

**IN THE SOUTHPORT PUBLIC INQUIRY**

**SIR ADRIAN FULFORD**

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**Opening statement on behalf of**

**(1) Leanne Lucas**

**(2) Heidi Liddle**

**(3) John Hayes**

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1. This opening statement is made on behalf of Leanne Lucas, Heidi Liddle and John Hayes.
2. Leanne was a children's yoga teacher and a primary school teacher. She organised and ran the Taylor Swift workshop that was targeted in the attack. She was stabbed five times seeking to protect children from the attacker, she could have died, and she has been profoundly impacted as a result.
3. Heidi was the dance teacher at the event. She was present when the attack commenced and began helping children out of the room. She barricaded herself and a child inside the toilets to protect them from the attacker. She continues to suffer substantial emotional trauma as a consequence.
4. John ran a business in the building where the attack took place. His wife is the Director of the company that owns the building and which had leased the event space to a tenant who sublet it to Leanne for the event. As the attack unfolded, John ran across his office towards the attack and came face to face with the perpetrator. He was stabbed and sustained life-threatening injuries. He too has suffered lasting psychological harm.

**Opening observations**

5. Leanne, Heidi and John each survived the heinous attack that this Inquiry is examining. They each acted with incredible bravery and selflessness. They did all they could to save as many lives as possible. They could have done no more than they did. As a result of the atrocity of that day, Leanne, Heidi and John have each suffered immensely: they were the victims of extremely serious injuries; they could have died; and they endured, and have been left to endure, the profound and traumatic consequences of the attack.

6. Of course, Leanne, Heidi and John recognise – and wish to make clear publicly, at the outset of this Inquiry – that no one has suffered more than the child victims and the bereaved families. Their suffering is beyond comprehension.
7. Leanne, Heidi and John seek answers and accountability. They look to this Inquiry for recommendations for improvements, so that another attack like this does not happen and others do not suffer the devastating harm that day has visited.
8. For Leanne, Heidi and John, openness and transparency – the fullest possible exposure and accountability – these must be the watchwords of this Inquiry; the guiding principles for its essential work. Inquiries serve many functions. Addressing and allaying public suspicions. Answering unanswered questions. Providing the public with the truth, holding those responsible to account, and, in doing so, restoring public confidence. Making recommendations to prevent, so far as can be achieved, a recurrence of the outrage that occurred. These are just some of the important purposes of this Inquiry.
9. There has rarely been an inquiry underpinned by such a degree of public suspicion, rumour and misinformation. The Southport attack led to some of the worst, racist violent disorder and rioting ever seen in this country. The false narratives propagated about the attack fed and fuelled that violence. There remains strong doubt and disquiet about the authorities' role, or failure to prevent the attack. Did State agencies fail to spot the warning signs? Could they have done more? Where warning signs were recognised, were there missed opportunities to avert the tragic consequences of that day?
10. Has there been candour, openness, and accountability? Or, instead, have we seen an effort at damage limitation, to sweep under the carpet uncomfortable truths?
11. These are some of the important questions with which this Inquiry must grapple.
12. The aftermath of the attack has also seen blame and vitriol directed at survivors who, bravely, did all they could in the face of unspeakable horror. Vile online abuse has been directed at those who are themselves victims or survivors of the attack. That should never have happened, yet it continues, and it requires correction.
13. This is the context of this Inquiry: public confidence has been shaken; rumour and misinformation has spread; questions need to be asked, and answered; and the record must

be put straight. This can only be done through openness, transparency, and the fullest possible exposure and accountability. Suspicion, conspiracy, allegations of cover-up, the perception that the State is covering its own tracks; these are matters that can form, grow and take root in the shadows, out of plain sight. They corrode confidence and undermine the search for truth. The solution is the disinfectant effect of sunlight and public scrutiny.

14. As was endorsed by the High Court over 20 years ago, in a case concerning the crimes of Harold Shipman, *“it is of great importance that members of the public should feel confident that a searching investigation has been held, that nothing has been swept under the carpet and that no punches have been pulled.”* (*R (Wagstaff) v Secretary of State for Health* [2001] 1 WLR 292, at 312, per Kennedy LJ and Jackson J<sup>1</sup>). Those words were never truer. The very confidence of the public is at stake.

### **The event at the Hart Space**

15. Leanne and Heidi recognise that the Inquiry will wish to consider the arrangements that were in place for the positive, joyful event that was so cruelly targeted on the 29 July 2024. They welcome a proportionate examination of these issues, and make plain at the outset of this Inquiry that it is reasonable for the Inquiry to examine these matters. John had nothing to do with the arrangements, but neither he nor anyone associated with the building could have done anything to prevent the attack, and equally he welcomes the scrutiny of the Inquiry in this respect.
16. For Leanne, Heidi and John, it is particularly important that all involved, and the wider public, understand the true position about the appropriate and reasonable arrangements that were in place. There have been deplorable instances of misinformation and false accusations about the organisation of the event or arrangements at the building. Some online abuse has gone so far as to suggest – entirely wrongly, and without foundation – that blame should be apportioned to those involved in arranging the event that was targeted by the perpetrator.
17. Leanne, Heidi and John look to the Inquiry to set the record straight: they bear no responsibility for what happened; they took appropriate and reasonable steps in the

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<sup>1</sup> Citing the observations of Clarke LJ in *The Thames Safety Inquiry* (into the sinking of the *Marchioness*) endorsing the observations of Sheen J in the inquiry into the sinking of the *Herald of Free Enterprise*.

organisation of the event; the heinous attack that occurred was entirely unforeseeable and beyond any reasonable contemplation; and they acted with commendable courage in response to the horrors of what unfolded that day.

18. In particular, the Inquiry will, we anticipate, wish to consider the following matters:
19. First, responsibility for the attack lies with the perpetrator. He deliberately targeted a children's event without any warning to Leanne, Heidi, John, or anyone else involved with the event or building. There was simply no reason for them to anticipate such a despicable attack, and there is no reasonable basis to suggest otherwise.
20. Second, far from being in any way to blame for the attack, Leanne, Heidi and John are amongst its victims and survivors. Not only that but they acted with incredible bravery and saved the lives of many of the children who were present.
21. Leanne courageously shepherded children away from mortal danger, saving their lives. Had she remained with the attacker, she would have been killed, along with more of the children she was attempting to save. In the building, while already severely injured, she called 999 to seek emergency help. Fearing the emergency services might not arrive in time and realising how hard the location was to find, Leanne ran into the street to seek help from anyone nearby. Leanne repeatedly fell in and out of consciousness at the side of the road, whilst continuously attempting to seek help for everyone else. Her thoughts that day were on saving lives; she did all she could and sought help at the earliest possible opportunity. No one could have done more. She has been profoundly impacted by the terrible events of that day.
22. Heidi was similarly brave in the face of life-threatening danger. She was present, witnessed the attack and whilst Leanne was on the floor, Heidi grabbed her by the elbow, pulled her up and they both ran. Heidi then pushed as many children as she could away from the attacker and out of the room. She saw one child run away from the exit, towards the toilet. She followed and barricaded herself and the child inside for protection, keeping the child safe from the attacker's efforts to reach them both. Initially Heidi refused to come out for the police as she was so terrified. She did everything she possibly could on that day, and continues to suffer significant emotional trauma as a result of what happened.
23. John ran towards the attack. As the attack unfolded, one of his colleagues saw a child outside with blood on them. John ran across his office, opened the door and came face to

face with the perpetrator in the midst of the attack. John was stabbed in the leg but managed to get back into his office where a colleague tied a tourniquet around his leg. He acted with great courage, putting others before himself. He could have died.

24. Leanne, Heidi and John could have done no more that day. They tried to save as many children as possible. Were it not for their efforts, there would have been further deaths.
25. As for the arrangements for the event, they were entirely reasonable in all the circumstances. The event took place in a private event space in the school summer holidays. It was advertised on Facebook and Instagram, as many such events are. It was organised and run by a qualified teacher and a teaching assistant. Both were responsible adults, with experience looking after children, and with an understanding of children's welfare and safeguarding. The event was subject to an appropriate risk assessment. Insurance and a proper register were in place. Children were supervised at all times. The arrangements complied with applicable regulations. Ms Scholes, who sub-let the space to Leanne, ensured that the premises were let out only to those with appropriate arrangements in place. That was the case on 29 July 2024.
26. The running of the event reflected the arrangements that were in place. It is a matter of common experience that at such events some parents and children will arrive early, and some late. Parents were permitted to remain during the event if they wished. Some parents would arrive early to collect their children; others later. Access to the toilets was through the door out of the upstairs unit. This solid wooden door was the only entry and exit from the upstairs unit. To access the door, it was necessary to enter the building on the ground floor, make one's way up the stairs, and find the door to the upstairs studio.
27. The door to the upstairs studio was closed and unlocked during the event: to allow children to use the toilets; so that parents could come and go; and, as a fire door, to provide an emergency exit if needed. Leaving the door closed but unlocked was therefore a reasonable approach in all the circumstances. There was no reason to consider that the door should be locked and there were multiple reasons for it to be left unlocked.
28. Had it been locked, it would have closed the one exit from the studio; it would have prevented or inhibited children leaving to use the toilet or in the event of an emergency such as a fire. Even had the door – which was solid, and had no window in it – been locked, someone seeking access would have been able to knock and the door would have been opened. That would have been a reasonable approach for a children's event to which

parents would be coming and going. And if the door had been locked, there is every chance that the horrific attack would have resulted in further deaths; Leanne would have answered the door, been attacked and killed, and would have been unable to save the lives she did and call for urgent help.

29. Any suggestion, now, that the risk of an attack meant that the door should have been locked throughout the event ignores the reality of the situation: there was no known or foreseeable risk of an attack. The event was appropriately organised, and criticism of the arrangements, made now, are the result of hindsight and an entirely understandable, but misguided, desire to suggest that the outcome could and should have been averted.
30. Despite their immense bravery and courage, and having done nothing wrong, misinformation and false accusations have been directed at the survivors of the attack then disseminated, repeated, and have spread. This has led to very significant upset and distress. Such abuse has grave real-world consequences for its victims. It also masks the truth and hinders effective accountability. Our clients look to this Inquiry to put matters right and set the record straight: in the interests of the survivors, the bereaved and the wider public.

### **The focus of the Inquiry**

31. As the Terms of Reference of the Inquiry make clear, the focus of the Inquiry's investigation should be on the authorities' knowledge of and interaction with the perpetrator. The Terms of Reference require the Inquiry to *"Establish a definitive account of the events leading up to the Southport attack and the attack itself, including an overall timeline of [the perpetrator's] history and interactions with various state systems including criminal justice, education, social care and healthcare"* and to *"Review the decision-making and information-sharing by local services and agencies which interacted with [the perpetrator] prior to the attack to examine whether there were opportunities to manage the risk he posed to the public, making any required recommendations for improvements."*
32. The focus is clear: what did the authorities know, what did they do, were there failures to take action? These are matters of the utmost gravity and public concern.
33. Were there warning signs that could and should have been identified? What response did the authorities take? Should there have been earlier, more effective intervention? Ultimately, why was the attack not prevented?

34. The Inquiry's disclosure has commenced. It is not yet complete. But what has been disclosed to date reveals serious concerns, and raises important questions that require answers.
35. There is evidence of significant contact with the perpetrator by multiple agencies. Child and Adolescent Mental Health Services (CAMHS) were aware of the case. Children's social care services had been involved. So were the transitional adult social care team. A social worker was allocated and met with the perpetrator. Schools raised concerns. The perpetrator was referred to Prevent on three separate occasions because of his obsession with extreme violence and terrorism. Following a violent attack at the school in 2019, in which the perpetrator carried a knife, the Criminal Justice Liaison Team were involved. The perpetrator was found on a bus by police officers in March 2022 carrying a knife. He stated he wanted to stab someone and had thought about poisoning people. After becoming lost to school education in 2022 and 2023, his school contacted the police to seek a welfare check. No action was taken by the police. A number of steps were not taken by the police call handler that should have been taken.<sup>2</sup> Throughout 2023 the perpetrator's absence from school continued. By February 2024, CAMHS were informed that the perpetrator had not left home in four to five months. Despite this, he was discharged from CAMHS provision. Two months later, in April 2024, he was discharged from psychiatric services due to non-engagement and inconsistency in taking his medication. The overall picture seems to be of a disturbed, dangerous young person who was gradually detached from State contact as his situation continued to deteriorate and his risk increased.
36. Reviews conducted following the attack, including the Lancashire multi-agency Rapid Review<sup>3</sup> and the Lancashire Review of Transitions Service Practice<sup>4</sup>, identify a series of failings. The allocated adult social worker appears to have been inadequate, overwhelmed and unsupported by appropriate management. There is no record of the perpetrator's case ever being subject to adult social care management oversight. The Transitions Review identifies that the case file was inadequate and incomplete in numerous respects, and there was a wholesale failure to engage other professionals and work in partnership. At CAMHS, no one practitioner had a complete view of the perpetrator's case and there were missed opportunities to escalate safeguarding concerns. Children's social care professionals lacked

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<sup>2</sup> LANC000063

<sup>3</sup> LANC000021

<sup>4</sup> LSS000434

appropriate curiosity about the perpetrator's reasons for carrying a knife in March 2022. Adult social care identified a gap in information sharing with children's social care. There were missed opportunities to escalate safeguarding concerns. There appears to have been a concerning lack of information sharing between Prevent and other agencies.

37. The multi-agency involvement in the case did lead to some multi-agency strategy meetings. But no one seems to have grasped the underlying concerns involved. There was a failure to recognise the gravity. Too quickly the proliferation of different State bodies seems to have resulted in a lack of professional curiosity, an unwillingness to get to the bottom of the issues, a too ready recourse to a 'not our problem' mentality. The Lancashire Rapid Review notes that *"there was no one meeting where all the information, including individual agency risk assessments, was brought together for agencies to form a full picture of [the perpetrator's] level of need."*
38. Ultimately, years of multi-agency involvement and multi-agency meetings appear to have produced no useful, effective product. Opportunities for intervention, opportunities to change course, were missed – in slow motion. The Inquiry must find out why, and what can be done to prevent similar drift and inaction in future.
39. The perpetrator's parents were also involved in his case. The Inquiry will no doubt seek to examine this issue with considerable care. The perpetrator was able to purchase and retain numerous knives at the family home. How was he able to buy them? Why was he not stopped? Why did the authorities not identify these alarming developments? Particularly given the perpetrator's youth and the known issues in his case, including a fascination with extreme violence.
40. He was also able to produce Ricin in the family home. How? How was he not stopped and reported? The Inquiry will of course want to look at this issue with similar care and focus.

### **The future**

41. The Inquiry's Terms of Reference state that Phase 1 will make *"any required recommendations for improvements"*. This is, therefore, an obligation arising from the Terms of Reference. But it is an obligation with the deepest of roots, grounded in a moral duty to learn from the depravity of what occurred in Southport: to aid future prevention, and to build something from the bleakest and darkest of moments.

42. Learning and recommendations will, of course, arise as the Inquiry hears evidence. Yet the information that is currently available provides plenty of indicators and opportunities for improvement. The perpetrator's access to knives, capable of wreaking the most horrific outcomes, is a significant concern. Tighter regulation on purchase and access must be considered. Since the attack, Leanne has led a campaign regarding the availability of sharp pointed knives.
43. The Prevent scheme has received robust and justified criticism in recent times. Too many heinous attacks have been carried out by those known to Prevent. Too often the post-attack reviews have revealed a system that does not identify risk and deliver effective intervention. There is a clear need for change.
44. The multi-agency involvement in the case begs a key question: what can be done to improve the approach to such cases in the future? If the Inquiry reveals that, at its heart, professionals in this case failed because they were under-resourced and over-stretched, under-qualified, and under-managed, the Inquiry should say so. If better outcomes in future will be rendered impossible by inadequate resourcing, recommendations that simply seek more punitive criminal justice measures will not prevent future atrocities. A suite of new, draconian quasi-criminal interventions will only be a false promise of safety if professionals are not enabled to identify risk and implement effective interventions. If the outcome of the Inquiry is simply greater powers for the police and the Security Services, and swinging punitive measures that foster distrust and resentment, we risk building an illusion of safety on quicksand. What is needed is introspection, reflection, and real improvements: recommendations which tackle head-on the problems resulting from under-resourced public services, and the effects of such under-resourcing, which include trying to pass on responsibility to other agencies, and failure to follow-through on a multi-agency approach. A public inquiry is not inhibited by the deference the courts are required to show regarding resource allocation. This Inquiry must be bold in making that clear. All those affected by the Southport attack are entitled to that much.

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