Wednesday, 17th September 2025

(10.00 am)

Opening statements on behalf of the bereaved parents

SIR ADRIAN FULFORD: Yes, Mr Bowen.

MR BOWEN: Good morning, sir. These are our oral submissions on behalf of the three bereaved families.

As we have heard in some distressing detail thus far, everybody knows, and I will be very brief on this aspect, on 29 July the perpetrator took a taxi, it was to a dance class. He was able to walk through unlocked doors, he ascended the stairs, he went through further doors, also unlocked, and he murdered and maimed as many children as he could get his hands on with the Amazon knife that he had purchased two weeks earlier for £8.39.

It was over just in a few minutes, and tragically, Bebe, Elsie and Alice, six, eight and nine, did not make it.

His attempts to kill eight other children and three adults, thank God, failed, but they have been left with serious physical and profound psychological injuries and it is going to be very difficult to recover from any of this if they are ever able to.

We understand on behalf of the families, sir, they understand why you have made it very clear, or your learned counsel has made it clear, that you have no case

to put. We have had a very comprehensive opening and hearing the heartrending commemorative portraits, it would have been obvious to everybody here, particularly with the impassioned way that they were delivered, that the families absolutely do have a positive case and that's what I'm going to attempt in my 20 minutes -- and I'm sorry if -- I will try to stick to the time limit -- that's what we are going to put.

It is a visceral conviction that the safeguarding apparatus of the State in totality failed them, but it was not only the responsibility of the public bodies; responsibility whether one at the moment restricts oneself to a moral outlook or looks on it through the lens of legal obligations.

Query whether responsibility should fall, as the families feel it should, on individual citizens. Most obviously as we have heard, AR's family, who knew and ignored the risk he posed to the public, and again as we have heard at some length, Mr Poland, the taxi driver.

I won't go into the detail. You have got it all in great detail from your counsel.

But for the multiple errors, omissions and fatal misjudgments, the perpetrator would have been seen for who he really was and they really believe he could and should have been stopped. Stopped through a combination

of competent diagnosis and risk assessment, appropriate educational and social care provision, and protective action taken both by the State, public bodies, and private citizens.

Mr Moss KC was absolutely correct to say that no one agency had the full picture. There is no clearer example, we say, than perhaps the bus incident on 17 March 2022, when the police, CAMHS, LCC, the social services department failed to join the dots and realise about his previous offending.

We suggest that it was inevitable, as I believe LCC admit in their opening, that AR would have been subjected to a full and rigorous section 47 assessment on the basis that he was out of parental control. The case would likely have been referred back to FCAMHS for an assessment, and then a full core assessment, not a children in need assessment, would have been carried out. It very likely would have discovered through proper examination, interrogation of the parents, what was really happening. They would have been interviewed, the risk would have been correctly assessed and managed.

It is very unlikely that the assessment which we say -- it is a section 47 assessment, sir -- which should in any case have been carried out, we say, back in December 2019, or early 2020, after the hockey stick

killing *[sic]*. Had that happened, it would not have led to the discovery of the horrific escalation of risk that we have heard about: aggression at home, parent's knowledge, purchase of weapons.

An example: the father took delivery of a machete, as we understand it, and I think I have got this right, "marked up in neon" I think was the phrase, "it must be delivered to a person over 18". He must have known, he should have warned. He would have warned, had he been behaving responsibly, the social workers of the hole into which his son was then descending.

But just really at the moment, as an aside, on the subject of warnings, we preface this in our written submissions, we would like you, sir, to note that in the absence of an explicit assumption of responsibility, the senior judiciary, particularly in a series of cases over the last ten years or so, have emphasised the common law's general reluctance to impose duties to warn or duties to assist another and that's as part and parcel of a lack of any general duty to protect somebody else.

That applies as much to public bodies as it does to private citizens because of course the liability of the State starts with the liability and the principles that apply to you, me, and everybody else.

There are very limited exceptions. We invite you in

due course, if you think it is appropriate, to give very careful consideration to whether on facts which are as stark as we have here, that protective action ought to have been taken by AR's family and the taxi driver, Mr Poland. But whether, given the current lack of any Civil Law/Common Law obligation -- I'm not talking about the HRA here -- that duty falls to be imposed by criminal sanction, if that's the way the argument might develop in due course.

It is a very complex issue and one perhaps more suitable for phase 2, but it is, we say, an important and potentially far reaching point that, given the general Common Law rule, that the only obligation on the State and the private citizen is not to make matters worse, only very occasionally to make things better, when you are within an exceptional -- obviously I'm not going to go into all of that now -- but the impact of this is, if, for instance, the taxi driver, Mr Poland, had told, or sorry, if AR had told the taxi driver what he was going to do, there is still no duty on him to do anything. And that is serious food for thought and how that feeds into where the Inquiry ultimately ends up is something that we say should not be forgotten.

I now move on to dangerousness. Knowledge of his homicidal intent was clear from early October 2019. We

have got the Childline contacts between 4th and 7th October. In October 2019, he rang Childline to say he was being bullied and as a result he had taken a knife to school. "I want to kill somebody", "there's somebody I hate at school I want to kill them. I have took the knife with me to school before but I would only use it if that person really annoyed me in the moment".

6 October there is a classroom assault. That's when he attacks himself, as I understand it. He just launches on the alleged bully. That's after of course the first Childline contact. The words in the papers are "he viciously attacked the bully in class and as a result he was put into isolation".

When he is interviewed by Lancashire Police the next day, after Childline waived confidentiality and contact the police, he said he was willing to use the knife, or when asked whether he was willing to use the knife, he replied yes, "pretty certain". The head recorded during the exclusion appeal that he showed no remorse, no regret, trusted no one and had refused all support.

We have also heard about repeated knife-carrying. He admitted on more than one occasion that he brought a knife to school on at least ten occasions. That included an admission to the deputy safeguarding lead, Mr Cregeen at Range High School on 8 October 2019.

Consequences. Well, he was swiftly and permanently excluded from mainstream school, made the subject of high risk vulnerable child referrals by the police, on 7th October by the police and then I think by the school on the 8th. As we have heard, he was placed then in a pupil referral unit, Acorns, who come out of the story we say with considerable credit, the one institution that emerges we say being able to hold their head up high in relation to the tragic events that followed.

The senior leadership team in that school made three Prevent referrals, December 19 and two in 2021. We heard that the Prevent process failed to recognise his dangerousness, but they of course were not standing alone.

The school's concerns articulated mainly through Jo Hodson and Janet Lewis, who I think was the safeguarding lead, were acutely concerned about his behaviour and his internet use. Their concerns were recorded by a chap called PC Harrison. He was the man who was responsible for suggesting that the first Prevent referral should be made. And both Hodson and Harrison appreciated really just how high the risk was, particularly given what happened on 11 December with the hockey stick assault.

Never forget, unprovoked attack on a friend. Acorns consistently resisted categorising him as low risk.

When he was interviewed on 17 October, Ms Hodson asked why he had taken the knife to school and he replied, emotionlessly and without eye contact, "to use it". The documents go on to say that her professional judgment was that:

"There was something so cold about the way he described the incident."

This information was or should have been available to CAMHS, FCAMHS and LCC. She constantly underlined the urgency of the need to fully and properly assess him, to provide tailored provision to protect, I say to protect both the public and of course to meet AR's needs.

There was a strategy meeting on 17 October. That is relevant because that's when Scott Morgan, the CAMHS practitioner, stated that he thought there was no diagnoseable mental illness, but a clear and credible risk of re-offending.

Ms Hallaron, who you have heard about in your counsel's opening, regarded it as a high risk forensic case. Immediate management was warranted via exclusion, bail conditions, CAMHS and FCAMHS referrals, Prevent involvement and close monitoring by the children's social services.

So that's after the first knife incident and before the attack.

We then have the hockey stick attack. We have heard about how he took the taxi. He showed initiative. He pre-booked it. He travelled to the Range. I think he had even called the bully's sister, I recall, although we don't have the full details of that yet. He was seen by the head wielding the hockey stick. Pursued off site and that's where he attacks his friend. He had intended to strike his original target, the bully, with the hockey stick and if required "finish him off with the knife".

He was indifferent to prison. He repeated that he carried the knife to use it. That the victim was a friend, he wasn't much worried, he said, because he wasn't that badly hurt. In fact, it seems it was a serious assault and I think he had a broken wrist. The father attended afterwards in the aftermath of that and according to the head's evidence, Mr McGarry failed really seemingly to appreciate the gravity of the incident.

The police records on that day recorded him as having deteriorating mental health, that he would and should be subjected to a full mental health assessment. They knew about the prior knife carrying. They knew about his internet research, as did everybody else. Just two examples: American school massacres and

beheading videos.

Assessed in custody by the mental health practitioner from the diversion and liaison service, Stephanie Hallaron, on the same day. He said "I would not have felt sad" if he hurt the boy. He wrapped tissue around the stick handle for grip and said "ideally I wish I did it" ie, he'd have been able to kill him. He would have killed him if it hadn't been for the fact that the lad was in assembly.

He liked the boy he hit. He wasn't bothered because he didn't get hurt that bad. It was a callous attack. He was simply a bystander in relation to his quest for revenge and that particular point was something of considerable concern and it made her think, Hallaron think, that there was a real danger here and it was necessary to refer it on straight, not to CAMHS itself, but to the specialist unit FCAMHS. And what did she refer him for? She referred him for a conduct disorder and management of offending behaviour.

She recorded in her document "Prevent concerns about radicalisation via online content". And his disclosures showed very clearly that he intended to kill and that he showed no remorse.

Escalating factors included clear intent to kill, lack of remorse, inappropriate effect. So, laughing

during the interview. Repeated knife carrying culminating in violent assaults. Fixation on grievances. Yes, ASD traits were noticed, but they were a working hypothesis only. Whether the behaviour was driven by mental illness, unlikely as per Mr Scott Morgan's analysis, or by a behavioural condition, ie, a conduct disorder, was something we say, with as much conviction as we can, required urgent determination.

So, by 11 October it was clear to everybody involved that he had wanted to use the hockey stick or the knife to kill the boy. Our written submissions tracks subsequent developments and your counsel has set out really everything you need to know in terms of the liaison, or lack of liaison, between LCC, CAMHS and other agencies.

So I now move on to develop the missed assessment point and other service decisions.

SIR ADRIAN FULFORD: You are getting very close to 20 minutes, Mr Bowen, so I must ask you to tailor your submissions so that we stay within the timeframe, please.

MR BOWEN: Yes.

So whatever the interaction between dangerousness and neuro-diversity, we say there was an urgent need for a child and adolescent psychiatrist. It was a crucial

missed opportunity.

There was effectively a dispute with Mr Hicklin at FCAMHS. There is a lot of detail there, but what effectively happened was CAMHS closed the case on 11 March and felt that it was legitimate to wait for the ASD referral. They knew it would take up to two years and effectively said to Mrs Hodson: I'm sorry, but you are now effectively holding the baby.

He suggested that there should be follow-up by Alder Hey Paediatrics and CAMHS, but we know from the documents that that didn't happen. There was no single agency focus on risk. And what we then see also that, with the Youth Offending Team assessments in April 2020, there were factual misunderstandings.

What they appeared to believe, and we see this at LCC000447, it is not thought the perpetrator had the intention of being proactive in harming anyone and he had taken the knife to defend himself against one particular pupil. Conclusion: medium risk.

What happened thereafter was he was contained during the period of the referral order. The risk was felt to reduce, despite the fact that Acorns felt that he was still a real danger and he sort of fell effectively below the radar.

When he was referred back ultimately to CAMHS for

psychiatric input, unfortunately the doctors who then saw him, Dr Ram and Dr Molyneux, knew nothing about the past, and they knew nothing about the past because of the scanning problem that had happened in May 2020 that you see -- it is paragraph 11 or 12 of Dr Killen -- where, for either systematic reasons or individual reasons, the material setting out the risk factors in 2019 were not on the system.

So, we know that Dr Molyneux did know something about Prevent, but there seemed to be a particular lack of -- there wasn't sufficient curiosity about the past and how he had ended up.

So we then have somebody who we say, and I know Dr Irani is going to be assisting you, sir, that that question about whether there was a conduct disorder, how that would have affected the outcome -- so did he have one then? What would have happened? And what can we learn from the fact that neuro-diversity was seen as his major presenting problem and that the colour and the horror of what had happened in 2019 was effectively sidelined.

SIR ADRIAN FULFORD: Mr Bowen, I don't want to be difficult. These submissions are supposed to supplement what has been set out in writing. So can I ask you, please, to draw to a close.

MR BOWEN: I'm virtually there, sir.

What we say just in conclusion is that it was always clear throughout that the risk was high. Nobody took effective responsibility on an overall basis and we say, with respect, fundamental change is required.

That means I simply now, with your leave, sir, would like to read an addendum. First of all, on behalf of the Stancombes, and they would additionally like to say this:

"We fought to protect our families, and to protect ourselves, as Elsie's parents. During the criminal trial, we refused to know the full extent of what she suffered. We couldn't bear it. Yet we were told it had to be heard. It had to be a fair trial for the perpetrator. It needed to be on record, our welfare wasn't important. The future damage that this was going to cause us did not matter. Protecting us, our family and our friends, Elsie's sister, protecting Elsie's name didn't matter because her name had been released her injuries could be made public, even with us pleading with them not to allow this. Because she was no longer with us she lost all her anonymity, all of her privacy, and all of her dignity."

The judge's sentencing remarks devastated us, they weren't necessary. The CPS and judge knew how important

it was to us that those details were not to be made public. But they were. And Elsie as well as us was failed. Those remarks never needed to be spoken in open court. They never needed to be live-streamed. We didn't do this, we tried to protect her, her dignity. We didn't fail her but we were failed over and over again.

We kept asking why are so many details of the event itself and the devastation he caused being released. We already know what happened, we already know the horror that unfolded. Why is it necessary to share these details again and again?

We stressed that surely releasing this information only proves the danger of having it accessible to other young people. Knowing the content the perpetrator was able to view and how he tried to imitate other terror attacks. Some of this content is no longer accessible in other countries, yet it was/is available here. Surely we cannot hope to break this pattern if we continue to release the very details that can drive other people to commit such crimes.

The fight for justice.

I often try to understand how this happened, I have no answers. But in my job, if I made a decision or judgment that led to someone being seriously injured or

worse, someone losing their life, I would be held accountable. I could be charged with corporate manslaughter, face a significant fine, or at the very least lose my job. That's the responsibility I carry and that's what I'm paid to do. Keep people safe and follow processes.

And if someone in my team made that decision, I would still be accountable. That's how it works in the private sector.

Accountability in my world means I do everything possible to prevent harm, I follow procedures. I flag when those procedures fall short. I know clearly that I am personally responsible for decisions. That's not a threat, it is to safeguard. It is what drives better decision-making. It's what protects people, protects the institution I work for.

But in the public sector? When mistakes are made, when bad judgments lead to real harm or even death, all we hear is: "lessons have been learned".

Where is the follow-up? Where is the accountability? Where is the consequence?

This isn't about wanting people punished. It is not about charges or job losses. It is about ensuring that the weight of decisions is felt by those making them. That they know their actions have consequences, not just

for others but for them personally. Only then will the culture change. Only then will people pause before making a choice and ask themselves: what does this mean for the people involved? What if I'm wrong? Have I done everything I can?

Elsie's life was taken by a young person, a perpetrator who was still legally a child, yet was known by those closest to him to be violent and dangerous. And yet, beyond the perpetrator himself, no one, not even his parents, who allowed that danger to grow inside their home, is being held accountable.

We are left with a painful and deeply unjust question: when a parent knows their child is dangerous, allows them to possess weapons, and authorities have already visited the home, how is that not neglect?

If a child were malnourished or unwashed, social services would act immediately. But when a child is surrounded by weapons, involved in violent behaviour and known to be a threat, the system does nothing. That is a failure.

The parents of the boy who killed our daughter were fully aware of the risk he posed. They lived with him. They knew he had access to weapons. He was involved in violent behaviour and he posed a danger to others. Police and safeguarding services had visited that home

and still it was deemed appropriate for a child to live there with no serious intervention. No action was taken. Why?

Our daughter paid the price for that failure. We are good, law-abiding parents. We have always taught our children the difference between right and wrong. We live in line with the law and contribute positively to our community. And yet we are the ones left with a life sentence of grief and pain, while the people who allowed this danger to grow in their home, people that treated him, continue their lives without consequence.

We demand accountability, so we urge this public Inquiry to ask the hard questions:

Why is it that, despite numerous interactions with institutions and programmes intended to protect our children, that an individual, now deemed by some as one of the most dangerous criminals in our prison system, was not prevented from committing the most serious criminality and terrorism?

When does a parent become complicit in a crime committed by their child?

Why is knowingly allowing access to weapons or violent behaviour not considered a serious form of neglect?

How can it be that services visited that home and

still took no steps to protect the public, including children like our daughter?

Why does our society enable minors to have access to hate, terror, violence and age controlled materials at their fingertips?

Should a venue and event full of young children be locked and secure and, if not, why not?

Was this a terrorist attack? If not, why was it not deemed a terrorist event?

What we are dealing with here is not simply a choice of weapon, it is about an individual who had been flagged repeatedly by various agencies and yet no meaningful intervention took place.

That is where the focus should lie: ensuring that individuals with the desire to cause harm are stopped long before they pick up any weapon, be it a knife or anything else. If we fail to address the underlying issues, the tools will keep changing, but the tragedy will remain the same.

So, that's the Stancombes.

Very briefly, just a few paragraphs from Ben and Laura King to add to their own contribution thus far.

"The evidence and information to date shows that this was not the fault of one person, one place, or one moment in time. This was a chain of failures across

systems, across services, across safeguarding, and every broken link in that chain allowed the events of the 29 July to happen.

"There were warnings missed, red flags ignored, risks underestimated. Agencies who should have spoken to each other but didn't. Safeguarding measures that should have been watertight but weren't. A children's class that should have been safe but wasn't.

"And because of those failures, my daughter -- my joyful, hilarious magical little girl -- was murdered."

SIR ADRIAN FULFORD: Thank you very much, Mr Bowen.

Mr Temkin.

Opening statement on behalf of the families of the physically and psychologically injured children

MR TEMKIN: Sir, this opening statement is made on behalf of 18 families whose children were physically and/or psychologically injured on 29 July of last year.

As you, sir, put it when opening this Inquiry, that knife attack on that date was "almost unimaginable but nonetheless mercilessly-calculated".

How was it possible for AR to have caused such devastation?

The families that we represent fully support this Inquiry. They welcome painstaking scrutiny and they yearn for answers. Their hope is that the

recommendations that you make, sir, at the conclusion of this Inquiry will be implemented.

These families have anonymity by necessity but they ask that this Inquiry doesn't remember the face of evil, but rather their brave daughters. It is they who will of course bear the physical and mental scars of that day for the rest of their lives.

It is crucial to record the families' enduring and deeply-felt gratitude to the emergency services attending on the day of the attack. Their skills, professionalism and rapid decision-making saved lives. The families also wish to thank the many medical teams from whom they have received, and continue to receive, outstanding treatment, care and support.

On 29 July last year, AR, equipped for mass murder, walked into a dance studio. There, innocent young girls were gathered to enjoy an organised event at the start of their summer holiday. But AR held the fixed intention of taking the lives of as many of those little girls as he could. He didn't exercise any restraint when faced with adults. They too felt the force of his blade. AR's actions were frenzied yet determined. This was deliberate and planned brutality.

The families we represent do not lose sight of the dreadful fact that the lives of three little girls were

extinguished that day. All of those who survived are having to come to terms with the enormity of what happened. The children of the families we represent ask questions to which the answers are complex, confusing, difficult or simply impossible.

The evidential picture continues to develop. This opening statement, sir, shouldn't be taken as a comprehensive list of the topics that are deemed to be of importance by those we represent. Rather, it is a summary of some of their key concerns. And for the purpose of this opening statement, we have focused on the wider picture.

Within the material currently available, common themes have emerged. The evidence strongly suggests that there were a series of highly significant missed opportunities. Missed opportunities for public bodies to identify and to respond to escalating risks.

At this stage we highlight missed opportunities in three particular areas: first, AR's propensity for serious violence; second, AR's educational needs; and third, AR's domestic family environment.

We turn to the first of those areas, AR's propensity for serious violence.

When sentencing, Mr Justice Goose said that AR had:

"a longstanding preoccupation with violent killing

and genocide."

Sir, the evidence demonstrates that the signs were there long before July 2024.

On 7 October 2019, when AR was just 13, he contacted Childline. He disclosed that he wanted to kill a fellow pupil at the Range High School. He admitted that he had taken a knife to that school on ten separate occasions. Following a referral from the police, AR was permanently excluded from that school. But one staff member remarked that AR did not seem to be aware of the risks that he posed in carrying a knife.

AR moved schools to The Acorns School. Within just a few weeks during a lesson he was found to be researching mass school shootings. In another lesson, he requested a picture of a severed head. The school recorded that AR was "hellbent on teaching staff and causing them harm" adding "we have major concerns over him". The deputy headteacher expressed her fears about AR in this pertinent way:

"with a West Lancs address and a Sefton GP, he is going to fall between the cracks."

That remark, we submit, is particularly important. She was concerned that without the right support there was potential for a serious incident and those concerns were expressed some years before the horrifying events

of July 2024.

It is the contention of the families that we represent that opportunities for this serious incident to be prevented were missed and in many ways the Inquiry might conclude that AR did indeed fall between the cracks. Yet those cracks should never have been present.

On 11 December 2019, AR took a taxi to the Range High School from where he had been permanently excluded. He found his way into the school. He was carrying a knife and a hockey stick. In a crowded corridor, AR used that hockey stick to strike a pupil. This was a premedicated attack. AR had booked the taxi in advance, he boarded it, armed and intent on violence.

Following his arrest for that offending, AR revealed exactly what his intention had been. He said he had intended to kill the pupil who had been bullying him. He showed not a jot of remorse. This, sir, was a marked escalation.

As long ago as late 2019, interest in serious violence had turned into actual violence. As a result of these events, AR was convicted at court of criminal offences, he was made the subject of a ten-month referral order, monitored by the Youth Offending Team.

It was against this background that AR was referred

to Prevent on three separate occasions. Prevent of course being the Government's programme that aims to stop people from becoming terrorists or supporting terrorism. It was The Acorns School that made the reference each time -- December 2019, January 2021 and April 2021 -- but, as we know, on each occasion Prevent concluded that there were no relevant concerns and the case was closed. As Lord Anderson's review has found, those Prevent referrals represented:

"three opportunities to progress towards Channel a troubled teenager who was already showing signs of an interest in terrorism and some disturbed and violent characteristics."

17 March 2022, AR went missing from home. Yet again, he was in possession of a knife. He was found on a bus a few hours later. Police attended and AR admitted his intention was to stab somebody.

He also referred to having attempted to make poison. It was noted that AR didn't seem to think that he was doing anything wrong. And the attending police officer concluded that no further action was required. Yet this was the third instance of AR carrying a knife with the intention to commit a serious offence.

It is in the context of this ongoing propensity for serious violence that AR made a series of concerning

purchases online.

For example, January 2022, he purchased the raw materials necessary for producing the highly potent poison Ricin.

March 22, he purchased a bow and 12 arrows.

June 23, a sledgehammer. Later that month, in October 23, he purchased two machetes.

The first of these was intercepted by AR's father who kept the item on top of a wardrobe, but later AR threatened his father with a knife, demanding to know where that machete was.

AR's father didn't inform the police and didn't take any other action.

On 22 July 2024, AR's father was helping his son clear boxes from his, that's AR's, bedroom, and AR's noticed a bow and arrow, he noticed chemicals, but astonishingly he didn't challenge his son.

Later that same day, AR attempted to leave his home address in a taxi. He had asked his father whether the Range High School had broken up yet. This surely was a clear red flag, given AR's history with that school.

Having found weapons and chemicals in AR's room just hours earlier, AR's father successfully begged the taxi driver not to take his son to the Range High School. But even then the family didn't seek advice, they didn't

seek help, or guidance. They did not contact the police, despite clear warning signs that AR, once again, was intent on serious violence.

The horrific events of the 29 January last year were at that stage just seven days away.

Sir, the families we represent consider that these matters present a clear and obvious pattern of escalating risk. Over a number of years AR demonstrated a propensity for serious violence and we submit that opportunities to identify and respond to that pattern were missed.

We invite the Inquiry to consider what more could have been done to mitigate the increasing risk posed by AR's interest in, and propensity for, serious violence.

I move on to the second theme of particular concern to the families we represent. That is the extent of engagement by professionals with AR's special educational needs.

In November 2019, The Acorns School sought to refer AR for an autism spectrum disorder assessment. However, a formal diagnosis was not made until early 2021. Might an earlier diagnosis have resulted in more effective steps to reduce the risks he posed? He needed, we submit, support and professional intervention. But when making that referral, the deputy head at Acorns emailed

the community paediatric team at Alder Hey saying:

"I really need some help with a referral for a young man ... We now have serious safeguarding concerns."

We know in 2019 he was displaying violent and aggressive behaviour and police described him as "high risk". But it is of concern to the families that, in March 2020, Lancashire Social Care stepped AR down to early help and social services stepped AR down to level 2.

On 21 January 2020, a meeting took place between CAMHS, social workers and AR's school. However, rather than working together, the approach appears to have been parochial.

At that meeting, a CAMHS representative offered a £5 bet to any colleague who could predict what happened next. The social services representative at the meeting seemed more focused on passing the responsibility for conducting a risk assessment from herself to the school.

Throughout the rest of 2020, Covid restrictions were in play. The Children and Family Wellbeing Team withdrew support in 2020 on the basis that they could only re-engage when the schools had opened. AR appeared to have fallen off the radar.

But when schools did re-open, AR's pattern of

attendance declined significantly. Teachers made repeated attempts to visit him at home, but his parents prevented school staff from seeing him.

By March 23, Presfield staff were concerned because they had not seen AR since 25 May 2022. The police had declined to conduct a welfare visit. Social services were unwilling to visit and that is when one teacher expressed their frustrations by saying:

"The red tape is frightening. Short of breaking in, I don't know how to see this kid."

Over the 26 months of AR being on the roll at Presfield School, his attendance was 0.7%. Once again, we suggest that AR had fallen off the radar.

March 24, his education, health and care plan was closed. 12th June 24, he was removed from the roll at Presfield School. And it is not without significance, we submit, that that moment was merely six weeks before the events at the Hart Space.

Sir, pausing there, the evidence shows that AR was lost to the education system for a significant period of time. He was a teenager with acute special educational needs and an anxiety disorder. We invite the Inquiry to consider whether there were missed opportunities here with the risk posed by AR's mental health conditions.

I move now but briefly to my third topic and final

topic, the family home.

We invite the Inquiry to consider this fundamental issue: the social care system is configured to protect children from serious harm, but is it adequately equipped to respond to children who themselves pose a risk of causing serious harm to others?

The emerging picture suggests not. AR's parents were not adequately addressed in their needs. The assessment of AR himself appears to have been seriously deficient.

After the Range High School assault, AR's parents were noted as being in denial over how serious that was. AR was noted as often violent towards his father in the home. His parents were clearly struggling. A home visit identified that AR was "quite a force in the household", he was argumentative, his parents were unable to challenge him. They had concerns noted in 2021 about AR's escalating aggression and verbal threats, intimidation. They felt "disempowered".

In the first half of 2023, the relationship between AR's family and the various institutions was deteriorating and a CAMHS psychiatrist reported that she didn't feel safe working with AR's father, given his behaviour towards professionals.

During this time, medication was prescribed for him,

but without AR being medically examined, without any discussion with him. There were sporadic family therapy sessions, but he was not there.

A note from a community dietetics record says that he had not left the home in four to five months. He was discharged from that service too.

In this context, one of the crucial opportunities to engage with AR in the domestic setting was his referral to the Transitions Service within social care. That service aims to identify the care and support needs of teenagers as they approach their 18th birthday.

A post-incident review by Lancashire County Council has identified serious failings in the Transition Service in AR's case. He was initially allocated to a case worker in February 22. That case worker appears to have taken no action whatsoever for six months.

AR was then re-allocated to a new case worker in August 22. She made introductory email contact. She made one visit to the family in November the following year but she didn't see AR. There were no general assessments and no risk assessments made in the two years and five months between the date of his allocation and the date of the incident.

The system as a whole, we submit, appears to have failed in respect of assessing AR in the transition from

childhood to adulthood and in the domestic context there were, we submit, missed opportunities to identify and mitigate the risk that he posed to others.

I reach the conclusion the families we represent are extremely concerned that the evidential picture indicates a series of system failings, complacency, a lack of curiosity and, at times, inadequacy.

Warning signs were missed, support was inconsistent, and opportunities to intervene were lost. The Inquiry may well conclude that there has been a collective failure.

What AR did was catastrophic, inhumane and heartbreaking, of that there can be no doubt. But there are many questions the families we represent wish to be posed to those who must be held accountable if there are errors and failings.

AR was known to require support, routine and structure. Had he received that, and had the relevant organisations acted in an appropriate and timely manner, we submit that the horrifying attack could have been prevented.

I finish in this way. The Prime Minister has said Southport must be a line in the sand, and by that remark it was made clear that this Inquiry is expected to be an engine for change.

For the 18 families we represent, there are a range of views and a range of points that are important to them. However, common to all of them is their deep-rooted wish that what they have experienced is not repeated in the future. Accordingly, in finishing our opening statement to the Inquiry, we adopt the words of some of those we represent:

"The Inquiry must confront the systemic failures that allowed such a horror to unfold. Accountability matters. Change is not optional. Change is urgent."

Thank you, sir.

SIR ADRIAN FULFORD: I'm very grateful to you, Mr Temkin.

Mr Weatherby, I have something that I have got to deal with now that is unavoidable and inescapable. So I will hear your opening statement at 11.30 am.

(10.53 am)

(A short break)

(11.30 am)

Opening statement on behalf of the adult victims

SIR ADRIAN FULFORD: Mr Weatherby.

MR WEATHERBY: Good morning, sir. As you know, together with Jesse Nicholls of counsel and Nicola Brook of BJC Solicitors and her team, I represent Leanne Lucas, Heidi Liddle and John Hayes, the three adult victims and survivors of this barbaric attack.

You have heard directly from each of them already with their impact evidence. You have heard that Leanne, assisted by Heidi, organised and ran the children's event. John ran the business next door to the dance studio and his wife is a director of the company which owns the building and which leased the space to Jennifer Scoles, who in turn sublet the space to Leanne for the event.

Leanne, Heidi and John each acted with remarkable bravery in response to this atrocity. They did all they could to save as many children as possible. They could have done no more than they did. Lives were saved as a result of their courage and selflessness.

I will deal with the arrangements for the event in a moment, but I want to start with what we anticipate the evidence will show with respect to the roles of each of the three. Much of this you have already heard, but I want to add a small amount of important detail.

The attacker arrived a short time before the end of the event, when one might expect parents to have started arriving. There are three initial points to make: firstly, a theme raised by Mr Moss KC: it is clear the attacker targeted the event and that he targeted children and women.

Secondly, the attack started immediately when he

arrived, without warning, and it was remarkable for its ferocity.

And thirdly, it was over in a short period of time.

Leanne was stabbed five times, as you have heard, with life-threatening injuries to her chest, back, spine and head, the physical effects of which took months to heal. The force of the attack broke her shoulder blade, fractured her ribcage and her spine, and collapsed her lungs. During the attack she fell to the ground, to be pulled up by Heidi, and together they did their utmost to push as many children as possible away from the attacker and from the screen. Leanne's injuries were life-threatening. Despite this, she insisted that children were treated ahead of her. Subsequent to her eventual discharge from hospital, Leanne suffered serious complications and had to be readmitted.

Heidi witnessed the attack commence and, whilst Leanne was on the floor, Heidi grabbed her by the elbow and pulled her up. Heidi 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, and so followed her and barricaded herself and the child inside for protection, keeping the child safe from the attacker's efforts to reach them both. You have heard evidence regarding the additional needs of

this child, and even in the extreme stress of the moment, Heidi's presence of mind almost certainly saved her, not least given the terrifying fact that the attacker made efforts to get to them.

On hearing the commotion, John, at his desk in his office opposite in the studio, rapidly came out and confronted the attacker. Although he was unable to overpower him, this inevitably distracted him from attacking others for vital seconds. John, as you know, suffered serious injuries. But for the fast action of a 18-year-old staff member who applied a tourniquet, he may well have died.

All three continue to suffer profound trauma and psychological distress which has affected each of their lives and those of their families in a major way.

Police evidence will show that Leanne exited the building some 39 seconds after the attacker was last seen after entering the building. By the point Leanne can be seen exiting, 9 children had escaped. 13 more were ushered by her or immediately followed her out.

On the police evidence and call logs, Leanne was the first person to call 999 despite her injuries and her attempts to save the children. Her clear recollection is that she did so whilst still in the building, but it appears the call connected once she was outside, some

7 seconds later.

You have the call transcript and it speaks for itself. Leanne did everything she could to save lives and to call for the emergency service response, and subsequently directed help to children and not herself.

I have set out that summary in the way in which I have because each of the three have been subject to misinformed criticism, some of which on social media has been vile abuse. None of them want the detail of their actions to obscure the loss and trauma suffered by so many children and their parents and families. But it is important to this process, which starts with establishing a true record of what did and did not happen, and to all those affected that the definitive account records what is materially correct.

All three recognise that this Inquiry will include an examination of the arrangements and organisation of the event and whether anything could have been done differently to avert this outrage. Not only did they recognise that fact, but they welcome it. Once again, the record must be straight, and in every aspect of this Inquiry there must be a close examination of whether there were failures and whether changes can be made for the future to minimise any repetition.

The spaces in which the event occurred were let to

Jennifer Scholes from whom you will hear. So far as we are aware, and this is another theme identified by Mr Moss KC yesterday in his opening, both the owners of the building and the lessee complied with all relevant health and safety and other legal standards, including risk assessments and fire regulations.

The studios were only sublet to individuals or organisations known to have full safeguarding and insurance. Leanne is a teacher and Heidi a teaching assistant; they are well versed in safeguarding matters. We anticipate that the Inquiry will find that the arrangements for the event were as one would expect. It was advertised on Instagram and Facebook, which is presumably where the attacker found out about it, although we understand there is no actual evidence confirming or verifying this.

The event was limited to an appropriate number of children and at no time were they unsupervised. For the first part of the session half of the children were in the downstairs studio and half in the first floor room. When they came together, the children downstairs were supervised when coming out of the studio into the yard and through the front door and up to the upstairs studio.

The door to the upstairs studio was a solid wooden

door. It was not locked. On any reasonable view that was appropriate in the circumstances. Firstly, parents and children arrive early or late at the start of events such as these and likewise at the end. That is the evidence here, with children arriving both before and after the 10am start time.

Parents were welcome to stay and observe. There was movement between the two studios. The toilets were on the landing outside of the studio. If the door had been locked there would be inevitable questions regarding fire safety, or other emergencies, given that the door was the only access in and out of the space.

Had the door been locked at the time that the attacker arrived, what might have happened? Given that when Leanne first saw the attacker enter the room she unsurprisingly thought he must be connected to one of the children. It is clear that she or Heidi would simply have opened the door to him, had the door been locked. Bearing in mind that none of the people who saw the attacker outside saw the knife, neither the taxi driver or the garagemen, and bearing in mind the door was solid with no window, why wouldn't they have reasonably done so?

So drawing the threads together, we anticipate that the evidence will show that the arrangements were

appropriate and there were no failures in the organising or arrangements for the event, though we reiterate that scrutiny is absolutely appropriate. We note what was said in the CTI opening regarding guidance for out of school events, again an entirely appropriate consideration, but again we anticipate that it will be found to be unrealistic to recommend requirements beyond those already in place for such small community-based events such as this.

There are two other factors in this regard. Firstly, such a brutal targeted attack on a children's event could not have been foreseen on any view. And secondly, the venue, a studio in a small business centre, nestled behind a nondescript residential road, was the last one place one could imagine such an outrage could happen.

I have addressed the arrangements and roles of the three adults for obvious reasons. I anticipate that the evidence regarding these matters, important though it is, will not be complex or take much of the Inquiry's time, and we respectfully agree with the approach to be taken to this evidence for those reasons and in particular to minimise re-traumatising those most affected for no good purpose.

As everyone ahead as asserted, the real questions

for the Inquiry relate to the history of the attacker and his family, what was known by a long list of institutions and authorities and public services, and what they did or did not do regarding the multiplicity of concerns about him. Was appropriate action taken following his violent attack at his former school in 2019? Was appropriate action taken after he was found on a bus by police officers in 2022 carrying a knife and stating he wanted to stab someone and had thought about poisoning people? Why weren't multiple reports of his interest in knives taken more seriously? Why were knives so readily available to him at his age and disposition? Did child and adolescent mental health services provide an adequate service? Was dropping out of education dealt with sufficiently? Did the police follow up welfare concerns appropriately or at all? Were the multiple referrals to Prevent fully dealt with? Did other agencies rely on the lack of action by Prevent as evidence that nothing was wrong, or that nothing could be done? Should more have been done regarding the attacker's fixation with mass violence? Did he fall between stools because his obsession with violence was apparently not ideological?

What about the role of social services? From the disclosures so far there were obvious failures, both

early on and in the transitional adult social care provision? What about interoperability and a joined up approach between services?

Because those issues have already been addressed fully by CTI and others, I will not repeat them, but I do emphasise that Leanne, Heidi and John all join in urging the Inquiry to rigorously look at what should have and could have been done differently, and in particular what multiagency interventions there were or should have been.

I conclude with three discrete submissions.

Firstly, we want to support and emphasise one of the final questions posed by Mr Moss yesterday. The Inquiry will obviously investigate what each agency did and did not do, and whether there was a general approach of seeking to pass on responsibility to other agencies. However, it is the follow-on point which is the most important: was there a failure of agencies to own responsibility for the clear risks posed by the attacker? Should a key recommendation from this Inquiry be that where an individual for whatever reason is deemed to be a potential risk, someone must take lead responsibility for ensuring that the risk is dealt with on a multiagency basis. We anticipate and hope that this may become a central theme.

Secondly, we anticipate that part of the evidence before the Inquiry will be that various public services had resource constraints. In short, underfunding led to poor or no action. While this may provide explanation, it provides no excuse or comfort. If underfunding of public services is part of the backdrop to why there was no effective intervention to the known issues and risks posed by this attacker, then this Inquiry must say so.

If agencies or services sought to offload responsibility for dealing with the known risks rather than dealing with them or following through with referrals to other agencies and services, then again that must be your findings.

In other legal proceedings judges of course are required to defer issues of resource allocation to the executive or the legislature. Not here. A public inquiry must definitively find the facts, identify failures and accountability and thereby make recommendations for the future. It can only discharge those three imperatives if it not only addresses the role of individuals but also systems. That includes whether they were adequately resourced and crucially whether they worked efficiently with each other. The Inquiry must be bold in making that clear. All those affected by the Southport attack are entitled to that.

And thirdly, as we know, the public suspicion around what happened led to some of the worst racist violence and rioting this country has seen. This provides an additional imperative as to why the Inquiry must be as transparent, open and searching as possible. You've made that clear from the Inquiry's side.

But low public confidence in public authorities and institutions telling the truth and a pervasive culture of institutional defensiveness evidenced in many other high-profile inquiries and inquests requires maximum candour from the public bodies involved in this process.

To this end, although in law they are currently entitled to do so, it is disappointing that some of them have chosen not to assist the Inquiry, those affected, the media, and the general public, by making opening statements and only three of them are to make oral statements today.

You will be aware that yesterday the Government laid a bill before Parliament focusing on just this problem. A new law with particular resonance in this city. When in force it will require public authorities and public servants to proactively assist inquiries and will remove any right for them to sit back and see what they might get away with.

Indeed, when in force it will mandate

Position Statements at the outset of public inquiries so that everyone may understand the perspectives of all participants in an inquisitorial process to which we should all be collaborating to achieve a common end: producing a definitive factual account, accountability and progressive change for the future.

Although plainly not in force yet, we hope that this development, this direction of travel, will weigh on the minds of those who direct the various public bodies involved in this Inquiry.

The beneficiaries will be this Inquiry, those most affected by this tragedy, and the wider public who those public bodies are duty-bound to serve. Thank you very much.

SIR ADRIAN FULFORD: Thank you very much, Mr Weatherby.

Mr Moss, apart from Dion R, is there any other core participant who hasn't provided an opening statement in writing?

MR MOSS: I would need to check that. I think there are a few. I was just going to say in relation to that, in light of what Mr Weatherby said, without wishing to cut across Mr Weatherby's submission -- and we understand the wider aspects in relation to the Hilsborough Law -- but I think it is fair to note that so far as this Inquiry is concerned, the opportunity was given to

provide a written opening and everybody was invited to indicate if they wished to supplement that with oral submissions. And last night, sir, as you know, the following -- in addition to those who are giving oral openings this morning -- the following additional CPs have provided written openings and our process was that they would be made public, and indeed I know that they went on the website overnight.

So that was Alder Hey, Counter-Terrorism Policing Headquarters, Counter-Terrorism North West, Dion R, who did make opening submissions in writing, Lancashire Constabulary, Merseyside Police and the North West Ambulance Service, together with the Secretary of State for the Home Department. It is right I should record that all of those took up the opportunity to make a written opening and that has been made public.

SIR ADRIAN FULFORD: I think, therefore, the written openings are either completely comprehensive, or very nearly.

MR MOSS: Sir, I think that is right. I think, by a process of elimination, I think Amazon, the Department for Education, DSIT, NHS England, Presfield High School and the Southport Learning Trust opted not to, but that shouldn't be seen as any failing on their part. They were invited if they did wish to make an opening

statement.

It is also right to say that, as I think I have made clear on a number of occasions, all of those bodies that I have mentioned -- of course there is the occasional extension -- but they have been responsive and co-operative to the Rule 9 requests that are made. In saying all of that, Mr Weatherby quite rightly has an eye to the changes and how things that are developing but that is the position of this Inquiry.

SIR ADRIAN FULFORD: So if not an opening statement, then there has been co-operation in relation to providing statements in response to the Rule 9 requests?

MR MOSS: Sir, exactly that. For example, those bodies have provided corporate statements that deal with the questions that the Inquiry have raised, and so some of them may have felt that matters were sufficiently set out in their corporate statements.

So if I made clear in my opening yesterday in relation, not to core participants, but to some organisations that we had contacted, those who had not co-operated, principally those were outside the jurisdiction.

It is right that I should make sure the record is clear in relation to that, in relation to the Core Participants there has been no lack of co-operation.

SIR ADRIAN FULFORD: And principally, those who haven't provided really any response are Meta and X/Twitter, I think?

MR MOSS: In their cases it would be fair to say that they have been engaging and that we are quietly confident that there will be some disclosure, but there are international or foreign laws involved and so that is a process of discussion that is ongoing. But in relation to both Meta and X, there is positive engagement and positive discussion and, as I said yesterday, we await to receive their substantive disclosure but there are sensible discussions ongoing.

SIR ADRIAN FULFORD: So I can be hopeful?

MR MOSS: Sir, I hope so.

SIR ADRIAN FULFORD: Thank you very much.

Lancashire County Council, Ms Johnson.

Opening statement on behalf of Lancashire County Council

MS JOHNSON: Sir, my name is Laura Johnson KC. With Samantha Bowcock KC, and solicitors from Weightmans, I represent Lancashire County Council, which I shall refer to as "LCC".

On behalf of LCC, we wish to express our profound sympathy to the families of Bebe King, Elsie Dot Stancombe and Alice da Silva Aguiar, and to the children and adults harmed so cruelly in this wicked, senseless

crime.

LCC pays tribute to the bravery of the survivors and family mention who have spoken with such dignity in their commemorative portraits and victim impact statements. We recognise the courage that it has taken to speak about the trauma of the attack and to share the immeasurable harm that has changed so many lives.

We understand that they have done so because of a belief that the work of this Inquiry is important, a belief that LCC shares.

We have listened to the questions that have been asked during those statements and we have also read with care the written openings that have been submitted on behalf of the bereaved parents, the families of the injured children and on behalf of the adult survivors.

We would like to say at the outset of this opening statement that we understand why you are asking them. You deserve answers and we will do all that we can to assist this Inquiry to provide them.

LCC takes the duty of candour seriously. It understands that approaching the Inquiry with openness and transparency is essential to public confidence. In the written opening, LCC has identified points where it considers things could, and at times should, have been done differently. For that we are very sorry.

Turning to the terms of reference, LCC's written opening addresses and reflects carefully on and in detail its contact with the perpetrator and his family. In this oral opening, we do not propose to focus on the perpetrator. Instead, we make two preliminary points that LCC considers are relevant to the work of this Inquiry and its recommendations for the future.

We will then turn to changes that LCC has already made to the services that it provides and its continuing commitment to improvement.

The traditional focus of social services has been, and continues to be, on safeguarding children from abuse and neglect. The role of education services is to meet children's educational needs. LCC accepts that it has an important safeguarding role in relation to risks posed by children to others, but the statutory framework that gives local authorities their powers to act was not designed for this and is not well-suited to it.

Following on from this, at the time of the perpetrator's contact with LCC, he fell outside the Prevent mechanism. As a result, he was managed through the multiagency safeguarding partnership, at a time when there was not a developed understanding nationally of the risks posed by individuals who had a fascination with violence, but who did not have a single ideology or

other features, such as gang affiliation.

LCC welcomes the fact that Prevent now accepts referrals for children who pose this category of risk and its experience is this has already strengthened partnership working and the multiagency response.

Turning to improvements, LCC wishes to reassure the bereaved, the survivors, their families and the general public that it has been proactive. We are sharing these points in our opening because we understand the importance of knowing that the system will do better in the future.

LCC is confident that important changes in multiagency working have already been made, although there is more to be done. The most important development is improved partnership working within the Prevent structure, as I have already mentioned. Internally, LCC has strengthened its strategy to promote the Prevent duty to its staff and to monitor compliance.

There are also more interventions available if a young person is not accepted by Prevent. There is now a greater focus within LCC on the assessment of risk posed by children and young people to others, a serious violence toolkit has been developed which offers evidence-based resources and responses. Children's Social Care is now supported by an autism support team

to ensure that the service can better meet the children who are neuro-diverse. Children's Social Care and early help employees now receive more sophisticated training in working with children with neuro-diversity needs.

There is also a greater focus on understanding the risks of online harm with tools and training addressing emerging issues and how to assess and work with children who are at the risk of perpetrating violence. LCC's contextual safeguarding has been strengthened with employees who deal with children missing from home and those who show potentially harmful behaviours now integrated into the multidisciplinary team, strengthening information-sharing.

LCC has made technical improvements to enable sharing of records across social care departments and auditing shows that measures taken to improve the quality of record-keeping are effective.

Significant work has been done and continues to be done within education to improve SEN and EHCP processes. In addition, LCC now has access to live attendance data so that it is no longer reliant on schools for reporting of issues with attendance and can act on any concerns that are flagged.

Undoubtedly there is more to be done. LCC supports the aspiration of this Inquiry to be an engine for

change and will do all that it is able to assist in its important work. It reiterates its sincere commitment to approach this Inquiry with transparency and a determination to implement any future recommendations that might be made.

SIR ADRIAN FULFORD: I'm very grateful to you, Ms Johnson. Thank you very much indeed.

Mr Browne.

Opening statement on behalf of Sefton Council

MR BROWNE: Good morning, sir.

The commission by the perpetrator of these unspeakable crimes has rightly caused revulsion across the entire country. The thoughts of all at Sefton and within the borough of Sefton will continue to be with the families of Alice, Elsie and Bebe, with the other victims of the attack, and with all those involved in the tragic events of 29 July last year.

Sefton and its residents remain deeply shocked and saddened at those events.

Sefton and other groups acted quickly to support the victims, families and the community. Its social care and community teams helped people emotionally and supported groups and individuals who raised an incredible amount of money for those who needed it.

The whole borough has come together in so many ways.

It remains undeniably united in its shared goal of doing everything it can to help those affected.

Sefton, along with partners, have led on specialist recovery operations which focus on, among other things, helping children and families heal and creating safer and more united communities.

Sefton coordinated, and will continue to coordinate, the support to anyone affected by the tragedy. It has also highlighted the means by which anyone affected can access psychological support for any needs which they have.

The events of 29 July last year were unprecedented for Southport and unlike anything the community has ever had to witness. The world's media outlets descended on Southport and the town will be remembered for those tragic events for a long time to come. Only time will tell what the full impact of the events of that day will have had on the community of Southport. There will be difficult days ahead while the community tries to recover.

However, looking forward, the families of Alice, Elsie and Bebe and all those affected by the perpetrator's crimes will remain at the heart of what Sefton do to support and enable children and families to heal.

A few words about the Inquiry please, sir.

Sefton welcomes this Inquiry. It is of critical importance that all understand the events that led to it. Sefton hope that this will help as part of the healing process for all affected, for the community and that all lessons which can be learned are learned. And it is right that we say that it is perfectly clear even at this early stage that lessons are there to be learned and must be learned.

In order to play its part as fully as possible, Sefton actively sought and were granted core participant status. In its engagement with this Inquiry, Sefton recognises and will fully comply with the duty of candour expected of all corporate and institutional core participants.

Its approach is both inward looking -- what did Sefton do or not do? It is also outward looking, how did it interact with other agencies? In both respects, Sefton will ask, critically, what else, if anything, could it or should it have done that might have affected the outcome?

It will look to take forward any learning that results from the findings of Phase 1 of your Inquiry.

Some observations then please, sir, about the applicable statutory framework.

Pursuant to section 17(1) of the Children Act 1989:

"It is the duty of every local authority ...

(a) To safeguard and promote the welfare of children within their area who are in need, and,

(b) so far as is consistent with that duty, to promote the upbringing of such children by their families."

For these purposes "area" is defined primarily to mean the local authority district within which the child is physically present. In the case of the perpetrator, this meant Lancashire County Council, to whom I shall refer as "Lancashire".

A child is of compulsory school age on the start date of term following their fifth birthday until the last Friday in June of the school year when they turn 16. Local authorities are responsible for attendance of children of compulsory school age who reside in their area.

While the child is of compulsory school age, Sefton's policy, pursuant to obligations under the Education Act 1996 is to perform functions related to school attendance. If Sefton is not satisfied that the parents are providing a suitable education to a child of compulsory school age, and it is appropriate for the child to attend school, they will take steps to seek to

ensure that attendance.

Where there is a need for a child to attend special educational arrangements, such as pupil referral unit, Sefton will make arrangements for a child of compulsory school age, who resides within their local authority area, to be provided with a suitable educational arrangement which meets their need.

As I said, this legislation applies to any child of compulsory school age. Upon the child ceasing to be of compulsory school age, the legislation and the Council's procedures no longer apply. If the child resides in Sefton's post-compulsory school age, Sefton will continue to provide safeguarding support through children and social care duties. However, in cases where the child resides in a home local authority different from the borough where they attend education, this duty remains with the home local authority and in those circumstances the home local authority should provide any educational support as part of safeguarding duties upon the child transitioning into post-compulsory school age education.

Turning then to AR. From 2017 onwards, AR resided in the Banks area of Lancashire, part of Lancashire's jurisdiction. As a result, Lancashire had duties under the Children Act 1989 while he remained a child. They

also had the primary statutory responsibility for ensuring that he received a suitable education.

As you know, sir, in 2017, AR's parents used parental preference to choose a school in Sefton, namely Range High School in Formby.

As Sefton was the local authority in which AR attended school, it had responsibilities to him so far as his education was concerned while he was a child of compulsory school age. Those duties included monitoring educational standards, providing training to designated safeguarding leads within the borough and supporting schools in managing the exclusions process, also ensuring that his attendance was tightly monitored.

Regulation for enforcement of attendance at compulsory school age lies with the local authority where the school is based. All safeguarding and support services are provided by the local authority where the child resides.

As the support services were provided and managed by Lancashire, they held responsibility for coordinating and delivering those services. Sefton were not involved in delivering support services and as such it would not have undertaken any risk assessments. Any interventions in relation to Prevent would be managed by the home local authority.

So far as Sefton's awareness and involvement with AR is concerned, they were aware of AR prior to the attack because of his time attending schools within their borough. They were notified by Range when he was permanently excluded over an incident relating to his having a knife in his possession and, as you know, sir, he was permanently excluded from Range on 9th October 2019. The exclusion letter was sent to Lancashire and a copy was sent to Sefton.

At the time of exclusion, and in fact now, the Range High School is an academy, and in relation to academy schools the statutory guidance on exclusion states that parents may request that the local authority where the school is based, and/or the home local authority, attend a meeting of the academy's governing board as an observer. That representative may only make representations with the governing board's consent. AR's parents did not request Sefton to attend the governor's meeting.

The governor's decision to exclude AR, upholding the headteacher's decision, could have been subject to an independent review panel had AR's parents requested it. They did not do so.

It is absolutely right to note that AR's attendance during his time at Presfield School was extremely poor.

He was at that time subject to an Education Health and Care Plan, maintained by Lancashire, and was subject to an enhanced transition plan during his enrollment year.

During his enhanced transition plan he was not known to Sefton school attendance team, as he was subject to an EHCP at that time and there was involvement from Lancashire support services, Sefton did not pursue proceedings for enforcement action in relation to his non-attendance against AR's parents. While he was at Presfield, he was of compulsory school age for only 13 weeks, and of those three weeks were school holidays.

There were, however, requests made of Sefton for assistance from the designated safeguarding lead at Presfield School, Cheryl Smith, and of her deputy, Jeanette Bannister, firstly on 2 February 2023, a request for support from the Sefton school attendance team which was provided, and secondly a request on 20 March 2023, that a welfare visit be undertaken.

On that second date, the designated safeguarding lead phoned Michelle Woodward, who works within Sefton's attendance team, and requested a welfare visit, stating they had concerns surrounding AR's attendance and that he had not been seen in person.

Joe Farrell, who was the team manager of the Sefton attendance team, agreed for a member of the team to

complete a welfare home visit. Angela Maguire from the Sefton attendance went to AR's home. Upon her going there, AR's mother made a complaint that she did not feel that the welfare visit was warranted and refused for AR to be seen.

Following the visit, Joe Farrell contacted Presfield by email with feedback of the visit and suggested the school contact Lancashire Police to complete a welfare check and inform Lancashire Missing Team and Lancashire SEN as this issue related to his EHCP.

AR was only referred to Sefton's attendance team on two occasions and therefore a decision was made not to intervene beyond this point given he was beyond compulsory school age.

Some observations on Sefton's actions on the basis of the material presently known.

On 20 March 2023, Sefton's advice to the school to contact Lancashire was correct as AR's EHCP was maintained by Lancashire and the support services were provided by them as that was where he lived. The majority of the time he was enrolled at Presfield he was above compulsory school age and as a result they did not have a legal power to enforce his attendance.

Turning then briefing, if I may, to steps that have been taken after the attack.

As of 19 August 2024, the Department for Education issued statutory guidance "Working together to improve school attendance". The relevant parts of that guidance has been incorporated by Sefton into its local procedures in 2024.

Steps have been taken to address the quality of information in EHCPs from other local authorities who send consultations to Sefton's schools. When receiving an initial EHCP consultation from another local authority, schools must ensure that the information provided includes a summary of social care needs not related to educational needs. So, for example, information about risk, risk-taking behaviours, to enable the potential receiving school to put in place risk assessments to mitigate those risks. If information is lacking, the local authority must be contacted for further details.

On 5 June this year, Sefton wrote to the local authorities who share borders with it in relation to the school attendance of children, including those with EHCPs who are placed in independent schools within its neighbouring local authorities. Sefton made a request to those neighbouring local authorities to share the protocols that they have adopted in response to the updated statutory guidance.

Can I then just deal with three other matters, please.

It is of course critically important, as we have said and others have rightly emphasised, that lessons are learned.

There are three matters that we would wish to raise at this stage please and we believe these to be of critical importance:

First, it should be made sure that children not attending education are seen by appropriate professionals.

Secondly, parents must not be able to refuse to let professionals see their children.

Thirdly, it should not matter what age the child is. School should be part of any meetings relating to a child, especially those children who are not attending school.

In this instance, AR's parents refused to allow access to AR and refused to let Presfield School attend meetings with health professionals.

Conclusions.

We will, sir, engage with the Inquiry to the fullest extent required. We welcome the opportunity to do so and we will look to contribute to and implement any learning that may prevent such an awful tragedy from

ever happening again.

SIR ADRIAN FULFORD: Mr Browne, that was very helpful. Thank you very much indeed.

Opening statement on behalf of the Youth Justice Board

SIR ADRIAN FULFORD: Mr Stein. This is the Youth Justice Board.

MR STEIN: Sir, as you know, with Rhys Rosser, I represent the Youth Justice Board.

On behalf of all at the Youth Justice Board and its legal team, may I express our most profound condolences to the families of the beautiful girls, Alice, Elsie and Bebe, brutally killed by AR.

We offer our sympathies and respects to all who have suffered through AR's actions on 29 July of 2024. However, the board knows that sympathies and respects are utterly insufficient and therefore commits itself to acting on the findings and supporting recommendations as part of this Inquiry.

As Mrs King said:

"Real change must be made because this was preventable. It should never have happened and no other child, no other family, no other community should ever endure what we now live with every single day."

Sir, the Youth Justice Board is a non-departmental public body, sponsored by the Ministry of Justice, and

is the only statutory body with oversight of the entire youth justice system in England and Wales.

Created by the Crime and Disorder Act 1998 with the aim of preventing offending by children, the board primarily undertakes the same by monitoring the operation of the system and providing advice to ministers on the best way of achieving this.

The board supports the Secretary of State for Justice in setting standards for the youth justice system and guidance on how children should be managed within it. It holds a strategic responsibility to learn from the circumstances that led to this tragic incident and share what the evidence tells us is effective and take action to effect and support change.

The Board believes that there is a group of children who present risks of significant harm to others who have been overlooked. We suggest that you consider the following two questions while going through the evidence in the next weeks:

Who is seeing everything at one time?

And, echoing the words of Mr Weatherby, who is holding the risk?

Without any continuity of information-sharing, or a robust and resilient plan agreed by all services, the system can and will fail. Statutory services who are

partners within the Youth Justice System tend to work in a siloed way where agencies focus on their own narrow responsibilities rather than on addressing the needs and therefore potential risks posed by children.

I will give you some figures. The figures for serious violence and knife offences committed by children aged 10 to 17 years, those figures are rising. I will give the figures for murder, manslaughter, grievous bodily harm, threats to kill, including what we would call the inchoate offences, offences of conspiracy and attempts, and knife offences in the home or with threats.

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So what is going so badly wrong that we see these number of offences being committed by children? The Youth Justice Board suggests that the focus has been on the numbers going through the adult justice system and the issues being managed within the prison system, probation services and courts and resourcing those services.

We say that is potentially at the detriment to exploring what further measures are needed to prevent offending, particularly serious offending by children.

Sir, you will have read the corporate statement from the chief executive of the board, Ms Stephanie

Roberts-Bibby. She there sets out and explains the serious incident notification system where serious crimes are reported centrally.

Her statement contains the following disturbing message, paragraph 181 sir:

"From my observation of serious incident reports to date, I think that there are very few cases we have seen come through where there isn't something that raises concern in the case before the child goes on to commit serious harm. These are rarely children not known to anybody or organisation."

I will repeat that:

"These are rarely children not known to anybody or organisation."

The Youth Justice Board corporate statement states that evidence shows that children with more complex needs are often involved in more serious offending and require concentrated interventions at the earliest stage to prevent an escalation of harm from their offending to themselves and others.

Building on these learnings and what we know works effectively, we must now strengthen and extend prevention measures to respond to the emerging risks in youth justice and ensure continued progress.

The measures proposed by the Board are urgent, we

say unarguable, and work must start now to implement what is required. They include:

Development of an effective risk assessment tool designed to assess the risks and need of children in respect of whom there is evidence of adopting extreme ideologies or a fixation on violence and serious criminal offending.

Targeted research to better understand what works to prevent children causing serious harm.

Improvements in the access to and quality of data.

Improved IT infrastructure across all statutory partners to improve information sharing.

Strengthened oversight of children who are not in school.

Clarity on what constitutes the Youth Justice System.

Redefining the standards of that system and strengthening strategic governance.

Clarification of ways of working between the Board, officials and ministers, as well as local, regional and national levels across the system.

Better multiagency systems across statutory partners to ensure a shared understanding of what contributes to the prevention of offending by children and of course increased regulation of social media.

The Youth Justice Board welcomes the opportunity, sir, to work with Mr Lammy, as the new Lord Chancellor, the Home Secretary, Shabana Mahmood, and their ministerial teams. But the Board suggests that there is a need to work with the Lord Chancellor and the Home Secretary and the other departments of state -- Department for Education and Health and Social Care -- to ensure that policies enable and reflect the complexity in which critical protective services are delivered to children.

Sir, section 5 of the Crime and Disorder Act 1998 requires the co-operation of named multiagency partners to deliver youth justice services locally. This includes youth justice services and statutory partners which are the local authority, including Children's Social Care and education, police, health and probation. But there must be much greater multiagency engagement. This could be achieved through a combination of the following:

Legislative change to require all statutory partners, including police, health and education and social care to share information and take responsibility for early intervention in response to risks and predictors of offending by children.

The introduction of a single case management system

or mechanism for sharing information, including material from youth justice services, as this would significantly improve risk management, the data quality and consistency of recording.

We would add, the use of systems which reinforce that safeguarding and child protection are not the responsibility of a single agency, but that every organisation, business or service has a responsibility to consider their processes and procedures in keeping children safe.

The change will not happen, sir, unless there is a clear ministerial will and drive to support the system in bringing together the agencies. The system must recognise where a child has complex needs that require attention and a thinking approach to whether a child might represent a danger to others.

Sir, it should not have taken the loss of life and devastation caused by the attack on 29 July in Southport to have woken up society to the need for greater concentration on the way our children live their lives and for the need of improvements in services provided by the adults responsible for them.

There is a need to listen to those in the sector who have the knowledge, who have the experience and who have the expertise to prevent serious offending by children,

and to make sure that they have at their disposal the skills and services needed to do so.

Sir, the Youth Justice Board stands ready to assist this Inquiry in delivering safety to the public.

SIR ADRIAN FULFORD: I'm very much indebted to you, Mr Stein. Thank you very much indeed.

Mr Moss, I think there are a few things to be addressed before we adjourn. Is that right?

Housekeeping

MR MOSS: Sir, just briefly, if I may. May I first of all take this opportunity to thank all of the staff here at Liverpool Town Hall who have been exceptional, if I may say so, in all of the arrangements that have been made. We are lucky to have such a suitable venue for the important work we are doing.

SIR ADRIAN FULFORD: I strongly echo that.

MR MOSS: Sir, we are not able to take advantage of those facilities tomorrow, however because of a pre-arranged booking here and that's the reason why we are not sitting tomorrow.

So we resume on Monday with the first of our witnesses, DCI Pye, in relation to the attack phase of the evidence and, as usual, as that is a Monday, we will sit at 11 am on Monday.

SIR ADRIAN FULFORD: And we are not in this chamber, we are

elsewhere in the building.

MR MOSS: That is right, sir. We move upstairs, so we have a slight change. Same hall of course, but move into what was always intended to be the appropriate hearing room within the Town Hall next week. I'm grateful.

SIR ADRIAN FULFORD: I am very grateful. I will sit again at 11 o'clock on Monday.

(12.25 pm)

(The Inquiry adjourned until 11 am on Monday, 22 September 2025)

I N D E X