

Thursday, 10 September 2026

(10.00 am)

Introductions

SIR ADRIAN FULFORD: Yes, Mr Jamieson.

MR JAMIESON: Sir, good morning. Welcome to you and to all the Core Participants to this our third seminar which is entitled: "Violence-fixated individuals: lessons from threat management and multi-agency processes other than Prevent."

This is the final seminar for this week. Next week our programme will move to presentations that cover the other areas of our Phase 2 Terms of Reference.

Sir, as before we have four speakers today and each will make their presentation before returning together this afternoon for a plenary session and we plan at this stage to have a short break between each of those presentations.

With your leave I will introduce our four experts now --

SIR ADRIAN FULFORD: Please.

MR JAMIESON: -- so that each may have a clean start to the time for their presentation. Thank you.

Sir, our first speaker will be Ms Becky Canning.

Ms Canning is the Joint Head of the national

Multi-Agency Public Protection Arrangements team, the

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Inquiry, he qualified as a psychiatrist in 2008 and since 2015 he has been part of the Threat Management Team of the Netherlands police force. His presentation to the Inquiry will cover the Dutch Care and Safety House scheme.

Thirdly, we have Mr Dan Diamond. Mr Diamond is a principal for the Serious Violence and Partnership Lead within the Greater Manchester Violence Reduction Unit. In that role he leads programmes that bring together communities, public services and partners to prevent serious violence through collaboration, innovation and evidence-based approaches.

He tells us he is a passionate advocate for community-led working and strengthening local systems.

Prior to his current role, Mr Diamond accrued relevant and valuable experience for this Inquiry working for many years in the National Probation Service. His presentation will cover the work and learning identified by the Greater Manchester VRU.

Then last but by no means least, Dr Aisling Martin is a Consultant Clinical Psychologist who has a special interest in attachment and development trauma. She has over 20 years of NHS experience working psychologically with children, young people and their families.

She has undertaken additional training in

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MAPPAs team, within HM Prison and Probation Service, the HMPPS. Hopefully she won't mind if I say she has almost than 30 years' experience in probation, public protection, risk management and multi-agency working, and provides national leadership for MAPPA policy and practice across England and Wales.

Her role involves developing that national policy, supporting operational delivery and driving improvement. She also led the implementation of the recommendations that arose from Jonathan Hall KC's review of MAPPA, something you know he mentioned yesterday.

SIR ADRIAN FULFORD: Indeed.

MR JAMIESON: Our second speaker is Professor Bram Sizoo.

Professor Sizoo was appointed Professor of Clinical Psychology of Radicalisation at the Faculty of Social and Behavioural Sciences at the University of Amsterdam.

His research focuses on exploring and investigating the clinical psychology of radicalisation and he has also published extensively in the areas of autism and developmental disorders. He holds Masters degrees in criminal law and medicine. Before his current role he has had an admirably varied career that included service, I think as a naval officer in the Netherlands Submarine Service, as well as directing a mission hospital in Malawi. Of more recent relevance to the

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therapeutic and trauma-specific approaches which she applies within her clinical practice. Dr Martin leads Trusting Hands in Gateshead, which is an award winning multidisciplinary mental health team integrated into the Gateshead Children's Social Care and operates as part of the NHS England Framework for Integrated Care or, as it is more commonly known, the Vanguard Pilot. She will tell us more about Vanguard and the principles that underpin it.

With that quite enough for me. Please can I invite Ms Canning to come forward please.

Presentation by MS CANNING

SIR ADRIAN FULFORD: Thank you very much, Ms Canning. In your own time.

MS CANNING: Good morning and thank you very much for inviting me to speak today.

My presentation, what I wanted to do today was to -- we have heard quite a lot of talk about MAPPA, Multi-Agency Public Protection Arrangements, and I have seen from previous seminar sessions and also from some of the questions that have been raised, there's been a lot of interest in MAPPA.

What I wanted to do today was actually do some of the basics and actually talk about exactly how MAPPA work, and then after that address the questions that

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were put specifically by the Inquiry.

Excuse me, I will be using my iPad so I will be asking if someone could click on the slides for me. So if we could go to the first slide please, the next slide please, sorry.

So as I said, MAPPA stands for Multi-Agency Public Protection Arrangements and the framework is underpinned by the Criminal Justice Act 2003, sections 325-327, which have been amended over the years but that's the legal framework which establishes those Multi-Agency Public Protection Arrangements.

They are operated by criminal justice agencies, the police, prison and probation, who are the responsible authority. They form the responsible authority together and they are responsible for delivering, MAPPA, these arrangements within the 42 criminal justice/police force areas, and the responsible authority, alongside the Duty to Co-operate Agencies, which are set out in statute, are responsible for delivering MAPPA in those areas.

They will be -- so -- yes, so they are arranged -- as at 31 March, there were over 97,000 people managed under MAPPA, and that number continues to grow and I will explain why that is later but we expect probably to reach the 100,000 mark fairly soon in the next year or two.

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working in silos. So that's the aim. Certainly when I started in probation almost 30 years ago, police and probation didn't talk to each other. It was almost a cultural anathema that -- for police and probation to talk to each other, and now police and probation work together all the time. It's not -- so it has effected or MAPPA have effected a real sort of cultural shift over the last 25 years.

Okay, so if we could go to the next slide please. You have probably heard a lot about MAPPA levels, MAPPA categories. You might have heard people getting them mixed up. I'm the head of the national MAPPA team, I still get them mixed up. So I thought it would be helpful just to go through exactly what we are talking about.

So, first of all, I want to talk about the MAPPA categories. So Category 1 are those individuals who are convicted of sexual offending and are subject to notification requirements under the Sexual Offences Act 2003, commonly known as being on the sex offender register. So people who are -- so that group of people will be Category 1.

Category 2 offenders are those individuals who have been convicted mostly of offences under schedule 15 of the Criminal Justice Act 2003. There are a few

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The other important thing to say about MAPPA, and you quite often hear "What does MAPPA do? What does MAPPA think?" MAPPA is not an agency. It is a set of arrangements. So it is not an organisation, it is not a separate agency. MAPPA are a coming together, a bringing together of the agencies, and the other thing I may repeat myself, but MAPPA do not confer any additional duties or responsibilities or powers aside from information sharing and the requirement to co-operate and coordinate. So MAPPA is not a magic wand and doesn't confer any additional powers.

So if we could have the next slide please. So, "Why do we need MAPPA?" MAPPA really were born out of serious cases from the mid- to late 90s, most notably the Soham murders and what was found by serious case reviews was a failure to -- of agencies to share information and coordinate. Similar really to the outcomes that we are seeing today, but MAPPA were a means of addressing those particular findings.

The purpose of MAPPA, as I said before, they are a way of bringing together agencies. It's the cliché really about the whole being greater than the sum of its parts. So they bring together -- serve a coordination role, where agencies can share information in a safe environment and coordinate their efforts rather than

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exceptions to that but most of those individuals, and they have to have received a sentence of 12 months imprisonment or more, that could include a suspended sentence, or subject to a Hospital Order. So with those Category 2 cases there is a seriousness threshold for those individuals.

Category 3 is interesting. They are discretionary management and they are cases where an individual has been convicted of an offence or has received a caution for an offence where that's indicative of a risk of serious harm, but it isn't listed in schedule 15 or they are not subject to notification requirements. But there is a risk of -- indication of a risk of serious harm. An example might be where somebody has been convicted of criminal damage and that offence is committed in the context of domestic abuse, and actually there is a lot of behaviour that sits behind that, which is really concerning. So you could manage somebody like that where the offence might seem fairly minor but actually the risk is quite significant.

Then we have Category 4, which is for Terrorist Act-convicted offenders: those who have been convicted of terrorist-connected offences or those who are assessed as posing a terrorist risk. That category and those offenders were introduced, or this category

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1 was introduced in response to Jonathan Hall KC's review
2 into the management of MAPPA offenders.

3 So, those are the categories.

4 Then we have the Levels on the other side and that
5 is -- so the categories, if you like, are the who: who
6 are we managing; and the levels are the how. So the
7 vast majority of individuals will be managed at MAPPA
8 Level 1, around 98 per cent, and those are individuals
9 who will be managed by their agency, by the lead agency,
10 but with support from other agencies. And it is
11 important to say that the duty to co-operate absolutely
12 exists for Level 1 cases as well as Level 2 and 3 cases,
13 and also you can have meetings at Level 1 but they just
14 won't be as formal and they won't have that sort of
15 formal oversight. Levels 2 and 3 are -- there will be
16 formal meetings and there will be that more formal
17 oversight and we would expect to see more senior
18 involvement for those cases.

19 An example I give about Level 3 management is maybe
20 perhaps someone like the Kray twins would have been
21 managed at Level 3: high-profile, high levels of risk,
22 really high levels of concern. So it is those. So you
23 get very, very few managed at Level 3. Level 2, you
24 would expect some seniority but not as much.

25 So, if I could have the next slide please. So we

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1 Then we have the Duty to Co-operate Agencies. So
2 they are agencies who are under a legal duty under the
3 Criminal Justice Act 2003. They are agencies that are
4 required to co-operate with the lead agency to assess
5 risk and to develop the risk management plan.

6 We have also introduced, again, in response to
7 Jonathan Hall KC's review, Associate Agencies, and that
8 was introduced in the Police, Crime, Sentencing and
9 Courts Act 2022 and that enables other agencies to be
10 brought in on a case-by-case basis. So, for example, if
11 you have somebody with a serious substance misuse issue,
12 or somebody who's perhaps working with a voluntary
13 organisation or someone whose GP is very involved with
14 their case, they can be brought in on a case-by-case
15 basis. They are not compelled to co-operate in the way
16 that Duty to Co-operate Agencies are, but it's
17 an ability to bring in those agencies as required and
18 that's something that we found very, very useful since
19 that was implemented.

20 Then we have the Strategic Management Board. The
21 Strategic Management Board is the board that actually
22 ensures that the arrangements are working within those
23 areas. Strategic Management Boards are independent and
24 they are made up of police, probation and prison. One
25 of those will Chair the board and other agencies will be

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1 have got six sort of component agencies in the
2 management of MAPPA. First of all, we have the
3 Responsible Authority and as I said before, that's HM
4 Prison and Probation Service and police, they come
5 together and they are responsible for delivering MAPPA
6 within the criminal justice -- respective criminal
7 justice areas.

8 The second sort of cohort is the lead agency. Most
9 of the time that will be prison or probation. It will
10 also sometimes be Youth Offending teams and/or mental
11 health clinicians. The lead agency is the agency with
12 the most power, and I notice that Jonathan Hall talked
13 about the agency with the powers yesterday when he was
14 talking about Sudesh Amman and in that case probation
15 had the power to return that individual to custody. You
16 still have to have a legal basis for doing that, but
17 it's the agency with the most powers to do something
18 about the risk.

19 So where somebody is on licence or subject to
20 a sentence, it will be probation or the youth justice
21 service or mental health clinicians. Where somebody is
22 subject to notification requirements but there's no
23 other requirements in place, then that will be the
24 police that's responsible for managing those
25 individuals.

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1 part of that, and that really, as well as ensuring that
2 the arrangements are in place, Strategic Management
3 Boards can be a really useful point of escalation where
4 there are cases that can't be resolved through the
5 normal panels, so that would be where that would go.
6 That's the sort of governance structure.

7 Then, finally, we have the Secretary of State. The
8 Secretary of State does a number of functions. So with
9 MAPPA, the Secretary of State responsible is the
10 Secretary of State for Justice. So it is
11 the Ministry of Justice, which sort of holds -- which
12 holds the kind of the ministerial oversight for MAPPA.
13 So the Secretary of State will issue statutory guidance,
14 and the statutory guidance can be found on the MAPPA
15 website and how we do that is we -- it is an iterative
16 document. So rather than having to wait until the next
17 version, we amend statutory guidance as we go and as
18 necessary. So it can be quite a sort of flexible
19 process.

20 They also issue the annual report, so we issue
21 a statistical report every year and the Secretary of
22 State also appoints lay advisers to each Strategic
23 Management Board, and the lay advisers are members of
24 the public who act as a critical friend to MAPPA
25 agencies and ask the questions, I suppose, that we would

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1 expect concerned members of the public to ask. So they
2 are ministerial appointments.

3 If I could have the next slide. I think I have
4 probably covered this. These are how we identify -- how
5 somebody -- MAPPA identification, so they are within
6 their categories. But MAPPA management will only last
7 as long as a power is in place. So for Category 1, they
8 will be MAPPA as long as they are subject to
9 notification requirements. Category 2, as long as they
10 are subject to a sentence of the court or a Hospital
11 Order. Category 3, as long as is necessary, and
12 Category 4, and I should have said earlier, as long as
13 they are subject to notification requirements under
14 part 4 of the Counter-Terrorism Act or subject to
15 a sentence.

16 So that's kind of where it begins and where it ends.
17 If I could have the next slide please.

18 Again, I probably don't need to repeat this.
19 Level 1 management. The important thing to say here
20 really is that it is for the lead agency to manage that
21 case as they would in any other case, but what they have
22 there is the support of other agencies and the duty to
23 co-operate absolutely, and the duty to co-operate and
24 the powers to share information are there in the same
25 way as they are for Levels 2 and 3.

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1 We have the monitoring and control, so those are the
2 sort of external things to help us manage the risks. So
3 that will be things like licence conditions, it might be
4 electronic monitoring, curfews, drug testing, polygraph
5 testing. Those sort of external things used to manage
6 the risk.

7 The interventions part is what it says really. So
8 that would be the treatment perhaps, perhaps a sex
9 offender treatment programme or drug treatment or --
10 it's that intervention that will manage the risk. Then
11 the last pillar is victim safety, and that's not just
12 the victim of the index offence, it could be potential
13 victims. So, for example, if somebody -- the risk would
14 increase because if they were to meet a new partner, the
15 risk of domestic abuse would increase, then we would be
16 concerned about that individual as a potential victim.
17 So then we would be looking to manage those risks.

18 So it is previous, current and potential victims
19 under the four pillars.

20 Just a quick word about ViSOR. Sorry, next slide
21 please. ViSOR, some people call it the sex offender
22 register and ViSOR isn't; ViSOR is simply a database for
23 managing MAPPA offenders and it is a national database
24 to which prisons, police and probation all have access.
25 So, it means that we can all upload information and use

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1 If we go on to the next slide. So, again, I think
2 I have probably said this, but the management at Level 2
3 and 3, you have formal meetings. We have an agenda
4 which is set out in the statutory guidance. So all
5 meetings should look roughly the same and cover the same
6 areas, and we would expect the meetings to be Chaired by
7 somebody -- well, Chaired and attended by people with
8 sufficient seniority to make decisions in those more
9 complex cases.

10 So, if we go on to the next slide and I think I have
11 said everything. So, the next one after that. The
12 whole point of MAPPA is to come up with a risk
13 management plan, and we do this under four pillars,
14 which was introduced by Hazel Kemshall of
15 De Montfort University.

16 The four pillars of risk management are supervision,
17 so that's the contact that an offender will have with
18 agencies. That will probably be the lead agency, but
19 other agencies might also be involved. So you might
20 say, okay, well, we have -- they are going to see their
21 probation officer once a week, they are also going to
22 see a work coach at the DWP once a week, they are going
23 to see their drugs worker. So the idea is that it is
24 a sort of collective, what supervision will that
25 individual be getting, so it is not just probation.

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1 that as a way of sharing information and, unlike a lot
2 of other databases, it is national.

3 Okay. So just some points really that I wanted to
4 iterate about MAPPA. So, first of all, MAPPA is about
5 managing risks posed by the offender, not by anybody
6 else. So there are other multi-agency forums that might
7 be focused on, say, the child, if it is child
8 protection, or MARAC, if it is domestic abuse. This is
9 very, very particularly focused on the offender and the
10 steps that can be taken around that individual.

11 The other thing about MAPPA is there must be
12 a conviction or a caution. MAPPA are not for anybody
13 that we are worried about: there has to be a conviction
14 or a caution; if there's no conviction or caution then
15 MAPPA just does not have a role.

16 Then, as I said before, there are no additional
17 powers or duties aside from sharing -- information
18 sharing and co-operating in the assessment.

19 Finally, and again this is something that you might
20 hear me say again and again, there need to be some
21 powers to manage that individual with. So if there is
22 no sentence, if there are no notification requirements,
23 if there's no civil order, then there's nothing for us
24 to manage that individual with. There are no powers.
25 And there aren't any extra ones just because they are

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1 MAPPA, so there has to be -- I call it a hook. I say
2 you have to have a hook and that hook is one of those
3 powers.

4 So the next slide please. So really we talked about
5 MAPPA and violence-fixated individuals and I have seen
6 some questions about categories. Because MAPPA are
7 about the offence and not about the individual, there
8 will be people -- violence-fixated individuals who will
9 come under MAPPA because they have been convicted of
10 a particular offence or they have been convicted of
11 an offence where there is a concern. So there is
12 absolutely -- violence-fixated individuals can be
13 managed under MAPPA but there isn't a separate category
14 for them.

15 I have said that we can use discretionary
16 management, which perhaps would cover where the offence
17 doesn't -- sort of belies a much more serious concern.
18 The other thing to say is that any agency can refer into
19 MAPPA. It's not just the lead agency, although they
20 would need to consult -- all agencies need to consult
21 with each other, that's the point, but any agency can
22 make a referral and raise a concern, so it doesn't have
23 to be police or probation.

24 Next slide please. So then just moving on to the
25 questions raised by the Inquiry. The first question is

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1 Jonathan Hall KC and also the justice inspectorates.
2 There have been two inspections, one on terrorism and
3 one more generally. There has also been Anglia Ruskin
4 University and I know the Inquiry has a report from
5 Samantha Lundrigan on the findings there.

6 But MAPPA generally are well understood, they are
7 seen as effective. They have the confidence of staff
8 who work within those arrangements and they also are
9 effective in reducing re-offending. The re-offending
10 amongst those managed under MAPPA is less than half of
11 those who aren't managed under MAPPA.

12 If the next slide there -- it's just some more
13 quotes for you. If I could have the next slide please.
14 The next one is about how well partners share
15 information. Really the thing about MAPPA is they are
16 dependent on relationships and so where there are
17 positive relationships, then information is well shared.
18 Where those relationships are a little bit more tricky,
19 then it may be that they don't work so well. We do
20 have, in terms of monitoring, we have key performance
21 indicators, so that the national team monitors
22 attendance at Strategic Management Boards and also at
23 meetings, and we address those where we think that's
24 dropping off. But engagement really, it does come down
25 to the people. This is very much a human business and

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1 really about MAPPA effectiveness. What we know is that
2 MAPPA is really effective at managing complex risk, and
3 is particularly effective at Levels 2 and 3, and
4 something again Jonathan Hall KC in his review talked
5 about MAPPA being well understood by all agencies. So
6 there is a sort of good level of confidence there. It
7 is not -- MAPPA aren't set up to manage new risks.
8 There has to be an established risk in the form of
9 an offence. But what MAPPA are really good for is
10 sharing. Once somebody is in that set of arrangements,
11 it can be really helpful for sharing sort of continuing
12 concerns and identifying perhaps offence paralleling
13 behaviour then being able to respond to those risks as
14 they arise.

15 Also, MAPPA can be replicated in other settings and
16 I think we will probably hear about that later from some
17 of the other speakers. So some of the principles of
18 MAPPA, and I think we see that all the time in other
19 multi-agency settings, so there is a lot about MAPPA
20 which can be replicated.

21 The limitations I think we have said -- I have said
22 is they don't introduce any new powers or duties. If
23 the next slide -- are simply some quotes really about
24 MAPPA effectiveness. So we have had certainly since
25 2020 MAPPA have been under a great deal of scrutiny from

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1 it depends on how people work together. But the
2 framework is there. There's absolutely -- it is
3 possible to do it. It then comes down to local
4 pressures, local resource issues, local personalities,
5 all those sorts of things that make the partnerships
6 work well or not.

7 Next slide please. So, our current -- we talked
8 about thresholds and categories and whether they are
9 suitable for violence-fixated individuals. The truth is
10 I don't know because I think this is an emerging area of
11 work for all of us. What I do know is that after the
12 last -- over the last sort of six years, since I have
13 been involved in the national team, because we have
14 flexibility around policy and guidance, MAPPA practice
15 has evolved to accommodate increasing knowledge on
16 particular cohorts of offending. I think the example of
17 that has to be the management of terrorism offenders
18 which has massively evolved over the last six years
19 since Jonathan Hall's review, but also the work we have
20 done on domestic abuse and the way that we have changed
21 guidance and practice and we have seen that really
22 develop.

23 So I would say that this an area of work that we can
24 definitely look at developing but I think that will --
25 that's for all of us really. That's a challenge for all

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of us to make that work but it is absolutely possible.

The question about mental health integration within mental health and safeguarding. They are all Duty to Co-operate Agencies. We expect to see attendance at Strategic Management Boards. We expect to see attendance at meetings. We monitor that quite closely. We are quite targeted. So where we see an area where attendance has dropped off, we will go into that area and speak to them about what's going on there. Attendance generally is very high and very stable. But, again, it does come down to how individuals work together. We have produced in the national team lots of resources to assist with social care departments and also mental health. So we work very closely on a strategic level and on a national level and with the aim that that goes to a local level. From my own experience, I have had really fantastic experience of agencies working together and solving very, very difficult problems.

So just to sum up really. Conclusions. On the positive side, MAPPA are effective at reducing re-offending, managing complex cases and they are well understood by those agencies and they have the confidence of those agencies.

The limitations, you have got to have a hook.

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construction, incidents do happen like the incident last year in September at the Erasmus Bridge in Rotterdam where a fatal stabbing occurred despite the fact that this individual was being discussed in Care and Safety Houses. So that is just to put the whole thing in perspective.

So I was asked three questions which I will deal with in this presentation. "How does the Dutch Care and Safety House model identify, assess and manage individuals who present a serious risk of violence but do not fit a clear criminal, ideological or mental health profile?"

The second question is: "How do partners within the Dutch Care and Safety House system work together to share information, assess risk, coordinate interventions, and maintain accountability for individuals of concern?"

And lastly: "To what extent does the Dutch approach focus on unmet needs, vulnerability and trauma rather than ideology, and what lessons might this offer for managing violence-fixated individuals in the UK?"

So what I would like to talk about is the Care and Safety House construction as such. Then I move into the subject of radicalisation, extremism and terrorism and its relationship with Care and Safety Houses. Then,

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There's got to be those powers, there's got to be a conviction, and people can only bring to the table what they already have. That concludes my presentation.

MR JAMIESON: Ms Canning, thank you very much.

SIR ADRIAN FULFORD: Thank you, Ms Canning.

MR JAMIESON: Sir, we are a little ahead of schedule but may I suggest that we break now for 15 minutes and come back at 10.50 am?

SIR ADRIAN FULFORD: Certainly. I will rise.

(10.36 am)

(A short break)

(10.50 am)

SIR ADRIAN FULFORD: Yes, Mr Jamieson.

MR JAMIESON: Sir, thank you. Professor Sizoo please.

Presentation by PROFESSOR SIZOO

PROFESSOR SIZOO: Thank you very much for the opportunity to give a presentation on the Dutch Care and Safety houses, and I sincerely hope that my presentation will be a modest contribution to this very thorough Inquiry.

Right. So my presentation will be about the Care and Safety Houses in the Netherlands. It is a construction, unlike MAPPA, also very much preventative-orientated and what you see on the first slide, the background is to emphasise that it is not a silver bullet. So despite the Care and Safety House

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having done that, I will highlight some of the advantages which I think the system has and also some concerns and finally I will wind up with the conclusions and answers to the three questions.

So, concerning the Care and Safety House construction, we will first look at the description. What is a Care and Safety House? We will look at the origin criteria; the network of participating partners; the process and legislation, which is relevant to the Care and Safety House construction and some "specials".

Right, what is a Care and Safety House? It is not a house; it is an organisation though. Unlike MAPPA it is more formalised than what we have just heard in MAPPA. It is a structural collaboration between network partners in complex cases with potential safety risk. Now this is of course a very broad definition. Especially what are complex cases? I will go into that a little bit later.

So this can be considered as the front office of Care and Safety Houses. The back office consists of a support bureau with process case management, knowledge and information hub. It also has the task of trend spotting and analysis, especially what goes on in the region where this Care and Safety House is positioned, and there is a regional network coordination between

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other Care and Safety Houses.

So these collaborative units or collaborative organisational structures, currently there are 31 in the Netherlands. Considering a population of 18-19 million, that would mean that in Greater London we would have roughly 16 Care and Safety Houses, just to give an impression of the population ratio to Care and Safety Houses.

Care and Safety Houses, they are mandated to local government. So that is the aspect of the regional organisation of Care and Safety Houses that the local government is responsible for running the front office and the back office, and the council also provides the process managers. The process managers are the people who lead the collaboration and there's a formal national training for process managers.

So the vision of Care and Safety Houses and this is an important vision, although it is a very short definition: safety and care are shared responsibilities. Now there is a lot to that definition.

First of all, that safety and care are regarded as something that belong to each other. So you can't provide care without safety and you can't guarantee safety without care or ensure safety without care. Also the shared responsibility aspect is very important. It

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So the police said "Well we are being asked to provide assistance in situations for which we are not trained. These situations are situations with disturbed people and we need mental health to solve these problems."

Now, not all the situations with disturbed persons were identified were cases which were for mental health services because they also concerned cases where people were drunk or under influence of drugs or there was a case of dementia or a case of extreme anger, for example, so it might appear that these people were in need of mental health services but formally mental health services couldn't do much about the majority of these cases.

However, the observation that there was something more needed than just security, led to the shift from Safety Houses to Care and Safety Houses. That developed quite rapidly in a national framework of Care and Safety Houses because this concern was recognised throughout the country.

So, for example, a Care and Safety House would deal with safety, care, finance and housing. So there was a sort of multiple concern.

So what is a complex case? A complex case is defined by the Care and Safety House construction as: problems which are either individually- or

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is not a lead agency, it is not one agency that's responsible, it is a shared responsibility. I will go into that a little bit later on.

So looking at the history of the Care and Safety Houses before the 1990s, law and order was managed by police and the Crown Prosecution Service and in the 1990s it was discovered that communication between those two was not optimal, like we heard the communication between the probation and police was not optimal either, and it has developed into something better.

Given the observation that the communication between these agencies and the safety domain was not optimal, there was an initiative in the security domain to start Safety Houses. So please note: not Care and Safety Houses but Safety Houses.

That developed into a nation-work network of safety houses but they were very diverse and there was no structure that guided them.

In 2015, the focus in the Netherlands shifted to "persons with disturbed behaviour", and this is a literal translation of Dutch. It is an indication which was initially given by the police. So police call-outs to situations where they found persons to be disturbed or confused. They had a label, it was called the E33 label, and they saw that this grew tremendously.

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family-related; problems in multiple areas and criminogenic factors, in other words factors that might lead to crime; objective facts or likelihood of crime, violence or public disturbance; multi-domain collaborations deemed mandatory for addressing the problems; and there can also be additional criteria which very much depend on the region where the Care and Safety House sits.

So the network -- and this is not -- there are more organisations involved but to give you an impression, the safety domain consists of the public prosecutor service, the police, the probation service, prison services, family safeguarding and, for example, Council for Child Protection.

The care domain might involve mental health care or forensic mental health care, the GPs or addiction support services.

And the municipality may represent housing agency, social welfare and employment agencies. The idea is that the agencies are involved, are chosen depending on which case is being discussed.

So, the process that is followed in the Care and Safety House construction is that there is a referral by a network partner. Then this referral is enriched by the back office of the Care and Safety House, so given

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1 a little bit more body. Then there is a triage of
2 assembled network partners, and in practice that is
3 a small delegation of the network partners who decide
4 whether or not it is a case for a Care and Safety House.

5 Then process management is started by the Care and
6 Safety House bureau. Again, under the responsibility of
7 the municipality, and a collective plan of action is
8 drawn up.

9 Now this is extremely important that the plan of
10 action is a plan of action which has been agreed on by
11 all the participating partners. In other words, the
12 police knows what mental health care is doing, knows
13 what the housing agency is doing and they coordinate
14 their action towards something which for the individual
15 concerned is very comprehensive.

16 If all goes well, there is a time for downscaling
17 and finalising the case. The legislation, I mentioned
18 medical confidentiality, which is not specific for Care
19 and Safety House construction of course, but it plays
20 a large role. In the Netherlands, medical
21 confidentiality legislation is extremely strict. So as
22 a psychiatrist I'm not allowed to share information
23 about a patient with another psychiatrist, unless that
24 psychiatrist is directly involved with the treatment of
25 a patient. And the repercussions are also very strict.

29

1 understood that you made your contribution as well as
2 possible to lead -- to derive a common plan of action.

3 Now with this legislation, legislations usually are
4 top down processes, although of course there is -- it is
5 informed by others, but the duty to share principle is
6 a sort of legal issue which we, at the level of Care and
7 Safety Houses, thought was a bit over done because it
8 was obvious that everybody shared the information
9 anyway.

10 However, the medical professions are exempted. So
11 if I participate in a collaborative meeting of a Care
12 and Safety House, I do not need to share information
13 about my patient because the medical confidentiality is
14 deemed to be higher in the hierarchy than the law and
15 the information sharing in collaborations. This of
16 course causes some friction where police might say,
17 "Well, the psychiatrist is not sharing information, so
18 why isn't he sharing information because it is very
19 important?" And you get this discussion. But in
20 practice we see that there is a lot of difference in --
21 depending on which clinician is participating in the
22 Care and Safety Houses. Some clinicians will also
23 regard the wellbeing of the individual discussed
24 important enough to share information, modestly, and
25 others will not say anything.

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1 So sharing patient details with others without
2 explicit consent of the patient involved is a crime.
3 And breach is permitted without patient consent
4 obviously to avert imminent danger and then only that
5 information which is needed to avert the danger, and if
6 there is a "conflict of duties". Now this is of course
7 a very arbitrary term but conflict of duties is
8 understood as something which keeps you awake. So
9 serious conflict of duties.

10 In 2025, so last year, a new law was introduced for
11 basically the data management in Care and Safety Houses
12 and other collaborative organisations, so not only for
13 the Care and Safety House constructions but also for
14 collaborations around fraud and criminal undermining,
15 which currently in the Netherlands is a big problem. So
16 this law is applicable to other collaborations as well.

17 It offers a legal base for sharing personal
18 information and there is a "duty to share" principle.
19 Now this is new because prior to this new legislation,
20 it was basically a sort of gentleman's agreement to
21 share information. So, the participating agencies in
22 a Care and Safety House would sign a covenant at the
23 beginning of a Care and Safety House, where they signed
24 that they are committed to discuss cases which meet the
25 inclusion criteria, and this was a sort of -- it was

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1 It formalises the criteria for the Care and Safety
2 House referrals. That is the last point of this law.
3 Now there are some specials. So this construction of
4 Care and Safety Houses developed and there were
5 initiatives to specialise in a certain area and we call
6 these "tables". So in the metaphor of a Care and Safety
7 House, in the house the different tables which are
8 specialised for areas of interest like domestic
9 violence, child sexual abuse, "persons with disturbed
10 behaviour", reintegration after prison sentence and life
11 span approach programme, which is the latest programme
12 which specifically deals with individuals where there's
13 a clear indication of a mental health problem which
14 makes them very vulnerable to disturbed behaviour and
15 also to committing a crime.

16 In addition to these specialised tables, there are
17 also "plus tasks" because it was recognised that the
18 infrastructure of the Care and Safety Houses was
19 extremely useful. So we have these plus tasks which are
20 delegated to Care and Safety Houses. One of the plus
21 tasks is reporting point "need for compulsory care".

22 For example, if somebody feels that a neighbour or
23 somebody in the neighbourhood needs to be sectioned,
24 needs to have compulsory care, he or she can report this
25 situation to the Care and Safety House and they do

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1 further investigation whether this is a proper referral
2 or not.

3 Then of course the whole process starts.
4 Neighbourhood justice is a project where the judge
5 descends into a neighbourhood to be the judge there, and
6 lastly, please note that we have not talked about
7 radicalisation, extremism and terrorism yet. But one of
8 the plus tasks is radicalisation, extremism and
9 terrorism.

10 Now, I will move on to this aspect of extremism and
11 terrorism by discussing the counter-terrorism strategy
12 in the Netherlands. So, this was a top down strategy
13 issued by the Ministry of Justice and it is the issue of
14 radicalisation, extremism and terrorism is mandated to
15 the National Coordinator for Counter-Terrorism and
16 Security, the NCTV, and there extremism and terrorism
17 are both defined as ideologically-motivated behaviour.
18 So this is the first time that the word "ideology"
19 appears in the presentation and also later in the Care
20 and Safety House construction.

21 So, the idea about the counter-terrorism strategy is
22 that prevention of terrorism, extremism is best
23 conducted locally, where there is knowledge about the
24 situation, where people know about individuals, where
25 the local network is thorough and is established and the

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1 Now these five elements, they are derived from
2 the -- a holistic view on radicalisation, extremism and
3 terrorism as was written about by Kate Barrelle. She
4 has written quite a lot about this holistic approach
5 towards radicalisation, extremism and terrorism. We
6 will come back to that a little bit later on.

7 The third phase in the process is the case
8 consultation. So if the assessment is positive, and it
9 is considered that somebody needs to be discussed in
10 a person-centred approach then there needs to be a case
11 consultation, and if this is all successful it can be
12 monitored and hopefully finalised.

13 Here are the five elements of the assessment: again
14 ideology, social relations, identity, self-support and
15 the intention to use violence.

16 So if we zoom in onto the case consultation process.
17 It is chaired by the municipality. There are permanent
18 participating agencies and agencies that can be invited.
19 Unfortunately in this new law, this legislation on the
20 case management of radicalisation, extremism and
21 terrorism, the permanent partners did not include mental
22 health. So for mental health services to join the
23 collaboration, they need to be invited especially to
24 join the collaboration, which I think is a missed
25 chance.

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1 intervention is seen in three phases.

2 First, prevention. A person-centred approach, and
3 detention and reintegration. Once again this has
4 nothing to do yet with Care and Safety Houses; this is
5 the strategy as it was drawn up by the
6 Ministry of Justice.

7 So we will focus on this person-centred approach in
8 the counter-terrorism strategy. The person-centred
9 approach says that the management of extremism,
10 radicalisation and terrorism cases, and the prevention
11 needs multidisciplinary case consultation. So this
12 a sort of starting point and that there needs to be
13 a mix of criminal law, administrative managers, care and
14 other interventions.

15 There are four phases defined in the person-centred
16 approach. First phase is reporting of a possible case
17 of radicalisation to the municipality by, for example,
18 somebody from the public or the police or healthcare.
19 Then there is the assessment by the municipality, police
20 and Crown Prosecution Service, whether there is
21 an intention to use violence; what the expression is of
22 extremist views; how the social network of this
23 individual is; and also whether there is
24 an identification with extremist group or ideology; and
25 to what extent somebody is able to self-support.

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1 The notification of subjects in person-centred
2 approach. This is very important.

3 People who are discussed in these collaborations
4 around radicalisation, extremism and terrorism need to
5 be notified, and they need to be told that they are
6 being discussed. One of the questions which I will sort
7 of make ahead and answer the question is that there is
8 no possibility for appeal -- although this is currently
9 a discussion. So, perhaps later in the questions we
10 will go into this with more detail.

11 There is a guideline professional judgement, and
12 this is the model from Kate Barrelle, the holistic
13 model, working model, case consultation radicalisation
14 and extremism. This is the same picture, only a little
15 bit bigger. The model sort of assesses what the level
16 of integration is in these five areas. So, a highly
17 integrated situation would mean that somebody is, for
18 example, if we look at ideology, somebody has
19 an ideology but is also able to put it into perspective
20 and live with this ideology without problems in his
21 surroundings. So that is a highly integrated. A low
22 level of integration is that somebody has an ideology
23 which he thinks is dominant and all else should go away,
24 to the benefit of this ideology. So that's a low
25 integration. We have the same for social network. It

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could be highly integrated or low integrated, identity, self-support and violent intent, and "identity" also includes mental healthcare and general healthcare.

So, the legislation. Parallel to this new law for sharing data in the Care and Safety Houses, there was also a new law for information sharing in collaborations about radicalised individuals. So it seems a bit overdone but this was considered to be necessary because still, in the perspective of the central government, radicalisation, extremism and terrorism is something very special, other than regular cases in the regions.

So, it offers a legal base for the local approach; a legal base for a person-centred approach. The Mayor is responsible. So again there is this delegated responsibility for running the collaboration. The infrastructure of the Care and Safety House can be used. This is no surprise really because in the other slides, in the previous slides, everything sort of sounded like, is this not a Care and Safety House construction which we are thinking of? And indeed, although it is legally something separate, the Care and Safety House construction is used as a separate table within the Care and Safety House to deal with radicalisation, extremism and terrorism.

There are also specials in this radicalisation,

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construction.

One of the other merits is that the participating agencies are similar for general complex problems and for radicalisation, extremism and terrorism. So, in general, they know each other and they -- hopefully there is enough trust for them to share information and to deal with complex cases.

Lastly, the regional Care and Safety Houses also are organised at a national level to share information and to share expertise at a national level and to provide training for the process managers in both a local approach and the Care and Safety House.

There are also some concerns that the effectiveness is as yet unknown. Now, please bear in mind that the Care and Safety House construction is only ten years old. So, there are initiatives at the moment to measure the effectiveness, although measuring effectiveness in a preventive setting is always difficult because how are you going to indicate that you have prevented something from happening? But there are initiatives on the way.

Medical confidentiality is still one of the issues that needs to be looked into because in certain cases it leads to frustration of the process, in other cases it is smoother. The decision to break confidentiality is the clinician's own decision. So that means that the

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extremism and terrorism collaboration area. For example, in Amsterdam we have an intensive person-centred approach radicalisation, which again centres on individuals with evident mental health problems who also hold an ideology up to a certain extent. But this is very complex case management and here the individual himself is invited to think along with the plan of action, which can lead to very interesting situations: even individuals joining a collaborative session.

So here there is extra attention for care. Now, looking at the advantages of the Care and Safety House system, with a separate table for radicalisation, extremism and terrorism, is that it is person-centred. So we focus on the individual rather than the label. There is a clear outline of responsibility. So the local approach for the counter-terrorism -- resulting from the counter-terrorism strategy is clear and the Care and Safety House construction for more general cases, not specifically for radicalisation, is also clear.

Now, given the fact that this is in the same house, the same Care and Safety House, it is easy to transfer cases from one table to another table and I think this is one of the great merits of the Care and Safety House

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clinician is -- has to make the decision for herself or himself to breach confidentiality with all the possible repercussions, and that for many colleagues leads to a, sort of, better be safe than sorry than not say anything situation.

Quality control is also a matter of concern. We have no formal quality of control measure as yet. Post-detention processes are still -- there is still room for improvement. We still see situations where individuals are released from prison and that there is insufficient preparation for his reintegration in society and, lastly, "label-myopia" is something that needs some explanation. It is a phrase I thought of myself. If you look at a timeline, the past, present and the future, then radicalisation is by definition a process which occurs in a period of time.

However, in the present we see a situation which we label as, for example, a situation which concerns a violence-fixated individual or a terrorist, or a nihilistic violent extremist case, or a case of a lone-actor. The question is of course, what does this label have adverse consequences? It can lead to a lens through which you look at the past and the present. For example, if we look at the label "nihilistic violent extremist", the question is whether somebody was always

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a nihilistic violent extremist? Of course not. So the question is how did a person develop into adopting, into embracing a narrative which warranted the label "nihilistic violent extremism"? So rather it is not the label that matters, it is what went on before, and what can happen afterwards.

For this -- and I don't know whether Richard Taylor mentioned this two days ago -- the terms equifinality and multifinality apply. Now equifinality is a term which signifies that there are many possible contributions to a process of radicalisation. And the risk of the myopia caused by the label is that prior events are being labelled as contributing to the violence which occurred, whereas in other cases where the same event occurred, it did not lead -- it has not led to a violent extremism or other problems.

It also applies for the future because we know that at a certain stage of radicalisation it may develop into different directions. It may develop into somebody joining an organised crime unit or going into indeed extremist violence, or leading into a pro-social behaviour situation where we don't hear of the individual any more.

So, this slide cautions against focusing on the label and emphasises that it is important to look at the

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to redirect the plan of action, if necessary. And a best fit is good enough. What I mean with this is that it doesn't need to tick all the boxes. So there is this -- in this discussion it will be decided whether this is a case which can be dealt with by mental health care alone or, despite the fact that it doesn't tick all the boxes, it is too important and it is too risky to let it go. So it will be taken up in a Care and Safety House anyway.

So the second question, I won't quote the question, I have done it before. There is a firm legal basis for information sharing. Risk assessment is based on the working model of Kate Barrelle and we use structured professional judgement with the results of these risk assessments and the knowledge of the different participating agencies and their disciplines and expertise.

Interventions are coordinated during the Care and Safety House meetings and these occur every two or four weeks, depending on the urgency. Also, the sort of running proceedings are conducted in dedicated secure mail groups to keep each other informed of relevant developments in the case.

Accountability for individuals of concern. There is this notification duty to individuals so they know

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developmental history of the individual concerned and to see where the opportunities for management are to direct the path into a pro-social direction.

So, the answers to the three questions -- how many minutes do I have? 12 minutes, okay.

So four minutes per question.

So "How does the Dutch Care and Safety House model identify, assess, and manage individuals who present a serious risk of violence but do not fit a clear criminal, ideological or mental health profile?"

Well, the identification is by the public, police, education et cetera. Any agency can report a situation of suspected radicalisation. Referrals are directed to the municipality as a general complex case or a possible counter-terrorism case.

The referral assessment in small committee decides whether the ideology is sufficient to guide into a radicalisation table or to guide it into another table, which is available, depending on where the priority lies.

The management is again a shared responsibility. So it is not just one agency or a lead agency that's responsible; all participating agencies are responsible for their own part in the plan of action.

There is a "Plan Do Act Check" procedure, obviously

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what's going on, they know that they are being discussed and this can have a therapeutic effect, by the way.

There is also an oversight committee which routinely reviews the processes.

Lastly, the focus of the model is based on holistic causality, so ideology is "a" factor and not "the" factor, and the level of integration concerning the ideology may direct the table choice.

Food for thought: collaborating in a Care and Safety House is not a skill or a method, it is an attitude. And this is -- there are different levels of working together. The first level is coordination. A more sophisticated level is cooperation, and the most sophisticated level is collaboration where you give up part of your agency to share information to arrive a common product. That is what collaboration is. To do that effectively, the participating agencies need to know about each other. So, the police need to know what mental health care can do and what they cannot do and vice versa. Mental health officials need to understand that the police also have rules and laws, which direct its operations.

So, if these people know from each other what they can and cannot do and there is a common trust, then you have possibilities for sharing information in a very

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conductive way and arriving at a plan of action which is carried and shared as a shared responsibility by all participating partners.

So this last slide, I couldn't resist the temptation to sort of make this picture. You see different objects with different shapes and a box with only a circular hole. So obviously only the cylinders will fit this box. However, if you have a box -- read Care and Safety House -- with different tables, different holes of different shapes, then despite the fact that you have different objects, they might all fit in the box.

So this sounds like a brilliant idea, the Care and Safety House. I'm a very warm advocate of Care and Safety Houses. However, it is not foolproof as I indicated right at the beginning. Last year we had a fatal knife stabbing at the Erasmus Bridge in Rotterdam despite the fact that the individual was being discussed in the Care and Safety House.

However, it was a summer period and there was -- the level of support from the fact team, from the flexible assertive community treatment team had to be scaled down because of holidays, and the ideology had been twice assessed as being absent, which was quite right because the person had schizophrenia and what he said was not what he intended.

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clearly poor information sharing after a prison sentence and there was no Care and Safety House referral. The police note that this was in 2019. This was very much in the early period of Care and Safety Houses.

I would like to conclude my presentation here.

Thank you for your attention.

MR JAMIESON: Professor Sizoo, thank you very much.

SIR ADRIAN FULFORD: Thank you very much, Professor.

MR JAMIESON: Sir, may I suggest we break again until 11.45 am.

SIR ADRIAN FULFORD: Certainly, I will rise.

(11.31 am)

(A short break)

(11.45 am)

SIR ADRIAN FULFORD: Yes, Mr Jamieson.

MR JAMIESON: Thank you. May we have Mr Diamond please.

Presentation by MR DIAMOND

MR DIAMOND: Good morning. I just want to add to the introduction, so the Violence Reduction Unit in Greater Manchester is hosted by the Greater Manchester Combined Authority and is posited within the office of the Deputy Mayor which is the Safer Stronger Communities Directorate. It is a partnership but it is hosted by the Authority.

Also it was nice to hear my CV read publicly.

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So unfortunately because of this confluence of events he committed this crime.

Another example is a triple murder by an Incel in September 2023. Here the Inquiry -- it was a modest Inquiry -- showed that there was a premature closure of case by multiple partners over the three-year period that this case developed and it cautioned against closing a case too soon. It concerned a very calculating, intelligent man who was training to be a doctor and who was very calculating. So when things became too difficult for him, like an eviction from his house because he didn't pay his rent any more, he would, two weeks before the eviction, take the initiative to suggest a payment agreement. And everybody relaxes and said, "Ah, fortunately it is not as bad as we thought," but it was. He was an individual who was focused on violence directed at animals, which in psychiatry is really a red flag, and this calculating perpetrator and a premature closure of cases over the three-year period led to a serious incident where he killed his neighbour, her daughter, and shot a teacher at the Erasmus University. Unfortunately no open source intelligence was available during these three years.

Lastly the tram attack a bit earlier on in March 2019. There was -- the assessment said there was

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I just wanted to reference very briefly the probation service, which I worked for for over 20 years, quite an extensive period of time, and a substantial part of that, perhaps the majority of it, was spent Chairing MAPPA meetings and specifically organised crime and serious group offenders.

But I wanted to make this point at the beginning that I left the probation service in 2019 when the violence reduction programme was launched by the Government at that time, and one of the chief reasons why I did that was I wanted to move upstream. I had a very satisfying and very fulfilling career in probation, but I got to a point in my career where I recognised that I wanted to stop people falling in the water in the first place and contribute to that activity, and that's really important and that sits at the heart of why I'm stood here talking to you today.

Before I proceed with the first question of the seminar, I also want to thank the Chair and the counsel for this opportunity to come along today and to share with you the learning and some of the experiences that we have had as a partnership. I'm here today to represent a number of people who have worked really hard in the violence reduction programme and I am grateful for that.

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1 I know that this piece of work is incredibly
2 thorough and incredibly detailed and for absolutely the
3 right reasons, given the tragic circumstances which this
4 of course is predicated on. However, I also welcome
5 this opportunity to share what I regard as really
6 valuable learning and experiences as the violence
7 reduction programme has evolved over the last
8 seven years or so.

9 I also work with a group of professionals who are
10 involved in a vocation which they are passionate about
11 and the work that they are doing they are committed to.
12 It is not just a job. It is a work that they are
13 passionate about and are committed to in ways that is
14 hard for me to truly represent here today. But I hope
15 that comes across when you start to see some of the
16 examples and hear of some of the things that we do as
17 a programme.

18 So what I'm going to do today is I'm going to --
19 I haven't provided the questions on the slides but
20 I will read the questions. So what I will do is I will
21 read the first question and then I'm going to work
22 through each question, through the body of the
23 presentation.

24 So the first seminar question which we were invited
25 to consider was this: "What role does the Greater

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1 violent-related crime. I think it was something like
2 67 per cent of that took place in those 18 to 20 areas
3 across the country.

4 So, the Government under the Home Office provided
5 some funding and enabled the programme to start, with
6 some quite blunt -- quite a blunt brief really, which
7 was essentially to reduce those metrics and to tackle
8 serious violence.

9 So there are 20 VRUs and they are not all the same.
10 They have a similar brief but they are not all the same
11 and of course they are quite contrasting in some cases.

12 The Violence Reduction Unit in Greater Manchester is
13 a partnership comprising of police, the probation
14 service, and these are organisations who you would
15 expect to be in there. But also we have clinical
16 health, we have public health, youth justice, as you
17 would expect. We also have strong representation from
18 the voluntary, community, faith and social enterprise
19 sector, which I will go on to talk more about shortly.
20 Community sports, communications and engagement, because
21 campaigns and communication is a vital part of this, as
22 you will know, in terms of the messaging and the way in
23 which we frame the discourse around violence, especially
24 when it comes to young people.

25 We have a very strong research element to the

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1 Manchester Violence Reduction Unit play in providing
2 strategic leadership, oversight and coordination across
3 Greater Manchester's local authorities, and what lessons
4 can be drawn from its public health approach to
5 prevention, early intervention, and public protection?"

6 So, I think what's important first of all is perhaps
7 to talk a little bit about VRUs and where they came from
8 and why they came about. Unlike MAPPA it doesn't go
9 back 30-plus years, it goes back to 2019. I think in
10 London it was 2018. The VRUs were developed following
11 the Government's decision to respond to what was clearly
12 unacceptable and concerning levels of knife-related
13 youth violence, emanating across the larger conurbations
14 across the UK, initially 18 areas and then two more were
15 added a couple of years later to 20 areas were
16 identified as probably responsible or where the problem
17 of youth violence was most concentrated.

18 Of course these will be larger population areas as
19 well. Nevertheless, these areas were responsible for
20 just under 70 per cent of -- and three quite blunt
21 matrix but important ones. Non-domestic homicides
22 involving under 25 year olds, either as victims or
23 perpetrators. Hospital admissions for under 25s
24 following violent assault. And under 25-year-olds,
25 either victims or perpetrators of knife- or

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1 programme and we have a committed, longstanding academic
2 partner, Manchester Metropolitan University, who we
3 commission to do some of our evidence-based and
4 evaluation. We have, therefore, access to a very --
5 also to the Directorate which I work in -- we have
6 access to the expertise of many other colleagues who
7 have various responsibilities pertaining to this type of
8 work.

9 So I guess what this does, it reflects a system-wide
10 response. It provides a -- could I have a glass of
11 water, please? *(Pause)*

12 So that kind of partnership really does reflect the
13 diversity and it brings in expertise and insights that
14 otherwise perhaps we wouldn't be provided.

15 When the VRU was established, we had to mobilise
16 quite quickly. I don't want to paint an idealistic
17 picture here, I want to be honest with you. The Home
18 Office, the Home Secretary at the time, was very keen to
19 mobilise resources, get the police forces on track.
20 I think what caught their imagination was the public
21 health approach that was taking place, the so-called
22 Glasgow model, the Scotland model and the violence
23 reduction programme that existed up there. So they
24 wanted to sort of replicate some of that. I will go on
25 to talk about this shortly, but a public health approach

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is not something you can do in six months. It is a longer sort of -- a longer process with a much more distant vision in terms of its outcomes. Nevertheless, there were clearly things we could do quickly and we could mobilise ourselves as a programme and start to get into some of the detail.

In order to do that, we had to develop what we call the serious violence action plan. It wasn't a strategy as such although it was a strategic document, if that makes sense, but it kind of outlined the strands of our commitments and the key sort of areas of work that we were going to focus on. So, you know, working better with education; working better with the Criminal Justice System to get better outcomes and also the voluntary community organisations; children's services; engaging them in a way that perhaps hadn't been done before; local Community Safety Partnerships and that broader place-based agenda that we hear a lot about now, but actually looking at what this means and how we get into that space to better effect the way we work together at a community level.

Can I have the next slide, please.

So, of course, that served us well and I'm just giving you a bit of a history here but it is really important I think for the purpose of your understanding

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and its causal factors on the streets of Greater Manchester.

So we embarked upon the development of this strategy, which was an extensive process, as I have said. And the consultation involved, as you would expect, a number of meetings, quite senior boards with senior officials from across the system, meeting all those various organisations, including local authorities and police, right across the statutory sector, probation boards, youth justice, but also and perhaps more importantly -- and I'm not playing them off against each other here, but I say this because of the experience we have had -- is our engagement with the voluntary, community, faith and social enterprise sector. Because we met with them. We actually ran a huge event at Manchester Cathedral in the city of Manchester, and we brought together over 100 organisations. We engaged them and we asked them a number of questions and we put to them some of our initial findings and thoughts. We shared with them some of our data and some of the trends, some of the things that were going on, and what we thought were the starting points for that discussion.

What that event did is it really sort of galvanised some of the discussions and it really enriched the content of the strategy and gave us, sort of, if you

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to sort of build this foundation, because I will be drawing on this when I start to share some of the examples of the work that we are about.

So, in 2023, we thought well we need to review the strategy or the action plan, so to speak, and therefore we sort of started to put together some thoughts around that. We met at the time with the Mayor of Greater Manchester and he was very keen that, actually, we didn't just review the action plan, but actually we put together a ten-year strategy, which we did. Now, the first slide was the picture at the front of that and it is called "Greater than violence", which is a nod to the campaign.

The developing of the strategy was a really, really important process for us. It wasn't simply a group of professionals and academics sat in a room somewhere for several months really working it out, which we probably could have done. However, we recognised that this had to be a very public-facing document, which made sense to people but not just made sense to them, but actually they could relate to, that they had ownership of it, that they could sort of see their own work in it. And when I say "they", of course I mean statutory partners but I'm also talking about the community and people who are actively involved and concerned about the violence

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like, as state operators or actors in this space, a much stronger sense and confidence in what we were doing, and it enabled us to really sort of move on.

The strategy is -- rests to two pillars. The first pillar -- these won't be particularly revelatory for you -- shall the first pillar is prevent, prevention. So what are we doing as a partnership to prevent violence and all of the myriad of things that can be done in that space? And secondly and of equal importance, how are we responding? So response. What does the response look like in Greater Manchester to violence and what do we do as a system?

I will come back to that and with some examples, but actually when we think of response, and I would have thought especially as someone who worked and operated within a very -- the constraints of MAPPA -- I say "constraints", it was a successful and very helpful process -- but seeing the State as the responder, the police and associated organisations. But I would argue, and we would argue, and this isn't to play fast and loose with process and the importance of criminal justice at all -- however, on the streets of this country, in the cities and the towns, there are significant things happening in the community where community members are engaging with harmful situations,

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1 they are mitigating, they are lowering the risk, they
2 are cooling the tensions and they are mediating at
3 community level, whether with our blessing or not.

4 So, it is really important to recognise that,
5 acknowledge that and harness that. I will come back and
6 talk a bit more about why that is the case and what that
7 looks like in Greater Manchester.

8 So those are the two pillars, prevention and
9 response. With then move into five key principles. Now
10 I know as someone who has worked in the statutory sector
11 for many, many years and I had to read lots of
12 strategies, that they are important but they do
13 sometimes gather dust and they do get put on a shelf and
14 we get on with our main work, and that's not quite what
15 this is about because the key principles are absolutely
16 the lifeblood of our work. And I can say that now --
17 I would have said that three years ago but I can say
18 that now with absolute sincerity because that's what
19 we've lived and experienced since we launched the
20 strategy in 2023, at the end of 2023.

21 The five principles which I will just mention
22 briefly are: (1) community-led, and I have talked about
23 that already and you can already hear in the things I'm
24 saying that being community-led is a critical part of
25 any violence reduction approach because we need to

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1 has been hard fought this, I think the Greater
2 Manchester has done the hard yards in some respects.
3 I have been involved in a number of multi-agency
4 programmes in Manchester. In fact the city of
5 Manchester was the first city in Europe to have
6 a multi-agency gangs team, and I use the word "gang"
7 advisedly there. That was MAGS programme, Manchester
8 Multi-agency Gangs Strategy. So we understand this
9 principle of working together but it is not something
10 you just do and tick off; it has to be revisited.

11 So we understood that the partnership that we had is
12 going to be -- that will unlock and enable those
13 changes.

14 The fourth one is equity, equality and justice. We
15 just know and the data bears fruit in this respect, that
16 unless we have an eye on inequality, unless we
17 understand the marginalised communities are actually
18 much more likely to be involved both as victims and
19 perpetrators in violence and crime, that if we ignore
20 that fact then it is at our peril.

21 Just a very quick point which I always share with
22 people. Like other cities, Greater Manchester as a city
23 region has its fair share of poor and marginalised
24 communities, and in that top domicile across the
25 country. If you are a young person and you live in

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1 listen to what the community is saying, and we need to
2 harness their voices and their energy and their insights
3 and skills and abilities and all of that good stuff.

4 The second principle is about early and timely
5 intervention, which is an obvious thing. We have heard
6 some of that already today, I guess, but it is about
7 working upstream, it is about identifying the causal
8 stuff that lead young people into those more adverse
9 pathways and intervening in a much earlier time. Again,
10 this isn't particularly revelatory but we are
11 actually -- so often we are focused on the event itself
12 and dealing with the aftermath of the event. That will
13 continue, unfortunately, because that's the nature of
14 life in many respects. However, there is clearly
15 something we are missing and this is why a public health
16 approach and the language of public health is so vital.

17 The second principle is about partnerships for
18 change, and that again sounds -- it rolls off the tongue
19 very comfortably but actually a partnership for change
20 is a formidable ambition and it takes a huge amount of
21 persuasion and patience and perseverance in order to
22 influence and permeate, if you like, the mindset and
23 also the traditions and the longstanding behaviours that
24 exist in partnerships and organisations.

25 But, actually, we know that in partnership, and it

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1 those communities with those said hardships and
2 challenges, you are five times more likely to present at
3 A&E following a violent assault. I will just leave that
4 there but that says so much. Of course that is a blunt
5 metric and there's far more to talk about in that
6 regard, but that's a really important point that has to
7 be retained in this.

8 And the final one, and again I really enjoyed the
9 Professor's comments in this respect, is being
10 trauma-informed. It is used a lot that word now, but
11 having a trauma-informed, trauma-responsive city region,
12 that actually trauma is ingrained in the culture of
13 organisations, so that those moments where -- of crisis,
14 the frontline actors or agents of the State or whatever
15 you want to call them, have a bit more going on when it
16 comes to understanding and perceiving what is presenting
17 to them in that moment of crisis.

18 So, it is my intention throughout this presentation
19 to sort of bring to life some of those principles and to
20 hopefully evidence those and articulate clearly.

21 Next slide please. So, again, once we launched the
22 strategy what we then needed to do, we have these lovely
23 big principles, as you can hear I can talk about them
24 and wax lyrically. However, we need to know what that
25 meant in terms of practice and delivery. We needed to

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1 know where to go in the system. We needed to know where
2 are our attentions and where are our resources best
3 spent.

4 I also need to also stress that the VRUs in this
5 country are not cash rich. They have a very limited
6 budget and so they were very much at pains not to be
7 simply seen as a commissioner, because we don't have
8 that type of money. We are not here to prop up
9 the system. We are here to try and get into the gaps,
10 to look at the system, to hold a mirror up to it, to
11 understand it and to really kind of get into the space
12 to where we feel we can offer value and change.

13 So the vision statements, and they are neatly set
14 out here, corresponding with the principles, but of
15 course you will see those principles apply to lots of
16 this. I'm not going to go through these, I will spare
17 that, but they are there just to sort of see as
18 an example of the focus of the work.

19 So that in essence is the strategy. The vision
20 statements focus on children and young people and
21 correspond with the principles of the strategy, and in
22 a later slide I will illustrate some of our approaches
23 to the themes that are identified here.

24 Can I have the next slide, please.

25 So due to extensive partner and public engagement,

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1 about, in our language, about behaviour relating to
2 violence, attitudes, beliefs and associated behaviours,
3 it also applies to system norms. So when we talk about
4 a public health approach, it is not just about people
5 who are involved and wrapped up in violence, it is about
6 the system that is there and expected to respond to it
7 and to protect the public.

8 So that plays an enormous part of that language and
9 is relevant to this discussion. Changing a system norm
10 is a hugely ambitious objective and from the outset it
11 was always understood that any meaningful change through
12 a public health approach needs to be nearer to ten years
13 to bear fruit.

14 The Violence Reduction Board commissioned a system
15 change evaluation, and this was carried out by our
16 colleagues at Manchester Metropolitan University. It
17 was included in our submission as part of our witness
18 statement, and people can look through that. It
19 evaluates the programme from '19 to '23, before we
20 launched the big strategy. However, it looks at the
21 kind of programmes and the process and the way in which
22 it was operating as a system change agent, as
23 an organisation trying to make a difference.

24 I was thinking about this recently. I was listening
25 to a conversation about something different, but it did

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1 the violence strategy is well positioned to guide the
2 system in the same direction by providing consistency,
3 and I would say through a common language, establishing
4 a sort of a set of principles, as we have, really gives
5 someone to identify. What has been our experience as
6 a small group in the middle of the city region of over
7 three million people is that they really speak to
8 people, both in terms of the State sector but as well as
9 our voluntary counterparts and colleagues.

10 The governance of our programme is overseen by quite
11 a senior panel and chaired by the Deputy Mayor
12 Kate Green, and that is the Violence Reduction
13 Governance Board. Also, through the Deputy Mayor, she
14 fulfils an convenient role in relation to the serious
15 violence duty, which is part of the Police Crime
16 Sentencing and Courts Act. We provide a coordinating
17 role in that respect. However, the duty is held by
18 local authorities, not the Violence Reduction Unit.

19 Again, so make this point, the VRU is not in and of
20 itself a sort of constituted organisation or entity; it
21 is a collaboration and it's a coming together and
22 a partnership, but it does have obviously some important
23 functions in that respect.

24 A prominent aspect of the public health approach is
25 changing behavioural norms. Whilst this is chiefly

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1 make me think about it was a metaphor. Because thinking
2 of those very high level blunt metrics that the
3 Government set for us, it would be understandable and
4 quite justifiable to judge the VRU directly against,
5 well what are homicides looking like for younger people?
6 What does hospital admissions data look like? And what
7 does youth violence look like? I will end this
8 presentation with a slide that kind of talks a little
9 bit about that for your own reference.

10 But, actually, it is more than that. It is not just
11 about that. The metaphor -- indulge me a little bit
12 here -- goes that a person wants to lose weight and they
13 embark upon quite a strenuous and disciplined regime of
14 behaviour change around exercise, diet, stop drinking
15 alcohol or they limited it, they've started to get some
16 good sleep, they've started to do more healthy
17 exercises, maybe meditate, and after three months they
18 go and weigh themselves and they haven't lost any
19 weight. They are quite upset and they are quite
20 disappointed and frustrated with that. But actually
21 that's not what this is simply about. They go to the
22 doctor, and the doctor says your blood pressure is down,
23 your cholesterol dropped, your blood sugar levels have
24 reduced, your liver and kidney functions have improved.
25 All these unseen things. The reason why I mention this

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is because the evaluation talks about the efficacy of the VRU and its ability -- and its impact on the way in which it has had an impact on the system and the way partners are now working, the way they are communicating, the way they are using data, the way they are focusing their resources around violence in a way that is evidence-based. Again, back to that public health language.

So, I will just go to the second question if that's okay. So the second question of the seminar is: "How does the Greater Manchester VRU support local partners, including policing, education, youth services, safeguarding, health and community organisations to identify risk earlier, coordinate interventions and reduce serious violence?"

Serious violence is preventable when partners act earlier, address root causes and connect prevention with safeguarding and public protection. Fundamental to the GM context is employing a public health approach, as I have stated. Operating at primary, universal provision; secondary, targeted provision; and tertiary, more acute provision. For those less familiar with the language or the concept of a public health approach it is sometimes easier to articulate it in a smoking reduction harm programme. So if you think about the

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locations but also the themes and modality of that violence and which groups are over-represented as I referenced before. That includes also minoritised groups as well, not just people who come from poorer communities.

The SNA takes a life course approach, it looks from cradle to grave, that whole developmental language and the discourse around that, and it helps to really map out what is appropriate at what stage and what we might want to do to address those concerns that come out of that.

As mentioned though, the VRU is not a constituted organisation in and of itself but rather a collaboration of relevant stakeholders. It can never be all things to all organisations but it does seek to meet partners where they are at and to find common and fertile ground to work from.

In the spirit of this, we pride coordination, stewardship but it is by consent not by compulsion.

Slide 7 is just an overview. I appreciate time is limited so I won't walk through each of these, but I do think it is important just to reference some of these. All they are is a collection of images that represent some of the core programmes that we commission as a programme. Now, you will see at the bottom there we

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Government's campaign to reduce smoking-related illness and deaths. The primary element would be stop smoking campaign, no smoking in public spaces or indoors. That would be the primary. The secondary would be smoking cessation clinics, better quality, more access, health warnings on cigarette packets. And then the tertiary would be more improved smoking-related illness pathways and treatment, including cancer treatment.

So we have learned that the public health approach to violence reduction really lends itself comfortably to a partnership approach in this respect.

Can I have slide 6, please. The SNA, so alongside the strategy we also developed the Strategic Need Assessment. The Strategic Need Assessment, again the strategy and the SNA, excuse the shorthand there, were mandated products by the Home Office, so we had to provide these. Of course they are vital to what we do.

So the SNA was put together by our team and our public health lead and it looks at all the causal factors. It looks at violence against Greater Manchester or any other city that's done one. It looks at the drivers, it looks at the population groups more affected by it. It gives you a sense or a view of where things are happening and where perhaps we need to prioritise our attention, not just in geographic

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devolve funding to the ten local authorities of Greater Manchester and that is a decision that we took, that the money that the Home Office give to us, we devolve at least a third of it to local authorities because we know they have those insights at a local level better than we do, but once we have taught them those principles and those ways in which violence needs to be addressed then they can govern that themselves. And we have some exceptionally good partnerships in Greater Manchester with some innovative and committed teams.

I will pick out two or three. The first one I want to look at is the Greater Manchester A&E Navigators service. What this is, and you may have heard of this, but we recognise that when a young person goes into hospital following violent assault, yes it's a crisis and an emergency, but it is also a really important moment in that young person's life. Obviously they need to be medically attended to appropriately. But actually they are very vulnerable. Also we know it is a teachable moment and it is an opportunity to engage them. So we have youth workers, who have lived experience and understanding around young people, camped out in various A&Es, it's like a peripatetic service, they will move about. We have 13 in hospitals in Greater Manchester, so the team is limited but obviously

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1 they need to be able to move about because the hospitals
2 aren't turning over that many individuals. They will
3 attend to that young person, support them, try and
4 understand why they are there, as in what's brought
5 about the situation to them being hurt and harmed. Also
6 engage the family in that. There's also another
7 critical part of this which is about the escalation and
8 retaliatory nature of violence, because when a young
9 person is hurt or a person becomes a victim of harm,
10 they are also very likely to go and commit further harm
11 themselves. There is a good chance of that. I'm not
12 accusing all victims of being violent but there is
13 an opportunity there, and I know that from the work
14 I have done. So it is intervening in that and
15 arresting that, and disrupting and interrupting that
16 potential cycle.

17 BLOCKS programme is a -- we call it a Primary School
18 Transitions Programme. We know there are lots of young
19 people in our primary schools who are living quietly and
20 unseen but are exposed to a whole raft of traumatic
21 experiences at home, in their communities, for all sorts
22 of different reasons and they need additional support.

23 When a young person transitions into High School,
24 that for anyone with social capital and support, that's
25 a challenging time enough. But if you are someone who

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1 I don't want to go into that too much but the fact of
2 the matter is their voices in this space are critical to
3 what we do and really play a really strong present part
4 of it because they have obviously got a perspective that
5 has been developed from trauma and really challenging
6 circumstances, losing a child.

7 So we need to give them an opportunity to influence
8 and speak to what we are doing. So the community-led
9 programmes, I'm just saying this, putting it onto that,
10 is that those alliances which are made up of half
11 a dozen small grassroots groups -- when we are talk
12 about grassroots organisations, they are not just small
13 businesses, they are often the mobilisation of
14 a person's story and someone who wants to get out there
15 and tell it and do some good in the community and use
16 their story to influence, for the better.

17 So those community-led programmes are funded across
18 Greater Manchester and it is a big open space of
19 business that, but it is one which we are really proud
20 of and one which really we can see progress, and we
21 really believe that those activities, those programmes
22 of support which are offered at a local level really
23 tell a story of transformation in some cases, where we
24 are seeing real movement in the lives of the most
25 vulnerable people in our community, and I include in

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1 comes from a vulnerable family without much support or
2 from a community where there is a lot of additional
3 challenges, then that transition period is more
4 vulnerable. We know that those gaps and just the
5 general concept of transitions is a really important
6 one, whether it is from the care system, criminal
7 justice system, from youth justice to probation, and I'm
8 sure Becky will have views on that and the difficulties
9 that that presents, housing and education.

10 So, the BLOCKS programme is an intensive mentoring
11 programme, a very structured one, where this
12 organisation, Salford Foundation, one of our local VCFSE
13 groups, will work with a group of young people over the
14 duration of that term and provide that stability. It
15 has been evaluated and it has rendered some really
16 positive results. That is available if people so wish
17 to see it.

18 Community-Led Programmes, and I will link this in
19 with community sport, if that's okay. These are
20 probably our flagship programmes. We fund across
21 Greater Manchester, in each of the ten boroughs,
22 a series of alliances and these alliances are
23 self-identified. So the groups of organisations which
24 are very often grassroots groups and agencies, including
25 parents who have lost children to violence, which --

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1 that the families, the parents as well.

2 Community sport likewise. Greater Manchester has
3 a very developed community sport offer. We're not
4 looking to make people into footballers or athletes.
5 What we're interested in is using sport as a real
6 vehicle of engagement to get young people in, and once
7 we have that hook, then it is about exposing them to
8 trusted relationships, trusted adults, positive role
9 models and providing a transformative experience for
10 a young person in their formative development.

11 I would love to talk about these all day but
12 I shan't, but I'm really happy to talk more about it
13 with others outside of this arena, but there is so much
14 more available on our websites and reports that also go
15 to this.

16 Can I go to slide 8, please. This is the final
17 question, which I have sort of ran the clock down a bit
18 and I apologise. But just to summarise. I will read
19 the question: "What role do Greater Manchester's
20 prevention partnership panels play in identifying early
21 signs of vulnerability to violence, and how suitable are
22 they for recognising potential violence-fixated risk
23 before individuals reach higher risk statutory
24 safeguarding or criminal justice thresholds?"

25 **MR JAMIESON:** Mr Diamond, I have stood up just to say don't

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1 feel under any pressure of time. This is important
 2 please do tell us about it.
 3 **MR DIAMOND:** Okay, I was going to 12.30 pm. Are you okay
 4 for me to -- Chair, is that okay?
 5 **MR JAMIESON:** That's fine.
 6 **MR DIAMOND:** Okay.
 7 **MR JAMIESON:** We have a little more time left, if you
 8 need it.
 9 **MR DIAMOND:** Okay, thank you. I didn't envisage this.
 10 Anyway.
 11 So I appreciate that this particular question, and
 12 it's the third one, is perhaps going to kind of bring
 13 things to a head. I think the slide already, you see
 14 there what our position is, but I will talk a little bit
 15 more about that. It is not a black and white issue and
 16 it certainly isn't a blunt one, because I have talked
 17 a lot in this presentation and I've thought a lot in the
 18 anticipation of this, in the validity of that public
 19 health community-led discussion and the vital role it
 20 has played in any changes that we've experienced and
 21 witnessed in Greater Manchester.
 22 Now I'm certainly not here today to paint a rosy
 23 picture. Greater Manchester, like any large
 24 conurbation, is beset with its own challenges, it's
 25 problems. We are hearing a lot about Manchester at the

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1 Intervention and Early Diversion. It wasn't called PIED
 2 at the very beginning. But what we did focus on, and we
 3 talk about this it sounds a little alarming that
 4 something wasn't already being done about this, and it
 5 possibly was but perhaps not in the structured way that
 6 we did. But the police were aware that there were young
 7 people who were on the periphery of instances where
 8 a knife had been used or there'd been a violent incident
 9 and there were other young people in that space, they
 10 weren't necessarily participating in the act of violence
 11 but they were certainly vulnerable because of where they
 12 were, in the proximity to it, and they were seen as
 13 maybe associates of those involved, and there was this
 14 sort of idea that we need to engage those young people,
 15 even though they have not actually done something yet.
 16 Why are we waiting for them to do something before we
 17 engage them?

18 Again, this throws up all sorts of -- not ethical
 19 issues -- but practical issues of the system in terms of
 20 naming people, sharing information about them. But you
 21 know we need to be -- I think a degree of pragmatism
 22 about that, and of course there is legislation that
 23 supports information sharing but ultimately we need to
 24 be really clear and it needs to be proportionate.

25 But these young people, we started to gather this

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1 moment in the media. In spite of the positive narrative
 2 that's out there, be assured there are still lots of
 3 challenges for people, especially our younger,
 4 vulnerable and less seen population. So this sits at
 5 the heart of our work.

6 In line with the public health approach the panels
 7 are intended to provide an early opportunity to
 8 intervene with a young person where initial signs of
 9 adverse or risky behaviours are manifesting themselves.
 10 So an upstream positioning of the system response to
 11 violence.

12 When the VRU was first established, the police in
 13 the unit -- and the police played such an important role
 14 in the programme because as you can imagine, getting all
 15 those programmes set up, which was my side of the
 16 business with the director and colleagues -- that takes
 17 a lot of time and it is not something you just conjure
 18 up. But the police of course, they are a response
 19 organisation and they can mobilise and work in that task
 20 and finish culture which was hugely important, and we
 21 were under pressure by the Deputy Mayor at the time.
 22 She wanted to see results, understandably. She was
 23 accountable to her electorate, or the Mayors, and
 24 therefore we wanted to do something quite direct.

25 So we developed a programme called PIED: Prevention,

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1 data and we started to look at them and we piloted on
 2 a couple of the boroughs. Just to cut to a couple of
 3 years later, we established the PIED programme in all
 4 ten boroughs. The PIED programme in essence is an early
 5 intervention model where young people who are maybe
 6 being stopped by the police but not charged for anything
 7 are now being sort of solidified as a group and brought
 8 together and reviewed.

9 So what happened was a panel was brought together in
 10 a given community and that panel would be, you know,
 11 a group of individuals from across the partnership,
 12 including VCFSE providers who would also be there to
 13 provide options for referrals to do something. So you
 14 go back to those programmes I mentioned before and of
 15 course the myriad of programmes that are -- I say that
 16 like there is an abundance of resource, there's not --
 17 but the local authorities who receive funding from us
 18 have a whole load of other providers available to them.
 19 They would then provide that service. But the panel
 20 does bring together these statutory partners.

21 It was primarily based on police intelligence, so
 22 a young person, the threshold might be they appeared on
 23 the police radar once in the last 12 months, or twice in
 24 some cases. You will know this when you look into
 25 anything when it comes to thresholding. Thresholding

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1 can vary from across city regions because the boroughs,
2 because of demand, because of the levels of -- sort of
3 level of demand and the turnover.

4 So they vary. It is not an absolute science but the
5 principle is the same. But then we also take referrals
6 in some cases from education and other partners started
7 referring as opposed to simply waiting for the police to
8 tell us they've got a concern. Because we know the eyes
9 and ears of teachers at the front end of -- who spend
10 the majority of time -- most, than other
11 organisations -- with young people, they need to go
12 somewhere with that. Of course it is important that we
13 have a clear process to do that and that, you know, you
14 look at the slide, it shows you the process there in its
15 raw form.

16 But those early signs are identified. They come to
17 a panel. There is a tailored support plan around that
18 young person. It needn't be that complex but it needs
19 to be meaningful and proportionate to the issues that
20 have been presented, and monitor and adjust it
21 accordingly. If there's no need to continue then we can
22 exit them, but if there are more concerns we can
23 escalate them.

24 As someone who has chaired hundreds of MAPPA
25 meetings in my career, all the MAPPA meeting was, was

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1 Next slide please.

2 This slide kind of talks through several areas that
3 we would sort of argue are important to consider in this
4 respect. I think terminology. There is no agreed
5 definition of violence-fixated individuals. Of course
6 violence fixation is a thing. That's not disputing
7 that. But actually as an individual, it might form --
8 as the Professor said, it is one thing of a number of
9 issues. So it is understanding the gravity of that, but
10 there is no identification so identification could be
11 subjective in that respect.

12 Panels can identify risk early but referral filters
13 generally mean lower level risk individuals enter
14 panels. So the panels themselves are not tuned in. The
15 optics of them aren't tuned in specifically for that.
16 But of course, if we are talking about an individual
17 where one of the issues is an unhealthy fixation with
18 violence, our argument would be that actually that might
19 prevail if other aspects of that young person's life are
20 neglected.

21 So it is not necessarily about addressing the
22 fixation with violence head on, because I don't quite
23 know what that looks like, but it is about addressing
24 the deficits in the gaps in that young person's
25 development. It is about providing them opportunities

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1 what's the problem and what are we going to do about it?
2 That's it, and that's the same as this panel. What are
3 the key issues? I'm not trying to be reductive here or
4 simplify it, but it is important to see it in that way
5 because actually we have this big system which has
6 ability here, we just need to match it and when you
7 bring partners together in that environment and you get
8 that expertise, you get that understanding and insight,
9 you then start to get a meaningful conversation.

10 Like any panel though, it's got to have the right
11 people in it, it's got to have the right organisations.
12 Again I will draw on my MAPPA experience. I chaired
13 some meetings where there was in excess of 30 people.
14 There was three children services departments and they
15 are representing different vulnerable children. But
16 then I also chaired meetings where it was me, the police
17 and one community member and that was because they were
18 category 3, the tide has gone out, the system is not
19 involved in it and therefore there's less sort of
20 purchase with that person and that really -- that can't
21 be the case and so the panels hopefully help to counter
22 that type of culture and provide that space.

23 So it is about identifying risk, referring in,
24 relevant partners gathered, individuals discussed and
25 support or escalation offered.

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1 and things to do and healthy relationships. Often young
2 people -- again, they often don't have positive
3 relationships, which almost sounds a bit cliché but if
4 you think about all of us in this room, there will be
5 people in your life who have really helped you which
6 bring you to this moment today and we can all think of
7 those people. In the lives of some young people, that's
8 a very few and far between set of people.

9 I'm just making that point. But ultimately, I kind
10 of want to read this little bit here:

11 "Low-level concerns without a recorded crime may not
12 reach referral. Low-level concerns with a recorded
13 crime may reach [the] panel but lack a full background
14 picture. Concerns labelled as violence-fixated may be
15 escalated to Police or Prevent, but where not deemed
16 serious enough may fall through gaps."

17 I'm just flagging some kind of problems with this.
18 Some of the practical implications, "A panel referral is
19 strongest". I talked about this here, about the
20 membership of the panel and it is convened with the
21 right personnel. I think a recommended strengthening of
22 them is framing Prevention Partnership Panels "as
23 suitable for early, low-level concerns only if referral
24 routes, discretionary referrals, partner representation,
25 training and escalation pathways are clear. Higher risk

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cases may be beyond panel scope and require statutory routes."

I think there are two sort of positions here which kind of come back to that question about suitability of the panels.

The first one -- and this is my summary of this really -- is purely preventative. So the panels remain purely preventative but potentially as of yet unseen young people with a fixation of violence. Sort of if you like, I do not want to use the word "scooped up", but kind of caught in that group as part of a broader diversion from risk-associated activity. Our argument -- "argument" is probably a strong word -- our assumption perhaps would be that in our efforts to limit and mitigate the impact of this idea of fixation with violence, if it sits with other things, and the Professor referenced this before, it is hard to evidence things that haven't happened. Of course the raw data will tell you what's happened and what's not happening as such, but actually to be able to point to that is really helpful.

Then the second bit would be: identifiable individual manifesting clear risk factors, explicitly associated with violence fixation. Probably not low risk and therefore should they not be brought to the

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taking a public health approach because of course it doesn't render immediate benefits in the short-term but a long commitment and an understanding to it, including culture change and bringing partnerships together, does over time start to bear fruit and I would sort of commend that as a thing worth further exploration.

Thank you.

MR JAMIESON: Thank you very much. Sir, we are bang on track of where we wanted to be. May I suggest that we take 10 minutes and come back at 12.50 pm.

(12.40 pm)

(A short break)

(12.50 pm)

SIR ADRIAN FULFORD: Yes, Mr Jamieson.

MR JAMIESON: Thank you, sir. Dr Martin please.

Presentation by DR AISLING MARTIN

DR MARTIN: Thank you very much for inviting me to speak and thank you to the presenters who have gone before me who have very helpfully laid out a number of the points that I'm going to cover this afternoon.

So, I'm Aisling Martin. I am a Consultant Clinical Psychologist and I lead Trusting Hands Gateshead which is a Vanguard site with the Framework for Integrated Care. What I'm going to do this afternoon is give you an overview of our service model, the operationalisation

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attention of key agencies such as police or social services or mental health services already?

I guess the point here as well is about advising or -- a plea is to not -- is more process might add to complexity, more complexity in a system which already feels complex at times. So it is just about thinking about what that would do.

The final slide is just a set of -- excuse me, it is not the final slide. I should have asked you to go to that before. Apologies. The final slide is the next -- excuse me, it is -- apologies. Go back. Thank you. Sorry about this. Know your material.

So this is just some very high level metrics and they are honest ones. So you will see that knife-enabled homicide up 67 per cent, which sounds massive but of course it is about the numbers and it is about understanding that. Our homicide levels in Greater Manchester -- along I think with the national trend but actually do stand out above that -- are lowest since 1990. I'm not standing here saying that's because the VRU has done a really great job, but it is important for us to recognise the data and actually that something is happening, but who can actually explicitly reference that? That's another issue. And I think therein lies the sort of -- not the mystery but the challenge of

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of the Framework for Integrated Care in Gateshead and how it can be used to inform multi-agency risk planning.

So we had three instruction questions for the seminar and, in order to respond to these, what I will do is first give an overview of the Framework for Integrated Care, of the systems and the children that it is designed to work with and why, and then I will move on to give some examples of our work in practice.

So, the Framework for Integrated Care, which has been published by Anna Freud and I believe has been made available to Core Participants, is a relationally informed whole systems approach that recognises that traditional services often cannot meet the needs of children who are in complex situations.

What happens is that this sometimes means that the care and the treatment that these children receive can become disjointed and we can sometimes see unhelpful system responses.

So the Framework, as I mentioned, is relationally informed. It is an approach for children who we would class as high risk, high harm, high vulnerability, which I will explain in a moment, due to the complexity of their needs in a number of overlapping domains. It is a trauma responsive model. It changes the question from "What's wrong with you?" to think about "What's happened

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to you?", and it recognises the parallel processes that we see through systems where we are working with trauma. And for this reason, the interventions that we provide are focused on the system around the child, rather than being directly to the child.

There are six guiding principles which you can see here on the side: "Every intervention matters"; "Trauma-informed, not trauma organised", which is recognising the impact on the system; "Integrating perspectives, enabling collaboration and co-production"; "Front-line practitioners as facilitators of change"; "Understanding behaviours in context", and I will go on to explain what I mean by that through some work around formulation; and "The rule of 167", which recognises that expert therapeutic intervention may be for one hour a week. There is another 167 hours in a child's life and we need to ensure that across that time the child is receiving the care and treatment responses that they need to meet those needs.

So when we talk about children in complex situations or who are referred to as high risk, high harm, high vulnerability, which was a term that was coined by Taylor and colleagues when they introduced the Secure Stairs Framework for Integrated Care, which preceded the Integrated Care Framework within the Community, we are

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it is important to note that these presentations in these children can be and are seen across a number of systems and a number of services, both within children's services, children's social care services, mental health settings and in justice environments as well.

So one of the reasons that this group receives disintegrated or disjointed responses relates to the level of anxiety in the system around them. This comes from some work from Sandra Bloom who talks about parallel processes of trauma within organisations. So an organisational trauma response is when the people working within that organisation are affected by the trauma they are working with. So the trauma that is experienced by those individuals and families is also felt by the professionals who work within the systems, and more broadly in the leadership and the systems themselves.

So what happens is, with increasing complexity of the situation for the child we have increased organisational trauma responses and we have increased disintegration in the system. So what happens then is we move into this position where our responses can become quite unhelpful or become polarised so we start to view individuals as either being dangerous or vulnerable, where the reality is that there is

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talking about children who present with one of these risk behaviours across the top. This is taken from work from Rogers & Budd called the DART Framework, which is Developmentally-informed Attachment Risk and Trauma approach which recognises these high risk challenging behaviours as coming from attachment needs and survival needs of children, that they are communicating through the behaviour that they show.

So the eight behaviours are: violence, harmful sexual behaviour, fire setting, self harm, food-based difficulties, disgust behaviours, and "away from adults" or exploitation, which refers to behaviours where children are missing from home or absconding from their place of care.

Underlying these behaviours there is often a commonality of experiences. So this group of children is much more likely to have been subjected to adversity, adverse childhood experiences, to have had experiences of neglect or trauma and subsequently they have difficulty in developing secure attached relationships. They are much more likely to have high levels of social disadvantage and to have multi-layered and complex needs across domains which are not necessarily being met by services traditionally in a timely manner.

We are here today in a threat management context but

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an intersection of those and both need to be considered at the same time.

We can also move into thinking about their needs being clinical or forensic, and again there is a crossover, the two are not mutually exclusive, but when we move into this polarised position it can actually prevent children getting the support and the care they need to meet their underlying needs.

So there are some signs that we can see when a system is becoming traumatised. This comes from work by Harvey and colleagues on the multiple self states model which is a relationally based model of how trauma impacts on systems, and specifically on leadership and on culture within those systems.

So when we see systems becoming traumatised, we start to see a lack of curiosity about both our own and others' responses; which is this kind of limited or interrupted reflective capacity. We are much more likely to become fragmented in perspectives, to not see the whole of the picture, to focus solely on our part of the picture and this can lead to "them and us" presentations within systems.

What comes from that, as I mentioned in the last slide, is we start to see these rigid or limited relational responses and these things together prevent a

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flexible and coordinated system response to multiple and complex needs.

So one of the reasons that we work with the system is to support that awareness and appreciation that this is a continuing pattern. The more we work with trauma the more traumatised the system becomes and we have to continue to recognise that over and over again, so that we can shift and respond in a different way. So we need to build awareness and reflect on capacity, giving people space to think about the work they are doing. We need to work to become more integrated, and these together will help us to create psychologically safe multi-agency ways of working.

So that is who we work with and why we work with system in the way that we do and I will explain a little bit more now about how we do that in practice.

So, Trusting Hands Gateshead, which is the service that I work in, and our counterpart, Future Focus Newcastle, which is the second site of our Vanguard, are a collaboration between Newcastle and Gateshead local authorities and CNTW NHS Foundation Trust, which is a learning disability and mental health trust within the North East of England.

Prior to the services mobilising in 2023, there was an existing offer from our locality mental health

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have translated that high risk, high harm, high vulnerability to be in children who are in care, whether that's residential, foster, connected or kinship care. Youth justice, contextual safeguarding or risk outside the home services, and we work closely with anyone who presents as part of those services.

Just to give a brief overview of our referral data. When I talk about a referral we don't have a referral form and we don't have thresholds that we need people to meet in order to access the service. Because we are co-located and embedded our referral process begins with a connected conversation, which is a single agency consultation and the start of our graduated approach which I will talk more about in a moment.

Since we mobilised the full teams in May 2023, we have received as of August this year, 516 referrals in total and the referrals, as you can see, have increased year-by-year and that looks to be a continuing trend this year as well.

In terms of where our referrals come from. The majority as you can see, 72 per cent are from colleagues within social services. Around -- just under 10 per cent of our referrals come from our colleagues within youth justice and the remainder come from other local authority services, so that could be independent

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service which provided a consultation approach for children in care and there was a small residential team of practitioners working in local authority residential homes across both Newcastle and Gateshead. That's really important because when we talk about relational approaches, those relationships are not just with the children and families, those relationships are also across services and between professionals. So having that pre-existing relationship really paved the way for our services to truly integrate when they mobilised.

We are psychology-led multidisciplinary teams. So we have clinicians from psychology, speech and language, occupational therapy, nursing and nursing and social work advanced practitioners. All of our clinicians are senior clinicians, so NHS band 7 or above. That's because we need clinicians who are highly skilled in working with this group of children. Our clinicians have all worked in contexts where children in complex situations present, so across Forensic CAMHS, adolescent inpatient, the Children and Young People Secure Estate and other youth justice environments.

The services themselves are fully embedded, we are co-located in the local authority, which again is a really important aspect of the relational approach to the model. We work with -- in our local services -- we

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reviewing officers or practitioners who are working in the transition arena, working towards adult services.

As a NHS England Vanguard we report quarterly on a specific dataset. This is because colleagues within NHS England are trying really hard to understand this group of children, to understand what their needs are and to think about what our responses are to those needs.

As you can see, these needs, which are reported by the referring practitioner, there is a wide range but you can see some of the highest numbers are around attachment and relational difficulties and emotional and mental distress.

In terms of diagnoses, we ask both for information on suspected and confirmed diagnosis and, as you can see, actually the majority of our cases have neither confirmed or suspected diagnosis. Where there is a suspected diagnosis, there is around 30 per cent of our cases where ADHD or autism spectrum is queried.

So in terms of what we do, the service uses a graduated process to supporting the systems around the children and system-wide support through training and reflective practice. So our interventions range from, as I mentioned, an initial connected conversation, which is a single agency discussion, which allows

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1 practitioners space to reflect on the child, the family,
2 their needs and also the system and the professional
3 response to that child.

4 So starting to understand what the needs are that
5 are presenting. We use "Understanding the Story", which
6 is what we call our multi-agency formulation, which
7 I will talk to more in the following slides. We also
8 have scaffolding to the system through joint working,
9 supervision and connecting with those teams where our
10 referrals come from.

11 Alongside that, we support the system to think in
12 a more trauma-informed or trauma-responsive way. We
13 have core training modules that we offer across the
14 whole of the system, which relate to areas such as
15 attachment, developmental trauma, formulation and
16 vicarious trauma and understanding the impact of working
17 with trauma on professionals, as well as specific
18 training that relates to speech and language and
19 occupational functioning as well.

20 We offer a reflective practice space, again that
21 alliances with the principle of trauma-informed
22 organisations. We know that often our systems become
23 reactive. Particularly when we are thinking about risk,
24 people become anxious, people respond in a reactive way.
25 Reflective practice is a means of helping the systems to

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1 working approach. This is an approach that allows us to
2 develop a shared understanding across agencies of
3 a child's risk, needs and vulnerabilities in the context
4 of their story. This also allows to think about the
5 story in relation to the system of care, so how it
6 responds or has responded in the past and those parallel
7 processes and traumatised system responses that we might
8 see.

9 So formulation is developmentally aligned. It is
10 a psychologically informed and evidence-based way of
11 integrating multiple perspectives. Based on this we can
12 start to understand how the difficulties, the risks and
13 the needs relate to each other. Including the
14 challenges within the system of care itself. The
15 formulation can suggest explanations for the development
16 of risks on difficulties at this time and in these
17 situations and how we understand those are maintained.

18 Really importantly it is a strength-based model. It
19 specifically identifies strengths both in the child and
20 within the system, and it provides a basis for us to
21 make decisions, to prioritise and set goals for
22 intervention and to think about risk management.

23 Regular reviews and re-formulation are also
24 an important part of the process. It is a dynamic
25 process and it should and does change.

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1 slow down and to think about what our responses are
2 based upon and what the needs are that are presented
3 before us.

4 We contribute to multi-agency care and risk planning
5 and we liaise closely with multi-agency partners. In
6 particular, we have an interface meeting with our
7 locality mental health service, where we can bring and
8 discuss cases where, through formulation, we have
9 identified a need for a psychologically-based
10 intervention -- evidence-based intervention or
11 psychiatric input or further assessment.

12 Likewise, our colleagues within our locality mental
13 health service, if they are working with a child
14 individually and they recognise that the system requires
15 support, they can ask us to step in and work around the
16 system at the same time. So we work closely with them.

17 We also have one of our main approaches is
18 recognising the role of care givers and again impacting
19 on that Rule of 167. Our first line intervention for
20 caregivers is a therapeutic parenting programme,
21 "Foundations for attachment", which is based on Dyadic
22 Developmental Psychotherapy, and it helps caregivers
23 respond to children who have experienced developmental
24 trauma to develop trusted relationships.

25 So, understanding the story is our main multi-agency

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1 So in terms of -- I just want to give an idea of
2 what that looks like in practice. So how do we do it.
3 So formulation for us starts with the gathering of
4 information. We are sat in a helpful position in that
5 we are employed by the locality mental health trust,
6 therefore we have access to electronic notes from the
7 mental health services but we are also embedded with
8 children's services. So we can access electronic notes
9 both across Children's Social Care and youth justice.
10 We still do rely other services to bring in multi-agency
11 information as part of the formulation sharing.

12 The meeting is facilitated by two experienced
13 clinicians and we find that important because it
14 promotes mentalising, it helps us to understand what is
15 going on for the professionals in the room and it also
16 helps to hold those multiple perspectives whilst we
17 understand how they interact with each other. It is
18 resource intensive, so our meetings are a minimum of
19 two hours.

20 Our model within youth justice is based on the
21 enhanced case management, which again I will talk about
22 in a moment, and the initial formulation meeting for
23 that is three hours long and that really recognises that
24 the wealth of information that services have about these
25 children and often they have been involved in services

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for a long time. It also gives us time to reflect on and to consider the impact of the experiences those children have had on their current presentation.

We invite all professionals who are involved with the child. So that will include a social worker, the social worker for the carers if the child is in foster or kinship care, education colleagues, health, police and where it is relevant we would also invite forensic services, paediatrics, crisis or liaison services or other voluntary organisations that might be involved in the child's care.

There are a number of models that can be used for formulation, including the 5Ps which is used frequently across mental health services. So this draws together predisposing, precipitating, presenting, perpetuating and protective factors and helps us to understand how those interact with one another.

We can use narrative or systemic formulations that focus both on the individual's relationships and relational patterns, both within the individual and the wider system, or we use timeline-based approaches, such as the enhanced case management model, which is developed in the trauma recovery model, which I will show you in a moment, to help us to sequence interventions according to the child's needs.

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until the green, number 4. So this model is based on a number of theories, including child development, attachment theory, neuroscience, as well as rehabilitation and assistance models, such as Good Lives and Offender Readiness. It helps us to think about what are the steps for intervention.

What we often find is that we try as services to jump too quickly, without addressing sort of fundamental survival strategies, so without providing kind of consistency -- we have already heard a lot about the importance of relationships -- and those things need to be in place first before we can move to direct interventions with the child. We can use formulations to start to move away from our understanding of intervention as being something done to the child and being something that is done around and with the system which also benefits the child.

So we have talked a lot about formulation and I just want to give you a really clear and explicit example of what is the difference between a behaviour-focused approach and an approach where we really understand the story and we use that multi-agency background information.

So I will introduce you to Joe. If we were looking at purely behaviour-focused way of working, we might see

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Across all of our models we also consider speech, language and communication, occupational needs, and social graces which are aspects of personal and social identity which can influence an individual's identity and how systems can interact with them.

Following a formulation we offer a written summary which includes the shared understanding of the child's risk, needs and vulnerabilities, as well as agreed recommendations and a coordinated plan to follow through with those.

Then given the way that our model works, we are embedded within the system and we can provide ongoing scaffolding to keep the system connected to the story of the child and influence that day-to-day care.

As I mentioned, this is the trauma recovery model. This was developed by Skuse and Matthew. It was actually first developed down in the Hillside Secure accommodation within Wales, and it was designed to understand, amongst other things, readiness for interventions. We often hear, particularly when systems become anxious around risk or about presentation, that something needs to be done to the child, there needs to be a therapy provided to the child and as you can see from this model, actually, children don't reach the state of readiness for talking therapies necessarily

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something like this written about Joe:

"Joe lacks motivation has 'conduct disorder' & suspected ADHD and depression. He is disengaged, defiant, displays violence and has 'anger management' difficulties."

If we respond to that in a purely behavioural way, the management of that may be behaviour management support, a referral for assessment or medication for ADHD, cognitive behavioural therapy for depression, thinking skills for anger management and violence.

Because we are focusing on the behaviour, it is the tip of the iceberg, we are not looking at understanding what is the underlying need that that behaviour is communicating for Joe.

I will now work through giving you some more information about Joe that we might get within a multi-agency formulation to think about how that would help inform our intervention planning.

So:

"Joe finds it difficult to recognise and manage his emotions, especially anger, due to early neglect, discrimination from others, and exposure to domestic violence. These experiences have likelihood shaped his stress response, leaving him in a constant state of high alert. This ongoing anxiety and potential impact on

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1 executive functioning is likely to affect his
2 concentration, emotional and behavioural regulation,
3 impulse control, and focus -- similar to ADHD traits."

4 With this information we can start to recognise the
5 impact of early developmental trauma on Joe's nervous
6 system and sensory functioning.

7 "His early relationships were emotionally
8 inconsistent and unreliable, and he has experienced
9 discrimination by others, leading him to become highly
10 self-reliant and expecting others to let him down. Deep
11 down, Joe anticipates rejection, which has shaped a
12 'street-wise' coping style. He avoids asking for help,
13 keeps his feelings hidden and tries to maintain control
14 through overthinking and excessive independence. While
15 this strategy helps him feel safe in the short-term, it
16 often results in a build-up of emotion that eventually
17 erupts in [an] aggressive or defiant behaviour, [which]
18 ... could be described as a 'bottle, bottle, bang'
19 pattern."

20 This information helps us to recognise the impact
21 that Joe's early experiences have on his attachment
22 relationships and on his development of regulation.

23 "Joe's low mood and motivation likely stem from
24 loneliness and repeated rejection. He tends to blame
25 himself when things go wrong, feeling ashamed, which

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1 importance of relationships. So Joe needs safe, trusted
2 relationship. He needs adults who can be fair and
3 consistent, who can help him manage these emotions that
4 he's feeling by staying regulated themselves and showing
5 him that it's okay to be vulnerable and to discuss those
6 emotions openly.

7 In order to do that, we need an intervention that
8 supports caregivers. So the adults around Joe need help
9 to stay aligned and regulated, to stay consistent and
10 compassionate so that they can provide that safe and
11 therapeutic environment for him to live in.

12 Joe might benefit from physical and social outlets.
13 Again Dan has just talked about the importance of sport,
14 in terms of giving both a structured, physical outlet
15 for emotional expression and regulation, but also those
16 wider opportunities for him to be part of a group
17 sporting activity, to develop relationships with
18 pro-social peers and importantly to have pro-social
19 guidance from trusted adults.

20 Joe might, at some point, need individual therapy.
21 That might be work around anxiety management, emotional
22 literacy, or it might be later on he would actually
23 benefit from a trauma-focused intervention. But those
24 can only be considered when he has that foundation of
25 relational safety and regulation.

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1 makes it harder to connect with others. His behaviour
2 can push people away, reinforcing isolation and
3 impacting self-worth."

4 Now we are starting to see the impact that this has
5 on Joe's internal working model, how he views himself,
6 how he views others and how he views the world.

7 "He likely missed opportunities to learn healthy
8 emotional expression and empathy. Professionals working
9 with Joe hold differing views, some see oppositional
10 behaviour needing boundaries, others suspect ADHD, while
11 some believe trauma is central and advocate for therapy.
12 These mixed perspectives have led to inconsistent
13 support, frequent referrals, and systemic frustration."

14 So here we can start to see how that disintegration
15 within the system begins to show.

16 So if we start to understand what's behind Joe's
17 behaviour we can start to recognise and respond to the
18 underlying need. For Joe, that might look like aligned
19 support. The first step would be for everyone involved
20 across home, education, mental health services, to
21 develop a shared understanding of his story and of his
22 needs, and that helps to create a consistent and
23 supportive approach. So that is why we use multi-agency
24 formulation.

25 Again, we have heard a lot this morning about the

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1 Consideration of a diagnosis for ADHD and treatment
2 options might also be warranted, but only when that is
3 within the context of the broader formulation.

4 I'm going -- I have talked through what our
5 interventions are and the purpose of multi-agency
6 formulation and I'm going to give a couple of real life
7 examples of how in practice that looks within our
8 service.

9 So thanks to both the young people and to the local
10 authority as corporate parents for consenting to this
11 information being shared today.

12 The first case example was a 16-year-old female who
13 lived in our local authority homes. She had a history
14 of multiple moves of home, including periods within
15 secure accommodation under section 25 welfare order.

16 There were considerable concerns for this young lady
17 in terms of harm to self and her missing instances would
18 often result in emergency service responses both from
19 the police and ambulance services.

20 So our intervention to the system around the child
21 was to begin with a multi-agency formulation, so that
22 everyone understood what the communication was of her
23 behaviour and what that was indicating that she needed
24 from those around her.

25 Alongside the formulation, our residential team

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worked frequently with the care team within the residential home, both to connect them to the story and to help them to recognise the patterns of behaviour and what that elicited in them and their own responses to the child, as well as providing reflective practice space to them to consider the anxiety that understandably came from supporting this girl.

More strategically, our residential team worked alongside the wider multi-agency partners to consider what an approach would be more helpful to her from emergency response services, to create a trigger plan that was based on her underlying need and on how we could address that in the most helpful way.

As you can see, over time there was a reduction in both the severity and the frequency of those high risk missing incidents. How we would understand that is the more the caregivers around this child understood her needs and were able to feel contained and to respond to her needs in a trauma-informed way, the safer she would have felt and the more trusted her relationships would have become, meaning she didn't have to resort to those high risk behaviours in order to communicate her need.

The second example is a young man who was open to two different parts of our service, so both the youth justice pathway and the residential pathway. He was 14

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team understand the "Child First" approach and to understand the realities of the youth justice and Criminal Justice System in terms of responses to this boy's behaviour.

Within our residential pathway, he received a speech, language and communication needs assessment. We know that there are a number of children, particularly in contact with youth justice, who have unidentified language and communication needs. This was really helpful in terms of both understanding how those communication needs impacted on this boy's presentation, but also thinking about any intervention that we provided, that it was adapted to meet his needs. So that included adaptations to things like his bail conditions and youth justice order, as well as adaptations to the intervention materials that were being used for his direct work.

Again similar to the last case example, our residential colleagues provided ongoing consultation to the people who were caring to him, to keep them connected to his story, help them to respond in a helpful way and to understand the communicative function of his behaviours, and reflective practice was offered to the teams as well.

In terms of the outcome for this young man, the

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at the time he was referred. He had a significant history of loss and neglect and developmental trauma. His presenting behaviours were a real vulnerability to exploitation. There were significant concerns particularly around county lines exploitation. He was open to youth justice as a result of violent and acquisitive offending and his school journey had been very disrupted.

So the intervention in this case was across the two pathways. Within youth justice we completed an enhanced case management formulation. As I have discussed, multi-agency meeting bringing together all of those agencies around him to really understand his story and the trajectory of his behaviours.

We completed a SAVRY, Structured Assessment of Violence Risk in Youth. Although the focus of our service isn't specifically on risk, the use of a structured clinical judgment tool was really helpful in terms of informing decisions that were made about and around this child in terms of these decisions not being made reactively to perceived risk or a felt sense, but based on what we know about this young person's behaviour.

We did some work across the youth justice and the residential team to really help the residential care

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outcomes were predominantly felt within the system. There was a level of containment within the system that led to much more collaborative working. We were able to use both the formulation and that structured clinical judgment tool to share risk management and decision-making around this boy.

In terms of his outcomes, there was a reduction in risk and offending behaviour. His youth justice rating was moved from high to medium risk of harm. His wellbeing was improved and he actively requested trauma therapy which he is still connected with at the moment.

I suppose it is thinking about how we apply these things as a whole system approach. So it is not just about the formulation meeting itself and having that understanding, it is how we then connect that to other parts of the system.

Coming back to answer the questions of instruction. In what ways does the Trusting Hands model integrate psychological expertise into safeguarding processes and what impact has this had? Hopefully what I'm showing you is that a psychologically informed formulation is used to develop a shared understanding of risk, need vulnerability and behaviour within the context of the child's life experiences and history.

So this model improves the identification of complex

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risks by ensuring that fragmented pieces of information aren't lost across siloed working services. Integrating multiple perspectives improves identification of complex risk. Particularly when we think about enhanced case management, we bring together professionals who know the child well across education, health, social care and criminal justice. They are the people who are seeing that child on a day-to-day basis, observing the child's behaviour, rather than decisions being made in a senior position with less of a line of sight.

Within those meetings, psychological expertise can help to identify patterns, trajectories and emerging concerns by drawing together information from those multiple agencies and across different stages of the child's life.

Having skilled and experienced mental health clinicians means we can hold a position of developmentally aligned psychological thinking. The model is important to our understanding of diagnostic presentations within their wider context and considering other developmental factors and whether they are associated with risk.

The approach also recognises and responds to organisational trauma and system anxiety which can otherwise lead to fragmentation, repeated referrals to

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that can apply here?

We can't look at violence in isolation and we can understand and respond to risk in the absence of a diagnosis. So the most effective approach is to understand all presentations within the broader context of developmental history, trauma experiences, neurodevelopmental needs, mental health and family and social services.

Psychologically-informed formulation is a risk assessment. It allows for shared understanding and integrated risk planning across agencies. It is crucial for developing that shared understanding of risk, need and vulnerability, rather than relying on a single agency assessment.

Identifying potential risk often depends on bringing together of seemingly minor or disconnected pieces of information from multi-agencies and having the people who know the child best as part of that is central to discussions about risk.

Individual risk needs to be understood in the context of the wider system. So effective interventions for risk requires engagement with the wider network around the child. That again includes education, social care, the family systems and mental health services.

Escalating anxiety within professional systems can

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different services and ineffective decision-making.

Clinicians embedded within the systems provide containment and risk tolerance within the professional system, which helps agencies to manage uncertainty and to escalate concerns appropriately, without overreacting.

The second question is what value does it bring? So, embedded co-located clinicians again can develop trusted relationships across agencies and this contributes both to formal and informal information sharing. We have heard a lot from colleagues who presented this morning about information sharing being based on relationships, to promote that as being a helpful process.

Psychological thinking helps agencies to understand behaviour in context. This reduces the likelihood of either simplistic or reactive interpretations of risk.

Formulation-based discussions integrate information from education, health, social care and justice agencies to create a coherent picture of the strengths, vulnerabilities, the risks and the protective factors for a child; and the model scaffolds and develops the wider professional network building collective capacity and capability to understand and manage complexity.

The final question is what lessons have we learned

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increase fragmentation and can lead to poor decision-making. Effective models need to provide containment and coordination to the wider system.

Disintegration is the natural resting state of a system and relational approaches are what support integration.

Finally, psychological and developmentally-informed thinking along with systemic practice leads to integration. So flexible, relationship-based, formulation-driven models are better suited to managing complex and evolving risk rather than rigid service structures. Clear recommendations, allocated responsibilities and shared ownership of risk are essential for translating formulation into effective risk management.

I think these references have been shared and thank you very much for your time.

MR JAMIESON: Thank you very much, Dr Martin, and thank you for all of our speakers.

Sir, I suggest we break there and return for our plenary session at 2.45 pm.

SIR ADRIAN FULFORD: We will.

MR JAMIESON: Thank you.

(1.31 pm)

(The short adjournment)

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1 (2.45 pm)

2 **Plenary session**

3 **MR JAMIESON:** Sir, before I ask my questions, do you have
4 any questions?

5 **SIR ADRIAN FULFORD:** I have a couple, thank you very much
6 Mr Jamieson.

7 Ms Canning, a question which I think may have been
8 indicated to you so that you could think about it over
9 lunch, but which I ought to get the question itself on
10 the record as it were is -- well it is a sort of
11 double-headed question really:

12 Given the conviction which AR had for possessing
13 an offensive weapon and for assault, in the context of
14 him having given indications that he would have used the
15 knife either to harm or to kill, would he have been, in
16 your view, in all likelihood adopted by MAPPA?

17 **MS CANNING:** Thank you, sir. So, it depends. First of all,
18 in terms of convictions, if the convictions had given
19 rise for an indication of a risk of serious harm, then
20 that would certainly qualify for consideration of
21 discretionary management under MAPPA. But it is the
22 second part, it's the other part really about what hook
23 would there have been, what powers would there have
24 been, that could have been exercised. So if he was
25 perhaps subject to a youth referral order at that time,

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1 an individual needs to be managed at Level 2 or 3,
2 depending on the information contained in the referral.
3 And what they ask and what we would ask is: what
4 additionality would that Level 2 or 3 management have
5 brought? So it is whether they could answer that
6 question.

7 Really, I suppose, it's the two things. It's what
8 powers would there have been and what value would that
9 Level 2 or 3 management have added beyond the
10 multi-agency and multidisciplinary risk panels that most
11 youth justice, if not all, services have.

12 **SIR ADRIAN FULFORD:** That's very helpful. The other and
13 very quick question is this for you Ms Canning, is
14 within the four categories, for Category 3 that can
15 require an assessment as to whether there are
16 indications of a risk of harm. When that assessment is
17 being made, whether there is an indication of a risk of
18 harm, who makes the assessment and is it a lengthy
19 process?

20 **MS CANNING:** I'm straying into youth justice service here
21 but offenders or young people will have an assessment
22 known as AssetPlus, which is the sort of full risk and
23 needs assessment. If they were an adult it would be
24 OASys, and these assessments are pretty lengthy.
25 If you were to assess for whether someone should be

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1 then he could have been managed under MAPPA.

2 The other thing which is perhaps a bit more
3 complicated with youth justice is that youth justice in
4 most areas has quite a comprehensive risk and --
5 multidisciplinary risk and vulnerability arrangements of
6 their own and the discretionary management, which
7 I probably should have said, you can only be managed on
8 a discretionary basis at Level 2 or Level 3. So the
9 question would be, what value would Level 2 or 3
10 management have added to what was already in place?

11 So in theory yes, but there would be quite a lot
12 more to take into consideration.

13 **SIR ADRIAN FULFORD:** There was in fact a ten month referral
14 order in place, so does that give you your hook?

15 **MS CANNING:** That would give the hook in terms of the
16 powers. The question would be what would Level 2 or 3
17 management have added, given that there would have been
18 a multidisciplinary panel because of his -- because he
19 was subject to a youth justice supervision.

20 **SIR ADRIAN FULFORD:** So in reality, therefore, there is
21 a real possibility that MAPPA may have said, this has
22 been dealt with, or AR is being dealt with elsewhere, so
23 is it appropriate for us to be --

24 **MS CANNING:** Yes, in reality it may have been that --
25 because MAPPA coordination units will decide if

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1 managed at Level 2 or 3 MAPPA management, you would
2 hopefully anyway be looking to get information from
3 other agencies to inform that assessment. But
4 individuals who are managed are subject -- in any case,
5 regardless of what they have done, they will be subject
6 to a risk and needs assessment.

7 **SIR ADRIAN FULFORD:** Right, and ultimately that's a decision
8 to be taken by MAPPA collectively, is it?

9 **MS CANNING:** Well, the lead agency would make the assessment
10 and would say this person is at a high risk of harm and
11 this is the nature of the risk. That's what the lead
12 agency in MAPPA would do. So they are responsible for
13 sort of holding that together and coordinating that, but
14 we would expect information from other agencies to
15 inform that risk assessment.

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

17 Professor, just one question from me. On your
18 slide 6, you are there dealing amongst other things with
19 a complex case and that includes what you described as
20 objective facts which could lead one to conclude that
21 there was a likelihood -- and that's the word
22 I stress -- a likelihood of crime, violence or public
23 disturbance. Can I ask who makes that assessment as to
24 likelihood? And really the same question I put to
25 Ms Canning: is that a short or a lengthy process?

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1 **PROFESSOR SIZOO:** Thank you, sir, this is an interesting
2 question. I think the assessment would be made in the
3 triage phase, so that would be a selection of the
4 participating partners looking at the facts available
5 and making an initial assessment of the likelihood that
6 this is the case. That is a pretty short process.

7 It might lead to further questions that there are
8 many areas which are unaccounted for, which need to be
9 answered in order to get a complete picture. So the
10 triage by definition needs to be short and as accurate
11 as possible, but the case management which follows will
12 gather more information.

13 This is also, if I may add, one of the risks of
14 triage is that you base your decision whether to include
15 somebody in a caseload or not, on too little
16 information. So this is always a -- it is the same with
17 triage in the battlefield where the chief surgeon has to
18 decide whether somebody is going to be operated on or
19 not based on too little information. So it is a tricky
20 thing.

21 **SIR ADRIAN FULFORD:** Thank you very much indeed. Yes,
22 Mr Jamieson.

23 **MR JAMIESON:** Thank you, sir.

24 There are four sort of general topics that I would
25 like the panel's assistance with please and the first is

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1 this morning, which is of course impossible but --

2 **MR JAMIESON:** Which are the best bits?

3 **PROFESSOR SIZOO:** The best bit is of course the Care and
4 Safety House. In all honesty, I think the best bit is
5 the public health bit, addressing the problem where it
6 originates in the community. That in combination with
7 excellent mental health provision and a clear sharing of
8 information where there has to be a need for reliable
9 information, not hearsay, but to seek out the source,
10 make sure that the information is reliable and a genuine
11 interest in the person in question. That doesn't mean
12 that you -- so it can be somebody who is with a violent
13 intent and that does not exclude interest in why this
14 person has a violent intent, and the multidisciplinary
15 aspect I would also include.

16 **MR JAMIESON:** Dr Martin?

17 **DR MARTIN:** I agree with everything that has just been said.
18 I think for me there is obviously a lot of our service
19 model is based around formulation and I think that takes
20 into account what we have talked about in terms about
21 understanding historical needs, neurodevelopment, mental
22 health needs. That and, as Professor Sizoo says, having
23 things arranged around an individual. I think the
24 difficulty is there won't be a single structure that
25 meets the needs of every individual who could probably

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1 the identification of the best structure for managing
2 and mitigating the risk in VFI cases.

3 The question which I would like each of the panel to
4 think about is this, in the Inquiry's consideration of
5 that question, what should such a multi-agency structure
6 look like? What would be the absolutely central
7 strengths, from each of your organisations and bodies,
8 that should be carried over, that should appear in that
9 structure?

10 If I may, I will ask Mr Diamond that one first.

11 **MR DIAMOND:** Thank you. I think in consideration of this,
12 I think I referred to this in my presentation, is
13 a clear and unambiguous definition of VFI or
14 violence-fixated individuals, because in order to draw
15 personnel and agencies around that structure, there
16 needs to be clarity of their purpose and what's being
17 asked of them, and I say that with real respect to the
18 issue here. But if we were to draw agencies together
19 and that clarity and that definition wasn't clear, then
20 I think it would be problematic. So that would be one
21 immediate thought on it.

22 **MR JAMIESON:** Thank you very much. Professor Sizoo?

23 **PROFESSOR SIZOO:** You are asking what would be the ideal
24 structure to deal with these risks? I'm inclined to say
25 that would be a combination of all four presentations

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1 present as violence-fixated because we need to be
2 addressing those individual needs within services.

3 **MR JAMIESON:** Yes, and Ms Canning?

4 **MS CANNING:** Thank you. So first of all I think there is
5 a clarity of purpose, which has already been said. Also
6 a shared understanding of risk. A shared understanding
7 of what is it that we are actually worried about that we
8 want to manage. A clear understanding of each other's
9 roles. Certainly I have spent quite a lot of time
10 really not understanding other people's roles and what
11 other people can do and what they can't do.

12 Strong professional relationships which we have
13 talked about. Clear leadership, accountability and
14 governance. Actually, quite a lot of MAPPA's strengths
15 lie in the Strategic Management Boards and the ability
16 to solve problems if you can't actually solve them in
17 that panel. And the other thing is that you do need the
18 resources to back it up, and it is really interesting
19 hearing Dr Martin talking about a traumatised
20 organisation and -- but you need that time to be able to
21 reflect, you need that time to be able to do those
22 formulations, you need the resources to have two
23 professionals in a formulation -- undertaking
24 a formulation.

25 So really -- and I think that's one of the

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1 limitations of MAPPA, is it doesn't bring the additional
 2 resources. I think that's probably really important.
 3 **MR JAMIESON:** That's very helpful, thank you.
 4 I just wanted to come back on one of the points that
 5 you raised there, Ms Canning, and open it to the rest of
 6 the board. Leadership and clarity of leadership is
 7 something that you have told us is valuable from your
 8 experience.
 9 For the panel's consideration, in a multi-agency
 10 structure, does there need to be an agency which is
 11 clearly in the lead; and, if so, does there need to be
 12 flexibility as to which agency fulfils that role in
 13 which circumstance?
 14 I'm going to ask that to Dr Martin.
 15 **DR MARTIN:** Yes. In short, yes. I think there needs to be
 16 a clear lead agency. However, that's not to suggest
 17 that whoever is in that lead agency role is the person
 18 that is solely -- or the agency that is solely
 19 responsible for having all of the information or having
 20 all of the answers.
 21 So, again, it comes back to having a lead agency but
 22 having like -- Becky's just suggested having that shared
 23 understanding of what our roles and responsibilities are
 24 within the process, and as well that the role of that
 25 lead agency is dependent on what our formulation of need

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1 doesn't have that intimate oversight but more it drives
 2 the system --
 3 **MR JAMIESON:** It has the leadership role, does it?
 4 **MR DIAMOND:** Yes, it absolutely does, yes.
 5 **MR JAMIESON:** Can you evaluate that for us? Is that
 6 helpful? Is that a good part of the structure?
 7 **MR DIAMOND:** Yes, yes.
 8 **MR JAMIESON:** I probably asked for that.
 9 **SIR ADRIAN FULFORD:** It would have been surprising if the
 10 answer had have been otherwise, I think, Mr Diamond!
 11 **MR DIAMOND:** Apologies. What was that, sir?
 12 **SIR ADRIAN FULFORD:** I just said it would have been
 13 surprising if the answer was otherwise.
 14 **MR JAMIESON:** Can I draw these together then and ask
 15 a question that probably sits behind a lot of this
 16 thinking.
 17 In England and Wales there are a lot of structures,
 18 multi-agency structures with what might be thought with
 19 some overlapping areas of responsibility. We have
 20 MAPPA, we have Vanguard, we have Violence Reduction
 21 Units represented here today, there are also MASHs,
 22 other structures, but commonality of what the Inquiry
 23 has heard in relation to all of those structures is that
 24 the importance is to have the right people around the
 25 table who can provide the right information.

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1 is and the sequencing of interventions for that
 2 individual. So, for instance, if the predominant needs
 3 are around offending, then it makes sense for our youth
 4 justice colleagues to be that lead professional.
 5 However, if there is a clear role for a mental
 6 health intervention, then that should sit with
 7 colleagues within mental health. But the thing that
 8 will strengthen that is the multi-agency working and the
 9 shared responsibility for risk.
 10 **MR JAMIESON:** Thank you. Professor Sizoo, how does it work
 11 in the Netherlands?
 12 **PROFESSOR SIZOO:** I would say that I think it would be most
 13 preferable if an independent agency is the lead agency.
 14 So in the case of the Care and Safety Houses,
 15 a municipality, and a municipality signed process
 16 manager. That prevents agencies looking at each other
 17 and entering in this sort of combative situation. So it
 18 is the administrative municipality task to run the
 19 process and to -- ultimately it is the Mayor who is
 20 responsible.
 21 **MR JAMIESON:** Thank you. Mr Diamond, does that sound
 22 a little like the VRU in Manchester or is that
 23 different?
 24 **MR DIAMOND:** The principles are but of course the VRU in and
 25 of itself isn't a case management structure, so it

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1 And it may be that many of those same people would
 2 be common across those structures. So I think the
 3 question is this, is there a risk that when we have so
 4 many structures with overlapping areas of
 5 responsibility, that complication gets in the way with
 6 the identification of management of risk? Or is it
 7 better to have bespoke arrangements?
 8 I'm going to ask Ms Canning that one first.
 9 **MS CANNING:** I'm not sure really. I suppose MAPPA, because
 10 they are so very, very clear that it is about offenders
 11 and because they are set out in legislation, that does
 12 feel fairly straightforward. But you can have certainly
 13 overlaps.
 14 So my experience was when I worked in Southwark we
 15 had a Serious Group Offending panel that actually was
 16 very much like MAPPA but it had the right people around
 17 the table in that it had the experts around Serious
 18 Group Offending. And so I think, yes, it probably can
 19 lead to some confusion and some overlap, and again you
 20 can have -- with something like MARAC, which is
 21 a multi-agency risk assessment conference, which is for
 22 victims of domestic abuse, sometimes those victims may
 23 also be themselves perpetrators or it may be that we are
 24 managing the risk to victims in two separate places.
 25 So I think probably there is that risk. But I think

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1 it comes back to the clarity of purpose and also it
2 comes back to -- it is not just about responsibility for
3 managing the individual case, it is about agencies
4 taking the lead right up the chain so that you have
5 senior leadership buy-in because you do need that in
6 order for the risk management to work on the ground.

7 **MR JAMIESON:** Thank you. Mr Diamond, you raised the concept
8 of clarity of purpose in relation to one of my earlier
9 questions. Does clarity of purpose require a bespoke
10 structure or can it fit in a general one?

11 **MR DIAMOND:** I do recall making that point and that's fair
12 enough. What I did consider is, in terms of the present
13 structures and Ms Canning and I were discussing this
14 actually during the break earlier, just going back to
15 some of my previous MAPPA experience.

16 When I first started to deliver MAPPA in the city of
17 Manchester, 25 per cent of the cases were youth justice
18 cases, which in some regards was arguably using
19 a sledgehammer to crack a nut because the power of MAPPA
20 is quite great and, with a child especially, leveraging
21 those sort of conditions over them could have been
22 excessive. So we worked very hard with youth justice
23 and very much similar to what has just been said about
24 the -- they were called the case planning forums and
25 they were essentially like a MAPPA structure. It was

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1 are local initiatives, and of course there is a risk of
2 so many organisations dealing with the same thing that
3 you -- that information doesn't get passed on and that
4 there is an assumption that other organisations will
5 take care of a problem.

6 So, I think the Care and Safety House construction
7 with its tables offers a lot of opportunities for
8 dealing with cases with different priorities, but it is
9 very important that other organisations are aware of the
10 existence of Care and Safety Houses, which is not the
11 case at the moment everywhere, in order to escalate
12 cases when the risk becomes too high.

13 **MR JAMIESON:** Thank you. Dr Martin, was there anything you
14 wanted to add?

15 **DR MARTIN:** I suppose just to think about regardless of
16 whether we have bespoke arrangements or continue with
17 the arrangements we have, it is just really important to
18 remember that that disintegration will happen around
19 cases where there is high levels of complexity and need.
20 So regardless of what those arrangements are, the
21 principles of working collaboratively and sharing the
22 information amongst those services I think still
23 applies.

24 **MR JAMIESON:** The final question on this topic which comes
25 from a question posed by the families and it is about

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1 a criminal justice focus with a clear eye on risk but
2 also it is a full partnership meeting. It just needed
3 tweaking a bit with the right personnel.

4 My immediate answer to this would be around youth
5 justice itself. Because youth justice isn't simply
6 working with convicted individuals or court orders, they
7 work in that, as you will be aware, within the
8 preventative space too, and they are a Child First,
9 trauma-informed, well seasoned body and they have been
10 around for some time and that is their work.

11 So I think as a structure, there is possible mileage
12 in sort of looking at that as a way forward.

13 **MR JAMIESON:** Thank you very much.

14 Professor Sizoo, can I come to you next. When you
15 gave us your presentation you explained the Safety House
16 a broad structure, tables within it. One of the
17 advantages of that is you didn't fall into the trap of
18 "label myopia" as you called it. Does that allow for
19 the clarity of purpose, that Mr Diamond has spoken to us
20 about, within that general structure or are there too
21 many general risks being managed?

22 **PROFESSOR SIZOO:** I suppose it does to a great extent but
23 what I didn't mention is that apart from the Care and
24 Safety Houses, there are many other organisations that
25 contribute to care and safety in the community and these

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1 how you keep the regional qualities that you have spoken
2 about. I think everybody has mentioned the importance
3 of individual relationships at regional level and how
4 you can apply that and get that benefit on the national
5 scale.

6 So I'm going to ask Ms Canning that first, given her
7 national role in MAPPA.

8 **MS CANNING:** So, as I said in my presentation, the Strategic
9 Management Boards are independent and they are local and
10 they need to be because the needs of London are going to
11 be very different to the needs of Cumbria or Devon, so
12 there does have to be that regional variation.

13 In terms of I suppose having a baseline and having
14 minimum standards, that comes through the statutory
15 guidance. So the statutory guidance, it is long, it is
16 quite detailed, it goes through all the different
17 aspects of MAPPA management and Strategic Management
18 Boards are required to have regard for that.

19 So that's the sort of stick, if you like, but also
20 nationally, certainly within the MAPPA community, we
21 have a website where people share -- where they consult
22 across regions and communicate across regions. We have
23 a very comprehensive communication strategy, so we have
24 national meetings three times a year with mental health
25 colleagues, with MAPPA coordinators, with SMB Chairs and

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1 we also produce or we are starting to produce quite
2 a lot of resources.

3 So, for example, last year MAPPA was 25 -- it was
4 25 years since the first legislation. So we used that
5 opportunity to produce training resources. For example,
6 we had one on the Child First approach and MAPPA. We
7 had another one on information sharing, and so we have
8 been able to put those resources on the website that
9 they are able to use.

10 **MR JAMIESON:** Thank you very much. Professor Sizoo, how do
11 you ensure consistency across your 31 regional Care and
12 Safety Houses?

13 **PROFESSOR SIZOO:** Thank you. As I mentioned, this is
14 something of concern that we have nothing in place yet,
15 which is comprehensive but it is work in progress. We
16 have set out the requirements for a national training
17 programme for participants of Care and Safety Houses, so
18 not just for the programme managers but for the
19 participants in order to get acquainted with each
20 other's profession and also to learn about
21 collaboration, because as I said it is not a skill or
22 a method, it is an attitude. So it is a work in
23 progress. Hopefully next year it will be better.

24 **MR JAMIESON:** I am going to move on to the second of my
25 topics or we will run out of time, apologies for that.

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1 young people and sort of separating them.

2 So we have a programme called Parent and Carer
3 Service, PACS, which was again commissioned. It was
4 co-designed with the community, with parents and
5 families and we took a lot of time in doing this so we
6 could get it right. What this is about, it is a service
7 which is -- it is a provision for parents who have
8 anxieties and concerns about their children, but their
9 children perhaps are either resistant and won't go to
10 local authority -- won't engage, the families themselves
11 are nervous about talking to authorities, even teachers,
12 never mind police or more formal processes. And what
13 PACS is a service where they can be referred in and they
14 can receive support, and it is a very structured
15 programme as well. But that's for those parents who
16 have concerns about their children who are perhaps at
17 risk, who are involved in street-based violence, weapon
18 carrying and have started to manifest those early
19 behavioural changes. But they are worried because if
20 they go to local authority or the teacher they might
21 invoke more of, I don't know, an intervention that they
22 perhaps aren't prepared for.

23 So this is more of an informal but equally effective
24 approach. So that's sort of a response to that.

25 **MR JAMIESON:** Thank you. Dr Martin?

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1 Interventions, and again a question for the panel at
2 large. The consistent message in the information that
3 the Inquiry has received is that early intervention is
4 optimal. What are the most effective early
5 interventions that your organisations have encountered
6 in the mitigation of risk of serious violence in
7 children and adolescents?

8 Can I come to you, Mr Diamond.

9 **MR DIAMOND:** Yeah, sure. I shared before a whole range of
10 different provision interventions, which is kind of the
11 mainstay of the VRU programme. It is about looking at
12 innovation opportunities to do things that haven't yet
13 perhaps been done or haven't been evaluated and -- a nod
14 to Youth Endowment Fund. To those aren't familiar with
15 that, it is £200 million fund launched at the same time
16 as the VRUs, for ten years, and it is looking at
17 interventions and programmes that are designed to
18 address violence in young people and reduce violence
19 risk.

20 A programme that I think is worth mentioning here,
21 and again it isn't the only one and there's so much
22 more, but one of the concerns that we had, and I didn't
23 get into this, is talking about parents because the
24 whole family issue is key here, is including parents,
25 including families and not just isolating children and

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1 **DR MARTIN:** I suppose like I mentioned in my presentation,
2 we need to be clear what we mean when we talk about
3 an intervention. So an intervention isn't necessarily
4 a violence-related programme or a therapeutic
5 intervention directly with the child --

6 **MR JAMIESON:** We need to think more widely than that.

7 **DR MARTIN:** We need to think much more widely. So I suppose
8 early interventions are interventions that are
9 developmentally aligned, and that are aligned with the
10 individual child's needs. A helpful way of thinking
11 about that can come from the trauma recovery model. So
12 if we think about how we provide safety and stability
13 for children and young people, followed by trusted
14 relationships in the first instance, those are
15 interventions themselves. Thinking about at a universal
16 level that would be how do we ensure that children are
17 connected with meaningful daily occupations? Are they
18 in school, are they in education or employment or
19 training? If not, what does their day-to-day routine
20 look like? Actually, routine and structure is our first
21 line intervention, followed by, like Dan said, they're
22 thinking about parents and carers as really important.
23 Who are the people caring for these children and do they
24 have the skills necessary to respond to challenges,
25 behavioural challenges or emotional dysregulation? And

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1 if not our intervention needs to be around those parents
2 and carers to equip them to manage and to support the
3 individual, but ultimately it comes back to the
4 intervention needs to align with what the specific need
5 is for that individual.

6 **MR JAMIESON:** Yes. Some of those interventions that
7 Mr Diamond was telling us about in his presentation, the
8 GMVRU organise sports, connections all of those things,
9 they would fall under that umbrella?

10 **DR MARTIN:** Yes.

11 **MR JAMIESON:** Professor Sizoo, anything to add?

12 **PROFESSOR SIZOO:** I think all these interventions that are
13 mentioned by Mr Diamond and Dr Martin are important, but
14 as Dr Martin stressed there are many more interventions
15 that we are possibly unaware of which they place at
16 a very fundamental and early level.

17 I would like to mention, for example, the community
18 police officers in the Netherlands who are our secret
19 weapon because they are integrated in the capillaries of
20 society and neighbourhoods and they know exactly what is
21 going on. Yearly polls show that there is a high
22 respect for these community police officers, despite the
23 fact that they are police. So individuals who are
24 against the government, against the police, against
25 everything, but the community police officer is their

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1 do you collate and release? And how do you ensure that
2 those measures are the right ones and that they are
3 being effective?

4 A difficult one but I will start I think with
5 Dr Martin.

6 **DR MARTIN:** I think -- we have talked about trauma-informed
7 practice and it is a very difficult thing to
8 specifically say what it is that we are doing, and
9 I suppose some of that is similar in terms of measuring
10 effectiveness.

11 From a Vanguard position, NHS England, have, as well
12 as collating our quarterly data, used case studies as
13 examples so we can look on an individual level in terms
14 of what difference we see and what the effectiveness is
15 of those interventions, and that can be looking at areas
16 such as we have already talked about in terms of the
17 intervention. That can be about engagement within
18 education and employment, that can be about stability of
19 the home environment, particularly for children in care,
20 reductions in isolation, reduction in risk incidents.

21 I think it is harder to do on a wider scale because
22 there is such individual difference both in the
23 intervention that we are offering and in the outcomes
24 that we would expect to see for those individual
25 children. Again at a local level, we evaluate more from

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1 friend. I think that is a sort of secret weapon where
2 you have a very early signal function in the form of
3 a police officer. The same goes for education of
4 course, teachers and mental health. Perhaps
5 summarising, the best intervention is probably not
6 identified as an intervention.

7 **MR JAMIESON:** Just unpacking that a little. What you have
8 in the Netherlands is a system of police officers that
9 are based in the community and have that level of
10 relationship with the people that they police?

11 **PROFESSOR SIZOO:** Absolutely, and in discussions with the
12 Metropolitan Police here in London I gather that it is
13 looked at with some envy that we still have this system
14 in place, although it is under pressure because also the
15 Force is saying it is not effective but I think it is
16 highly effective.

17 **MR JAMIESON:** I'm going to resist making any sort of comment
18 about that.

19 **PROFESSOR SIZOO:** I understand!

20 **MR JAMIESON:** Ms Canning, anything to add?

21 **MS CANNING:** I don't. I feel that it's all been said.

22 **MR JAMIESON:** The related question then, please, and
23 a difficult one but if there is insight you can give, we
24 welcome it. How do you measure the relative
25 effectiveness of those measures, if you can? What data

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1 the professional perspective in terms of motivation and
2 confidence and knowledge in understanding the child and
3 how to meet their needs, which is helpful for us to
4 think about how services might act differently with the
5 child but it is less about the specifics of what changes
6 for that child.

7 **MR JAMIESON:** Thank you.

8 Mr Diamond, in your presentation you highlighted
9 some of what you called the "blunt metrics" of the
10 overall violence numbers. Has your public health
11 approach to violence allowed you any more specific
12 evaluations of the effectiveness of the programmes, what
13 works, what doesn't? Is there better data that you can
14 analyse and consider?

15 **MR DIAMOND:** Yes.

16 **MR JAMIESON:** Can you help us?

17 **MR DIAMOND:** Absolutely. I was using that as the Government
18 measure, which is understandable, I get that, the
19 urgency of it. But our programmes, most of them are
20 being evaluated or have been evaluated, and it is
21 important that those programmes are exposed to rigour,
22 academic rigour and are sort of challenged as well. It
23 is easy for me to sit here and make claims about the
24 efficacy of one thing or another, but I think the actual
25 validity of the evaluations really is important.

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1 **MR JAMIESON:** How is that done? How is that evaluation
2 taking place?
3 **MR DIAMOND:** For example, the BLOCKS programme I mentioned,
4 which is the primary school transition one. That's
5 about looking at the data, the feedback from the child
6 itself. Thinking about the heart of it is the child's
7 voice and understanding it, and having appropriate ways
8 of eliciting that information. You can't just ask
9 a child a bunch of questions. You have to have a proper
10 way of engaging that and that requires expertise and
11 professionalism.

12 It is also about interviewing and assessing the
13 parents and the teachers and the people around the child
14 and getting a more holistic view. It is ensuring that
15 we are in the space where that information sits.

16 **MR JAMIESON:** And where a profession of some sort, perhaps
17 a teacher, perhaps somebody else, has been the person
18 who has made the referral in the first place for that
19 child, would that include going back to that person and
20 getting information from them?

21 **MR DIAMOND:** Yes, because it is about understanding the
22 progress that young person has made and they can measure
23 that.

24 **MR JAMIESON:** Professor Sizoo?

25 **PROFESSOR SIZOO:** As I mentioned the evaluation process is
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1 groups. We also looked -- they also looked at serious
2 case reviews and what we can learn from that.
3 I think where perhaps we need to do some more work
4 and HMI Probation did that and we need to follow that
5 up, is what the people being managed think about the
6 effectiveness of MAPPA. But also with MAPPA it's what
7 people bring to the table, so it's how effective are
8 those interventions that come with it.

9 **MR JAMIESON:** Thank you. I think I'm probably going to come
10 straight back to you, Ms Canning, with my final question
11 on this topic but let me explain why.

12 A number of the other seminar speakers have been
13 telling the Inquiry about the importance of the internet
14 and the contents of the internet that some of these
15 young people encounter.

16 Are there any interventions available to MAPPA that
17 would limit the access either to the internet wholesale
18 or to aspects of the internet, particularly as regards
19 young people and adolescents?

20 **MS CANNING:** So remember that MAPPA is just a set of
21 arrangements and not an organisation. So it is whether
22 there are powers that are available to individual
23 agencies that are involved with managing somebody under
24 MAPPA.

25 **MR JAMIESON:** Perhaps somebody under a referral order or
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1 still something we are working on but I think it is
2 extremely important what Mr Diamond has stressed, that
3 it's necessary to speak with individuals who are being
4 discussed, instead of only about individuals, because
5 they can give clarity of what interventions or what
6 measures they feel awkward about or has actually helped.

7 So I think that is a very important aspect not to
8 forget, and that includes the parents of course of
9 individuals being discussed.

10 **MR JAMIESON:** Thank you. Ms Canning?

11 **MS CANNING:** I think it is difficult because in this area of
12 work it's what doesn't happen. You want things not to
13 happen, you want bad things not to happen, you want
14 people not to do these awful things that others have
15 done, and proving a negative is always really difficult.

16 You can have the metrics and in terms of MAPPA we
17 have our key performance indicators. There's also
18 quality assurance tools that kind of look at the
19 process. But probably the most valuable measure of
20 effectiveness has been the Anglia Ruskin University
21 research which gave a very candid evaluation of MAPPA,
22 and it combined the numbers. So they looked at
23 re-offending data which is, after all, why we are here,
24 and showed that was effective. But they also did a lot
25 of work with practitioners and held various focus
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1 a sentence, something of that nature.

2 **MS CANNING:** Yes, so under sentence. Certainly under
3 sentence there are licence conditions that limit the use
4 of the internet. I remember when we started we simply
5 used to ban people from using the internet and we can't
6 do that.

7 **MR JAMIESON:** Why can't that be done any more?

8 **MS CANNING:** That's because there is so much of your life
9 that you have to use the internet for. It is very hard
10 to conduct yourself as a citizen without access to the
11 internet. So we have kind of nuanced those conditions
12 a bit more. So it may be that you can only have one
13 device that's internet enabled, and it may be that you
14 have to give that device or allow that device to be
15 checked.

16 I think police probably have more of the technology
17 around providing surveillance. It is a very live issue
18 actually at the moment about how do we get in under the
19 skin of what people are doing online and we are not
20 there. But there are some licence conditions certainly
21 around not owning more than one device, and not deleting
22 your browsing history to make it possible to see what
23 you have been up to.

24 **MR JAMIESON:** Thank you. Professor Sizoo, are there any
25 interventions of that nature available in the
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1 Netherlands?

2 **PROFESSOR SIZOO:** There are formal interventions in prisons,
3 obviously, and also in -- when there is a constraining
4 order in mental healthcare there is a possibility of
5 denying somebody access to the internet. However, Big
6 Brother is savvy, especially youngsters. What we see in
7 the problem and the emerging problem of COM groups -- do
8 I need to explain the COM groups?

9 **MR JAMIESON:** No, we have heard about them.

10 **PROFESSOR SIZOO:** COM groups that are potential perpetrators
11 that are so savvy that in these secured institutions
12 where they are awaiting trial they manage to bypass all
13 preventive measures. So it is a huge problem.

14 The other side is that if you deny -- if you
15 successfully deny them access to internet, with some of
16 these perpetrators and also victims, they are almost
17 addicted to their COM network and they show
18 neurobiological signs of being denied access to
19 internet.

20 So it is something which there are still many
21 questions about.

22 **MR JAMIESON:** With the understanding of the two panelists,
23 I will move on to the third topic, which is something in
24 common with all of these platforms: information sharing
25 powers, consent and resourcing.

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1 **MR JAMIESON:** Thank you.

2 Mr Diamond, the pre-, the lower risk voluntary
3 engagement panels that you were describing, how do you
4 deal with this question of consent?

5 **MR DIAMOND:** Obviously the VRU, again we don't manage the
6 cases ourselves, so the prevention panels which
7 I mentioned are convened at a local authority level.
8 Partners across the ten boroughs oversee that.

9 Information sharing generally is done under the
10 Crime and Disorder Act. So there's sufficient provision
11 in there to share on the basis of necessity, to address
12 crime and harm. Obviously I think when we are dealing
13 with a young person, I think it is about necessity and
14 proportionality. I think people use a common sense
15 approach to this.

16 Again I know we talked about this before, but there
17 is something about trust and agencies feeling
18 comfortable and having that sort of co-located
19 engagement which does break down quite a few of those
20 anxieties.

21 So yeah, I don't think there is an exact science to
22 it. There is some legislation, what I won't sit here
23 and say is that it's absolutely pinned down and there
24 are different schools of thought around it and different
25 degrees and variance in the practice.

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1 For each of you, how dependent are your systems on
2 the consent of the person being considered and their
3 wider family, and what does your multi-agency structure
4 do if consent is not provided?

5 I think I will start with Dr Martin, please, in
6 relation to that.

7 **DR MARTIN:** For our service, the client, as it were, is the
8 multi-agency system around the child, so we have less
9 difficulty in terms of obtaining consent because the
10 child isn't necessarily involved in the formulation or
11 the intervention.

12 We use generally existing information sharing
13 procedures, we seek consent. Often for children in
14 care, the local authority is the corporate parent who
15 will provide consent, and within our youth justice
16 workstream we have recently adapted our consent forms so
17 that we are explicitly asking for consent to share
18 information across the different agencies as part of
19 formulation.

20 **MR JAMIESON:** And if it is not provided?

21 **DR MARTIN:** If there is a risk, if is a significant risk we
22 would -- because we are not asking the child to engage
23 in anything directly, we would continue with that
24 multi-agency consultation approach with a view that risk
25 would supersede confidentiality.

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1 **MR JAMIESON:** I think that reflects some evidence we have
2 heard or some opinion we have heard elsewhere about
3 frontline professionals' nervousness or worry about
4 exchanging information in those circumstances and the
5 way you have overcome that, or you do overcome that
6 sounds like individual relationships?

7 **MR DIAMOND:** Yes.

8 **MR JAMIESON:** Is it wider than that?

9 **MR DIAMOND:** Yes, but also there is a sense of collective
10 responsibility. I think rather than it -- going back to
11 some of the points that have been made already by my
12 colleagues, you know, not pinning it all on one
13 responsible person. Actually we are all together on
14 this and there is a collective agreement around what
15 needs to be shared, what needs to be discussed and what
16 needs to be done. As long as that agreement is in
17 place, and I think that's one of the strengths of MAPPA,
18 not to dump it all on MAPPA of course, but that same
19 principle does exist within our prevention partnerships.

20 **MR JAMIESON:** That sense of collective responsibility is
21 very much something I will come back to, so I will put
22 a pin in that for the moment, if I can.

23 Coming to you, Ms Canning, and MAPPA, one of the
24 things Mr Hall told us that he was most proud is as
25 a result of his recommendations, this new statutory

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1 gateway for information sharing in MAPPA had been
2 created, and it might be thought that if that were
3 needed, was there a difficulty in the sharing of
4 information in MAPPA before?

5 **MS CANNING:** The difficulty I think was the lack of clarity,
6 and the other difficulty before that information sharing
7 measure was brought in was people was sharing
8 information, they were sitting around the table, but
9 they were sharing information under different bits of
10 legislation. So now everybody is sat round the table
11 sharing information under the same legislation.

12 And I know Jonathan Hall is -- we have had those
13 discussions -- is rightfully very proud of the fact that
14 legislation was brought in on the back of that review
15 and it has been really helpful amongst MAPPA partners.

16 The other thing -- we are talking about information
17 sharing between MAPPA partners, but there's also the
18 other bit of it, which we term as "disclosure", which is
19 where you share information on a case-by-case basis with
20 somebody who isn't a MAPPA partner. For example, it
21 might be we might have to disclose information to, say,
22 a private landlord, and we have processes in place to be
23 really clear about those disclosure decisions. And
24 every single meeting, in fact every single case, whether
25 it is Level 1, 2 or 3, there is a requirement to

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1 **PROFESSOR SIZOO:** That is a very good question. I suppose
2 it boils down to the individual; to what degree the
3 individual contemplates what the risks are of sharing
4 bits of information and that can be something like
5 "I feel very uncomfortable about this case," full stop.
6 That is a very relevant piece of information for the
7 other agencies.

8 For myself I always try to imagine what I would
9 explain to the judge, would it come to that point. And
10 so the wellbeing or the welfare of the individual as
11 an argument to breach your confidentiality, is
12 considered -- has been considered not valid because it
13 is very subjective of course to the clinician involved.

14 However, jurisprudence nowadays is moving in the
15 direction of considering that a breach of your
16 confidentiality is valid if you think that will benefit
17 the individual. But of course you would have to explain
18 that in the end.

19 **MR JAMIESON:** It sounds like a difficult position that the
20 psychiatrist is in. One of the things Dr Betts
21 suggested may be a way of doing it, for your
22 consideration, is not to reveal the detail of the
23 information, but simply to indicate whether they were
24 very worried about this situation, red; partially
25 worried, amber; not worried, green. Is that --

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1 consider disclosure and to have that agreed. There is
2 a proper process for agreement to that.

3 **MR JAMIESON:** So that external disclosure, you have to have
4 a bespoke way of dealing with that?

5 **MS CANNING:** Yes.

6 **MR JAMIESON:** That's your view.

7 Professor Sizoo, may I come to you but with
8 a slightly different gloss on it. You have told us in
9 the Netherlands that psychiatrists, medical
10 professionals, have this overarching data
11 confidentiality duty with criminal sanction and they
12 will be sitting sometimes in these meetings with that
13 information, with a conflict of drivers, their own
14 personal responsibility in that circumstance but wanting
15 to inform the meeting in front of them.

16 That may have a parallel with what one of our
17 seminar speakers, Dr Betts told us yesterday, about in
18 some circumstances counter-terrorism police officers in
19 this country having some information that they have to
20 protect but may be relevant to the issue that's under
21 discussion.

22 How in the Netherlands do those psychiatrists
23 balance those responsibilities? How do they make sure
24 that they meet their responsibilities but the evidence
25 is given to the meeting?

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1 **PROFESSOR SIZOO:** Oh yes, absolutely. That is the example
2 I gave about the participating clinician because it is
3 not confined to psychiatrists, it also concerns
4 psychologists and mental health nurses. That they
5 express their feeling about the case exactly in these
6 terms.

7 **MR JAMIESON:** Mr Diamond, may I come to you again with
8 a slightly different gloss. You explained in your sides
9 that the GMVRU had managed to gain community trust in
10 this respect. What steps had been taken with those
11 communities, with sections of the community, who perhaps
12 may not have welcomed or responded to your interest to
13 begin with, to gain that trust?

14 **MR DIAMOND:** I approach this question quite respectfully
15 because first of all communities are not homogenous, you
16 will appreciate that, and they are multifaceted and
17 multi-layered and complex. And that's something that
18 when we started as a programme, we didn't have right of
19 access. In fact we had to take quite a lot of sort
20 of -- "flack" is the wrong word -- but we engaged in
21 quite some contentious discussions, not on our part, we
22 thought we had to defend ourselves and we realised there
23 was a lot of unrest, uncertainty and distrust in the
24 community because of the way in which quite often State
25 operators would treat community members. I'm not

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1 talking about policing and things like that. I'm
2 talking about engaging the community to understand
3 something better than just dropping them -- at a drop of
4 a hat when we have got our information.

5 So it look a long time to establish rapport and
6 develop relationships with our communities. And I'm
7 pleased to say that we are in a much more developed
8 place now and that's come about because I think one of
9 the things that's really helped is having -- is about
10 having high level political buy-in, and I said this in
11 my presentation, the Mayor of Manchester at the time --
12 or Greater Manchester, excuse me -- was very, very
13 public about the community element of this and stood in
14 that space.

15 I'm not about to venture into a political discourse
16 here, but the point is that works as a real enabler.
17 Actually giving and validating the community's voice and
18 putting them in that place of trust, and listening to
19 them and allowing that to be reflected what we are doing
20 so they could see what they had to say meant something,
21 and it had an impact.

22 We have a specific forum now called the
23 Community-led Network for Violence Reduction, which is
24 a quarterly meeting. It was launched last year. It
25 took us a while to get this going. It was developed by

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1 our voluntary community infrastructure organisations and
2 the VRU. But that's really a developing picture at the
3 moment and where a lot of this stuff is opened up. What
4 we are doing is we are sharing information with them, we
5 are sharing data, we are sharing insights and stuff.
6 Whilst of course there is a lot of subjectivity amongst
7 community groups, because their experiences say one
8 thing and we are saying perhaps another, when you share
9 with them an honest, open book with information about
10 what's happening it actually lands really well. I said
11 that in a surprised tone, but I was relieved. So it is
12 about --

13 **MR JAMIESON:** Transparency --

14 **MR DIAMOND:** -- bringing them in. Yes, really mirroring
15 that. I will say this in all seriousness. If you are
16 going to engage the community on this agenda
17 specifically, around violence and violence reduction, it
18 is very, very emotive as you know, and you have to
19 expect to get a bloody nose, figuratively speaking, and
20 that's part of the situation.

21 **MR JAMIESON:** Thank you. Ms Canning, anything to add on
22 this topic?

23 **MS CANNING:** I'm sorry, could you repeat the question?

24 **MR JAMIESON:** Anything to add to what the other panelists
25 have said?

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1 **MS CANNING:** No.

2 **MR JAMIESON:** I will move on, if I may, to the final topic
3 that I have for you all to think about and that is risk
4 assessments and risk management culture.

5 I'm going to start, if I may, with Professor Sizoo.
6 Just to explain why that is. One of the findings of the
7 Chair at stage one of this Inquiry is that there had
8 been -- many of the agencies that had been involved in
9 the case of AR had -- there had been a failure
10 collectively to take responsibility. Each had applied
11 their own criteria, closed cases and referred on. There
12 had not been what you described as a best fit/good
13 enough approach, where agencies sitting around the table
14 had recognised that, perhaps, whilst not all of their
15 referral criteria were satisfied, this was a risky
16 enough case that somebody needed to pick up.

17 The question and it is a difficult one is how has
18 that culture been created?

19 **PROFESSOR SIZOO:** Well, it is an interesting question as
20 well. I think it starts with the desire to solve
21 a problem together. There is a word for that in the
22 Netherlands and we call it "boulderen". It's a verb.

23 And boulder is -- I mean, Holland is built by
24 bouldering, by enclosing the sea and pumping out the
25 water and making land available for agriculture. So

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1 this mentality of working together to solve a problem is
2 sort of engrained in the society. And I think this is
3 a very, very important aspect of the success of these
4 Care and Safety Houses.

5 However, they are not foolproof. I gave the example
6 of the attack by the -- the incel attack two years ago
7 in Rotterdam, where a young man unfortunately killed
8 three people and had a self proclaimed neurodiversity
9 problem. In this case the inquiry showed that indeed,
10 as you said, the different agencies had closed their
11 case, pressured by time constraints and personal
12 constraints and that is a factor we haven't discussed,
13 but it is of course the fact of reality that we can't
14 solve all the problems. Now the recommendation was to
15 hang on a little bit longer and to get the overall
16 picture because nobody asked the question, who is this
17 guy?

18 **MR JAMIESON:** One of the reasons why agencies may be anxious
19 to close cases and move on is because in the
20 21st Century all are operating under limited resources,
21 all have many cases to deal with. How do we overcome
22 that feature, that driver, and end up where agencies are
23 willing to recognise that these are risky cases and for
24 somebody to pick them up? Mr Diamond?

25 **MR DIAMOND:** Can I give that some more thought please?

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1 I need to absorb what you just asked.

2 **MR JAMIESON:** Certainly. Ms Canning?

3 **MS CANNING:** I think there are -- and I think it is what

4 I said before -- that resources are limited and

5 unfortunately agencies will have to operate within that.

6 So, for example, within the probation service, when

7 someone comes to the end of a sentence, we have to close

8 the case because we are not able to work with them

9 because the court has deemed that they are no longer

10 serving a sentence.

11 **MR JAMIESON:** May I just pick you up on that. So a case

12 where it has been accepted under one of MAPPA's

13 automatic categories because they are serving a sentence

14 or notification requirements, whatever it may be; that

15 comes to an end, but the view is still that there is

16 a risk, would that not be taken on as a discretionary

17 case?

18 **MS CANNING:** We don't have any powers to supervise that

19 person.

20 **MR JAMIESON:** So what would be done with the risk?

21 **MS CANNING:** So what we would expect, certainly under MAPPA,

22 is that there is a final sort of -- if we are looking at

23 somebody who is being managed at Levels 2 and 3 but even

24 at Level 1, we expect to do what we call a termination

25 risk assessment and so then we would look to try and

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1 **MR JAMIESON:** Dr Martin, do you have an insight as to how

2 I daresay agencies may be more Dutch and have this

3 desire to solve problems together?

4 **DR MARTING:** I think if we hold in mind what we know about

5 organisational trauma, then we need to understand that

6 that level of disintegration is inevitable with

7 services, and actually the patterns that we see both of

8 repeated referrals to different agencies, which we often

9 see when a single agency is under threat, it is --

10 **MR JAMIESON:** So that in itself, referrals out, that is

11 a sign that an agency is under threat --

12 **DR MARTING:** Yes because people are saying, "I can't

13 tolerate this risk, I want other people to take the

14 responsibility for it." That is a sign of the

15 organisation becoming traumatised; we will see these

16 multiple referrals to multiple agencies.

17 Then, the other side of that, is we often see

18 agencies saying, "It is not for us," or passing that

19 around. The difficulty with that is that -- it is

20 understandable -- but it means that we are left in the

21 situation where there isn't that shared responsibility.

22 I think some of what we need comes back to points

23 that my colleagues have already made: how do we consider

24 as agencies together what our individual roles are? And

25 what we would advocate for is that multi-agency approach

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1 mitigate that risk. But that would quite often be

2 a question of passing that on. Quite often the police

3 pick those cases up because their sentence has come to

4 an end. But that is a real concern.

5 There may be -- I don't want to speak for the

6 police, but there are -- if they continue to be subject

7 to notification requirements, do we need to think about

8 a civil order that might manage that risk? But there

9 is -- where agencies don't have legal powers to continue

10 to manage those individuals -- and at the moment you

11 will know certainly with probation's caseload and the

12 prisons being full and probation having to manage more

13 individuals, it is a concern.

14 But in terms of how MAPPA work, one of the things

15 that we do expect, certainly with Level 2 and 3 cases,

16 is that we talk about standing membership and there is

17 standing membership which is -- which would comprise

18 police, probation, social care, mental health, where we

19 do expect people from those agencies to attend every

20 meeting. And it may be that their insight or

21 something -- they may not necessarily be able to hold

22 the risk -- but that information -- bringing that

23 information together, we do know that having that

24 standing membership is really important to try and pick

25 some of that up. It isn't straightforward.

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1 which allows us to think about again the needs of the

2 child and the system around that child.

3 Sometimes services -- those referrals go to services

4 who don't have a role and it is right that they should

5 close the case, but that can happen within the context

6 of a collective discussion and a shared understanding of

7 which services are required and when and which services

8 aren't. So it is not about saying all of those services

9 need to remain involved indefinitely.

10 I think, again, the use of that kind of multi-agency

11 understanding the story formulation can also help people

12 to stay connected to understand why their service may or

13 may not need to be involved and at what the time. And

14 I think from what we have discussed today and holding

15 onto -- it is the principles of working both from our

16 perspective, from (unclear) care, but similar to some of

17 the principles that my colleagues have discussed, there

18 is something about working together to increase

19 workforce capacity and tolerance of risk that will help

20 people to move to that more Dutch position, where we can

21 work together for a collective agreement and

22 strengthened coordination of risk.

23 I guess one other point we were thinking about, the

24 question that you posed there to Ms Canning about what

25 happens at the end. So to think about the same thing

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1 happens at the end of a youth justice order, there are
2 opportunities for children to remain involved
3 voluntarily, but, equally, we need to think about exit
4 planning and again understanding, from the formulation
5 perspective, what the ongoing needs are for that child
6 and that family, is an important part. It matches what
7 we do when they are open to the services.

8 So that may involve thinking about who else is there
9 to meet those needs of the child on an ongoing basis.
10 For example, if that's around the support that we talked
11 about to parents; is that about bringing early
12 intervention from our social care colleagues on board,
13 as youth justice step back, that early intervention
14 might step in or similar to other voluntary sector or
15 community organisations that might meet some of those
16 needs.

17 **MR JAMIESON:** Thank you. Mr Diamond, you have had some
18 time.

19 **MR DIAMOND:** I have. It appears to be here there is clearly
20 an issue between ongoing accountability, capacity and
21 an appetite to hold that space when there's no, I guess,
22 statutory duty or licence to do that.

23 I'm sort of racking my brain. Obviously, you know
24 from everything that I have said today about the VRU,
25 that we are not in the thick of it with this level and

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1 **MR JAMIESON:** And could refer back in if the risk came back
2 up again?

3 **MR DIAMOND:** Potentially. Absolutely. Yes.

4 **MR JAMIESON:** Thank you. I'm going to come to my final
5 question, if I may. Again, Professor Sizoo may I start
6 with you and with the language that you have used.

7 You told us about the balance of safety and care in
8 the Care and Safety House and how it started off as just
9 a safety house.

10 One of the features of this case, perhaps, at
11 Phase 1, was people looking at AR in terms of what he
12 needed and what his requirements were and not
13 recognising the risk that he posed to other people.

14 How, in the Netherlands, do you ensure that both
15 sides of that, care and safety, are balanced and given
16 their due weight?

17 **PROFESSOR SIZOO:** I think the simple answer is if the case
18 is being discussed in a Care and Safety House, both
19 perspectives are present. So, whereas, for example,
20 a clinician will say, well, his needs are that he needs
21 a house and he needs a job and he needs comfort and
22 tender loving care; the police officer present might
23 say, well, this might all well be, but I'm afraid he is
24 going to commit a crime.

25 **MR JAMIESON:** It is built into the structure?

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1 the type of casework that has been discussed by my three
2 colleagues --

3 **MR JAMIESON:** What I was interested in was the concept of
4 pragmatism that you have told us about that you have.

5 **MR DIAMOND:** I was just thinking about then about -- we
6 commission, as you know, a number of community groups
7 and we worked with some very specialised ones.
8 Individuals who they themselves have been in prison,
9 have served lengthy sentences, have been involved in
10 crime, who actually really get it and understand. We
11 have got information sharing agreements with the police,
12 with these individuals, we are not rolling the dice or
13 anything. And we have seen some incredibly skilful, and
14 an absolute clear reduction in risk and potentially the
15 prevention of further death because of the intervention
16 of some of these community organisations.

17 So whilst it won't wash to simply say, we are going
18 to hand them over to this organisation; what we do know
19 is there is something in the community that has the
20 power, the credibility and the influence to work with
21 some people who are no longer, if you like, subject to
22 the rigours of the State agent, and actually are in
23 a much more informal but no less effective, in fact,
24 arguably more effective relationship with some of those
25 people. So I think there is something in there.

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1 **PROFESSOR SIZOO:** Exactly. Yes. The risk is that -- this
2 is a risk everywhere, that if a decision is made at
3 a very early stage that this is a typical example of
4 radicalisation or potential extremism, that it will be
5 tunnelled towards a safety domain management, where
6 there is too little knowledge of the care aspect. And,
7 vice versa, if something is considered to be a mental
8 health case, just paraphrasing what's being said, that
9 somebody will end up in a closed psychiatry unit where
10 there is no sensitivity for what he is saying and he is
11 in fact very radicalised.

12 So it is a continuous problem and it involves
13 informing each other and hopefully professionalising the
14 Care and Safety Houses even further.

15 **MR JAMIESON:** So taking all of those perspectives?

16 **PROFESSOR SIZOO:** Absolutely. These are not the only two
17 perspectives. There are more perspectives of course.
18 That's why the system designed by Kate Barrelle of the
19 holistic interpretation, it sounds a bit wishy washy,
20 but the holistic approach is very useful, looking at all
21 these aspects.

22 **MR JAMIESON:** Rather than coming to everybody, thank you,
23 I will ask if anybody else wants to add anything to --

24 **DR MARTING:** Can I just add that this is one of those
25 dichotomous positions, is this dangerous or vulnerable?

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1 It is not a neither or --

2 **MR JAMIESON:** Two sides of the same coin?

3 **DR MARTING:** Absolutely and being child centred and keeping

4 the child's voice at the centre of things shouldn't and

5 doesn't negate the needs of victims. Actually, it can

6 help us to better understand the thoughts and the

7 motivations of that individual, which actually in itself

8 can then be useful to risk management planning.

9 **MR JAMIESON:** Thank you. Anybody else? No. Yes,

10 Ms Canning?

11 **MS CANNING:** I think the structure for MAPPA is there under

12 the four pillars, which talks about the supervision and

13 intervention and also the monitoring and the protection

14 of victims, that obviously the structures won't stop, or

15 the kind of organisational issues that Dr Martin talked

16 about so eloquently, but the structures are in place to

17 have that balance of the care and control.

18 **MR JAMIESON:** Thank you. Anything? No.

19 Sir, may I ask you -- those are all of my questions,

20 may I ask if there's anything that arises out of the

21 questions that I have asked?

22 **SIR ADRIAN FULFORD:** Nothing else from me. Thank you very

23 much.

24 My sincere thanks to all four of you. It has been

25 an incredibly useful day and I'm very grateful that you

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1 have taken the time and the trouble to prepare and to

2 come for what has, I imagine for each of you, been quite

3 an exhausting session. Thank you very much indeed.

4 Mr Jamieson, I think we next meet on Tuesday at

5 10 o'clock. Thank you all very much. I will rise.

6 **MR JAMIESON:** We do, sir.

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

8 **(4.00 pm)**

9 **(The Inquiry adjourned until 10.00 am on Tuesday,**

10 **15 September 2026)**

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