Witness Name: Mark Winstanley, Jacqui Old, Jane Scattergood
Statement No: 1
Exhibits: 0
Dated: 02.09.2025

SOUTHPORT INQUIRY

JOINT WITNESS STATEMENT OF JACQUI OLD, MARK WINSTANLEY & JANE SCATTERGOOD

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1. Personal details

A. I, **Jacqui Old**, will say as follows: -

1. I am the Executive Director Education and Children's Services for Lancashire County Council.

2. I am the Chair of the Lancashire Children's Safeguarding Assurance Partnership ("LCSAP") Executive Board. I have over 40 years of experience in health and social care, currently serving as the Executive Director for Education and Children's Services at Lancashire County Council. As Chair of the LCSAP Executive Board, I lead multi-agency collaboration to ensure the highest standards of safeguarding and wellbeing for children and young people across the county. I am a Registered Nurse, Health Visitor, and Nurse Practitioner educated to master's degree level. I offer strategic leadership, driving system-wide improvements in children`s services, integrated care, education, and safeguarding. I promote cross-sector partnership and the development of inclusive, child-centred services that improve outcomes and reduce inequalities.

B. I, **Mark Winstanley**, will say as follows: -

1. I am the Assistant Chief Constable (Crime) for Lancashire Constabulary

2. I have held this post since March 2024. In my role I have Chief Officer responsibility for the thematic areas of crime and specialist capabilities, investigations and protecting vulnerable people. Within my role as Assistant Chief Constable ("ACC"), I am the

Delegated Safeguarding Partner ("DSP") for Lancashire Constabulary on the Lancashire Children's Safeguarding Assurance Partnership ("LCSAP").

C. I, **Jane Scattergood**, will say as follows: -

1. I am the Acting Chief Nurse NHS Lancashire and South Cumbria Integrated Care Board ("the ICB"). I commenced in post on 18 August 2025, having previously held the post of Director of Health and Care Integration for South Cumbria within the ICB.

2. In my role I am accountable for all professional leadership themes across nursing, midwifery and the allied health professions. I am the designated accountable officer for statutory functions that the ICB must perform, examples of these functions include quality assurance, patient safety and experience, and safeguarding. I am the board-level executive lead for safeguarding people of all ages. I am responsible for ensuring that the ICB performs its functions effectively as relevant to safeguarding. I am the Delegated Safeguarding Partner ("DSP") for the ICB on LCSAP.

D. This witness statement is provided on behalf of LCSAP in response to the Rule 9 request received dated 5 August 2025.

E. We make this statement jointly as the three DSPs within the LCSAP Executive Board. As detailed in the witness statement of Sam Profitt dated 22 July 2025 **LCSP000003** LCSAP is a partnership arrangement between Lancashire County Council ("LCC"), Lancashire Constabulary and NHS Lancashire and South Cumbria Integrated Care Board ("the ICB") to enable the safeguarding and promotion of welfare of children in Lancashire. LCSAP is not a legal entity or statutory body. As such, the delivery of its functions concerning the incident in Southport on 29 July 2024, as detailed in this statement, is the equal responsibility of each partner agency.

F. The information within this statement is based on a collaborative review of the relevant documentation by the partner agencies unless indicated otherwise.

2.The Rapid Review Meeting

A. The purpose and scope of a Rapid Review Meeting ("RRM")

i. The purpose and scope of an RRM is defined as per statutory guidance: Working Together to Safeguard Children 2023[1] and the Child Safeguarding Practice Review ("CSPR") panel guidance Sep 2022, updated in June 2025.[2]

ii. For the purposes of this statement, We have referenced the September 2022 version of the CSPR Guidance as this was applicable at the time of the incident. Please note there are references within the CSPR Guidance of 2022 to the previous version of Working Together to Safeguard Children 2018.

iii. There are three key stages in the process of learning from serious incidents:

1) Serious incident notification to Panel shared with Ofsted and the Department for Education (DfE).
2) Rapid Review, which should be completed within 15 working days of the notification.
3) Consideration of a Local Child Safeguarding Practice Review ("LCSPR") or national review.

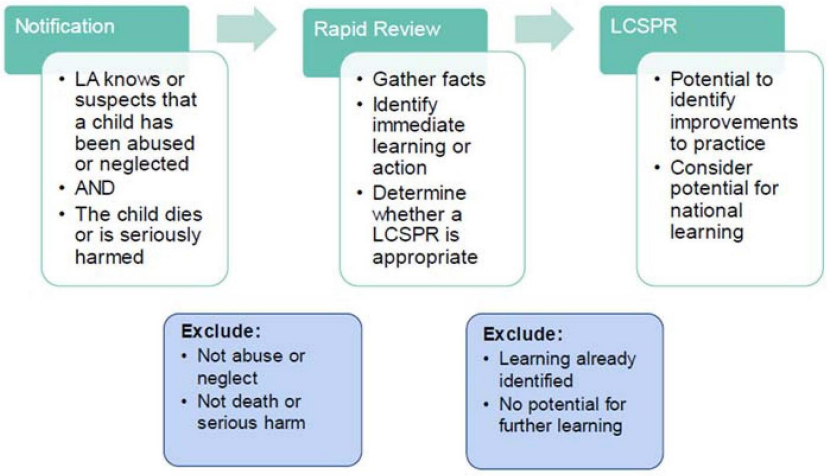
iv. Under the Children Act 2004, if a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if (a) the child dies or is seriously harmed in the local authority's area, or (b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.

v. Although the responsibility to notify rests with the local authority, all three safeguarding partners should agree which incidents should be notified in their local area.

vi. The Child Safeguarding Online Notification System must be used to submit Significant Incident Notifications ("SIN") on all incidents which meet the criteria within 5 working days of the safeguarding partners becoming aware of the incident, followed by the submission of a Rapid Review within 15 working days. Only one notification is needed per incident, regardless of the number of children involved. Please see figure 1 as below:

[1] Working together to safeguard children 2023: statutory guidance
[2] Child Safeguarding Practice Review Panel guidance for safeguarding partners
Child Safeguarding Practice Review Panel: guidance for safeguarding partners

Figure 1: Decision making around reviews



[3]

vii. Safeguarding partners are required to promptly undertake a Rapid Review following all notified serious incidents. Rapid Reviews should identify, collate, and reflect on the facts of the case as quickly as possible to establish whether there is any immediate action needed to ensure a child's safety and the potential for practice learning.

viii. For safeguarding partners, the Rapid Review should conclude with a decision about whether a LCSPR should be commissioned using the criteria set out in CSPR Guidance 2022 (which draws from Working Together to Safeguard Children 2018).

ix. If the decision is to commission an LCSPR, the key lines of enquiry and the questions that are to be answered by the review process should be set out in the conclusion to the Rapid Review. Good practice would be for partnerships to identify what has been learned and how this learning will be disseminated and acted on across the local partnership.

x. The CSPR Panel Guidance 2022 does not prescribe a set format or template for a Rapid Review but highlights the importance of local safeguarding partners acting on learning which is useful to them. It acknowledges, where a case is particularly complex, or the potential for further learning is identified, a Rapid Review, carried

[3] Child Safeguarding Practice Review Panel (CSPR) Guidance (September 2022 - pg.7)

out within tight time constraints, cannot replace the rigour and transparency of an LCSPR.

xi. A Rapid Review reflects the records held by partners. It is a process to quickly identify any single and multi-agency early learning opportunities and to determine what other areas might need to be further examined in more detail. This is especially prevalent in matters that are subject to a criminal investigation as it is accepted that within the short timescale applicable to Rapid Review all relevant information is unlikely to be available.

xii. The panel stipulates that as a minimum; Rapid Review records should consist of:

1) Date of birth, gender, ethnicity of the child(ren) and if they had any disability.
2) Family structure and relevant background information.
3) Immediate safeguarding arrangements for child(ren) involved.
4) Concise summary of the facts.
5) Clear decision and reasons as to whether the criteria for a LCSPR have been met;
6) Any immediate learning and plans for dissemination.
7) Which agencies have been involved and explanation for any agency omission.

xiii. The CSPR guidance also asks the Rapid Review to consider several other factors including race, culture, faith, ethnicity, disability, physical or mental health issues, risk factors, learning from national reviews, identification of good practice etc.

xiv. Page 12 and 13 of the CSPR Panel Guidance 2022 also advises as to other scenarios in which Rapid Review would be appropriate:
"If the harm has been caused by another child, without any evidence of adult involvement or coercion, that would typically constitute child-on-child violence rather than being considered abuse or neglect.

In cases of extra-familial or child-on-child violence without any evidence or suspicion of exploitation or of coercion by adults, decisions on whether to notify and carry out a Rapid Review should be based on whether there are safeguarding concerns associated with the case. In determining this, safeguarding partners should consider the ability of the parents or carers to provide a safe and nurturing environment for the child, the role of different agencies in supporting the child and family, whether the victim was known to children's services as well as the possible

impact of multi-agency action or inaction. For example, risk assessments, school exclusion, failures to address known trauma. In any such cases, consideration should be given to the potential for meaningful learning around safeguarding in deciding whether to undertake an LCSPR."

B. How the RRM was convened

i. The Rapid Review process is engaged on receipt of the notification to the Local Authority that a child has been seriously injured or killed. Generally, the police will be the first agency to become aware of the incident, with the Child Death Overview Panel SUDC (Sudden Unexpected Death in Children) nurses notified and in attendance soon after. Whilst the LA will then be notified, any of the safeguarding partners can put in a request for Rapid Review. This case was referred into the business unit by Det.Supt Neil Drummond (now retired) in the Vulnerability and Governance Unit at Lancashire Constabulary, who requested an urgent meeting between the partners on the day following the index event (30 July 2024).

ii. The meeting on 30 July 2024 was attended by senior leaders of the three safeguarding partners in Lancashire (LCC, Lancashire Constabulary and the ICB). Those in attendance were: Det.Supt Neil Drummond; Ann Dunne, Director of Safeguarding at the ICB; Louise Anderson Director of Childrens Social Care, LCC; Andy Smith (now retired) was at the time, the Head of Service for Safeguarding, Inspection & Audit Service within LCC and Medina Patel, Senior Business Manager, Lancashire Safeguarding Business Unit ("LSBU").

iii. The attendees discussed whether the criteria for a formal learning review was met in respect of the victims. Whilst the deaths were not as a consequence of abuse or neglect but it was nevertheless considered that the circumstances would warrant a Rapid Review, focussing entirely on AR (as we have outlined above - paragraph 2a xiv).

iv. There was discussion as to what was known about AR between the different services but given the short time since the index event, a full picture was not available. It was decided that Andy Smith would chair the RRM and that further meetings would need to take place to give consideration as to its participation from other agencies. There

was an initial consideration that the RRM timeline should be from 2019 onwards and a proposal for the preliminary date for the RRM to be on 6 August.

v. Whilst not the focus of the meeting, Det.Supt Drummond also flagged safeguarding issues concerning ARs family. He was in custody at the time and it was known that he was in the middle of a mental health assessment, he had a disabled sibling and the police were in the process of safety planning regarding this.

vi. It was determined at the meeting that LCC were to take the lead on submitting the SIN, however, as the incident had occurred within the boundaries of Sefton Council, communication took place between Sefton Council to discuss which would be the appropriate lead. Sefton partnership's business unit were also consulted to aid the preparation of the chronology and identify participants to the RRM before the SIN was lodged. As demonstrated in **LCC000789** the SIN was submitted on 2 August 2024.

vii. LCSAP worked collaboratively with Sefton Council to navigate the relevant guidance and legislation taking into account the unique set of circumstances of this tragic incident. We determined that LCSAP would be the appropriate partnership to lead on the RRM with the assistance of the Sefton Partnership.

viii. As evidenced in **LCC000801**, **LCC000804**, **LCC000836**, **LCC000809** and **LCC000839** discussions took place both over the telephone and via email between the LSBU, Senior Business Manager, Medina Patel and the National Panel Secretariat:

1. To clarify which partnership should convene the Rapid Review and practical considerations relating to this e.g. which authority should submit the SIN and how a joint RRM with one authority leading could be appropriate.
2. To request an extension to the submission date of the RRM to 30 August 2024 which was agreed by the National Panel Secretariat (**LCC000809**).
3. As the focus of the Rapid Review would be solely on AR clarity was sought (and it was subsequently agreed by the Secretariat) as to the appropriateness of not seeking information to produce chronologies on the victims who would be subject of Child Death Review processes and inquests.

ix. A letter was drafted to be sent to the National Panel jointly by Childrens Social Care leaders at LCC and Sefton Council (**LCC000839**) confirming a proposed joint

approach to the RRM. This letter was not however required and left unsent as the National Panel Secretariat confirmed its agreement with our proposal for a Rapid Review on AR to be convened, led and directed by the LCSAP.

x. LCSAP's liaison with Sefton in relation to the SIN was completed over 2 days which did not impact on the 5-day timeframe ordinarily applicable to submission. Thereafter, whilst discussions with National Panel were ongoing between 5 and 7 August 2024 LCSAP continued to progress with the arrangements for the Rapid Review. Again, this communication/liaison did not impact or cause delay to the progression of the Rapid Review. The extension sought was premised on the degree of complexity of the case, requiring detailed chronologies from multiple agencies spanning the two partnership boundaries, some of which were still dealing with the response to the index event (**LCC000809**).

xi. On behalf of CSAP, the LSBU convened the Rapid Review meeting, providing administrative and business support for the process.

C. Convening the RRM on 27 August 2024

i. The LSBU have a standard distribution list of Single Point of Contact (SPOC's) for agencies in Lancashire who we send information to on all SINs to identify if the child and family subject of the Rapid Review is known to services. This enables LCSAP to determine who needs to participate in the Rapid Review meeting (**LCC001270**).

ii. The LSBU would then send out the chronology template for information to be gathered from agencies who have worked with the child and family.

iii. Andy Smith was the Independent Chair of the Rapid Review panel.

iv. Further to the meeting that took place on 30 July 2024 (as described at §2B (ii-v) above) the following actions also occurred that day to progress the RRM:

1. Several meetings took place between Andy Smith, Medina Patel and Lisa Slack, Head of Service, Adult Social Care at LCC to discuss logistics of the Rapid Review.

2. Within LCC, Childrens Social Care, Adults Social Care and Education provided details of the schools and services who had engaged with AR and his family to enable the LSBU to reach out to providers. This was complicated by reason of

the fact the index event had occurred during the school holidays but was nevertheless achieved within hours of identifying the need for a Rapid Review.

3. Medina Patel was in regular communication with her counterpart, Tracey Overs, the Business Manager of the Sefton Safeguarding Childrens Partnership who agreed to disseminate the request to agencies in their partnership.

4. Through discussions with partners, in particular Ann Dunne at the ICB and Tracey Overs, we were able to determine health providers (and the relevant contact details within those organisations) who had engaged with AR and his family, namely Alder Hey Childrens Hospital NHS Foundation Trust ("Alder Hey") and Mersey Care NHS Foundation Trust ("Mersey Care").

5. On receipt of Children's Services Serious Incident Briefing for AR which mentioned the CAF (child and family) assessment from April 2020 it was noted that there was a reference to the Counter Terrorism Police North West ("CTPNW") Prevent team having assessed AR and closed their involvement.

v. On 30 July, Medina Patel contacted Garry Fishwick, Review officer within the Lancashire Constabulary HQ Vulnerability Governance Unit, to request he link in with CTPNW in relation to the Prevent information and whether referrals were dealt with by them or went through to the Pan-Lancashire Channel/Dovetail Team based in Blackburn with Darwen Borough Council.

vi. At 16:03pm on 30 July, Detective Superintendent Geoff Tachauer, Regional Operations for CTPHQ provided Gary and another colleague with a response regarding their request for information. He advised that CTPNW would be reviewing their casework and utilising their own multi-agency structures and processes to review any involvement they had previously. This established review process was best placed to identify any learning and to dock into the relevant CTPNW structures, where change in process or policy were necessary.

vii. Due to this, CTPNW were not in a position to supply any information to locally commissioned reviews at that time. They would be following their own national processes for review activity and supporting statutory review processes (e.g. Child Death Reviews or Serious Case Reviews) where these were to be commissioned. If

through this process they identified any learning relevant to public protection, they would look to see how they could be shared. Similarly, if we identified any learning for CTPNW through our review, they would like that to be shared with them.

viii. Garry forwarded the email to the LSBU confirming no Prevent information would be included in the chronology provided by Lancashire Constabulary (**LCC001318_0001-0002**).

ix. This matter was escalated by Lancashire Constabulary with CTPNW colleagues. Unfortunately, it could not be resolved prior to the RRM taking place. Subsequently the Senior National Coordinator for Counter Terrorism Policing communicated their commitment to engaging fully with any future CSPR (**LCC000797**).

x. Following receipt of the responses to the chronology request sent on 30 July 2024 (**LCC001270_0001-0002**), the Rapid Review Chair and lead safeguarding partners determined the agencies who needed to attend, based on whether AR and his family were known to them. These agencies then identified who was best placed to attend from their organisation/service. Panel members needed to have sufficient knowledge of AR and his family's engagement with their agency, awareness of the safeguarding system and single/multi agency learning being senior enough to constructively engage in challenging discussions on multi agency practice.

xi. Invitations to the RRM were therefore sent to the following individuals:

Name	Role	Agency	Reason for Invite	Attendance
Nichola Osbourne	Associate Director for Safeguarding and Statutory Service	Alder Hey	Alder Hey were delivering the CAMHS service for AR and family	Yes
Dr Sally Al-Bachari	Consultant Psychiatrist	Alder Hey	Alder Hey were delivering the CAMHS service for AR and family	Yes
Karen Garside	Designated Nurse for Safeguarding Children,	Cheshire and Merseyside NHS ICB	Representative of NHS Cheshire and Merseyside ICB who commission the majority of Health Services for AR	Yes
Adele Farrell	Lead GP,	Christiana Hartley Medical Practice	GP Service for AR and Family	Yes
Rebecca McGeown	Lead for Safeguarding and	HCRG Care Group	0-19 Service providing school nursing and attended AR strategy meetings	Yes

Name	Role	Agency	Reason for Invite	Attendance
	Children in Care (Lancashire),			
Anna Howarth	Named Nurse for Children in Care and Care Leavers	Lancashire and South Cumbria Foundation Trust	Completed health assessments for AR and provided consultations for school	Yes
Nick Connaughton	Detective Chief Superintendent	Lancashire Constabulary	Statutory Partner. Police involvement with AR and family	Yes
Jessica Hyett	Information, Advice Support Officer, SENDIAS service	Lancashire County Council	Provided support to school and family of AR	Yes
Paul Turner	Director of Education,	Lancashire County Council	Strategic lead for Education services for local authority	Yes
Lisa Slack	Head of Service, Adult Social Care	Lancashire County Council	Adult Social Care assessment of AR as part of transitions	Yes
Georgine Lee	Head of Service, Front Door assessment and Adolescent Services, LCC	Lancashire County Council	Statutory Partner. Children Social Care representative for Lancashire	Yes
Colin Clements	Team Manager, Child Youth Justice Services,	Lancashire County Council	Supporting AR and Family through Youth Justice Referral Order	Yes
Sarah Callon	Senior Manager, Child Youth Justice Services,	Lancashire County Council	Supporting AR and Family through Youth Justice Referral Order	Yes
Kathryn Ashworth	Head of Service, Child Family Wellbeing Service	Lancashire County Council	Support for AR and Family through Early Help Referral and assessment	Yes
Sharon Barrett	Senior Family Support Worker, CFW,	Lancashire County Council	Support for AR and Family through Early Help Referral and assessment	Yes
Mark Howe	Principal Social Worker, Adult Social Care,	Lancashire County Council	Adult Social Care assessment of AR as part of transitions	Yes
Andy Smith	Head of Service, Quality Assurance Inspection and Safeguarding	Lancashire County Council	Independent Chair of Rapid Review	Yes
Vaishali Bamania	QA and Performance Coordinator,	Lancashire Safeguarding Business Unit	Note taking and completing Rapid Review outcome form	Yes
Medina Patel	Senior Business Manager,	Lancashire Safeguarding Business Unit	Note taking and completing Rapid Review outcome form	Yes

Name	Role	Agency	Reason for Invite	Attendance
Helen Hargreaves	Designated Nurse, Safeguarding Children	Lancashire & South Cumbria ICB	Statutory Partner.	Yes
Angi Cullen	Named Midwife/Safeguarding Children Specialist Nurse,	Mersey and West Lancashire Care Group	Support for AR and Family through delivery of Health services and provision	Yes
Barry Greene	Named Nurse Safeguarding Children,	Mersey Care NHS Foundation Trust	Support for AR and Family through delivery of Health services and provision	Yes
Sue Hinds	Detective Chief Inspector	Merseyside Police	Police involvement with AR and family	Yes
Tracy McKeating	Interim Head of Service, Education,	Sefton Council	Sefton Council Education Services (on behalf of Presfield School)	Yes
Joe Banham	Assistant Director, QA and Safeguarding, Sefton Childrens Social Care	Sefton Council	Strategic Lead for Children Social Care, Sefton	Yes
Tracey Overs	Business Manager	Sefton Safeguarding Partnership	Sefton Partnership Liaison	Yes
Joanne Hodson	Headteacher	The Acorns School	Education provision for AR and Family engagement	Yes
Lucy McLoughlin	Headteacher	Presfield School	Education provision for AR and Family engagement	No - out of the country, Tracey McKeating covered
Rosie Goodwin	Named GP for safeguarding	Cheshire and Merseyside ICB	Representative of NHS Cheshire and Merseyside ICB who commission the majority of Health Services for AR	No - on leave, Karen Garside attending
Sharon Kelly	Head of Safeguarding Children and Children in Care	Lancs & South Cumbria ICB	Statutory Partner.	No - Helen Hargreaves attended
Rachael Strutz	Business Manager	Lancashire Safeguarding Business Unit		No - not required, Medina Patel attended
Laura Morris	Sendias Service	Lancashire County Council	Service provided support to school and family of AR	No (invited but Jessica Hyett attended as representative)

D. Procedural considerations relevant to the RRM on 27 August 2024

i. As outlined at §2B(vi-x) above, there were some procedural considerations relevant to the RRM but no difficulties existed in terms of the two partnerships and how they intended to proceed with the Rapid Review. The SIN was submitted on 2 August 2024 with ongoing dialogue with the National Panel about their interpretation of the guidance over the next two working days, 5 and 6 August 2024, which was resolved.

ii. A Memorandum of Understanding ("MoU") was drafted by LSBU which outlined the role of the two partnerships in relation to the Rapid Review (**LCC000783, LCC000784** and **LCC000798**)

iii. The importance of the Sefton Safeguarding Children Partnership being involved in the Rapid Review was reinforced as AR and his family were known to services across the two areas. The MoU was amended with a further point of clarity to reaffirm both Lancashire & South Cumbria ICB and Cheshire & Merseyside ICB would collectively work in partnership to ensure all health providers participated in the Rapid Review. This is due to the service provision being primarily commissioned by Cheshire & Merseyside ICB although Lancashire & South Cumbria ICB would be the health safeguarding partner decision maker on the Rapid Review.

E. Material available to the RRM

i. The LSBU has a standard distribution list of SPOCs (Single point of contact) for agencies in Lancashire, who we send information to on all SINs, to identify if the child and family subject of the Rapid Review is known to services. This enables CSAP to determine who needs to participate in the RRM (**LCC001270**).

ii. The LSBU then send out the chronology template for information to be gathered from agencies who have worked with the child and family. LCSAP do not have direct access to single agency material i.e. social care record, medical history, education health care plan etc. The LSBU are reliant on each agency completing the chronology template, providing a salient summary of the interactions, service provided, and any learning and good practice identified.

iii. LSBU then extract the information on the single-agency chronologies received and amalgamate this into a multi-agency chronology within an information pack to inform the RRM attendees (**LCC001235**). The SPOCs are asked for relevant, proportionate information that is pertinent to the Rapid Review and the circumstances of the incident. This is limited to a summary of that information as directed within the chronology template. It does not request or require records or additional information/documentation to be annexed or attached and is therefore limited summary information. Unless any information is marked within any single agency chronology as being withheld then the information provided is not restricted.

iv. The combined chronology is analysed by the LSBU in conjunction with the chair to identify key learning, good practice and themes which are already addressed in previous local or national reviews.

v. All panel members are required to sign a standard template prior to the RRM (**LCC000880**).

vi. **LCC001191** is the agenda for the Rapid Review based on a standard template (this is a standalone document).

vii. **LCC001235** is a combined pack of documents, sent out in advance of the RRM, for all panel members' preparation and consideration. This includes the agenda, referral form, family information sheet and combined multi-agency chronology.

viii. As previously highlighted, there was no information regarding Prevent from CTP (**LCC001318**) in the Rapid Review, which left a gap in the understanding of decisions undertaken. The Rapid Review identified this was a key line of enquiry to be explored in the LCSPR.

ix. Medina Patel was part of the expert group supporting the Department for Education to update the CPSR Panel guidance and feedback provided has led to the June 2025 iteration to have a specific section on Prevent and CTP information for reviews.

F. The interaction between the RRM and other investigations, including the Merseyside Police criminal investigation/prosecution

i. Rapid Review is not ordinarily impacted by an ongoing police investigation. It is accepted that the short timescales within which it is to be completed is very often too soon for relevant information to be provided or of assistance to the Rapid Review. A Rapid Review will therefore ordinarily proceed in the absence of such information. The interaction with Merseyside Police therefore did not impact or influence the progression of the Rapid Review.

ii. Lancashire Constabulary and Merseyside Police were in regular discussions in the aftermath of the incident and during the criminal investigation (gold meetings, DCI Hinds with DSI Neil Drummond etc.)

iii. Merseyside Police were part of the Rapid Review process with DCI Hinds in attendance at the panel meeting. The Rapid Review outcome was shared with panel members including DCI Hinds on 30 August 2024.

iv. On 1 September, DCI Hinds asked Andy Smith if the document could be shared with the SIO for inclusion in the investigation policy books. Following consultation with the CSAP Executive, LSBU were seeking legal advice in relation to the request and asked for further clarification on the purpose from the Senior Investigating Officer, Jason Pye (**LCC000807**)

v. There was further communication with the SIO Jason Pye and Medina Patel. Merseyside Police had thought the Rapid Review outcome was a LCSPR report, when they realised it wasn't, they withdrew their request for it to be included in their investigation policy book and confirmed they would wait for the LCSPR report when it was completed. Medina Patel advised Jason Pye that she would be in contact with him as soon as the National Panel had ratified the decision by LCSAP to initiate a LCSPR. A meeting would then be scheduled to discuss how the LCSPR would proceed alongside the criminal investigation, with himself, CTPNW and LCSAP colleagues.

vi. Multi Agency Review Coordination Meetings were scheduled with attendance from Medina Patel (Chair), Jason Pye (Merseyside Police SIO), Det. Chief Supt. Nick

Connaughton (Lancashire Constabulary, Head of Vulnerability Governance Unit), Dave Wells (Head of Prevent, CTPNW), Elizabeth Ratcliffe (Regional Head of Nursing, Safeguarding & Investigations Lead NHS England - North West) and Carolyn Cassie, (Senior Programme & Case Manager, NHS England – North West Region).

vii. These meetings were held monthly. Their purpose was to share information in relation to the forthcoming LCSPR and for each agency to provide salient updates and discuss the logistics of parallel proceedings i.e. criminal investigation, LCSPR, connectivity with the work of CTPNW in relation to Prevent etc. The group acknowledged the importance of consultation and a coordinated agreement in relation to the approach to both the child and all families, recognising there were many sensitivities to consider as well as legal aspects.

viii. The LSBU and Merseyside Police continued to communicate, following the criminal conviction, in relation to the decision to pause the LCSPR and how this was communicated to the victims and their families.

G. The RRM agenda

i. The LSBU have a standard agenda template for all Rapid Reviews which is based on the CSPR Panel Guidance (in this RRM, from 2022 - **LCC001191**).

ii. LSBU staff met with the Chair, Andy Smith in advance of the Rapid Review to prepare for the meeting and drafted a supplemental, briefing agenda for him which included information pertinent to his role and specific to this case:

1) Housekeeping (meeting was in person),
2) National Panel advice in terms of the details of victims,
3) Support for staff involved in the incident and thereafter
4) Terms of reference
5) Rapid Review category: Other
6) Rapid Review process and decision making
7) Attendees
8) Key lines of enquiry – the RRM will aim to identify what these should be however as we outlined above (§2E(iv)), the LSBU had already analysed the

multi-agency chronology and identified some areas to focus on within the context of the Rapid Review criteria. These were as follows:

- *Transition to ASC aged 15 in August 2022 – what was the result of this?*
- *Did ASD have an impact on his behaviour and offending?*
- *Record keeping – timeliness, details, supervision – with respect to all agencies, have mechanisms been put in place to address these issues?*
- *Neurodiversity, EHCP, CME*
- *Cultural competence and response taking into account his ethnicity, culture. Family history (Rwanda)*
- *Impact of Covid*
- *Prevent referrals*
- *Bullying/paranoia*
- *Cross border working*
- *Engagement with the family*
- *Multi-agency meetings and risk assessments – were the right agencies involved at the right time?*

9) Other reviews with similar themes

H. The RRM on 27 August 2024

i. An overview of the discussions and the decisions made, during the meeting can be seen at **LCC001234** and **LCC000786**. **LCC000786** is a summarised version of the contents of the chronology and the information provided in the meeting, and not detailed minutes.

ii. In summary, the RRM invited each agency to summarise its involvement with AR following which some learning was highlighted. This included the poor attendance at EHCP review meetings and the knock-on effect this would have on the decision-making capability of the SEND case workers in so far as their knowledge of AR being up to date. Good information sharing was noted generally but no single, overarching meeting bringing this (including individual agency risk assessments) all together. This impacted the ability of agencies to form a full picture of AR. The meeting concluded that there was a lack of connectivity within both health and social care systems across the sectors and this hindered professionals from obtaining a full picture. There were also missed opportunities for the escalation of

safeguarding concerns to take place in supervisions which did take place but the frequency, record keeping and follow up could be strengthened.

iii. It was also unclear as to whether the impact of AR's neurodiversity was fully understood and whether this impacted on his behaviour and the index incident. It was felt that more could have been done to understand AR's family dynamics and how this might have impacted AR.

iv. The RRM reached a determination that a LCSPR would be appropriate (**LCC000786_0013-0014**). In summary the RRM considered the threshold to have been met and raised issues of both local and national significance. The key lines of inquiry were determined to be as follows:

a. The impact of the EHC (Education Health Care) to support Child AR.
b. The understanding by agencies of Child AR's neurodiversity and mental health support and impact on his behaviour.
c. Risk Assessments: how they were used on this case by both single and multi-agency, the assessment tools used and their impact.
d. The response to the multiple Prevent referrals and potential missed opportunities for multi-agency information sharing, risk assessment, oversight and intervention from an early help, prevention perspective.

v. At the point of submission to the National Panel on 30 August 2024, there was no requirement (within the 2022 CSPR Guidance) to attach an action plan. Under the revised 2025 CSPR guidance however this is now mandated.

vi. Nevertheless, on 12 September 2024, the LSBU circulated to relevant agencies in Lancashire and Sefton, an initial draft of the Action Plan which detailed learning identified at the Rapid Review. Agencies were requested to complete columns titled, *Improvement Action, Further actions planned, Evidence of progress & Impact, Lead/Responsible Officers and Timescale.*

vii. A meeting took place on 17 October 2024 to discuss the action plan which has been subsequently kept under review by both Lancashire and Sefton Safeguarding Partnerships.

I. Documenting the RRM

i. Notes were taken electronically by staff from the LSBU, namely Medina Patel and Vaishali Bamania (LSBU Business Coordinator) during the Rapid Review meeting to aid the drafting of the Rapid Review meeting outcome (**LCC000786**).

ii. The outcome was shared with Andy Smith, Medina Patel and the three representatives of the Lancashire Safeguarding Partners, namely Georgine Lee (Head of Service, Front Door, LCC), Helen Hargreaves (Head of Safeguarding Children and Children in Care, the ICB) and Nick Connaughton (Chief Superintendent, Lancashire Constabulary) for comments and review. Some further amendments were made before the final version (**LCC000786**) was ratified and shared with the National Panel, panel members and senior leaders of the three Lancashire Safeguarding Partners.

iii. It is not standard practice for the LSBU to take formal minutes of Rapid Review meetings, which routinely take place online via MS Teams. However, due to this Rapid Review taking place in person, the complexity of the case and several members of the LSBU supporting the process (due to peak summer leave period), to aid internal record keeping, the Senior Business Manager, Medina Patel asked the team to draft up the notes onto the standard CSAP minutes template. This document (**LC001234**) was completed retrospectively and not disseminated to panel members.

J. Confidentiality of an RRM

i. The Confidentiality Clause quoted in **LCC000871** and **LCC000872** is standard practice and included in the Lancashire CSAP Rapid Review Meeting agreement.

ii. It specifically relates to multi-agency information that agencies receive as part of the process, which they normally would not have access to in their own single agency record keeping and case management. For example, the multi-agency chronology collated by the LSBU consists of personal information relating to not only the child subject of the review, but family members and other children from a range of organisations including health, school, social care etc.

iii. The clause explicitly advises panel members to retain information submitted to the Rapid Review by their own agencies as per their own agency's information governance process.

iv. The LSBU retain all information sent to them by single agencies as part of the Rapid Review process including documents that have been collated and disseminated to panel members as per the LCC retention policy.

v. In this Rapid Review, the confidentiality clause was explicitly highlighted due to the high-profile nature of the case, the significant media and political attention and the need to minimise any potential risk of information leaks with an ongoing criminal investigation whilst being sensitive to the victims and families.

K. Sharing the RRM outcome and material available to it

i. All requests to the LSBU for the Rapid Review meeting outcome to be shared with any individual or agency who would not normally receive it were flagged to the CSAP Executive for consideration, with advice being sought from Legal services or Information Governance. Consultation with Merseyside Police took place when required.

ii. CSAP were highly cognisant of the sensitive nature of the contents of the Rapid Review, the high level of public interest, the need to preserve the integrity of the ongoing criminal proceedings and the importance of confidentiality within the investigation.

iii. The Rapid Review Meeting Outcome (**LCC000786**) was shared with the National Panel, who informed the LSBU they had shared the document with senior officials within the Department for Education on a confidential basis, citing Working Together to Safeguard Children 2023 (**LCC000803**).

iv. As we have outlined above at §2F(iv), on 1 September, DCI Hinds asked Andy Smith if the Rapid Review Meeting outcome could be shared with the SIO for inclusion in the investigation policy books. Clarification on the purpose of the request was sought (LCC000807) and there was further communication as regard to this request with Merseyside Police, the National Panel and Safeguarding

Partners (as detailed above at §2F(v) and **LCC000807, LCC000810, LCC000812, LCC001195, LCC000817, LCC001219, LCC001223, LCC001224, LCC000792, LCC000816, LCC001322**).

v. On 4 October 2024 Medina Patel shared the outcome of the Rapid Review with Elizabeth Ratcliffe (Regional Head of Nursing, Safeguarding & Investigations Lead NHS England Northwest) (**LCC001310**). The circumstances of the Southport incident met the criteria for an independent Mental Health Homicide Review ("MHHR") to be undertaken by NHS England. Acknowledging the issues that multiple reviews could create i.e. duplication and cost of several parallel processes, impact on families and practitioners etc, discussions took place between the Lancashire CSAP Executive, NHS England and the National Panel. Following which, it was agreed that in lieu of a separate MHHR, the CSPR would incorporate this element, with NHS England recruiting an independent expert consultant to support the LCSPR.

vi. During October 2024, Lancashire Constabulary had two information sharing requests from CTP to enable them to brief the Home Office. The initial request was for access to the multi-agency chronology from the Rapid Review which was rejected as being disproportionate in terms of this containing sensitive and confidential personal information that must not be shared without a legitimate and necessary purpose. The meeting was also subject to a confidentiality agreement.

vii. This was responded to by Lancashire Constabulary and led to a second request to their Deputy Chief Constable (**LCC000833**). Medina Patel and DCS Nick Connaughton agreed advice would be sought from the National Panel, Legal and Information Governance in relation to the request. This would then be collated and circulated to the CSAP Executive for a viewpoint before a response was sent to CTP.

viii. A letter was sent to DAC Vicky Evans, CTP Headquarters and ACC Potts on 30 October 2025 asking for further clarity on their request including the legal basis, what information specifically was requested and what they intended to do with the information including who it would be shared with and how.

ix. A formal request for information was sent by CTPHQ to the LSBU on 15 January 2025. On 16 January 2025, a response was provided which included a briefing

document that had been shared with No 10's Private office, the Home Office and was due to be shared at the time with the DfE deputy director who led on serious incidents. This document contained no personal identifiable information and was produced by the Lancashire CSAP for the purpose of providing a confidential briefing to specified persons (**CSPRP000019**).

x. **LCC001167** relates to an email which was not sent to CSAP or the LSBU but to LCC's Director of Public Health, Dr. Sakthi Karunanithi on 11 December 2024 from Adam Bernstein who led on Prevent in the Cabinet Office and worked with No.10 on the post Southport follow up. Adam was querying if a statutory Rapid Review had been undertaken and requested a few lines on the scope.

xi. There was some initial confusion in the communication as to whether the report had been shared with the Home Office which led to Adam also requesting a copy of the review.

xii. Following consultation with the LSBU, Sakthi provided further clarity that a Rapid Review had been undertaken as per the statutory guidance and shared with the National CSPR Panel. A LCSPR would be commissioned focusing on key lines of enquiry including Prevent. Sakthi included details of how Adam could formally request information and recommended CTPHQ be contacted with regard to its internal Prevent Review.

xiii. On 10 January 2025, National Panel liaised with CSAP via the LSBU regarding a request from the Prime Minister's Office for a copy of the Rapid Review to enable No.10 to prepare for interest in the trial. CSAP sent a response to them on 13th January 2025 (**LCC001174**).

xiv. During the consultation, National Panel advised they had also received a request for the Rapid Review outcome from the Home Office. Medina Patel agreed with the National Panel that a similar response could be drafted for them as well, with the offer of a briefing note and meeting to provide context (**LCC001171**, **LCC001172** and **LCC001178**).

xv. A meeting held with the National Panel, CSAP Partners, DfE, No. 10 Cabinet Office and the Home Office on 16th January (**LCC001185_0008**). The briefing note was shared with various departments within the DfE including special advisors

("SpAds"), the Private Sectary to the DfE Secretary of State and the Deputy director job-share who led on serious incidents in the DfE. The LSBU reiterated to the National Panel of sharing on a 'need to know' basis, who confirmed they would not run every name by CSAP and would make a judgment call, restricting this to a very small number of 'need to know' senior officials (**LCC001185**).

xvi. The then chair of the National Panel, Annie Hudson also made contact with Louise Anderson, Director of Childrens Services for Lancashire County Council on 19 January 2025 regarding sharing the Rapid Review outcome with the Secretary of State for Education, Bridget Phillipson (**LCC001186**). The Rapid Review was shared by the National Panel.

xvii. **LCC001584** refers to a letter from CSAP in response to a request from the CQC for the Rapid Review outcome. It provided an explanation as to why the document would not be shared and provided information for them on the involvement of Adult Services in the Rapid Review process.

3.The decision to initiate a Local Child Safeguarding Practice Review

A. The relationship between a RRM and an LCSPR;

i. We have outlined the process leading from the RRM to a LCSPR at §§2A and 2H above.

ii. It is important to note the Rapid Review is an initial review. Wider information which was not available at the time of the Rapid Review will be taken into consideration during the LCSPR which provides a more detailed analysis, the findings of which could differ from those of the Rapid Review.

iii. The CSPR process itself is confidential and led by independent reviewers supported by Safeguarding Partners.

iv. The CSPR is a systematic investigation of serious child safeguarding cases to identify improvements in practices and prevent future incidents of abuse or neglect.

B. Other options available besides initiating an LSCPR

i. There are other options available besides initiating an LSCPR which are considered as part of the RRM and form part of the outcome (**LCC000786_0012 - 0014**):

1) Immediate action to ensure the child (or siblings) is safeguarded
2) Immediate and potential learning and improvement
3) National Review – If the case highlights or may highlight on a national level, improvement needed to safeguard and promote the welfare of children, including where those improvements have been previously identified; and/or the case raises or may raise issues requiring legislative change or changes to guidance issued under or further to any enactment; and/or the case highlights or may highlight recurrent themes on a national level in the safeguarding and promotion of the welfare of children.
4) No review required but any local learning noted and acted upon

C. The decision

i. It is for safeguarding partners to determine whether a LCSPR is appropriate, using the criteria set out in Working Together, considering the overall purpose is to identify improvements to local practice and wider systems.

ii. The decision to initiate a local CSPR into this case (as detailed above at §2H(iv) was agreed by the three safeguarding partner representatives at the Rapid Review panel (**LCC000786_0015**) Georgine Lee, Nicholas Connaughton and Helen Hargreaves.

D. When this decision was taken

i. The decision was taken on 27 August 2025 during the RRM.

E. How this decision was recorded

i. The Rapid Review outcome template was used to set out a clear rationale for undertaking an LCSPR and included the key lines of enquiry the LCSPR would seek to answer (**LCC000786)**.

F. Input from the National Child Safeguarding Practice Review Panel (CSPRP) in respect of this decision

i. As per the CSPR guidance, the outcome of the Rapid Review is shared with the National Panel to enable them to discharge their function and maintain oversight of the system for national and local reviews. In relation to Rapid Reviews, they offer feedback on the decision making, analysis and learning as well as comments on the key lines of enquiry for the LCSPR.

ii. It is standard process for CSAP to wait for the feedback from the National Panel, which is always in a letter form, before the outcome of the Rapid Review is communicated wider or steps taken to initiate the LCSPR.

iii. Whilst the National Panel will offer a view, the ultimate decision to progress to a LCSPR is a local one for which safeguarding partners are accountable.

iv. The feedback in the communication with the panel (**CSPRP000003/LCC000855**) was taken into consideration and shaped the Terms of Reference of the LCSPR.

v. Members of the National Panel and key representatives from LCSAP including the chair of the Rapid Review met on 3 October 2024 to discuss the feedback in more detail and to understand the links between the LCSPR, criminal investigation and other processes (**CSPRP000004**)

vi. National Panel continued to provide CSAP with ongoing advice, support and challenge throughout the review process.

G. The timelines set for the LSCPR

i. Although Working Together to Safeguard Children sets out a 6-month timescale for LCSPRs this is not mandatory as it is not always possible in complex cases with overlapping elements, parallel processes and criminal proceedings. It is standard practice for LSBU to keep the National Panel updated on any delays to the timescales of a LCSPR and why.

ii. The start date for this LCSPR was anticipated to be January 2025. CSAP commenced work to recruit a panel of reviewers, a lead reviewer to author the report and a deputy with expertise on Education Health Care and SEND in October 2024. NHS England were responsible for recruiting an individual to provide expertise on Mental Health and Neurodiversity.

iii. All parties were acutely aware the progress of the CSPR would need to be carefully coordinated with the ongoing criminal proceedings. The initial provisional date for the criminal trial to start was March 2025, with an anticipated duration of 5 – 6 weeks.

H. Announcing the initiation of the LSCPR

i. On 22 January 2025, at an in-person pre-sentence media briefing, organised by Merseyside Police at their headquarters, statements were read out by ACC Mark Winstanley, then Chair of the Lancashire Child Safeguarding Assurance Partnership (LCSAP) and Louise Anderson, Director of Children's Social Care at Lancashire County Council.

ii. During the briefing ACC Winstanley explained that the Partnership had commissioned an Independent CSPR to look at the roles of all the agencies involved with AR and this review would commence the following month. The information was embargoed until after the sentencing which was due to take place on 23 January 2025.

iii. The CSAP statement was also shared in a written format with the media as part of this briefing

I. LCSAP's intention to initiate and announce the LCSPR vis-à-vis a potential Public Inquiry

i. **CSPRP000012** is an internal email between the National Panel Secretariat to Senior leads in the DfE summarising a meeting on 3 October 2024 between CSPRP and LCSAP. Within this email is the suggestion that LCSAP were *"very much hoping to avoid calls for a public enquiry by being on the front foot and having their LCSPR ready to go as soon as possible after the trial concludes".*

ii. This email was not shared with LCSAP or the LSBU until the Rule 9 request dated 5 August 2025. The letter sent by the National Panel to CSAP following this meeting (**CSPRP000004**) did not reference this discussion.

iii. **CSPRP000013** are minutes of this meeting, recorded by the National Panel Secretariat and reflect informal notes undertaken by LSBU staff. Neither of which include any comments to infer LCSAP were in any way, hoping or intending to avoid calls for a public inquiry.

iv. National Panel member Ian Critchley highlighted during the meeting that information could come out in the trial which may lead to a Public Inquiry and questions may arise as to if a LCSPR was required. Louise Anderson confirmed that no government agencies had mentioned a Public Inquiry. LCSAP wanted to move at pace to publish the public elements of the LCSPR as soon as possible after the criminal proceedings had concluded, as this was important in terms of public confidence.

v. LCSAP decided to initiate a LCSPR at the Rapid Review meeting on 27 August 2025. The possibility of a Public Inquiry was not contemplated and did not factor in their decision making. For the avoidance of doubt, the decision to announce the LCSPR was not in any way intended, in whole or in part to avoid the need for a public inquiry.

vi. The Home Secretary announced the Public Inquiry on 21 January 2025. LCSAP were mindful about the public response to the incident and the subsequent disorder. The decision to announce the CSPR post sentencing, was intended to reassure the public, Lancashire CSAP were taking steps to learn from the incident and make any necessary changes to safeguarding practice to prevent a similar incident in the future.

J. The interaction between the LSCPR and the Public inquiry

i. Following the announcement of the Public Inquiry in January 2025, the LCSAP executive have been conscious of the parallel process and the potential complexities which could arise in relation to the CSPR.

ii. Given historical precedence, where Public Inquiries have taken years to conclude, the compressed timescale for the Southport Inquiry was unexpected. It placed LCSAP in the uniquely difficult position of wanting to progress with the CSPR as they had intended, but with the risk of prejudicing the Public Inquiry, if they did.

iii. Below is a summary of the many consultations undertaken by CSAP with the National Panel and Home Office to enable to come to an agreed position.

1) LCSAP Partners and the National Panel met with DfE, No. 10 Cabinet Office and the Home Office on 16 January 2025 (**CSPRP000008**). During the discussion, LCSAP and National Panel set out their roles, provided clarity on the Rapid Review and LCSPR process. It was noted in the minutes that a Public Inquiry could be a means by which multiple reviews be brought together to discern total coverage of an issue. Public Inquiries also have a role in relation to public confidence and transparency.

2) On 30 January, in discussions with the National Panel, LCSAP Partners agreed to continue to proceed with the LCSPR to identify learning for the safeguarding system, acknowledging Public Inquiries can take years to conclude and may have a different focus to the LCSPR. LCSAP informed the Home Office and Prime Minister's Office of their intention which had also been communicated publicly.

3) Annie Hudson highlighted there was a strong argument for undertaking the LCSPR even though a public inquiry had been announced. The LCSPR will provide early learning, analysis and explanation and this needed to be referenced in the Terms of Reference.

4) The discussion covered the possibility the focus of the Public Inquiry could be different to that of the LCSPR which would focus on the vulnerability of AR as a child and the systems response to him and services around the family.

5) Louise Anderson highlighted CSAP considered it important that the LCSPR captures any system learning in a timely manner, the public inquiry may take years to conclude, LCSAP could adapt and flex its approach as required but would want to manage it as business as usual as much as possible whilst acknowledging its high-profile status. (**CSPR000014_0005**)

6) At the LCSAP Executive Board on 5 March 2025, members reviewed their decision to instigate a Local CSPR in this case and agreed to continue with the commission but to have follow up discussions with both the National Panel and the Home Office.

7) On 6 March 2025, Medina Patel sent an email to Louise Holliday, lead for the development of the Terms of Reference for the Public Inquiry in the Home Office to arrange a meeting to discuss the Terms of Reference of the LCSPR and what might be planned for the Public Inquiry to minimise any potential conflict and promote synergy between the two processes.

8) Jacqui Old, as the LCSAP Executive Chair met with National Panel Chair, Annie Hudson on 13 March. Annie provided an update on the Public Inquiry and potential timescales, with both parties discussing the impact of this on the CSPR process and its timescales (**CSPRP000017**).

9) On the same day, Medina Patel sent a further email to Louise Holliday and Tim Holland (Home Office Public Inquiry team) referencing the meeting with the National Panel and the information which had been provided re the timescales for the Public Inquiry commencing. She highlighted it would coincide with the CSPR and CSAP would value an early discussion to enable them to assess the impact and consider next steps.

10) On 17 March, a meeting took place between the Home Office Public Inquiry team and Jacqui Old, to discuss the draft Terms of Reference for the Public Inquiry and the LCSPR. Tim Holland confirmed an independent chair had been appointed and details would be announced in a couple of weeks.

11) Both parties discussed the potential for duplication, likelihood of similar witnesses, timescales for each process, financial implications and the perception of the public of the cost of multiple reviews and of LCSAP reneging

on their decision to commission a LCSPR. The discussion also touched on the ongoing Prevent review by Lord Anderson. This was followed up by email communication where the terms of reference for both the CSPR and Public Inquiry were exchanged.

12) On 18 March a meeting took place between Jacqui Old and the Home Office team working on the Lord Anderson Prevent Review to understand the scope and methodology of the review and provide an update on the progress of the CSPR.

13) On 21 March, another meeting took place between National Panel and Jacqui Old to further discuss the Public Inquiry and CSPR. Jacqui advised that LCSAP were looking at options to expedite the process but were going to seek legal advice and reflect on whether to pause the CSPR or not, given the timescales of the Public Inquiry. Annie Hudson was asked to articulate a viewpoint re the CSPR for CSAP.

14) A letter was sent by the National Panel to Medina Patel dated 26 March 2025 expressing it would be wise to pause and take stock, given the pace at which the Public Inquiry was moving, the overlapping Terms of Reference, the need to avoid duplication, and the Inquiry's need to speak to some of the same witnesses. Annie Hudson recognised it would be sensible for LCSAP to reflect first on recommendations coming from the Inquiry, before concluding what further learning and analysis might be needed locally.

15) On 3 April Medina Patel emailed Tim Holland and Louise Holliday to request an update on the timeline of the Public Inquiry as the Terms of Reference had not been published by the end of March, as anticipated.

16) On 4 April, Medina Patel sent a further email to Tim Holland and Louise Holliday to advise the LCSAP Executive had been in discussion regarding the timescales of the statutory Public Inquiry and the cross over with the intended timeline of the LCSPR, highlighting the timelines, Key Lines of Inquiry, LCSPR process and methodology etc overlap with the Public Inquiry Terms of Reference, with the potential for significant duplication.

17) LCSAP were concerned about the potential risk of prejudicing the Public Inquiry by continuing with the LCSPR and in view of the exceptional circumstances, believed a meeting between the Public Inquiry chair and LCSAP Executive would be beneficial to discuss the two processes and enable LCSAP to consider next steps. This was forwarded to the Solicitor to the inquiry for their consideration.

18) Following the Public Inquiry Announcement and publication of the Terms of Reference, there was further communication from Medina Patel to Tim Holland on 8 April. Medina asked Tim to facilitate a meeting (if possible) with the Chair of the Public Inquiry or the Solicitor to the Inquiry to seek their view as to whether the LCSPR would be prejudicial to the Public Inquiry. This would assist LCSAP to make a decision as to whether the LCSPR should proceed.

19) **CSPRP000010** is the first iteration of the Terms of Reference for the LCSPR. At the time these were drafted, the timescales of the Public Inquiry were unknown. LCSAP were continuing to progress with the review and recognised the importance of maintaining contact with the National Panel and other relevant parties to appropriately coordinate and manage parallel processes.

20) At a meeting with National Panel on 30 January 2025, post-conviction and following the announcement of the Public Inquiry, it was recommended that the interface with the Public Inquiry be reflected in the LCSPR Terms of Reference. This was reflected in the updated version of the Terms of Reference (**CSPRP000006_0003**)

21) **CSPRP000016** is an email between the National Panel and the Home Office to which LCSAP have not been privy to prior to receipt of the Rule 9 request dated 5 August 2025 and therefore cannot provide comment on it.

22) **LCC001160** is a letter sent by Louise Anderson in response to an email from Sara Callon, Northwest Regional Lead, Ministry of Housing, Communities & Local Government, who wanted information on reviews being undertaken by local authorities to provide to the Home Secretary (**LCC001162**). The letter included details of the Rapid Review and that a LCSPR was commissioned to include the necessary aspects of a MHHR to avoid duplication and multiple

reviews. It provided details of who would be involved and how the review would be undertaken. It did not reference the Public Inquiry.

K. LCSAP's work to advance the LSCPR: (1) following the RRM and (2) following the conclusion of the criminal proceedings against AR on 23 January 2025

i. Following the Rapid Review work was undertaken to progress the LCSPR. Some of these actions were standard practice whereas others were in response to ongoing developments, e.g. the meeting to discuss the Terms of Reference was scheduled prior to the criminal trial outcome (we were anticipating 5 – 6 week duration) and not necessarily as a direct response to the conclusion of either the Rapid Review or trial.

ii. We detail these actions as below:

Following the RRM

1) An Action planning meeting took place on 17 October 2024 in response to the findings of the Rapid Review with multi-agency partners. A Learning Action Plan was agreed with agency leads signing off the action plan, post-meeting.

2) Commencement of the recruitment for a lead reviewer and deputy reviewer with SEN specialism. An advert and expression of interest form was shared with safeguarding leads for review, before it was disseminated to networks locally, regionally and nationally including the association of safeguarding partners ("TASP"), National Panel's Pool of reviewers, Northwest Business Managers, and reviewers who had previously led on high profile reviews. The deadline for application was set as 8 November 2024.

3) LSBU reviewed applications and sent shortlisting documents to safeguarding partner leads who discussed the preferred reviewer. Alternative options were considered for the SEN specialist as applicants did not meet the criteria.

4) LSBU worked with NHS England to support the procurement of a Mental Health specialist to lead on the MHHR aspects of the LCSPR.

5) LSBU engaged in liaison with CTP Northwest regarding their participation in the LCSPR and multi-agency coordination meeting. They confirmed they would fully participate in the LCSPR and attend the multi-agency meeting. The outcome of the Rapid Review was shared including the key lines of enquiry, decision to commission LCSPR and feedback from National Panel.

6) Multi-agency review coordination meetings between the LSBU, Merseyside Police, CTPNW and NHS England, chaired by the LSBU Senior Business Manager were arranged to take place on a monthly basis with email communication on key matters. Agenda items included:

   i. progress on recruitment of reviewers,

   ii. methodology of the LCSPR including publication considerations,

   iii. National Panel expectations,

   iv. panel representation the three agencies,

   v. timescales of parallel processes (including investigation),

   vi. information sharing and data storage considerations etc.

7) In December 2024 the Lead reviewer role was offered and accepted.

8) A SEN specialist was identified and approached to submit an application which was reviewed by Safeguarding Partners. The role was offered and accepted.

9) An Equality, Diversity and Inclusion expert was commissioned to support the CSPR as a consultant focusing on the methodology and providing constructive feedback.

10) Recruitment and HR related actions: references, contracts, provision of secure emails and storage, information governance training and individual reviewer meetings to provide a short overview of the LCSPR.

11) Engagement with CTPHQ, Prime Minister's Office, Home Office, Cabinet Office, MHCLG etc. to manage several disclosure requests and inquiries regarding the Rapid Review and LCSPR.

12) Consultation with the National Panel (**CSPRP000004**, **CSPRP000012**, **CSPRP000013**, **CSPRP000008**)

13) Consultation with Warrington Safeguarding Childrens Partnership as to how they managed their high profile LCSPR (Child Scarlett)

14) Liaison with Sefton Safeguarding Childrens Partnership

15) It was standard practice for LCSAP to appoint a chair from within the safeguarding system who was independent of the case. Partners agreed this would be a Head of Service within Childrens Social Care. The LSBU engaged

with him regarding the Terms of Reference and agenda of the first panel meeting.

Following the criminal trial

16) Continuation of consultation with the National Panel to discuss the LCSPR progress, Terms of Reference and implications of the Public Inquiry including the timeline focus, family engagement, Equality, diversity and Inclusion considerations, key lines of enquiry, Mental health interface in LCSPR etc (**CSPRP000006**).

17) Conclusion of the NHS England Mental Health Reviewer recruitment (February 2025)

18) Further multi-agency coordination meeting (outlined above at §3K(ii)(6))

19) Liaison with Sefton Safeguarding Childrens Partnership

20) Liaison with Merseyside Police SIO re family engagement

21) Correspondence to families and victims re the LCSPR

22) Initial discussion re the Terms of Reference and introduction with lead reviewer and deputy Delegated Safeguarding Partners ("DSPs").

23) Following a recommendation from the National Panel (**CSPRP000006-0003**), LCSAP recruited a suitably experienced chair, independent of the Lancashire Safeguarding system, set them up on the system and other administrative necessities.

24) Dissemination and review of the Prevent Learning Review, National Panel Race report and its interface with the LCSPR Key Lines of Enquiry ("KLOE").

25) Working with the lead reviewer and chair to prepare and convene scheduling the first panel meeting.

26) Ongoing monitoring and progression of the Rapid Review action plan.

27) Pre-meet with reviewers, chair, Deputy DSPs to further discuss the draft Terms of Reference and KLOE, finalise the scope and timeline etc.

28) Discussion with the chair and lead reviewer to draft up a bespoke template for this CSPR which would be based on Incident management reports ("IMRs") and enable partners to build on the initial multi-agency chronology prepared for the Rapid Review and have improved analysis of the learning and development areas and identified good practice.

29) Meetings with both the Home Office Public Inquiry Team and Lord Anderson Review team.

30) Discussions with each reviewer re reflective supervision and wellbeing support

31) Finalisation of the CSPR Terms of Reference and methodology

32) Establishing an MS Teams Channel for communication, information sharing etc.

33) Meetings with the LCSAP executive to discuss the impact of the Public Inquiry timescales on the CSPR and consider next steps.

34) Letters drafted relating to the decision to pause the LCSPR including the rationale, before being sent to the Home Office, National Panel, Public Inquiry etc.

L. The draft terms of reference for the LSCPR

i. The LSBU have a standard template for LCSPR Terms of Reference which is updated to be reviewed dependent on the circumstances and requirements. An initial version was drafted in February (**CSPRP000010**) before being updated in March ahead of the first panel meeting.

ii. The Rapid Review had already identified areas of learning within this case, which were being explored through other LCSPR's and practice development and therefore the Rapid Review panel identified the four themes requiring exploration within the LCSPR (as at §2H (iv) above)

iii. The lack of information on the Prevent referrals from Counter Terrorism Police Northwest and their non-engagement in the Rapid Review process made it difficult for the Rapid Review panel to understand and assess what work was undertaken and if there was any learning which could improve the response from local agencies and the wider safeguarding system.

iv. Partners agreed the timeframe for the LCSPR should start from January 2019 up to the date of the attack, with agencies invited to partake in the review from both Lancashire and Sefton. The LSBU would lead on the recruitment to appoint a suitably experienced reviewer.

v. Due to requirements for anonymisation, LCSAP designated AR as "Child Brian" as the pseudonym for this LCSPR.

vi. The lead reviewer drafted up a proposal for discussion with the Deputy DSPs (**LCC001666**).

vii. By 6 March 2025, when LCSAP leaders met with the reviewers and the independent chair, to discuss the Terms of Reference and methodology, they were in a different position to when the Rapid Review had taken place. Additional information was available through the publication of information post-trial including the Prevent learning review: Southport attack and the announcement of the Public Inquiry.

viii. LCSAP wanted to have an open and transparent process to draw out meaningful systemic learning that would make a difference in our engagement with children with a similar profile to AR by focusing on his lived experience as a child in the system. We know there are children with similar needs, complexity, ideology who carry weapons or have an intense interest in serious violence and want to explore if the risk and vulnerabilities are sufficiently understood by partners and appropriately responded to.

ix. Lengthy discussions took place on the timeframe of the review and if it would be from 2019 or going back to when AR was a child in Cardiff. We agreed to focus on critical incidents in his history, how the risk evolved and was understood, signs regarding neurodiversity etc.

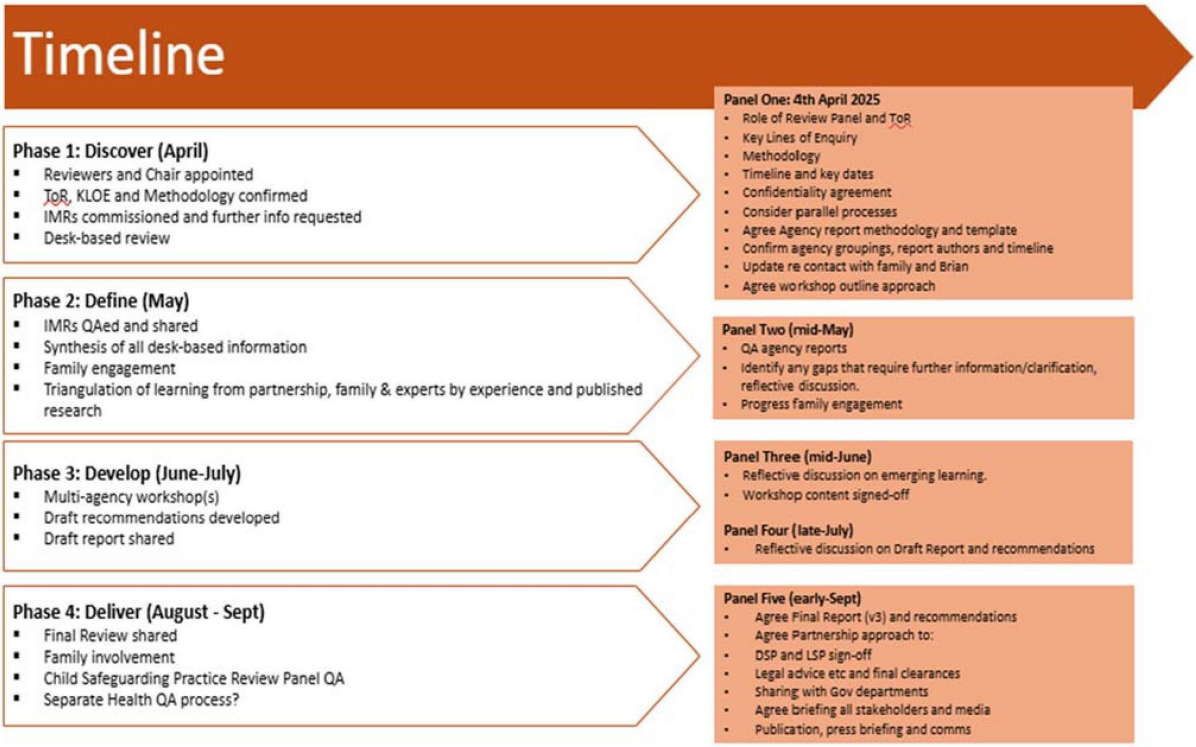
x. Reviewers were asked to take into account, feedback and recommendations from the National Panel for inclusion in the Terms of Reference and scope of the review.

xi. Following the meeting, the lead reviewer drafted up *Child Brian High Level KLOE Methodology v2* and sent to partners for feedback. The review principles would be a whole system approach with EEDI (Equality, Equity, Diversity & Inclusion) at the heart of it, restorative, relational and strength based.

xii. Within the document she simplified the Key Lines of Enquiry into:

    a. How well were Child Brian's complex and intersecting vulnerabilities in relation to neurodiversity and Special Educational Needs (including his Social Emotional and Mental Health needs) understood and responded to across universal, targeted and specialist levels of support and intervention?

b. Was his developing intense interest in violence sufficiently understood and responded to in an evidence-informed way?
c. (How) were the levels of need and risk understood and responded to across the partnership in relation to Child Brian?
d. Were single and multi-agency assessments (1) sufficiently robust and (2) used effectively to inform interventions?
e. What approach was taken to understanding how to best engage to Child Brian and his family with help and support?
f. Was Child Brian's intersectional identity, and experiences as a Black, neurodiverse, boy, sufficiently well recognised and responded to?
g. Was there an effective whole-system approach to working inclusively and in partnership with his parents and wider support networks?
h. The methodology spanning February - September 2025, would have four distinct phases:
    i) Discover – establishing the facts of the events / case history
    ii) Define – synthesis of the initial learning within the wider local context
    iii) Develop – test and challenge draft findings
    iv) Deliver – a final version of the report with recommendations and executive summary.



i. It was intended that the Terms of Reference and methodology would be formally signed off at Panel 1 after being disseminated and reviewed by panel members.

M. The MHHR being incorporated within the LSCPR

i. The circumstances of the Southport incident met the criteria for an independent MHHR to be undertaken by NHS England (as outlined above at §2K(v)).

ii. In recognition of the issues, multiple reviews could create i.e. duplication and cost of several parallel processes, impact on families and practitioners etc, discussions took place between the LCSAP Executive, NHS England and the National Panel. Following these discussions, it was agreed that in lieu of a separate MHHR, the CSPR would incorporate this element, with NHS England recruiting an independent expert consultant to support the LCSPR independent reviewer.

4. The decision to pause the LSCPR

A. Why the CSPR process was paused

i. LCSAP Partners held a meeting on 27 March 2025, to discuss if they should continue with the LCSPR. The decision to pause and reflect on the outcome of the Public Inquiry before deciding if they will resume or not, was not an easy decision for LCSAP to make with several meetings between themselves, consultations with the National Panel and legal advice being sought. LCSAP considered the following before reaching this decision:

1) The risk of continuing with the process prejudicing the Public Inquiry which takes precedence over the CSPR
2) Agencies may need to present evidence to the Public Inquiry which could impact on the dynamics of the LCSPR
3) The CSPR methodology requires consultation with practitioners. Due to the Public Inquiry there were concerns staff may have or request legal

representation in these meetings which is contrary to the LCSPR process and may hinder transparency and openness.

4) Concerns agencies would require legal oversight of IMRs.

5) Level of duplication of the two processes and the implication on the public purse.

6) Learning being implemented following Rapid Review and single agencies were looking at their own agency actions, with internal reviews ongoing.

7) Prevent wasn't part of the Rapid Review but the Prevent learning review was published in February and Lord Andersons review was due to be published in June with agencies considering how to respond to them.

ii. In terms of the MHHR, NHS England supported the decision to pause. LCSAP sent correspondence to the Home Office, National Panel and Public Inquiry to inform them of their decision to pause the LCSPR citing the above considerations, its discussions with National Panel and legal advice as the rationale for this decision:

B. Input from other agencies in respect of this decision

i. The decision to pause the LCSPR was taken after several meetings with the National Panel and Home Office. There was consultation with NHS England regarding the MHHR. A view from the Public Inquiry Chair was also sought by LCSAP (§3J(iii) (17-18) above and §4D (i) below) and Legal advice.

C. Reflection following the announcement of the Public Inquiry

i. **CSPRP000017** is an email summarising a meeting between the National Panel and LCSAP on 13 March 2025. During that meeting, it was communicated to LCSAP that the Public Inquiry would be proceeding at a much quicker pace than had been previously anticipated and would cover similar areas to the LCSPR. In response to this and the complexities arising as a consequence, Louise Anderson is recorded as stating that "*on reflection if they* [LCSAP] *could turn back time they would probably not have announced the local review*".

ii. LCSAP did not necessarily regret their decision to announce the LCSPR however did have concerns regarding the effect of the Public Inquiry on the LCSPR (as outlined above at §4A) and it reaching a decision to pause the LCSPR. LCSAP was mindful of

the impact of this decision on victims and families, who may not understand its rationale to pause and would therefore be upset by it. Withdrawing or pausing the LCSPR risks the perception that LCSAP are not fulfilling promises and risked undermining public confidence in the system

D. The delay to announce the pause of the LSCPR

i. There were several factors that caused LCSAP to delay its announcement of the decision to pause the LCSPR as outlined below:

1) In early April 2025, following the announcement of the Public Inquiry Terms of Reference, LCSAP reached out to the Public Inquiry to try and obtain a viewpoint from the Chair regarding the potential of the LCSPR to cause prejudice the Public Inquiry. The Solicitor to the Inquiry, Caroline Featherstone discussed this with Medina Patel in a phone call on 7 May 2025, and whilst she could understand the rationale for the decision to pause the LCSPR she advised that she would bring this to the attention of the Chair when he returned the week after and provide a response. No further response on this point was however received. This is not intended as criticism of the Inquiry but included as one of the factors as to why LCSAP delayed the announcement.

2) Legal advice was being sought in relation to the letters drafted.

3) The LSBU were engaging with Merseyside Police regarding the correspondence with victims and families who we felt needed to be informed first. We were concerned that sharing the information with multiple agencies could risk it being leaked and did not want the families to find out in this manner. We were also mindful of taking into account any sensitivities re timings and ensuring families were contacted in the most appropriate manner.

4) We were initially asked by Merseyside Police to hold off on sending the letters as they were waiting for the Family Liaison Officer ("FLO") to return to update the families. The last communication sent by Merseyside Police had informed the SIO that it would be preferable to send communication to the solicitor(s)

representing the families. He also highlighted that the families did not want to see AR's name written down.

5) Sefton Partnership also flagged up some consideration re the timing due to a number of personal and sensitive issues that the families were dealing with at that time. The Prime Minister had also written to all the families that week, so they had had a lot to take in/deal with.

6) Further communication took place to obtain details of the families (who had consented to have their details shared) so each letter could be personalised. It was agreed others would have the correspondence sent via other means:

    a) A letter to bereaved families was sent via their solicitor.

    b) A letter for 1 adult was sent via their solicitor as they were not responding to police correspondence and had not given permission.

    c) 2 of the adults were sent the letters directly by the LSBU.

    d) Letters were sent directly to 14 families by the LSBU.

    e) 2 of the children were linked to police officers so Merseyside Police handed over copies of the letter.

    f) For 3 of the children, letters were sent via the FLO.

5. Implementation of the RRM Action Plan

A. Implentation and LCSAP's oversight of the RRM action plan

i. An Action planning meeting took place on 17 October 2024 in response to the findings of the Rapid Review with multi-agency partners. A Learning Action Plan was agreed with agency leads signing off the action plan, following that meeting.

ii. The LSBU monitored the progress with agencies requested to send updates on their actions. Lancashire and Sefton DSPs have had oversight of their single agency learning and internal actions and monitored progress with providers.

iii. Alder Hey Childrens Hospital NHS Foundation Trust ("Alder Hey") have transferred all actions from the Rapid Review to their internal learning review terms of reference. Reassurance was received from Cheshire and Merseyside ICB that Alder Hey's internal review has been extended to July and will go through a period of sign off and internal review before being shared as part of the Rapid Review evidence. Alder Hey have submitted some evidence to date. It was agreed any evidence will need to be clearly labelled against corresponding actions contained in the action plan on future submissions. This will support Lancashire and Sefton DSPs with monitoring and oversight of Rapid Review Action Plan. Monthly assurance meetings are in place.

iv. Agencies have provided evidence of completed actions to assure both CSAP and the Sefton Safeguarding Children Partnership of their implementation.

v. On 16 July 2025, a half day meeting in person was held at County Hall in Preston with leaders from both safeguarding partnerships to go through the Rapid Review action plan, the evidence provided for completed actions and updates to ongoing actions (as detailed below §5B).

vi. It is accepted that the action plan is in response to the Rapid Review and accordingly, the information as known in August 2024. Had the LCSPR been undertaken this would have provided an opportunity for agencies to update on the progress of those actions, any internal reviews or other relevant information that had subsequently become available. It would allow a 'deeper dive' into the safeguarding practice to identify any further learning and recommendations, and this would be reflected within the LCSPR report.

B. Summary of the actions and their status:

The following actions have been marked as completed with supporting evidence or assurance:

i. <u>Information Sharing & Governance</u>

1) <u>LCC Child and Family Wellbeing Services ("CFW") were to review the current process by which minutes are received by all relevant parties following multi-agency meetings led by the service</u>

A review was undertaken of the system-based sharing arrangements for Team around family ("TAF") meeting notes that are built into LCC's Early Help Module (Liquid Logic system). These are clear, operable and robust. Advice and guidance on TAF meeting requirements have been shared. Specific focus on this has been enhanced within the multi-agency training courses delivered from Autumn 2024 onwards, specifically the 'Early Help Assessment - principles and approaches 2-day training course' and the 'Early Help lead professional and TAF roles and responsibilities' Half day course.

2) Lancashire Constabulary were to compare the referrals to Children's Social Care ("CSC") Improvements to Operation Encompass referrals (a programme designed to support children who are the victim of domestic abuse – ensuring schools have timely information as to Police-attended incidents of domestic abuse) so as to understand whether improvements to information sharing could be made

Training and quality assurance is in place. Lancashire Constabulary is a pioneering force in this area. Improvements to the Operation Encompass process are ongoing and with IT to amend field options which will prevent officer error, incorrect destinations for referrals and subsequent administrative delays. Enhancements to include 'Early Years' and 'NEET' children in progress.

3) GP information pathways to be reviewed and strengthened

Sefton Health visitors and School nursing service jointly complete the Memorandum of Engagement document in partnership with their link GP surgery. This details the expectations from the 0-19 service and how they will communicate with each individual GP practice regarding child safeguarding concerns and information. Agreements are bespoke for each practice and will be agreed on an individual basis. Every GP practice has a Memorandum of Engagement in place. Mersey Care endeavours to update them annually to ensure they are still meeting the needs of GPs and 0-19 years services. Sefton GP practices have access to the child health records completed by the 0-19 service which supports information sharing.

4) A Prevent/radicalisation alert was included in the records as a 'managed' alert. This coding alert could not be audited to support oversight of prevalence of patients with this vulnerability factor registered with the GP practice

A review of coding alerts in respect of Prevent/ radicalisation has been undertaken within the practice. Coded alerts are reviewed monthly and a list is downloaded to support oversight including any demographic changes or missed appointments. This now includes coded alerts in respect of prevent/ radicalisation. Implemented changes in respect of coding will be shared via Cheshire & Merseyside ICB Safeguarding Newsletter for Primary Care to support wider learning at Sefton Place on the use of managed/ coded alerts.

Assurance was sought on the levels of Prevent training compliance across Cheshire & Merseyside ICB and Sefton facing health services (November 2024). The Sefton health services involved in this review evidence >90% compliance against the required Prevent training offer. All GP practices are compliant with training. A Prevent 'lunch & learn' webinar for primary care had been delivered in June 2024.

5) Primary Care do not routinely get informed of a child who has an EHCP plan, although in Sefton, the GP does have access to the plan should parents inform them. A Sefton GP would not have access to EHCPs held by another local authority due to other areas having differing child health systems

A scoping summary was completed on the notification of EHCPs to GP's /Primary Care in Sefton and their access to EHCPs. Initial learning has been shared with the Designated Clinical Officer (DCO) for discussion at Cheshire & Merseyside SEND Collaborative Unit. An EHCP briefing to raise awareness has been sent to all GP practices (December 2025) and reiterated at GP Safeguarding Leads meeting in January 2025.

ii. Record Keeping

1) Alder Hey were to explore the delays in documentation in the electronic patient record and the reasons for this, i.e., training, access to equipment, multi-agency information sharing

Alder Hey have developed a record keeping Standard Operating Procedure (SOP) and audits are in place.

2) Missing LCC Childrens Social Care Child in Need meeting minutes in 2020

Lancashire Children's Social Care record keeping has improved and audits confirm compliance. Since 2020 practice has changed significantly. Monthly Learning Spaces (audits) and regular dip sampling take place. The quality of record keeping is reviewed as part of the process and has not emerged as an area for improved practice over the last 12 months. Statutory meeting minutes are consistently on children's records. In Quarter 4 2025 101 learning spaces were completed. Statutory meeting minutes were also recorded on children's files.

3) LCC Adult Social Care to ensure cases are allocated in appropriate timescales for the identified service

Allocation guidance has been implemented. A Managers Handbook has been introduced that includes comprehensive allocation guidance which has standardised the allocation process across all teams. The RAG (Red, Amber, Green) rating system has been operationalised across all teams, allowing the identification of those most at risk and prioritise their cases effectively. To support individuals waiting for services, a "Waiting Well" framework has been implemented which ensures the well-being of those waiting for support by maintaining regular contact and monitoring any changes in their needs". There has been a reduction in 'Red' cases being waiting to be allocated.

iii. Professional Disagreement & Supervision

1) LCC Education team to highlight the professional disagreement and escalation policies directly with schools to ensure understanding of the policy.

The escalation policy has been widely shared with schools via the DSL portal, newsletter, education bulletin, the headteacher briefing on teams etc. It is included in the DSL handbook which was shared with all DSLs in September 2024 and given out on the School Advice line. Education receives regular updates on the escalation policy and contact details for CSC managers. DSL's will appropriately escalate concerns to Team managers, Senior managers and Heads of Service.

2) Alder Hey to complete a Trust wide review of safeguarding supervision arrangements.

Alder Hey safeguarding supervision arrangements have been reviewed and shared with the Chief Nursing & AHP Officer for agreement of next steps. Their internal review includes discussions with practitioners.

3) LCC to offer monthly supervision to all Adult Social Care Social Workers and any delays in identified actions to be addressed by the next supervision.

Monthly supervision embedded in Adult Social Care. Roll out of additional supervision training for managers commenced in January 2025 and is ongoing. The Supervision Policy outlines the requirement for supervision to be held monthly. Heads of Service utilise the supervision dashboard to ensure supervisions are being held monthly, as required. The Quality Team undertook a further audit on supervision frequency and quality is in line with the Supervision Policy.

iv. Multi-Agency Working

1) All agencies were to cascade information about the importance of attending EHCP review meetings.

HCRG Care group (provider of 0-19 providing school nursing in Lancashire): work closely with Designated Clinical Officer (DCOs) and cascaded information (June 2024) on the importance of timeliness and quality of information sent to DCOs to inform EHCP plans. HCRG have SEND champions in place who hold monthly meetings and meet regularly with DCOs across Lancashire. The SEND champions are in place in all localities and several members of staff have received additional training from the DCOs to quality assure the EHCP health information being shared with DCOs. The 0-19 service audited the new agreed process in relation to information sharing to ensure it is adhered to (January 2025). The audit of this process and of the quality of EHCP information shared will take place on an ongoing quarterly basis

Child Youth Justice Service ("CYJS"): Messages were raised in management meetings and added to the work development plan to ensure staff are proactive in terms of the importance of attending reviews. CYJS will consistently attend the meetings and provide quality contribution to the assessment/review process. CYJS inform the relevant schools when a child is open to service. The information sharing request form sent by CYJS to the school has been updated to request information regarding the EHCP assessment date and/or date of the next EHCP review. In addition, CYJS have included a request to be invited to relevant ECHP assessment/review meetings. CYJS practitioners have been reminded of the

importance of attending EHCP reviews and following up with schools to ensure they are invited to review meetings.

Lancashire South Cumbria Foundation Trust ("LSCFT"): A Trust wide bulletin was circulated in November to reflect the importance of health professionals attending a child's annual EHCP review. The September 2024 SEND bulletin was issued and circulated Trust wide, which highlighted the SEND Policy and Procedure and is available on the LSCFT Trust intranet. The Policy and Procedure refers to attending and/or submitting updates for annual reviews on pages 12 & 13. A SEND basic e-learning module is available on LMS-X, referencing and providing e-links to the SEND code of practice. Enhanced children in care Nurses have incorporated a SEND slide into their training that is delivered to LSCFT health professionals and also circulated a 7-minute briefing to reiterate the importance of completing the EHCP health advice and attendance at SEND meetings.

Merseycare: A SEND (including EHCP) 7-Minute Briefing was circulated to all Sefton Children and Young People ("CYP") team managers on 1 October 2024, this was then cascaded to all practitioners within the service, including narrative to reinforce the importance of attendance to EHCP meetings.

Cheshire & Merseyside ICB (Sefton Place): Sefton and Liverpool have SEND Health Partnership group meetings monthly, which provides opportunity to share information, challenge progress and share best practice. Forums are available to ensure key messages and learning, and best practice is shared across health system. Promotion of monthly DCO training sessions to support overview of SEND, DCO role and EHCPs within Sefton. DCOs attend, as required. SEND Champions meetings take place in both AHCH and Mersey Care to reinforce key messages. SEND partnership training and resources disseminated.

v. Professional Curiosity

1) To raise awareness and curiosity across the workforce relating to vulnerable children who demonstrate an intense interest in violence and children who may be accessing harmful material on the internet.

The family safeguarding approach has since been implemented across LCC children's services. This approach magnifies the voice of children and parents significantly and

works more holistically to meet need. Education and children's social care professionals have been given practice tools and guidance on online safety for children and young people to use in their work to raise their awareness and ability to be curious about what children and young people are viewing on-line. They have received updated resources on serious youth violence and Prevent. A programme of lunch and learn sessions has been launched for CSC and CFW staff on online safety. This training will inform risk assessments going forward.

Staff have tools and access to Practice Development Managers to support their work with children who may be at risk of harm due to the content they are exposed to on the internet. Evidence of impact will be gathered through quality assurance arrangements. Information has been disseminated to schools about the range of training they can access on these subject matters from both Prevent and the Violence Reduction Network.

2) To incorporate professional curiosity training and awareness in all multi-agency training delivered by the partnership.

CSAP Professional curiosity embedded in training, webinars, and case review workplan with resources added to CSAP website. Professional Curiosity is a cross-cutting theme included in learning briefs and learning from review webinars.

vi. Voice of the Child & Lived experience

3) LCC to explore training to improve practitioners awareness about what can help to engage children with neurodiversity needs and enable reintegration within schools and their community

LCC CSC have delivered training to their workforce to improve practitioners' awareness about what can help to engage children with neurodiversity needs and enable reintegration within schools and their community. A Practice week on Neurodiversity was held which addressed the areas of learning identified in this review and included specialist in the subject with briefings available to staff via an MS teams Channel. The Specialist Teaching Service run courses linked to the Autism Education Trust on neurodiversity and these provide a basic understanding as well as more sophisticated information.

The training offered around Autism is now offered more frequently. In addition, the education service provides bespoke INSET for schools on SEND at their request. A range of autism training is available for all staff. The current programme offer is promoted in weekly briefs. The take-up of this is now being monitored to ensure all staff have completed the basic level training by the end of May 2025.

4) The attendance and placement at AR's specialist placement and at the Pupil Referral Unit ("PRU") should have been more regularly reviewed and other provision or enhanced provision sought more quickly that met his needs

The Alternative Provision ("AP") quality assurance officer and AP lead are now in place to create a wider catalogue of specialist support available and discuss with PRU's their most vulnerable pupils more regularly. Daily attendance data from most of our independent settings enables a dip in attendance to be followed up quickly. Recruitment of more case managers will allow more time to review placements, attend annual reviews where necessary and seek suitable provision.

Reintegration from PRU's back into mainstream settings and their placements are reviewed at least termly, poor attendance is followed up with a discussion about whether the placement is suitable and putting in more section 19 (of the Education Act 1996 which mandates local authorities to arrange suitable education for children who cannot attend school due to illness, exclusion, or other reasons) provision to ensure children are receiving a suitable education.

There has been a decrease in children who are CME (under 800); A decrease in children on part time tables (reduce to 2%); and a decrease in children persistently absent (reduce to primary 16%, secondary 24.5%)

The following actions are still in progress or under review:

vii. Information Sharing & Governance

5) Revision of the Children and Adults Safeguarding, Overarching Tier 1 Data Sharing Agreement for Pan-Lancashire partners, followed by awareness raising and training to

reiterate good practice and enhance the confidence of practitioners to share information in a timely and proportionate manner.

A refreshed Pan-Lancashire Information Sharing Agreement is in final draft to be launched in September, with webinars and 7-minute briefings to improve frontline staff confidence and multi-agency practice in information sharing. An initial staff survey undertaken by Lancashire CSAP showed low confidence so a follow-up survey will be planned post-webinars to evidence impact.

6) Alder Hey to review and understand how staff across the Trust access all of the information held about CYP across multiple electronic patient record systems and whether this has led to some practitioners not having a complete holistic picture of the whole clinical pathway of AR.

Alder Hey's internal review on patient records access underway with evidence submission ongoing.

viii. Record keeping: Childrens Social Care Plans

7) LCC CSC and partners to review systems to ensure all agencies have the most up to date care plan for the child following the meeting

Audit Findings showed mixed compliance. Improvements have been implemented, i.e. the administrative process now mirrors Child Protection plan distribution. The department is developing an electronic solution that will be able to automatically share plans with partners through the Children's Portal that is being added to the electronic children's record system in May 2025. It has begun in MASH with a wider launch to other areas of the directorate to be undertaken after September.

As of 13 June 2025, a new system and process was developed whereby all completed CiN review meetings (initial and review) send an alert to a business support monitored tray. From here, business support are picking up the records and sending out to all who have attended the meetings and case recording such so that we have a clear record. Information has been cascaded through the workforce

Partners consistently have a copy of Child Protection plans. Most CiN plans are sent to partners. This will continue to be monitored through dip sampling.

8) Alder Hey to explore why there is no record of the Early Help or CiN plans in the electronic patient records.

Record keeping has been included in the terms of reference of the Trust internal review which is ongoing.

ix. Multi-agency working

9) All agencies were to cascade information about the importance of attending EHCP review meetings.

Lancashire and South Cumbria ICB: ICB Commissioning Intentions were published earlier this year and include the roll out of a Service Specification for all health providers. This service specification will include clear governance, quality assurance and reporting of the entire EHCP process including annual reviews. The specification is being co-produced with providers and the first workshop of 3 has been held. The timeframe for this being rolled out is April 2026. The training has been updated and is offered on a rolling basis to all NHS providers which specifically references the importance of the EHCP process and the need for health services to engage. The ICB has stepped up a workstream specific to Primary Care which is looking at rolling out a SEND handbook to all practices. Alongside this the DCO team have met with the Primary Care team in the ICB and attended a Primary Care event to talk through the impact and expectations of practices in contributing and receiving EHCP's. The ICB is working with Hitachi on developing an AI digital programme to support the collation of Health Advices from all NHS services and the dissemination of EHCP's to all relevant health practitioners.

10) Alder Hey to explore how decision making was communicated to wider multi-agency partners (e.g., acceptance of referrals, discharge from service, changes of practitioner etc).

Alder Hey is reviewing communication of decisions to partners within its ongoing internal review.

x. Voice of the Child & Neurodiversity

11) Alder Hey to explore the issues arising in relation to ARs disengagement from Sefton CAMHS and how his voice could have been better captured.

Alder Hey reviewing engagement and voice of AR within its ongoing internal review.

12) LCC to explore training to improve practitioners' awareness about what can help to engage children with neurodiversity needs and enable reintegration within schools and their community

An E-learning autism course has been made mandatory for all social care staff to complete by September 2025. Neurodiversity training delivered; Confidence survey to be scheduled for post training. The long-term goal is to embed training into business as usual and align with public inquiry findings.

xi. Alternative Provision (AP) review process

13) The attendance and placement at AR's specialist placement and at the PRU should have been more regularly reviewed and other provision or enhanced provision sought more quickly that met his needs

Reports are now available which enable greater understanding i.e. data on CME (Children Missing in Education). These are integrated into LCC systems but further work is to be completed by September 2025.

xii. Policies & Procedures

14) Alder Hey to explore if prescribing of medications was in line with Trust policy.

Alder Hey reviewing prescribing practices within its ongoing internal review.

Statement of Truth

I believe that the facts stated in this witness statement in so far as they relate to Lancashire County Council are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: **Signature**

Name: **Jacqui Old**

Dated: 02.09.25

Statement of Truth

I believe that the facts stated in this witness statement in so far as they relate to Lancashire Constabulary are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: **Signature**

Name: **Mark Winstanley**

Dated: 02.09.25

Statement of Truth

I believe that the facts stated in this witness statement in so far as they relate to NHS Lancashire and South Cumbria Integrated Care Board are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: **Signature**

Name: **Jane Scattergood**

Dated: 02.09.25