

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

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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

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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

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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

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

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

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

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1 Consequences. Well, he was swiftly and permanently
2 excluded from mainstream school, made the subject of
3 high risk vulnerable child referrals by the police, on
4 7th October by the police and then I think by the school
5 on the 8th. As we have heard, he was placed then in
6 a pupil referral unit, Acorns, who come out of the story
7 we say with considerable credit, the one institution
8 that emerges we say being able to hold their head up
9 high in relation to the tragic events that followed.

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

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

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

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

8 6 October there is a classroom assault. That's when
9 he attacks himself, as I understand it. He just
10 launches on the alleged bully. That's after of course
11 the first Childline contact. The words in the papers
12 are "he viciously attacked the bully in class and as
13 a result he was put into isolation".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 **SIR ADRIAN FULFORD:** You are getting very close to
 19 20 minutes, Mr Bowen, so I must ask you to tailor your
 20 submissions so that we stay within the timeframe,
 21 please.

22 **MR BOWEN:** Yes.

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

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1 beheading videos.

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

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

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

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

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1 missed opportunity.

2 There was effectively a dispute with Mr Hicklin at
 3 FCAMHS. There is a lot of detail there, but what
 4 effectively happened was CAMHS closed the case on
 5 11 March and felt that it was legitimate to wait for the
 6 ASD referral. They knew it would take up to two years
 7 and effectively said to Mrs Hodson: I'm sorry, but you
 8 are now effectively holding the baby.

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

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

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

25 When he was referred back ultimately to CAMHS for

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1 psychiatric input, unfortunately the doctors who then
2 saw him, Dr Ram and Dr Molyneux, knew nothing about the
3 past, and they knew nothing about the past because of
4 the scanning problem that had happened in May 2020 that
5 you see -- it is paragraph 11 or 12 of Dr Killen --
6 where, for either systematic reasons or individual
7 reasons, the material setting out the risk factors in
8 2019 were not on the system.

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

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

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

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

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

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

22 The fight for justice.

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

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1 **MR BOWEN:** I'm virtually there, sir.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 So, that's the Stancombes.

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

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

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

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

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

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

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

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

25 How can it be that services visited that home and

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1 systems, across services, across safeguarding, and every
2 broken link in that chain allowed the events of the
3 29 July to happen.

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

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

11 **SIR ADRIAN FULFORD:** Thank you very much, Mr Bowen.
12 Mr Temkin.

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

15 **MR TEMKIN:** Sir, this opening statement is made on behalf of
16 18 families whose children were physically and/or
17 psychologically injured on 29 July of last year.

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

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

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

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

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

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

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

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

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1 and genocide."

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

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

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

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

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

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

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

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

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

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

24 When sentencing, Mr Justice Goose said that AR had:
25 "a longstanding preoccupation with violent killing

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1 of July 2024.

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

8 On 11 December 2019, AR took a taxi to the Range
9 High School from where he had been permanently excluded.
10 He found his way into the school. He was carrying
11 a knife and a hockey stick. In a crowded corridor, AR
12 used that hockey stick to strike a pupil. This was
13 a premeditated attack. AR had booked the taxi in
14 advance, he boarded it, armed and intent on violence.
15 Following his arrest for that offending, AR revealed
16 exactly what his intention had been. He said he had
17 intended to kill the pupil who had been bullying him.
18 He showed not a jot of remorse. This, sir, was a marked
19 escalation.

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

25 It was against this background that AR was referred

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

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

14 17 March 2022, AR went missing from home. Yet
 15 again, he was in possession of a knife. He was found on
 16 a bus a few hours later. Police attended and AR
 17 admitted his intention was to stab somebody.

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

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

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

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

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

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

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

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

27

1 purchases online.

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

5 March 22, he purchased a bow and 12 arrows.

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

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

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

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

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

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

26

1 the community paediatric team at Alder Hey saying:

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

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

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

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

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

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

28

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

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

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

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

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

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

25 I move now but briefly to my third topic and final
29

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

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

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

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

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

24 The system as a whole, we submit, appears to have
25 failed in respect of assessing AR in the transition from
31

1 topic, the family home.

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

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

11 After the Range High School assault, AR's parents
12 were noted as being in denial over how serious that was.
13 AR was noted as often violent towards his father in the
14 home. His parents were clearly struggling. A home
15 visit identified that AR was "quite a force in the
16 household", he was argumentative, his parents were
17 unable to challenge him. They had concerns noted in
18 2021 about AR's escalating aggression and verbal
19 threats, intimidation. They felt "disempowered".

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

25 During this time, medication was prescribed for him,
30

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

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

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

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

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

22 I finish in this way. The Prime Minister has said
23 Southport must be a line in the sand, and by that remark
24 it was made clear that this Inquiry is expected to be
25 an engine for change.
32

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

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

11 Thank you, sir.

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

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

16 (10.53 am)

(A short break)

18 (11.30 am)

19 **Opening statement on behalf of the adult victims**

20 **SIR ADRIAN FULFORD:** Mr Weatherby.

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

33

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

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

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

17 Heidi witnessed the attack commence and, whilst
18 Leanne was on the floor, Heidi grabbed her by the elbow
19 and pulled her up. Heidi pushed as many children as she
20 could away from the attacker and out of the room. She
21 saw one child run away from the exit, towards the
22 toilet, and so followed her and barricaded herself and
23 the child inside for protection, keeping the child safe
24 from the attacker's efforts to reach them both. You
25 have heard evidence regarding the additional needs of

35

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

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

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

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

25 Secondly, the attack started immediately when he

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

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

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

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

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

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1 7 seconds later.

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

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

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

25 The spaces in which the event occurred were let to
37

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

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

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

24 So drawing the threads together, we anticipate that
25 the evidence will show that the arrangements were
39

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

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

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

25 The door to the upstairs studio was a solid wooden
38

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

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

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

25 As everyone ahead as asserted, the real questions
40

1 for the Inquiry relate to the history of the attacker
 2 and his family, what was known by a long list of
 3 institutions and authorities and public services, and
 4 what they did or did not do regarding the multiplicity
 5 of concerns about him. Was appropriate action taken
 6 following his violent attack at his former school in
 7 2019? Was appropriate action taken after he was found
 8 on a bus by police officers in 2022 carrying a knife and
 9 stating he wanted to stab someone and had thought about
 10 poisoning people? Why weren't multiple reports of his
 11 interest in knives taken more seriously? Why were
 12 knives so readily available to him at his age and
 13 disposition? Did child and adolescent mental health
 14 services provide an adequate service? Was dropping out
 15 of education dealt with sufficiently? Did the police
 16 follow up welfare concerns appropriately or at all?
 17 Were the multiple referrals to Prevent fully dealt with?
 18 Did other agencies rely on the lack of action by Prevent
 19 as evidence that nothing was wrong, or that nothing
 20 could be done? Should more have been done regarding the
 21 attacker's fixation with mass violence? Did he fall
 22 between stools because his obsession with violence was
 23 apparently not ideological?

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

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

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

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

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

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

11 I conclude with three discrete submissions.

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

42

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

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

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

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

25 Indeed, when in force it will mandate

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

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

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

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

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

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

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1 statement.

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

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

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

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

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

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

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

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

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

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

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

13 **SIR ADRIAN FULFORD:** So I can be hopeful?

14 **MR MOSS:** Sir, I hope so.

15 **SIR ADRIAN FULFORD:** Thank you very much.

16 Lancashire County Council, Ms Johnson.

17 **Opening statement on behalf of Lancashire County Council**

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

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

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1 crime.

2 LCC pays tribute to the bravery of the survivors and

3 family mention who have spoken with such dignity in

4 their commemorative portraits and victim impact

5 statements. We recognise the courage that it has taken

6 to speak about the trauma of the attack and to share the

7 immeasurable harm that has changed so many lives.

8 We understand that they have done so because of

9 a belief that the work of this Inquiry is important,

10 a belief that LCC shares.

11 We have listened to the questions that have been

12 asked during those statements and we have also read with

13 care the written openings that have been submitted on

14 behalf of the bereaved parents, the families of the

15 injured children and on behalf of the adult survivors.

16 We would like to say at the outset of this opening

17 statement that we understand why you are asking them.

18 You deserve answers and we will do all that we can to

19 assist this Inquiry to provide them.

20 LCC takes the duty of candour seriously. It

21 understands that approaching the Inquiry with openness

22 and transparency is essential to public confidence. In

23 the written opening, LCC has identified points where it

24 considers things could, and at times should, have been

25 done differently. For that we are very sorry.

1 other features, such as gang affiliation.

2 LCC welcomes the fact that Prevent now accepts

3 referrals for children who pose this category of risk

4 and its experience is this has already strengthened

5 partnership working and the multiagency response.

6 Turning to improvements, LCC wishes to reassure the

7 bereaved, the survivors, their families and the general

8 public that it has been proactive. We are sharing these

9 points in our opening because we understand the

10 importance of knowing that the system will do better in

11 the future.

12 LCC is confident that important changes in

13 multiagency working have already been made, although

14 there is more to be done. The most important

15 development is improved partnership working within the

16 Prevent structure, as I have already mentioned.

17 Internally, LCC has strengthened its strategy to promote

18 the Prevent duty to its staff and to monitor compliance.

19 There are also more interventions available if

20 a young person is not accepted by Prevent. There is now

21 a greater focus within LCC on the assessment of risk

22 posed by children and young people to others, a serious

23 violence toolkit has been developed which offers

24 evidence-based resources and responses. Children's

25 Social Care is now supported by an autism support team

1 Turning to the terms of reference, LCC's written

2 opening addresses and reflects carefully on and in

3 detail its contact with the perpetrator and his family.

4 In this oral opening, we do not propose to focus on the

5 perpetrator. Instead, we make two preliminary points

6 that LCC considers are relevant to the work of this

7 Inquiry and its recommendations for the future.

8 We will then turn to changes that LCC has already

9 made to the services that it provides and its continuing

10 commitment to improvement.

11 The traditional focus of social services has been,

12 and continues to be, on safeguarding children from abuse

13 and neglect. The role of education services is to meet

14 children's educational needs. LCC accepts that it has

15 an important safeguarding role in relation to risks

16 posed by children to others, but the statutory framework

17 that gives local authorities their powers to act was not

18 designed for this and is not well-suited to it.

19 Following on from this, at the time of the

20 perpetrator's contact with LCC, he fell outside the

21 Prevent mechanism. As a result, he was managed through

22 the multiagency safeguarding partnership, at a time when

23 there was not a developed understanding nationally of

24 the risks posed by individuals who had a fascination

25 with violence, but who did not have a single ideology or

1 to ensure that the service can better meet the children

2 who are neuro-diverse. Children's Social Care and early

3 help employees now receive more sophisticated training

4 in working with children with neuro-diversity needs.

5 There is also a greater focus on understanding

6 the risks of online harm with tools and training

7 addressing emerging issues and how to assess and work

8 with children who are at the risk of perpetrating

9 violence. LCC's contextual safeguarding has been

10 strengthened with employees who deal with children

11 missing from home and those who show potentially harmful

12 behaviours now integrated into the multidisciplinary

13 team, strengthening information-sharing.

14 LCC has made technical improvements to enable

15 sharing of records across social care departments and

16 auditing shows that measures taken to improve the

17 quality of record-keeping are effective.

18 Significant work has been done and continues to be

19 done within education to improve SEN and EHCP processes.

20 In addition, LCC now has access to live attendance data

21 so that it is no longer reliant on schools for reporting

22 of issues with attendance and can act on any concerns

23 that are flagged.

24 Undoubtedly there is more to be done. LCC supports

25 the aspiration of this Inquiry to be an engine for

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

6 **SIR ADRIAN FULFORD:** I'm very grateful to you, Ms Johnson.

7 Thank you very much indeed.

8 Mr Browne.

9 **Opening statement on behalf of Sefton Council**

10 **MR BROWNE:** Good morning, sir.

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

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

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

25 The whole borough has come together in so many ways.

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1 A few words about the Inquiry please, sir.
2 Sefton welcomes this Inquiry. It is of critical
3 importance that all understand the events that led to
4 it. Sefton hope that this will help as part of the
5 healing process for all affected, for the community and
6 that all lessons which can be learned are learned. And
7 it is right that we say that it is perfectly clear even
8 at this early stage that lessons are there to be learned
9 and must be learned.

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

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

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

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

55

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

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

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

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

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

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1 Pursuant to section 17(1) of the Children Act 1989:
2 "It is the duty of every local authority ...

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

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

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

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

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

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1 ensure that attendance.

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

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

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

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1 So far as Sefton's awareness and involvement with AR
2 is concerned, they were aware of AR prior to the attack
3 because of his time attending schools within their
4 borough. They were notified by Range when he was
5 permanently excluded over an incident relating to his
6 having a knife in his possession and, as you know, sir,
7 he was permanently excluded from Range on
8 9th October 2019. The exclusion letter was sent to
9 Lancashire and a copy was sent to Sefton.

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

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

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

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1 also had the primary statutory responsibility for

2 ensuring that he received a suitable education.

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

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

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

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

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

4 During his enhanced transition plan he was not known
5 to Sefton school attendance team, as he was subject to
6 an EHCP at that time and there was involvement from
7 Lancashire support services, Sefton did not pursue
8 proceedings for enforcement action in relation to his
9 non-attendance against AR's parents. While he was at
10 Presfield, he was of compulsory school age for only
11 13 weeks, and of those three weeks were school holidays.

12 There were, however, requests made of Sefton for
13 assistance from the designated safeguarding lead at
14 Presfield School, Cheryl Smith, and of her deputy,
15 Jeanette Bannister, firstly on 2 February 2023,
16 a request for support from the Sefton school attendance
17 team which was provided, and secondly a request on
18 20 March 2023, that a welfare visit be undertaken.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 Conclusions.

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

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

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

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

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1 ever happening again.

2 **SIR ADRIAN FULFORD:** Mr Browne, that was very helpful.

3 Thank you very much indeed.

4 **Opening statement on behalf of the Youth Justice Board**

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

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

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

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

19 As Mrs King said:

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

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

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

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

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

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

20 Who is seeing everything at one time?

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

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

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

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

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

12 I will repeat that:

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

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

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

25 The measures proposed by the Board are urgent, we

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

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

13 2022 - 548. 2023 - 550. 2024 - 791.

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

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

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

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

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

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

10 Improvements in the access to and quality of data.

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

13 Strengthened oversight of children who are not in
14 school.

15 Clarity on what constitutes the Youth
16 Justice System.

17 Redefining the standards of that system and
18 strengthening strategic governance.

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

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

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

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

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

25 The introduction of a single case management system
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1 and to make sure that they have at their disposal the
2 skills and services needed to do so.

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

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

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

9 **Housekeeping**

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

16 **SIR ADRIAN FULFORD:** I strongly echo that.

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

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

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

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

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

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

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

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

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1 elsewhere in the building.

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

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

8 **(12.25 pm)**

9 (The Inquiry adjourned until 11 am on Monday,
10 22 September 2025)

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