Thursday, 5th November 2026

(10.00 am)

SIR ADRIAN FULFORD: Please remain standing for a moment.

MS JACQUELINE TOTTERDELL (affirmed)

SIR ADRIAN FULFORD: Thank you very much, please have a seat. Yes, Mr Jamieson.

Questions by MR JAMIESON

MR JAMIESON: Good morning, sir. Ms Totterdell good morning to you, please may we have your full name for the record.

A. My name is Jacqueline Ann Totterdell.

Q. Thank you so much. If you just wait there, I will ask Amanda, please, to bring up your statement, NHSW000046. Thank you very much.

This is a statement dated 4 August 2026, with your name at the top of it, and if we went on to page 65 NHSW000046_0065, please. We would see that there is a statement of truth and then your signature, which we have redacted and again, that date repeated, 14 August 2026. Is this your statement?

A. It is my statement.

Q. Is it true and accurate to the best of your knowledge and belief?

A. It is true and accurate to the best of my knowledge and belief.

Q. Thank you so much. Please can we go back to page number 1 NHSW000046_0001. So you and I going through that short process proves that statement, it becomes part of our evidence base. That means I don't need to ask you about each and every paragraph but there are some important bits that I would like to pick out as we go through, okay?

Before we get to that, please may we introduce you. You are, you tell us in your paragraph 1, the Director General of the Health, Care and Prevention Group, within the Welsh Government. So that's a senior role within the Welsh Government?

A. It is.

Q. And you are, concurrently, the chief executive of NHS Wales?

A. I am.

Q. And is that an accident that you hold both of those roles or is that something that happens by design?

A. No, that is by design.

Q. Thank you. I will come to that and to the set-up of the NHS in Wales shortly but before that, let's just complete your introductions. You tell us in your paragraph 2 joined the Welsh Government and the NHS in Wales relatively recently in 2025?

A. I did, yes.

Q. But before that, you have a long career in the senior management of hospitals and hospital trusts in England?

A. That is correct.

Q. And you tell us, at paragraph 3, indeed, that your professional background is "rooted in healthcare leadership, operational improvement and large-scale service transformation" and you hold both master's and bachelor's degrees in that general field from Durham University and the University of Huddersfield?

A. I do.

Q. So, if you will excuse me for that truncated introduction, we have the rest of the detail there.

Before I come to the structure of the NHS in Wales, may we just deal with the topic of definitions and can we just, please, have paragraph 6 on the page, which is on page 2 NHSW000046_0002.

I deal with this at the start and I introduce it in this way because your statement has this issue of definition and the lack of a definition and the impact of a definition all the way through it, doesn't it? That's the core that runs through your statement?

A. It does.

Q. It does. So I wanted just to introduce that here at the start and then we will see how that manifests as it goes along. You tell us here:

"Although the term 'Violence Fixated Individual' does not currently have a defined status within Welsh legislation ... policy ... or ... safeguarding frameworks, NHS organisations ... routinely provide services to individuals who may present with behaviours, needs or vulnerabilities that are potentially relevant to the Inquiry's consideration ..."

So:

"In addition to adults these may include children and young people exhibiting serious behavioural disturbance, violent ideation, aggression ..."

And all of the rest.

Paragraph 7:

"As there is no developed or adopted specific VFI framework, risk assessment process, policy or statutory guidance in Wales, this statement should therefore be red as observations based on existing adult and child safeguarding, health, social care and multi-agency arrangements in Wales rather than descriptions of a dedicated VFI system."

That is the core, isn't it? We don't have a definition. There aren't any dedicated frameworks, policies, legislation, guidance. What you are going to tell us about, in the currency of your evidence, is how existing structures that cover other areas overlap with

this cohort of risk?
A. That is correct.
Q. Thank you. Let's look then at some of the other things that you have said about the definition and the lack of a definition, just so we have all of that in mind.
Please can we skip ahead to page 42 NHSW000046_0042 and to paragraph 163 and 164. I understand that you followed the evidence of Dr Goodall when he gave evidence to the Inquiry and indeed, I put these paragraphs to him at the start of his evidence but just to get you to speak to them. You say that:
"A fundamental challenge in considering VFIs from both a policy and service-delivery perspective is the absence of a clearly defined and operationalised ..."
Does that mean a definition that can be used on the ground?
A. Well, that means a definition that we can develop. A policy, a framework, by which we can assess individuals and hopefully prevent harm occurring. So, it starts with the definition and then will flow down through those processes that I have just described --
Q. So that's what operation -- so sorry, I spoke over you. Was there something else you want to --
A. No, no, that was fine.
Q. So that as the fundamental challenge as you see it:

"... the absence of a clearly defined and operationalised clinical or public-service 'case definition'. Whilst the Inquiry Terms of Reference define VFIs as individuals at risk of extreme violence where ideology is not the primary driver ..."
Which was the term that we were given -- that we were set for our terms of reference, you observe that:
"There is considerable uncertainty ... as to the essential features required for an individual to be regarded as falling within such a category. It is unclear whether the presence of a single characteristic, such as violent ideation or fixation on previous attacks, would be [enough], or whether multiple features would need to be present and, if so, in what combination, how many episodes over what period of time, how severe the consequences, or the wider circumstances. These might just be a few of the defined parameters that would be needed for prospective identification and risk assessment."
Are you there putting yourself in the shoes of a frontline healthcare professional seeking to work out if a person that they are concerned about is within this umbrella term, within this cohort, drawing our attention to the fact that, on its face, "VFI" isn't enough because it doesn't tell you all of those matters that

you set out?
A. I am, yes.
Q. Yes, thank you, and you tell us at 164 that:
"This lack of definitional clarity creates practical difficulties for services and for those setting policy and providing strategic guidance."
Which is rather more your end of the telescope?
A. It is.
Q. "Effective identification, assessment, and management arrangements depend upon a clear understanding of who is being identified and for what purpose. Without an agreed definition, it is difficult to establish meaningful prevalence estimates, develop consistent referral criteria, determine thresholds for intervention or assess the effectiveness of any risk-management approaches. Most importantly, it limits the ability to identify predictive factors associated with future serious violence and therefore makes risk estimation inherently challenging. Risk assessment is nevertheless the cornerstone of prevention, and it would be good to create systemic focus on these features of violence as a potentially avoidable public health threat."
So lest it be thought that, in focusing on definitions, this Inquiry is just messing around with words. From your perspective, as a health leader, the

head of the NHS in Wales, it is absolutely essential that we get this right?
A. It is absolutely essential.
Q. Thank you, and you make some suggestions as to what that -- you make some further observations about the shortcoming in the VFI definition and some suggestions as to what a definition might look like. If we went all the way towards the end of your statement, page 63 NHSW000046_0063, paragraph 265, it is the same theme that we were just talking about earlier in your statement. You are talking about the violence-fixated definition and you say there is a further issue as to whether that:
"... adequately describes the population of concern. The phrase may suggest violence pursued as an end in itself, which may be directed indiscriminately at strangers or communities, and might be obsessionally or ideologically driven. However, some recent incidents involving children and young people might be more accurately characterised as acts arising from interpersonal grievance, frustration, resentment, perceived injustice or emotional dysregulation."
Not violence for its own sake, violence in some way to redress some subsisting deficit that individual feels that they have?

A. That is correct and a real concern.
Q. So the concern that you are voicing here is, if we define this cohort, we shouldn't do it so narrowly to exclude these individuals?
A. That is correct, yes.
Q. You go on to say:
"There is also the consideration of psychotic states where individuals are, at the time, out of touch with reality. This range of scenarios suggests that a focus solely on 'fixation with violence', may risk overlooking wider developmental, psychological and social factors that contribute to serious acts of violence."
A. Yes.
Q. And you go on, underneath there, to make some suggestions about how that may occur. Thinking then about what is needed, is this -- well, my analysis, or my reflection on what you have just said to us in those paragraphs, is that it needs to be a simple and widely understood definition, which is broad enough to capture I think what's been called a heterogeneous cohort and then, underneath such a definition, clear guidance as to the risk factors or areas of vulnerability or threat that would contribute to membership of that category?
A. That's correct, yes.
Q. And you set out the problems that you have with VFI as

it is. Can I ask you about the other working definition that we have been given. Just before that, may I just -- can we please look at 267 just to make sure there's nothing I have missed.
So you call for greater research, essentially, as to the factors underneath?
A. Yes.
Q. Can we just leave the statement for the moment and have on the screen HOM001011. This is a Home Office issued document, "Interim guidance to support the management of non-ideological extreme violence concerns".
This has a new definition in it, "NIEV". You can see its date of issue, 6 October 2026. Can I ask, was NHS Wales or your aspect of the Welsh Government consulted in the creation of this document?
A. No, we weren't.
Q. And in the development of the definition within it?
A. No, we weren't.
SIR ADRIAN FULFORD: I imagine you would have had some things to say?
A. We would have liked to have had some input, sir, yes.
MR JAMIESON: Yes. Have you seen it before?
A. I have seen it before, yes.
Q. Because I don't want to just confront you with the definition --

A. No, I have seen the definition.
Q. Fine. Well, let's look then at page 2 HOM001011_0002, please, at the bottom. This is the definition that we have been given:
"The use or threat of extreme violence, not driven by a clear ideological purpose, which is communicative in nature and intended to shock, intimidate or outrage the public or a section of the public."
Which I have described to many witnesses many times. Three general criticisms that others have made are: is it describes a type of violence not a person; it has intent at the centre of it which is very hard to assess, particularly in an early intervention stage; and the violence -- the effort to distinguish this cohort from other, more commonly encountered, violence is this final aspect "intended to shock, intimidate or outrage the public or a section of the public".
Firstly, that can only really be evaluated after it has happened and, secondly, the communicative nature of it is designed to be -- to catch both those who do it expressly, "I'm doing this to send a message" and also those who do it implicitly, which AR, it is said, would be one; there was no explicit expressed intent to be communicative but it is said to be implicit in what happened. So, again, the criticism is, difficult in the

real world for professionals to assess that in any meaningful way.
Would you agree with those criticisms? Would you add to them?
A. I would agree with them but I would also add that I'm not sure that it also includes the cohort of individuals that we talked about at the beginning, those who are affected because of frustration, because of being overlooked, being undermined, et cetera. I'm not sure that quite covers all of that.
Q. Those motivated by grievance of one sort or another?
A. Yes.
Q. And some of the other evidence that the Inquiry has heard from the experts in our seminars is that this sense of grievance is a really powerful driver for this species of risk and so you would make the observation that that sense of grievance does not seem to be four-square within this definition?
A. No.
Q. Okay, and as the Chair has already said, if you had been asked about this definition before it was published, no doubt, you would have provided that feedback before it went out into the guidance?
A. Possibly --
Q. Yes, thank you.

Just finally on this topic of definitions, for your thought. Professor Cassam in the -- who is a philosopher -- provided an alternative to the Inquiry in his seminar that he gave at the outset, of a "non-ideological violent extremist". So it sounds very similar in terms of the acronym but the focus is on the individual, rather than the harm.

And if that was the individual of concern or the potential category, often in safeguarding concepts, or indeed in terrorism concepts, individuals can be considered "vulnerable to" or "at risk of becoming" such a person and that's a familiar concept from those circumstances, I think.

Would such a definition perhaps supported by proximal urgent risk factors and distil further away but still of concern risk factors, be potentially attractive? Proximal factors would include things such as making plans, voicing those plans, taking steps to bring an attack to fruition. More distil ones would include grievance, isolation, fascination with violence, those sorts of things. Would that have an attraction?

A. I think it is the extremist element of that that raises some concerns.

Q. Just explain that for us.

A. Because "extremist" or "extremism" gives a connotation

of something very different and idealisation which is -- that's why I'm worried that that doesn't quite cover what you are trying to address today.

Q. Okay, it is a very interesting reflection. So the Home Office's objection to that definition is in England, "extremist" means, as you say, somebody with ideology. But as a matter of fact, that definition of extremism has not been adopted in Wales. But still your instinctive reaction to that term, even as a senior member of the Welsh Government, is that to you extremist means something ideological?

A. And I think the population would view in that way, despite it not being part of our policies and procedures.

MR JAMIESON: Thank you very much. Sir, I was going to move on from definitions, unless you wanted to pursue that any further?

SIR ADRIAN FULFORD: I will just for a moment, please. Thank you very much, Mr Jamieson.

It seems to me that there are two issues here really. You need something short which captures the essence of it so that you have got a label that can help construct the systems, the digital infrastructure that is going to garner the statistics, get in the information. But the very short descriptor isn't going

to be enough by itself, you have got to have some words underneath it which really does give practitioners on the ground a proper understanding of who it is you are seeking to look at.

So, in your view, first of all, would it be workable to have those two things, a short label but indissolubly attached to it is the paragraph, or few sentences, which describes what you are after?

A. Yes, and I think also, sir, that getting the description right first is the most important thing. Being able to tag something to it that gives an identification to it, is the second bit. So I'm more interested, because of the ability to write policies, develop frameworks, train staff, that that description is the best it can be.

SIR ADRIAN FULFORD: Right. There is a choice between making the short description focus on the individual or on the type of activity and there have been some representations to us both ways on that.

Well, I'm not going to lead you. Where do you stand in relation to those two when you are coming to formulate the short description?

A. Between?

SIR ADRIAN FULFORD: Between either a description which focuses on the individual, so "violence-fixated individuals", or the NIVE definition, "non-ideological

violent extremist", that's an individual. So where are you on that?

A. I suppose, in terms of for individuals, the question is are we looking for a label or are we looking for something that actually prevents?

SIR ADRIAN FULFORD: Yes.

A. I suppose that's where I come from, is the first bit of that, which is why I go more to the descriptor and the definition of it and the name of it. We are looking towards something that will help us prevent individuals from -- or help prevent, or recognise individuals, who may be at risk or a risk to the population.

SIR ADRIAN FULFORD: Do I understand correctly that the second of the -- the Professor Cassam definition that was put to you, you are not really objecting to the "non-ideological violent"?

A. No.

SIR ADRIAN FULFORD: So that all works?

A. Yes.

SIR ADRIAN FULFORD: It is the last word?

A. Yes.

SIR ADRIAN FULFORD: So if there is another word that doesn't carry the ideological connotations, then that, in your view, would work?

A. Would be preferable, yes.

SIR ADRIAN FULFORD: Would be preferable. And finally this, do you have your own formula?
A. No, in terms of --
SIR ADRIAN FULFORD: In terms of a definition?
A. No. However, through our various groups across Wales, like the violence prevention unit, we are collecting data, or starting to collect evidence around what that might be. So I think engaging with us might help actually begin to do some of that.
SIR ADRIAN FULFORD: My concern is that we are now heading to two and a half years after this happened and although the luxury of, you know, getting feedback from people on the ground and trying to gather statistics would be a very pleasant indulgence, I think we do have to reach some kind of finality on this quite quickly so that data can be collected and we can get a better understanding and we can actually start implementing things that will stop future attacks like the one perpetrated by AR.
A. Would it be more helpful if we wrote to you with something that might be helpful for you?
SIR ADRIAN FULFORD: It would, as long as you can do so before Christmas.
A. I am sure we can do that, sir.
SIR ADRIAN FULFORD: Thank you very much indeed. Sorry, Mr Jamieson.

MR JAMIESON: No. Please, sir, it's very interesting and insightful. Just picking up on something the Chair was asking you about, you said, in response to the Chair's question, essentially, you can decouple the term and the guidance underneath it. It is important to have the term, so you have something to work to.
A. Yes.
Q. Policies to develop and in fact, the research, the development of risk factors and those words that sit underneath it, that can follow on, that can be developed as the evidence base grows, as research is brought in. In fact, there is, sir, and we have captured it elsewhere in the Inquiry, other evidence or research that has been carried out under the umbrella of "nihilistic violence" from which many of these risk factors come. So that's essentially your response, what you are telling us.
A. Yes.
Q. We need the term. Yes, of course, there will need to be guidance but that can follow after?
A. Yes.
Q. Thank you. All right. Well, having taken that diversion into that substantive topic, I will now introduce the NHS in Wales with you, thank you. But I'm going to do that in outline. You have given us a lot of

detail in your statement, and we are grateful for it. You will understand I won't go through all of those structures now.

Please may we have the statement back on the page, page 3 NHSW000046_0003, paragraph 10. I will just deal with these matters in outline. You tell us that:

"Healthcare has been devolved since ..."

Well, for a quarter of a century:

"... since 1999, and the Welsh Ministers (served by [your aspect of] the Welsh Government's Health Care and Prevention Group) are responsible under the ... Act ..."

For that aspect of life in Wales.

You tell us, at paragraphs 11 and 12, that the Government sets the policy and the operational matters are delivered by the trusts and the different structures.

If we just scroll down the page, you tell us at paragraphs 13 and 14, how instructions can be issued, whether mandatory or advisory, to those bodies by ministers and again, we have got those paragraphs. I'm not going to ask you questions about them.

If we looked over to page 4 NHSW000046_0004 and to paragraph 16, you would introduce your role, which I asked you at the outset was it an accident or by design that you held both of those posts and I think

Dr Goodall, in fact, also held both of those posts, not as your immediate successor but in the past. In a nutshell please, tell us why those two posts have been combined in Wales; what is the benefit?
A. So the benefit -- and it is similar in Scotland as well; there's also a director general who also holds the chief executive of NHS Scotland -- gives the advantage being that we are quite a small nation of a population of 3.4 million, of combining -- looking towards Government to develop standards and policies and then looking towards the NHS and social care to actually implement those policies and hold those organisations to account.
Q. So in one person, there's that connection between strategic and the operational?
A. Yes.
Q. Yes. So you have set that out there. I do not think I need to ask you anything more about that. If we went down to page 6 NHSW000046_0006 and to paragraph 26. I will just introduce the fact that there is a section of your statement that is devoted to explaining for us the structure of the NHS in Wales. Sir, for your note it runs to page 16 and to paragraph 61.
SIR ADRIAN FULFORD: Thank you very much.
MR JAMIESON: We are very grateful for that and for the detail, we have it, we can use it, I'm not going to take

you through it now.

What I would like to ask you about, please, is the way that, in Wales, health and social care are integrated and how that is delivered. So please could we go to page 17 NHSW000046_0017 and to paragraph 66.

We have had a little of this evidence before but we would be really grateful for your expertise and insight.

A. Thank you very much.

Q. So what does it mean to say that health and social care are integrated in Wales?

A. So, in terms of both sitting together, number one, at Government level where we set the standards, policies and strategies, which then integrate down through -- and if we look particularly through the safeguarding lens, because I think is the most relevant here at the moment, there is also a national safeguarding board that advises the Government for which we then get the strategies/policies et cetera. That then goes down through both the NHS lens, as well as the social care lens, which is the responsibility of local Government.

We have regions in Wales as well, we have three regions: north, southeast and southwest. There are regional partnership boards, where multi-agency senior partners sit round there and as part of that, there is a regional safeguarding board. That safeguarding board

looks at policy, looks at strategic matters relating to that area that relates back to -- back up through Government and each area health board works with a number of local Government and social care areas, where they also have local safeguarding boards and processes by which to identify collectively, look collectively, at next steps and also pass them to the relevant or correct area for individuals.

Q. Thank you. I'm going to pick up on a couple of those matters that you have raised. May we just go over the page NHSW000046_0018 and have paragraph 67 on the page.

So, then we will -- if you scroll down a little please so we can have 68 as well.

So, I introduce paragraph 67 because you are there telling us about a piece of legislation that we have heard about before, the Social Services and Well-being (Wales) Act 2014, which is the key safeguarding statute, the social care statute, and a feature of it, unlike in England, you have that one statute for the safeguarding and social care both of children and adults, don't you?

A. That is correct, yes.

Q. So it is a single framework and whilst there are differences as to how children and adults are treated, you tell us, at paragraph 68, about part 7 of the Act, which creates the safeguarding duty, doesn't it?

A. It does.

Q. And there is a safeguarding duty both in relation to children and also adults?

A. That is correct.

Q. It is a particular cohort of adults of potential vulnerability, but as to the muscle memory of the system, there are safeguarding duties and responsibilities both for children and adults?

A. That is correct.

Q. And I suppose, if it were appropriate, the category of adults that fell into that safeguarding duty could be changed?

A. Yes.

Q. You told us about -- if we just look at your paragraph 69 -- the regional safeguarding boards?

A. Yes.

Q. You tell us that the "Welsh safeguarding system is inherently multi-agency".

A. It is.

Q. So those safeguarding boards are part of the discharge of that safeguarding duty, aren't they?

A. The safeguarding boards have the strategic oversight of that, yes.

Q. I will come onto just how they work in a minute but that's what they are for, they are a multi-agency

structure that was designed, in part, to discharge that responsibility?

A. Yes.

Q. Again, what's important for our purposes is that there are regional safeguarding boards for children and also for adults and in some regions, they are combined into a single structure that does both?

A. That is correct.

Q. However, before we get too excited about that, it is important to say, as you have just reminded me, those are strategic boards, aren't they?

A. They are.

Q. They deal with the gathering of data, the identification of what I might call macro problems, the consideration of items of safeguarding that have gone wrong and the making of recommendations?

A. That's right, yes.

Q. They don't receive individual referrals in relation to particular individuals of concern; they are not front doors to interventions?

A. That is correct.

Q. But in terms of the general framework, it is to exercise a safeguarding duty, both towards children and to adults and it is to act in a multi-agency structure both for children and for adults; that is the approach that Wales

takes?
A. It is, yes.
Q. Thank you. You tell us there and one of the manifestations of that, the "Working Together to Safeguard People" is the statutory guidance. Sir, I was not going to bring it up, unless you particularly want to?
SIR ADRIAN FULFORD: No.
MR JAMIESON: But again, we know it is a single piece of guidance, under the statute for both adults and children, and indeed there is the information guidance, I think if we went down just one more paragraph over the page NHSW000046_0019. There, "Information Sharing to Safeguard Children and Adults". Perhaps that is worth just a short look at it. Again, sir, we have seen it before, but please may we have it. NHSW000029, because it is advice on a page, isn't it, to practitioners?
A. It is.
Q. And it is in relation to the safeguarding of both children and adults; they are not subdivided. I think they are called seven principles or rules are given, but the approach is general and I think it is probably worth just dwelling on it just for a moment:
"Remember that [these are the provisions] and human rights laws are not barriers to justified information

sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately."
So: don't be scared by these rules, they are not reasons not to share, it is just to provide the structure to do it. That is rule 1:
"Be open and honest" about what you are doing; "seek advice"; "where possible" seek consent. Number 5:
"Consider safety and wellbeing: base your information and sharing decisions on the considerations of the safety and wellbeing of the individual and others who may be affected by their actions."
It doesn't say it expressly perhaps but is that aimed at circumstances where the information sharing is not necessarily put for the protection of that individual, but for the guarding against of the risk that they may pose?
A. That is my understanding.
Q. That's what it's at least covering indirectly. Yes. It is probably not relevant to go through the rest of it. But if we just flicked over to the second page NHSW000029_0002. Again, so we have seen this briefly before but there is a flowchart as to how that can happen. Have you got a reason to share the information? Yes. Is it personal data; can the person be identified?

Yes. Have you got a reason to share it? Yes? Well, you can do it. No? Even in those circumstances, you can, if you get consent.
I observe the fact that the question of consent and legal justification are the other way round in that flowchart than they are in the guidance. But there it is, it is a document on two pages.
I think I can just see on the bottom of that page it looks like a document that has been in use since 2019. I think just about. My eyesight catches that. Is that a -- brilliant. Is that a useful and well known document within Wales?
A. I understand so. And I say "understand so" because obviously I don't use this, this is used in the field.
Q. All right. Well, we will come onto information sharing as a general topic. Please may we go back to the statement though, it will be a little while before we get to that. Look at -- may we introduce a different structure, the violence prevention unit. That's on page 20 NHSW000046_0020 and paragraph 77.
So, I have skipped over the national safeguarding board which is above. You have told us about that in general. It is another strategic body, isn't it?
A. And it advises the Government, yes.
Q. The violence prevention unit is also a strategic body,

I think. Before I come to this, may I ask you a rudimentary question: is there one or two in Wales, violence prevention units?
A. There is one which sits underneath Public Health Wales.
Q. Okay, because the reason I ask that is because the Youth Offending Service managers suggested that there were two violence reduction units, one in North Wales and one in South Wales. I don't know if violence reduction units are different to the violence prevention units?
A. I understand so, but I couldn't quite tell you how.
Q. Okay, all right. Something for us to get to the bottom of. But certainly one violence prevention unit. This was created in part to meet the violence reduction duty, which applies in England and Wales, is that correct?
A. That is correct.
Q. And it is a strategic-level body that brings multi-agency partners together, essentially, to address the reduction of violence, or prevention of violence as a public health matter?
A. Yes, that's right.
Q. To gather data, analyse the data and devise interventions to reduce violence on a population level, rather than on an individual level?
A. Yes, that is correct.
Q. So, we have that and -- thank you.

The other point that you make under this heading, just as we leave the issue of the arrangements within NHS Wales is -- may we just go to page 22 NHSW000046_0022 and to paragraph 84 -- you tell us, I think, a fact which is well known to those who have followed the evidence of this Inquiry, that this issue of VFIs, this cohort, whatever they are called, cuts across different departmental mandates. And that's got a particular importance for Wales because some matters, health and social care, are devolved, whereas others, of which, most relevantly policing, counter-terrorism, are reserved?

A. Reserved.

Q. So it is an area in which there must be collaborative working, multi-agency working, if I can call it that, between Wales and Westminster, but I think you tell us here that that is something that you are familiar with?

A. Yes.

Q. I think in other areas?

A. Yes.

Q. But that's an important thing that we should bear in mind as we consider this area.

A. Thank you.

Q. I will ask you something about that as we go along.

We will leave that topic then, please, and may we go

to page 23 NHSW000046_0023, paragraph 89 and your next topic is the one that you have set out there, the "Identification of VFIs in Wales".

As I go through, we will firstly deal with identification and then we will come on to to look at, eventually, risk management and structures. But the answer will be the same in relation to each. There is no bespoke, targeted framework to allow this to happen?

A. That is correct.

Q. But what you have done in the body of your statement is to identify other structures, other existing capabilities, principally through a healthcare lens but not limited to that, which do, or can potentially do, some of this work currently?

A. Yes.

Q. As I introduced at the start, you shouldn't be taking as saying that that is enough or sufficient, you have that very firm view about the definition of the need to work thereunder?

A. That is correct, thank you.

Q. Right. So we have that and that will allow us to move more swiftly through it. But you set out here some of the services that may provide some coverage of this issue of how VFIs may be identified in Wales. You list safeguarding, mental health, multi-agency systems, which

would include, or would also encompass CAMHS, FCAMHS, urgent and emergency mental health services, primary and community care and others.

You mention Prevent and Channel. I will say now, because those are reserved matters, I'm not going to ask you very much about that as we go through.

You say that:

"Together, these systems provide opportunities ..."

For identification but, as you and I have agreed already, that's not the same as assured systemic coverage, is it?

A. No, that is right.

Q. If we went just over the page NHSW000046_0024 to paragraph 90, we would see your acknowledging exactly that. This is ad hoc coverage:

"Existing systems can identify many of the factors but they are associated with future risk ..."

I'm reading the final sentence:

"... but are less explicit in recognising [these particular factors of concern] fixation, grievance and pathway-to-violence [behaviour] before serious harm [can] occur."

That is really what we are missing in terms of focus in these existing structures, in your analysis?

A. It is.

Q. Thank you. I would simply observe, I think implicit in the point you are making here, it is very hard for the healthcare practitioners to identify something, a matter of concern, when they don't know what they are looking for in the first place, they haven't had any guidance?

A. That is correct, or training.

Q. Or training. Exactly so. And so what you say at paragraph 91:

"Where concerns arise, practitioners are expected to act through existing [processes]. This may include referral[s] ..."

The final sentence:

"The overarching aim is early intervention, information sharing, coordinated assessment and risk reduction before concerns escalate into significant harm."

That is the aim but it is presently, with this cohort, an aspirational aim rather than a reality?

A. That is fair.

Q. Thank you. If we just went down to paragraph 93, you draw our attention to the fact that, the NHS in Wales, nor your element of Government, neither of those hold primary responsibility for monitoring online content and other matters, criminal activity or assessing national security threats.

It is the online content that I just want to focus on for a moment because again, one of the important themes of the evidence that the Inquiry has received is that the online life of an individual of concern is very relevant, very important to the risk that they may pose.

Is there a way, is there a process in which online life can be currently, systemically captured in healthcare settings to allow that element of risk?

A. Not that I'm aware of, given that we have no authority over-viewing any of that.

Q. No, I would be surprised but I wanted to ask you the question and that's obviously an area of risk that needs to be addressed. Sir, you wanted to add something?

SIR ADRIAN FULFORD: Yes, can I come in at this point. So it is not caught now. I imagine that, given how things have developed over the last very few years, this is an area of increasing concern to you, I would have thought? I see you nodding; is that right?

A. Yes, sir.

SIR ADRIAN FULFORD: Have you given any thought as to how this could be captured by frontline workers in a way that helps them address the problem, without it being disproportionate in terms of its impact on, you know, what people -- young people do in the privacy of their own bedrooms and getting on with their own lives? So we

have had a lot of evidence, you know: this is not caught, this is not caught. I'm very interested in knowing whether there are realistic mechanisms for getting hold of this material when there is a cause for concern?

A. It is not something I have given huge amounts of thought to in terms of NHS frontline staff, sir. Mainly because understanding what online content individuals are looking at is difficult to know unless there are other areas that can view that. It is not my area of expertise. We can always think about how that might be done. I just haven't really given it much thought, sorry.

SIR ADRIAN FULFORD: No, unfair to put you on the spot. You have got one piece of homework before Christmas. Can I give you a second?

A. You may, sir.

SIR ADRIAN FULFORD: I would welcome it, if you felt it would help, you would discuss this with others working alongside and underneath you, to see whether there are any ideas that emerge.

A. I can certainly do that, sir.

SIR ADRIAN FULFORD: Thank you very much. Sorry, Mr Jamieson.

MR JAMIESON: No, not at all, sir. I will just develop that

line for a moment and obviously recognising that you are speaking about this from a healthcare perspective.

A. Yes.

Q. But in terms of this heterogeneous cohort and the ways in which they might interact with the healthcare system, their areas of vulnerability, online life is potentially an area, a domain that cuts across all sorts of species of risk. There are coercive, potentially, ways in which that information can be captured by other partners which are unlikely to be tools in the kit of healthcare.

A. Yes.

Q. But people could be asked, in the currency of assessments, parents of young people could be asked. That is a way of capturing that information --

A. Yes, that's true.

Q. -- if it is important. And if the information is provided, that's one answer. If there is a refusal to provide information, that's an answer in itself, isn't it? That provides some data for assessment of risk. So, I offer those thoughts for your consideration.

A. Thank you.

Q. That's not me doing your homework, that's just me potentially giving some context. Thank you.

So, we have noted all of that frank and importantly candid limitations to the systems and I'm grateful for

it. It means that I can look at the individual settings that you have talked about swiftly and let's just do that now.

Firstly, the safeguarding setting. Just over the page, please NHSW000046_0025, to paragraphs 94 and 95. So we have talked about safeguarding and we have talked about part 7 and how that works and we have talked about the regional safeguarding boards.

You say, rightly, that:

"Health professionals are often the first public service practitioners to identify concerns about ..."

If we just scroll down a little, we see at (f):

"Risks posed by or to, children and young people.

In common with education professionals, healthcare professionals are often those that are encountering children at risk and children of vulnerability at the earliest stages and so there is a real potential there for practitioners to play a part in the identification of risk early?

A. Yes.

Q. Thank you. You set out a little bit more detail about that at paragraph 96. If we went onto the bottom of page 25 and to paragraph 98. You talk about the next setting "Children and young people's mental health services" and the potential role of CAMHS.

If we just rolled over the page NHSW000046_0027 so we could see, you set out the different aspects of CAMHS and you tell us that, just in relation to this. Since 2024 essentially there has been regional collaboration in Wales to deal with the -- what you do with -- you have a slightly different problem to our cohort, but a small number of high need, high risk individuals.

And the answer to what you do with that is, it requires regional collaboration, so you can fund the expensive specialist provision that they need, but not disproportionately. So every region has got its own secure beds, wasting money that isn't necessary, there has been that regional collaboration. Is that a model that could also be applied for this cohort? If, for instance -- and we will get onto it -- there needed to be a specialist mental health provision, whether that's CAMHS or Forensic CAMHS, that multi-agency structures could call upon to assist their analysis of the risk posed by particular individuals referred to them; a regional provision could potentially provide that specialist coverage in a more cost-effective and realistic way than a series of local services?

A. Yes, I would absolutely agree with that.

Q. So it is a different context but that was a regional way that the NHS in Wales approached an analogous problem?

A. Yes.

Q. And came up with a solution. We will just look at Forensic CAMHS in a little more detail, if we may. Can we go to page 27 NHSW000046_0027 and paragraph 107.

Because, as you tell us there, particularly relevant to us, because:

"Forensic [CAMHS] are concerned with the provision of mental health services to children and young people, who present a risk of harm to others, and who have mental health or neurodevelopmental needs."

So that's their purpose. Individuals who have some sort of mental health or neurodevelopmental need and present an external risk of harm to others.

You have provided us with the service specification there, NHSW000041. I did just want to have a quick look at that, if we may. So there it is. It has been in place since August 2023.

If we went to page 7 NHSW000041_0007, please, we could just see the introduction. It tells us that FCAMHS there, at the bullets, essentially does two different areas of service in Wales. The first is a consultation service to CAMHS. So when CAMHS have an individual on their caseload that they are worried about the risk of harm that they pose, they can come to Forensic CAMHS. And they also offer a similar service:

"Consultation, Advice and Enhanced Case Management ... for Youth Offending Teams ..."

So an individual that's not on a CAMHS caseload but is on a youth justice caseload. Now, this service framework only covers the first of those bullets, not the second, but I wanted just to acknowledge that they also fulfil that role.

If we just looked at "Background" at the bottom there, just to set the frame of this:

"Children and young people who present significant harm to others frequently experience high levels of mental health and complex needs."

So this question -- and we are not eliding causation between occurrence of mental health needs and neurodiversity with harm; they are different things?

A. Yes.

Q. But we are noting that it is all too common that those who do present significant harm to others, do have those needs, and that's the purpose of this service?

A. Thank you.

Q. And that's a difficulty, a complexity, a challenge that is not limited to this cohort, it is more wide?

A. Yes.

Q. And so this is an existing lever that is available to meet this exact need:

"Children and young people within the criminal justice system have higher ..."

So that's those who have gone on to offend:

"... have higher rates of mental health problems, learning disability and difficulties, speech, language and communication problems, substance misuse, physical health problems and a history of head injury."

If we just went over the page to page 8 NHSW000041_0008:

"These children and young people often present with multiple areas of need; ...

"Forensic [CAMHS] are concerned with the provision of mental health services to [those] children ..."

And then it tells us that:

"In 2001, the Welsh Government recognised the requirement for an 'integrated, multi-agency, multidisciplinary child and adolescent forensic mental health service' ..."

Which is what we are looking at. So again, a quarter of a century ago recognised that this complex cohort of high risk, high harm individuals needed this forensic service?

A. Yes.

Q. That's what it is for. So, so far so good. But what we are going to look at now, please, just shows us how

restrictive the criteria are for access to this service at the moment. If we went to page 11 NHSW000041_0011, please. And if we just roll down the page so we can see "Access Criteria".

So firstly, we recognise that this is an advisory service that's being offered to CAMHS. CAMHS would already be managing/supporting somebody on their caseload. In order to access the forensic service, firstly, the person has to be under 18 and must meet all of the following criteria. So: receiving care from CAMHS, and a tier 3, which I think is the tier below this so I'm not going to get into the detail of it, but a reasonably high level of support already:

"Have a mental disorder ... and/or significant adversity/trauma with related severe psychological difficulties.

"Present a serious risk to others ..."

What this guidance says is:

"... (this would often be encapsulated in a seriously violent index offence ..."

Ie something that has happened already, some sort of demonstration of a serious risk of violence, rather than something being entirely anticipatory. Then there is a further criterion about young people presenting with "a diagnosed/documented learning disability",

case-by-case basis, with respect to suitability.

Then it says:

"Given the nature of the service, it is expected that most children and young people referred will be aged between 12 and 18 ... however ..."

Those 11 or under would be "accepted in exceptional circumstances".

But those are the criteria. I'm not saying anything critical about this actually, but that is a relatively restrictive list of criteria before this service can be accessed, which no doubt reflects resourcing concerns. Am I right in that inference?

A. I suspect so, but this is not an area of understanding that I have -- a great understanding of.

SIR ADRIAN FULFORD: Would you have it otherwise? Do you think it should be broader?

A. I think there needs to be -- we talked about -- earlier about having more regional based services, rather than individual health boards. I think there is more to be done across mental health full stop, around how we should regionalise and bring together mental health service in a different way, both in terms of inpatient and how we treat more patients in the community. So I think there is a bigger picture there that means that we might be able to do something different. Equally, we

send a lot of patients to England, particularly for level 1/2 forensic psychiatry, high risk patients, and that would include super high risk children as well, if need be.

SIR ADRIAN FULFORD: So: organise it differently and potentially expand the cohort, if the resources permit it?

A. Yes.

MR JAMIESON: Because that's the purpose of looking at this. That service exists to offer that specialist input in cases that are selected against criteria. Whilst we have to recognise that in the real world this is a finite resource, those criteria could be amended in appropriate circumstances --

A. Yes.

Q. -- to allow a multi-agency structure to access that resource?

A. Yes.

Q. Thank you. We will just go back to the witness statement. If we just looked at page 28 NHSW000046_0028 and paragraph 112. I'm just going to note that you have provided detail of the health services that are provided in secure settings for children and young people, essentially, those in either secure children's homes or in detention. Thank you for that detail. I'm not going

to ask you about it because we are principally looking at early intervention stages.

So that runs to paragraph 120. For your note, sir, if we went onto page 29 NHSW000046_0029. I'm not entirely certain of my note as I say this. Yes. Can we just look at paragraph 116.

So this is "Urgent and emergency mental health care for children and young people". Not in a prison setting but in the general population.

You have set out what is available and how that will work and again, I'm not going to ask you about it in particular because this comes with the general caveat that these are mental health structures that are not really focused on this cohort, but potentially provide some coverage?

A. Yes.

Q. What I do want to look at, just very briefly, is at paragraph 119 NHSW000046_0030, please. So just over the page. Which is where you say this:

"The Health Care and Prevention Group leads policy relating to urgent mental health care transformation, crisis pathways ..."

And the like, and:

"... a 'no wrong door' approach for children and young people."

I just wanted to understand what that "no wrong door" approach is?

A. So we have moved away from multiple referrals going to multiple areas, they all go into one area. In each health board, children are seen, regardless of the reason for referral, within four weeks and should they require therapeutic intervention, that is done within the following four weeks. So within eight weeks any child referred, needing assessment because of mental health concerns, will be seen and treated within eight weeks. That does not include neurodiversity.

Q. Well, thank you for making that -- because I was going to come back to you in relation to that but just in terms of the process, and again, to explain directly why we are interested in this, one of the problems in AR's case was agencies operating restrictive criteria, not accepting him onto their caseload, referring him on to somebody else, effectively, as an action that was treated as mitigating risk. It didn't, because the next agency didn't accept him either. I over-simplify but that is the picture.

No wrong door, your explanation of that, is that specifically in relation to mental health provision?

A. It is.

Q. But essentially, the principle is that, whichever mental

health service a child presents to, there will be a global consideration of them? They will not be turned away?

A. No.

Q. And how does that work?

A. How does it work?

Q. So if I made -- I don't know, if I presented to a community setting and I was not appropriate for their caseload, but I might be appropriate for somewhere else, how would that occur?

A. Any patient can be referred into the no front door by any practitioner. What will happen by 2028 is that there will be no referral process and any child will be seen on the day and assessed. At the minute, we have 12 hubs around Wales going through that process of -- before we roll that out. So there are two different ways.

Q. And are we to take it that that "no wrong door" principle was developed in response to a similar problem that was encountered by AR: you don't fit our criteria, sorry, you have come to the wrong place?

A. And also long waits. People being referred on and on and on because they haven't landed in the right place first time.

Q. Which bakes in delay?

A. Which bakes in delay, yes.

Q. Because, as your experience in Wales is similar to that England, that the delay in diagnosis, the delay in care provision is itself a significant factor in relation to risk?

A. Yes.

Q. Both of harm to the individual and externally?

A. Yes.

Q. Now, you caveated it by saying that that eight-week -- aim, guidance, guarantee, doesn't apply in cases of neurodiversity. What's the sort of wait, in that circumstance?

A. So the aim is to see all children within 26 weeks and at the minute, 50 per cent of children are seen within that time. At the minute, we are trying to -- we have diverted some resource into actually getting all that backlog of children seen and diagnosed, looking at different ways that we can assess children. There are good digital models now to do that for the majority of children referred in, which leaves experts looking at those with more need.

Q. So half within six months. Is that what you just said? 26 weeks?

A. 26 weeks.

Q. So half within six months. Of those that are not seen

within six months, what is the sort of -- how long does it go on for?

A. It can go on up to a year. But those of concern and risk will be seen a lot sooner.

Q. That's what I was going to ask you about because we will come onto it but one of the Westminster actions -- I dealt with this with Dr Goodall -- there was a meeting of the senior committee, the National Security Committee, in March of 2025, which directed the Department of Health & Social Care, not the Welsh Government, to seek to prioritise the VFI cohort, or those at risk of this behaviour for the provision of services. And I asked Dr Goodall if that was communicated to the Welsh Government and he said "no".

A. That is correct.

Q. And I take it it is the same with NHS Wales?

A. Yes.

Q. But there is a provision within how you deal with neurodiversity to escalate cases of concern?

A. There is.

Q. Do we take it that VFIs -- essentially, there isn't any guidance that would gauge -- that would assist practitioners to try and identify a potential VFI as being somebody of risk within that group; they would be relying on general principles?

A. They would be relying on general principles and risk principles that we operate already.
Q. But if we had a definition and we had a process and we had some guidance, you have that structure there to provide that escalation already?
A. It will, and I think you mentioned education earlier and they are really critical as being partners in that.
Q. Yes, because they often -- they have -- as long as the child is engaging with education, they will have more face time -- to use the vernacular -- with that child more than anybody else will --
A. Yes.
Q. -- and be able to provide that into your structure?
A. Yes.
Q. But the idea of prioritisation for risk is there already in your "no wrong door"?
A. It is, yes.
Q. And I make clear -- and it is important that we do so -- this is only in relation to healthcare and the provision of mental health support. It is not a multi-agency process but it is something that you have arrived at in order to meet that problem?
A. We have, and should we identify a child or individual that has high risk factors, we would refer them appropriately for mental health.

Q. What does that mean?
A. So if a child comes in and gets assessed and actually the risk factors are not mental health, they are to do with other areas of that child's life, or other things that need putting in place --
Q. Potentially safeguarding concerns?
A. Yes, we will -- the professionals are trained to appropriately refer that child to the appropriate area.
SIR ADRIAN FULFORD: Is this set out in a document?
A. I am sure it would be. We can forward that.
SIR ADRIAN FULFORD: Could you forward it? Thank you very much.
A. Yes.
MR JAMIESON: We have a document or two, sir, but nothing that comprehensively sets it out, so that would be very useful, thank you. I have focused rather a lot on three words you have written there, but I hope you can understand why.

Just finally on that question of referral onwards, would the mental health team hold that case until the referral is accepted by, for instance the safeguarding body, or are they just trained to make the referral?
A. If it was appropriate to do so.
Q. Well, I think, as ever, the devil will be in the detail. We will look forward to that documentation.

You can just see, poking onto the bottom of the page, "CONTEST", which, as we know, is the counter-terrorism strategy. I'm not going to ask you about that because, as we say, it is a reserved activity.

Could we -- sir, that runs, for your note, all the way to paragraph 128. We will just look very quickly at the Serious Violence Duty again, page 32 NHSW000046_0032, paragraph 129.

So you tell us about the Serious Violence Duty, which, as we have covered already, was an England and Wales process. We have talked about the creation of the violence reduction or violence prevention unit and at 130, there is that guidance which has been used. I don't need to ask you anything about it, thank you, other than to confirm, as we have done already, we are talking here about public health, macro consideration of issues rather than individuals?
A. Yes, we are.
Q. May I just ask you about data. Page 33 NHSW000046_0033. So just over. Paragraph 131. So, again, you tell us frankly and candidly that data on this group is not currently being collected or reported. I don't want to keep coming back to it but there isn't any definition to record the data to?

A. That is correct.
Q. But you say that effectively there is -- or there are existing, potentially useful, data gathering structures that you flag for our attention?
A. Yes.
Q. Public Health Wales you tell us about at 132 and you say that:

"NHS data is included in the Wales Violence Prevention Portal which provides a national violence surveillance for Wales, bringing together ..."

Data from all of those sources, enabling:

"... partners to identify patterns, hotspots and ... trends ..."

If I just came down, I'd see that that portal is managed by the violence prevention unit and you say, essentially, that might be useful.

As I say, it is not a publicly accessible -- you have to -- I can tell you from my own efforts -- be attached to a relevant entity to get into it, to have a look at that data. Are there any conclusions, are there any species of data within there that you are drawing to our attention of particular worth, or are you just telling us that it exists?
A. Not related to this.
Q. Anything from which analogies can be drawn?

A. There might be some. But again, without that definition, it's quite difficult. So we can tell you about knife crime and where it is and where the hotspots are. Why it is happening may or may not be part of that; is it county boundaries or is it a different matter?
Q. So essentially, what you are telling us -- and we are grateful for it -- is: this exists, it has the potential to help you in the future --
A. Yes.
Q. -- rather than there is useful data there now?
A. Yes.
Q. Okay. Thank you. Similarly, the Wales safeguarding repository, which if I just went over to paragraph 134 NHSW000046_0034, that's a place where safeguarding reviews, essentially -- you have given us a list there of all sorts of retrospective reviews that happen after a serious event has occurred, where multi-agency structures sit around and work out what's led to it, is there any learning --
A. Yes.
Q. -- what can we put right in the future? And those are, in a nutshell, collated in Wales into a single place --
A. That is correct.
Q. -- and so that's a place of potential use for us?

A. That is correct.
Q. Thank you. Again, I won't go into the detail of it. The next topic is there just on the page:

"Policies and guidance in Wales."

Again, we can deal with this relatively swiftly because you set out, in those paragraphs that are on the screen there, detail -- important detail for us as to how policies and guidance are promulgated and distributed in Wales. But what it comes to is, if we looked at page 36 NHSW000046_0036 and paragraph 146, not to spoil the story, but there aren't any that specifically exist, that deal with this issue?
A. That is correct.
Q. Not a surprise to us, for reasons that we have already covered. So you set out that detail. I won't ask you about it.

What you go on to say, as with the identification of VFIs, you say:

"There's nothing specific", paragraph 147, but there are some wider policies which are of relevance that may provide some tangential coverage. There are just a couple of those that we will look at. If we went down and looked at paragraph 148 NHSW000046_0037 over the page. We would see Working Together at 148, which we have looked at already, I won't ask you about. We will

see "Preventing and Responding to Child Sexual Abuse" which I think I can properly call tangential and I won't ask you about.

But if we just went down to look at the "NEST Framework" at 150, you describe that as a:

"... whole-system framework for improving mental health and wellbeing support for babies, children, young people and their families."

The idea is that it is a:

"... trauma-informed and person-centred approach, with an emphasis on ensuring children receive support at the earliest opportunity and don't fall between ... boundaries."

In a nutshell, what is that and how does it work?
A. So it is a framework and it seeks to ask the question, not: why is this child behaving like this? It seeks to ask -- or this child is badly behaved -- what would help, in terms of NEST? And NEST is about how the family unit works and supporting the family unit to actually enable children to feel nurtured, empowered, safe and they have trust.

So it is a framework, rather than an action. How it is actually deployed, I can't tell you. That gets into operational detail but it sits there as a guidance to actually enable multi-agency practitioners to ask the

right question about what has gone on with this child previously that means they might need support and help.
Q. That's very helpful because -- I'm not suggesting we do -- if we called up that guidance, it is quite a long document which has lots of aspirations and ideas, but not necessarily concrete proposals as to how they would be achieved. But that encapsulates, essentially -- and it is my inelegant shorthand -- when a child is misbehaving, don't be Victorian and simply respond to that, seek to understand why because that's going to be more effective in the end?
A. Yes.
Q. And we have heard a similar sort of approach, sir, in relation to Vanguards and how they appreciate --
A. And it is all linked with the trauma --
Q. So it is a general piece of guidance that's essentially intended to promote that approach across public services, or across healthcare?
A. Across anybody who looks after and is part of a child's life.
Q. Thank you.

We can move on from that then. We will just note, if we went over the page to paragraph 152 NHSW000046_0038, you have told us about the general strategies for mental health delivery in Wales and

I think you have told us about some aspirations and targets about that that are particularly relevant to us.

We have that detail, thank you. I won't call up the details. They are large and important strategic plans that you have created across the piece in Wales.

Are you aware -- so we spent some time with the DHSC in England and indeed with NHS England, yesterday looking at the Fonagy review of mental health provision in England. Is that a document that you have looked at?

A. No.

Q. Let's just look at it very briefly just to introduce it to you. Please may we have on the screen ILT000365. That's what it is:

"Independent review into the prevalence and support for mental health conditions, ADHD and autism.

"Final report."

It is very recent, as you can see, October 2026.

A. Yes.

Q. It is a substantial and important piece of work. It is about 600 pages long. But its core recommendations, or the core problem that it is aimed at and its recommendations, can be shortly summarised. If we just looked at page 5 ILT000365_0005, which is the executive summary. And just went down the page to paragraphs 4 and 5 and 6. Sir, I'm sorry, we did this yesterday but

just for this witness's reflection and response. Essentially, it is a recognition that in England, ADHD and autism are perhaps not well understood and the re-statement that they are neurodevelopmental conditions, strongly genetically influenced, present from early life, influencing all -- a number of aspects, but with the right adjustments many people can live full lives. Within the cohort:

"... some face substantial difficulties and lifelong high support needs. Traits related to these conditions, including inattention, social difficulties and emotional regulation, occur to varying degrees across the population, but having some of these traits, or identifying as neurodivergent, is not the same as having a diagnosable ... condition."

So there are a number of people who have the diagnosis, there are a rather wider population of people who have the traits:

"Diagnosis depends not simply on the early developmental presence of traits, but on their severity, persistence and impact on functioning."

Then the core recommendation, or the core approach that this strategy is suggesting:

Recognition of ADHD and autism has gone up substantially. There is a very long wait for diagnosis

in England and in England, there at 6, and over the page onto 7 and 8 ILT000365_0006, treatment sits behind diagnosis. Treatment doesn't begin until diagnosis is provided.

And the suggestion is, there at 8: don't do that any more, start to provide intervention and treatment pre-diagnosis, to assist with those areas of need. Yes, still diagnose important cases but bring that support forward.

I'm not going to ask you for a considered response to that strategy, but I think the fact that you haven't seen it before probably tells us what we need to know, that this is not something that collaboration has been invited with your approach in Wales?

A. I suspect that's true.

Q. Because, sir, I think you --

SIR ADRIAN FULFORD: Does it sound sensible?

A. It does sound sensible. Clearly, having not read all of it, I don't know some of the tools they are describing that might help do that -- because there are tools out there that can do that and I mentioned those earlier -- but it does sound appropriate and reasonable.

MR JAMIESON: I think you have told me already that whilst you have that target of pretty quick assessment and provision of treatment for mental health generally in

Wales -- for neurodiversity we are six months at 50 per cent and then up to a year for others -- this is potentially a way of bringing forward certainly the provision of some support to that cohort. Well, as I say, I'm not going to ask for a sort of official response to a document that I have shown you four paragraphs of. But there it is. Perhaps something to be considered.

A. Yes, thank you.

Q. If we just went back to the statement to complete this aspect. Paragraph 156 which I think is on page 39 NHSW000046_0039.

You have given us the "Wales Without Violence" framework which again, provides tangential coverage that we have looked at before. If we go over the page to page 40 NHSW000046_0040. "Trauma-Informed Wales Framework", another general application document that advocates the approach that you have explained already and then we can just see, the paragraphs underneath deal with some youth justice documents that we have looked at with other witnesses and I'm not going to ask you to speak to.

So you tell us about all of those. May we just look very briefly at paragraph 161 on page 41 NHSW000046_0041, where you give a little more detail

about online safety, which is a matter that the learned Chair was talking to you about shortly before.

You draw our attention to the Hwb, which I have learnt how to pronounce since Dr Goodall came, and to the keeping safe online guidance which is there, which you give us. Again, we have looked at that before unless there is any specific part of it you want to draw to our attention?

A. No, thank you.

Q. I'm not going to bring up -- in general, it is a general piece of guidance. As with everything, it is not particularly focused on this, but you have that Hwb, which is a resource for parents, for young people, for education and indeed, for the population at large?

A. It is.

Q. To advise, guard against some of the risks that the internet poses. There are pages, aren't there, that relate to particular apps and programmes and some of the problems with particular apps and programmes and risks that might not be apparent?

Sections dealing with extreme violence and gore could be added to that, couldn't they?

A. It could. I mean, it is clearly run by the education directorate but yes, and it is also, I suppose, a safeguarding tool as well.

Q. Yes, thank you very much. Just to round out this topic. Page 42 NHSW000046_0042, paragraph 165. The heading is "Training". I won't go through it all but, again, the point is, there isn't any specific, there is general coverage with other sorts and general principles and general professional experience but we need something assured, targeted, particular?

A. Yes and I think my preference, or our preference would be that any -- when we do get to getting that training, or that -- to know what we need train for, that actually that would be part of safeguarding. Safeguarding is a statutory responsibility and that helps us make sure that we train everybody in recognising.

Q. Sorry, just explain that for me for a moment. So the safeguarding responsibility is there and, what, that's a hook that allows to you provide that training more widely?

A. Yes.

Q. Because it is a duty that sits on everybody?

A. Yes.

Q. Does that entirely work? Because safeguarding is principally about risk to the individual and safeguarding the individual, this is, on one view, risk to others, although it could be characterised as also involving risk to the individual.

A. But I think where we come from is that, actually, the assessments that you will take will actually be aligned with safeguarding practice. So actually, whether it be protection for the individual or of the individual, there is some commonality there that actually would be better to be actually keep it together.

Q. Sir, I'm just going to aim to deal with one more topic, if I may, before we break.

Let's see how I get on. As long as that's all right, with you? How are you doing?

A. I'm good, thank you.

Q. So to round out our coverage of those topics, let's deal with information sharing, if we may. You deal with this in your statement at page 44 NHSW000046_0044, paragraph 172.

You set this out between paragraphs 172 and 182. You put some common frameworks and mechanisms through which information can be shared and in summary, your view is there are adequate powers within Wales for information to be shared between agencies?

A. Yes.

Q. Yes. Powers, however, when Dr Goodall gave evidence, I suggested to him that the evidence that we had received from experts, frontline practitioners and other witnesses was that, yes, the legislation was there --

and we know that there is some Wales-specific legislation which is helpful -- but that on the ground, the proper sharing of information was an endemic problem and he agreed with that.

And that what sat behind that were cultural, technological and practical concerns that prevented information sharing from happening in practice. Would you agree or disagree with that?

A. I would agree with that.

Q. Here is the question: how do we fix it?

A. So I think there is also sitting behind that, not just barriers and boundaries around organisations but also people's understanding about what they can and can't share, despite some training. They are worried they will be unlawful if they share data.

Q. Yes. The first line of the seven principles that we looked at: these are not barriers, this is a framework but it remains a persistent problem?

A. It does. And I think a lot of that is about cultural change and how we actually give people confidence, number one, to actually be able to use the data and report data appropriately. Number two, I think the leaflet that we have, that was from 2019, I think that could do with refreshing and we have other tools now that we can now use more digitally, to enable people to

understand online that actually what they can and can't do. And I think also around health board, particularly being proactive about allowing that.

Q. I suppose there is a question of familiarity, isn't there, because the more often it happens, the more often it is part of the routine of practice? The more familiar individuals will become with it, the more it seems difficult and bespoke and legal, the more challenging potentially for individual healthcare practitioners?

A. Yes.

Q. Is that an argument for, or is that a factor in support of -- we haven't looked at multi-agency structures yet, but there are lots that deal with different problems, a crowded field, as it has been called before. If we rationalised those, if there were fewer -- if there was a no wrong door approach, in the same way that you have done with mental health provision, I take it, frankly, intrinsic within no wrong door is, if you get some information about a person and that's not the right service for you, you send it to the right service; that is the sharing of information?

A. Yes.

Q. That is baked into the process. That's what you do. That's what they do every day. If we had

a rationalised, multi-agency safeguarding, care and safety structure, that sharing of information would potentially become more routine?

A. Are you talking about the big front door concept?

Q. Yes, in simple terms.

A. So I think there are positives around that, around streamlining, clarification, one process. There are also I think quite a lot of legislation, cost and change to do that and I think go back to I think what the Permanent Secretary, Dr Goodall said, there's also a culture that we need to change and that won't be changed by any of that. So the bit for me is what will be -- how can we do both cultural change whilst also thinking about how we organise ourselves differently?

Q. So, I wasn't intended to come on fully to the big front door, but this idea how we do build that culture, my suggestion to you was that familiarity, frequency would be a way of doing that. The way you are going to make this more frequent is if fewer people do it more often, rather than it being spread disparately across a population. Are there other ways of addressing that culture?

A. I think by -- there is a lot more informing, I think, of frontline staff. Because those individuals who normally think about this are people who come in directly with

individuals -- so whether that be in education, police or health or other multi-agency colleagues, social care -- is how we actually do more around informed understanding of what that actually means. And I'm talking off the top of my head here, rather than giving you an informed view.

Q. I think the response to it is probably to say the challenge of this culture is something that has been recognised for a long time and it is proving resilient to improvement and so I don't want to keep adding to the things that you are going to come back on, but if there are particular items, that would be very useful.

May I just make one small point before we move to our break and it is this, you are telling us there on the page about the Serious Violence Duty in a way that that might help with information sharing. The Serious Violence Duty, as we have said already, is a strategic, macro co-operation between agencies to address violence on a public health level, isn't it? So the information that they are going to be sharing in that forum is not about individual cases and individual risk factors?

A. No.

Q. It is going to be macro data about what's happening, hotspots and the rest of it; is that right?

A. That's my understanding.

Q. Yes, thank you. Just to clarify that. Then the -- I keep saying final -- the very final thing, at 176, just over the page NHSW000046_0045, you say you are:

"... not aware of any situations presenting particular problem[s] in Wales where parents of young people withhold, withdraw or manipulate their consent to information sharing."

I have mentioned to you about the particular incident in Wales, where -- the Ysgol Dyffryn Aman attack, where the teenager stabbed, attempted to kill teachers and a student. Now, the National Education Union shared with us the learning account of that. That particular risk was a feature of that case. But I think what you are saying to us there is that, strategically, that hasn't been drawn to your attention and what's your proposal to address that?

A. Part of this, I think, is actually understanding how many parents do actually do that and we don't collect that data. And going forward, we have a new intelligence hub that will be developed as part of the new care service that we are developing in Wales and that should -- and we will be intent to make sure that that data is collected.

SIR ADRIAN FULFORD: Non-cooperation?

A. Yes. So at least we know, because we don't -- I don't

think we actually have the data on that.
MR JAMIESON: Sir, thank you very much. With apologies for saying "final" four times, may we take our break there?
SIR ADRIAN FULFORD: Yes, we will sit again at 11.45 am.
(11.35 am)
(A short break)
(11.46 am)
SIR ADRIAN FULFORD: Yes, Mr Jamieson.
MR JAMIESON: Thank you, sir. Ms Totterdell, can we move to the next topic, which is the assessment and management of VFI risk. Please may we look at your statement, page 46 NHSW000046_0046, paragraph 183.
I'm not going to read it out but the -- you tell us essentially the position is the same as we have been looking at in other areas, nothing bespoke, nothing targeted, coverage, potentially ad hoc by other existing structures and you set out the detail of that in your statement.
If we went on to page 148 and to paragraph 190 and have -- sorry page 48 NHSW000046_0048, paragraph 190. So you offer your thoughts there as to what effective management of the VFI-related risk might look like in a multi-agency structure. Can you explain to us what your thinking is behind these paragraphs?
A. So, for us it is about how do we have complementary

building on what we currently have, in order to develop policy, frameworks and identification and treatment that will run alongside some of the frameworks and processes we already have because we are using the same people to actually -- across multi-agencies, to identify individuals, as we are for a wide variation of other conditions.
Q. Just to sort of reflect that back at you for a moment, is that a pragmatic solution to what we do now, with this risk that we currently have, that is unquantified and uncontrolled, how are we going to deal with it? You have these structures, you have these professionals who are already meeting in different settings, aimed at slightly different risks. And so for now, the thing to do is to make use of those structures?
A. I would say for now and going into the future.
Q. Okay.
A. For the reasons that I have just outlined. Once we have a clear definition, that then helps us understand where there is complementary and supportive processes and where others would be needed.
Q. And so -- I will come back to the "into the future" in a moment but what are the features that, in your advice, your expertise, we should be looking to build on to ensure that we capture this risk?

A. Expertise, current legislation, I know safeguarding is about safeguarding individuals, not safeguarding individuals from others, but those are the areas. And the risk assessments that we undertake are all things that we can build on and the multi-agency way in which we work up and down the Welsh system.
Q. So, expertise will be needed but needs to be targeted in the right place?
A. Yes.
Q. We looked at the restrictive criteria for FCAMHS generally.
A. We did.
Q. If we are going to add to their workload, there needs to be some sort of triage and assessment that identifies the cases upon which they should be focused. Let's come back to, then, your --
A. That, of course, is if individuals who are violence-fixated actually have a mental health issue.
Q. Because they may not?
A. Because they may not.
Q. That is quite right and it is an important thing to say. But just coming back to the big front door and I think a reticence or a caution that you are describing in relation to that. One of the other features of evidence that we have had is this sense that those same

professionals are sitting around different tables in different settings, with partial pieces of information, thinking about different risks at different times, rather than thinking about it globally, effectively, systematically. Of course, it would be a big change to arrive at a big front door. It would require resource, it would require careful planning, it is not a solution for tomorrow. But are there reasons why we shouldn't be looking in that direction?
A. I suppose, the -- I have only read about it from the documentation we received yesterday. So I suppose the bigger bit is understanding -- is actually really understanding what that means in terms of changes to be made, processes to be changed, individuals that would or wouldn't be sat round that big front door or behind that big front door and I feel uneasy saying any more, given that I'm giving you my opinion based on what I have read about it in the last 24 hours, rather than from knowledge.
Q. Okay. Well, then, I will give you a simple explanation of it for your response, with those caveats that we understand.
In common with the approach that you have followed in relation to mental health, in your "no wrong door" process, a single point of referral for concerned

practitioners, members of the public, whoever it may be, that does not require them to differentiate, for instance, whether this is a safeguarding risk, a risk of non-ideological extreme violence, or a terrorism risk. A single front door for them to refer to. Cases then triaged to a structure that sits behind that big front door. Prevent would take some cases. Safeguarding would take some cases. There may be a particular panel that deals with these individuals. So that triage function. But also, potentially, a case management function to ensure that somebody, an agency, a structure picked up this risk. That's the broad idea. It has been called "MASH plus" or "MASH plus plus".

A. I was going to say, it reminds me of MASH, yes, it sounds like a MASH.

Q. It sounds like a MASH, but it is not just safeguarding, it is public protection too.

A. For that, I understand -- because building on MASH -- and that would require every area to have a MASH and in Wales, and possibly in England, not everywhere has a Multi-Agency Safeguarding Hub.

Q. And even where they do, they don't always work the same?

A. No, so that would -- and that would actually sit within how we want to run or develop the care service for Wales, about how do we standardise processes across

Wales and standardise how we behave across Wales.

Q. Well, is there some insight, because you are right to identify if we are going to try and use MASH for this process, one of the problems we have got is it is not everywhere and it is not the same everywhere. It sounds like you have a similar problem in and you are trying to standardise it?

A. We do.

Q. How are you doing that?

A. We have only just set up the care service. It is something -- two months old, but that will take -- particularly social care, where it is actually focused, on a different journey about how, across all of social care, we standardise best practice use and so that can be taken one step further, potentially, looking at how we operate Multi-Agency Safeguarding Hubs, ensuring that everybody should have one and that they operate under certain principles.

Q. So, taking --

A. Of course, I'm straying into lots of other people's -- police, social care.

Q. We understand and that's what we are asking people to do. That's what we are asking our witnesses to do. But taking good examples of local practice, distilling those into -- at a national level, distilling those into

principles and approaches that then can be -- I hate this word -- cascaded elsewhere for adoption locally. That is the process by which you can end up with -- you can bring everybody up to a standard systematic level of provision?

A. Yes, which I suspect is easier to do in Wales.

Q. Because it is smaller?

A. Because it is smaller.

Q. But the principles are potentially transferable?

A. Yes.

Q. All right. Well, thank you. You have also set out for us, from paragraph 195, some thoughts about the relevance of FCAMHS and neurodiversity to risk. We have talked about that as we have been going along. I don't need to ask you anything more about it. And at page 51 NHSW000046_0051, paragraph 205, you have told us about the neurodevelopmental pathways and training resources that you have been putting into place, but I believe we have covered those themes when we have talked about waiting lists already and how that's being addressed. So again, I'm not going to ask you about that.

What I would like to look at, please, is may we look at paragraph 213, which I think is on page 53 NHSW000046_0053. Because in -- may we just have the bottom half. Thank you.

What you are doing in these paragraphs is reflecting upon some of the recommendations that were in the Phase 1 report and some of the questions that were posed in the Rule 9 and -- well, I think let's look at them in turn.

So no specific VFI framework or risk assessment tool. You say that you don't have a position as to whether a single, shared tool should be developed. You say, in that paragraph, there might be some benefits, but there might not.

Is it a good idea to have a single, shared risk assessment tool?

A. I'm always for standardisation. The bit will be, as I put in there, about how we get through the differing statutory responsibilities, professional obligations et cetera. But I think the bit that would be most important in developing that is it is done with people rather than to people, ie we involve the people who actually will be using that because it is not just in health.

Q. Yes. Of course. Yes, evidence would need to be sought, but a model -- I'm not suggesting this is immediately applicable -- but MAPPA, you are aware of MAPPA?

A. Yes.

Q. They have -- that is a multi-agency arrangement. They

have three categories of risk, for individuals, 1, 2 and 3, that different agencies feed their consideration into. There is a common discussion and a common understanding. It is simple language that everybody -- the nuance of each practice area will feed into that common risk, but it is a way in which that can be achieved. And if that could work, in terms of practitioner consultation, buy-in, all the rest of it, you would be in favour of that?

A. I would be supportive of it.

Q. I'm not going to ask what the difference is, "in favour" or "supportive of", but we have your answer.

Thank you. The next topic that you have dealt with is between 216 and 221, which is a specific VFI framework. Again, you say some good things, some bad things. We have talked about the big front door. If we are not doing the big front door, if we are maintaining our existing structures in the short term, should we be creating another structure for VFI risk? Should we be picking one structure to put it in? What should we be doing?

A. I think I sort of started to answer this earlier, which is having complementary processes and risk assessments.

Q. What does "complementary processes" --

A. It means we take what we currently have and whatever is

needed, it fits -- it is complementary to what currently is there, particularly around risk association.

Q. So: don't create a new structure but amend guidance, or --

A. Supplement, yes.

Q. And which structures are you thinking of in particular?

A. I'm thinking particularly around safeguarding structures because they are the bedrock of actually beginning to identify one sort of -- risk to individuals and the bit will be -- the complementary bit is also how we then identify individuals who are at risk to the public.

Q. So principally MASHs?

A. Yes.

Q. In terms of the management of individuals. But there are other safeguarding structures that you are thinking of that will manage individuals, rather than strategically?

A. We are going beyond my knowledge of the structures around safeguarding.

Q. All right. But if we are thinking about MASHs, we are going to run into those problems that we have just talked about --

A. Yes.

Q. -- about patchy coverage, regional variation and all of the -- but that's where you would fall, rather than the

creation of another structure in a crowded field?

A. Yes, in a complicated, crowded field.

Q. Yes. At 218 you talk about the benefits to a lead professional or coordinating agency. 218 are the benefits. 219 are the detriments. What do you think?

A. This is somewhere where I am in two minds. Number one, it sounds perfectly reasonable, particularly when you look at the evidence from your Phase 1, of the lack of someone coordinating, enables an individual to drop through various cracks and gaps. The other bit is, if you only have one -- and let's say in this instance it could be the police -- doing that, then what you wouldn't want is everyone stepping back and that is a real worry about this, is that -- and equally, individuals worrying that they would then be held accountable. When actually, for most of the individuals we are talking about, this is absolutely multi-agency working.

Q. Yes. So, there should not be -- we have to devise a way in which responsibility can't be handed off from one agency to another?

A. Yes.

Q. There has to be some sort of supervision. But that should be multi-agency?

A. Absolutely.

Q. Not of a nature where, because there is supervision, the remainder agencies say: well, you are dealing with it, we don't have to?

A. Yes.

Q. And that is something that could be set out simply in the rules, in the structure of an organisation?

A. Yes.

Q. This agency -- and would you also see benefit in the identity of the lead agency being flexible to context?

A. Yes.

Q. So if somebody's principal needs are health, health-led, but bringing in other agencies. If they are principally safeguarding, safeguarding-led but bringing in other agencies?

A. Yes.

Q. If they are principally public protection, police-led, bringing in other agencies?

A. But as you indicated, there would have to be particular rules or a requirement to engage.

Q. Yes, and would that, to be most effective, be statutory?

A. I don't know and that's probably reserved for Welsh Government, if I'm being honest. I haven't got a clear view about statutory or not.

Q. I think, given the extent to which you have been helpful with the rest of it, I will accept that level of

fence-sitting, unless the learned Chair thinks otherwise. Thank you. And you set out, I should say, at paragraphs 222 to 228, further evaluation of multi-agency structures but I think that we have covered it in that exchange, unless there is anything else that you wanted to add that I have missed in that discussion?

A. No, thank you very much.

Q. That's very helpful. The next topic is interventions and the suitability of the Mental Health Act. May we look at page 56 NHSW000046_0056. Thank you.

Firstly, on the topic of interventions, you say that your aspect of Government "has not undertaken any work in relation to interventions to reduce the risk posed by VFIs". Then you go on to explain why that is: lack of a definition and all of rest of it.

We heard yesterday that the Department of Health & Social Care is part of the Cabinet Office NIEV Taskforce and an aspect of that is something called the "Early Intervention Working Group", which first met in June 2026. Perhaps we will just have a look at that document that relates to that. DHSC000037.

So here's the read-out of this first working group. June. But it is trying to do what it says on its face. It is a working group to work out the best early interventions. And if we -- there's its purpose. There

are the discussion points. If we went over to the second page DHSC000037_0002, these are the tasks that people are being asked to do: provide some feedback; confirm some team representation. Essentially to build this process.

So this is going on in Westminster, there is this working group thinking about early interventions. DHSC and NHS England are involved. Is NHS Wales involved?

A. No.

Q. If we are to have interventions that deal with the risk of this cohort, they will have to be delivered in England and in Wales. Should you be involved in this?

A. Yes.

Q. Would you like to be?

A. Yes. Thank you.

Q. Well, that is clear. That can come down, thank you.

If we go back to your statement then, please. Page 56 NHSW000046_0056 and paragraph 233. So that's interventions because you haven't done anything particularly and you have not been invited to that, I am not going to ask you anything about it. But obviously we need early interventions for this cohort to prevent the risk crystallising. That's to their benefit, it is to our benefit, it is, if I may say, an obvious thing we need to achieve. And as health is devolved to Wales --

perhaps you would agree -- equally obvious that Wales needs to be involved in the design and the delivery of those interventions?

A. It does, particularly as the reserved area, such as police, that aren't devolved, should be part of this as well. So it would make sense that we are.

Q. There needs to be that collaborative working?

A. Yes.

Q. All right. Let's look at the Mental Health Act issue because you have done some helpful reflecting for us. In fact, you are setting it out there. We are familiar, from the questioning yesterday, this problem about whether or not the power to detain for assessment can be used for people such as AR, who are withdrawing and not co-operating, but the evidence that they may have a detainable mental health condition may be opaque or not clear.

And if we -- that's -- you are setting out that circumstance. You tell us, at paragraph 235, that the recent statutory amendments don't deal with that problem, they don't "create a new power to intervene solely because an individual presents a risk of violence or is considered fixation-driven".

A. Yes.

Q. But you offer some reflections underneath. At 237. You

say there are particular challenges in this circumstances where a child doesn't meet the criteria for detention; highly concerning behaviour. If we just roll over the page NHSW000046_0058.

You evaluate for us some of the existing powers and options that might fill some of that gap. So you have put there, for instance, section 25 of the Children Act, which is a limited power which relates only to looked after children, doesn't it?

A. I believe so. Yes, looked after children.

Q. You say underneath -- and is this the summary of your position -- essentially, there are no frameworks that are direct substitutes for detention, this may indicate a broader gap?

A. Yes.

Q. And is that your analysis, that there is potentially a gap here?

A. Yes.

Q. If we rolled down. Thank you. Again, you are identifying a gap with -- the heading probably suffices for our purposes:

"Individuals who decline to engage with services or assessments."

Again, there is no power to detain in that circumstance. You have set out sections 135 and 136 but

those really deal with acute situations of presentation and risk, rather than the early intervention phase that we are talking about?

A. Yes.

Q. And you say that. If we just went on to paragraph 248 NHSW000046_0058. You say this:

"In practice, the management of individuals presenting serious violence concerns in the absence of Mental Health Act ... powers is likely to depend heavily on multi-agency arrangements involving health services ..."

And the rest. You say that "wider public protection mechanisms" may have to be the primary means of managing risk, rather than Mental Health Act disposals. Can you explain that point of view for us? Why do we need to be looking at public protection mechanisms rather than mental health mechanisms to plug this gap? I'm not saying you are wrong, I just want to understand.

A. I think it goes back to -- and this is the area where I'm really not an expert on -- the fact that some individuals are not presenting with a mental health issue. They are presenting with other issues that might be causing them to be fixated on violence and so the Mental Health Act would not be the right thing to use. I think that's what that means.

Q. All right. Let's just look at the next paragraphs that you have got, just to help you. So, chiming with that:

"The existing ... framework [is] broadly effective ... where [the] violence risk is clearly linked to a qualifying mental disorder ... However, there is a potential gap where serious violence concerns arise but the individual either does not meet [the] detention criteria or refuses engagement ..."

You helpfully identify, for us, three particular circumstances where that gap appears to be present.

So:

"Children and young people whose risks arise primarily from trauma, adverse childhood experiences or behavioural difficulties rather than a detainable mental disorder."

A. Yes.

Q. So the behaviour may be risky, troubling, difficult, concerning, but you are drawing the Chair's attention to fact that, unless the cause of that can be shown to be -- or is truly suspected to be a detainable mental disorder, the Mental Health Act, as currently framed, can't operate?

A. Yes.

Q. (b) is the same point, I think, in a different way. And (c) is the particular concern of individuals who decline

participation in the assessment or treatment.

Can I offer this for your thought, in that circumstance, where perhaps there is a detainable mental health condition, but perhaps there isn't, and the person is declining to participate and poses a risk of harm, might that be a circumstance in which detention for assessment should be more likely to happen? The purpose of assessment is to decide the question, whether or not there is a detainable mental health condition. Sometimes there will be, sometimes there won't. The fact that there isn't at the end of an assessment doesn't mean it was wrong to assess.

In those circumstances that I'm setting out, the practitioner doesn't know and can't know -- they have a suspicion perhaps, there are some circumstances that suggest there may be -- but really what I'm drawing your attention to is, should the factor that the individual is refusing to co-operate be a factor within guidance that makes detention for assessment more likely, in those circumstances?

A. I don't feel qualified to answer that. But we will add that to the list, if that's appropriate and acceptable.

Q. Okay. Sir, is there anything you want to follow up on that particular -- no, just add it to the homework list. And just if we put 252 on the screen.

You say this -- and it is important that we don't lose sight of this -- essentially, demurring as you just have:

"Whether stronger powers are required is something that [needs] to be considered" carefully. But you give us this warning:

"... if the objective is to enable compulsory assessment, monitoring or intervention in respect of VFIs who do not meet the ... detention criteria ... [they] would ... require specific statutory provision ..."

And they would have to be "carefully balanced" individuals rights?

A. That is right.

Q. They would have to be proportionate?

A. Yes.

Q. You would have to think about the fact that these are individuals who may pose a risk but who have not done anything wrong at that point and we would be detaining them for the purposes of treatment, which is obviously --

A. Or assessment.

Q. -- or assessment, which is obviously a significant infringement of general liberties.

A. Yes.

Q. So you give us that warning and we have it well in mind. Thank you.

I will come to the final topic then, which is effectiveness of current laws and systems.

We can just see it there, if we just scroll down the page to 253. You draw our attention to the social services safeguarding framework, if I can call it that, that we have already looked at.

A. Yes.

Q. You tell us the fact that multi-agency working is embedded, but at 254 -- and we have looked at this, essentially, already -- when we are thinking about whether that's enough, over the page, please NHSW000046_0060, safeguarding has got these limits, you tell us:

"... 'at risk' in the 2014 Act ..."

So the direction of focus for the structures under that Act is for children who are experiencing the risk of abuse, rather than posing the risk?

A. Yes.

Q. And so, when we are thinking about the suitability of that structure to accommodate those individuals, we should be aware of that.

I have said to you already, the fact that those structures exist, the particular cohort, the particular

focus could be the subject of amendment?

A. Yes.

Q. It would require a statutory amendment, but --

A. And that would be the decision of the Welsh Government, yes.

Q. Yes, but that would be -- that's not the same of ripping everything up and building new structures?

A. No.

Q. That is expanding the scope of the structures that are there?

A. Yes.

Q. Is there anything in addition that you want to say about (b) and (c) that goes beyond what I have just set out in that discussion?

A. No, thank you.

Q. Essentially, they are aspects of the same thing, aren't they? Thank you. At page -- I will just give it for the Chair's note, but at paragraph 257, you remind us of the particular complexity of devolution in this circumstance and at 258 and 261, you describe the limitations in the current structures which we have been discussing as we go through and we won't do again.

But at page 62 NHSW000046_0062 and paragraph 262, you make some suggestions for improvements that would be practicable and make an effective difference.

Here, you are advocating on focusing on concerning behaviours, rather than particular psychiatric or neurodevelopmental conditions, to identify our cohort of concern. Have I encapsulated --

A. Yes, you have.

Q. That's the thing that you suggest that we should be doing. You also make the point that those behaviours are of wide scope and are displayed in education settings and at home.

A. Yes.

Q. Do you have recommendations to make as to how either existing or future structures can properly capture information about what's going on in the home? I have asked you about computers, but what about families?

A. So, the only way I can think about that is by how we use information from, for example, health visitors who actually see children in their home with their parents, to actually inform some of that, which happens in part already.

Other than that, not at the moment, but something, I think, to consider.

Q. I mean, health visitors -- a universal provision for health visitors is pretty limited, I think. It is right at the beginning of children's lives?

A. It is, I think it is up to the age of five. Don't quote

me.

Q. No. And so, perhaps not -- would not provide systemic coverage?

A. Towards that, no.

Q. One of the features of AR's case that some of our experts described as a really significant red flag is that his parents were afraid of him, and of the threat of violence that he posed to them, and generally. And I say that not in any way to excuse anything about it but that was one of the features that really struck some of our experts as particularly significant. Training and focus on those sorts of issues, not necessarily direct surveillance -- "surveillance" is the wrong word -- direct visiting and insight into a family by visit, but recognising the significance of information that is being provided by the family?

A. Yes.

Q. That's something that could be the subject of training --

A. Yes.

Q. -- and guidance --

A. Yes.

Q. -- to achieve that?

A. And also informing communities.

Q. Yes. So, to chime with the public health approach

that's -- VRU's approach to violence, to train the public, as to the sorts of features of concern --

A. Yes, and know where support is available from.

Q. Where support is available. Again, one of the pieces of expert evidence that we have received is that, in the preponderance of cases of terrorist or non-ideological mass casualty attacks, there is some leakage, some declaration from the person who perpetrates the violence to people around them as to what they are going to do or what they are planning to do. If there were a public health campaign about the significance of that sort of information -- it is obviously a long way from early intervention -- but it is a way in which that information could potentially be captured. Could you see that working?

A. Yes, I can.

Q. The other key ask that you make, in these paragraphs dealing with improvements, is to repeat the theme that we began with, the need for a definition, the need for conceptual clarity, the identification of risk factors, trajectories and interventions.

Just as a final thought, can you just reiterate for us, why that is so essential?

A. Sorry, I coughed in the middle of that.

Q. No, no. So, your key ask is about needing a definition,

conceptual clarity, risk factors, trajectories and interventions that could interdict those interventions.

A. Yes.

Q. Just reiterate for us why that is so core, why that is essential?

A. I think mainly because -- I think you have taken, through my statement, on a journey about the things that would be or would not be helpful. I think for that -- could you pull this up? Sorry, would you mind?

Q. Can you just scroll up, sorry. So, that was the summary I think, the paragraph that relates to that -- that was the summary I have given you about capturing education and the family voice. If we went to 264, just over the page NHSW000046_0063, and 265. That is where you are talking I think about conceptual clarity and the need for it.

A. And I think the bit about -- I was trying to find where it is -- the bit about conceptual clarity, is understanding for me how we can visualise the multi-agency system working, the clarity of that, the clarity of how all this fits together and fits with what we have got.

Q. Because at the moment, we are talking in hypotheticals about where this is going to fit.

A. Yes, we are. So --

Q. But in the real world, you need -- if you are going to work out where this fits in the multi-agency structure, you need to know what you are aiming at?

A. We do and how we are going to do it and how we are going to treat it.

Q. Is there anything in here that I have omitted to ask you about, in terms of your recommendations?

A. No, I don't believe so. Thank you.

MR JAMIESON: Sir, do you have any questions at this stage before I look to my left? Shall I do that first?

SIR ADRIAN FULFORD: I have just a couple of things. Thank you very much, Mr Jamieson.

Questions by SIR ADRIAN FULFORD

SIR ADRIAN FULFORD: I'm going to be a little bit like a dog with a bone for a minute and go back to definitions. You have been very clear that what you don't like is the label "extremist" because that is sort of redolent of terrorist, or something to do with ideology?

A. Yes.

SIR ADRIAN FULFORD: I completely understand that. If we go back to the Home Office definition, so NIEV, "non-ideological extreme violence", so not extremist, but "extreme", just before I put the question, I think the real concern is that one captures a level of seriousness which means that we are not going to be

collecting in such a large group as to be unmanageable. So, you know, sort of, gangs not liking each other, young people who fall out with each other who have uttered threats, but so as to try to get the seriousness of it at an elevated state.

Just as a catchphrase, would you -- would that work for you, "non-ideological extreme violence" as the tag? Or to think about it?

A. I think to think about it. We received obviously the document from October 6, where that begins to be laid out and we are working through what that actually means and at some speed. The only caveat would be what I said before.

SIR ADRIAN FULFORD: Exactly. What I would -- so the second part of my question on this is that, if the tag works in terms of explaining, in a very short form, what one's interested in, then, really in line with what we talked about earlier, that one would have, sitting underneath that, potentially, not the definition that's been provided, with all the intention and all the public display and all the rest of it, but instead the notion of there being a real risk that the individual may be drawn in to some form of extreme violence, for all of the various reasons that you have identified in your report. So not restricting it in a way that would be

artificial and would leave some outside, but making it sufficiently broad so that frontline workers know what they are looking at.

A. Yes.

SIR ADRIAN FULFORD: Can I ask you to think about that in particular?

A. Yes.

SIR ADRIAN FULFORD: So that we get -- potentially get away from the difficulties which you and a number of others have identified in relation to "extremist", but come back to the word "extreme"?

A. Yes, happy to do that, sir.

SIR ADRIAN FULFORD: My other thing is this. Can we, just for a moment, imagine -- because you have obviously -- I'm not asking you to have read every single word of the Phase 1 report, but you are familiar, I imagine, with the sort of general circumstances.

Someone like AR, aged 17, who is identified in Wales as posing this kind of risk. So, whether it's come from the police, or a visiting health visitor who happens to be there seeing a younger sibling, somebody from social services, or the school. Under present arrangements in Wales -- so we now know what we are looking for and we want to do something about it -- can you, in fairly straightforward terms, explain to me how, in Wales,

somebody in that position would be dealt with? What would happen to them?

A. In terms of what would happen if we actually found somebody like that?

SIR ADRIAN FULFORD: Yes, you have got a teacher who is reporting back, "I found somebody who I believe there is a real risk they are in this cohort" and then the question is: what are we going to do? I'm curious to know, in practical terms, whether you think -- what I'm really aiming at, is whether you think something would have happened in Wales which conspicuously didn't happen in the north of England.

A. I suppose my concern in answering that is whether what would be consistent throughout Wales.

SIR ADRIAN FULFORD: Right. I see.

A. So I think -- and I sit here and recollect the case in Wales that.

SIR ADRIAN FULFORD: Mr Jamieson referred to.

A. Mr Jamieson referred to and, you know, would I feel comfortable saying: it could never happen in Wales because of x, y and z? And I don't think I can because actually, that case demonstrates that we still have got some loopholes.

SIR ADRIAN FULFORD: Could we go to what you would view as, without naming names, one of your better functioning

areas? So if everything was working, under present arrangements, as you believe they ought to. Any thoughts?

A. Well, I suppose --

SIR ADRIAN FULFORD: Or again, is this unfair? I haven't given you any warning of this. Would you like to come back to us?

A. Yes, would that be okay? I say that because (1) you are asking some operational details that I don't have full understanding of, and (2) I think it is still related to who knows what about dealing with individuals who might have a VFI, without us actually having coined that with appropriate risk assessments. So what I have said in my statement is, there are risk assessments that could identify. What we haven't said is "would". And I think that is why I hesitate slightly.

SIR ADRIAN FULFORD: Yes. What I really have in mind is one's gone beyond the risk assessment stage, one has identified somebody who, certainly at least one reliable worker has said, "This person is, in my view, a real risk of this kind of thing". And really this then leads me very neatly to the last question I have got which is this: one of the potentially really significant things in relation to how AR was handled was that for very, very long periods of time, in one sense, he wasn't

really handled at all, he was just kind of left and he spent a huge amount of time by himself without any obvious productive activity.

And this really -- so, one thing I'm going to ask you to do is whether, in those circumstances, somebody who has been identified as being a risk, whether you would have thought, within Wales, there would have been a different reaction to him, under -- in the sort of best performing parts of the principality, something different was happening.

The other aspect is this, Mr Jamieson has absolutely rightly asked you about the sort of problem that any compulsion under the Mental Health Act is very specific.

A. Yes.

SIR ADRIAN FULFORD: And we have heard quite a lot of evidence about how there's really an absence of -- even in relation to the sort of criminal justice sphere, that -- I am sure that the most likely answer to that is that, in this country, we don't believe in detaining people for indefinite periods of time simply because it is apprehended that they might do something very bad in the future.

One of the striking things about AR was that nobody felt able, so those visiting from authority didn't feel able to go upstairs, knock on the door, and talk to him.

So there was -- they felt that that would be -- underneath it, maybe a form of trespass really, going into a part of his parent's house, when he had not -- they had not been invited to do so.

So, when you are thinking about this area and coming back to us, I would be interested in any views that may emerge in relation to a kind of halfway house, that one is not talking about removing the individual necessarily from the home, but one is creating a sort of enforceable possibility, that at least an attempt can be made to engage with the individual?

A. Okay.

SIR ADRIAN FULFORD: Do you see what I mean?

A. Yes, I absolutely see what you mean.

SIR ADRIAN FULFORD: Knock on the door and just see whether they will talk to you. That that, either in guidance or if it is needed, some kind of legislative permission, would at least enable that to happen, so that you can start to get a sense of what may be going on?

A. Yes, we will consider that.

SIR ADRIAN FULFORD: I hope this isn't too onerous.

A. No, not at all.

SIR ADRIAN FULFORD: Thank you very much.

A. Thank you.

SIR ADRIAN FULFORD: Very helpful. Very grateful for your

attendance and for your witness statement. I think that then brings us to a pause, Mr Jamieson?

MR JAMIESON: It does, sir. In mitigation of my earlier crime of the mammoth first session, we have finished some time before 1 o'clock. May I suggest we take lunch there for the full hour?

SIR ADRIAN FULFORD: Certainly, and sit again at 1.35 pm?

MR JAMIESON: 1.35 pm, sir.

SIR ADRIAN FULFORD: Yes, we certainly will. Then I will rise.

(12.35 pm)

(The short adjournment)

(1.35 pm)

SIR ADRIAN FULFORD: Can you remain standing just for a moment, thank you.

DR NINA CHAMPANERI (affirmed)

SIR ADRIAN FULFORD: Thank you very much. Please have a seat. Yes, Mr Moss.

Questions by MR MOSS

MR MOSS: Thank you, sir. Doctor, just start by giving us your full name, if you would, please.

A. It is Dr Nina Champaneri.

Q. Thank you. Dr Champaneri, if we could have on screen, please, DNC000002, we have your statement to Phase 2 of this Inquiry and if we go to page 11 DNC000002_0011 of

the statement, please, we see that this is a statement which you signed on 31 July of this year. Can I just ask you to confirm that the contents of this statement are true to the best of your knowledge and belief?

A. Correct.

Q. Thank you. If we go to page 1 DNC000002_0001, paragraph 1 of your statement, we see set out there, right at the start, that by way of professional background, I think you are a consultant child and adolescent psychiatrist, registered with the GMC, obviously, is that right?

A. Correct.

Q. We have seen, in relation to statements from a number of other witnesses in this area, that they describe themselves as dual qualified, with accreditation in both child and adolescent psychiatry and also forensic psychiatry. As we will come on to, you, I think, work in community Forensic CAMHS, do you have that dual accreditation or not?

A. No, I don't.

Q. Thank you. I don't ask that in any way to undermine your expertise because, as we will come on to, yours is significant in that area.

So, if we just look at paragraph 3, you give your professional background in terms of where you did your

training. It is all set out there. I don't need to ask you anything about that.

You also explain that you are an approved clinician under the Mental Health Act. Just explain, in brief terms, what the effect of that is?

A. An approved clinician is where you have powers, if you were -- part of it is being a section 12 approved doctor. So you automatically have section 12 approval to be able to detain children, young people, adults in the community. But also, if there was a young person or adult in hospital, then you could act as their responsible clinician.

Q. And I said that I would come back to your seniority and experience and we start with the fact, see paragraph 4, that you have over 20 years' experience in Child and Adolescent Mental Health Services, I think?

A. That is correct.

Q. Thank you. And on the same theme, please, if we could just look at the bottom of the page, you are currently, I think, employed by the Birmingham and Solihull Mental Health NHS Foundation Trust as a consultant child and adolescent psychiatrist in the West Midlands community Forensic CAMHS team. So there, we see that community Forensic CAMHS experience. But you also say, relevant to one of the reasons for our asking you to give

evidence, it is at the very foot of the page:
"I hold a leadership role with NHS ..."
Over the page DNC000002_0002:
"... England as Co-National Clinical lead for Community Forensic CAMHS ..."
So just explain what that leadership role entails?
A. Sure. So, I share the clinical lead role with a colleague from another community Forensic CAMHS team but I work with NHS England, so the commissioning team within NHS England, and really it's a supportive role around bringing together a clinical network, so a clinical network of 15 community Forensic CAMHS teams in England, supporting the CPD, supporting the training, any clinical queries and also development of any sort of service specifications and frameworks. So it is more a supportive role.
Q. Thank you. Then, relevant, too, to our reasons for approaching you to assist the Inquiry, in paragraph 6 your particular areas of expertise are set out. And that includes, as you have set out there, "assessment of young people with neurodevelopmental disorders, personality difficulties, trauma, psychosis, [and] severe mental illness and complex safeguarding concerns".
But it also, I think, includes those involved with

the youth justice system, secure and custodial placements and secure hospitals, is that right?
A. That is correct.
Q. Within that, have you had experience of dealing with those who, amongst other presenting concerns, have a significant risk of violence to others?
A. Yes.
Q. Thank you. So, against all of that background and expertise, can I ask you about our first substantive topic, which is the vexed questions of definitions of VFIs, however they are to be termed. If we look at paragraph 8, just a little bit further down on the same page. You start off by saying that:
"The term ... (VFI) is being used within clinical practice in FCAMHS."
But you go on to add:
"There is no agreed definition however and this is not a recognised Psychiatric diagnosis in accordance with ..."
Either ICD 10, or the US equivalent DSM; is that right?
A. That is correct.
Q. This may be a difficult question, but how has "violence-fixated individuals" come to be a term that has been used in FCAMHS, if it is not a recognised

psychiatric diagnosis? Is that because it had an element of currency within Government departments, or what?
A. I would say that is correct but also I think we use it more to describe a set of behaviours, rather than an individual. So, an individual that comes into forensic CAMHS usually does have a mental health need or a neurodevelopmental need, but display a set of behaviours and I think that's how we tend to use that term. So we do use "violence-fixated individuals" and "violence-fixated behaviours" probably interchangeably to describe a subset of young people who come into the service.
Q. Thank you. Should we take it from your reference to the fact there's no agreed definition, that in broad terms you think that an agreed definition would be helpful?
A. Absolutely.
Q. You say "absolutely". Why are you strongly of that view?
A. I think we think about different things -- different agencies think about different things when they come across the term "violence fixation" or "violence-fixated" individuals or behaviours. Certainly, say, from a psychiatric sense or a mental health sense, when we think about the word, for example

"fixation", that might lead us to think about certain neurodevelopmental disorders or mental health disorders. But "fixation" in another setting, outside of health, might mean something different. So I think then, when we -- and I guess, in community Forensic CAMHS, we work very closely with the multi-agency. So when other agencies are using that term and we are using that term, we might be talking about completely different things and not necessarily communicating the risk effectively.
Q. And so -- my layperson's summary and perhaps interpretation of what you have just said -- but should we understand that fixation has a clinical meaning, that could arise, for example, in psychosis or certain types of delusional belief and has a clinical meaning, but other agencies, in particular, may use that phrase "fixation" to connote more a fascination, without any suggestion of mental disorder?
A. Yes, that is possible.
Q. And it is that sort of confusion of terms?
A. Yes.
Q. So amongst a number of our witnesses, Mr Basu formerly of Counter Terrorism Police was one of those, one suggestion is that one should think about violence-fascinated individuals rather than fixated because "violence fascination" gets away from the

potential confusion with clinical terms.

So we will come onto other definitions completely but do you think that if one is going to use "VFI" at all, "violence-fascinated" is better than that "violence-fixated"?

A. It could be used. I think the difficulty with all of the terms is that you might then miss a section of -- for us, for young people. So if they are fascinated, then they may have a slight interest in something but then, are you then missing those -- that subset that maybe are fixated? So I think different schools of thought and you are trying to, I guess, capture that entire group, not missing anyone out.

So, yes, I think there are different schools of thought on it.

Q. Thank you. We know that since "VFIs" was an early term being used, sometimes as fixated, sometimes as fascinated, things have moved on. I think you are aware that the Home Office has published interim guidance, HOM001011. As I think you will be aware, we have been asking all witnesses in this topic about this.

So if we could go to page 2 HOM001011_0002 and paragraph 6. The most recent attempt by Government to give what they stress is a non-statutory, not legal, and not operational and only a working definition is what we

see at the bottom of the screen. So:

"The use or threat of extreme violence, not driven by a clear ideological purpose, which is communicative in nature and intended to shock, intimidate, or outrage the public or a section of the public."

Before I ask you anything about that, Mr Emmett, as the senior Home Office witness, stressed that the thinking with this definition is that is the end act of violence and one should be thinking about those who may be on the pathway towards that sort of an act. That's the cohort of interest. But the ultimate act that one is seeking to avoid and intervene is as per the description.

So, with that background caveat, what is your view on this working definition?

A. I think, from my clinical point of view, I think the first half of that is very helpful, so where it goes up to the "communicative in nature". I think what I see, and probably my colleagues see in community Forensic CAMHS, is that the second part of that, so the "intended to shock, intimidate or outrage the public", we don't necessarily see that in all of the cases that are presenting to us.

So, for example, we might have young people that are fascinated, fixated on violence but they are not

necessarily wanting to use that in a way to shock or outrage. So they may be fixated on one particular person or a couple of people. So, I think then this definition would potentially exclude that group.

Q. Thank you. I think we know from Mr Emmett's statement that the Home Office and wider Government thinking that sits behind this is that the intent could be overt or implicit and in some cases, you could imply that the intention was to shock and intimidate without it being explicit or overt and that the guidance would make that clear.

But should we understand that even with that, you have reservations about the "intent" element of this definition?

A. I think so. I think you would exclude a group of young people potentially that we see with this definition.

Q. Thank you. As you may know, Professor Cassam in our seminars put forward an alternative suggestion of "non-ideological violent extremist" and with witnesses, we have been exploring, if that is a description of the individual who might be carrying out this type of act of violence, whether the cohort of concern could be described as those vulnerable to being drawn into non-ideological violent extremism. Do you have a view on that as an alternative?

A. I think my view is that I can see where he's going with that definition, so drawing that group that are vulnerable and that's the group that we see. I think, again, from a clinical perspective, I do have difficulties with the term "extremist" because if I think about, again, the cohort that come into community FCAMHS, our typical age group -- and I'm not suggesting that our age group is -- you know, we get from age 10 onwards, sometimes younger, I'm not suggesting that they all have violence-fixated behaviours, but I think if you had a younger cohort and labelling a younger person as an extremist, you know, when they are developmentally maturing, I think I would have some difficulties with that. So I don't have difficulties with the fact that he wants to bring in that vulnerable cohort, but it is maybe just that word.

Q. Yes. So that's really partly, I suppose, a risk of stigmatising, but also a bit more than that, maybe counterproductive with very young patients, as I have understood your evidence. In fact, Professor Cassam was giving "non-ideological extremist" as his suggested definition and it is something of an extension that we as an Inquiry team are exploring, whether you can try to capture the cohort by adding on "those vulnerable to being drawn into" that category.

Your ten or 11-year-old who sadly, has got involved in, let's say, gore or violent material online and a fascination with it, while wanting to avoid the risk of stigmatising a very young child in reality, doesn't "vulnerable to being drawn into that" capture the risk there, that, unless there is an intervention, they may end up going down that path?

A. Yes, I agree with that.

Q. Thank you. Like our previous witness though, we sense a hesitation or a concern about the use of the phrase "extremist" or "extremism" in that.

Do FCAMHS -- and I appreciate that you have a co-lead function, you can't speak completely for them, but do you have a better formulation?

A. I think what we are tending to use is "violence-fixated behaviours". Now, again, there is no definition that sits behind that but I think that could be expanded to think about sort of subcategories of that. So that could be taken forward and I think that seems to be what we are using more often in the absence of an agreed definition nationally.

Q. I think part of -- certainly, as I understood it -- a matter for the Chair, obviously, ultimately -- but as I understood the evidence that was being given by the Home Office, reflecting the cross-government thinking,

they had sought to move away from any concept of violence-fixated or violence-fascinated individuals and they might extend that perhaps to violence-fixated behaviours because -- my summary -- they see that as a typical symptom, rather than a defining characteristic of the cohort. In other words, that might be present in many of the cases but it is not really part of the definition of the cohort of concern.

So the concept of "non-ideological extreme violence", for example, includes, the sort of Com networks, who may be rather deliberately using extreme violence, to some extent for its own sake, rather than necessarily out of any fixation or violence about it. So it captures that nihilistic group who don't necessarily have a fascination with violence but nevertheless are perpetrating and encouraging extreme violence, without necessarily displaying fascination. And it is that area of concern, trying to find a catch-all term that covers that group. So, in one sense, would you agree that "violence-fascinated behaviours", if one was thinking about Com networks, doesn't particularly marry well there?

A. No, I would agree.

Q. Thank you. If, as with other witnesses, this exchange leads to thinking by you or your colleagues in

leadership roles in FCAMHS, have further thoughts on an appropriate short-form definition, obviously, there would have to be explanatory text that sat behind it, but it would be extremely useful because it may be thought that if there was a simple straightforward solution to this, it would have been alighted upon much sooner. It is a difficult issue and we would appreciate your further assistance.

A. No, it is and I think we can take that back through the network as well.

Q. Thank you. I think, getting ahead of the likely intervention from the Chair, a lot of thought has been going into this for a long time and certainly to assist the Inquiry, I think before Christmas, because it might be thought that progress needs now to be made on this important issue urgently. So any assistance you can give in relation to that would be helpful.

A. Yes.

Q. Could we just look, for contrast and further assistance, please, at DHH000001, this is the statement of Dr Heidi Hales, who I anticipate you will be familiar with as a clinician. If we just look at paragraph 1, she says:

"I am a consultant psychiatrist, dual trained in adolescent and forensic psychiatry."

So there is the point I was touching upon earlier. So that's who she is in very short introduction.

If we look at page 2 DHH000001_0002, paragraph 4. She says:

"... I have not used the term 'Violence Fixated Individuals' ... in my clinical or research practice. However, I am familiar with assessing children, young people and adults for whom there are concerns about the risk they pose to others."

It goes on to say, at the bottom of that paragraph, coming to the point about definitions:

"In my opinion, whilst professionals could work together to formulate a term (such as VFI) and its definition, ideologies and identities of young people are currently changing at such a speed that definitions become outdated quickly. More important are formulations around risk behaviours; which consider the what, who, why, where and when of any risk behaviour, alongside a narrative of any escalation and trigger factors to enable us to consider the individual and their particular needs."

Do you have an observation on Dr Hales' views there?

A. I absolutely agree with the formulation. You know, that needs to happen for a young person that is presenting with those behaviours, but I think there's something

around when you are receiving a referral, to know what it is you are dealing with and having a definition that you can then expand on later, either through subcategories or through that formulation, would be helpful. But, a formulation is often quite a long piece of work and it would be difficult to kind of communicate that to a multi-agency.

Q. Yes, and that may be something -- so, Dr Broughton yesterday for NHS England was referring, I think, to descriptive frameworks or narrative frameworks, thinking about that as a psychiatrist. Of course, they are useful but they are not well-suited to a quick, one line or so, definition that can be used as a short-form for the cohort of concern, would you agree?

A. Agreed.

Q. Although you have to develop them in the individual patient?

A. Yes.

Q. Thank you. Could we go back to your statement please, doctor, might we just look at page 2 DNC000002_0002, please. The bottom of the page. You say that you have not personally undertaken or contributed to statistical analysis, but you add this:

"... as part of my role as co-National Clinical Lead for FCAMHS, NHS England hold an annual review process.

This reviews each FCAMHS service in England against the national FCAMHS service specification."

Then you say DNC000002_0003 that:

"In [the] years 2024-2026 every team has been requested to record the numbers of children and young people under the age of 18 who present with these behaviours. Although there has been no statistical analysis performed on this data, each team has recorded seeing increasing numbers of children and young people with this presentation."

Now, several questions arising out of that. First of all, what is your understanding as to the reason behind the increasing numbers of children and young people with this presentation? Is that better clinical awareness, perhaps following Southport or the programme Adolescence, or is that a substantive increase in prevalence?

A. I think we have definitely seen an increase since Southport and I think most teams have reported that. I guess, just to say that, you will have noted that we have only looked at this particular cohort since 2024. So, we wouldn't have collected any data on them, if they were prevalent from before then, in the community FCAMHS cohort.

Q. Thank you. Does it follow that, by the dates that have

been taken, it seems to point to a genuine increase, although over a relatively short period that the data has been taken?

A. Yes.

Q. You will forgive me for asking this, how are you getting this information if there isn't a definition?

A. Yes, and that's a very good question and I think that's where we rely on the "violence-fixated behaviours" but it is open to interpretation. FCAMHS, if I could go back, was set up, commissioned in England for the whole of England from 2018 and as part of that, there is a national service specification and since 2018, all the teams have recorded the numbers of types of presentations that they are seeing. So there are standard presentations that we would have seen from 2018.

And one of those categories would have been "violence and aggression". Since 2024, we have asked teams to record sort of violence fixation or violence-fixated behaviours, but there may be some overlap between that category of "physical aggression". So I think these aren't validated numbers. They are sort of more, in the absence of a definition, we are just asking team to record what they are seeing.

Q. Thank you. You say that there has not been statistical

analysis performed on this data, why is that?

A. There was. In 2018, when community FCAMHS was first commissioned, the Anna Freud Centre did an evaluation with statistical analysis of the cases that came through and I think that was published in around 2020. So there is that historical Anna Freud report. I guess, with the current recording around violence-fixated behaviours, there isn't an agreed definition, so we can't be sure that those numbers are accurately reflecting that group. But we can, anecdotally, say that teams are reporting an increase in those types of behaviours.

Q. Thank you. Are you able to give any indication, with all those caveats, on what the numbers show, in raw terms?

A. I'm not able to give an indication but we do have the numbers and I am sure that would be happy -- I am sure NHS England would be happy to share them.

Q. I think, even with those caveats, that would be helpful if I can ask you to follow up in relation to that but we will take the figures with the caveats that you have rightly drawn attention to.

Presumably, with an agreed definition, hopefully nationwide, although it may not then become perfect, that data would then become more reliable because, subject to points about interpretation, everyone will be

working to the same understanding?
A. Agreed.
Q. Does that, of itself, show the dangers of not having a definition? Some witnesses have talked, I think, in a theoretical sense, about the difficulties of obtaining reliable data on the effectiveness of interventions. But this is a solid example of it, in that you are asking people to give numbers of cases in this area but without an agreed definition and that automatically, as I have understood your evidence, leads you to say, "But the data may be unreliable because we don't have a shared common understanding"?
A. Agreed.
Q. Thank you. I would like to turn, next please, to the question of Mental Health Act powers. I wonder if we could have the Phase 1 report, please, second volume, that's CHAIR000002. Could we go to page 292 CHAIR000002_0292 and could I just ask for the Chair's indulgence and that of you doctor and others, because I'm going to read some reasonably significant passages here but it is the most effective way to get the background back in front of our minds.
So this is the learned Chair's finding about Dr Irani. I think you took a direct interest, did you not, in the Phase 1 evidence?

A. Yes.
Q. And indeed, in what Dr Irani was saying because of your professional interest?
A. Yes.
Q. So you may be familiar with this, but:
"Dr Irani noted that, by this time ..."
And we are talking here about the latter period in the months leading up to the attack, in short:
"... AR was out with parental control, had been presenting a risk in the family home, was withdrawn, spent considerable periods of time on his computer and was not looking after himself, going considerable periods without showering (I note that although Dr Molyneux was informed that AR had showered on 27 September 2023, a single instance of AR showering does not by itself demonstrate that he had started to look after himself properly: Dr Molyneux's view on this, [was] that, 'if a parent is saying it is good news here, good news sounds like good news,' was facile and unrealistic). Dr Irani noted that, when AR did not attend the clinic and refused to be seen at home, no one had access to his mental state, or knowledge of what he was doing in his room, in order to inform his risk assessment. Instead, parental information was relied upon. As a result, Dr Irani considered that

an intervention should have been carried out to review AR's risk of harm to others either at this point or before AR's discharge. She considered that concerns should have been raised with the relevant safeguarding lead, liaison with Children's Social Care and, given the historic risks (in practice, factors which had been lost and were unknown to those treating AR at this stage) and deterioration in presentation ..."
Here, perhaps, is the key point:
"... there should have been consideration of a Mental Health Act assessment. She accepted that there would be a range of views as to whether an assessment should have been attempted and that it was likely that such an assessment would not have led to evidence to suggest a need for hospital treatment. However, it would have allowed an in-depth and face-to-face assessment of AR, including of his risk to others."
Then, if we may turn, please, to page 315 CHAIR000002_0315, paragraph 364. The learned Chair went on later, to say this:
"I have set out Dr Irani's view that AR should have been subject to a Mental Health Act assessment."
Pausing the quote there. That's the passage that we have just looked at a moment ago, all right?
"Underlying Dr Irani's view was that AR's case was

highly concerning because he had not been physically seen for a considerable period of time by a mental health professional (or indeed by other professionals). He was, instead, essentially locked away in his own room, refusing to meet with professional visitors. However, the challenge in this area is that the likely assessment of AR at this stage would have been that there was a lack of evidence that he was suffering from a recognised mental illness (such as severe depression or psychosis) which was potentially treatable in a psychiatric hospital. On that basis there was no Mental Health Act power to assess AR."
Then over the page CHAIR000002_0316, please:
"Accordingly, Dr Irani accepted that the decision not to carry out a Mental Health Act assessment was a reasonable exercise of professional judgement. As NHS England have observed in their closing statement, the use of a Mental Health Act assessment in such a situation represents only an imperfect solution. In reality, such an assessment may have required a somewhat artificial justification relying on the possibility that AR may have been psychotic when isolating himself in late 2023 to early 2024, even though no clinician had considered that was the case, or had raised it with as a possibility at any stage since AR was first arrested

in December 2019. Indeed, even then, on examination, psychosis was ruled out. As both Dr Irani and NHS England acknowledge, this gives rise to a wider and difficult question as to whether there is a gap in the legislation. There is a risk of a cohort of cases (of which AR was arguably one) where mental health clinicians cannot assess a child or [a] young person in the community despite the fact that they have completely self-isolated at home, are not attending education, have mixed neurodivergence and anxiety conditions (or similar) with marked risks of violence, and are not meeting the current thresholds for a Mental Health Act assessment. The issues to which this gives rise are complex and beyond the scope of the Inquiry's Phase 1. I therefore make the following recommendation for matters to be covered in Phase 2."

And that led to recommendation 56, that this phase of the Inquiry:

"... should consider whether further legislative change is required to allow mental health clinicians to assess children and young people who are isolated from professional support and may pose a risk of violence, particularly where powers under the Mental Health Act 1983, as amended by the ... [2025 Act], do not permit assessment or detention."

Now, with apologies for the long introduction. There is no better way, really, of getting to the crux of the problem than reflecting the content directly of the Phase 1 report.

Sir, for your note, section 2, we don't need to bring it up, but the legislation here, section 2, is at ILT000374 at page 3.

SIR ADRIAN FULFORD: Thank you.

MR MOSS: And the section 3 powers at page 5, obviously, of the same document. Doctor, you don't need those on screen, you know them and work with them every day. Could I invite your initial observations in this difficult area, first of all?

A. Sure. I think going back to the original statement that Dr Irani made around whether a Mental Health Act assessment should have been considered, I would think that that would be an appropriate use of an assessment under the Mental Health Act.

Q. Thank you. Can you expand upon why?

A. I think, going back to the original statement that Dr Irani had made, around the fact that AR was isolating himself in his room, there was no real professional eyes on him, I think there was a history around parents maybe using disguised compliance, maybe not necessarily being completely truthful about things and the fact that it

seems like his self care had deteriorated. I would -- yes, I would be concerned about a potential psychotic illness but I would also be concerned about a mood disorder and also, given the fact that I think AR had had periods on medication for mood and anxiety, I think those things together would make me wonder around a deterioration in his mental health and if professionals weren't able to see him, for example, with him not attending appointments or not allowing professionals in, then, for me, that would be an appropriate use of the Mental Health Act. For an assessment under the Mental Health Act. I'm not saying he would then meet the criteria for detention but I think it would be an appropriate use of an assessment under the Mental Health Act.

Q. Thank you. So initially, that would be an appropriate use of section 2 powers; is that what you are saying?

A. Yes, an assessment under section 2.

Q. Yes, and in real-world practice, how would that play out? I mean, if the situation -- let's take it away from the immediate circumstances of AR, but envisage a broadly similar situation in which you have, perhaps partially complying parents, but a young person who, whenever a clinician attends -- so perhaps they attend to seek to carry out an assessment under section 2 --

just refuses to come out of their room; where do you go next?

A. I think if I could take it back a step, if I may. With the Mental Health Act assessment, it is not just one professional, it is three professionals. So you have two doctors who are section 12 approved, one who would most likely know that young person, an independent doctor and an approved mental health practitioner.

Q. The AMP?

A. Yes, the AMP, who typically is a social worker by background. So you already have an MDT there; it is not one person's judgement, it is three people's judgement. You have the medical view, so thinking about whether there is a mental disorder there, under the Act. But you have also got the AMP view and they would collect that information from family, they would be professionally curious to ask about how the family are finding things at home, is there anything amiss. You would have that collateral information and all that background information around risk before you even entered the property.

Q. I understand that and I am sure I was taking it too shortly.

A. Sorry.

Q. No, not at all. But allowing for all of that, because

the learned Chair has a familiarity with those processes and I was taking it too shortly. Of course, all of that has to happen and you have to have the right number of clinicians approving. But you might still then have the difficulty that the adolescent has disengaged and is not willing to be seen. So, are you then into section 135 territory?

A. If you -- it depends on -- I guess, if you are in the home and you are significantly concerned, then you do have powers, under section 135, to be able to convey to a place of safety, to be able to assess. I am not saying that that would be the case in this case but theoretically, that is a power that is available.

I think it would be difficult if you were in the home and he was choosing not to engage but at least that allows you a window of going into the home, being able to understand what is going on in the surroundings, have an appraisal of the risk, to be able to then inform further steps, which might trigger a sort of multi-agency approach, not necessarily the Mental Health Act, but thinking about what other agencies could become involved at that stage.

Q. All right. So -- because we know that, not just in relation to mental health workers but other forms of support workers, eventually the case did become that AR

was refusing to see professionals, whether attending educators or social care workers or mental health professionals.

Should we understand that -- again, you must correct me if I have got this wrong -- but that the team, in that situation, having gone into the home, would have to realistically probably gather such information as they could and then withdraw and reassess the position as to whether they wanted to apply for the use of section 135 powers, which will effectively mean the use of the police ultimately to detain, or whether the better route was to not -- to go down what would ultimately potentially be the use of force, to get the young person into a place of safety so the assessment could be carried out, but instead to think: right, we may have to go down different multi-agency options here and use different powers. You would have to have a meeting to discuss those options. Is that the reality of what ought to happen?

A. Yes.

Q. If we go back to your own statement, please, at page 3 DNC000002_0003, paragraph 12. You make clear, in this context, that the 1983 Act offers the ability to detain an individual only where they are suffering from a mental disorder, section 2, for 28 days for

assessment, or for assessment and treatment, section 3. But:

"A fixation on violence, attack planning, or a risk of serious violence does not, in itself, provide a lawful basis for detention under the ... Act, in the absence of a Mental Disorder."

Now, that obviously underlines the issues that we have just been exploring.

If we look at your paragraph 20 DNC000002_0004, you say:

"I have personally not experienced a situation where I have assessed an individual who does not have a mental disorder, within the ..."

Mental Health Act definition:

"... but are assessed as posing a risk of harm to others."

Now, I wanted to think about that and explore it with you.

Is that because, as a consultant psychiatrist working in a community FCAMHS team, those who are referred to you, who get through your door, are effectively self-selecting, in that they will have a mental disorder; or are you saying, in practice, that the two come together, this sort of risk of harm in practice only does arise where there's some form of

mental disorder?

A. I think it is the former. In my clinical practice, I would -- people don't come into FCAMHS unless they have some form of mental disorder or neurodevelopmental condition. So that is the cohort of young people that we see and even in other clinical practice, in terms of if I'm, say, on call, and that doesn't necessarily cover community FCAMHS, the cohort of people that we would see would have some form of mental disorder because they are coming into a mental health service for an assessment.

Q. Yes, thank you. I'm afraid, as lawyers, we have a tendency to look at issues like this with a standard of proof in mind, so: does one consider there is a mental disorder on the balance of probabilities or is there a reason to suspect, or are you sure that there is a mental disorder?

Can you just help us with what the clinical best practice is for the exercise, for example, of section 2 powers. How satisfied do the authorised clinicians need to be of the existence of a mental disorder in order to support the use of section 2 powers?

A. You would need to -- there would need to be a mental disorder and that you are suspecting that there is a mental disorder but of a nature and degree. So it is of a level that would require treatment in hospital. So

I think that's what you are looking for. I guess, going back to my previous statement, I have seen young people and adults where I have done a Mental Health Act assessment and they haven't been detained. They have got a mental disorder but might not have been to a nature and degree that they need to be in hospital.

Q. Okay. So I think you are helpfully alighting on two different aspects of that and I would just like to dissect those two issues a little bit.

One aspect is that you're correctly reminding us that it is not any mental disorder, but a mental disorder of a nature and degree that would warrant treatment in hospital, yes?

A. Yes.

Q. But the other aspect, which you indicated in your answer is, it would need to be a mental disorder that you are suspecting. Is that sufficient? A good faith suspicion that there may be, is that enough?

A. Yes, because essentially, you are saying that there is a mental disorder that would require them to be in hospital. So you are saying -- I guess, when you are going into -- I'm probably not phrasing this correctly, you are going in and you are suspecting there is a mental disorder. But once you have done that assessment, you are saying that there is a mental

disorder.

Q. That there is. But in order to justify seeking to do the assessment -- would this be right -- is a properly informed suspicion or reasonable belief sufficient to justify wanting to carry out an assessment?

A. Yes.

Q. Because it is in that context, of course, in AR's case, there was a difficulty of things that ought to have been on the record, ought to have been passed on and ought to have been known by clinicians, that were not in the minds of the clinicians at the time and that had an impact on what, for example, Dr Molyneux knew and aspects of that were bad record-keeping. Another aspect of that were an element of not reading into the prior notes. We explored that and it is dealt with in the report.

But as things were with AR, it would seem that his treating clinicians may have said at the time: realistically, we would think on balance he's probably not suffering from a mental disorder of a nature and severity that would warrant treatment in hospital because whenever we have seen him previously, when he was allowing us to see him, we assessed that there were anxiety needs, a need for talking therapy or CBT, had he been willing to do it. But he wasn't suffering from

a mental disorder.

So, really what we are trying to explore is, if that may be a common feeling among psychiatrists, is that level of thinking a problem? Does there need to be more robust advice to treating psychiatrists, to, in a case where you can't get eyes on, to be quite robust about the potential need for an assessment? Because it didn't seem to work well in AR's case.

A. I think it is about taking all the information that you have available. So, in this case, it felt that there was a change in that presentation, in that he wasn't, he was self-isolating. There was a deterioration in his self care. So those two things in itself, made that presentation different to before and I guess, I would be wondering whether that was taken into account by the initial clinicians, in the background of what you have mentioned around the record-keeping.

Q. Thank you, and thinking perhaps beyond your own seniority and expertise, which, on any view when one looks at your experience, sits right towards the top of the tree; if you think about the profession as a whole, is there a need for better guidance on that area in the case of adolescents who are self-isolating, where there is "risk to others" concerns? Do you think this needs greater emphasis and training or guidance?

A. For any doctor to become a section 12 approved doctor, they do have to have a certain -- a minimum level of experience. So that's typically three years. They also have to attend a training course, so a section 12 approved course which is typically one or two days. And those courses do cover aspects of child and adolescent psychiatry, so when you are assessing children and young people.

So there is training mechanisms in place.

Q. Of course, and it wouldn't be a suitable system if there wasn't. But forgive me, that was not really the question. Of course, the clinicians in AR's case had that training. But it didn't seem to trigger, in his case, sufficient thinking. Now, one must make allowance for the fact that they didn't have the full picture, but even so, do you think, allowing for the fact there is a system of training, my question was not: is there a system for training? It is: does the system for training need to be improved and does the guidance need to give greater emphasis?

A. It is a difficult one. I guess, I have been through the training myself. So -- and I think, as Dr Irani said, there's different psychiatrists that would take different views and there might not be consistency across different professionals doing that. I think

there needs to be some thinking around, maybe individuals, if they have got -- if there are gaps in their training needs. But I think it would be difficult to say that, as a broad brush, the training needs to change because of that.

Q. Thank you. Is there any mandatory refresher training on the exercise of powers?

A. Yes, there is.

Q. Do you know whether that training has taken into account learning from the Southport Phase 1 report?

A. I don't -- I wouldn't know the answer to that, I'm afraid.

Q. Is that something you could find out?

A. Yes. Most of the training is offered by the Royal College of Psychiatrists. But I can absolutely find that out.

Q. Well, we have got Professor Dave coming on Monday, so perhaps that's something we will pick up with him, if the training is through there, thank you.

I want to turn to a slightly different aspect of this now which is the changes being brought about by the 2025 Act, which we have touched upon with previous witnesses, but, effectively, having the effect that once the relevant provisions of that Act are in force, neither learning disability, nor a neurodevelopmental

condition such as autism, by themselves, would be capable of justifying the exercise of section 3 powers. One would have to have a comorbid mental disorder that justified the detention. What is your assessment of the potential impact of that in relation to the VFI type of cohort?

A. So I think that -- so I think you have touched that it is for section 3. So I guess, theoretically the Act, for section 2, does not necessarily change a huge amount. So if you were thinking about section 2 for assessment, that would still stand. I guess, when you are thinking about a section 3, you are thinking about that longer term detention in hospital for treatment and there being appropriate treatment and that young person or adult benefiting from that appropriate treatment.

And I think, if you are thinking about autism alone, without a comorbid mental illness, it is not a treatable condition. There may be aspects of it that can be managed and obviously if there is a deterioration in that young person or adult, that tips him over into a mental illness comorbidly, then you could use that part of the Act. But I guess, as it stands, you have to think about the treatability and what would be the aim of that admission, if there's not something to treat from a mental disorder point of view.

Q. Thank you. So I think you started that answer by saying theoretically, it doesn't change the effect of section 2 but I think your answer suggests that in practice it might do because if the focus is on treatability, and we know that there's obviously no pharmacological treatment for autism, in reality, these changes are going to make it less likely that section 2 powers will be used for assessment in the VFI cohort, if they are neurodivergent?

A. Theoretically, that could be the case.

Q. Thank you. We have seen reference in other evidence to care, education and treatment reviews. Are you familiar with the use of those?

A. Yes.

Q. So, could you tell us in a nutshell, first of all, just what they are and when they apply?

A. It is essentially a multi-agency framework for children and young people and adults that have either a learning disability or autism and the aim of this care and education treatment reviews, or CETR for short, is to prevent hospital admission, to think about more community options, to have a multi-agency around them and to think about alternatives to admission.

At the moment, certainly from my experience, most children would have a CETR, if they meet that criteria

for a learning disability or autism before they go into hospital. But, in the future, they will become mandatory.

Q. So that's another part of the 2025 Act changes, I think, that those which have been in place as a matter of policy are becoming mandated under statute, is that right?

A. Yes.

Q. Thank you. Let's go back then to your statement page 3 DNC000002_0003, paragraph 14. We get back to this difficult position that:

"Where an individual is refusing engagement and there is concern about a risk of serious violence, the options available to psychiatrists are relatively limited unless the threshold for intervention under existing legislation is met."

What are the available options, limited though they are?

A. I think this is when you would be drawing on your multi-agency network. I guess, in this situation, you are saying -- well, I would be saying, as a psychiatrist: there is no mental disorder, I can't -- I don't have any powers to admit, but, there are concerns about violence. So do we need to look at this from a slightly different lens, which is either

a safeguarding lens, public protection, both, what frameworks do we need to have in the community to keep that young person and others potentially safe?

Q. All right, and I don't want you, for a moment, to interpret this as a criticism of your answer, but when one goes into that area of this is where you are drawing on your multi-agency network, what does that mean, in real terms? So, in these sort of difficult cases -- obviously, I don't want you to go into any individual case of which you have experienced, but drawing on your extensive experience with adolescents who present risks to others, what statutory powers available to other agencies are drawn on, in practice? I mean, are you thinking, for example, that in the social care setting, one then goes to looking at the child as a section 47 Child in Need?

A. Yes.

Q. Any others?

A. So, I guess, thinking about if there was that risk of violence, then I would be thinking about the police as well and going through that route and other agencies that would be connected with them. Not an exhaustive list but, I guess, thinking about if there is that violence fixation behaviour, Prevent and other agencies around that, if possible.

You would also be thinking about education as well and I think -- if there was a section 47, then that framework in itself would pull that multi-agency together.

Q. All right. So a couple of aspects arising out of that. Also as part of Phase 1 of this Inquiry, we were exploring with Lancashire County Council a degree of disparity between their Continuum of Need and definitions of the thresholds, in which, on its face, a significant risk of violence to others appeared to fall within the higher categories on the Continuum of Need, including section 47 cases, but which, in practice, that didn't seem to match up with practice and understanding of practitioners, in that a risk of violence to others wasn't readily identified as being a typical section 47 type case.

What's the position, more widely, in your experience? If you, as a psychiatrist on the community FCAMHS side, are saying, "We don't have Mental Health Act powers that we can use here, but this is a child of concern", is there a problem with getting children's social services to exercise section 47 powers when the risk is really a risk of harm to others?

A. There can be and in those circumstances, we use escalation routes. So we have escalation systems within

our operating frameworks that we operate through in community FCAMHS and so we would escalate that through senior managers and through our own safeguarding routes within our trusts. I'm speaking from my personal experience. That's what I have done previously, to be able to get that response.

Q. Thank you, and if that is taken and pushed through, you then do have relevant statutory powers there, in terms of potentially leading even to care proceedings, if the child is at significant risk following section 47 assessment, in simplistic terms?

A. Yes.

Q. And have you seen that done effectively, in high risk cases?

A. I have seen it done effectively, and I have seen it -- where it's taken some considerable time to escalate that through.

Q. What practical change or improvement could there be in that area, if we are saying, well, Mental Health Act powers have their limitations in this cohort and if, in particular, one is adding, rightly so, and they shouldn't be expanded, what -- if section 47 is an alternative power, but is sometimes difficult to get exercise, what needs to change in relation to that? What would make a difference?

A. I think greater understanding and maybe some training as well around that would be really helpful. I guess -- and I'm drawing from my own clinical practice and experience -- sometimes other agencies might take a slight step back, if you are considering the Mental Health Act because, you know, I guess people are thinking: Okay, we are going to go down a particular route and then when that doesn't happen, then it can be difficult to get those agencies sort of back involved. So, from my experience, then that leads to escalations within those agencies to get that response that you need.

So I think there is some work to do around sort of a shared understanding about the legislation, that each agency can use and the powers that they have.

Q. Thank you. Then the other aspect I wanted to explore in your answer was the aspect about, you were saying, multi-agency partners would then have to have the discussion about the use of other powers. What framework is that arising in? You call a multi-agency meeting, perhaps as a psychiatrist, but under what process? Where would that be sitting?

A. I think in this instance, that could be sitting under the safeguarding realm, so it would be under section 47. If it then progressed, I guess you would be thinking

about Child in Need, child protection, under that safeguarding realm. If there is something around public protection, then that would sit with processes within the police sphere.

Q. Thank you, and should we take from -- I don't want to read too much into it but when you say "I guess it would sit in this sphere" and so on, there is some variation and uncertainty about those processes?

A. There can be because I think there is multiple needs. I mean, these young people present with multiple needs, social, public protection. So I think sometimes it can be difficult to maybe think, in that initial stage, around actually what agencies need to be involved and maybe what agencies need to take the lead.

Q. Thank you. If we could look, please -- perhaps we could just have paragraph 16, at the bottom of the page -- you say there:

"In clinical practice" what you would do:

"... seek to obtain information from other agencies which may include family, social care, other health based services such as CAMHS or Paediatrics, education, police and youth justice. This would allow all agencies to share their concerns which could be brought together into a shared narrative or formulation. If this suggests that there is reason to believe that the

individual may be suffering from a mental disorder, consideration can [then] be given to an assessment ..."

And if not, you go on to talk about the other powers that might be in play, including Prevent, probation services and so on.

I think where this leads, later on in your statement, if we look at page 6 DNC000002_0006, paragraph 32, you lead into it in paragraph 31 -- it is fine, as it is on the screen at the moment:

"[It] permits compulsory assessment and detention in hospital only where an individual is suffering from a mental disorder ...

"This creates a potential gap in circumstances where an individual presents with significant concerns regarding a fixation on violence and an associated risk of serious harm to others, but does not appear to be experiencing a mental disorder that meets the threshold for compulsory intervention."

You say this:

"In such cases, mental health practitioners may have limited powers to intervene under the Mental Health Act despite concerns about the risk posed. Management of such individuals may therefore require alternative legal, safeguarding, public protection, or multi-agency approaches rather than reliance on mental health

legislation alone."

Now, that's exactly what I have been exploring with you, that then potentially police, potentially children's social services, section 47. So that's one answer to that. But what about an increase in powers for the mental health team, to allow an assessment power that is slightly wider to help the mental health team get eyes on and do an assessment; even if the period of any detention in relation to that might be very short, is that not an alternative possibility?

A. I think earlier, I guess, I have set out that you could assess someone under the Mental Health Act but at that point, if you have done that and there is no mental disorder of a nature or degree, then there may not be need for that mental health input at that stage.

Q. If we look at page 4 DNC000002_0004, paragraph 18, you say that the Act:

"... was established to provide a legal framework for intervention where there is a mental disorder present ... insufficient evidence [at the moment] to support the view that all individuals presenting with VFI [do] have a mental disorder. Extending compulsory powers to those without a mental disorder would represent a significant expansion of the scope of mental health legislation beyond its original purpose."

Now, one understands that that must be right but do we infer from that, that in your clinical lead for community FCAMHS with NHS position, what you are really saying is: use the existing power under section 2, wherever it might be appropriate. But you would not be in favour of an extension of those powers to help psychiatrists get eyes on the self-isolating child with a risk to others, if they don't currently fall within section 2?

A. If you are not suspecting a mental disorder then, yes. From my clinical experience.

Q. Thank you. But you would accept, even though there is training in play, that -- for psychiatrists and others who are approved clinicians, that there may be a need to make clearer the importance of the section 2 powers to help in this area?

A. Yes, there is potential for that.

Q. And also, it sounds like to make clear to partner agencies the importance of them being prepared to use their statutory powers -- my words -- to the full potentially, if it is appropriate, in cases where the mental health team don't feel that section 2 can be brought to bear?

A. Yes.

Q. Thank you. Could we turn, next please, to

neurodevelopmental conditions. If we have the bottom of page 4, paragraph 22, you say:

"Neurodevelopmental conditions can affect how risk is understood, assessed and managed."

Then you say this:

"Risk can arise from the neurodevelopmental condition itself, co-occurring mental illness or situational aspects which can be related to a person's neurodevelopmental profile."

Focusing, if you would, on the VFI type cohort, can you just explain what you mean by that?

A. Yes, sure, and I think you have heard in previous evidence that there isn't a causal link between autism and violence fixation, but we do know that there are certain aspects of autism that can lead to some of those violence-fixated behaviours.

I think, commonly -- again, I'm drawing on my own clinical practice here -- there may be parts of an autism spectrum condition that can lead -- again, in my case, clinical experience -- children and young people to become more fixated on things as part of their autism. They are more likely to become socially isolated. Sometimes they have poor social communication difficulties that again, leads to that social isolation. They are more likely to become fascinated with, then,

the online world and then being drawn into things from there. So that's kind of commonly some of the things that we see, from clinical experience.

Q. Thank you. If we look at, further down on page 5 DNC000002_0005, paragraph 25. You state your awareness of the over-representation in the Prevent caseload of individuals who are autistic. You stress "no causative link" but "some of the symptoms and vulnerabilities from having a diagnosis of autism can lead to a fixation with violence" and you have just been addressing that:

"Cognitive rigidity, perseverative thinking ..."

Just help us to explain what that is?

A. Perseverative is when there is a repetition, so thinking the same things over and over again, sort of repetition.

Q. Thank you, and does that typically, or can that typically be in relation to adverse thinking, or ruminating on --

A. Yes, or ruminating. Yes.

Q. And:

"... having circumscribed and limited interests, social isolation and social communication difficulties may increase susceptibility, however, this is not the case for every young person with autism."

Although, you have expressed it slightly different to other witnesses, that this is important but by now

familiar ground to the Inquiry. The question arising out of that is for those less experienced and less specialist than yourself, whether that complexity is made clear in current guidance and training. So I want you to think about two groups of clinicians who may be involved in that. The first is actually in relation to FCAMHS practitioners themselves. But the second is wider clinicians, so CAMHS clinicians who are not in the forensic sphere who may be doing first-level assessments. Do you think that this slightly complex picture is sufficiently clear?

A. I think because this concept of violence-fixated behaviours is relatively new, I think there could be some more clarity around it.

Q. For both of those cohorts, both the FCAMHS practitioners and CAMHS practitioners?

A. I think from an FCAMHS point of view -- and again, I'm sure speaking for maybe myself and clinicians that I know, I think we are -- we see this, commonly. We have had some training around this but I think, maybe for CAMHS colleagues who maybe aren't as familiar, that could be an issue.

Q. Because the suggestion may be that in the absence of frontline, non-forensic clinicians having an understanding of this and the potential for this,

that risk behaviour could be put down to, or excused by, the neurodevelopmental diagnosis. In other words, as sometimes happened with AR, he would be violent, it was known that he was either likely to obtain a diagnosis of autism, or in the later period, had that diagnosis, and, therefore, there was a tendency for frontline practitioners to think: he is autistic and that is why this is happening and then not to refer on the risk for more specialist intervention or consideration.

Frontline practitioners, including mental health front line practitioners, need to have your understanding of your paragraph 25, don't they, if they are to avoid that trap?

A. Yes.

Q. Would you agree that one particular risk, thinking about the awful gravity of Southport, is that underestimating the risk, or overlooking violent, risky behaviours, can actually come from benign thinking: we must make adjustments because this child -- this patient has autism and we must make allowance for that?

A. I think that may be situational. I think it may depend on who's seeing that child. I wouldn't say that that's the case for every practitioner that sees someone.

Q. No, and I'm not suggesting that it would be but one can see that benign trap of falling into overlooking or

treating more leniently, actually risky or violent behaviours, on the basis of wanting to treat the person fairly and even might think: this is an adjustment we ought to be making because they are autistic. When actually, the more careful assessment of this complex situation, may say: well, this behaviour may not be happening in the first instance because the child is autistic but in any event, it needs to be looked at more closely?

A. Yes.

Q. If we look at paragraph 23 at the top of the page, with apologies for jumping around, you make the obvious point that:

"There is no pharmacological 'treatment' for autism ..."

And you refer to the management for autism centring around:

"... psychoeducation and supportive measures which may include psychological input to support relational difficulties and comorbid conditions, occupational therapy input around managing activities of daily living and speech and language therapy input to support communication needs."

You say:

"Although these supportive treatments are not

specifically designed for an individual fixated on violence, they would be helpful in this context in managing behaviours that may lead to risk."

What is your professional experience -- we are getting, to some extent, onto interventions -- but what management support for autism, in particular, is most likely to also have a benefit in seeking to mitigate risk to others?

A. I think there are several things that could be helpful. I think a -- first of all, going back to sort of grounding principles, you need a good formulation. You need to understand what is going on for this young person and I think that formulation then would drive what interventions you might want to put in. So, for example, if there is -- in your formulation, if there is an element of social isolation that's causing that young person to go online to look up things that maybe aren't helpful, you would want to sort of pull that out and think about an intervention around that.

So I think this would be maybe formulation driven. There could be a whole host of things, including individual therapy, occupational therapy, some psycho-education, some specific work around some of those violent thoughts and ideas. But I think you would have to kind of go back to your formulation principles,

to be able to think about that.

Q. Thank you, and as a community FCAMHS practitioner, when you are assessing that those sort of responses to the assessed needs following a formulation are likely to be beneficial, what's the reality of getting access to them? So, what's the availability of funded provision for them? Because one of the concerns we looked at in Phase 1 was the relative paucity of support post-diagnosis for those who are autistic.

A. I would agree that is an issue.

Q. Significant issue?

A. I think it is variable geographically. I think it would be variable geographically.

Q. Where FCAMHS are involved, and particularly where FCAMHS are involved because of the risk to others and the risk of significant violence, is the system responsive to prioritise such interventions as are available to the sort of cases where there is a risk to the public?

A. Again, I think that's variable geographically.

Q. Is there any standard guidance that applies nationwide, to help guide the allocation of funds in relation to that or is it local negotiation with local availability of funds?

A. I think it is local. There is no guidance, as far as I'm aware.

Q. So even in a case where the forensic -- community FCAMHS team is flagging up that interventions are required to not just benefit the patient in terms of decreasing their social isolation, but parallel process of mitigating the risk to the public, I don't want to descend to the cliché, but a bit of a postcode lottery as to whether those levers work?

A. It can be but what I would say, again, is we use our escalation processes to be able to highlight that risk and to be able to try and bring things forward, if possible. But I accept that that wouldn't happen in all cases and speaking from my own personal experience.

MR MOSS: Thank you. Sir, we have been going for just over an hour and 20 minutes. I'm probably about halfway through, perhaps just a little bit more. Shall we take a 10-minute break?

SIR ADRIAN FULFORD: I think that's sensible. We will sit again at 3.10 pm.

MR MOSS: Thank you, sir.

(2.58 pm)

(A short break)

(3.10 pm)

SIR ADRIAN FULFORD: Yes, thank you, Mr Moss.

MR MOSS: Thank you, sir. So if we could turn, doctor, to risk assessment tools, next please, and if we could have

page 6 DNC000002_0006, paragraph 33 of your statement on screen.

You make clear there, that:

"There is no single validated tool that accurately predicts the risk in violent fixated individuals. Psychiatrists would usually carry out these assessments as part of their role in a forensic team ... The assessment is often informed by multi-agency information ..."

And you say that:

"Psychiatrists rely on structured professional judgement in assessing risk and a formulation is developed which integrates psychiatric, developmental, social factors and threat assessment principles."

Then you go on to deal with, against the background that there isn't, at the moment, a single validated tool specifically designed for this area, to address tools that are in use, so structured assessments. The first of those is SAVRY, which we have heard a reasonable amount of evidence about.

Could I ask you a few matters in relation to that. First of all, as I think you are aware, Dr Richard Church, who was the psychiatrist in our expert cadre, gave evidence to the effect that earlier in his career, SAVRY was a quicker and more efficient process and he

has got concern that it's got longer and longer over the years and unnecessarily so.

In effect, he said, you can use the SAVRY headings, numerous though they are -- I think he said there were 26 of them, from memory, but anyway a lot of headings -- but he said he could use those to gather information quite quickly from informed professionals and come to usable early conclusions, albeit that the process of gathering further information and refining it would take a longer period. Do you have any observations on that observation?

A. I think what I would say in response to that is that we are seeing -- so again, I'm going back to my experience in community FCAMHS, we are seeing young people coming in much earlier to services. I think I mentioned the age ranges before. And these young people are coming in with significant histories. There are -- so there is 24 items in the SAVRY and then there is six more coded items around protective factors. And I think, to be able to -- there is a lot of information to gather. These young people as well, are in many multi-agency settings. So when you are completing a SAVRY you are getting the information from lots and lots of different agencies. And the SAVRY is only as good as the information that you get from it.

I do agree that there are maybe different ways of completing a SAVRY, so SAVRYs can be done when you gather the information, you write it up, you code it up, you do your formulation at the end, which is really important. You can do it with -- in conjunction with other teams as well. So there are different ways of doing it. But I think what we are seeing is the complexity of young people coming through, the information that comes through with them is significant.

And I think that might be some of what's leading to them taking longer.

Q. Thank you. There was perhaps something of a difference of emphasis, between Dr Broughton on behalf of NHS England, himself, of course, a consultant psychiatrist, and Dr Church. Dr Church looking at both AR's case in the six case studies that the cadre examined on the Inquiry's behalf, was really saying, although he accepted that it wasn't validated in the violence-fixated area, he said that it was really quite striking how the SAVRY factors did resonate with the factors that were evident in the case studies.

So, saying although it is not validated for that, it married strikingly well with the factors that would have been apparent on assessment of the case studies.

Dr Broughton for NHS England, I think without

disagreeing with that, was flagging the fact that it is more designed around more traditional interpersonal violence and also that it's not designed to give a gradation of how serious the risk of violence to others is.

Do you have any observations on that debate?

A. I mean, I think the SAVRY is a good tool for interpersonal violence, I absolutely agree. I think for this group, so for young people with violence-fixated behaviours, it does miss out things like the online activity and that's quite key and that's one of the things that we see quite a lot with this group. And I think that's something that -- that's a little bit difficult with the SAVRY.

It is very good for other factors and obviously we use all of those factors and you would use them in any risk assessment and you are able to put in the things that are maybe missing from the SAVRY when you are doing your formulation, but there are some key things that --

Q. Yes, we shouldn't think of this as being a blinkered assessment tool that disregards things that sit outside it. You would look -- in a structured judgement, you could add on additional factors not captured by the tool, presumably?

A. Yes.

Q. Thank you. And then you refer to Historical Clinical Risk Management-20, version 3, HCR-20, we have heard somewhat less about that. You say that it's used in adults. Is it broadly similar to the SAVRY but validated for adults, or is it different?
A. It is broadly similar to the SAVRY and that is more about the historical contextual individual factors. It doesn't capture positive and pro-social factors which is -- there is another tool that is used for that in adults.
Q. Thank you. What's the other tool used for the pro-social?
A. It is called SAPROF.
Q. Thank you. Then just over the page, please DNC000002_0007, you also refer to the "Forensic Assessment of Risk and Safety Framework", can you explain what value added that gives or when that's used, as opposed to the SAVRY or the HCR-20?
A. Sure. With the FARAS, is more of a framework so it is not a structured tool as such and so it can help to form your formulation. That's specifically around when you are assessing young people and adults with autism and it goes through each of the factors. There are various different factors, so thinking about fascination, say with weapons, extremism, social isolation. It goes

through factors that you might see in autism and how they link in with that risk, to be able to inform your formulation.
Q. Thank you. We have heard some evidence about the AREVA tool, I think not yet fully validated but under development and trial, I understand that you are well sighted on how that is progressing. What's your view, first of all, of that? What stage it is at and the potential benefits it might bring?
A. So the AREVA is an assessment of the risk of extremist violence in adolescents. And it is a very new tool. So it is in a consultation version at the moment. It is developed by the -- my understanding is that it is developed by the authors of -- one of the authors of the SAVRY, so Professor Randy Borum and colleagues from the UK and other places as well. And this really kind of looks at that extremist violence end. So I guess, thinking about that, that might be more helpful when we are looking at this population around violence-fixated behaviours.

It's -- I think I mentioned, it is in a consultation phase and the team are looking to, I guess, test it out and obtain feedback, before they can then properly refine it to be the final version.
Q. But shows promise as, at least in part, filling the

current gap; would that be a fair high-level summary?
A. Yes, I think so.
Q. Thank you. So, if one was looking at best practice, in terms of an adolescent presenting with violence-fascinated or violence-fixated behaviours and with a concern about the future use of violence, going towards the more extreme end, what, at the moment, would be the best approach with current tools? I appreciate that a lot depends upon the individual circumstances but what would the best current practice be?
A. Again, it depends on individual circumstances. But, a formulation is key, first of all. So a risk formulation would be very important. You can use tools like the SAVRY or the frameworks like the FARAS. What I would say is there should be some caution around just having a blanket: you should do this on everyone, because it might not be applicable. We know that people with violence-fixated behaviours present in very different ways. So, I think you have to take it with some nuance around the presentation that is facing you. Regardless of whichever tool you use, every young person should have a formulation, where it draws out those risks and you can think about potential interventions for them.
Q. And is there clarity -- in cases that get referred to

FCAMHS, is there clarity about whose responsibility it is to draw the formulation in that way?
A. I think when there are cases that come into FCAMHS, one of -- the sort of primary role of FCAMHS is to think about that formulation and develop a shared formulation with agencies and have that multi-agency approach.

So I think FCAMHS are very well placed to do that work. But I think it does require that information from -- and that co-working with the multi-agency.
Q. So when it works well, FCAMHS might guide and even lead that process, or at least give advice in relation to it. Is there not a risk that responsibility for that falls between the gap between FCAMHS and the CAMHS practitioners?
A. There could be a risk around that but I think that communication is very key in that sense and I think if a referral has come into FCAMHS and there is that risk to others, then, I think FCAMHS would maybe take the lead on that but work together with the CAMHS team. So it is not saying that FCAMHS would complete the formulation but there's some discussion around how it is best completed.

Young people who come into FCAMHS are typically known to other agencies for quite some time. So it might be that a young person seeing someone from CAMHS

and they have seen them for therapeutic work so they have got a lot of information that would contribute to that formulation. So it might be, in that case, that CAMHS would lead that and FCAMHS would input into it. So I think there is some negotiation around that.

Q. Thank you. If we look at paragraph 40 of your statement, it is on page 7 DNC000002_0007. You were asked to address the potential for there being a single assessment tool. And you said, in principle, that would be more practicable and accessible if it could be used across the public sector. You said:

"... however in practice, my experience is that each agency focuses on risk in a different context, eg health services are more likely to view risk with the lens of mental illness or neurodevelopmental difficulties and justice services may view risk with a greater emphasis on public protection."

It may be that there is a risk of confusing different aspects here. Would this be fair, that you are not going to be able to design a multi-agency assessment tool that would have the detail and the sophistication of something like SAVRY or AREVA because that, as we understand it, requires trained professionals to apply it?

A. Yes.

Q. So if one starts to think about the sort of assessment tools that might be used at an initial referral level, to get a first feel or assessment for a case, and then those more specialist tools that professionals in individual areas might use, can we think about the former type of case for the moment.

So, at the moment, there doesn't seem to be any IT system or any assessment tool that for frontline practitioners first making an assessment of the generality of a case. Would you see benefits in having that sort of first referral type assessment tool that could be used to gather initial information at least by frontline practitioners, whether they be teachers or a mental health nurse, as opposed to the more specialist type of risk assessment?

A. Yes, I think so.

Q. In relation to that, our expert cadre said, effectively, that when you look at the difficulties with IT systems talking to each other, one of the things that the multi-agency process ought to hold is a key chronology of central events and key vulnerabilities, that is kept up to date, not a 200 to 500-page chronology, but a shared understanding of key events and key vulnerabilities.

That sounds, on the face of it, obviously, desirable

and perhaps one might think ought to be capable of being done but it doesn't seem to exist at the moment. Do you know why that sort of document is so hard, in practice, to have in multi-agency processes?

A. I think there is a number of reasons why. I think each agency probably records their information differently, is probably one of the first things. And, again, just drawing from my own clinical experience, and our clinical notes which are on an electronic system, you have -- you have got what we call progress notes, so notes for every time you see a young person. You have got separate tabs for risk assessment that's built into that electronic programme record. There's space for documents. So you can already see that there is going to be information in different points and that's in one agency. So, if there were other agencies that have similar systems, I think there's lots of information that sits in different places and it is quite difficult to pull, from one agency, that information together to then pull into that shared document. So that might be something that's -- you know that --

Q. That is a practical barrier to that happening?

A. Yes.

Q. Do you have any experience of seeking to have -- in the multi-agency type discussions or processes in which you

have professional experience, of trying to have some sort of shared document? I mean, you will forgive me reducing it to the slightly superficial but we live in the world of OneDrive, I am sure other shared facilities are available, but systems in which now multiple people from different organisations can access a single file and update it. Do you have professional experience of trying to use improved technology just to have a simple document that's shared amongst agencies?

A. I don't, in that sense, in terms of shared drives because I get there would be some governance difficulties around that, with each agency having their own governance. But we have -- I have had personal experience of being able to contribute to a shared document. It might not necessarily have the full chronology that you are describing but to be able to have a shared document; that's something that have I have worked with other agencies to do for some young people.

Q. Again, the cadre were very clear that it is risky and probably counterproductive to try to make that, the full chronology, the 200-page version, but having key events shared in that way, and key vulnerabilities to have that shared understanding, where you have tried to do it, is that profitable, does it work?

A. Yes, it does work. A couple of cases that we have done that and it has worked because it does allow -- again, it is not the full information but it has been quite helpful, particularly for some of the cohorts of young people that we see and I guess, I'm not necessarily talking about violence-fixated behaviours here, but other young people where there is risk to others, that's been really helpful, particularly when they are moving around. We see -- particularly within FCAMHS, we have a lot of young people that move between different geographical areas. They may be looked after children and that's also a challenge, when children move out of area and getting information from their old service but then also their new service that they are in.

Q. Thank you. Just looking at questions of guidance and training next, please, within this topic. We see the passage, in fact, on screen in front of us. You say in paragraph 38, "there may be inconsistency in the threshold for undertaking specialist assessments". That reflects "the absence of [a] nationally defined referral criteria".

You say, paragraph 39:

"Establishing evidence informed guidance on referral thresholds and risk assessment standards would facilitate a more consistent approach to improve the

identification of risk posed by VFIs, for all agencies."

What, in practical terms, would that look like? I mean, what is absent that you think needs to be brought to bear on the situation?

A. I guess, when I wrote this I was thinking about all agencies. So there is something around all agencies and thresholds for assessments, or thresholds for interventions that all agencies provide. There is something around -- and I know you have heard some evidence around with FCAMHS, the threshold for specialist assessments and that there is a consensus statement that -- sitting with NHS England just now, that's been developed by FCAMHS practitioners, just highlighting this point around thresholds and what that looks like.

Q. If one took the example of a teacher, other than the Prevent duty and the guidance about potentially making a Prevent referral, would frontline educators, who may be the most common type of professional potentially to see concerns in this area, do you think that they have access to guidance on when to refer to mental health practitioners around concerns around violence fixation?

A. Well, I guess with the Prevent programme there is training available for all staff.

Q. You can make a Prevent referral but potentially, if

there was concern about mental health in that area, if they were going down that route, do they have guidance from mental health teams on when to refer to mental health teams about that sort of violence fixation?

A. I think that would be difficult to answer because I think there may be some geographical variation around that and the relationships between, say, CAMHS teams and their schools. Certainly, in FCAMHS, in our area, we receive referrals from schools and I know that CAMHS receive referrals from schools but I could not speak to other areas.

Q. Thank you. So the referral thresholds and risk assessment standards that, by implication in paragraph 39, you are saying are not clear and consistent, that's partly about thresholds within CAMHS and FCAMHS but partly about, in other agencies as well, we should understand?

A. Yes.

Q. Then page 8 DNC000002_0008 paragraph 45. You say that:

"To my knowledge, there is no specific ..."

Sorry, just above that in 43, let's pick it up there:

"... there is no specific training offered to Psychiatrists around VFI. There may be training offered locally around neurodevelopmental conditions and risk

but I am not aware of any specific training around VFI."

Then 44, you say:

"Within the FCAMHS network there have been online sessions delivered around violence fixation to FCAMHS teams but this is not profession specific."

Then you say, in 45:

"I believe that specific training around VFI would be beneficial ..."

So I just want to understand where that takes us. No specific training offered to psychiatrists around VFI but for FCAMHS, there have been online sessions around violence fixation, is that right?

A. That is correct.

Q. So you are drawing the distinction there, are you, between psychiatrists generally and psychiatrists within the FCAMHS network?

A. Yes. I guess, I'm thinking about the Royal College of Psychiatrists and then within FCAMHS, psychiatrists form part of a multidisciplinary team, so we work in a very -- you know, a multidisciplinary team with other professionals.

Q. Thank you, but forgive me, I'm looking at paragraph 43 and you are saying, "No specific training to psychiatrists around VFI". Then in 44, you are saying, "Within the FCAMHS network there [have] been online

sessions delivered around violence fixation". Is the distinction between psychiatrists generally and FCAMHS psychiatrists, or is it the distinction between VFI and violence fixation?

A. So I think it is around -- I guess taking it back, there's no training delivered by the college to psychiatrists as far as I'm aware but within the FCAMHS network, we have delivered training to -- myself and colleagues have delivered training, or organised training to the network of which psychiatrists are part of that if they work in FCAMHS.

Q. Thank you, and so that training that you are aware of, the FCAMHS network, what has that covered?

A. So, again, if I could take it back a step. So within the FCAMHS network, there's always been a culture of CPD and training. So since the network was set up by predecessors of mine back in 2018, there's always been some form of training. And I think each of the clinical leads that have been in post have tried to tailor that training around some of the needs that are coming through FCAMHS at the time. So for example, delivered training around harmful sexual behaviour, when that was an increase in referrals at that time. And I think more recently, we are recognising that violence-fixated behaviours is something that's coming through and so we

wanted to sort of think about some specific training around that. I do have a list of training that has been offered to psychiatrists. I'm happy to go through it, or happy to provide that to you.

Q. Thank you. So you courteously, when I introduced myself to you this morning, indicated that you had brought something like that to the hearings today, and I think if you could disclose that and we will disclose it on, that will be helpful.

So that CPD-like training that has been offered to the FCAMHS network, let's then look at paragraph 45, where you say:

"... specific training around VFI would be beneficial ..."

What training, and to whom should it be offered?

A. Again, apologies, going back a little bit, the training that we have delivered to the FCAMHS network, that's been something that we found has been of interest to the network. I think there is something around thinking about what type of training should be delivered. So I think we have to take a back step around understanding what violence-fixated behaviours are, we need to understand a lot more about prevalence, how we recognise them.

I think that's for, not just the FCAMHS network, but

to wider audiences such as CAMHS but also other multi-agencies as well. So I think there is training generally needed across the board.

I guess, it is difficult because this seems like it is such an emerging picture of young people that are presenting. So, it is difficult to know what training to deliver, when it is quite a new concept.

Q. Yes, and I understand this is relatively new training for the FCAMHS network but, at the risk of oversimplification, are you really saying that the training that has been offered on a CPD voluntary basis to FCAMHS network, has been of use and of interest and you are really identifying that there is a case for rolling out that type of training, no doubt, needs to be tweaked for its audience but more widely, amongst not just mental health practitioners outside of FCAMHS, but also to other agencies as well?

A. I think that would be helpful.

Q. Thank you. So, I think you indicated you have got a list of that training. If you have the training itself, as opposed to a summary list of it, that would be of interest as well, to see what is covered, whether it is -- you may be able to help us. Does it take the form of an online lecture or online questions? What sort of format does the training take?

A. So there have been online what we call masterclasses. So they can vary between one to four hours long. They cover different topics. So it is not just specifically around violence-fixated behaviours but topics around that. So legal issues, formulation, there's quite a bit around that specific, I guess, topic.

Q. Thank you. Could you allow the Inquiry access to the actual training materials?

A. Yes.

Q. Not now, but when you can, because that would be of interest and assistance?

Thank you.

Of course, one aspect of this is no doubt that the risks will fluctuate over time. It is not static, would you agree, in general terms?

A. Yes.

Q. Does any of the training draw attention -- I'm drawing here on issues that the victims and survivors team have raised. But does it give assistance on particular factors of concern? So for example weapon-carrying, specific threats and the significance of particular factors that may arise in cases?

A. Yes, I think it would cover some of that. I would have to go back and just double-check but there are definitely some things in that list that you have

mentioned.
Q. Thank you. It is a difficult question but how does it tackle distinguishing violence-fascinated or violence-fixated behaviours and the perhaps more commonplace risk of more conventional forms of interpersonal violence?
A. That is a difficult question. I guess, with the -- we have historically had training around interpersonal violence because that was one of the key reasons why community forensic CAMHS was set up, was one of those categories at the time. So there has been historical training around that.
I think what we have moved more towards now is understanding the effects of kind of the online world. So more around the online world, the effects that has on young people and then how that leads to potential violence fascination or violence fixation.
Q. Thank you. I want to turn, just briefly, to information sharing. We have explored this extensively with other witnesses. We have it on screen at the moment. I'm taking it deliberately slightly out of order. So paragraph 47, at the bottom, you say:
"Barriers to effective information sharing can include differing organisational thresholds for risk and intervention, incompatible data sharing systems,

differing organisational thresholds for risk, professionals understanding of risk and fragmented commissioning arrangements in different areas."
Again, ground that we have trodden with other witnesses. What are the -- what's the top difficulty, in your professional experience, in getting risk shared between agencies where it relates to the risk to others?
A. I think it is gathering that information. So, if -- I think I alluded to this before -- where that risk information is stored, actually physically getting it to someone because it is finding it on a system and then, I guess, being able to share that. And how you share that information is probably -- I guess from my clinical experience, that's what seems to take some time to get that.
Q. Thank you. And then I said I was taking it out of order. If we go back to the preceding paragraph, 46 on the previous page DNC000002_0008, please. You say:
"Clear information sharing protocols between health services, policing, education, and social care and other relevant agencies are essential to support the assessment and management of individuals presenting with violence fixation concerns."
Now, I don't want to suggest for a moment that protocols are not helpful, nor that they may not indeed

be essential, but if, even with the existence of protocols, information sharing remains a persistent problem, the challenge to that is, hasn't the time come to put a duty to co-operate and a duty to share information between agencies in the context of risk to others, onto a statutory footing, so that the matter is beyond doubt?
A. I think that would be helpful.
Q. Thank you. Turning next, please, to two areas of potential under-diagnosed disorders relevant to risk. Again, we have put you on notice that we wanted to explore this with you.
So I think you will be familiar with the evidence of Dr Richard Church from our expert group, in relation to conduct disorder and indeed with, in broad terms, Dr Irani's evidence in Phase 1.
So Dr Church, in passages of evidence that I read yesterday and I won't repeat, from the 7 October transcript, said, in effect, there is a cultural reluctance amongst mental health teams to use the diagnosis of conduct disorder and he said that that is particularly unfortunate because there is NICE guidance on interventions for conduct disorder.
And also that conduct disorder is useful because, as a formulation, it can be helpful to agencies outside of

CAMHS and FCAMHS to understand the child's case. And he said, moreover, he was particularly concerned that in some -- for some CAMHS organisations, conduct disorder is actually a diagnosis of exclusion. So if the diagnosis is of conduct disorder, then the CAMHS service won't assist.
Do you recognise those concerns, first of all?
A. Yes, I have experienced the latter.
Q. So you have experienced it being used as a diagnosis of exclusion, leading to CAMHS not being involved?
A. Yes.
Q. What about the under-diagnosis and the cultural resistance to using it as a diagnosis; do you recognise that as well?
A. I do recognise it. I think we do use formulation though -- I guess, just drawing from FCAMHS experience -- we have used formulation to drive out some -- I guess, to draw out some of those factors that you see in that diagnosis. So, may be using it more as a formulation rather than giving it as a diagnosis.
Q. In broad terms -- again, you must correct me if my layperson's understanding is wrong -- I think in CAMHS' practice, there can be something of a reluctance -- would this be right -- to give a diagnosis, given how young some of the service users are, and a concern about

stigmatising with a firm diagnosis when they are so young? And so perhaps the reliance upon formulations. Is that a tendency that you recognise?

A. I think so, yes.

Q. Which one sees in other areas, such as personality disorder?

A. I think -- I guess, in my experience dealing with under 18s, we don't tend to use -- or diagnose personality disorder because the personality hasn't developed at that stage.

Q. Perhaps illustrates the point. Getting to Dr Church's concern, is there a risk that, in the use of formulation rather than a clear diagnosis under ICD 11 of conduct disorder, that you then miss the NICE approved interventions?

A. Not necessarily because I think with a formulation, one of the points of having a good formulation is that you would be able to think about the interventions that you would put in place. So the interventions might actually still be the same but you are just drawing it out in a different way.

Q. But if the diagnosis of conduct disorder, putting it bluntly, is being missed, how confident are you that practitioners in this area are thinking, "Well, even though we are not going to formulate this as a diagnosis

of personality disorder, we ought to be turning to the NICE guidance to think about the interventions"?

A. I think, going back to the earlier point about conduct disorder being an exclusion diagnosis, I think sometimes it can be helpful to have it formulated so that you can access interventions because I think there is, again, in my clinical experience, a resource issue at times and I think there's something around when you have got young people that maybe have a serious mental health condition or a mental illness, that maybe resources around say individual therapy, psychological therapy might go to someone who may have, say, a more severe form of an illness, rather than to someone who maybe does have a conduct disorder. You know, I guess it is just thinking about how you would be able to access resources for young people.

Q. So, I am gently going to put you on the spot, I'm afraid, on this. What should CAMHS and FCAMHS be doing differently to meet the concerns expressed by Dr Church?

A. I think having a shared understanding. I think, first of all, understanding what is a diagnosis of exclusion to services would be really helpful because I think there is variation around what the services -- what the inclusion and exclusion criteria are. But also understanding what interventions are in place for, say,

someone that does have conduct disorder. I think if you were confident that if you made a diagnosis and that that young person would receive the intervention that they needed, then that would be really helpful.

Q. But how are they going to get the interventions if some CAMHS services are saying: having a diagnosis of conduct disorder means you will not be open to CAMHS? It seems circular.

A. It does and I think that's where the discussion needs to happen and I guess -- I do not think that can be between individual practitioners, but that might need to be on a commissioning level.

Q. Dr Broughton didn't immediately seem to recognise -- although it was concerned by the suggestion that for some CAMHS services, conduct disorder excludes being open to the service. Does that worry you, that that is happening? You say you have experience of it.

A. Yes.

Q. So that does need to change?

A. Yes.

Q. And then, presumably, there needs to be national consistency about that?

A. I would imagine so.

Q. Why is there not that at the moment? Why are some CAMHS services allowed to have a provision that says: if the

diagnosis is conduct disorder, you won't be open to this service? It doesn't seem right.

A. I think there is variation around commissioning. Again, from experience, around -- we see it in services for diagnosing autism or ADHD or other neurodevelopmental conditions. You know, those services are in different places and I think there is -- there might not be that consistency in commissioning.

Q. Thank you. Broadly similar exploration in relation to foetal alcohol spectrum disorder. Again, the cohort -- the expert cadre, were concerned that foetal alcohol spectrum disorder may have been a missed diagnosis in some of the case summaries that they looked at. And in broad terms, their concerns were an absence of professional curiosity about FASD, that there was a high rate of co-occurrence of FASD with neurodevelopmental conditions but importantly, the support that was required is different from ASD and ADHD and also, that FASD is preventable by abstinence during pregnancy.

So those were all matters that they flagged up. Do you recognise those concerns? Do you come across this in your own practice?

A. I do recognise some of those concerns. My own experience is that there are specialist FASD services around -- they commonly sit within paediatrics though,

which is maybe why they don't necessarily come into contact with mental health services.

I think again, those services might be patchy, I do not profess to know the answer but I'm not sure if every area has got a FASD service.

Q. I think, in part, the concern that was being raised was that the FASD as a comorbidity was being missed because the young patients may have had autism or ADHD but also FASD and the FASD was being missed when it was appearing alongside neurodevelopmental conditions, but would have justified different interventions and a different approach, or additional approaches; do you recognise that risk?

A. I think that could be a concern. I guess, just to think about -- because I know there were six cases, so it is difficult to draw conclusions from that.

Q. Of course. It's a small sample.

A. But I do recognise that that could be a concern.

Q. For those, including mental health practitioners who are dealing with cases of risk to others, are you aware of any guidance cautioning against the risk of FASD being missed because it might -- my words -- be masked by the effects of a neurodevelopmental condition?

A. I'm not aware of any guidance, no.

Q. Thank you. Can I turn, then, to deal with multi-agency

working.

If we can have page 9 DNC000002_0009 paragraph 50 of your statement.

You start by helpfully explaining that:

"Psychiatrists (typically Child & Adolescent Psychiatrists, Forensic Psychiatrists or dual trained Psychiatrists) working within FCAMHS play a clinical advisory role within multi-agency arrangements for the management of VFI. Their contribution can include assessment of the presence of mental disorder, neurodevelopmental conditions and psychological vulnerabilities, formulation and using structured professional judgement and identification of appropriate therapeutic and risk management interventions where appropriate."

And that they work as part of a multidisciplinary team in FCAMHS and would work collaboratively with multidisciplinary team members in this.

So in a sense, that's how it ought to work. We have heard, both from Dr Broughton yesterday and in Phase 1, that for the most part, FCAMHS is not a case-holding service and, with some exceptions, generally speaking, does not offer direct interventions itself. Would you agree with that, in broad terms?

A. That is correct.

Q. I want to ask this, given that the cohort of violence-fixated individuals, however defined, may be relatively small nationwide, if you take the Prevent proxy numbers, is there a case for FCAMHS having a more directly involved role for this cohort? The reason why I ask that is it may appear to be a cohort for whom the additional forensic skills of FCAMHS practitioners are particularly well suited and if they are few in number, doesn't more intense FCAMHS involvement have a real benefit for this cohort?

A. It could have a benefit. I think that probably comes with the caveat of the role and the way that FCAMHS is commissioned, in terms of being primarily a consultation and advice service, offering some assessment and very little direct intervention. So I think -- and also bearing in mind that FCAMHS takes referrals for lots of risks, other types of risks to others. So this is a very, very small cohort. I think as well, just thinking about the delivery of FCAMHS, each FCAMHS service covers a really wide geographical area.

So I think there is different factors that kind of come into play with this.

Q. So one area that we are exploring in relation to that is -- I don't know whether the regions coincide, they may not, but Counter Terrorism Policing is also based on

a regional unit basis. And it may be, certainly an issue to be explored, that a pathway -- and we will come onto what the pathway may be -- for those in this cohort could also be organised on a regional basis, rather than on a tier 1 local authority basis.

So would you agree, that may not be a barrier in itself, the fact that FCAMHS is commissioned on a regional basis?

A. Yes, I agree.

Q. Obviously, there would be resource and funding implications?

A. Yes.

Q. But there are already, as I understand it, exceptions to the principle that FCAMHS doesn't, itself, deliver direct interventions?

A. Yes.

Q. Thank you. Then, in paragraph 51, you say:

"Psychiatrists in FCAMHS would attend and input into the multi-agency public protection arrangements (MAPPA) ..."

Would attend:

"... multi-agency safeguarding hub (MASH) and may provide multi-agency consultation and advice ... [and] can make referrals to Prevent."

You are describing there what should happen and the

benefits to be brought. We know, from Phase 1, that what happened in AR's case was that FCAMHS failed to attend two of the multi-agency strategy meetings; FCAMHS could have stepped in to organise a SAVRY, in AR's case, but they didn't do so; there was also, to quote:

"Considerable confusion as to which was the lead agency as between FCAMHS, CAMHS and the criminal justice liaison and diversion team, and any other relevant non-healthcare agency."

And the Chair also found that there was a need for a significant cultural change, to ensure that the relevant agencies are prepared to own and manage risk appropriately, as opposed to referring it onto others or simply assuming that other agencies have taken on this responsibility.

And that applied to FCAMHS in AR's case, but not just to FCAMHS. I mean, is there a risk that in your paragraphs 50 and 51, I might suggest because of your own expertise and seniority and knowledge of what good practice looks like, that you are presenting here what should happen but that on the ground, in individual FCAMHS regional -- based regionally, practice and quality falls short of this, in reality?

A. There is, I guess, in answer to that, I think earlier on in my evidence, I mentioned that there is an annual

review process. That used to be primarily conducted by NHS England, but now is jointly, at times, with NHS England and local commissioning bodies. So provider collaboratives in this instance, or ICB. And that annual review process is fairly robust. So it looks at -- each FCAMHS team produces a report yearly and that, I guess, draws out some of the key performance indicators and one of those is attendance at meetings such as MAPPA, any other multi-agency meetings, and activities that FCAMHS have been involved in and things that they have been doing to strengthen relationships between teams.

So, I think if that was a continued problem then that would be picked up within those spheres.

Q. What confidence do you have that those annual assessments pick up the sort of issues that we saw in AR, which was a referral to FCAMHS but effectively, an assessment that until there is a diagnosis in relation to autism, there was little more that FCAMHS could offer and the case being closed to FCAMHS before a structured type tool such as SAVRY had been offered? Now, would that be caught by performance indicators that are assessed in the annual review?

A. I think now that there is local -- more local commissioning of the services, that might be more likely

to be picked up. I think, just again, reflecting back and thinking about the FCAMHS network. The FCAMHS network has been thinking a lot about some of the outcomes from Phase 1 and thinking around improvements, how services can adapt as well and doing that jointly with the local commissioning bodies.

Q. One of the aspects that came out from our seminar, from Professor Sizoo looking at the Dutch model, which I'm not going to go into, but one of the approaches that is encouraged in the Netherlands is the concept of "a best fit". In other words, the team offering what they can bring and the services that they can offer, rather than an approach of looking for reasons why they do not fit thresholds or don't fit the service. But the latter being perhaps understandable in a world of limited resources and pressures on services.

From your leadership position, do regional FCAMHS teams take an approach of: we take cases on best fit and offer what we can? Or are they inclined to say, "Ours is a limited resource and this doesn't fit the threshold?" I appreciate that is a very general question.

A. I think I would find that difficult to answer for other services --

Q. Of course.

A. -- to be honest. I mean, I guess speaking from our clinical experience in my own service, I think we try and be proactive and take referrals and do what we can.

Q. Thank you.

If we look at paragraph 52, you say:

"The strengths of MAPPA, PREVENT and MASH are that they provide a statutory multi-agency framework with defined responsibilities for professionals from different agencies."

Now, no argument from me in relation to MAPPA and Prevent. But the concept that MASH is a statutory multi-agency framework, is that quite right? One appreciates that MASHs can make referrals to children's social services who have statutory powers but we do not understand that MASH are themselves set up with any particular statutory powers of their own.

A. Yes, I would accept that.

Q. Thank you. Taking a step back and thinking about the structure of multi-agency systems in the future, as you will understand, we are looking at this in two stages. The first one is which process or organisation should be involved in an initial screening and triage of referrals of concern for the VFI cohort?

And arguably, the body that is principally doing that at the moment, not exclusively because referrals

could come into CAMHS, they could come into Youth Offending Teams and so on, but principally, at the moment, that's probably Prevent. They have had a large increase in the numbers and the Inquiry has heard evidence that that's problematic.

So taking it as shortly as I may. For Prevent themselves, there is concern that there is a risk of overload because of the increase in referrals. There's also a risk of dilution that the most serious cases of vulnerability to be drawn into terrorism may be at risk of not getting the attention they deserve because of the increase in numbers, including in referrals that are not taken on.

It is also, on the evidence we have heard, problematic for those other than Prevent because of the bounce-back effect of referrals. So Dame Rachel de Souza's report in relation to Prevent draws attention, as we have seen, to the relatively low numbers of referrals to Prevent that are taken on by Channel and the relatively high proportions of referrals to Prevent that end in Prevent or Channel referring it back out to the very body who made the referral.

Do you recognise those concerns, first of all?

A. Yes.

Q. So looking for options to the future, there are

suggestions of a big front door. So a process to take referrals instead of Prevent who would screen them or triage them and then refer on. So the cases may go to Prevent, or it could go to social care, or it could go to a pathway designed for the VFI cohort who are not taken on by Prevent.

Can I understand from your position and your leadership position for community FCAMHS, is that a process that you would support as a reform?

A. I think, from a clinical point of view, I would support that.

Q. Thank you. It may be that there is no reason why the community FCAMHS profession has really sort of gone into this in this level of detail, but that could be arranged in different ways. So the body taking the referrals could just look at the public protection referrals, which would be traditional type of Prevent referrals, largely dealing with ideological terrorism risks, and the VFI cohort, fascination with violence and non-ideological; that would be one way of doing it.

But they would then be sitting alongside the more traditional type of MASH, who is taking referrals for safeguarding risk to the child themselves more typically.

Or you could put all of those together and have

a single very big front door, that's looking at risk to the child themselves, so abuse in the home of a traditional kind, Prevent and VFI, all being dealt with by one single body.

Does the community FCAMHS team have a view on which of those different approaches would be more beneficial or more appropriate?

A. I think from my own clinical point of view, I think having a big front door reduces the risk of people falling through the cracks. And I think that's -- I think what we are seeing at the moment is that bounce-back and then people falling through. So I think something that reduces that would be more beneficial, from my own clinical point of view.

Q. So you might have a danger of falling between the cracks if you had MASH as one part of a front door but some new process, looking at the public protection ones and a risk of bouncing between --

A. Potentially, yes.

Q. Thank you. A number of reports and commentators have put MASH forward as the best of the current processes that could be expanded, up-scaled and resourced to deal with that. There would be implications for that; they would have to have a level of Counter Terrorism Police input or knowledge brought to bear.

Is that something that you support? Have the community FCAMHS teams given thought to what that process may look like and who could carry it out?

A. Again, just speaking from my own clinical point of view, I think that would make the most sense because, I guess, that cohort of young people with the violence-fixated behaviours, a significant proportion of them do have safeguarding needs as well, just albeit of a different kind.

Q. Thank you. Your emphasis will obviously be on children but would you recognise that a challenge for this is that you would also have to cater for adults?

A. Yes, I think that would be challenging.

Q. Thank you. Then, thinking about the next stage, the pathway beyond. So assume for the moment that as Prevent is set up on its statutory footing at the moment, Prevent would still be taking some of these referrals but I want to think about the most appropriate body to take our VFI, however it is defined, cohort who do not get taken on by Prevent and Channel.

So if we look at your paragraph 55 at the bottom of the page that we have got on at the moment, you explain there, going through it quickly:

"MASH is primarily designed as an information-sharing and safeguarding ... MAPPA

provides a framework for the management of individuals who have committed ... offences."

But you explain that DNC000002_0010:

"Many individuals who present with concerning fixes on violence ..."

Won't qualify because they won't have had the serious offences. Then:

"PREVENT aims to identify and support individuals being drawn into terrorism with the Channel process providing a multi-agency framework ... but on a voluntary basis. The threshold would have to be met to progress to Channel. [And] individuals without terrorism related interests but with [violence] fixation would likely not be accepted."

So you draw the conclusion, taking it briefly, these offer valuable principles but -- my words -- they are not a good fit, I think is what you are saying.

What you go on to say:

"Adapting these services would require significant operational changes including workforce and expertise, governance arrangements and potentially legislative changes, particularly if they are a designated lead agency."

Then you say:

"A dedicated new structure could address this

emerging cohort but would need to maintain strong interfaces with ..."

Those other bodies.

So where do you end up in relation to this, if you do have a position on it in community FCAMHS, as to what the pathway should look like?

A. Again, from my own clinical point of view, I think there are pros and cons for either.

Q. When you say "either", do you mean adapting one of the existing bodies or creating a new process?

A. Yes. Because I think creating a new process, you might then run the risk of then another gap. Whereas, if you have -- if you -- I guess the con of expanding an already there process, would be that sort of change, the organisational change that would need to come with it. So I think it is a bit of a balance of the pros and cons of each one.

Q. Thank you. Obviously individual cases would vary, but if one thinks about a multi-agency process with a chair, however that looks like, or co-chairs, and a standard list of agencies who should either be standing members or certainly invited to consider appropriate cases, should community FCAMHS be clearly on that list?

A. Yes.

Q. What is the potential -- the expert cadre and others

have drawn attention to the lack of psychological input and particularly forensic psychology input -- what is the capacity of FCAMHS to bring that speciality to bear on multi-agency discussions and case management planning?

A. I think with all of the FCAMHS teams, each FCAMHS team does have a forensic or a clinical or a dual trained psychologist in both of those. But I think, again, it comes back to a resource issue in that we know that each of the teams have got -- are resourced quite differently. And I think, this -- if there was an expectation that there needed to be something additional that a team would provide, I think then a resource or a funding issue would need to come along with that.

Q. Thank you. We have also been exploring -- assuming for the moment that a multi-agency pathway would have to be defined -- what the best practice would be, in terms of ensuring proper case ownership and delivery and really looking at two schools of thought.

So if we look at your paragraph 57, you were asked to address one school of thought, which is: should there be a lead agency that is designated for each case?

Now, pausing there. It may be thought to be relatively obvious that for some cases, the agency would

be one organisation, but others the lead agency would have to be another. So you might have one where the police need to be the lead agency and another may be potentially CAMHS, but defining a lead agency.

The other school of thought which was pressed on the Inquiry by the cadre was that that actually creates problems because as soon as you designate one agency as being in the lead, there is a risk that other agencies will somewhat fall away. And those suggested that the better way to ensure ownership and delivery is to define the lead process, so you identify clearly which multi-agency team has responsibility and then your chair or co-chairs of that process have the ultimate operational responsibility to ensure appropriate handling of that case and you have to have a governance arrangement above them to ensure that they are performing correctly as a process.

Now, in fairness to you, those two schools of thought weren't put in your Rule 9 request and you said, in paragraph 57, in your opinion it would be helpful to allocate a lead agency. Where do you sit in the debate of those two schools of thought as to which is the most effective?

A. I think as long as there is a process behind it that has got clear guidance around ownership and escalation,

I think my own personal opinion is that either of those could work but I think there needs to be some guidance around how it would work and that escalation process.

Q. Thank you. So, a clear escalation process if agreement can't be reached or one agency has concerns at the direction of a case?

A. Yes.

Q. And the guidance -- others have suggested that, yes, guidance, but actually you need to put the process on a statutory footing so that you have, as is the case with MAPPA, a clear statutory basis for the agencies to understand: we have a statutory duty to co-operate, including in relation to information sharing. Would you agree that that's probably the best way to go forward?

A. I would agree.

Q. Thank you. Penultimately I think in relation to interventions, could we just look at page 10 DNC000002_0010, paragraph 60, please. You say that, in your clinical practice, you have seen interventions offered by Channel, offered by an intervention provider -- we are familiar with their role -- you say you are unable to comment on if the interventions are accessible, as you don't have any data around young people who have not been offered intervention via Channel:

"However, the young people offered intervention through Channel had some form of extremist ideology."

Are you saying there that Channel interventions, in your experience, have been effective but cautioning that some of them are targeted around extremist ideology; is that the essence that you were getting at in that paragraph?

A. Yes, I think from my own clinical experience, yes.

Q. Then, for paragraph 61, you say:

"... young people who do not have a mental disorder and do not have fixed ideological beliefs but would still present with violent risk and it is unclear what intervention, if any they would receive."

Now, were you alighting there on the lack of clarity about who should provide interventions in that case and what access and funding is available?

A. I think so, yes.

Q. Were you additionally alluding to a lack of clarity about what interventions help in such cases?

A. I think it was more around what interventions could be provided.

Q. In broad terms, for that cohort -- so perhaps not immediately amenable to treatment, mental disorder, no fixed ideological beliefs but fascination with violence and extreme violence -- what, in broad terms, type of

interventions are likely to be effective for adolescents?

A. Again, that would probably go back to something like a formulation, to be able to understand what some of the risk factors are for that young person. So is it around -- you know, thinking about education, support at home, whether they need individual work, whether there is some family work that needs to happen. I think there is a wide range of things that you could consider but it would be to go back to sort of understanding what that young person's needs are.

Q. And at the moment, practitioners such as yourself who felt that nonclinical interventions were the most likely way forward, who would you turn to, to try and get those interventions funded and put in place?

A. I think, again, just drawing on my own clinical practice, my first port of call was usually via social care and then thinking about other agencies that we could access via them.

Q. Thank you. Is community FCAMHS involved in any of the current assessments and research into what interventions may work best for this cohort?

A. I am aware that there is a team within community FCAMHS that are looking at MBT, so mentalisation based therapy. Not specifically for the VFI -- sorry, the

violence-fixated behaviour cohort but just generally across FCAMHS. So there is a group.

Q. And just explain for us a little what lies behind MBT, what the nature of that is?

A. So again, I have got very limited knowledge of this, I'm not involved in this at all but it is mentalisation based therapy, which is some individual therapy offered to young people and so it is a pilot project that one of the FCAMHS teams are leading on, with -- and they have got various sites and I believe that they have already started the work and are looking to sort of, I guess, produce an evaluation around its progress.

Q. Thank you. You will correct me if I'm wrong, that sounds to me like you are speaking of work that is being done perhaps by colleagues that you are not directly cited on?

A. Exactly, yes.

Q. Would you be able to link us up with those --

A. Yes, of course. I would be happy to.

Q. -- so we can understand more about that. Thank you. Then finally, just in terms of improvements, if we look at the end of your statement, please, page 11 DNC000002_0011. I think we have covered most of the ground in relation to this. So paragraph 63, a nationally shared definition; we have dealt with that.

But also, you say there, that that would help to:

"... improve communication, reduce variation in thresholds for referral and intervention, and ensure that individuals receive equitable responses irrespective of their home locality."

So I think there is quite a lot in that but is that drawing out, in part, the absence, at the moment, of a clear pathway for VFIs and the absence of what the referral thresholds are for that and currently a patchwork of variation, from area to area, on what's currently available?

A. Yes.

Q. And then: the role of agencies requires clarification. And we have dealt with the fact that there isn't a clear pathway at the moment. And you say, with:

"... guidance outlining referral criteria, consultation responsibilities [and] assessment expectations ..."

Can you just put that into more concrete terms. What are you actually talking about when you say "consultation responsibilities" and "assessment expectations"?

A. I think this goes back to some of our earlier discussion around the pathway for these young people. So when they are coming in through that front door, what does that

look like? Which agencies are being consulted with? What does that -- if they then come through that front door, where do they go after that? So it is more around that pathway.

Q. And then paragraph 65:

"Development of a comprehensive training programme should be developed for professionals across the system ..."

So that goes back, I think, to rolling out to a wider group of mental health practitioners the sort of training, quite nascent though it is, on violence fixation, that the FCAMHS network have started; yes?

A. Yes, but I think also to wider professionals --

Q. I was going to come onto that. But starting with mental health teams generally. There is a training need there but also, we need to look at training across other agencies outside of mental health services; is that right?

A. Yes.

MR MOSS: Thank you. I think those are my questions. I'm just turning to see whether there are any questions from my learned friend Mr Temkin. I think not. Sir, do you have any questions?

SIR ADRIAN FULFORD: I don't. Doctor, thank you very much indeed. There have been a lot of questions that you

have had to answer. I'm indebted to you for those and for your report. Thank you.

A. Thank you.

SIR ADRIAN FULFORD: That brings us to the end of this week.

MR MOSS: It is the close of the week and I think we are 10 am on Monday. Thank you, sir.

SIR ADRIAN FULFORD: And the theme next week?

MR MOSS: So we are continuing, at the start, with Topic 1 and health through to its continuation, but we move, mid-week into Topic 2, online harms.

SIR ADRIAN FULFORD: Thank you very much indeed. 10 o'clock Monday.

(4.28 pm)

(The Inquiry adjourned until 10.00 am on Monday, 9 November 2026)

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