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Dear Mr Knight,

Re: Request for Further Information Following Seminar One Evidence: Screening and Triage Approaches - your letter of 11 September 2026

Thank you for your letter and for the opportunity to expand on some of the points I made at the seminar. The views are my own personal views and arise from my experience of national counter-terrorism clinical consultancy casework, previous publications in the field of forensic psychiatry, MAPPA and public figure threat assessment and more recently our research collaboration at the CCS with UCL Dept. of Crime Science.

I am not writing on behalf of the Clinical Consultancy Service, North London NHS Foundation Trust or Counter Terrorism Policing. I understand that this letter will be disclosed to Core Participants.

Assessments, SPJs and Screening tools

Before answering the specific questions, there are a few general points which I think are important to emphasise, albeit the Inquiry team are no doubt familiar with this territory.

Forensic psychiatry/mental health assessments and SPJs

The gold standard for assessing violence risk in adult forensic mental health settings is the combination of the two SPJs, the HCR20 (Historical Clinical Risk) and the SAPROF (Structured Assessment of Protective Factors). These SPJ assessments are typically completed on in-patients. They require a full forensic psychiatric assessment comprising a thorough review of medical and criminal records, multiple psychiatric interviews, multiple interviews by a clinical psychologist and a multi-

disciplinary assessment and discussion which includes nursing, social work and occupational therapy input. The HCR20 and SAPROF would supplement forensic psychiatric reports and clinical psychology assessments which would include a personality assessment and a psychopathy checklist (PCL-R) and where appropriate a full ASD assessment. It is a piece work that requires several weeks and the input of senior specialist clinicians measured in multiple days rather than hours.

In an outpatient setting a young adult referred for a forensic assessment by adult mental health services to forensic services in the context of concerns about potential violent behaviour (short of actual criminal proceedings) in the context of suspected mental disorder/neurodivergence it is unlikely that a full SPJ would be conducted. What would be more common practice would be a single clinician assessment by a forensic psychiatrist comprising a full interview of at least an hour, limited social enquiry and a thorough review of the available records both criminal and medical. In a case of suspected ASD this may be supplemented by a full single clinician ASD assessment. The output would be a detailed forensic psychiatric report which would provide a diagnosis, differential diagnosis, clinical formulation and a consideration of violence risk factors and management recommendations which would fall short of a full SPJ violence risk assessment. The resources involved would amount to, conservatively, a full day of a senior clinicians' time. The ASD assessment would be a further two full days of an ASD specialists time.

In other words, SPJs are very resource intensive.

I am not experienced in forensic CAMHS but the SAVRY is the equivalent SPJ. In-patient admissions are much more infrequently used in FCAMHS settings and I defer to FCAMHS experts on the frequency and resources required for provision of the SAVRY in addition to a forensic CAMHS clinical assessment in an outpatient setting.

Screening, triage and 'action checklists'

It is an important point to note that a screening tool needs to act upon immediately gatherable information, and at the point of referral, information is much more limited than at a SPJ stage.

It is important also to note that there is a difference between screening tools, triage tools and action checklists albeit some tools use a combination of two or three of those elements in combination.

A screening process is intended to identify concern and decide what should happen next. It may identify factors which mean a case should be looked at quickly. It may also help decide whether the case can be dealt with by one service, needs several agencies involved, or needs a more detailed assessment. It is not the same thing as a

structured professional judgement assessment. In particular, it cannot tell us which individual person will go on to commit serious violence. The limitations of risk prediction in this area are well known.

For that reason, I think a big front-door screening tool should be designed so that it does not miss concerning cases. In statistical terms, it should favour sensitivity over specificity. In other words, it is probably better at the first stage to include some people who later turn out not to be high concern than to screen out somebody who actually needed a closer look. The false positives can then be sorted out at the next stage, using fuller information and, where appropriate, downstream an SPJ assessment.

Regarding the terminology used here, sensitivity means the proportion of actual cases which a tool manages to identify. Specificity is the proportion of people without the outcome who are correctly screened out. Positive predictive value is slightly different. It asks: of all the people who test positive or are screened in, how many really are true cases?

This matters particularly when the adverse outcome event one is looking to screen for and ultimately to prevent is rare. Even a very good screening tool will produce a lot of false positives if the underlying event is uncommon. To put rough numbers on this: suppose one referral in every fifty would otherwise go on to commit an act of violence - at least an assault (knife attacks and mass-casualty attacks are of course much rarer still). A tool which correctly identifies 99 per cent of true cases and correctly screens out 90 per cent of the rest would, in 1,000 referrals, pick up nearly all of the 20 true cases, but would also flag around 100 others. Only about one positive in six would be a true positive: roughly five false positives for every true case. That is the unavoidable arithmetic of screening for events of this kind, and it is why the handling of the false positives matters as much as the screen itself. I think this illustrates why the purpose of the screen should be routing and action based, not prediction.

The comparison I made at the seminar was with safety systems in medicine and aviation. The most successful examples are often not prediction tools at all. They are short 'action checklists' which make sure that sensible actions which are already known to reduce risk have actually been done. I think that is probably the more useful model for a VFI/NIEV front door.

Screening, triage and action checklists

There is a three-way distinction which I explore in more detail under 2(a) below. Screening is case finding: asking whether a referral raises concern at all and whether further assessment is needed, as in population screening programmes such as cervical screening. Triage is prioritisation: sorting the cases of concern by urgency

and nature so that limited resources go to the right cases in the right order, as with the Ottawa rules on who needs an ankle X-ray (see below). Action checklists, such as aviation pre-flight and WHO pre-surgical action checklists, do a third job: they do not detect or sort cases at all, but make sure that the actions already known to reduce risk have actually been taken.

A front-door instrument for VFI/NIEVs would in practice, in my opinion, need elements of all three - case finding, prioritisation and routing, and 'have the essential actions been taken' items - which is one reason why no existing tool can simply be taken off the shelf.

A single screening-triage instrument may be able to do all this if the door is narrowly drawn, but the wider the big front door, the stronger the case for separating the stages into screening and triage/action checklist rather than all three together.

1. Which professional groups or agencies would be best placed to undertake the screening process and make referral decisions?

Screening, I suggest, would be best undertaken by a local multi-agency panel, not by any single agency. I suggest that a useful framework to consider would parallel the structure of Multi-Agency Public Protection arrangements i.e., aligned to the 43 police force areas in England and with alignment to the 12 BCUs in London. On that basis I suggest regional VFI/NIEV 'big front door' 'panels' could have a core membership of key stakeholders whose own agencies would be responsible for delivering interventions downstream of the screening process. Panels could include: local policing (with a counter-terrorism policing link), children's and adults' social care, education and health, including CAMHS, with links to FCAMHS.

I have extensive experience with MAPPA having been involved with developing early guidance for police and subsequently guidance for mental health professionals and almost twenty years on the London MAPPA Strategic Management Board. I have only limited experience of MASH so I am not in a position to comment on the advantages or otherwise of that model.

There are a number of features of MAPPA which could, in my opinion, be usefully applied to a VFI/NIEV big front door including that MAPPA was on a statutory footing from the outset with subsequent legislation refining the concept for example the 'duty to cooperate' principle. MAPPA was, as stated, 'arrangements' put in place by existing agencies to improve communication about cases meeting the criteria.

With regard to resources, it is worth noting that MAPPA, as I understand it, was incorporated into the existing workload and resources of the core agencies (Police and HMPPS and latterly the 'duty to cooperate' agencies). In other words, it was a

set of 'arrangements' not a new agency with its own funding, albeit police and probation staffing had to be re-deployed to form the jigsaw teams. In mental health, MAPPA work was gradually incorporated into the function and job plans of, for example social workers and psychiatrists in forensic services. The point I am making is that a system of big front door regional panels need not necessarily require very expensive resources, but it would require existing stakeholder agencies to allocate staff time by an adaptation of job plans (to attend a monthly meeting and deal with recording information, doing screening assessments and correspondence etc.)

MAPPA itself would, as has been discussed, not be suitable as the front door because the entry criteria are too restricted. It could, however, be one of the downstream routes for an individual with a qualifying conviction or MAPPA category 3 status.

The people actually completing a screening tool should, in my view, usually be trained frontline professionals rather than scarce specialists. If the tool is properly designed, it should be possible for an experienced police officer, social worker or senior CAMHS practitioner to complete it to a reasonable common standard. A system which requires a consultant psychiatrist to perform the initial screening of every case will simply not be workable at national scale.

Existing pathways into Prevent, criminal justice, adult mental health, CAMHS, social services and other services could (depending on decisions about the size and positioning of the big front door) continue alongside the new arrangement. In my opinion the front door should not be placed in front of them. I would see its role mainly as providing a safety net for cases which do not fit existing thresholds, and perhaps also providing some tracking of cases which are moving through existing services but remain of concern. Specialist forensic mental health advice and specialist counter-terrorism policing advice should sit behind the initial screen and be available when needed.

As has been discussed every case would need one named person from the big front door panel, responsible for it from the time the referral is received. Otherwise, there is a real risk of everybody assuming that somebody else is dealing with it. There also needs to be cover when people are on leave. One useful feature of a MAPPA-type system is that the case sits on a common list and comes back to each monthly meeting. If the usual representative is absent, somebody else can step in to ask for an update. The case is less likely simply to disappear because one member of staff is away.

Consistency between different regions would need to be supported by common training, written guidance, some peer review of decisions and audit of what eventually happened to the referrals and in the long term evidence based outcome research.

I think this kind of parallel system also helps with a concern raised by RUSI and others about the risk of unnecessarily securitising children or young adults, particularly those who are neurodivergent or have mental health problems. A young person who does not have a counter-terrorism nexus should be able to receive help without automatically acquiring a counter-terrorism label (Wallner, 2025).

This would also help with the problem of CTP/Prevent resources silting up with non-ideological referrals.

2(a). What sort of tools or assessment should be used at the triage screening stage?

Before answering this question it may help to be clear about the difference between screening and triage, because the two words are often used together but they do different jobs. Screening is case-finding. It is applied to everything coming through the door and asks whether this is a case of concern at all, whether further assessment is needed, and whether the essential checks with the other agencies have actually been completed. Triage is prioritisation: sorting the cases of concern by urgency and nature so that limited resources are matched to cases in priority order. The design consequences are different. Sensitivity, and the false-positive arithmetic described above, belong to the screen. Timescale standards and matching to service capacity belong to the triage step.

Whether the two functions need separate tools depends largely on how wide the front door is. If the door is scoped to the VFI/NIEV population, as this letter proposes, a single combined screening and triage instrument is feasible: one brief tool which establishes the nature and urgency of the concern, checks that the essential steps have been taken, decides whether further assessment is required, and helps route the case. If the door were drawn much wider, the population becomes far more heterogeneous and there is a stronger argument for a two-stage design - a common initial screen for every referral, followed by more specialist triage of the VFI/NIEV extreme-violence stream. I will return to the width question at 2(d) below.

A full structured professional judgement assessment would not be practical at the screening stage. There are likely to be too many referrals, decisions need to be made fairly quickly, and an SPJ usually assumes that much more information is available, often including direct assessment of the person (as described above). At referral, that information frequently will not exist.

I think what is needed is something much shorter, based more on screening, triage and 'action checklist' principles. Probably no more than seven to nine behaviour-based items at each stage or "pause point". For example, one part might deal with behaviour, another with mindset, another with family and social circumstances,

another with education, and another with red flags. I do not think the exact structure can be settled without further discussion, piloting and testing.

The important point is that the tool should be capable of being completed from the information which is actually available at referral. It should also be possible for a trained non-specialist to use it reasonably quickly. There should be a small number of red flags which trigger urgent escalation whatever the rest of the screen shows.

During the seminar I did not have time to explore the use of checklists that have been shown to improve outcomes in other areas of healthcare. There are quite good precedents in medicine for each of the three types of tools described above.

Screening tools

The clearest examples are the national population screening programmes, such as cervical screening: a deliberately sensitive test applied widely in order to pick up possible cases, with more definitive assessment downstream for those who screen positive.

NEWS2, which is used throughout the NHS, is a good example. Nursing and other clinical staff record a number of routine physiological observations (pulse, BP etc.) which produce an early warning score. Once that score reaches a particular level there is an expectation that the patient is escalated for further review. A non-specialist clinician can of course still exercise judgement, but the system is there partly to stop a deteriorating patient being missed because somebody was falsely reassured by their general impression. NEWS2 (Royal College of Physicians, 2017) scores six physiological parameters plus one weighting, each on 0–3: Respiration rate (breaths/min); Oxygen saturation; Supplemental oxygen; Systolic blood pressure; Pulse rate; Level of consciousness; Temperature. The aggregate runs 0–20, and the response is mandated by threshold: 0–4 routine ward monitoring; 5–6 urgent clinical review (e.g., because the changes in physiology might be a harbinger of, for example, undetected sepsis); 7 or more emergency assessment by a critical-care-competent team. Crucially, there is also a single-parameter trigger: a score of 3 on any one parameter — a "red score" on the colour-coded chart — mandates urgent review. This would be similar to any red flag risk factor on a VFI/NIEV screening tool.

Triage tools

The Ottawa Ankle Rules, for example, use a small number of findings from the history and examination to help decide which patients with an ankle injury actually need an x-ray. They are designed to be very sensitive, because the important thing at that stage is not to miss the significant injury even though it will mean that there will be many normal X rays because of false positives. The Ottawa rules are also

straightforward enough to be used by clinicians who are not specialists in orthopaedics e.g., A & E triage nursing staff.

The same broad principle applies to head injuries. The Canadian CT Head Rule in adults, and PECARN in children, use a relatively short list of clinical features to identify who is more likely to need imaging and, just as importantly, who can safely avoid it. These rules were developed by looking at very large numbers of actual cases rather than simply relying on expert opinion.

There are other examples. The HEART score is used with patients presenting with chest pain and helps clinicians decide fairly quickly who may be suitable for discharge, who needs further observation and who requires more urgent investigation or treatment. I think that is quite a useful analogy here. It is really a routing device. It is not attempting to predict exactly what will happen to a particular patient.

Action checklists

Action checklists are different in kind: they do not find or sort cases at all. I briefly mentioned the WHO Surgical Safety (action) checklist, developed by Atul Gawande and colleagues. It is deliberately very simple and takes only a few minutes. It makes sure that some basic but important things which are already known to reduce harm have actually been checked: is this the right patient, are we operating on the right site, have antibiotics been given where needed, and has the team discussed any particular problems they are expecting? When the (action) checklist was first tested across eight hospitals internationally, both deaths and major complications fell substantially (Haynes et al., 2009).

None of these medical tools can tell us with certainty what is going to happen to one patient. That is not what they are designed for. What they do quite well is make the next step more consistent. Some patients can safely remain on a routine pathway. Others need somebody more experienced to take a closer look. That is broadly how I see a front-door tool working here. It should not try to predict who will become violent. It should do something more modest: identify which cases need further assessment and make sure they get there reasonably quickly.

For the narrower VFI/NIEV front door proposed in this letter, I think the practical answer is that a single brief instrument would need to combine all three functions: screening items which find the cases of possible concern in the first place; triage rules, including the red flags, which sort those cases by urgency and route them; and action-checklist items which make sure that the essential steps - in particular the checks with the other agencies who hold pieces of the picture - have actually been completed. The three functions are conceptually distinct, but for a door of this size I think they can sit within one short tool.

There are some precedents closer to the forensic mental health and criminology field.

T1E

At the seminar, I briefly mentioned from my own experience at FTAC, T2D

T2D

T2D who may present the risk. Even so, I think some of the principles are relevant.

T1B

I appreciate that some of the detail around these two examples may be sensitive.

There is of course no validated 'off-the-shelf' instrument that currently exists specifically for the VFI/NIEV or fascination-with-extreme-violence and mass casualty attack population, although, as set out below, the AREVA suite now includes a consultation-version triage aid which is directly relevant. A VFI/NIEV screening tool would therefore have to be purpose-built, initially as a pilot, and then tested and altered in the light of what was found, albeit there is a substantial opportunity to link it to aspects of the AREVA.

It must be noted that the AREVA goes beyond the SAVRY in that it is designed specifically as an SPJ (with associated triage tool) for ideological/extremist violence and not general interpersonal violence.

Downstream SPJ

There is another issue which I think is worth considering, which is continuity between screening and later assessment. The new structured instrument for assessing extremist violence risk in adolescents, AREVA-CV (Borum, Logan, Hart and Pyszora, 2026), is currently in beta consultation form. It is not a screening tool. It is intended for the fuller, second-stage assessment. It covers areas including behaviour, mindset, social and relational factors, individual factors and development. It also looks at resilience as well as risk, and allows the assessor to say that there is insufficient information to rate a particular item. Although the instrument has not yet been validated, I think it would make sense for any new

screening tool to use broadly compatible domains where possible. For example, the proposed VFI/NIEV screen might include weapon preoccupation and access, engagement with violent or extremist material, major stressful disruption, loss of status or significance, and social disconnection. That way, if somebody screens positive and goes on to a fuller AREVA-type assessment, some of the information is already organised in a familiar way. The more immediate warning behaviours, such as threats, leakage, attack-related research and rehearsal, would in my view still need to sit prominently in the screening tool and particularly among the red flags.

Since attending the seminar on 8th September I have been able to review the triage component of the same suite, the AREVA-Triage (Consultation Version). This is a brief decision aid for prioritising cases that may require immediate action or further assessment. It has six domains, each rated present, absent or unclear: grievance; violent preoccupation and identification, including glorification of previous attackers and 'legacy' or notoriety thinking; ideation and communication, which includes leakage as well as direct threats; indicators of intent, covering attack-related research, planning and acquisition together with markers of imminence such as last-resort thinking, finalisation behaviours and recent acceleration; weapon preoccupation, access and capability; and moderating or resilience indicators. The evaluator then assigns a priority of high, moderate or low and records a short narrative and plan. It therefore covers proximal factors, and its 'unclear' rating usefully reflects the information-sufficiency point made at 2(b) below.

It is, however, a prioritisation aid for a case already in front of a trained evaluator rather than a case-finding screen: it assumes familiarity with the AREVA-CV manual, it is framed for adolescents and extremist violence, and it does not include the contextual and developmental items, the 'have the essential checks been done' items, or the routing and escalation rules which a front-door instrument would need. Nor has it yet been validated. My view is that it complements rather than replaces the proposed front-door screen.

Further work needs to be done on the extent to which a VFI/NIEV screening/triage tool could link to items in the AREVA-CV and AREVA-Triage.

One possible source of data for examining these issues and for developing such a tool would be the forthcoming cluster analysis of the CCS cohort of approximately 170 FEVMCA cases. A pilot tool could also potentially be tested against the wider Clinical Consultancy Service national caseload, which now includes more than 1,500 clinically screened referrals.

We, namely the CCS and UCL research collaboration led by Professor Paul Gill and Dr Caitlin Clemmow are also planning to examine the beta version of AREVA against the CCS sample in a study proposed and led by Dr Clemmow. That work may also be useful in developing the screening instrument.

If the Inquiry thought it appropriate and helpful, I it would be possible to bring together a small vetted working group involving CCS, UCL, Counter Terrorism Policing and independent clinical and academic expertise, including links with the AREVA team. A first pilot version VFI/NIEV screening/triage/action checklist could probably be produced over a period of a few months rather than years, although proper validation would obviously take longer. I address this further below.

2(b). The factors to be considered when determining whether further assessment is required

I think the factors should mainly be dynamic and relate to actual behaviour, changes in mindset and the person's circumstances. The existing literature does not give us one reliable profile of the lone actor who goes on to grievance-fuelled violence. For violence-fixated individuals, there may not even be a clear grievance. In some cases the driver may be notoriety, fascination with previous attackers, or personal motives which are difficult to understand from the outside.

I would probably group the screening factors into several areas. The first would be warning behaviours which can actually be observed at referral. This would include pathway behaviour such as researching an attack, planning, preparation and acquiring weapons. There may also be information about the person's mindset, although at screening stage this is usually indirect because the person has not yet been interviewed. It may come from something said to a teacher, parent, police officer or social worker. Examples might include curiosity about violence, an unwanted or ego-dystonic obsessional interest, a more persistent fascination, or what clinicians would usually call fixation, where a preoccupation begins to dominate the person's thinking and functioning.

The second group would be contextual factors which change the level of concern. These include age and developmental stage, known or suspected neurodevelopmental conditions, mental disorder, whether the behaviour is escalating across different settings or over time, recent events such as loss, humiliation or exclusion from school, and access to weapons.

A third area is protective factors. Is the person engaging with services? Are family members involved? Are they still in education? Are those supports strengthening or beginning to fall away?

The fourth area is simply whether there is enough information to make a safe decision. A case should not be screened out because one agency happens to hold

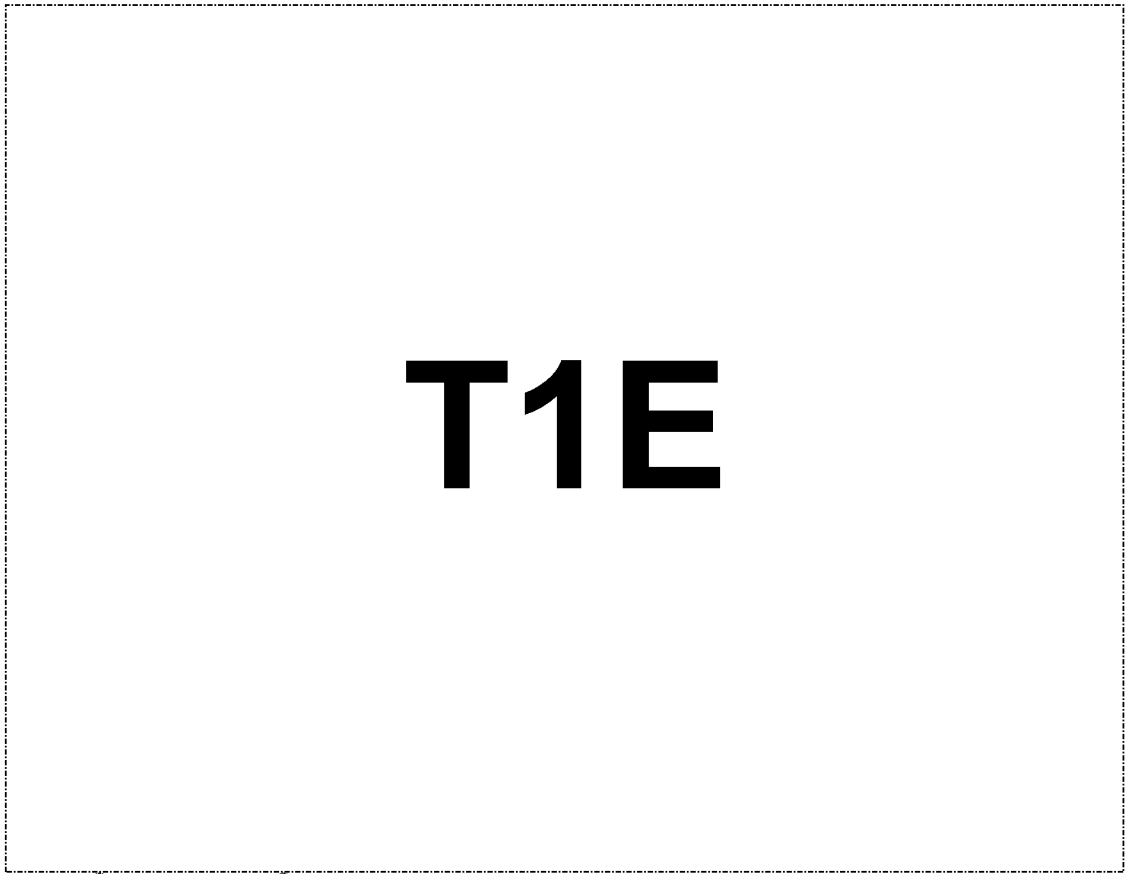
only a small fragment of the picture. "Further information required" may therefore need to be an actual screening outcome.

Another issue which comes up in CCS work is disagreement between professionals which has been in my experience associated with elevated risk. If one agency thinks somebody is high concern and another thinks the same person presents little or no concern, that disagreement is itself worth noticing. It may indicate that different agencies hold different information, or are interpreting the same behaviour in very different ways.

Finally, there are the red flags, which I deal with below.

2(c). Red flags that should automatically trigger more detailed or urgent assessment

Yes - and in my view the red flags are the most important element. The set should be short and easily identified.



This list would need to be refined but any red flag could, I suggest, mandate same-day escalation to territorial policing and, where a mental health contribution is

suspected, urgent clinical advice through a pre-established escalation pathway - regardless of how the remainder of the screen scores (see below).

Two issues must be noted about the red-flag set.

The absence of a red flag is not reassurance - in the comparative research, direct threats do not discriminate attackers from others, and most attackers never threaten their targets (Meloy et al., 2014).

And the red-flag list must be reviewed against outcomes, so that the screening tool can be iterative and refinable. (An example from medicine is that for NEWS version 2, new onset confusion was added as a scoring item as a result of research on medical outcomes).

Adult and CAMHS forensic MH escalation pathways

The VFI/NIEV cohort need, in my opinion, a pre-agreed escalation pathway with local forensic CAMHS and forensic adult MH services.

Adult and CAMHS services could for example be required (ideally by a statutory responsibility) to provide an urgent single point of contact for same-day referrals from the VFI/NIEV panels.

As an aside in my experience in MAPPA, FTAC and CCS settings, achieving urgent escalation for risky cases in adult and forensic is hugely problematic for reasons which are covered in a paper from FTAC work (Wilson et al., 2019). Problems include out of date websites, lacking of genuinely Single Points of Access, fragmentation of mental health services into small local silos e.g., home treatment team's vs early onset psychosis vs primary care mental health and postcode lottery of thresholds and available services. In my experience in the highest concern cases (a handful each year in FTAC and the CCS) an urgent escalation response is only secured after escalation to senior service leads, clinical directors board level management e.g., medical directors.

2(d). Balancing prompt triage, identification of complex cases, and potential extremist concern

I think the easiest way of thinking about the screen is as having three possible routes rather than simply "positive" and "negative". Some cases will clearly need urgent action. Some will clearly be suitable for a routine service. The difficult group is in the middle. These may be younger people, people with mental ill health or neurodevelopmental conditions, cases where the available information is incomplete, or cases which simply do not fit comfortably into one service's usual criteria.

Those cases should not be pushed artificially into either the urgent or the routine category. They should go to multi-agency discussion and, if necessary, to a fuller formulation-based assessment. In my experience it is often the shared formulation which eventually helps separate vulnerability and need from genuine threat in these difficult cases. That cannot always be done quickly. The purpose of the screen is therefore partly to protect the time needed for those more difficult cases by moving the straightforward cases on more quickly.

The question of possible extremism is slightly separate. I do not think a front-door system should interfere with the existing route into Prevent. If a professional already believes that somebody may be being drawn into terrorism, they should continue to refer directly to Prevent. Nothing about the front door should delay that.

The screening tool should nevertheless include explicit questions about ideological material and any possible terrorism nexus. If that emerges during screening, the case should move immediately into the Prevent or counter-terrorism pathway. Where there is also concern about mental health or neurodevelopmental issues in cases in the CTP space, CCS advice could then be sought through Counter Terrorism Policing in the usual way.

The system should also work in the other direction. Prevent, police, mental health services or other agencies should be able to send into the front door cases which do not quite meet their own thresholds but which they remain worried about. Equally, the front door should be able to send a case back into those specialist routes as soon as the relevant threshold is reached.

The schematic at Annex A shows how I think this might work. The important point is that the front door would not replace existing pathways and should not slow them down. Its main value would be in dealing with the cases which currently sit between services and for which nobody has a particularly good answer.

In my opinion the big front door panels could record VFI/NIEV cases that have gone into mainstream routes but this would require some form of notification i.e., a case that goes into Prevent should be notified to the local big front door panel for recording purposes. If the case were then subsequently excluded from Prevent after information sharing and Prevent section 36 considerations, then the case could be re-referred to the big front door panel. I suggest that it would be onerous and impractical for the big front door panel to track all outcomes and for example, 'accepted by Prevent' would be a reasonable final outcome for the panel.

There is a related policy question which is how big is this big front door? The term has been used to mean anything from a gateway for the VFI/NIEV population alone through to a much wider single front door sitting upstream of Prevent, MAPPA and social care. This letter assumes the narrower version: a VFI/NIEV door running

alongside the existing pathways, which continue unchanged. The design principles described here - sensitivity at the gateway, a small red-flag set with same-day action, a named case holder, notification and tracking, and routing discipline - would hold at any width. What changes with width of the front door is the arithmetic of screening vs triage and the necessary framework and structure of big front door panels. The wider the aperture, the lower the base rate of true cases, so the false-positive burden and the case volumes rise sharply; and a single instrument becomes harder to design for a heterogeneous population, which points to the two-stage design described at 2(a).

The width of the aperture is a policy decision which as I understand it has not yet been settled.

The schematic at Annex A illustrates the model this letter proposes: the narrower door working alongside existing pathways, and a short note beneath it describes how different a much wider front door would look. The definitional work described under Terminology below - an enumerated inclusion and exclusion list - is in practice part of the mechanism by which the width of the door might be settled.

3. The options as a result of screening/triage

I think there are probably five main outcomes.

The first is urgent escalation because of red flags. That would mean immediate referral to territorial policing, or to counter-terrorism policing where appropriate, with urgent referral through CAMHS/FCAMHS, adult / forensic mental health on pre-established fast track escalation pathways (with agreed single points of contact and senior staff for escalation) for clinical advice where needed.

The second is referral to Prevent where there is concern that the person is being drawn into terrorism. The existing process would remain unchanged. If there is also a suspected mental health or neurodevelopmental contribution, CCS input could be sought through the normal CTP route.

The third is referral to one ordinary service where one need is fairly clearly predominant. This might be children's or adults' social care, CAMHS, adult mental health services, or education-based support.

The fourth is that the VFI/NIEV panel retains the case for a period because it remains genuinely complex. This might apply where there are several overlapping needs, poor engagement, incomplete information or continuing uncertainty. Those cases might be reviewed monthly using something broadly similar to a MAPPA structure.

The fifth outcome is no further action, with appropriate signposting. A sensitive front door will inevitably pick up a substantial number of cases which, after screening, do not require further specialist involvement. That is not a failure of the system. It is what one would expect from a screen designed not to miss the important cases.

There also need to be some safeguards around what happens after referral. Once a case has been sent to another service, the panel should check after a defined period whether the service actually received the referral and did something with it. After that, the case should usually be closed to the panel. There must be an end point that is clear. Thepanels need to remain screening and routing arrangements. If they gradually become another layer of long-term case management, they will become overloaded and eventually stop functioning properly.

Information sharing is central to the whole proposal. My own view has consistently been that information sharing for this purpose should have a statutory basis, as it does for MAPPA and as has also been proposed in relation to CCS, rather than requiring agencies to renegotiate the legal basis every time a difficult case arises.

Overall, what I am describing is a public-health approach to screening, triage and intervention that aims at prevention of very low base rate but exceptionally high impact events, without pretending that we can predict the individual who may be most of risk of going on to serious violence. There are examples of this type of approach in the Fixated Threat Assessment Centre in the UK, the UK CT CCS and in the Australian services which followed FTAC, and it is evidence based and has been recently supported by the Royal Australian and New Zealand College of Psychiatrists (James et al., 2010; Pathé et al., 2018; RANZCP, 2023).

A well-designed screen should route to intervention quickly; it will not identify in advance the individual attacker. The safeguards that matter most are therefore: sensitivity at the gateway, red flags with same-day action, a named case holder, outcome review, audit, and services on the other side of the door resourced to accept what is routed to them.

Further issues

UCL/CCS Research programme – immediate priorities.

At the seminar I described some of the early research findings emerging from the joint UCL and CCS research project. The UCL side is led by Professor Paul Gill and Dr Caitlin Clemmow. Our next research priorities for the next few months are a more detailed analysis of the 170 CCS FEVMCA cases. Caitlin Clemmow has proposed both a descriptive statistical analysis (e.g., demographics, problem

behaviour, interventions) and a cluster analysis of these cases with the aim of looking for patterns or subgroups.

A further research priority is an analysis of the beta version of the AREVA SPJ against adolescents from the wider 1,500-case CCS database. A further opportunity exists to map the AREVA-Triage domains, together with the CCS data, against the CCS FEVMCA population, in order to identify what is already covered well and what additional indicators would be needed.

Both these strands of research could potentially inform work on an NIEV/VFI screening tool on a short timescale i.e., over months.

T2D

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T2D

T2D so that it can work on real casework rather than abstractions - drawing together four kinds of expertise: the national clinical casework (CCS clinicians); the UCL academic team already analysing the CCS cohort, including the forthcoming cluster analysis of the FEVMCA cases; counter-terrorism policing; and independent expertise in structured professional judgment and adolescent assessment (a member of the AREVA team is available).

I should make clear that none of the agencies or individuals referred to in this letter as potential contributors has been formally approached, and no formal agreement of any kind has been made. T1H

T1H

T1H; but membership, governance and commissioning would all require formal organisational agreement.

Its method would be rapid and empirical: definitional scoping and a background review; drafting of the screening items and red-flag set; retrospective testing of the draft against anonymised CCS cases with known outcomes; and refinement with frontline users - organised around a project lead, a series of full-day meetings with short online meetings and drafting between them.

On that pattern the instrument, its one-page guidance and a short report could be delivered, subject to further discussion, over a two-to-three-month time frame.

There would need to be subsequent development, such as frontline focus groups and a live pilot.

I would be glad to provide the full proposal if this would assist the Inquiry.

Terminology

On terminology, while debate is ongoing regarding definitions of VFI/NIEV I would propose, rather than trying to find a 'one size fits all' title that captures everything, an enumerated inclusion list, kept under review, would in my opinion be helpful. It would include (not limited to) the following:

- Children, adolescents and adults presenting with concerning evidence of interest, obsession, fascination or fixation on NIEV
- Children, adolescents and adults presenting with concerning evidence of behaviour associated with extreme violence and mass casualty attacks, including, verbal comments or threats
- Any involvement in Com-type hybrid-harm networks
- History of weapons acquisition or possession outside of legitimate occupational or recreational purposes especially if under 18.
- Evidence of weapons being taken into schools or expressed concerning comments/explicit threats in education settings
- Grievance-based non-ideological workplace threats
- Evidence of interest in the incel and school-massacre milieus.

There could be express exclusions for violence in the context of acquisitive offending and drug-gang or county-lines activity, which belong with existing structures. Although this would again depend on the positioning of the big front door.

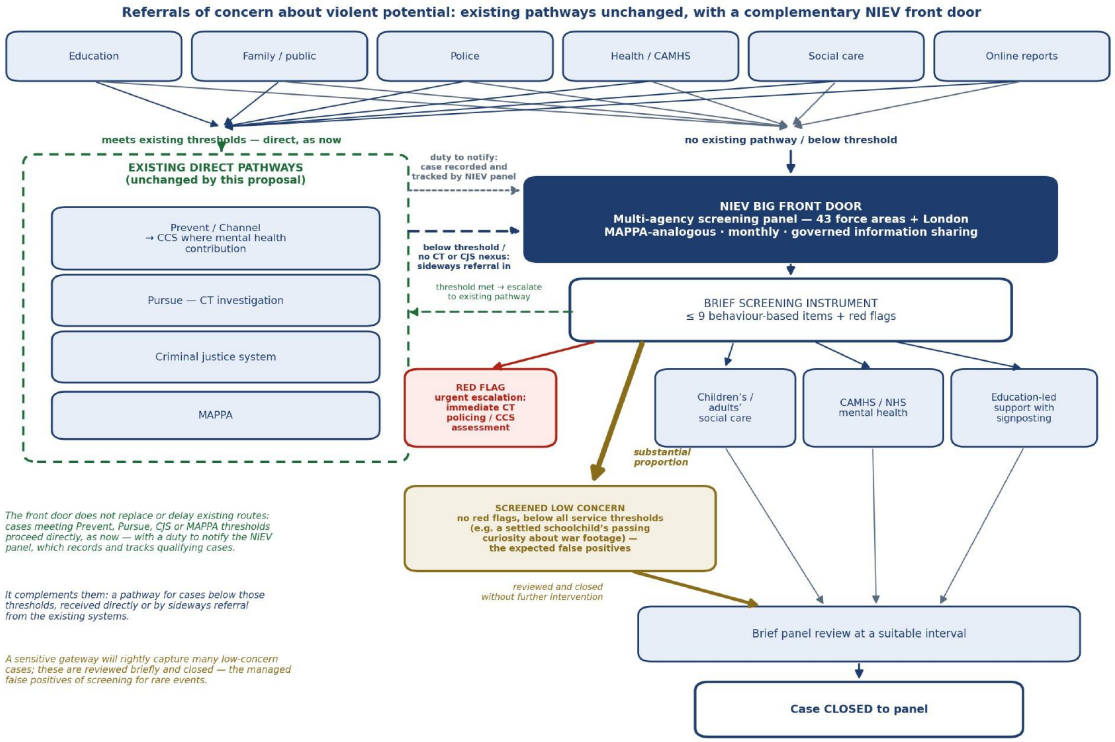
I am willing to assist the Inquiry further in any way that is useful,

Yours sincerely,

SIGNATURE

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Annex A: schematic - referrals of concern about violent potential: existing pathways unchanged, with a complementary front door.



The model proposed in this letter: a VFI/NIEV-scoped front door working alongside the existing pathways, which continue unchanged. The door provides a safety net for cases below existing thresholds and a recording and tracking function.

By way of contrast, a much wider big front door - of the kind contemplated in some current policy discussion - would look quite different from the schematic above. There would be a single wide gateway sitting upstream of Prevent, MAPPA, social care, mental health and education, through which all referrals of concern would pass: a common brief screen applied to every referral, followed by more specialist triage of the extreme-violence stream, with emergency and statutory routes bypassing the gateway unchanged. The screened-out majority would also be considerably larger, because the wider the aperture, the lower the base rate of true cases. I have not attempted to draw that model here.

Annex B:

Big Front Door policy

This structure would build on substantial public support for the concept. Lord Anderson recommended that violence-fascinated individuals be brought expressly within the scope of Prevent rather than hived off to a separate scheme (Anderson, 2025); the Government has since confirmed that a clear identifiable ideology is not mandatory for a Prevent referral, and has established a Home Office-led taskforce to 'develop a new approach to managing the risk from individuals fascinated with violence' (HM Government, 2026), alongside its commitment to legislate this session, including a proposed new offence of preparing a mass casualty attack (Home Affairs Committee and Government Response, 2026); and RUSI has proposed a single, locally-led multi-agency triage system on the Multi-Agency Safeguarding Hub pattern, with Prevent and Channel engaged only where terrorism-related risk is present (Wallner, 2025). Referrals in the fascination category, meanwhile, continue to rise (Home Office, 2026).

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