Monday, 9 November 2026

(10.00 am)

SIR ADRIAN FULFORD: Could you remain standing for a moment to take the oath.

PROFESSOR SUBODH DAVE (affirmed)

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

Questions by MR MOSS

MR MOSS: Thank you, sir.

Professor, just start by giving us your full name if you would please?

A. I'm Professor Subodh Dave.

Q. Thank you. If we could have on screen, please, RCP000001. This is your statement to the Inquiry. Professor Dave, if we could have page 32 RCP000001_0032. We see this as a statement that you signed on 7 August 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. That is correct.

Q. Thank you. If we go back to the very first page RCP000001_0001 and indeed, the very first paragraph, we will see that you give evidence in your role as President of the Royal College of Psychiatrists, yes?

A. That is correct.

Q. Thank you. Before I go to your posts and your experience, I think there's something that you wanted to say?

A. If I may. I would like to begin by expressing my deepest condolences on my personal behalf and on behalf of the Royal College of Psychiatrists to the victims and the families. My thoughts are with the families of Alice, Bebe and Elsie and all the others who have been affected.

Q. Thank you. If I may say so, you are beautifully softly spoken, but do try to keep your voice just a little bit up, not least because our stenographer has to take a note and it is being broadcast, thank you very much. So, we see, on paragraph 2 on screen, in terms of your roles, first of all, you are a Consultant Liaison Psychiatrist in the NHS in Derbyshire. For those who are not familiar, just explain what a liaison psychiatrist is?

A. So I work in acute hospitals. So that is a hospital where people with physical health problems are admitted for, say, conditions to do with their heart, or kidneys or lungs or whatever it may be. If they have concurrent a mental health problem or if they have been admitted on account of a mental health problem which has led to physical health issues, be it self-harm or something

similar, I get involved in assessing them and managing their treatment, while they are in the acute hospital.

Q. Thank you. So that crossover between physical illness and psychiatric illness, in a way?

A. That is correct.

Q. Thank you. Is that with adolescents or with adults?

A. So I primarily work with adults. I think, it is inevitable that sometimes there are people who are older than -- and fall in the over-65s, I occasionally manage them as well.

Q. Thank you. You also explain in paragraph 2 in terms of a second role that you are a Professor of Psychiatry and Head of the Centre of Mental Health at University of Greater Manchester. In essence, what areas are you involved in there on the academic side?

A. So it's primarily to do with medical education, so developing curricula and setting standards for training, for medical students, in that particular role.

So that's my primary area of interest in that academic role.

Q. So medical education. And then we see, as I have introduced you, President of the Royal College of Psychiatrists, having previously served as Dean. When did you take up your position as President and how long do you hold that post for?

A. So I took up my position in June this year and I will be in my post as President until June 2029.

Q. Thank you. So a three-year --

A. Three years.

Q. Thank you. Professor, if we can just have a bottom of page 1, and I'm not going to read through it all but I will just allow the Chair just to review it -- I know that wouldn't have been able to read it all -- and just over the page RCP000001_0002.

If we just go the whole page, please, Amanda. You set out there a good deal of your background. You have, I think, taking it very shortly, long experience in medical leadership and education and you have authored, I think, more than 50 peer-reviewed publications; is that right?

A. That's correct.

Q. And various awards to which you draw our attention to illustrate your seniority and experience. I won't go through it all but I think you have set it out in your statement so that we have a feel for it.

A. Thank you.

Q. Thank you. If we look, please, right at the bottom of this page now, if we could focus in on paragraph 11, you explain the nature of the royal college:

"... professional medical body responsible for

supporting psychiatrists. [Which] works to secure the best outcomes for people with mental illness, intellectual disabilities and developmental disorders by promoting excellent mental health ..."

Just over the page RCP000001_0003:

"... supporting the prevention of mental illness, training outstanding psychiatrists, [and] promoting quality and research, setting standards and being the voice of our members and the profession."

So that's important. You set out, it has 22,000 members. Could you just, in a nutshell, explain the interplay with other key bodies in the area because I don't think you actually enforced the standards or check on the standards being followed, do you?

A. So that's correct. So the college's primarily role is in setting standards, be it in educational training or occasionally in services and mainly that is in the service of supporting our workforce of psychiatrists in delivering the best healthcare they can provide to their patients. So we do not deliver services ourselves. We do not regulate services, which is the job of the regulators such as the Care Quality Commission in England. The service is delivered by healthcare organisations like mental health trusts. But the college is involved in setting standards. The college

does not even deliver training to the resident doctors, which is the responsibility of the Deaneries and the schools of psychiatry which ultimately are commissioned by NHS workforce, training and education.

Q. Thank you. Sir, as we see in paragraph 13, you emphasise support of members, education, training and research being core objectives. But I think you say even in the actual delivery of education, that tends to be the Deaneries who are teaching the specialist registrars and so on?

A. That is correct.

Q. Thank you. In paragraph 14, at the bottom of the page, if we may, please, we see those areas set out in terms of core aims of what the college seeks to do. I just note in relation to -- most of it speaks for itself and I don't need to go through it all, but at (d) it says:

"Supports quality improvement and accreditation of services (for example, through the College Centre for Quality Improvement ... and programmes such as Accreditation for Community Mental Health Services ..."

That seems to get slightly closer to that threshold, when you say "supports quality improvement and accreditation of services", what does that relate to specifically?

A. So that is a wing of the college that starts with

a network of clinicians, so psychiatrists and multidisciplinary team members in a particular area. So there is one example listed there, which is the community mental health services. So it would then set standards for what does a good service look like and then these services are evaluated against those standards and if they meet those standards, then they are accredited and there is a ranking system depending on how well you meet those standards.

Q. Who, in that situation, would be doing the evaluation?

A. So the evaluation is done by a team led by our evaluators but there are both professional members on the team, so psychiatrists and there are lived experience or carer members as well on the team who evaluate.

Q. So in that specific area, there is an element of the royal college being involved in evaluation and accreditation of services?

A. To support our psychiatrists in delivering the best quality care for the patients.

Q. Thank you. Paragraph 17, please, over the page RCP000001_0004. You say:

"While [you develop] evidence-based guidance and quality standards [you do] not have [power] to mandate adherence to them or to monitor compliance across

services."

Is that right?

A. So, that is correct. Going back, if I may, to the previous point about the quality centre for quality improvement, that's a voluntary service that organisations may choose to take part in. It is not mandated and there's no requirement, nationally or regionally or locally, for organisations to enroll their services in this accreditation framework.

Q. Thank you, but presumably the Care Quality Commission, when doing inspections and checking on the standard of services actually being provided, would look across the range at guidance that is in place, so part of that may well be NICE guidance, but would also presumably look at royal college guidance, to see whether that is being adhered to?

A. I can't speak for the CQC but I think that's one of my actions I have initiated since I have become president, is to try and bring together a degree of alignment between the way CQC assesses those standards and how our standards are laid out in support of our members.

Q. Thank you. I want to turn, against that background Professor, if we may please, to my first substantive topic, which is the definition of the cohort with which we are concerned in this part of our work.

So, if we could start please in your statement, page 5 RCP000001_0005, paragraph 23. You say there that the college:

"... is aware of the use of the relatively novel term Violence Fixated Individuals ... [in] some policy, security and operational contexts."

You say:

"While the term VFI may have utility in other settings ..."

I'm going to come back to that:

"... the College does not recognise VFI as a clinically valid or reliable psychiatric term."

Do you want to explain, first of all, why the college doesn't recognise VFI in that way?

A. So the college is the professional body of psychiatrists, Chair, and so I think what we deal with is the diagnosis and assessment of mental disorders. Mental disorders are based on diagnostic categories which are set not by the college but by the World Health Organisation as part of their international statistical classification of diseases and regular health problems --

Q. So that is ICD and DSM --

A. The two main ones are those two, that is right. And I think -- so the college uses those categories. "VFI"

or similar terms are -- don't have any clinical validity, don't really have operational reliability or interrelated reliability and so the college does not tend to use them -- those terms.

Q. If we look at paragraph 24, you say that the college:

"... is concerned that the term VFI may inadvertently be interpreted by non-health agencies as representing a recognised clinical condition or diagnosis."

So, just pausing there. What we have gathered so far is that the college's opposition to the use of VFI is, it is not a recognised ICD or DSM diagnosis, but the wording of it may lead people to think that it does represent a psychiatric disorder, is that right?

A. So that is correct and I think it may kind of confer a degree of assumption about its validity or about its usage in terms of integrated reliability or in terms of its ability to dictate prognosis. None of these would have been studied with this particular label which is the thing that would have happened with diagnostic categories that we have alluded to earlier.

Q. I follow. Presumably -- but you must tell me if I'm wrong about this -- the use, in particular, of the word "fixation", which I think, in some other contexts, is part of a diagnosis and may have a psychiatric

significance and appropriate in other contexts, in other disorders, is potentially confusing there because it has the ring of a psychiatric disorder but in the context of a VFI, is not actually properly recognised; is that right?

A. So that is correct. I think we know that fixation or over-involvement or repetition or a kind of degree of obsessionality with particular areas is a feature of certain neurodevelopmental conditions, such as autism. And I think there is that ring, as you say, that can be associated by the use of terms such as VFI.

Q. Thank you. We don't perhaps need to go into the detail of this, but perhaps you could just give the learned Chair the nutshells. You warn about previous experience with the term "dangerous and severe personality disorder". Just give us the nutshells of why that was problematic in your experience in your knowledge?

A. So the term, Chair, "dangerous and severe personality disorder", was an invention. It wasn't a diagnosis but it sounds like a diagnosis, especially given the fact that it has the suffix "personal disorder", which is a recognised category in ICD and indeed in the DSM, and this led to a whole programme of management of DSPD, which was quite an expensive programme. In a resource-constrained environment when you launch

a programme that actually does mean that that money or that resource is not available elsewhere.

And I think that undermines the whole principle of evidence-based care, evidence-based strategy planning and evidence-based commissioning and I think that is our principal objection.

I think, then, it also particularly led to this -- the development of DSPD then led to the idea that once you identify somebody with DSPD, let us then seclude them and then treat them separately, which I think then creates that risk that I outline in my report of encouraging "warehousing" -- I use the term deliberately because that's what was the concern at the time -- in quotation marks of people providing effective treatment. Effective treatment should be based on a validated diagnosis.

Q. All right. So if we look at paragraph 26 of your statement, could we have the bottom of page 5 and the top of page 6 RCP000001_0006, please, Amanda.

What you emphasise -- and I'm going to come back to this -- is that:

"Where there is a need to describe an individual's apparent preoccupation with extreme violence or mass casualty events, the College considers it preferable to refer to violent-fixated behaviours ..."

Okay, so that's the key issue that you give then further emphasis to in your statement. If we scroll back up to paragraphs 24 and 25 RCP000001_0005, I just want to understand where the college is coming from on this.

Are you saying that in terms of giving this cohort a short-form definition, the college is opposed to "VFI" being the definition? Or are you saying that you don't think it's helpful to have a short-form definition at all?

A. So, there are two elements if I may, Chair. So firstly, I think are the concerns that I outlined in relation to this being mistaken for a diagnosis and I think there is that real concern, I think without there being (unclear) individuals being labelled with that label and carrying the consequence of that label without there being the availability of the evidence-based treatments that should normally form, if there was a valid diagnosis.

But the second concern relates to the utility of the term. I think if the term doesn't have agreed definition across agencies, then the utility of that term becomes significantly diluted.

Q. So if there was a better short-form term to describe the cohort, that didn't have the ring of a psychiatric disorder about it, would you agree that that would be

useful?

A. So I think -- conceptually, I don't think there is an opposition to the use of a term to describe these behaviours. I think the main challenge here is to have agreement across agencies. I think that is a process I would like to see, that if there was an agreement that all the stakeholders were signed up to, then that definition could actually have utility and value.

Q. Looking at paragraph 25, you, in common with others, refer to the fact that VFI:

"... appears to combine several overlapping but distinct phenomena ... grievance-fuelled violence, stalking, fixation ... interest in extreme violence or mass casualty events."

And you emphasise that they have different psychological, behavioural and clinical characteristics. So a heterogeneous cohort, as others have referred to it, yes?

A. That is correct.

Q. Would you not agree that if it is a wide group that we are trying to capture, that, in a sense, it is all the more important to have some kind of short-form definition, agreed amongst agencies, so that we understand partly the breadth of those with whom agencies would be dealing?

A. So, Chair, if I may, I think there is a tension here in terms of having a very tight definition. I think if you have a very tight definition, the reality -- and I think we may come to this later here -- if we look at the numbers of referrals that Dr Taylor, for example, pointed out in his testimony, I think the likelihood is that any definition we use will be used to make referrals to the agency or whatever structure we have.

If the number of referrals increased substantially and the lack of -- if there isn't that resource to manage referrals, then the definition will be used to reject those referrals and I think that lands us in the same problem that we are in right now.

Q. So it becomes exclusionary?

A. It becomes exclusionary and that definition becomes the reason by which that particular agency has been signed now to manage that definition, says: well, this falls beyond our remit. And it would then exclude the very people that we are trying to kind of address. So I think there is a real tension here about, you know, (a) having a definition that is acceptable to all, that then actually delivers the purpose that it is meant to deliver and relying not solely on the definition but recognising that there needs to be enough capacity in the system to deal with whatever definition that we may

use.

Just to sum up, I think -- to me, I think that agreed -- the multi-agency agreement on a particular definition is almost more important than the specific words that we may use for the definition and then secondly, I think making sure that the resources are available to deal with the consequences of using that definition are important too.

Q. So a definition, looking through the other end of the telescope, that didn't have buy-in from agencies wouldn't work and the practical application of the definition will fall apart if there aren't resources to deal with those who fall within the definition?

A. That is correct.

Q. And you don't want a definition that can be used by agencies inappropriately to exclude people who need support and assessment from having that?

A. That is correct.

Q. All right. So, against that being the college's areas of concern here, could we have a look at HOM001011. I know that you have been put on notice of this. So this is the Home Office's interim guidance to support the management of NIEV, non-ideological extreme violence concerns. It is the 6 October.

Before this was drawn to your attention by the

Inquiry, had it already come to you in a professional context?
A. No, I don't think we have been consulted on this particular definition.
Q. If we look at page 2 HOM001011_0002, please. Right at the bottom. Familiar territory. So, not statutory, not legal, not operational in nature and it is a working definition. But:
"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."
What is your assessment, Professor, of that working definition against the concerns that the college has about definitions?
A. So, as I said previously, I think to me the concern would be that, again, this could be used to exclude people. I think so, for example, if there was a particular individual who was expressing threats of extreme violence, not driven by a clear ideological purpose, but which was also not communicative in nature as in was not intended to shock, intimidate or outrage the public and then it is possible that the agency might say -- or whatever structure or function we come up with -- would then reject the referral and say: it does

not meet our inclusion criteria. And then, for me, I think that would then fail to deliver the purpose that I think this Inquiry is trying to address.
Q. Thank you. I should say, although it is not perhaps apparent from this document itself, that Mr Emmett of the Home Office was keen to emphasise that this definition was really pointing towards the end act and that what agencies would need to assess is whether somebody was on the pathway to this final act. So, the essence of an "intended to shock intimidate or outrage the public" is the final act and you would be looking at the pathway of whether they are on the route to that.
Does that allay the concerns, if that explanation was made clear, or would you still have concerns about this definition?
A. I think in the real world what tends to happen is that we are faced with a scenario where there are more -- there's more demand than there is capacity to meet that demand. So I think we are always trying to see whom to prioritise and whom to then kind of, you know, put at the back of the queue, as it were. So I think in this case, if there was no clear intention, then you can imagine that a person, even when a structured professional judgement and an individual formulation might deliver a different result, would not be included

solely because the communication element was not very, very clear, or the intent to communicate wasn't very clear.
So, I think ultimately, it will depend on -- this is for the Inquiry to decide what structure does it recommend or what function does it recommend. I feel that the key elements here are about the requirement to be very clear as to which agency is dealing with the referral.
Q. We are going to come onto the question of agencies. So, professor Cassam was one of our experts in our seminar and he suggested that there is an alternative definition of "non-ideological violent extremist", which he suggested as a definition because it got away from any inclusion of intent, in the definition, of -- that we have just been looking at and the Inquiry, building on Professor Cassam's suggestion, has been exploring with witnesses a possible definition of "those being vulnerable to being drawn into non-ideological violent extremism". What would you say about that as a definition of the cohort?
A. So I think the generic critique that I have of these labels remains. I think that they are (a) not psychiatric diagnoses, (b) they are not founded in studies or evidence base and I think so, if you are

going to use them as descriptors I think the most important element of that descriptor is the shared agreement across agencies.
Q. Yes. I'm just going to pause you there. The cohort is likely to contain some who do meet ICD diagnoses and some who don't?
A. That is correct.
Q. And there may be some within the cohort who don't have any mental health disorder at all. So I'm not quite following at the moment when you say, as you have just done in your answer, that the generic critique is that they are not psychiatric diagnoses because, by definition, they shouldn't be psychiatric diagnoses nor should they sound as if they are. So one of the potential benefits of "those being vulnerable to being drawn into non-ideological violent extremism", is it doesn't seem to have any language connoting psychiatric disorder.
A. I guess my concern is that on the ground these can then begin to sound like diagnoses and can be used interchangeably with diagnosis, especially given the fact that there is a degree of association between, as you said, a proportion of the cohort which has a mental disorder. And which is why I feel that the most important element is that various agencies and

including -- you know, we probably need to bear in mind that the families and carers who actually are managing, on a day-to-day basis, these young people, I think have an important voice too and I think having their buy-in is absolutely critical as well, as well as the other stakeholders. If there was an agreed definition then I think it is far less likely that there would be this degree of interchangeability with diagnosis.

Q. So the concept of "vulnerable to being drawn into", is designed, in part, to get away from the stigma of labelling somebody as a non-ideological violent extremist, when you may be dealing with early behaviours. So the "vulnerable to being drawn into" aspect attempts to deal with that.

Professor, if you don't mind me pressing you a little bit on this.

A. Please.

Q. One of the challenges is that it is one thing for witnesses such as yourself to say, "It is important that agencies all agree to it", but the difficulty that we are having is actually coming up with the definition or the starter for ten, if you like. And the starter for ten offered by the Home Office is met with quite a lot of opposition from witnesses. Do you have any better suggestion?

A. Well, I don't, but I think we haven't been invited to contribute and I think, given that I think we have expertise within our college, of people with both forensic and CAMHS experience, I think we would be quite happy to participate in a roundtable with other stakeholders to think of better terminologies --

Q. Thank you.

A. -- that may meet the descriptor criteria that I have made reference to.

Q. So we will try not to make the homework list too long but would you please take that away as being an area because, certainly so far as the Inquiry is concerned, when you say that you haven't been invited to contribute, that's really the exercise of inviting the college here today and continued involvement with you, we would welcome any thoughts you have on that.

Could I just raise these issues that, in order to capture this cohort, in our seminars one of the points that Professor Cassam raised was the importance that the definition works to exclude what might be thought of as ordinary interpersonal violence and also conduct such as gang-related violence. So, in whatever terminology one is trying to capture, nihilistic violence, violence for its own sake, violence-fixated type behaviour, but not that those other kinds of violence because otherwise the

cohort will be too wide. So that's part of the difficulty, conceptually, of the definition.

So if, in the work that you do and views you take, you could take that into account?

A. Thank you, I will.

Q. So if there is anything that can positively be suggested that would be helpful. Just finally on this, would you agree that if all that was in a definition was "violent-fixated behaviours" without any definition at all, that would be problematic because that's going to be difficult to sort of capture the cohort if all one says is: you need to be on the lookout for violent-fixated behaviours?

A. So, I think as I alluded to before, I think there is a tension between having something which is wide enough and something that's quite narrow. I think it is inevitable that given this is an evolving field which has not been researched adequately that one of the things that we will have to make a clear commitment to is that whatever definition we use is reviewed periodically based on the data and then following on the outcomes for the individuals who come in, using that definition, to see what are the outcomes for them, whether they end up with health or social care or criminal justice or a combination of those. And how

well does the definition function in predicting those outcomes.

I think that will hopefully help -- I mean, that's how science works and I think we will have to come up with iterative measures.

Q. I think probably you would agree with this, would you not, not just the definition but whatever definition is used in guidance, there will have to be some underlying text that speaks to, for example, behaviours and that will need to be kept under review as well?

A. I think that's critical and I agree with you completely.

Q. Quite so. Thank you. Can I turn next to Mental Health Act powers which you address in your statement. So if we could look at page 6 RCP000001_0006, please, paragraph 30.

So, I'm not going to read all of this out, but just so that we have it for our notes, you see at paragraph 30, you are setting out the framework and over the page RCP000001_0007 at paragraph 31, again, it is application to all individuals. Then we see if we could just have paragraph 32 and 33 on the screen -- I'm taking this relatively quickly, Professor, because the learned Chair has heard this and we have been through this with earlier witnesses.

But you set out at 32 and 33 the changes that are

being brought into effect by the Mental Health Act 2025, noting, however, that the changes in relation to learning disability and autism, as you will be aware, are not yet in force.

A. That is correct.

Q. Can you just explain, first of all, whether those changes from the Mental Health Act 2025, once they do come into force, whether you think that they will have a knock-on impact on the use of section 2 powers, which -- you know better than me -- are powers for assessment rather than treatment, whether section 2 powers will be affected by those changes even though the direct change is made to section 3 powers?

A. So it is difficult to predict. As you quite rightly say, the section 3 is the main change. I think it might be useful -- so, Chair you may have already heard of this, but I think the reason why these amendments were brought in because there was a concern that people with solely autism or neurodevelopmental conditions were being detained for prolonged periods of time, using the Mental Health Act provisions, and then there was a concern that there was a significantly large number of people in that cohort.

Q. Just pausing there, just so that we have it, I think not just that they were being detained but that the

detention itself was damaging to their wellbeing?

A. That's correct. So I think that was the background. I think the college's concern is mainly around a small group of individuals with autism who do not have a comorbid mental disorder and the new provisions would then mean that they would then be excluded from the part 3 -- the section 3 provision of detaining them for treatment and then that restriction would mean that the assessment would only last 28 days and once that ran out, I think it would be quite a difficult thing for both families and indeed for the clinicians concerned.

Q. Let me just pause you there for a moment. Can we just have a screen page 12 RCP000001_0012 because you go on to deal with this in a later section. So if we can have paragraph 54 at the top of the screen, please. I'm going to put that on the screen if it is helpful to you as you are explaining this. Do carry on.

A. I think what we recommended was that -- let me finish the previous point, sorry. Then the second point I think was that there was obviously, in the provision, that those people with autism who had been previously involved with the criminal justice system, for them, the routes were unchanged, so they could still be detained under section 3 for treatment. So that created a parallel, two-track system, one for those on a civil

detention and another one for those who were coming through the criminal justice route. So I think it just fundamentally seemed inequitable and is inequitable in our opinion.

So we recommended that there should be provision by which detention can be continued after 28 days allowed under section 2 of the Mental Health Act for people with learning disabilities or autism, but in tightly defined exceptional circumstances, so as to reduce the number of detentions that we have seen and then the problem we were trying to address through the amendment of the Mental Health Act.

Q. Thank you. So in part so the learned Chair has this to see what the royal college said about it, could we briefly put up on screen, without necessarily going through it, RCP000002 which I think was the submission made to the joint committee, is that right?

A. That's correct.

Q. When you say the suggestion that was made for the amendment, I think this is the June 2025 explanation from the college of the amendment that was sought and the reasons for it?

A. That is correct.

Q. All right. Now, without going through the detail of this -- in fact it is a relatively short document, but

it is helpful -- could you just explain -- obviously don't use a real-world case -- the type of case where this concern would arise? So, there is an emphasis, in this document, on those with learned disabilities. But it may be helpful to take a case in relation to autism. What type of case was the college concerned about?

A. Let's take a case with someone with autism where they are also exhibiting significantly challenging behaviours, aggression within the house, aggression outside, in the educational environment and on assessment, it was clear that they did not have a mental disorder such as psychosis or severe depression or a mood disorder or an anxiety disorder of a nature or degree that would warrant the use of the Mental Health Act. Now, in the current scenario, as the Mental Health Act stands now, if there was serious irresponsible conduct or aggressive behaviour, then the provisions of the Mental Health Act could be used in this scenario, with the exclusion of autism in the 2025 amendment to the Act, I think this person would then -- could only be detained for a period of 28 days. Now, in that period of 28 days, the assessment concludes there is no mental disorder so there would not be the ability to detain them further under section 3. The risk associated with their behaviour would remain. And there would be no

other means of containing that risk, apart from allowing them to go down the criminal justice route.
Q. So, the concept of being allowed, in those exceptional cases, a period longer than 28 days, that doesn't perhaps sound, if one takes the case of autism because it is not, as it were, "treatable". So that doesn't sound as though the extended period would be with a view to treatment, would it be with a view to complex case planning and putting in place measures of support and needing time to assess and arrange those? Is that what it is driving at as a solution?
A. Yes, I think we have seen that assessment is quite complex in this scenario. So if you take -- if I go back to the example of that aggressive behaviour, I think you would require to understand what was driving those behaviours, what were the factors that were worsening those behaviours, what were the factors that would mitigate those behaviours. So that individual formulation, the detailed formulation and based on that, a personalised care plan that with then mitigate against that. That is what the purpose of the assessment would be. So you are right to say that it is not to treat, as it were, or cure the autism, but it is actually to manage the behaviours associated with it.
Q. Now, in your answer several minutes ago, you drew

attention to the current guidance where there is provision for the compulsory powers to be used in the cases where autism is associated with serious irresponsible conduct or aggressive behaviour. So it is that cohort that you are concerned with?
A. That is correct.
Q. Obviously there are circumstances in which that can arise. For some -- it is obviously totally dependent on the individual, but for some that can arise in learning disability or those with autism and one understands that.
Does that current provision of serious irresponsible conduct or aggressive behaviour also potentially capture -- I don't want to reopen the debate about VFI -- but those in the VFI cohort, or is this really a totally separate problem?
A. So, I think it may capture some of them because I think what we have seen is that there is an association between autism and people exhibiting either thoughts or actual aggressive behaviour. So I think it may be that a proportion of those people may be captured by that group.
Q. And it must follow that -- this suggested amendment not having been taken up, that as things stand at the moment, when the 2025 Act provisions in relation to this

come into force, that power will be lost for those displaying that sort of behaviour arising out of VFI type concerns and one is left just with section 2 powers for the maximum of 28 days?
A. That is correct.
Q. Thank you. If we go back to your statement please at page 9 RCP000001_0009, and it is paragraphs 42 to 45, so the bottom half of the page. What you really set out here is, paragraph 42:
"The legal powers available to manage an individual depend on the circumstances giving rise to concern ..."
You deal with the situation where they have a mental disorder and the statutory criteria are met. But you also say, paragraph 43:
"Where neither the statutory criteria for detention under the [Mental Health Act] are met nor a criminal offence has been committed, there are generally in equivalent legal powers to detain adults solely on the basis of concerns about potential future risk."
Then you say that:
"... reflects the principle that compulsory detention should only occur where there is a clear legal basis ..."
You also indicate, in broad terms, that the college's position is that the existing framework is

sufficient. Have I summarised it fairly?
A. That is correct.
Q. Thank you. I would just like, if we could bring on screen please CHAIR000002, the Phase 1 report in volume 2, and page 292 CHAIR000002_0292 and paragraph 290. I'm not going to read this out but there is a reference there which we have looked at on previous occasions, to Dr Irani's assessment of what could have been done in terms of a Mental Health Act assessment in AR's case. I just wanted to check, Professor, that you have before coming to give your evidence today had an opportunity to digest that section?
A. I have.
Q. Thank you. If we could look please at page 315 CHAIR000002_0315 paragraph 364. It is the bottom of the page. The learned Chair, in his Phase 1 report, came back to that view from Dr Irani and the use of Mental Health Act powers and issues about whether there was a gap in the legislation and if we go over the page, please, CHAIR000002_0316 that continued on this page. If we just have it zoomed out just a little bit more Amanda, leading 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 [1983 Act], as amended by the [2025 Act], do not permit assessment or detention."

Again, I have not read it all out, but can I just check that by the evidence proposal notice you've had a chance to digest that as well?

A. I have indeed, thank you.

Q. I'm very grateful. So, looking at the position overall, the area of particular concern to the Inquiry is AR's type of case and so what you had there was an adolescent with a serious conviction for violence in terms of the knife that had been taken into the school and the threats that had been made previously. But he had then withdrawn completely by late 2023, early 2024. So he wasn't being seen by mental health professionals because on home visits he would refuse to come out of his room. But it wasn't as though he was being seen by education, by teachers, or by social care workers because effectively, he had withdrawn from seeing them as well.

There was an ongoing violence risk that was either known or should have been known. There had been the further incidents of him taking a knife onto the bus and reference to the use of poisons in the context of that

and saying that he had taken the knife on the bus in order to stab somebody.

But he was not just locked in his room, or locking himself in his room when professionals came, that's where he was spending the majority of his time and there came a time where he hadn't been out of the house for months and there were grounds to be very concerned about his consumption of online violence material. Again, more should have been known about that but even from what was known about that, he had been known to be looking at inappropriate material on school computers and he had had three Prevent referrals.

So forgive me for putting it in that way, but in that sort of context, are the Mental Health Act powers sufficient? How do Mental Health Act professionals actually get eyes on an adolescent in that position?

A. So Chair, we have spent a considerable amount of time looking at this because this, as you say, goes to the nub of the matter. I think, to me as an adolescent psychiatrist who has been involved in these situations, I think the powers are sufficient because I think when you have an individual who -- where there is some preliminary evidence to suggest that there may be a mental disorder -- they don't need to have one, we don't need to know they have one, but that there might

be one. I think an individual locking themselves in their bedroom, not eating, drinking could be a result of depression, for example, could be a result of psychosis. Say there is suspicious grounds to suspect there is a mental disorder and there is an associated risk to their health or to their own safety or to the safety of others, I think then there is enough powers to trigger an assessment under the Mental Health Act.

Now -- so the question -- if the question is about is there legislative gap? I do not think there is one. If the question is: is there a practice gap? I think that may be a different issue because I think practice standards may vary depending on the individual circumstance, depending on how the services are -- I think in this particular case I think you pointed out that not all the information about risk was available to the clinicians when they made that decision not to instigate a Mental Health Act assessment, for example. Now, I wonder what might have been in the outcome had they had that risk --

Q. To be accurate, some was not available and some was available but hadn't been read by the psychiatrist. So it's a combination of the two.

A. Correct. So, I think, to complete I think my point -- I think to answer your question, I feel that in case --

for whatever reason -- the clinicians have decided the Mental Health Act is not applicable, then the door is still open to them in this case -- in this particular case, if we look at where somebody has locked themselves in, is not making themselves available for an assessment, to raise a safeguarding concern. And within the safeguarding framework currently, I think -- I'm not an expert in this area but I think my understanding is that there is -- there are various tiers, "early help", "child in need", "child at risk".

Q. Yes.

A. And if there is child at risk and depending on the urgency of the risk, I think there are powers available to social care, under safeguarding, to kind of ask for that assessment to be made possible.

Q. So, can we put to one side, without ignoring it, that last aspect, that if the genuine assessment is Mental Health Act powers aren't appropriate, then one needs to think about safeguarding interventions. Put that to one side for the moment. Focusing on your point that it is not a legislative gap but it may be a practice gap. In AR's case, it may be thought that the reason why more thought wasn't given to a Mental Health Act assessment was that prior to disengaging, AR had been seen by a number of mental health practitioners who, taking it

shortly, assessed that there may have been issues about anxiety, so his reluctance to go outside, that he had indifferent engagement with any type of talking therapy, he didn't really want to explore that further and they hadn't assessed that there was any more significant mental disorder, than that sort of anxiety type problem, and had, on the Inquiry's finding, missed a diagnosis of conduct disorder. But the thinking may have been: well, when we have previously seen him, he hasn't been suffering from significant mental health disorder of the kind that would warrant detention for assessment, let alone for treatment, and so now that he's locking himself away, we don't really have adequate grounds to use Mental Health Act powers.

Do you think that, in particular for the adolescent who is not being seen, where there is a concern about risk to others, there needs to be a change of practice there and a greater willingness to use section 2 powers, in particular?

A. So I think my impression, having read and digested the sections that you have highlighted, but also the overall report, is that there needs to be clarity around who is holding the ball. So in this case, I think what we didn't end up with was a clearly defined risk formulation and a safety plan emanating from that. Now,

if, when you have clinicians say that: we can't assess the person and therefore we are not able to come up with a risk formulation, then I think there needs to be a thought of how are we going to arrive at the risk formulation, do we need to instigate the Mental Health Act or go down the safeguarding route to make that happen?

I think that is the practice gap here and I think the legislative powers were available to be used. You mentioned conduct disorder. I think that may be a part of the discussion but I think the most important thing here is about what we don't actually have a risk formulation on the basis of which we can make an individualised care plan and that is what is needed here.

Q. All right. So trying to put this in more concrete terms, would you say in a similar situation in the future, treating psychiatrists, if they came to the view in this type of a case that a Mental Health Act assessment was not appropriate or they had a Mental Health Act assessment that didn't support the use of section 2 powers, for the adolescent locked away type case, that needs to be married with good multi-agency working, particularly with social care, to ensure that the risk is addressed by other powers, in particular by

child at risk powers in social care?

A. I agree completely.

Q. What about the adult? Because you don't have the same type of powers for adults as you have under the children's legislation, so narrower powers around neglect or abuse?

A. So adults, I think the situation would be that you would have to make a decision about which legislative framework was applicable. So I think if, as you say, the Mental Health Act assessment had been done and had decided -- and this does happen quite a lot in the real world, that you make a decision that the Mental Health Act is not applicable here, that the mental disorder is not of a nature or degree where those powers are available -- I think then you have to consider whether there is a criminal justice route, that that needs to come in, or indeed whether there is any role for the Mental Capacity Act to play a role, whether the person has capacity. So I think there are various frameworks that have to be used.

I think -- will that cover every single instance of risk of any kind? I'm not sure that would. I think because sometimes we are dealing with situations where there is a worry about the risk, there is an expression or thought rather than any action that one could take

concrete action on and then, so I think that is the matter of judgement and which is where I think that multi-agency working becomes absolutely critical, so that you don't lose sight of -- and there's no lack of oversight of that case, where it has been difficult to use a particular legislative framework to manage the risk in that particular adult.

Q. Thank you. Having regard to the royal college's responsibility for standard setting, has the college done anything to change guidance? In particular, has anything been done to emphasise that need to make sure that psychiatrists know who is holding the ball in this type of case?

A. So, I think if you look at CR201 which is in the pack and I think -- that is our guidance, that that talks very clearly about information sharing, about this exactly, about -- the thing about whose -- that you do not lob the ball and expect someone to pick it up, I think that you hand it over. And I think -- it didn't use the acronym "SMART", but I think the implication there is that you do that, the very clear understanding and I think that is in the description of how the handover should happen. I think that guidance is due for renewal and I think I, having taken over as president, have identified safer services as one of my

presidential priorities and I was appointed a presidential lead specifically to focus on safer services and then one of the outcomes will be to update this guidance.

Q. All right. So RCP000004, that's what you are referring to?

A. That is correct.

Q. And I'm sure, verging on the unfair for me, Professor, when you have taken up post relatively recently, but if we just go to page 2 RCP000004_0002, when you say that it is due for renewal, if we look at the college report 201 heading, just a little bit lower, it is written in 2016. It was due for revision five years ago?

A. That is correct and I think the college was in the throes of Covid at the time which is why this didn't happen then. I think the view at the time was that the substantive elements in the guidance were reasonably up to date. I think it is probably worth bearing in mind, Chair, that there has been a significant awareness of neurodevelopmental conditions and autism in the last decade and I think -- so there has been other activity happening within the college in that space. But not specifically looking at the association of autism and risk, which I think would be included in the updated guidance now.

Q. Thank you. Do you know what the timetable for improvements and updating of this is, given that the revision date has already been lapsed by five years?

A. I think we will commence the work fairly soon but I think part of this, I would want to hopefully have some clear direction about the agreed nomenclature between agencies. I think if there is a settled view on that, that will actually help us design our guidance in a more tailored fashion for our clinicians.

Q. Thank you. That sounds then like it won't be completed before the Inquiry reports in the spring of next year; would I be right about that?

A. I think that would probably be sensible. We will commence the work so that substantial elements of the changes that need to happen will have been in train but I should think that I would like to include the new descriptors that we hopefully will arrive at in the new guidance.

Q. Thank you. Professor, one of the branches of the Inquiry is that it can receive policies that are in draft before they have been completed and it would, subject to the Chair's agreement, I think be helpful for proposed amendments that are in train to this, in the work that it sounds like you are going to be doing in coming months, to be communicated to the Inquiry, even

though the updated guidance won't have been completed. In particular, any aspect of this guidance which is going to be updated to take account of the not dropping the ball, who is holding the ball, because if the college's position is the Mental Health Act powers are sufficient, but there needs to be a very careful focus on who holds the risk in cases when Mental Health Act powers aren't going to be used, it would be helpful to the Inquiry to see how that is taking shape in the updated version of 201. Is that something you could look at, sharing a draft in progress?

A. I should be most happy to do so.

SIR ADRIAN FULFORD: Thank you very much.

MR MOSS: Could we turn away, then please, from Mental Health Act powers and look at the identification and management of VFIs. If we look at your statement at page 6 RCP000001_0006, paragraph 28 please.

28 and 29 would be ideal. So, you come back to the refrain that the college doesn't recognise VFIs, so I think your first response on identification and management of VFIs is: we don't recognise the term. But you say there have been no publications by the college on this topic because there is no empirical validity. But then you say:

"The College has not undertaken any data-based or

statistical analysis of the risk posed by VFIs, nor the prevalence of [violence-fixated behaviours] in individuals with certain characteristics or diagnoses, for the same reason".

I just wonder about that. Is the absence of a definition getting in the way of the college doing work in this area?

A. So the main reason where the college would get involved in doing such data-based, such statistical analysis would be as part of its quality improvement work where it might be commissioned to do so. And I think if that were to happen, then I think the college might look at that. So for example, it could be that -- just hypothesising -- that if there was a network of all the forensic CAMHS services and, if there is a quality network and we were asked to develop standards of those services, I think then you could evaluate how they were operating, for example.

Q. We are told that the FCAMHS network, in recent annual reports, have been asked to give a return for cases that are fitting this broad area. We were told about that by Dr Champaneri last week. Is the college aware of that?

A. I was aware of the fact that that had happened but it is not something that we have been given directly, is my understanding.

Q. Is the college aware of the general trend, that FCAMHS network and indeed others -- Prevent being one of them -- have been indicating that the cohort seems to be increasing?
A. Yes. Again, I'm aware of that fact from having read some of the testimonies in the report but also from my colleagues.
Q. Does the college have any understanding of why that increase may be happening?
A. So I think this, Chair, again, goes back to the broader question, I think which has at least been looked at by Professor Fonagy in his report of the prevalence review; I think this question of whether there is an increased prevalence or administrative prevalence, as Professor Fonagy refers to.
Q. I'm referring here to the prevalence of violent-fixated behaviours rather than neurodevelopmental conditions.
A. No, I'm coming to that, if I may. So I think this feeds into that kind of issue where we are seeing perhaps a similar rise in the number of referrals because of awareness from the general public, but also awareness in the professionals and indeed, the awareness on account of Inquiries such as Calocane and then Southport, which kind of draws attention to such cases and I think that makes plain the rise in that cohort.

Q. So some of it may be an increase in knowledge and awareness?
A. That is right. I think there's also an association between -- that we have -- I have commented upon, that we see with neurodevelopmental conditions, autism and risky behaviours, for a range of factors. I think I'm aware, Chair, that you have clarified very -- in no uncertain terms, that there is no causation implied here. So I just wish to reiterate that.
Q. We will come back to that. If we look at page 14 RCP000001_0014 of your statement and paragraphs 58 through to 60. You stress there, how:
"Neurodevelopmental conditions ... form an important part of the overall clinical assessment and inform ... formulation[s] ..."
You note that it is not an illness, not treatable in itself, ASD:
"The principal challenge is not the recognition of neurodevelopmental conditions ... but the availability of appropriate services following assessment.
And you mention Professor Fonagy's report, if we just have a look at it briefly, ILT000365 and there is an executive summary at page 5 ILT000365_0005.
Again, if you will forgive me, I'm not going to read it out. But could you just have paragraphs 4 and 5 on

screen. May I just invite you to read paragraphs 4 and 5 to yourself.
(Pause).
Then we see, in paragraph 6:
"Continuing as we are is not sustainable ..."
Then over the page please, ILT000365_0006, paragraph 8:
" ... fundamental shift from a diagnosis-dependent system to a needs-led plus diagnosis system. The heated debate about whether there is too much diagnosis or too little risks reinforcing the centrality of diagnosis rather than need and timely access to support and treatment. The government must address two failures at the same time: people wait far too long for support, diagnosis and treatment, and diagnosis has become the primary gateway to support that could and should be available earlier. These failures sit alongside insufficient capacity for people with the most severe, enduring and complex needs."
Now, we have been told that the Government response to this report is reasonably imminent. Does the college have any views on these central findings in Professor Fonagy's report?
A. So I think the overall thrust of the report we have welcomed. I think it has been helpful to kind of shed

light on this polarised world of over-diagnosis/under-diagnosis and instead, focus on the fact that, in the face of rising demand, we need to have a system that can support -- offer support without having to wait for diagnosis. I think later in the report, Professor Fonagy does talk about a model of ensuring that there is expert at hand, as he calls it, which I think is absolutely critical here. I think in my own experience, I think it's not entirely unfeasible to see people either being misdiagnosed with a neurodevelopmental condition, or a severe mental illness being missed. And I think -- so, if we have a model of a front door, offering open access to needs-led support, which doesn't have the capacity to recognise people with a severe mental illness, then that could be just not problematic, it could be risky.
Q. Thank you. I said that we would come back to the issue of the lack of a causative link between Autism Spectrum Disorder and violence. If we look at, back in your statement please, page 15 RCP000001_0015, paragraph 63.
You make that point about the lack of a causal relationship. You say that:
"Any apparent over-representation in Prevent referrals is more likely to reflect a range of interacting factors rather than autism itself increasing

the risk of serious violence."

Now, I'm not going to dwell on the lack of causal relationship, not because it's not important, but because it's, by now, familiar territory. I deliberately want to miss out but come back to paragraph 64.

If we look at paragraph 65, you say:

"The increasing prevalence of online harms is also likely to be relevant. Assume autistic children and young people may be particularly vulnerable to exposure to harmful online content, including extremist material or graphic violent content without an ideological component."

What led you particularly to draw out that factor?

A. So I think online harms is something that we are recognising more in this world of CAMHS and adolescents, so children and adolescents. And I think autistic children, in particular, are more vulnerable to this because they often shun social engagement and resort to engagement in the online world and are therefore more vulnerable to either becoming fixated on particular ideologies that they are exposed to on the online world, or indeed to be exploited by people who are -- may be real or may be pretending to be someone else in the online world.

Q. Thank you. If we just scroll back up and look at your 64. Having looked at 65 and that factor, you put some other factors in paragraph 64. You say:

"Possible explanations for an apparent overlap include improved recognition and diagnosis of autism ... [and] increased awareness of neurodevelopmental conditions among[st] professionals making referrals; and broader multi-agency training, leading to greater identification of autistic individuals who may be experiencing vulnerabilities."

Now, it may be me, Professor, but one follows that all of those factors go to why there may be increasing diagnosis of autism or increased reporting of autistic-like behaviours, and please take that as read, but why would those factors by themselves lead to those with Autism Spectrum Disorder being over-represented in the VFI and Prevent type cohorts?

A. So I think this goes to the issue of, is this -- so if you look at -- it could be, for example, I mean, let's pose a scenario for you, that the prevalence has not increased at all. The prevalence is exactly the same over the last five years of VFI and autism. But it is just that there is better recognition, which means that more people are now being referred. So that is one possibility. So unless we know what the denominator is,

I think just solely looking at the numerator doesn't give us any data to make assumptions about what is happening at the population level. All we can see is that more people with autism and VFI are being referred to the -- I think your second question was about the link between --

Q. I'm just wondering why increasing diagnosis and recognition of autism would lead to there being a higher than statistically expected proportion of those with autism who are in the VFI/Prevent cohort?

A. Well, I don't know whether we have the data about higher than statistically expected. I mean, that would require --

Q. Well, we do because it's clearly set out, that when one looks at the expected population levels, those who, for example, go to Prevent, have a much higher percentage in relation to that. So if we look at DRT000005.

A. I guess the point I was trying make was that unless we know what the proportion of people with VFI is in the population, which is the denominator, so, we wouldn't be able to say -- if we are looking at x number of people with VFI, and then -- because now we are more aware of autism, we are more aware of the fact that we should be looking for autism and assessing autism, so we are diagnosing autism more often than we would have done

otherwise, I don't think we can make an accurate assumption about what is the actual prevalence of VFI and autism in the population. That was my point.

Q. All right, so there may be -- if we just look at page 10 DRT000005_0010 on this. We don't need to spend too long on this, but it is -- the diagram at the top of the page shows the neurodevelopmental or mental health conditions of those in the Prevent cohort, I think it is. And one sees "ASC" and "ADHD", which is the pink and red respectively, against the different age groups. And the very large proportion of those, especially in the younger adolescent cohort. And that's consistent -- and this is Dr Taylor's piece, but that's consistent with what we have heard from others about there being a significant over-representation.

So even if one assumes that the prevalence rates for autism in the country may be underestimated, there's a much higher level of those with autism spectrum conditions than you would expect, being referred to Prevent. I'm just trying to get at why the increased recognition of autism would lead to that disproportionality?

A. Again, I think Dr Taylor himself mentioned in his own testimony about the fact that there could be -- this referral. I mean, so his views are based -- his data is

based on the referrals they received within their service, which is obviously a very niche area. So I think going back, I think it could be -- and this is likely and this was what we discussed in my testimony, that there are the same factors that are increasing, one (unclear) towards autism and to fixation with violence. So that is one likelihood.

So, there may be multiple examples of that kind. But I think we know that the general features of autism does make one -- so I think in the Al-Attar paper that has been quoted in the report, that is reference to those push/pull factors, so features in autism that we see, which are, you know, preoccupation with certain material, the social isolation, social communication difficulties, all of that can make one more vulnerable to risky behaviours as well.

Q. All right. Can we have on screen ILT000177. I think when you say push/pull factors in the paper available to the Inquiry, were you referring to this paper by Professor Al-Attar?

A. That is correct.

Q. Yes, thank you. So I won't go through her paper because we saw it in the seminars and a number of witnesses have referred to it. But, when she sets out those push/pull factors and how there may be this quite complex

interplay that needs examining in any individual case about how vulnerabilities associated with autism may interplay with risk -- my summary, not Professor Al-Attar's words -- I wondered whether the college has done anything to bring home that complexity to psychiatrists, to resident doctors and consultants who are psychiatrists? Because that does seem to be an area that it is very important for leading clinicians to understand.

A. So, I think what the college has done is significantly enhanced its training offer in the area of neurodevelopmental conditions. There have been a series of masterclasses on this topic. There has been a particular training programme called the national autism training programme. There have been masterclasses on ADHD and more recently, we have been commissioned to develop a credential which is a fairly extensive programme to build capacity in this area. We also have e-learning modules and then there have been articles in our journals, our staple journals on this topic.

The more specific issue about Autism Spectrum Disorder and -- I mean, the term that you have used so far about "violence fixation", as I have said before, the college hasn't really used that term, so I think we

talk more broadly in terms of risk --

Q. Leave the terminology to one side, you will forgive me, Professor, but if I come back and challenge an aspect in relation to this, it risks sounding as though those important measures that you have set up of more training in neurodevelopmental conditions is unimportant. I don't suggest that for a moment and that's clearly a significant and appropriate priority. But I'm getting at this sub-issue of the interplay between neurodevelopmental conditions and risk behaviours and risk fixation, whatever terminology is applied, and if we take that down from the screen and look at page 23 RCP000001_0023, paragraph 94 of your statement.

It is the bottom of the page. You explain there, that:

"Current psychiatric training covers the assessment and management of neurodevelopmental conditions ... and the importance of considering [it in a] formulation ..."

But you said:

"... there would be value in strengthening training on how neurodevelopmental conditions may influence the presentation of [violence-fixated behaviours], communication, vulnerability, engagement with services and multi-agency risk management. Such training should reinforce that neurodevelopmental conditions are not, in

themselves, predictors of violence or serious offending."

So that is the emphasis on not direct causation, but my question was: is such training now going to happen and if so, when?

A. So, I mean, this is part of the -- so I don't want to labour the point, but as part of my presidential priority was to develop a whole strategy around this. So we appointed as lead. We have agreed a draft strategy and I'm happy to share the document with the Chair, if that would be helpful, that would outline the work streams that will happen within the safer services category. But I should thing that this would be one of the areas that we will particularly focus on, given the importance to safety overall, which is part of my presidential priority.

Q. Because without that understanding, as demonstrated by AR and how agencies, including but not limited to the mental health agencies responded to it, otherwise there is a risk of overlooking, or acting in a too benign way, to violence and acts of violence if the perpetrator is autistic or has another neurodevelopmental condition. In other words, putting it down to autism, rather than recognising that the risk behaviour needs to be tackled regardless of the fact that the child is autistic?

A. I understand your concern. I mean, just to place this in context, I think risk is a big lens for psychiatry in general and I think it's something that is difficult to ignore. So I think -- so although we may not have used specific terms that have been in the conversation today here, I think the general idea of risk formulation and specific safety planning is very, very much core business for psychiatry and psychiatrists and is reflected in the training and assessment frameworks that the college has set out.

Q. Yes, and one understands that a difficulty with an Inquiry such as this, is we are looking at one subarea and you are entitled to say: well, if guidance covered every single area across all of ICD and DSM, it would get to dictionary-like proportions.

But without going to lots of documents to prove the negative, I do not think any of the guidance exhibited to your statement specifically averts to this area of the risk of overlooking risk in the cases of those who have comorbid neurodevelopmental conditions?

A. I think just to reiterate that as we revise our CR201, there will be real opportunity to kind of include that and I think following the revision will be the opportunity to socialise that in our training programmes and in our continued professional development.

Just as an aside, if I may, I think as a separate piece of work -- not related to this -- but I think in my role as Dean and then what has continued, is a strengthening of the process of formulation training and assessment for future psychiatrists which I think is something that the Inquiry has been made aware of time and again, the importance of individual formulations. So I think that's something that has been happening which I think will align the objectives of this process.

Q. Thank you. I think you indicated that one of the things that you put in place here was the identification of a lead for this within the college. Have you actually identified that individual?

A. I have. It is Professor Mayura Deshpande. He is a forensic psychiatrist and is quite a respected figure in this area.

Q. Thank you. Just finally on this topic before we take our mid-morning break, we put you on notice, albeit slightly belatedly, for which I apologise, of just wishing to seek your knowledge and experience in relation to conduct disorder. The context for this is Dr Church indicating that the case studies that is the expert cadre looked at, showed -- he was concerned about a number of cases where conduct disorder may have been missed. That's on the back of Dr Irani saying that AR

should have been diagnosed with conduct disorder. But of perhaps greater concern was Dr Church indicating that there is, particularly within CAMHS services, a cultural reluctance to diagnose conduct disorder, which he saw as being a negative trend. Negative because there are NICE-approved interventions for conduct disorder and negative because the formulation around conduct disorder can be very helpful to non-mental healthcare agencies in understanding the type of case they are dealing with.

Do you have any professional experience of that? Is that tendency not to diagnose conduct disorder something that's come to your attention?

A. Something I have had feedback from colleagues and I think it is probably fair to say that there is a degree of tension, as you have described, around trying not to label a child, which will take them in the direction of criminalising, or something to that effect, their behaviour. And then conduct disorder can be viewed in that conceptual space. Versus coming up with a detailed formulation that sets in context their behaviours.

I think the answer, to my mind -- and I'm aware this is a forward-thinking phase of the review -- lies in a better multi-agency working that works with parents so that a diagnosis is not viewed as a stigmatising label

or as a label that pins all the problems with the child but remains alive to the wider context and thinks of solutions that need to be -- so, I think -- and examples of this kind of thing, you know, I think where it doesn't appear to be stigmatising would be street triage, for example, where police, in their role -- where police and healthcare work together and then their joint work is not seen in those stigmatising terms.

So I think I accept that there is probably a cultural issue that we need to address but I think I'm not sure the training alone or the college guidance alone would solve it. I think it would have to also be solved at a practical level on the ground with a structure that allows for that coordinated working, that involves families also to feel that a label such as a conduct disorder is not a negative label; it is actually an enabling label that opens up solutions.

Q. So I follow what you are saying in terms of others would need to be involved in this. But, when you say "training alone or college guidance alone wouldn't solve it", has there been a change in training or college guidance to tackle the cultural reluctance?

A. Not specifically, to my knowledge. I think there's been kind of broader guidance around developing detailed formulations and the importance of diagnosis more

generally, and I think --
Q. Forgive me for interrupting, but the emphasis on formulations may actually undermine it. Because the risk there is that you get at the conduct disorder features in a formulation but avoid the diagnosis so as not to stigmatise. So the risk there is you don't then go to the NICE interventions and you are not telling other agencies, as Dr Irani put in Phase 1: AR has conduct disorder, the interventions for that are long-term and quite difficult because it involves familial relationships that need consent, engagement and will take place over time. In the meantime, you need to understand, as other agencies, that there is no mental health quick fix here and if there is criminal behaviour going on, you need to take action, not think that a referral back to CAMHS will make a difference.
A. Just to clarify, Chair, I was not defending the current position. I think all I was saying was that that's how the scenario is. But I take your point completely, that formulation and diagnosis are not mutually exclusive, not at all, I think we need both, underpinned by good assessment and I think both are needed and I think the college guidance remains, that diagnosis and formulation are both central to personalised care planning.
Q. All right. Again, if before Christmas, there is any

move towards guidance -- new guidance in relation to that cultural reluctance, or Dr Church's evidence that some CAMHS services have exclusions that if you have conduct disorder you are excluded from the service, if there is anything that the Royal College plans to do in that area, if you could let us know before Christmas, again, I'm sure that would be helpful.
A. I will do that, Chair.
MR MOSS: Sir, would that be a convenient moment?
SIR ADRIAN FULFORD: It certainly would. Thank you very much, Professor. We will take a quarter of an hour break and sit again 11.45 am.
MR MOSS: Thank you, sir.
(11.32 am)
(A short break)
(11.47 am)
SIR ADRIAN FULFORD: Thank you very much, Professor. Do have a seat. Yes, Mr Moss.
MR MOSS: Thank you, sir. Professor Dave, could we turn to the question of risk assessment next, please. If we have back on screen please RCP000004. For the Chair's note, this is something you address in paragraph 91 of your statement, but if we can just have a document back on screen.
So this is CR201 that we were looking at earlier.

We got slightly ahead of the topic list in dealing with this. So if we go over the page RCP000004_0002, just to remind ourselves that this is the one that is overdue for revision and you said that you will keep the Inquiry updated on its progress. I didn't want to, in any sense, overlook the content of this which is of use and is directly relevant.
So if we can take it as briefly as I may, if we could go to page 26 RCP000004_0026 of this document, there is a summary of good practice and principles. If we just focus in on the bottom left paragraph.
So:
"A structured professional judgement approach is a helpful adjunct in certain settings."
I'm not going on to go through it all, but if we look top right now, that's then followed by a whole list of bullet point principles of the importance of structured risk assessment, the role of unpaid carers, in making judgements of risk, for example, and how risk assessments should be carried out. We see the penultimate one on the screen, that it needs to be dynamic.
So I bring that up just to make good the point I think that you raised earlier, that there is a lot of good material, albeit now slightly outdated, in this

guidance on risk assessment, would you agree?
A. I agree, thank you.
Q. Thank you. Then just page 30 RCP000004_0030, please, within this. I think one of the aspects that, in this 2016 document, was being pulled out, it is the bottom right-hand corner, please Amanda:
"The College recognises a need for improved information sharing and more regular communication between mental health teams, and also between teams and criminal justice agencies. Good information-sharing agreements are advanced as best practice in the recent Mental Health Crisis Care Concordat ([DoH], 2014)."
So I think, so that we don't have to come back to it later when we look at information sharing, we just note that that was an area that the college was recognising needed improvement?
A. That is correct, thank you.
Q. Thank you. That can come down. If we could go back please, Professor, to your statement. I just want to look at risk assessment tools and structured judgement tools. So, if we could have page 17 RCP000001_0017, paragraphs 72 and 73.
You say:
"Psychiatrists do not use specific tools to assess VFI because VFI is not a recognised psychiatric

diagnosis ..."

I want to slightly get away from the repeated refrain about the terminology. So, you go on to say:

"Psychiatric assessment tools are designed to identify and assess mental disorders and, where appropriate, to inform clinical judgement ... They are not intended to assess an operational category ..."

Then 73:

"More broadly, most currently available risk assessment tool is capable of predicting serious interpersonal violence at an individual level with sufficient precising to support clinical or legal decision-making in isolation. Clinical judgement, informed by comprehensive assessment and formulation, therefore remains essential."

Now, in some senses, that might nudge towards a truism, but certainly you are drawing attention to the fact that you can't, from even the best of the structured professional judgement tools, get to an accurate assessment of the likelihood of future violence by any individual; would that be fair?

A. That is correct.

Q. And still less so in the context of VFIs, however defined, presumably because mass casualty attacks, while appallingly catastrophic, are in prevalence relatively

rare?

A. That is correct.

Q. So whereas you could look at a very large sample size for assault, GBH, for example, and have a bigger data sample, you would have a much smaller data sample if you were looking at mass casualty attacks?

A. That is correct. But just to place this in context, even for suicide, which is compared to a catastrophic attack of this sort, is a more frequent condition. Even there, the predictive ability of tools is imprecise.

Q. Yes, thank you. So hence your emphasis on the fact that you need to build in, as well, clinical judgement, comprehensive assessment and formulation, rather than just relying on data from a tool?

A. That is correct.

Q. If we look at page 23 RCP000001_0023, paragraph 92. You nevertheless go on to address the validated assessment tools that aren't available, so SAVRY, the HC Risk Management-20, which we have heard about, you say that there's no version of SAVRY validated for Autism Spectrum Disorder that can be used alongside FARAS, which we have also heard about.

We have had, in relation to SAVRY, different views expressed. So NHS England has emphasised how resource intensive the use of SAVRY is and -- but Dr Church has

said that in his experience it used to be not so intensive and not so long and the risk that it is getting longer and longer. And he also said that, effectively, if you get the right professionals around the room, you can get a good assessment done in a single meeting, albeit that you then need to refine it with further information. But, effectively, saying that -- my words, not his -- but perhaps the best was becoming the enemy of the good. Are you familiar with that debate on SAVRY in particular?

A. Yes, I am familiar with it, having spoken to colleagues in preparation of this report. And I think I have some broad sympathy with that position, that if the tool becomes very long and ends up with a 40/50-page report, it obviously makes it harder for busy clinicians or indeed, other busy professionals to read and make use of it. So, I think it also depends on where is that particular assessment directed. And I think if this is to be used at the front door, I think then it needs to be far leaner. I think for individuals where then they have been streamed into a particular area of concern, that there is a significant risk element here that needs to be assessed in greater detail, I think that's where I think we would probably be using one of these tools in detail.

Q. Thank you. That's helpful. So, if we look in your statement, please, at page 21 RCP000001_0021, paragraph 85 and it may be that there was some confusion as to terminology, which may well have been our fault. You say:

"We do not support the introduction of a single risk assessment tool for [violence-fixated behaviours]. There is no agreement definition of VFB, nor is there a validated evidence base from which such a tool could be developed. We would therefore have concerns about introducing a tool that has not been developed and validated for the UK population."

What the Inquiry was really trying to focus on here was the point you have just raised, a single tool that could be used at the front door stage as an initial assessment, rather than the structured professional judgement tools such as SAVRY, that require trained specialists to conduct at, really, a more secondary stage of assessment.

Does the college have a view about the benefit or otherwise of some sort of risk assessment tool at the initial referral stage?

A. Yes, I mean not wishing to sound very pedantic but I think the risk of any tool, if it kind of predicts a score or a yes/no judgement, I think is that it could

be very facile for -- and kind of lead to judgements without that individualised attention that every referral needs and I think the key element here is that multi-professional judgement informing what the next steps should be.

Q. I follow.

A. And I think -- so I guess, my -- the phrase I would use is a framework rather than a tool, which might be scored by an individual practitioner to say what should happen next and I think that we have seen tend to have very poor predictive validity.

Q. So you would caution against the: certain questions, score, get a mark, and then try to use that as an indicator of risk?

A. That is correct.

Q. So the Inquiry has heard some useful post-seminar information on this from Dr Taylor. Could we just have on screen DRT000011. Just so that you get your bearings on this, this was Dr Taylor's post-seminar letter in which he puts forward thoughts about what this might look like, some sort of tool in this area and if we could go, please, to page 2 DRT000011_0002.

If we just have the totality of page 2, first of all. Do you see that there is a heading "Screening, triage and 'action checklists'" at the bottom of the

page? If we could have that bottom of the page highlighted, please Amanda.

Page 2:

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

Would you agree with that?

A. Yes, I agree that there is a difference between triaging and then actual structured professional judgement tools.

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

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

Over the page DRT000011_0003:

"... a structured professional judgement assessment. In particular, it cannot tell us which individual person will go on to commit serious violence."

Just pausing there. I think that is a similar concern to yours, that if you tried to do a scoring to judge risk, you would fall into error at that stage?

A. That is correct.

Q. Thank you. And then:

"The limitations of risk prediction in this area are well known."

Emphasising the same point. Then he says:

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

Would you agree with that, in broad terms?

A. So in broad terms, obviously I think the detail matters here because I think all of this is happening in the context of limited capacity.

Q. Yes.

A. And I think -- any tool I don't think can be viewed in

isolation of the context. And I think if we totally forego any concerns about the false positives, I think it could (unclear) well any other service, any service that's meant to deal with them. So I think it is just worth kind of looking at the detail and I think that that's the job of evaluation and research, to figure that out.

Q. Thank you. Could we just go on to page 6 DRT000011_0006 of this letter. And if we could just take it -- can we try to get a bit of zoom in from the heading 2(a) down to the bottom of the page. Without wearying you by reading it all out, could I ask you to read to yourself the text under 2(a) and tell me when you have got to the end of the paragraph that ends 2(d) below.

(Pause).

A. Yes.

Q. Just scroll down just a little bit so we get to the bottom of the page.

So that end point for Dr Taylor that there is merit here in looking at a cross-agency tool, that's based more a screening triage checklist principles, "seven to nine behaviour-based items" and there is your emphasis on violence-fixated behaviours:

"... at each stage or 'pause point'. For example, one ... might deal with behaviour, another with mindset,

another with family and social circumstances ..."

And then over the page, please DRT000011_0007:

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

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

Do you think that there is merit in this concept, that something in that area could be taken forward and would have a utility for the referral type stage, when you are doing a first assessment?

A. So I think I agree with the concept of screening and triaging. I think, however, the devil is in the detail in terms of whether there is acceptance of that tool and the process by all agencies concerned. I think, if, for example, a particular agency or maybe people likely to be referring into, find the tool cumbersome, and then don't use it, and are therefore less likely to use it, it is likely to fail.

Q. So you have to have buy-in from those using it?

A. Exactly. So I think the process of developing the tool I think is -- and I think Dr Taylor was making reference to that, in terms of how we need to pilot this et cetera -- so I think conceptually, I can see that that might be helpful. Whether the science supports it and then whether there is a process of -- where there's buy-in from all agencies concerned, I think both those things need to be actually worked out. So I think that would be something that needs to be actioned, I would have thought.

Q. Thank you. I want to turn next to information sharing, although we have already touched on it. So that can come down from the screen. If we could go back, please, to the Professor's statement, it is page 24 RCP000001_0024, paragraph 96.

You say that the college considers:

"... that the key barriers to the effective sharing of information about risk include a lack of interoperability in respect of digital patient records between agencies."

And:

"At present, the agencies involved ... do not have digital record systems that can 'speak to' each other."

Unfortunately, the problem is easier to state than

the solution, in this area. Does the college have any particular suggestions to create or enhance interoperability of digital patient records between agencies?

A. So I think, firstly, you are right to state that the problem is a difficult one to solve. I know that there are processes to look at a single patient record. Now, this may be a longer-term ambition that may achieve fruition over a period of time. But I think as was outlined in this case, the difficulty is -- and I think this is my own personal experience too -- that sometimes you are having to go through 50, 60 pages of records to find that one record, one note, or one letter that actually has a detailed historical information. You know, individual information about their background history, their family history, their early life history, that hasn't really changed. That should have been available at one or two clicks, rather than 50 clicks. That (a) saves time and (b) also informs the clinical discussion that you are having with your patient and indeed, helps that individualised formulation that we have been referring to time and again during our discussions today.

So, I feel that that is something which is not mandated at the moment. I think different electronic

patient records have different specifications. Some make access -- such access more easy. As indeed seems to have happened in the case of the local mental health trust here, where they have changed their system so that that kind of information is now available when you first log in.

Q. The front page --

A. The front page, exactly. So I feel that mandating that would be quite helpful. I think, so how do you make access to such information, which is a detailed assessment, detailed history, hopefully diagnosis and differential diagnosis, if applicable, a detailed formulation. I think that these things are -- you are right to say that it is not easy to solve but it is not completely impossible. I don't think it requires that complete interoperability either. This could be an early transition requirement that could happen sooner, before we get to that single patient record stage.

Q. So that's really about the healthcare providers, whether they are working on EMIS or SystmOne or whatever particular system of record-keeping they are on, having what wasn't on AR's records but what we were told the local health services had changed to, of those reminders --

A. Yes.
Q. -- but that's just the first stage. One also then has to be thinking about sharing that with other agencies because you can't just allow data scraping from medical records to go to other agencies because of the obvious point of medical confidentiality.
A. No, that is correct. So I think having said that, I feel that the barriers that I talked about are to do more with logistics than to do with attitudes or culture about sharing. I think you saw that in the CR201, we emphasised sharing. So this is a few years old. Every safeguarding training I go to, information sharing is emphasised over and over again. So I think information sharing, in that it should be shared, I think is a cultural issue, I think it is a logistics issue. Getting the right information and then who do we share it with and how do we share it. So I think systems and protocols that are simple and easy to follow and don't change when you go from one organisation to another, so they are the same kind of processes. I think I don't have to find five different clicks on one EPR or a different form to fill in when I'm working in Derby as opposed to working in Manchester. I think something of that sort would really help.
Q. When you say that the first stage of this is to have

different healthcare electronic patient record systems that all having the ready reminders of key points.
A. The spec.
Q. Yes. We know that there are different ones in operation. Why has that not yet been mandated, do you know? It seems such an obvious point.
A. It does seem an obvious point and I do not know and I think it probably frustrates every single clinician in the country.
Q. That they are having to bury through hundreds of pages of records to find records that may something as important as: two years ago this patient took a knife into school and threatened to kill people?
A. That is right. I think, the risk is an obvious lens but occasionally there is medically important information which is also similarly important. And I think if there was a space where detailed records -- and I think -- I mean, in the case of someone like AR, where those detailed records were available, I think if that was easily accessible -- and clearly, we have seen this trust has solved that problem by bringing it to the front of the record. So I think potential solutions do exist and I think what needs to happen is to evaluate those potential solutions across those EPRs and then to require commissioners to mandate that as a feature that

should be made available. At least in the beginning, to healthcare, where I think integrated care commissioners could look at making similar features available across the health and social care system.
Q. Whose responsibility should it be it to take urgent action in that area?
A. I think it falls with the commissioners.
Q. So integrated care boards?
A. In England, yes.
Q. Yes, but also, as things are currently audited, NHS England, where they are the commissioners for specialist services?
A. That's correct.
Q. Thank you. Could we have on screen, please, page 23 RCP000001_0023, paragraph 93. So you say it's more about logistics than cultural issues, but you do say, in 93, there is scope to strengthen existing training. You say:
"We consider it would be more appropriate to strengthen education on the identification, assessment and management of violence-fixated behaviours ..."
You go on to say:
"This should include greater awareness of behavioural indicators, structured professional judgement, emerging patterns of concern, appropriate

referral and escalation pathways, and effective information sharing and multi-agency working."
So you do seem to see that, within other areas of training need, there is still a need for training on effective information sharing in this area, is that right?
A. I agree and I think in particular, thinking about where your involvement ceases, how do you involve other agencies effectively and safely and consistently. I think we could probably strengthen that training.
Q. One view would be that there's been, over the years, so much guidance, but so many different reports and cases of bad practice where information hasn't been shared, that the time has come to put this beyond doubt and make it backed by statute that there is an obligation to co-operate and to share information that's relevant to risk to others. What do you say about that?
A. My concern with that is that, on the one hand, it sounds like an effective solution but I think it is a bit like fixing accountability when the system doesn't allow that accountability -- doesn't allow that authority to be exercised. So unless there is a way in which, if I, as a busy clinician, can really access that information, I think requiring me to do that would just worsen the cultural fear, which I think kind of is a big factor

when I speak to my colleagues. And the cultural fear of ending up in the coroner's court, cultural fear of the regulators, cultural fear of the GMC, or the professional regulator.

Q. So you are alighting there, if I have understood your answer correctly, on the concept of the duty to share. What about giving a statutory basis to the freedom to share? So, in other words -- I'm not going to draft a statute on my feet, obviously -- but something that gave confidence to mental health practitioners that, in an area where there is a -- assessed to be a current and a future risk that the patient will harm others, that they have a power to share that information in the situation where there's a risk to others, so that they don't then fear action by the information commissioner or by GDPR or by regulators for sharing information?

A. Not wishing to labour the point, I appreciate where the concern is coming from but having spoken to colleagues and my own personal experience, it is probably not the fear to share that is the main problem. I think it is the mechanisms of sharing and the ease with which you can share and I think -- I suggest that --

Q. What do you mean by that specifically?

A. I suggest that -- it is a design feature, right? I think we are more likely to do things that are easier

to do than which are cumbersome to do. I think -- right now, I think sharing can become a very difficult process which may require several steps and there are no clear consistent national mechanisms. By that, I mean a physical mechanism of me sharing data, saying: this is how I share data with the safeguarding lead, this is how I share data with the social care person or the criminal justice system. Or the other way round, how the police share data with me. In the absence of that protocol and process -- an actual process being very clear and easy, I think, even if we had the freedom to share, I fear that we may not achieve a desired result because it will remain so cumbersome that people will not actually adhere to the requirement.

Q. So a mental health nurse, or a specialist registrar in psychiatry, working on a case who has an initial feeling, "I'm worried about this and I think this probably is something that ought to be shared", if the steps that follow are so cumbersome that they know it is going to have to be a request that is going to having to through several stages, that's all a disincentive to start the process, is that what you are saying?

A. I think it is human nature. I'm not suggesting that people will be unprofessional and not follow their professional duty, I think most people will endeavour to

do so. But we see that adherence to guidance can vary significantly. We see that there is significant variation in the implementation of NICE guidance, for example, evidence-based treatments. And the variation comes because of those human factors and I feel addressing the human factors is possibly quite important here, apart from the freedom to share that you have alluded to.

Q. Again, the challenge to that might be that we have seen that there are local information sharing agreements and there are concordats in this area, so it is not as though gateways to the sharing of information haven't been tried and established; they have. But there seems to be a stubbornly resistant problem here in actually effecting change because, not just in AR's case, but in many other cases involving fatalities, when one looks back, one sees poor information sharing lying at the heart of it.

So I just wonder how this concept of: well, you need to have simpler mechanisms, because in a sense that seems to have been tried with information sharing agreements?

A. So there are examples of good practice. MAPPA, you referenced that before, obviously in a slightly different context but I think we know that where there

is a requirement to share and there is a mechanism where people are present in the same structure and function, and then do share proportionately, I think that can work. I think it is about now expanding the remit of that so that that information is made available in that way and it then becomes a simpler process.

Q. But forgive me, Professor, I'm so sorry to interrupt you, but some of the evidence to the Inquiry supports that the reason why it might work better in MAPPA is because there is a statutory duty to co-operate. But when I raise that with you, you said: well, the difficulty with that is you may put pressure on the practitioners who may fear that they are under a duty to do it and therefore you get defensive practice. But isn't there, in fact, benefit in having a statutory duty to co-operate and share information?

A. The point I was making was that the statutory duty to co-operate without there being the mechanisms allowing for that to be reasonably easy to do, will create fear and I think then would create defensive practice and I think that's the bit that I'm worried about. So I think it is not either or, it is about ensuring that we create a system that actually delivers the results that we want to. We all know the statute is a little bit like what the college does sometimes, is it creates

guidance, which then doesn't get followed because nobody bothers to read things in detail. So I think it needs to be then followed up with an implementation plan and making sure that the implementation plan is robust enough to actually take hold.

Q. Thank you.

I would like to turn next, please, to the role of psychiatrists and multi-agency arrangements and future reform of those multi-agency arrangements. So if we could have page 26 RCP000001_0026, paragraph 103 and 104 on our screens please.

You explain there, that:

"Psychiatrists have an established role within multi-agency arrangements ..."

And you set out:

"Their contribution is to assess and treat mental disorder, making an appropriate diagnosis ... provide clinical formulation, advise on risk, and share relevant information ..."

Then in 104, you say it is well established in MAPPA:

"... and may contribute to Prevent ... Psychiatric involvement in MASH is generally more variable and depends on local arrangements and the presence of mental health concerns."

Other than the fact that local authority arrangements differ, is there anything more lying behind why the role of psychiatrists in MASH is less clear or more variable?

A. Well, I think there is a general issue of capacity and I think we should bear the context in mind, that one in six CAMHS posts are vacant, and so you can imagine those five in posts are then trying to work harder to try and do the job of the sixth vacant post. So I think that is a factor.

But, again, I feel that there could be solutions in place here that could make that process easier and then that would help.

Q. What would those be?

A. I think digital access to information is key here I think and an easier digital way of sharing information is key. And a standard way of doing that, so that we reduce regional and geographical variation. So, you know, it is a similar process everywhere, not dependent on which EPR you are using or which particular area you are working in, it is a similar process. And I think that we know there is significant variability at the moment.

Q. Thank you. Then at paragraph 107, please, just over the page RCP000001_0027, I think, you address the issue of

FCAMHS, and say:

"The operation of FCAMHS varies considerably ... with differences in service models, capacity and available resources. Many FCAMHS operate primarily as consultation services, providing specialist advice to partner agencies rather than delivering ongoing case management."

You alert that that variability:

"... can lead to inconsistent access to specialist expertise and differing levels of support across the country".

Leaving aside, again, the difficulties of definition, the VFI -- in as many inverted commas as you like -- cohort, may be relatively few in number, the proxy numbers if you look at Prevent is not great nationwide; do you think that there may be a case for FCAMHS' involvement in tackling VFIs to be enhanced so that it may have a more direct, and even a case-holding role, once you have got to that secondary stage where they have been triaged and you have assessed that this is a patient within the worrying group?

A. So I think capacity is an issue. I mean, in this case I think we saw that the role that the team saw for itself was a consultative role. I'm aware now that that has changed now, they are able to do some assessment

themselves now, for example autism assessments. So I think streamlining the process, going back to the point that Dr Taylor made about screening/triaging, I think not everyone on the waiting list is equal and how do you know which ones need that urgent assessment and management? And then the formulation of the risk. I think -- so, if those conditions of this criteria were well designed, FCAMHS could play a role, because the expertise resides there, expertise to do those structured judgements, the expertise to devise those individual formulations resides that. I think that would help.

But obviously, that needs to be matched with -- I think my concern always in this case is that sometimes we apply solutions in one part of the balloon and that creates -- if that's going to suck capacity from core CAMHS services, then we would have some unintended consequences. You just need to be aware not to do that.

Q. There will be cost consequences to recommendations in phase 2; it is inevitable. So I was really asking, if funding were made available to that, if the numbers were relatively small, would that be beneficial? So for example, Dr Monica Lloyd, psychologist in our expert cadre, pointed to the concern about the lack of expert forensic psychology input, which she saw as being

potentially very beneficial for this cohort. And at a regional level, it seems likely that FCAMHS is going to be the key to delivering that sort of specialist service?

A. The short answer is "yes". However, my concern would be I think is that this doesn't suck capacity from core CAMHS, at all levels, psychologists, nursing --

Q. You have got to make sure this is genuinely resource provided and funding provided?

A. That is right and I think that would be worrisome if that happened.

Q. Thank you. I want to step back from that and just seek your assistance with the impact and importance of the Inquiry's Phase 1 findings generally. So I think you will be aware, from the Phase 1 report, that in relation to FCAMHS there were findings that they failed to attend multi-agency strategy meetings, that they could have stepped in to organise the SAVRY but they didn't do so, and that there was considerable confusion as to which was the lead agency, FCAMHS, CAMHS, or the criminal justice and liaison diversion team. Then that's FCAMHS.

In relation to CAMHS, could we just have CHAIR000002, which is chapter 10, at page 293 CHAIR000002_0293.

I know that you have been given notice of this.

Sir, again, I don't want to read out huge tracks of the report. But at -- if we just have the whole page, please. So we start with the assessment of FCAMHS -- with CAMHS, forgive me. If we can just go on to page 303 CHAIR000002_0303.

One sees, at paragraph 331:

"... the underlying weakness in managing risk persisted and, in certain respects, was exacerbated."

There is a reference there to Dr Ram having a poor understanding of the events and then page 305 CHAIR000002_0305 -- I'm just picking out, obviously, psychiatrists particularly for your attention.

Paragraph 333. The later stage when his care was transferred to the second psychiatrist, Dr Molyneux, he took lacked an understanding from some of the crucial background and while some of that related to information that was not apparent from the notes, other aspects of that were available from the notes but he had not reviewed them.

And page 307 CHAIR000002_0307, paragraph 340. Steps that should have been taken by the psychiatric team overlooked because of the continued lack of appreciation of historical risk. And then 307, paragraph 341, the next paragraph, the missing of a diagnosis of conduct disorder.

Appreciating that action in relation to this, in large part, sits with the Department of Health & Social Care, with NHS England, has the college digested those findings and reflected on them?

A. Yes, we have.

Q. Has the college itself taken any specific action as yet, and do you intend to take any action?

A. Yes. So as I have outlined, I think my presidential priority of safer services will look at -- and I also appointed a separate presidential lead on integrated care which is kind of broader than this particular issue -- but looking at the case of fragmentation in care pathways and how do we reduce and what kind of role -- what can we advise, as a college, to make care pathways more robust and less -- I think the fragmentation is one of the things that was seen here, between CAMHS and FCAMHS and between other agencies.

So I think the reality is that care pathways are not -- I think for most patients and carers, this is the big worry, is that no one is owning their care and they fall between two stools. So making that robust, reducing fragmentation, having a commissioning lever that encourages and incentivises sharing across a pathway I think is important. Right now, pathways are not designed like that. Pathways almost -- not

almost -- pathways encourage silo working and I think maybe that is a reflection.

So I mean, if we, as college, have commented on this in other scenarios, including some of our submissions to other major Inquiries. But I think in broad terms, I think for me, the main concern here is that the commissioning rewards processes rather than outcomes. I think if you reward processes, then individual -- not just organisations, but sometimes individual teams within organisations are then incentivised to protect their boundaries, rather than to look at how do they manage the entire pathway and have a stake in the entire pathway and the actual outcome of the individual.

Q. Thank you. So, would an example of that be, if you have taken a case on, you need to have dealt with a case within a certain time in order to get good scores on the assessment but that acts as a disincentive to take cases on?

A. That is right. I think -- so, that is an example. There are many other examples I think where it encourages you to pass something on to someone else, some other team, or it creates that operational interface issues and then, in the absence of very clear guidance around interface management, then a lot of time is spent in negotiating rather than in actually owning

the ball.

I think this has probably become a real problem because over a period of time I think we have seen more and more specialist teams emerge, more and more sub-teams emerge and I think unless there is very clear guidance around interface management and very clear guiding principles about, as we have talked about, about ownership of the entire case, I think that discourages, you know, real incentive in the entire pathway.

Q. Thank you. So, again, if before Christmas there is the start of any clear outputs or product in your drive towards safer services, any update on that area would be extremely helpful.

A. I would be happy to provide that, thank you.

Q. Thank you. And then looking to the future, and the pathways, we have touched on an assessment tool at the referral stage and the Inquiry has been looking at the concept of a big front door and then I am sure you understand what I mean by that in general terms, we know that many cases at the moment, in the cohort of concern, however defined, end up with a referral to Prevent and that is problematic, problematic for Prevent because there is a risk of overwhelm, too many cases going in, and a risk as well of dilution that focus on the most serious cases that are referred to Prevent maybe

inhibited by the sheer number, but problematic for other agencies as well. Because we have been look at how education and health may refer into Prevent for this cohort of concern but a very large percentage don't get taken on and just get bounced back, getting referred out of Prevent or Channel back to the organisation who referred in the first place.

So the concept of a big front door would be designed to deal with that. Does the college have any view on the suggestion that there should be a big front door; so a process other than Prevent looking at these referrals at the first stage?

A. So the success or failure of a big front door does depend on what is that definition that we talked about earlier in the day today, about replacing VFI, or treating VFI, or whatever the criteria used. Because I think what we don't want -- and you made reference to that yourself -- is yet another process that essentially is acting as just a gateway to the same kind of things that are happening today.

Q. One understands that but take it as read that as a minimum, the big front door would need to deal with the public protection type of case. So that would be both ideological terrorism, your standard Prevent referral, and the type of referral to Prevent that's

happening at the moment in terms of non-ideological cases of concern, fascination with mass casualty attacks. So those taken together would go to a different agency for the first referral and they could then refer on to Prevent, if it was a Prevent case, or could go to some other agency if it was a "VFI type cohort".

A. I think if there was a clear process around referring it and that was accepted by all the agencies that when it comes to health because there is a significant concern there is a health issue, goes to social care, and if there was a multi-agency working together and then the processes were clearly defined, I think such a big front door could be a useful step in the current processes.

Q. Thank you. Concerning the pathway that would need to be available after that stage for those showing concerning, violence-fixated behaviours. If we look at page 28 RCP000001_0028 of your statement, please, paragraphs 112 to 114. You say there that you recognise that "multi-agency arrangements are generally associated with clearer governance".

Then 113:

"... there is merit in considering whether aspects of existing non-statutory multi-agency arrangements could benefit from a stronger statutory basis."

Paragraph 114, you don't consider that a new multi-agency structure is required:

"Existing frameworks should be strengthened and used more effectively, rather than creating additional arrangements that risk duplication, uncertainty and the transfer of responsibility between agencies."

Now, pausing there. On one level, of course, that must be right. Others have referred to this being a crowded space with lots of processes. And intuitively, one feels the last thing anyone wants to do is add another agency. But how would this actually work in practice because what you are saying is build on existing non-statutory multi-agency processes.

But if we look at those, first of all, MAPPA by definition at the moment, by its statutory remit, only deals with those who have had at least a caution if not a conviction and although there is the category 3 option, in general terms, most of those taken on by MAPPA have a lengthy -- have had a lengthy term of imprisonment, which won't capture many of the adolescents who are involved and witnesses have spoken to the fact that because that is what MAPPA deals with, it is not actually well suited to combating the risks and vulnerabilities of adolescents.

In terms of Prevent, it is principally designed for

ideological cases, so vulnerable to being drawn into terrorism. And the whole problem is one of potential risk of overwhelm to them.

So, even taking Prevent and MAPPA together, there might be thought to be concern about their capacity and suitability to take on these cases?

A. I wish to qualify my evidence in 114 to say that there is no philosophical objection as such to a new structure. I think the main concerns to that being what I have outlined before, in terms of creating yet another interface and often -- well often, almost by default, these interfaces not having a clear process of managing and negotiating them.

So I think that is the main concern here. So I think, given that we don't manage current interfaces very well, I think creating yet another interface would seem problematic. But I think if a new structure was being designed with solutions that will address those concerns, then there is no philosophical objection to the structure specifically. I think it is more about the function of how that multi-agency working would be truly embedded in, addressing all the points that we talked about, about information sharing, about ensuring that the right agency had the lead agency. If that agency felt that that wasn't their remit, how would they

hand over the case to another agency that would accept the lead, et cetera, and so on.

Q. All right. So those problems would now need to be dealt with if there was a new process and a new multi-agency arrangement. But sticking with what seemed to be the thrust of this section of your statement, that you would expand current arrangements, what would that actually look like? Because it might be thought one struggles slightly to see -- I mean, would you envisage some cases going to MAPPA, some cases going to Prevent and some cases being addressed by the MASH? Because then you have the difficulty you have got three bodies looking at it.

A. Yes. I think that is the current structure and I think maybe MASH is the one that would end up receiving quite a few of these: I think the reality is that a fair few would probably end up remaining in health, given the fact that there is a likelihood that some of -- at least a subsection of the cohort would have comorbid mental disorders. For others, it may be that MASH would end up being the lead. So that was --

Q. But in the concept of MASH being the lead, the Inquiry is aware that, at the moment within England, not all MASH even take adult cases and that some MASHs are set up as -- important role though it is -- effectively,

a hub that provides ongoing referrals. So it takes referrals, considers them, and finds the best agency to pass it out to. It doesn't hold cases itself.

So if MASH were to take on a considerable role in case management here, they would need to be very significantly up-scaled and up-resourced?

A. I agree with that. I think it wasn't my intention to convey here that there would not be any such changes. So I think the "strengthen" phrase there possibly alludes to the kind of description you have just made.

Q. Thank you. But whichever solution is adopted, subject to assessment that there really is a psychiatric element in play -- which there may be in many cases, but not all -- presumably, the college would encourage a system that ensured that there is the correct input from psychiatric services to that multi-agency arrangement, including, if necessary, FCAMHS?

A. Absolutely.

Q. Thank you.

I'm going to turn next to interventions, if I may. Could we just have page 30 RCP000001_0030, paragraph 123. You say that a new standalone clinical treatment for VFIs isn't necessarily required, it's:

"... more likely to depend on coordinated multi-agency working ... clear case leadership and

routes for referral ... There should also be strong information sharing, consistent access to specialised advice, and sufficient resources for agencies to participate effectively. Relevant interventions may include treatment of an identified mental disorder, psychological therapies, social care support, family work, educational or occupational support, and criminal justice or safeguarding measures. None of these interventions sit solely within health services, because [violence-fixated behaviour] is not ... a mental illness."

If we look, please, at CHAIR000002, against that background, at page 315 CHAIR000002_0315. Do you see there, paragraph 363(c)? There was concern raised in the report about the service gap relating to:

"... violence fixated children/young people who do not have a serious mental health disorder, but who would benefit from psychological intervention to mitigate the risk that they pose."

And recommendation 55 at the bottom of the screen, which I needn't read out.

In relation to that aspect, if we look back in your statement at page 26 RCP000001_0026, paragraph 105. It is about halfway down the paragraph, you say:

"Dr Irani was asked about specialist interventions

which could have been considered around 'violence fascination' and suggested that 'this is a piece of work psychologists do but not necessarily sit within the mental health domain. So it would ... in some FCAMHS services but ... it's rather tricky about where it sits'. In the absence of a mental disorder, it is hard to see in what context mental health services such as FCAMHS would take on a patient with 'violence fascination'."

I think what Dr Irani was driving at, and what that section of the report was driving at, is there can be a case where the vulnerabilities of a child are such that that sort of psychological intervention is a necessary intervention and a helpful one, but it doesn't co-exist with any significant mental health disorder. Yet, those sort of psychologically informed therapies would be very helpful and likely to mitigate risk. And Dr Irani was pointing that out. The expert cadre said similar things, but it is totally unclear where the provision of those services sit.

Do you recognise that problem?

A. So I recognise the service gap. I think that is an accurate description. I think -- as to where would it sit, I think we need a pragmatic solution, so I would suggest that this is probably for the Department of

Health & Social Care to convene a roundtable involving us and other stakeholders so that we can think about where is the best solution for this.

I think -- I acknowledge that psychological interventions in this space could have a preventative element, which would help and early intervention helps too. So, if that need is identified, where should that sit, where so that provision sit, I think is something to be pondered. But I think the gap is a ground-level factor right now.

Q. Like many issues faced with the Inquiry, it overlaps with bigger policy issues beyond our terms of reference but thinking about the VFI cohort, one is really talking about a problem that input by way of therapeutic psychologically-informed therapies of one kind or another might help to mitigate the risk but they are not readily available through CAMHS or FCAMHS because they are not resourced to supply those in the absence of a mental health disorder?

A. That is correct. That is the commissioning arrangements currently, that CAMHS and FCAMHS are designed particularly for dealing with mental disorder. And I think there is a philosophical issue here around the involvement of psychiatric services in conditions which involve, essentially, risk management and is that the

best place for that service to be provided? Or -- so I think I can't see how CAMHS -- routine CAMHS could get involved in this.

With FCAMHS, it is a slightly different picture which I think needs to be looked at because FCAMHS has that expertise probably sitting within its ranks of making those structured professional judgements, deriving those individual formulations. And the kind of psychological intervention that you describe might be relevant here; may be present in some of the FCAMHS but that's not what they have originally been commissioned for, that is not what they have the workforce for. So I think it would involve a significant change to the way they are commissioned and the way they are -- their capacity -- workforce capacity is built within them.

I think that is a matter for discussion and debate as to where that sits. I can see why that makes sense but I think we need to look at the -- and certainly the consequences and unintended consequences.

Q. Thank you. Finally, in relation to recommendations, in part to give you the confidence that it has not been overlooked, Professor, could we just have page 31 RCP000001_0031 of your statement. You have helpfully set out there, starting at paragraph 126 and the rest of the page, a whole section on recommendations. It is

clear and straightforward and we have touched on many of them. So I don't intend to go through the list, save this, if we could have paragraph 129, you do stress, as you have done a number of times during this morning in your oral evidence, that:

"... arrangements ... require adequate investment to be effective. Existing multi-agency frameworks and mental health services are already operating under significant workforce and resource pressures. Additional funding should be provided to support dedicated capacity for multi-agency working, timely access to specialist mental health assessment where indicated, workforce development and training, and the consistent implementation of existing frameworks across England. Strengthening the capacity of existing services is likely to deliver greater benefit than establishing new structures without the resources to support them."

So we should take from your evidence that recommendations about further processes and improved processes are very well, but we need to recognise that the system is already under significant strain?

A. I agree completely. I think that's a real concern because workforce numbers have -- psychiatry and mental health services, more broadly, have been significantly

underfunded over decades and even the mental health investment standard is not always met and that is a minimum; that is a floor, not a ceiling. So I think there are real concerns here. As I have outlined before, we need to be creating new capacity here and not pulling from somewhere else.

MR MOSS: Thank you. I'm just going to look to my left. Those are my questions. I think there is just one question from my learned friend Mr Nicholls.

SIR ADRIAN FULFORD: Yes, Mr Nicholls.

Questions by MR NICHOLLS

MR NICHOLLS: Professor, good afternoon. I'm asking questions on behalf of the bereaved and victim groups and I just have one short topic that follows on from an answer you gave in your evidence to Mr Moss. You were asked by Mr Moss about a statutory duty to share information and you will recall, you had a discussion about that. Chair, for your note, this is at transcript page 80, lines 7 to 8. You referred, in your answer, to a cultural fear of regulators and the GMC; do you recall that?

A. I did, yes.

Q. But in the same answer, you also referred to a culture of fear of ending up in the coroner's court?

A. Yes.

Q. I just have one or two questions about that final point. It is about the cultural fear of ending up in the coroner's court. Inquests and Inquiries have, on a number of occasions in the past, identified that a failure to share information has given rise to significant concern in fatal cases. And so wouldn't that mean that a concern about ending up in the coroner's court would encourage information sharing?

A. As I said before, I don't think my concern was around the culture or the desire to share information. I think it was just placing a duty to share information, while not making that process of sharing information easy enough for it to be done. So I think if a clinician is placed in a situation where they have a duty to do that, but the structures around them don't allow that to happen, in a pressured environment where you are trying to manage multiple risks and manage multiple -- you are managing the care of multiple people, where there are competing risks, I think that then creates a fearful environment to operate in. That was the point I was making.

But I agree with your point that actually sharing information is likely to alleviate that problem. So I think just to labour the point, simply bringing in

a duty to share without making any changes to how do we make it easier for clinicians to share will not help.

MR NICHOLLS: Thank you.

SIR ADRIAN FULFORD: Thank you very much, Mr Nicholls. Professor, thank you very much indeed. That has been extremely helpful evidence and I'm grateful to you for your detailed report and for those others who collaborated with you in drawing it up.

A. Thank you so much.

MR MOSS: Sir, might we break, may I suggest, until 1.40 pm?

SIR ADRIAN FULFORD: Certainly.

MR MOSS: Thank you, sir.

SIR ADRIAN FULFORD: I will rise until 1.40 pm.

(12.53 pm)

(The short adjournment)

(1.40 pm)

SIR ADRIAN FULFORD: Remain standing for a moment, thank you.

DR HEIDI HALES (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?

A. Dr Heidi Joanna Hales.

Q. Thank you. If we could have on screen, please, DHH000001. We see your helpful statement to this Inquiry. If we go to page 17 DHH000001_0017, bottom of the page, we see~-- sorry, top of the page -- we see it is dated 9 September and you have signed it. Can I just ask you to confirm that the statement is true to the best your knowledge and belief?

A. It is.

Q. Thank you. If we go back to page 1 DHH000001_0001. You give, at paragraphs 1, your qualification and information about your background at paragraph 2. So I think we start with the fact, in paragraph 1, that you are dual trained as a consultant psychiatrist in both child and adolescent psychiatry and forensic psychiatry, is that right?

A. That is right.

Q. We are going to come back, a little bit later in my questioning, about the benefits of that, how relatively rare it is and whether more needs to be done in that area. But in these two paragraphs, you also tell us about your current posts.

So you tell us, first of all, that you are a consultant CAMHS and adolescent forensic psychiatrist in the North Wales Adolescent Service General Adolescent

Unit of Betsi Cadwaladr University Health Board, is that right?
A. That is right. I currently work across the inpatient CAMHS service and outpatient CAMHS service.
Q. Thank you, and in addition to that, we see at the bottom of paragraph 1, that you have various education posts. So an Honorary Senior Research Fellow with Bangor University, an Honorary Senior Lecturer with Cardiff University and Visiting Honorary Professor at the University of Bristol.
Just help us in terms of your specialisms within those posts, what you focus on?
A. My research focuses on secure care for young people and how to avoid secure care for young people or improve secure care for them, how to think about their risk behaviour and how to manage it.
Q. Thank you. We see in paragraph 2, if we can just have the totality of that, that in terms of other parts of your experience, you explain that you co-founded and co-chaired GIRAF, Group of International Researchers in Adolescent Forensics, and an online transdisciplinary international research community. You are also part of an international research group considering risks associated with identifying as an incel. You say your particular interest is in pathways into joining these

groups, so areas of interest to this Inquiry. You are also past chair, is this right, of the Royal College of Psychiatry's Adolescent Forensic Special Interest Group, over the page DHH000001_0002?
A. That is right.
Q. And you remain on the executive of that group and co-opted, I think, to the Royal College of Psychiatry forensic faculty?
A. That is right.
Q. Thank you. So you bring all of that experience to bear. I should have just touched also that just on the previous page, if you would, DHH000001_0001, at the end of paragraph 1, you have experience in the secure estate. So one sees HM Young Offenders Institute Feltham and Cookham Wood and Holloway, amongst others. I think you have experience in those sorts of environments as well?
A. So, yes. I have experience in young offenders institutions and prisons and also secure hospital wards and then also community FCAMHS.
Q. Thank you. Against that considerable background and expertise, can I turn to definitions. We have covered a lot of this ground with other witnesses but obviously we are interested in your views. If we could start on page 2 DHH000001_0002, paragraph 4, and have the whole

of paragraph 4. So, you say you have not used the term "violence-fixated individuals" in your clinical or research practice. And as some other clinicians have done, at the end of paragraph 4, you say:
"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."
Now, I don't want to, in any way, ignore the importance of formulations, but would you agree that there does need to be some sort of definition to capture the cohort of concern in this area?
A. I understand in terms of developing services, in terms of thinking about cost, in terms of doing research, why people would want a definition. That's different from a clinical way of working but I can see where you are coming from in talking about the definition might be useful.
Q. Thank you. So, more perhaps for other agencies than for treating clinicians, you can see that there is a need to have some common understanding of the group of concern?
A. Yes.
Q. Now, our previous witness, Professor Dave, spoke in terms of the fact that "violence-fixated individuals",

he thought -- my words -- was a peculiarly ill-suited phrase because the concept of fixated sounds as though it is a sort of ICD/DSM type disorder, when in fact, VFIs is no such thing. Would you broadly speaking agree with that, that "violence-fixated individuals" risks that ambiguity?
A. The dilemma we have of any definition is we can stigmatise people and we can try and make it sound codified as a diagnosis when it is not actually a diagnosis, which is also problematic. I think we all use definitions to have shorthand communication with each other and it is useful to know what we are talking about with a definition, if that's the way people want it to be. But we need to be clear if it is a diagnosis or not. So we felt into that problem with DSPD before and we need to be careful that we are not stigmatising because language can really stigmatise.
Q. Thank you. So if we can have HOM0001011. This is the Home Office's really quite recently publish interim guidance, dated 6 October 2026. As an individual practitioner, it might be that there's no particular reason why you should have yet seen this. Other than the Inquiry drawing this to your attention, had it come to your desk as a practitioner?
A. No, it hadn't.

Q. So if we look at page 2 HOM001011_0002, paragraph 6. Working definition, subject to the outcomes of this Inquiry, not statutory, not legal, not operational in nature. But the current Government interim working definition is:

"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."

Have you had a chance, in recent days, to think about that definition?

A. I have.

Q. And what are your views on it?

A. I understand the idea to say it is non-ideological because that's very important for us to understand the difference from people who have been drawn and groomed into ideological thinking and we have had the idea of salad bar ideologies, which also make things complicated. There have been other things suggesting we should think about those who are vulnerable to being groomed into, or vulnerable to being drawn into. This is talking about a particular behaviour or threats of behaviour and I suppose the difficulty we don't always know when a threat will become an action, which is one of our dilemmas.

a definition and you codify it, people know what you are talking about. And if you have to do that, you have to do that. It is never going to be ideal. It will go out of date, it will become stigmatising and you might want to change it again at a later date.

Q. Thank you. We heard in our seminars from Professor Cassam, who suggested an alternative of "non-ideological violent extremist", as an alternative. Now, he said the benefit of that was twofold. Firstly, you are getting away from any requirement that it is intended to shock, intimidate or outrage the public, which may not be present. And, secondly, by using the concept of "violent extremist", within "non-ideological violent extremist", you are deliberately focusing down on the group who are interested in violence for its own sake, in nihilistic-type violence, mass casualty attacks, as opposed to the serious end of more conventional interpersonal violence or gang-related violence and matters of that kind.

But conscious of the evidence that you and others have given about the risk of stigmatising, the Inquiry has been exploring the possibility to define the cohort as "those vulnerable to being drawn into non-ideological violent extremism". How does that latter concept sit with you?

Q. Thank you. Others have alighted upon the "intention to shock, intimidate or outrage the public or a section of the public". Two concerns about that have been expressed. One is that it is difficult to know in advance. The other is that it may risk being exclusionary because you would wish to identify and mitigate the risk of somebody who is at risk of using or threatening extreme violence not driven by a clear ideological purpose, whether or not their intent was to shock, intimidate or outrage the public, or a section of the public. Do you have any views on those concerns?

A. I suppose, the people I have worked with who have told me they wanted to do something like this, have said it to their or therapist or to their clinician, which may or may not come under this rule of "a section of the public" because their clinician might be -- is, by virtue, a member of the public too, and sometimes it is to shock and intimidate. My dilemma here is that a lot of people -- it is what you do with this definition. A lot of people say things to their clinicians or people like me that they are not actually going to act on and it is how -- it is just making sure we don't stigmatise or overreact to some things, or how we know who's going to do what.

But in terms of -- I think once you make

A. As a clinician, I'm certainly very interested in those who are vulnerable to that and services to support those who are vulnerable to that because we don't yet know who is going to act.

Q. Thank you. So that -- I don't want to put words in your mouth -- but seems to be getting closer to something with which you would be comfortable?

A. Yes. I would be much closer to the vulnerability as long as being vulnerable doesn't mean that we treat them badly.

Q. Yes. There's no particular reason why you should have done, but it is actually not easy to draw up a definition in this area. Have you had any independent thoughts of your own as to how it could otherwise be defined?

A. I mean, I suppose I do think it is very, very important to separate it from the child, criminally exploited young people, who do things in a more social way. I mean, we used to have "unsocial and socialised conduct disorder" which we don't have anymore, but there is the idea about people who do things on their own and the people who do things in groups and are groomed as young people into gangs. That is a different cohort. So I think by having this, it does separate them into different groups of young people which is important

because they have different vulnerabilities and different needs.

Q. Thank you. You have emphasised the concept of not stigmatising. The difficulty may be with that, that if the cohort are those who are at risk of carrying out mass casualty attacks, school shootings, mass stabbings, and awful attacks of that kind, that, at the same time, one doesn't want to shy away from the seriousness of the risk of the cohort that we are dealing with. Does a definition emphasising the vulnerability to be drawing into that, do enough to avoid the stigmatising? If not, how do you have a definition that flags up the seriousness without stigmatising?

A. So my dilemma here and the bit that concerns me is that a lot of people will fall into this group. Clinically, we will hear a lot of young people -- and it is increasing -- saying things they want to do. And some, very few, very few, will do something and the majority won't.

And the difficulty is what we then do for this group of young people. And my dilemma is we could cause iatrogenic harm by labellising somebody and we could make them a risk if we treat them in the wrong way. So it is not the definition that I actually have a problem with, it is what you do with the group you define and

how you make sure that you do a pedagogical, child-centred intervention to support them, rather than something else and causing harm to them.

Q. Thank you, and that concept of the iatrogenic harm, you mean by putting them into some sort of a pathway that has that sort of a label, that that itself, the very treatment pathway, causes harm because of the stigmatisation?

A. Yes. So if this group already feel bad about authority figures and society and how society have treated them -- which I think is this group -- and we treat them badly and we isolate them more and we judge them more and we push them away more, then they will become more extreme and we will push -- if you think about it -- we don't know enough, but say, it is a curve and the hard end of the people who might do something, and we push them that way, we might push more people to behave in that way. And these are young people who have got the rest of their lives to go so we might make them higher risk as adults.

Q. Thank you, and should I take it from your answers that you would be emphasising to the Inquiry that this cohort contains those who are very typically, socially isolated and already have a sense of grievance, for whatever reason?

A. That's my experience.

Q. Thank you. I want to turn relatively briefly to risk assessment issues, please.

Could we have a look at page 7 DHH000001_0007, paragraph 18 of your statement.

As other witnesses have done, you say that:

"There is currently no single validated risk assessment tool available to use with a young person who has no history of violence but is ruminating on violence."

Previous health witnesses have spoken about the various tools that are available, including SAVRY, which you refer to in the middle of the page. Is there anything particularly that you want to draw to the Inquiry's attention about the advantages and the disadvantages of the risk assessment tools that are currently available?

A. So the SAVRY is a useful tool that we do and you don't get a score but what you do is, it gives you various risk factors for violence and you rate them as "low", "moderate", "high", by quite defined factors. And on that, you can work out what are the high risk factors and you can then plan your intervention to work out how to support somebody in a formulation-based way. The thing is that it does rely quite a lot on previous

violence. So if you have got somebody who is ruminating on it, it kind of misses out on what might be a one-off single event that is a mass act that is high risk.

And that's why it is not particularly helpful. So if you were doing that -- and I would say we should do it on people we are worried about -- then doing it alongside something like the FARAS, which gives you an idea if they are an autistic, an idea of where the factors of autism comes along. But what it does is it helps you with a formulation, but it doesn't give you a number.

Q. It doesn't give you a risk score?

A. It doesn't, and clinicians are guided against a risk score these days but I understand other people want one.

Q. Thank you, and are you familiar with the AREVA tool that is currently being tested, not yet validated?

A. Not yet, sorry.

Q. Thank you. If we could look at paragraph 23 on page 9 DHH000001_0009, please. You say:

"I understand that there is consideration being given to whether a new risk assessment tool that can be used by all in the public sector can be developed. In my opinion, creating a risk assessment tool for all to use is likely to reduce the function, specificity and sensitivity of the tool: to be accessible to all

professionals, it would have to avoid requiring particular expertise."

Now, there may have been some misunderstanding here, which is no doubt the Inquiry's fault, rather than yours. But, there couldn't be any suggestion of doing away with structured professional judgement tools such as the SAVRY, used by experienced and trained clinicians. But what the Inquiry was keen to explore is whether, at first referral stage, which could involve a number of agencies, whether at that initial stage, there was a more simplistic first referral tool -- others have said perhaps it needs to be a checklist rather than an assessment tool -- that would help draw together the immediate information that's available and help in the screening and triage process. Do you have any observations about that slightly different concept?

A. I appreciate that and I -- when some questions came to me, I realised why I might have slightly misunderstood this. There is no problem in having a checklist to get information together. Sometimes the asset does that but I have not found the asset tool particularly helpful when I have read through because also, drawing the information together requires an expertise of whoever is drawing the information together to check that they have got the right information and they have interpreted the

information correctly. So I think it is quite a highly skilled job anyway. But I suppose, when I was getting to the SPJ, just thinking of any of it. I think each discipline brings a different perspective, all of which are valuable and important, because they are a different piece of a jigsaw puzzle and what's important is that we each bring our disciplinary knowledge into the assessment together. That's what I was saying. I don't think we should all be able to do it because I couldn't do what an educationist could do, but they couldn't do what a psychiatrist could do. And actually, both of our perspectives are important, we just need to bring them together.

Q. Thank you. So if we look at page 8 DHH000001_0008, paragraph 21. Before making that observation, you say:

"... it is my practice to consider completing a [structured professional judgement] focusing on the particular risks of concern ... In my experience, good clinicians in local services can complete good assessments of young people, and reports from social care, CAMHS and Youth Justice teams contain much of the information that is needed to complete these assessments. Therefore, utilising these risk assessment tools within a multi-agency professionals network is likely to be much more helpful than one service

completing it alone and sending it to be filed away in a young person's notes."

Is that the same thing that you are getting at there, in terms of what's needed is everybody bringing their own detailed assessments together and then pooling it as a resource, to come up with one big formulation of risk and the plan that's going follow from it?

A. So my experience, clinical experience, is if I have gone away to see a young person -- and I have significant clinical experience, I can go and see them, I can take a history, I can pull it together, I can write a really, really good thorough report -- but actually, when I present it to the services working with young people, if they don't have the resources, or if they don't believe it, or if it doesn't make sense to them, they are not going to put in place the recommendations. And certainly I have spoken to colleagues who talk about one of the issues about whether something works is whether recommendations are taken into account.

If you sit down all together, all the services together and go through it all together, which takes time and resources, actually getting a shared understanding of the experts, the people working on the floor, the people who know the young person best, enables us to have a shared understanding, a shared risk

assessment and a shared plan. And it enables people to sit together to say: well, I can do that bit and I can do that bit and you can do that bit. And that makes -- in my experience, is people can then work together better.

Q. You alluded to it halfway through your answer but I think part of the difficulty with that is the challenge that it needs protected time to really go through that process, would you agree?

A. It needs a lot of protected time. It takes me -- it takes somebody to put the work together and then -- if I'm doing the SAVRY with people and a formulation, two or three hours, across two or three settings, we would sit down and do it and make a plan. But a lot of people don't have the time to do it and then you might want to meet -- when I have done work in this type of thing, weekly and then monthly, to really, really do it. And people don't have time to put aside those multi-agency meetings.

Q. Thank you. If we could just look on a slightly different aspect. You say -- and we touched on this in definitions -- page 8, paragraph 20, it is probably just above on the same page, you say there, that:

"Furthermore, for young people -- many of whom are vulnerable -- who are developing their identity and view

of how they fit into the world, the way we (carers, services, people in authority) interact with them will itself impact upon their future risk. If we stigmatise and isolate them as a result of our concerns of their risk, we may inadvertently increase their risk. Therefore, it is essential that our response[s] to risk rating needs to be carefully measured and the subsequent intervention to work towards rehabilitation and support, focusing on enabling the young person to find their positive place in society."

Any question that I ask in response to that is bound to be seen to be denigrating the important concepts that you refer to there. But how is that approach, important though it is, to be married to the potential need for criminal justice intervention? Let me give you an example. Those in -- earlier, in topic one, who gave evidence about the safety and public risk elements, have spoken about how difficult it is to get visibility on young people's devices and in appropriate cases, where there has already been violence, and the risk seems hard to mitigate, we have been exploring the need that in some cases, where there has been criminal behaviour, which might, in other circumstances, be deliberately treated in a way to avoid criminalising, may justify an arrest and a search, potentially legitimately, to get

hold of the device.

How can you bring that sort of potentially necessary expertise to bear in a multi-agency way alongside the non-stigmatising trust building aspects that you are emphasising?

A. So I have had young people arrested on their birthday when it could have been done the day after their birthday. You know, what you do is you look and think about triggers. You talk about -- if you are in a multi-agency network, of course, consequences and boundaries, all of that is very important. I would always say any crime goes to justice services and is put through properly, as it should be because people need to learn places in society and rules of society. But how you then treat people in the justice system or how you manage them, how you decide to do the arrest, how you decide to do the search, how you decide to do the intervention afterwards, how we treat them then and treat them well then, can have a real impact in their future, whether they feel able to re-join society or whether, after you have finished your group of work -- and there might be a group of them -- that you do a short piece of work and then you put them back, they might then have an increased risk in society because of the way we have treated them, in terms of our

multi-agency networks. And they might have grown out of it, if we would have left them alone and those are the people we put extra risk -- you know, we create the risk.

Q. Thank you. So, trying to capture that and put it into concrete terms, would you envisage a multi-agency process in which if a sort of disruptive police action, or potentially Counter Terrorism Police actions, are going to be taken, you would want the input of the appropriate experts from CAMHS, or potentially FCAMHS, to be giving input into the how it is done and what is done afterwards, to mitigate those other risks?

A. So if there needs to be an arrest to look at a phone and you have got a period of time you could do it in, then the police and Prevent can talk with the social care or education, or CAMHS or FCAMHS, whoever is involved, and say, "Right, we really need to do something with this young person. Can you help us with the best way to do it which is the most humane, most child-centred for them? Because we need to do it and we need that boundary and we need that consequence and we need to keep safety, but we also need to do it in a way that the child then keeps trusting the police". Because quite a lot of these young people actually do follow rules. So you have keep the rules in place so that they trust

the rules. But if they feel you are treating them worse than somebody else who bullied them, who they think got away with it, we are going to make things escalate in their heads.

Q. Thank you. A slightly different aspect again, I said I would come back to it. If we could look at page 9 DHH000001_0009 paragraph 24. You say:

"... an understanding of and training in risk behaviours generally will enable the professional to understand the training and therefore to better utilise the risk assessment tool. Within psychiatry there is the option of forensic psychiatry training alongside Child and Adolescent training to provide a dual training in adolescent forensic. This was popular 20 years ago but availability has declined and there are few dual trained (forensic and CAMHS) psychiatrists working in forensic CAMHS."

Of course, you are one of them:

"This is an area of debate amongst psychiatrists and there are differing opinions about how important this dual training is."

Why is it an area of debate as to how important that dual training is?

A. So, I think it is important. I have raised this -- we have discussed it in our AFSIG several times about

whether we should be pushing it or not. If you do a dual training, your training is longer. You enter the consultant grade later. So you delay your salary rise, you delay progression in your career. So actually, if somebody can do a shorter training than a longer training, often that's what people would prefer to do. So there is a disadvantage of being a dual trained person, in terms of your career progression.

That said, what you get is you get an understanding of developmental psychiatry, which people in CAMHS say is very important -- you should not deal with an under 18-year-old unless you have done CAMHS training -- and you get an understanding of risk and violence which you get from forensic, which I would say is important. That part is slightly less pushed.

I think, having the experience of working with people who have offended, with the system -- justice system and secure services, which you get in forensic, to me, is very important in understanding this group of people and then putting that into practice.

A lot of people now aren't dual trained. There aren't enough people to do the jobs and the jobs aren't asking people to be dual trained which means people don't then seek the dual training because of the disadvantage it gives. And I think it is a little bit

of a circular issue to think about it. And what you could do -- and has also happened -- is sometimes you have people who are single trained then they get a modular increase once they have become a consultant. So there are various ways to think around it but there are differences of opinion and my opinion is dual training is good, better.

Q. So paragraph 25, you speak there in your statement about the benefits that it's brought for you and over the page, at -- at the top of the following page DHH000001_0010, you have given some detail on that point that you have mentioned a moment ago in your oral evidence about the prolongation of the training. Is anything being done about this, in terms of the importance of retaining if not increasing the cohort of those who are dual qualified?

A. I mean, at the moment, there's differences of opinion about whether it is necessary.

Q. It may be that from the Inquiry's perspective, focused, as we inevitably are, on in cohort, it would seem that those with the dual qualification are those who would be best placed to advise on these cases. So, the relatively paucity of dual qualified is a matter of potential concern.

A. I would say that because I'm dual trained. I agree.

But I think there is a way of getting somebody who is single trained and when they are a consultant, you ask them to do the upgrade of it, a second training. But yes, my personal view would be having both trainings are beneficial.

Q. Thank you. I want to touch on neurodevelopmental conditions and their relevance here. If we could just have page 6 DHH000001_0006, paragraph 16 on the screen please. And could we have paragraph 17 at the same time on the screen.

So, you start by saying that:

"Considering [neurodevelopmental disorder] is part of any mental health assessment."

But you flag that there is a separation in services, so that neurodevelopmental disorder clinics tend to be separated from CAMHS clinics; what's the impact of that?

A. So you have got very long wait lists in the neurodevelopmental disorder clinics for assessment and we know, from the Fonagy report, that they are not triaged, so you go on the list and you wait. In CAMHS, people come to CAMHS for mental health and emotional health needs. Now, obviously, some people in neurodevelopmental disorders, develop emotional and mental health needs and then they are also referred to mental health and they come to us, but some CAMHS

services don't then do a neurodevelopmental assessment because that's waiting for the neurodevelopmental clinic to do it. So you can have two pathways and you have to work hard to make sure the two pathways are merged together.

Q. Thank you. In paragraph 17, you reference the Phase 1 report findings, that risk in relation to AR were minimised due to suspected autism, as it was in his case. You go on to say:

"[While] not all those with [neurodevelopmental disorders] are high risk, those who show risk behaviours with [neurodevelopmental disorders] need their risk to be understood within the context of their [neurodevelopmental disorder] rather than [being] minimised."

So just pausing there. You seem to accept that minimising risk behaviours because of neurodevelopmental disorder is to fall into error?

A. Yes.

Q. But you flag that, at the same time -- and this perhaps is part of the complexity -- that:

"Those with [neurodevelopmental disorders] and risk behaviours [together] have often also experienced childhood traumas."

A. So, not all people with autism are a risk but a lot of

people with these risks have autism. So you have to understand the two differences, is that whilst you might see a preponderance of autism in the group of people we are talking about, the majority of people with autism don't have the risk. So understand that part of it.

Those people who come through often have other -- you know, it is lots and lots of intersecting risks that come along, which is why our formulation ends up being really important and neurodevelopmental disorder or autism within it has to be part of that formulation. So when the risk comes, you don't -- risk is risk. Risk isn't less just because they have got autism or a neurodevelopmental disorder. The risk is there but the presence of the neurodevelopmental disorder is one of the aspects of the formulation to think about what you need to offer to reduce the risk, or manage the risk.

Q. Thank you, and that would be the case even if there was no interplay between the disorder and the risk, because you would have to consider about how do you mitigate the risk with someone who is autistic?

A. Well, every aspect of somebody is taken into account when you are looking at the risk assessment and the risk formulation. Whether it contributes to how they have reacted to being bullied or to things that have been

said to them, or whether -- how they react to the intervention you are going to give, because you would give a different intervention to somebody according to their different factors, so neurodevelopmental or personality factors, so it interplays with all the parts of it --

Q. I think we are driving at the same point, that for those, for example, who are autistic, we have heard evidence about how that may mean that they are more likely to be socially isolated, they are more likely to have a sense of grievance, they are more likely to have been bullied, objectively speaking. They may also be more prone to subjectively feel that they have been bullied, even if that may not be objectively the case. And there may be interplays also about the particular vulnerabilities of those who are autistic to online bad actors, some of them -- again, it all needs to be individual, but some of them could be more easily exploited online, would you agree?

A. Totally.

Q. And then narrow focus of interests could also play a part?

A. Yes.

Q. So, if we could just go over the page DHH000001_0007, so we can just see without reading it all out, the rest of

your paragraph 17. So, you talk therefore about the importance of the formulation and the multi-agency team working together to plan interventions, taking all of that into account.

So, you are really there giving us a very helpful best practice guide to how it should look like. And I am sure, when you are driving it, it does look like that. But what's the reality of this, do you think, more widely across agencies' work in this area? Is this complexity understood and the need to go through this process understood?

A. I think people want to do this but I think the resources are not there to be able to do this in all the occasions when people should be doing it. And it takes people -- it takes a particular -- driven professionals, to be able to try and push for this to be the multi-agency working needed to do it.

Q. Accepting entirely that answer, can I press you a little bit. Do you really think that the complexities of that interplay are understood by frontline practitioners and the need to understand it? So even by all mental health workers in CAMHS, for example? Is there a risk of going down the minimisation line?

A. Well, I mean, that's why we have FCAMHS and that's why we have experts in adolescent forensic. They are the

people who pick up this. And yes, CAMHS, education, social care have to refer to FCAMHS, have to refer to justice, to have those conversations about it, that's why it is a multi-agency network. So I don't think you can make all frontline staff absolutely experts in this, because they have to be experts in other things as well. But what you can make them aware of is where to get the experts and then have a framework where it is possible to do this kind of work, so that the frontline staff are supported by the experts to do the work that is needed in these kind of situations.

Q. But that does, at least, require to take CAMHS workers -- and I don't want to make it solely focused on psychiatrists -- but CAMHS workers of different levels of qualifications, they do, at least, need to have the understanding not to fall into that pitfall of overlooking or minimising risk behaviours on the basis that the person is autistic. They need to say: we need to look at the risk behaviours and deal with them in the context of someone who is autistic.

A. I mean, all clinicians and practitioners, whatever agency, yes.

Q. Thank you, and do you think that there is a knowledge or a training gap there, or at least that that's something that needs to be strengthened?

A. I have to say, in my experience, people are more likely to flag up if they are concerned than if they are not and it is whether or not we can then react to that.
Q. Thank you. A slightly different aspect on this. Dr Richard Church, a part of our expert cadre, did flag up quite significant concern in his evidence, based on the case studies, that conduct disorder had been under-diagnosed in the case studies. Dr Irani said that conduct disorder should have been diagnosed in AR's case. And of particular concern, Dr Church said, in his evidence on the case studies, that there was a cultural reluctance to diagnose conduct disorder especially in CAMHS services and he said, of even greater concern, that conduct disorder was actually a diagnosis that would exclude CAMHS involvement for some CAMHS services and he thought that this was particularly deleterious because there are NICE-approved interventions for conduct disorder and he also thought that the formulation around conduct disorder was positively helpful for other agencies, better to understand the type of case that's being dealt with and what interventions may be necessary.
Can I ask, first of all, are those concerns that you recognise?
A. Again, it is a debate that people have about the

usefulness of a diagnosis of conduct disorder because conduct disorder describes behaviour and at the point you are doing the risk assessment, you are describing the behaviour. So, yes, I can see that we sometimes don't put in conduct disorder because we are describing the behaviour and we think we have already done that. So if conduct disorder is about breaking rules, doing criminal behaviour and that kind of stuff, then you are already defining it and it is again, a bit circular.
I do have concern that conduct disorder is sometimes a reason for people to exclude from services because they will say: well, they have got that, so that is justice, it doesn't come into mental health or other types of services. And labels and stigmatising people. But I can understand concerns that we should be able to define it and diagnose it when it is there and it should be just part of the overall formulation, as everything else is.
Q. To your knowledge, is anything being done about that reluctance and is anything being done about the case -- because you seem to recognise the problem that some CAMHS services exclude those with conduct disorder; is anything being done about those two different but related issues?
A. I think, as adolescent forensic psychiatrists, we do

discuss it and we share thinking about it. So there is some kind of academic, clinical thinking about it in peer groups. In terms of whether it is being done across -- it's all about thresholds and resources and who gets the interventions in each agency. I suppose, my concern about this group of people, and the conduct disorder group of people, is they don't necessarily hit the threshold for any particular service but they need every service. And that's one of the dilemmas we have for that group.
Q. Thank you. The expert cadre also raised concerns about the prevalence in the case studies of the potential, at least, for foetal alcohol spectrum disorder. And they flagged concerns around an absence of professional curiosity about FASD. They spoke about the high rate of co-occurrence with neurodevelopmental conditions and the risk that foetal alcohol spectrum disorder, therefore, might be masked or overlooked because of neurodevelopmental conditions which young people had at the same time, in circumstances where foetal alcohol spectrum disorder required different approaches. And they also flagged, more widely, that the importance of FASD because ultimately it was preventable by abstinence in pregnancy.
Others have spoken about those aspects being

typically taken on by paediatrics to some extent, rather than psychiatry. Do you have experience in this area? Do you recognise those concerns?
A. So I'm not an expert on FASD. The people I've seen who have had it or there's questions about it, I've seen in adolescents and so I'm looking at their behaviours then and what the outcome is. So then it is whether a diagnosis of autism or ADHD or learning disability and whether it has had an impact on their reactivity and emotional dysregulation.
Of course, managing pregnancy and people not drinking too much in pregnancy is very important as a preventative. And if you need a diagnosis in order to improve mental health, then I suppose we need to do more about their diagnosis of that. But I have not found it necessarily. And the only thing I have been told is FASD is a difference -- would change the way you manage somebody in adolescence, is occupational therapists told me that it changes the sensory sensitivity profile. But apart from that, I'm managing the behaviour in front of me and I'm thinking about how to help them within the profiles of different NDD types of disorders.
Q. Thank you. I want to turn briefly, please, to information sharing. If we look at your statement at page 13 DHH000001_0013 paragraph 35. You say that:

"Multi-agency working requires good information sharing."

Important, but obvious. And you reference the comments about issues of consent to joint working and information sharing in the Phase 1 report.

What's your own experience? I want you to focus, if you would, doctor, on the cohort of patients who are a risk to others. What's your experience of the actual barriers to information being shared appropriately?

A. So my personal practice is if there is a risk, you share information in under-18s and that's how it is. I think people are worried about breaking confidentiality and so, quite often, if you are working in prison, even CAMHS won't share the information with the CAMHS service in prison because they need to get consent and then either they don't have access to the young person because they are in prison to get the consent or the young person feels paranoid, which is one of their needs, and therefore they don't give consent. So I think there is a lot of confusion about why do you need consent, when actually you are all working as public agencies to do stuff.

I think one of the concerns about sharing information with the GP -- and my personal view is that the GP is the holder of all health information to send

it out to different agencies as and when they need it, if there are risk issues -- is that people are worried about sending information about use of justice services to the GP because they think that's outwith health needs. So if it's got an address of a prison, or a young offenders, or if it talks about an offence, they think that breaks confidentiality because that's not a health issue, that is a justice issue and the GP doesn't need to know that. But I suppose, if you are sending health information somewhere to be shared, to me, it is the GP.

Q. Thank you. So your answers to that, inevitably, carry the interpretation that this remains a problem?

A. Yes.

Q. So your practice is, if we are dealing with risk to others, and they are under 18, we share, that's your starting position. But you are obviously flagging that that doesn't happen. What needs to change? Because this seems to be a perennial problem. There are all sorts of protocols, concordats, advice, guidance and yet, the problem doesn't seem to be either resolved or close to be being resolved?

A. I suppose, it lies with each public sector agency being clear that when there is risk, you share information. But I do not think -- you are right, the message isn't

getting across, because repeatedly -- you know, if I was in FCAMHS or if I was in the prisons and was asking for information, it wasn't coming and people were going off and seeking consent.

I think it is just reiterating it and getting each of the public sector agencies to be clear with their workers about it.

Q. So if we look at paragraph 38 at the bottom of page 13. You say:

"Where there are concerns about risk, information sharing and multi-agency working is essential, even if consent is withheld. We should always seek consent, but when working with young people and their families, must always be clear that information will be shared where there are concerns about risk."

So that's where, in your statement, you are getting at these same issues. As we raised with Professor Dave this morning, one gets to a situation where one asks whether there should be just clear, statutory protection for sharing information, including health information, in circumstances where there's a risk to others. Would you support that statutory change so that it is put beyond doubt?

A. I have never felt at risk for sharing information, I have to say, so, yes, put it statutory. But I have

never -- when I have shared information, I haven't thought somebody was going to come and criticise me because it was whether there was a risk and I think there is that rule anyway.

Q. No, but I'm really seeking to look at the problem of the others that you have experienced, where you have had difficulty getting information because they are reluctant to and they are seeking consent. It seems that those are very real barriers still?

A. I suppose, the other bit is making sure it goes all ways. Certainly, I have read -- and I know in experiences I have had is that I will be asked to share my risk, certainly into a Prevent panel, and then been asked to leave and haven't been told the other bits I need to do, to do my risk summary. So when you are a multi-agency network, you do need to share risk always and understand it always, but if that is statutory, yes.

Q. Thank you. The particular aspect about parental consent, if we could scroll up to paragraph 35. You say:

"Professional opinion and practice about when information can be shared and when consent is needed varies."

Then you give this example:

"... referrals to FCAMHS requires consent from the

young person and their carer and information is shared with the GP ..."

Now, just pausing there. Does that remain the case, that you can't make a referral even to FCAMHS without consent from the young person and their carer or parents?

A. I think there's a tick-box and the tick-box is: if consent wasn't given, is there a reason why? So if you say: could not get consent because it would raise the risk, you would do the referral.

Q. Thank you. What about if consent was sought and refused?

A. There's still the tick-box that says: I still need to share this information because of risk.

Q. But what about the referrals to FCAMHS? Typically, it might be to get advice from FCAMHS. Can CAMHS and other practitioners go to FCAMHS and seek FCAMHS' input, even though consent has been rejected or not deliberately not given?

A. So it is three years since I left English FCAMHS so I can't say the difference in three years. But my experience is I would take a referral, when I was working there, even if they had said it, if there were concerns about risk, because concerns about risk always trump consent.

Q. So you think cases could still come to FCAMHS even with the refusal of consent by the young person or the parent?

A. If there are significant concerns about risk.

Q. Thank you. And then the contrast was:

"... referral to the Youth Justice Liaison and Diversion service does not need consent but information sharing with the GP is limited to where there are active concerns."

Is that right?

A. So again, this was my clinical experience where I was working but, yes. There was a long discussion about whether we should share information with the GP and it was decided that not every routine assessment would be.

Q. Thank you, and is that out of some -- does this link back to your answers earlier on, that there was some sort of sense that somehow there was some breach of confidence in telling the GP that, for example, an adolescent had been arrested for an offence and seen in custody?

A. Yes, absolutely. Whereas, from my perspective, if somebody has been arrested and seen in custody, even if there's no concern, that's quite important because if, two years later they are seen, and there is a concern, I'm quite interested that two years ago there wasn't

a concern. I want to see how things have changed over time.

Q. Thank you. Do you have any observations about, in concrete terms, what needs to change in those areas? Do you think that parental consent and consent are still being overly relied upon? And if so, what can be done about it?

A. I mean, I suppose it is about having a concordat and a national guidance that where there is risk, multi-agency working is essential and information is to be shared.

Q. Thank you. I want to come on to the frameworks for managing VFIs next, please. With other witnesses, we have been exploring the concept, first of all, about who should first assess cases within the VFI cohort. Now, at the moment, while some of those cases may come to CAMHS, they may come to Youth Offending Teams, to youth justice workers, for the most part, they seem to be coming as referrals to Prevent. And we have heard evidence that that is problematic. Problematic because there is a risk of overwhelm for Prevent, the number of referrals has gone up, and a risk of dilution of their key serious cases from the number of referrals.

We have also heard evidence that it is problematic for other agencies. So, when health agencies refer into

Prevent, we have heard that, for the VFI type of referrals, there is a high percentage who are not taken on by Prevent and Channel and a lot of those bounce back to the health service who made the referral. And similarly, a lot of those that come from education, bounce back to the schools or colleges that made the referral as well.

First of all, are those patterns and concerns that you recognise?

A. I do. I think -- I mean, the reality is every agency will feel overwhelmed when you direct these young people to a set agency. So I think that stands for all. I have had people bounce back from Prevent. One of the reasons given to me recently was because the violence was in the home and not outside of the home and yet, to me, that's a trigger warning that one needs to think about. In terms of -- do you want to ask me --

Q. So -- yes, so you recognise that problem.

A. Yes.

Q. So let's assume for the moment that one takes the burden off Prevent and that those types of referral for ideological terrorism or those where there is a concern about being drawn into terrorism, but also the VFI cohort, however defined, were assessed by a different process and from then -- from that triage or screening

stage, they could be referred to Prevent or referred a different pathways if they were more VFI-like.

First of all, do you think that that may be an advantageous change, to bring in that sort of big front door?

A. I am a fan of the big front door, or any door, so that whenever children first present and whoever they engage with, that should be the lead agency working with them because that meets their main need and then everybody else form a circle around them.

Q. Yes, thank you. When you say "any door", is that drawing on the Welsh experience of how that's addressed?

A. Yes.

Q. Thank you. From your knowledge of systems, do you have a view on who would be best placed to do that initial referral and assessment, bearing in mind that they would need to be looking at the referrals that are currently dealt with by Prevent, as well as those that are more VFI-like and potentially also those that are more to do with more traditional safeguarding concerns of risks to the child?

A. I'm not sure I have an idea about what a central group would be to do it. And I have read other bits of evidence and I probably sound like all the other medics who say I think quite a lot of this sits in social care

rather than anywhere else, in social care to hold and send out and get support from other agencies.

But I think it depends on what the main need is. So I think the triage happens with the lead agency who is meeting the main need but I would request maybe a statutory need for the multi-agency working, once that need is requested, or -- and people saying: but we really need a multi-agency group around this child.

Q. All right. Well, let's move on to that stage then of what the multi-agency process would look like after any initial triage. And if we could have page 11 DHH000001_0011 paragraph 29 and we are grateful to you because you have somewhat nailed your colours to the mast here, in suggesting a concrete proposal. So you say:

"There are many local meetings to discuss young people at risk, including MASH, MAPPA, Child at Risk (of Exploitation) panels and the Dynamic Risk Register. In my opinion, where there are concerns that a child may be a VFI, they should be included in discussions in a Child at Risk Panel. This may be part of a MASH and/or MAPPA panel. However in my experience, the threshold for discussing individuals in a MASH or MAPPA panel are higher than that for a well-functioning Child at Risk panel and being able to discuss concerns about young

people who are worrying but not yet a high risk enables preventative multi-agency working to start earlier for the young person."

So, pausing there. You are putting this into the social care framework and suggesting that the best solution to this would be a child at risk panel; is that right?

A. Yes.

Q. Now, there may be a number of advantages to that system, not least that it is an existing system and it is one that also has statutory powers that lie behind it.

But could I explore some of the potential difficulties of that. One of the challenges that may be encountered in that sphere is a cultural one, that if it is a social care lead looking at matters through a child at risk panel, there may be difficulties with children's social services, thinking predominantly about the risk to the child, rather than the risk that the child poses to others, including the public. Do you think that that is a problem with child at risk panels in this type of a case?

A. So I have worked across 14 different local authorities and then also fed into many other local authorities when I was in the prisons. And I worked in some local authorities who have had these kind of child of risk of

exploitation type panels. So not a child at risk in the home, but child at risk of exploitation. And certainly some of them have worked incredibly well when they have been a multi-agency network and social care have led but all the agencies have attended and thought quite carefully about the young people in that local authority who are at risk.

Yes, I do agree that working with the local authority, with the Children Act as it is, people talk about -- and often when I make a referral, will send them back to me, saying: no, the risk is not in the home to the child and therefore, they don't hit our thresholds. Which I kind of disagree with because I think if the child is out to do harm or criminal behaviour, they are at risk of harm themselves and therefore, they should be within threshold. But it is for each local authority -- their legal teams kind of manage the thresholds and it differs.

Q. Thank you. So I think you are referring there to the MACE, the Multi-Agency Child at risk of Exploitation type of setting and that may include in other cases where they are at risk of being drawn into criminality or being exploited by others to commit criminal acts, yes?

A. Yes.

Q. And so would involve, for example, policing bodies --
A. Yes.
Q. -- on the team, perhaps different to child at risk in the home of abuse, or at least a different focus?
A. Sorry. Yes, absolutely. So you would have social care, health, CAMHS, physical health as well, education, the police and justice services, and local voluntary bodies as well. So that you can all get together and see the temperature of the local authority but also see what's -- of the local area. See what's happening in groups and see what's happening in individuals.
Q. Thank you. That's broadly similar to what our panel of experts, in particular Ms Gianfrancesco, alighted on as a model in Brighton, where she suggested you could draw on the high-risk adolescents work of social care and the MACE-type concepts and have something that's co-chaired -- as hers are in Brighton, co-shared by social care and police, and have buy-in from the other agencies and the case management is looking both at the risk to the child but also the risk of criminality by the child?
A. Yes.
Q. So that sort of a model?
A. Yes.
Q. I follow, thank you. The other potential downside, or

at least complication in relation to that sort of an approach, is what you do when the VFI cohort -- individual case is an adult rather than a child?
A. So the Dynamic Risk Register -- I could tell you areas of good practice but they are a good few years ago. But the Dynamic Risk Register has a similar set-up, where it is looking specifically at people with a neurodevelopmental disorder, so autism, ADHD, LD, but are in placement and placement might break down. And they have a children's panel and they have an adult panel and it is a multi-agency framework for the adult panel too. There is no reason why you couldn't have that kind of "at risk of exploitation" or "at risk of vulnerability to being drawn into" these things for adults as well.
Q. All right. So, just a couple of matters in relation to that. You, and a number of others, have spoken about Dynamic Risk Registers as being one of the aspects that in the 2025 Act is being strengthened by being made a statutory requirement. Just expand a little bit on what they are and how they exist as a non-statutory tool, for the moment?
A. So I was there at the first ever Dynamic Risk Register and they are really useful as they work and as I say, they are run by health -- they are run by health

commissioners, or the ones I was in were run by health commissioners but they brought together a multi-agency framework. And as I said, they looked at people with neurodevelopmental disorders and it was for people who were at risk of placement breakdown, who might need admission. So it is looking in a health framework of if your placement might break down, so education placement, home placement, local authority placement, school placement might break down and it might precipitate an admission to a mental health hospital. That's obviously with the 2025 Mental Health Act and we are not going to be able to do that in quite the same way, with the admissions in that way anyway.

But even now, if somebody with a neurodevelopmental disorder happens, you shouldn't admit them because of an neurodevelopmental disorder and placement breakdown. But it tries to look at that as a preventative way so that people are monitored and checked and thought about. So where there is risk escalating of placement breakdown, there is multi-agency working and thinking, to see what can be put in, in the community to prevent placement breakdown happening, to support the young person. So as a model, I found it to be really, really effective.

In some areas -- again, it relies on the

professionals in that area. I have been to some that have been fantastic and work really well and I have been to some that didn't work very well because people didn't work together very well.
Q. Right. So the need for good multi-agency working sits across. So, just translate that back to you. You said in relation to those Dynamic Risk Registers, that can happen for children and for adults as well. Just help in relation to our VFI cohort. If you had something similar to the MACE-type approach, there's no difficulty, in theory, in the hosting of that by children's social services if it is a child and the involvement of the police and the use of the statutory provisions for children as part of the statutory framework to give that multi-agency process powers. You might wish to have further powers.

But one of the things our expert cadre said was really challenging, and was happening in Brighton, is that once they had become an adult, there's no current statutory basis for adult social care to become involved, because the -- as an adult, even though they are simply 18 years and a week old, but suddenly the test is whether they are vulnerable to abuse or at risk of neglect. And quite narrow thresholds applied for that, for adult social care intervention and so wouldn't

conventionally come within adult social care casework.

So, how would the approach that you are advocating at paragraph 29 -- how would that actually work for adults?

A. So I'm not entirely sure. But thinking on my feet, there are vulnerable adult teams and when I'm working with young people, I do ask them to be referred into the vulnerable adult teams and as I say said, I think they are vulnerable. So if they are vulnerable to do something, they are vulnerable, so they should be considered.

But we also do have the human slavery stuff and the MPN, so that if they're at risk of exploitation, then they could be considered under that and the MPN very much would advocate a multi-agency framework with them. So I suppose, there are some mechanisms that we can use but you might need to put something more statutory about definitions. It comes back to your definitions and thresholds.

Q. Yes, so there might need to be something carved out to ensure that the cohort, in appropriate serious cases at least, came within the statutory purview of adult social care?

A. Yes.

Q. Thank you. An additional aspect that was raised by our

cadre -- could I seek your input on this -- was a concern that if such panels were going to take the VFI cohort, that they would not, without further resourcing, training and expertise, be well suited to addressing the online nature of the harms. So, understanding about the online harms risks, whether it is Com networks or material that's online and what to do about it in terms of devices and understanding what to do about it in terms of legitimate supervision of what adolescents do online.

What's your view on that? Do you think that panels, as currently constituted, would have sufficient knowledge and expertise in that area, or is that a gap?

A. It is a gap and we are all on catch-up to understand online harms and how to manage online harms. And the young people know more than professionals, in the main. We are trying to develop a tool actually called the HOUSE tool, Harmful Online Usage Screening Examination, which is being done by a colleague of mine in New Zealand, and just to guide us on how we screen to ask questions about online usage. But I think, yes, it is a gap for all of us to catch up on.

Q. Is that work that you could share with the Inquiry?

A. I can definitely share you the name of the guy leading it in New Zealand. It is at the process where we are

developing -- we have just got ethics to try out on university students, to see whether the tool works.

Q. Okay, so it is something that's in development?

A. It is in development.

Q. Thank you. If we could look, please, at page 8 DHH000001_0008, paragraph 22. You say that it is your:

"... opinion that the appropriate lead agency to manage the management plan should be a function of the predominant need identified from the young person's neurodevelopmental profile, functional analysis of behaviour and risk formulation -- again noting that managing the risk of VFIs should be with the support of a multi-agency network meeting regularly to review the risk and support plan."

So, take it as read for the moment, that if you had a lead agency approach, you couldn't identify in advance any particular agency that should always be the lead agency because it would always be fact-sensitive and indeed, even within the same individual, it might change over time. So take that as understood.

The Inquiry has really been hearing two schools of thought on this. One is that, having a designated lead agency, and potentially a designated individual within that agency, is a positively good thing because you clearly identify a responsibility for overall

supervision and you reduce the risk of things falling between the cracks. So clear designation, less risk of it getting lost. Always accepting that other agencies still need to carry their own responsibilities.

The contrary school of thought, which our expert cadre supported, was to say that actually, it is the multi-agency process that needs to be clearly identified and it is the chair or chairs of that process who need to be in the lead and need to be responsible and you need to have governance above the chairing of the multi-agency process to make sure that it is working well. But it is potentially positively unhelpful to have a single agency designated within that process as being in the lead because the risk then is that all the other agencies drop off. Where do you stand within those schools of thought?

A. Okay, so let me take it a little bit at a time. There is a risk, when you've got a young person with these types of needs, that it is -- everybody steps back and the last person to step back ends up as the lead agency and that's not particularly helpful. We do have heated debates in the multi-agency network and I think they are driven by financial resources, resources of staff and actually, fear of being the lead agency for risk, that puts people off being the lead agency which is why

people step back.

So, yes, I think there should be something that drives and demands us to do multi-agency working, that means other people can't drop out. And the fear is, if you are left as the lead agency, that other people will drop out bit by bit, by saying: well, I'm not doing anything, or I don't have a role here. And leave you as a single agency. So I completely and utterly agree that there should be governance that drives and makes sure we are doing multi-agency working because from my experience, that's what makes the difference in things working well. Okay.

I suppose my driver for saying that you can't specify the lead agency -- and I will come back to lead worker in a minute -- is that the people who are best placed to lead on the work for the young person is where the formulation specifies the need is. Now, there will be lots of different intersecting needs but there is -- usually, you can see a pattern of where the lead need is. And you need somebody to set up the meetings and somebody to do the minutes and somebody to just make sure drawing people in and to me, that is the lead agency.

Let me come on slightly separately to the lead worker. One of the things that has interested me -- and

I have never quite got to do, but I would love to study -- is the stigmatisation in terms of who people work with. Certainly, my experience is if you are working with a child or their family, you can't quite predict which agency -- you might be able to predict which agency they prefer to work with. So some people might prefer to be labelled as mental health, some people might prefer to work with social care, some people might prefer to be labelled in the justice system. And what's most important is engagement. So if that family and the young person prefer a certain type of agency to be the lead agency, then actually, they are more likely to engage and that's quite important.

Then the other thing is, is just thinking about the person who is doing the face-to-face work. Because you don't want to overwhelm them with ten people working with them, you want to have a person they engage with, or a small team they engage with. Not one, because if you go on holiday or become sick, that is a problem, but a small group. And it might be that gender might be important, the ethnicity might be important, their sexuality might be important, their own neurodiversity might important. And if there is a way of identifying what agency they are most likely to engage with and what type of work they are most likely to engage with and

match them, I think that's when you get the best outcome.

And then the multi-agency surrounds and gives advice to that frontline worker, to think about: we need to think about this, can we add this in. And to me, that's how you put it together.

Q. So some degree of flexibility to take account of the adolescent's preference and what's going to work best, rather than defining it by what would best suit the agencies?

A. Definitely not what would best suit the agencies. That's where we have problems.

Q. Thank you. Is there anything else you wanted to add in terms of multi-agency working?

A. I just think it is really important.

Q. Thank you. I want to turn to Mental Health Act powers next, please. If we look at page 4 DHH000001_0004, paragraph 9 of your statement.

A. Sorry, the other thing about multi-agency working, just to flag up, is it is really hard, as well as important and people need support with it. And there will be times when people really disagree and have massive arguments but it is the coming together and things like the AMBIT model that helps you come together and rise above that, that you need the support to do it.

Q. Thank you. I'm going to pick up on the AMBIT model in my questions just a little bit later. Just coming to the Mental Health Act. So in paragraph 9, you refer to the 2025 amendments to the 1983 Act and we have picked that up with others.

You refer there to CETR and Dynamic Risk Registers becoming a statutory requirement.

In paragraph 10, you say:

"... currently, a Mental Health Act assessment can be requested to facilitate assessment and discussion of need for Violent Fixated Individuals who have isolated themselves and disengaged from services. The 2025 amendments may prevent such assessments for those with [neurodevelopmental disorders]."

Now, I want to ask you about both aspects of that. So the first aspect is you expressing confidence that, under the current provisions, until the amendments come into force, a Mental Health Act assessment can be requested to facilitate an assessment for individuals who have isolated themselves.

Now, I know that you have looked at the relevant parts of the Phase 1 report. You have been notified about them and you know the Inquiry's concerns about that situation where essentially, mental health professionals and others can't get eyes on the

adolescent who is a risk to others because they are refusing to see professionals.

What gives you the confidence that, in those sort of situations, a Mental Health Act assessment can be requested, or rather, in practice, that it would be requested?

A. I might not have requested the Mental Health Act assessment in that situation. So I think there are questions about what are the benefits. A mental health assessment, yes. A Mental Health Act assessment, maybe not. But if you are concerned about somebody who might have a mental health disorder and they might be a risk, you can request a Mental Health Act assessment because section 2 is, of course, all about assessment anyway.

Q. Yes. I'm interested in what you said that you might not, I think you were saying in AR's case; do you want to just expand on that?

A. I mean, I wasn't involved and I don't know what happened. I have read the Phase 1. You can do mental health assessments and you can go in with many different agencies to do shared assessments. So you can go in with social care, you can go in with other agencies, with justice agencies when they are working with them, you can do home visits. So you can do mental health assessments that don't have to be Mental Health Act

assessments and people can engage or not engage in the same way.

Q. Yes, of course. But in AR's case, by late 2023, early 2024, there came a time when he was refusing to see mental health professionals but also other professionals on any sort of home visit. So the hard-edged question then becomes whether a Mental Health Act assessment should have been done in that case, but if not, what should have been done instead?

A. I mean -- I'm just picturing it. If I went in to do a Mental Health Act assessment in somebody's home because they refused to come in and see me, they could still refuse to see you for a Mental Health Act assessment.

Q. Yes, and then what?

A. Well, then you discuss where somebody needs to be for further assessment.

Q. And so that may mean supporting detention, for the purposes of assessment in an appropriate case, yes?

A. (Nods).

Q. What's the alternative?

A. The alternative is to go down the social care route and to think about a secure order or a DOLs order.

Q. Yes. So, in terms of going down the mental health section 2 powers in that case, the Inquiry is concerned

to understand whether there is a gap in those powers, whether there needs to be something else, maybe a shorter period of detention for assessment, where the principal concern is the very inability to get eyes on to somebody who may be suffering from a mental health disorder but where there's also risk to others.

Or, alternatively, whether there just needs to be more ready or robust use of section 2 powers and a bit of a re-balancing of the guidance, potentially. Do you have a view as to those different approaches?

A. I think when I have been in similar situations, I have asked more for somebody to go to a secure children's home, or a DOLs order, in order to have the eyes on in that kind of way, with the carers around them. And then think about the Mental Health Act because I have not necessarily thought hospital is the right place. But if you wanted them to have an assessment in hospital, I suppose the concerns about an assessment in hospital -- and I have had this experience, people can get stuck in hospital because then they don't have a placement to go back to and I have found that to be harmful.

So you could, I suppose, consider a short section 2 but it would have to come with a proviso that if it isn't mental health and admission isn't recommended,

then social care find a placement that's appropriate. But certainly, if you talk to most mental health practitioners, most responsible clinicians, they will all have had young people stuck in hospital because social care couldn't help find them a placement and certainly, we have been in court about them.

Q. Thank you, and you refer in your statement to codes of practice and to the guidance in this area. Could we look at DHSC000051, please. So that's the Mental Health Act 1983 code of practice. I assume that's what you were referring to in this context?

A. Certainly, that's how I practice my Mental Health Act work, I hope.

Q. The statutory guidance, thank you. If we just look, please, at page 205 DHSC000051_0205, chapter 20. There is a section there on "People with learning disabilities or autistic spectrum disorders". Again, taking it as briefly as I may, you reference -- we don't need to look it up -- in your statement the risk that hospitalisation for those with neurodevelopmental disorders may lead to a deterioration in their behaviour?

A. Yes.

Q. And to the use of guidance in this area that warns against those risks. And I think it is chapter 20 of the statutory guidance, the code of practice, that you

were referring to; have I got the right section?
A. Yes, it is definitely this principle, that it is better to not admit people with autism or a learning disability unless it is essential.
Q. Thank you. Sir, I'm not going to go through that but we've identified the relevant current guidance, if it were felt that more robust guidance needed to be given on the use of section 2 powers.
You have referenced the potential for DOLs in this area. Let's leave Mental Health Act to one side and just look at those social care interventions.
So, you talked about a placement and you talked about DOLs. Do you want to just take those one by one. So start with the need for a placement?
A. So say, you have got a young person who is showing risk behaviours and you think it is more within the realms of a neurodevelopmental disorder and you want to have -- they are not engaging and maybe their parents are not able to help them engage and settle with you and their parents can't put in the boundaries. You think this person and the family system needs support. Unless I thought they had depression, psychosis, my general recommendation would be to think about a social care placement and when I say "social care placement", then social care think about how they can -- what level of

restrictions/security they need to do that, but I suppose in the case of AR, it would have gone up to something like DOLs or secure, because of the concerns people had. You could either have a secure children's home, in which case they're staffed all the time and people can report back and you have got mental health input in there. There is a mental health assessment when they go in and there is a mental health in reach, so they can do it.
Or you can have a DOLs order by the inherent jurisdiction of the family court and there are varied opinions about whether a DOL order is good or not, because of whether the placements are regulated or not. But if you had a good team providing the DOL order and a good multi-agency network around the team, like I have worked in before, then that gives you the opportunity, as well as something being in a safe placement, with those provisos, because it does need to be carefully --
Q. What sort of placement would that be, in practice? What sort of a --
A. So I have been a psychiatrist for people in what you call 2 to 1, 4 to 1, 8 to 1 placements, where they are in a house, they are on a DOL order which restricts their liberty and they have a team around them that are enough team to keep them safe and they have various

restrictive measures that are permitted under the DOL order.
Now, as I said, there are various discussions about how they are regulated and how they are set up and they have to be carefully monitored, which they are not quite yet. But if you have got a good multi-agency team or if you had a statutory framework which meant they were well monitored, then that would give you the eyes on and would give you more flexibility than a hospital would.
Q. And those deprivation of liberties could include in terms of use of the internet, access to the internet?
A. So the young people I have had -- and I had one person who had problematic use of the internet -- in fact, that wasn't added on the DOL order and that was taken as parental consent and the parents said they could not use it. So that was interesting, the judge doing the DOL order didn't put that in into it. So that's is a discussion for family lawyers, to decide whether that is parental consent or whether that's under a DOL order. But certainly, the DOL order gives permissions to various restrictions that you can do.
But you don't have to do. So as they get better, their restrictions can be reduced. So you can have people on a DOL order going out to the park and going to do things, when you feel the risk is being monitored.

But I think the DOL orders work if you have a really good multi-agency team around them, which they don't currently have to have. And when they don't have it, of course, they are seen as not particularly good orders. So it goes to the framework.
Q. Yes, but presumably, it also goes -- may go hand-in-hand with a multi-agency team, but it also requires the funding to do it in the locality?
A. Exactly. They are expensive placements and there aren't enough secure children's home placements. So you have a big discussion about which is preferred and least restrictive. So, yes, they are expensive, which is why people tend to say: let's put them in hospital. Because you can get them into hospital quicker, but then you have the problem that people get stuck in hospital or then you have a later discussion about institutionalising them or medicalising them and of not meeting the needs that they need because hospital isn't the right place for them.
Q. Thank you. Are you aware of any analysis of the numbers of those whose risks are being mitigated by the use of DOLs outside of secure children's homes?
A. Well, I know -- I mean, because we are trying to study various bits about DOL orders, I know that -- I think it is something like it used to be 1,000 applications for

secure orders and 200 for DOLs, in something like 2014 or something and it's gone up to be the opposite. The Nuffield Family Justice Observatory are the people who counted the numbers and it is now about 1,000 applications for DOL orders and 200 applications for secure orders, so they have swapped around. But there's no -- the trouble is we don't yet have outcome studies for those either, to know what works and what doesn't.

MR MOSS: Thank you. Sir, I note the time. I have one topic left, but we have been going for an hour and a half. So I wonder if we might break perhaps until 3.20 pm and then conclude the questioning and I think we will be able to deal with our Topic 1 evidence summary.

SIR ADRIAN FULFORD: Excellent. We will take a short break. 3.20 pm.

(3.10 pm)

(A short break)

(3.20 pm)

SIR ADRIAN FULFORD: Yes, Mr Moss.

MR MOSS: Thank you, sir. Dr Hales, my final topic was on interventions for this cohort. If we could have on screen page 12 DHH000001_0012, paragraph 32.

Others have emphasised what you emphasise in your first sentence there, there's currently a "real lack of

research outcomes nationally and internationally", in relation to what interventions work.

You say that:

"Nationally, the Anna Freud centre lead on evaluations of various models of care and interventions."

I think they are a mental health charity, are they not, but with a heavy emphasis on research?

A. A mental health charity that's linked to UCL, so yes, very much an academic centre, but the ambit is, I suppose, clinical.

Q. Thank you. Then you give a couple of examples of your own experience. So the first one you have mentioned a couple of times and I promised to come back to. So you say you:

"... have had good experience working with the AMBIT model (designed and training given by the Anna Freud centre) ..."

Do you want to give us the thumbnail sketch of what that involves?

A. And I won't do it justice because I'm not an expert, but the AMBIT model is about -- well, the bit I like about the AMBIT model which is a multi-agency network framework, and it helps you think about how to work within your team, and how to work across agencies. And

it helps you -- I suppose, from the training I have had in it, it helps me think about the other person from the other agency that I might be having an argument with, in order to try and work out how we can come together to have an agreement to work together.

And so it is very helpful from that perspective and they offer training for teams to work together as an AMBIT model and then they offer ongoing supervision to help people have top-ups or to think about that kind of working. I just think within this kind of work, it is really difficult because people have differences of opinion and the paper that I submitted, that Gwen Adshead and I had co-authored with some colleagues, tried to emphasise that we might all want the best thing for a child but we might disagree with what the best thing is. And then feelings can get heated or resources can be limited and then it is quite hard for the best of ourselves to work together. I think the AMBIT model tries to rise above that and help collaboration work.

Q. Thank you, but it is the Anna Freud Centre themselves who would be best placed to --

A. I think talk to them about that.

Q. Thank you, that's helpful. Then you say you have had positive experience when you have worked with young people offered multi-systemic therapy. Can you just

help us with what that's a reference to?

A. So again, there are other experts, not me. But multi-systemic therapy came from the States. When you think about young person, there is this thing called the ecological framework. You think about the young person's genetics, the young person's lived experiences that made them who they are. Then you think about the family around them and then you think about their peer group and their school and their community and each bit is a system and so multi-systemic therapy looks at each bit of the system, about putting interventions into each bit of the system to try and reduce the risk. So it is kind of a multifaceted intervention, just like multi-focal foster therapy would be as well. The MST is very intensive work for, I think, six months and they have a therapist and they go in and they do an assessment and they think about where the intervention should be and then they put in people on call to answer calls -- to the parents usually, but it could be the carers -- about supporting when things go wrong.

So it is a very intensive intervention, to look at the whole systemic framework around the young person and their carers, in order to do try and do small bits of intervention throughout, to reduce the risk.

Q. Thank you. Then you also refer to "MBT", mentalisation-based treatment, I think?
A. So mentalisation-based treatment is -- again, I'm not an expert, but it's where -- so the thing about adolescent forensic psychiatrists is we know bits of everything so that we can plug people into the right place, rather than being the therapist ourselves. But MBT is where you understand that -- it is helping somebody internalise the good frameworks of other things. So, the good mother, or the important other adult. To understand the rules, to understand that they can be cared for.

So if you care for a person, you will internalise being cared for. So you will care for yourself and -- sorry, if somebody cares for you, you internalise being cared for, so you can care for yourself and somebody else. If somebody follows the rules and shows you how to do it, then you can follow the rules yourself and you can guide other people to follow the rules. So it's about internalising frameworks from how your carers have done that to you. And that can be done through a therapy as well if you haven't had it from your parents or the carers around you. And again, that just helps people to internalise ways of behaving.
Q. Then, fourthly, the Good Lives model developed in

Manchester?
A. So the Good Lives model is mainly given for sexually harmful behaviour but I think it works for quite a lot of stuff and my understanding of the bit that goes to that, is that, it looks at the goods in somebody's life. So it has a holistic view about the goods in somebody's life, and it defines some of them, and in fact, we are trying to develop a holistic outcome measure to think about goods like this. So some people value education, or leisure, or family relationships, or peer relationships, or sexual behaviour.

Different people value different things and want different things from their lives and if you encourage and help them to focus on what they want to gain and what they want to improve, then you can dissuade them from things that will get in the way of them getting there. And it stops you having -- certainly, for the sexually harmful behaviour, because if you say, "Did you rape them?" "No, I didn't". Well, then you have a fight, if you are looking at the offence-related behaviour. Whereas if you try and divert them and say, "What do you want to get to? Where do you want to get to? What do you want to attain in your life? Let's work out how to get there". Then you don't have the argument about the offence, but you are diverting them

to think about where they want to get to, what the positive is they want to get to in their life.
Q. Now, the challenge, in some senses for the Inquiry, Dr Hales, is that you are then drawing on different intervention approaches that you found helpful. You have obviously drawn from different bits from different therapies there.

But we haven't sensed that any of those are specifically recommended for the VFI cohort. How can that sort of experience be moved on, so that it is more available in practice? Because, I don't criticise your evidence for a moment in relation to this, but it is quite anecdotal in terms of what you found to be helpful --
A. It is not anecdotal.
Q. Forgive me. Anecdotal in the sense of "I have found this helpful", but we don't see it in current guidance for anything in relation specifically to this cohort. So that's what I'm interested, in translating what you may think is good practice that could be used for interventions into more concrete guidance. Forgive me.
A. So you do see multi-systemic therapy, multi-focal therapy, MBT. You see that in conduct disorder NICE guidelines. The Good Lives stuff is absolutely recommended -- I don't know if it is in the NICE

guidelines about sexually harmful behaviour, but in protocols for sexually harmful behaviour it is absolutely there. And they do have some evidence, though it is limited and there are various issues about translating it. So I agree, we need further evidence, we really, really do.

For this group of people, they are slightly different from the conduct disorder, which is what -- they are more of the -- what used to be "dissocial/unsocial conduct disorder" than the "socialised conduct disorder", which these look at more. So, yes, we do need to do studies.

The difficulty we have of doing the studies -- of course we need to do studies and I've told you I like doing research -- of course I'd say we need to do studies -- but is when you have got a low -- when -- there is a lot of people who say they are going to do stuff and only a few people who will do it. How will you know you have stopped doing it? So, for example, we want to look at outcomes of people who have been put in a medium secure unit and we are putting in a grant at the moment to look at outcomes if we put in a secure children's home or on a DOL's order. When -- we don't yet know the baseline or benchmark outcomes of those types of things at the moment, so we don't know if

an intervention has stopped it.

So in the same way, your VFI group, or whatever you are going to call them, we don't know how many of the people who say they are going to do something will do something. So when you do an intervention, you don't know how many you have prevented or how many people would have grown out of it. So you have to design quite a careful study and those kinds of studies, because the numbers are so small, are very difficult to do. And that's why, for example, GIRAF is an international group, because if you do it internationally, and actually, talking to my colleagues in Finland -- they're also in this group -- and my colleagues in New Zealand, they are getting this group of people -- we know the Americans have got this group of people. So internationally, we have this group of young people. So having international studies, or seeing what -- you can do naturalistic studies, so you can see what different countries do to see which ones get the best outcomes, or you can design a study, which will take a while, but I think it is better to do it. Because the numbers are so small, you have to do a big study.

Q. Thank you. So when we look -- I won't go through it all, but when we look, in paragraph 34 at the bottom of the page -- and we promise not to take it as a bid for

your own funding -- but at the further clinical academic posts in this area, no doubt associated with funding, but studies of interventions in other countries and there, you reference GIRAF and if we go over the page DHH000001_0013, you say:

"To enable this, we first need to compare systems and processes. This is underway."

What is the "this is underway" a reference to?

A. So, I suppose what GIRAF does is we are doing lots of naturalistic studies, to say: what are you doing, what are we doing, what are the differences, what are your outcomes? So we are trying to start setting up baseline stuff, but we have no funding, so it makes it very difficult. But you need to get funding to -- it is hard -- if you wanted to study, you would do a randomised control trial. Obviously, you can't do that here -- well, they are doing a MBT randomised control trial for CAMHS. But it is quite difficult because of the risks involved. So, first of all, you can see what other people are doing and what other people think works and then you could incorporate that into a study. That would be how I would go forward with it.

Q. Thank you. Then you talk about the EFCAP being a useful group to showcase research in this area.

We have heard, in relation to other aspects that are going on in terms of the Five Eyes group nationally and looking at work on that, that has come out of counter-terrorism considerations in that area, which also I think is doing some work in this area.

Can I ask a difficult question: pending that sort of evidence-based, what should be happening? So in the evidence of those approaches being validated for the VFI cohort, what is the advice to practitioners on what interventions to try, on the basis -- even if on the basis of, by analogy, this would seem to be a reasonable best practice, pending further evidence?

A. Well, I would go back to what I had said before, is I would look at the local MST. It is not nationally set yet, but I would like at that. I would look at MBT that people can do and that is being devised in FCAMHS. I would look at the Good Lives and do something around that. They are other therapies. But you know -- you also look the baseline. So quite a lot of people have had trauma, so you might want a trauma therapy to go along.

I mean, the thing is, there is some really basic stuff -- and you might come onto it -- but what about just keeping people in school? You know, what about giving more support to families rather than judging

them? There are certain societal things we can do as well, which will help before you get into tier 3 CAMHS and interventions.

But at the moment, it is formulating and it is saying, we have got -- where is the fracture point of this person? And understanding the fracture points of this person, what interventions can I go to which I know will be impactful for them?

Q. So page 12 DHH000001_0012, paragraph 33, final sentence:

"I would also encourage further consideration of the role of education, including the consideration of the harms of exclusion and the need for assessment and support plans to avoid exclusion where possible."

I think that's what you were referring to?

A. I suppose, I'm always challenged that we think about excluding kids from primary school or even early secondary school and we don't necessarily do an assessment. It is so unusual and problematic if a child is being excluded from primary school. Surely we need to think: why is that child being excluded and what do they need and how can we put a support into place for that person? And we are getting schools counselling in and we are getting those kind of things. But if you exclude somebody, you know that they are going to go off and do other things during school time

and the people who are also not in school are not the group of people you want them to engage with and they will be vulnerable to them. So keep them in education, keep them doing positive things and you can hopefully divert them.

Now, I know schools with classes of 30 can't manage people who are going to be disruptive in class, so I know there has to be a different framework about thinking about how to manage them. But education is so important for one's self esteem and self confidence, about how you view your future. Rather than dismissing them and excluding them, let's try and hold on them and give them a future and then we reduce risk.

Q. Some of the pro-social interventions available in Channel, mentoring, gym memberships, positive activities other than the internet, sports club involvement --

A. Absolutely, absolutely.

Q. Again, one perhaps doesn't need -- one doesn't need detailed academic papers to make a reasonable assumption that those are likely to be helpful?

A. It is not a rocket science to know that somebody would rather talk to a young man who takes them to a gym than talk to a middle-aged woman who talks to them in therapy. Engage them with mentors, that's much better, and then let me talk to the mentor about things to think

about when they're seeing them. Do the stuff on the ground and help the agencies then guide the mentors and things like that.

I would put money into social care and mentoring and leisure activities and education.

Q. All right. Final question from me. In the way that you express it, it all sounds, both from your professional experience but also common sense, that those things should be done. But are -- those various measures that we have been exploring, are those drawn together anywhere as, in the meantime, guidance on what is most likely to be effective for the VFI cohort in terms of interventions, pending further study? Do we find that in any guidance available to practitioners?

A. No, I don't and my dilemma that I see is -- I don't know if people explained our tiers of services. So tier 3 is CAMHS; tier 4 is specialist CAMHS like FCAMHS and inpatient; tier 2 is kind of school GP level; so tier 1 is primary health type stuff. You want to get them before they come into CAMHS. You want to do the intervention which is the early intervention, the non-medical, non-therapeutic intervention. But sometimes I feel that people jump from tier 2 to tier 4 because you miss them and you miss the bit of helping them in education, getting them -- a teaching assistant

to sit with them, getting them leisure activities because for some reason their family haven't had the money or opportunities to get them to go and see whatever activity they could do, and you have lost them. And then by the time you get them, they are in tier 4 and they're doing crimes or they're saying stuff and it is really high need.

So get them at tier 2 in the community. Do community support, community services. And I have said Sure START stuff and I know you have had some -- there is a new thing from the Labour Government that is going to be modelled on Sure START. Absolutely, do the interventions early. I mean, we are going to end up with firefighting because we have got a group of kids post-Covid who we need to support, but let's prevent the next group getting there as well.

MR MOSS: Thank you. I'm just going to look to my left. I don't think there are any questions. Sir, do you have any questions?

SIR ADRIAN FULFORD: No. Dr Hales, you have been a mine of information and you have put a lot of work into this and thank you very much for your report and your evidence today. I'm very grateful. We are going on to something else now, so you are free to leave us. Thank you very much.

(The witness withdrew)

CTI Summary of Evidence Relating to Topic 1

MR MOSS: Thank you, sir. Now, with some exceptions that my learned friend, Ms Woods, will explain, Dr Hales, in fact, is our last Topic 1 witness, but we haven't called all of the witnesses by any means who have offered evidence on this topic. And with your permission, my learned friend will address some of the evidence from witnesses we have not called.

SIR ADRIAN FULFORD: Thank you very much. Yes.

MS WOODS: Thank you very much, sir. I anticipate this will take us through to the end of the day.

SIR ADRIAN FULFORD: Fine.

MS WOODS: As Mr Moss KC flagged, we are now at the conclusion of the live evidence for Topic 1, the adequacy of arrangements in England and Wales for managing the risk posed by VFIs.

There are two caveats. The first is that Mr Emmett, given the centrality of the Home Office, has agreed to come back towards the end of Topic 3. He is attending principally in order to address matters which have arisen in the evidence of others, given that he gave evidence as our first Governmental witness.

Second, the Inquiry hopes to take evidence from Sir Declan Morgan in December. Diary issues have meant

that his evidence could not be accommodated within the Topic 1 hearings.

Sir, subject to those caveats, the evidence for Topic 1 has now concluded. As in Phase 1 of this Inquiry, for each of the topic areas in our Phase 2 evidence, we intend to give a brief presentation on the evidence which has been made available to the Inquiry, where that witness has not been called.

I should say for clarity at the outset, that this presentation is not intended to cover all of the material that has been disclosed to the Inquiry. Instead, it is intended to give a high-level overview, that makes public key aspects of the statements which have been received.

SIR ADRIAN FULFORD: Yes.

MS WOODS: I will take this thematically, beginning with statements from existing multi-agency structures that work with persons who pose a risk of harm to others and statements which comment on the efficacy of those structures.

Starting with some Vanguards. Claire Ruiz, the Senior Programme Manager of NHS England for the London region, has provided evidence in relation to the operation of the London Violence Reduction Vanguard Programme. That statement is at LVAN000002, dated

22 September of this year.

She states that the:

"... London Vanguard is commissioned by NHS England to evaluate trauma-informed, health-led approaches to supporting children and young people affected by violence, exploitation and adversity."

The Vanguard, which is funded through September 2028, uses multi-agency collaboration to provide psychological support and early intervention from birth through to age 25.

Ms Ruiz explains that the Vanguard receives referrals from a broad range of agencies, including the NHS, local authorities, youth justice and education. Psychological formulation is used in order to understand behaviour, to understand vulnerability and risk and in that context, Vanguards do encounter children presenting with violent ideation and attack-related fantasy, although they are not commissioned specifically to assess or identify VFIs.

When a VFI is identified, they are referred within existing multi-agency safeguarding frameworks. So vanguards consider neurodevelopmental needs as part of their holistic assessment and some Vanguard services have developed pathways to support early access to specific neurodiversity assessments.

Ms Ruiz also disclosed to the Inquiry a report, setting out the results of an independent evaluation of the Vanguard model, which was undertaken by the Anna Freud Centre, which we have just heard reference to, in February of this year. That, for your reference, sir, is at NHS000590. While the results include positive learning related to multi-agency collaboration, relational work and accessibility of services, Ms Ruiz warnings for the need for careful consideration of resourcing and other practical matters before consideration can be given to expanding the remit of the Vanguards.

Another Vanguard which has provided evidence to the Inquiry is the Humber and North Yorkshire Integrated Care Board system. They provided evidence, which is at HNY000002, from 11 September 2026, and the statement comes from Amanda Stanford, who is the Executive Director of Nursing and Quality for the Integrated Care Board.

As in London, the Vanguard in the Humber and North Yorkshire region works to provide a multi-agency approach to identify and support children and young people who have experienced trauma in order to reduce risk factors and involvement in anti-social behaviour or criminality and to improve educational attendance and

relationships with trusted adults.

An important part of its role is testing new models of care. Ms Stanford explains that no two Vanguards are the same because they are tailored specifically to meet local need and complement existing provision in the area. The Humber and North Yorkshire provision supports young people up to the age of 19 with the delivery of a range of interventions, including: a pilot programme that deliveries one-to-one therapeutic intervention and group diversion; a programme designed to engage hard to reach children and provide them with safe places and positive activities; and a tiered partnership service of coordinated early help, which includes the use of a bespoke app on phones, to support children and young people to express their feelings and views.

Ms Stanford emphasises the importance of addressing isolation as a risk factor and states that one of the Vanguard's partners is involved in work on the Social Connection Framework, which is commissioned through the Government's Social Connection, Isolation and Loneliness team within DCMS, in order to identify and support young men at risk of loneliness and isolation.

In relation to VFIs, Ms Stanford explains that the term is not in common usage within the Vanguard or among its partners. She raises the risk of labels creating

stigma or potentially minimising the complexity of an individual's vulnerabilities and experiences.

She explains that the Humber programmes do not assess specifically whether or not an individual is a VFI, and they do not use specialist VFI assessment tools.

Ms Stanford supports the use of a lead agency for case management, to be determined by reference to the primary needs of the child in question.

The statement acknowledges that a single risk assessment tool would be helpful to improve consistency of approach, if supported by significant multi-agency training, but she raises a number of questions about how such a tool could be implemented in interface with existing processes.

Ms Stanford also addresses the challenges that arise in providing interventions for a person who has not committed an identifiable offence, who does not pose an immediate threat, and does not meet thresholds for mental health interventions.

She identifies a number of gaps in the existing legal framework and raises concerns that professionals may have limited powers in those circumstances to compel assessment or engagement. When considering potential legal reforms in order to address that gap, Ms Stanford

suggests that a carefully defined, preventative assessment regime would be more appropriate than a power of preventative detention.

The statement also refers to the cliff edge of children's services and the difference in thresholds for adult services, which it states "makes the delivery of needs led interventions more challenging for persons aged between 18-25".

The statement highlights the importance of trauma-informed interventions, which are not time-limited, in order to enable trust building with workers, the development of a tailored care plan and the embedding of protective factors.

Moving, sir, from Vanguards to Violence Reduction Units, we begin with a statement from the London Violence Reduction Unit, provided by Lib Peck, Director of the Mayor of London's Violence Reduction Unit, which is at LVRU000010, dated 23 September 2026.

She explains the structure and functions of the London VRU, which was established in 2019. The statement sets out a range of interventions developed by the London VRU, including a network of parents and carers, a programme for supporting fears as positive role models for young boys, education programmes, speech and language development, mentoring, youth clubs and

work related to online harms and digital safety.

The VRU funds and deliveries those interventions as programmes, rather than undertaking individual case management. Although they do work closely with local authorities and provide strategic guidance on the identification of risk related to violence.

Ms Peck refers to problem with the management of VFIs, including practitioners being aware of risk but unclear about where referrals should be made. And to cases being passed between agencies because the subject does not meet an established threshold.

The London VRU also identifies issues with information sharing, including that they too often encounter different services each holding low-level risk information, which cumulatively would demonstrate a higher level of concern.

The statement advocates for better training for practitioners, especially in relation to digital concerns and appropriate referrals.

The London VRU is supportive of the use of a single, central risk assessment tool in order to ensure consistency of approach across London boroughs and also the creation of a lead agency in the form of a statutory body. It supports putting existing, non-statutory arrangements, such as MASH, on a statutory footing.

The London VRU is also responsible for overseeing the Young Futures Panels pilot, which, as we heard from Mr Emmett for the Home Office, identifies children who are vulnerable to criminal exploitation and refers them to support.

The statement indicates that an evaluation of that pilot has been successful, with richer, multi-agency information supporting tailored preventative interventions and, sir, a final evaluation report is expected in January 2027.

The next VRU which provided evidence to the Inquiry is the Greater Manchester Violence Reduction Unit, in the form of a statement from Mr Daniel Diamond, the partnership lead at that organisation. Sir, you may recall that Mr Diamond attended the Inquiry as part of the seminars on 10 September of this year.

SIR ADRIAN FULFORD: Indeed.

MS WOODS: His written statement is at GMVRU000008, dated 26 August.

Like the London VRU, the Greater Manchester VRU brings together policing, local Government, health, education and youth justice, to promote a whole-system response to serious violence.

It develops and deliveries community-led programmes, including mentoring, community sport, education and, of

course, the Young Futures Prevention Panels.

Mr Diamond explains that the VRU in Manchester does not use the term "VFI" but it is recognised in the context of national policy discussion and the VRU is likely to encounter VFIs through other aspects of their presenting needs or risks.

Mr Diamond raises concerns about the potential of the use of "VFI" as a label to stigmatise or skew risk assessments in a way that results in disproportionate system responses. Nonetheless, he acknowledges the need for a clear, agreed definition of the term.

The statement also explains that VRUs do not use specific VFI risk assessment frameworks, but at paragraph 35, it sets out a list of potential early indicators of progression towards violence, drawing on the work that Greater Manchester VRU has been undertaking.

The statement raises concerns about existing systems and their efficacy, including variation in the provision of services across different areas, lack of clarity in referral thresholds, problems with information sharing and a gap in the system for people who do not meet the thresholds for Prevent, criminal justice measures or mental health treatment.

Mr Diamond's position is that a big front door model

would facilitate earlier interventions and reduce fragmentation. He also highlights the need for a formal mechanism to ensure ongoing oversight of cases, where a referral to Prevent is not accepted.

He supports the use of an existing multi-agency structure, such as MASH, or the Prevention Partnership Panels, PPPs, for the management of VFI cases, rather than the creation of a new multi-agency body.

But he does recommend integrating specialist expertise from VRUs and other agencies into the initial triage process of that structure.

Greater Manchester VRU support a public health approach to the management of VFIs, noting that many of the factors associated with violence fixation overlap with established risk factors for serious violence, which does fall within a VRU's remit.

The statement also highlights the role of the Voluntary, Community, Faith and Social Enterprise sector, in effective grass-roots working, in order to access people whom statutory services may find harder to reach and recommends strengthening the capability of that sector to communicate concerns to statutory agencies.

The final VRU is the Humber Violence Prevention Partnership and we have a statement from Richard Kendall

who is the Director of that organisation, HVPP. The statement is at HVPP000009, dated 12 August 2026.

Mr Kendall explains that HVPP has started to use the term "VFI" over the course of the past year, but that there is no local definition and the VRU would welcome a single national definition in order to promote consistency.

He states that awareness of the cohort is good amongst police and local authorities, but awareness in other organisations is variable. Mr Kendall explains that the Violence Reduction Unit commissions targeted interventions for young people who are at risk of being drawn into violence in order to test and evaluate the efficacy of those interventions. Like other VRUs we have heard of, HVPP operates a Young Futures Panel pilot and Mr Kendall, in his statement, provides detailed information about that programme.

The interventions available through the work of the HVPP include a range of sports-based diversion programmes for young people, education and mentoring programmes and a programme called ED Navigator, which engages with young people who attend Emergency Departments in circumstances which are linked to violence.

Mr Kendall also provides information about the

different approaches which each of these interventions take to risk assessment, ranging from simple RAG rating systems to identify persons who are in need of more intensive support, to more complicated assessments.

The statement addresses the issue of parental consent being a practical challenge to engagement with interventions and it notes its experience that the use of terminology such as "serious violence", can be a barrier to families consenting to the interventions where they are concerned that support services may be punitive or that they may be labelling the children.

Mr Kendall explains that their experience is that re-framing programmes as "early help" or "wellbeing services", rather than a response to risk of serious violence, assisted in addressing this problem.

Overall, HVPP supports the adoption of a public health approach to the management of VFI risk and indicates that VRUs could play a role in convening such a process, similar to the role which they undertake in relation to the Young Futures Panel pilot.

They also can play a role in commissioning and evaluating interventions.

Turning, sir, to the statement from Dyfed-Powys Police, from Assistant Chief Constable Andrew Edwards, regarding his experience of offender management in the

context of Potentially Dangerous Persons Panels, or PDP panels, and of MAPPA. That statement is at DPP000009, dated 7 September this year.

ACC Edwards gives a detailed explanation of the structure and functions of MAPPA and the PDP panels in his force area, including in relation to how they identify risk of violence fixation in order to develop risk management plans for individuals.

The statement confirms that the Dyfed-Powys Police are very familiar with the term "VFI" in the context of MAPPA and violent offenders, but he explains that where there is also concern about susceptibility to radicalisation, referrals would be made to Prevent. He states that there is increasing awareness among other agencies of the term "VFI".

ACC Edwards identifies a number of challenges in this area of work, including clarity of referrals, especially where the subject is a child, and the gap which can arise in ability to assess a person who displays violence fixation but who has not yet committed a specific criminal offence.

To address the latter issue, ACC Edwards recommends amending the assessment scoring criteria which is used by MAPPA in order to capture not just criminal offending, but behaviours.

For the management of VFIs, ACC Edwards expresses some reservations about the use of a big front door, noting that "bigger does not always mean better", and that a unified body which could manage VFIs already exist in the form of MAPPA.

He suggests amendment to category 3 of the MAPPA framework to allow for the inclusion of individuals with no previous conviction, or the addition of a fourth category, for persons without convictions who pose a significant risk of serious harm to the public.

He notes that the benefit of this approach is that the MAPPA framework is already in place, with a clear legal duty requiring other agencies to co-operate. He recommends the use of Prevent as a tactical option available for use as part of a risk management plan behind a front door.

Sir, the Inquiry has also received two statements from the Fixed Threat Assessment Centre within the Metropolitan Police Service's Specialist Operations, also known as FTAC. One statement has been provided by each of the joint leads of the team. The first statement is from DI Trevor Plumb, who is the police lead for FTAC. He is the Threat Assessment and Intelligence lead for Royalty and Specialist Protection within the MPS and his statement is at FTAC000003, dated

26 August 2026.

DI Plumb explains that FTAC is a small multidisciplinary team which is responsible for the assessment and management of threat posed to public figures by fixated lone individuals. Its role is to undertake assessments and to provide advice and information to other agencies with the power to undertake early intervention as necessary in order to prevent harm. The statement highlights the distinction between the cohort which is the focus of FTAC's work and the VFI cohort, with emphasis on persons suffering from mental disorders and fixation on specific high-profile persons, rather than on violence.

DI Plumb says that FTAC's activity is highly targeted and it therefore does not have specific expertise in relation to VFIs to lead case management for that cohort. FTAC operates its own admission criteria, as well as the THRIVE+ assessment, for the purposes of risk assessment.

The statement is clear that those assessments are not undertaken in order to predict or assess the likelihood of future violence. Instead, they are used for the purposes of internal case prioritisation. DI Plumb states he is not aware of fascination with violence being captured and assessed as part of

traditional risk assessment tools.

His view is that, Multi-Agency Safeguarding Hubs, MASHs, are meaningfully positioned to risk-assess and work in partnership with other services to foster a whole-systems approach to case management. Although the statement acknowledges the potential limitation, which is that not all MASHs work with adults.

The statement recommends onward diversion to MAPPA in relation to offending behaviour and to Prevent where ideology is present. DI Plumb speaks in positive terms about FTAC as an example of integrated policing and healthcare working for the purposes of threat management.

He emphasises the benefits of combining police intelligence with specialist psychiatric and psychological expertise, in order to enable understanding of risk. He considers there would be benefit in wider national education regarding behavioural threat assessment, regarding fixation and pathways to violence across frontline services, so that there is better integration of these factors into traditional risk assessments.

The second FTAC statement comes from Dr Simon Wilson who is the clinical lead for FTAC. His statement is at FTAC000001 and is dated 18 August of this year.

Dr Wilson explains the role and functions of FTAC. He states that VFIs are not referred to FTAC often, if at all. While the name of the team contains the word "fixation", its focus, he says, is on individuals who become fixated protected persons and the cohort is primarily made up of adult it is over the age of 50 who are driven by severe psychotic mental illness and neurodevelopmental disorders are not a common presentation within that cohort.

Dr Wilson explains that FTAC have not previously used the terms VFI or NIEV but that its role does include facilitating interventions to reduce the risk posed by fixated persons. The majority of interventions for this cohort are related to mental health treatment, although criminal justice interventions can also be utilised.

Dr Wilson's view is that FTAC's structure of police and mental health staff working side-by-side for case management and information sharing is highly effective. He notes that there has been a significant deterioration in the quality and availability of adult mental health services, with variation in levels of accessibility across the UK. And he highlights challenges with referrals, such as mental health services which refuse to accept information from FTAC on the basis that the

patient in question has not consented, as well as the difficulty in balancing autonomy against the interests of the patient, where chronically psychotic individuals refuse treatment, but fall below the threshold for assessment under the Mental Health Act 1983.

In that context, he raises concerns about the Mental Health Act 2025, raising the threshold for intervention to the level of serious harm. Dr Wilson also says that he has visited the Dutch Care and Safety Houses in the Netherlands which this Inquiry learned about in the seminar session from Professor Sizoo on 10 September. Dr Wilson's view is the Dutch model has much to commend it as the proliferation of many different multi-agency panels in the UK offers greater opportunity for cases to, in his words, "fall between the schools".

I turn next to Professor Samantha Lundigren. Sir, as you are aware, our intention was to call Professor Lundigren to give evidence as part of Topic 1 but unfortunately, this was not possible due to ill health.

Professor Lundigren is a Professor of Investigative Psychology and Public Protection and Director of the International Policing and Public Protection Research Institute at Anglia Ruskin University. She was the lead researcher and co-author on the national MAPPA research

programme which was a study of the effectiveness of MAPPA that was commissioned by the Ministry of Justice. The Professor's statement is at PSL000004, dated 27 July, 2026 and it exhibited the detailed outcomes of that research programme and confirmed that although the programme did not address VFIs specifically, it speaks to the general capacity of MAPPA's assessment architecture to accommodate those who are presenting with other risk factors.

In high-level summary, the Professor found that MAPPA's category and level thresholds could struggle to accommodate risk presentations that did not map neatly onto offence-based criteria and that its risk assessment tools were geared towards conventional definitions of sexual and violent re-offending risk.

There were some positive findings from the research programme, including that MAPPA was associated with meaningfully lower re-offending than the general population. However, category 3 individuals, which is the category where, as we have heard, VFIs could potentially be accommodated if they were to engage with MAPPA, that category had the highest rate of re-offending and the shortest time to re-offending behaviour.

The Professor observed that the findings likely

reflect who ends up in category 3, rather than being a failure of the arrangements themselves.

The research programme found meaningful variation in practice, in MAPPAs across different areas and identified that information sharing was a central and persistent practice gap within MAPPA.

The Professor found that practitioners frequently lacked confidence about what could be shared lawfully, with whom and for what purpose, and that this could lead to practitioners sitting on relevant information.

The Professor supported the use of a shared risk assessment tool as what she described as a "necessary but not sufficient step" to improve information sharing. Requiring also training, manageable document design and clear lines of responsibility.

The research programme also found that there were two cliff-edge transition points within MAPPA, the first is the transfer from youth offending services to probation at the age of 18 and the second is transfer between different geographic areas.

In relation to the former, the research found an abrupt withdrawal of wraparound support at the age of 18, which is the point where risk of offending is often highest. The Professor concluded in their statement that MAPPA, in its current form, is not the

most appropriate multi-agency structure to manage VFIs. Instead, she recommends the use of a bespoke structure that takes MAPPA's core architecture, being statutory responsible authority, defined review levels, a duty to co-operate list of agencies and a formal case review mechanism and detaches, from that, eligibility based on conviction and attaches it instead to a concern threshold.

Sir, the final statement in this category of evidence comes from His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, HMICFRS, the independent inspectorate for policing in England and Wales and fire and rescue services in England. The reference is HCFRS00001, dated 5 August of this year.

The statement explains the role and functions of that organisation and exhibits a report entitled "An Inspection of Counter-Terrorism Safeguarding Arrangements", which was published on 14 October 2026.

Sir, the reference for that report is HCFRS000002.

The report presents the findings of an inspection of how police and partner organisations safeguard young and vulnerable people in the context of counter-terrorism work. The inspection identified growing concern about individuals fascinated by extreme violence without a clear ideological motivation, noting that such

individuals often fall between traditional safeguarding, policing, mental health and public protection arrangements in a way that creates uncertainty about which organisation is responsible for arranging interventions.

The inspection also identified that information sharing between police, CTP and partner organisations is not consistently effective and feedback is not routinely provided, meaning that agencies often do not know what happened after they transfer responsibility. The conclusions of the report in relation to VFIs are summarised at page 8 of that report, as follows:

"We found that those who investigate violence-fixated individuals have an increased awareness of the risks they pose. Policing has taken steps to develop guidance and improve oversight. But we also found that:

"Policing and partner organisation arrangements remain fragmented and inconsistent;

"Different organisations often apply different thresholds and approaches to risk;

"There isn't a consistently understood national operating model for managing [VFIs];

"Existing safeguarding and public protection tools don't always support effective management of

violence-fixated individuals; and ...

"There is still uncertainty about national responsibility and accountability.

"We have concluded that organisations need clearer governance arrangements, stronger partnership working and greater clarity about roles and responsibilities when managing these risks."

The report makes a number of formal recommendations in relation to VFIs, which are set out at page 13. I draw your attention, sir, to three. Recommendation 5 is that:

"By 30 September [of next year], the Home Office, working with Counter Terrorism Policing, the [NPCC] and other relevant organisations, should define and communicate clear national responsibilities and governance arrangements for dealing with people with non-ideological vulnerability, and/or those who have a fixation with violence."

Recommendation 6 is that by the same date, the Home Office, working with those same partners, as well as the Department for Education, the Ministry of Justice, and other relevant safeguarding organisations "should establish a clear national multi-agency framework for managing people with non-ideological vulnerability and violence fixation".

And third, recommendation 7, by 30 September of next year, the Home Office, working with Counter Terrorism Policing, the NPCC and statutory safeguarding organisations "should make sure there is enough appropriate specialist intervention provision for people assessed as violence-fixated or presenting non-ideological risks of serious violence".

Sir, I turn now to evidence related to education settings. You will recall that Mr Baisley and Ms Mulholland gave evidence on 22 October and the Inquiry has received statements from two other education unions; the NASUWT and the NAHT. The first statement is from Darren Northcott, who is the National Official for Education at the NASUWT, the Teachers' Union, which represents teachers and headteachers across the UK.

The statement is at NAS000017, dated 17 July of this year.

NASUWT explains that the term "VFI" is not established or routinely used in education settings and DfE guidance does not refer to VFI as a standard category for use by schools or staff. However, it emphasises the prevalence of violent incidents in schools and a need for a national conversation, to ensure that schools and colleges are safe and free from violence.

The statement refers to a report, sir, which is published by NASUWT in 2025, entitled "Behaviour in Schools". That report is at NAS000002. The report found in the previous 12 months, 40 per cent of respondents had experienced physical abuse or violence from pupils, while 85 per cent reported verbal abuse or violence from pupils. The report found that 7 per cent of respondents had been threatened with assaults with a weapon by a pupil in the previous 12 months and 3 per cent had experienced an assault with a weapon by a pupil in that period.

In relation to VFIs, the NASUWT expresses concerns that in the absence of clear terminology, teachers may not recognise risk factors as indicating that pupils may fall within that cohort. Mr Northcott says, at paragraph 24:

"In the absence of clear and shared terminology, there is a risk that staff identify fragments of concern without a common framework for escalation ..."

He gives some examples of fragments: behaviour, safeguarding, SEND, mental health, online safety and then he says:

"... each category may be relevant but VFI-type risk may fall between them unless the framework is clear."

The NASUWT told the Inquiry that it is not aware of

any VFI-specific training that is routinely delivered to teachers and the statement comments that the extent and quality of Prevent training varies across different areas. It argues for standardised safeguarding training to ensure consistency and for increased training provision related to the interaction between safeguarding, SEND, neurodevelopmental conditions and mental health.

But it caveats that teachers are not clinicians and cannot be relied upon to compensate for wider system variance. The statement identifies a gap in the national framework in that the statutory guidance, Keeping Children Safe in Education, does not include information about VFIs, or provide staff with criteria for recognising NIEV.

Its position is that teachers do have an important role in identifying concerns and sharing information, but that they should not be expected to act as police officers, clinicians, youth justice workers or specialist threat assessors.

The statement raises concerns about anxiety to external supports, with long waiting times, insufficient capacity and unclear referral thresholds for CAMHS and other services.

In terms of frameworks, the NASUWT considers that

VFI cases should be managed through a multi-agency structure, which does have education input, but in which teachers do not hold either a lead agency or lead duty holder role. It supports the creation of a clear national framework for VFIs, with thresholds and referral pathways and a central VFI risk assessment tool, shared between teachers, safeguarding professionals, police and other agencies.

Our second education union statement is from NAHT, the National Association of Headteachers. It is at NAHT000005, dated 31 July 2026 and was written by Paul Whiteman, in his role as General Secretary of the NAHT.

NAHT also tell the Inquiry that the term "VFI" is not widely recognised and used in schools, but, it says that teachers are alert to signs of pupils becoming involved in violence through the wider lens of safeguarding, noting that the focus within schools is on the safety and wellbeing of the individual child.

NAHT confirms that, while it meets regularly with the Department for Education and Ofsted, it has had no engagement with either body on the topic of VFIs. There is no training on VFIs of which the NAHT is aware, though it would support the provision of more focused training on the identification of VFIs, and the actions

which can be taken in response.

The statement explains the role of the 93 Government sponsored behaviour and attendance hubs, which are available to support schools in improving attendance and pupil behaviour, but it does not comment on the effectiveness of the hubs or specifically in relation to their use with VFIs.

The NAHT does not express a view on frameworks for the management of VFIs, but it does state that school leaders do not have the experience, skills or time to coordinate a multi-agency management and identifies the local authority as the preferred lead agency.

Sir, I turn now to the evidence which the Inquiry has received from non-Government organisations, from charities and advocacy groups, beginning with the Centre for Peace and Security, which is a research centre based at Coventry University. Their statement is at CFPS000028 and is dated 15 August of this year.

The statement is jointly authored by two senior academics within the centre, Professor Andrew Glazzard, who is the Centre Director and Professor of National Security Policy and Practice, and Professor Joel Busher, who is the Professor of Political Sociology, specialising in responses to extremism.

The Professors refer the Inquiry to a range of

research on matters relating to Prevent and counter-terrorism. They identify a sharp increase in overall referrals to Channel and in the proportion of referrals being adopted by the Channel programme. Though they question whether this reflects an increase in extremism or an increase in the sensitivity of the system and the professionals becoming more risk averse.

The authors note that for Prevent referrals with no ideology, there are far higher rates of attrition from referral to adoption.

The statement refers to it the existence of research which suggests that terrorist and extremist motivation is changing to become more mixed and less ideological, with the important caveat that the complex and overlapping nature of categories for referral potentially impacts the reliability of statistical analysis.

The authors acknowledge that some studies suggest that online ecosystems can promote ideological eclecticism, but they express the view that there is not yet sufficient evidence for this to be considered as a new phenomenon.

Professor Glazzard and Professor Busher state that while the Prevent referral mechanism is probably the closest thing that the UK has to an early warning system

for the detection of extreme violence, widening the scope of CONTEST to include non-ideological violence has potential to overload the system.

They suggest distinguishing between individual risk identification or management and prevention at individual, community and societal levels.

The Professors state that the use of Prevent to identify VFIs may be the optimum approach, at present, in the absence of other mechanisms. They observe that because there may be fewer constraints on information sharing for VFI cases, as opposed to terrorism cases, there is greater scope within that cohort for collaborative partnership working.

The statement provides information about the approach to risk assessment within Prevent, including the ERG22+ assessment and the Vulnerability Assessment Framework. The authors express the view that these tools are unlikely to be suitable for the assessment of VFIs and NIEV because ideological factors are treated as a principal factor.

However, they stress that empirical studies of structured professional judgement tools have demonstrated acceptable reliability and predictive validity when compared with unstructured professional judgement.

The authors also explain the role of multi-agency centres, or MACs, within their statement, which were set up as pilots in three regions to collate information and to form a baseline behavioural assessment, against which changes in behaviour could be identified.

They highlight research from 2016 on the use of a public health model as an intervention for extremism and they suggest that this may be applicable in the context of VFIs. And, sir, the reference for that research is CFPS000027. It is an article from the Behavioural Sciences of Terrorism and Political Aggression journal.

The Inquiry also received a statement from Milo Comerford, the Senior Director of Policy and Research into Counter-Extremism at the Institute for Strategic Dialogue. His statement is at ISD000049, dated 4 August this year. Sir, again, you will recall that ISD is an international counter-extremism think tank and that Mr Comerford gave a presentation as part of Seminar 4 on 15 September.

ISD states that the term "VFI" has become increasingly ubiquitous in UK policy engagements and that that started from early 2025. They describe it as a disaggregated subcategory of activity previously referred to as "mixed, unclear and unstable ideology".

ISD considers that the term is overly broad, observing that exclusive focus on violence fixation doesn't provide insights on the pathways to violence and that it does not reflect the symbolism of victim selection or the performative nature of violence conducted by the cohort, noting that it could be misanthropic in nature and geared towards achieving online notoriety. ISD also states that the term "VFI" is not generally recognised outside of the UK, although the cohort is part of a highly transnational phenomenon.

ISD sets out a number of other terms which are used to refer to the cohort, including "grievance-fuelled violence" and "mixed, unclear and unstable threat", observing that the blurred terminological landscape suggests confusion across governments and agencies.

The statement emphasises that clearly defined terminology, along with a well defined threat and clear referral pathways, are essential in order to avoid cases falling between the cracks.

ISD itself uses the term "nihilistic violence" to refer to misanthropic violence without a clear ideological motivation, but it considers the cohort falls on a spectrum, ranging from nihilistic violence through to ideologically motivated violence.

In relation to frameworks for triage and case

management of the cohort, ISD observes that no existing apparatus was designed with VFIs in mind and it refers to Channel as having some capacity to respond to VFI risk, subject to achieving greater clarity regarding roles and responsibilities within that structure, where ideology is not a motivating factor.

The statement takes the position that new threats should not be bolted on to counter-terrorism apparatus and that many individuals who are referred to Prevent, would be better served in a broader system of violence prevention and safeguarding support.

The statement suggests that VFI management may become a health and social care-led response, but in doing so, warns against over-securitisation of poor mental health.

ISD suggests integrating local authority safeguarding boards, such as MASH, with Channel boards, in order to cross-refer safeguarding duties with Prevent's counter-terrorism expertise.

It is highly supportive -- in its words -- of the introduction of a big front door, but hesitant -- again, its words -- about the creation of a new agency for the management of VFIs.

The statement notes the absence of clear evidence on preventative interventions for VFIs, and on

comprehensive training programmes, which offer a sophisticated understanding of the phenomenon. In relation to this, ISD tells the Inquiry that it has developed its own in-house resources and training presentations on the subject of VFIs.

The next statement was provided by Amnesty International. Its Chief Executive, Kerry Moscogiuri, provided a statement at AI000018, dated 14 August of this year.

They state that the organisation does not use the term "VFIs", they do not share a definition or endorse the use of the term and they have not seen the term used in their engagement with the Government or civil society organisations.

The statement indicates that Amnesty International does not believe that the current system of identifying VFIs is fit for purpose, while caveating that it has not undertaken data-based or statistical analysis on this issue, nor research into MASH or MAPPA. The author states that Amnesty International does not consider Prevent to be an appropriate mechanism to support individuals at risk and they oppose expansion of its criteria for referral to encompass the VFI cohort.

The statement from Amnesty International raises concern about the use of a big front door, noting that

without sufficient resourcing and without additional investment in rehabilitative measures in education, mental health provision and community support, it is unlikely to be effective.

It expresses support for the use of a named duty holder, and suggests they should be embedded within MASH for each individual case.

The author of the statement also expresses concerns about the high prevalence of neurodiversity among referrals to Prevent and refers to anecdotal evidence of Prevent being used as a method of more reliably accessing support for mental health and for neurodiversity than through mainstream mental health provision.

The Inquiry received a statement from the Child Rights International Network, and specifically from Alasdair Roxburgh, a legal policy and advocacy advisor, who you may recall again, sir, attended the Inquiry's seminars on 9 September. His statement is at CRIN000002, dated 14 August of this year.

His organisation does not use the terms "VFI" or "NIEV" and does not see the terms used much in its work. Expressed the view that they are ill-defined and contested terms which have significant problems.

The statement notes the absence of a clear

definition, risks inconsistency in assessment. In its statement, CRIN observes that the quality of data on the counter-terrorism sector needs to be significantly improved including in relation to VFIs and it urges that information should be collected and presented by the Office of National Statistics. It urges robust evaluation of structures and interventions for those at risk of engaging in extreme violence, in order to assess their efficacy.

In keeping with this, the statement strongly opposes the use of Prevent for the management of non-ideological extreme violence, on the basis that its efficacy has not been evaluated and noting the risk of becoming overwhelmed. Instead, it suggests that Prevent could be used as part of a set of tools which are available behind a big front door.

The statement highlights the importance of MASH in addressing underlying vulnerabilities and suggests that it is the most effective existing multi-agency structure, though it raises concerns about the adequacy of resourcing for participating agencies.

The statement does not support the creation of a new multi-agency arrangement to manage VFIs but instead, suggests that existing knife reduction programmes could serve as a model for VFI interventions.

The statement also expresses the view that staff in the education sector are not adequately trained or equipped for their role in the management of VFIs and emphasises that effective training across the public sector would rely on clarity of definition.

Sir, the Inquiry has also received a statement from Prevent Watch, which is at PVW000017, dated 29 July 2026 and authored by Dr Laila Aitlhadj, the Director of Prevent Watch. The statement indicates that Prevent Watch has not seen VFIs engaging with their organisation and that it has not seen any Prevent referral form within the category of "mixed, unstable or unclear ideology" in its work.

At paragraph 3.1, the statement prevents that Prevent Watch does not use the term, or any associated phrase, that there is no working definition of the term and that it is not in common usage among civil society and community groups.

The statement says "building statutory duties or structures upon a term that practitioners cannot consistently apply, would, in our view, reproduce that problem on a larger scale".

Prevent Watch expresses opposition to the continued incorporation of VFI cases into Prevent on the basis that its focus has become blurred, creating what the

author describes as a policy spiral.

It highlights concerns about the absence of feedback when persons are referred to Prevent. The author recognises Multi-Agency Support Hubs as an important mechanism for coordination of cases -- we understand this to be a reference to MASH -- for cases involving complex needs and for the initial identification of concerns.

Prevent Watch raises the possibility of using a safeguarding-led front door, in which a concern is received and assessed, before being referred onward for interventions.

It endorses the use of a public health model of violence prevention. I note that Prevent Watch is also broadly supportive of the use of the SAVRY assessment tool, describing it as a reasonable example of what assessment looks like when done properly. However, Prevent Watch questions the ability of any assessment to identify whether a person may go on to commit violence and it does not support the introduction of a single, central, risk assessment tool.

The next statement is from Sarah St Vincent, who is the Executive Director of Rights and Security International, or RSI, who also, sir, gave a seminar presentation to the Inquiry on 9 September.

RSI does not use the terms "VFI" or "NIEV" as it takes the view that they are not established categories of medical diagnosis with a scientific basis and they express concern that the terms could potentially be viewed as dehumanising. RSI is not aware of other organisations using the term "VFI".

Sir, I note I did not read aloud the reference. The statement is at RSI000001.

RSI argues there is not strong evidence to support a causal link between viewing violent material and engaging in serious violence and it argues that there is a risk of persons who have a lawful interest in violence being inadvertently captured by the definition.

The statement also argues that there should be no distinction in this context between ideological and non-ideological violence. RSI indicate that they are not able to provide evidence on the suitability of Prevent for case management of VFIs, although the statement argues that Prevent is not generally effective in the prevention of violence and that incorporating VFIs into programmes which are designed to identify and address ideology, would -- in their words -- appear to RSI to lack a logical basis.

RSI states that it would not support the introduction of a lead duty holder for case management

of VFIs or the use of a shared risk assessment tool. It expresses the view that it would be inappropriate, sir, for staff in education settings to play a role in identifying, supporting or treating those who pose a risk of harm to themselves or others.

RSI expresses the view in its statement that neurodivergence is not relevant in the context of VFIs, stating, at paragraph 104:

"If there is no potential causality, then there is no risk to talk about neurodivergence in relation to VFIs."

I note that this statement from RSI also discloses a number of reports to the Inquiry, including a literature review addresses the absence of relationship between autism and violence and, sir, the reference for that is RSI000027.

Our final evidence from the NGO sector is from Resilience in Unity and, sir, it is at RIU000001 dated 4 September of 2026.

The statement is from Travis Frain, who is the managing director of Resilience in Unity. It is a civil society organisation established following the Westminster Bridge attacks in order to act as a voice for victims of terrorist attacks.

Resilience in Unity does use the term VFI and

recognises it as a term which is used widely across the counter-terrorism and public safety community. It notes that its adoption appears to have been slower in the context of education and safeguarding settings.

At paragraph 6, Mr Frain emphasises the importance of having a clear definition of the term saying:

"We cannot expect the public to know how to respond to a threat like this if they cannot identify or diagnose the issue in the first place."

Mr Frain observes that Prevent is currently the only system through which to identify and manage VFIs. He expresses the view that, in the absence of viable alternatives, Prevent should, in the short-term and subject to reform, be the first port of call for the management of VFIs. He identifies the changes needed for this to be effective, including up-skilling existing Prevent practitioners, developing a separate risk assessment framework for VFIs and refocusing Prevent away from ideology towards prevention of acts of mass violence.

Resilience in Unity acknowledges that making Prevent responsible for managing VFIs could have an adverse impact, including diluting the focus of the programme and diverting attention and resources away from ideological terrorism.

The statement refers to a letter sent by the national Prevent leads in 2019, which indicated that those with a connection to or personal interest in extremism, terrorism or massacre should be given the same consideration for support as those with clear ideological motivations. It acknowledges the necessity of this clarification for the management of VFIs but expresses concern that this sends mixed messaging to the public and may increase reticence to make referrals.

In the longer term, Resilience in Unity recommends the creation of a parallel system to Prevent to manage non-ideological extremism, with the ability for cases to move between the parallel systems as motivations change.

The author highlights the central importance of MASH and other multi-agency structures in managing those who fall below thresholds for Prevent, while noting that there is variance in the provision of services across different areas.

Finally, Mr Frain refers to the role of Resilience in Unity in the creation of a support hub for victims and survivors of terrorism. He says that the victims of Southport attack have been excluded from the hub and denied access to support on the basis that the attack was perpetrated by a violence-fixated individual and that, therefore, they have not been deemed to be victims

of terrorism.

At paragraph 62 Mr Frain says:

"This case exemplifies the real world consequences that occur within a legal and policy limbo like the one in which we now find ourselves with VFI, and only serves to further strengthen the argument for clarification and clear guidance on whether or not VFIs fall within the terrorism and counter-terrorism sphere and, if not, where they are instead to be situated...."

He goes on to say:

"This further strengthens our personal belief as an organisation that VFIs should be managed through Prevent in the absence of a more appropriate system, and the victims of a VFI attack or incident, should be treated as victims of terrorism-accordingly, receiving the same access to enhanced support and treatment that is now offered to victims of other acts of terror."

Sir, the final category of evidence related to Topic 1 is the further material which has been provided as a result of follow up from the seminars in the second week of September.

The Inquiry has received a detailed letter and accompanying disclosure from the author of the AREVA tool, the Assessment of Risk for Extreme Violence in Adolescence. The letter is at ARV000005 and is authored

by Dr Randy Borum, Dr Caroline Logan, Dr Stephen Hart and Dr Natalie Pyszora.

The letter sets out in detail the background to AREVA and its potential applications, including in cases where ideology is unclear.

The Inquiry has also received additional evidence from Dr Richard Taylor further to his seminar presentation on 8 September. His letter is at DRT000011 and it addresses potential terminology to describe the VFI cohort, then sets out in detail a range of different methods for assessing risk, including structured professional judgements, forensic psychiatry assessments, screening tools, triage and action checklists.

Dr Taylor recommends that risk assessment of VFIs is best undertaken by a local multi-agency panel, rather than any single agency, with input from policing, social care, education and health, including specifically CAMHS.

Dr Taylor identifies a list of factors which he thinks should trigger more detailed or urgent assessment and then sets out five potential outcomes to follow that risk assessment, depending on the nature and the urgency of the conclusions.

Sir, as you will be aware, in his further evidence

Dr Taylor has extended to it the Inquiry an offer to establish a working party to draft a pilot VFI or NIEV screening tool. I can confirm that the Inquiry has been liaising with Dr Taylor to support this proposal.

Following the seminars, the Inquiry sent requests to Child Rights International Network, RSI, Jonathan Hall KC, Lord Anderson and Dr Paul Betts asking about the availability of relevant data regarding Prevent and Channel, including whether there is information that is not currently being collected or held which could be obtained, and whether there have been any previous requests to obtain data which have been refused.

The responses to the Inquiry from CRIN and from RSI are at CRIN000019 and RSI000064. Both recommended the release of data related to the ethnicity and religion of those referred to Prevent, as well as early data on the percentage of those referred who have mental health or neurodevelopmental conditions.

Jonathan Hall KC responded to the Inquiry to confirm that he was not aware of what categories of unreleased data may exists in relation to Prevent and Channel, but that it would be helpful to understand how many individuals have been subject to repeat referrals and, if known, which online platforms have been associated

with the risk of a given individual being drawn into terrorism.

He did not identify any previous requests for data which had been refused and, sir, his response is at JHKC000001.

Lord Anderson's response is at LDA000001. He set out the statistical and databased work undertaken during his tenure as the Independent Prevent Commissioner and noted that no data has been published in 2026 in relation to the rates of suicide and self-harm risks among persons referred to Prevent.

He also raised the potential utility of reviewing the categorisations of ideologies assessed as suitable for Prevent and, in that process, considering whether existing data sources are adequate to support amendment of those categories.

No refused requests for the provision of data were identified by Lord Anderson.

Finally, Dr Paul Betts wrote to the Inquiry to provide a list of suggested additional data which could be disclosed, including types of concern as originally recorded by the referrer and as subsequently revised by case officers; decision-making data, such as reasons for non-adoption or case closure; and data about repeat referrals.

Dr Betts identified a range of additional data which could be collected, including information about contextual and vulnerability factors; behavioural indicators; positive and protective outcomes and longitudinal follow up of all those who are referred including those who never enter Channel or who decline support.

In relation to the latter, Dr Betts observed that this data is the only way to understand effectiveness and close gaps in delivery going forward using a methodology of continuous improvement.

The reference for that response, sir, is DPB000001.

Sir, that concludes the evidence which the Inquiry has received but not called in relation to Topic 1. I would like to express our gratitude to all material providers who have engaged with the Inquiry and provided evidence on this topic.

There are a small number of additional Rule 9 requests which are being issued as a result of evidence which was given during the Topic 1 hearings. That includes a Rule 9 request to the Association of Directors of Adult Social Services and to its counterpart in Wales. Once received, that evidence will be disclosed to Core Participants in the usual, sir, save for Mr Emmett and Sir Declan.

That concludes the evidence which we intend to call in relation to Topic 1.

SIR ADRIAN FULFORD: That was Herculean. Thank you very much, Ms Woods.

MS WOODS: Thank you, sir.

MR MOSS: Sir, I'm grateful to Ms Woods for the efficient way in which she's summarised many hundreds of pages of evidence. Those statements will be available on the website in due course.

Sir, I have to update on some procedural matters in relation to Topic 2, but I note the hour. I will do that, with your permission, first thing. We sit again at 10 am tomorrow. Mr Hadley, Tech Against Terrorism, Ms Maszczynska, the Deterrence Center, and Mr Ahmed, the Centre for Countering Digital Hate.

Thank you very much indeed.

10 am tomorrow morning.

(4.44 pm)

(The Inquiry adjourned until 10.00 am the following day)

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