

Tuesday, 8 September 2026

(10.00 am)

Introductions

SIR ADRIAN FULFORD: As I indicated in July, today marks the commencement of the evidence gathering sessions for part 2 of this Inquiry. Although we are now moving on from the detail of the events of 29 July, 2024, I want to say directly to the victims and their families that what happened to them on that day is the sole reason for us being here as we seek to achieve the greatest possible understanding of why AR and others have been inspired or driven to such extreme levels of violence and to identify for Government the measures which appear to be necessary to reduce, to the extent we are able, the risk of any repetition.

It does not need me to say that this is a truly challenging task, but I'm confident that the involvement of the wide range of participants from truly diverse disciplines and occupations in the seven seminars which are to be held over the next two weeks, will provide invaluable insights into the nature of the problem and the most effective solutions.

I am very grateful to the participants, for the extensive work they have undertaken in advance and their willingness to assist. We are working to a very

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individuals and speak to the challenges of their definition.

Sir, our second speaker will be Dr Tina Irani. Dr Irani is a consultant child and adolescent forensic psychiatrist. For you, sir, of course Dr Irani needs little introduction as she acted as the Inquiry's independent expert psychiatrist in Phase 1.

For those who were not directly involved in Phase 1, Dr Irani has over two decades of medical experience with dual specialist accreditation in both child and adolescent psychiatry and forensic psychiatry. Of particular benefit to the Inquiry's work is that Dr Irani has held senior clinical and leadership roles across NHS in-patient, community and forensic mental health services, including clinical leadership of specialist adolescent secure services. She has additionally held leadership positions with NHS England and the Royal College of Psychiatrists. With that wealth of experience, Dr Irani will provide a psychiatric perspective on non-ideological extreme violence.

Our third speaker today will be Professor Laura Smith. Professor Smith is a professor of psychology at the University of Bath and co-director of the Bath Institute for Digital Security and Behaviour. Following

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carefully constructed and tight timetable and I will say no more, save that, Nicholas Moss, Counsel to the Inquiry will act as compere to these seven seminars and, without more ado, I hand over to him.

MR MOSS: May it please you sir, with your permission I will simply introduce each of those speakers now so they have a clear start for their seminar slots during the programme today. I will leave each of them to introduce the detail of the sub-topics on which they are speaking. So our first speaker today will be Professor Qassim Cassam. Professor Cassam is a Professor of Philosophy at the University of Warwick, a Fellow of the British Academy, and an Honorary Fellow at Keble College, Oxford. His range of research interests include, most relevantly to this Inquiry, the philosophy of extremism and terrorism. In addition to his many academic papers, his published books include "How to think about terrorism: reflections on philosophy, history and politics", and "Extremism: a philosophical analysis".

He has collaborated with Jonathan Hall KC, the UK's independent reviewer of terrorism legislation and one of our speakers for tomorrow's seminar on a range of subjects of direct interest and relevance to Phase 2 of this Inquiry. In broad terms, Professor Cassam will address a conceptual analysis of violence fixated

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postgraduate qualifications from the University of Exeter, she held academic positions at the University of Queensland, Australia, from 2008 to 2011, before joining the Department of Psychology at Bath.

Professor Smith was chief editor of the British Journal of Social Psychology from 2020 to 2022. She has published widely over the past 20 years on the psychology underlying polarisation, radicalisation, social movements and collective action.

Sir, her expertise covers the interaction between human psychology and behaviour and our evolving digital technologies. So she will be addressing today how an interaction between psychological, social and technical factors can produce radicalisation and why they need to be understood in combination.

Sir, our fourth and final speaker today will be Dr Richard Taylor. Dr Taylor is a forensic psychiatrist. Sir, he brings particular insight to this Inquiry's Phase 2 issues because he is the National Clinical Lead for the Counter-terrorism Clinical Consultancy Service.

Sir, as you know, that service evolved from the Counter-terrorism Vulnerability Support hubs about which we heard evidence in our Phase 1.

After an earlier wider medical practice, Dr Taylor's

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30-year career specialising in forensic psychiatry has included prisons, secure hospitals, the Metropolitan Police Special Operations and the Fixated Threat Assessment Centre.

Also of direct relevance and benefit to the Inquiry, Dr Taylor is a leading expert on information sharing between mental health professionals and law enforcement. He co-authored indeed the Royal College of Psychiatrists guidelines on information sharing with MAPPA, as well as the national guidance on data sharing between mental health professionals and Counter Terrorism Policing.

So, sir, each speaker will give their seminar presentations for about 45 minutes, with short breaks in between, they won't take questions at that stage. We will break for a late lunch to be followed by questions to them as a panel.

So, sir, with your permission, Professor Cassam, please.

SIR ADRIAN FULFORD: Thank you very much.

Presentation by PROFESSOR CASSAM

Thank you for the introduction.

The first question I was asked to address today concerns the definition of a violence fixated individual; the question is how should VFIs be defined.

Now, I'm aware that official thinking has evolved

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reference as a definition, I think you would run into a number of problems. So I'm going to now identify three problems with defining VFI in this way, and then I will suggest a way of addressing these problems.

Sir, the first problem with that definition, taking it to be a definition, is that it generates false positives. There are individuals who are at risk of extreme violence where ideology is not the primary driver, but who are not VFIs.

I will give you a simple example. In the late 1990s, Dylan Klebold and Eric Harris, planned an attack on their High School in Columbine, an attack that subsequently killed 13 children in their High School. During the period when Klebold and Harris were preparing their attack, the pupils in their High School were at risk of extreme violence, where ideology wasn't the primary driver. But of course the pupils in their High School were not VFIs. It seems an obvious point.

Now, of course, I am sure that the original intention was not to include the victims of extreme violence in the category of VFI. I imagine that the original intention was that VFI referred to the perpetrators of extreme violence, where ideology is not the primary driver. So I think it would be helpful if that were made explicit.

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since I was first invited to participate in this seminar and that the focus now is on a new concept and a new cohort that's definable by reference to this new concept. The new concept is NIEV, non-ideological extreme violence. And I will have some things to say about the concept of an NIEV in a moment.

However, for completeness, I would like to begin with some observations about the concept of a VFI. In the Phase 2 terms of reference, VFIs are characterised as "individuals at risk of extreme violence, where ideology is not the primary driver".

So one question about this is whether that's intended as a definition -- that's one possibility -- or whether it is simply intended as a practical steer for the Inquiry's work, an attempt to identify a cohort of individuals but without offering a definition.

However, whichever way you understand the statement and the terms of reference, if the label "VFI" is to be used, I think it is important to have a precise definition of it. I think this is an area where conceptual precision is extremely important.

Now, it seems to me that if you were to define VFIs as individuals at risk of extreme violence, where ideology is not the primary driver, in other words, if you were to interpret the statement in the terms of

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So at the bottom of that slide, it is made explicit. So here is an amended definition that solves that problem: supposing we say "VFIs are individuals at risk of committing extreme violence, where ideology is not the primary driver."

That explicitly excludes the victims. So that seems to me to be a very simple and intuitive conceptual fix for the initial definition.

However, I do have qualms about the phrase "at risk" in these cases. It seems to me that "at risk" is a term that originates in safeguarding, and when you talk about an individual as being at risk of something, you are typically talking about the possibility that something is going to happen to them, something will befall them. So if I say people with obesity are at risk of type 2 diabetes, what I'm saying is that people with type 2 diabetes, with obesity, are likely to develop type 2 diabetes but they aren't the agents of their own diabetes. In this case diabetes is something that happens to them, something that befalls them, they are not agents of their diabetes.

In contrast, if you think about a murderer, or a potential murderer, if someone is planning a murder, I think it would be peculiar to say they are "at risk" of committing murder. That would be a strange way of

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speaking. The reason it is a strange way of speaking is that the murderer is the agent of the murder; murder is what they are going to do. Being or becoming a murderer is not just something that happens to them, in the way that developing type 2 diabetes is something that just happens to you.

So my concern is that the "at risk" terminology with its safeguarding origins tends to occlude what I think of as the agential aspect of the individuals with which we are concerned with today. I'm not saying that "at risk" is incompatible with agency. So when we say that "prisoners are at risk of re-offending", of course re-offending is something that they do, but nevertheless it does seem to me that it is preferable in these cases to use terminology that acknowledges that -- that fully acknowledges the fact that the individuals who are of concern to us today are individuals who perpetrate, carry out, are agents of acts of extreme violence. They are not the victims; they are the agents. The violence that they commit isn't something that happens to them; the violence that they commit is something that they commit.

So that's a second reservation. A third reservation is that VFI talks about violence fixation but actually it is not clear that it offers any account of violence

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useful in this context. So there is an academic paper, very influential and highly cited academic paper by Meloy & Rahman in which they define what they call pathological fixation. A pathological fixation is "a preoccupation with a particular person or cause that is accompanied by deterioration in social and occupational functioning".

So this makes it clear that fixation goes beyond mere interest or fascination. So you count as being pathologically fixated when your interest starts to get in the way of your ability to live your life.

So if we adopt that technical notion of pathological fixation, then perhaps we can define a VFI in those terms. So here is a very simple definition, which would be to say: a VFI is an individual with a pathological fixation on extreme violence. And an individual who is pathologically fixated in that sense may have an ideology or they may not. So on that conception, violence fixation is compatible with ideological commitment but it doesn't require it.

So putting all that together, a non-ideological VFI is someone with a pathological fixation on extreme violence, where ideology is not the primary driver and then it is an empirical question whether individuals with that fixation are, in fact, likely to commit acts

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fixation. After all, a person can be highly likely to commit an act of non-ideologically motivated violence for reasons that have nothing at all to do with violence fixation. A member of a gang might be likely to commit an act of extreme violence but they needn't be fixated. So violence fixation need not be the explanation of their disposition to commit acts of extreme violence.

Conversely, it seems to me that a person can have a violence fixation without thereby being at risk of committing extreme violence. Imagine someone who is fixated on violence but has absolutely no interest in committing acts of violence. Supposing that violence for them plays an important role in their fantasy life, but they have absolutely no intention or perhaps even no capacity to carry out acts of extreme violence.

So it is not entirely clear what this notion of violence fixation has to do with actual violence. It may be true that being fixated on violence is a risk factor for committing violence but that is an empirical claim, it is not a definitional truth. I think it is important in this domain not to build into definitions claims that can only be empirically established.

Now, it so happens, and my distinguished colleagues will talk about this I am sure, that there actually is a technical definition of fixation, which might be

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of extreme violence; and that is a question that cannot and should not be settled by a definitional manoeuvre. We need empirical research to discover whether there is indeed a link between a pathological fixation with violence and violence.

So we now have emerging a possible violence trajectory. So here is a trajectory that might be the trajectory of some individuals. We start off with an initial interest in violence; that results in the active search for violent material online; the repeated consumption of violent material; an increasing preoccupation with it, which morphs into a pathological fixation and results in extreme violence.

Here you have a kind of violence escalator. At the bottom of the escalator is something somewhat innocuous, a mere interest, that then -- and then the escalator goes up to the point where you have not just an interest but a fixation and then ultimately violence.

But this is just a possible pathway. There is no suggestion in this diagram, the arrows do not mean you go automatically from one stage to the next stage. There is no necessary progression here. And the precise relationship between violence fixation and extreme violence, that relationship in particular has not been established, it has just been hypothesised in this

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1 diagram.

2 From a kind of policy point of view, or a prevention
3 point of view, the interesting question is: if someone
4 is on this escalator, how do you get them off it? How
5 do you stop someone who has an initial interest in
6 violence or who searches for violent material online?
7 What can be done, if anything, to prevent them from
8 developing a fixation and ultimately carrying out acts
9 of violence?

10 However, I think even with all these modifications
11 and qualifications which I have introduced, I think the
12 story I have been telling so far misses out something
13 very important about the Southport case in particular.
14 Here I quote a passage from the report from Phase 1 of
15 this Inquiry, a very striking passage, where AR is
16 described as having "a deep and enduring preoccupation
17 with extreme violence and the brutal death of others".
18 So that's the VFI element. But there is another element
19 which that doesn't really take account of, and this
20 other element is brought out by this statement that AR
21 made to the police after his arrest. I won't read this
22 deplorable statement out in full. I will simply draw
23 your attention to the highlighted expressions. What is
24 very striking about this is AR's repeated description of
25 his atrocity as a "good thing". So he is using

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1 I take it, instrumental. It is violence in pursuit of
2 prestige or power or control of a particular territory.
3 So they are not going to count as VAls.

4 So here's a way to think about the relationship
5 between the idea of a VFI and the idea of a VAI. To
6 describe someone as a VFI is to describe their
7 psychological orientation; it is to say that they have
8 a particular psychological fixation. To describe
9 someone as a VAR (sic) is to describe not their
10 psychological but their evaluative or, if you prefer,
11 normative orientation; it is to talk about what they
12 value what they think is a good thing.

13 Now, of course, human beings are capable of valuing
14 all sorts of things. Our evaluative orientations make
15 us the people that we are, and the most disturbing,
16 among many disturbing features of the case presently
17 under consideration, is the idea that there are people
18 who actually value of all things violence and the brutal
19 death of others. That's a kind of perverted evaluative
20 stance that is characteristic of the individuals that
21 I am calling VAls; and one of the other advantages with
22 this terminology is that it foregrounds the agency of
23 VAls. It brings out the fact that extreme violence is
24 something that VAls positively value and are committed
25 to perpetrating, and of course this feeds into the

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1 evaluative terminology here.

2 Now, if you simply talk about fixation, then that
3 gets you as far as the idea that he was preoccupied with
4 extreme violence and the brutal death of others. What
5 it doesn't get you, what it doesn't get you, what it
6 doesn't highlight or do justice to is this peculiar
7 affirmation of violence. So he wasn't merely fixated
8 with it, he was affirming it and the affirmation is
9 manifested by his repeated use of the expression "it's
10 a good thing".

11 So when I talk about his affirmation of violence,
12 I'm talking about the fact that he valued or endorsed it
13 and was committed to its perpetration. So, at the risk
14 of multiplying acronyms, I would like to suggest the
15 following as a supplement to VFI: VAI. So VFIs are
16 individuals who are fixated, pathologically fixated on
17 violence. A violence affirming individual has these
18 three characteristics: they value and endorse extreme
19 violence and the brutal death of others; they are
20 committed to the perpetration of extreme violence; and
21 they regard extreme violence as an end in itself rather
22 than as an instrument for achieving some further end.

23 That's a VAI. So if you think about gang members,
24 I mean gang members might be committed to the
25 perpetration of extreme violence but their violence is,

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1 intuition that individuals like this are fully
2 responsible for their actions. They are not victims of
3 some fixation that has come over them for unknown
4 psychological or psychiatric reasons. They are
5 individuals with an evaluative -- a pro extreme violence
6 evaluative framework. They are individuals who are
7 committed to carrying out these acts of violence, and
8 for those reasons they are individuals who can and
9 should be held morally and legally responsible for their
10 actions.

11 So that's VAI as an alternative or a supplement to
12 VFI. Even if you like VFI, even if you want to continue
13 to use it, I think it is helpful to focus on this
14 affirmative dimension of these very peculiar cases that
15 we are discussing.

16 Now, of course, there are many things that we still
17 don't know and I think a degree of epistemic humility is
18 very important in this area. For example, we do not
19 know to what extent violence fixation and violence
20 affirmation are risk factors for actually committing
21 acts of violence. So we don't know how many individuals
22 with a fixation on violence are going to commit acts of
23 violence, but at least, on the face of it, the link
24 between violence fixation and violence is less clear
25 than the link between violence affirmation and violence.

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Someone who affirms violence, who is actually committed to perpetrating it, such a person one would have thought is more likely to actually commit violence than someone who is merely obsessed with it or fixated on it. But these are empirical matters and I just reiterate my point that we need more research.

Of course, we don't know or at least I haven't proposed any explanations for how it is that someone becomes a VAI or VFI in the first place. That is still a matter that needs to be determined, as I say, empirically. So there is a lot that we don't know -- at least that I do not know; my colleagues may know.

I now want to move on to the question of ideology. VAs, as I have represented them, need not be ideologically motivated, but it doesn't follow that they are not extremists. Now, I realise of course that the official UK Government definition of extremism is couched in ideological terms, extremism means ideological extremism, but I think that assumption that link between extremism and ideology is starting to be called into question in the academic literature.

An alternative would be to say that someone can be an extremist because of what they value and are committed to doing, independently of their ideological commitments. If you have someone who values extreme

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applicable theory of man and society and to derive therefrom a programme of political action."

I will just do that again:

"A systematic, all-embracing doctrine which claims to give a complete and universally applicable theory of man and society and to derive therefrom a programme of political action."

So that's a fairly demanding notion of ideology; ideology there means political ideology.

So the individuals that I'm talking about here today, the non-ideological extremists, don't have an ideology in the Scruton sense, but they certainly have an evaluative framework. It is an evaluative framework in which value is attached to extreme violence for its own sake. Value is attached to the brutal death of others. These are individuals who are committed to enacting the brutal death of others.

The fact that they don't have an ideology in the Scruton sense, seems to me to be a very weak reason for saying they can't be extremists. They are extremists when you really, really grip the idea that extremism consists in a disposition to go to extremes in doctrine or practice.

I think this is an idea that is starting to gain respectability in the academic literature. I recently

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violence and the brutal death of others and is committed to perpetrating it, I think there are good reasons to describe such a person as an extremist. I do not think the general public would be impressed by the insistence: no, they are not an extremist because they don't have an ideology. If they are really preoccupied with violent killing and are actually committed to doing it, why isn't that sufficient for them to count as extremists in a perfectly intelligible sense of extremist?

So etymologically, "extremism" refers to a disposition to go to extremes in doctrines or practice. I think that someone who has those values and those commitments is someone who has gone to extremes in doctrine and practice. The doctrine needn't be an ideology, more like a value system than an ideology. But it is a recognisably extremist value system.

So what you have in these cases is extremism without ideology, extremism without ideology. I should perhaps just interpolate a definition of ideology here. This is a term that gets bandied around a lot. Here is my preferred definition. This is a definition of ideology from Sir Roger Scruton in which he says that:

"An ideology is a systematic or all-embracing doctrine which claims to give a complete and universally

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published an article called "Extremism without ideology" and expecting my colleagues to disagree with it, but in fact some of the responses actually started out by saying "We agree with this", and that came as a bit of a surprise to me, but I think it shows which direction the water is flowing in the academic understanding of ideology and extremism.

So what I would like to propose is a placeholder, a new placeholder concept which will cover all these different cases that I'm talking about. So, in some cases we are dealing with violence affirming individuals, in some cases we are dealing with violence fixated individuals and maybe there are other cases too. So what we need is a placeholder for the wide range of cases where we are not dealing with an ideological motive or cause, but we are also not dealing with ordinary criminality.

How should we label these individuals? Take someone who is committed to the perpetration of the extreme acts of violence not for financial gain and not for any ideological cause. What would be a helpful placeholder concept? Well, my proposal is that we should describe these individuals as non-ideological violent extremists, NIVEs as I call them, non-ideological violent extremists. And non-ideological ideological violence

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extremist is a placeholder concept because it applies to a range of different cases. So it would apply to a VFI, it would apply to a VAI, and perhaps it would apply more broadly than that.

Now, as I said in my opening, official thinking seems to have moved beyond talk of VFIs in any case. So a new concept that has been introduced only very recently is NIEV. So now we have two concepts that sound quite similar. So there is my NIVE, and now there is this one: NIEV. NIEV, as it's defined, involves the use or threat of extreme violence that has no clear ideological purpose. So NIEV refers to a type of violence. So it is non-ideological and it is extreme. That's NIEV. And the implicit or explicit purpose of non-ideological extreme violence is to shock, intimidate or outrage a wider audience.

Now of course if you just stop there, you then have a whole lot of false positives. So think about gang killings. So gang killings can be non-ideological and extreme violence. But obviously NIEV is not intended to cover that kind of case. So the way those false positives are excluded is by a codicil. So the codicil says when we are talking about NIEV we are not talking about violence whose primary driver is gang-related, drug-related and so on.

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supposing, supposing it turns out that he didn't care at all about shocking anyone or outraging an audience. Supposing he simply wanted to kill for the sake of killing. Then, his violence would not be NIEV. Now that I think is something that should concern us. I think it should concern us. I mean that looks like a problematic false negative for the non-ideological extreme violence, and the cause of the trouble is the insistence on a wider audience. That's what's causing the trouble here.

It seems to me that the most disturbing cases, the most disturbing cases are cases of individuals who actually don't care about an audience. They are not doing it to shock anyone. They are doing it just because that's what they want to do.

So, after the events of 29 July 2024, the Prime Minister, Sir Keir Starmer referred to extreme violence seemingly for its own sake. I think that is a helpful way of putting it. Saying it is extreme violence seemingly for its own sake is not the same as saying it is extreme violence in order to shock or outrage an audience.

So, that's a kind of reservation I have about NIEV. I think it generates -- two reservations. I mean one is unless you include this clause about excluding gang

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Now I have some reservations about this new concept of an NIEV. Let me now just say what the reservations are.

You will see from the definition of NIEV, that it is audience-directed violence. So non-ideological extreme violence, it is a type of violence and it is a type of violence that is directed at an audience. The intention is to shock, intimidate or outrage a wider audience.

Now, I don't doubt that there can be violence of that type, but what about the following case. Consider someone who positively values extreme violence, who wants to kill people brutally, who actually commits a mass casualty attack, has no ideological, sexual, gang or drug-related purpose and is completely indifferent to whether a wider audience is shocked, intimidated or outraged. Such a person would not be an NIEV. Or to put it more accurately, their violence would not count as non-ideological extreme violence. Why not? Because it is not directed at an audience. Now this is not -- this isn't just a kind of hypothetical case. You might think that actually what I have described there in the second bullet point is in fact AR. I mean AR looks very much like someone who has all those characteristics. When I say that of course I'm speculating because I don't know what was in his head, but you know,

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violence and so on, unless you do that you are going to have a whole mass of false positives. There is lots of violence that is extreme and not ideological. You don't want to include all of that in this category. So you then have to have this codicil and say: well I'm not talking about gangs and all that.

Okay, fine. So there you have dealt with the false positives but you still have the problem of false negatives, you still have the problem that there are cases of extreme violence that is not directed at an audience, extreme violence for its own sake, as Starmer called it.

I now want to compare NIEV with my NIVE. I'm going -- I want to make the case that -- well I think NIVE is better, that's basically what I want to say. Let me kind of compare them, right. One thing to say straightaway is that they answer different questions. What do I mean by that? NIEV characterises a type of violence, right, whereas my NIVE doesn't characterise a type of violence, it characterises a type of person.

So when I talk about a NIVE, I'm talking about a particular type of person, a non-ideological violent extremist; whereas NIEV isn't, in the first instance, about a type of person, it is about a type of violence. Of course, you can go on to characterise a cohort of

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1 individuals by reference to NIEV. You can say, maybe
 2 NIEVs are a risk cohort. So maybe there is a cohort of
 3 individuals who may commit extreme violence which is
 4 intended to shock, intimidate or outrage. But that's
 5 rather weak: individuals who may commit? I mean ... may
 6 in what circumstances? You need something stronger than
 7 that. For this to be an interesting risk cohort you are
 8 going to have to say something like: we are talking
 9 about individuals who are likely to commit
 10 non-ideological extreme violent, or individuals who are
 11 disposed to commit non-ideological extreme violence. If
 12 you simply say "individuals who may commit
 13 non-ideological extreme violence", you have got a risk
 14 cohort that I think is very, very weakly and loosely
 15 defined, and may be I think unhelpfully defined.

16 The main point I want to make, this is the point
 17 I want to really hammer home, is that NIVE is a category
 18 of person. NIEV is not a category of person; NIEV is
 19 a kind of violence. That's a simple point. Of course
 20 that means that NIEV and NIVE are perfectly consistent.
 21 You could use NIEV and you could use NIVE. That would
 22 be just fine, conceptually speaking. But nevertheless I
 23 think NIEV is problematic for the reasons I gave
 24 earlier.

25 **SIR ADRIAN FULFORD:** Professor, I think that takes us very
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1 psychiatrists and how do we think about these young
 2 people, particularly in the adolescent world and how do
 3 we think about where we can put in the interventions we
 4 need to put in.

5 The questions asked was about how a grievance, unmet
 6 need, trauma, developmental vulnerabilities or social
 7 isolation develop into fixations and progress along
 8 a pathway towards serious violence in children and young
 9 people?

10 I think I want to caution here, it isn't, as
 11 Professor Cassam mentioned, a linear process
 12 necessarily. I think we need to understand it as
 13 a multifactorial process and think about it in the
 14 context of the systems the young people belong in and
 15 their own individual characteristics.

16 From my perspective what is really important is that
 17 these young people touch and kind of come in contact
 18 with the whole range of services and sectors and you
 19 want to really be able to think through all of these
 20 services issue: when does somebody need to think about
 21 these young people and what do they need to do about it
 22 and how do they reach that conclusion? What do we
 23 actually rely on? I think it is really important to
 24 consider adolescence being different to adults and
 25 that's where really for us as clinicians to focus on.

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1 close to the time that we need to end but are there any
 2 other finishing remarks you would wish to make?

3 **PROFESSOR CASSAM:** I'm just getting to my last slide.

4 **SIR ADRIAN FULFORD:** Fine.

5 **PROFESSOR CASSAM:** I think the simple point I want to make
 6 is that the idea of non-ideological extremism needs to
 7 be taken seriously and may have application in these
 8 cases.

9 **SIR ADRIAN FULFORD:** I'm extremely grateful to you. Thank
 10 you very much indeed.

11 **MR MOSS:** Sir, thank you. Professor, thank you very much
 12 indeed.

13 So, sir, if we may be ready please to make a prompt
 14 start back at exactly 11.00, please.

15 **SIR ADRIAN FULFORD:** We will take a short break.

16 **(10.50 am)**

(A short break)

18 **(11.00 am)**

19 **MR MOSS:** Thank you, sir. Dr Tina Irani please, thank you.

Presentation by DR IRANI

21 **DR IRANI:** I have been asked to talk about really the
 22 psychiatric perspective and to think about
 23 interestingly, Professor Cassam has talked about the
 24 debate around the definition and the terminology, but
 25 I'm looking at this from the perspective of us working

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1 It is really important that we do not kind of put them
 2 under the same umbrella because, as we all know,
 3 adolescence is a developmental stage and we need to
 4 consider risk in the context of what the mechanism is
 5 and understand it in their developmental phase.

6 We all know that adolescents undergo significant
 7 biological, social and emotional and cognitive changes.
 8 I'm not necessarily going to talk about the terminology
 9 because it isn't a diagnosis. It isn't a clinical
 10 diagnosis that we rely on and really we do need this
 11 defined clearly for the purpose of us to understand the
 12 cohort we are working with, but it is not something that
 13 we necessarily diagnose or it meets any of our
 14 diagnostic criteria, and Professor Cassam has explored
 15 this in his presentation.

16 However, what do we do? And do we think what we
 17 have currently around the clinical risk assessment
 18 frameworks is it adequate and does it kind of meet the
 19 needs of this group? Currently there are a couple of
 20 things under development. We have Randy Borum and his
 21 team working on "the Assessment of Risk for Extremist
 22 violence in Adolescents". The consensus is that we need
 23 to use a structured professional judgement instrument,
 24 and his tool kind of focuses on considering a whole
 25 range of factors and whether these increase risk, reduce

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1 resilience and weighing the balance whilst making
2 a decision around this.

3 We have then got the terrorist radicalisation
4 assessment protocol, the TRAP-18. Again it is
5 a structured professional judgement instrument, but this
6 is more about using it to know when or the acuity of
7 whether somebody is going to carry out the act. And
8 then the further work that has been done by colleagues
9 in New Zealand. This is Dr Enys Delmage. He is looking
10 more at understanding young people's use of the internet
11 and their online use and how that fits into the risk
12 around the specific functions of this.

13 This is still in the developmental phase and hence
14 I'm not going to really talk about it. So, thinking
15 through what Randy Borum and his team have done around
16 AREVA. It is currently under consultation. It focuses
17 on assessing risk and resilience, as I said, across five
18 domains, but really the purpose of this is to understand
19 risk in the context of a developmental context.

20 In assessing risk of extremist violence, we need to
21 understand that young people will justify violence due
22 to a number of factors and what we need to focus on is
23 whether there is something we can prevent. Primarily,
24 is there secondary prevention that we can take and do
25 and can we disengage them and can we supervise their

29

1 Again, within the adolescent population this is really
2 something that is developing. They have their peer
3 group, they have the push and pull around how they
4 engage, what they identify with, and really if they are
5 struggling at this stage and they get pulled towards
6 an affiliation of extremist groups or other extremists
7 then that becomes a concern.

8 The other bit is about psychosocial maturity. This
9 is again something that within the adolescent phase is
10 the development of their cognitive, social and emotional
11 skills to make sound decisions. So most younger
12 adolescents don't really -- struggle with that, can't
13 really make those decisions and as they go through that
14 adolescent phase and young adulthood that's when they
15 will develop both an understanding and maturity around
16 making these decisions.

17 It includes having a temperance that is self control
18 and impulse management, having responsibility and
19 accountability for their choices and actions, and having
20 a perspective both about themselves and what the impact
21 might be or what the wider society understands.

22 Looking at the risk assessment under the other kind
23 of domains. He's focused on behaviour, mindset, social
24 relation context and the individual factors. Now,
25 behaviour (unclear) is about whether a young person is

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1 decisions.

2 The purpose of the risk assessment is to inform
3 intervention and mitigation efforts. It should consider
4 all factors that increase risk, as well as those that
5 mitigate against it, and it should include
6 a formulation-based understanding of risk.

7 What Borum actually focuses on is thinking about --
8 so when we talk about right at the bottom, maturity of
9 judgement, it is thinking about identity and the
10 psychosocial maturity in a developmental context for
11 young people. Adolescents, we know, are at the stage
12 where they are exploring themselves, they are
13 considering where they sit in their identity; they think
14 about their personal identity and their social identity
15 and what does that mean. Personal identity is their
16 self concept, it encompasses traits, goals, values and
17 beliefs and also moral identity, which is a big part of
18 their personal identity where they kind of then consider
19 moral values and bring that into their self concept.
20 This is really, really important as a developmental
21 phase because to begin with, young people often are
22 struggling with this and as they evolve through the
23 aging stages that becomes more ingrained.

24 Social identity refers to the groups, roles and
25 affiliations with which individuals identify with.

30

1 law abiding in adherence to the social rules, about
2 activism and being involving in non-violent acts of
3 political or social change. Why is this important?
4 Often young people will identify with some sort of pro
5 social reform or some kind of ideation. However, they
6 go on to then value the impact or the effects of it on
7 others and also this gets determined with the peer
8 groups they kind of identify with.

9 We also know that past activism can also be
10 a precursor to future acts. Then comes violence,
11 aggression and conflict management, and again this is
12 kind of weighed around behaviour as well. So again, one
13 of the biggest predictors of future violence is any past
14 act of violence and we know that from AR's case as well,
15 and difficulties with confront management. So this is
16 more likely to lead on and needs to be considered as
17 a risk factor for the future.

18 School achievement is another one. If you have done
19 well at school, that isn't a surprise you are more
20 likely to be influenced by positive factors and less
21 likely to engage in negative activities.

22 Then he talks about the mindset and the attitude:
23 attitudes towards social norms and controls. So
24 believing in the legitimacy of laws protects against
25 radical behaviours and makes somebody feel -- is

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conscientious and wants to stick to the rules, and the other way round is more likely to mean that you are going to be against these. Perceived procedural injustice and discrimination is another key factor, and this is where we talk about grievances, where young people feel like it is either towards them or their kind that there has been an injustice or discrimination carried out.

Then comes inter-group emotions and attitudes. Identifying with groups that -- with similar emotions and attitudes is likely to increase the risk, and if you value what out of the groups or you don't value those out of the groups then you are more likely to be at risk.

Attitudes towards violence again is an affirmation towards increased risk and kind of associated with carrying out the acts in the future. Then comes social and relational factors, and again this is really important for adolescents as they are shifting away from their families, to their peer group: what do they value and how do they kind of connect with it and what are the factors that destabilise them?

So when you are thinking about risk you want to think what the drivers are, you want to think about what destabilises the individual and then you want to think

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how they feel towards school and other democratic institutions. If you have been rejected by your school or if you have rejected school norms then you are more likely to be at risk. And then you have adult attachments. If you have no positive adult attachments or no supportive pro-social adults then that's going to have a significant impact on your risk.

Then comes caregiver environments and this is really, really important where it is not about actually attributing blame but it is actually thinking about the factors that influence risk. So, this includes parental behaviour and family dynamics, and these are linked very much to violent behaviour. It also includes instability within the family home and that's important to think about, especially if you are thinking about where do you want to hit the intervention.

And then it also builds on resilience. So if you have got a good supportive family, positive parenting, a positive parental involvement and, you know, engagement with yourself, then this is likely to have a positive impact on your risk.

We can't forget peer associates, whether you have positive peer associates or you have negative has an impact, but also being excluded by your peer group has an impact and it is really valuable to consider; and

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about what actually disinhibits them to carry out the acts. Quite often social factors play a significant role in this. Stressful disruption is a key factor, whether there has been a sudden life change or there has been a crisis, or whether there has been cumulative effects over time is really important to consider.

Part of this includes thinking about peer rejection, which is often what young people identify with. Then comes the sense of personal status of significance. We all recognise young people as growing and developing and wanting a sense of identity, and this is a really important factor for young people where they are trying to get a sense of meaning, purpose and worth during their adolescence. And linking these identity-related developmental tasks has an implication in these young people and their risk.

Then comes the exposure to extremist norms. So if you are struggling with your identity, if you are struggling where you sit with your personal status and significance and then you are exposed to extremist norms, whether you are actually accepted by them is a separate thing but being exposed to extremist norms and what you think about this increases your chance of engaging in extreme violence.

Further to that comes institutional attachments and

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being socially connected and being included, and characteristically often for these young people, they are socially alienated, they don't have a peer group or a social group to engage with and that can be a massive risk factor for them.

One of the things that has become more and more concerning is weapon preoccupation and accessibility, and this is a factor we are less likely to ask about or less likely to think about in our clinical situation, which wasn't -- which was apparent with AR as well. It's if you weren't thinking about the wider picture, you won't necessarily ask for these questions but this is a factor that increases risk.

Finally, Borum talks about individual factors that matter, and these include self-control. This is really, really important. For example, young people who have low self-control often lead to criminal behaviour. We know this, and this is not just in this context, in any context of violence and aggression. But if you have a high self-control it can act as a protective factor. Then you have their individual mental health and any adjustments. This is really important. This is not necessarily just about a diagnosis, but this is thinking about overall their mental health and wellbeing.

There is -- well it is not a direct link something

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we need to be mindful for, including if there is a mental disorder then it needs to be assertively treated as it will increase their risk.

Then finally, risk taking. Adolescence is a period in our lives where we are more likely to take risks. That is a given fact. Your frontal lobe is not developed enough to stop us from thinking things through the way we should. It is not that we don't know what's risky but you are more likely to take that risk because of the way we are.

That's really, really relevant in the fact that carrying out the act, there's going to be less of a kind of barrier to doing that.

So, Borum's view is that we kind of think about these factors within the areas he's talked about, but both aspects, whether there are things that increase the resilience or increase risk, and the purpose of this, the real purpose of doing this is to think about where we can intervene.

Meloy and team looked at TRAP-18 which identified more acute factors, which means the intervention has to be early on, and then distal characteristics, where there might be the development of these views and thoughts, which might need monitoring or might need to be early consideration given to it from a distance. But

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The next question asked was from a forensic child and adolescent perspective: how should agencies distinguish between risks to children and risks posed by children to others, and what interventions may reduce fixation, disrupt escalation and support safer outcomes?

So going back to the earlier slides, I think having a clear risk formulation is really important. I'm not going to go into details because Dr Taylor does that next. But it is really important that we don't necessarily think of these children as, you know, exclude them from their vulnerabilities. We need though think about all the factors and then think about addressing that.

It needs to be multi-agency approach. I think this is said by every single academic, clinician. You know, I have only put police, education, social care, health, voluntary sector but there are so many more professionals and clinicians involved with these young people. It should be driven by a structured professional judgement assessment tool and not rely on our individual instincts. I have done 20 years of this and I still don't rely on my own. We do need though think about a lead agency within a structured form like MAPPA or MASH. I think that is really important because that's one of the things we still question: who is going

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your eight proximal warnings are what increases the need for intervention.

I have put in the structured -- the SAVRY which is a Structured Assessment of Violence Risk in Youth, which we have been using for a long, long time, and in the absence of the other risk assessment tools which have yet to be validated or to get a general consensus, this is still a very good tool, especially for somebody who has committed an act of violence.

It doesn't -- it allows you to adapt it, so you know it doesn't necessarily talk about mental health and it doesn't necessarily talk about acquisition of weapons, but there is no reason why we can't be incorporating this in the vignettes to create different scenarios. It is really important to think about it. It has 24 risk items which, you know, kind of fit with what Borum said through his new tool. It also has protective factors, and again this is where we want to build those resilience. What is -- the intention for clinicians is to understand where can we intervene and what can we build and to mitigate against the risk.

We also have SAPROF which is a particular tool focusing on dynamic protective factors again, and it is really important that we look both at the risk as well as the resilience and protective factors.

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to do this, how is it going to be done?

Like I said, we also need to think about the child in the middle of this. We need to really think through young people who are increasingly socially isolating themselves. This has become a key concern for us now. You have young people who were inherently finding it -- struggling to come to school. We now have fines levied towards parents if they don't make it to school. Parents are taking them out and home schooling them so they become completely lost to the system, and for me that is a big, big place where we could be doing something systemically.

Then there is a lack of parental and professional oversight. This is often manufactured by that young person, whatever the predisposing conditions might be. Yes, they manufacture it but we are the ones who are meant to be the adults, we are the ones who are meant to be looking after them and we need this think about how we support that, and we need to work with the transition from victim to warrior role. This is really important to how they might manage themselves. I've put neurodiversity and mental health because supported in the right way, and if there is a diagnosed mental disorder treated, often will help with this.

I go back to it being multi-agency. Young people

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1 shouldn't be out of education or vocation. I think
 2 today's headline was about eight out of how many are not
 3 in education or vocation? That is staggering. They
 4 need to be engaged. They need to have a sense of
 5 belonging and achievement. We need to make sure parents
 6 are supported. They need to receive education around
 7 online risk and monitoring of this. But equally, we
 8 need a social input into this because young people are
 9 way, way smarter and quicker than us. Okay? So once
 10 they have accessed something online, they know how to
 11 break every -- I know my 12-year old niece can get
 12 through every single parental safeguard put on my
 13 brother's phone. That's just what they do. They know
 14 how to do it and the more you do it, the more they will
 15 do it.

16 But we need to support parents in not losing contact
 17 with their children. We need to think about what
 18 training they receive and how we provide it. I've only
 19 put NVR as an example, but when a parent feels
 20 threatened or scared of their child, that is quite
 21 a telling tale. We need to support them in managing
 22 that. As I said, treatment of the mental disorder is
 23 relevant, if it is there, and then external monitoring.
 24 What are we doing? I know you don't want to be in a Big
 25 Brother of the house. But you do need to think about

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1 (A short break)

2 (11.45 am)

3 **SIR ADRIAN FULFORD:** Yes.

4 **MR MOSS:** Thank you, sir. Professor Smith please.

5 **Presentation by PROFESSOR SMITH**

6 **PROFESSOR SMITH:** Hello everyone. So I'm a social
 7 psychologist, so I'm going to focus on the social and
 8 relational context now.

9 (Pause).

10 So I have been asked to talk about this first
 11 question on the heading here which is about how
 12 motivation for non-ideological violence can develop and
 13 how it differs from ideologically driven or impulsive
 14 violence. So I have some starting assumptions here.
 15 I understand non-ideological extreme violence as
 16 violence perpetrated by individuals for whom ideology or
 17 a group-based sociopolitical grievance is not a primary
 18 driver. I will unpack that phrase a little later.
 19 I also assume this involves developing capability and
 20 motivation for violence over time, as opposed to
 21 impulsive violence which might be a reaction to
 22 an immediate circumstance. I am going to refer to the
 23 motivation for non-ideological extreme violence as
 24 radicalisation, and by that I mean extremisation of
 25 views around violence, to coming to support violence

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1 what are we doing with their systems, and really
 2 internet safety is one of those key factors.

3 I guess what next? The definition. I will leave
 4 that to the academics. We have got a couple of tools
 5 that are coming in development and in validation stages
 6 and I think those are really important, that we don't
 7 really want to develop more new things, we need to see
 8 how this pans out and really use the stuff that has got
 9 a national and international consensus.

10 There is a lot of research still outstanding and we
 11 need to join up with our colleagues again across the
 12 globe really. I think really important for me is
 13 legislation to ensure online safety and security. That
 14 is one of the key bits that we can influence while
 15 individually we will be doing other things.

16 I really want to say thanks to Dr Delmage and
 17 Dr Champaneri for sharing with me some of their
 18 expertise. I have put in the references if anybody
 19 needs them. Thank you very much.

20 **MR MOSS:** Dr Tina Irani, thank you very much indeed. Sir,
 21 I think we are now slightly ahead of schedule so can I
 22 suggest we take a slightly longer break and perhaps
 23 resume please at 11.45 am, with Professor Smith.

24 **SIR ADRIAN FULFORD:** Certainly. 11.45 am.

25 (11.26 am)

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1 over time, and that an individual comes to believe that
 2 violence is acceptable.

3 I'm going to also note at the beginning that the
 4 vast majority of research in social psychology and
 5 similar domains on radicalisation has assumed either
 6 an ideological or a group-based sociopolitical
 7 motivation, and I'm going to point out where that's
 8 relevant and where we need to diverge in our
 9 understanding.

10 So a traditional approach to understanding
 11 radicalisation often talks about a linear pathway or
 12 staircase. We hear words like "elevator" or "escalator"
 13 to describe the way that people might move linearly from
 14 not supporting violence to supporting violence. So
 15 a staircase model has become quite well known. However,
 16 actually thinking has moved now and we don't understand
 17 it as a linear pathway anymore.

18 This has caused a few problems, one being
 19 specificity. Because if you assume that people start
 20 off at the bottom and lots of people developing
 21 grievances, lots of people then have a motivation that
 22 might explain why they support violence but that doesn't
 23 actually predict who ends up at the top of the staircase
 24 prepared to commit an act of violence.

25 Focusing on that development of motivation for

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1 violence among the masses doesn't enable us to be
2 specific about who would then go on to perpetrate an act
3 of violence.

4 Moreover, this assumes that there's some kind of
5 100 per cent causal connection between people's
6 attitudes and their behaviour, and we know from decades
7 of research in psychology that the correlation between
8 people's attitudes and their behaviour is conditional,
9 it is not 100 per cent. So you may hold an attitude
10 that supports violence but you are never going to enact
11 violence yourself.

12 So to overcome this, McCauley and Moskaleiko
13 described their two pyramids model of radicalisation
14 instead. One pyramid describes people's progression on
15 their opinions around violence, so they become
16 radicalised in support of violence, so that is their
17 cognition; and the other pyramid is behavioural
18 radicalisation. So they are separating their opinions
19 around violence from their behaviour. This second
20 pyramid describes progression in behaviour towards
21 engagement in violence.

22 They say the motivation development is a phenomenon
23 of mass psychology. Lots of people develop motivation
24 but only a few people, a few individuals might develop
25 the capability and then go on to engage in the behaviour

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1 because they are fearful of the consequences of law
2 enforcement or they don't have the resources to be able
3 to commit an act of violence and therefore they are
4 unlikely to engage in the violence.

5 On the other hand, somebody may not support
6 violence, not believe in the need for violence, however,
7 they are materially incentivised to commit an act of
8 violence and therefore they may do. So people may fall
9 anywhere on these two bisecting lines and we need to
10 understand why they might have this different variation
11 in their association between their attitudes and their
12 behaviour. So we need to look at their different
13 conditions, the structural enablers, incentives and
14 disincentives, the factors that might build their
15 capability and motivation for engaging in violence.

16 Having said that, most research and theory and
17 psychology and social psychology in terrorism research
18 has looked at the motivations: why an individual would
19 decide that they support violence. In the social
20 psychology domain, the support for violence has been
21 described as group-based, and broadly, there is a series
22 of factors that I have listed on the slide here that
23 might predict why somebody would want to enact violence
24 on behalf of their group.

25 So this is -- think of this as an individual's

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1 of violence.

2 This is helpful because it enables us to start
3 understanding how the risks and processes of
4 radicalisation are separate for opinion and action
5 radicalisation, and also enables us to look for
6 different risk factors and different interventions.
7 However, separating them in this way then looks like
8 they are independent of each other, but like I said we
9 know attitudes and behaviours have a conditional
10 correlational relationship.

11 So Khalil describes his ABC model here to try and
12 explain this conditional relationship between attitudes
13 and behaviours around violence. He talks about
14 ideologically justified violence but I want you to
15 ignore that for now because it is actually not relevant
16 for this example. Broadly, he described these two
17 bisecting lines where on the bottom we have attitudes,
18 so sympathy towards violence, and on the vertical line
19 we have the behaviours, so the extent of involvement in
20 that kind of violence.

21 He says that people vary in where they fall on these
22 two different lines. So, for an example, some people
23 might be fully sympathetic towards the idea of violence,
24 they have support for violence, however, they are
25 disincentivised to participate in violence, maybe

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1 perspective but thinking of themselves as a group
2 member. Dr Irani earlier introduced the idea of social
3 identity; somebody's social identity is their feeling of
4 belonging with a particular group.

5 According to these theories, if you feel that that
6 group is a part of who you are, but there has been some
7 kind of injustice perpetrated against your group, so you
8 have a group-based grievance. If you feel angry about
9 that and you are morally convinced that it is the right
10 thing to do to take some action to address that
11 imbalance, and you feel efficacious about doing that,
12 you have this personal or social efficacy to do so, you
13 may decide that taking action is appropriate. Violent
14 action is more likely if you feel contempt for members
15 of other groups. If you feel that your group has failed
16 politically and there's no other option than to engage
17 in violence, you may be more likely to choose violence
18 over legal forms of action.

19 So, these are often the predictors talked about when
20 people discuss ideological violence or group-based
21 violence, it has a sociopolitical cause.

22 These may not be applicable in the case of
23 non-ideological extremism. However, further theorising
24 has argued that actually a proximal process that people
25 go through when they are feeling that there's some kind

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of injustice in the world is to talk to each other about it and find people who have the same thoughts about the situation as they do. Now, it is those processes of social interaction and socialisation with like-minded others that can give people the confidence to act, and those processes of social interaction and socialisation are relevant in many different kinds of domains, and that's why I'm giving you this example now because I'm going to show you how socialisation can be really important with the new reality of what we are seeing online with youth radicalisation.

So talking to each other about perceptions of a social context or society can give people the confidence to act, the validation. They might feel there is some kind of consensus with like-minded others that violence is acceptable and it will enable them to internalise specific norms for violence.

It also provides a signal. If people are interacting online about their perceptions, it provides data and a signal of impending threat.

So, this is usually used to describe group-based or ideological violence. What we are seeing now online is something that's been described in Canada, by the Canada Centre here, as nihilistic violence extremism. Nihilistic violence describes a set of attitudes or

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online networks and the pathways in.

Next I'm going to describe how personal characteristics might interact with the technical environment online and the social interactions that they are having to produce risk of perpetration of violence.

So these three strands we have been conducting over the last 12 months. The first were two expert roundtables with practitioners from multiple agencies and with academics from different disciplines where we defined the problem of online youth radicalisation. We then did a systematic review of academic research on online youth radicalisation to identify what we know now and what's applicable to this new kind of threat, and currently we are analysing data from one of these nihilistic violent extremist channels to understand what the people are talking about within the channels and how it relates to the risk of violence.

So, our systematic review we identified thousands of papers. Ultimately through our screening, we analysed the insights in 218 different academic studies. We found that there was evidence for three sets of factors that interact to produce risk of radicalisation. The first being personal factors, so what we might consider the psychological intra-personal factors. Dr Irani outlined many of these earlier in her presentation, so

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beliefs involving disillusionment with society, glorification of violence and the desire to bring about social instability, chaos or collapse. That is contested definition of what is happening online with young people when they radicalise at the moment. In our own work we have reached a definition that describes online communities that advocate violence as competitive, sadistic and exploitative online networks in which members achieve status and social capital gains for the perpetration or incitement of violence. That really describes the new set of motivations for violence that develop through socialisation processes and online networks.

As this figure shows, there are multiple different entry points into these nihilistic violent extremism communities. They are all extreme interest communities. So instead of those group-based sociopolitical motivations, people might start out in a self harm or eating disorder extreme community or a gore community and find themselves from encrypted chat channel or social network into a different chat, involving extremist violence.

So this is the new reality of online youth extremism. We have conducted three different strands of work to try and understand what is happening in these

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particular life experiences, poor caregiver monitoring and attachment and perceptions of discrimination and bullying and so on.

We also found evidence for the role of social interactions, both online and offline, that can produce a set of norms within these communities that focus on status-based incentives for perpetration of extreme harm.

So, by status-based incentives I mean that many of these groups offer status within the group for -- in return of evidence of harm. So, posting graphic depictions of harm that might be self harm or it might be harm they have coerced others into perpetrating, and the more harmful the more status they will be rewarded with within the group.

Finally, we looked at the evidence that the design of the socio-technical system, so social media, chat channels, algorithms and so on produce more likelihood that individuals might encounter extreme violent content.

We then produced a model with our propositions for how these three different sets of factors intersect to produce risk. On the left-hand side we have got what we call distal antecedents. So they are things like the personal characteristics and life experiences of

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individuals. So it might be prior victimisation, it might be threat sensitivity, experience of bullying, it might be something like eating disorders or self harm. That might lead people to be more likely to seek out extreme content online or other users who engage in the same kinds of behaviours. The important thing here is that, although they might have an initial interest in seeking out such content online, as soon as somebody engages with content like that, even by a dwell time, how long they linger over reading something, if there is a recommendation system embedded within that network, in that platform, they are mostly likely to see more content like that because the algorithm learns their patterns of engagement. So if somebody has a predisposition or interest in any particular type of content, they then engage with it in any way, they are more likely to see more of it, so it becomes self-fulfilling.

So also some members of these communities, the established members will seek out those who they believe are vulnerable to recruit them and coerce them into producing harm.

Another pathway in appears to be those people who have a perceived status deficit, so they may feel like they don't have any status or recognition in their

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a world view or ideology that supports reading any particular content, or if you feel a sense of injustice that you have experienced discrimination or been excluded in your personal life, you are more likely to be attracted to extreme kinds of content. The algorithm then picks that up and this might resonate with the individual. They are more likely to see more of it. The "illusory truth effect" shows that the more people are exposed to some content, the more they believe that it's true and it's valid. So the more you see something it reinforces the belief and that creates this initial attraction to extreme content.

They then talk about how this is reinforced because people enter echo chambers, so networks of people like them. It means that AI will selectively surface similar content. Large language models, so chatbots, are more likely to surface connections between different types of extreme content. Chatbots are used for grooming as well, under recruitment. This means that people will start seeing more and more like similar content, like minded others will also reinforce and validate that content, and they will then become integrated into these networks and they will start to feel belonging with these groups. So this can increase risk of violence.

We looked at one of these networks. So we have data

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everyday lives and therefore these groups offer a pathway to achieving that recognition. So perception of any kind of deficit, and that might be a gendered grievance, they then find a group that gives them a structured pathway to achieving recognition through the perpetration of harm.

This is moderated or conditioned by things like how much they start to internalise that group into who they are. So the more they become attached to the group and the way it works, the more likely they are to engage going forward and to extremise in their behaviour in the production of harm. If they don't have caregivers who are monitoring their internet usage or they are not attached to, they are more likely to engage. There is also the presence of financial incentives for the production of harms in these networks.

I want to touch little bit more on how algorithms can amplify the risks in these settings. So this is a review paper by Kunst et al published this year and they review the evidence for how AI can exacerbate and amplify risk. They talk about how people in general are more likely to engage with negative and moralised content online and so most people are more likely to click on that kind of content. But if you also have a predisposing factor like a sensitivity to threat, like

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from about half a million messages from 1500 users in one of these nihilistic violent extremist groups. We analysed the text data to look at the kinds of content we were seeing. Harm is present, significant harm, but at the same time the atmosphere in these chat channels is very convivial, talking about Christmas and New Year's Eve. I'm going to show you in the next slides some different topics they talk about. It is as you might expect from a largely adolescent network is they talk about lots of different topics, highly disorganised and somewhat banal, if it wasn't for the harm.

So these are the kinds of topics that we found in these half a million chats. A lot of it was sexual hazing. So established members were trying to force compliance from less established members to produce material that they would then share and they would use that to coerce and humiliate other members. It's very conflictual, very combative. But also they talk about video games, family. They have a bit of politics chats. They talk about recreational drugs, animals and so on. So lots of different topics and we argued that actually the success of this network and the popularity of it is actually in its status of a social network. People socialise from this network and they can achieve status if they are willing to share content and coerce harm.

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1 There is also appears to be some differences in
2 female and male presenting users within the network.
3 Where the orange bars here are female-identifying users.
4 We don't have evidence whether they are male or female
5 but they are presenting as if.

6 The female members were more involved in
7 perpetrating the conflict within the channel and
8 coercing the generation of harm, which was an unusual
9 and unexpected finding, but they are agentic in these
10 networks as well as being victims of the harm.

11 So that is the new reality of what we are seeing
12 online at the moment. The other two questions I was
13 asked to speak to is how we might identify the
14 behaviours that signal risk to society.

15 One opportunity in studying online behaviour is that
16 we have data and we can model risk associated with using
17 the data that we have. Research so far suggests that
18 the social side of engagement in these kinds of networks
19 where harm is perpetrated, so joining and engaging in
20 these groups as I just showed you, and the group's
21 specific behaviours can be indicative of risk in that
22 people are developing motivation and conformity to the
23 norms of these groups. However, as I said before,
24 motivation doesn't always mean action.

25 So, one way in which we can try and ascertain risk

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1 actually carry out violence.

2 On the other hand, talking about ideology was
3 negatively associated with the perpetration of violence.
4 So -- and hate speech as well. So, talking around that
5 motivation for violence itself wasn't helpful in
6 predicting those people who went on to commit acts of
7 violence. It was their talking about developing the
8 capability of the violent action, the weapons, that was
9 the signal that seemed to differentiate those who
10 perpetrated violence, and that is interesting because it
11 speaks to that behaviour, the capability side of things
12 rather than the motivation. So on those two pyramids it
13 was the signal of the act of violence that we were
14 looking for.

15 A second match case control design compared the
16 Facebook activities of 48 terrorists in 100 days prior
17 to their attack and compared that against a control
18 group of non-violent, what they call radicals, so those
19 who had similar views but didn't commit an act of
20 violence. Whereas the previous study looked at markers
21 or signals of capability building, in this study the
22 highlighted -- the words in yellow here that
23 I highlighted, these are the things that predict the
24 difference between these two samples, and the
25 interesting thing here is it's not capability building,

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1 and predict -- look for the signal of who might go on to
2 perpetrate violence. We can hold motivation constant in
3 a matched case design and compare the signals, the
4 behaviours, online of those people who went on to commit
5 violence offline and those who didn't.

6 I'm going to talk about two studies that had this
7 matched case design next. So in the first study, we had
8 a matched case-control design of right-wing extremists,
9 so they were all motivated and all supported violence.
10 Half of them had been convicted of a violent offence and
11 half had not. We looked at their online behaviour and
12 used that to predict the likelihood of violence.

13 So these kind of methods can be used in threat
14 detection techniques but also could be used in social
15 media platforms to identify and moderate. So, we looked
16 at their actual online behaviour. On this diagram, the
17 long red tail indicates that those things predicted
18 those individuals who had been convicted of a violent
19 offence. So this one, I know it is too small to see,
20 violent action, talking about violent action, so talking
21 about weapons and operations and the perpetration of
22 action, was most associated with those people who had
23 been convicted versus they weren't. So that was the
24 signal that differentiated between people convicted of
25 violence and those who had the motivation but didn't

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1 it is around the social network.

2 So, differential associations with terrorists mean
3 that those individuals were more likely to share and
4 glorify the actions of other terrorists so that they
5 would post about a terror attack that had been committed
6 by somebody else. They were more likely to go on to
7 commit a terrorist attack if they had been sharing other
8 people's posts but also had their own posts shared, so
9 a signal that they were getting validated in their
10 interactions and they were being -- acting part of
11 a network and they were less likely to have authored
12 textual posts. So they weren't writing but they were
13 sharing and glorifying others' actions. So this seems
14 to point to a signal that's around the social network,
15 whereas the previous matched case-control design looked
16 at signalling operational capability.

17 So that was a whistlestop tour but I wanted to
18 highlight some implications that I believe are relevant
19 to the Inquiry. To understand risk markers,
20 particularly in online behaviour, we need to understand
21 and separate motivation and capability development, and
22 that might be of the self but also in others, so social
23 networks are resources that they can support the
24 radicalisation of others as well.

25 Any multi-agency risk assessment needs to audit

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online behaviour. It is a Wild West out there. We need to understand people's browsing, search history, app usage, gaming and social media usage as standard to understand the kinds of networks they are interacting with and the kind of content.

Internet access should be restricted for those people where harm has already been perpetrated or where there's a significant risk they pose a risk to others.

And the safety should be out of the box. At the moment people and parents have to set up controls but this should really be opt out rather than opt in. Any intervention needs to address the socio-technical not just the personal vulnerabilities, and ideology isn't always relevant, as Professor Cassam has described.

Through our roundtables with practitioners we found there were several different ways in which the response to youth radicalisation could be supported, specifically with consensus on a multi-agency definition of this new threat. A strategy to deconflict and clarify operational responses, so who is responsible when. People need more awareness of the risks and threats currently online, so that includes frontline staff and the NHS and education but also parents and carers, what are the risk signals of engagement?

We need training and education material for

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I'm speaking from the point of view of a practitioner, but I'm speaking on behalf of a large team, which I do need to briefly acknowledge. A lot of the data I'm going to be presenting has been produced by Professor Paul Gill, Caitlin Clemmow, Amber Seaward at University College London Department of Crime Science.

I need to acknowledge Chief Inspector Mike Nelson, Fayz Allyboccus who I worked with very closely, along with almost 30 mental health professionals in our team and seven police officers. I'm also going to refer to previous research from the Fixated Research Group, David James, Frank Farnham, Professor Mullen, Michelle Pathé.

Just briefly on definitions; we have had a lot of discussion about definitions but the work I'm presenting will mostly be focusing on the fascination with extremist violence and mass casualty attacks; that is fascination with the commission of those attacks.

In forensic psychiatry, fixation is actually a narrower definition than that. Although, in Counter-terrorism Policing, VFI is the broader category, FEVMCA is the narrower category. But fixation for us is an intense preoccupation, pursued to an irrational degree; the preoccupation progressively colonises the individual's thinking, dismantles social and occupational functioning, so that the life around it

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frontline staff, for parents and carers and we need mechanisms for sharing insights and standard operating procedures across agencies.

So this picture really shows that we need to understand how the sociotechnical environments intersect with personal vulnerabilities and characteristics in order to understand risk.

Thank you.

MR MOSS: Professor, thank you very much indeed. Sir, we again are ahead of schedule but it is helpful to have a break between our speakers. May I suggest that we take until 12.35 pm.

SIR ADRIAN FULFORD: Certainly.

MR MOSS: Thank you, sir.

SIR ADRIAN FULFORD: I will rise.

(12.13 pm)

(A short break)

(12.35 pm)

SIR ADRIAN FULFORD: Yes.

MR MOSS: Thank you, sir. Dr Taylor please.

Presentation by DR TAYLOR

DR TAYLOR: Good morning, Sir Adrian, Members of the Inquiry Legal Team and Core Participants.

Thank you very much for giving me the opportunity to talk about our work at the Clinical Consultancy Service.

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shrinks. It is ego syntonic, so it is embraced and not resisted, which distinguishes it from a clinical obsession, which I will come back to briefly at the end. I'm not going to address the issues around NIEV any further.

So, we are a joint mental health and police team. We are entirely funded by Counter Terrorism Policing from their grant, although we are all employed by the NHS, so we work on, effectively, a secondment on a contract.

We consist of seven counter-terrorism police officers and that large team of mental health staff that I have mentioned, and we are all employed by North London Foundation Trust or Greater Manchester Mental Health Foundation Trust.

You will be aware that we were a pilot from 2016 but we went live in 2024 as a fully commissioned national service.

So we were up and running 1 April 2024 and since the dreadful events of July 2024, as Counter Terrorism Police have adapted, so have we. Our team consists of a counter-terrorism Detective Sergeant, forensic mental health practitioners, who are usually experienced social workers or forensic nurses who have worked in police custody settings, prison in reach, secure hospitals

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generally and then each team is chaired by a consultant forensic psychiatrist and a consultant clinical psychologist. So we are fully multidisciplinary.

Health staff are all vetted, so that we can receive information from our police colleagues in a safe space.

So the CCS, police officers and mental health professionals are effectively firewalled from CTP; so any information that we obtain from the NHS, for example, is not automatically passed onto Counter Terrorism Policing.

I will come back to information sharing in a moment. We see around 1200 referrals per year. We do not interview the subjects, we do an indirect assessment. So it is, effectively, a desktop exercise based on records. Given that Prevent programmes saw just under 9,000 referrals in 2025 and the most recent 12 month rolling figures are now over 10,000, we are effectively seeing approximately 10 per cent of those Prevent referrals at the CCS. I say seeing; doing indirect assessments.

So, we are seeing a filtered group, hence, as we come onto numbers, as you would expect, high rates of mental ill health, using a very broad category and neurodiversity.

We also see 200 cases from other parts of Counter

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Midlands, covering East Midlands, West Midlands and Wales and our team in Manchester covering the North East and the North West.

We don't rely on a mental health diagnosis, we use a holistic approach. This is derived from psychology rather than forensic psychiatry, but we use The Five Ps Model formulation. So, once we receive a case and the case is screened in, we will start working on a formulation and it may take a number of weeks to finalise, depending on what information we receive. But we are looking at the presenting problem: what is the behaviour that's brought an individual subject into contact with Counter Terrorism Police? Is it internet activity? 40 per cent of Prevent referrals, as you well know, come from education. So commonly a ticket of entry is a school report, for example, sharing extremist content with peers.

We then look at what are predisposing factors, which may be mental health diagnosis but it may be psychological factors and other subthreshold issues and, for example, family issues. And then what's the precipitant? What's tipped somebody over into this behaviour? Was there a loss? A grievance? An exclusion from school for example? Finally, what are the perpetuating factors? What is it that's maintaining

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Terrorism Police. Our remit is for safeguarding and mental health safety of individuals referred to us and for reducing the risk of serious harm to the public and it is that dual responsibility which I will come back to again under information sharing.

We don't duplicate Channel, but we do sometimes attend where there are sticking points and where Channel are having difficulty linking in with mental health services or social services.

Our key output is providing advice and consultancy to counter-terrorism police officers; looking at the impact of mental ill health, neurodiversity and its impact on the individual's behaviour. And our second key function is the liaison and diversion with mental health/social care services, trying to break down barriers, facilitate communication and two-way information sharing.

Finally, what we are looking to facilitate is the best intervention for any individual, subject to reduce both mental health concern and counter-terrorism concern, and of course with the FEVMCA, counter-terrorism has a much broader remit than it did two years ago.

Geographically we operate out of three hubs. So three of our teams are based in London. One in East

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the concerning behaviour and whether that's family dynamics or an educational issue?

Then, of course, when we are talking about interventions, the last P we are looking at protective factors; what can we or what can other mainstream services put in place to resolve the problem or to protect from returning to the problem behaviour effectively?

Information sharing is a crucial part of our work. I would say that a large part of our job is the sharing of Counter Terrorism Police information with mental health services. Information does flow the other way, but I think that NHS and social care services are often blind to information about concerning behaviour, offending, or evidence of violent extremist mindset and associated behaviours, either because they have never been told it or because the subject has moved between mental health teams or moved catchment areas or because of problems with fragmented information systems.

So we aim to ensure that any mental health assessment and intervention is based on a full picture, as full a picture as is possible.

In order to share information, we have a process within the CCS, within our firewalled teams, where we agree what's called action on. That's police permission

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1 to share information outwards. And in terms of health
2 information, we provide what we call a permission to
3 share with our in-house counter-terrorism office, who
4 then will share with Counter Terrorism Police outside
5 our team.

6 We have an air-gapped information system, again, so
7 that wider CTP do not have access to the information
8 that we may have obtained and, of course, when we go to,
9 for example, a NHS community mental health team, the
10 decision to give us information is theirs. We have
11 an information leaflet; we declare who we are and we
12 explain that we are a NHS team working with Counter
13 Terrorism Police and we have an information leaflet
14 which we can supply if needed.

15 I'm just going to give you a quick example. So,
16 part of counter-terrorism involves managing those
17 convicted of Terrorism Act offences. In this case there
18 was an individual who was being managed in the community
19 via a probation licence, and he was receiving both
20 supervision and encouragement to engage in desistance
21 and disengagement from his activity, which had been the
22 online promotion of violence with an extremist --
23 an ideological extremist content.

24 He was showing signs of a relapse, in clinical
25 depression and the local mental health service received

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1 extremism or all the various types that we have talked
2 about this morning, and also to prevent serious harm to
3 a third party. In the public interest; prevent a threat
4 to life, to national security, to prevent and detect
5 serious crime.

6 I have lifted those exact wordings from various
7 professional guidances and I have been working in
8 information sharing for a long time, particularly with
9 MAPPA and I think there's -- my impression is that
10 there's often a misunderstanding about information
11 sharing amongst my mental health colleagues because
12 there's no single bit of legislation, NHS guidance or
13 professional guidance that provides a pathway for
14 information sharing.

15 So, starting with legislation and the Human Rights
16 Act; of course there is a conflict between Article 8,
17 right to privacy, and Article 2, Human Rights Act, right
18 to life. Should information be shared in order to
19 prevent serious harm that may protect someone's life and
20 that is a tension. There is a legal pathway through the
21 Data Protection Act and GDPR. It is fearsomely
22 complicated to read through, but there is a pathway.
23 Counter Terrorism Security Act, we rely on the Prevent
24 duty. Social workers in our team have the Care Act,
25 which provides a pathway for information sharing for

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1 the GP referral and offered an appointment 8 weeks hence
2 for a primary care review. We were approached by the
3 community team looking after this individual, Counter
4 Terrorism Police and Probation, and through them we were
5 able to get access to MAPPA minutes, which showed that
6 he had been assessed by no less than four psychiatrists
7 at the beginning of his prison sentence. There was
8 a dispute about the relationship between his mental
9 health and his offending. He had had a history of
10 psychotic depression. We put all that information
11 together, shared it with a senior clinician in the
12 mental health trust and, on the basis of that full
13 picture, they agreed to see him the next day. He was
14 re-engaged with his medication and what might have been
15 a return to offending or a breakdown in licensed
16 supervision, was effectively resolved through a mental
17 health intervention.

18 I think it is an important nuance that this is not
19 about queue jumping, it is about making sure that it is
20 risk informed decision-making rather than
21 prioritisation, unless the risk justifies it.

22 So, broadly speaking, as it says on the slide, it is
23 this dual role, looking at the interest of the subject's
24 health, safety, welfare, to safeguard them and reduce
25 their vulnerability of being drawn into terrorism or

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1 safeguarding. There is a number of Common Law
2 precedents, which I won't go into.

3 But, again, individual cases provide rulings on
4 various aspects of information sharing. I think the
5 most useful one of which, which I have referred to in
6 documentation for the Inquiry legal team, that
7 a forensic psychiatrist must weigh in the balance
8 a decision about information sharing.

9 Then we have our professional codes of practice. So
10 as a psychiatrist, I need to adhere to the
11 General Medical Council, British Medical Association,
12 Royal College of Psychiatrists and all of them have
13 slightly different wordings, but overall the
14 General Medical Council is the one guidance that a lot
15 of the others refer to.

16 So, we have collected data on our first 1534 cases
17 from 1 April 24 until 16th January this year.
18 Fortunately we have been able to repurpose staff funding
19 to provide funding for a full time postdoctoral research
20 fellow, who has senior academic and professorial
21 oversight from UCL Department of Crime Science. It was
22 a complicated negotiation because of course the data has
23 to be anonymised and dealt with under appropriate levels
24 of security.

25 We now have substantial data, although we only went

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live as a research project in April of this year and we already have peer reviewed research in preparation for publication. So, our aim at the CCS is to present our data in the public to allow scrutiny of what we do.

What do the numbers show? So, it is a very young population. 90 per cent male with a peak age of around 18. It is an increasingly younger cohort and the largest single age band are the 11-15 year olds.

Looking at ideology breakdown, the largest group is extreme right-wing. 34 per cent of the sample Islamist extremism at 16 per cent. Multiple ideologies at 12 and crucially, FEVMCA at 11.3 per cent. So since April 2024, we have seen -- at this data point in January, 170 FEVMCA cases, by now well over 200. If you add up the FEVMCA and no ideology and multiple ideologies, then it is approaching 40 per cent of our caseload that are outside the framework of single ideology terrorism.

So this graph looks at the breakdown of age groups across ideologies. The coloured bars represent different age groups. So the red bar represents under 15 year olds. The orange bar 16-17 year olds and the yellow bar 18-21 year olds. For extreme right-wing, for example, we have 45 per cent. That's the left-hand column. 45 per cent under 18. But when you look at

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autism spectrum conditions, but we are seeing these dramatic elevations in the proportion coming into contact with CT policing and coming onto the CCS. We don't fully understand this.

One popular hypothesis is that the online extremist environments have evolved in recent years in a way that they tap uniquely into the vulnerabilities of autistic individuals, who may then follow the algorithms into the pathway. I draw attention to the work of Dr Zainab Al-Attar, who works in HM Prison Probation Service. She has written a number of pages but she identifies seven facets that may contextualise engagement with extremism. For example, narrow circumscribed interests; rich fantasy life; impaired social imagination. So where there may be a failure of social realisation in the real world, there is an online community that provides an outlet for that. Repetition and collection and social interaction and communication difficulties.

You can see that if you are a collector, if you have a narrow circumscribed interest which might be, I assume, somebody who wanted a complete set of tools in his garage, once he has done that he moved onto something else. You may have individuals who have decided they want to collect effectively the entire set of Al-Qaeda or ISIS videos of literature and it is all

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FEVMCA almost 80% of the referrals were under 18, with 30 per cent of them under 15, which is of course a very striking finding; how young the cohort is.

Moving on to diagnosis by ideology category, and obviously there are terminology issues around mental ill health and neurodevelopmental diagnosis, but putting that to one side: combined, confirmed prevalence of autism spectrum conditions was around 40 per cent. ADHD 26 per cent, Schizophrenia 8.9 per cent. It is important to bear in mind that the population rates of Schizophrenia is somewhere under just 1 per cent and for autism figures vary but certainly 1 per cent of children perhaps slightly higher than 1 per cent in the overall population, given the increased recognition of a broader spectrum of autism in the community.

So, autism is 26 x the population rate. Schizophrenia nearly 9x. Breaking it down via ideology, for the FEVMCA 170 cases, 30 per cent had an ADHD diagnosis and 40 per cent had an autism spectrum condition diagnosis, which is the lilac bar on the graph, the second column from the left. Which of course begs the question, why is autism linked with fascination on extreme violence and mass casualty attacks specifically? I have to say there is no research evidence of an increase of violence among those with

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about having the complete collection rather than the content. In the sense, the completeness of the collection is not a measure of the severity of the extremism.

So, again, leaning on research by my UCL colleagues, this was a sample of our formulations at the end of 2025. So this was drilled down into what was actually written in our formulation, on our information system. We do have data points which can be converted into numbers very quickly but our formulations are long form text. So it is quite a task for the researchers to make sense of them.

But the sorts of issues identified in our formulations will be all too familiar. Problems with waiting lists, thresholds for referral, acceptance, a cliff edge when somebody turns 18 and there are no adult services for autism, for example. Problems with miscommunication between agencies, information sharing problems, medication changes, medication discontinued due to side effects, non-attendance and non-compliance, non-engagement by the subject.

We need to do more research on outcomes and interventions, but I think, apart from advising our CT police colleagues, mitigating these problems and trying to improve access to interventions is a key part of our

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work.

We have already heard about the hybrid online communities referred to as the Com Network. Again we have a study of 16 cases. These are particularly troubling and disturbing cases.

The activities involve cyber crime, sharing of indecent images, coercion into online self harm. There have been two cases internationally of death by suicide with an online audience across continents. There have been homicides induced by communications via these networks, and the ideology is a mixture of Satanism, accelerationism, and neo-Nazi ideologies. But I think you could say that this area is about pure violence and wanting everything to burn, effectively. I know you are going to be hearing more about this by experts further down the seminars, but in our 16 cases there was a reversal of the gender proportion, they were mostly female with an overlap of victim offender profile. Three-quarters were involved in extortion and another three-quarters were also involved in self-harm with high rates of desire to hate others, idealisation of mass killers. So the implication is that we need to treat these individuals both as victims and as sources of risk. I mention it because it is a growing problem in our casework.

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their national network meeting to improve lines of communication, as it has been a key intervention for us to link these high concern adolescent cases with them. We have also formed links with the national Adolescent At Risk Service, which is run by South London and Maudsley Trust with links to the Michael Rutter research centre, and there is an extra contract between Counter Terrorism Police, again, this is Counter Terrorism Police funding a health intervention to provide specific detailed adolescent assessments for high concern cases.

We are also developing an autism service that's currently going through a business case, but what we are proposing is a service that could provide fast-track autism assessments for up to 50 cases per year, again, funded via CTP to try and plug that gap where substantial delays in ASD assessments are contributing to risk.

I have been asked to cover briefly the difference between -- what contribution does forensic psychiatry make. Firstly, mainstream forensic psychiatry provides secure care through high, medium and low secure hospitals. We have liaison projects with the criminal justice, for example, police custody, court diversion and community schemes. The key issue here is that a criminal court proceeding or at least a police

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I will give you an example. An under 13 year old, with linked to another who had taken a weapon into school, with a mixed ideology, interest in violence, concerns about violence in the home, and the subject was in contact with Counter Terrorism Police investigations, was in Prevent through Channel, had Social Services intervention, was subject to a Channel and had been turned down by CAMHS and the main intervention was that we suggested to the Channel Chair that they escalate in the local mental health services and in FCAMHS. Assessment was sourced in that particular case. Sorry, it is not a particular case, it is a composite of cases, but those are the sorts of issues.

So, in terms of new initiatives we continue the research. We have not yet examined in detail the FEVMCA group and that's the next priority of research, and we need to understand this cohort and I hope that it may give us some insights into what is the difference between a young person who is merely fascinated on violent material and sharing it with peers and one who may be going down the pathway to develop a fixation and move to action.

You will be hearing from Professor Paul Gill later this week. In terms of our initiatives, we are linking in with the national FCAMHS network. We are joining

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investigation is the ticket of entry. We do take disturbed cases from local services that can't be contained. But it is a key issue that a police investigation and a possible court proceedings does not necessarily mean somebody is going to have a criminal justice outcome, but it really is the ticket to more intense involvement of the forensic part of mental health services.

So our casework in mainstream forensic psychiatry involves mentally disordered offenders. Of course if you are being detained under the Mental Health Act you must have a mental disorder to meet the Mental Health Act criteria. But typically our patients will be in hospital for two, three years or more, and we can provide a very detailed assessment of the link between their mental health problem and their behaviour, whether it is violence, fire setting or sexual offending.

So when we are doing a risk assessment for somebody who is leaving a secure hospital, there will be multiple interviews by clinical psychologist, interviews by a forensic psychiatrist, a social inquiry, there may be a particular rating scales of personality, assessments, of substance misuse and, as the picture on the left describes, it is a very detailed piece of work, completed over months if not years.

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In the world of threat assessment, which has been developed by the US Capitol Hill Police, the Lone Actor Violence Group in Australia and the Fixated Threat Assessment Centre in the UK, this is a different approach. So, essentially it is bringing together the culture of policing and health. We are very different cultures. In the NHS we have a flattened hierarchy where, for example, NHS consultants are all the same level, whereas of course police have a command structure, and police are used to taking a radio call and acting immediately. In threat assessment and threat management we also may receive a referral from our Counter Terrorism Police colleagues in real time, where advice is being sought within the hour as it were. So we may have to provide advice based on initially very limited information and then as new information comes in, we change our threat assessment and adapt our threat management.

So both policing and my context, Counter Terrorism Policing, and mental health professionals bring different skillsets to the table and I have heard it described as a sweet spot between the law enforcement approach and the mental health approach, and there are of course times where that is difficult, the gears mesh.

We have heard a lot about risk assessment tools. In

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be an obvious candidate for a red flag risk factor. I draw the Inquiry's attention to the work of Atul Gawande who wrote the checklist manifesto. He is a surgeon who was asked to update the pre-surgery checklist around the world and he consulted aviation industry and construction industry and he found that, first of all, his new checklist cut deaths and complications by more than a third globally, we are talking about cutting off the wrong leg and absence of surgical equipment before somebody was put to sleep, for example. He found that good checklists are short, they have five to nine items per pause point, specify priorities and force a communication pause amongst the team. A checklist doesn't predict outcomes but it manages risks by guaranteeing that the actions known to reduce risk have been taken.

So I think the key point is that we don't -- we can't predict poor outcomes and in fixated there are approximately over 1500 referrals per year. These are individuals who have approached and communicated. It is not possible to identify which of those will commit or try to commit an act of serious harm to their proposed target. But the way that FTAC works and the way the CTCCS works is to provide interventions and appropriate health assessment and diversion for all the cases, and

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mainstream forensic psychiatry we use SPJs, structured professorial judgement, particularly the historical clinical risk, 20 for adults, but I would say that even the most structured risk assessment, our prediction of adverse outcomes is not very accurate. So in the threat management setting we don't routinely use structured professorial judgement tools. It doesn't mean we are not trying to understand risk and look at risk factors, but in a threat management setting it may be that checklists for action are more useful than trying to predict bad outcomes.

So one example in the fixated threat, this is the team that works with Royalty protection police dealing with individuals who have made unwanted approaches or threatening communications, there is a communication threat assessment protocol. It has 25 items developed by David James, Frank Farnham and colleagues, and it identifies factors that lead to actions to manage the risk. It also has red risk factors so that there are particular issues which may not compute into an SPJ but warrant significant attention, and I think if a big front door policy were going to be considered, with some sort of screening process, then I think red flag risk factors would be a useful component of that and I think where a child has taken a knife into school, that would

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the aim is that if you give everyone the diversion and mental health intervention they need, then you will pick up within that cohort an individual who may have gone on to commit an attack.

So my suggestion is that it is about public health approach rather than trying to predict which individuals are the ones that you target, although that's also needed of course.

This has been endorsed helpfully by the Royal Australian and New Zealand College of Psychiatrists who have published this on their website as a policy that it is a population level strategy to significantly decrease the rates of grievance-fuelled violence and we will come onto what we mean by that.

I was asked a question about what are the signs of escalation from obsession, grievance through fixation and violence? So we do need some definitions here. An obsession in psychiatry means an unwanted thought, a repeated obsessional thought, for example that your house might catch fire because you have left the gas tap on. It's the intrusive obsessional thought which is unwelcome, pushes the person with obsessive compulsive disorder to return and turn off the gas tap. In the same context, somebody may be obsessed with violent images but find them unpleasant and want to avoid it but

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1 finds themselves being pulled back.

2 Ideation can be thought of as an individual who is
3 starting to form ideas and perhaps thinking about
4 a course of action. Fascination is much broader and
5 I won't go into that again.

6 Grievance is commonly found in individuals drawn
7 into terrorism, other types of attack, for example,
8 Incel motivated attacks, school shooter attacks, attacks
9 on prominent individuals. And these individuals have
10 a grievance about a problem in their own life which is
11 then wrapped into an ideology and is part of the pathway
12 towards violence. Preparation clearly is when somebody
13 is making plans, collecting weapons and undergoing
14 hostile reconnaissance.

15 So the concept of lone acts of grievance-fuelled
16 violence came from the convergence of research firstly
17 into stalking, as I've mentioned, those who harass and
18 attack public figures. And the second tradition was the
19 threat management and terrorism studies literature,
20 particularly American protective intelligence work. For
21 example, Fein and Vossekuil's study of school attacks.
22 They found the attackers fit no profile, moved along
23 an observable pathway, rarely threatened their targets
24 directly. Paul Gill's research on lone-actor terrorists
25 described antecedent behaviours of a group of over 100

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1 through these different steps? Again that is a focus or
2 research for us.

3 An example of a case -- a composite of a case, but
4 a man in his 20s involved in online hybrid communities
5 looking at violence and indecent images of children; he
6 planned a grievance-based attack, had a specific target,
7 had a cash of improvised weapons which were viable. He
8 engaged in hostile reconnaissance and at the very last
9 minute went to accident and emergency and said he was
10 feeling terrible and gave an account of what he was
11 about to do. He was processed through the Criminal
12 Justice System and also had mental health interventions.
13 So what was it that caused him to desist at the last
14 minute and that is something we don't fully understand.

15 I want to briefly mention the Safe School Initiative
16 in the United States. 37 incidents of targeted school
17 violence. Attacks were planned, sometimes over months.
18 Most attackers had experienced loss, humiliation,
19 persecution, many were suicidal and obtained weapons
20 from home but few gave a directly communicated threat to
21 their target. We have mentioned copycat. It is
22 an important issue. A substantial proportion of school
23 attackers have explicitly referenced, studied or sought
24 to outdo previous attacks, and we have had Columbine
25 mentioned.

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1 and found there was no single profile but there was
2 extensive leakage and family or friends were aware in
3 the majority of cases. The umbrella term of lone-actor
4 grievance-fuelled violence has been operationalised by
5 Michelle Pathé in Australia, and further work has been
6 done modelling the interaction of drivers of
7 grievance-fuelled violence with different pathways by
8 Caitlin Clemmow and colleagues at UCL.

9 If you look at -- apologies -- we have covered that
10 slide. So if you divide different types of violence,
11 for example hate crimes, attacks on the prominent school
12 shootings, single issue violence, domestic violence,
13 there are actually more similarities than there are
14 differences between certain subgroups. So there is more
15 similarity, for example, between a school shooter and
16 a lone-actor terrorist than there is between the
17 different groups.

18 Just moving towards the finish here but there's work
19 on pathways, Calhoun and Weston writing for the American
20 threat management practice; proposed violence,
21 grievance, ideation, research, planning, preparation,
22 breach and attack. It is practicable but it's not based
23 on empirical research. Individuals can skip steps or go
24 from the end right back to the beginning again, and the
25 question is how do we understand how individuals move

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1 Notoriety. For a subset of mass casualty attackers,
2 fame itself is the point. Fame-seeking mass shooters as
3 a growing category, the argument is that saturation
4 coverage in the press converts infamy into an achievable
5 form of significance for individuals whose grievance is
6 precisely their own perceived insignificance.

7 And we have unfortunately seen copycat, or at least
8 reference to ideation about copycat Southport attacks
9 which is of course very disturbing.

10 So, finally, we have had the TRAP-18 items
11 mentioned. Pathway is anything to do with research,
12 planning preparation. Fixation we have already covered
13 in detail. Identification might include a psychological
14 desire to be a pseudo commando, an agent or a cause, a
15 warrior, association with weapons, collecting law
16 enforcement paraphilia, identification with previous
17 attackers, collecting and venerating them. Novel
18 aggression might be an act of violence as essentially
19 assaulting a stranger or an animal which appears to test
20 the individual's capacity to be violent. There may be
21 an energy burst, an acceleration in activity. Leakage,
22 which I will come back to in a second as I finish up.

23 Last resort, this is useful context in the fixated
24 threat environment, but violent action imperative:
25 somebody getting to the end of their rope, effectively.

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1 Directly communicated threats are important because
2 they are often not made. So absence of a threat is not
3 reassurance because many who threat do not go on to act,
4 and many who act don't threaten.

5 Final comment is on leakage. In 81 per cent of
6 school attacks, family or friends knew and my only
7 question here is this something we need to consider
8 public education about? It would be a big step to
9 prepare schoolchildren, for example, to always tell
10 a teacher if they are aware of somebody who is talking
11 about bringing a knife to school, but that's something
12 worth considering.

13 So just to conclude, we have been running for
14 eight years but as a fully commissioned service for two
15 and a half years. We have adapted alongside our Counter
16 Terrorism Police funders and colleagues. We are going
17 to be studying this FEVMCA group although we already
18 know a bit about them, as I presented. We are entirely
19 funded by law enforcement although we are filling gaps
20 in mental health services, so I would advocate for
21 increased involvement and funding via the Department of
22 Health. We are effectively a local initiative between
23 mental health trust who have experience in this area and
24 Counter Terrorism Policing. We are struggling with our
25 funding. We have difficulty covering the national

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1 footprint, particularly taking into account sick leave
2 and leave and, as any person in the public health system
3 would say, we need more funding.

4 As a personal note, not speaking on behalf of my
5 employers or the service, but I would support a big
6 front door policy to capture a very wide range of
7 individuals who may have a fascination or a fixation
8 with violence, however we define it, and the Clinical
9 Consultancy Service can continue to assist Counter
10 Terrorism Policing in managing those who are thought to
11 need the attention of Counter Terrorism Policing, but
12 a multi-agency screening panel and I think structured
13 professorial judgement is unlikely to be applicable at
14 the wide open -- sorry, the wide open door upstream
15 element. At that point I would suggest that checklists
16 for action may be more useful than a risk prediction
17 tool.

18 Finally, our information sharing is critical. We
19 have developed around protocol. We have to argue it
20 sometimes on a case-by-case basis and I would advocate
21 for that being put on a statutory footing in the same
22 way that Multi Agency Public Protection Arrangements in
23 2003 there was a duty to co-operate was brought in for
24 health services.

25 Thank you very much, Sir Adrian.

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1 **SIR ADRIAN FULFORD:** Thank you very much.

2 **MR MOSS:** Thank you very much indeed.

3 Sir, there is a deliberately long lunch break to
4 allow thought to be given to questions. So may I with
5 your permission suggest that we resume at 2.40 pm. But
6 could I please just ask that the advocates for the Core
7 Participants or the representatives present for the Core
8 Participants who have lodged questions in advance, just
9 remain in the hearing room perhaps just for five or
10 ten minutes so my learned friend Mr Jamieson can have
11 a word with them about key questions.

12 **SIR ADRIAN FULFORD:** Thank you very much indeed.

13 (1.20 pm)

14 (The short adjournment)

15 (2.40 pm)

16 **Plenary Session**

17 **MR MOSS:** Thank you, sir. So we now come to the first of
18 our plenary question sessions. At the risk of stating
19 the obvious, may I just make clear that, first of all,
20 the Inquiry legal team is extremely grateful for all the
21 work of the Core Participants in providing questions.
22 They, if taken individually, would probably exceed by
23 a factor of three or four the amount of time available,
24 so we will do our best to cover the ground both of the
25 Inquiry legal team and those that have been put forward

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1 but I hope everybody will understand that not all
2 questions can be reached.

3 Sir, before I turn to those, did you have any
4 immediate questions with which you would wish to start?

5 **SIR ADRIAN FULFORD:** Thank you very much, Mr Moss. I do.
6 I have three quick questions, thank you very much.

7 Ladies and gentlemen, no need to stand up in
8 answering these, please remain where you are. My first
9 question is really directed at Dr Taylor. Dr Taylor,
10 you have made it fairly clear in your very helpful
11 presentation this morning that you don't particularly
12 support the use of risk prediction tools or indeed
13 structured professional judgement for those coming in
14 through a big front door, if one was to be instituted,
15 and you have really emphasised two other things. First,
16 the need for a checklist for action and, second, the
17 value that you believe there is on clinical-based
18 assessments and treatment. All of that makes sense if
19 I may say so with respect, save for one question which
20 I think remains outstanding: if one isn't going to use
21 risk prediction tools or structured professional
22 judgement for assessing who should walk through a big
23 front door or, once they have walked through it, what
24 should happen to them, how do you judge who they should
25 be in the absence of risk prediction tools?

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1 So, what would be the basis, how would you assess
2 who should be, as it were, looked after and who should
3 be left outside, to avoid overwhelming the health
4 services and police and all the rest in this country?
5 **DR TAYLOR:** Sir Adrian, thank you. It is clearly a very
6 good and difficult question in many ways. I think
7 structured professional judgement -- by the time you get
8 to C and FCAMHS professional, then absolutely structured
9 professional judgement, SAVRY, AREVA is what's needed
10 and likewise in an inpatient or outpatient forensic
11 adult mental health setting, we use SPJs.

12 In the CCS we don't have the time or the staff
13 training to use an SPJ on the volume of cases we see,
14 and if we had a big front door you would be looking at
15 an even larger volume of cases, so it would be taking
16 a sledgehammer to crack a nut in the sense of, you know,
17 to have -- Dr Irani obviously has more expertise in the
18 FCAMHS and SAVRY, but it is a very intensive piece of
19 work and resource-wise is one problem but also false
20 positives and false negatives at that point, with the
21 potential for bringing people in that we don't need to
22 and the other way round.

23 So I think what's -- what I'm suggesting is some
24 sort of looser screening tool, rather than trying to
25 predict which of these individuals is going to go on and

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1 people could put their heads together in that sort of
2 timeframe. I'm not volunteering personally, but I'm
3 happy to contribute, but I think there's something that
4 springs to mind spontaneously which is a process for
5 managing risk to MPs and there's a system which you may
6 well be aware of, but --

7 **SIR ADRIAN FULFORD:** FTAC I think.

8 **DR TAYLOR:** I'm talking about JOPRA, the Joint --

9 **SIR ADRIAN FULFORD:** You are quite right, too many acronyms.

10 **DR TAYLOR:** Yes, I'm not sure how much of it is in the
11 public domain, but there are processes used by that
12 organisation which I think might be applicable here.

13 **SIR ADRIAN FULFORD:** I think we probably shouldn't extend
14 this now because of the lack of time but I think that is
15 dealing with a relatively small cohort of individuals,
16 whereas potentially we are looking here at a very large
17 number of people. But Doctor, thank you, we might come
18 back to you separately on this issue following today's
19 seminar.

20 A very short one for Dr Irani. How developed is
21 Borum? Are we going to be able to use it as part of our
22 conclusions?

23 **DR IRANI:** So he has got it out to consultation and he is
24 hoping clinicians will use it and feedback to him, and
25 that's part of what he would like, and he's hoping to be

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1 commit an act of violence. There's no off the shelf
2 screening tool. That's what I'm alluding to. I think
3 it would need a group of professionals to get together
4 from policing, mental health, social services, other
5 agencies to agree what are the much broader factors of
6 concern that would allow you to do some kind of
7 filtering. I don't know if that answers it.

8 **SIR ADRIAN FULFORD:** It absolutely does. My problem is that
9 I'm hoping to deliver the report for Phase 2 in the
10 spring of next year and if what I'm left with is
11 a helpful but very loose general suggestion of a looser
12 screening tool, that is not going to be good enough for
13 the Home Secretary. I'm going to have to offer some
14 kind of really solid mechanism by which you can make
15 a determination as to whether a teenager who is showing
16 some signs that they may be going off the rails, that
17 they should be, as it were, looked at intensely and
18 helped and all the rest of it, or whether they should be
19 left alone.

20 Now, I think at the moment what you are saying is,
21 apart from saying there should be a looser screening
22 tool you don't really have anything in mind. There's no
23 reason why you should do, but I think that is the
24 position, isn't it?

25 **DR TAYLOR:** Yes. I think it is something that a group of

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1 able to do it and get it out for early spring 2027.

2 **SIR ADRIAN FULFORD:** Right.

3 **DR IRANI:** But there's no reason why we can't link up with
4 him and his team closely to feed into this.

5 **SIR ADRIAN FULFORD:** Yes. I think we might see whether we
6 can get at least some early results because otherwise it
7 is going to either coincide with publication or come
8 afterwards. Thank you very much, Dr Irani.

9 Finally, Professor Smith, could you get up your
10 slide 22. Can we get that on screen easily?

11 So third interest the bottom there should be
12 a "further ability to restrict or monitor access to the
13 internet if a significant threshold ..." I want to
14 linger on those words, "if a significant threshold is
15 passed concerning the risk that they pose to others ..."

16 So Professor, what I have in mind is this, that this
17 would obviously be a very, very significant intervention
18 and with this proposal, do you have in mind a process
19 that's been gone through which has arrived at the
20 position where you think you are able to make that
21 assessment in relation to a particular individual? So
22 who makes the judgement? How is it reached? And what
23 is the -- what is the definition of a significant
24 threshold?

25 **PROFESSOR SMITH:** Yes. Thank you. So this is a phrase that

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1 I read in the reports from Phase 1. This is
 2 a suggestion this might be something that could be
 3 implemented and I leapt upon it because the evidence
 4 shows how dangerous internet access can be if
 5 an individual is accessing extreme violent content,
 6 engaged in networks where such content is generated and
 7 shared. And at the same time, in the reports it
 8 described several different adults recognising AR's
 9 engagement with the internet and in that case where
 10 there's been safeguarding issues, where referrals were
 11 made based on internet access and known searches, gore
 12 or other harmful content at that point, it seems to me
 13 that there should be an action taken to restrict
 14 further -- prevent further searches along those lines.
 15 Those risks are already being caught by the processes
 16 and absolutely that should then be restricted. So in
 17 schools, for example, it's relatively straightforward to
 18 prevent internet access. But for me it was the
 19 reading -- the unfettered access is a significant risk
 20 factor that needs to be prevented.

21 **SIR ADRIAN FULFORD:** For those where there is evidence
 22 demonstrating that they have been gravely misusing.

23 **PROFESSOR SMITH:** Absolutely, yes.

24 **SIR ADRIAN FULFORD:** Thank you very much indeed.

25 **MR MOSS:** Thank you, sir. So we have organised questions
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1 example, in the case of extremism, there was a focus on
 2 religious extremism, which came into focus much more
 3 towards the end of the 20th century.

4 Now of course we are looking at phenomena that seem
 5 to be in the extreme ballpark where but there isn't
 6 an ideology. So the choice is well, you can be very
 7 purist about this and say, no, we are just going to
 8 continue to insist that if it is ideological, it is not
 9 extremist. But there is another option, and really what
 10 I was trying to do was to put this other option on the
 11 table for consideration, and I have kind of three sorts
 12 of consideration in favour of the approach I was
 13 recommending.

14 The first, picking up on something that
 15 Professor Smith said, so she had this very striking
 16 phrase in her presentation where she talked about the
 17 extremisation of views around violence. And I think
 18 that's exactly what we are dealing with in some of these
 19 cases. Extremisation of views around violence would
 20 include, for example, the view that violence is
 21 worthwhile in and of itself. Now that would be
 22 an extremist view about violence. If we are going to
 23 talk about the extremisation of views around violence,
 24 it is not clear to me why we should, as it were,
 25 puritanically refuse to use the word "extremist" in
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1 under four topics and the first of those is looking at
 2 the VFI or non-ideological extreme violence cohort and
 3 what their distinguishing features are.

4 Firstly, under that topic, Professor Cassam could
 5 I please come back to you. You have indicated that your
 6 definition of NIVE, non-ideological violent extremist,
 7 includes the use of extremist, extremism and you have
 8 touched on the fact that the UK's formal definition of
 9 extremism from the Government starts with "extremism is
 10 the promotion or advancement of an ideology based on
 11 violence, hatred or intolerance that aims to do" and
 12 then there is a number of options.

13 I just wanted to come back to that because I think
 14 at the end of your presentation, when we ran out of
 15 time, that was an issue that you wanted to come back to.
 16 How do you see that area? Do you think, in fact, that
 17 that definition of extremism by the Government is now
 18 outdated?

19 **PROFESSOR CASSAM:** Thanks for the question. It seems to me
 20 that it is a definition that certainly has a perfectly
 21 good rationale if you look at the history of the 20th
 22 century, where the varieties of extremism that were of
 23 the greatest concern were clearly ideologically-driven.
 24 But I also think that, as the facts changes, our
 25 concepts need to develop and evolve. I think that, for
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1 those contexts, and if we are prepared to use the word
 2 "extremist" in these contexts then we effectively
 3 dropped the ideology requirement.

4 The second consideration, and this is picking up on
 5 Dr Irani's talk, she talked about the Borum article,
 6 which is a very useful and very important article. But
 7 Borum and his colleagues don't refrain from using the
 8 word "extremist". They talk about "violent extremism"
 9 or "extremist violence", perpetrated by adolescents. So
 10 there isn't the idea there that, well, we mustn't use
 11 this word because there's an official definition that
 12 requires extremism to be ideological. And I think that
 13 by going for the kind of more purist option one is in
 14 a way depriving oneself of a conceptual tool that is
 15 already being employed by authors like Borum to describe
 16 a phenomenon that is of interest and concern to this
 17 Inquiry.

18 A third consideration, this is my last
 19 consideration, also just thinking about the
 20 international angle. The way we conceptualise these
 21 phenomena in the UK, of course we are all in
 22 a conversation with the way these phenomena are
 23 conceptualised in other jurisdictions. So, in the US
 24 the FBI and Department of Justice have adopted their own
 25 label for some of the cases we have been talking about
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and their own label is "nihilistic violent extremism",
NVE. And that has become the standard label in the US.

Now, I think there are issues with the way that they
define NVE, if I may, can I just read out -- so this is
the Department of Justice definition of nihilistic
violent extremism:

"Criminal conduct in furtherance of political,
social or religious goals that derive primarily from
a hatred of society at large and a desire to bring about
its collapse by sowing indiscriminate chaos, destruction
and social instability."

I don't like that because I think that makes it too
ideological, but nevertheless it is striking that they
do use the E word, it is nihilistic violent extremism,
and insofar as we are interested in engaging in a kind
of dialogue with other jurisdictions that are wrestling
with the same problems, it is sort of obvious to me why
we should be hobbled by the official UK Government
definition and say "We are not going to use this word
because it is not extremism if it lacks an ideology".

So I'm not saying that I wouldn't say that the
current official definition is outdated, I mean it
has -- you know, it has some value but I do think it
needs to -- we do need -- look at the way that the world
is changing and use the conceptual tools that are both

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MR MOSS: Dr Taylor, if I may, speaking individually rather
than on behalf of the service, do you have a view on
that?

DR TAYLOR: I just want to say that nihilistic violent
extremism from America, I take that to refer to the
accelerationist Com Network communities that were in
a sense -- the violence is the extremism because it is
about a communal approach to promoting violence for its
own end. I would see that as a specific subgroup.

In terms of NIEV, I think that it is a -- we can
work with it. In the Clinical Consultancy Service
I think that we have a rather practical approach.
I think we know what sort of cases are that we need to
work with. Yes, we need a clear definition but I don't
have any particular problems with NIEV.

MR MOSS: Just briefly on this, that sense of you perhaps
know what a need is when you see a case of one, might
have its attractions but some of the information the
Inquiry is receiving is that the lack of a clear single
definition is problematic, not least in terms of keeping
track of data. Would you agree with that, that actually
having a clear definition is important?

DR TAYLOR: Yes, I would agree that a definition is
important.

MR MOSS: I see nods generally. Thank you very much.

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available and that have some intuitive plausibility in
relation to these cases.

MR MOSS: Thank you. May I ask the other three panel
members, briefly, if you would, from your more clinical
perspectives, do you have a view on whether
non-ideological violence should be included within
extremism, and do you have any observations on what
Professor Cassam led on? In terms of definitions NIEV
and NIVE, do you have any observations on that based on
the presentation we heard earlier? Dr Irani.

DR IRANI: I think from my point of view we shouldn't merely
not be talking about extremism because again I don't
think it is ideology specific, but equally we need to be
clear about what we are conceptualising here because
every time we shift the definition or the parameters we
are losing sight of what we need to do. Either which
way we need to get to a conclusion so we can then carry
on doing what we need to do really.

SIR ADRIAN FULFORD: Professor Smith?

PROFESSOR SMITH: I mean in social psychology, ideology is
understood very differently. So when I spoke about
extremisation that is much more how we would understand
a process. If it is extremisation of views around
violence that does not require ideology, so I have the
same perspective of Professor Cassam on that.

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Could I ask this, presentations touched this morning
on violence as an end to itself, and Professor Cassam
you addressed that as an important concept.

Dr Irani first, do you agree that seeing violence as
an end in itself is correct or is that possibly too
simplistic? The reason why we ask that is that some of
the research I think that you have considered and
referenced touches on concepts that even when it may
appear that violence is for its own sake, that there are
aspects of the perpetrator still seeking some sort of
psychological, emotional, social or communicative or
symbolic purpose in what they do, even though it may
look like violence for its own sake; do you have any
comment on that?

DR IRANI: Yes, especially if you think about the adolescent
in its developmental perspective, then often it is in
the context of something. And I think that's primarily
why when we talk about either risk assessments or
checklists, what you are looking at is a bigger picture
to determine where you want to intervene with and for
what. So I don't think the checklist and the structured
professional judgement tools sit separately, they
actually sit together to help kind of understand where
is this young person coming from, why are they doing
what they are doing, and yes, it might in context be

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1 that the violence is the ultimate goal but there is
2 going to be a process before that and it actually might
3 serve a different purpose for them.

4 **SIR ADRIAN FULFORD:** But someone, for example, who is
5 tempted into and interested in violence and committed
6 acts of violence without an ideology, there might be
7 a driver for recognition for them, for their sense of
8 grievance and injustice.

9 **DR IRANI:** Absolutely.

10 **MR MOSS:** In that sense it is not purely just without any
11 aim; there is some aim behind it, even if not in any
12 sense a conventional terrorist cause.

13 **DR IRANI:** Yes, absolutely, and I think that's what we need
14 to understand a bit better.

15 **MR MOSS:** Does anyone else wish to come in on that?
16 Professor Cassam?

17 **PROFESSOR CASSAM:** I think it is helpful in these cases to
18 distinguish between the purpose of an action and its
19 motive.

20 So these are two different things. When I talk
21 about violence for its own sake, I'm talking about
22 violence has no further instrumental purpose. That's
23 what I mean by for its own sake. But of course you
24 could have an act of violence that's for its own sake in
25 that sense, in other words it is non-instrumental, that

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1 around the motivation, does that tell us anything about
2 the risk factors to look out for in this cohort?
3 Professor Smith? Dr Irani?

4 **PROFESSOR SMITH:** Yes, in terms of, if we were going to look
5 at a signal of behaviour, they would vary very much
6 depending on the underlying motives.

7 So just giving the example of the online networks
8 I spoke about earlier, the behaviours there that would
9 provide a signal of risk around status gain are very
10 different from the risk of violence that would be
11 created by a completely different motive like
12 an ideological one, so yes, completely.

13 **MR MOSS:** Dr Irani?

14 **DR IRANI:** I just go back to my structured risk assessments
15 because in that you would be able to surmise which of
16 these factors actually matter and don't, or which of
17 them are the ones that you would be considering and
18 putting more weightage on than others.

19 So I do think, like Dr Taylor, it depends on what
20 you have been presented with and then you need to kind
21 of think about multiple factors around it.

22 **MR MOSS:** Thank you. Change of subject, still within this
23 topic, if I may. One of the aspects that the Youth
24 Justice Board has fed into this session is a concern
25 that when thinking about this cohort, so the VFI loosely

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1 nevertheless has other motives. So it might be
2 motivated by the quest for recognition, for example. So
3 the psychological payoff might be, for example,
4 recognition even though the violence -- that isn't the
5 purpose of the violence, the violence isn't serving any
6 other instrumental purpose. The distinction I am
7 drawing here between motive and purpose is implicit in
8 the terrorism definition as well, because the definition
9 of terrorism is violence for the purpose of advancing
10 political, religious, racial or ideological cause. That
11 doesn't in itself tell you what the motive is.
12 Individual terrorists might be motivated by the desire
13 for recognition or notoriety or whatever. But it is the
14 purpose that counts.

15 So I think it is helpful in this context, as in the
16 normal terrorist context, to be clear that what I'm
17 saying does not preclude the recognition that
18 recognition might be one of the payoffs.

19 **MR MOSS:** Thank you.

20 Dr Taylor, is there anything you would wish to add
21 to that?

22 **DR TAYLOR:** No, just the issue around recognition at the end
23 echoes what I was saying about notoriety and the copycat
24 phenomenon, but other than that nothing else to add.

25 **MR MOSS:** Thank you. Does that discussion particularly

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1 termed cohort, should those who obsess or fixate or
2 fascinate with serious sexual violence also be included
3 together with those who fixate on extreme physical
4 violence?

5 But can I add to that, on the other hand, might the
6 interventions or the teams that need to deal with those
7 who are fixated on serious sexual violence be perhaps
8 different, so that the two groups are equally important
9 but perhaps need to be handled separately? Where would
10 you sit on that difficult topic?

11 **DR IRANI:** I think they are equally important but need to
12 sit separately, because again they have very specific
13 risk assessments and interventions for both cohorts that
14 are different. I don't think you could put them under
15 the same umbrella, primarily when you are thinking about
16 interventions that are specific around the risk of
17 fixated interest versus sexual harm. They are not
18 necessarily completely different for the adolescent
19 world but there are enough differences that they need to
20 be held separately.

21 **MR MOSS:** Would anyone take a different view to that?

22 **PROFESSOR SMITH:** This isn't a completely different view but
23 just in line with the online networks where harms are
24 perpetrated. So sexual harm is one of three different
25 types of harm created by the same incentive structure.

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1 That's the only exception that the harms might be
2 triaged or treated by different agencies, but ultimately
3 understanding the mechanisms that give rise to the harm,
4 they may be the same mechanisms, so the same with
5 cybercrime as well as sexual harm and violence, they're
6 all known to be the threats that are created by these
7 networks, but the same incentive structure might lead to
8 them.

9 **MR MOSS:** So there would be overlaps and perhaps learning
10 from the two groups but the interventions might need to
11 be different?

12 **PROFESSOR SMITH:** Exactly.

13 **MR MOSS:** Thank you. Can I come back then to, without
14 wishing to exclude you at all Professor Cassam, but to
15 come back to your suggestion of an individual with
16 a pathological fixation on extreme violence, and just
17 group together a couple of areas of controversy or
18 complication about this. The first is the difference
19 between fixation and fascination and, linked to that,
20 the suggestion from Professor Cassam of pathological
21 fixation and whether that might be going too far. Is
22 that a clinical diagnosis? One of the issues I think
23 that the families have raised is whether there is a risk
24 that a narrow definition of "pathological fixation"
25 might lead to risky individuals being excluded.

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1 want to regulate and manage differently. Both are
2 equally important and one doesn't exclude the other.
3 I hope that kind of makes sense.

4 **MR MOSS:** Before I come to Professor Smith, could I ask
5 Dr Taylor, as another psychiatrist, whether you have
6 anything to add to that?

7 **DR TAYLOR:** I wouldn't -- for me the term "fixation" as
8 defined by Paul Mullen: "... an intense preoccupation,
9 pursued to an irrational degree ... a preoccupation
10 colonising the individual's thinking, dismantles social
11 and occupational ..."

12 That is pathological. It is not called
13 pathological, that is the definition of fixation. So
14 I wouldn't distinguish between fixation and pathological
15 fixation. For me it is a continuum. It doesn't
16 exclude -- certainly I would not see it as an overly
17 exclusive box to put subjects in and certainly our
18 Counter Terrorism Police colleagues would see fixation
19 as a broader category than the FEVMCA. We are back to
20 difficulties agreeing terminology here. But for me,
21 fixation is by definition pathological but it doesn't
22 require a medical diagnosis of delusion. We are talking
23 about somebody with an irrational degree of
24 preoccupation, this could be -- sometimes we distinguish
25 between delusions and overvalued ideas.

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1 On the other hand, drawing on some of the medical
2 papers that you have referenced, should we be
3 understanding pathological fixation not to be limited to
4 cases of clinical delusion and obsession, but also the
5 concept of extreme overvalued belief? So that's drawing
6 together several factors in the same general area.

7 Dr Irani, could I start with you?

8 **DR IRANI:** I think one of the things to be quite clear is
9 when we talk about the risk assessments and the
10 information that you are gathering, it isn't necessarily
11 that the intervention has to be a medical intervention.
12 So what you are trying to -- when you talk about
13 pathological fixation, that's very clear. It has to be
14 something that has an impact on your day-to-day function
15 otherwise it would not be pathological, and that might
16 need a very specific medical intervention. However,
17 fascination or preoccupations which might be the
18 psychological state of the young person might benefit
19 from a slightly different intervention.

20 And so it isn't about exclusion but really being
21 able to think about this in the context of the
22 adolescent development and the risk it presents with.
23 And so one, yes, very clear definition of delusions we
24 treat with anti-psychotic medication; two, is the way
25 a person might be inclined to think and which you might

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1 **MR MOSS:** So we should understand pathological fixation as
2 dealing with effect on day-to-day life rather than
3 a medical diagnosis?

4 **DR TAYLOR:** That's my position, yes.

5 **MR MOSS:** Professor Smith?

6 **PROFESSOR SMITH:** I'm not a clinician so I can't comment on
7 the fixation or fascination aspects but I do share the
8 concern that focusing on psychopathology would narrow
9 the window because if we are talking about extreme
10 violence as a behaviour, that is not a person, and
11 anybody can perpetrate it, no matter whether they have
12 a mental disorder or not. I also wanted to pull out
13 a passage of the Kunst review article I spoke about in
14 my presentation, where they talk about the risks
15 associated with AI and how some people are more likely
16 to be affected by the actions of recommendation systems
17 because they are attracted to specific types of content.
18 They say that this transforms a niche anomaly into
19 a potential mass phenomenon and that's because lots of
20 people share that interest, and when you have systems
21 that push more and more content, that means that it is
22 not going to be driven just by psychopathology but
23 anybody could be at risk.

24 **MR MOSS:** Thank you. Professor Cassam briefly if you would.

25 **PROFESSOR CASSAM:** First of all I wanted to echo what

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1 Dr Taylor said. Fixation, as I was understanding it, is
2 pathological. That's what the notion of fixation is.
3 I wasn't intending the prefix to serve any exclusive
4 purpose. I think the broader question is this, that
5 supposing you are trying to work out what are the risk
6 factors for non-ideological extreme violence, supposing
7 you are trying to work out what the risk factors are.

8 Now, you could look at fascination with violence.
9 But the connection between being fascinated with
10 something and doing it, seems at least on the face of it
11 to be a fairly loose connection. I'm fascinated by
12 politics but I have no desire to be a politician. But
13 if you say, well look, this person is not just
14 fascinated by extreme violence but fixated upon it, then
15 at least intuitively you have as it were a somewhat
16 stronger connection with the act than if you merely talk
17 about fascination.

18 So I think there is a kind of push and pull in these
19 cases between the cause and the effect. The blander the
20 cause that you posit, the harder it is going to be to
21 identify how it leads to that effect. And I think
22 fixation earns its keep in this conversation I think
23 because it looks as though it might be more intelligibly
24 connected to the outcome which we are trying to explain.

25 **MR MOSS:** Thank you.

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1 Dr Taylor said, it is about the acuity, the TRAP-18
2 works more like the checklist and is more effective at
3 that stage and so you can use both of them I think once
4 we have got total access to them.

5 **MR MOSS:** Thank you. Linked to this, and of course the
6 Chair has asked about the timing so I won't cover that
7 ground again.

8 First of all, I don't know whether this is
9 an impossible question but one of the issues that has
10 been raised by one Core Participant is what the relative
11 importance is between psychological analysis of each
12 individual against more practical signals such as the
13 individual has been information gathering or conducting
14 tactical planning et cetera?

15 **DR IRANI:** I guess going back to what I just said. There
16 are two aspects to it. One is where you look at all the
17 factors that you can put an intervention with, and then
18 the acuity factors, the ones about the listing, the
19 leakage et cetera, those factors are about when you need
20 to act immediately, and what level of immediacy and what
21 does that look like. So two slightly different things.

22 So when you talk about a formulation-based
23 assessment using the structured professional tools, this
24 is more about the longer term management of a young
25 person over time. If you know somebody is doing x, y

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1 Now, our second area is about how the riskiest
2 individuals can be identified. Do we have workable
3 tools and who can use them? And a number of the
4 questions that were fed in were asking about are there
5 currently available risk assessments, and to a large
6 extent I think you have covered those. I hope I'm not
7 taking it too simplistically, Dr Irani, if I put to you,
8 do I gather that, at the moment, you would be commending
9 the use of SAVRY, although it is a long process, but the
10 hope is that the work of Borum will lead to potentially
11 the best tool to be used if validated for this cohort.

12 **DR IRANI:** I would like to correct just one thing. None of
13 these tools are going to predict an act from being
14 commissioned and I think that's one of the things we
15 have to take with caution. All of the tools that are
16 recommended or considered are tools looking
17 multifactorially at potential risk and what we can do to
18 mitigate against it. I think that is really important.
19 I am not necessarily saying that the SAVRY is the tool
20 we should or shouldn't use, but it is a tool that we use
21 for young people who have committed an act of violence
22 and hence can be used and shouldn't be dismissed until
23 such point as the AREVA has been tested and we are able
24 to use that in the way it should be used.

25 We have also got the TRAP-18 but that's, like what

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1 and z and you need to intervene now, put in measures of
2 supervision to ensure that they can't access the
3 computers et cetera, then that acute intervention is
4 a slightly different thing.

5 **MR MOSS:** Professor Smith and Dr Taylor, is there anything
6 else you would like to add to that or points of
7 clarification?

8 **PROFESSOR SMITH:** It could be a point of clarification but
9 so far the discussion has been around tertiary
10 interventions, so when significant risk has been
11 identified and there are obviously primary and secondary
12 interventions as well and it might be that, if a whole
13 of society approach is taken, that other interventions
14 that seek to identify those practical signals or other
15 kinds of signals earlier on might also be appropriate in
16 combination for different communities, different people
17 at different time points.

18 **MR MOSS:** Thank you. Dr Taylor.

19 **DR TAYLOR:** I didn't mention it in my talk but we are at
20 very, very early stages of discussion but there is
21 a potential for us to look at the AREVA on our cohort.
22 I can't give a timeframe for that but that's something
23 that's literally just come on the table for discussion.
24 I don't want it to be thought that I'm negative about
25 SPJs, it is really a question about at what point they

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1 kick in and at which point down the filter cone can you
 2 bring in an intervention that's pretty resource
 3 intensive.

4 **MR MOSS:** Thank you. To what extent do the tools need to be
 5 different for adolescents and adults? Dr Irani?

6 **DR IRANI:** As I mentioned in the slides earlier, it is about
 7 having a developmental perspective and they do need to
 8 sit differently to the adult population because there
 9 are very specific factors that we have considered, where
 10 with the adolescent things are in a developmental stage.
 11 You have to think about the weightage of the peer
 12 relationships. You have got to think about the
 13 weightage of their relationships with their families and
 14 parents and the wider system, which is less significant
 15 once you become an adult. There might be a historical
 16 element to it, but less significant on what changes you
 17 can put in place as an adult.

18 **MR MOSS:** It may be I should know the answer to this, but
 19 does the Borum AREVA going through work at the moment,
 20 does that cover adolescents and adults?

21 **DR IRANI:** It is primarily an adolescent tool.

22 **MR MOSS:** Is there an adult equivalent?

23 **DR IRANI:** Well the TRAP-18 is the adult tool. I'm looking
 24 at Dr Taylor.

25 **DR TAYLOR:** We have general violence risk assessments, the

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1 related to each other, and I think it is important to
 2 consider both and how they combine but what we have seen
 3 is that in all people that have motivation for violence,
 4 it is those signals that they are preparing, they are
 5 developing their capability, that they are learning.
 6 That seems to be an indicator that they are -- an attack
 7 might happen.

8 **MR MOSS:** So it is going back to the two pyramids of looking
 9 at the actions and the motivations and the combined risk
 10 from that?

11 **PROFESSOR SMITH:** Yes, but it is also possible that someone
 12 will act without the motivation and vice versa.

13 **MR MOSS:** Thank you. When a young person who already has
 14 known risk starts refusing support and professionals can
 15 no longer see them, which of course was a factor in AR,
 16 at what point should that disengagement itself become
 17 an urgent need for escalation of concern rather than
 18 allowing services to step away?

19 **DR IRANI:** It is extremely tricky in that situation because
 20 the issue is around what information was accessible to
 21 everybody prior to that point and how they reached that
 22 conclusion and decision, and I think if you looked at
 23 just the proximal factors within the TRAP-18, and
 24 I think that those are relevant, is you have got
 25 an accumulation of factors which would then make you not

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1 HCR20 and SAPROF. SAPROF protective factors, HCR20,
 2 historical, clinical and risk management factors. TRAP
 3 is, as I say, looking backwards from attacks that have
 4 been completed and a number of those risk factors will
 5 be found in individuals that don't go on to complete
 6 an attack. So the evidence --

7 **MR MOSS:** -- a slightly different task.

8 **DR TAYLOR:** The evidence is limited for the TRAP-18. So we
 9 don't have a direct equivalent for adults is the short
 10 answer.

11 **MR MOSS:** Is that a practical gap that does need to be
 12 addressed, do you think?

13 **DR TAYLOR:** Potentially yes.

14 **MR MOSS:** Thank you. A number of issues raised, if I may
 15 put them to you for a relatively brief answer if you
 16 would, but they are important because they come from the
 17 victim legal representatives.

18 So what behavioural changes most reliably indicate
 19 that a young person has moved from an interest in
 20 violence towards active preparation or mobilisation?
 21 Professor Smith? It is a difficult question,
 22 I appreciate.

23 **PROFESSOR SMITH:** Yes, I think in my presentation I talk
 24 about the difference in signals of motivation and
 25 behavioural capability development and how they are

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1 step away. But that's only if you knew the accumulation
 2 of factors and I think that is really important, is when
 3 you are thinking about this particular question, if you
 4 had from the beginning you were aware that they were
 5 creating a pathway at the points that Professor Smith's
 6 mentioned, you are aware that they have been collecting
 7 materials, there has been leakage around it, family is
 8 aware, the systems are aware then you are more likely to
 9 continue intervening rather than stepping away. But if
 10 you don't have the information that gives you the number
 11 of factors that come together, then you are left with
 12 anybody who disengages. So if you go to the GP and you
 13 stop going the GP is not going to come out to see you,
 14 if that makes sense.

15 **MR MOSS:** Simplistically one might say, well any stepping
 16 away from that kind of psychological support should be
 17 of concern but in the real world it happens a lot.

18 **DR IRANI:** Absolutely, and we won't be following up and
 19 chasing and trying to engage somebody if they have made
 20 an informed decision to disengage. So I think if you
 21 have accumulation of factors and you can then make
 22 a judgement on whether that needs to be where you
 23 continue with the intervention, or you then make
 24 a decision to step away is slightly different to rather
 25 than just somebody stepping away.

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1 **MR MOSS:** Thank you. I don't know Professor Smith or
 2 Dr Taylor whether your experience lends itself to
 3 seeking to answer this further question from the
 4 victims' teams, but when the individual does progress to
 5 violence, to what extent does the cause of the perceived
 6 injustice predict the target of the violence? So to
 7 what extent does their target selection map across to
 8 their perceived injustice? Or does it vary in a way
 9 that we don't yet understand?

10 **PROFESSOR SMITH:** I think the case of AR suggests the
 11 latter, that it varies in a way we don't understand, but
 12 going on all of the research and evidence and theory and
 13 psychology we would assume that they would be aligned,
 14 that the source of the perceived injustice would be the
 15 target.

16 **MR MOSS:** What is -- is it an area for further research or
 17 what does cases like AR, where the dreadful selection of
 18 victims appeared to bear no relation at all to his own
 19 perceived senses -- whether that was because he
 20 perceived he was bullied -- what does that tell us of
 21 that type of dreadful attack?

22 **PROFESSOR SMITH:** I think it tells us that we need more
 23 research and more evidence to understand it. I don't
 24 think there is an evidence base for me to be able to
 25 answer that unfortunately.

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1 young people move away from parents, families et cetera
 2 and are more focused on getting peer notoriety and
 3 acknowledgement and recognition. Partly that factors
 4 in. I think it needs to be kept in mind when thinking
 5 about training and educating adolescents around this
 6 because the issue around being a snitch or a grass is
 7 quite a significant thing within peer groups, and that
 8 needs to be thought of in a way that facilitates this
 9 discussion rather than it becoming a taboo or more of
 10 a telling off.

11 **MR MOSS:** Thank you. There is a topic that cuts across the
 12 different areas and I must be mindful of the time, so
 13 could I ask you to keep it bullet point like, but you
 14 have mentioned the need for further research and could
 15 you pithily tell us each what your top research
 16 requirement would be in this area? Professor Cassam?

17 **PROFESSOR CASSAM:** We need more research into the tightness
 18 of the connection between violence fixation/affirmation
 19 and violence. I think that is an area where research is
 20 needed, but there's one thing, just going back to your
 21 previous point. I mean one thing more needs to be made
 22 of is we may have concerns about young people who are
 23 fascinated by violence or look into it, who are
 24 preoccupied by it, but the point at which the Rubicon
 25 has been crossed is the point at which a young person

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1 **MR MOSS:** Thank you. Then a number, as well as the Inquiry
 2 legal team, wish to raise some issues about leakage.
 3 Dr Taylor, do you know if research has been carried
 4 out on why peers don't come forward when they have been
 5 made aware of a possible attack? Sadly we are all aware
 6 of cases where that has happened but has any research
 7 been done to categorise the reasons?

8 **DR TAYLOR:** I'm not aware of research on that specific point
 9 but in a general sense, there is the concept of
 10 bystander inaction: nobody else is saying anything, why
 11 should I be the one to step out of line. There is
 12 a much more general understanding of the way people
 13 don't act. In terms of -- again, this is talking about
 14 school age, adolescent group, telling tales, snitching,
 15 it is not a psychiatric psychological evidence-based
 16 issue but I think it is something that needs to be
 17 thought about. If we are going to be having some kind
 18 of public health programme we will need to take into
 19 account these very general social behavioural issues.

20 **MR MOSS:** So in terms of the adolescent peer group,
 21 educating peers not to ignore it and to have the courage
 22 to raise it may be an important area to take forward?

23 **DR TAYLOR:** Yes, I think so.

24 **MR MOSS:** Dr Irani?

25 **DR IRANI:** Yes, and to be mindful that is the stage when

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1 explicitly states their intention to commit serious
 2 violence. I think it is not rocket science to see that
 3 at that point -- we don't need research to tell us that
 4 we should be worried at that point.

5 **MR MOSS:** Dr Taylor?

6 **DR TAYLOR:** We have a sample of 170 closed cases where we
 7 have formulations for most of them in this FEVMCA
 8 category and that's a priority and my UCL colleagues are
 9 able to move quite quickly on that, so that would be
 10 very much our next research priority.

11 **MR MOSS:** Looking specifically at?

12 **DR TAYLOR:** Looking at really to start with descriptor study
 13 of what does this cohort look like, what are the
 14 demographics? What are the problem behaviours? What
 15 are the associated mental health issues and what
 16 interventions and outcomes did we provide? That's our
 17 priority in this area for the next few months.

18 **MR MOSS:** Thank you. We may come back to you in writing on
 19 that if we may just about (unclear). Professor Smith?

20 **PROFESSOR SMITH:** We need data, a lot of data, but really
 21 looking at the relationship between person
 22 characteristics, person-based characteristics and their
 23 online behaviour so we can predict over time those who
 24 are more vulnerable and more at risk and predict
 25 outcomes.

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1 **DR IRANI:** I think it is about -- looking at the cohort that
 2 Dr Taylor already has, seeing whether we get a clearer
 3 picture of what the antecedents are and where the
 4 intervention has worked.

5 **MR MOSS:** Thank you. I wish to turn to the third topic now,
 6 what is the significance of neurodiversity and mental
 7 illness and where should psychologists and psychiatrists
 8 best be deployed.

9 Dr Taylor, very helpfully in your presentation, if
 10 I may say so, you referred to Dr Al-Attar's 2020 paper
 11 in relation to neurodiversity and autism in particular,
 12 and the Inquiry is acutely aware of the controversy in
 13 this area. It is a sensitive and a difficult area and
 14 we must be mindful of course of the difference between
 15 association and causation. But looking, Dr Taylor, at
 16 your figures from your presentation, there would appear
 17 on the face of it, in the cases at least that your team
 18 has looked at, to be a high level of association which
 19 I stress is different from causation. So you pointed to
 20 the Al-Attar assessment of those seven facets but
 21 I wanted to give Dr Irani and perhaps Professor Smith as
 22 well just an opportunity to comment with any
 23 observations that you have in that difficult area.

24 **DR IRANI:** I think clinically, mental disorder is a lot
 25 easier, if you diagnose somebody with a mental disorder

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1 people with diagnoses of autism and mental disorders in
 2 the criminal justice system than are in the general
 3 population and think that there is a risk there, but
 4 there can also be resilience factors, and if we flip the
 5 statistic around, we can think well how many people who
 6 have diagnoses are also perpetrating violence? No more
 7 than the general population, right. So that really
 8 shows that it is very important to make that
 9 distinction.

10 In terms of my presentation, I said that if somebody
 11 has had -- has a specific interest or a sensitivity to
 12 extreme violent content, they may be more likely to
 13 engage with it. That doesn't require a diagnosis, being
 14 neurodiverse or being -- have a mental disorder. But it
 15 might be that somebody who has had difficult life
 16 experiences because of those diagnoses, who are more
 17 sensitive to injustice, for example, who have
 18 experienced bullying or discrimination, are more likely
 19 to engage with that content. It just shows that there's
 20 very conditional and very indirect effects between all
 21 of these variables and it is not as simple as somebody
 22 with a diagnosis is more likely to engage.

23 The other point I made was that they may be more
 24 likely to be targeted by others in those groups because
 25 they have shown vulnerabilities. So if you are in

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1 you can effectively treat it. When you have somebody
 2 who has carried out an act and they might have a mental
 3 disorder or a neurodiversity, that increases the risk.
 4 So the factors mentioned by Dr Taylor are very relevant
 5 to the risk. Not everybody with autism necessarily will
 6 go on to carry out any offences, but if they are likely
 7 to be preoccupied by something, that is going to be more
 8 intense.

9 So it is important and relevant to understand that
 10 and, like you say, if there is young people with
 11 neurodiversity to consider that as part of the risk
 12 assessment. That is relevant but it doesn't mean
 13 everybody with a neurodiversity is going to be
 14 presenting with that same kind of risk or any risk at
 15 all. It is holding those two factors together.

16 **MR MOSS:** And Professor Smith, do I take it from your
 17 presentation that if we are trying to move to a more
 18 developed understanding of this area, that one factor
 19 that may be in play is the sense in which harmful
 20 materials online may either deliberately or by their
 21 very nature actually be taking advantage of those who
 22 are neurodiverse?

23 **PROFESSOR SMITH:** I think it is more complicated. So the
 24 prevalent statistics are interesting because we can flip
 25 them around. We can look at a higher prevalence of

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1 a channel online where people talk about eating
 2 disorders or self harm, those are the places that
 3 recruiters prey upon others, so it opens you up to being
 4 groomed into those communities. Again the risk is not
 5 straightforward and it's not unidirectional.

6 **MR MOSS:** Dr Taylor, you dealt with this issue very
 7 helpfully in your presentation. Is there anything you
 8 would like to add on it? It is an important area for
 9 the Inquiry.

10 **DR TAYLOR:** Yes. So back at the vulnerability support hub
 11 in around 2019 we looked at just under 500 cases and the
 12 proportion of autism spectrum disorder in that cohort
 13 was around 12 and psychosis was 30. So we have seen
 14 a flip around in terms of proportion of diagnosis in the
 15 cases we are seeing in the CCS, but that is of course
 16 because of the adaptation and the referral criteria, so
 17 we are almost certainly seeing more referrals from
 18 school into Prevent, more of that particular cohort
 19 coming through to us. But in amongst that 170 we are
 20 looking at approaching 40-fold increase in autism
 21 spectrum condition, confirmed or suspected diagnosis as
 22 against a population base rate. So it is a striking
 23 phenomena that we -- as I say, we are going to be
 24 looking at that cohort.

25 In terms of the online environments, we need more

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1 evidence but I think there's something about the way
2 online environments have evolved in recent years that
3 seems to have tapped into vulnerabilities in that group
4 of the population in a very toxic and unhelpful way.

5 **MR MOSS:** Thank you. One of the issues that's been fed in
6 by a Core Participant is noting the importance of
7 incorporating psychological and clinical factors into
8 risk assessments, and given the prevalence of mental
9 health and neurodiversity-related vulnerabilities in
10 many of the potential NIEV cases, would there be value
11 in routine involvement of forensic clinical specialists
12 in assessment and risk management processes, and
13 I intervene to say, well, it is tempting to say yes of
14 course, that would always be beneficial but in the real
15 world how are limited available resources best to be
16 deployed? Dr Irani?

17 **DR IRANI:** I think the authors of AREVA would kind of argue
18 that if clinicians are trained and it doesn't have to be
19 a psychologist or a psychiatrist, it could be a social
20 worker, it could be the police, it could be within the
21 criminal justice system, wherever the young person comes
22 up or presents, I think we need to consider who is best
23 suited to do the assessments in those places, and you
24 need to be trained to carry out those assessments.

25 So just looking at the team with Dr Taylor, they are
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1 the role of the CCS within Prevent into VFI/NIEV case
2 management? I appreciate that that's a risk of asking
3 you a question like "Would you like more funding?" But
4 what do you say about that?

5 **DR TAYLOR:** So, strategically and technically that is
6 a matter for Counter Terrorism Policing. We are funded
7 by them and we are part of their remit, as it were.
8 What we are developing is -- we are an advisory and
9 consultancy service to Counter Terrorism Policing that
10 seeks to categorise mental health interventions and
11 share information but we are developing bolt on services
12 which provide direct patient assessment and contacts.

13 So the Adolescent Advisory Forensic Service, AAFS,
14 they are a national service that in a sense they are
15 above FCAMHS and they currently exist and will see
16 children and adolescents from all over the country
17 referred by probation, courts, local mental health
18 services. CTP are funding that team to provide
19 fast-track adolescent assessments within a month instead
20 of nine months potentially.

21 So I think there is a role for that to be expanded.
22 It is new. We have only started doing it. It took us
23 a year to negotiate it but we only started doing it
24 a couple of months ago, and likewise we are -- as I say
25 there is a business case for an autism service, so

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1 not just a psychiatrist and a psychologist, it is
2 a multidisciplinary team and they are all trained to be
3 able to do the piece of work they can do. So I think
4 similarly we shouldn't be focusing on a discipline doing
5 it, because there just isn't enough of us to do it, and
6 actually if a young person presents in, say, education
7 in school, is there a process through which they might
8 go to Prevent or they -- the police being involved, is
9 there a process within that team that can then carry out
10 the assessment to meet the need?

11 I think that is more relevant rather than saying
12 every young person presenting needs to be seen by
13 a forensic psychologist or psychiatrist. It will be
14 six years before they get seen. There are very few of
15 us and I think we need to not rely on a particular
16 discipline to do it but you need to have enough trained
17 clinicians to be able to understand the risk and inform
18 the management.

19 **MR MOSS:** Thank you. Dr Taylor, you gave an example, a case
20 example of where CCS -- or a composite example of where
21 CCS engagement was able to not queue jump, I think you
22 explained it, but the full picture, so that clinicians
23 viewed the priority with more information leading to the
24 person in that case being seen very quickly.

25 Do you therefore think there is a case for expanding
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1 fast-track assessment for up to 50 cases a year.

2 So whereas the day-to-day work of the CCS is not
3 about queue jumping, it is about making sure services
4 have all the information they need. I think there is
5 a cohort where there is a high concern where resources
6 could be expanded to provide an actual face-to-face
7 assessment.

8 **MR MOSS:** Thank you. Could I ask both Dr Irani and
9 Dr Taylor a difficult but understandable question, again
10 drawing on concerns that understandably have been raised
11 by the victim teams where they have a concern and have
12 an issue about how do you stop a focus on diagnosis or
13 somebody's vulnerabilities, however understandable they
14 may be, becoming the principal focus of professionals at
15 the potential expense of the risk that that person may
16 pose to others? Dr Irani.

17 **DR IRANI:** I think it is a really tricky one, isn't it, in
18 that, if you identify the risk, you would be thinking
19 about these factors as part of the precursors to the
20 risk and where the intervention sits; but if you haven't
21 considered the risk, then obviously these get looked at
22 as the factors in themselves.

23 So what I think it is really important to
24 differentiate particularly with AR, is that the risk was
25 not thought of in the same way as we are now thinking

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1 about it now. So, if they were thinking about the risk,
2 you would have thought about all of these factors and
3 how you would mitigate against it. And I think that is
4 really relevant.

5 With the young people coming into the team with
6 Dr Taylor, they have been referred in because they were
7 very clear about the risks, that these are the risks for
8 the young people; we need to support; to think about how
9 we work with them.

10 When you don't think about the risk, it is very hard
11 and so I don't think they are mutually exclusive.
12 I think you think about those factors equally in as much
13 about mitigating or intervening with, to reduce that
14 risk, if you are considering the risk, if you are
15 actually thinking about the risk. Does that make sense?

16 **MR MOSS:** Thank you. Dr Taylor, anything to add to that?

17 **DR TAYLOR:** Nothing to add to that.

18 **MR MOSS:** Thank you. Would it be right in that sense to
19 think that it is only with the careful structured
20 consideration of what the vulnerabilities are, keeping
21 the risk to others in mind, but that a proper analysis
22 of what somebody's vulnerabilities and diagnosis are,
23 that you will get the best measure of what the risk to
24 others are? I suppose another way of saying, they are
25 not mutually exclusive. [No audible response]. Thank

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1 be out of education and hence a lot of them lost to
2 interactions which should have mitigated against this.

3 So there is something about primary and secondary
4 interventions and then the assessment that you can plead
5 whether -- and the structured professorial risk
6 assessment tool that I talk about use the 5Ps to kind of
7 pull the formulation together, where the intervention is
8 required. So I think Dr Taylor's work around
9 identifying whether the interventions have worked with
10 this cohort, will be really crucial. I don't think it
11 is a single intervention. I think you have to look at
12 it alongside systemic interventions that we put in at
13 primary and secondary level, but also with the
14 individual and the system around the child; so the
15 families, the education system around the child, the
16 access to mentorship and positive adult role models and
17 getting that -- depending on what the individual factors
18 are for the child and the young person.

19 **MR MOSS:** Thank you. Professor Smith, perhaps particularly
20 with an eye to the online risks and interventions?

21 **PROFESSOR SMITH:** Yes. In the paper I referenced, the
22 systematic review that we have conducted, we wrote a
23 section on primary, secondary and tertiary
24 interventions, specifically focusing on youth
25 radicalisation online.

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1 you.

2 Then the final area please. What interventions will
3 best manage risk? How can they be evaluated? Can
4 I ask, in relation to that, first of all, what sorts of
5 interventions will most effectively manage the risk in
6 this area? I know we have touched on that area already.
7 But also, how can effectiveness of interventions
8 actually be managed for this cohort?

9 **DR IRANI:** I think starting off from what -- you talk about
10 the primary and secondary interventions that are
11 required. I think there is something to be thought
12 about, about what we can do nationally around
13 monitoring, supervising and how do we support the system
14 generally, particularly around internet access;
15 accessing and fashioning weapons. I mean, young people
16 manage to use 3D -- what do they call them? 3D printers
17 to make weapons, et cetera.

18 So you really need to think about those
19 interventions alongside what is identified for the
20 individual young person. So the interventions -- and
21 there are bigger pieces of work around education and
22 ensuring that every young person is engaged in
23 education, and I mean properly engaged in education, and
24 not lost to follow-up. I think that is a crucial one,
25 because a lot of these young people, they were found to

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1 So I have itemised them there and I have submitted
2 that to the Inquiry as well. There is already work on
3 the kinds of algorithms that can be implemented to
4 change what people are presented with online. So
5 bridging and diversity algorithms have been assessed and
6 shown to change the nature of what people see. So we
7 know that there are technical, design based
8 interventions that can change people's experiences
9 online. More research can be done specifically on the
10 kinds of affordances of encrypted chat applications and
11 how the different design features can affect the types
12 of chat that happens and the types of behaviours that
13 get enforced and so on.

14 There are digital literacy interventions that can be
15 implemented in schools to help children and young people
16 understand the risks associated with specific behaviours
17 and locations online and the apps that they use. So
18 there is a wealth of information on digital
19 interventions.

20 In terms of measuring the impact, it depends on what
21 the intervention is targeting online but broadly any
22 intervention should seek to decrease the amount of
23 harmful content that people see or that is available
24 online. So that should be ultimately the primary
25 outcome of interest for online interventions and then

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1 the hope then that people experience less harm because
2 they are not seeing the same kind of content or the same
3 kind of people.

4 **MR MOSS:** Thank you. Dr Taylor from the perspective of the
5 work that you have been doing?

6 **DR TAYLOR:** Just to say that really the interventions needs
7 to be on a case-by-case basis, depending on whether it
8 is mental health driven, family, school exclusion. The
9 interventions need to be tailored and then I would say
10 that it is very difficult to know when interventions
11 work because we are dealing with such a rare --
12 incredibly rare, thankfully, outcome.

13 For example, our 170 cases, we have facilitated
14 interventions in those cases and of course we don't know
15 if we scooped up in that group someone who may have gone
16 further down the pathway to action. So that is
17 difficult. But a case-by-case basis and, again, for us
18 to look as a priority at that group in terms of what
19 interventions we did and how we think the risk has
20 reduced.

21 **MR MOSS:** Dr Taylor, on an allied issue, several of the
22 presentations touched on this, but the protective
23 factors that can help children; are those also factors
24 that can help children stay or move away from violence
25 fixation in the first place, rather than just improving

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1 children who are identified as needing intervention is
2 extremely important?

3 **DR IRANI:** In amongst other things, yes, it is.

4 **MR MOSS:** Thank you. And continuity of care an important
5 factor as well?

6 **DR IRANI:** Yes.

7 **MR MOSS:** Does anyone wish to amplify on that as to why
8 those aspects may be particularly important?

9 **DR TAYLOR:** It is certainly something we see a lot, moving
10 area and effective handover of carers is definitely
11 an issue. It is a problem. It doesn't happen as well
12 as it should. Just on the previous point, a trusting
13 relationship with the child is always -- if the
14 relationship with the parent that brings the child back
15 to the next appointment, that's the difficulty.

16 **MR MOSS:** Thank you. Dr Taylor, should we understand, just
17 in terms of the mechanics -- and we know that you have
18 helpfully provided a statement to the Inquiry which will
19 I think explain this -- but should we understand that
20 referrals into the CCS at the moment come from the
21 Prevent cohort, from counter-terrorism officers? That
22 is the referral route, would that be right?

23 **DR TAYLOR:** Yes. We only -- our referral criteria are:
24 there must be a Counter Terrorism Police case officer
25 and that's mostly Prevent, but approximately 20 per cent

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1 the prediction or the management of risk?

2 And can you shed light on, practically speaking,
3 some of the key protective factors that the Inquiry
4 should be keeping in mind or again does it vary
5 completely case by case?

6 **DR TAYLOR:** Yes, again, it is case by case but in general
7 terms availability of pro-social real world activities,
8 if we have got somebody with an autism spectrum
9 condition, it is in a very dark space online; are there
10 ways of finding an alternative activity. Parenting
11 interventions; I'm thinking of the work of Stephen Scott
12 on a younger age group, but where ineffective parenting
13 has contributed to this problem, it is more of
14 an upstream intervention. And of course safe internet
15 parental monitoring of internet will also be important.

16 **MR MOSS:** Dr Irani, I think you wanted to contribute as well
17 on that.

18 **DR IRANI:** Again education, even in the sense of being in
19 education and achieving in education is quite
20 a significant factor for young people.

21 **MR MOSS:** Thank you. One of the Core Participants has put
22 the following questions forward and it may be that the
23 answers are simple yeses, but for your confirmation:

24 Should we understand that the development of
25 a trusting, professorial relationship when dealing with

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1 coming from other areas of Counter Terrorism Policing.
2 There must be at least some evidence of a mental health
3 concern and there must be an identified
4 counter-terrorism concern, which in Prevent means being
5 past the Section 36 decision. Those are our referral
6 criteria. So we don't see any other referrals outside
7 of the CTP pathway.

8 **MR MOSS:** Certainly the Inquiry legal team understand what
9 potentially a radical change this would be, but if
10 outside agencies can't -- other than Counter Terrorism
11 Police -- can't directly refer into your service, would
12 the ability for other professionals to refer into you be
13 beneficial, or would that risk overload or would it be
14 a radical change of the service and so need a huge
15 upscaling? Could you help us about that? Has it even
16 been thought about?

17 **DR TAYLOR:** It has not been thought out. It really would
18 have to be -- the way things are established at the
19 moment, it would have to be a separate project. It's
20 taken as I say a six year pilot and probably 18 months
21 negotiation to get the information sharing agreements
22 signed off for the way we are set up now. So there's no
23 reason why the approach and expertise of the CCS
24 couldn't be extended to another group. But it would
25 need to be separate from us as we are currently

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1 functioning.

2 **MR MOSS:** Thank you. Professor Smith, turning back to you
3 if I may, again the victims' groups in this case raise
4 the fact that your research suggests that harmful
5 networks often function primarily as social communities
6 and not necessarily as ideological spaces. And they
7 seek your assistance on how that should alter the way
8 that monitoring intervention and disruption are thought
9 about and addressed. Can you help on that?
10 **PROFESSOR SMITH:** Yes. So if we think about the contents of
11 discussion in different communities. If it was
12 an ideological community, threat detection algorithms
13 would pick up particular trigger words, for example. If
14 it is a social network that is operating for the sake of
15 being social, those words are not going to be there, so
16 any threat detection algorithm is not going to work
17 there.

18 By the same token, the psychological function of the
19 group is different; they are there because of the social
20 incentives to stay there, so any intervention would need
21 to target that social function and replace it with
22 something that's not associated with violence. So if,
23 for example, somebody is -- their internet access has
24 been taken away from them because they are high risk,
25 they have lost a community that was giving them status

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1 measures could be available for mitigating the online
2 risks other than preventing access. I think you have
3 talked about algorithms that divert interest away.

4 **PROFESSOR SMITH:** Yes, so there are different levels of
5 interventions. So primary interventions would be things
6 like digital literacy campaigns, so that young people
7 and parents understand the risks and young people don't
8 get involved in these networks in the first place. So
9 just preventing engagement before it has happened. Then
10 secondary interventions would be more threat detection,
11 so threat detection algorithms identifying networks and
12 disrupting them. So that would be more of a law
13 enforcement intervention.

14 **MR MOSS:** Professor Cassam, I started with quite a few
15 questions to you and then moved away for reasons I hope
16 you understand, in terms of psychiatric and
17 psychological questions, but can I come to each of you
18 finally and just give you an opportunity to add anything
19 that perhaps you have been waiting to say.
20 Professor Cassam could I start with you?

21 **PROFESSOR CASSAM:** Yes, I think when one is thinking in
22 terms of the risk of somebody committing extreme
23 violence, one can look at very general factors, such as
24 mental health diagnoses and family dysfunction; but of
25 course, in those cases, you are going to get lots and

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1 and belonging; that would need to be replaced in their
2 everyday life so that need is fulfilled, for example.

3 But if it was an ideological group and the function
4 of being in that group was for the sake of meeting like
5 minded others with that ideology, then the intervention
6 would look quite different.

7 **MR MOSS:** Thank you. And touching on some issues that have
8 been raised by the Ministry of Justice, noting what you
9 have said about a multi-agency tool and potential to
10 restrict or monitor access to the internet; they are
11 interested in drawing on your research and expertise in
12 terms of, in headline terms, what other measures should
13 be available for managing or mitigating the risk of
14 acting on violence fixation when it is identified,
15 particularly in terms of online material? So
16 restricting access, but there are obviously practical
17 difficulties in relation to that in many ways. Can you
18 help us with what other measures might need to be
19 thought about?

20 **PROFESSOR SMITH:** Can you clarify which agencies need the
21 tools or interventions?

22 **MR MOSS:** I think that they are pointing to accepting for
23 one moment that you have raised the need to prevent
24 access and use of the internet in appropriate cases,
25 I think they are interested in understanding what other

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1 lots of false negatives. I think there is much more
2 hope if one focuses on the obvious point, that at least
3 in some of these cases there is the declared intention
4 to commit acts of violence.

5 I think one should keep hold of that as a genuinely
6 concerning risk factor, which doesn't require a lot of
7 speculation about broader links between mental health
8 and violence.

9 **MR MOSS:** Dr Irani?

10 **DR IRANI:** I'm good.

11 **MR MOSS:** Thank you. Professor Smith? Dr Taylor? Sir,
12 that takes us very nearly to 4.00pm. Do you, sir, have
13 any further questions arising out of those answers?

14 **SIR ADRIAN FULFORD:** I don't, thank you.

15 **MR MOSS:** Sir, thank you.

16 **SIR ADRIAN FULFORD:** Dr Irani, Professor Smith,
17 Professor Cassam, Dr Taylor, can I thank the four of you
18 very much indeed for the work that's gone into this,
19 both the written materials and an absolutely fascinating
20 day. It has been immensely helpful.

21 Tomorrow we sit at 9.00 am. Can I please encourage
22 everyone to be here ready to start a good 10 minutes
23 beforehand. We have got a sort of lengthy and difficult
24 day and I really don't want to start late, if we can
25 possibly avoid it.

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1 Thank you all very much indeed. I will sit again
2 then tomorrow at 9.00 am.
3 (4.00 pm)
4 (The Inquiry adjourned until 9.00 am the following day)
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