

Wednesday, 7th October 2026

(10.00 am)

SIR ADRIAN FULFORD: Yes, Mr Moss.

MR MOSS: Sir, good morning. We have the benefit this morning of our five experts looking at the case studies and I wonder if, first, they could just be sworn in.

SIR ADRIAN FULFORD: Thank you.

DR RICHARD CHURCH (sworn)

MR NEIL BASU (affirmed)

DR MONICA LLOYD (sworn)

MS ANNA GIANFRANCESCO (affirmed)

MS ELIZABETH SWAN (affirmed)

SIR ADRIAN FULFORD: Thank you all very much.

Expert Discussion

MR MOSS: Thank you, sir.

Good morning to all five of you. You have given valuable assistance to the Inquiry in your detailed reports and may I start by thanking you all for the work that has gone into that.

So that you and others know the road ahead for the next two days, I'm going to follow essentially the following topics: firstly, some preliminary matters, so we will deal with your qualifications, adduce your reports, look at your methodology and necessary limitations to your report. Secondly, I'm going to ask

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Inquiry -- or the two relevant parts are I was in counter-terrorism as a deputy assistant commissioner in 2015 and served in the three senior posts in counter-terrorism consecutively until July 4, 2021. So for three years, 2018 to 2021, I was assistant commissioner specialist operations, which is the National Police Chiefs' Council's lead in the UK for counter-terrorism policing and the responsibility of that post is to deliver policing's input into the Government's counter-terrorism strategy called CONTEST, across four major pillars: prevent and pursue, protect and prepare. I think I'm the only officer in history who has served in all three of the senior posts in counter-terrorism, and did so consecutively for six and a half years. The period in question clearly does cover Southport Phase 1 in some respects.

I describe myself as a professional detective. I was a detective constable through to detective superintendent, senior investigating officer qualified in anti-corruption, homicide, kidnap command and serious and organised crime. I was also strategic firearms commander and a counter-terrorism firearms commander, so I have a lot of experience of dealing with very high-threat -- rapid decision-making in high threat situations.

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you relatively shortly about definitions of VFIs.

Thirdly, I want to cover risk factors in identifying VFIs and fourthly, vulnerabilities in VFIs.

Fifthly, we will turn to multi-agency working, starting with the case studies and how multi-agency working appeared in the case studies. Then, sixthly, we will move to options for change in multi-agency working, what methods of working and what pathways may need to be in the future. Seventhly, I'm going to cover matters of professional practice. Eighthly, interventions. And ninthly, the online environment. So that's going to be our order of play. We have two days and we are not under pressure of time.

So can I start with the preliminary matters. I'm simply going to ask you each in turn please just to give your full name and to give us a précis of your experience and your qualifications so far as they are relevant to the Inquiry. So might I do that in alphabetical order and start with you Mr Basu, please.

MR BASU: My legal name is Anil Kanti Basu. I was known as Neil Basu as my professional name. I'm a retired assistant commissioner, sir, from the Metropolitan Police service. I joined in 1992 as a constable and I finished as assistant commissioner and retired in November 2022. The relevant parts, perhaps for this

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I could go on but I won't.

MR MOSS: Thank you very much. Dr Church.

DR CHURCH: Good morning, sir.

My name is Richard Church. I'm a medical doctor. I studied medicine at the University of Cambridge and then specialised in psychiatry, specifically two subspecialties: child and adolescent psychiatry and forensic psychiatry. I subsequently worked as a frontline clinician in Child and Adolescent Mental Health Services, CAMHS, and forensic services across a whole range of levels of security, in inpatient settings, in community settings, with young people, with adults.

I have taken on a number of roles, including as a site medical director for a secure hospital and in fact at the moment, I work as a regional medical director in Cygnet Health Care. I'm also a chair of the adolescent forensic psychiatry special interest group at the Royal College of Psychiatrists, and I have worked for nearly 20 years as an expert witness in some of the most serious offending presented by young people in the UK, in England and Wales, and other jurisdictions.

MR MOSS: Thank you very much. Ms Gianfrancesco.

MS GIANFRANCESCO: I'm Anna Gianfrancesco. I have been a social worker since 1994. I have worked across

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1 a broad range of areas within social work, mainly
 2 children. I trained as a probation officer/social
 3 worker but moved into youth justice and remained in
 4 children, working across safeguarding, youth justice,
 5 mental health, substance misuse and specialist
 6 adolescent services. More latterly, I was the director
 7 of safeguarding and care in Brighton and Hove for
 8 five years I then left in March this year, having been
 9 the director of commissioning and communities in
 10 Brighton and Hove for the last 18 months. There, I had
 11 under me services such as Prevent, Channel, community
 12 safety, migrant refugee services, Violence Against Women
 13 and Girls, as well as various other community services.
 14 So I have worked across a broad range of services that
 15 have managed risk within local authorities.

16 **MR MOSS:** Thank you very much indeed. Dr Lloyd.

17 **DR LLOYD:** I'm Dr Monica Lloyd. I have a BA in psychology.
 18 This is many years ago, there is quite a lot of years to
 19 account for here and then I did a Masters in forensic
 20 psychology and a PhD in extremist violence. I worked
 21 for 12 years as a prison psychologist, mainly with high
 22 security offenders. 12 years as head of thematic
 23 reviews in HM Inspectorate of Prisons and then
 24 three years working with Terrorist Act offenders,
 25 post-7/7, when a cohort of Terrorist Act offenders came

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1 career, a Masters in psychology, postgraduate
 2 certificate in education, qualified teacher status and
 3 the national award for coordination of special
 4 educational needs.

5 My particular area of specialism in special
 6 educational needs is autism and ADHD. I now work as
 7 an independent expert, providing expert witness reports
 8 and support for children and families with complex
 9 special educational needs, as well as working with
 10 schools and local authorities, to help ensure that
 11 children receive the right support at the right time.

12 **SIR ADRIAN FULFORD:** An extraordinary well qualified group.

13 Thank you all very much.

14 **MR MOSS:** Thank you, sir.

15 Can I now just deal with the formality, as it were,
 16 as adducing your reports formally. So could we have on
 17 the screen, please, ILT000344 and generally, I just want
 18 to give that unique reference number. I won't keep
 19 repeating it because this is the reports that we will be
 20 turning to for most of the day. It is dated on its face
 21 22 September 2026 and within the overall report, there
 22 are three sub-reports I want to deal with.

23 So, if I can start with you first, please,
 24 Ms Gianfrancesco, Dr Lloyd and Ms Swan. If we turn to
 25 ILT000344 page 6, please, we see a report from the three

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1 into prison for which forensic psychologists really had
 2 no training so we worked up the evidence base ourselves.

3 Then my swan song has been 12 years in academia, so
 4 teaching dual forensic psychologists and continuing my
 5 international work. So I think that's probably enough.

6 **MR MOSS:** Thank you very much indeed. Ms Swan.

7 **MS SWAN:** My name is Elizabeth Swan. I'm a qualified
 8 teacher and currently an education consultant with over
 9 25 years experience in mainstream and specialist schools
 10 from early years through to post-16. I have held senior
 11 leadership roles including deputy headteacher of
 12 mainstream secondary schools and headteacher of
 13 a specialist SEMH school; SEMH is social, emotional and
 14 mental health needs school. Also senior leader in
 15 a large, multi-academy trust.

16 Throughout my career I have also worked directly as
 17 a special needs coordinator, designated safe-guarding
 18 lead, inclusion lead and mental health first aider.
 19 Alongside my school roles, I attended the in-year fair
 20 access panel and chaired the local quality assurance
 21 board for independent and alternative provision. I have
 22 also written and delivered training for trainee and
 23 early career teachers and provided wider professional
 24 development for schools. My qualifications include
 25 a Masters in modern languages which informs my teaching

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1 of you, so the first of the sub-reports and it is dated
 2 16 September. If we could just go to ILT000344 page 64,
 3 please.

4 There's a signature page there for a statement of
 5 truth. Sir, we have received signed statements of truth
 6 from all of the witnesses. The document needs to be
 7 updated on our system. Can I just ask the three of you
 8 to confirm, please, that the opinions expressed
 9 represent your true and complete professional opinion on
 10 the matters to which they refer? Can I just ask the
 11 three of you to confirm that's the case?

12 **MS SWAN:** Yes.

13 **MS GIANFRANCESCO:** Yes.

14 **DR LLOYD:** Yes.

15 **MR MOSS:** Thank you. Then, Dr Church, again just to adduce
 16 your report, could we go, please, to ILT000344 page 73.
 17 We see your sub-report is dated 11 September 2026. If
 18 we could just go to ILT000344 page 95, again, we have
 19 since received a signed statement of truth from you.
 20 Thank you. Could I just ask you to confirm, please,
 21 doctor, that the opinions expressed represent your true
 22 and complete professional opinion on the matters to
 23 which they refer?

24 **DR CHURCH:** Yes, they do.

25 **MR MOSS:** Thank you. Mr Basu, for you, please, if we turn

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1 to ILT000344 page 117, we see your sub-report, so the
 2 third of the sub-reports. It is dated 17 September and
 3 if we could just turn, please, to ILT000344 page 174,
 4 the same applies, so again, we have the signature page
 5 which will be updated, but Mr Basu, could you just,
 6 please confirm formally that the opinions you express
 7 represent your true and complete professional opinion on
 8 the matters to which they refer?

9 **MR BASU:** They do.

10 **MR MOSS:** Thank you. Tied to the methodology of the report,
 11 I think you can confirm that you have been instructed as
 12 a panel, as a cadre of experts. But for good reason,
 13 including the short timescales in which, I'm afraid, we
 14 ask you to work and the time it took to gather the
 15 underlying case study documentation, you were not able
 16 to produce a single report. We have seen that
 17 Ms Gianfrancesco, Dr Lloyd and Ms Swan, you were able to
 18 provide a draft combined report which has then been
 19 finalised and now signed. Dr Church and Mr Basu, as we
 20 have seen, you have provided individual reports. Can
 21 I just ask you, for form sake if nothing else, to
 22 confirm that although you have provided three reports in
 23 that way, you have also been able to communicate about
 24 your views as a group to have discussions ahead of
 25 giving evidence today?

9

1 you have worked?

2 **ALL:** Yes.

3 **MR MOSS:** Thank you. If we can turn next, please, to
 4 ILT000344 page 8, paragraph 2.4. So still in the report
 5 from the three of you. So we just have paragraph 2.4.
 6 So the three of you, in the combined report, said this:
 7 "The young peoples' motivations in the six cases
 8 varied, but they involved seeking attention, identity,
 9 revenge and significance through violence, notoriety and
 10 infamy. Two went on rampages with shotguns, another
 11 killed two women as part of a satanic pact to kill and
 12 the fourth killed a twelve-year-old boy, all of them
 13 tragedies. None of the six wanted to advance
 14 a political cause, but they shared a sense of grievance
 15 with those who had carried out extremist violence, and
 16 several had access to extremist material online, both
 17 Islamist and Far Right that reinforced their drive to
 18 seek renown through violence. They had retreated from
 19 lives they could not manage and rather than continuing
 20 to search for success and status they sought to gain
 21 recognition and self-worth through violence."
 22 Now, Dr Church and Mr Basu, I have quoted there
 23 a report from the first sub-report. As an overview, is
 24 that something with which you would agree?

25 **MR BASU:** I think in a very broad sense, yes, I would agree

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1 **ALL:** Yes.

2 **MR MOSS:** Thank you. So there is transparency about this
 3 sir, we are an Inquiry, we are not in litigation and
 4 I think you can confirm that you have been encouraged by
 5 the Inquiry to have those discussions and they have
 6 taken place, I think, some by email and some in groups
 7 discussions telephone calls and so on?

8 **DR CHURCH:** Yes, that is correct.

9 **MR MOSS:** Thank you. The Inquiry selected six case studies
 10 which appeared to the Inquiry to be examples of Violence
 11 Fixated Individuals. If I refer to "the combined
 12 three", it will now be obvious that to which I'm
 13 referring, so the first of the reports from you Ms Swan,
 14 Ms Gianfrancesco and from you, Dr Lloyd. If we can look
 15 at that report, please, it helpfully summarises them to
 16 an extent, it is ILT000344 page 11 please,
 17 paragraph 3.5. So:
 18 "The Inquiry selected six case studies that
 19 monitored their progress from birth to the index
 20 offence. This provided a wide evidence base for
 21 tracking the trajectories that have provided the
 22 evidence base from which the cadre identified wider
 23 themes, patterns and learning. They are not treated as
 24 separate investigations."
 25 Is that, in broad terms, the way that all five of

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1 with that and there is a lot more --

2 **MR MOSS:** We will come onto the details. Mr Basu?

3 **MR BASU:** Overall, you will see from my report we make very
 4 similar -- despite having not worked together to do the
 5 reports, there is probably an advantage in that in some
 6 respects because there is nothing in this that I would
 7 not have said myself. When I talk, I often talk because
 8 I'm dealing with ideological violence in this and the
 9 way that the threat changed. All I would be concerned
 10 about is this is a very small -- I think we all agree
 11 this is a very small study. They are positive cases and
 12 therefore have to be seen as somewhat anecdotal. The
 13 idea that you could, for instance, put all of those risk
 14 factors in one place and identify a potential cohort of
 15 offender would be the wrong path to take.

16 **MR MOSS:** Thank you. We will come onto that. Can I just
 17 deal with the anonymity aspect because helpful in the
 18 combined three, the first of the sub-reports, and you,
 19 of course, are aware that there are anonymity orders in
 20 place for case studies A and B so we won't be providing,
 21 in asking questions and in the answers you give, any
 22 identifying information about A and B and, sir, that's
 23 a convenient time for me to remind all of those who may
 24 be following that the terms of your Restriction Order in
 25 relation to A and B is available on the Inquiry's

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1 website.

2 Again, just so that those following can understand
3 how we will be referring to matters, I think you can
4 confirm that for case studies C to F, I identified their
5 names in opening. Their identities are not subject to
6 an anonymity order but the Inquiry, as I think all five
7 of you are very familiar with by now, are not referring
8 to them by names due to the risk of feeding their
9 notoriety and the risk of encouraging copycat behaviour.
10 May I, sir, just through were you, if I may, just
11 encourage again all those who may be reporting on
12 today's proceedings to have in mind the importance of
13 that reason for using ciphers for case studies C and F
14 even though their names are not anonymous.

15 **SIR ADRIAN FULFORD:** Thank you. That is to be emphasised.

16 **MR MOSS:** Thank you.

17 Could I just ask about the underlying papers. Can
18 you just confirm that you have had a wide range of
19 underlying papers in relation to all of the case studies
20 but can you just confirm that you haven't seen, by any
21 means, every single piece of paper that would have been
22 produced in there. So you have seen a proportionate
23 collection of relevant papers; is that the case?

24 **ALL:** Yes.

25 **MR MOSS:** Thank you. Can you confirm that you have analysed

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1 **MR BASU:** Yes.

2 **MR MOSS:** Thank you. You sought, I think, through your
3 discussions to reach agreement where possible. Can
4 I ask just as a preliminary question. We will come to
5 differences of emphasis perhaps and differences of
6 terminology and some nuance of differences, but have you
7 found any fundamental disagreements between you as
8 a group?

9 **ALL:** No.

10 **MR MOSS:** Whenever there is a difference of emphasis or
11 nuance please feel free, during the course over the next
12 two days, to make that clear because we want the benefit
13 of the different perspectives that your different
14 specialities provide.

15 Could I turn again to just introduce so that we have
16 it on record, the approach to recommendations.

17 So in the first sub-report for the combined three
18 report, could we have ILT000344 page 62. Ms Swan, could
19 I just ask you to lead for the moment for the three of
20 you. Could you just confirm that section 10 of your
21 combined three report contains, helpfully brought
22 together, introduced earlier in your report, but
23 a series of recommendations arising from the work that
24 you have done? I think all of them are in the format,
25 not of: this should definitely happen, but: the Inquiry

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1 those papers and sought to draw out recurring themes and
2 an analysis of the systemic issues rather than to give,
3 as it were, an individual judgment of the rights and
4 wrongs of agency dealing in each case?

5 **ALL:** Yes.

6 **MR MOSS:** Thank you. I want to turn -- again, I appreciate
7 that these are preliminary matters but they are
8 important, so we should cover them. Could I just deal
9 with some aspects in relation to limitations.

10 So, if we look at ILT000344 page 12, please, the
11 first sub-report and paragraph 3.6, you say, at 3.6.1:

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

22 Can I just check again, please, because that's in
23 the first sub-report, Dr Church and Mr Basu, can you
24 just confirm that that applies equally to your reports?

25 **DR CHURCH:** It does.

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1 should consider recommending this based on the work that
2 the three of you did for this report; is that a fair
3 summary?

4 **MS SWAN:** Yes.

5 **MR MOSS:** Thank you. Dr Church, if we can turn to you again
6 just to adduce the way that you have dealt with this.
7 Could we look, please, in the second sub-report,
8 ILT000344 page 75. If we go right to the bottom of the
9 page, you very helpfully have set out a summary of
10 identified problems and recommendations, so the fact
11 that you have done it in a different style doesn't
12 matter at all. It goes over the page, so we see
13 critical items are indicated with a red -- sorry. Let
14 me just go back, please.

15 Critical items are indicated with a red filled box
16 in the number or column and you start with online
17 safety.

18 Over the page now. Then, on the left-hand column
19 you have got the problem and on the right-hand side, the
20 recommendation and very helpfully you have put a red
21 border on those that you consider to be critical areas.
22 Is that a fair summary?

23 **DR CHURCH:** Yes.

24 **MR MOSS:** Thank you. Again, we will pick up the detail of
25 that.

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1 Thank you. Mr Basu, again, a slightly different
 2 approach and that really doesn't matter, but at
 3 ILT000344 page 121, paragraph 3.2, you say:
 4 "Throughout I make no recommendations, only
 5 observations."
 6 You say that:
 7 "It is for [Sir Adrian, as] the Inquiry Chair to
 8 determine if my observations are useful in reinforcing,
 9 adding to or detracting from his recommendations."
 10 Then if we can go to ILT000344 page 129, within the
 11 policing section of your report, as we can see here, you
 12 have, in emboldened text, a number of those observations
 13 pithily set out in subparagraphs, in particular in the
 14 policing section, yes?
 15 **MR BASU:** Yes.
 16 **MR MOSS:** And if we can just look at ILT000344 page 169.
 17 There are quite a few others of these. As well as the
 18 policing section, if we can go to page 169, 12.2.17. So
 19 a little bit further down. You have other observations
 20 throughout the report but you have drawn together,
 21 I think, towards the end of your report, following
 22 further observations which you say are actually outwith
 23 the main thematic analysis. So you start with one on
 24 discrimination and if we go over the page,
 25 "adulthood risks" and we can see just at the bottom

17

1 three) ..."
 2 So, it is an act of:
 3 "Extreme violence.
 4 "The purpose.
 5 "No clear ideological purpose."
 6 And third requirement:
 7 "(Explicit or implicit) intent to shock, intimidate
 8 or outrage [a] wider audience."
 9 If we can go over the page, please, HOM000964_0057,
 10 we see, at paragraph 160 in relation to the act, he
 11 says:
 12 "Extreme violence: includes homicide, grievous
 13 bodily harm ... or coerced suicide. Typically, this
 14 will include mass casualty (or intended) attacks but can
 15 include a single-victim if the attack meets the purpose
 16 of intending to shock, intimidate or outrage an audience
 17 beyond the immediate victim ..."
 18 Then next paragraph, please:
 19 "The purpose. No clear ideological purpose: NIEV is
 20 not driven by a clearly identifiable ideological
 21 purpose. Interpersonal, domestic, gang-related, drug,
 22 financial, sexual elements can be present however, as
 23 long as they are not the primary driver of the
 24 violence."
 25 Then the next paragraph:

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1 of the screen at the moment, "diluted information". So
 2 I think your approach is not recommendations, lots of
 3 detailing observations in the policing section and then
 4 in other sections of your report, observations you have
 5 made in wider areas. Again, is that a fair summary?
 6 **MR BASU:** That is a fair summary and my apologies, I could
 7 have been --
 8 **MR MOSS:** Not in the slightest. So, we will pick up those
 9 individually but, sir, I adduce those from the start so
 10 we have the relevant references.
 11 **SIR ADRIAN FULFORD:** Thank you.
 12 **MR MOSS:** So those are the preliminary matters. Can I turn
 13 to the second topic which is definitions. Now, as you
 14 as a panel are aware, the Inquiry's terms of reference
 15 referred to Violence Focused Individuals as being
 16 individuals at risk of extreme violence where ideology
 17 is not the primary driver. However, Government thinking
 18 has moved on in this regard and can I ask to have on the
 19 screen, please, the Home Office document, so that's
 20 HOM000964. This is Mr Emmett's statement from the Home
 21 Office. If we could go to HOM000964_0056, page 56,
 22 please. Bottom of the page, paragraph 159 please. Sir,
 23 forgive me for reading this out, but Mr Emmett explains
 24 that, in terms of NIEV, as it is now thought of, the:
 25 "Essential components [and he says] (must meet all

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1 "Intent to shock, intimidate or outrage wider
 2 audience. The violence is communicative and intended to
 3 shock, intimidate or outrage an audience beyond the
 4 immediate victims, often generating fear in broader
 5 society. This can be explicit through a perpetrator's
 6 statements, threats or plans. Where this intent is not
 7 explicit, but it can be reasonably assumed the
 8 perpetrator sought to reach a wider audience, the act
 9 can also meet this threshold. This implicit intent may
 10 be evident in the choice or location of target(s),
 11 method of violence, or the behaviour of the
 12 perpetrator(s)."
 13 I will end the quote there.
 14 So that's the Government's current thinking on
 15 definitions. The Inquiry, as we have given you notice,
 16 has received the seminar from Professor Cassam which
 17 engaged with this and if we can just have on screen,
 18 please, ILT000136. If we could go, within that, to
 19 page 13 ILT000136_0013, one of Professor Cassam's
 20 criticisms, in the third bullet point, was that the NIEV
 21 definition, so Non-Ideological Extreme Violence, that
 22 I have just taken you to, needs to be supplemented,
 23 third bullet point:
 24 "... by a clause excluding extreme violence whose
 25 primary driver is gang-related, drug-related, etc." (As

20

1 read)

2 Et cetera. Then over the page, please

3 ILT000136_00134, he also drew to the Chair's attention

4 a concern that the definition of NIEV violence appears

5 to be audience-directed. So he postulated:

6 "Consider someone who positively values extreme

7 violence, wants to kill people brutally, commits a mass

8 casualty attack, but has no ideological, financial,

9 sexual, gang or drug-related purpose and is completely

10 indifferent to whether a wider audience is shocked,

11 intimidated or outraged." (As read)

12 He posited that that may create a problem because

13 the lack of any desire to have a wider audience or shock

14 them means that such a person apparently would not come

15 within the Government's definition of NIEV and he posed

16 the question: is this a problem?

17 So I'm not going to focus at length today on

18 definitions but it is an important early topic. So

19 could I just invite any views on that problem of

20 definition. Dr Church, could we perhaps start with you?

21 **DR CHURCH:** Yes, thank you. As a doctor I deal with

22 diagnosis and symptoms that could be indicative of

23 a diagnosis. So none of these labels, Violence Fixated

24 Individual, or NIEV or other acronyms particularly

25 relate directly to symptoms or medical diagnosis. So in

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1 I settled, without too much fuss, on "Violence Fixated

2 Individuals". I thought that was a generally useful

3 term because I think once you get into the weeds of all

4 those specific sort of concerns about what constitutes

5 an ideology and everything, then it becomes extremely

6 difficult.

7 **MR MOSS:** Thank you. Mr Basu, in a moment, is going to talk

8 to us about fixation and fascination, I suspect but can

9 I come first to Dr Lloyd, as to whether you have any

10 view on the definition, in particular in relation to

11 those elements of NIEV?

12 **DR LLOYD:** Yes. Well, first of all, I would like to say

13 that, yes, this is an act of theatre. I accept this.

14 But it also needs to be understood to be an act of

15 achieving -- at the personal level for them, of

16 achieving revenge, respect, recognition, notoriety and

17 significance through violence. So it is meeting

18 personal need as well as being an act of theatre. But

19 I'm not saying that this means that it is not a good

20 acronym because I think it is very difficult to find one

21 that is going to cover everything, but I do think it

22 will help to distinguish young, traumatised, isolated,

23 aggrieved, inevitably neuroimmature young people from

24 mature adults who are cognitively and emotionally intact

25 and able to frame their grievances by means of

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1 some ways they feel a little removed from our core work;

2 but, of course the word "fixation" is used, as other

3 seminar participants have discussed, used in literature

4 related to stalking, and where psychiatrists have been

5 very prominent in research and the word "fixation" has

6 definitions within that context.

7 I think in my report I make the point that "Violence

8 Fixated Individual" may have all sorts of objections and

9 ambiguities but actually it has a face validity which

10 makes it readily understood by people of all disciplines

11 and agencies and a layperson and so there is some value

12 in having that broadly accessible sort of label.

13 I think there's definitely a need for rigour in

14 diagnosis when it comes to accessing some of the other

15 agencies and the sort of fine criteria or definition,

16 for example, for referral to counter-terrorism agencies

17 and any agencies that pick up a leadership role for this

18 cohort.

19 **MR MOSS:** You said "a rigour in diagnosis", do you mean more

20 broadly in definition for referral?

21 **DR CHURCH:** Beg your pardon, yes, thank you. A rigour in

22 definition is helpful for other agencies and perhaps for

23 a multi-agency understanding. But the more specific and

24 detailed it becomes, the more letters perhaps, then the

25 less accessible it becomes to people. So that's why

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1 a political and/or religious ideology. Which means that

2 the ideology requires you to be mature enough and

3 cognitively sharp enough to be able to work that into

4 your motivation.

5 Whereas we are talking here about younger people who

6 are very stressed and traumatised and very much captured

7 still in physiologically carrying trauma, which I would

8 like to talk about in a little bit more depth. But

9 the -- so what I'm saying is that the VFI, if you like,

10 the younger person, doesn't have the cognitive capacity.

11 It remains a very visceral drive.

12 **MR MOSS:** We will come back, if we may, a little later to

13 look at age as a vulnerability or risk factor and why

14 that's a case and neuroimmaturity in that context. You

15 said that you accepted -- you started that answer,

16 Dr Lloyd, by saying you accepted that there is

17 an element of theatre involved in this. The concern

18 that Dr Cassam was raising was that may well be the case

19 in some cases but not in all. There wouldn't need be,

20 in every type of this cohort's actions, a desire to

21 cause shock and outrage to the public as a whole.

22 I think you said it could be a reflection of their unmet

23 needs. Do you think that a part of the definition that

24 requires an element of implicit or explicit intent to

25 shock the public, is too narrow as a definition from

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1 a forensic psychology point of view?

2 **DR LLOYD:** Probably from the psychological point of view.

3 Obviously we are focused on the perpetrator. But

4 I understand that there is also a perspective from

5 society, society's perspective, which is going to focus

6 on other elements of it. But I mean from my

7 perspective, there clearly are those who carry out

8 violence without an ideology and we do need to describe

9 that and I think the definition of NIEV is acceptable

10 because I don't think we are going to find something

11 that's going to capture everything and please everybody.

12 **MR MOSS:** Thank you. Mr Basu, I said I would come back to

13 you because throughout your report you were very

14 careful, having noted the definition in the terms of

15 reference, to stick with the use of "fascination" rather

16 than "fixation" in your report. Do you want to just

17 explain the importance as you see it of that point?

18 **MR BASU:** Yes and I'm not academically qualified to talk

19 about the difference but my personal opinion is

20 fascination is a much broader concept. So someone who

21 is violence fascinated is not necessarily going to be

22 a violent person, they are just fascinated by the topic.

23 So I saw elements of -- I said at the start, this is not

24 an offending cohort for me, it is a risk indicator. So

25 it is one of many risk indicators which demands a bit

25

1 life, was "Non-Ideological Violent Extremists" which

2 might define a cohort of people. Once you have defined

3 a cohort of people it is incredibly important that

4 everyone who is using this definition agrees with it

5 because of the actions you might take, as any particular

6 agency, in my case policing, probation, prison,

7 intelligence community. If you are going to make

8 decisions, you need to know exactly who you are looking

9 at and why and I think Dr Cassam is right to say there

10 is potentially a problem because the unintended

11 consequences of getting such a rigid definition wrong is

12 that people slip off the edge.

13 So, as a police officer, if I want to address this

14 cohort, particularly because we are talking in -- this

15 entire Inquiry really is talking about a pre-criminal

16 architecture to try and stop an offence happening before

17 the offence has actually happened, that is something we

18 do in counter-terrorism, it is not something generally

19 policing does very well. It doesn't have the same

20 capabilities. But if you are going to have that and you

21 are working to that definition, is that going to affect

22 any law that comes in to say: well, you can exercise

23 certain powers, authorities, intrusion into somebody's

24 life, provided they fit that criteria and then you may

25 be able to charge somebody but you can't charge them for

27

1 more professional curiosity, if you see somebody who

2 is -- and I don't care whether you use the terminology

3 "fascination" or "fixation". I saw fixation as more of

4 a clinical term so I thought there might be some

5 psychiatric or psychological purpose behind using the

6 term "fixation" and that might be somebody who is more

7 predisposed to actually going on to commit real world

8 violence. So "fascination" is just an interest in the

9 topic and that might combine with a lot of other adverse

10 indicators to create risk and therefore I just use that

11 as the generic because it didn't necessarily mean --

12 obviously in the case studies you chose, you chose them

13 for a reason, but I have dealt with an awful lot of

14 people who are fascinated by violence, many of whom are

15 journalists, media and a lot of people who listen to my

16 podcasts. You know, they are not all people who are

17 going to go on to commit an offence.

18 I like what Monica says about this being a bit of

19 theatre. I'm used to the Home Office spending a great

20 deal of time trying to define something in excruciating

21 detail. I'm less interested in the detail than as to

22 whether it has a practical implication by defining this.

23 I think "Non-Ideological Extremist Violence" is

24 a definition of a problem that I'm prepared to live

25 with. What's more important for me, or in my previous

26

1 an offence you created because they were completely

2 indifferent. In other words, the last part of the

3 offence was missing. That would be an unintended

4 consequence.

5 I agree with Jonathan Hall's work about trying to

6 have a pre-preparatory offence for non-ideological

7 violence simply because that is what allows us to be

8 effective in counter-terrorism to interdict an offender.

9 So be very careful how you are phrasing it. It has to

10 be agreed by everyone who is going to use it and make

11 sure there are no long-term unintended consequences of

12 being unable to exercise powers, or charging powers if

13 you come to prosecute the offender.

14 **MR MOSS:** Thank you. Ms Gianfrancesco and Ms Swan, is there

15 anything you want to add on the difficulty of

16 definitions or their importance?

17 **MS GIANFRANCESCO:** For me, I would just add in terms of

18 NIEV, the idea that there may be someone who wants to

19 shock their audience because I would actually consider

20 two of these case studies whether they had intended to

21 shock their audience or whether actually it was more the

22 violence and what it meant to them and how they were

23 expressing themselves.

24 I think, to kind of agree with Monica, we see young

25 people -- and I have seen a lot of young people over the

28

years in social work -- who have a fascination with violence, who have experienced extreme trauma in their childhood and part of that is then acting out that trauma through violence and somebody is just talking about it, fascination and somebody is acting it out. Some of those I think would then fit the definition of "violent extremist" or Violence Fixated Individuals. I don't think they would fit the definition of NIEV in terms of they are indifferent to whether they shock an audience.

I think if we are then looking at multi-agency work later on, if we have too tight a definition, we are already seeing people falling through gaps. That tight definition about whether they are there to shock an audience would just mean that some of those young people and the young people we have seen in the case studies could potentially fall through gaps. The other thing is what we have seen in the case studies is that young people's lives are online and it is the adults around them, people don't necessarily know what their online life is. So somebody may think actually they are not desiring to shock somebody, but after the fact we know, through the police investigation, what their online life is. So, again, there is potential to fall through that gap.

29

bad things that are happening, and that repetition and the understanding of essentially the individual recognising the good sides of that violence and that's come across in our case studies as well. So I think that element of not only having that fixation but also affirming that fixation is incredibly important to extract and to highlight.

MR MOSS: Thank you very much.

Sir, I'm going to move on now, if I may, to the third area of looking at risk factors and can I say, first of all, that it may be that there is no bright line at all between risk factors and vulnerabilities but it is just a convenient way of dividing matters.

Before we look at some of the individual risk factors, and what the case studies had in common and what the significance of that is, could we just look, Dr Church, please, at some limitations in relation to any attempt to prescribe a list of risk factors. Mr Basu, you touched on that in your opening remarks. But could we just have ILT000344 page 81 please of the report up. It is section 5, please. If we go through just at the bottom of the page:

"In the case studies provided, a number of early life features stand out. A high number have a diagnosis or traits of an autism spectrum disorder ... which is

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MR MOSS: Thank you. Ms Swan?

MS SWAN: There are two points from Professor Cassam's seminar that I wanted to highlight. The first is pathological fixation and he referred to the work of Meloy and Rahman in that regard. The element of pathological is particularly important within an educational context because of the impact on functioning and the impact on changes. What we have seen throughout the case studies is measurable data in terms of attendance, attainment, behaviour, not just measurable from a quantitative perspective, from education stuff, but also from peers and from siblings. Those significant changes in that young important's capacity for functioning.

So from an education perspective, that understanding around pathological fixation, I think, is incredibly important for understanding that difference between fascination, and like Anna has already said, in education we come across many young people who are very interested and have a fascination in elements of violence and historical elements and so on.

Then the other aspect from Professor Cassam was "violence affirming" and I think not only did we see that with AR but we also have seen that in some of the case studies. The idea that it is a good thing, these

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one of the reasons for being selected. The cases also feature exposure to domestic violence or other forms of abuse, parental separation or instability, and a development along a conduct disordered trajectory, with some exhibiting behavioural problems in early childhood."

Then if we go over the page, please. Obviously I'm not going read out all of this section, which asked you to look at common features, but if we scan through it and look at the bottom of that page and then over the page ILT000344_0084 and to paragraph 5.16. I don't go through, for the moment, all of that analysis, but where you reached after that, is this:

"In summary, it is impossible to provide an exhaustive list of possible indicators that should raise concerns, but ..."

Then you emphasise some matters:

"... but any instances of law-breaking, risk of harm to themselves or others, and any signs of ill-health in a young person should prompt further action as required."

So, would it be right to say that, while it is important to look at common risk factors that are present, it is a trap not to fall into, to try to give a list as a sort of tick-box exercise and say: well,

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1 those are present, or enough of those are present, this
2 is a case of VFI? Would that be a summary of your
3 analysis?

4 **DR CHURCH:** Yes. I think it is a situation where, for
5 example, there may be a list of indicators or risk
6 factors in a screening pool, for example, at some point,
7 where perhaps certain indicator is not met or there
8 isn't evidence to support it which could lead -- a very
9 strict, actuarial type of approach, to lead to
10 underestimation of risk. I think, in any sort of
11 analysis of risk factors, there is a lot to be said for
12 front-loading expertise. So, having someone of
13 experience and suitable skill or training to actually
14 review an individual and have a sense of their overall
15 presentation because there can be one or two critical
16 factors or red flags that should raise concerns and
17 indicate a need for intervention even in the absence of
18 other factors.

19 They may be factors that would never really appear
20 on a list as such and my worry is that there is
21 a tension, I suppose, between a need to have some sort
22 of agreement, to know what we are talking about, but
23 also to enable some flexibility to exercise opinion from
24 an experienced, skilled person. Does that make sense?

25 **MR MOSS:** To distill that into my layperson's thinking, even

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1 there are in a unique position to sort of be able to
2 notice those more micro-shifts, those changes, those
3 patterns over time and provide that longitudinal
4 evidence. One of the challenges we have seen across the
5 case studies is that education settings were not given
6 opportunity or were not listened to, or their opinions
7 did not carry as much weight as other agencies may have
8 done and particularly in settings such as alternative
9 provisions or in specialist schools, where the staff
10 there have additional skills and expertise in terms of
11 supporting young people, even in those circumstances,
12 those views were not given adequate weight.

13 **MR MOSS:** Thank you. Mr Basu, if we could have on screen
14 please, page 123, ILT000344_123, your paragraph 4.2.1.
15 Touching on similar themes that I have just been
16 exploring, you say:

17 "The most consistent pattern is not one single
18 factor but the accumulation of factors over time."

19 Then you go to give examples of them. But at the
20 end of that paragraph, you say:

21 "The repeated issue was the interaction between
22 neurodiversity, adverse childhood experiences, social
23 isolation, obsessive interests, online exposure, and
24 deteriorating emotional regulation. Pre-index offending
25 in the form of low-level criminality was common and

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1 if you were to have a list of ten factors, somebody that
2 might have two factors that were "positive" but the
3 detail and the needs and the risks that lay behind those
4 two could be so strong in a case that it would require
5 further intervention and further action, even if, on
6 a very simplistic approach, they had a score of two out
7 of ten?

8 **DR CHURCH:** Yes. So, for example, perhaps there is a lesson
9 here from hospital paediatrics. There will be all sorts
10 of assessments that are conducted in an accident and
11 emergency department for a child. But there's
12 an overriding principle that if there is parental
13 concern about the child, then that should be taken
14 seriously. So it is almost acknowledging the expert
15 status of the parent who knows their child to raise
16 a red flag and that shouldn't be ignored really.

17 **MR MOSS:** I don't want to jump ahead too much but I suspect
18 that Ms Swan may say educational concern, because of how
19 much exposure those in the teaching environment have to
20 young people, should be given particular weight because
21 of how much those in the teaching environment and
22 support teachers in special needs environments can
23 divine about behaviour and needs because they see the
24 child simply for longer; would you agree?

25 **MS SWAN:** Absolutely. When the child is in school the staff

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1 leniently dealt with."

2 We may come back to that last sentence, but do we
3 rightly understand that you were emphasising in your
4 report the same thing that I was just exploring with
5 Dr Church, that on no view can this be approached as
6 a checklist because it is the overall pattern and
7 moreover, it is a pattern that can change and develop
8 with time?

9 **MR BASU:** Yes. I do want to agree with that, just some
10 caveats.

11 **MR MOSS:** Yes, of course.

12 **MR BASU:** You used the expression "layman". That's what
13 I always considered myself as a police officer who
14 doesn't understand educational context, doesn't
15 understand social work, doesn't understand psychiatric
16 or psychological issues. I'm only ever going to have
17 a layperson's perspective on that. As a police officer,
18 if someone hasn't committed an offence, doesn't look
19 like has committed an offence, or might be about to
20 commit an offence, there is a tendency for policing to
21 say: well, that's the end of the matter. A layperson
22 needs some kind of decision-making framework in order to
23 think there may be more to this than meets the eye.
24 A good doctor will take a history, a great detective
25 will learn everything they possibly can know about the

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1 victim or perpetrator of a crime. That involves asking
2 a lot of questions.

3 We used professional curiosity a lot in the
4 Southport Phase 1 and I've seen a lot of that as
5 a criticism of people not asking the right questions.
6 The trouble is they have to have an indication of where
7 to start and a lot of people who are referring people of
8 high risk don't know where to start. So what
9 a checklist does is it gives them at least
10 an understanding of somewhere to start asking the right
11 questions and then I completely agree with Richard, that
12 the person who then takes that and starts putting
13 professional judgment on it, has to be somebody who has
14 got the skills to interpret what they are seeing and
15 that means having more in-depth conversations perhaps
16 with the subject in question. It can't be done as
17 a paper-based exercise.

18 The trouble with all the case studies is all of
19 these multiple factors developed over a very long period
20 of time, so most people are only seeing a tiny snapshot
21 at one moment in time, that doesn't -- it is very easy
22 for us, with hindsight, to look back at the horror of
23 these cases and immediately join everything together.
24 That initial person who doesn't have the skills I have
25 described and is seeing one isolated element described

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1 example, violence fixation may emerge in the context of
2 severe mental illness such as psychosis, as part of
3 an obsessive-compulsive disorder, as an intense,
4 restricted interests in an autism spectrum disorder, as
5 part of a depressive, resentful presentation in the
6 context of a grievance, or as an interest held by
7 an individual with a significant primary dissocial
8 presentation. The risk of harm to others associated
9 with a violence fixation will be largely determined by
10 what drives the fixation."

11 Yes?

12 **DR CHURCH:** Yes. So I make the point that in clinical
13 practice, VFIs, or what appears to be a Violence Fixated
14 Individual, could pop up in a number of settings
15 associated with a number of different sorts of disorders
16 and in some cases -- I know Dr Richard Taylor mentioned
17 this in his evidence I think in the seminars -- that
18 actually if an obsessional interest in violence is part
19 of an obsessive compulsive disorder, that can actually
20 be an ego-dystonic thought which is subjectively
21 unpleasant for the individual and is actually associated
22 with perhaps a lower risk of violence, maybe protective
23 against violence.

24 In a sense, it is associated with a fear of ever
25 committing a violent act, for example. But it is, or

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1 in there is going to be in a very tricky position
2 deciding what to do next.

3 You have got to give them some best help in terms of
4 a professional decision-making framework to help them
5 through that and I spoke, in my previous life, to the
6 psychiatrist and psychologist who helped us develop the
7 original Prevent Assessment Framework -- Monica knows
8 much more about this than I do -- but they made that
9 exact point to me. That in some respects, this is not
10 the science you think it is but I need to give you
11 a framework to help you. The science is really
12 difficult even for the scientists. It is impossible for
13 us.

14 **MR MOSS:** Thank you. When it gets to referral, Dr Church,
15 for someone like you, with your qualifications, so if we
16 look at page 80, ILT000344_0080, and your paragraph 4.2,
17 please:

18 "From a forensic psychiatry perspective, the
19 management of VFIs will vary according to the specific
20 characteristics of that individual, with additional
21 potential variation in clinical practice arising from
22 local arrangements. Whilst the intensity, breadth and
23 persistence of fixation on violence will contribute to
24 a risk assessment, the psychiatrist is equally or more
25 interested in what is driving the fixation. For

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1 can be, associated with confessions or compulsive
2 confessions and those individuals can cause concern and
3 confusion sometimes in law enforcement agencies and then
4 there is a referral to psychiatry, where sometimes we
5 recognise it quite quickly and say we understand what
6 that is, that can be treated. So that is a very
7 distinct, different sort of cohort really. Quite small.
8 But there is a wide range of other contexts in which
9 there would be more significant concern regarding
10 an interest progressing to something more, yes.

11 **MR MOSS:** Thank you. Sir, I'm going to come on, in just
12 a moment, to look at risk factors individually and
13 vulnerabilities but I do so in that context of avoiding
14 a prescriptive list type of approach. Really what
15 I want to do is to get the benefit of your expertise on
16 what people should be looking for and how significant
17 these factors may be in not treating them as
18 a prescriptive checklist. Before I start to move on to
19 look at some of them individually, Ms Gianfrancesco,
20 Dr Lloyd, is there anything you wanted to add on the
21 limitations, as it were, of risk factors and
22 vulnerabilities and not treating them as a checklist?

23 **DR LLOYD:** Yes, I mean, I do actually think that we have
24 got -- it is helpful not just to see individual adverse
25 child experiences but to actually look at how that can

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build complex trauma, which becomes the vehicle for violence and I think that we need to understand that in terms of the fact that very many of these young people -- and again, it is -- I'm quite keen that we should understand that these -- these are a group of young people who are -- have all sorts of jeopardies that they are struggling with and that develops -- so that they are actually functioning on a chronic threat alert a lot of the time, because of the backgrounds that we have explored through these six cases which indicates that there is plenty of violence and neglect of these young people, which means that there's lack of protection against the possibility -- the likelihood of actually developing chronic trauma, which is longstanding.

So, I just wanted to explain that in adolescence, the lower brain is very different -- well, and the executive brain, the upper brain need to come into a form of -- well, they need to mature so that they are actually helping the young person to make sense of their situation and to decide how they behave and go forward.

I have mentioned before that it is a very visceral thing. It is something that happens at a very visceral level. There is something called the HPA axis, which refers to the lower and the upper brains and how they

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sorts of adverse child experiences, and haven't been helped to learn how to manage their autism and have been left in a chronic state of trauma alert, which -- I mean, the good news being that it is actually reversible and there are therapies for this and when we come onto interventions we can look at what should be in place for these individuals who are neurodiverse, convergence with having mental health problems.

MR MOSS: Thank you. We may pick up some of those aspects again with you in more detail as we look at them but if I have understood correctly, I think the overall emphasis that you giving there is a risk of a list of individual risks or indicators, is that you have got to look at the whole and what may be going on in terms of their vulnerabilities from the complex situation that you explain and the interface between autism and this sense of violent alert and the difficulties that that can give rise. We will come back to some of those points, if we may. Ms Gianfrancesco, is there anything else you want to add on this before we look at some of the individual points?

MS GIANFRANCESCO: I concur really with the rest of the panel. For me, the danger of a list is that it becomes a tick-box exercise and I think as Dr Church was saying, if someone looks at a list of 10 and thinks: oh, this

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form the body's central stress system, which actually keeps them in a constant state of threat alert, with difficulty actually regulating emotional and cognitive functions.

Now, this is associated with neurodivergence and autism in particular. So I have looked into -- I think most experts accept that autism itself does not drive violence. But when it is combined with this threat alert and the -- co-morbid mental health problems, the co-morbidity in itself does create a risk of violence.

Mental health, in itself -- I'm quoting the work here of Salman and Al-Attar who are very expert in this area -- they are pointing out that:

"There is an elevated risk in general for those with psychopathology that includes depression, anxiety, psychosis, schizophrenia, narcissistic personality disorder, OCD and psychopathy and all these, when they are co-morbid with autism, can create quite a toxic mix." (*As read*)

Particularly in combination of schizophrenia and psychosis apparently, that research shows creates a greater risk of both individual and mass violence. So there are some -- it is not a neat list of risk factors but there are elements of individual neuroimmature people who have been subjected to domestic violence, all

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person has only got two, they are low risk, but actually the person with two might be of much higher risk than the person with 10. So it is about having something that enables professionals to think: actually, I need to be more curious here and sort of supporting them to go away and ask more questions, rather than thinking: oh, well, this is a list and I have got to reach this point before I go on to the next phase of the assessment. But it is also about thinking about all of the other risks that we haven't identified and whether they should be on the list. So one of the things we spoke about in our report is foetal alcohol spectrum disorder alcohol syndrome and for me, through 30-odd years of social work, I have seen a lot of that but professionally, actually, we don't talk about it very often. It is not always identified because you have to understand the level of drinking.

MR MOSS: Right, sorry, I'm going to come back to that but that's helpful, thank you.

All right, thank you. So with those strong caveats in mind, and you will understand why I have gone to that issue first of all, can we look at some of the factors but bearing in mind the warnings against a tick-box approach.

So the first one I wanted to explore with you is

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1 grievances. So if we could have on screen, please,
 2 page 23, ILT000344_23. This is in the combined three
 3 report, the first sub-report. Paragraph 5.7.6:
 4 "It is evident that some of our cases and those in
 5 the broader incel groups carry multiple shared
 6 grievances, of which their involuntary celibacy is but
 7 one, but the influence of the growing manosphere offers
 8 the possibility of this being framed as
 9 a misogyny-motivated ideological terrorist movement,
 10 which confers a degree of power and status on those who
 11 seek this."

12 Dr Church, if we could have page 83, ILT000344_83.
 13 Paragraph 5.9, you said in your report:

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

19 So you have both, in slightly different ways, drawn
 20 attention to that. Detective Chief Constable Court, who
 21 is our witness from the National Police Chief's Council.
 22 Sir, I will just give the reference. I don't think we
 23 need to bring it up, but for your note, it's page 8,
 24 paragraph 36(c) of his statement.

25 **SIR ADRIAN FULFORD:** Thank you.

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1 individuals and so on, and is sort of then spilling into
 2 activity of some sort, then, all that would add to
 3 concern around the seriousness of a grievance.

4 But, in the population there would be a very wide
 5 range of presentations, of course.

6 **MR MOSS:** Dr Lloyd, as a forensic psychologist, anything to
 7 add to that? Specifically on weighting grievances or
 8 assessing different grievances and how concerning they
 9 should be?

10 **DR LLOYD:** Well, grievances are very common background to
 11 both adult terrorist offending and young person's
 12 violence. So, it is important to be able to locate it
 13 and understand it and have a conversation about it
 14 because it is relevant. It could be quite ideopathic,
 15 you know, just something which only this individual can
 16 experience and will find it difficult to talk about it
 17 as well. There is not a lot of talking going on with
 18 adolescents. So what I'm saying is it is not cognitive,
 19 it is very much more visceral than that, but they could
 20 have a particularly ideopathic, extreme overvalued
 21 belief but if that is the case, we need to find out what
 22 it is because it helps us get -- build a rapport and
 23 understand what we are dealing with.

24 But, yeah, I mean I agree with Dr Church that there
 25 are many forms of grievance and many strengths of

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1 **MR MOSS:** He said that:

2 "Grievances are a significant risk factor which
 3 authority should pay particular attention to." *(As read)*
 4 From the case studies, is that something with which
 5 you would all agree, the importance of grievances?

6 **ALL:** Yes.

7 **MR MOSS:** Are any grievances more concerning than others?
 8 What should practitioners be looking out for?
 9 Dr Church?

10 **DR CHURCH:** I would say the quality of a grievance would
 11 include elements such as the intensity; is it
 12 a grievance that is held in mind every day, for most of
 13 the day, for several hours a day? The persistence of
 14 that grievance; is it one that has actually persisted
 15 for days, weeks, months, years? And what is the nature
 16 or the content of that grievance? So it is about
 17 encouraging, I would say, practitioners to -- any
 18 professionals from my agency to actually illicit more
 19 information about it, to understand the nature of it and
 20 of course, if it is something that's quite lightly held,
 21 for one or two days, it might not be something that
 22 comes to professional attention at all, but if it is
 23 something that's a grievance that's really established,
 24 deeply entrenched, held over many months or even years,
 25 and has led to a degree of involvement with like-minded

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1 grievance and it is the job of the person doing the
 2 assessment to actually establish what function this is
 3 causing in this individual's life.

4 **MR MOSS:** Thank you.

5 I want to turn, unless anybody else has anything to
 6 add on that particular issue of grievances, to
 7 consumption of violent content online.

8 Could we have page 22, ILT000344_0022, on screen
 9 please and paragraph 5.7.2. Ms Gianfrancesco, Dr Lloyd
 10 and Ms Swan, in your report, you said:

11 "In several cases there was evidence that they had
 12 searched online for information on bomb making and
 13 knives from Islamist and Far Right sources, but this did
 14 not include ideology."

15 Then you refer to AR's case coming:

16 "... to the attention of Prevent and was charged for
 17 possessing material that could be useful for
 18 a terrorist, though his search history was more
 19 consistent with VFI motivation. The evidence revealed
 20 increased searches into how to cause serious harm which
 21 should raise the question of whether the individual has
 22 moved beyond interest towards an intent to harm."

23 Dr Church on this theme, page 82, ILT000344_0082,
 24 please, paragraph 5.3, you said:

25 "A further common feature is that the nature and

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1 extent of the young person's immersion in a toxic online
2 world was often not known to parents or professionals,
3 and remained private, constantly accessible, with
4 potential for access across a number of devices. The
5 online activity was usually not monitored or supervised
6 effectively, or at all."

7 And page 91, ILT000344_0091, paragraph 8.2:

8 "Evidence in several case studies indicates that the
9 role of extreme online materials and communities was
10 most likely critical in the adoption and reinforcement
11 of extreme views."

12 It is why I particularly wanted to go to this
13 paragraph:

14 "Engagement in communities that shared these extreme
15 views likely normalised them, and caused socially
16 isolated individuals with ASD to feel included and that
17 they belonged to a community. This would have been
18 an encouragement to persist, to the extent of enabling
19 extreme violence. The term 'echo-chamber' is sometimes
20 used to describe the amplification and affirmation of
21 extreme views, and disconnected nature of such online
22 communities."

23 Then for you, Mr Basu, before I ask some questions
24 about this, page 123, ILT000344_0123, please.
25 Paragraph 4.3.1:

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1 Crime Agency that did a detailed analysis of
2 everything -- and they described the browsing of that
3 particular individual as rather unremarkable. So I just
4 caveat everything with saying actually sometimes -- the
5 online browsing is always there. I probably say this
6 with some confidence, 100 per cent of the cases of
7 terrorism that I dealt with had an online browsing
8 element. So they are either looking at media,
9 mainstream media or social media through an online lens.
10 It didn't mean that all of them would flag up
11 immediately as massively concerning until you look at
12 the type of content and the acceleration of content. So
13 more obsessive, more extreme, whether that's violence or
14 pornography. If there is a sort of escalating path to
15 the amount of content they are consuming and how extreme
16 it is, that's a real worrying indicator.

17 The problem in the cases you are discussing here is
18 there are certain ways and means in which somebody has
19 already been referred and has already been looked at as
20 a potential high risk that allows you to see that in
21 advance of something happening. But it is a definite
22 trigger or a mobilisation factor that would make you
23 think: we need to intervene at this point.

24 **MR MOSS:** So we will come on, a little later, in looking at
25 the online environment more generally, to getting better

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

6 Over the page, please, ILT000344_0124:

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

15 So, against that background of what you have said in
16 your report, one of the difficulties in this area is,
17 given how common -- and Ms Swan, you touched on this --
18 an interest in violence is and the fact that we live in
19 the digital age, what should one particularly be looking
20 for as higher risk in looking at violence online? What
21 do you draw from that from the case studies? Mr Basu
22 can I start with you?

23 **MR BASU:** So, at least one of the case studies, the
24 browsing -- and there is a report done by a sort of
25 professional public Inquiry, I think it was the National

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1 access but while maintaining proportionality in that
2 sphere. But Ms Swan, could I turn to you in terms of
3 how widespread violence online is amongst young people
4 of school age and attendance, and what you would say
5 about this as a risk factor, because in some senses, one
6 would say: well, it is going to be so common that it
7 would almost always be present in this type of case.
8 What's your experience as to factors to look out for as
9 a frontline education practitioner?

10 **MS SWAN:** I think one of the challenges -- or there are
11 multiple challenges here and in terms of -- we have the
12 benefit of hindsight when looking at the case studies.
13 However, there are patterns and certainly from my own
14 experience, they resonated and reflected what I have
15 seen first hand as well. The glaring omissions was
16 a lack of questioning around digital browser history or
17 asking about it and having those questions with the
18 parent as well as with the young person, with the
19 knowledge that some of the young people are using VPNs
20 and increasingly, young people are -- they are digital
21 natives. They are much more proficient in understanding
22 how to access a VPN, whereas many parents don't know
23 what a VPN is let alone how to access one and with the
24 lack of age checks around VPNs as well, that's an issue.

25 So much of browser history can be deleted as well.

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1 But in terms of indicators, one of the ones that
 2 I certainly saw across the case studies was a blurring
 3 of fantasy and reality. I think, in particular in one
 4 case, there was so much immersion in that online life
 5 that they were describing one of the characters from
 6 an online game as a real person who was part of their
 7 life and they attributed real emotional connection to.
 8 And with the development of games and the fact that with
 9 so many of these online games you can, as a player,
 10 change the outcome of those games and you can determine
 11 the level of violence, one of the young people in the
 12 case studies -- and this also reflects what we are
 13 seeing across schools -- was playing a simulation of
 14 school shooting games, prior to an incident in which he
 15 planned that.

16 So, you know, in terms of those risk factors, it
 17 comes back to what we have already heard about,
 18 professional curiosity and asking. Across all of the
 19 case studies there was very, very little conversation
 20 about that digital history and actually what was
 21 happening online and often, in many of those cases where
 22 you have disrupted education, or where you have children
 23 who are not in education, employment or training, that
 24 isolation will draw them, as we have already discussed,
 25 towards spending more and more time online.

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1 it is consumed by young people.

2 Where does one start in trying to graduate that as
 3 a factor of concern if you are beginning to be worried
 4 about violence, given how widely it is consumed.

5 Dr Lloyd, can you help on that?

6 **DR LLOYD:** It is not a particular area of expertise for me
 7 but I know that from some research with those who are on
 8 incel websites, that two-thirds of them also reach
 9 a threshold of diagnosis for autism. So it is something
 10 that those with that diagnosis are drawn to and we are
 11 not sure -- I'm not really entirely sure how that
 12 happens. I think probably Lizzie is in a stronger
 13 position to explain that.

14 **MR MOSS:** Ms Swan?

15 **MS SWAN:** May I ask you to repeat the point?

16 **MR MOSS:** Yes, so the observation that Dr Lloyd was making
 17 was that although it is not within other areas of
 18 expertise, she noted that research has suggested that
 19 those with an autism diagnosis appear to be particularly
 20 drawn to incel-type material online and was suggesting
 21 that you might have insight into what the reasons for
 22 that might be?

23 **MS SWAN:** I can't speak to that specific research but
 24 I certainly can speak to the sense of seeking out
 25 belonging, seeking -- and also, as I have already

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1 One of the points I did want to raise as well, from
 2 a special educational needs perspective, is dopamine,
 3 and I defer to Dr Lloyd in this regard as well but
 4 actually the sensory seeking that comes from
 5 increasingly gory, increasingly violent online
 6 engagement.

7 My final point around that is also about the
 8 algorithm and the fact that with so many of the case
 9 studies and young people certainly in schools, that they
 10 are encountering violent content that they may not have
 11 expected to encounter, similar with incel and violent
 12 misogyny. It is hard to interpret, are they seeking out
 13 that content or is the content seeking them? So it is
 14 about having those conversations and as much as
 15 possible, increasing that visibility of their online
 16 lives.

17 **MR MOSS:** Thank you. You touched on misogyny there and
 18 I wanted to come to that, appreciating the overlapping
 19 nature of it but as a separate topic. Can we just deal
 20 with that now. I don't need to turn up the references
 21 in the reports. Sir, just for your note, page 22,
 22 5.7.4, and page 83, 5.9, are helpful references, but we
 23 do not need to turn it up. Can you just, again, in that
 24 area, we know in broad terms, sadly, how widespread in
 25 the manosphere, misogynistic content is and how widely

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1 mentioned, being sought out through that algorithm and
 2 through that exploration looking as well. I think
 3 I would be more inclined to direct my thinking away from
 4 the context of autism as opposed -- whereas, autism
 5 intersecting with other facets, because I think there
 6 are other elements across the case studies and certainly
 7 in practice, around -- that may be more relevant in
 8 terms of the amount of exposure to domestic abuse that
 9 certainly most -- very nearly all, but not all, of the
 10 case studies demonstrated.

11 And also what I wanted to raise as well was in terms
 12 of sexualised behaviour that we saw across the case
 13 studies and where I could see that intersection with
 14 autism certainly is around how we interpret sexualised
 15 behaviour, whether it is inappropriate, problematic or
 16 harmful, within the context of the individual's
 17 development and particularly around autism and that
 18 understanding.

19 But certainly, from experience and from the case
 20 studies, what was marked was an increase in
 21 inappropriate and problematic comments to female members
 22 of staff within a school environment, which then
 23 progressed to touching or inappropriate touching and we
 24 saw that across multiple case studies and certainly
 25 there is that escalation from that online identity which

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1 can be fueling this perhaps, certainly through into
 2 an increase into acting on those things within school
 3 which, in some cases, we have to be really mindful that
 4 we don't certainly dismiss anything on the basis of that
 5 young person's developmental needs, whether it is
 6 autism, conduct and so on, but also making sure that we
 7 are logging it, recording it, so that we can identify
 8 that when that pattern is increasing or is emerging.

9 **MR MOSS:** Thank you.

10 **MS GIANFRANCESCO:** Can I just build on that. So I think
 11 what Lizzie was saying there around sexualised behaviour
 12 is absolutely right. And for me, it is about where
 13 young people don't understand social norms and
 14 parameters. So one is around sexualised behaviours in
 15 school, sexualised behaviours that they may be
 16 displaying within the family home or outside of school
 17 settings, but the other is in terms of online us --
 18 looking at violence or misogynist content online is also
 19 doing that in schools, and schools being more aware.

20 We saw, in two of the case studies, that young
 21 people were looking at content within schools and
 22 actually, for me, that is a red flag because if a young
 23 person hasn't got the understanding around the social
 24 norms, in some ways, that is a positive because they are
 25 not hiding it. But in other ways actually they are

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1 people within the definition.
 2 Professor Cassam floated, as one of the
 3 possibilities, another acronym, NIVE, and this is trying
 4 to capture not the action but the individual,
 5 a Non-Ideological Violent Extremist. So, I think the
 6 idea is you get away from having to attach it to
 7 a concept of terrorism or similar, it is
 8 non-ideological, it is violent and again, as
 9 I understand it, by attaching at the end the word
 10 "extremist" you are trying to capture the notion that
 11 this person is actually at risk of going on to do
 12 something about it.

13 It may be useful, if I'm able, to come up with
 14 a definition that seems to work and that one, as it
 15 seemed to me, did appear to tick some of the boxes. Can
 16 I ask the five of you to reflect on it and obviously
 17 just because I have suggested it doesn't give it any
 18 weight at all but can we perhaps return to this at
 19 a convenient moment or at the end of your evidence to
 20 see whether that has any advantages?

21 **MR MOSS:** Sir, with that in mind, could I invite you to give
 22 the opposite of the usual warning?

23 **SIR ADRIAN FULFORD:** Yes, quite right. So, throughout the
 24 entirety of my career I have had to say to witnesses at
 25 breaks: you are under a firm injunction not to discuss

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1 beginning to say: I'm taking this outside of the
 2 parameters of something just being an interest for me
 3 solely online, so that --

4 **MR MOSS:** So the fact that they feel a need to do it during
 5 the school day shows perhaps the intensity of the draw
 6 of the material?

7 **MS GIANFRANCESCO:** Yes.

8 **MR MOSS:** Sir, would be that a convenient moment to take our
 9 mid-morning break?

10 **SIR ADRIAN FULFORD:** Yes, it would. Just before we part,
 11 can I indicate a question I'm going to ask, not today
 12 but probably tomorrow at the end. This returns to issue
 13 of definitions, a subject which I had earnestly hoped
 14 I was going to be able to avoid altogether but I don't
 15 think I'm going to be able to access that escape route.
 16 VFIs which, in some ways, captures the idea of trying to
 17 identify those in relation to whom there is a real fear
 18 that they are going to go on to do something very
 19 violent has, for understandable reasons -- and Dr Church
 20 you have mentioned at least some of them -- come under
 21 some criticism not least because you can be violence
 22 fixated without posing any risk at all and so there is
 23 a real danger that if you then don't go on to have
 24 a sort of an attached definition, some kind of text that
 25 goes with it, you are going to be gathering up too many

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1 your evidence with anyone else. The exact opposite
 2 applies here; feel free to talk about any element of
 3 your evidence that you would wish to discuss over the
 4 break that we will now have and we will sit again at
 5 11.45 am. Thank you very much.

6 **(11.31 am)**

(A short break)

8 **(11.45 am)**

9 **SIR ADRIAN FULFORD:** Yes, Mr Moss.

10 **MR MOSS:** Thank you, sir.

11 Before the break we were looking at risk factors and
 12 I would like to turn to bullying as another, recognising
 13 of course, that that may be seen as a vulnerability as
 14 much as a risk factor.

15 Could we have page 8, ILT000344_0008, of the report
 16 please, paragraph 2.6. So for Dr Lloyd and
 17 Ms Gianfrancesco and Ms Swan, in your report, you said
 18 this:

19 "There was no single characteristic pathway or
 20 assessment that could reliably identify a child at risk
 21 of engagement in extreme violence. Across cases, their
 22 grievances came from the accumulation and intersection
 23 of vulnerabilities and adversity over time."

24 Just pausing there. That's some of the matters that
 25 we touched on in our first morning session:

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"These included neurodivergence", which we will come onto, "mental-health difficulties", which we will come onto, "adverse child experiences", but then this: "... bullying and social exclusion that contributed to their self-hate, loneliness, isolation and loss of a sense of belonging, with online spaces as their own source of connection."

Mr Basu, we don't need to turn it up, but for the Chair's note, page 123, paragraph 4.2.3, you refer also to bullying as a matter from which you had drawn.

Can I ask this first of all, does this extend to the young people being bullies themselves or is it about them being bullied? Are both a risk factor or are you mainly picking on the sense of them being bullied? Ms Swan?

MS SWAN: I think in this context we were highlighting the young person's perception of being bullied. In the case studies that we read, there was little if no evidence -- or contemporaneous evidence that the young people were themselves bullied. However, in their later accounts, they described having been bullied. What we also saw in the case studies, particularly in two of them, that there was evidence from nursery age upwards, so from age 2/3, of other children -- and this is in their documented statutory assessments of special educational

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in one of the case studies there were a lot of examples of self-loathing and that very much drove that young person, it seems, online asking questions and trying to better understand themselves which, through the algorithms, led to more and more time spent exploring dark matter online. But I defer to my colleagues here to see if there was any aspect where we saw otherwise in terms of bullying.

MR MOSS: Yes. Mr Basu, did you want to come in?

MR BASU: I mean, I think it is a bit of both. So it is definitely a perception of being bullied, but whether it is a layperson's perspective or not, I see a lot of people who would have been described as bullies commit violent offences, have aggressive personality. But people who perceive they are bullying -- I go back to your earlier conversation before the break about grievance. There is almost always an underlying grievance in serious violent offenders. We find it -- we normally find it when we are interviewing them after the offence and those who want to talk, there's almost always -- I have described in almost every case that I have dealt with over 30 years the back stories of the individual would make you weep and part of that back story -- and we will go into all of those other factors, but one of them might be that they were a victim, they

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needs and their EHCP plans -- that other children were afraid of them and there were acts -- when one of the case studies was aged four or five, of physically tormenting other children and that there were repeated examples across other case studies as well.

The reason for raising that is there are instances where there is social interaction, from even the earliest age, with their peers was affected and increasingly their peers distanced themselves from the young person and that was all that was known for those young people as they grew up. So again, we are intersecting that with neurodevelopmental conditions, possible foetal alcohol spectrum disorder and the other factors that those young people were experiencing at home.

So we were very much exploring the young person's self-report of being bullied themselves and compounded by the lack of records, that led us towards that notion of perceived. But there were also -- in terms of us looking with hindsight at the young people's experiences, there were records that their peers, and in some cases their teachers, described them as: weird, odd and used potentially isolating language to describe them and that sort of perpetuates that sense of that young person's sense of isolation. Certainly, again, lastly,

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were socially excluded.

The opposite of that is the protective factors of having a stable, loving family or a good peer group of positive individuals around you is immense. If you lack that, you become more and more socially excluded. Where do you go for any kind of validation or understanding of the kind of person that you are? We were seeing people going for that online, where they might be quite communicative online in the way that they could not be in the real world. But they would be looking -- they would be easy prey and very malleable to people online who might be predisposed to taking them down a certain path.

In the real world of terrorism, that would be radicalisers, looking for people who would be the tip of the spear, to use a rather blunt term. In this case, and you mentioned incel. Incel is a very wide spectrum of people. At the very dark and violent end of it -- it is how people move from one end of the spectrum to the other, based on: I don't understand who I am, no one will speak to me, I'm socially excluded, this is what I'm thinking.

Then when you try to discover that -- we were seeing this back in 2019 when we first saw the phenomenon -- is it started off with: you are not alone and a relatively

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1 anodyne community. They were talking about the reasons
2 why they could not find partnership and then you would
3 watch that get progressively darker and that's the thing
4 I would worry about, that people with this sense of I'm
5 being bullied, the perception that: I'm being bullied
6 and I'm different, seeking that identity elsewhere makes
7 them very easy prey, particularly online.

8 **DR CHURCH:** In various ways we see, or can see, a spiral of
9 adversity occur and when it comes to bullying, it is
10 often the case that there is some factor that
11 predisposes an individual to being bullied and in this
12 cohort, in these case studies, we are looking at young
13 people who are in some ways -- in various ways
14 disadvantaged and that puts them then at risk of being
15 bullied and experiencing peer rejection or isolation.
16 I use the term "peer rejection", that is actually one of
17 the items from the SAVRY risk assessment; which is then
18 of course an indicator of a risk of future violence.

19 So, as others have said, it is intimately connected.
20 The adversity leading to some sort of different
21 treatment with peers or peer rejection or bullying,
22 which then changes the individual's view of themselves
23 in relation to others which perhaps makes it less likely
24 that they will create opportunities for pro-social
25 engagement with peers because of withdrawal, for

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1 disclose will be impacted. So I don't want to diminish
2 or divert away from that.
3 **MR MOSS:** No, and I don't wish, by asking that question, to
4 suggest that there may not equally be cases where they
5 are being bullied, whether because of neurodivergence or
6 otherwise. But, secondly, in terms of trying to find
7 some assistance and conclusion in this area, would it be
8 right that "even if" it is a case of perceived bullying
9 rather than they are, in fact, being bullied, it is
10 important to dig beneath what that says about their
11 needs and what is not being met and the sense in which
12 they may perceive that they are being bullied because
13 they are in fact isolated? That is a very layperson's
14 simplistic explanation but again, does that sit behind
15 some of the significance of the perception of bullying
16 as a risk factor? Dr Church?

17 **DR CHURCH:** I would say that yes, in some cases, it can be
18 the case that there is no objective evidence of bullying
19 but I have a phrase from a young person on my notice
20 board and I wrote it down in quotes in my office, which
21 says that they experienced "an exclusion so subtle that
22 nobody else could see it" and what they were referring
23 to was not just not being included in games or
24 conversations, but actually all sorts of aspects of
25 school life that made them feel very, very different.

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1 example, from opportunities for social engagement and
2 then that sort of perpetuates the isolation and the view
3 of being seen as different from others.

4 **MR MOSS:** So, for the Inquiry, one of the aspects of
5 interest here is -- to look at it also in terms of AR,
6 the Chair's findings in relation to that must be taken
7 from the report itself -- but in high-level summary, AR
8 reported in a number of ways a sense of being bullied
9 but on examination it didn't appear that that was
10 objectively correct. In particular, at his second
11 school they had clear documentation and some of the
12 instances appeared to be at most six of one, half
13 a dozen of the other, and in other cases sometimes AR as
14 the instigator.

15 But should we take it, first of all, that that
16 perception of being bullied is itself an important
17 aspect of risk even if objectively it doesn't seem to be
18 warranted, that doesn't invalidate that as a concern in
19 terms of the risk, would you all agree with that?

20 **ALL:** Yes.

21 **MS SWAN:** I would not want to dilute or diminish the
22 evidence-informed facts that certain children are more
23 vulnerable to being bullied and therefore, specifically
24 for autistic children and children with specific
25 communication and interaction needs, their ability

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1 So, yes, that was the subjective experience but it
2 is quite hard to put ourselves in the shoes of that
3 person. Sometimes it may be quite an unreasonable --
4 there may be an unreasonable basis for someone to claim
5 that they have been bullied.

6 **MR MOSS:** That is, no doubt, a spectrum.

7 **DR CHURCH:** Yes, sometimes individuals have been the cause
8 of their isolation or bullying by doing something at
9 some point which caused peers to withdraw perhaps and
10 the individual may have moved from that but then is
11 surprised that others are still avoidant or have
12 a negative view towards them in some way and they might,
13 for example, describe that as being bullied by others,
14 by exclusion for example.

15 **MR MOSS:** Ms Swan, I suspect that has a close intersection
16 with your specialism?

17 **MS SWAN:** Yes, certainly. I think where we have children
18 who have identified needs around social communication
19 interaction and they have an Education, Health and Care
20 Plan that should be securing provision for that, then
21 the child is not in school and is not receiving that
22 provision, we are further compounding those issues as
23 well, but certainly I agree with what Dr Church has said
24 there.

25 **MR MOSS:** Thank you. That leads -- I'm so sorry,

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1 Ms Gianfrancesco, please.

2 **MS GIANFRANCESCO:** Also what I think we are talking about
3 here is children who have numerous adverse childhood
4 experiences. Now, some of these children will be
5 incredibly resilient because they have had to learn
6 resilience to actually manage their home environment but
7 they may not necessarily have resilience in the same way
8 as other children that are being brought up in stable,
9 safe, secure environments, in terms of their social
10 interactions. So as Dr Church was saying, they may have
11 experienced something which we are then seeing as
12 perceived bullying but for them actually, it was a true
13 experience because their resilience hasn't been -- isn't
14 there to enable them to actually feel: okay, yes, well
15 that happened and they didn't invite me into that game
16 or they didn't do that, but that's okay because tomorrow
17 this will happen.

18 So I think it is very subtle for some young people
19 and we won't necessarily see it, but for them it is
20 real. It isn't perceived, it is real, but they don't
21 have the skills, the resilience, the ability to be able
22 to express and verbalise for them what they are
23 experiencing. That becomes very subtle and very
24 difficult as professionals for people to identify when
25 that's happening.

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1 separating themselves away from that individual and that
2 in and of itself can be a factor that we need to take
3 notice of. As I said, in at least two of the case
4 studies, that was happening from nursery age onwards and
5 was just further and further compounded and that is
6 an element that is -- alongside perhaps bullying, that
7 social exclusion is really important to consider.

8 **MR MOSS:** So exclusion by peers, peer rejection. Dr Church,
9 the SAVRY aspect that you mentioned. Thank you.

10 I was going to turn next to social isolation and
11 NEET but to some extent, we have touched on that
12 already. I'm not going to go to specific parts of your
13 reports because really, throughout your reports, you all
14 refer to the significance of this. But the accumulation
15 of factors leading to social isolation, would you agree
16 that that's a strong theme that comes out from the case
17 studies?

18 **ALL:** Yes.

19 **DR CHURCH:** Absolutely.

20 **MR MOSS:** In terms of not being in education, employment or
21 training as a factor, Dr Irani amongst others in the
22 seminars, I think metaphorically if not actually
23 literally, almost banged her fist on the table and said:
24 you cannot underestimate -- my paraphrase -- of keeping
25 a young person in some form of education as a protective

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1 **MR BASU:** The bit that strikes me is how dangerous it is for
2 risk that when professionals dismiss the perception, so
3 they prove effectively that the person themselves was
4 the bully, or they were never really bullied, if you
5 dismiss that and you don't look deeper than that, that's
6 going to compound the grievance of the individual.

7 **MR MOSS:** That's really the purpose of my questioning in
8 this area, is that one needs to get beyond the stage
9 of --

10 **MR BASU:** Of professional curiosity, yes.

11 **MR MOSS:** Yes. So in looking at this as a factor, one talks
12 about a list of things that need to be explored but
13 would this be a fair summary, that it is very important,
14 even if the evidence might suggest that there isn't at
15 least a direct as opposed to the subtle forms of
16 bullying, and on objective assessment that the school
17 may have checked: is this other boy behaving this way?
18 Well, he doesn't seem to be. You need to go beyond that
19 and not, at that stage, then dismiss. There needs to be
20 the professional curiosity to examine that and what that
21 says about isolation, needs not being met. Ms Swan?

22 **MS SWAN:** Just to add to that, I think across the case
23 studies what we saw was a need to listen to peers, other
24 students, other online users as well. One of the things
25 that we do notice in schools is when other children are

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1 factor. Again, that seemed to be something that came
2 out as a strong theme throughout all of your reports.
3 Would you agree?

4 **ALL:** Yes.

5 **MR MOSS:** Thank you. Dr Church, if we could have page 82,
6 ILT000344_0082, please. Allied to that, paragraph 5.7:

7 "A strong pattern in the case studies is the
8 emergence of individuals acting alone, not in
9 a partnership or group, nor in a gang. These VFIs
10 characteristically undertake lone, solitary violent or
11 other anti-social acts, often driven by internal
12 factors, with potentially devastating consequences."

13 So do -- is the duality here that we have got not
14 only socially isolated but then, in terms of the ways
15 that they are acting in violence, they are not acting in
16 a partnership or group. So there is a double problem
17 there?

18 **DR CHURCH:** Yes, I think as we mentioned earlier, these
19 factors all intersect and actually work together in
20 a harmful way. So, the combination of isolation and
21 consumption of violent content online, for example,
22 means that there isn't peer or family or parental
23 influence in modulating the response or interpretation
24 of any of that material.

25 Perhaps in other cases, in my experience, young

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1 people have engaged online and it is very clear that
 2 other peers have actually been involved in that and in
 3 these cases, there is a very clear solitary sort of
 4 component. So the isolation made the immersion in the
 5 online content much more harmful than in other sort of
 6 contexts, and certainly then appears to have proceeded
 7 to solitary action, yes.

8 **MR MOSS:** Thank you. So the opposite of what one might come
 9 across frequently of a group of friends at school
 10 engaging in inappropriate material online of whatever
 11 kind, at least has one benefit that there are others who
 12 are involved in it and, if needs be, can talk about it.
 13 But here, another particular risk factor is that they
 14 are doing it either alone or at least not with their
 15 peers, with strangers online, is that a fair summary?

16 **DR CHURCH:** Absolutely, because young people learn from
 17 their peers and an individual with the sorts of
 18 vulnerabilities that we have been discussing here,
 19 including autism spectrum disorders, can't always
 20 benefit from peer learning in the same way, or they are
 21 at risk of that learning being somehow impaired or
 22 limited in some way. So, yes, they are disadvantaged by
 23 that loss of peer relationship, that in other
 24 individuals in a day-to-day, moment-to-moment, manner is
 25 consequently providing them feedback in terms of what's

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1 the cause of it and are less likely to want to pick up
 2 the phone, call the police and say: would you mind
 3 coming and arresting this child.

4 So when I say "lenient", it is perhaps a pejorative
 5 term, because it sounds like they are not taking the
 6 matter seriously. I think they do take the matter
 7 seriously but they don't want an outcome that involves
 8 a criminal charge or a criminal caution for a child.

9 Now, if those -- that behaviour is very persistent,
 10 and we have a case study with multiple cases and
 11 multiple exclusions and temporary exclusions, that's
 12 a big problem and at some point somebody has to sort of
 13 intervene with what is offending and at least record it
 14 and get that child into a system whereby there might be
 15 more restrictive measures around the child, whether they
 16 end up with a youth conditional caution or some form of
 17 Criminal Behaviour Order, or restrictive -- but it may
 18 have gone to such a level where that needs to happen.

19 If the initial offending, so say it doesn't
 20 escalate, and there may be a period of years between
 21 that early offending and what happens next but it has
 22 never been recorded, it is never shared with other
 23 practitioners, it becomes part of their history that
 24 I talked about earlier, this person did have
 25 a predisposition towards violence at a certain point.

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1 appropriate, what's not, why did you do that, don't you
 2 think this, the other? So that sort of learning, peer
 3 learning, is not available, yes.

4 **MR MOSS:** Thank you. I want to turn to one of the other
 5 factors that has been drawn out as a risk factor and
 6 that's lower-level violent offending. So Mr Basu, if
 7 I can turn to you on this. If we can have page 123,
 8 ILT000344_0123. I think we have looked at this in
 9 a different context. It is paragraph 4.2.1. I won't
 10 read it all out because I read it earlier, but you said:

11 "Pre-index offending in the form of low-level
 12 criminality was common and leniently dealt with."

13 What were you alighting upon there as to the
 14 significance of low-level offending in terms of the risk
 15 matrix in the case studies? I don't want to go into
 16 individual cases, but as a whole?

17 **MR BASU:** I understand that and it is important that when
 18 I say this it is not a criticism, it is a reality and it
 19 also largely comes from a place of compassion and we
 20 have spent decades getting to the point where we are
 21 trying not to criminalise children, whether you are in
 22 policing or in any other form. I would think that
 23 teachers who are reporting low-level offending assaults
 24 on other people or assaults on teachers themselves do
 25 want that behaviour to stop and they do want to examine

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1 That may be explicable by the age of the person or the
 2 issues they were going through at the time, or it may be
 3 indicative of the fact that they are potentially at
 4 further risk in the future, but it is not recorded
 5 because we decide to deal with it in a common sense and
 6 lenient fashion. I mean, I wasn't actually critical of
 7 some of the decisions that were made because I can see
 8 myself as a young police officer making exactly those
 9 decisions.

10 **MR MOSS:** So again, of interest to the Inquiry is the fact
 11 that in AR's case we saw territorial policing on
 12 a number of call-outs to the home for relatively
 13 low-level matters. So relatively low-level assaults on
 14 father, some instances of physical damage being caused
 15 within the home. There was one to a car. And one can
 16 see, in a sense, that one wouldn't perhaps, taking those
 17 in isolation, expect them to lead to a more significant
 18 intervention in terms of charge and so on. But, first
 19 of all, we shouldn't think that AR was a one off in
 20 that. That's something you have picked up from the case
 21 studies, that that sequence of lower level offending
 22 that perhaps isn't grasped, the cumulative significance
 23 of it?

24 **MR BASU:** Can I caveat that with what I would expect. So
 25 I would have expected there to have been

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1 a computer-aided dispatch message of repeated calls to
2 that family address. So there would be an intelligence
3 of repeat potential offending. I would expect those,
4 where an allegation has been made, for a crime report to
5 have been put on the system. Even if the father, the
6 teacher, a member of the public didn't want to proceed,
7 there would be on a crime report delivered.

8 That sometimes does not happen because it is an easy
9 way of keeping your crime figures down and it is a lot
10 of paperwork for not actually getting to a point of
11 prosecution or charge, so it is seen as a kind of: well,
12 that's unnecessary, there is a record on the system
13 anyway. But it should be recorded as a crime report and
14 the reason for that is obviously important if the
15 behaviour deteriorates because what you are not going to
16 then do is have a child who is receiving continual
17 leniency again and again and again. You should be
18 looking at repeat patterns of behaviour as potentially
19 a much higher risk --

20 **MR MOSS:** Presumably not just deteriorate, but accumulative
21 effect. I think once it's happened eight or nine times.

22 Yes. Ms Swan, I think you wanted to -- so sorry,
23 could --

24 **SIR ADRIAN FULFORD:** Just before Ms Swan does, can I, just
25 for my note, Mr Basu, where you say, "a computer-aided

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1 the case studies, certainly within three of the case
2 studies, but this is something that is recognisable
3 within alternative provision, specialist settings, where
4 there may have been a pattern of behaviour leading up to
5 it, but there is certainly in some instances
6 a reluctance from the police force to come over to the
7 school when that happens because there can be situations
8 where the police force don't have the capacity, the
9 resource to deploy to the school and so they would
10 suggest that's a school issue to deal with.

11 But there's also -- exactly as Mr Basu said, I think
12 on behalf of the teachers and the school staff, there is
13 a reluctance to pursue making -- going forward and
14 making complaints to the police force because -- out of
15 compassion, or misdirected in some cases because we miss
16 out on that opportunity to identify emerging patterns
17 and get the right support in place. But also criminal
18 damage in schools is increasingly an issue, not just in
19 specialist settings, same with assaults. It is also
20 happening increasingly in mainstream.

21 There is a sense of normalising violence in some of
22 these settings and by not making those referrals and not
23 pursuing it, there can be a sense of normalisation and
24 the professional's threshold of what they think is
25 acceptable or criminal just gets higher and higher out

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1 dispatch message" and, "making a record that this
2 reflects some kind of criminality", that is independent
3 of bringing a charge or are the two co-dependant?

4 **MR BASU:** It is independent, sir.

5 **SIR ADRIAN FULFORD:** It is independent. So you would
6 register it on the system as criminal behaviour by the
7 young person, but they wouldn't necessarily have been
8 arrested, or --

9 **MR BASU:** It depends how it is resulted on that
10 computer-aided dispatch because it might be: nothing to
11 see here. So it won't contain the detail you would
12 require. If, for instance, six months later you are
13 looking at a violent offence at that house and it says:
14 well, we were called to the house but there was nothing
15 to see and the father made no complaint. But actually
16 the detail behind that was far more significant but it
17 wasn't recorded because no crime report was put on with
18 much more detail.

19 **SIR ADRIAN FULFORD:** Okay, thank you.

20 **MR MOSS:** Ms Swan and Ms Gianfrancesco wanted to come in,
21 but Ms Swan first.

22 **MS SWAN:** I just wanted to add to what Mr Basu said about
23 the patterns of behaviour in terms of the assaults on
24 teachers, physical and verbal assaults, and assaults on
25 peer. Those definitely -- and this is not just within

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1 of a desire to help the child.

2 **MR MOSS:** Ms Gianfrancesco, you wanted to come in?

3 **MS GIANFRANCESCO:** I agree completely with what Lizzie and
4 Neil have said. For me, one of the big issues, if we
5 separate kind of school and crime that's reported to the
6 police, is when crime is reported to the police, as Neil
7 said, Mr Basu said, it will be on a record somewhere.
8 It may be minimum, it may be: father called police and
9 then didn't pursue with any charges or anything. But
10 there will be a record there.

11 When something's held within the school, that
12 behaviour is only on the child's school record. What
13 I have seen -- and we didn't see in these cases, but
14 what we will see -- is as young people move into
15 adulthood, and -- things will become lost. So as young
16 person transitions over into 18 -- and I saw this when
17 I was sitting as Channel chair, that we would get
18 information on someone who was 18 but we would not have
19 the full picture because they were no longer in school
20 and their school records didn't come through into
21 Channel. So when I would ask things like: has there
22 been a history of violence? What history of violence is
23 that? Other than the information from the police, we
24 weren't getting the school records. Now, I used to
25 insist that I want the information from the school

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1 records and was able to get that because of my position
2 and where Prevent sat within the local authority at the
3 time.

4 So it means we could see that a child had escalated
5 in school and some of this behaviour. But it is a real
6 issue in terms of information sharing, particularly when
7 we are talking about these young people, the
8 neuro-immaturity and that transition, that at the point
9 of 18, you can lose a whole tranche of records. So
10 overnight all of that information doesn't transfer with
11 a young person if they are no longer in education.

12 **MR MOSS:** Thank you.

13 **DR CHURCH:** If I may, Mr Moss. On the subject of
14 lower-level violence offending, I would extend that to
15 include lower-level anti-social behaviour in all forms,
16 which is often not even documented, as we were saying,
17 in one organisation or agency, let alone shared with
18 others.

19 But the breadth of anti-social behaviour could
20 include aggression or destruction of property or damage
21 to property, as we have mentioned, but also
22 deceitfulness or theft or other violation of rules and
23 I'm actually reading from the criteria for a diagnosis
24 of "conduct disorder" or "conduct dissocial disorder" in
25 ICD-11 because all that contributes to a profile of

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1 that conversation needs to be considered and further
2 exploration around: well, what do we do if the young
3 person has, in some cases maybe a grievance towards the
4 police or there may be, of course, generational issues
5 around criminal behaviour, but that relationship and
6 that response to the police force, I think, is
7 important. I don't know if Mr Basu has anything to add
8 on that or would disagree but certainly in schools there
9 is a fear there for practitioners around: where do we
10 go?

11 **MR MOSS:** We may come back to this in interventions perhaps,
12 in looking at whether mentors have a role in that as
13 an intervention. Thank you.

14 I want to touch briefly on weapons as a risk factor
15 which may seem a very obvious risk factor but there is
16 two aspects of this; an interest in weapons,
17 particularly weaponry online, but then progressing to
18 researching weapons and purchasing weapons which, of
19 course, was seen extensively in AR's case.

20 I just wanted to ask about this, and again, Ms Swan,
21 it comes back to the point you made about how common
22 an interest in violence is. I don't suppose that
23 an interest in weapons is unusual in young men, in
24 teenage boys, particularly in the digital age. Again,
25 what should practitioners be looking out for? As

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1 concern but is often not identified, again, because of
2 not recording these or sharing those sorts of concerns
3 of general anti-social behaviour, not even just the
4 violence.

5 **MR BASU:** Can I add an additional point about, I wouldn't
6 want my evidence to be seen as what I'm advocating is
7 that every child who commits --

8 **MR MOSS:** No, I understand that and if I may, I'm going to
9 park that and come back to it because it comes back to
10 what reforms there may need to be, and not going over
11 the top in that in suddenly charging every child when
12 there is an incident in the home. So, yes.

13 **MS SWAN:** I just wanted to add one further point which is
14 around what we have observed, and what we have seen in
15 the case studies and unfortunately I have seen in
16 practice of note is the interaction between the young
17 person and the police. In some of the case studies
18 there are examples of the young person, at a very young
19 age, assaulting police officers, damaging police cars
20 and from an education perspective you are calling in the
21 police and where there is that, even on a lower-level
22 offending perspective, where there is that complete
23 disregard for any authority, the fear is: where do we go
24 if they won't listen to their parent, the teacher or the
25 police? I think that's something that perhaps within

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1 opposed to perhaps an obvious shock and horror about
2 looking at weapons online, what practical help is there
3 in assessing what should be seen as really worrying
4 beyond the fact that of consumption of that material
5 online? Can anyone come in on that? Dr Church?

6 **DR CHURCH:** Yes, in my experience it is always helpful to
7 ask a young person if they have tried obtaining, or are
8 interested in obtaining weapons, and some will readily
9 admit to this in my experience. And that's a crucial
10 step, I would say. It goes from an intense interest to
11 something that could be described as a capability, if
12 they actually have weapons to actually enact something.

13 Again, some may obtain weapons, perhaps illegally
14 but purely out of their interest in weaponry with no
15 intent to cause anyone harm. But, again, if no one asks
16 the young person what they intend to do with it, then
17 they will not necessarily get the answer to that
18 question. But, again, professionals should be
19 encouraged to be able to have these conversations with
20 young people who, in my experience, very often are able
21 to describe what their intent is.

22 So, again, it comes to a sort of curiosity and
23 interest and equipping professionals with the training
24 and the environment really in terms of a team and
25 supervision and so on, to be able to make those

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1 enquiries, to not shy away or recoil from those
2 enquiries about weapons and actually ask those questions
3 which may seem difficult. It may come very naturally to
4 a police officer, for example, but come less naturally
5 to someone who is accustomed to working with young
6 people who present very different sorts of difficulties.

7 **MR MOSS:** Ms Swan, again, I suspect this is an area in which
8 you sadly have wide experience?

9 **MS SWAN:** I would agree. I think it was Professor Smith in
10 the seminars that said that those interests are actually
11 core predictors of action and rather than looking at
12 someone with those strong interests, actually what are
13 the more notable markers are around the operational,
14 planning, logistics, action and efficacy. And what we
15 have seen unfortunately -- well, in the case studies but
16 also in my day-to-day practice, is -- if I just use one
17 of the case studies as an example, there is a huge
18 amount of research that was done in terms of the
19 logistical planning, in terms of contacting schools,
20 doing research online. The challenge is we know that,
21 with hindsight, it is about trying to understand what
22 was happening. In schools some of the ways that we see
23 this is through graffiti -- which may sound quite
24 trivial but through graffiti, through notes, through
25 drawings.

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1 possible violence (Melay & O'Toole ...). Such
2 communication does not establish violent intent or
3 dangerousness. Its significance depends on its content,
4 context and relationship to other information known
5 about the young person. Where sufficiently concerning,
6 it may therefore require further exploration rather than
7 being interpreted from the communication alone. This is
8 consistent with KCSIE 2026, which requires the DSL,
9 where there are concerns about a child carrying or using
10 a weapon or expressing an intention to do so, to assess
11 risk to the pupil and others, taking account of wider
12 information and concerns."

13 And Dr Church at page 83, ILT000344_0083,
14 paragraph 5.10:

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

25 Finally Mr Basu, page 124, ILT000344_0124, please.

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1 Certainly, in many of the case studies what we saw
2 was increasingly gruesome, increasingly gory,
3 increasingly detailed drawings and depictions. I think
4 it is trying to understand actually where the planning
5 and the intent -- and I would defer to my colleagues
6 further down the tables in terms of what those
7 indicators may mean, but, you know, in schools we see
8 things through -- I see, in IT lessons certainly that
9 was the case and also through PSHE lessons, those views
10 can come across and we are there to challenge and ask
11 questions.

12 **MR MOSS:** Thank you. Can I come onto disclosures and
13 leakage next. Can we have page 49, ILT000344_0049,
14 please, from the first of the sub-reports. It is
15 paragraph 8.12.4. An interest in violence, weapons or
16 violent offenders can have different meanings for
17 different young people:

18 "Professional curiosity was required in response to
19 concerning online communications. These may include
20 statements, messages, posts or other communications
21 about violence, weapons, harming others, or intentions
22 to cause harm. The forensic literature uses the term
23 'leakage' where a person intentionally or
24 unintentionally communicates thoughts, feelings,
25 fantasies, attitudes or intentions that may indicate

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1 4.5.1, second half of the page:

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

15 Now, I have read those three passages out because
16 there might be thought to be a bit of a conundrum here.
17 On the one hand, you seem to be identifying that
18 leakage -- or warning behaviour, to use Mr Basu's
19 phrase -- is a serious indicator and needs to be treated
20 seriously and needs to be explored. But, on the other
21 hand, I think you are emphasising that the context needs
22 to be looked at because it isn't always an indication of
23 an imminent threat of an actual attack, and the
24 inference might be there is a risk of acting too
25 strongly or too forcefully in relation to them. So is

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1 that a false conundrum? Can you comment on that,
 2 Dr Church?
 3 **DR CHURCH:** I think it is one element in a broad formulation
 4 of a young person's presentation, how they have arrived
 5 to this point and it is very -- it would be very unwise
 6 to dismiss any data point or item of this sort, but, at
 7 the same time, on its own, shouldn't necessarily trigger
 8 the most severe or harshest police response. So there's
 9 a need to interpret it, I think.

10 Again, on further examination of this sort of
 11 information, which can be very varied in all sorts of
 12 media, if there is a sense of threat to recipients of
 13 information that was present in some of the case
 14 studies, for example, if they discovered preparatory
 15 acts and were then threatened: don't tell anyone or
 16 else, then that has a certain -- might raise more
 17 concern than, for example, something that's disclosed in
 18 a different way. But, neither of those can be
 19 dismissed, of course. There may be some characteristics
 20 that make it more concerning.

21 **MR MOSS:** Thank you. Dr Lloyd, as a psychologist?

22 **DR LLOYD:** I'm sorry, I'm finding it really hard to read
 23 what's on the screen here because of the lights.

24 Disclosures, I mean there were two occasions from
 25 our case studies on which a child did actually disclose,

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1 see it in context.

2 **MR MOSS:** Thank you. Ms Gianfrancesco, you wanted to come
 3 in?

4 **MS GIANFRANCESCO:** Yes. For me within social work, actually
 5 young people very, very rarely tell their social worker
 6 what's happening directly. They won't say, "I'm being
 7 abused" or, "I'm thinking of going and committing this
 8 offence". But what they will do is, unconsciously quite
 9 often, drop massive subtle hints. And it is the
 10 professional's job as the professional to keep all of
 11 their senses open to look for these hints and be aware
 12 of them. You know, some of them may be, as we were
 13 referring to before, a young person looking at violent
 14 or extremist websites online in school, or it may be
 15 drawing a picture of something that's violent or
 16 extremist, or it may be saying something misogynistic to
 17 a teacher or friend. It may be telling their social
 18 worker something, it may be indicating about an offence
 19 that they were involved in at the weekend. There are
 20 lots and lots of things. It is for the profession to
 21 have the profession curiosity to begin to ask more
 22 questions of that young person, to be able to draw out
 23 really what is happening here.

24 So, as Monica was saying, we saw some of that within
 25 the case studies. Within one of the case studies we saw

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1 including whispering in the ear of one teacher, "I need
 2 help". So, I mean, that really struck us as being quite
 3 upsetting really to think that these children were
 4 really struggling and to -- and disguising the fact that
 5 they are struggling, except with one particular teacher,
 6 with whom the child --

7 **MR MOSS:** If we avoid too much of the detail of the
 8 individual case studies, but just thinking about -- what
 9 I'm really grappling at is that this could happen a lot
 10 and have a spectrum of seriousness and I'm interested in
 11 exploring any practical guidance for what needs to be
 12 looked at in the level of risk because there seems to be
 13 a risk of sometimes overreacting to this but also it
 14 shouldn't be dismissed in any case, says Dr Church. Can
 15 you help on that without reference to any particular one
 16 of the case studies but just as a psychologist, what the
 17 further question should be or the action should be to
 18 dig beneath the surface?

19 **DR LLOYD:** I do agree that shouldn't be ignored and there
 20 should be a conversation about that. Yes, I mean
 21 I think that it is very, very important that we see this
 22 as part of a much -- in its context and look at the
 23 other factors that are at play here. So we are not just
 24 making a decision on one element. So, yes, there are
 25 conversations that need to be had and it is important to

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1 a young person who was becoming more and more violent
 2 and acting out and acting out more in school,
 3 experiencing more exclusions and sort of violence within
 4 the community. For me, what needed to happen was the
 5 professionals to begin to say: what is happening here?
 6 Why is this happening? I think quite often
 7 professionals get into a catching up mode of thinking:
 8 we have got to try and contain. They do have to try and
 9 contain, absolutely, but at the same time as the
 10 containment, they have got to understand what they are
 11 containing.

12 So I think quite often in Channel you will see that,
 13 that what Channel does is referrals of a child who's got
 14 that extremist behaviour in school, it goes into
 15 Channel. But that's good because then you are getting
 16 the professional curiosity from numerous professionals.
 17 So it isn't just the one professional being curious,
 18 it's then having the wider, multi-agency discussion and
 19 actually everybody who knows that child and
 20 professionals with expertise then beginning to look at:
 21 what is happening here?

22 So we are not saying that every time a child gives
 23 a disclosure you have got to have a multi-professional
 24 meeting, what should happen is that professional
 25 involved in that child should begin to ask more

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1 questions and if they have concerns around that, then
 2 they need to go and ask further questions of other
 3 professionals: have you noticed this? What's happening
 4 over here? And begin to drawing something together.
 5 **MR MOSS:** Thank you, and presumably to get ahead onto some
 6 of the issues we'll look at under professional practice,
 7 but make sure it is documented and decision-making: do
 8 I refer this on, do I not? That there is --
 9 a defensible decision-making is documented as to what
 10 has been happening?

11 **MS GIANFRANCESCO:** Yes.

12 **MR MOSS:** Thank you very much. The final factors of the
 13 factors on risk factors that I wanted to touch on is
 14 Mr Basu, what you have referred to as "disguised
 15 compliance" and we are familiar with that as a term from
 16 Phase 1 of the Inquiry. Can we have page 125,
 17 ILT000344_0125, please, on the screen and it is
 18 paragraph 4.5.2:
 19 "Disguised compliance is another recurring risk.
 20 Subjects could attend sessions, appear calmer, say the
 21 right things, present aspiration, or minimise their
 22 behaviour while still continuing harmful online activity
 23 or maintaining violent fantasies. Periods of
 24 improvement were sometimes treated as evidence that risk
 25 had reduced, leading to closure or step-down. The

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1 detectives on day one -- and this is a little insight
 2 for the Inquiry on how cynical police officers become --
 3 is because your initial training is: assume nothing,
 4 believe nobody, check everything. How often is that
 5 actually done by all the professionals in this case --
 6 in these cases?

7 That's something that's very difficult to do.
 8 I think the layperson also thinks that somehow police
 9 officers have this innate ability to spot when you are
 10 lying. There's been some studies done on that over the
 11 years in various jurisdictions. We are marginally
 12 better than the average person in society, but not great
 13 and we are a lot worse than psychiatrists and
 14 psychologists.

15 With this esteemed panel here, they will want to
 16 come in on this, but the time it takes you to adduce
 17 that is a lot longer than you think. You know, a lot of
 18 police officers have a very short period of time
 19 engaging with an individual and some of these case
 20 studies, the amount of time spent with a subject to try
 21 and understand who they are, what they are feeling, what
 22 their risk factors are is remarkably short and for
 23 a layperson looks nowhere near long enough to determine
 24 if they are a risk or not, but certainly some of the
 25 police interactions were frighteningly short to make any

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1 thematic concern is that improvement in presentation was
 2 not always tested against wider evidence, particularly
 3 online activity, family accounts, school observations,
 4 and prior patterns of cyclical escalation."

5 Mr Basu, do you just want to take the opportunity to
 6 expand on that and why you see disguised compliance as
 7 a significant factor?

8 **MR BASU:** I have unfortunately dealt with a lot of
 9 terrorist acts that were committed by people who were,
 10 at the time, seeming to be complying with or working
 11 with or engaging with other services that were designed
 12 to be protective factors around them but at the time,
 13 that was not spotted by any of the professionals
 14 involved. Without going to these cases, these were all
 15 convicted or otherwise cases. So the Parsons Green
 16 bomber in 2017, Forbury Gardens, Fishmongers' Hall, all
 17 people who would have been seen as a failure of Prevent,
 18 who were effectively disguising what their true intent
 19 was and had deceived some professionals but not all. So
 20 one of them, in particular, had not deceived a prison
 21 psychiatrist whose report was dismissed by both the
 22 parole board and then people who were charged with
 23 monitoring that offender on release.

24 So, my point about this is it is incredibly easy for
 25 people to dupe you if you are not careful. Professional

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1 kind of solid deduction about whether this person was
 2 a risk or not.

3 **MR MOSS:** Thank you. Ms Swan, I think in the context of
 4 VFIs, perhaps demonstrating the complexity of this, is
 5 there also, though, the need to recognise, particularly
 6 in relation to neurodivergence, how different
 7 communication styles may come across, and so some things
 8 that may be disguised compliance may also be reflective
 9 of communication styles for those with neurodivergence;
 10 can you help us on that?

11 **MS SWAN:** Yes, in short. You have the complexity of
 12 masking, so the individual's observing certain
 13 behaviours, camouflaging, trying to adjust to that
 14 situation, particularly around their very specific
 15 social communication needs. One of the challenges with
 16 the case studies, and with AR to a certain extent as
 17 well, is this broad brushstroke where autism is used and
 18 as we have said, once you have met one autistic person,
 19 you have met one autistic person, but understanding
 20 actually specifically what aspect of autism may provide
 21 that barrier and I think that helps us better understand
 22 and explore that notion of disguised compliance.

23 I'm not in any way suggesting that there would not
 24 be -- just because somebody is autistic, there won't be
 25 any disguised compliance, I'm not suggesting that. But

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1 it is so important -- and I think this is one of the
2 recommendations from Phase 1 is that training and
3 understanding of front-line workers across a police
4 force to be able to just question whether that is
5 disguised compliance or if there is something more.

6 Similarly, for the context of the young people
7 across those case studies, we are not dealing with one
8 element, one indicator, nearly all of the cases,
9 experienced significant trauma in childhood -- and
10 I defer to my colleagues here, from a psychological and
11 a psychiatric point of view -- but certainly that fight,
12 flight, freeze and appease, particularly that desire to
13 appease people around you, particularly if you have
14 grown up in an environment of domestic abuse will
15 influence how you interact and how you can read and how
16 you respond in those situations. But it just goes back
17 to questioning and understanding. I recognise that time
18 is a resource that most professionals just don't have,
19 particularly when responding to a critical incident, but
20 it is -- yes, it's challenging those assumptions and not
21 allowing diagnostic overshadowing to create an easy
22 answer, but actually having those discussions.

23 **MR MOSS:** Thank you. Mr Basu?

24 **MR BASU:** Just -- the point for me is it is incredibly
25 difficult to tell just from a one-to-one conversation

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1 for all of those responses.

2 Can I turn then onto the next topic in looking at
3 some areas of vulnerabilities. We have touched on some
4 of these but I just want to give you the option if
5 there's anything you want to add. So the first of those
6 that I wanted to raise was in respect of age as
7 a vulnerability and to do so by reference to page 15,
8 ILT000344_0015, of the first sub-report please. So
9 page 15, paragraph 5.1.1:

10 "The young people were within the age span
11 associated with neuro-immaturity at the time of the
12 relevant offending. Neuro-immaturity describes the
13 developmental period during which the upper brain
14 continues to acquire the learning and capacities needed
15 to regulate the sensation-seeking that is associated
16 with puberty. The extent to which this develops is
17 influenced by positive developmental opportunities and
18 experiences, which were few in number for the case
19 studies."

20 Now, Dr Lloyd, this is what I meant when I said that
21 I would come back to this as an issue and you have given
22 your helpful evidence in relation to that. Could
23 I perhaps turn to you, Dr Church, and ask if there's
24 anything in particular you wanted to add in relation to
25 that, of the importance of bearing in mind age and

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1 with someone, but there was evidence in the case studies
2 of people accepting what that person said and never
3 triangulating it against anything else. Now, that was
4 easy to spot in hindsight because you could see that the
5 person was telling two people two very different things
6 or had lied to one person and told a completely
7 different story to another. How do you get to
8 a point -- and there is a systemic problem here -- if
9 the information is not all in one place and
10 chronologically delivered. It is a big problem for all
11 of us to actually create a chronological timeline of
12 different agencies, in different interactions and
13 different moments -- I spent a long time putting that
14 together. Wouldn't it be great if that existed in the
15 first place because then you could just look at that and
16 you could tell where there were different stories being
17 told. Now, that is just basic detective work. It
18 doesn't work with foresight because you may not have the
19 piece of information you need to triangulate, but you
20 might want to go and ask. So: this person is telling
21 their youth worker this, what did they tell their
22 teacher?

23 **MR MOSS:** So we will come on to the issues about a single
24 chronology and we look at options for reform, but we
25 will put a bookmark in there for a moment. Thank you

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1 neuro-immaturity in the assessments that are necessary?

2 **DR CHURCH:** It is a huge component of this cohort and as we
3 have heard from contributors to the seminars as well,
4 a very significant cohort of those who come to the
5 attention of Prevent and these related services more
6 generally. So there is something very significant about
7 young age and neuro-immaturity and I guess, as a child
8 and adolescent psychiatrist, I work with psychologists
9 in a multidisciplinary team serving young people where
10 it is taken for granted that young people are forming
11 a sense of identity, they may change very quickly from
12 one day to another. We know that some symptoms or
13 concerns can be vague in nature and changeable, that it
14 is a dynamic time where there are lots of different
15 influences. So age, just taking age on its own, is
16 vitally important. Yes.

17 **MR MOSS:** Thank you. Do any of the other panel want to come
18 in? Yes, Ms Gianfrancesco.

19 **MS GIANFRANCESCO:** When we look at age, I'm going to say
20 again a young person at 18 falls off a cliff and what we
21 are talking about here is young people around their
22 neurodevelopmental neuro-immaturity. Services for
23 people post-18, otherwise known as adults, have a very,
24 very fixed way of working and we have a group of young
25 people who don't necessarily fit into that fixed way of

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1 working. I think we have seen this very much within
 2 these case studies in having young people who have
 3 transitioned from under 18 into adult services and then
 4 have refused, understandably, because they are now
 5 adults and they have a choice and they can't be made to
 6 go to services and their parents can't take them and
 7 say: we want you to go and see the mental health
 8 professional or whoever. They choose not to engage in
 9 services. Then it becomes very, very difficult when we
 10 are talking about this cohort of people and what Mr Basu
 11 was talking about before about people with disguised
 12 compliance, actually how we engage them or how we
 13 triangulate information. Because I guess they are able
 14 to make choices as adults but we are not necessarily
 15 working with people who have the same level of maturity.

16 **MR MOSS:** It may be a very simplistic aspect but as one
 17 looks at those 17, 18, 19, 20, again, without going into
 18 any detail on individual case studies, is it important
 19 to bear in mind that while, in legal terms, they have
 20 reached adulthood, they haven't reached neuro-maturity
 21 in biological terms?

22 **MS GIANFRANCESCO:** Yes, from my perspective, absolutely, and
 23 therefore services don't meet their needs.

24 **MR MOSS:** Thank you. Ms Swan, did you want to --

25 **MS SWAN:** I totally agree. I wanted to add as well, in
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1 you are on the globe, if you have a large demographic
 2 with that feature, male, 16-24, you are going to get
 3 higher crime. You are also going to get higher violent
 4 crime and it is interesting that the case studies were
 5 all based around a single gender.

6 So I'm not, for one second, saying that in my
 7 professional experience that you would not get this kind
 8 of level of very serious offending among females or
 9 people obviously outside of this age group, but that
 10 demographic, 16-24 and male, is what we mostly see in
 11 policing and what most criminologists will say is
 12 a striking demographic for the academic reasons you will
 13 hear from my colleagues.

14 **MR MOSS:** Thank you. So can I move on to that very topic,
 15 as you rightly predict, Mr Basu. First of all
 16 a confession, in as far as CTI are allowed to make
 17 confessions, you have raised the point that all the case
 18 studies were male and can I indicate that that was
 19 because, as it happened, the clearest VFI-type cases
 20 available to the Inquiry happened all to be male. It
 21 wasn't a deliberate choice to exclude by gender. But on
 22 reflection, it may have been a weakness.

23 So not from the case studies, but from your wider
 24 professional experience, are there aspects in relation
 25 to young women that the Inquiry should be particularly
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1 terms of age, it is really significant, many of the
 2 young people in these case studies were in receipt of
 3 an education health and care plan or, because of the
 4 time, a statement of special educational needs. In the
 5 context of what we call "EHC plans" they extend to the
 6 age of 25 for a good reason but also unfortunately, what
 7 was also reflected in the case studies and is reflected
 8 in my own professional practice is unfortunately
 9 an impatience to cease those EHC plans when a child
 10 is 16 or 18, rather than actually considering that
 11 transition, whereby one of the benefits of where they
 12 work well, of an EHC plan, is highly-scaffolded, secured
 13 provision. Again, as Anna has said, it disappears and
 14 I think there is two points there. One is the fact that
 15 EHCPs extend to 25 for good reason but the second is
 16 that where then? And there isn't the same mechanism for
 17 continuing to engage in meaningful employment which is
 18 so important for purpose and belonging.

19 **MR MOSS:** Thank you.

20 **MR BASU:** Mr Moss, can I just make a point. So I'm not
 21 a published Doctor of criminology, but I do live with
 22 one and I have met a lot of them in my time. I have
 23 checked this point. So professionally, your experience
 24 is that a demographic -- this will segue you into
 25 gender -- that is male, 16-24. It doesn't matter where
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1 aware of in terms of risk factors and vulnerabilities in
 2 this area, violence fascinated or fixated individuals,
 3 that you would wish to draw to the Chair's attention,
 4 bearing in mind that there weren't any case studies?
 5 Have we missed something from your general experience in
 6 not having a female case study? Dr Church?

7 **DR CHURCH:** My experience of working with females in this
 8 cohort is limited because there are fewer females with
 9 this sort of presentation. But those that I have met,
 10 assessed, I would say might present more in the way of
 11 more sophisticated social manifestations of anti-social
 12 behaviour than the males do, and there may be more in
 13 the way of bullying, emotional bullying or behaviours
 14 that might be referred to as manipulation by
 15 professionals.

16 **MR MOSS:** So could we have a look at that at page 100,
 17 ILT000344_0100, please. What I'm turning to here is the
 18 International Classification of Diseases, 11th edition.
 19 What you have given as an appendix in relation to
 20 "conduct disorder". It is the bottom of the page,
 21 please. It is the section on "sex and/or gender-related
 22 features".

23 "Conduct-Dissocial Disorder is more common among
 24 males.

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

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

9 Was that touching on the point you were mentioning
10 a while ago, that you need to look at for slightly
11 different traits between the genders in how that may --
12 in layperson's terms -- play out.

13 **DR CHURCH:** Yes and the red flag may not be an escalation in
14 physical aggression over time, severity for example, but
15 actually the red flag might be the relational aggression
16 and the quality, the nature of that relational
17 aggression.

18 **MR MOSS:** And "relational aggression", many will familiar
19 but for those who are not, can you explain what that is
20 referring to?

21 **DR CHURCH:** It could be the most severe emotional bullying
22 or belittling of more vulnerable peers. So for example,
23 encouraging them to harm themselves or end their lives
24 or somehow abusing them psychologically, emotionally and
25 crucially, not necessarily physically.

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1 **MS SWAN:** May I raise one point?

2 **MR MOSS:** Yes, of course.

3 **MS SWAN:** My understanding -- and I'm happy to be
4 corrected -- I just wanted to clarify, that males are
5 not four times more likely to be autistic, they are four
6 times more likely to be diagnosed and I think it is
7 really important that we make sure that, whilst we all
8 likely share that understanding, for others reading or
9 listening to this, they make that incorrect assumption.
10 Because that does fuel a narrative in various settings,
11 around looking for observable behaviours and the way
12 that -- again, I don't want to generalise, but for the
13 purpose of this, the way that an autistic girl, that
14 their traits may manifest in a classroom environment,
15 for example, may, in many cases be different. I don't
16 want to speak for Dr Church, but I think we all agree
17 with that point, but I just wanted to showcase --

18 **MR MOSS:** Yes. I hope that I read it out accurately, that
19 it was females to be diagnosed and the section that said
20 that this may reflect undetected autism in girls. But
21 I think that is something to which want to draw
22 particular attention, so as to not feed into this
23 simplistic view: males are four times more likely to be
24 autistic.

25 **MS SWAN:** Certainly, and similarly, my own experience in

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1 **MR MOSS:** So severe mistreatment of relationships but not
2 taking the form of physical violence?

3 **DR CHURCH:** Yes.

4 **MR MOSS:** Thank you. Could we look also at page 109,
5 ILT000344_0109, and this similarly, in relation to
6 autism spectrum disorder and the sex and/or
7 gender-related features there:

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

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

16 So I'm very mindful of Ms Swan's appropriate warning
17 in terms of if you have met one person with autism, you
18 have met one person with autism, but, again, might this
19 be part of the background as to the very significant
20 overrepresentation of males within this cohort?

21 **DR CHURCH:** Yes, I think those are two elements that would
22 be relevant. But it is not to say that females do not
23 go on to perpetrate extremely serious violence, it is
24 just simply rarer than males.

25 **MR MOSS:** Thank you.

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1 specialist education settings and pupil referral units
2 is that the gender balance tends to be more towards
3 males within those education settings as well.

4 **MR MOSS:** Thank you. That leads neatly to neurodivergence
5 as a vulnerability, which is something I would like to
6 deal with, if we may, before we break for lunch.

7 So, forgive me, I'm tending to start with you,
8 Dr Church, but it is helpful to start with the
9 psychiatry view. This is one of the questions that
10 comes from the -- one of the victim's teams. You
11 referred to a number of the case studies involving
12 individuals who had received a diagnosis of ASD and you
13 were asked if you are able to comment as to how, from
14 your respective areas, neurodivergence should be treated
15 with regard to the identification, risk assessment and
16 management of individuals who may go on to commit such
17 acts. Now, there is a lot wrapped up in that question
18 but it comes from one of the victim's teams. So could
19 I start with you, Dr Church, and then I will come to
20 others?

21 **DR CHURCH:** Yes. So a diagnosis of Autism Spectrum Disorder
22 should raise concerns about potential vulnerabilities in
23 an individual and on page 106, ILT000344_0106, there is
24 a very short paragraph within the International
25 Classification of Disease published by the World Health

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1 Organisation. It is about halfway down the page, where
2 it says:

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

7 So, that describes the vulnerability, the social
8 vulnerability that we have been discussing, in a very
9 tidy way. Now, how that is linked to any risk to others
10 is not clear here because actually what I would say is
11 the emergence of any anti-social behaviours are perhaps
12 a parallel or different sort of process, with other
13 contributory risk factors of which a diagnosis of autism
14 is just one, really.

15 But -- so, that's why I emphasised the importance of
16 considering a diagnosis of a conduct disorder or any
17 other diagnosis alongside an Autism Spectrum Disorder
18 and the particular vulnerabilities associated with the
19 autism make those other disorders perhaps more
20 significant in various ways, in how they develop and
21 how, in some ways, access to treatment may be obstructed
22 as well.

23 **MR MOSS:** Thank you. Could we have on screen, please,
24 page 16, ILT000344_0016, and if we can navigate to have
25 5.2.4 to 5.2.6 on the screen please. It is others to

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1 emotional reactivity as normal, when it can be
2 interpreted by teachers as disobedience. If this is not
3 understood, made explicit and managed between the school
4 and the home, those with neurodevelopmental conditions,
5 or FASD, can come to believe they are lazy, naughty or
6 not good enough, which in turn can lead to shame,
7 anxiety, impression, emotional overwhelm and defensive
8 aggression.

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

22 So, Ms Swan, I have read that out because of its
23 potential significance. Is there anything that you
24 particularly wish to add to that?

25 **MS SWAN:** I mean, I think it would be helpful to highlight

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1 judge importance, but I am going to make no apologies
2 for reading out a fair size of the text here because of
3 its potential importance. So from the joint first
4 sub-report:

5 "Across the case studies, young people were
6 identified as neurodivergent at different stages of
7 their development. Neurodivergence does not cause
8 misconduct, but as neurodivergent children grow, they
9 need understanding and support to adjust to the
10 neurotypical world, which can present additional
11 difficulties when parents themselves are also
12 neurodivergent. Both ASD and ADHD are lifelong
13 conditions that are considered to be heritable. ASD is
14 associated with difficulties in social interaction,
15 communication and emotional relation, while ADHD
16 includes attention deficits, hyperactivity and
17 impulsivity, as well as emotion dysregulation. These
18 overlapping features can make diagnosis and treatment
19 complex.

20 "Awareness of neurodiversity is relatively recent,
21 such that it is unlikely that the parents of the
22 children we reviewed were aware of their own potential
23 neurodivergence. Where parents are themselves
24 neurodivergent, they are likely to view their child's
25 impulsivity, attention deficits, sensory avoidance and

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1 the importance of understanding the heritability of
2 neurodevelopmental conditions, autism and ADHD, in terms
3 of -- I mean, this is included in Working Together to
4 Safeguard Children. But really understanding that those
5 communication needs or those needs we can identify in
6 the child may also exist in the parent. So how we
7 communicate and engage with those parents is really,
8 really important there, and particularly that
9 understanding -- so much of this comes down to training.
10 It is not about raising awareness, it is about deepening
11 understanding of what this actually means, but very much
12 it is about the intersection. It is not just ADHD, it
13 is not just autism spectrum disorder, it is how those
14 things intersect.

15 What I wanted to add as you were reading that and
16 I noted down is notably, in the case of AR, when the
17 third school -- I think this was later, when they had
18 reflected and with hindsight, they said: well, we would
19 not have offered AR a place at our school because autism
20 was not the main presenting need. So it's about
21 understanding -- and I have these conversations when
22 I am considering EHCP plans and the consultation
23 process -- for me, it is about understanding what is the
24 main presenting need, what is that main presenting
25 barrier and what do we do to meet that need and I think

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1 that was highlighted across the case studies certainly,
2 but also in the case of AR.

3 **MR MOSS:** Thank you. Anybody else on that? There is
4 another facet of this I wonder if we can look at. So,
5 Al-Attar was referenced earlier on. If we can have on
6 screen, please, ILT000177. This was a paper widely
7 referred to in the seminars and it has been referred to
8 this morning. If we can just go over the page, please.
9 So the abstract:

10 "There is no empirical evidence to link autism and
11 terrorism in the general population. However, when
12 terrorist acts are planned or executed by individuals
13 with autism, it is important to develop an understanding
14 of the individual's autistic functioning and how it may
15 contextualise factors that push them towards terrorism
16 and aspects of terrorism that may pull them in, in order
17 to manage and reduce risk. The role of autism in
18 resilience also needs to be considered in order to
19 capitalise on natural and individually meaningful
20 sources of motivation and protection." (As read)

21 She goes on to say:

22 "This paper explores how different features of
23 autism may contextualise risk and resilience and the
24 implications for support and diversion approaches.
25 Caution is encouraged against drawing conclusions of
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1 collecting. Page 15, ILT000177_0015, facet five: social
2 interaction and communication difficulties. Then
3 page 17, ILT000177_0017, facet six: cognitive styles.
4 And page 20, ILT000177_0020: sensory processing.

5 Now, those are the seven facets. There is a lot of
6 detail obviously in the paper that sits below that but
7 in general terms, would you agree that very careful
8 analysis of the individual circumstances of a young
9 person who is autistic, looking at how those potential
10 facets in the individual case may be impacting on push
11 and pull, is the sort of nuanced, individual assessment
12 that is required to consider how autism might be making
13 the young person more vulnerability? Dr Church?

14 **DR CHURCH:** Yes, it is a widely cited publication, has been
15 very influential in a lot of thinking and I think it
16 also fits very well with clinical and practical
17 experience. I think we always need an individualised
18 approach to risk assessment in these cases with young
19 people and consideration of autism, the manifestations
20 of autism in that individual, I think are key in
21 identifying the risks, but the opportunities for
22 intervention as well, the levers of change. So, I think
23 it provides a lens through which -- this article
24 provides a lens through which to observe or consider
25 assessment and intervention. I don't think it provides
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1 causality and oversimplification of autism-terrorism
2 links, especially in individuals with co-existing mental
3 health problems and psychosocial adversities. The need
4 for highly individualised formations that take into
5 account the heterogeneity of autism and how it is
6 functionally expressed, as well as the complexity of
7 terrorism, is strongly advocated. Finally, the
8 limitations in the empirical evidence and research in
9 the field of autism and terrorism are highlighted." (As
10 read)

11 Now, of course, that's relating to terrorism rather
12 than VFIs, which we must bear in mind.

13 If we go to page 3, ILT000177_0003, please. There
14 is a paragraph there on risk assessment and formulation
15 tools adopted, sir, which I just flag for the moment for
16 your note.

17 **SIR ADRIAN FULFORD:** Thank you.

18 **MR MOSS:** If we can go on to page 4, ILT000177_0004, she
19 goes on to describe seven facets which she then analyses
20 in terms of push/pull. So: circumscribed interests on
21 page 4. If we can go to page 7, ILT000177_0007: rich,
22 vivid fantasy and impaired social imagination, and
23 page 10, ILT000177_0010, facet three: need for order,
24 rules, rituals, routine and predictability. Page 13,
25 ILT000177_0013, obsessionality, repetition and
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1 the whole package, of course, but it's a helpful
2 reference when approaching this, absolutely.

3 **MR MOSS:** Ms Swan?

4 **MS SWAN:** To speak plainly, I'm very cautious about
5 discussions whereby autism is seen as the bedrock upon
6 which everything else is based and I would not support
7 that discussion.

8 But I understand that autism is one facet of that
9 individual's context, their life experience. What
10 I would question is what is the -- and it is not just
11 going to be one factor of anything -- but actually, in
12 all of the cases we have looked at, there was such
13 significant adversity -- and we have talked about
14 adverse childhood experiences here, but particularly
15 substance abuse, parental substance abuse, domestic
16 abuse and parental mental ill health, and in that
17 capacity therefore, on parenting, it is about trying to
18 understand how they all intersect.

19 Certainly I would agree that there are, of course,
20 vulnerabilities but I would be cautious about any
21 suggestion of causality that could be inferred from
22 those discussions and I think that so often what we see
23 in practice and what we see in the case studies is that
24 autism gives a quick, final answer: that's the reason.
25 And I think what we saw certainly in Phase 1 is that
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1 there was very little challenge to understanding
 2 behaviours, just going with the quickest, easiest fit
 3 there, and what happens is we don't start looking at
 4 actually what's driving these behaviours, because
 5 I think in too many cases we take autism as a broad
 6 brushstroke reason without looking further and
 7 certainly, conversations we have had as a cadre has been
 8 around conduct disorder and have been around the impact
 9 of developmental trauma and all of the other elements
 10 and foetal alcohol spectrum disorder, and we have had
 11 the privilege of time and all of the agencies present to
 12 have that discussion, but that is probably many words
 13 for something in a nutshell, but I just wanted to raise
 14 those points.

15 **MR MOSS:** Thank you very much. Dr Church?

16 **DR CHURCH:** Absolutely. The article just focuses on autism
 17 in this particular context of terrorism actually, but
 18 from the case studies, there are some warnings I think
 19 of over attribution to autism and not an appraisal of
 20 other factors that might explain a behaviour actually
 21 better than autism.

22 **MR MOSS:** Yes, so in AR's case with Dr Irani suggesting that
 23 there was a missed diagnosis of conduct disorder.

24 **DR CHURCH:** Yes.

25 **MR MOSS:** That, perhaps again, has echos of that?

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1 specialist professionals and is thereby ... overlooked,
 2 but because of its overlap with other neurodevelopmental
 3 conditions, there is a risk of diagnostic overshadowing,
 4 with difficulties attributable to FASD interpreted
 5 through the lens of neurodivergence. Identifying the
 6 young person's full pattern of neurodevelopmental and
 7 functional needs is important for a statutory SEND
 8 assessment and a suitably individualised plan of
 9 educational, health and care support, with adaptations
 10 and interventions matched to those needs."

11 You go on to say:

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

25 Now, I appreciate it can be tedious with me just

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1 **DR CHURCH:** Absolutely, yes.

2 **MR MOSS:** Sir, would that be a convenient moment. I'm
 3 conscious of the material we have to get to, may
 4 I suggest 2.05 pm?

5 **SIR ADRIAN FULFORD:** You certainly can. We will sit again
 6 at 2.05 pm.

7 (1.15 pm)

(The short adjournment)

9 (2.05 pm)

10 **SIR ADRIAN FULFORD:** Yes, Mr Moss.

11 **MR MOSS:** Thank you, sir. Can I continue then with
 12 vulnerabilities and can I turn to foetal alcohol
 13 spectrum disorder. Could we have page 15,
 14 ILT000344_0015. This is the first sub-report and it is
 15 paragraph 5.2.2, and you say:

16 "Although there was no recorded diagnosis of foetal
 17 alcohol spectrum disorder ... the case study material
 18 included evidence of maternal substance and alcohol
 19 misuse during pregnancy in a number of cases. This is
 20 not an equivalent to a diagnosis, although 'possible
 21 FASD' was identified by a psychiatrist in one case.
 22 Where there is evidence of maternal alcohol use during
 23 pregnancy, this forms an important part of the young
 24 person's developmental history. Possible foetal alcohol
 25 spectrum disorder ... is often not confirmed by

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1 reading text out but I have done so deliberately there
 2 because I took it from the tone and nature of the report
 3 of the three of you that this is an area that you
 4 particularly wanted to emphasise, is that right?

5 **DR LLOYD:** Yes, it certainly is.

6 **MR MOSS:** Dr Lloyd and Ms Gianfrancesco and Ms Swan, do one
 7 or several of you just want to briefly explain why?

8 **DR LLOYD:** Well, the thing is that it is not something that
 9 is generally accepted or spoken about, it is not
 10 something that we are really very familiar with, and
 11 I was quite surprised when I saw the extent of
 12 addiction, alcohol and cocaine addiction, in three of
 13 the mothers of those --

14 **MR MOSS:** Again, you'll remember just be a little bit
 15 cautious about numbers in case studies, but do carry on.

16 **DR LLOYD:** Okay. So, then, I looked into it in more depth
 17 and it turned out to be a very serious condition which
 18 has effects on the central nervous system which
 19 manifests in lots of different ways, and it began to fit
 20 in with what we were seeing was coming from the case
 21 study information, particularly from those who were in
 22 special educational needs and it just seemed very
 23 important that it should be more recognised. Certainly
 24 in this context because we have to understand that what
 25 we are looking at in these six cases, that they are all

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1 true positives in as much as they did commit offences or
2 get very close to committing offences, which means that
3 it is a very significant thing to look out for if it was
4 actually present in half of those cases.

5 And because it is also avoidable. It is a jeopardy
6 that's there from birth and it is an avoidable jeopardy.
7 So it is something which I think those people who are
8 working with young people in an educational context need
9 to understand how it can be understood and managed and
10 what sort of support needs to be in place for those
11 children, which will differ from those who have got
12 similar diagnoses in terms of ADHD and autism.

13 **MR MOSS:** Thank you. Forgive me, when you say it is
14 "an avoidable jeopardy", do you mean that it is
15 a syndrome that can be avoided by absence during
16 pregnancy?

17 **DR LLOYD:** Yes.

18 **MR MOSS:** Yes, I follow. Ms Swan, you wanted to come in on
19 the educational side?

20 **MS SWAN:** Yes, and just to add, whilst I say this as a
21 non-clinician, why it is so important to be able to
22 identify FASD is because it is considered a permanent
23 brain injury caused by that prenatal exposure to
24 alcohol. This isn't something that is
25 a neurodevelopmental condition. The strategies and the
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1 **MS GIANFRANCESCO:** For me, FASD is really, really important
2 because it is about the parental care of that child. So
3 if a child has FASD, there has been significant alcohol
4 use during pregnancy, then during childhood would
5 probably more -- if that alcohol hasn't been addressed
6 during pregnancy, the alcohol use is likely to continue
7 during sort of the childhood of that child. So then you
8 have got to look at actually what is the parenting of
9 that child. Is there neglect on the child? We saw in
10 all of these families there was domestic abuse on the
11 child. So where is -- is there safe parenting? What
12 are the boundaries, what are the parameters for that
13 child? So it is really significant because it isn't
14 just about the brain injury, it is also about actually
15 the environment and the safety of that child.

16 **MR MOSS:** Social and family environment.

17 **MS GIANFRANCESCO:** Particularly during their formative, you
18 know, from 0-2, where you have also got the significant
19 brain development. If that's being compounded again,
20 due to the parental alcohol use -- and yes, this is in
21 relation to the mother's parental alcohol use, but we
22 often don't know whether -- if there is a father
23 present, what the relationship is and whether there is
24 alcohol use there as well, actually it can have a real
25 significant impact on the child and their longer term
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1 provision that is required in order to meet the needs of
2 a child, young person, or adult who has FASD are
3 different.

4 As I understand, there is a high preference of
5 co-occurrence between FASD and diagnoses of ADHD or
6 Autism Spectrum Disorder. Whether that's because the
7 diagnoses are present or whether because there is
8 an overlap in terms of how it presents, I would defer
9 that response to somebody clinically trained, but it is
10 very important in terms of understanding the context of
11 the child's experiences and what that may present, but
12 also just getting the right provision at the right time
13 because particularly in EHC plans, where we are writing
14 outcomes and we are measuring progress towards outcomes,
15 where a child has a permanent brain injury, the
16 expectations and the provision there would be different
17 to a child whose developmental trajectory could move at
18 a more rapid pace, perhaps.

19 But this was really prevalent across the case
20 studies and there was an absence of professional
21 curiosity about it and as we have said, it was picked up
22 in some of the reports minimally but almost just
23 overlooked and it is incredibly important that we have
24 an accurate understanding, where possible.

25 **MR MOSS:** Thank you very much. Yes?
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1 development.

2 **MR MOSS:** Thank you. Yes, Ms Swan.

3 **MS SWAN:** Very quickly, just to add that particularly during
4 adolescence, the need -- and the risky behaviours that
5 can become apparent, in each child or young person with
6 FASD become more apparent. The risks escalate and the
7 difference between that young person and where their
8 peers are developing, that gap becomes wider and that's
9 why, particularly for this cohort of adolescents, it is
10 so important.

11 **MR MOSS:** I want to turn next to mental health and we have
12 covered some of the ground in relation to this. Could
13 we have on screen, please, page 16, ILT000344_0016, and
14 it is paragraph 5.3.1:

15 "There was a clear pattern of young people being
16 referred to mental-health services, and in more than
17 half of the cases there was evidence of deliberate
18 self-harm or suicidality. These young people therefore
19 had substantial and, in some cases, increasing
20 mental-health and therapeutic needs. All suffered with
21 low mood and anxiety, though few were clinically
22 diagnosed because of their young age and
23 neurodivergence, and because mental health professionals
24 are careful not to apply adult diagnoses to young people
25 when they are not fully mature."
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1 Then, if you will forgive me, I won't go through the
2 totality of what follows. It's clearly stated in this
3 report, but if we can go to page 18, ILT000344_0018, you
4 will find, from memory, in the top third of the page,
5 the recommendations flowing from this which are twofold.

6 Firstly:

7 "The Inquiry should explore whether clearer
8 arrangements are required for the assessment and
9 coordination of support where mental health, SEND,
10 trauma and safeguarding needs overlap and there are
11 emerging or escalating concerns about harm to self or
12 others. This should include ensuring that mental-health
13 assessment and treatment are accessible to
14 neurodivergent young people, that relevant agencies
15 jointly review the young person's needs and risks where
16 necessary, and that responsibility for coordinating
17 support and escalating concerns is clearly identified."

18 Pausing there. It may be that it is a matter for
19 others but it may be that few would quarrel with that,
20 but would it be fair to say that that is a wider and
21 very big national challenge?

22 **MS GIANFRANCESCO:** Yes, I mean, it is massive. In some
23 ways, that's part of the review at the moment, that
24 Peter Fonagy --that is what he is called? -- is doing
25 around the mental health review for young people.

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1 which used to be called -- so I sponsored the
2 predecessor, the pilot programme called Vulnerability
3 Support Hubs and it addressed precisely this problem
4 because it was impossible, on diagnosis, to get people
5 that we knew had a high risk of radicalisation or
6 potential going down the terrorist pathway, it proved
7 impossible for them to get clinical care because they
8 simply didn't meet any kind of threshold for the system
9 that was available. So the VSH was set up essentially
10 to put pressure on the system, to say: we know stuff you
11 don't know, so although it doesn't meet your threshold
12 there are additional vulnerability factors that make
13 this a high-risk case, so you need to treat them.

14 That was essentially a way of overcoming a resource
15 dilemma that still exists today. So it has been
16 successful -- it must have been successful because they
17 made it a full-time programme. That has been successful
18 for Prevent and counter-terrorism. Doesn't exist here
19 at all, which is pretty much the point you have made.

20 **MR MOSS:** Dr Church, if I'm reading the body language right,
21 I'm seeing some nods of recognition from you as well?

22 **DR CHURCH:** Yes, there is a degree of local variation in
23 terms of the provision of CAMHS services and perhaps the
24 sort of early help availability of counselling and
25 related sort of interventions.

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1 **MR MOSS:** Thank you. Secondly:

2 "The Inquiry should explore whether a clear
3 therapeutic pathway is required for children and young
4 people with significant trauma-related needs who do not
5 meet the criteria for specialist mental-health services,
6 particularly where these are accompanied by self-harm,
7 suicidality or escalating behavioural concerns."

8 Again, against the background that part of what we
9 are seeking to do here in Phase 2 is to check the wider
10 evidence base, in AR's case, one of the issues that was
11 raised by Dr Irani, and also I think by some of the
12 treating clinicians, was the lack of counselling and
13 other support if the young person didn't qualify for
14 those because of a treatable mental health condition but
15 nevertheless had a significant need for that. It looks,
16 from that second recommendation, that that's not by any
17 means restricted to AR's case, that is a wider problem
18 too. The lack of a pathway for supportive counselling
19 and other therapies when it falls short of the
20 thresholds for treatment for a mental health condition.

21 Mr Basu?

22 **MR BASU:** Can I make a point from counter-terrorism
23 experience?

24 **MR MOSS:** Yes, of course.

25 **MR BASU:** So I think you have received evidence on the CSC,

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1 In any one area, geographic area, there will be most
2 likely over five different CAMHS teams. They may have
3 names such as tier 2, tier 3, neurodevelopmental team,
4 the YOS CAMHS team, there will be a number of community
5 services. Some of those embedded in other agencies
6 working very closely with other agencies. And some, at
7 the very, very earliest stage, where it's almost
8 pre-CAMHS and there's an emphasis perhaps on guided,
9 self-help, so, a very light touch sort of approach.
10 I think all those interventions really depend on the
11 young person and their family engaging and talking about
12 some of the hardest things in their life.

13 So, the challenge is considerable really. There is
14 the availability but also the need for a structure to
15 enable engagement and building of trust to enable to
16 have actually a therapeutic experience of that
17 provision.

18 So, how is that achieved? Well, sometimes by
19 meeting young people in their environment. So, for
20 example, in recent years we have seen the development of
21 schools teams, where there is a CAMHS presence in
22 school. Fantastic. What we have seen as well has been
23 successful is having CAMHS teams that are commissioned
24 to work under the same roof as a Youth Offending
25 Service. So the young person is coming anyway to that

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building, it is not the local CAMHS service that might be linked to a local mental health trust, which carries negative connotations of mental health institutions and so on. So, it is less stigmatising in that sense and it can be delivered where the young person is in a way that can be more acceptable.

Then that is certainly, through and through, a trauma-informed service because it has to be in the Youth Offending Service context because of the numbers with those difficulties. But that's a sort of outline of the sort of provision.

MR MOSS: Yes, as you say, there is variability in access to those sort of services. The lay perception may be of significant waiting lists in some cases for patients whose needs do cross the traditional mental health boundary for counselling services, particularly towards the lower end. So being realistic, is that too part of a big challenge, part of which is about resources?

DR CHURCH: It certainly can be and it depends on the level of risk that's presented because what you are describing is a level of concern that is sufficient to enter the service, but not a level of risk that warrants an immediate, same-day response for a Mental Health Act assessment, for consideration of hospitalisation, for example, and much of CAMHS work is dealing with acute,

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through there. So while it is good that we have seen an increase in routes, actually what we are seeing for our most highest risk young people is they are still falling down the gaps and from my perspective, actually, we very clearly need a pathway for young people who have experienced trauma because they don't necessarily have a diagnoseable mental health condition, which would mean they would not get into a tier 3 community CAMHS, but they do need something and we have too many gaps for them to fall through.

MR MOSS: Thank you.

MS SWAN: Just to build on what the others have said, educators are signposted towards research by the Youth Endowment Fund who provide a violence prevention toolkit and that analyses the effectiveness and the impact of various interventions and I recognise we will probably come onto this later, but the high impact, in terms of reducing the -- apologies -- reducing children and young people's involvement in violence is cognitive behaviour therapy, clinical cognitive behaviour therapy and also trauma-specific therapies. I know that will probably be explored later, but I think that in itself highlights the link between trauma and addressing that in order to reduce young people's involvement in serious violence.

MR MOSS: Thank you. On conduct disorder, we have covered

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immediate concerns.

So, yes, there will be, in some cases, a long waiting list for assessment and intervention but there will also be third-sector providers and other provision in other contexts, alongside CAMHS.

MR MOSS: Thank you.

MS GIANFRANCESCO: I think what Dr Church said there, I completely agree with and we have seen much more creativity in terms of delivering mental health services for children over the last years, particularly over the last ten years as demand has grown, and with the increasing mental health services in schools and in Youth Offending Services, as is described. However, there's always going to be a caveat and it does come down to resources. What we have seen in these case studies and what we know about some young people, particularly our most high-risk adolescents is that they are not necessarily in school. They are either school avoidant themselves or they have been school excluded. So for those young people they would not be able to access the mental health services in schools because they are not physically within the schools.

As we have seen in these case studies, I think all of them weren't in the Youth Offending Service. So again, they wouldn't have accessed the CAMHS service

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much of the ground but Dr Church, I just wanted to pick up on one aspect of that, which is -- so you have referred in your report and we touched on it this morning to the risk of that diagnosis being missed. I wanted to ask you what you see as the significance of that in terms of the treatment pathway. So what information is opened up by a diagnosis of conduct disorder in terms of both the treatment pathway but also what perhaps other agencies need to be told and advised about the best approach?

DR CHURCH: Yes, well, I think it is a huge topic, very significant in CAMHS because my belief is that there is a cultural -- I think it has been present for many, many years -- a cultural -- quite embedded culture against diagnosing conduct disorder. It is a diagnostic category that has been included in the International Classification of Disease by the World Health Organisation with many top professionals from around the world contributing and yet, it is a diagnostic category that's not used in our CAMHS teams, by and large.

It appears to be a very active avoidance of that -- of the usage of that diagnosis. It is not unusual at all that it has not been used in the cases we have looked at. Sometimes "oppositional defiant disorder" is used and that's very closely related to conduct

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disorder. But, the importance of making a diagnosis of conduct disorder is that -- well, first of all, in a CAMHS caseload, it gives commissioners an indication of the need in that patch. So if a commissioning body asks: what's the rate of conduct disorder in your caseload? It is quite helpful to say: well, half of them, because actually then that naturally leads to a sort of plan for interventions and there is NICE guidance on what works for conduct disorder.

There are all sorts of obstacles to delivering effective treatments for conduct disorder but the other benefit actually is that it is a very descriptive category, the benefit is that it can communicate a young person's presentation to other professionals in a more accurate way and that means that the young person's needs are more likely to be met in a multi-agency sort of context because it is a form of effective communication between professionals.

MR MOSS: Just in a nutshell if you would, the NICE guidance in terms of treatment would encompass what sort of activity?

DR CHURCH: So the emphasis is really on working with parents, with schools, in the systems around individuals. So there will be, for example, parenting programmes and then, at the individual level, there are

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trio for the children who haven't received the support that they need from their parents. VFIs will resist intervention because of their chronic stress pattern which is of isolation and self protection. So, the trauma that they hold can be corrected through trauma-informed therapy such as EMDR, Eye Movement Desensitisation and Re-processing, and somatic therapies. These allow the body to release the frozen threat response, to allow complete resolution of the full fight or flight cycle.

Now, that then would be followed by an intervention that was missing in their childhood when they didn't get the protection from their parents in the form of help to understand and manage their neurodivergence, which in itself would then improve their mental health. So it seems to me we are talking about a toxic trio of chronic trauma, neurodivergence and mental health and that is the sort of toxic trio.

MR MOSS: Thank you. So one of the questions, again, that comes from one of the victim's teams is this: with respect to domestic violence and adverse childhood experiences that was another feature that appeared in some of the case studies, is the position similar to neurodivergence in the sense that it is not an identifying characteristic for a potential for

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interventions that are based on cognitive behavioural sort of models, that emphasise thinking skills and resolution of difficulties in more pro-social ways and coping strategies.

So, there's generally a lack of conduct disorder pathways in the community to deliver interventions but there are several obstacles to that.

MR MOSS: Thank you. Next, in terms of vulnerability, I wanted to look at adverse childhood experiences and what's been described also as "the toxic trio". Could we have page 21, ILT000344_0021, on the screen, please, and it is paragraph, I think, 5.6.2. So:

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

So I suspect in a sense, Ms Swan, Ms Gianfrancesco and Dr Lloyd, in whose report this appeared, much of what we have been talking about so far today, I think, perhaps feeds into that observation, would that be fair?

MS SWAN: Yes.

MS GIANFRANCESCO: Yes.

MR MOSS: Dr Lloyd?

DR LLOYD: I would say as well that there is also a toxic

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serious violence but it is relevant once the person is identified as such to the multi-agency response and to the treatment and support that is required? Would you agree with that characterisation, Ms Swan?

MS SWAN: Yes. I think it is part of the context and it is about -- what we have hopefully tried to highlight is it is how those things intersect and help you better understand that child's experience. I think we are all very clear that an individual who has experienced domestic abuse or any of those adverse childhood experiences, that is not an indicator that they will go on to commit serious violence or become fixated with violence, but it is about actually understanding that child's experience and what may be making them more vulnerable to certain influences and other risks.

MR MOSS: Thank you. Ms Gianfrancesco?

MS GIANFRANCESCO: Absolutely. I mean for me, there are roughly around 400,000 children that are opened each year to social work across the country. The majority of those children will have been referred in because of an element within -- of the toxic trio within the home environment, so either domestic abuse, parental substance misuse, or parental mental health, that has created concern around safeguarding and welfare for that child.

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1 The numbers of those that then go on to be people
 2 within -- young people within this cohort are absolutely
 3 minute, but it is the interaction between that home
 4 environment and those toxic trios with -- for the young
 5 person who has a diagnosis, around their neurodiversity,
 6 their social interactions, the support that they have
 7 got outside the home, their school environment. There
 8 are all of those other factors that will interplay and
 9 their social integration which I think is absolutely key
 10 to this in terms of whether they have friendship groups,
 11 whether they are isolated, who they are being supported
 12 by. It is about professionals unpicking and
 13 understanding how all of those factors come together.
 14 So there isn't one -- in any of this, there isn't one
 15 particular factor but they are all important factors
 16 that will interplay with each other.

17 **MR MOSS:** Thank you. Ms Swan, can we add in, please, the
 18 next vulnerability that I wanted to touch on, albeit
 19 perhaps briefly, of special educational needs and
 20 disability. So if we can have a look at page 14,
 21 ILT000344_0014, please. It is paragraph 4.3, the bottom
 22 of the page, I think. You said this:
 23 "The nature and extent of support received by the
 24 young people and their families varied significantly.
 25 Repeated referral to CAMHS was common across the cohort,

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1 understanding what is driving a behaviour. In
 2 education, and certainly likely in most contexts, we
 3 talk about "all behaviour is communication" and we have
 4 touched on this already today. But it is about having
 5 that professional curiosity, as we have said, as well,
 6 about understanding that behaviour. But similarly --
 7 and this is clearly already in guidance -- it is about
 8 ensuring that where there are concerns, that we are
 9 ensuring that we have the communication strategies, the
 10 support, to enable the child or the young person to
 11 express their views and to make sure that their voice is
 12 heard.

13 Similarly, in terms of the special occasional needs,
 14 some of the challenges that were evident across the case
 15 studies was a lack of returning and re-assessing needs.
 16 With all special educational needs, there is going to be
 17 changes that comes as a consequence of adolescence and
 18 other contextual factors or interventions being
 19 successful or not, and what we weren't seeing was
 20 application of what's in the SEN code of practice which
 21 was the graduated approach of: assess, plan, do and
 22 review.

23 Some of the statutory SEN assessments that were
 24 disclosed were written for 15/16-year-olds or
 25 14-year-olds and the information that was defining their

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1 although there were also instances in which young people
 2 did not agree to engage with CAMHS."
 3 Then you said this:
 4 "Several had identified special educational needs
 5 and disabilities (SEND), and statutory plans to meet
 6 these needs that included Statements of [Special
 7 Educational Need] or Education, Health and Care ...
 8 Plans that were common across the cohort. Specialist
 9 educational provision catering for social, emotional and
 10 mental health ... needs also featured in the case
 11 studies."
 12 So with your particular background, what did you see
 13 as the particular significance of the way that those
 14 SEND issues contributed to the vulnerabilities and the
 15 risks?

16 **MS SWAN:** It is acknowledged in statutory safeguarding
 17 guidance within education, particularly Keeping Children
 18 Safe in Education and Working Together to Safeguard
 19 Children, that children with special educational needs
 20 and disabilities may be more vulnerable in a variety
 21 of -- in terms of being potentially at risk of suffering
 22 or risk of harm and understanding that practitioners
 23 need to have that increased vigilance.
 24 One of the ways in which that was apparent, across
 25 the case studies certainly and in practice, was about

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1 needs were from assessments when they were 4 years old
 2 and there was no attempts to remove out-of-date
 3 information. So the guidance is there.
 4 Certainly, with children who required their special
 5 educational needs to be provided for through statutory
 6 planning, what was unfortunately also apparent was
 7 an absence of oversight or input and responsive support
 8 from the local authority, statutory SEN services team
 9 and what was happening was an over reliance on
 10 discretionary effort of teachers to muddle through and
 11 make the best as opposed to the needs that were defined
 12 in their Education, Health and Care Plans being actually
 13 met.

14 It's so difficult to sort of encapsulate this
 15 because there are so many different ways in which things
 16 created wider gaps, but the essential challenge is that
 17 at no point in the evidence that was disclosed to us was
 18 there an accurate, contemporaneous record of the child's
 19 needs. So much of it was out of date and consequently,
 20 the provision was not accurately identified and in the
 21 cases where it was, it wasn't -- there was no evidence
 22 that it was actually in place and the impact of that
 23 measured. So SEN increases some vulnerabilities and we
 24 saw that here.

25 **MR MOSS:** Thank you. If we can look at page 87,

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1 ILT000344_0087, and what at least I understood to be
2 a slightly related point in Dr Church, your report. If
3 we can have paragraph 6.15:

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

22 Again, I want to be careful not to go into too much
23 detail in relation to any of the individual cases but
24 I wanted to give you the opportunity, Dr Church, to
25 comment on that paragraph and in particular the

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1 **MR MOSS:** It sounds as though that's something that is
2 already useful to be in the proverbial toolkit but the
3 threshold wouldn't be reached in every case. But in
4 terms of thinking about potential solutions, that sort
5 of availability to call on a review, based perhaps on
6 deterioration or an immediate point of crisis, even
7 short of hospitalisation, I'm understanding you are
8 saying the benefit of that is it gets the right senior
9 people around the table, saying: this is a case we need
10 to be focusing on more and critically now because things
11 are reaching a difficult point; my layperson's
12 interpretation, but is that broadly accurate?

13 **DR CHURCH:** Yes, because local authorities are now asked to
14 hold a register of individuals posing these sorts of
15 risks and it is a way, absolutely, in which senior
16 expertise can be drawn in. Yes.

17 **MR MOSS:** Thank you. So, having looked at some of the risk
18 factors and vulnerabilities, before we leave that topic,
19 I want to turn to the question of how triage and
20 screening may take place and the tools that may be used
21 for that.

22 Firstly, one of the issues that we are asked to
23 explore with you is what sort of triggers, in the first
24 place, should lead practitioners to be referring -- I'm
25 going to use the phrase "potential VFIs" -- for more

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1 potential benefit of the option of a care educational
2 treatment review.

3 **DR CHURCH:** Thank you. Yes, in the last few years, I would
4 say in the last ten years or so, there's been
5 a mechanism for a review of young people at risk of
6 hospitalisation who have a diagnosis of ASD or
7 a learning disability.

8 The drive is to reduce admission to hospital
9 actually because young people with Autism Spectrum
10 Disorder and learning disabilities do not do well in
11 psychiatric hospitals, by and large. Sometimes it may
12 be necessary but it can lead to a cycle of intervention
13 and prolonged hospital admission which is in nobody's
14 interest.

15 So, this mechanism, which is formalised in the
16 wording of the Mental Health Act 2025 which is being
17 implemented, provides a mechanism for a multi-agency
18 review and I have observed instances where the review
19 can be called from one day to the next with very senior
20 engagement and it enables a plan to be drawn up somehow.

21 So it really raises the profile of individuals with
22 these particular conditions, with Autism Spectrum
23 Disorder and learning disability, but there does need to
24 be the potential for hospitalisation which may be
25 a reason why it was not considered.

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1 detailed referral or for the question of adoption? So
2 before we get into who does the screening and what tools
3 are used, what should practitioners, whether in schools,
4 or in CAMHS, or in policing, or in Youth Offending
5 Services, what should they be looking at to refer the
6 cases, what sort of triggers? It may be that the answer
7 is we go back to there is no checklist and it is the
8 totality, but can you give practical assistance on that?

9 **MS GIANFRANCESCO:** We have gone through a whole broad
10 spectrum, haven't we, in terms of what are the risks,
11 starting a neurodiversity and moving through sort of
12 ACEs in terms of DV, trauma, Youth Offending, substance
13 misuse, and it is really difficult because we can't say:
14 actually, if a child has these things -- as we said at
15 the very beginning -- you should be considering this and
16 screening them. But one of the things Dr Church said at
17 the very beginning, if a child is talking about
18 violence, if a child is drawing violent pictures, if
19 a child is talking about weapons, actually one of the
20 things that is absolutely essential is that people begin
21 to explore that with them and actually unpick what it
22 means to them, what is their thinking. Giving
23 permission for a young person to talk about it, to
24 enable them to be in an environment where they can
25 express their thinking and if, then, a practitioner

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1 feels: I have real concerns here, they need to escalate
 2 that. They need to be talking with the
 3 multidisciplinary team around that child. They need to
 4 begin to understand what other people are seeing and
 5 hearing.
 6 Equally, if the child isn't opening up and isn't
 7 talking about it, they also need to be doing that
 8 because they may have opened it up to somebody else and
 9 that person may not have realised the importance of it.
 10 So I think in terms of the sort of red flag: this is the
 11 thing I need to be acting on, it is the minute a child
 12 starts talking about violence, acting out violence,
 13 whether they are showing sexual violence or physical
 14 violence, professionals need to see that as a warning
 15 flag.
 16 **SIR ADRIAN FULFORD:** So that is often going to be in school,
 17 isn't it?
 18 **MS GIANFRANCESCO:** Yes, it can be in schools, but equally,
 19 it can be in the communities, families can be seeing it.
 20 You know, within social work, you will often get
 21 referrals from families where they are saying: actually,
 22 we took Jimmy to his cousin's this weekend and this
 23 happened and we have got concerns and I think that needs
 24 to be a red flag for all professionals.
 25 **SIR ADRIAN FULFORD:** Thank you.

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1 weight any particular risk factor, it's when you are
 2 starting to hear people discussing violence, discussing
 3 violence as a normalised thing and then acting out
 4 violence. All of those are very serious red flags. It
 5 is interesting, when the first conversations about
 6 Prevent -- who should you refer for Prevent and people
 7 said: I don't know what the signs are about why I should
 8 refer -- unless it is very obvious that they are waving
 9 an Al-Qaeda flag at me or they have turned up with
 10 a swastika on their arm, how do I know that this is
 11 a potential Prevent referral? This goes back to my
 12 earlier point about I don't want a tick-box exercise,
 13 but there are some lay people out there who need some
 14 very basic signs which you are kind of asking us for, to
 15 say: these are points at which you have got to
 16 intervene. You've got to intervene, you've got to get
 17 some state help, whether that is through the school,
 18 whether it's through social services or whether it's
 19 through the police and "violence" is the trigger word.
 20 That should be, you know, excuse my vernacular,
 21 a DEFCON 1 approach, to whatever you are seeing, but
 22 social isolation, withdrawal, truancy, there are a whole
 23 myriad of other things that happen before that point.
 24 **MR MOSS:** Yes. So violence on the background -- not
 25 treating it like a tick-box exercise, but violence

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1 **MS SWAN:** I was going to add to that, I think where it is
 2 being seen more and more is online. Because I think
 3 that there is a level of perceived protection or
 4 disguise from being behind a screen, so you know, there
 5 is going to be that expression and I think I saw in one
 6 of the seminar notes a recommendation that
 7 I wholeheartedly agree with, which is about some
 8 guidance for schools around improving curriculum for
 9 online safety to include how to identify those risks.
 10 You know, those expressions, as Anna has described, as
 11 potential -- talking about acts of violence and so on
 12 and then what to do about it.
 13 Because children in schools, on the whole, are
 14 pretty good at identifying CEOPS as being the button
 15 they need to press on the website if they need to report
 16 online safety concerns. But what there is a lack of
 17 curriculum and guidance around is actually what to do if
 18 there is an indicator of serious violence. We have seen
 19 from the case studies certainly, and I think in AR as
 20 well, that young people do want to share and do want to
 21 do the right thing and so it is just making sure that
 22 that curriculum is there to put that safeguard in.
 23 **MR MOSS:** Mr Basu?
 24 **MR BASU:** I agree with everything that has been said and the
 25 trigger word is "violence". So if you are going to

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1 against a sort of background of other risk factors and
 2 vulnerabilities that we have been exploring -- you don't
 3 have to have them all, one of them being very strong
 4 might be sufficient -- but that sort of an approach?
 5 I'm not going to try to reduce it to writing now, it's
 6 something in that space -- to use that dreadful
 7 phrase -- is what we are looking for, in terms of
 8 a professional saying: I think this needs a closer look
 9 at. Would that be a fair summary?
 10 **MR BASU:** Yes and I think it depends on who the professional
 11 is who is dealing with that first indication of
 12 violence, that professional curiosity about the
 13 questions they would then ask and I would suggest they
 14 would be more limited in a police officer's case than
 15 they would be in a psychiatrist, a really good youth
 16 worker or a teacher. They may be asking some much more
 17 in-depth questions which might get to the heart of this
 18 holistic approach to a young person. We might be rather
 19 narrow in our focus and that might be problematic. We
 20 are the people most likely to even cross violence in the
 21 community, for instance, or even perhaps even in the
 22 family home.
 23 **MR MOSS:** Thank you. If we can, for the moment, leave aside
 24 the complexities of who might be carrying out -- which
 25 body might be carrying out an initial screening exercise

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of those referrals, can I ask what sort of assessment, on referral, would be most suitable to take that closer look, but it may have to be an initial closer look at the referral? I think we need to keep ourselves in the real world here because one needs to bear in mind that there might be a large number of these referrals. So they may potentially be going to some sort of Big Front Door in the future, possibly in the form of a MASH. They may remain as potential VFIs concerns going to Prevent. I don't want to be prescriptive at all, let alone at this stage about what the body is but more about what sort of screening exercise, what sort of triage, so the denoting of a level of urgency is going to be useful at that stage.

Dr Lloyd, as a psychologist, obviously there are more detailed assessments that can be carried out at a subsequent stage by deeper specialists but at that initial stage, what are your thoughts on that?

DR LLOYD: Well, it is difficult to say, I think we definitely do need a risk assessment methodology that is similar to the original ERG but which is including the special and different needs of young offenders, VFIs.

And with that, you have got the possibility of being able to make an accurate assessment of that violence because the key is the violence and when I look at the

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and passed on for more detailed scrutiny?

DR LLOYD: Well, obviously it is a SPJ framework and it does require a lot of background information to be useful. So it wouldn't be a screening tool as such. But it would be -- at least it does grow the understanding of the people who are accepting these referrals about what needs to be looked at and "violence" being the trigger word. So, I really think that the learning that would come with an assessment framework like that would just be very, very useful for anybody whose responsible for making decisions at that stage.

MR MOSS: Dr Church, Dr Taylor, in the seminars talked about the fact that there might need to be more of a checklist approach at the screening stage, not in the sense of tick boxing to see whether or not it met a threshold but more in terms of immediate safety checks and system checks, to make sure that the right things were being done by the right people at that stage and then pass it on for more detailed assessment. With your clinical experience, does that ring true to you as what may be necessary?

DR CHURCH: I can understand a need for an initial level of a sort of checklist approach but my experience of CAMHS services, for example, receiving about 30 referrals a week, is that those referrals are looked at by a small

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SAVRY, which is obviously a very, very useful mechanism for doing an assessment, it doesn't -- it is not specified for extremist violence. It is an assessment of adolescent criminality, which in itself would not be as useful as something which actually has been developed specifically to assess the risk of violence.

MR MOSS: So if we can look at page 21, ILT000344_0021, to pick up on that, please. Second half of that page, paragraph 5.6.7, very bottom of the page:

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

So that, I think, is touching upon what you are talking about, about not the EGR-R revised -- the second version of the EGR 22, but an adapted form of it.

Could I gently press you on that. Is that realistic for what may be a reasonably busy body, taking quite a lot of referrals, or is that more an expert, second-line specialist assessment that would need to be carried out if the referral, as it were, were accepted

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panel of senior staff and there's a component of checklist referrals -- sorry, the referral form may have an element of checklists -- and again, this will vary from one CAMHS team to another -- but there will also be free text sort of sections of those sorts of forms which would inform much more often than the tick boxes. So, I think that whatever the referral -- whatever form of referral document takes, there should be scope for inclusion of material that might not neatly fit into tick-box items.

MR MOSS: What sort of professionals ought to be -- again, one can easily put together a panel that would be ideal, but keeping it in the real world, if there are going to be quite a few referrals that will need to go through an initial screen to work out what pathway is most appropriate: is this a Prevent case, is this a potential VFI-type case, or NIVE or NIEV case -- I don't want to get wrapped up into what acronym -- that needs to go further for assessment? Or alternatively, does this look like youth offending early intervention might be sufficient? It's those sort of judgment calls, what -- in practical, realistic terms, which professionals are you going to have round the table?

DR CHURCH: Perhaps the actual discipline is less important than the experience that they have with young people but

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ideally, it would be a multi-agency group. I think there certainly could be input from psychiatry or psychology, social care and policing, I guess. But if we are looking at a very large number of referrals, then there has to be a realistic expectation around how this could be managed.

But, your first question was really about what should be included in those referrals and I have mentioned the SAVRY on several occasions and I think it is a very strong risk assessment tool. The first item, the history of violence, immediately gives a sense of the level of concern and perhaps immediacy of any intervention that's required.

But the bits from the ERG that I think complement the SAVRY and may be part of Randy Borum's new tool, includes the domains of engagement with groups or other anti-social or extremist groups' intent, that may have been elicited and what steps towards capability that young person, or VFI, or possible VFI, may have taken. Those aren't explicitly included in the SAVRY of course but could fit into categories there.

I'm not saying there should be a SAVRY but I guess those are some of the headlines that others have mentioned too, that would raise particular concerns. So if there is some way of formulating that, I think any

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of that it shouldn't be seen -- I'm paraphrasing -- by the Inquiry as a panacea because don't underestimate how time-consuming and resource-impactful it is.

So against that background, your reference to "was historically undertaken in a concise manner" is a point of interest. Do you want to expand on that?

DR CHURCH: Absolutely. There has been a trend over the last decade or so towards our structured professional judgments used in mental health to become longer and longer documents and there have been articles published on this that, for example, one of the most widely used in adult populations, the HCR-20, Historical Clinical Risk 20 risk assessment can now extend to 50 or 100 pages in some cases and the clinical utility of that has been questioned.

Historically -- I have been in medicine for over 20 years, I guess, but I remember at the start of my career, sometimes the HCR-20 was done in a very concise way and for research purposes, it can be done on one sheet of paper where "high", "moderate", or "low", or "0", "1", "2" is just sort of totalled up on each factor and it can be used as a more actuarial tool, but it is a structural professional judgment. So actually, there is scope for, of course, inclusion of key information in a sort of narrative for each item, but it doesn't need

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experienced individual would immediately be concerned by elements in each of those categories.

MR MOSS: All right. So, you are referring there to the AREVA, I think; the tool that's in development. Before I bring others in on this, Dr Church, I will stick with you for a moment because there are a couple of matters on this that I want to explore with you. Can we have, please, first of all, page 86, ILT000344_0086, because you have brought up the question of the SAVRY. So page 86, paragraph 6.9 there was one clause that I wanted to ask you about. So you say, in 6.9, it is on the screen now, at the bottom of the page:

"I'm a strong advocate of the SAVRY ..."

Then you said this:

"... which was historically undertaken in a concise manner that provided very effective assessment and communication of risk ..."

Now, I was interested in that phrase, "was historically undertaken in a concise manner" because some of our evidence in Phase 1 tended to suggest that the SAVRY was, at the very least, a multi-week, if not multi-month, exercise that involved a careful and extensive bringing together of evidence from many different specialisms, and then careful analysis against a large range of factors. But that -- in part, because

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to extend to 50 or 100 pages and my view is that in frontline CAMHS services, there is potential to use this in a more concise way as long as that information is available.

So if there is a professionals meeting with individuals who hold good knowledge of the young person in question, then the information is all there and I would say within an hour or two, the items can be discussed and the risk assessment can be populated. It can be added to at a later date, but a lot of the key information can be populated very quickly.

Of course, it can be developed and there are all sorts of templates or ways in which the risk assessment can be expanded, to include precipitating and other sort of -- predisposing, precipitating and perpetuating factors and there can be other formulations alongside it and action plans and so on, but the core risk assessment can be concise and I would say in the past, that that was more commonly seen than today.

MR MOSS: Thank you.

Dr Broughton for NHS England -- sir, I won't bring it up, but for your note it is NHS000602, pages 15 and 16, paragraphs 70 and 75. Dr Broughton refers to the fact that the SAVRY isn't designed to quantify risk and cannot be relied on as a predictive tool for those yet

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to demonstrate violence but if I have understood your evidence today, you are not saying that SAVRY perfectly fits the bill. You are saying we perhaps need to look at elements of SAVRY, elements of the EGR revised, the new AREVA looks promising -- my paraphrase -- but that there are good points at least to be taken from the SAVRY, alongside your evidence that actually it needn't be a very, very long drawn out process?

DR CHURCH: Yes, no risk assessment on its own will predict all future risk events and we have to be realistic about the limits of risk assessment, especially, as we were alluding to earlier, many of the risks are covert or hidden through the style of engagement that might mask risk and disguise compliance.

So I think there are limits to risk assessment of course but we can equip clinicians to use these tools alongside their clinical judgment and sometimes the interpersonal quality of the assessment of a young person, to try and gain as full as possible an impression of risk.

MR MOSS: Thank you. If we turn to page 84, ILT000344_0084, and your paragraph 5.18, what you do say, which we haven't yet touched upon is that you found that it was striking that the risk factors and features contained in the case studies are extremely well represented in the

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in foetal medicine or in foetal alcohol spectrum disorder, but that's just leading up to conception.

So, between conception and birth, then there is a typically nine-month period, during which there are a host of factors that impact the development of that child. So, again, parental nutrition, substance misuse. We mentioned heavy alcohol misuse, that is part of the foetal alcohol spectrum disorder. The most severe forms are visible with physical characteristics as well as the neurodevelopmental aspects that overlap with ADHD and ASD. But of course there are consequences of other substances, again, make this on a spectrum depending on exposure, frequency and intensity of exposure, cocaine exposure associated, I believe, with craniofacial and other developmental abnormalities and, very significantly, exposure to domestic violence in utero. This is the subject of research that describes pre-natal priming for a harsh post-natal environment and there is some evidence that that exposure to domestic violence in utero actually brings about changes in gene expression for a particular phenotype in infancy and later life.

We haven't got to delivery yet because the parent may not engage in anti-natal care, so the pregnancy may not even be known to services. So none of the usual checks or maternal advice would necessarily be given and

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items of the SAVRY, which, very helpfully, you pasted below.

So I'm not going to go through them all but, from your report, it sounds as though you look at the SAVRY assessment factors and the 24 are set out on screen at the moment and reference that against the risks and vulnerabilities of the case study and saw -- my words -- a very good correlation between the two?

DR CHURCH: Yes, very much so, I think in all areas, the historical, social contextual risks and individual risk factors. I think just to expand on early adversity as well. Because my colleagues mentioned foetal alcohol spectrum disorder and if I may just make a comment about early adversity which I think is quite significant, that a lot of these risks are present before the child is even born. So, if we are looking at a very disadvantaged population, then -- and we will be often looking at parents who may have a history of poor nutrition themselves, substance misuse, it may be quite disorganised or chaotic life styles, may not actually know that they become pregnant at the point of conception, and apart from substance misuse, there may also be exposure to sexually transmitted infections or other infections or pathogens that we know can have an impact on the developing foetus. I'm not an expert

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then the delivery itself may not be planned at all, and more likely to include emergencies or prematurity anyway.

So, apologies for sort of going on a bit, but I'm labouring the point that even actually before birth, the child has been significantly disadvantaged in many cases. I'm not saying that applies to all our case studies or every VFI, but I wanted to set out, from a developmental perspective, the significance of factors before birth.

MR MOSS: Yes, thank you. Can I just come back to your four colleagues and the question about screening and triage and tools, to see if there's anything you wanted to add about that, that balance between keeping it realistic in terms of what can be done within a time if there is quite a few referrals, but also gathering the necessary information and trying to make a good first assessment at a screening or a triage stage. Is there anything that the four of you want to come into? Mr Basu?

MR BASU: So I feel like we have skipped a stage. So the SPJ, the senior professional judgment that's required to -- not only to answer all of these questions but then to make a judgment about what they actually mean, would be a big step removed from a first-line responder or a young teacher coming into contact with a child and

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1 young person with which they have concerns about. So it
 2 is a bit like I was talking about Prevent referrals.
 3 How do you decide --
 4 **MR MOSS:** Pulling in the information --
 5 **MR BASU:** Yes, how do you decide that you are going to refer
 6 this person to something that will be quite intrusive,
 7 will involve multi-agencies. So nailing my colours to
 8 the mast, none of those case studies or any of my
 9 30 years of professional career say that one agency has
 10 the answer to these problems; we just don't. It always
 11 requires a multi-agency response if you want to assess
 12 the need and deal with the needs because no one single
 13 agency has the skill or the ability to do everything
 14 involved.
 15 How do you get to that point? That is the bit that
 16 worries me. It has been 30-plus years since I filled in
 17 a Merlin report on a child at risk in the community. So
 18 I wouldn't be able to tell you today what exists in that
 19 Merlin report, but something has to trigger
 20 a conversation at the next stage, that this has got to
 21 be a multi-agency approach. It is that first stage, the
 22 initial triage, without getting overwhelmed by huge
 23 numbers -- and I have seen David Anderson's figures and
 24 the CFC figures about current Prevent referrals
 25 post-Southport Phase 1, which has resulted in something

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1 difficult questions. I need to make sure this goes to
 2 level 2. Does that make sense?
 3 **MR MOSS:** But if it was going into some sort of body, leave
 4 aside for the moment who it is, but let's say some sort
 5 of local authority body, does that first level of
 6 screening need the ability to say: on the face of this
 7 referral, this is what, in MAPPA terms, might be level 1
 8 management? In other words: this can go to a single
 9 agency lead as -- my phrase -- "a normal case". They
 10 obviously do need to deal with other agencies but we are
 11 not going to pull in all the information because that
 12 looks like a case at that sort of level 1 and to be able
 13 to distinguish the case: well this case looks concerning
 14 and so we need to gather the information urgently,
 15 perhaps over the course of a week and put this to
 16 a panel to see whether it should be taken on as a VFI
 17 case. Does it need some sort of screening at that
 18 stage? Because, otherwise, you might be saying you get
 19 all of the multi-agency information in every case and
 20 that feels like, perhaps, a recipe for overwhelm.
 21 **MR BASU:** So my experience of policing, particularly when
 22 there has been a catastrophe, is defensive policing
 23 leads to your 100-page 20-point risk assessment. That's
 24 exactly what happens. An example of that, when I was
 25 a custody sergeant in the mid-1990s, it took me

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1 like a 40 per cent increase in referrals, many of which
 2 will be in this space because people are so concerned,
 3 the publicity has been enough to generate that concern
 4 and push it forward. How do we give, not just young
 5 professionals, first-line responders, people who are
 6 very busy, the tools to be able to make that decision,
 7 but also parents, community members, social workers,
 8 people who are helping families, how do we give them
 9 that tool before we get to this level of detail?
 10 I know we don't like the idea of a tick box, but at
 11 least those questions start -- for me, as a young
 12 officer, I would be looking at that and saying: I should
 13 have asked those questions. That question could only
 14 come from a teacher, so why haven't I asked what school
 15 they go to? I am being very basic but at least you're
 16 teaching professional curiosity, from early on in
 17 somebody's career, by giving them a series of questions
 18 that they either can or cannot answer and saying: you
 19 can't move to stage 2 until you have answered these
 20 questions. How do you make that simple? So I'm
 21 a massive fan of that SAVRY tool, that does fit every
 22 case study I have read and all of my professional
 23 experience. No first responder is going to be capable
 24 of doing that, but they are capable of looking at that
 25 and going: somebody else needs to answer some really

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1 10 minutes to book a prisoner in. You'd be lucky if it
 2 takes 45 minutes now and a massive amount of paperwork
 3 to go through the risk assessment because of deaths in
 4 custody.
 5 So, there is absolutely the danger that if you don't
 6 produce something that allows people to make a decision
 7 at first stage, you are going to overwhelm whatever body
 8 you set up to look at these. So that's my point: what
 9 is that system? This is definitely good for level 2,
 10 when everyone is sitting around the table with their
 11 knowledge -- we will get onto this, I know -- but
 12 bringing the knowledge of their individual agency and
 13 professionalisms and knowledge of the young person to
 14 the table. But before you get there, how do you do that
 15 in a way that doesn't miss risk but doesn't overwhelm
 16 the system, I think is a significant problem.
 17 **MR MOSS:** Thank you. Yes, Ms Gianfrancesco.
 18 **MS GIANFRANCESCO:** I completely agree with what Mr Basu is
 19 saying. I have been thinking about this a lot and
 20 I think it is really difficult to think about how we are
 21 going to identify these young people without creating
 22 overwhelm in systems that are already stretched because
 23 we don't know -- I don't know how many people we are
 24 talking about, but I have to assume we are talking about
 25 very, very small numbers. But equally, what I know is

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1 that there is a lot of anxiety within systems that
2 people are going to miss somebody and another incident
3 like Southport happens again and nobody wants that to
4 happen again. That's why we are all here, to think
5 about how do we prevent that happening again.

6 What we also know is when you overwhelm systems
7 actually things happen because systems are overwhelmed
8 and people miss things. So we have that balance of how
9 do we create something that doesn't overwhelm systems
10 that mean we miss somebody, but we create a process that
11 enables people to identify someone.

12 Now, for me, I very strongly believe that there are
13 already a lot of systems and processes in place through
14 which we should be able to identify people that are at
15 risk of violence. There are a number of things that
16 then stop that. There are things like professional
17 curiosity, there are things about professional
18 overwhelm, there are things about people not being
19 trained very well. There is a whole collection of
20 things. But there is also something around people not
21 being clear about where to go with something. I know
22 that's part of your ask.

23 When I look at systems, we have MAPPA, we have --
24 every area has a child exploitation process. We have
25 Child Protection, we have Prevent, we have community

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1 But that process and that person that's leading that
2 process, so the Prevent Chair, has the ability and the
3 authority to scrutinise the work that I could be doing
4 as a social worker under Child Protection, if they think
5 I'm not delivering in terms of Prevent. Am I making
6 sense?

7 **MS SWAN:** I would say I agree with you entirely.

8 **MS GIANFRANCESCO:** So there's something around how do we
9 enable professionals to understand the processes that
10 they have to work to -- and they may be working under
11 a care plan approach, a Child Protection approach, and
12 a Prevent approach, or a MAPPA approach. But which is
13 the highest risk to everybody? Now, that's probably
14 going to be the violent element. And they are all being
15 held account under that one process.

16 **MR MOSS:** Yes.

17 **MS GIANFRANCESCO:** Then within that -- and this is where
18 I struggle then with the screening bit -- how do we get
19 to that bit in terms of screening? For me, that should
20 be their professional judgment. But like the SAVRY is
21 a really, really good, simple risk assessment in terms
22 of if you take all of those things, and say: actually,
23 I have concerns about all of these, then actually that's
24 a concern about violence. So I'm not sure I have
25 answered your question at all.

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1 safety systems and panels. So we have lots and lots of
2 systems.

3 I guess my question that I'm asking myself -- and it
4 is an open rhetorical question at the moment -- is: do
5 we need to create something else or do we need to look
6 at the systems that we have already got?

7 One of the conversations we have been having -- and
8 I have been saying quite strongly as we have been
9 writing the report is we got into conversations quite
10 a lot about who is the lead professional and I have
11 always been very clear in my working that you are only
12 the lead professional for your bit. So I was a lead
13 professional as a social worker but if I was working
14 with Dr Church, he would have been the lead professional
15 around mental health. You are not the lead professional
16 for the case and for me, it is about the process and the
17 system that is the highest risk in some ways that needs
18 to be the least.

19 So if we are saying: we think this young person,
20 they are open to Child Protection because of maybe
21 neglect and abuse at home but we are also really
22 concerned around Prevent and them being drawn into
23 terrorism, then Prevent and them being drawn into
24 terrorism is the lead process around that and the Child
25 Protection element feeds into it.

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1 **MR MOSS:** You have answered the question I haven't asked
2 yet. There is no harm in that.

3 **MS GIANFRANCESCO:** But I think, in terms of getting to
4 a screening, for me, it is to understand why you are
5 screening and where are you going.

6 **MR MOSS:** Thank you.

7 Sir, we have jumped ahead into future topics, as
8 I say and I meant it seriously, there is no harm in
9 that. But would that be a convenient moment because
10 I have reached the end of my topic 4.

11 **SIR ADRIAN FULFORD:** Yes. We will take a 10-minute break
12 and sit again at 3.35 pm.

13 (3.25 pm)

(A short break)

15 (3.35 pm)

16 **SIR ADRIAN FULFORD:** Yes, Mr Moss.

17 **MR MOSS:** Thank you, sir. So I turn now to my fifth topic,
18 which is to look at multi-agency working as it was in
19 the case studies. The purpose of this is to identify
20 shortcomings and weaknesses in the multi-agency working
21 as they were in the case studies, to inform the sixth
22 topic, which is options for change, what needs to change
23 in multi-agency working.

24 So, can we start with some of the overall
25 observations that are important, could we look at page 8

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of the report, please, ILT000344_0008, so this is within the first sub-report and it is paragraph 2.7. It is right at the bottom of the page:

"Across several cases there was a concerning inverse pattern: as needs and concerns accumulated and intersected, input from specialist services reduced or fell away, leaving families and education providers to manage their increasingly complex needs without specialist support. These young people required more rather than less help because of the challenges they posed. Ironically, their increased withdrawal and isolation in the home, in the absence of protective factors and parental awareness of their online activities, took place when and where it was least likely to be seen."

Then you go on to say:

"In reality, even with better informed practice it would have been difficult to predict their offences, given the low prevalence of such offences and when it was their first offence."

So, anybody who has read the Phase 1 report would see, in that, echos of AR where indeed there was a withdrawal of services towards his index offending. Can I ask one of the three of you just to lead on what it is, in essence, that is leading to,

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But particularly in a number of the cases, there are significant gaps in education due to permanent exclusion. In many of those cases also, there's children who have Education, Health and Care Plans. There is a statutory duty on the local authorities to step in and ensure that -- in fact for all of them to ensure those children have full-time education, but similarly, for EHC plans, that therapeutic provision or of the other provisions identified in their plan must still be secured and there was no evidence of that.

And so what happened was almost "out of sight, out of mind". There was this longer and longer periods where the young people were away and nobody seemed to really have a grip on what support was needed.

MR MOSS: Ms Gianfrancesco, do you want to add to that?

MS GIANFRANCESCO: I think in terms of where young people are out of school and have SEN needs, we know that nationally there is a shortage of specialist SEN places. That means it is very difficult for local authorities to move children between education placements particularly if they are excluded from one education provision and then children can be out of placements, sadly, for months. I think in these case studies we saw that and we saw that repeated pattern where they were struggling to get into school, they themselves weren't engaging,

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counter-intuitively, a withdrawal of services perhaps at the very time when services need to increase? Ms Swan, does that perhaps fall to you?

MS SWAN: I think, particularly from an education context, what we saw is that there was an escalation of risk, in terms of the behaviour of the young person within the school environment, which led to either successive suspensions from school or ultimately permanent exclusion, or there was a disengagement, that sort of slow, seeping withdrawal from education. In many of the cases what was happening, particularly in two or three of them, there was this escalation of need and nobody seemed to know what to do and all of the agencies at the time, those that were communicating, were signalling: well, it is not us, and there was this passing between agencies and where the complexity increased, there was an increase in saying: sorry, we don't have that support.

One example that we have seen in the case studies and we also see in practice is particularly where there is a diagnosis of autism because services may find that they don't have autism-informed provision or interventions and so, rather than commissioning or brokering that support as appropriate, the provision is not made.

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they either didn't engage with school or they were excluded again. New searches would have been undertaken but they were, in effect, out of school.

And Lizzie is right, that it is the local authority, particularly if they are excluded from school, that have to be providing an education provision book. Quite often that is via a tutor for a set number of hours a week, so not within a school setting, or online via a tutor. So, again, that increases their isolation, pushes them more online. I think we saw that quite a lot in these case studies, of these young people not being in school and being pushed online, in effect.

And then they fall through -- I keep talking about it -- they fall through a gap because their need is an education need, there isn't an education provision. But in terms of social work, there wouldn't necessarily be a need for social work because there wasn't a welfare concern as such. Mental health may be saying: well, we are supporting them with their ASD. We have done a certain amount of diagnosis, this is the ASD support but there isn't necessarily any specialist ASD services or neurodevelopmental services in areas. So it then becomes really difficult for families where their need is around education but they are not getting their education provision.

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1 **MR MOSS:** The risk of the young person -- without going into
2 details of any particular case study, but the risk that
3 the young person may have posed to others, why was that
4 in general terms not being picked up?

5 **MS SWAN:** I can speak to that in terms of education, if
6 I may. So, within the context of special schools or
7 children who are in receipt of an Education, Health and
8 Care Plan, at the time of identifying and naming
9 a setting in that plan, the information is sent to the
10 school for consideration or consultation, there is
11 a statutory process around that. However, it is so
12 dependent upon accurate information and accurate
13 representation of risk where that applies. We saw this
14 in the case of AR, as I have already identified, in that
15 move between the schools, those gaps in sharing of
16 information about risk and one of the schools said: had
17 we known at the time, we would not have admitted that
18 young person because we cannot meet their needs.

19 One of the factors that we see in the case studies
20 and we see generally in practice is it is so important
21 that the information we are sharing before the child or
22 young person moves to that school, it is critical that
23 that information is shared, and so often what can happen
24 is that a child will be identified to the best fit
25 provision because, for many children who is displaying

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1 SEND framework, we have four broad areas of need and
2 autism, whilst it crosses over, is most commonly within
3 "communication interaction" and there are specialist
4 placements for communication interaction in many cases.
5 Conduct disorder, or ADHD, would be SEMH, "social
6 emotional health needs", and so that's why it is so
7 important to have that better understanding of what
8 their main presenting need is, whilst there will be
9 overlap, we just need to identify that and again, that
10 information sharing, that accurate understanding is
11 really key.

12 **MS GIANFRANCESCO:** But I think it is also really important
13 in these case studies to recognise that not all of the
14 children were in SEN provision and some of them were in
15 mainstream.

16 **MR MOSS:** Yes.

17 **MS GIANFRANCESCO:** Within mainstream, their social
18 isolation, their withdrawal wasn't necessarily being
19 recognised. So those young people were withdrawing
20 themselves but actually, the school being busy,
21 mainstream schools, if you are a quiet young person, you
22 often go under the radar. So then they became quiet
23 young people and they were going under the radar. In
24 some cases, it was being identified but nobody was
25 really -- it didn't really progress I think and even in

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1 this unusually high level of risk, there are -- it is so
2 hard to find the right full-time education provision for
3 those young people outside of the secure units and so
4 on.

5 So it is just to find the right level of therapeutic
6 provision, but also incredibly important that we are
7 transparent before that placement is named and there
8 unfortunately -- there isn't, in practice, those
9 mechanisms and it should be because -- it should be that
10 the reports and all of the chronologies and information
11 is in what we call section K of the plan, but in nearly
12 all situations we just don't get that full précis of
13 risk.

14 I think in some cases there is a reticence to be too
15 overt because there is a focus, as there should be, on
16 strengths -- not focusing on the child's deficits but
17 I think there is a professional concern about not
18 allowing a young person that fresh start. Whereas
19 actually what we should be thinking about is making sure
20 that everybody understands their needs and doesn't just
21 make sure we have got the right provision for that
22 child, but keeping everyone else safe.

23 I think it is really key that in the discussions
24 about autism, and also discussions about conduct
25 disorder -- this is just a brief tangent, but within the

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1 conversations with the family, it didn't progress. So
2 the young people then withdrew from schools and then
3 became isolated in their bedroom. So, there was risk
4 there but it wasn't a risk in terms of a violent risk,
5 it was a risk of isolation and people weren't really
6 considering that to be a risk.

7 **MS SWAN:** We talked about the first aid response, that you
8 go to the quiet person first when responding and the
9 quietness was just easier to deal with within that
10 classroom environment. There still needed to be that
11 professional curiosity because it was apparent in young
12 people's attainment or attendance, so the warning signs
13 were still there but they were quiet.

14 **MR MOSS:** Thank you. Then another factor, if we go to
15 page 27, ILT000344_0027, and paragraph 6.3.5:

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

24 Ms Gianfrancesco, does that come back to a point you
25 were making earlier on about the cultural need, as it

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1 were, for professionals to retain their responsibility
 2 for the parts that they are responsible for, even if
 3 a case has been referred on to a different agency for
 4 that agency to look at a particular aspect?
 5 **MS GIANFRANCESCO:** Yes, absolutely. I think we saw a number
 6 of cases, particularly in relation to Prevent, where
 7 referrals had been made to Prevent and then there seemed
 8 to be a concept within the cases of: well, we have
 9 referred to Prevent, so we are not going to do anything
 10 until we know what Prevent are doing, rather than
 11 actually still holding onto their professional
 12 accountability and continuing to work with that case.
 13 **MR MOSS:** Again, and it is my fault, getting slightly ahead
 14 of ourselves and looking at professional practice, but
 15 while we have this in mind, it is relatively easy,
 16 I think, for you to describe what good professional
 17 practice looks like, but what practical measures are
 18 needed to reinforce that so that busy professionals,
 19 perhaps struggling for resources don't think: well, we
 20 tried, we have now referred that on -- my simplistic
 21 paraphrase "our job done". How do you fight that
 22 perhaps understandable culture in busy professionals?
 23 **MS GIANFRANCESCO:** For me, it starts with a really simple
 24 thing, very, very clear case management systems and
 25 people understanding what their role and their

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1 "Several cases also show risk being managed in short
 2 cycles. A referral was made, risk was considered,
 3 limited support was offered, presentation improved or
 4 engagement was poor, and the case was closed. The
 5 individual then deteriorated again."

6 You say:

7 "This 'fire brigade' model is ill-suited to subjects
 8 whose risk emerges over years, fluctuates, hides online,
 9 and becomes visible only when observations are combined
 10 across agencies. The reason for non-engagement by the
 11 subject or family should have been explored and treated
 12 as a risk factor rather than as a reason to close it
 13 down and step away."

14 Again, more than echos of findings from our Phase 1
 15 in relation to AR. Again, with hindsight, the problem
 16 is easy to state and, if I may say so, well identified
 17 in this pithy paragraph. What needs to change?

18 **MR BASU:** You are absolutely right; that is the trouble with
 19 hindsight, isn't it? It was very easy to make that
 20 statement but also I'm very sympathetic to professionals
 21 who are seeing a problem delivered to them, either at
 22 crisis point because it's come to them late in this
 23 cycle, and then having to deal with that issue and not
 24 really understanding what other professionals are doing
 25 around the person concerned, or feeling that they are

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1 responsibilities are, through to actually their
 2 supervision and how robust their supervision is, how
 3 closely their managers are supervising what they do.
 4 Audits, so are there good audits and processes in place?
 5 You know, who is doing the audits of the cases and what
 6 happens when cases are audited and it is seen that
 7 people are maybe stepping back? What's the -- so it is
 8 about management and accountability and governance
 9 within the organisation and then alongside that, it is
 10 about training. It is about understanding what other
 11 processes do.

12 So, have professionals been trained in Prevent? Do
 13 they understand actually what Prevent's limitations is,
 14 or do they understand and have got good working
 15 relationships with the other social worker or the CAMHS
 16 professional? So there are various different factors
 17 that should be in place, but one is about management and
 18 accountability. The other is training and then there is
 19 stuff around individual professional practice so people
 20 being accountable for their own work.

21 **MR MOSS:** Thank you.

22 Mr Basu, turning to an allied observation that you
 23 make. Can we have page 125, ILT000344_0125, on the
 24 screen, please, and it's paragraph 4.6.3. It is this
 25 concept that you identified, as:

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1 solely responsible for ameliorating whatever risk that's
 2 there.

3 I was slightly surprised -- I'm not a professional
 4 in the clinical side of things, so looking at what CAMHS
 5 were doing, looking at the interventions that were being
 6 made by other agencies, I was quite surprised how short
 7 that they were and I certainly know that in my side of
 8 the world, with things that have been brought into place
 9 like Youth Restriction Orders which may order some kind
 10 of engagement from a young person, they tend to be
 11 time-limited to something like 16 weeks. There's a case
 12 study that shows sort of having an in-depth CAMHS
 13 assessment of a young person's neurodevelopmental and
 14 mental health needs was effectively, I think, eight full
 15 days over a significant period and that's considered in
 16 depth.

17 As a layperson, that surprised me because when you
 18 look at the trajectory of all of these cases, they all
 19 start through various transition points, from very
 20 young, toddlers, and we have talked about pre-foetal as
 21 well, but exhibiting behaviours that are outwith the
 22 norm and if a teacher says that, parents or
 23 inexperienced parents may not see the behaviour as out
 24 of norm, but teachers who see lots of children all of
 25 the time might say that's out of the ordinary.

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1 Then there is a big gap and then it appears again
 2 later on in primary school, then in transition to high
 3 school. There is such big time gaps here, it is easy to
 4 write a paragraph like that but it is very hard to see
 5 how anybody could have seen that trajectory increasing
 6 and do anything other than with resources being what
 7 they are, dealing with the immediate problem in front of
 8 them at the immediate time.

9 It takes a step back, knowledge of all of the
 10 information that was held by all the agencies and being
 11 able to look at that cold, to understand where those
 12 gaps were and how short the assessments were and how
 13 sometimes -- I made a statement earlier that this person
 14 is talking to two separate professionals and saying two
 15 different things but that's never triangulated. How do
 16 you improve that? You improve it by -- well, the first
 17 thing is it has to be a multi-agency system. So if we
 18 got past your last section, if we have a good screening
 19 process and we have got people into a system that now
 20 form a cohort, where we have done a serious professional
 21 judgment of what risk they might hold, and we have
 22 various agencies that could deal with part of the needs
 23 assessment of that individual, and they are all working
 24 concurrently on that issue, and they are all
 25 regularly -- I think it was you, Liz, who said the

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1 I said, when I was talking about audits, I think it
 2 could have been clearer as well in terms of saying, you
 3 have to recognise, we currently don't have multi-agency
 4 chronology and multi-agency notes. We know that, we
 5 accept it, we have never had it. People need to work in
 6 a different way.

7 But actually what Mr Basu was saying there was
 8 right, is that individuals come in, people work with
 9 them for a little while, then they close again, then
 10 they come back two or three years later or six months
 11 later, and actually quite often what we see in cases,
 12 and I think this is common within serious case reviews
 13 and is often spoken about, is a "start again" culture.

14 We may not have multi-agency chronologies but if you
 15 have worked with a family, you should know that that
 16 CAMHS service was involved and the school were doing
 17 this. It should be in your notes as a single agency
 18 because you have been doing multi-agency working. Then
 19 six months later, when that child comes back in, with
 20 a different issue, there shouldn't be a start again
 21 culture because you have all of this information over
 22 there. So you may not be able to do a full,
 23 multi-agency chronology and getting everybody together
 24 at the very outset, but you have a lot of multi-agency
 25 working.

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1 review model -- you come back around a table, you have
 2 all had interaction with the young person and you are
 3 talking about what level they have reached and that
 4 regularly happens as a review.

5 It doesn't need to be the whole of the multi-agency
 6 process doing that, but that review process regularly
 7 happens. It was difficult to see evidence of that. So,
 8 I think how I described it elsewhere was it wasn't that
 9 agencies weren't interested, it wasn't that agencies
 10 weren't there, it wasn't that people were not being
 11 referred, it was just entirely fragmented because the
 12 actual system of a multi-agency approach seemed to fall
 13 down.

14 So in every case, everybody knew that there were
 15 agencies that had specific skills, that would need to --
 16 somebody would need to be referred to. Once that was
 17 done -- and I think my colleagues said it best: out of
 18 sight out of mind. Once that referral was made, that's:
 19 my job done, my signpost is done. I have no idea where
 20 the risk is now, but it is not with me or my agency; it
 21 is with that agency. That is not what I would describe
 22 as an effective multi-agency system.

23 **MS GIANFRANCESCO:** Mr Moss, sorry, can I just come back in?

24 **MR MOSS:** Yes, of course.

25 **MS GIANFRANCESCO:** So building on what Mr Basu said and what
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1 So in terms of expectations and what would make --
 2 what we should expect from professionals, whichever
 3 organisation that is, is that they go back and they
 4 don't start again and they use all of the history that
 5 they have to begin to do a new assessment.

6 In using that history, they can then go to the
 7 school and build on the information that the school gave
 8 them six months ago or two years ago to find out what
 9 has happened in between and actually, there was a little
 10 bit of concern there about he had kicked somebody in
 11 school and had the school seen any more escalation in
 12 violence or something else.

13 So I think one of the big things is about ensuring
 14 people don't have the fire brigade model, we don't keep
 15 starting again. But every assessment needs to go back
 16 and build on the previous assessment even if the
 17 previous assessment was two or three years ago.

18 **MR BASU:** Sorry, Mr Moss, can I just add -- this might be me
 19 just being cathartic for the task you set the five of
 20 us, but that thing about we have never had a chronology,
 21 there has never been a single record that follows the
 22 young person, we have just accepted that. I appreciate
 23 there is a commentary in one of the seminars, saying:
 24 don't go there, it was too complicated. That may have
 25 been evidence given to you from somebody who used to

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work for me, or I asked to put that system in place for counter-terrorism, so you should listen to Dr Paul Betts because he knows what he's talking about and how difficult that was, that doesn't mean it shouldn't be an aspiration.

Because it's senior investigating officer, homicide investigation 101, that the first thing you do is create a very detailed chronology. I found myself having to do that with each of the case studies because one did not exist, and that is an incredibly difficult position to put professionals sitting round a table in, if they don't know it.

Also, on those multi-agency meetings where the same people are not always turning up. It is the same agency turns up, but it's not the same person with the same knowledge. What are they relying on to come to that meeting with in terms of knowledge? If I'm chairing one of those meetings and if the police turn up, I expect that police person to know everything the police knows about that person, the same with health, the same with social services.

I can't speak for the others but that police officer won't necessarily know everything the police know about that person, and I suspect it is the case because of the fragmentation of healthcare and different teams doing

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in and got everything I needed almost instantaneously. We need to get to that point. So if that's possible, I don't understand why somebody gave evidence saying: that's just too difficult to do. It is not too difficult, but it might be very expensive. So I don't think the practicalities of having one system that can ingest data from different systems from other agencies is necessarily a practical issue about IT. It will be about cost.

The other thing is about trust. So it is whether agencies -- and this is a problem we found significantly in counter-terrorism because everyone understands that they have a right to share information. It is very different in the pre-criminal space because when you tell them you have an absolute right to share if there is a law and order or a community safety issue, they say: well where is that in this case? They might be thinking about it, but they haven't done anything. So why should I be divulging confidential information to a national security professional or a MI5 agent? I do not want to be in that space. Also, in doing that, I might ruin my relationship with the family and the young person I'm working with. So there is a lot of trust issues that you have to -- and I have had information sharing agreements signed between doctors

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different things. So all of those things have to be fixed. It is easy to say a multi-agency process. It is easy to say it is too difficult to produce that. You do create gaps if you don't attempt to address it.

MR MOSS: So, insofar as I'm allowed to say so, Mr Basu, fear not, because one of my questions for later on was about the single chronology, the single story, as it is referred to in the combined three, and let's deal with it now. The question: why is it seen as so intractable just to get a good multi-agency account of where we are up to with this young person with each of the relevant agencies filling in? Why is that so apparently difficult to achieve, in practice? Is it IT? Is it information sharing culture? Is it concern about the Data Protection Act? All three?

MR BASU: Yes. When you said "fear not", I have always dreaded that expression throughout my career, but unfortunately it is all of those things. So even within policing, there is multiple information technology systems that doesn't necessarily talk to each other. We are getting to a stage in information technology -- and I say this with some experience -- where AI will be able to aggregate data in a way that could make sense of this. So it wouldn't be very long before I could have pressed a couple of buttons, put all of your information

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and spies. It is difficult work for precisely that reason. So it is anecdotal, but it is absolutely true that the trust issue is a really difficult thing to overcome.

But I think it is more about cost and it is more about trust and it is more about we have just never done it that way. But if you have to do an exercise like this, anybody who wanted to do an exercise like this -- and if you think about all of the public inquiries and inquests -- and I'm a veteran of lots of them, as you are -- how much easier those processes would be and how much quicker you'd be able to see what the problem was and learn for the future, how much easier it would be to hold people to account because you had that chronology. It is a very difficult to do that in our current systems.

MR MOSS: Ms Swan, I think you wanted to --

MS SWAN: I was just nodding furiously, just out of agreement. At the end of September, the Department for Education brought in the "information sharing duty" which I think has provided more clarity around data protection and information sharing because across the case studies, there was evidence of barriers in terms of sharing information between agencies, seeking consent and so on.

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1 But there is already guidance, statutory guidance
2 and non-statutory guidance around the fact that we
3 should not be asking families to re-tell their stories.
4 As we have described the context of many of these young
5 people, it would be re-traumatising. But also there has
6 been, through the case studies, patterns where --
7 I mean, recollections of memories will change by nature
8 but also there is evidence of minimising behaviours by
9 the parents by the young people and having that
10 consistent chronology can support that.

11 The challenge is -- I'm sorry to keep talking about
12 EHC plans, but from a SEND perspective, EHC plans within
13 the SEND reforms, possibility of a digital, individual
14 support plan, the challenge is adherence to these
15 methods. There is certainly no disagreement that it
16 would have been hugely beneficial as a practitioner and
17 also in this process to have that single chronology but
18 it is about adherence, time and resource as well.

19 **MR MOSS:** Well, let's pick up on that and again, deal with
20 it while it is fresh in our mind. So if we could
21 have --

22 **MS GIANFRANCESCO:** Sorry, can I just come in on that
23 information?

24 **MR MOSS:** Yes, of course. Could you just park it for
25 a moment. I will come back because it may be that we
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1 what you have referred to -- or your panel have referred
2 to, would apply to a child who may pose a risk to
3 another child in terms of -- my paraphrase of her
4 evidence -- but a pathway to disclose information.

5 But both in education and social care, is it likely
6 to be understood that way? Are people going to see the
7 safeguarding needs of a child as being an appropriate
8 justification for the sharing of information, if the
9 primary concern is actually about the child harming
10 another person, whether a child or an adult?

11 **MS SWAN:** I would like to talk about Keeping Children Safe
12 in Education and a recent change.

13 **MS GIANFRANCESCO:** Shall I talk about broader changes under
14 the Wellbeing Act? So, under the Wellbeing Act, there
15 are broader changes around information sharing duties
16 and the thing that it is about, behind the Wellbeing in
17 Schools Act is -- what's it called? Keeping --

18 **MS SWAN:** Keeping Children Safe in Education.

19 **MS GIANFRANCESCO:** No, not Keeping Children Safe in
20 Education. Working Together Effectively. So Working
21 Together 2026 -- there's Working Togethers every few
22 years that are -- it is the guidance that supports
23 professionals around safeguarding and working together,
24 multi-agency working. Working Together 2026 produced
25 guidance which came out in September, specifically on
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1 can deal with it in the point that I'm just going to
2 come onto. So if we can have a look, please, at
3 page 46, ILT000344_0046, I think it is,
4 paragraph 8.10.7. I just wanted to deal,
5 Ms Gianfrancesco, if you'll forgive me, with Ms Swan's
6 point about changes. I think this is what you were
7 referring to?

8 **MS SWAN:** Yes.

9 **MR MOSS:** So:

10 "These findings are relevant to current reforms ...
11 The Children's Wellbeing and Schools Act 2026 introduces
12 strengthened information-sharing duties and provision
13 for a consistent child identifier across different
14 systems. This provides an opportunity to consider how
15 these reforms could support a more accessible view of
16 multi-agency involvement with a child. Such an approach
17 could build on existing models of proactive information
18 sharing, including Operation Encompass [which we have
19 heard some information about] and complement the
20 development of digital records proposed within the SEND
21 reforms."

22 Now, sir, for your note, Kate Dixon, our Department
23 for Education witness, the reference DFE000297. Is it
24 is page 7 and paragraph 27 -- forgive me for not
25 bringing it up for speed -- suggests that this, Ms Swan,
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1 information sharing.

2 That guidance is there to support all professionals
3 to understand when they can share information and one of
4 the blockers for years has been that people have
5 believed that they can only share information if it is
6 under Child Protection. Working Together is now very,
7 very clear. It goes beyond Child Protection and is
8 about the welfare of a child. So if you have concerns
9 around the welfare of a child, you do not have to get
10 consent from the parents to share information.

11 Which should, for me, also mean that if you have
12 concerns about a child who may be at risk to other
13 individuals because that is about the welfare of that
14 child. Because you should be concerned that that child
15 actually is going to harm themselves in harming others.

16 So it should make it much easier for wider
17 professionals to start sharing information and not be
18 fearful of complaints because I think that is one of the
19 big blockers around data protection and complaints about
20 you as an individual professional or complaints into the
21 agency as well, in terms of breaching Data Protection
22 and then, as an organisation, there's always concerns
23 around an investigation, around -- sorry, I have
24 forgotten the name -- the Information Commissioner. So
25 those things should help.
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1 The other thing that the wellbeing -- that Working
2 Together is clear about is about the development of the
3 child identifier, which should enable some form of
4 chronology. I think we have to be careful when we are
5 talking about multi-agency chronologies. I don't know
6 if anyone has ever seen a multi-agency chronology, but
7 if you're working with a complex child and you ask for
8 a multi-agency chronology for about a year, it is
9 generally two or three hundred pages long at least,
10 maybe five or six hundred pages. So we have to think
11 about what do we mean by multi-agency chronologies.

12 I think when we are talking about child identifiers
13 it very much is a case of being able to see who a child
14 is open to, when they are open and maybe significant
15 incidents, like if they are arrested or something. But
16 it shouldn't have all of the detail in because it would
17 be too much information and then you would lose
18 information.

19 The other thing around multi-agency chronologies is
20 also, as Mr Basu was saying, about thinking around what
21 it means for young people if some of that information is
22 shared. So, I have managed some substance misuse
23 services and we have had to be really careful over the
24 years of what information we give other professionals
25 because we sometimes work with young people who have

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1 which high risk was identified, but somehow not managed,
2 with very high risks being identified even in the days
3 prior to a significant adverse event."

4 Again, avoiding if you would, going into the
5 minutiae of individual case studies, but I wanted to
6 give you the opportunity at this stage of just talking
7 about the overview on multi-agency failures as you
8 understood them to be from learning from the case
9 studies.

10 **DR CHURCH:** Thank you. There is quite a lot I could say
11 about this actually but I think in mental health
12 services we are very accustomed to working with
13 unwilling patients, unwilling young people and unwilling
14 families. So that sort of barrier is very common in
15 mental health services and we are accustomed to working
16 with individuals who withdraw and are isolated and hard
17 to assess. That's not a UK phenomenon, it is a global
18 phenomenon. Child and adolescent psychiatry colleagues
19 from Japan for the withdrawal to a bedroom,
20 "hikikomori", and actually it is one example of
21 a barrier to assessment and appraisal of risk. I think
22 what's relevant to this topic and the behaviours -- the
23 multi-agency behaviour observed, is that in some cases
24 it may be that agencies actually recoil from high risk.

25 Now, conduct disorder and difficult behaviours were

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1 wanted a career where if it's been known that they have
2 been using substances, they wouldn't be able to go into
3 that career but they have come to services at 15 or 16
4 because they want help to move away from alcohol or
5 whatever drugs they are using. So it is thinking about
6 what it means. But Working Together should help
7 professionals understand how better to share information
8 and how to begin to move to multi-agency chronologies.

9 **MR MOSS:** Thank you. So sir, just for your note, the
10 reference for the Working Together guidance is
11 DFE000262. I don't think we need to bring it up, but
12 that is the reference for it. Thank you very much. Did
13 that deal with the point you wanted to come back to?

14 **MS GIANFRANCESCO:** Yes.

15 **MR MOSS:** It did. I'm most grateful, thank you. So
16 Dr Church, going back to overall issues on multi-agency
17 working, if we could just have page 86, ILT000344_0086,
18 please and paragraph 6.3. Perhaps we can take 6.3 and
19 6.4 together, they are pithy paragraphs, you say:

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

24 Then you said, at 6.4:

25 "Perhaps equally or more concerning are cases in

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1 one of the most common -- were identified as one of the
2 most common reasons for referral to CAMHS and yet, what
3 we have heard is that a few CAMHS services, perhaps more
4 than a few, identify conduct disorder as an exclusion
5 criteria.

6 So, that immediately perhaps gives a flavour of the
7 sort of population that the CAMHS team might be willing
8 to engage with. So risk to others may sometimes not be
9 seen as part of CAMHS work, not necessarily core CAMHS
10 work. In some localities, it may be part of the
11 workload of one of the teams, perhaps a tier 2 or Early
12 Help sort of team, but as risks increase, then the
13 standard CAMHS toolkit feels more limited and perhaps
14 less effective and the practitioners less confident in
15 being able to deliver anything meaningful.

16 So, it is not surprising to see that CAMHS may
17 intervene when it is something that they are comfortable
18 with, such as low mood, anxiety, self-harm, suicidality,
19 but the moment that there are risks to others, my view
20 is that many CAMHS practitioners would feel ill-equipped
21 and in the absence of appropriate training, skills and
22 supervision, would actually stand back from that.

23 I think there's an element of that in other agencies
24 as well, where they feel they don't have what it takes
25 to intervene. So a high risk may be identified but yet,

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1 the practitioner may not have a framework to actually
2 intervene or address that risk.
3 **MR MOSS:** Thank you. I just want to test, lastly on this
4 topic, from a couple of observations from others. So
5 could we go to the Inquiry's questionnaire analysis from
6 Crest, first of all, that's ILT000219. Page 6,
7 ILT000219_0006, please. We see here on the screen, the
8 third bullet point. So this is a summary from
9 questionnaires to frontline practitioners:

10 "Responsibility for managing VFI cases is often
11 unclear, with no single agency consistently taking the
12 lead. Only one in three of CAMHS' respondents said
13 a lead agency is clearly identified in high-risk cases,
14 while less than one in five of DSL's [safeguarding
15 leads] respondents said a single agency is designated.
16 Even within forensic CAMHS, fewer than half said a lead
17 agency is typically identified for cases involving risk
18 posed to others. This suggests strong evidence of gaps
19 in ownership across the system." (As read)

20 Is that consistent with the analysis of the five of
21 you in the case studies? Ms Gianfrancesco?

22 **MS GIANFRANCESCO:** I guess this comes back to the point
23 I was making earlier where people look for a lead
24 agency, but actually every agency is a lead in their
25 specialism. So for me, it isn't about who is the lead
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1 significant under use of forensic psychologists as
2 experts in this area. You may or may not have pointed
3 out -- followed that there is no mention of forensic
4 psychology in the entire report.

5 So, the expertise of forensic psychologists has not
6 been drawn on in the context of this work. And in terms
7 of the work that is done by forensic psychologists
8 within HMPPS, DDP and various other discrete places,
9 internationally we are the envy of the world; the fact
10 that they have got this area of forensic expertise in
11 terrorism and now beginning to work within Dr Taylor's
12 CCS with VFIs as well. So that expertise is beginning
13 to spread, but it is very under used.

14 I'm just surprised and always disappointed that you
15 can't get access to forensic psychology in the
16 community.

17 **MR MOSS:** But is it under used or are there just not enough
18 of them?

19 **DR LLOYD:** They just don't operate in those -- it is just
20 historical and serendipitous really. We worked within
21 HMPPS when it was a big issue with the first wave of
22 terrorism to work out what their needs were and how we
23 could work with them to reduce their risk. So that was
24 a really big learning opportunity.

25 Since then, that hasn't spread out to clinical
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1 agency in managing this person, it is under what process
2 are we going to manage this person's risk because CAMHS
3 has to manage that person's mental health, social care
4 has to manage and --

5 **MR MOSS:** I follow that and you made that point previously,
6 but can I change the question then slightly. Do you
7 think, from the case studies, that the lead process for
8 VFIs was clear?

9 **MS GIANFRANCESCO:** Yes, I was going to say and I don't think
10 that was clear in these things. In fact, in the
11 majority of them it was hard to even see that there was
12 multi-agency working under any processes. So I think
13 only some of them -- only a handful of them were open to
14 social work at the time, none of them were open under
15 Child Protection, a few were open under CAMHS. So there
16 wasn't anything that actually -- some had been in and
17 out of Prevent at different times, I think. I can't
18 remember, but I think possibly at the point of --

19 **MR MOSS:** We will come onto -- Youth Offending Teams
20 generally weren't involved.

21 **MS GIANFRANCESCO:** Yes. So there was no process, I would
22 say, around any of them that was actually taking any
23 lead.

24 **MR MOSS:** Thank you. Yes, Dr Lloyd.

25 **DR LLOYD:** I would like to mention -- point out as well the
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1 psychologists. We have CAMHS, we have FCAMHS who are
2 working in these areas with these people who haven't got
3 access to that learning. So, I mean, I do think that
4 there is a real opportunity here to get psychologists to
5 work in the community and not just with offenders once
6 they have committed a nasty offence.

7 So, I'm just pointing out that -- even within
8 Prevent there aren't any forensic psychologists. There
9 are clinical psychologists who have a lot of expertise,
10 and they have picked up on that, but there's no forensic
11 psychologist working within Prevent and I think this is
12 a huge oversight.

13 **MR MOSS:** Thank you. Mr Basu.

14 **MR BASU:** I just wanted to absolutely echo that point and
15 say that within counter-terrorism -- I have to be
16 slightly careful about what I say --

17 **MR MOSS:** If you could err on the side of caution because
18 there are some areas here that are sensitive, so just
19 err well on the side of caution.

20 **MR BASU:** I would say when you are making operational
21 decisions in high threat situations and you want to
22 understand that coalition of risk factors that we have
23 been talking about all day, you want somebody who
24 understands how those things intersect and increase the
25 risk, and the best people to do that are forensic
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1 psychologists.

2 So if that is missing, it makes it very hard for any
3 multi-agency process to not over-compensate or withdraw
4 because you don't have the expertise to make that
5 decision. So I just wanted to absolutely say that is --
6 they have also been very clear in the past saying it is
7 guidance, it is not -- we all know there is no single
8 route to understanding or predicting a violent attack.

9 So they will never say that that's an absolute
10 guarantee, but they will give advice on the
11 decision-making framework and the fact that that's
12 missing and I didn't realise it was quite so absent is
13 very bad.

14 **MR MOSS:** Thank you. Ms Swan, I think you wanted to --

15 **MS SWAN:** I just want to take us back to a point about
16 sharing information about risk. I think it is probably
17 at an earlier level than the involvement of specialists
18 and analysis. Is now an appropriate time?

19 **MR MOSS:** I am going to come to record keeping and
20 information sharing as a separate topic, if perhaps we
21 can come back to it.

22 Finally on this, could we have on screen please.
23 LGA000032. This is the statement of Mark Norris and the
24 Local Government Association. Again, just by way of
25 testing what some others have said about this, it is

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1 learning disabilities, who present high risks, including
2 to others. And I think the availability of that will
3 vary enormously across the country and very often there
4 will be quite a high threshold to access that service in
5 terms of, sort of, very high risks.

6 Also, there are some cases in which mental health
7 services will very clearly be a lead provider and be
8 responsible for managing risk, especially if a young
9 person has been admitted to a psychiatric hospital or
10 presents certain risks that require that monitoring.
11 For example, if they are on medication, psychiatric
12 medication. So, I think there are some cases in which
13 individuals can fit into mental health services and
14 fixation/stalking risks are one example where the
15 approach, recommended by pioneers in the field,
16 recommend that mental health and police, law enforcement
17 authority to work hand in hand to deliver what's
18 required. So it is the combination of mental health and
19 probation or whatever other service.

20 So they have crossed a certain threshold by the time
21 they have reached that of course, in terms of
22 seriousness of behaviours. In the case studies they did
23 fall short very often on both of those.

24 **SIR ADRIAN FULFORD:** It does sound fairly hit and miss.

25 **DR CHURCH:** Yes.

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1 paragraph 130 at the bottom of the page please. So
2 "barriers to referrals" is what he is addressing. He
3 says:

4 "A further barrier is the gap between services
5 designed to support neurodevelopmental or mental health
6 needs and services designed to manage public protection
7 risk. Autism, learning disability and mental health
8 services may focus on care, support, communication,
9 sensory needs or reducing the risk of hospital
10 admission. Public protection pathways may focus on
11 offending, domestic abuse, terrorism, stalking or other
12 defined risks. People who present fixation related
13 risks may not fit neatly into either route."

14 Again, does that find resonance in your assessment
15 of the case studies of falling between the gaps?

16 **MS SWAN:** There is example of forensic autism services but
17 they are not available consistently. So there are
18 mechanisms and there are examples and this potentially
19 builds on what Dr Lloyd was saying about that gap, but
20 it is not consistently applied across the country.
21 I don't know if anyone else can speak to that?

22 **MR MOSS:** Dr Church?

23 **DR CHURCH:** There will be quite specialist services, and I'm
24 referring to mental health services here, that will
25 support individuals with Autism Spectrum Disorder and

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1 **SIR ADRIAN FULFORD:** Is that fair?

2 **DR CHURCH:** Yes, in the case studies or across --

3 **SIR ADRIAN FULFORD:** No, across the board?

4 **DR CHURCH:** Yes, across the board very much so.

5 **MS GIANFRANCESCO:** Can I clarify with Dr Church, forensic
6 autism services would they be for under 18s or for over
7 18s because in my experience they are over 18s?

8 **DR CHURCH:** Certainly for over 18s but there can be local
9 tier 4 case by case commissioned input, depending on
10 geographical location.

11 **MS SWAN:** May I ask, sorry it is a question for Dr Church --
12 sorry Dr Church -- but would that require -- the
13 "barriers we are facing" that we have been discussing,
14 would that require a conviction in order to be able to
15 access forensic autism services or something equivalent?
16 Because in the case studies the challenge we are finding
17 is, at the same time as trying to balance not
18 criminalising children, the lack of conviction or
19 pursuing that meant that children and young people could
20 not access the relevant services. Would it be required
21 for forensic?

22 **DR CHURCH:** In any locality there is usually a CAMHS team
23 that is dedicated to neurodevelopmental needs in
24 children in their population and they will be accustomed
25 to managing very high risks to themselves and others

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1 actually in that sort of team. So that wouldn't be
2 a forensic team as such but a neurodevelopmental CAMHS
3 team for example.

4 Now, it depends what's meant by forensic --

5 **DR LLOYD:** Is there a forensic psychologist?

6 **DR CHURCH:** Is there a forensic psychologist... I think
7 most people would accept there isn't really that
8 availability across the country of a forensic child ASD
9 service. I would say that they do exist, but they are
10 often commissioned on a case-by-case basis at a sort of
11 tier 4 spot purchase basis.

12 **MR MOSS:** Sir, your panel have successfully filibustered me
13 from starting on record keeping and information sharing,
14 which we might pick up in the morning. Is that
15 a convenient point?

16 **SIR ADRIAN FULFORD:** It certainly is. I'm afraid I'm going
17 to hold you hostage just for a moment.

18 Ms Studd, can I thank you for your attendance this
19 afternoon and I would like, if I may, through you very
20 briefly to direct some general observations for the
21 benefit of the Bar and although I will not, of course,
22 seek to shut you out in any way, I'm not in any sense
23 seeking a response at this stage this afternoon.

24 The previous Home Secretary set a very tight
25 deadline for this Inquiry which I hasten to indicate

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1 departments, setting out a final and I emphasise the
2 word "final" approach to be taken to unravelling this
3 problem and seven steps have been identified.

4 I want to stress that this simply must be followed
5 with carefully applied and fully thought through
6 redaction requests and without delays. If this doesn't
7 happen, we risk losing the ability to complete the
8 evidence within the allocated timeframe this year,
9 thereby seriously delaying the delivery of the report.

10 That would be a very serious result indeed given the
11 urgency of this Inquiry and the need to make
12 recommendations aimed at preventing a repetition of the
13 terrible events of July 2024.

14 I hope I do not have to return to this but sensible
15 work needs to be undertaken, resulting in
16 a proportionate and realistic approach to redactions.
17 All that said, I do recognise, understand and have been
18 informed that a good deal of work has been undertaken
19 over the last few days.

20 So, Ms Studd, I want to stress that I'm only
21 addressing you because you represent the Cabinet Office
22 which has a coordinating role for Government and is
23 concerned, therefore, with the redactions that need to
24 be resolved and it is for that purpose, rather than in
25 any sense for the purpose of blaming your professional

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1 I entirely support. This has necessitated us all not
2 only being fleet of foot, but additionally that the Core
3 Participants discharge their duties, including
4 importantly the duty of candour, on a collaborative,
5 informed and co-operative basis to ensure we are able to
6 meet the delicately constructed timetable that has been
7 established as a matter of absolute necessity.

8 Although I'm not going, in any sense, to descend
9 into the detail, certainly not this afternoon,
10 a significant disclosure problem has arisen because of
11 what seems to have been, at least to an extent,
12 something of an uncoordinated and potentially
13 overprotective approach that has been taken to
14 redactions across some parts of His Majesty's
15 Government. What has not been consistently provided are
16 clear, cogent and concise reasons for suggested
17 redactions, nor have the reasons that have been received
18 consistently been on time.

19 This has seriously delayed disclosure to all the
20 other Core Participants. The first witness who is
21 potentially affected by this breakdown is to be called
22 on Monday of next week and this is now self-evidently
23 dangerously close.

24 A letter was sent today by the solicitor to the
25 Inquiry to a number of His Majesty's Government

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1 client.

2 Ms Studd, that's all I wished to say about this this
3 afternoon. As I say, I'm not intending to shut you out
4 but I am not anticipating a response, but having
5 directed that at you, you are of course free to respond
6 if you wish to.

7 Would you mind coming to the empty lectern in the
8 front because there isn't a microphone where you are
9 standing, I'm sorry.

10 **MS STUDD:** Chair, there has been considerable reviews over
11 the last few days of all of the material and progress
12 has been made. That material has been provided to the
13 Inquiry, but I'm not sure it's made it through the
14 system yet. But, because of Mr Emmett giving evidence
15 on Monday, I have been in touch with counsel
16 representing Mr Emmett today. We are reviewing his
17 statement for a final time and the exhibits and I'm very
18 hopeful that by close of play or in the early hours of
19 tomorrow morning, that will be totally resolved so that
20 he will be able to give evidence appropriately on
21 Monday.

22 **SIR ADRIAN FULFORD:** Ms Studd, thank you very much. You
23 will understand why this is for me a matter of urgency.

24 **MS STUDD:** I completely understand. It has been -- you will
25 appreciate I know, it has been an enormous amount of

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1 work over a very, very short timeframe.

2 **SIR ADRIAN FULFORD:** I understand.

3 **MS STUDD:** And people who sit behind me have been working

4 hours that the Health and Safety Executive would not

5 approve of.

6 **SIR ADRIAN FULFORD:** Thank you very much for your

7 attendance.

8 Ladies and gentlemen, just before you go, this is

9 the second point I'm going to ask you to think about

10 overnight, if you will. I have detected in the sort of

11 lead up to Phase 2 that from certain quarters there's

12 been a certain amount of resistance to the idea of

13 a lead professional.

14 Now I can understand why, for a range of reasons,

15 why this may be an unpopular suggestion, particularly

16 because it places, as it were, front and centre stage

17 a particular person who could be identified as carrying

18 a huge degree of responsibility. That said and

19 I understand what has been said this afternoon about how

20 it is important for, as it were, individual agencies to

21 work out for themselves what their responsibilities are

22 and who should take the lead for that within the

23 agencies; but what I very much have in mind are really

24 some observations partly made by Ms Swan this afternoon

25 as to sometimes -- and I am now quoting~-- "no one knew

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1 what to do, there was a passing between agencies, no one

2 seemed to have a grip on what support was needed" and

3 an increase in it being said, "we don't have that

4 support".

5 Now, in those circumstances, and in the words of

6 Ms Gianfrancesco, there is a real risk of individuals

7 simply falling between the gaps and although there is

8 a coming together of agencies, no agency actually taking

9 it upon themselves to make sure that something is done.

10 It may not fall neatly within the terms of reference or

11 the modes of working that historically have been

12 adopted, but unless one person tries to sort out the

13 impasse, if I can in layman's words describe it in that

14 way, there is a real risk of nothing happening at all,

15 if there's no one who performs some kind of coordinating

16 role.

17 Can I ask you to think about that overnight, perhaps

18 if there is a moment to discuss it between yourselves

19 and I will ask Mr Moss, at some convenient moment before

20 we release you tomorrow, to see whether there is

21 an answer to that. Thank you all very much indeed. Is

22 10 o'clock still appropriate?

23 **MR MOSS:** 10 o'clock.

24 **(4.40 pm)**

25 **(The Inquiry adjourned until 10.00 am the following day)**

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I N D E X

3	DR RICHARD CHURCH (sworn)	1
4	MR NEIL BASU (affirmed)	1
5	DR MONICA LLOYD (sworn)	1
6	MS ANNA GIANFRANCESCO (affirmed)	1
7	MS ELIZABETH SWAN (affirmed)	1
8	Expert Discussion	1

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