for a social care placement or detention under a Secure Accommodation Order, not under a Child Protection Plan – but yet Education and family typically raised significant concerns, with ineffective, uncoordinated intervention. For young people with ASD or a learning disability at risk of hospitalisation, there was the option of a Care Education and Treatment Review (CETR) which was not often utilised. Even in emergency crisis situations there is potential for a so-called 'Blue Light CETR' led by the local Integrated Care Board (ICB) with urgent involvement of health, social care and education, but often this does not appear to have been used or even considered.

6.16. In such cases of high and immediate risks, rather than forms and referrals, my view is that a multi-agency high-risk adolescent team with co-located agencies would have been required, and would have been far more likely to bring about the individualised, proportionate and effective intervention that was required.

Do the case studies suggest gaps between identification of risk and the provision of effective intervention?

6.17. In several cases risk was not being identified in the first place. In those where risk was identified, there was some intervention, but often too piecemeal, discrete and too disconnected from other agencies to have any benefit.

6.18. My view is that effective intervention for this group requires a degree of multi-agency cohesion, coordination and integration in approach to deliver anything meaningful.

What strategies were used for the Case Studies who did not meet criminal thresholds but demonstrate escalating behaviours? Were they effective?

6.19. These case studies generally exemplify a lack of effectiveness in managing individuals whose behaviour does not meet criminal thresholds.

6.20. The unsuccessful interventions included family courses acknowledged for conduct disorder, but delivered in a manner somewhat disconnected from other agencies, oblivious to ongoing challenges such as ongoing victimisation of the young people.

6.21. Several case studies included referrals to Prevent, especially from school staff. This information was not always shared more widely, such as with CAMHS, and the overall effectiveness was limited – due to the lack of meaningful intervention, but also due to the lack of general information sharing between agencies and a lack of coordinated activation of the agencies around the young person.

6.22. Referrals to CAMHS were often declined or re-directed. Even after a diagnosis of ASD there was limited support offered. Although not stated explicitly in the case studies, community CAMHS services are generally not equipped to deliver interventions for the violence fixation aspect of the VFI population, and have limited resources for intervention for conduct disorder generally, to the extent that conduct disorder is sometimes on the exclusion criteria for CAMHS. Nevertheless, my view is that there was more scope for consideration of CAMHS and psychological or pharmacological responses to low mood, anxiety, distress, anger and conduct disordered behaviour – but in a coordinated way with other agencies. There was very little evidence of such working.

7. Inter-agency working, safeguarding and information sharing

Please consider the adequacy of the multi-agency systems in place for the case studies. How well do relevant agencies and systems work together in identifying, assessing, escalating and managing risk?

7.1. My view is that effective agencies are in place, but much can be done to improve multi-agency working. In cases of elevated risk, engagement of necessary agencies should not depend on unnecessarily elaborate referral forms, delays in processing, triaging, screening, and invitations to meetings. Rapid and effective multi-agency work, in my experience, is best achieved when agencies are co-located and have established joint meetings to discuss high risk individuals.

7.2. A shared child risk information system would also go a long way towards identifying, assessing, escalating and managing risk appropriately.

Please identify the issues with multi-agency working in the case studies. For example: the allocation of responsibility, threshold disputes, siloed records, uncertainty about lawful information sharing, lack of shared understanding of risk, differing risk appetites, resource constraints or unclear leadership?

7.3. Overall, the case studies indicate a striking lack of information sharing and coordination across agencies. In one case I read a CAMHS chronology that was so different from the Social Care chronology that it could have been for a different child – the CAMHS assessment had none of the significant historical child protection information.

7.4. Some cases exemplify silo working, with independent processes in social care, school and CAMHS, and episodes of care opening and closing multiple times, with little in the way of a summative, multiagency risk management plan. In several cases there is no lead agency as such, despite input from youth offending services (YOS), Social Care, CAMHS and potentially third sector organisations at various times.

7.5. I note that some cases features the not-uncommon London complexity that arises from a family having a postcode in one London Borough, but having a GP under another Borough's ICB. This can often lead to confusion and delay when referrals go to the wrong Borough's services.

7.6. A number of references are made to not being able to proceed or share information due to a lack of consent, when in some cases this should clearly not be a barrier due to the risks involved.

7.7. In other cases an ASD assessment may be completed and a diagnosis given, but seemingly with minimal onward care and no broader assessment of need or risk, abruptly concluding service involvement and leaving the child and their family at a loose end.

7.8. More mundane obstacles relate to delays in email communication and response, delays in arranging meetings and appointments, lack of representation of agencies at multiagency meetings due to annual leave, sickness, part-time work or competing commitments such as duty shifts.

To what extent did those matters may have limited effective identification, assessment, management, escalation, information-sharing, or intervention in relation to risks relevant in the case studies?

7.9. The examples of obstacles above, amongst many others, are unfortunately routine, day to day examples of very common ways in which effective and rapid multiagency work is obstructed.

7.10. My view is that the obstacles are symptoms of the lack of integration and coordination of services for children.

7.11. Furthermore, some cases include the well-known element of difficulty in the transition from children's to adult services at the age of 18, which is well known to be a time of heightened distress and risk for individuals with ASD and comorbid difficulties.

7.12. Based on the case studies and your expertise:

7.13. *Which single agency or what structure should be appointed or established to record, monitor and co-ordinate interventions for VFIs. In answering this, please consider any good practice and transferable models from counter-terrorism risk management, organised crime and public protection arrangements for high harm individuals (e.g. MAPPA).*

7.14. Other experts may be better placed to comment on this. My view is that in the case of child VFIs the single agency should be Children's Social Care. I concur with the recommendation from others that a child who presents a risk of serious harm should be considered suitable for Child in Need or Child Protection frameworks.

7.15. In the case of adult VFIs that do not fall neatly under other agencies (e.g. mental health or probation) it may also be appropriate for social care to hold the responsibility to record, monitor and co-ordinate interventions.

7.16. My concern regarding establishment of a new structure is that VFIs are a heterogenous group of individuals, and a new structure may cause more confusion. My view is that it would be preferable for an existing organisation to absorb or expand its existing provision to accommodate this group, and host a meaningful multiagency approach to managing this population.

7.17. *How can agencies develop an appropriate culture so that they are prepared to own and manage risk appropriately, not just refer it on to others.*

7.18. As stated above, there is scope for development of the workforce to increase skills and the emotional capability to engage with the challenges of working with violence and other antisocial behaviour . Genuine multi-agency working and ownership of risk by a named agency is likely to help give practitioners a secure base from which to jointly own and manage risks. Effective supervision and ongoing reflective support is essential for staff to manage the demands of working with violence.

Should there be the development of a shared multi-agency risk-assessment tool that is clear, accessible and suitable for use across public sector services?

7.19. I very much support the development of a general, shared multi-agency risk assessment tool. A familiar tool is far easier to interpret, and therefore more effective for communicating risk.

7.20. Aside from a general risk assessment, I would also advocate for a specific shared tool for violence (such as SAVRY), and potentially development of a further specialised tool for VFIs.

8. Online influence, access to material and enabling factors

8.1. *What role, if any, online use appear to play in influencing, reinforcing, normalising or enabling extreme violence in the case studies? Please consider the impact of online communities, social media, search activity, instructional material, violent imagery, algorithms and Virtual Private Networks (VPNs).*

8.2. Evidence in several case studies indicates that the role of extreme online materials and communities was most likely critical in the adoption and reinforcement of extreme views. Engagement in communities that shared these extreme views likely normalised them, and caused socially isolated individuals with ASD to feel included and that they belonged to a community. This would have been an encouragement to persist, to the extent of enabling extreme violence. The term 'echo-chamber' is sometimes used to describe the amplification and affirmation of extreme views, and disconnected nature of such online communities.

8.3. I cannot comment on algorithms, beyond the general sense in which individuals on social media are provided with prompts to further material related to their interests, with potential for rapid re-enforcement of interests and introduction to related topics. There is certainly scope for this to be harmful for young people and vulnerable adults.

8.4. From my knowledge of computers and working with offenders, I am aware that VPNs can be used to enable computer users to present as if they are from another country, with another identity, and can make it difficult to track activity. I am also aware of TOR browsers and the dark web, where it is also difficult to monitor and track activity, with potential for contact with very extreme and violent material and communities.

8.5. *Did the agencies involved with the Case Studies demonstrate any capabilities to detect online behaviours linked to fixation or pre-attack planning.*

8.6. The capability to detect concerning online behaviours prior to attacks appears to be limited, with most such reports that identify harmful online behaviour appearing to come from school or declared by the individual themselves. My understanding is that the majority of the most concerning material was often discovered post-attack.

8.7. What barriers were there, if any, to monitoring, reporting and responding to online harms, and proportionate options for improvement.

8.8. This is beyond my scope of expertise.

How should the Inquiry understand the relationship between online activity and offline risk in the case studies, including where there is ideology is not the primary driver or where the motivation appears mixed, unstable or unclear?

8.9. It is very difficult to evaluate the potential for offline enactment from online behaviours. This is partly due to the so-called 'online disinhibition effect', whereby individuals exhibit behaviours online that they would not display in a face to face situation, due to a sense of protection and distance from danger afforded by the computer screen.

8.10. However, it appears that some vulnerable individuals, perhaps especially those with vulnerabilities such as ASD, may be at risk of literal interpretation of online material and may be more vulnerable than others to enactment in the real world.

8.11. An important factor in this appears to be the state of mind of the individual. The greater the distress, loneliness and grievance with the real world, the greater the sense of relief and belonging when welcomed into an online community. The individual with ASD is more likely to misjudge online interactions, but will also often lack the real-world friendships and input from others that would otherwise help correct misjudgements and prevent the slide towards adoption of more extreme views. In other words, the symptoms of ASD combine with the social isolation of ASD to render the vulnerable individual particularly exposed to extreme material.

8.12. The individual characteristics of the VFI, from an assessment including a risk assessment, would help determine the nature and immediacy of risks to others.

8.13. *Please address whether there were, or should be, lawful and proportionate mechanisms to identify concerning patterns of online behaviour, including: online browsing and searching activity;*

8.14. *patterns of online purchasing;*

8.15. *behaviours designed to evade safeguards, such as the use of VPNs, multiple accounts, or changes of names and delivery addresses.*

8.16. I note that in some cases, young people were blocked from purchasing blades online due to age verification measures, which appeared effective. However, on other occasions this was not the case, and young people were able to acquire bladed and other weapons – sometimes easily, and on other occasions with a high degree of preparation and planning.

8.17. I understand the concerns regarding civil liberties if internet usage were strictly monitored for all, but my view is that there must be a technological solution to manage and monitor internet access for children and vulnerable adults.

8.18. Of note, we are able to do this routinely in secure mental health settings, with control over access to individual devices, and granting patients different internet privileges over the hospital patient wi-fi network.

8.19. *Please consider whether the case studies support the need for:*

8.20. *A further ability to restrict or monitor access to the internet on the part of children and young people, if a significant threshold is passed concerning the risk they pose to others; and Age verification for the use of VPN software and other options to avoid VPNs being used to circumvent the age-related protections in the Online Safety Act 2023.*

8.21. As stated above, my view is that there must be a technological solution to manage and monitor internet access for children and vulnerable adults. We currently do this in secure settings such as psychiatric hospital and children's homes.

9. The effectiveness of current laws and systems for identifying, monitoring, and disrupting the activities of VFIs

9.1. *To what extent was current legislation adequate to identify, monitor, and disrupt VFIs prior to harm, including in the disruption of preparatory activities and management of individuals who pose a risk but fall below criminal thresholds.*

9.2. I defer to the Policing expert on these matters. I only suggest that there should be appropriate powers to enable detailed assessment in cases where there are concerns of serious harm.

9.3. *Do current legal powers adequately support the identification and escalation of risk arising from the acquisition of dangerous but legal items.*

9.4. I defer to the Policing and counter-terrorism expert on these matters

9.5. *Did statutory powers sufficiently address modern online threats.*

9.6. I defer to the Policing and counter-terrorism expert on these matters.

10. Sale and possession of offensive weapons and articles with a point or blade

10.1. *Where weapons were purchased by the Case Studies, or items that could be used as weapons, please consider the adequacy of controls on any such purchases and whether further measures should be introduced to address their purchase. For example, should measures specifically address purchases by identified VFIs.*

10.2. I defer to the Policing and counter-terrorism expert on these matters.

Signature

Dr Richard Church

MB BChir FRCPsych DCH AKC

Consultant Psychiatrist

General Medical Council UK: 6040373

11th September 2026

The Southport Inquiry

Phase Two

Statement of Truth

Expert: Dr Richard Church

Report: Expert Report

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

I understand that proceedings for contempt of court 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 in its truth.

Signed: Signature

Name: DR RICHARD CHURCH

Dated: 22/09/2026

11. Appendices

Appendix 1: ICD-11 (2025-01)

International Classification Of Disease, 11th Revision

World Health Organisation

6C91 Conduct-Dissocial Disorder

https://icd.who.int/browse/2025-01/mms/en#719572464 retrieved 05/09/2026

Description

Conduct-dissocial disorder is characterised by a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms, rules, or laws are violated such as aggression towards people or animals; destruction of property; deceitfulness or theft; and serious violations of rules. The behaviour pattern is of sufficient severity to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. To be diagnosed, the behaviour pattern must be enduring over a significant period of time (e.g., 12 months or more). Isolated dissocial or criminal acts are thus not in themselves grounds for the diagnosis.

Diagnostic requirements

Essential (Required) Features:

A repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate social or cultural norms, rules, or laws are violated. Typically, there are multiple behaviours involved, including one or more of the following:

Aggression towards people or animals, such as bullying, threatening or intimidating others, instigating physical fights, using weapons that can cause serious physical harm to others (such as a brick, broken bottle, knife or gun), physical cruelty to people, physical cruelty to animals, aggressive forms of stealing (e.g., mugging, purse snatching, extortion), or forcing someone into sexual activity.

Destruction of property, such as deliberate fire setting with the intention of causing serious damage or deliberate destruction of others' property (e.g., purposely breaking other children's toys, breaking windows, scratching cars, slashing tires).

Deceitfulness or theft, such as stealing items of value (e.g., shoplifting, forgery), lying to obtain goods or favours or to avoid obligations (e.g., 'conning' others), or breaking into someone's house, building or car.

Serious violations of rules, such as children or adolescents repeatedly staying out all night despite parental prohibitions, repeatedly running away from home, or often skipping school or work without permission.

The pattern of behaviour must be persistent and recurrent, including multiple incidents of the types of behaviours described above over an extended period of time (e.g., at least 1 year). The mere commission of one or more delinquent acts is not sufficient for the diagnosis.

The behaviour pattern results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Specifiers for age of onset:

Two subtypes related to age of onset can be specified in individuals who meet the diagnostic requirements for Conduct-Dissocial Disorder.

6C91.0 Conduct-Dissocial Disorder, childhood onset

All diagnostic requirements for Conduct-Dissocial Disorder are met.

One or more features of the disorder have clearly been present and persistent during childhood prior to adolescence (e.g., before 10 years of age).

6C91.1 Conduct-Dissocial Disorder, adolescent onset

All diagnostic requirements for Conduct-Dissocial Disorder are met.

None of the features of the disorder were present prior to adolescence (e.g., before 10 years of age).

6C91.Z Conduct-Dissocial Disorder, unspecified

Specifiers for limited or typical prosocial emotions:

The specifier 'with limited prosocial emotions' may be applied to individuals who meet the diagnostic requirements for Conduct-Dissocial Disorder and also exhibit a pattern of limited prosocial emotions sometimes referred to as 'callous and unemotional traits.' Individuals with these characteristics represent a minority of those with Conduct-Dissocial Disorder diagnosis. The 'with limited prosocial emotions' specifier represents a relatively more severe and less common presentation of Conduct-Dissocial Disorder, compared to those with this diagnosis and typical prosocial emotions.

In evaluating prosocial emotions, it is important to obtain information from others who have known the individual for an extended period of time, in addition to the individual's self-report of their own behaviours and experience.

Limited or typical prosocial emotions in individuals with Conduct-Dissocial Disorder can be specified as follows:

6C91.y0 with limited prosocial emotions

In the context of a diagnosis of Conduct-Dissocial Disorder, the presence of a characteristic social-emotional pattern in which several of the following features are repeatedly manifested:

Limited or absent empathy or sensitivity to others' feelings or concern for their distress; the individual is more concerned with how behaviours affect himself/herself rather than how they affect others, even if they cause harm.

Limited or absent remorse, shame, or guilt over one's own behaviour (unless prompted by being apprehended); lack of concern about the consequences of his/her actions on others and relative indifference toward the probability of punishment.

Limited or absent concern over poor/problematic performance in school, work, or other important activities; may put forth little effort and blame others for his/her poor performance.

Limited or shallow expression of emotions, particularly positive or loving feelings toward others; emotional expression may appear shallow, superficial, insincere, or instrumental.

This pattern is pervasive across situations and relationships (i.e., the specifier should not be applied based on a single characteristic, a single relationship, or a single instance of behaviour).

The pattern is persistent over time (e.g., at least 1 year).

Among those with Conduct-Dissocial Disorder, those with limited prosocial emotions tend to display a particularly severe, aggressive and stable pattern of antisocial behaviours.

6C91.y1 with typical prosocial emotions

In the context of a diagnosis of, this specifier represents a more common pattern of Conduct-Dissocial Disorder that is not characterized by the features of limited prosocial emotions.

Although some features similar to limited prosocial emotions (e.g., low concern, limited remorse) may be evident at times, they are generally infrequent, transitory, and less pronounced and do not represent a persistent pervasive pattern of social-emotional deficits.

Most individuals with Conduct-Dissocial Disorder exhibit typical prosocial emotions.

6C91.yZ unspecified

Additional clinical features:

Individuals with Conduct-Dissocial Disorder may be part of a delinquent peer group where delinquent activities are often conducted in association with peers. This may be particularly common among those with adolescent onset.

The relationship between Conduct-Dissocial Disorder and Oppositional Defiant Disorder has historically been conceptualized as hierarchical and developmental in nature, with Conduct-Dissocial Disorder being generally considered as more severe than, and commonly preceded by, Oppositional Defiant Disorder. However, Conduct-Dissocial Disorder frequently co-occurs and can be diagnosed with Oppositional Defiant Disorder, particularly among individuals with a more persistent history of behaviour problems.

Individuals with Conduct-Dissocial Disorder with limited prosocial emotions and individuals with Conduct-Dissocial Disorder, childhood onset are at greater risk for exhibiting a more persistent and severe pattern of antisocial behaviour over time. However, the subtypes for age of onset and the specifier for prosocial emotions are distinct characteristics that should be considered separately. In particular, childhood onset does not necessarily indicate that the individual will exhibit limited prosocial emotions.

Conduct-Dissocial Disorder frequently co-occurs with Attention Deficit Hyperactivity Disorder, Developmental Learning Disorder, Anxiety or Fear-Related Disorders, Mood Disorders, and Disorders Due to Substance Use.

Boundary with normality (threshold):

Engaging in political protests should not be regarded as indicating the presence of Conduct-Dissocial Disorder.

The behaviours that contribute to a diagnosis of Conduct-Dissocial Disorder can include criminal offenses and may entail legal or disciplinary repercussions, particularly for adolescents and adults. At the same time, many individuals who commit such criminal offenses do not exhibit a persistent and recurrent pattern of antisocial behaviour in which the basic rights of others or major age-appropriate social or cultural norms, rules, or laws are violated. Criminal behaviours may occur impulsively or opportunistically, or in relation to substance use or intoxication. Clinical assessment and diagnosis should focus on the broader pattern of behaviour rather than solely on the criminality of specific behaviours or incidents.

Course features:

Earlier age of onset and greater symptom severity are predictive of worse prognosis with these individuals being more likely to engage in criminal behaviour and substance abuse as well as experience additional co-occurring mental and behavioural disorder diagnoses during adulthood.

The course of Conduct-Dissocial Disorder is highly variable with some individuals experiencing a full remission of symptoms by adulthood. Initial symptoms of Conduct-Dissocial Disorder are typically less severe in form (e.g., lying) but may progress in their severity over time (e.g., assault).

There are significant individual differences in course features and progression of symptoms over time.

When Conduct-Dissocial Disorder is present in adulthood it has generally been preceded by a history of serious behaviour problems during childhood and adolescence.

The persistence of Conduct-Dissocial Disorder into adulthood is often marked by continuity in types of behaviour problems (e.g., property violations in contrast to theft). Individuals with Conduct-Dissocial Disorder who are violent during adolescence typically continue to engage in more frequent violence than their peers in adulthood. Status offenses (e.g., running away, truancy) are less relevant in adulthood but are a risk factor for continuing rule-breaking behaviour and criminal arrest.

Developmental presentations:

Although onset of Conduct-Dissocial Disorder can occur in early childhood during the preschool years, typical age of onset is during early to middle adolescence. Onset of Conduct-Dissocial Disorder is rare after the age of 16.

Culture-related features:

Assessment of conduct problems should account for contextual factors to determine whether a diagnosis is appropriate. In some cultural settings, for example, school-age children may be away from school for long periods of seasonal employment, rather than for conduct reasons. Alternatively, in communities with high levels of organized violence (e.g., gangs) or in the midst of civil conflict or war (e.g., where children as recruited as soldiers), children may be coerced into participating in interpersonal violence or property theft, which they may carry out for their own survival. A diagnosis of Conduct-Dissocial Disorder should not be assigned in such cases.

Conduct-Dissocial Disorder in adolescents often co-occurs with Disorders Due to Substance Use, especially those associated with use of alcohol. The rates of co-occurrence are influenced by sociocultural variation in availability of substances.

Sex- and/or gender-related features:

Conduct-Dissocial Disorder is more common among males.

Males with Conduct-Dissocial Disorder are more likely to exhibit symptoms of stealing, vandalism, fighting, and school discipline problems, whereas females are more likely to exhibit lying, truancy, substance abuse, absconding, and prostitution.

Males with Conduct-Dissocial Disorder more commonly exhibit both physical and relational aggression, whereas females are more likely to exclusively exhibit relational aggression.

Boundaries with other disorders and conditions (differential diagnosis):

Boundary with Oppositional Defiant Disorder: For a diagnosis of Conduct-Dissocial Disorder to be assigned, the pattern of behaviour must be severe and dissocial (i.e., violating major rules, norms, or the rights of others), such that it extends beyond the noncompliant and defiant behaviours that are characteristic of Oppositional Defiant Disorder. However, Oppositional Defiant Disorder and Conduct-Dissocial Disorder frequently co-occur, particularly among adolescents and individuals with a more persistent history of behaviour problems, and may be diagnosed together if the full diagnostic requirements for both disorders are met.

Boundary with Attention Deficit Hyperactivity Disorder: Individuals with Attention Deficit Hyperactivity Disorder may exhibit disruptive behaviours as a result of their impulsivity or hyperactivity; however, these disruptive behaviours are not typically severe and dissocial in nature (i.e., they do not violate major rules, norms, or the rights of others), and therefore would not warrant an additional diagnosis of Conduct-Dissocial Disorder. However, Conduct-Dissocial Disorder and Attention Deficit Hyperactivity Disorder can co-occur, and both may be diagnosed if the full diagnostic requirements for both disorders are met.

Boundary with Mood Disorders: Conduct problems, aggressive behaviours, risky behaviours, and irritability/anger can occur in the context of Mood Episodes (Depressive, Manic, Mixed, or Hypomanic). Moreover, in children and adolescents, depressive, manic, or hypomanic mood can manifest as irritability. When the behaviour problems occur entirely in the context of Mood Episodes, a separate diagnosis of Conduct-Dissocial Disorder is generally not warranted.

Boundary with Intermittent Explosive Disorder: Individuals with Intermittent Explosive Disorder may come into conflict with other people and the law because of their explosive outbursts, but these episodes do not constitute a more general pattern of antisocial behaviour characteristic of Conduct-Dissocial Disorder (e.g., rule violations, lying, theft). In addition, Intermittent Explosive Disorder is characterized by impulsive aggression, while aggression in Conduct-Dissocial Disorder is often premeditated and instrumental.

Boundary with Personality Disorder: Conduct-Dissocial Disorder is not a Personality Disorder, although it is related to specific Personality Disorder categories in the clinical and research nomenclature (i.e., Dissocial Personality Disorder, Antisocial Personality Disorder). Personality Disorder is characterized by a relatively enduring and pervasive disturbance in how individuals experience and interpret themselves, others, and the world that results in maladaptive patterns of cognition, emotional experience, emotional expression, and behaviour. These maladaptive patterns lead to significant problems in psychosocial functioning that are particularly evident in interpersonal relationships, manifested across a range of personal and social situations (i.e., not limited to specific relationships or situations). Individuals with Personality Disorder may have prominent dissocial features as an aspect of personality traits. The diagnosis of Conduct-Dissocial Disorder is made based on a recurrent pattern of antisocial behaviour that may range in duration from a discrete period lasting a number of months to a pattern that persists across the lifespan. Conduct-Dissocial Disorder and Personality Disorder can co-occur, and both may be diagnosed if the full diagnostic requirements for both disorders are met.

Boundary with Disorders Due to Substance Use: If the pattern of dissocial behaviour is limited to obtaining or using illicit substances, or if the behaviour is exclusively related to the effects of

intoxication, dependence, or withdrawal, Conduct-Dissocial Disorder should not be diagnosed and a Disorder Due to Substance Use should be considered instead. At the same time, co-occurrence of episodes of dissocial behaviour and substance use is common among individuals with Conduct-Dissocial Disorder. This distinction may therefore depend on a complex clinical judgment that takes into account the onset, sequencing, and context of the relevant behaviours. However, Conduct-Dissocial Disorder and Disorders Due to Substance Use frequently co-occur, and both may be diagnosed if the full diagnostic requirements are met.

6A02 Autism Spectrum Disorder

https://icd.who.int/browse/2025-01/mms/en#437815624 retrieved 05/09/2026

Description

Autism spectrum disorder is characterised by persistent deficits in the ability to initiate and to sustain reciprocal social interaction and social communication, and by a range of restricted, repetitive, and inflexible patterns of behaviour, interests or activities that are clearly atypical or excessive for the individual's age and sociocultural context. The onset of the disorder occurs during the developmental period, typically in early childhood, but symptoms may not become fully manifest until later, when social demands exceed limited capacities. Deficits are sufficiently severe to cause impairment in personal, family, social, educational, occupational or other important areas of functioning and are usually a pervasive feature of the individual's functioning observable in all settings, although they may vary according to social, educational, or other context. Individuals along the spectrum exhibit a full range of intellectual functioning and language abilities.

Diagnostic requirements

Essential (required) features:

Persistent deficits in initiating and sustaining social communication and reciprocal social interactions that are outside the expected range of typical functioning given the individual's age and level of intellectual development. Specific manifestations of these deficits vary according to chronological age, verbal and intellectual ability, and disorder severity. Manifestations may include limitations in the following:

Understanding of, interest in, or inappropriate responses to the verbal or non-verbal social communications of others.

Integration of spoken language with typical complimentary non-verbal cues, such as eye contact, gestures, facial expressions and body language. These non-verbal behaviours may also be reduced in frequency or intensity.

Understanding and use of language in social contexts and ability to initiate and sustain reciprocal social conversations.

Social awareness, leading to behaviour that is not appropriately modulated according to the social context.

Ability to imagine and respond to the feelings, emotional states, and attitudes of others.

Mutual sharing of interests.

Ability to make and sustain typical peer relationships.

Persistent restricted, repetitive, and inflexible patterns of behaviour, interests, or activities that are clearly atypical or excessive for the individual's age and sociocultural context. These may include:

Lack of adaptability to new experiences and circumstances, with associated distress, that can be evoked by trivial changes to a familiar environment or in response to unanticipated events.

Inflexible adherence to particular routines; for example, these may be geographic such as following familiar routes, or may require precise timing such as mealtimes or transport.

Excessive adherence to rules (e.g., when playing games).

Excessive and persistent ritualized patterns of behaviour (e.g., preoccupation with lining up or sorting objects in a particular way) that serve no apparent external purpose.

Repetitive and stereotyped motor movements, such as whole body movements (e.g., rocking), atypical gait (e.g., walking on tiptoes), unusual hand or finger movements and posturing. These behaviours are particularly common during early childhood.

Persistent preoccupation with one or more special interests, parts of objects, or specific types of stimuli (including media) or an unusually strong attachment to particular objects (excluding typical comforters).

Lifelong excessive and persistent hypersensitivity or hyposensitivity to sensory stimuli or unusual interest in a sensory stimulus, which may include actual or anticipated sounds, light, textures (especially clothing and food), odors and tastes, heat, cold, or pain.

The onset of the disorder occurs during the developmental period, typically in early childhood, but characteristic symptoms may not become fully manifest until later, when social demands exceed limited capacities.

The symptoms result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. Some individuals with Autism Spectrum Disorder are able to function adequately in many contexts through exceptional effort, such that their deficits may not be apparent to others. A diagnosis of Autism Spectrum Disorder is still appropriate in such cases.

Specifiers for characterizing features within the autism spectrum:

These specifiers enable the identification of co-occurring limitations in intellectual and functional language abilities, which are important factors in the appropriate individualization of support, selection of interventions, and treatment planning for individuals with Autism Spectrum Disorder. A qualifier is also provided for loss of previously acquired skills, which is a feature of the developmental history of a small proportion of individuals with Autism Spectrum Disorder.

Co-occurring Disorder of Intellectual Development

Individuals with Autism Spectrum Disorder may exhibit limitations in intellectual abilities. If present, a separate diagnosis of Disorder of Intellectual Development should be assigned, using the appropriate category to designate severity (i.e., Mild, Moderate, Severe, Profound, Provisional). Because social deficits are a core feature of Autism Spectrum Disorder, the assessment of adaptive behaviour as a part of the diagnosis of a co-occurring Disorder of Intellectual Development should place greater emphasis on the intellectual, conceptual, and practical domains of adaptive functioning than on social skills.

If no co-occurring diagnosis of Disorder of Intellectual Development is present, the following qualifier for the Autism Spectrum Disorder diagnosis should be applied:

without Disorder of Intellectual Development

If there is a co-occurring diagnosis of Disorder of Intellectual Development, the following qualifier for the Autism Spectrum Disorder diagnosis should be applied, in addition to the appropriate diagnostic code for the co-occurring Disorder of Intellectual Development:

with Disorder of Intellectual Development

Degree of Functional Language Impairment

The degree of impairment in functional language (spoken or signed) should be designated with a second qualifier. Functional language refers to the capacity of the individual to use language for instrumental purposes (e.g., to express personal needs and desires). This qualifier is intended to reflect primarily the verbal and non-verbal expressive language deficits present in some individuals with Autism Spectrum Disorder and not the pragmatic language deficits that are a core feature of Autism Spectrum Disorder.

The following qualifier should be applied to indicate the extent of functional language impairment (spoken or signed) relative to the individual's age:

with mild or no impairment of functional language

with impaired functional language (i.e., not able to use more than single words or simple phrases)

with complete, or almost complete, absence of functional language

Table for Diagnostic Codes for Autism Spectrum Disorder

	with mild or no impairment of functional language	with impaired functional language	with complete, or almost complete, absence of functional language
without Disorder of Intellectual Development	6A02.0	6A02.2	_
with Disorder of Intellectual Development	6A02.1	6A02.3	6A02.5

This Table shows the diagnostic codes corresponding to the categories that result from the application of the specifiers for Co-occurring Disorder of Intellectual Development and Degree of Functional Language Impairment.

6A02.Y Other Specified Autism Spectrum Disorder can be used if the above parameters do not apply.

6A02.Z Autism Spectrum Disorder, Unspecified can be used if the above parameters are unknown.

Loss of previously acquired skills

A small proportion of individuals with Autism Spectrum Disorder may present with a loss of previously acquired skills. This regression typically occurs during the second year of life and most often involves language use and social responsiveness. Loss of previously acquired skills is rarely observed after 3 years of age. If it occurs after age 3, it is more likely to involve loss of cognitive and adaptive skills (e.g., loss of bowel and bladder control, impaired sleep), regression of language and social abilities, as well as increasing emotional and behavioural disturbances.

There are two alternative specifiers, to denote whether or not loss of previously acquired skills is an aspect of the clinical history, where x corresponds to the final digit shown in Table 6.5:

6A02.x0 without loss of previously acquired skills

6A02.x1 with loss of previously acquired skills

Additional clinical features:

Common symptom presentations of Autism Spectrum Disorder in young children are parental or caregiver concerns about intellectual or other developmental delays (e.g., problems in language and motor coordination). When there is no significant impairment of intellectual functioning, clinical services may only be sought later (e.g., due to behaviour or social problems when starting school). In middle childhood, there may be prominent symptoms of anxiety, including Social Anxiety Disorder, school refusal, and Specific Phobia. During adolescence and adulthood, Depressive Disorders are often a presenting feature.

Co-occurrence of Autism Spectrum Disorder with other Mental, Behavioural or Neurodevelopmental Disorders is common across the lifespan. In a substantial proportion of cases, particularly in adolescence and adulthood, it is a co-occurring disorder that first brings an individual with Autism Spectrum Disorder to clinical attention.

Pragmatic language difficulties may manifest as an overly literal understanding of others' speech, speech that lacks normal prosody and emotional tone and therefore appears monotonous, lack of awareness of the appropriateness of their choice of language in particular social contexts, or pedantic precision in the use of language.

Social naiveté, especially during adolescence, can lead to exploitation by others, a risk that may be enhanced by the use of social media without adequate supervision.

Profiles of specific cognitive skills in Autism Spectrum Disorder as measured by standardized assessments may show striking and unusual patterns of strengths and weaknesses that are highly variable from individual to individual. These deficits can affect learning and adaptive functioning to a greater extent than would be predicted from the overall scores on measures of verbal and non-verbal intelligence.

Self-injurious behaviours (e.g., hitting one's face, head banging) occur more often in individuals with co-occurring Disorder of Intellectual Development.

Some young individuals with Autism Spectrum Disorder, especially those with a co-occurring Disorder of Intellectual Development, develop epilepsy or seizures during early childhood with a second increase in prevalence during adolescence. Catatonic states have also been described. A number of medical disorders such as Tuberous Sclerosis, chromosomal abnormalities including Fragile X Syndrome, Cerebral Palsy, early onset epileptic encephalopathies, and Neurofibromatosis are associated with Autism Spectrum Disorder with or without a co-occurring Disorder of Intellectual Development. Genomic deletions, duplications and other genetic abnormalities are increasingly described in individuals with Autism Spectrum Disorder, some of which may be important for genetic counselling. Prenatal exposure to valproate is also associated with an increased risk of Autism Spectrum Disorder.

Some individuals with Autism Spectrum Disorder are capable of functioning adequately by making an exceptional effort to compensate for their symptoms during childhood, adolescence or adulthood. Such sustained effort, which may be more typical of affected females, can have a deleterious impact on mental health and well-being.

Boundary with normality (threshold):

Social interaction skills: Typically developing individuals vary in the pace and extent to which they acquire and master skills of reciprocal social interaction and social communication. A diagnosis of Autism Spectrum Disorder should only be considered if there is marked and persistent deviation from the expected range of abilities and behaviours in these domains given the individual's age, level of intellectual functioning, and sociocultural context. Some individuals may exhibit limited social interaction due to shyness (i.e., feelings of awkwardness or fear in new situations or with unfamiliar people) or behavioural inhibition (i.e., being slow to approach or to 'warm up' to new people and situations). Limited social interactions in shy or behaviourally inhibited children, adolescents, or adults are not indicative of Autism Spectrum Disorder. Shyness is differentiated from Autism Spectrum Disorder by evidence of adequate social communication behaviours in familiar situations.

Social communication skills: Children vary widely in the age at which they first acquire spoken language and the pace at which their speech and language become firmly established. Most children with early language delay eventually acquire similar language skills as their same-age peers. Early language delay alone is not strongly indicative of Autism Spectrum Disorder unless there is also evidence of limited motivation for social communication and limited interaction skills. An essential feature of Autism Spectrum Disorder is persistent impairment in the ability to understand and use language appropriately for social communication.

Repetitive and stereotyped behaviours: Many children go through phases of repetitive play and highly focused interests as a part of typical development. Unless there is also evidence of impaired reciprocal social interaction and social communication, patterns of behaviour characterized by repetition, routine, or restricted interests are not by themselves indicative of Autism Spectrum Disorder.

Course features:

Although Autism Spectrum Disorder can present clinically at all ages, including during adulthood, it is a lifelong disorder the manifestations and impact of which are likely to vary according to age, intellectual and language abilities, co-occurring conditions and environmental context.

Restricted and repetitive behaviours persist over time. Specifically, repetitive sensorimotor behaviours appear to be common, consistent, and potentially severe. During the school age years and adolescence, these repetitive sensorimotor behaviours begin to lessen in intensity and number. Insistence on sameness, which is less prevalent, appears to develop during preschool and worsen over time.

Developmental presentations:

Infancy: Characteristic features may emerge during infancy although they may only be recognized as indicative of Autism Spectrum Disorder in retrospect. It is usually possible to make the diagnosis of Autism Spectrum Disorder during the preschool period (up to 4 years), especially in children exhibiting generalized developmental delay. Plateauing of social communication and language skills and failure to progress in their development is not uncommon. The loss of early words and social responsiveness, i.e., a true regression, with an onset between 1 and 2 years, is unusual but significant and rarely occurs after the third year of life. In these cases, the qualifier 'with loss of previously acquired skills' should be applied.

Preschool: In preschool children, indicators of an Autism Spectrum Disorder diagnosis often include avoidance of mutual eye contact, resistance to physical affection, a lack of social imaginary play, language that is delayed in onset or is precocious but not used for social conversation; social withdrawal, obsessive or repetitive preoccupations, and a lack of social interaction with peers characterized by parallel play or disinterest. Sensory sensitivities to everyday sounds, or to foods, may overshadow the underlying social communication deficits.

Middle Childhood: In children with Autism Spectrum Disorder without a Disorder of Intellectual Development, social adjustment difficulties outside the home may not be detected until school entry or adolescence when social communication problems lead to social isolation from peers. Resistance to engage in unfamiliar experiences and marked reactions to even minor change in routines are typical. Furthermore, excessive focus on detail as well as rigidity of behaviour and thinking may be significant. Symptoms of anxiety may become evident at this stage of development.

Adolescence: By adolescence, the capacity to cope with increasing social complexity in peer relationships at a time of increasingly demanding academic expectations is often overwhelmed. In some individuals with Autism Spectrum Disorder, the underlying social communication deficits may be overshadowed by the symptoms of co-occurring Mental and Behavioural Disorders. Depressive symptoms are often a presenting feature

Adulthood: In adulthood, the capacity for those with Autism Spectrum Disorder to cope with social relationships can become increasingly challenged, and clinical presentation may occur when social demands overwhelm the capacity to compensate. Presenting problems in adulthood may represent reactions to social isolation or the social consequences of inappropriate behaviour. Compensation strategies may be sufficient to sustain dyadic relationships, but are usually inadequate in social groups. Special interests, and focused attention, may benefit some individuals in education and employment. Work environments may have to be tailored to the capacities of the individual. A first diagnosis in adulthood may be precipitated by a breakdown in domestic or work relationships. In Autism Spectrum Disorder there is always a history of early childhood social communication and relationship difficulties, although this may only be apparent in retrospect.

Culture-related features:

Cultural variation exists in norms of social communication, reciprocal social interactions, as well as interests and activities. Therefore, signs of impairment in functioning may differ depending on

cultural context. For example, in some societies it may be normative for children may avoid direct eye contact out of deference, which should not be misinterpreted as impairment in social interaction.

Sex and/or gender-related features:

Males are four times more likely than females to be diagnosed with Autism Spectrum Disorder.

Females diagnosed with Autism Spectrum Disorder are more frequently diagnosed with co-occurring Disorders of Intellectual Development, suggesting that less severe presentations may go undetected as compared to males. Females tend to demonstrate fewer restricted, repetitive interests and behaviours than males.

During middle-childhood, gender differences in presentation differentially affect functioning. Boys may act out with reactive aggression or other behavioural symptoms when challenged or frustrated. Girls tend to withdraw socially, and react with emotional changes to their social adjustment difficulties.

Boundaries with other disorders and conditions (differential diagnosis):

Boundary with Disorders of Intellectual Development: Autism Spectrum Disorder may be diagnosed in individuals with Disorders of Intellectual Development if deficits in initiating and sustaining social communication and reciprocal social interactions are greater than would be expected based on the individual's level of intellectual functioning and if the other diagnostic requirements for Autism Spectrum Disorder are also met. In these circumstances, both Autism Spectrum Disorder and the Disorder of Intellectual Development should be assigned and the 'with Disorder of Intellectual Development' qualifier should be applied with the Autism Spectrum Disorder diagnosis. Because Autism Spectrum Disorder inherently involves social deficits, assessment of adaptive behaviour as a part of the diagnosis of a co-occurring Disorder of Intellectual Development should place greater emphasis on intellectual functioning and the conceptual and practical domains of adaptive functioning rather than on social skills. The diagnosis of Autism Spectrum Disorder in individuals with Severe and Profound Disorders of Intellectual Development is particularly difficult, and requires in-depth and longitudinal assessments. However, the diagnosis may be assigned if skills in social reciprocity and communication are significantly impaired relative to the individual's general level of intellectual ability.

Boundary with Developmental Language Disorder with impairment of mainly pragmatic language: Individuals with Developmental Language Disorder with impairment of mainly pragmatic language exhibit language deficits involving the ability to understand and use language in social context (i.e., with pragmatic language impairment). Unlike individuals with Autism Spectrum Disorder, individuals with Developmental Language Disorder are usually able to initiate and respond appropriately to social and emotional cues and to share interests with others, and do not typically exhibit restricted, repetitive and stereotyped behaviours. An additional diagnosis of Developmental Language Disorder should not be assigned to individuals with Autism Spectrum Disorder based solely on pragmatic language impairment. The other forms of Developmental

Language Disorder (i.e., with impairment of receptive and expressive language or with impairment of receptive and expressive language) may be assigned in conjunction with a diagnosis of Autism Spectrum Disorder if language abilities are markedly below what would be expected on the basis of age and level of intellectual functioning.

Boundary with Developmental Motor Coordination Disorder: Individuals with Autism Spectrum Disorder may be reluctant to participate in tasks requiring complex motor coordination skills, such as ball sports, which is better accounted for by a lack of interest rather than any specific deficits in motor coordination. However, Developmental Motor Coordination Disorder and Autism Spectrum Disorder can co-occur and both diagnoses may be assigned if warranted.

Boundary with Attention Deficit Hyperactivity Disorder: Specific abnormalities in attention (e.g., being overly focused or easily distracted), impulsivity, and physical hyperactivity are often observed in individuals with Autism Spectrum Disorder. However, individuals with Attention Deficit Hyperactivity Disorder do not exhibit the persistent deficits in initiating and sustaining social communication and reciprocal social interactions or the persistent restricted, repetitive, and inflexible patterns of behaviour, interests, or activities that are the defining features of Autism Spectrum Disorder. However, Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder can co-occur and both diagnoses may be assigned if diagnostic requirements are met for each. Attention Deficit Hyperactivity Disorder symptoms may sometimes dominate the clinical presentation such that some Autism Spectrum Disorder symptoms are less apparent.

Boundary with Stereotyped Movement Disorder: Stereotyped Movement Disorder is characterized by voluntary, repetitive, stereotyped, apparently purposeless (and often rhythmic) movements that arise during the early developmental period. Although such stereotypies are typical in Autism Spectrum Disorder, if they are severe enough to require additional clinical attention, for example because of self-injury, a co-occurring diagnosis of Stereotyped Movement Disorder may be warranted.

Boundary with Schizophrenia: The onset of Schizophrenia may be associated with prominent social withdrawal, which is either preceded by or results in social impairments that may resemble social deficits seen in Autism Spectrum Disorder. However, unlike Autism Spectrum Disorder, the onset of Schizophrenia is typically in adolescence or early adulthood and extremely rare prior to puberty. Schizophrenia is differentiated on the basis of the presence of psychotic symptoms (e.g., delusions, hallucinations) as well as a lack of restricted, repetitive and inflexible patterns of behaviour, interests or activities during early childhood typical of Autism Spectrum Disorder.

Boundary with Schizotypal Disorder: Interpersonal difficulties seen in Autism Spectrum Disorder may share some features of Schizotypal Disorder, such as poor rapport with others and social withdrawal. However, Autism Spectrum Disorder is also characterized by restricted, repetitive and stereotyped patterns of behaviour, interests, or activities.

Boundary with Social Anxiety Disorder: Social Anxiety Disorder is associated with limited engagement in social interaction due to marked and excessive fear or anxiety about negatively evaluated by others. Typically, when interacting with familiar others or in social situations that do not provoke significant anxiety, there is no evidence of impairment. Individuals with Autism

Spectrum Disorder may experience social anxiety, but they also exhibit more pervasive deficits in initiating and sustaining social communication and reciprocal social interactions than are typically observed in Social Anxiety Disorder. Persistent restricted, repetitive, and inflexible patterns of behaviour, interests, or activities are not features of Social Anxiety Disorder.

Boundary with Selective Mutism: Selective Mutism is characterized by normal use of language and patterns of social communication in specific environments, such as the home, but not in others, such as at school. In Autism Spectrum Disorder, a reluctance to communicate may be observed in some social circumstances, but deficits in initiating and sustaining social communication and reciprocal social interactions and persistent restricted, repetitive, and inflexible patterns of behaviour, interests, or activities are evident across all situations and contexts.

Boundary with Obsessive-Compulsive Disorder: Obsessive-Compulsive Disorder is characterized by persistent repetitive thoughts, images, or impulses/urges (i.e., obsessions) and/or repetitive behaviours (i.e., compulsions) that the individual feels driven to perform in response to an obsession, according to rigid rules, to reduce anxiety or to achieve a sense of 'completeness'. These symptoms may be difficult to distinguish from restricted, repetitive, and inflexible patterns of behaviour, interests, or activities that are characteristic of Autism Spectrum Disorder. Unlike those with Autism Spectrum Disorder, it is more common for individuals with Obsessive-Compulsive Disorder to consciously resist their impulsive/urges to perform compulsive behaviours (e.g., by performing alternate tasks), though adolescents and adults with Autism Spectrum Disorder may also try to suppress specific behaviours that they realize are socially undesirable. Autism Spectrum Disorder can also be distinguished from Obsessive-Compulsive Disorder by its characteristic deficits in initiating and sustaining social communication and reciprocal social interactions, which are not features of Obsessive-Compulsive Disorder.

Boundary with Reactive Attachment Disorder: Reactive Attachment Disorder is characterized by inhibited emotionally withdrawn behaviour exhibited toward adult caregivers, including a failure to approach a discriminated, preferred attachment figure for comfort, support, protection or nurturance. The diagnosis of Reactive Attachment Disorder requires evidence of a history of severe neglect or maltreatment by the primary caregiver or other forms of severe social deprivation (e.g., certain types of institutionalization). Some individuals reared under conditions of severe deprivation in institutional settings exhibit autistic-like features including difficulties in social reciprocity and restricted, repetitive, and inflexible patterns of behaviour, interests, or activities. Also referred to as 'quasi-autism', affected individuals are differentiated from those with Autism Spectrum Disorder based on significant improvement of autism-like features when the child is moved to a more nurturing environment. Differentiation between Reactive Attachment Disorder and Autism Spectrum Disorder is difficult when no reliable evidence is available of intact social and communicative development prior to the onset of abuse or neglect.

Boundary with Disinhibited Social Engagement Disorder: Disinhibited Social Engagement Disorder is characterized by persistent indiscriminate social approaches to unfamiliar adults and peers, a pattern of behaviour that may also be seen in some children with Autism Spectrum Disorder. The diagnosis of Disinhibited Social Engagement Disorder requires evidence of a history

of severe neglect or maltreatment by the primary caregiver or other forms of severe social deprivation (e.g., certain types of institutionalization). As in Reactive Attachment Disorder, Disinhibited Social Engagement Disorder may be associated with generalized deficits in social understanding and social communication. Although they may occur, restricted, repetitive, and inflexible patterns of behaviour, interests, or activities are not typical features of Disinhibited Social Engagement Disorder. Evidence of a significant reduction in symptoms when the child is provided a more nurturing environment suggests that Disinhibited Social Engagement Disorder is the appropriate diagnosis.

Boundary with Avoidant-Restrictive Food Intake Disorder: Individuals with Avoidant-Restrictive Food Intake Disorder sometimes restrict their food intake based on food's sensory characteristics such as smell, taste, temperature, texture or appearance. Individuals with Autism Spectrum Disorder may also restrict intake of certain foods because of their sensory characteristics or because of inflexible adherence to particular routines. However, Autism Spectrum Disorder is also characterized by persistent deficits in initiating and sustaining social communication and reciprocal social interactions and persistent restricted, repetitive, and inflexible patterns of behaviour, interests, or activities that are unrelated to food. If a pattern of restricted eating in an individual with Autism Spectrum Disorder has caused significant weight loss or other health consequences or is specifically associated with significant functional impairment, an additional diagnosis of Avoidant-Restrictive Food Intake Disorder may be assigned.

Boundary with Oppositional Defiant Disorder: Oppositional Defiant Disorder is characterized by a pattern of markedly noncompliant, defiant, and disobedient disruptive behaviour that is not typical for individuals of comparable age and developmental level. Individuals with Oppositional Defiant Disorder do not exhibit the social communication deficits or restricted, repetitive, and inflexible patterns of behaviour, interests, or activities that are characteristic of Autism Spectrum Disorder. However, oppositional or 'demand avoidant' behaviour may be prominent in some children with Autism Spectrum Disorder, whether or not they have accompanying intellectual or functional language impairments and may sometimes be the presenting feature in school-aged children with Autism Spectrum Disorder. Disruptive behaviour with aggressive outbursts (explosive rages) may also be a prominent feature of Autism Spectrum Disorder. Among individuals with Autism Spectrum Disorder, such outbursts are often associated with a specific trigger (e.g., a change in routine, aversive sensory stimulation, anxiety, or rigidity when the individual's thoughts or behaviour sequences are interrupted), rather than reflecting an intention to be defiant, provocative, or spiteful, as is more typical of Oppositional Defiant Disorder.

Boundary with Personality Disorder: Personality Disorder is a pervasive disturbance in how an individual experiences and thinks about the self, others, and the world, manifested in maladaptive patterns of cognition, emotional experience, emotional expression, and behaviour. The maladaptive patterns are relatively inflexible, manifest across a range of personal and social situations, relatively stable over time, and of long duration. They are associated with significant problems in psychosocial functioning that are particularly evident in interpersonal relationships. The difficulties some individuals with Autism Spectrum Disorder exhibit in initiating and maintaining relationships because of their limited skills in social communication and reciprocal social interactions may resemble those seen in some individuals with Personality Disorder.

However, unlike Autism Spectrum Disorder, persistent restricted, repetitive, and inflexible patterns of behaviour, interests, or activities with onset in early childhood are not characteristic features of Personality Disorder.

Boundary with Primary Tics or Tic Disorders including Tourette Syndrome: Sudden, rapid, non-rhythmic, and recurrent movements or vocalizations occur in Primary Tics and Tic Disorders, which may resemble repetitive and stereotyped motor movements in Autism Spectrum Disorder. Unlike Autism Spectrum Disorder, tics in Primary Tics and Tic Disorders tend to be less stereotyped, are often accompanied by premonitory sensory urges, last for a shorter period, tend to emerge later in life, and are not experienced by the individual as soothing.

Boundary with Diseases of the Nervous System and other medical conditions classified elsewhere: Loss of previously acquired skills in language and social communication in the second year of life is reported in some children with Autism Spectrum Disorder, but this rarely occurs after the age of 3 years. Diseases of the Nervous System and other medical conditions associated with regression (e.g., acquired epileptic aphasia or Landau Kleffner syndrome, autoimmune encephalitis, Rett Syndrome) are differentiated from Autism Spectrum Disorder with loss of previously acquired skills on the basis of an early history of relatively normal social and language development and by the characteristic neurological features of these disorders that are not typical of Autism Spectrum Disorder.

Boundary with Secondary Neurodevelopmental Syndrome: Autistic features may become manifest in the context of acquired medical conditions, such as encephalitis. Identifying accurately whether the symptoms are secondary to another medical condition or represent the exacerbation of pre-existing Autism Spectrum Disorder may have implications for both immediate management and prognosis. When autistic symptoms are attributable to another medical condition, a diagnosis of Secondary Neurodevelopmental Syndrome rather than Autism Spectrum Disorder may be assigned.

Appendix 2: Example of a SAVRY scoring sheet

Structured Assessment of Violence Risk in Youth (SAVRY)

R. Borum, P. Bartel, and A. Forth (2002)

Patient:	DOB:

Ratings: Lo (0) = low/none; Mod (1) = moderate/possible/less serious; Hi (2) = high/definite/serious

Historical Risk Factors	Evidence	Rating	Critical
1: History of Violence			
2: History of Non-Violent Offending			
3: Early Initiation of Violence			
4: Past Supervision/Intervention Failures			
5: History of Self-Harm or Suicide Attempts			
6: Exposure to Violence in the Home			
7: Childhood History of Maltreatment			
8: Parental/Caregiver Criminality			
9: Early Caregiver Disruption			
10: Poor School Achievement			
Social/Contextual Risk Factors	**Evidence**	**Rating**	**Critical**
11: Peer Delinquency			
12: Peer Rejection			
13: Stress and Poor Coping			
14: Poor Parental Management			
15: Lack of Personal/Social Support			
16: Community Disorganization			

Individual Risk Factors	Evidence	Rating	Critical
17: Negative Attitudes			
18: Risk Taking/Impulsivity			
19: Substance Use Difficulties			
20: Anger Management Problems			
21: Low Empathy/Remorse			
22: Attention Deficit/Hyperactivity Difficulties			
23: Poor Compliance			
24: Low Interest/Commitment to School			
Protective Factors	**Evidence**		**P/A**
P1: Prosocial Involvement			
P2: Strong Social Support			
P3: Strong Attachments and Bonds			
P4: Positive Attitude Towards Intervention and Authority			
P5: Strong Commitment to School			
P6: Resilient Personality Traits			
Overall Opinion on Risk			

Assessor(s):	Date of assessment:	

Appendix 3: References

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Nice Guidance. Antisocial behaviour and conduct disorders in children and young people: recognition and management. Clinical guideline. Reference number: CG158 Published: 27 March 2013 Last updated: 19 April 2017 https://www.nice.org.uk/guidance/cg158 **ILT000356**

The Southport Inquiry

Phase Two

Expert Report 3

Author:

Anil (Neil) Kanti BASU QPM, D Hon.Laws BA (Econ)

17 September 2026

Expert Report: Anil (Neil) Kanti Basu

1. Introduction

1.1. My sincere condolences to the bereaved families and those injured physically and psychology by the tragic events of Southport. I also want to express my deep sympathies to anyone similarly affected by the case studies used in the Southport Inquiry Phase 2. I hope you find answers in this Inquiry. I also hope that its future recommendations make sure that the likelihood of such events ever happening again are reduced as much as possible, so your loved ones have a legacy of changing the system for the better.

1.2. Lastly I want to express my thanks to my former police colleagues, blue light partners and colleagues of other professional agencies who this Inquiry will examine. I know exactly what you do, exactly how difficult it is, and exactly what it feels like when tragedy strikes. I thank you for the service you give even though it can sometimes feel thankless and damaging.

1.3. Policing happens in the moment not in hindsight. Whenever I review the actions of others I bear in mind the following quote from Anthony Hidden QC, author of 'Investigation into the Clapham Junction Railway Accident report'; "There is almost no human action or decision that cannot be made to look more flawed and less sensible in the misleading light of hindsight. It is essential the critic should keep themselves aware of that fact." I do.

1.4. Career summary

1.4.1. I was a serving Metropolitan Police Service police officer for 30 years between 1992 and 2022. I retired as an Assistant Commissioner, the London equivalent of a Chief Constable. The Inquiry has a detailed curriculum vitae, and I provide a brief summary only. I have provided further 'detailed expert credentials' most relevant to this task separately. I do not have academic qualifications in policing, criminal justice or criminology. However, I have deep and wide professional experience of policing strategy, policing systems and policing tactics, as well as its culture.

1.4.2. I spent a third of my career in uniform, the first five as a first responder at constable and sergeant ranks. However, I consider myself a career detective having served in every rank from trainee detective constable to detective superintendent. As a detective, I was a senior investigating officer (SIO) of anti-corruption, professional standards, homicide and serious and organised crime; a qualified and experienced Strategic and Counterterrorism Firearms Commander and an Authorising Officer of covert operations. Latterly I worked in Counter Terrorism Policing (CTP) at executive level (Deputy Assistant Commissioner or DAC), running protective security for people and places, then high threat operations against terrorists with MI5. I was promoted to Assistant Commissioner Specialist Operations (ACSO) in March 2018, before stepping down from this position and operational policing on July 4th, 2021.

1.4.3. In the role of ACSO, I was the UK national lead for CTP responsible for the oversight of UK policing's contribution to the four pillars of the Government's counter terrorism strategy

called CONTEST namely; Protect (target hardening people and premises from attack), Prepare (ensuring the UK was resilient to an attack and able to recover), Prevent (identifying and intervening on a voluntary pre-criminal basis with those susceptible to being radicalised and drawn into Terrorism), and Pursue (working with MI5 to gather intelligence, arrest and help prosecute terrorists before they can commit terrorist acts or investigating the case post attack). I was directly responsible for this in the Metropolitan Police Service and its five major commands, the London Counter Terrorism Unit (CTU) called SO15 (now called CTP London), Royalty and Specialist Protection, Parliamentary and Diplomatic Protection, Aviation Policing and Protective Security Operations. I had two deputies – the Senior National Co-ordinator (SNC) of Protect and Prepare and the SNC Prevent and Pursue. I did both these jobs consecutively before being promoted to ACSO.

1.4.4. The CTP system is co-ordinated through Counter Terrorism Policing Head Quarters (CTPHQ), and I was responsible for the oversight of training, policy, and guidance across the network, working with the Government's Office of Security and Counter Terrorism (OSCT) now called Homeland Security Group. The role involves the matrix management and co-ordination of the other eight regional CTUs and managing the relationship with the UK Intelligence Community (UKIC), Government OSCT, Police Service of Northern Ireland (PSNI) and Police Scotland. I answered to the Commissioner of the Metropolis and the Home Secretary.

1.4.5. From July 2021 to November 2022, I was seconded to The College of Policing Board as the non-executive director representing UK Chief Constables. I was also its senior advisor on leadership and international development and directed the 2021/22 Strategic Command Course (SCC), policing's most senior leadership programme. I retired on the 29th of November 2022.

2. Executive summary

2.1. This report considers the policing and multi-agency lessons arising from Southport Inquiry Phase 2, the AR material from Phase 1, and six case studies A-F. Its central conclusion is that the problem is not the absence of agencies, concern or legal frameworks. The recurring failure is that risk was seen in fragments, held by different systems, assessed through different professional lenses, and too often closed or de-escalated before the cumulative trajectory was understood.

2.2. Across AR and the six comparator case studies, the strongest pattern is cumulative risk without cumulative ownership. The individuals differed in background, motivation, diagnosis and pathway, but common features recur; violence fascination, online immersion, social isolation, grievance, neurodevelopmental or mental health complexity, adverse childhood experiences in some cases, warning behaviour, disguised compliance, and moments where family, schools, police, health or safeguarding services saw parts of the risk but not the whole.

2.3. The report therefore recommends a single nominal multi-agency chronology, a living shared risk assessment, clear risk ownership, auditable closure decisions, and structured escalation thresholds. The question that should sit at the heart of every referral, meeting, disposal and

closure is simple: who owns the risk now? If the answer is unclear, the system has not discharged its public protection responsibility.

2.4. Prevent and Channel remain essential where ideology, susceptibility to radicalisation or terrorist risk is present, but they cannot be the sole answer to violence fascinated individuals whose motivation is mixed, unstable, unclear, nihilistic, misogynistic, copycat or not ideological at all. The Inquiry terms of reference use the terminology Violence Fixated Individual (VFI). I have used fascination instead of fixation as I believe this to be the more accurate presentation of this new phenomenon. The national security system I believe is using the term fascinated because it better describes the evolution in how individuals are radicalised. Fixation escribed a targeted pathological obsession with a specific group, grievance or ideology. Fascination implies a broader more fluid threat landscape in which the subject has become immersed. I believe the term is used in Lord Anderson's Prevent Review (HOM000079) and in the UK government parliamentary sessions, 7th report of sessions 2024-2026 'Combatting new forms of extremism' 1st April 2026 (ILT000099). I adopt it and use it throughout. The report supports a wider front door, with the ability to triage cases into appropriate pathways and move them between Prevent, Multi-Agency Safeguarding Hubs (MASH), Multi-Agency Public Protection Arrangements (MAPPA), youth justice, health and policing as the risk develops.

2.5. The report also identifies two connected gaps. First, the law is strong once terrorism, weapons offences, threats, attempts or preparatory conduct are proven, but weaker where a non-terrorist individual is plainly moving towards extreme violence before existing criminal thresholds are crossed. Secondly, the online environment has become a powerful accelerator of grievance, violence fascination, copycat aspiration and practical capability. Platform accountability, regulation of algorithmic amplification, age-appropriate protection from extreme violence content, and proportionate digital enquiry must therefore sit alongside any new criminal offence.

2.6. The principal message is one of balance. The state should not criminalise thought, vulnerability, adolescence, neurodiversity or disturbing but non-criminal interest. Nor should it allow obvious escalation towards serious violence to be passed between agencies until tragedy occurs. A defensible system must be lawful, proportionate, accountable and necessary, but it must also be professionally curious, digitally literate, properly resourced, and clear about who is responsible for protecting both the individual and the public.

3. Methodology

3.1. I am working to a letter of instruction dated 1st July 2026 from Elaine Bruce, Assistant Solicitor to the Inquiry Team. I have also met with the Inquiry Barrister Nicholas Moss KC, Hannah Joseph and other members of the team on several occasions and with the other expert witnesses to discuss progress. At no time have I been given any instruction on what I can say. This report is entirely independent and my own opinion based on a literature review of the material I have been given access to and my professional knowledge and experience of policing.

3.2. Throughout I make no recommendations, only observations. It is for the Inquiry Chair to determine if my observations are useful in reinforcing, adding to or detracting from his recommendations.

3.3. I could not fulfil one part of the instruction – that I work with the other expert witnesses to produce a joint report - but I have been provided with a copy of theirs, and they will be provided with this.

3.4. I am aware of the irony that in an inquiry where multi-agency processes are being questioned as necessary or effective, this assembled multi-agency expert panel could not meet regularly together in full quorum due to other competing professional, leave and family considerations. This was compounded by the huge quantity of material made available to us and the limited time frame to produce a report.

3.5. I have used the Relativity platform and the expert space extensively. The documents on which I rely for each case study are listed in order in separate confidential notes to the Inquiry team. These contain my notes and observations on each case study and my observations on chapters 7 and 8 of Southport Inquiry Phase 1: essentially my 'rough workings out', including detail that would otherwise allow jigsaw identification of the case studies. I used Microsoft co-pilot to produce a high level thematic analysis of my notes and observations in those confidential notes and to explore the common themes across case studies A-F with particular regard to policing. I also used Microsoft Copilot to compare my notes and observations on the Southport Inquiry Phase 1 where relevant to policing and Prevent (chapters 7 & 8) and against that thematic analysis of case studies A-F. This was to determine what similarities and differences exist. The results are shown in section 5, 6 and 7.

3.6. These analyses answer the majority of the questions provided in the letter of instruction. Separate sections (8-11) describe proposed changes in the law, but I would defer to the expertise of Jonathan Hall KC and the Home Office. However, I make some comments throughout the analysis on the potential need for new legislation to combat violence online and to intervene in violence preparation at a much earlier stage than currently allowed under the Criminal Attempts Act 1981, similar to that described in s5 Terrorism Act 2006. Such a law would allow earlier deployment of covert policing techniques, earlier executive action, (arrest and search), and increase the likelihood of a substantive charge to place a subject into the criminal justice system where risk reduction might be diversion with support services mandated, or incarceration.

3.7. I have also included observations on a proposed system for managing violence fascinated individuals (VFIs), and a broad outline of how policing works with other agencies to manage those individuals today in two ways; through the Prevent/Channel framework and the MASH framework.

3.8. This methodology has had two limitations. The scale of the endeavour has made reading all the relevant material impossible. It is possible I have missed something – a theme or a nuance in a theme or a current improvement to the system. If I have I apologise and I hope that this will be picked up by others.

3.9. I am a detective and in doing any paper based review I am always cognisant that I have never met the witnesses or taken their statements, seen them cross examined, or will ever have the type of in depth case knowledge the SIO and his or her case officer would have had. Only the major investigation team, a Judge, coroner and/or jury has that privilege. There are two detailed reports, one from the NCA and one from the IOPC in Case Study F that illustrate my dilemma.

3.10. As a result, I am highly reliant on chronologies and summaries and I have favoured those relating to my area of expertise – i.e. policing, coroner, Crown Prosecution Service (CPS) and the Home Office. I have read more widely where I could, and I have referenced those documents in the provided closed reports.

3.11. Similarly, I was asked to read the Inquiry phase 1 - concentrating on chapter 1 and the chapters relevant to my expertise – i.e. chapters 7 and 8. I have read it all.

3.12. It was not possible to understand the foundations of the recommendations holistically without doing that, which is another useful analogy to the way effective multi-agency partnerships work. You don't have to be an expert in their disciplines, but it helps to understand in general what they do, why and how they do it, and especially when they are making decisions based on risk assessments that are not necessarily the same as yours.

3.13. I concur with the findings of Southport Phase 1 and its recommendations. I know they have already been accepted by the Government in full. Again, in the thematic analysis below comparing Southport Phase 1 to case studies A-F, I make some additional comments that I hope add value in demonstrating similarities and differences.

3.14. I am also grateful to have been given access to other key reports which have influenced my thinking. These are:

3.15. The statement of SNC DAC Vicky EVANS (CTPHQ000006)

3.16. The statements of Director of Prevent Cathryn ELLSMORE (HOM000078 & HOM000223)

3.17. The statement of PS Carmen Thompson (CTPNW000180)

3.18. The statement of DCS Sarah Kenwright (CTPNW000169)

3.19. The Review of Prevent by Lord David Anderson (HOM000079)

3.20. The Joint Terrorism Analysis Centre report (HOM000539)

3.21. In how they describe the work of, and evolution of, Prevent, and in the later documents analysis, I concur with their factual accuracy and their recommendations. I commend them to the Core Participants. They helped form my thoughts here. I hope they find them consistent.

4. The thematic learning from case studies A-F, as it relates to policing

4.1. This thematic analysis draws together the common and unique factors apparent across the six case studies A-F. It considers three linked questions: first, what characteristics were present in A, B, C, D, E and F; second, what methodology was used or contemplated in their offending; and third, how different agencies identified, assessed and responded to the risk they posed. The analysis is necessarily cautious: the material shows patterns, but it does not support a simple predictive profile. The stronger conclusion is that cumulative risk was often visible across agencies, but no single agency had the full picture at the time.

4.2. Common characteristics across the six case studies

4.2.1. The most consistent pattern is not one single factor but the accumulation of factors over time. Several subjects were male adolescents or young adults, often moving through transition points such as puberty, exclusion or withdrawal from school, the move from children's to adult services, or loss of structured support. Neurodevelopmental conditions or suspected conditions were prominent, particularly autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder or possible co-morbidity with other mental health or personality features. These were rarely sufficient explanations in themselves. The repeated issue was the interaction between neurodiversity, adverse childhood experiences, social isolation, obsessive interests, online exposure, and deteriorating emotional regulation. Pre-index offending in the form of low-level criminality was common and leniently dealt with.

4.2.2. Adverse childhood experiences (ACE) were present in several cases, including domestic abuse, parental separation, absent or violent fathers, parental substance misuse, chaotic family environments, physical abuse, neglect, or disrupted attachments. However, Case C is important because it appears to have had fewer obvious early adverse childhood indicators. This prevents any simplistic conclusion that ACEs are a necessary precondition. The commoner theme is that where ACEs were present, they made later deterioration harder to interpret and easier to normalise as behavioural, familial or adolescent difficulty rather than escalating risk.

4.2.3. Social isolation, disengagement from education or employment, poor communication skills, bullying, low self-esteem, grievance, humiliation and rejection appear repeatedly. In a number of cases the subject retained intelligence, aspiration or apparently ordinary functioning, which made risk harder to recognise. Several were described as bright, capable, employed or able to plan. This is important because intelligence, aspiration and periods of apparent stability did not remove risk; they sometimes enabled concealment, planning, deception or disguised compliance.

4.3. Violence fixation, grievance and online immersion

4.3.1. A powerful common factor is violence fixation. Across the case studies this appears in different forms: fascination with murder, serial killers, mass shootings, manifestos, weapons, extremist material, satanism, incel ideology, misogyny, pornography, self-harm

content or violent online communities. The case material suggests that some subjects were not passive consumers. Several uploaded, distributed, posted, messaged, searched actively, attempted to buy weapons, discussed plans or disclosed violent thoughts to others. The distinction between browsing, participation, confession, fantasy and mobilisation was often unclear, but that ambiguity is itself a theme.

4.3.2. The online environment was frequently where risk was hidden from parents, teachers, clinicians and police. It enabled immersion in harmful material, reinforcement of grievance, and contact with others who may have encouraged or normalised violent thinking. However, the material also shows the limits of treating online history as a predictive tool. Some browsing may be disturbing but not actionable; some may be common within wider online subcultures; and even detailed post-event digital analysis may struggle to identify a clear trigger. Online behaviour therefore needs to be treated as one element of a cumulative assessment, not as either a decisive predictor or something to be ignored.

4.4. Methodology and pathway to offending

4.4.1. The methodology across the six cases shows both planning and impulsivity. Some offences involved clear premeditation: research, target selection, attempts to acquire weapons, concealment, deletion of material, use of virtual private networks (VPNs), written notes, manifestos or staged preparation. Other offending appears more spontaneous, reactive or triggered by a domestic confrontation, humiliation, rejection, disrupted routine or acute emotional dysregulation. The important theme is that these categories overlap. A subject may have long-standing fixation and capability, yet the final act may be triggered quickly by a short-lived crisis.

4.4.2. Victim selection also shows recurring themes. Several cases involved very vulnerable victims, including children, family members, women, school communities or strangers unable to defend themselves. In some cases, there was evidence of copycat thinking, a desire for notoriety, admiration of prior killers, or an attempt to imitate or surpass them. In others, the immediate victim was closely connected to the subject and the offence emerged from domestic tension, dependency, grievance or rage. The common factor is not a single target type, but the movement from grievance and fixation into violence against accessible or symbolically significant victims.

4.5. Disclosure, warning behaviour and disguised compliance

4.5.1. A striking theme is that the subjects often disclosed, hinted at, or telegraphed risk before the index offence. This took the form of comments to friends, online posts, written notes, threats, statements to health professionals, comments to family members, or self-disclosures of violent or suicidal thinking. These disclosures were not always explicit enough to trigger action and were often ambiguous: they could be read as fantasy, distress, adolescent bravado, mental health presentation or attention-seeking. Nevertheless, across the cases, warning behaviour was present often enough to require a system that treats such disclosures as cumulative risk indicators.

4.5.2. Disguised compliance is another recurring risk. Subjects could attend sessions, appear calmer, say the right things, present aspiration, or minimise their behaviour while still continuing harmful online activity or maintaining violent fantasies. Periods of improvement were sometimes treated as evidence that risk had reduced, leading to closure or step-down. The thematic concern is that improvement in presentation was not always tested against wider evidence, particularly online activity, family accounts, school observations, and prior patterns of cyclical escalation.

4.6. Agency response: strengths and recurring weaknesses

4.6.1. The agencies were not generally absent. Schools, parents, police, child and adolescent mental health services (CAMHS), children's social care (CSC), multiagency safeguarding hubs (MASH), Prevent, youth offending services (YOS), firearms licensing and other support services all appear at different points. Teachers and family members were often observant and frequently identified that something was wrong. Police sometimes took positive action, including arrest, search, seizure of digital devices and referral. Health and safeguarding agencies often recognised vulnerability and attempted support. The problem was not simply indifference; it was fragmentation.

4.6.2. The repeated weakness was the absence of a single, live, multi-agency chronological record and a shared risk assessment. Relevant information sat in separate systems: school records, police reports, CAMHS notes, GP records, social care assessments, Prevent records, firearms licensing files, youth justice records and family disclosures. Some information was not recorded, some was summarised too briefly, some was not shared, some was delayed, and some was not available to the people making critical decisions. This meant agencies could respond rationally to the fragment they saw while missing the cumulative pattern.

4.6.3. Several cases also show risk being managed in short cycles. A referral was made, risk was considered, limited support was offered, presentation improved or engagement was poor, and the case was closed. The individual then deteriorated again. This "fire brigade" model is ill-suited to subjects whose risk emerges over years, fluctuates, hides online, and becomes visible only when observations are combined across agencies. The reason for non-engagement by the subject or family should have been explored and treated as a risk factor rather than as a reason to close it down and step away.

4.7. Prevent, Channel and the VFI problem

4.7.1. The case studies expose a recurring ambiguity around violence-fascinated individuals, mixed, unstable or unclear ideology, and the boundary between terrorism, vulnerability, mental health and criminality. Some subjects had extremist interests; others had misogynistic, satanic, incel, copycat or grievance-based motivations that sat outside a conventional terrorism framework. Prevent and Channel sometimes appeared to work as intended, sometimes appeared to close too quickly, and sometimes were not engaged because the case did not fit the policy understanding at the time. This creates a policy gap:

individuals may present as dangerous, fixated and susceptible to violent ideological influence, yet not meet a clear counter-terrorism threshold.

4.7.2. The analysis suggests that Prevent cannot be expected to solve the VFI problem alone. It has specialist value where ideology, radicalisation or susceptibility to extremist influence is present, but many of these cases require broader multi-agency risk management, mental health expertise, safeguarding, youth justice, digital assessment and, where necessary, police executive action. The key question is who owns the risk when a subject is dangerous but not yet prosecutable, not acutely mentally ill, not clearly terrorist, and either unwilling or unable to engage voluntarily?

4.8. Unique or distinguishing factors

4.8.1. Each case also has distinguishing features. The case studies included features such as early Prevent and Channel intervention, Another is distinctive because there were fewer obvious early warning signs, high intelligence, concealed online deviance, firearms acquisition through deception, extreme premeditation and post-event revelation of the scale of fixation. A case shows a long multi-agency history, repeated handoffs, ASD diagnosis, Channel involvement, engagement with extreme right wing (XRW) and other disturbing quasi-religious material suicide ideation, substance abuse and a later offence with misogynistic and occult features. Another is distinctive for very early and severe behavioural disturbance, ADHD/ODD/conduct disorder, repeated aggression and self-harm, allegations of sexualised behaviour at a very young age, and a pattern of high risk to self and others that was more visible than in some other cases. Another case is distinctive because he was an adult with a legitimate shotgun certificate, a long childhood history of ASD/ADHD and weapons obsession, firearms licensing failures, incel immersion, possible steroid contribution, and a spontaneous spree killing and suicide following acute domestic escalation.

4.9. Cross-cutting implications

4.9.1. The central implication is that the system needs a cumulative, longitudinal and multi-agency model for managing high-risk violence fascination. This should include a single nominal chronology, a living shared risk assessment, structured escalation thresholds, a named lead agency, mechanisms for challenge and review. The protocols should mandate that cases are not closed to an agency merely because that agency has completed its action. Closure should require evidence that overall risk has reduced or is being actively managed by another agency.

4.9.2. The second implication is that digital enquiry should become a normal consideration in cases involving violence fascination, serious threats, weapon interest, extremist or grievance material, or unexplained deterioration. This does not mean indiscriminate surveillance. It means that where lawful powers, consent, safeguarding duties or criminal investigation permit, online behaviour should be triangulated with family, school, health, police and social care information. Refusal to permit proportionate checks, deletion of

material, concealment or use of anonymising tools should all be treated as red flags elevating risk.

4.9.3. The third implication is that agencies need a shared language for risk to others, not only risk to self. Health services were often more practised at assessing self-harm than harm to others; police sometimes saw vulnerability and diversion rather than wider public protection; schools saw behaviour and concern but did not always have the authority or confidence to escalate without consent; and Prevent had to work within fluctuating policy boundaries. A common framework would not remove professional judgement, but it would make the basis of that judgement visible and contestable.

4.10. Overall conclusion

4.10.1. The common theme across the six case studies is cumulative risk without cumulative ownership. The subjects were different, their motivations varied, and their pathways to violence were not identical. Yet the same systemic problems recurred. Information existed in fragments, risk rose and fell over time, online behaviour was often unseen, specialist assessment was difficult, and agencies sometimes closed cases when the longer pattern required continued attention. The lesson is not that all such offending can be predicted or prevented. It is that the current system is not designed well enough to see the whole person, over time, across agencies, before the point of catastrophe.

5. Observations on policing and Prevent judgements arising from this thematic analysis

5.1. This section identifies the principal police-specific errors in judgement apparent from the thematic analysis of A-F, before setting out my observations. The purpose is not to criticise individual officers with hindsight, but to identify recurring judgement, process and system weaknesses that affected police decision-making in cases involving violence fascination, neurodiversity, online risk, vulnerability and risk to others.

5.2. Specific errors in judgement by police:

5.2.1. **Over-weighting vulnerability and under-weighting public protection**. In several cases, police decisions appear to have treated age, neurodiversity, vulnerability or previous good character as reasons to avoid prosecution, escalation or intrusive safeguarding action. That approach may have been compassionate and consistent with diversionary policy, but it sometimes placed the welfare of the subject above the risk posed by the subject to others.

5.2.2. **Insufficient professional curiosity before disposal decisions**. Decisions to take no further action, downgrade offences, use restorative justice, or refer to diversionary schemes were sometimes made without a full understanding of the subject's cumulative history. The central error was treating incidents as isolated when fuller checks would have revealed patterns of violence, weapon interest, online fixation, domestic concern or previous agency involvement.

5.2.3. **Missing the connection between lesser but still violent incidents and future use of lethal weapons risk.**

5.2.4. **Failure to take measures to prevent access to weapons**: including failure to test accounts, failure to seek wider records and consider open-source material, failure to apply sufficiently precautionary approach. Inadequate use of digital enquiry. Police digital investigation was often reactive rather than preventive. Where there were indicators of violence fascination, weapon interest, extremist or misogynistic material, threats, concealment, or online disclosure, proportionate digital enquiry should have been considered as part of risk assessment, subject to lawful powers, consent or safeguarding thresholds.

5.2.5. **Fragmented recording and weak information flow**. Police information sat across crime reports, intelligence records, Merlin or safeguarding reports, Prevent records, firearms licensing files and local systems. The absence of a single cumulative view meant that individual police decisions could appear rational on the fragment seen, while still being unsafe in the wider history.

5.2.6. **Failure to treat repeated low-level incidents as escalation**. Missing episodes, minor criminality, school assaults, domestic concerns, harassment, weapon interest and threatening behaviour were sometimes considered separately. The error was not always the decision on any one incident, but the failure to recognise repetition and escalation across time.

5.2.7. **Over-reliance on apparent cooperation or apparent normality**. Subjects who were intelligent, aspirational, employed, polite, compliant or willing to engage were sometimes treated as lower risk. This underestimated the possibility of disguised compliance, concealment and planned violence.

5.2.8. **Insufficient challenge of partner-agency assumptions**. Police sometimes appeared to accept that risk was being managed elsewhere, whether by health, social care, education, Prevent, Channel or YOS. The recurring unanswered question was: who owns the risk to others now?

5.2.9. **Operational failures in responding to victims**. This can compound victim and bereaved trauma, damage confidence and reduce the likelihood of future co-operation

5.2.10. **Insufficient trust-building with victims and families.** The case studies contain some evidence that further concerns were not reported because those affected did not believe the police would act meaningfully. Loss of confidence is itself a public protection risk because it prevents intelligence from reaching the system.

5.2.11. **Inconsistent understanding of violence-fascinated individuals.** Police and Prevent-related policing struggled with subjects who were dangerous but not clearly terrorist, not acutely mentally ill, and not yet prosecutable. This was particularly acute where motivation was mixed, unstable, unclear, misogynistic, satanic, incel-related, copycat or grievance-based.

5.3. Overall observations the Inquiry may wish to consider for its recommendations

5.3.1. Create a single nominal multi-agency chronology. Every high-risk VFI case should have one live chronology showing all agency contacts, incidents, referrals, decisions, closures and changes in risk.

5.3.2. Introduce a shared multi-agency risk **assessment.** Police, schools, CAMHS, social care, youth justice, Prevent, firearms licensing and health services should work from one common framework covering both risk to self and risk to others.

5.3.3. **Appoint a named lead agency for every complex VFI case**. There must be one agency responsible for ensuring that risk is actively owned, reviewed and escalated.

5.3.4. **Require closure decisions to evidence reduced or managed risk**. No agency should close a case simply because its own action is complete. Closure should state who now owns the risk and why it is safe to step down.

5.3.5. **Treat non-engagement as a risk factor**. Refusal by the subject or family to engage with CAMHS, CSC, Prevent, youth justice or digital checks should trigger exploration and review rather than closure.

5.3.6. **Make digital enquiry a standard consideration**. Where there is violence fascination, weapons interest, threats, extremist content, misogyny, incel material, self-harm content or unexplained deterioration, agencies should consider lawful digital enquiry or consent-based review.

5.3.7. **Strengthen firearms licensing safeguards**. Firearms and shotgun licensing should apply a precautionary public safety test, require robust medical follow-up, include social media or open-source checks, mandate family or household interviews where appropriate, and automatically trigger review after relevant police contact.

5.3.8. **Create automatic police-to-firearms licensing alerts**. Any certificate holder named as suspect, victim or relevant person in violent, domestic abuse, mental health, threat, stalking, harassment or weapon-related incidents should trigger automatic notification to the firearms licensing unit.

5.3.9. **Mandate deeper checks before diversionary disposals**. Before downgrading, taking no further action, restorative justice, youth diversion or pathway referral in cases involving violence, threats or weapons, police should always check relevant history and consider multi-agency referral.

5.3.10. **Develop a VFI escalation pathway outside terrorism**. There should be a clear route for dangerous violence-fascinated individuals who do not meet terrorism thresholds but present public protection concerns – perhaps a second Channel away from CT that still provides the same wrap around care to manage the risk.

5.3.11. **Clarify the Prevent and Channel boundary**. Prevent should not be expected to manage all VFIs, but mixed, unstable, unclear, misogynistic, incel, extremist or copycat ideology should be triaged rather than dismissed solely because it does not fit conventional terrorism categories.

5.3.12. **Improve police training on neurodiversity and risk**. Training should help officers avoid both over-criminalising neurodiverse people and under-reacting to serious risk because the person is vulnerable. It must be appreciated by the profession, officers and society that this is awareness only and the issues require complex long term clinical assessment.

5.3.13. **Improve training on disguised compliance**. Police and partner agencies should recognise that apparent calmness, politeness, aspiration or engagement does not necessarily mean reduced risk.

5.3.14. **Create a specialist multi-agency VFI panel**. A local or regional panel should bring together police, mental health, education, social care, youth justice, Prevent, firearms licensing and digital expertise for complex cases potential in a second Channel for non-terrorist cases.

5.3.15. **Ensure teachers' and families' concerns are weighted properly**. Schools and families see deterioration first. Their observations should be recorded, tested and incorporated into risk assessments. Positive bias should be tested. The child's voice is crucial and must not be dismissed as the case studies show missed self-declarations and potential calls for help.

5.3.16. **Give equal emphasis to risk to others**. Health and safeguarding systems often focus on self-harm. The framework must explicitly assess threats, fantasies, fascination or fixation, weapon access, grievance and harm to others.

5.3.17. **Introduce structured review after repeated low-level incidents**. Multiple low-level reports should automatically trigger a cumulative risk review, even where each event alone seems insufficient.

5.3.18. **Improve information-sharing law, policy and confidence**. Agencies need clearer guidance on when consent is not required because safeguarding, public protection or serious harm thresholds are engaged.

5.3.19. **Develop lawful monitoring options for high-risk cases**. Where there is no terrorism threshold, but serious concern exists, the system should explore civil orders, youth restrictions, licence conditions or other lawful mechanisms for monitoring risk.

5.3.20. **Preserve proportionality and civil liberties**. Any VFI system must avoid creating an indefinite database of children or vulnerable people without offence history. It must include thresholds, necessity, proportionality, review and exit routes.

5.3.21. **Improve victim and family confidence in police action**. Police must ensure early reports of threats, domestic abuse, harassment and weapons concerns are taken seriously so that

teachers, families and victims confidence is not so undermined they stop reporting and escalating risk.

5.3.22. **Commission national analysis of prevalence and demand**. The inquiry should seek data on whether VFI-type offending, mixed ideology cases, youth violence fascination and online-enabled grievance violence are increasing, and what additional resources are required.

5.3.23. **Review the legal threshold for early intervention**. Consider whether current law leaves a gap where individuals are clearly moving towards violence but have not crossed the threshold for intervention outside terrorism legislation.

5.3.24. **Build a joint assessment model similar to counter-terrorism practice**. For the highest-risk cases, adopt the discipline of joint intelligence assessment, trigger-point monitoring, escalation planning and executive action options used in counter-terrorism case management.

5.3.25. **Use the central test: who owns the risk now?** Every meeting, referral, disposal and closure should answer the same question: who is currently responsible for understanding, reducing and monitoring the risk to others?

6. The learning from AR (Southport Inquiry Phase 1 volumes 1 and 2) as it relates to policing

6.1.1. This section compares my analysis of AR and The Southport Public Inquiry Phase 1, and my observations of its chapters 7 and 8, specifically his interactions with police and Prevent, against the thematic analysis at sections above, and the police-specific learning identified from A–F.

6.1.2. The purpose is to identify whether AR is an outlier, a confirmation of the wider pattern, or a case that exposes a particular weakness in the Prevent and policing interface.

6.1.3. In my view, AR is not an outlier. He is the clearest example in the material of the same cumulative risk problem seen across A–F, but with a particularly important Prevent dimension: the system saw enough to refer, assess and reconsider him, but did not hold the risk long enough or cumulatively enough to prevent escalation.

6.2. Overall picture

6.2.1. AR's case demonstrates the central section 5 thesis: the danger lay not in one characteristic but in the accumulation of factors over time. The relevant picture included autism, social and communication difficulties, isolation, school difficulty, violence fascination, interest in notorious attackers, online exposure, possible grievance, risk to self, risk to others, and repeated contact with statutory systems. That combination mirrors the wider case studies.

6.3. Similarities with thematic analysis of A-F at sections 5 & 6

6.3.1. The first similarity is cumulative risk without cumulative ownership. A-F repeatedly identifies that information existed in fragments across different agencies and that no single system held a complete living picture. AR's Prevent and police history illustrates precisely that problem. There were referrals, assessments, contacts and decisions, but there does not appear to have been a single, longitudinal record that forced each agency to ask whether the totality of the information showed escalation. The system responded to episodes; it did not consistently manage the trajectory.

6.3.2. The second similarity is the relationship between neurodiversity, vulnerability and public protection. Across A–F, autism, ADHD, ODD, conduct disorder or suspected co-morbidities, are not treated as causal explanations in themselves. They are relevant because they may increase vulnerability to obsessive interests, online grooming, social isolation, bullying, grievance, rigid thinking or difficulty with emotional regulation. AR fits that pattern. The danger in his case was not autism; it was autism interacting with violence fixation, online material, grievance, disclosure, and planning. The police-specific analysis in section above repeatedly warns against over-weighting vulnerability to the point that risk to others is diminished. AR is a direct example of that warning.

6.3.3. The third similarity is online concealment and the need for digital enquiry. Across A-F there is harmful online conduct and this was often where the strongest evidence of fascination even fixation, mobilisation or fantasy lay. AR reinforces that theme because the Prevent and police assessment could not safely be made without understanding the online picture. The later discovery or assessment of digital material is therefore not incidental; it is central. AR, like several of A–F, demonstrates that an apparently ambiguous presentation in the community can become far more serious once online research, downloads, searches, communications, manifestos, attack material or weapon interest are examined.

6.3.4. The fourth similarity is disclosure or telegraphing. Section 5 notes that several subjects hinted at, disclosed or confessed violent thoughts before their offences or before decisive intervention. AR's case is consistent with that pattern. The critical point is that such disclosures may look like distress, adolescent fantasy, attention-seeking, mental health presentation or a cry for help. They may be all of those things and still be relevant to public protection. A system that separates safeguarding from threat assessment risks misreading precisely the warning behaviour it needs to understand.

6.4. Comparison with the police elements of case studies A-F thematic analysis

6.4.1. The police-specific analysis in Case Studies A-F identifies several recurring errors: insufficient professional curiosity, fragmented recording, under-use of digital enquiry, over-reliance on diversion or safeguarding, and failure to identify who owned the risk to others. AR's case engages each of those points. The question is not whether officers or Prevent practitioners acted in bad faith. The more important issue is whether they had the structure, information, training, policy clarity and confidence to treat AR as a cumulative public protection risk as well as a vulnerable child.

6.4.2. Where AR differs from some of the A–F cases is that his case sat much closer to the formal Prevent system from the outset. In some of the other case studies, particularly those without a clear ideology, agencies struggled to know whether Prevent was engaged at all. AR's difficulty was different. Prevent was engaged, but the interpretation of mixed, unclear and unstable (MUU) ideology and violence fixation appears to have been too narrow or too transient. The case therefore exposes not only a referral gap but an assessment, retention and escalation gap. A case can enter the Prevent orbit and still not be managed effectively if the risk is viewed episodically or if autism is treated as an alternative explanation rather than a factor increasing vulnerability and risk. Similarly a subject can be referred to prevent by those with a statutory duty because they feel it fits a criteria that Prevent professionals disagree with, but that judgement of whether it meets the threshold test for Prevent and Channel is not consistent amongst the national security professionals in the same region let alone those assessing cases in other geographic areas. A lack of consistency creates a post code lottery for whether a subject enters Prevent and Channel or even whether they are referred in the first place. Better training and less ambiguity are clearly required.

6.4.3. AR also supports the thematic analysis conclusion that police action may sometimes be the only way to safeguard both the individual and the public. The later police action in AR's case in the school hockey stick attack assault, namely arrest, investigation, seizure and digital forensic submissions, — shows the value of intervention once a criminal threshold is reached. It also shows the catastrophic limitation of waiting until that point and then not taking what you've discovered and recognising that what you have is a massively increased risk. A police response may be operationally correct when an acute threat becomes apparent, but by then the system may have missed opportunities to understand and manage the trajectory earlier and it may be too late. One case study demonstrates what risk can be averted if the initial information is treated seriously and positive police action takes place.

6.5. Differences from case studies A–F

6.5.1. There are also important differences. AR is more central to the Inquiry because his case is the anchor against which A–F are being tested. The other case studies are comparators; AR is the case through which the adequacy of police, Prevent and wider multi-agency systems is most directly examined. His Prevent history therefore carries particular weight. It tests whether the post-2019 understanding of VFI and MUU ideology was sufficiently clear, embedded and operationalised.

6.5.2. AR also differs from Case C and Case F because there were more obvious pre-offence opportunities to identify risk through Prevent or safeguarding routes. Case C appears to have concealed much of the most serious risk until after the offence. Case F involved an adult firearms licensing failure and a later acute escalation. AR, by contrast, involved direct Prevent relevance (in that some statutorily obliged Prevent referrers thought it appropriate, and some if not all national security professionals agreed), violence-fascinated material, explicit concern, and opportunities for police and Prevent to view the case through a public protection lens. For that reason, AR is less a case of complete invisibility and more a case of insufficient cumulative interpretation.

6.5.3. AR differs from Case E because the case was less dominated by a long-standing, highly visible pattern of severe behavioural disturbance from very early childhood – pre-primary school age. Case E's risk to self and others was repeatedly visible through aggression, self-harm, school incidents, missing episodes and youth justice contact. AR's case appears to have had a more distinct Prevent and online violence-fascination profile but the deterioration in his behaviour manifested later on after he started high school. That distinction matters because it shows that a VFI pathway may be obvious through behaviour in one case and more visible through ideology, online material and disclosed fascination in another.

6.5.4. AR also differs from Case D in timing and context. Case D involved a long history of CAMHS, school, social care and Prevent contact, with concerns stretching back many years and complicated by satanism, extreme right-wing material, suicidal ideation, ASD and later misogynistic violence. Although AR's case has a similar history of multi-agency support, the mistake is more sharply focused on whether Prevent and policing recognised the significance of violence fixation and the study or glorification of previous attackers. However, both cases share the same difficulty: a disturbing interest may sit at the edge of terrorism, mental health, adolescent grievance and criminality, allowing each system to conclude that another system is better placed to manage it.

6.6. Conclusion

6.6.1. The overall conclusion is that the case of AR confirms rather than contradicts the thematic analysis of A-F in section 5 and police-specific analysis in section 6. AR's case shows the same recurrent features; cumulative but fragmented information; neurodiversity interacting with vulnerability and risk; online violence fixation; disclosure or warning behaviour; uncertainty about ideology; uncertainty about whether Prevent, MASH, local policing, health or youth justice should lead; and an unresolved question of who owned the risk to others. The difference is that AR's case places those issues directly inside the Prevent and policing interface even though it was not accepted as such at the time by narrow threshold definitions and inconsistent interpretation of what should and should not be accepted into the Prevent and Channel pathway. **It therefore demonstrates most clearly why a wider front door, a single nominal chronology, a shared risk assessment, named risk ownership, lawful digital enquiry, and clear escalation thresholds are required**.

7. Issues relevant to Phase 2

7.1. Policies, roles, bodies, and multi-agency systems applicable to the way in which your area of specialism handles violence fascinated individuals

7.2. The inquiry should undertake a review of National Police Chiefs' Council (NPCC) Authorised Professional Practice in the areas of Multi Agency Public Protection Arrangements (MAPPA), Multi-Agency Safeguarding Hubs (MASH), Multi-Agency Risk Assessment Conferences (MARACs) to safeguard abused partners, Local Authority Community Safety Partnerships (CSPs) and troubled families programmes, and Violence Reduction Units (VRUs). None have been specifically established to deal with VFI, which is a relatively new

concept, but all encompass the basic principles of multi-agency co-operation and their role in planning, information sharing, decision making and the unique role of policing as it relates to violent offending. They have a read across to the Prevent and Channel programmes in Counter Terrorism, pre-existed current CT processes, and informed their development.

7.3. I adopt DAC Vicky Evans and Director of Prevent Cathryn Ellsmore's statements on the history and mechanics of Prevent. Duplication would be a waste of time, but I can make some observations on the system and potential improvements that could be made in relation to learning from AR and Case Studies A-F, which I make below. If necessary and on request I am prepared to provide my detailed analysis of those statements made to the Inquiry by these Prevent professionals alongside Lord David Anderson's review, but I broadly concur with them so would like to adopt them. My general thoughts are incorporated in the body of this report, and again, I hope they will find them consistent.

7.4. A proposed model for dealing with violence fascinated individuals (VFIs)

7.4.1. The following sections also try to deal with the letter of instruction subcategories in these specific areas:

7.4.2. VFIs and Risk Pathways

7.4.3. Identification, assessment, management and intervention

7.4.4. Inter-Agency working, safeguarding and information sharing

7.4.5. Online influence, access to material and enabling factors

7.4.6. There is no current system to deal specifically just with VFIs given this is a new term that only recently replaced violence fixated individuals – itself a relatively modern term - in the national security lexicon. There have always been violent individuals, child and adult, capable of committing atrocities, which society has long found difficult to explain. Those individuals have found inspiration, incitement, and instruction online in recent years, and it has driven an increase in this cohort which is also younger.

7.4.7. I have seen a rise in violent offending by a younger cohort since my days in Trident 2003-2006 and organised crime 2006-2008 and later 2014-2015 but most alarmingly within CT from 2015-2021, and in current media reporting now I sit outside the community. I also see statistics that show a correlation between the rise of social media applications and smartphone ownership since 2012, which I appreciate is a correlation and not proven causation. But given that every case I have seen in terrorism involves an element of online browsing, research, distribution, posting or engagement with others, I am convinced that the single biggest driver of violence fascination, radicalisation and extremism is the internet and our collective inability to police its content.

7.4.8. The drivers of violence fascination I think are best described by the national security system in its previous terminology of 'mixed unclear and unstable' ideology or MUU, compounded

by those who perhaps have no ideology at all except nihilism and a want to kill. There are perhaps too many systems dealing with violent offenders and too many different types of risk assessment and diagnostic assessment. It is certainly clear from AR and these six case studies and the Joint Terrorism Analysis Centre (JTAC) (HOM000539) document that examined 16 case studies, some duplicated in Phase 2 of this Inquiry, that no single agency can manage this relatively new and increasing problem.

7.4.9. That does not mean that current systems have no merit and there is no need to go back to the drawing board. In fact, that may be a mistake. The national security mechanisms specifically relating to the identification and interdiction of terrorists and potential terrorists – perhaps they could be described as violence fascinated individuals with an ideological cause - are the Prevent and Pursue systems.

7.5. Prevent

7.5.1. Prevent and the Channel Programme are voluntary and require consent either of the individual, or if a child, their parent or guardian. Mandated programmes of desistance and deradicalisation can only be prescribed post-conviction but have for some years been considered part of the Prevent system, undermining the strap line that it is a 'pre-criminal' pillar of CONTEST reliant on voluntarism.

7.5.2. Prevent has been described in detail by the Director of Prevent Cathryn ELLESMORE and the SNC of Prevent and Pursue DAC Vicky EVANS in their statements to this Inquiry. That is a much more fulsome and accurate description of the current system than I can give, and again, I don't seek to duplicate it here.

7.6. Pursue

7.6.1. Where a Subject Of Interest (SOI) to MI5 has been identified and declared by them as a potential or active terrorist that requires a covert investigation, the mechanism that manages them is the Pursue system described above.

7.6.2. Both Prevent and Pursue are mechanisms relevant to the management of non-terrorist VFIs where the ideology does not exist or is MUU – essentially those simply absorbed and fascinated by violence in whatever form and seemingly interested in committing a violent act. Nihilists may be the correct term.

7.7. Observation – non-ideological VFIs and Prevent

7.7.1. The contentious issue is what to do if Prevent and Channel will not take an individual who has not shown any vulnerability or susceptibility to being radicalised into terrorism? The system developed by MI5, CTP and the Government in Prevent and Pursue can be used or replicated to manage these individuals. But that raises fundamental questions.

7.7.2. Could you change and widen the definition of terrorism, simply making violence fascination an ideology in its own right?

7.7.3. Could you make violence fascination when ascribed to research, planning and preparation for a mass killing motivated by school shootings, a terrorist ideology?

7.7.4. Could you define Incel and the research, preparation, and planning of violent misogyny, including rape and murder, a terrorist defined ideology?

7.7.5. Would these simple changes to the Terrorism Act, through secondary legislation, expanding the definition of terrorism be the answer?

7.7.6. I would defer to the Independent Reviewer of CT Legislation, currently Jonathan Hall KC, whose report pre-dated Phase 1 and can be found at "Independent Review on Classification of Extreme Violence Used in Southport Attack on 29 July 2024" (ILT000100) and can be found here: https://terrorismlegislationreviewer.independent.gov.uk/wp-content/uploads/2025/03/IRTL-extreme-violence-review-13.3.25.pdf.

7.7.7. My opinion is that I don't think so. The problem is that as much as we want to describe these acts of horror as acts of terrorism, they are not. In all their horror they are not committed in order to advance a cause currently stated in terrorism law as political, religious, racial, or ideological, (the latter is an unhelpful vague and ill-defined term admittedly). Nor are they committed to advance those causes in order to influence a government, another state body, or a section of the community.

7.7.8. These are our legal foundations for declaring terrorist acts which are so fundamental in their potential effect on our society that extraordinary powers, well above and beyond those available to normal law enforcement, are given to both the UK intelligence community (UKIC) and CTP in order to try and identify and stop these offenders before they act. To try and squeeze in a larger cohort of potential offenders either for their 'criminal thoughts', or for admittedly horrific but not society changing acts, could have three serious consequences.

7.7.9. The first is to put massive pressure on the current CT system. It could create a far larger haystack in which to find the needle that really counts and prevents the identification and interdiction of that individual or cell whose design is to bring down a government or change society. That missed opportunity would be because limited investigative resources are diverted trying to identify a deeply disturbed individual with no real cause at all, whose act may be equivalent in methodology and casualty count to a terrorist attack, but does not have the same psychological or economic impact on wider society. I appreciate that is at odds with the sentencing remarks in R v AR and the fact that it is those remarks and public pressure that may led to debating this momentous shift in the operating model.

7.7.10. Identifying these people using covert methodology, when much of the behaviour is hidden online, is a massive task, as is demonstrated by the current Pursue machine's workload. It raises issues of potential mass population surveillance to find those engaging in forums or browsing material that is both illegal and legal but harmful. The large numbers that would identify, all requiring secondary investigations to triangulate their activity and risk,

could overwhelm the system. This diversion would be a terrible derogation of the national security system's duty to defend the realm.

7.7.11. The second is to give exactly the type of infamy that some of these individuals seek, by directly associating them with the national security system. They would glory in the title of terrorist and their pursuit by MI5. Others would be inspired by them and copycat the additional notoriety this gave them.

7.7.12. The third and final consequence would be that the powers that are necessary to intervene early in somebody's thought processes in order to divert them from these acts, stigmatising though this disturbing research and planning is, would add the stigma of suspicion of terrorism to their behaviour and record. The potential long term ramifications for their life, should they be able to rehabilitate through treatment, would be grave.

7.7.13. Despite these reservations I believe we should use the current systems we have, but in common with Lord David Anderson KC's Prevent Review HOM000079, I support the idea that we should 'widen the front door.' At the first point of assessment there then needs to be a competent investigative system capable of triaging the individual and deciding how they should be managed.

7.7.14. It should not be forgotten that even those individuals who are not accepted through the Prevent Gateway Assessment into the Channel programme for support should, if they have got that far, be diverted through local authorities and their MASH's into the same support services, whose only missing element is the ideologically experienced or trained Intervention Provider that Prevent provides.

7.7.15. Even that role might be fulfilled by good adult mentoring, which is essentially what an Intervention Provider is providing. The problem as Anderson recognises, is that the MASH system is neither consistent, well resourced, or necessarily effective across the UK. The danger therefore is that if Prevent and Channel cannot deal with the individual, and should not for the reasons outlined above, a dangerous handoff occurs to a system that is either equally under pressure or not as effectively joined up. I suspect that the MASH system is already under far more pressure by volume than the Prevent and Channel system is.

7.7.16. The majority of Channel services are exactly the same services required for a Prevent VFI individual as are required for a non-Prevent VFI individual. As Anderson recognises, the wider front door should probably be located in a local authority safeguarding hub as the single repository to triage the system with MASH colleagues conducting that initial triage as they have access to the full story of that subjects interaction with the state.

7.7.17. The CTCO will have access to all relevant counter terrorism systems through their local Field Intelligence Management Unit (FIMU), and the MASH should have access to every other non-security and law enforcement system that might hold data on the individual.

7.7.18. This intelligence gathering on the individual should not remain on multiple separate systems. In terrorism it is updated on the Police Case Management Tracker (PCMT)

database. Even if the risk is too high for Prevent or the individual, or their appropriate adult refuses consent, CTP can still decide to manage an individual on the PCMT through the so called Police Led Partnership or PLP.

7.7.19. What single system would hold all of the records for an individual who has not been accepted into Prevent or PLP? This appears to me to be the significant weakness of the current system because there is no single place, no single report, that would provide an entire history of an individual's touchpoints with the state. If there was then Case Studies A-F would have been simple to review and this report would have taken a fraction of the time to construct. For any public inquiry, the accountable agencies and individuals and systems that worked or did not work would be much more transparent too.

7.7.20. There is also no single living risk assessment understood by every one of those agencies providing that touchpoint.

7.7.21. The multi-agency meetings that take place now, whether they are Channel, MASH, MAPPA or any other multi agency process, are meetings designed to share information that could already be known to the participants of the meeting if they were vetted and had access to that single record and risk assessment that's been regularly updated by whichever agencies have touched the subject's life.

7.7.22. They could familiarise themselves with it before they attended the meeting. The meeting would therefore be more focused on determining a. who was in charge, b. which agency takes the lead, c. what the action plan and trigger points are going to be, and finally d. the red line that must not be crossed before some form of executive action needs to take place.

7.7.23. Given the pressure on those meetings in terms of time and participation this would be a far more effective use of time and resource and would be far more likely to produce a holistic assessment of the individual.

7.7.24. If the record was accurate and detailed (a problem in itself), it would also minimise the risk of not having consistent agency individuals at the meeting. Whoever attended, provided they were experienced, would have access to the full intelligence picture through that single record without reliance on a potentially diluted verbal handover. More importantly it would not just be narrowly confined to their own agencies records and assessment of the individual, but everyone's.

7.7.25. This is a relatively small tweak to an existing system of multi-agency partnership work. It is simple to say but would be difficult and expensive to deliver. It is also difficult culturally, as every agency has its own subjective view of risk, of what confidentiality means, of when to share, of how to maintain the trust in its relationship with individuals and their families, and this would all be affected by a single system and a single record.

7.7.26. I also suspect it would be fearsomely expensive in terms of the information technology ask. It would require an artificial intelligence overlay capable of aggregating data, much of

which could be unclean, being misspelt or in the vernacular of different agencies. Too complex perhaps to ensure a fully accurate, coherent, readable picture. That could create risks of its own even before the interpretation of the aggregated data had contact with a human decision maker. But I believe that is not only possible but would be less prone to errors than the current system reliant on multiple human interventions. It would however invite civil liberty scrutiny. The ability for one agency to access the data gathered from every state touchpoint with a subject would be controversial – certainly if it was CTP or UKIC, but perhaps less so if it was the Chair of the Local Authority Safeguarding Board managing the subject. It would require careful consultation whatever system was introduced if this database aggregation was considered a potential solution to the better management of risk.

7.8. Observation – system pressure

7.8.1. The Inquiry should be cognisant of making recommendations that put extra pressure on multi-agency teams to meet more consistently and more frequently and to discuss more cases, if it does not also warn against the additional risk it will impose by not resourcing that operating model effectively.

7.8.2. I wholly accept an effective Multi-Agency response is absolutely necessary and the best way to manage complex risk holistically, but it will need better information technology, more human resources that are better skilled, experienced, consistent members of those panels, and absolute trust between partners in sharing information knowing that that they are protected by law, and that sharing is fundamental to the very reason they are meeting – to protect or safeguard and individual AND the public from that individual.

7.8.3. I say this because I have no doubt (and this is repeated in Lord Anderson's Prevent Review), that as the result of the Inquiry's first report on AR, compounded by the globally successful Netflix hit 'Adolescence,' the type of MUU VFI that, pre-2019, would not have been consistently referred to Prevent, are now being referred en masse as a 'safety first,' risk averse approach.

7.8.4. This understandable reaction amongst Prevent referrers will be flooding the assessment and triage system of CTP policing, its FIMUs who deconflict the subject from other law enforcement activity and putting pressure on CTP's limited cohort of CT Case Officers (CTCOs) and their partner Local Authority Prevent Coordinators, Panel Chairs and Panel members.

7.8.5. I have publicly stated this approach could overwhelm the system and dilute the Prevent system as it was designed. I read that the Prevent system had 6,922 referrals in the 2023/24 year, broadly equivalent to the number on my watch. In 24/25 the number was 8,778 – a 27% increase. The latest report for 25/26 is not yet available at the time of writing, but a rolling 12 month figure to September '25 showed it to be 10,293 with a clear surge in extreme right wing cases (XRW) now taking up 20% of the case work. This rolling figure, (reported on www.gov.uk and in The Guardian on the 6th of August 2026), is a massive 39%

increase from the previous 12 months and as usual, around 78% are being triaged out of the system.

7.9. Observation – system resourcing

7.9.1. How safe is that triage if the system is overwhelmed? What risks lie in the 78% of subjects triaged out of Prevent? Has the government, policing and other Prevent partners increased the system resources by 40% to cope with that 40% increase in demand? The Inquiry should ask.

7.9.2. The danger of this approach was mooted by Sir William Shawcross in his 2023 Prevent review, who stated that Prevent should get back to basics and concentrate only on those individuals with an identified ideology. The Government accepted all the recommendations. It should not have accepted this one. I disagree with Sir William. MUU ideologues are a growing part of the case work and have been since 2017. They have to be addressed. As ACSO, I wrote to government before June 2019 to make that point and this resulted in the network wide joint letter from my national Prevent Co-ordinator DCS Nik Adams and the Home Office Director of Prevent, Sarah Skodbo dated 25 June 2019 (CTPHQ000134).

7.9.3. This letter was referenced in Phase 1 of the Southport Inquiry , and seen by some as ambiguous, given that AR was not accepted at his first Prevent referral when he should have been. I agree. But I read the letter to mean that MUU individuals with a violence 'fixation,' (the 2019 terminology), should be considered for Prevent referral and potentially as a Channel subject, But it needed greater clarity. The addition of this MUU ideology being seen as 'a vulnerability to being drawn into terrorism' may be the issue as if the CTCO makes a judgement that terrorism is not engaged at the point of referral, they would probably not accept the referral without greater clarification. It is the MUU ideologies that create the vulnerability that's important, not whether you think they could be drawn into terrorism at some point in the future. Quite frankly who knows at that point? I accept that the letter could have been misinterpreted and that audits had not been carried out sufficiently swiftly to the system's understanding. If it was hard for policing to interpret it would have been even harder for other referrers with the same Prevent duty.

7.10. Observation – open Prevent front door to VFIs

7.10.1. Participants should be able to move between the two Channels if a clear ideology is identified by partners as the case develops or is indeed dismissed. I note that one of the only differences in the kind of specialist intervention required with CTP Prevent referrals is the skills of the particular Intervention Provider. It may also be that those expert partners in Health and Social Services have Psychiatrists and Clinical Psychologists with greater expertise on extreme violence, crime and CT related offending. I accept that both Channels are going to create pressure on these agencies and resources would have to concomitantly increase there as well as in law enforcement Regardless of the construct, both Channels would need greater resources, especially in those health related disciplines.

7.11. What systems currently exist for dealing with violence fascinated individuals.

7.11.1. I will try to briefly summarise the options open to policing today though there are those more qualified. If the child has not been convicted of an offence the responsibility will be shared between the police and the youth offending service (YOS) through early intervention and civil frameworks.

7.11.2. Without a conviction, no formal criminal sentencing options like a court ordered tag are available. But there are non-conviction tools available. For example, the YOS has prevention and diversion schemes designed for children at risk of offending or entering the justice system. They can assess and enrol a child in localised crime prevention or diversionary programmes, such as the Pathfinder programme evidenced in case study F. Where a child comes to the attention of police for an offence and has not been prosecuted, as in AR and case study F, the police can seek a community resolution including restorative justice.

7.11.3. If there is persistent antisocial behaviour that causes harassment alarm or distress, a feature that might be frequent in low level aggressive behaviour that might be a precursor for future violent offending, civil injunctions can be sought by either the police or the local authority at the youth court. Any applicant has to consult the YOS before applying.

7.11.4. Those injunctions can impose strict restrictions including curfews and exclusions zones as well as positive requirements such as attending support sessions. The court will designate an individual or an agency, who are frequently youth or social workers, to supervise and monitor the youth's compliance. Although breaking a civil injunction is not a criminal conviction for young offenders between the age of 14 and 17, it could lead to a civil detention order. It is at least a measure of control in the community and may be underutilised.

7.11.5. Prior to a legal injunction the police and local authority will more likely seek an Acceptable Behaviour Contract. This is a voluntary written agreement made between the child, their parents, police, and local agencies. The local police team and YOS actively monitor the child's compliance with the rules laid out in the contract. As with Prevent this relies on voluntary cooperation and engagement with those services. Any refusal to engage after the contract is signed should be seen as a breach of that contract and a red flag for future behaviour. Again, I suspect this is under-utilised.

7.11.6. If the child exhibits high complex, high risk behaviour that crosses multiple safeguarding thresholds as is evident in case studies AR and A-F, then a dedicated multi-agency approach is essential. Such a fixation as obsessively consuming violent material, violent gaming, browsing illegal extremist, or exploitative material, or even legal but harmful material inappropriate for their age group, is a red flag. If it is accompanied by escalating aggression, including physical violence towards fellow pupils, teachers or adults, and temporary or permanent exclusions, then an intervention is imperative.

7.11.7. There then has to be close co-ordination between the school's Designated Safeguarding Lead (DSL), the police, Children's Social Care (CSC), and the YOS. Various frameworks can handle this coordination.

7.11.8. The first is the multi-agency safeguarding hub (MASH), which is reached through a CSC referral. A child who comes to notice of police through routine investigation either in response to emergency calls in an acute threatening environment, long term investigations into offending either against or by the child, or as a peripheral part of an investigation into parents, siblings or other guardians or adults around the child, should result in a report to the local authority. These are known as Merlin reports and is a UK wide system of police referral to CSC. In my operational career, Merlin reports were sometimes overlooked by officers as bureaucratic when the call was not directly relevant to the child, meaning family history and risk assessment could be diluted.

7.11.9. Merlin reports should contain detailed information of why the child is considered at risk or a risk to others including detailed observations and comments including hearsay on what the child has been exposed to or done. The danger is that this material can easily become diluted by summarising or paraphrasing other people's intelligence or information sacrificing accuracy for brevity and speed.

7.11.10. It is common for the local authority to be the chair of the MASH and so the Merlin is the first referral point into CSC who will make a determination on what support services are available to the child and or the parents.

7.11.11. In this scenario a level of aggression and isolation indicates potential trauma, exploitation, or severe behavioural conditions. For a child this kind of adverse childhood experience is well known as a potential precursor to further behavioural problems and even criminal offending into adulthood.

7.11.12. CSC should refer this level of child at risk to the MASH. That referral triggers a statutory multi agency assessment to look at the family and any underlying causes that are putting the child or the people around the child at risk.

7.11.13. The second framework is Prevent, the first pillar of the governments counter terrorism strategy called CONTEST described above. A referral to Prevent is a duty under the Counter Terrorism and Security Act 2015 for certain state services including education, health, and the police. It is voluntary for other state sectors, the private sector, and for parents and friends. Referrals can be made from those individuals, but the number is very low. It is a weakness in the system. The bulk of the referrals – over a third each usually - are from education and policing.

7.11.14. It was only following the realisation in 2019 that Prevent was closed to individuals who had a fixation on violence or mass casualty events, but did not have an ideology as defined by the s1 Terrorism Act 2000, that an attempt was made to educate the Prevent system that even when ideology was mixed unstable or unclear (MUU) then VFI (then violence 'fixation' rather than 'fascination'), and an interest in mass casualty attacks, should still be

considered for Prevent and the usual Prevent Gateway Assessment process should occur. This was the purpose of the letter in June 2019 referred to above, written and co-signed by the then Home Office Director of Prevent and the National Coordinator of Prevent for CTP, to the Prevent system network.

7.11.15. Today, in 2026, violence fascination and/or obsession with mass casualty events, paired with downloading or watching illegal or extremist content online, meets the direct criteria for a Prevent referral in the UK. But there may still be occasions where this is being inconsistently applied and Prevent is being closed to those individuals. This can be seen in the case studies where it can sometimes take multiple Prevent referrals before the individual is accepted, or they are too quickly closed.

7.11.16. What should happen, is their school's DSL or a police officer should complete a Prevent referral form. CTP's specialists, the counter terrorism case officers (CTCOs), then screen the referral if there is an ideological driver or a violence fascination. First it will be run through the CTCO's local CTU FIMU to deconflict the subject of the referral from any ongoing police operations. If there is no conflict, the CTCO will make the decision not to proceed or to escalate to the local Channel panel.

7.11.17. It is important to remember that Channel is a voluntary process that provides tailored mentoring, anger management, and psychological support to de-escalate the fascination with violence before it becomes a criminal act. The unique nature of Channel is its access to Intervention Providers who have experience or specialisms in dealing with the kind of terrorist ideologies that are most common. The most common ideology was and remains Islamist terrorism, which remains by far the predominant source of terrorist acts within the UK too, but has been joined by a growing number of individuals interested in or fascinated by extreme right wing ideology (XRW), as well as what was called left wing anarchist or single issue terrorism (LASIT).

7.11.18. I am aware this terminology may have changed and as I said I adopt DAC Vicky Evans and Director Catherine Ellsmore's statements to the Inquiry, who detail the current Prevent system far better than I can.

7.11.19. Regardless of whether the framework used is MASH or the VFI is accepted for Prevent, low level criminal activity by the subject should not be ignored or minimised. It represents violence offline mirroring violence online. If adults, either parents or teachers, report common assaults or worse to the police, the police are still unlikely to rush to prosecute a child following decades of understanding that criminalising a child was also an adverse childhood experience that could lead to problems in adult life. Current NPCC policy and guidance seeks to avoid criminalising children.

7.11.20. Police are more likely to seek an out of court disposal issuing a youth diversional community resolution, but it is important that this is recorded and available to other agencies in case there is repeat offending in the future. It should not become normalised behaviour that low level offending can be repeatedly dealt with this way. In fact, it is policy

that repeat offending would be an aggravating factor that should prevent such lenient case disposal of an allegation.

7.11.21. Nevertheless, if referred to the YOS as an out of court disposal, YOS are capable of delivering mandatory or voluntary intervention programmes focusing on aggressive behaviour, the setting of boundaries, the reality of violence versus online content, given some of these case studies demonstrate that at a younger age some of the perpetrators fail to distinguish between fantasy and real life, and programmes on weapons and assault awareness.

7.11.22. In my history these latter programmes have been controversial depending on how they are delivered, as some psychologists have seen demonstrating the consequences of violence and weapons in graphic ways as equally traumatising for children and not necessarily constructive in diversion.

7.11.23. I'm not qualified to say whether or not this is still the case as my experience dates back to my years as a homicide detective on Trident 2003-2006. I suspect we are far better at this now and investing in these programmes is taking on increasing importance if properly written and delivered.

7.12. Observation – managing online harm in education settings

7.12.1. There are also school led alternatives to total exclusion, given that exclusion is definitely an adverse childhood experience that has been seen to be a relevant risk factor in future offending and again is present in the case studies. Repeated exclusions that fail to curb behaviour and remove the child from the school are only likely to increase their time alone online being exposed to illegal or legal but harmful content – something I predicted would happen with adverse consequences as a result of the COVID pandemic lockdowns, which may also be present in the case studies. Social isolation is a theme.

7.12.2. In this case the school, as is evident in these cases, should seek alternative provision through a special educational needs assessment to a specialist school, or through to a pupil referral unit, both of which will have a higher staff to pupil ratio and on site therapeutic support. This does happen in some of the case studies.

7.12.3. There must be a strict risk assessment put in place both to protect teachers and fellow pupils which could include restricting the child's access to IT systems at school and helping in their transition. Two of these case studies show that teachers were observant in spotting children accessing inappropriate content on the school's systems. It is noted that the Department for Education has issued guidance for schools on how they can better protect their systems from making this material available.

7.12.4. I am not qualified to assess whether that has been widely taken up or is successful. But it is incredibly important that children's access to that kind of online material is restricted as we know that platforms have reduced their moderating guidelines and consistently failed to implement systems to keep children safe despite global condemnation.

7.12.5. There is currently civil litigation in the USA and Australia, and progressive legislation in Australia banning social media for under sixteens. The idea is spreading to other jurisdictions. The 2023 UK Online Safety Act 2023 is pivotal to this approach here. It will have to be vigorously enforced if it is to have any effect on major social media providers who continue to argue that they are not publishers but platforms, and therefore not responsible for content. I support an Australia type ban.

7.12.6. Big Technology has also relaxed their terms and conditions, reduced the resources they put into moderating content, and rely on illegal and harmful content being flagged to them from other authorities such as the Home Office and CTP, before they act.

7.12.7. They are passive and reactive in their approach, which I condemn. That has become widespread opinion resulting in major court cases; for example, the recent 32 US States class action against META just settled in the USA. That class action could be a useful precedent for multiple countries class actions against these platforms in order to force them to make them safer for children.

7.12.8. The settlement (£18 billion over 10 years in compensation for the class action applicants, many of whom will be bereaved parents), is less than 1.3% of META's capitalisation and 1% of its annual revenues. It is insufficient to deal with the problem we face. Not least because it only limits the amount of time in the day that children can access their products; it doesn't address the actual content.

7.12.9. No access overnight or during school hours, or even restricted to two hours a day, is still 2 hours potentially obsessing on violence, mass casualty attacks or extreme pornography or other violence related content including self-harm. If that content remains accessible that's two hours too much.

7.12.10. It is the content and the algorithms driving the content that needed to be dealt with, and this does not appear to be the case. It is also contingent on META's competitors agreeing to do the same, which since it isn't dealing with the real problem, has the potential to kick the real issue into the long grass for years to come. It looks like a win for social media tycoons not children. When the UK seeks to apply the USA precedent here, it will need to be much firmer in its approach.

7.12.11. The Inquiry may wish to note that in 2019, the five heads of counter terrorism law enforcement for the USA, UK, Australia, Canada, and New Zealand wrote to the major technology founding members of the Global Internet Forum on Counter Terrorism (GIFCT), asking for a meeting to discuss the effects of content on their platforms in the War on Terror. They refused to meet us.

7.12.12. A short time later the 'Five Eyes' countries respective Attorney Generals invited the same providers to meet in London at an event hosted by then Home Secretary Dame Priti Patel, and the UK Attorney General, Geoffrey Cox. I opened the event.

7.12.13. It precipitated the Online Safety Act 2023, which the same big tech providers then spent over 4 years lobbying to ensure it was watered down. They waged a very successful campaign to ensure that their operating model continues, and that operating model can be seen in AR and all six case studies and in the vast majority of every terrorists subject profile I have seen in my nearly seven years in counterterrorism. I cannot emphasise enough how important it is to this theme of online access that children are not exposed to this.

7.12.14. It is clear that not all children or vulnerable people are going to be affected or are even going to want to view this kind of material, but the fact is some do. That can have a devastating effect on those with other risk factors such as neurodiversity conditions, including the prevalent ADHD or autistic spectrum disorder diagnosis in the case studies, alongside potential comorbidities of other psychological conditions. This should be more than pause for thought.

7.12.15. The campaign to force Big Tech to change by law must continue. Any form of voluntary engagement has conspicuously failed. Corporate social responsibility has taken second place to shareholder value, and an alleged wish to put the privacy of their customer base before security, which is failing to accept the effect of some of its content on some of its customers, and then the effect of those affected customers' actions on wider society.

7.12.16. I appreciate that this is very contentious when it comes to free speech and certainly in the USA, the Holy Grail of the 1st amendment is the impenetrable wall behind which Big Tech providers stand, until recently almost uncontested.

7.12.17. It is perhaps not for law enforcement – even ex-law enforcement - to argue this point; it is for society and the politicians they elect. If we continue to be more interested in allowing almost anything on these platforms in the interests of free speech, rather than protecting the most vulnerable in our society, then we should also accept that we are taking the risk that its effect on certain individuals will lead to further atrocities. That is evidenced in AR and four out of the six case studies.

7.12.18. It is only early intervention in the other two case studies that prevented this being a 100% horrific study.

7.13. Observation – the importance of early intervention by law enforcement

7.13.1. Police officers who are assessing a child occupying this critical intersection between safeguarding, national security in terms of Prevent and CTP, and an early criminal justice intervention, will focus on early diversion, multi-agency safeguarding referrals, and civil disruptive frameworks. Their intention will be to stop an escalation into serious violence. But given the high risk cocktail of a fixation both on violence, illegal online content, and in these case studies, physical aggression against peers, teachers and parents, should invite the following immediate steps under the current architecture.

7.13.2. Filing a Prevent referral to initiate immediate national security screening.

7.13.3. Ensuring it's received by the local CTP Prevent team.

7.13.4. Ensuring that team has deconflicted the referral through the CT FIMU to ensure that the subject is not already known to CTP or is not already under active investigation by local policing, or under a current Prevent or Channel panel.

7.13.5. The CTCO then using the Prevent Gateway Assessment framework, whether or not the individual passes the tests for referral into a Channel panel.

7.13.6. Three key metrics must be met.

7.13.7. First, an ideological driver in that there is an identifiable narrative, whether it's Islamist, extreme right wing, MUU or violence fascination on mass casualty attacks under updated recent guidelines. A clear textbook ideology is no longer required for a case to progress if the fascination on mass violence is present and assessed as dangerous.

7.13.8. Secondly an intent and capability to cause harm. What harm would this individual cause to others or what harm could be caused to them via exploitation.

7.13.9. Third, vulnerability factors and their own agency in that the individual may have a psychological predisposition to exploitation.

7.13.10. In this case downloading illegal violent content online alongside offline physical violence, flags high intent and high risk. Additionally, the vulnerability factor of a neurodiversity condition or other mental illness, which might make the person vulnerable and susceptible to online radicalisation or extremism or nihilistic violence, is very relevant to AR and the six case studies.

7.13.11. If the CTCO decides the case does not meet the CT threshold it doesn't mean the risk is dismissed. The following operational protocol takes over. The CTCO will de-escalate to mainstream safeguarding where the vulnerability is deemed behavioural, mental health, or a social issue and not a potential terrorism risk.

7.13.12. In those circumstances the CTCO has to refer back to mainstream local authority services i.e. the MASH run by their local authority and also provide them with any intelligence gathered on the subject including digital intelligence.

7.13.13. This should also be provided to the schools DSL, for their protection and for their use in helping manage risk. Referrers must be updated on what is happening with the case they were concerned enough to refer. This updating is inconsistent in the case studies. The steps outlined here are notable by their absence in the case of AR.

7.13.14. Again, if there is a parallel criminal justice process such as a Youth Conditional Caution (YCC) for minor criminal offending, that intelligence must also be factored into the YOS assessment.

7.13.15. The overriding principle here is that the intelligence on the subject has to be fully disseminated to all agencies who may be able to help manage the risk, and if the risk is not being managed by CTP, it must be managed by those other agencies. Passing the risk back to parents and teachers alone is not, in my view, dealing with risk.

7.13.16. The risk may still be high, even if no ideological driver has been identified, in which case Prevent deescalates to what is known as the Police Led Partnership (PLP), which may actually be one of two processes.

7.13.17. The first is that the risk is so high it could not be managed by Prevent and the second reason is that the subject or their appropriate adult, does not consent. That could mean the subject effectively becomes of priority interest to law enforcement and potentially becomes a subject of Pursue.

7.13.18. Or it may mean that local policing rather than CTP take over the management of the child's risk under a Multi-Agency Public Protection Arrangement (MAPPA) style process, which could be available for children and adults even if they have not been criminalised by the criminal justice system. This is despite MAPPA originally being designed with statutory underpinnings for the post-conviction management of serious offenders. The gap allowing the MAPPA framework to be used for those not convicted or cautioned has been closed by the NPCC authorised professional practice policy of defining those individuals as Potentially Dangerous Persons (PDPs).

7.13.19. The final process that could be used is an Anti-Social Behaviour framework, which is a non-law enforcement process managed by the school and the local authority using civil restrictions.

7.13.20. An acceptance onto the Channel panel, upon which CTP will sit, and local policing should be invited, opens up access to specialist Intervention Providers with ideological, psychological, and in future I hope neurodiversity experienced mentors, that are able to talk to and potentially de-radicalise or de-escalate violent tendencies in the child, without criminalising them.

7.13.21. Any offending should be recorded and as a minimum an out of court disposal process initiated. Often the case will simply be closed with no further action. In high threat, high risk cases this is a mistake. The case studies show this, but there is some sympathy is that in the moment the offending does not look high risk, and certainly not without a complete picture of an offender stretching back potentially years. That may only be visible to their doctor, social worker, teachers or parents and perhaps not to all these agencies at the same time.

7.13.22. Without contacting them all, how is it possible to make an informed decision on disposal? But this regularly happens based on 'no history of previous offending' or the subjective assessment of the severity of the offending. This assessment can be seen in some of the case studies too.

7.13.23. That minimum out of court disposal process must happen even if the victim, be it parent, teacher or fellow pupil, does not want to cooperate. The crime should still be recorded. It is an important part of the intelligence picture going forward. It is also what will trigger the joint police and YOS triage.

7.13.24. Police will work with the YOS if they are not charged with the criminal offence and route the youth through a youth diversionary scheme or into a YCC.

7.13.25. The YCC requires that there is sufficient evidence for a realistic prospect of conviction if the child was prosecuted, that there is an admission of guilt, and that there is true informed consent from both the child and their appropriate adult. The effect of the caution on the child's future has to be explained in the presence of an appropriate. If a child stays silent, denies it, or claims self-defence, there can be no YCC. If there is no caution the options are to take no further action, although it must still be recorded on police systems, or to charge the child with the substantive offence. This will not always be possible or desirable without the victim's co-operation.

7.13.26. If they do meet the conditions of the YCC, the YOS can mandate an intervention programme that is capable of being delivered within 16 weeks. The programme will specifically address the child's aggressive behaviour, cognitive distortion around violence, and the impact they are having on other people around them. If choose not to engage they will need to be charged and go for a criminal disposal if it's possible. The refusal to engage should be seen as a red flag and a risk escalator.

7.13.27. If it's obvious through repeated behaviour and repeated temporary exclusion, that a child is not engaging with adult supervision, school, or is not benefiting from good parenting, and they are spending significant unmonitored time online escalating their risk this would indicate a total breakdown in safeguarding. This is a prevalent theme across the case studies.

7.13.28. It is very important to establish and deal with the cause of the behaviour though it might be necessary, if the level of offending reaches a level that is too serious to be considered for an out of court disposal, that the child is charged or receives the YCC if possible.

7.13.29. If this happens youth restriction orders (YROs), or other court appointed restrictions can be made.

7.13.30. Even if a child is criminalised by this process, it no longer excludes them from the Prevent/Channel process. Similarly, a child who is being overtly investigated for a terrorist offence can still receive support through Prevent/Channel.

7.13.31. This is an important advance in Prevent operating methodology, which may have followed the well documented case of Rhianan Rudd - a girl who was being investigated for XRW ideology as a potential terrorist. As a result of that Pursue investigation – albeit overt – she was not entitled to Channel support under the policy in force at that time. It appears to me, though CTPHQ would need to confirm this, that after she took her own

life, her extreme vulnerability and the grooming she was subjected to online meant that the policy should be revisited. Channel is now open for those under overt investigation who might benefit from that level of intervention and support. A positive step in relation to a tragedy.

7.13.32. This assertion would need it be checked with CTPHQ, but regardless of the reason, this policy change is a welcome advance. It is imperative that a child displaying the traits evidenced in AR and case studies A-F has full wrap around care and support from all relevant agencies, even if being criminally investigated. If there appears to be a breakdown in safeguarding, and serious criminal offending is present, it is imperative that there is a referral into the MASH through CSC. If it hasn't already been submitted by the child's school designated safeguarding lead, it should be submitted through an intelligence led police referral at the start of the investigative process. Lord Anderson recommends a joint referral to MAASH and Prevent in the VFI cases under discussion. I agree.

7.13.33. That process requires a section 47 strategy discussion under the Children's Act 1989. This forces the local authority, police, school, and health services to co-author a robust child in need or child protection plan. This plan can mandate intensive family support and address potential online exploitation or trauma driving the aggression. Children who have an absence of good parenting, the absence of a male role model, or a failure to set appropriate boundaries, will need this kind of intense intervention. That describes the majority of these case studies.

7.13.34. It is possible for policing to disrupt the subject's immediate access to harmful content online whilst MASH or Channel safeguarding and criminal diversion pipeline processes continue. This can be done through an Acceptable Behaviour Contract working with the school's designated safeguarding lead and the local council anti-social behaviour team. Strict conditions can be imposed such as 'handing over phone' policies at school and restricting unsupervised Internet access.

7.13.35. Police should ensure that the MASH or Prevent teams engage the parents to install robust monitored parental controls on home Internet routers and personal devices, treating illegal content consumption as an urgent safeguarding risk. The school should do the same, ensuring that its servers are protected, and students use of online Internet activity is constantly monitored.

7.14. Observation – the advantage of decision making tools and frameworks for risk management

7.14.1. The police should use the National Decision Making Model (NDMM), when assessing the risk posed by VFIs. The model's structure relies on policing recognising its code of ethics and the value of intervening i.e. what would the public say if police did not intervene in the protection of the most vulnerable members of society? Would they expect police to do this? This is especially for children and children who are suffering from potential trauma through adverse childhood experiences, compounded by neurodiversity or mental illness. That is the case in both AR and case studies A-F.

7.14.2. The model then requires policing to consider all avenues to gather intelligence and information on the subject that might assist in assessing and managing risk, making that assessment based on the judgement of anyone who can help assess that risk, using the best possible risk assessment framework.

7.14.3. In my time this framework was the 'Extremism Risk Guidance 22 plus' based system that created the Prevent 'Vulnerability Assessment Framework' or VAF, which I understand has been updated to a new Prevent Assessment Framework. I hope this is not only more robust but based on the early findings of this Inquiry and the JTAC report that has been shared, and the PAF is a document shared and used by all partners in Prevent. The Inquiry will want to confirm this with CTPHQ.

7.14.4. Given the commonality of factors evident in AR and the six case studies, it should be possible to devise a framework that sees the cumulative risk of multiple factors, though it is perhaps important to ensure the no single factor receives excessive weighting depending on the cultural views or professional experiences of individual agencies.

7.14.5. Police and other professionals in a multi-agency system then need to consider what powers and policies are available to them, a non-exhaustive list would include:

- The powers available under the criminal law, depending on the offence reasonably suspected, and whether there is a possibility of a charge or caution,
- NPCC policy and College of Policing Authorised Professional Practice on the safeguarding and well-being of children, and current government policy, both of which refer to not criminalising children if possible,
- Section 47 of the Children Act 1989 as it relates to safeguarding,
- The Counter Terrorism and Security Act 2015 as it relates to Prevent and the Prevent duty, and
- The Crime and Disorder Act 1998 as it relates to out of court disposals.

7.14.6. Once these powers and policies have been reviewed there has to be a professional decision made on what option to take. This has to be accompanied by clear understanding of who is making that decision, which agency is leading on the implementation of any action related to that decision, who reviews that decision and how regularly, and who carries the residual risk of that decision. This residual risk should be carried by the chair of the MASH or the chair of the Channel panel.

7.14.7. In conclusion, there are multiple, multi-agency, safeguarding approaches to managing the risk of children who have a violence fascination, and they have developed over decades. It is not the absence of multi-agency safeguarding systems but their effectiveness that is being challenged by AR and case studies A-F. The more agencies involved, the more complex the process, the more experienced, consistent and well trained the members of

those multi agency processes have to be. The failures are always a combination of an individual's failings and the systems, and quite often the system has actually set up the individual to fail.

7.14.8. As a former system leader, leadership should always take accountability for systemic failures and responsibility for putting them right through an organisational learning system that is robust, auditable, transparent, and therefore challengeable.

7.14.9. When systems fail, public accountability through Public Inquiry, Inquest or trial should not be the way the system finds out how it failed. It should be able to do that itself and retain the memory of what it did and why for future generations. This has been a consistent failure in my profession and other agencies involved in serious case reviews. That appears to be no different in AR and case studies A-F. We are learning too late and after the fact.

7.14.10. For a system leader, comprehensive policy guidance and training based on the current law, and sufficient resources in terms of human, financial, and technological capital to fulfil the mission, must be established. The human resource has to be better trained and more experienced as the decision making becomes riskier. It seems that decisions on managing potentially very high risk violent offenders is about as high risk a decision making process as you can get.

7.14.11. It is no disrespect to my uniform colleagues, including first responders and neighbourhood policing, that I make the following observation. All police officers whether they are uniform or detectives should be naturally inquisitive and capable, quality investigators. But it is reasonable to suggest that detectives have a higher skill level in investigation both by training and the natural interest they have shown in becoming one.

7.14.12. If one of the major criticisms is that we fail to gather the intelligence and information required to make good judgments, it is because we lack professional curiosity, and professional curiosity is the bedrock of quality detective work. I make this comment because it is apparent that there may be insufficient experience and detective capability within the Prevent network on the cases that have been studied.

8. The effectiveness of current laws and systems for identifying, monitoring and disrupting the activities of VFIs

8.1. The following comments regarding current law, relating to both VFIs with no ideological bent and the sale and possession of offensive weapons, is personal opinion based solely on operational experience.

8.2. There are three distinct legal problems connected with the Southport Inquiry.

8.3. What to do with someone browsing obsessively violent material but not planning or preparing to convert that online interest into real-world action?

8.4. What to do with someone moving towards extreme violence but is not a terrorist?

8.5. How to stop that someone acquiring the means to carry out violence?

8.6. The first question is not one for law enforcement. It is one for diversion programmes preferably with the voluntary cooperation of that someone or their appropriate adult. These programmes can be provided by the YOS, or other clinical interventions coordinated by multi-agency arrangements such as MASH and MAPPA level 3 or Prevent and Channel.

8.7. At the time of writing, I believe the Government has accepted that the existing legal framework doesn't completely answer the second question. I understand it is also considering changes to legislation affecting the acquisition of weapons.

8.8. The fundamental problem I've been asked to address is that there is a legal gap where people are violent but have no ideology. AR was not a terrorist in any conventional sense. His obsessive fascination with mass violence, terrorism, genocide and attacks, did not reveal any established political religious racial or ideological cause driving him to act in furtherance of that cause.

8.9. This matters because the UK's counter terrorism system I worked within has been built around terrorism, radicalisation and ideology. The Terrorism Acts, which provides strong laws and early intervention to prevent terrorist attacks, did not apply.

8.10. I note that Phase one of the Inquiry was particularly critical of the way the absence of a clear ideology was treated. It should be recognised that one Sir William Shawcross Prevent Review recommendation in 2023 made it clear that Prevent should only be dealing with people who had a clear ideology. The Southport Inquiry Phase 1 conclusions and that Shawcross recommendation have confused Prevent practitioners across the system.

8.11. There have been changes to the system after both Shawcross and Southport Phase 1 that suggest to me that Prevent is now likely to accept people who pose a very serious risk of violence but are not necessarily vulnerable to being drawn into terrorism. I do not know whether the new Prevent Assessment Framework allows for this or whether the subjective decision making of CTCOs could still lead to a Prevent referral being refused. CTPHQ should confirm this.

8.12. There is also a legislative gap. I am aware that Jonathan Hall KC has been asked to examine the issue. I agree with what I have heard, that terrorism law is substantial and capable of dealing with terrorism, but there is no equivalent offence where someone is planning an extreme violent attack without an ideological motive. The only offence that would cover this is the Criminal Attempts Act 1981, which requires the subject to have acted in a way that was 'more than merely preparatory' to commit an attempted offence. For police to wait until that act might be too late in an era where VFIs are copying low tech terrorist methodology.

8.13. Section 5 of the Terrorism Act 2000 was designed to intervene early where people are found to be engaging in any conduct giving effect to an intention to commit terrorist acts or assist others in doing so. In allowing the early intervention of those commissioning, preparing, or instigating terrorist acts law enforcement can intervene early. They are also more successful

in presenting a strong evidential base to charge and are more likely to see the subject receive a very substantial sentence, which is of course the most foolproof way of protecting the public - the incarceration of someone motivated to extreme violence for a terrorist cause.

8.14. These people are extremely difficult to de-radicalise and persuade that they should desist from terrorism, and our criminal justice system does not invest enough in the rehabilitation. This was proved by terrorist attacks committed by previously convicted terrorists released under licence and even engaged in counter terrorism offender monitoring who still went on to attack. There are also numerous high profile and infamous examples of subjects who have been engaged by the Prevent programme and Channel still going on to commit attacks.

8.15. Nevertheless, police are able to take early action that they cannot take in scenario 2 where someone who is plotting even a violent mass casualty attack has not taken any 'more than merely preparatory steps'. This is the gap that the Government needs to fill to enable early police intervention and successful prosecution where justified.

8.16. There needs to be a new offence of preparing or planning an attack involving extreme violence where there is no underlying ideology. I understand that the Home Secretary committed to such legislation in an April 2026 statement.

8.17. This is a significant development, but it only solves one part of the problem. It allows the state to prosecute somebody who has crossed the threshold into preparation for an attack. It doesn't solve scenario one. What about the child who has become obsessed with mass murder, watches violent attack videos every day, talks about wanting to kill people, searches for weapons and perhaps conducts reconnaissance, but has not yet committed a crime or actually begun to prepare an attack? That is the harder problem and is relevant because every case study, AR and A-F, shows that theme.

8.18. Society cannot criminalise being dangerous, disturbed, violent, fascinated by violence, or 'likely' to offend. That runs into fundamental principles of criminal law, proportionality, freedom of expression, and the rights of children. It goes directly against all current police and government policy in not criminalising a child unless it is absolutely necessary.

8.19. UK law is extensive for people who have committed an offence with powers covering the possession of knives and offensive weapons, threats with weapons, preparation for certain offences, conspiracy, attempted offences, terrorism offences, the possession and distribution of certain prohibited material, stalking and harassment, threats to kill, malicious communications, and some other aspects of online criminality. The police are not short of legislation providing offences to charge where people have demonstrated the intent and an act. There is however no criminal law capable of dealing with people who are merely fascinated with violence.

8.20. There is a dangerous gap between concerning behaviour and criminal preparation, and the danger is that we are creating public expectation that this problem can be solved by law enforcement.

8.21. The government's potential VFI offence for a possible new act that covers 'acts preparatory to extreme violence' by individuals identified as violence fascinated will, I suspect, be very difficult to draft. The formulation is important. It suggests something analogous to Section 5 of the Terrorism Act 2006 giving police the ability to intervene before the terrorist act, or in this case the violent act, happens.

8.22. That leaves a policy question for Government and law enforcement in how far the state should be allowed to intervene before an individual has committed an ordinary criminal offence with that obsessive violence fascination as the driver of fascination is not itself criminal. Watching extremely violent material is not usually criminal. Of course, threatening violence, acquiring weapons reconnoitring and planning can all be criminal offences, though the latter are difficult to prosecute. Attempting the attack or actually committing the attack can obviously be charged but no one is going to want to wait that long to intervene.

8.23. The Southport Inquiry and the case studies I have been provided with illustrate that gap. The answer to that gap is unlikely to be more Prevent referrals although that is clearly happening now as a risk averse reaction. Both Southport and the Lord Anderson review have already discovered what CTP has known since 2019 alongside the Home Office, that VFIs, particularly adolescent VFIs, were becoming a growing problem with the system unable to articulate MUU ideology and find a convincing driver that would allow use of the Terrorism Act. Even the letter to the Prevent system by Skodbo and Adams in 2019 was too ambiguous and may have led unintentionally to inconsistency in how those referrals were handled (CTPHQ000134).

8.24. Observation - early intervention measures

8.24.1. The Inquiry should take care not to assume that even with an effective multi-agency system, this type of extreme violent offending can be predicted and stopped in every case. It requires constant surveillance and assessment. Where CTP have information or intelligence on terrorists that cannot be prosecuted because the evidence cannot be heard in court, they are subject to something called a Terrorist Prevention Intervention Measures (TPIM), which is an incredibly restrictive and controversial tactic. Some of the measures underpinning a TPIM, can also be seen in criminal behaviour orders and youth restriction orders and are designed to allow supervision, random inspection and therefore a form of monitoring, including online.

8.24.2. For non-ideological potentially violent offenders or VFIs an analogous intervention measure akin to a VPIM could be introduced on grant from a judge. Perhaps called a Violence Prevention Intervention Measure. This would be incredibly controversial if it was introduced for children and/or adults who were not criminals but suspected of one day becoming one. For children, even with the consent of a parent or guardian, it would be very difficult to overcome an accusation of state overreach by civil liberty organisations. But if the risk assessment states that a person is so dangerous they cannot be safely managed in the community, but they cannot be arrested and do not reach the high bar for medical section to a secure hospital, there is no current option at all. That gap needs to be addressed or the risk accepted.

8.24.3. I am aware from Jonathan Emmett's detailed statement (HOM000964) contents shows that the Home Office is seemingly in an advanced state of planning to address many of the problems I evidence here and not passively waiting for the Inquiry to report. Good. I believe that part of that approach is a recent Home Secretary policy announcement on an online/offline diversion programme specifically aimed at young people who display violent tendencies or a fascination with violence without a clear ideology. It is intended to provide diversion and specialist support rather than treating every such person as a terrorist. That seems a sensible solution which could be commissioned by either of the current multi agency approaches such as MASH and MAPPA or Prevent and Channel.

8.24.4. Prevent doesn't simply need to be expanded and can remain focused on people who are vulnerable to being drawn towards terrorism with an alternative channel for people who are not. As stated above, a capability of moving between those two different channels triaged through Anderson's idea of a wider front door is an approach that providing it was correctly resourced, I would support.

9. The sale and possession of offensive weapons, and articles with a point or blade

9.1. The UK laws on offensive weapons and knives is, like terrorism, extensive. It is however fragmented and increasingly difficult to enforce against modern supply chains as Southport Phase 1 discovered. The Inquiry described the legislation as a 'patchwork quilt', and I think that's right. The more voluminous the law the more complicated it is to enforce, and the more likely mistakes or oversight are to happen. Officers are required to navigate the Criminal Justice Act 1988, the Knives Act 1997, the Restriction of Offensive Weapons Act 1959, Offensive Weapons Act 2019, Criminal Justice Act 1988, Offensive Weapons Orders, Online Sales Restrictions, Age Verification Requirements on purchase and delivery, and new legislation dealing with particular types of weapons.

9.2. A useful addition to that plethora of legislation was introduced in the Crime and Policing Act 2026 creating a new offence of possessing a knife or offensive weapon with the intention of using it in unlawful violence, causing fear of such violence, or causing serious unlawful property damage. Usefully, this offence is open to people possessing such a knife or offensive weapon in a private place not just being found, perhaps as the result of stop and search or an intelligence lead, in public. It's also useful that the maximum sentence is a substantial seven years' imprisonment. Both of these provide a deterrent for people wishing to possess knives or offensive weapons with violent intent, but it should be noted that the kind of subjects examined within the case studies and AR, were highly unlikely to be put off by such an offence given that there are examples of those trying to overcome age restrictions, hide their purchasing and acquisitions from responsible adults.

9.3. Nevertheless, this does move the law closer towards the problem or gap that the Southport Inquiry exposes in that you don't necessarily have to wait for somebody to use a weapon or be caught in public with it.

9.4. I am also aware of a Home Office consultation to introduce a licencing system for sellers and importers of knives and bladed articles. The law currently regulates what can be

possessed, what can be sold, to whom it can be sold, and licences particular prohibited weapons. A licencing regime potentially moves towards who is authorised to participate in the knife supply chain in the first place, bringing the possession of knives much closer to the philosophy used for firearms. I support that.

9.5. I am aware of other specific proposals to restrict the sale of sharp tipped knives, to prohibit the online sales of certain bladed articles, for example machetes, (though I think this would be complex given the multiple legitimate uses for such items), stronger online age verification, stronger age verified delivery, mandatory reporting of suspicious behaviour, the scrutiny of the importation supply chain, and controls around multiple subcontractors in the delivery chain. Major courier companies would need to be bought in to this. As a former law enforcement professional, I support this as necessary and proportionate. I would also add crossbows to the list of prohibited weapons that require a licence to possess and use, in the same way as firearms, and make them subject to the firearms and explosives licencing regime.

9.6. As for firearms themselves, there is a restrictive regime in the UK which has proved to be of massive benefit to public safety. However, the licencing system has always been archaic and at least one of these case studies exposes that. There have been reviews, not least the Durham review, that made sensible suggestions for improving the licencing regime. One of the most significant problems is the licencing regime does not pay for itself and came under pressure during austerity that resulted in unsafe practise. This was exposed by one of the case studies.

9.7. His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) has described the firearms licencing system as 'not fit for purpose' where it identified significant inconsistency between police forces and cases, like one of these case studies, where people with serious histories were granted firearm certificates.

9.8. There needs to be more national consistency, stronger medical information that is capable of being shared without concerns of breaching confidentiality, better digital verification of certificate holders identification and possession of certification, better intelligence checks conducted by better trained and experienced firearms inquiry officers, and potentially a nationalised licencing structure and database. To pay for this, shotgun and firearms certificate applicants should be required to pay the proper cost of maintaining such a system. The current regime is too cheap. As I have said I would expect crossbows, because of their lethality and portability, to be included in such a regime.

9.9. We do not need a law completely banning guns and crossbows, but the system does not currently and reliably prevent a dangerous person from obtaining a lawful weapon.

9.10. In conclusion for this section, I wouldn't consider a law to intervene early with VFIs who have no ideology, and tighter laws on the possession of weapons has separate problems. The scenario in which a VFI adolescent showing obsessional interest in school shootings, terrorism and mass murder, begins to increasingly consume such extreme material, moving on to expressing admiration and studying the manifesto of previous killers, to the

point where they start communicating the potential of an attack either on or offline, then starts to research weapons and how to acquire one, then starts to conduct reconnaissance, target selection and the logistics of carrying out such an attack, and then commits the attack is evidenced in AR and some of these case studies. It is a clear and present danger not a hypothetical risk. I think Southport is trying to answer the question of how the state can intervene at any point in that continuum from when the consumption of increasingly extreme material begins to show itself and even before it becomes clearly obsessive.

9.11. I have stated above the legality proportionality, necessity and accountability concerns of law enforcement in a liberal democracy, and their use of the kind of intrusive and potentially covert and unavowed techniques used against terrorists and serious criminals against those who have not yet committed an offence, or who have even reached the level of reasonable suspicion that they will. You might colloquially refer to this as turning UK law enforcement into the 'thought police.' This could seriously undermine trust and confidence in the Government, national security system and the police who depend upon that for consent, rather than policing by force. The principal problem is how did you see that escalating pattern of behaviour when it is online if the subject is not communicating with anyone likely to see it and report them? That sort of hidden behaviour is often discovered after the fact and too late. In the case of children there needs to be controls on their access to such content and more importantly there needs to be concerted action against the content itself of which more below.

9.12. I think there needs to be 3 different but connected reforms:

9.13. A new 'act's preparatory to extreme violence' offence as recommended by Jonathan Hall KC, that deals with deliberate preparation for an attack by somebody who isn't a terrorist.

9.14. A VFI management system, which is more important than the offence itself. There needs to be a lawful and proportionate mechanism for managing someone who is high risk but not yet criminal. The Inquiry may want to consider the lessons of the controversy caused by the Trident risk management 'Matrix' in London's Metropolitan Police Service in the mid 2010s. The Matrix was a database containing the details of both perpetrators, suspected perpetrators and victims of violent gangland offending. It was designed to protect and safeguard individuals and the public from those individuals but was challenged as both discriminatory and disproportionate. A new VFI matrix containing largely juveniles I suspect would be similarly challenged, especially if managed by the police, though I support its consideration.

9.15. As stated above, there already exists multi agency frameworks to deal with violent and potentially violent offenders, including Prevent and Channel for those at risk of being radicalised or drawn into terrorism and MASH and MAPPA, (which will accept children who have not yet committed an offence). Any new system should build on these rather than create yet another system with its own bureaucracy, as the membership of such frameworks tends to be agencies and professionals with the same skills and access to the same information for essentially the same purpose – to preserve safety and law and order.

9.16. I do not see the point of creating a separate agency for this newly defined VFI cohort. This might exacerbate some of the problems this study has found in the huge resource commitment, duplication of both information and risk assessment, and confusion about thresholds i.e. where such an individual sits and in whose framework. Why would you do that? If there is any possibility of terrorist ideology and motivation, whether obvious, mixed, unstable or unclear, they should sit within the national security system. If it is prior to offending in the pre-criminal space that is Prevent. If they are potentially so dangerous or refuse to consent, they should be in the Police Led Partnership or potentially treated as part of the Pursue machinery.

9.17. Where there is NO ideology at all, or further investigation and information gathering has dismissed MUU as not moving towards radicalisation or terrorism, they should be managed by the MASH and/or MAPPA. The two systems, Prevent and MASH, should be capable of talking to each other and moving subjects between them, given that ideology can develop over time or be successfully countered, even without complete de-escalation.

9.18. Things that most concerned me in the case studies and with AR were; the inability of the system to predict behavioural trajectory; the ability of the subject to lie or disguise compliance fooling even experienced professionals; and the treatment of subjects in silos by individual agencies. This could lead the early closure of that support after the first sign of any progress towards de-escalation or better behaviour, when underlying conditions including neurodiversity and mental illness can be lifelong. In other words, the interventions have to be better coordinated and much longer term before a decision is made that the risk no longer exists. It will always be difficult to determine that point, and I am aware that what I am recommending would put far more pressure on limited resources and would be more expensive.

9.19. The regulation of the potential weapon supply chain seems to me the right direction of travel in that licenced sellers who take responsibility for stronger age verification and controlled delivery, and who are held accountable in the online marketplace and required to have systems that monitor suspicious behaviour and mandatory reporting conditions, together with importation controls on foreign registered suppliers, is the right way to go.

9.20. I am nervous that we are on the verge of creating an offence of simply being a VFI. I think this is dangerous for a liberal democracy and conceptually wrong. I should not need to remind either the Inquiry or those conducting research that the law should criminalise conduct, not a state of mind or personality. If there is such a thing as a general cohort of VFIs, and they can be identified early, that early recognition should lead to risk management systems in the pre-criminal space very much like the online offline diversion programme the government is suggesting. The Matrix that could contain then VFI cohort, their single record and risk assessment, I accept will be controversial as would ensuring all agencies could access, read and update it, but this is, in my view necessary. If they later developed into a Prevent case they could be removed from the matrix into PCMT which would become the single record for VFIs vulnerable to being radicalised and drawn into terrorism.

9.21. However, I do agree that any preparatory acts to extreme violence must be made a criminal offence. Defining the preparatory acts that qualify will be key in the drafting as they will also act as a clear warning and deterrent. The Government should be wary of giving police a system that allows them to arrest and charge people just because they think they might become dangerous in the future. This distinction between criminalisation, safeguarding, and preventative risk management outside of terrorism is clearly the central argument of Phase two of the Inquiry.

10. Online safety and proposed regulation and legislation

10.1. I leave the most important observation to last. The policing of the Internet. The Internet can turn an isolated individual fascinated by violence into a self-reinforcing ecosystem of material, recommendation, validation, incitement, and escalation. This is not an issue just for children and adolescents but for vulnerable adults too who are susceptible to the same drivers.

10.2. The UK has legislated. The Online Safety Act 2023 was a very positive move in the right direction. I note the government has already accepted all the Inquiry's initial recommendations regarding online harms. The Act works on the principle of following the identification of harmful or illegal content, requiring the platforms to assess the risk of that content, and then requiring them to mitigate that risk or remove it. If they fail to do this regulation through fine and the criminalisation of directors can follow.

10.3. It has been extremely hard to get platforms to moderate their content and in fact they have reduced that capability over recent years. This is very concerning. The UK will want to study in depth the legal ramifications of the recent settlement by META in the USA as I have stated above. It seems to me that platforms are still unwilling to police the content on their platforms. In Southport and the case studies that I have been provided with, together with my experience of dealing with violent offenders including terrorists, the pattern is clear. The modern phenomenon is the extensive browsing, obsessive interest in and capability of, finding thousands of individual illegal and legal but harmful pieces of content. It is then how they combine to create a dangerous pathway for an individual by inspiration, incitement or instruction.

10.4. Where the content is clearly illegal, most responsible providers do not want that material on their platforms, and if it's flagged to them they will remove it. Most will declare that they have systems to detect this content for themselves often because various hashtags or URLs have been supplied to them by the Home Office, or CTP's Nationals Digital Exploitation Service (NDES) and their CT Internet Referral Unit (CTIRU), as well as the public reporting of such material by. I don't believe this system is capable of dealing with the volume and it only addresses illegal content. Publishers are allowed to use their own discretion about whether legal but harmful content breaches their terms and conditions. As I stated above I have not seen examples of Big Tech platforms putting their corporate social responsibility before their shareholders' interests or the privacy and free speech of their customers. It's leaving a lot of legal but harmful content that is easily accessible for

vulnerable people who are suggestible. That danger persists regardless of the recent settlement in the USA.

10.5. Browsing this legal but harmful content does not commit an offence, but the trajectory could be very concerning. How do you spot the increasing trajectory unless you are constantly monitoring an individual's use of the Internet? Schools, parents and guardians must clearly do more to monitor children's use of the Internet. Unsupervised use by not just children but vulnerable adults, is ubiquitous.

10.6. I am not aware of a proportionate technique to monitor that kind of browsing of legal but harmful content. Unless an individual hits on a particular illegal piece of content or site, or is engaging with covert law enforcement online, it is unlikely to be spotted unless there is a reactive digital investigation triggered by that child or vulnerable person coming to police notice. It is why in the case studies it is so important that a digital investigation is conducted the moment a potential VFI commits even a minor offence or is referred to Prevent or MASH.

10.7. This digital investigation could be overt and done on a consent basis, by the subject or their appropriate adult, or by the use of a warrant. The ability to gain that warrant should be made easier for law enforcement on the grounds of reasonable suspicion that somebody is a VFI and may be moving towards a potentially violent offence. This prevents a simple refusal to co-operate, but again this suggestion will excite civil liberty concerns.

10.8. The concept of algorithms and techniques to keep children online and actively engaged is very current. Rather than thinking of a single piece of content as either illegal or legal but harmful, algorithms are presenting a pathway of multiple content, allowing vulnerable people to consume increasingly extreme material in volume and at speed. It is that system that requires regulation, not just the removal of individual pieces of content.

10.9. The Online Safety Act 2023 already asks platform providers to conduct risk assessments and take measures to mitigate risks, but does it have the teeth? Is extreme violence content adequately described? This is not just gore, or ordinary violent films or legitimate news reportage. This is material which glorifies mass killing; school shootings or terrorist attacks; celebrates the perpetrators of those attacks presenting them as heroes or martyrs and publishing their manifestos; provides instruction for carrying out attacks; encourages hate and violence against identifiable groups or individuals or invites imitation.

10.10. This material should be described and proscribed. It should be technologically agnostic, covering video, text, images, audio live streams, AI generated material and interactive content. I am not advocating criminalising mere possession of this material, though that would be tempting. Banning violent material even as insidious as this creates serious civil liberty questions in a liberal democracy. There is a real need to retain freedom of speech and expression, although this not an absolute right and never has been. There is no absolute right to cause harm by your free speech or free expression.

10.11. There are already legal exemptions for journalists and academics studying terrorist material and this would clearly apply here too. In short I would not criminalise possession or viewing of such material. I would regulate its distribution. I would heavily regulate the algorithmic amplification of such material. I would make the targeting of vulnerable children with it the criminal offence and ensure that there was strong regulation capable of enforcement by Ofcom. I would suggest that if it could be defined, material that is deliberately designed to facilitate or encourage extreme violence, would be criminal to possess, distribute or create.

10.12. The Southport Inquiry should ask the Government to consider the regulation of algorithms which bombard the user with harmful content, however legal. It has to be able to prevent platforms saying they are not publishers with editorial responsibility. This may be true for individual pieces of content and even a defensible position. But they create the algorithms and the system that allows the bombardment process, including infinite scrolling. They should be required to mitigate this under penalty of legal sanction.

10.13. Ofcom would continue to be the auditing body and regulator, and they should require platforms to demonstrate that their systems do not produce this effect. The burden of proof should switch to the platform not a bereaved parent and a class action.

10.14. This might be described as an 'algorithmic duty of care'. Platforms would have to ask whether their algorithms progressively escalate violent material. Whether they recommend perpetrators to users. Whether they connect users with violence focused communities. Whether they recommend weapon acquisition. Whether they recommend a violent methodology. Whether they reward increasingly extreme content. And whether they create communities centred on the glorification of violence. If the answer to any of those questions is yes, the platform would have a legal obligation to alter that system and mitigate that harm.

10.15. The system currently plays a never ending game of 'whack-a-mole' with individual pieces of content. This will never be enough. The amplification duty of care might come closer to tackling the real cause of VFIs escalating towards real world violent acts.

10.16. For me this is not just about children but also about vulnerable adults. Nevertheless, age assurance was another feature of Southport Phase 1, and I am aware that the UK is moving strongly in that direction as are many other jurisdictions. Ofcom has a child safety regime that requires platforms to prevent children encountering specific categories of particularly harmful content including; pornography, suicide, self-harm, and eating disorder content. Age assurance technology is increasingly being deployed across social media, gaming, messaging, and other services. This is extremely welcome news for those engaged in preventative activity and is a good example of proactive legislation.

10.17. The same age verification systems should be used against extreme violence content. Children should not be exposed algorithmically to material glorifying mass murder any more than they should be exposed to such material suggesting suicidal self-harm. It is the reason we have had British Board Film Classification age relevant coding for many

decades, and editorial guidance for television and streaming services have codes to cover pre and post watershed material. Why should this not be applied to the Internet?

10.18. Age appropriate risk controls would not ban adults from accessing legitimate material because adults are supposed to have the maturity and critical thinking skills to cope. Of course it does not protect the suggestible, mentally ill or those with cognitive disorders that may be lifelong, from falling prey to this material. However, it is a start. It helps deals with the free speech and anti-censorship arguments which will undoubtedly follow and are legitimate debates in a liberal democracy.

10.19. I am unsure whether the next suggestion is even technically possible, but establishing a feature whereby platforms can detect algorithmic searches and increasing frequency of harmful content should be explored. The platform could then be given a legal duty to report that to the authorities and would create a system whereby the technology could be a potential Prevent referrer by itself. This would in effect extend the CTSA 2015 Prevent duty into the private sector.

10.20. This does not make it automatically a law enforcement issue but a safeguarding issue, and violence fascination should be considered as safeguarding signal. There are already systems for child sexual exploitation, self-harm, suicide risk, and grooming. Why can't platforms have a duty to report violence fascination?

10.21. Any intervention could be progressive. At the lowest level the platform could intervene by reducing the power of the algorithm to make recommendations, interrupting the browsing or that pathway, or better still providing counter content and a better narrative. At the next level the platform could recommend a safeguarding referral given that they are witnessing evidence of an individual becoming violence fascinated. That referral would trigger the next level of multi-agency VFI assessment where information sharing and intelligence gathering and a common risk assessment framework could deduce the actual risk. Is it a Prevent or MASH referral that is required? It is only at the highest level where police intervention would be necessary where there is already evidence of offending, such as threats, weapons acquisition, preparation or any other criminality. This would be a more progressive and sophisticated system than simply requiring platforms to report browsing to the police. However, in the latter scenario, they would have a difficult argument to defend if they are capable of spotting illegality but choose not to report it.

10.22. Given that we have seen harmful content go viral in crisis, including the violence that erupted as a result of disinformation spread after the horrific attacks by AR, I am aware that Ofcom has proposed stronger crisis response requirements on platforms to prevent the rapid spread of illegal material during major events. If it has not done so already it should consider the same intervention to counter mis and disinformation and the rapid spread of lawful but harmful content. I appreciate this latter point would be much harder to define and enforce but it should be considered as part of the consultation given that it should be a wide enough definition to cover anything that promotes violence escalation.

10.23. Could the platforms create a system for monitoring the digital supply chain by which I mean detecting someone who is clearly violence fascinated by their browsing content but then goes on to search weapons or attempt to acquire or purchase weapons? That is a risk combination that should be brought to the attention of the police. This would be reasonable suspicion that someone is moving towards an offence and engage a new law that would allow early intervention regardless of ideology. This combination if detected could move rapidly through the escalatory process described above straight to warning the authorities of an individual.

10.24. This is analogous to the cumulative effects of multiple individual risky behaviours seen in the case studies provided. It is the combination of concerning signals, not individual searches, that tells its story. In reactive investigations as some of the case studies prove, it is the combination of searches and the increasing frequency and violent content that telegraphs what comes next. It is somewhat pointless discovering that after the horrific event other than to learn the lesson I'm preaching here – that you have to do everything you can to detect it as soon as it starts, and definitely when it escalates, to prevent a key board warrior moving into a real world violent act.

10.25. I realise that this creates very serious civil liberties issues. I am not advocating the creation of a system in which because the police think you are dangerous the platform is required to hand over everything to the police and the state intervenes. There would need to be clear thresholds, not vague descriptions of concerning behaviour. There would need to be independent oversight already provided by Ofcom for platform compliance but also provided by judicial oversight on intrusive state powers with a number of independent commissioners already in existence.

10.26. The intervention must conform to the Human Rights Act which every law enforcement professional is steeped in, namely that it must be proportionate, lawful, accountable, and necessary. It is particularly important that children's rights are preserved and that we don't ride roughshod over decades of safeguarding and compassionate non-criminalisation of child safeguarding and well-being law and policy. It would be important that the management of intelligence and information gathered through this process, including risk assessments, was subject to defined time limits before deletion. Law enforcement should be required to prove why they should be retained to an independent commissioner or judicial authority as they do now with biometric data. The individual or their appropriate adult would have to have a mechanism to challenge the decision to retain records through a right of appeal.

11. Overall conclusion of proposed legislative and regulatory reforms

11.1. The concept of a new VFI offence should be designed alongside these changes in Online safety legislation. Platforms will need to be forced to take responsibility for stopping algorithms creating or accelerating an individual's pathway to violence. Multi-Agency systems must be capable of safeguarding VFIs by identifying and managing people who appear to be moving towards extreme violence along that pathway. And lastly the criminal law should engage where actual threats, weapons possession with violent intent, and acts

preparatory to extreme violence are identified, as the policy of last resort with a child who cannot be deterred.

11.2. This suggestion creates a continuum of state intervention at each point in the escalating chain. Where content might lead to a pathway for an individual that elevates their risk and leads to the preparation of a potential offence and then an attack, the state has the option to intervene at every stage.

11.3. Online harm should not be understood as something that is merely contained within the Internet. It is now part of the everyday causal environment in which violence develops. That is my professional experience, but the Inquiry will want to consult experts who have studied whether there is a connection that can be academically and statistically proven between content online and action in the real world.

11.4. CTP was pointing out the dangers of the Internet to Big Tech as far back as 2016. Sir Mark Rowley my predecessor and now Commissioner of the Metropolis, regularly made those public statements and I continued that from 2018. The world has rapidly caught up. People who spend years progressively consuming violent material online and are then algorithmically introduced to increasingly extreme communities or use encrypted platforms to communicate with those individuals, acquire an obsession for mass murder, research weapons online, are capable of buying online those weapons, and eventually prepare and commit attacks are now well documented and there is plenty of evidence in what I was asked to review. For a platform to now say that it merely hosted the material, or that the material had no effect on the outcome, is an impossible position to sustain.

11.5. This does not mean that I am saying the state should monitor everyone's Internet activity for signs that they might become violent. This kind of mass population surveillance would be anathema to a liberal democracy. I have said many times that I could describe a national security architecture that keeps you 100% safe, but it would be a society in which I would not want to live. Mass population surveillance would be that step too far and unacceptable.

11.6. That does not mean that it is not possible to create platform accountability, targeted safeguarding, and tightly defined criminal thresholds which would address the gaps the Southport Inquiry has uncovered. You can create a VFI framework in which online behaviour is just one risk indicator amongst several, rather than creating a new offence based on somebody's thoughts or Internet history. This is a defensible model. It is not trying to criminalise violence fascination. It is simply using violence fascination as one factor in an elevated risk assessment.

11.7. I am interested in Ofcom's first statutory report due in October 2026 examining content harmful to children, which will be an opportunity for the Government and Parliament to decide whether the Online Safety Act 2023 really is adequate or has been too diluted. It will precede this Inquiry's final report. The Inquiry will want to consider that report and Ofcom should be asked to provide a preview to the Inquiry legal team.

11.8. I'm aware that the Inquiry faced difficulties from obtaining evidence from platform providers and I can only say how sympathetic I was to the frustration that must have caused. I have been there.

12. Observations out with my letter of instruction

12.1. Observation – home office access to the police case management tracker

12.1.1. I have one comment to take issue with and that is that the Home Office should have access to the Police Case Management Tracker (PCMT) for the purposes of data analysis, learning and potentially as a secondary safety net for decision making. I have not been able to ascertain a reason why CTP has not chosen to accept this in Lord Anderson's Prevent review, and I hope the appointed independent commissioner of Prevent, my former close colleague, retired deputy chief constable and a former SNC Prevent and Pursue himself, Tim Jacques, will revisit that in due course. I adopt much of the above statements but make some additional comments in the thematic analysis.

12.2. Observation – institutional bias and its effect

12.2.1. I note that the case studies do not always include ethnicity details and are all male. These are themes to explore, but I appreciate this could easily identify cases and may be more appropriately addressed separately. I am informed that they were chosen as a series of well-known cases which appeared to demonstrate many of the characteristics that appear to be common in VFI cases. They included some parallels with AR but also raised a range of issues for consideration. The cases were not selected by gender and no conscious decision to select only male cases. It was by chance that all the cases drawn to the Inquiry's attention happened to be male. Criminologists will tell you that males aged 16-24 years old tend to dominate crime statistics, and men dominate violent offending, so although there are notorious female offender cases of both CT ideologically driven violent offending and violence fascination, they are not included here.

12.2.2. That means that potential themes related to ethnicity and gender are difficult to adduce, but my point on the dominance of male offending and violence is well documented in criminological study.

12.2.3. There would be three issues to discuss which are difficult to exclude but need comment outside the thematic study because of these limitations:

12.2.4. First, whether there is a form of institutional bias or discrimination to perpetrators depending on their ethnicity or neurodiversity,

12.2.5. Second, whether there is a greater chance of someone of a particular ethnicity being more vulnerable to mental health illness or neurodiverse conditions,

12.2.6. Third, did institutions understand the cultural significance of offenders or families failing to engage with mental health or support services because of a greater stigma in specific communities.

12.2.7. I cannot comment on the evidence that lies behind the second and third statements, but I have seen it reported, especially in Black communities, possibly as a result of racial trauma from post slavery, racism or other issues such as emigration from war zones, or escape from extreme famine and poverty.

12.2.8. I have also seen reporting of the over diagnosis of conditions because of this assumption, and seen Police officers over-react to cases of Black people displaying mental illness in public using their s136 Mental Health Act powers. This has improved though training. I was certainly given such training throughout the second half of my career, and the relatively new post 2022 policy of 'right person, right care,' preventing the inappropriate deployment and use of police powers, may also have helped. If this disproportionality in diagnosis within certain communities does exist, other experts would need to comment. But if so, it would create an additional theme and potential risk factor for the Inquiry to debate.

12.2.9. On the third issue I could not see that anyone even asked the question of cultural stigma of parents or perpetrator at any point, though it may have existed, so it's hard to make a judgment The Inquiry should consider whether it might form part of any future risk assessment process. It goes to the issue of a lack of parental or subject consent to engage and how to overcome that.

12.2.10. I can comment on the first issue in relation to policing and institutional bias, especially racism. There are long standing metrics and many reports from the '80s and '90s that demonstrate that policing and the criminal justice system disproportionately arrests, uses force on, stops and searches, charges, convicts and provides longer sentences for ethnic minorities. These metrics remain a concern in 2026. I do not believe policing or the criminal justice system has yet overcome its issue with institutional bias towards minorities, especially race, but also women and other sectors of society including LGBTQ+ and the physically or mentally less able. The metrics remain stubbornly disproportionate, as does the trending lack of trust and confidence of these sector demographics.

12.2.11. 'Adultification' or treating a vulnerable child as an adult offender became a prominent issue in 2022 with the inquiry into the case of Child Q in the Metropolitan Police Service. A 15 year old Black girl was subject to an intimate drugs search by two female officers without an appropriate adult present. She was menstruating. It was clearly wrong that she was treated harshly and as an adult.

12.2.12. It is my experience of thirty years that we often treat children and young people under the age of 18, suspected of committing adult crimes, as adults. Over the decades changes in legislation, policy and guidance since 1988 has meant we have become more compassionate and aware of our responsibilities to safeguard children, not criminalise them. The Inquiry may test if this has gone too far.

12.2.13. This is demonstrated by the National Police Chiefs Council (NPCC) policy and the Children and Young Persons Policing Strategy dated 2021, referred to in DAC Evans statement. It states that policing should avoid criminalising children if possible.

12.2.14. Modern safeguarding practices started as far back as 1988 and accelerated post 2003/4 with the Victoria Climbie inquiry. There has been a constant evolution for agencies not to treat children as adults or to criminalise them by unnecessary or disproportionate police action. It can also be seen in modern diversion practises in youth offending services (YOS), and violence reduction services that avoid charging and bringing children into custody. Also post 2018 is the change in treatment of children swept up in so called 'County Lines' drug supply investigations. They are now seen as potential victims not just as suspects, even if they have perpetrated major crimes.

12.2.15. This is relevant to this Inquiry if you believe in the element of right wing political thinking that has entered the vernacular post the 2020 Black Lives Matter movement. For some, the policing of this protest movement was considered too 'woke.' This effectively meant that the police were accused of being soft on you if you had a protected characteristic under the Equality Act 2010 – especially being Black - after George Floyd, whose murder caused world-wide protests against police brutality and racism.

12.2.16. It started the language of 'two tier policing' in the Conservative party, now adopted by Reform and Restore that is very dangerous for front line officers. I believe the majority of policing adheres to the fundamental principle that you should police to the rule of law 'without fear or favour,' not differently depending on the people or causes you support. There is little real evidence of the later except in individual anecdotal cases often quoted. It may well happen as a result of individual officers subjective decision making. It is after all a highly discretionary profession. But it is certainly not National Police Chiefs Council (NPCC) policy despite some clumsy and ambiguous wording in the now revised NPCC Race Action Plan. Alternatively, the progressive left would say that the police are far too hard on individuals with protected characteristics, and the metrics do lend some support to that interpretation as discussed above. The truth will lie somewhere in the middle as usual.

12.2.17. I make the following further observations out with the main thematic analysis:

12.3. Observation – discrimination

12.3.1. For the purposes of this report, was there any evidence that police (or any other agency) went 'easier' on a suspect for an offence because they were Black or neurodiverse and consequently underestimated their long term risk? It is a reasonable question to ask and there is certainly evidence in AR and Case Study F that a child and/or the neurodiverse condition was treated as a mitigating factor when investigating a preceding violent offence such as possession of a weapon or assault.

12.3.2. There is other evidence of this, but it's not in every case. It would be wrong to assume that this is prevailing policy and would be wrong to conclude that from such a small sample

size. However, putting the vulnerability and the safeguarding of an individual first carries risk if the officer (or other agency) does not also consider the risk to wider society from that individual – a conclusion in the case of AR and Southport Inquiry Phase 1 that I agree warrants further inquiry.

12.4. Observation – adultification risks

12.4.1. I would not want the Inquiry to condone a return to adultification of children and reverse decades of safeguarding learning and a more compassionate, consensual and partnership style alongside social services, educators and medical professionals. It would be a retrograde step, but it is worth emphasising that protection of the public from the individual is an equal consideration. It is also worth emphasising that sometimes only the arrest, detention and criminal justice system can provide safeguarding services for both an individual and society. A Violence Fascinated Individual (VFI), left in the community with no ongoing support or surveillance is as much at risk of having police use force, potentially lethal force, should they offend. Sometimes an early arrest and incarceration, at least in the short term, is the only viable safe option for both. Officers and partner agencies should not forget their obligation to both the child and the community.

12.4.2. Other experts will have to comment on the issue of institutional discrimination and its effect within their own service, discipline or profession.

12.5. Observation – diluted information

12.5.1. My reliance on the methodology I outlined above means important detail can be missed as document summaries dilute language, which could underplay or miss a key piece of information. I note that this is exactly the trouble that exists in multi-agency work where there are multiple systems recording summaries of events being passed electronically, internally and externally. Multiple hand offs create multiple points of failure. The diluted description of an event or the language or actions of a subject can completely change the overall risk assessment made by an individual, an agency or a panel, especially if the author is not a member of that panel, and/or not a consistent member of that panel.

12.5.2. This is a potential theme.

12.6. Observation – single nominal record

12.6.1. There is a need for a single nominal record that follows the person throughout their life and how that can be created, accessed and updated by multiple agencies with their own objectives, cultures and confidentiality thresholds. How do you create a single holistic record of a person's touch points with the state such that you can have an evolving and iterative way of assessing that persons escalating or de-escalating risk confident that you have the whole picture? Difficult but I think essential.

12.7. Observation – command and control

12.7.1. If you do that, what agency or person should be in charge of it? Who should be the risk owner or decision maker in that multi-agency forum, and can that person or agency change as the picture develops? The lack of a clear single decision maker or risk owner in a multi-agency setting is a theme in these cases whether they were MASH led or Channel led. It cannot be that everyone owns the risk because in that case no-one does. There are lessons to be learned from police major incident management and the way CTP and MI5 manage high threat CT investigations.

12.8. Police major/critical incident management

12.8.1. In police major or critical incident management, policing works to a command and control philosophy where it sets a command structure based on a hierarchical metallic badge system called Gold, Silver, Bronze. Gold – the senior risk owner - sets the strategy and makes sure the resources are in place; Silver sets and monitors the daily operation of a tactical plan to meet that strategy and appoints a series of Bronzes to deliver the tactics; (e.g. intelligence, investigation, communication, partnership management, legal services etc). All Bronzes report through Silver to Gold. These metallic badges are not based on rank anymore but occupational accreditation and operational competence.

12.8.2. In any crisis situation, a clear chain of command, clear responsibilities, and clear ownership of tasks is important to deliver a safe outcome. In the event of a tragedy (or even a success as both success and failure should be debriefed for learning), it is also much easier to find individuals and systems accountable.

12.8.3. The Joint Emergency Service Interoperability Principles (JESIP), are well practised amongst blue light partners to allow them to operate jointly in a major disaster. They are a potential model for how slower time multi-agency decision making frameworks like MASH and Channel/Prevent could operate.

12.9. Pursue – managing subject of interest to MI5 declared a national security risk

12.9.1. The way CTP and MI5 manage Pursue investigations could also be studied here and the inquiry may want to ask CTPHQ to elucidate. In brief, when considering multiple thousand numbers of potential or known terrorists, MI5 take the lead in gathering the intelligence, assessing it and triaging it. They decide what resources are required to develop that intelligence depending on the graded risk, they inform CTP where a subject of interest has been declared so a CTP SIO (an experienced detective) understands what is being done to develop the intelligence and whether they can convert it to evidence for a future prosecution.

12.9.2. CTP and MI5 work side by side using in person Joint Operational Team (JOT) meetings to manage the intelligence flow between them and continually assess the risk. But MI5 are in the driving seat, managing that risk, and are the clear owner of that risk.

12.9.3. If that risk reaches a threshold where there is a threat to the wider public, any member of the team (the MI5 case officer or the CTP SIO) can ask for an Executive Leadership Group

(ELG) to be called. This meeting is chaired by the senior operational CTP leader – the SNC for Prevent and Pursue – a Deputy Assistant Commissioner and the second highest rank in policing. The meeting may include any relevant and necessary partners.

12.9.4. A plan will be developed by the SNC and partners in that room that includes mobilisation trigger points – a series of red lines which if crossed by the subject might result in what is called Executive Action – i.e. the arrest and detention of the subject. The bottom line is that it must always be clear where the risk sits. Where there is a real threat to the wider public (and it need not to be imminent), the police always take the lead, because it is their prime public duty to save life and only they have the powers required to intervene.

12.10. Observation – lack of clear consistent process and leadership

12.10.1. A theme has been picked up where multi-agency work in the non-CT space may not be consistent or have clear leadership in managing the risk before them. It won't be the same everywhere but the principles behind police crisis management and CTP/MI5 CT Pursue management would have some benefit when applied to Prevent in both Channel and Police Led Partnership investigations, and also the MASH process if they are to manage VFIs who exhibit no ideology at all.

13. Conclusion

13.1. The enduring lesson from Southport, AR and the case studies is stark. The warning signs were rarely absent; they were dispersed. They sat in school records, police logs, health notes, family concerns, online behaviour, safeguarding referrals, Prevent assessments, youth justice decisions and missed moments of professional curiosity. Each fragment could be rationalised. Together, they told a different story.

13.2. No system can guarantee that every future atrocity will be predicted or prevented. But a system can be designed so that it sees the whole person, over time, across agencies; records risk accurately; shares information lawfully; challenges optimistic closure; recognises disguised compliance; understands online escalation; and makes one named body or person responsible for asking the most important question in public protection; who owns the risk now?

13.3. The answer cannot be more process without more capability, more meetings without more ownership, or more referrals without more judgement. It must be a coherent operating model: one chronology, one living risk assessment, one lead agency, clear thresholds, clear escalation, digital competence, lawful intervention, and the financial and skilled human resources to make those duties real. Anything less risks recreating the same fragmented architecture and asking conscientious professionals to succeed inside a system that has already set them up to fail.

13.4. The central challenge for the Inquiry is therefore not simply to identify what went wrong, but to insist on a system capable of learning before catastrophe rather than after it. That means protecting civil liberties while acting earlier against real risk; safeguarding

vulnerable children while not ignoring the danger they may pose; holding platforms to account without creating mass surveillance; and ensuring that policing, health, education, social care and national security partners can act as one system when the evidence demands it.

13.5. If Southport is to leave a legacy worthy of those who were killed, injured and bereaved, it must be this; the state must never again allow a foreseeable pattern of escalating violence fascination to remain invisible because it is divided between agencies, systems and thresholds. The future test is whether the next warning signs are seen together, owned clearly, and acted on decisively before another family, school or community is left to ask why the system only understood the risk when it was too late. It is cold comfort to the bereaved reading this report but I think this Inquiry is very capable of recommending a system that will greatly minimise this happening again and again. Once again my deepest condolences and I hope you get the legacy your pain deserves.

The Southport Inquiry

Phase Two

Statement of Truth

Expert: Anil (Neil) Kanti Basu QPM

Report: Expert Report

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

I understand that proceedings for contempt of court 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 in its truth.

Signature

Signed: 

Name: Neil Basu QPM

Dated:

29/09/2026